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IN REPLY REFER TO
COMNAVSURFPACINST 6000.1/
COMNAVSURFLANTINST 6000.1
N01H
6 Mar 14

COMNAVSURFPAC/COMNAVSURFLANT INSTRUCTION 6000.1

From: Commander, Naval Surface Force, U.S. Pacific Fleet
Commander, Naval Surface Force Atlantic

SUBJ: SHIPBOARD MEDICAL DEPARTMENT PROCEDURES MANUAL

Encl: (1) Shipboard Medical Department Procedures Manual

1. Purpose. To establish policies for the operation of Medical Departments within the Surface Forces.

2. Cancellation. COMNAVSURFORINST 6000.1.

3. Scope. This manual applies to all Medical Departments under Commander, Naval Surface Force, U.S. Pacific Fleet (COMNAVSURFPAC) and Commander, Naval Surface Force Atlantic (COMNAVSURFLANT).

4. Administration. COMNAVSURFPAC and COMNAVSURFLANT are responsible for the administration and update of this instruction.

5. Action. Ensure widest dissemination and implementation of this instruction.

6. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per Secretary of the Navy (SECNAV) Manual 5210.1.

D. M. NASHOLD
Chief of Staff

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Chief of Staff

Distribution:
Electronic only, via COMNAVSURPAC Directives Web site,
https://cpf.portal.navy.mil/sites/cnsp/Pages/Directives.aspx

COMNAVSURFPACINST 6000.1/
COMNAVSURFLANTINST 6000.1
6 Mar 14

SHIPBOARD

MEDICAL

DEPARTMENT

PROCEDURES MANUAL

PUBLISHED BY:
COMMANDER, NAVAL SURFACE FORCE, U.S. PACIFIC FLEET
AND
COMMANDER, NAVAL SURFACE FORCE ATLANTIC
(N01H) FORCE HEALTH OFFICES

Enclosure (1)

Table of Revisions/Changes

COMNAVSURFPACINST 6000.1/ COMNAVSURFLANTINST 6000.1	Basic Consolation and Re-issuance Date

Change Number	Revision Date

EXECUTIVE SUMMARY

While the directives and the information the Shipboard Medical Department Procedures Manual (SMDPM) are not all encompassing, they address the common medical administrative situations and issues encountered by Medical Departments within the Surface Forces.

This instruction is a complete revision from the previous guidance and should be reviewed in its entirety. Since medical policy and procedures evolve dynamically causing medical instructions to change frequently, each Medical Department is expected to post such changes as they are issued.

The SMDPM has been designed to replace many ship-specific instructions and may be adopted verbatim, with a minimum of additions, to compensate for varied ship types. As such, Medical Department personnel will use this instruction supplemented by the various references listed within this manual for the basic operation of their departments.

Forward recommended changes to this instruction to:

Pacific Fleet Command	Atlantic Fleet Command
COMMANDER NAVAL SURFACE FORCE US PACIFIC FLEET FORCE HEALTH OFFICE 2841 RENDOVA ROAD SAN DIEGO CA 92155-5490	COMMANDER NAVAL SURFACE FORCE ATLANTIC FORCE HEALTH OFFICE 1430 MITSCHER AVE NORFOLK VA 23551-2494

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Ref: (a) BUMEDINST 1520.34A, Continuing Education Programs for Medical Corps and Nurse Corps Officers
(b) BUMEDINST 6320.66E CH-4, Credentials Review and Privileging Program
(c) BUMEDINST 6440.5C, Health Services Augmentation Program (HSAP)
(d) COMNAVSURFOR MSG DTG 111532Z MAY 06, Policy on Employment of Medical Personnel on VBSS Teams
(e) COMNAVSURFORINST 5400.1, Naval Surface Forces, Force Regulations
(f) COMFLTFORCOMINST 6600.1, Dental Standard Operating Procedures (SOP) for Operational Units
(g) COMNAVSURFPAC/COMNAVSURFLANTINST 3502.3, Surface Force Readiness Manual
(h) COMNAVSURFPAC/COMNAVSURFLANTINST 6000.2B CH-1, Medical Readiness Inspection Program
(i) COMNAVSURFPAC/COMNAVSURFLANTINST 6320.2, Health Services, Credentials Review/Privileging and Quality Assurance Programs
(j) COMNAVSURFPAC/COMNAVSURFLANTINST 6400.1, Training Certification, Supervision, and Employment of Independent Duty Corpsmen (IDC) in Commander Naval Surface Forces Pacific (CNSP) and Atlantic (CNSL)
(k) COMUSFLTFORCOM/COMPACFLTINST 6320.2B, Credentials, Review and Privileging Program
(l) COMUSFLTFORCOM 6820.1B/COMPACFLTINST 6820.1A, Medical Professional Books, Publication, and Instructions
(m) NAVMED P-117, Manual of the Medical Department (MANMED)
(n) NAVMED P-5055, Radiation Health Protection Manual
(o) NAVPERS 15560D, Naval Military Personnel Manual
(p) Navy Warfare Publication (NWP) 4-02 Jan 08, Naval Expeditionary Health Service Support Afloat and Ashore
(q) OPNAVINST 3120.32D, Standard Organization and Regulations of the U.S. Navy
(r) OPNAVINST 6100.3, Deployment Health Assessment Process
(s) OPNAVINST 6320.7A, Health Care Quality Assurance Policies for Operating Forces

(t) OPNAVINST 6400.1C, Training, Certification, Supervision Program, and Employment of Independent Duty Hospital Corpsmen (IDCs)
(u) SECNAVINST 5210.8, Department of the Navy Records Management Program
(v) SECNAV M-5210.1, Department of the Navy Records Management Program, records Management Manual
(w) SECNAVINST 5216.5, Navy Correspondence Manual
(x) SECNAVINST 6120.3 CH-1, Periodic Health Assessment for Individual Medical Readiness
(y) United States Navy Regulations 1990

SECTION 1 – INTRODUCTION

1. Shipboard Medical Department Procedures Manual. The Shipboard Medical Department Procedures Manual (SMDPM) provides guidance and direction for Medical Department personnel assigned to the Surface Forces.

2. Surface Force Healthcare System. The goal of this health service system is to promote health and wellness, increase medical readiness, and provide optimal healthcare to the fleet. The Type Commander (TYCOM) has ultimate responsibility for attaining this goal.

3. Acronyms. Appendix A contains a list of acronyms used in this instruction.

4. References

a. References are listed at the beginning of each chapter for further guidance and clarification.

b. Each Medical Department will maintain the materials listed in reference (l).

SECTION 2 – ORGANIZATION AND RESPONSIBILITIES

1. TYCOM/Immediate Superior in Command (ISIC)

a. TYCOM Force Surgeon. Commander, Naval Surface Force, U.S. Pacific Fleet (COMNAVSURFPAC) and Commander, Naval Surface Force Atlantic (COMNAVSURFLANT) Force Surgeons are the senior Medical Corps Officers for Surface Forces.

(1) The Force Surgeons are the special assistant and principle advisor to their respective TYCOMs for all healthcare issues, and the staff advisor to the subordinate commands. The Force Surgeons provide professional oversight and expertise in shaping the surface force healthcare system, formulation of policy, and measured assessment to assist COMNAVSURFPAC/COMNAVSURFLANT in achieving a combat ready, responsive and flexible Surface Force.

(2) The Force Surgeons are assisted by a healthcare team, which may include Medical Corps, Nurse Corps and Medical Service Corps officers and senior enlisted staff professionals that provide health services leadership.

(3) Coordinates Health Services Augmentation Program (HSAP) training for Casualty Receiving and Treatment Ship (CRTS) platforms in accordance with reference (c).

(4) Medical Readiness Division (MRD) located in heavy fleet concentrated areas of San Diego, Norfolk and Mayport are reportable to the respective TYCOM Fleet Surgeon; MRD San Diego to COMNAVSURFPAC, MRD Norfolk and MRD Mayport to COMNAVSURFLANT.

(a) These units will have the same responsibilities listed in sections 2.c. and 2.d.

(b) Conduct a Safe-to-Sail inspection on all new pre-commissioned vessels utilizing Appendix B prior to sail away and submit results to the Force Surgeon.

b. Commander, Amphibious Task Force/Expeditionary Strike Group (CATF/ESG) Surgeon. In addition to the duties defined in chapter 6 of reference (e) and Appendix F of reference (p), the responsibilities of the CATF Surgeon will include, but are not limited to, the following:

(1) As the Senior Medical Authority Afloat, serves as medical advisor to the Task Force/Expeditionary Strike Group (TF/ESG), the staff, and the ships of the task force. The TF/ESG Surgeon also serves as the health services advisor of the task force, ensuring that all medical and dental administrative requirements are met. Ultimately responsible for all care provided within the TF/ESG.

(2) Ensure, as officer in charge (OIC) of the Fleet Surgical Team (FST), that all members of the FST meet professional requirements through ongoing training.

(3) Maximizes the medical and dental readiness of all units in the TF/ESG. Shall regularly exercise shipboard medical facilities, including the provision of specialty medical and surgical services both afloat and pier side in support of readiness.

(4) Collaborate with the Marine Expeditionary Unit (MEU) Surgeon and/or the MEU medical planner in preparing the medical annex to Operational Plans (OPLAN) and Operational Orders (OPORDs).

(5) Coordinate and ensure compliance of the Performance Assessment and Improvement (PA&I) program within the TF/ESG in accordance with reference (i).

(6) Exercise the oversight necessary to ensure that all medical personnel of the TF/ESG, including civilian, foreign national, and Temporary Additional Duty (TEMADD) military providers, are properly credentialed and privileged to exercise only those clinical privileges that can be supported by the platforms upon which they are embarked.

(7) Ensure medical personnel of the MEU augment the ship's Medical Department in which they are embarked.

(8) Request any required medical augmentation.

(9) Ensure shipboard medical supplies are used to provide appropriate medical support to all embarked personnel, reserving MEU medical supplies for ultimate use ashore.

(10) Establish standards of medical policy, practice and triage within the TF/ESG.

(11) Ensure most effective use of all embarked medical personnel and equipment throughout the TF/ESG.

(12) Ensure all personnel are properly trained in self and buddy first aid.

(13) Ensure a proactive practice of health promotion and preventive medicine throughout the TF/ESG.

(14) Establish the medical regulating plan with the MEU surgeon and/or the MEU staff medical planner and other staff officers.

(15) Coordinate medical mass casualty evacuation from shore, using dedicated communications whenever feasible.

(16) Coordinate medical support among ships of the TF/ESG.

(17) Coordinate medical supply/resupply among ships of the TF/ESG.

(18) Coordinate Medical Evacuation (MEDEVAC) of casualties from the TF/ESG to outside of the amphibious objective area.

(19) Establish a blood bank for the TF/ESG and act as the TF/ESG blood bank director.

(20) Keep the Commander, TF/ESG, the Fleet Surgeon, and the Force Surgeon informed concerning the medical and dental status of the TF/ESG.

(21) Submit a post-deployment/after-action critique pursuant to section 3.8.

c. Regional Medical Representative, Senior Medical Officer (RMRSMO). A senior medical officer (SMO) assigned to the Immediate Superior in Command (ISIC) of the units or to regional support areas will act as agents for the Force Surgeon in administering established policies. RMRSMO duties include, but are not limited to, the following:

(1) Serves as special assistant to the ISIC Commander and reports to the chief of staff or chief staff officer for administrative purposes.

(2) Provides medical liaison between the ISIC chain of command and medical and dental departments ashore and afloat.

(3) Coordinates with the Force Surgeon to ensure medical assets under their purview are maintained in a high state of medical readiness.

(4) Advises ISIC commander and unit commanders on matters affecting the health of assigned personnel.

(5) Prepares medical annexes to ISIC commanders OPORDs as required.

(6) Collects and disseminates medical intelligence, and submits required reports per current directives.

(7) Coordinates all health care support within the ISIC command or the regional support area. Although the bulk of consultative services should be provided by shore Military Treatment Facilities (MTF), Regional Medical Representative (RMR) staffs should assist with medical consultations, Physical Fitness Assessment (PFA) screens and physical examinations to the extent of their ability. Note: Although RMR administrative spaces may include offices for conducting medical consultations, performing clinical or invasive procedures in these spaces is not permitted.

(8) Ensure Medical Department maintain the highest state of medical readiness through periodic Medical Readiness Inspections (MRI), monthly administrative quality assurance, and performance assessment and improvement programs in accordance with references (h) and (i).

(9) Ensure Medical Department assist commands in maintaining a viable health promotion, preventive medicine, and sanitation program per current directives.

(10) Ensure performance and review of semiannual audit of radiation health protection programs in accordance with reference (n) for commands with radiology capability.

(11) Periodically observes sick call on units, ensuring the appropriate delivery of quality health care to all personnel, including proper documentation and follow-up.

(12) Ensure Medical Department personnel understand and comply with the Navy supply system with regard to medical material.

(13) Coordinates annual medical and dental Shipboard Equipment Replacement Program (SERP) submission to the TYCOM per current guidance. Assists in coordinating emergency equipment procurement for the units as may be necessary.

(14) Coordinates and manages health care training for all Group/Squadron personnel to include self-aid, buddy aid, and Basic Life Support (BLS) courses.

(15) Provides counseling, mentorship and training to all medical and dental personnel within the RMR office.

(16) Arranges emergency relief, as necessary, for Medical Department's within the ISIC organization or regional support area in response to TEMADD assist request.

(17) Facilitates medical/dental evacuations (DENEVAC) as may be necessary.

d. Regional Medical Representative (RMR). When serving independently, without on-site medical officer supervision, the senior medical enlisted staff member is responsible for providing medical guidance to their ISIC commander and ensuring subordinate commands are in a high state of medical readiness. When serving with a CATF surgeon or RMRSMO, the senior regional medical enlisted representative assists the RMRSMO in the details of Medical Department administration and all aspects of medical readiness. The RMR staff will perform the following duties:

(1) Advise and assist the shipboard Senior Medical Department Representative (SMDR) on all medical administrative matters, particularly those involving procedures, methodology, and procurement.

(2) Jointly, with the SMDR, provide technical supervision of all subordinate enlisted personnel.

(3) Coordinate, monitor and assist cognizant Medical Department's other procurement, Navy (OPN)/centrally managed equipment inventory and annual budget call submissions.

(4) Coordinate and monitor required personnel shipboard certifications and training in accordance with chapter 3 of reference (g).

(5) Provide counseling, mentorship and leadership to all subordinate enlisted medical and dental personnel.

(6) Assist in coordinating replacement, or serve as a short-term TEMADD assist resource, in the event of an unplanned loss of a shipboard HM.

(7) Ensure the most effective, in-rate use of all enlisted medical personnel and equipment under their purview.

(8) Assist with the monitoring and coordination of all ISIC or regional medical inspections. Coordinate tracking and resolution of any identified discrepancies.

(9) Coordinate, monitor, and assist Medical Departments as needed during routine overhaul (ROH), selected restricted availability (SRA), and similar evolutions.

(10) Serve as a training resource in support of shipboard medical training.

(11) Jointly, with the SMDR, schedule and conduct MRIs as required. Additionally, perform a technical assist visit (TAV) as requested by the unit’s commanding officer (CO).

(12) Assist in coordination of all commissioning and decommissioning evolutions involving loading or offloading of medical material and equipment.

(13) Coordinate dissemination of information and tasking’s to subordinate units as assigned by the TYCOM.

(14) Senior medical enlisted personnel are expected to visit ships under their cognizance no less than once per month or more often as necessary on ships requiring assistance in the implementation of various medical programs.

e. Centrally Managed Medical Warehouse Program. RMRs may maintain a regional medical warehouse to function as a collection and redistribution point for excess medical and dental equipment and consumable items. Medical warehouses ordinarily receive, stow, issue, and inventory medical and dental material in support of shipboard Medical Departments. In addition, regional medical warehouses may be used to manage specific materials as in chemical, biological, radiological and nuclear (CBRN) medications for deployable units; facilitate pharmaceutical return programs; coordinate vaccine distribution to Fleet units; and conduct Defense Reutilization and Marketing Service (DRMS) transactions for equipment and consumables that have not been re-issued within six months.

2. The Shipboard Medical Department. The Medical Department is charged with the responsibility of safeguarding the health of personnel and maintaining emergency medical capability. To fulfill this responsibility, the Medical Department makes recommendations and advises the CO and all departments on matters that may affect the medical readiness of all personnel.

a. Composition. The Medical Department will be composed of personnel, facilities, and an administrative structure allocated to provide comprehensive healthcare. At a minimum, the Medical Department will have:

(1) Medical Division with the SMDR onboard serving as the department head advising the CO on medical issues in support of the command's overall mission.

(2) Commands with a dental officer billeted will have a Dental Division.

(3) Corpsmen will be assigned per their Navy Enlisted Classification (NEC) and general duty corpsmen will be assigned in such a way as to maximize their utilization and efficiency.

(4) Medical Department leadership should ensure a robust cross-training program is in place for hospital corpsmen to enhance their capability.

b. Medical Department Organization Manual (MEDORM). A copy will be maintained for each ship. It will provide detailed instructions covering all duties and responsibilities within the

Medical Department. The MEDORM will be kept up to date, by the SMDR, and approved by the current CO with annual review.

(1) Medical Department Personnel Watchstanding. Due to the requirements for completing shipboard PQS and the expansion of in-port duty sections, CO's often require Medical Department personnel to stand non-medical shipboard watches pursuant to article 1063 of reference (y), which prohibits Medical Department personnel from standing non-medically related watches while assigned to a combat area during a period of armed conflict. This restriction is necessary to protect the non-combatant status of these personnel under the Geneva Conventions of 1949 Article 3. Medical personnel are "on call" at all times, thus non-medical duties and duty-section watchstanding are discouraged.

(a) When assigning Medical Department personnel to non-medical watches, it is of utmost importance to ensure the individual's ability to respond in case of an actual medical emergency is not inhibited.

(b) Commands that utilize Medical Department personnel for any non-medical shipboard watches must establish written procedures for the immediate relief of these individuals if the need arises. Emergency relief procedures will be maintained in the Officer of the Deck/Command Duty Officer (OOD/CDO) binder.

(c) The practice of utilizing Medical Department personnel for duties that require them to be off the ship, such as pier sentry and duty driver, is prohibited due to their inability to respond to emergencies.

(2) Collateral Duties. Non-medical collateral duty assignments should not interfere with the performance of primary duties. If assigned to non-medical duties, Medical Department personnel must be able to respond immediately to perform their primary duties as a health care provider.

(3) Members of a Visit, Board, Search and Seizure (VBSS) Boarding Party Team. Medical Department personnel can participate in VBSS evolutions only to provide medical support for the team or in the capacity as a health care provider to render medical assistance

to U.S., NATO, other coalition personnel, detainees, or other personnel as may be directed by the CO pursuant to reference (d).

(4) Off-duty Employment. Medical Department officers assigned to COMNAVSURFPAC/COMNAVSURFLANT commands will refrain from engaging in professional off-duty employment without prior approval of their CO. A copy of the approved request will be submitted to the Force Surgeon and required reports submitted to the Medical Staff Service Professional (MSSP). Medical officers will not perform duties nor stand watch for commands outside the TYCOM without the specific prior approval of the Force Surgeon pursuant to references (i), (k) and (m).

(5) Temporary Additional Duty (TEMADD) Assist Request. Replacement medical personnel may be assigned temporarily to ships or units in order to provide continued healthcare services when an unplanned loss of medical personnel is experienced. Appendix C provides a template for a TEMADD message.

c. Senior Medical Officer (SMO)/Medical Officer (MO). The ship's SMO is designated as the subject matter expert (SME) for the Medical Department and the SMDR.

(1) In addition to those duties prescribed by Navy Regulations for a department head, the SMO will be responsible, under the CO, for maintaining the health of the crew and all embarked personnel, conducting inspections, and advising the CO with respect to matters of health and sanitation affecting the ship.

(2) The SMO will be responsible for ensuring that all medical providers attached to the ship are properly credentialed and privileged, and that they exercise only those clinical privileges that can be reasonably supported by the ship’s medical capabilities.

(3) The SMO will be responsible for all medical material on board and will be in charge of the sick and injured.

(4) The SMO may be required to give medical support to other ships in port or underway, to include training and oversight of Medical Department personnel. Specific duties of the SMO are outlined in reference (q).

d. Medical Administration Officer (MAO). The assigned Medical Service Corps (MSC) officer (Healthcare Administration) will be the Medical Department's MAO and assists the SMO with the administrative details of the Medical Department. The MAO will serve as the medical division officer and will be assigned as the medical division training officer, ensuring that all medical and non-medical personnel of the ship's company are trained in first aid and other appropriate health matters as outlined in this instruction and other applicable directives.

e. Senior Medical Department Representative (SMDR). An independent duty corpsman (IDC) serving afloat in a unit without a billeted MO or the SMO is designated the command's SMDR and will function as the command's Primary Care Manager (PCM). The IDC will assume the medical responsibilities of a ship's MO as defined in section 2(2)(c), as well as reference (h), insofar as qualifications of the individual concerned allow. The SMDR is responsible to the CO for the care of the sick and injured, preventive medicine and occupational health programs, overall medical readiness, preparation of medical reports and records, the maintenance of medical supplies, equipment and spaces, along with the training of medical and non-medical personnel.

(1) In all non-medical matters, the SMDR reports directly to the executive officer (XO). In the case of deployed staffs without an MO assigned, the SMDR will report to the chief of staff or chief staff officer, as directed.

(2) For organizational purposes, the SMDR and all other hospital corpsmen on a ship with an IDC as the SMDR will be assigned to the Medical Division within the Executive Department per the ship's organization.

(3) The performance evaluation of the SMDR will not be delegated below the XO.

(4) SMDRs will seek MO advice whenever they are in doubt about a patient's condition or when conditions exist as discussed in section 2.2. of chapter 4.

SECTION 3 – MEDICAL DEPARTMENT ADIMINISTRATION

1. Medical Emergencies at Sea. Medical emergencies, hospitalizations, transfer of patients, and procedures for obtaining consultations are discussed in reference (e) and the respective Fleet Commander OPORD Annex Q.

a. Messages requesting emergency medical advice or a MEDEVAC will include appropriate Fleet Commander and TYCOM as information addressees in addition to the required chain of command. Include information regarding the clinical status of the patient and circumstances surrounding the injury or illness to keep the chain of command fully informed and able to respond to inquiries, or to coordinate or direct appropriate action. In case of MEDEVAC, when an MTF is not feasible, follow the respective Fleet Surgeon guidance which may include the utilization of International SOS (ISOS).

b. Further information pertaining to ISOS can be found within the respective Annex Q or at http://www.internationalsos.com/en/.

2. Correspondence and Related Procedures

a. Correspondence. Official correspondence originates from the CO and will be prepared as specified in reference (w). Official correspondence will be clear, concise, complete, correct, and courteous. Officers and senior enlisted personnel of the Medical Department are authorized to correspond formally with the Force Surgeon on professional matters. Such correspondence should normally be routed via the administrative chain of command. Direct correspondence to the Force Surgeon, with chain of command intermediaries as information addressees, is authorized for time-sensitive matters in which the well-being of a patient might be placed at risk by using routine channels.

b. Filing and Records Retirement. Files will be maintained, used and disposed of in accordance with references (u) and (v).

c. Watch, Quarter and Station Bill (WQSB). A WQSB will be maintained in the correct format, kept up-to-date and posted in medical administrative spaces. The bill will include all personnel assigned to the Medical and Dental Departments,

stretcher-bearers and non-medical phone talkers as assigned to each battle dressing station (BDS). Additional information to be included within the bill is the projected rotation date (PRD), and assigned position for all members in the event of a mass casualty.

d. Reports. SMDRs will ensure that required reports, such as Disease and Non-Battle Injury (DNBI), Individual Medical Readiness (IMR), and any other required reports are submitted in compliance with current directives. A reports tickler file will be established to ensure conformity with these requirements. The TYCOM will be included as an information addressee on all messages requesting medical assistance from any activity outside the ship. The nature of the medical condition and underlying circumstances will be fully explained.

3. Periodic Reports and Requirements. The following are representative of the periodic requirements for conducting business in the Medical Department. Requirements should be accomplished and reported as required in pertinent articles.

a. Daily

(1) Potable water halogen residual (while underway or in non-US controlled ports).

(2) Sick call log for CO endorsement.

(3) Situational examinations.

(4) Routine examinations.

(5) Health record maintenance.

(6) Inspection of Culinary Specialist (CS) and Food Service Attendants (FSA).

(7) Walk through messing and berthing spaces.

(8) Shipboard Automated Medical System (SAMS)/Theater Medical Information Program-Maritime (TMIP-M) computer system re-indexing and backup.

(9) Eight O'clock Report submission to the chain of command.

b. Weekly

(1) Safety/Sanitation walk-through to include habitability and berthing. Formal report not required.

(2) Conduct bacteriological testing of ships potable water and ice machines.

(3) Conduct crews' medical training per the long-range training plan (LRTP). Attend Planning Board for Training (PB4T) meeting.

(4) Conduct Preventive Maintenance System (PMS) checks and update weekly 3-M SKED Program.

(5) Submit Defense Enrollment Eligibility Reporting System (DEERS) Report (SAMS ships only).

(6) Ensure IMR report uploaded to Navy Medicine Online (NMO).

(7) Commands with an audio booth onboard will export an electronic copy of completed DD2215 reference audiogram and DD2216 hearing conservation data to the DOEHRS Data Repository at https://doehrswww.apgea.army.mil/doehrsdr.

c. Bi-weekly (periodicity – every 14 days)

(1) Pest control survey/spray. Enter data into SAMS/TMIP.

(2) Stretcher bearer training.

d. Monthly (periodicity – every 30 days)

(1) Conduct Food Service Sanitation Inspection and submit Food Establishment Inspection Report (NAVMED 6240/1) to chain of command (CoC).

(2) Verify outstanding supply requisitions.

(3) Conduct birth month recall - Periodic Health Assessments (PHA), Tuberculosis Screening, record verification.

(4) Address IMR deficiencies.

e. Quarterly (periodicity – every 3 months)

(1) Validate current CBRN inventory and command demographics on the Shelf Life Extension Program (SLEP) web site at https://slep.dmsbfda.army.mil/portal/page/portal/ SLEP_PAGE_GRP/ SLEP_HOME_NEW.

(2) Conduct appropriate cardiac life support drill.

(3) Conduct habitability and sanitation inspections (e.g., laundry, barbershop, vending machines) pursuant to NAVMED P-5010 and submit reports to CoC.

(4) Controlled Substances Inventory Report. Note: Required monthly if a transaction has occurred. Report will be submitted to the CO by the senior member of the Controlled Substances Inventory Board (CSIB).

f. Semi-annual (periodicity – every 6 months)

(1) Schedule with the cognizant NEPMU or other local Preventive Medicine Office for Ship Sanitation Exemption Certificate/Ship Sanitation Certificate Program inspection. Note: Shipboard Preventive Medicine Technicians (PMT) cannot perform inspection for the ship they are assigned to.

(2) Conduct a graded mass casualty drill.

(3) Complete an inventory of all emergency Authorized Medical Allowance List (AMAL) gear and equipment.

(4) Conduct a health record audit (ships without dental divisions will audit dental records as well).

(5) Schedule a biomedical technician (BMET) visit for required 3-M checks.

g. Annual (periodicity – every 12 months)

(1) Submit LRTP (based on training cycle) to the command training officer.

(2) Submit Exposure to Ionizing Radiation (NAVMED 6470/1) report as pursuant to reference (n).

(3) Request assistance from local MTF to conduct required external radiation health audit.

(4) Submit Shipboard Equipment Replacement Program (SERP) information to Force BMET.

(5) Conduct bulkhead-to-bulkhead inventory of all medical spaces.

(6) Request annual calibration of x-ray equipment.

(7) Retire files per current Navy directives.

(8) Conduct medical record verification per current Navy directives.

(9) Schedule annual calibration of audiometers and audiometric booths as required.

(10) Conduct annual inventory of the force health protection (FHP) AMAL and update on the SLEP web site.

(11) Submit annual budget requirement to supply officer.

(12) Request annual lab assessment from MTF.

(13) Ensure annual calibration of anesthesia machines.

h. Biennial (periodicity - every 2 years)

(1) Request radiation health survey of x-ray equipment.

(2) Industrial Hygiene Survey (requested by the command).

i. Situational

(1) Submit MRI/TAV inspection discrepancy follow-up reports to CoC no less frequently than monthly.

(2) Memorandum for the Record (as may be necessary to document significant events).

(3) Medical Event Report (MER) submission via Naval Disease Reporting System Internet (NDRSi).

(4) Maritime public health declaration prior to port visit.

(5) Report of heat/cold injury on NAVMED 6500/1 Revision 5-99 with a copy to the TYCOM, Navy and Marine Corps Public Health Center (NMCPHC) and the NEPMU for the current area of operation (AO).

(6) Inpatient disposition record (MO ships only).

(7) Accident/Injury report. Signed original to be maintained by the command safety officer with a signed copy for medical. Report is entered into web-enabled safety system (WESS) by the safety officer.

(8) Medical joining report with entering a command region or zone (INCHOP) message to new AO.

(9) Appointment letters for CSIB members and stock custodians.

(10) Accidental Exposure to ionizing radiation (NAVMED 6470/1).

(11) Report of hospitalization at non-federal facilities (via situation report (SITREP) in accordance with reference (o), article 1770-030).

(12) Competency for duty exam.

(13) Death report.

(14) Aviation accident report.

(15) Heat stress survey.

(16) Post-deployment critique to appropriate Fleet Commander (Medical) via chain of command.

(17) Pre-deployment, Post-deployment Health Assessment, Post-deployment Health Reassessment screenings.

(a) Are only required for personnel who have returned from a deployment under one or more of the following conditions:

1. Deployment ashore of more than 30 days with duties involving outside the continental United States operations without a fixed U.S. Military Treatment Facility (MTF).

2. Individual and unit deployment to United States Central Command (USCENTCOM) or other areas designated by appropriate authority.

3. Commander exercising operational control (regardless of deployment area, duration, or MTF support) determines a health threat exists (e.g., a deployed ship conducts operations that may expose service members to contaminants, disease, or traumatic events).

(b) Service members assigned to ships and squadrons conducting routine deployments with their ship or squadron are exempt from this requirement, unless paragraph 16a1. or 16a3. applies.

(c) For further guidance refer to reference (r).

(18) MEDEVAC message (Required if patient is transferred for other than routine care or any care to be received in a non-US medical facility).

(19) Dosimeter report as required (about every 6 weeks per the Navy Dosimetry Program).

(20) Acknowledge SERP equipment received onboard the ship in the Fleet Procurement Program data base located at https://gov_only.nmlc.med.navy.mil/int_code04/internal-code04.asp.

(21) Operational and safety checks performed by the BMET on medical equipment per 3-M schedule.

4. Personnel Medical Tickler File. A personnel medical tickler will be maintained utilizing the Master Tickler module of SAMS/TMIP. This information must be maintained and backed-up daily.

5. Health Records. Health records will be maintained in accordance with chapter 16 of reference (m) and reference (x) and will be verified annually in conjunction with the PHA,

special physical exams, and on receipt or transfer of the individual.

6. Health and Dental Records Audit. A semi-annual health and dental record audit will be conducted using a ships personnel roster to ensure SAMS/TMIP database accuracy and all records are accounted for. A health and dental records audit is required to be conducted at least 90 days prior to every deployment.

7. Procedures for Relief

a. Permanent Change of Station. A SMDR reporting to a command for duty will, in company with the person being relieved, be advised of the status of the Medical Department regarding staffing, equipment, and supply prior to assuming duty. The RMR will conduct a TAV, whenever possible, prior to the turnover process in accordance with reference (h). At a minimum, turnover will include:

(1) An out-brief of the TAV results will be conducted by the RMR to the CO. A completed copy of the TAV will be attached to the Letter of Relief and maintained on file.

(2) Letter of Relief. Upon completion of the turnover procedures, the relieving SMDR will advise the CO in writing (within 30 days) as follows:

(a) I have on this date assumed responsibility as the Senior Medical Department Representative.

(b) I have, in company with (departing individual), assured myself that the management and accountability of the Medical Department onboard this ship is in accordance with current directives. Discrepancies, if applicable, will be noted on the enclosed TAV check list.

(3) Adjudication of discrepancies noted upon relief will be handled as a matter of individual command prerogative, consistent with determining responsibility, taking any disciplinary or administrative action necessary, adjusting accounting records, and initiating action to replace missing material.

b. Hull Swap. To prevent critical items from being overlooked during this transition crew and hulls, Appendix D is

a checklist that both ISICs and IDC need to ensure are completed for the hull swap.

8. Post-Deployment/After-Action Critique. All ships/units returning from deployment are required to submit a written, post-deployment, after-action critique (letter format) concerning medical and dental aspects of the deployment up the CoC to the appropriate TYCOM/Fleet Commander (Medical). This critique need not be lengthy nor should it necessarily provide chronological histories of all Medical Department events. It should, rather, succinctly pinpoint problem areas, unusual medical problems, unexpected diseases, major injuries/accidents, medical intelligence, lessons learned, recommended changes to current publications (e.g. port directory), supply support/problems, and other areas of concern or interest. The purpose of the critique is to assist other commands who are to deploy in the future to properly prepare for their deployments and to inform cognizant shore facilities of important events/problems in their respective AOs. The critique shall be submitted within 30 days of the end of the deployment. Time sensitive medical matters which need speedy reporting should not be held for this post-deployment after action critique, but should be reported in appropriate format as they occur.

9. Routine Overhaul (ROH) Planning. The routine overhaul (ROH) environment often imposes extraordinary difficulties for the ship's Medical Department. Some of the more significant problems involve medical supply, including inventory and ordering of new material. Storerooms are emptied and material is stored in off-ship warehouses without environmental controls and with minimal access. Security of any material remaining aboard ship is marginal. Unique health hazards exist, and may include toxic vapors, asbestos exposure, hearing and eye hazards, and aggravated sanitation problems.

a. Medical Responsibilities

(1) During an ROH, Medical Department responsibilities to the crew remain the same. However, due to the nature of an ROH, some methods for fulfilling these responsibilities may change. In most cases, the Medical Department is moved to a barge facility usually located within close proximity to the ship and the capability to perform some routine functions is limited (e.g., ancillary services, computer connectivity).

Therefore, medical personnel must plan in advance and make prior arrangements for the crew's routine and emergency medical needs. In some geographic regions, arrangements may be accomplished with the assistance of the fleet liaison offices of local MTFs that provide services to the shipyard where the ROH is to be accomplished. If medical is to remain functional on the ship, storage space must be found for medical material while repairs are being accomplished.

(2) All repairs required in medical spaces must be identified and submitted to the ships material and maintenance officer (SMMO) at least six months prior to the ROH. Work requests for Medical should be submitted at the Maintenance Availability Pre Planning conference by the SMMO. Constant communication is necessary between the SMMO and the SMDR before, during and immediately after the ROH to ensure all necessary repairs are completed.

(3) Major equipment replacement or acquisition should be planned at least two years in advance. At least one month before overhaul, arrangements should be made with the nearest MTF to have a BMET perform preventive maintenance on all major medical equipment.

b. Medical Facilities During ROH

(1) Temporary facilities. The average ROH may preclude the use of the shipboard medical spaces for at least some portion of the overhaul. Excessive noise levels or the securing of potable water and electricity to parts of the ship will at times severely hamper normal routines and the handling of emergencies. Therefore, the use of temporary facilities, either a barge or pier side facility, may be necessary. Whether ashore or on a barge, the facilities must provide the following:

(a) Hot and cold running water.

(b) Adequate space to conduct routine sick call and medical administrative functions. Patient privacy and space for medical record stowage, sick call supplies, emergency resuscitation kit, exam table and a stretcher should be considered.

(c) The space must be enclosed and equipped with a door that locks for record and supply security

(2) Availability to the Ship. The SMDR is still responsible for safety, sanitation, and the proper completion of any scheduled repairs to the ship's medical spaces. It is imperative that an SMDR spend at least part of each working day on the ship to observe safety and sanitation conditions, check first aid supplies, check security of medical material stored aboard, and monitor work being accomplished in medical spaces.

c. Medical Material

(1) Inventory:

(a) At least 60 days prior to overhaul, the ship’s SMDR will ensure that a bulkhead to bulkhead physical inventory of all medical material is accomplished, with particular attention to items that will expire during overhaul.

(b) Upon commencement of the ROH, all material from emergency stocks (e.g., BDS, MCB, FAB, Gun Bags) not required for operation of the temporary sick bay are to be boxed, sealed, and labeled with the location from which taken “FWD BDS box 1 of 10”.

(c) Items not easily boxed, such as sterilizers, may be labeled by location. All boxes will have inventory lists attached to them.

(d) A copy of all inventory lists must be kept in sickbay.

(2) Disposition of Material:

(a) If medical storerooms are to be left intact, materials may remain stowed there. Affected storerooms should have special security arrangements, such as adding those storerooms to the hourly sounding and security checklist. Additionally, an SMDR should regularly check medical storerooms.

(b) If storerooms are to be emptied during overhaul, the items stored in them must be boxed as noted in paragraph 9.c.(1)(b) and (c). Medical material must be stored in an area that provides security, preferably in a single location such as

a warehouse. To aid in security and centralization of material, CONEX boxes or similar containers may also be used. They will be properly locked and the SMDR will retain the keys to preclude unauthorized access.

(3) Quality Control and PMS:

(a) Medicinals and Supplies. Since quality control is difficult during overhaul because of inaccessibility of medical items, all material due to expire must be identified to permit future planning and ordering of material. During the 60-day pre-overhaul inventory, all items noted to expire during overhaul should be set aside for later disposition. If possible, expiring material should be used or traded with an MTF or other shipboard Medical Departments for an item with a later expiration date. Medicinals and supplies in use will receive routine quality control. Specific emergency AMALs are to be maintained at 100% during an ROH. At a minimum, the MO/IDC response kit and an appropriate number of Junior HM bag(s) will be maintained in a constant state of readiness.

(b) Equipment. Medical equipment that will not be in use during overhaul should be checked for proper operation and then placed in lay-up in accordance with the 3M system. Equipment in use will continue to receive routine PMS. Equipment should be stored with other medical items and added to the inventory lists. New equipment received is to be controlled in the same manner.

(4) Routine and Special Programs:

(a) Routine Programs. All routine programs and surveys, including individual medical readiness, training, sanitation inspections, and occupational health and safety assessments will be continued as applicable. Sanitation and safety inspections should include barge berthing, head facilities, and food service areas.

(b) Special Programs. SMDRs must be kept aware of any major overhaul requirement for asbestos rip-out. Although shipyard workers will normally do all asbestos removal, NEPMUs or MTF preventive medicine units should be contacted to arrange for required training. SMDRs and supervisors who have not received the training should do so prior to overhaul.

(5) First Post-Overhaul Underway - Sea Trials:

(a) Prior to the first post-overhaul underway, or as soon as feasible, all stored medical material should be transferred back on board and stowed in the appropriate location. As medical equipment is replaced, it must be checked for proper function and routine PMS is begun (this is to include sinks, operating room lights, operating room tables, sterilizers, and emergency fresh water tanks).

(b) Routine quality control should be resumed on medical supplies. Ensure that medical supply locations are correlated with the supply module in SAMS/TMIP.

(6) TYCOM Assistance:

(a) Facility Design. TYCOM approval is required prior to any permanent design alterations to medical spaces.

(b) Technical Assistance Visits (TAV). A Medical TAV should be arranged with the RMR after the completion of the ROH. This visit is meant to provide a baseline to develop a meaningful and continuing plan of action and milestones (POA&M) for the Medical Department. Allow sufficient time to correct discrepancies before the commencement of the training cycle.

(7) Appendix E provides a checklist to assist the Medical Department during the overhaul process.

10. Pre-deployment preparations for Medical Departments. Appendix F provides a POA&M checklist to assist with preparing the Medical Department for deployment.

11. Emergency Bills. The SMDR is responsible for establishing and maintaining bills for handling emergency situations in accordance with ship's doctrine. The SMDR will ensure that all assigned medical personnel are familiar with their responsibilities under each bill. All bills will be kept current and circulated throughout the Medical Department. These bills may be included in the ship's Standard Organization and Regulations Manual (SORM), MEDORM or they may be published as stand-alone instructions.

a. Mass Casualty Bill. Outlines the responsibilities of Medical Department and other ship's personnel during a mass

casualty situation. Appendix G provides a sample bill for reference.

b. Battle Bill. Outlines the responsibilities of the Medical Department personnel under hostile and non-hostile emergency conditions. Appendix H provides a sample for reference.

SECTION 4 – QUALITY ASSURANCE, CERTIFICATION, TRAINING AND REVIEW

1. General. The purpose of these programs is to provide professional review of health care in order to improve the quality of care. Guidance for implementing this program may be found in references (b), (k), (i) and (s). It is not meant to be punitive in nature. It offers an ideal teaching situation and will be used by both the provider and the supervising physician in this spirit. Health care delivery must be reviewed when performed in an independent setting. These reviews will ordinarily be performed by RMRSMO, CATF surgeon, SMO, and designated physician supervisors. The responsible RMR will ensure that these reviews are accomplished on time and documented.

2. Health Care Quality Assurance Program

a. It is Department of the Navy (DoN) policy that all health care providers assigned to the operational forces will:

(1) Participate in ongoing monitoring and evaluation to identify and resolve problems which impact directly or indirectly on patient care. The findings of this program will be used in the periodic credentials review or evaluation of all health care providers.

(2) Be credentialed at least every two years or be qualified to provide health care per specific Personal Qualification Standards (PQS).

(3) Be granted clearly delineated privileges or be qualified separately for each MTF, unit, or ship where they may be assigned.

b. Upon completion of the quarterly review, all reports will be routed to COMNAVSURFPAC/COMNAVSURFLANT (N01H) from the RMR within two weeks from the close of the quarter.

3. Credentials Review and Privileging Program. The DoN recognizes that the quality of health care services depends on the coordinated performance of clinical and administrative processes. Performance improvement and total quality management in the DoN is the primary means for ensuring health care quality. The potential consequences of unqualified or impaired

health care providers misconduct is so significant that complete verification of credentials and adequate control of clinical privileges are imperative.

a. DoN policy states all licensed, independent health care practitioners will be subject to credentials review and will be granted a professional staff appointment with delineated clinical privileges by a designated privileging authority before providing care independently.

b. Practitioners must possess a current, valid, unrestricted licensure or certification, a licensure or certification waiver, or be specifically authorized to practice independently without a licensure or certification or waiver, to be eligible for a professional staff appointment with clinical privileges.

c. Credentials and privileging functions are accomplished at the TYCOM level in accordance with reference (b).

4. Continuing Medical Education (CME) Program. A CME program is required in order to maintain national accreditation standards for healthcare professionals and meet criteria of state boards of licensure pursuant to reference (a).

5. Certification, Training, and Use of Independent Duty Corpsman (IDC). In accordance with references (j) and (t), IDCs must be certified as capable of providing health care, independent of a medical officer, on ships at sea and any other isolated assignment.

a. IDC competency training must be tailored to permit the IDC to identify and treat common and uncomplicated conditions.

b. IDCs are expected to complete a minimum of 15 CME credits annually. This may be completed by using self-study correspondence courses, computer generated training materials, multi-media material, and other pertinent materials that award CME, continuing education unit (CEU), and Naval Medical Education and Training Command (NMETC) approved locally developed programs.

SECTION 5 – MEDICAL READINESS INSPECTION (MRI)

1. General. In order to determine the operational readiness of a Medical Department afloat, a formal MRI will be conducted. This inspection evaluates the ability of the Medical Department to function in accordance with the ship's Required Operational Capability/Projected Operational Environment (ROC/POE). Medical staffs conducting the inspection may utilize other available external resources such as MTFs and NEPMUs to accomplish the inspection.

2. MRI Schedule

a. Utilizing reference (h), the RMR/MRD will conduct an MRI ensuring that all chapters and applicable sections are fully inspected using the timeline below:

(1) Ships aligned with the Fleet Response Training Plan (FRTP).

(a) During Basic Phase, preferentially in the period between the eighth and twelfth week.

(b) No greater than D-120 or less than D-60 days prior to the departure date for any deployment anticipated to be greater than 90 days.

(2) Forward Deployed Navy Forces (FNDF) and Littoral Combat Ships (LCS) will be inspected no less frequently than every 18 months.

b. MRI certification is valid for a period of 18 months and shall not exceed the 18 month periodicity without a TYCOM waiver. Platforms exceeding 18 months without a waiver will lose certification.

3. Technical Assist Visit (TAV). The TAV is considered an informal review of the Medical department and the results of the visit are for use by the inspected command and the ISIC to provide guidance to the SMDR and their CoC. A command may request a TAV in the following circumstances:

a. To assist the Medical Department with MRI preparation.

b. Upon turnover of the SMDR.

c. When questionable circumstances exist within the Medical Department.

d. At any time the CO feels it is warranted.

4. Reports. The following documents will be submitted to the TYCOM within 10 working days of the inspection.

a. Cover letter. Signed, dated and serialized by the ISIC.

b. Completed inspection checklist.

5. Plan of Action and Milestones (POA&M)

a. POA&M will be submitted to the TYCOM within 14 working days of MRI result notification if the inspection score is C-3 or C-4.

b. Created by the ship's SMDR and the RMR, the POA&M provides the SMDR's plan to correct all discrepancies.

c. The senior evaluator will follow up on the POA&M and provide updates to the TYCOM within 60 days of the inspection.

CHAPTER 2 - TRAINING

Ref: (a) ATGPACINST 3502.1
(b) BUMEDINST 1510.23C, Hospital Corpsman Skills Basic (HMSB)/Tactical Combat Casualty Care (TCCC) Program
(c) BUMEDINST 6230.15B, Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases
(d) BUMEDINST 6250.12C, Pesticide Applicator Training and Certification for Medical Personnel
(e) BUMEDINST 6440.5C, Health Services Augmentation Program (HSAP)
(f) COMNAVSURFPAC/COMNAVSURFLANTINST 3500.11, Surface Force Exercise Manual
(g) COMNAVSURFPAC/COMNAVSURFLANTINST 3502.3, Surface Force Readiness Manual
(h) COMNAVSURFPAC/COMNAVSURFLANTINST 6400.1, Training, Certification, Supervision Program, and Employment of Independent Duty Corpsmen (IDC) in Commander Naval Surface Forces Pacific (CNSP) and Atlantic (CNSL)
(i) DoD Instruction 1322.24, Medical Readiness Training of 6 Oct 11
(j) NAVEDTRA 14295B, Hospital Corpsman Rate Training Manual (RTM)
(k) NAVEDTRA 14325, Basic Military Requirements Rate Training Manual (RTM)
(l) NAVEDTRA 43119-J (CH-1), Personnel Qualification Standards for Damage Control (DC)
(m) NAVEDTRA 43241-J, Personnel Qualification Standards for 3M
(n) NAVPERS 15909G
(o) OPNAVINST 1500.22F, General Military Training (GMT) and Navy Military Training (NMT)
(p) OPNAVINST 5100.19E, Navy Safety and Occupational Health (SOH) Program Manual
(q) Navy Warfare Publication (NWP) 4-02, Naval Expeditionary Health Service Support Afloat and Ashore
(r) OPNAVINST 6400.1C, Training, Certification, Supervision Program, and Employment of Independent Duty Hospital Corpsmen (IDCs)

SECTION 1 – GENERAL MEDICAL TRAINING

1. Shipboard Medical Training. The goal of shipboard medical training is to support combat readiness by developing individual knowledge and skills to preserve health and promote physical vitality.

a. Personnel. In accordance with references (a) through (r) and under the direction of the CO, each SMDR is to establish and maintain an effective and ongoing training program for junior hospital corpsmen, hospital corps strikers, stretcher-bearers, mass casualty assistants and the officers and crew of the ship.

b. Goal of Training. The goal is to ensure that each person is prepared to do their part in an emergency. A training program must be coordinated between PB4T and Afloat Training Group (ATG).

c. Conducting the Lesson. A variety of methods can be used to conduct sustainment training. Site TV, Plan of the Day (POD) notes, lectures, PowerPoint presentations, Navy Knowledge Online (NKO) web site and e-mail are valuable assets, but should not completely replace practical training. Practical application will be utilized in training the crew and stretcher bearers in first aid, casualty evaluation, treatment, and patient transport.

d. Documentation. Training accomplishment will be documented using the SAMS/TMIP Training Module, Relational Administrative Data Management (R-ADM) or another TYCOM approved training database. At a minimum, the documentation will include: date, topic, group receiving the training, instructor's name, number of personnel present, and the type of presentation.

e. Medical Training Team (MTT). In keeping with the concept of establishing ships training teams as outlined in the Surface Force Exercise Manual (SFEM), all ships will establish a Medical Training Team (MTT). The MTT will be composed of at least one medical representative and other personnel as necessary. These individuals should be highly qualified, motivated and organized to assist in training individuals and teams and in evaluating performance during drills and exercises. Training sessions for MTT members will be documented in SAMS/TMIP, R-ADM or another TYCOM approved training database. Medical exercises, evolutions and drills must be documented via the Training and Operational

Readiness Information System (TORIS) and Training Figure of Merit (TFOM) for Fleet Support Operations - Medical (FSO-M).

2. Responsibilities. In addition to the responsibilities itemized in the SFEM, the SMDR shall be responsible for the following:

a. Instruction in self-aid, buddy aid, and BLS which may be required for all officers and enlisted personnel of the crew. Each ship will have at least two certified BLS instructors on board. This training should be offered to embarked personnel.

b. Instruction in the medical aspects of CBRN warfare.

c. Training of medical personnel as set forth in the Manual of Medical Department (MANMED), Navy Enlisted Manpower and Personnel Classifications, Occupational Standards, HM In-Rate Training Manual, Fleet directives and this instruction.

d. Appropriate documentation of training in SAMS/TMIP, R-ADM or other TYCOM approved training database.

3. Indoctrination of Newly Reporting Personnel. The Medical Department will conduct training during Indoctrination ("I") Division and/or during check-in. Training will include at a minimum:

a. A description of onboard medical and dental services, along with procedures for receiving such services. To supplement this training, it is recommended that appropriate handouts be provided to each newly reporting member. Handouts should provide helpful information such as sick call times and procedures for receiving emergency medical treatment on board and ashore.

b. A description of services provided by ashore medical facilities (federal and non-federal) and the procedures for receiving such routine services.

c. Explain location, purpose, and proper utilization of emergency medical gear throughout the ship (first aid boxes, litters and stretchers, mass casualty boxes, battle dressing stations and other first aid supplies) during required orientation tour.

d. Provide information on suicide awareness and prevention.

e. Provide initial and annual refresher training in the hearing conservation and heat stress programs.

f. Provide information on personal hygiene and sanitation.

g. Provide information regarding the prevention and treatment of sexually transmitted diseases.

h. Provide information on pregnancy awareness and birth control options.

i. Provide TRICARE information as it relates to the ship’s company and enrollment options for dependents. Include a local point of contact.

4. All Hands Training Requirements

a. In accordance with references (f) and (o), planning and implementation for all hands training shall be established by the PB4T. The SMDR will be a regular member of the PB4T. The SMDR will be the commands medical SME for the design and implementation of all medical-related training programs and will provide appropriate recommendations and advice regarding required training topics. The requirements for all hands medical training shall be included in each long range and short range training schedule and incorporated into the ship's training programs. Medical training schedules shall be submitted to the ship's training officer as required.

b. Appendix I lists medical training requirements in the area of “Health and Wellness.” As such, resources outside of the Medical Department should be used to facilitate training (e.g., physical readiness can be taught by the ship’s PFA coordinator, or alcohol and drug prevention can be taught by the Drug/Alcohol Program Advisor (DAPA)).

c. A comprehensive list of training events, drills, evolutions, lectures, general military training (GMT), assist visits and inspections shall be maintained throughout the ship's operational cycle and will be reflected in the LRTP. The LRTP need not duplicate training established in other directives, but must include all required medical oriented all-hands training and specialized training.

d. A short-range medical training schedule derived from the LRTP will be prepared for each department on board. This schedule should cover a period of at least three months and shall include all medically oriented training events planned for each department. Operational considerations may occasionally require postponement of the training schedule; in such cases, the affected instruction periods will be rescheduled at a more opportune time.

5. Level of Knowledge (LOK) Exams. A sound and efficient training program is based on a logical continuum of training. An effective measure of the crews understanding of the training is based on their level of knowledge as it relates to first aid. (Reference TAB K of reference (a)).

6. First Aid and Rescue. Each crew member must be knowledgeable and able to demonstrate the principles of first aid and rescue. First aid training will begin with completion of the applicable sections of Damage Control (DC) PQS. Periodic drills listed in section 1.11, will support proper application of treatment principles. Crew members must be prepared to apply lifesaving procedures to themselves or to shipmates in emergency or combat situations. Accordingly, first aid, BLS and other rescue training shall be continuously emphasized to ensure that each individual can satisfactorily perform first aid and rescue procedures at any time in accordance with references (a), (b) and (f).

a. References (j) through (m) will be used to establish basic first aid and rescue joint qualification requirements (JQR) for all hands.

b. Sustainment training will be conducted in order to ensure proficiency in first aid and rescue procedures.

7. Drills and Exercises. The MTT leader shall coordinate with the Integrated Training Team (ITT) to ensure medical training drills and exercises are conducted and evaluated in accordance with reference (f). Completion of training will be documented in SAMS/TMIP, R-ADM, TORIS/TFOM or another TYCOM approved database, and submitted to the training officer for reporting. Pursuant to reference (f), all medical drills are to be conducted periodically and during training evolutions with ATG as operational mission permits.

a. The Readiness Evaluation RE-04 Conduct Non-GQ Mass Casualty Drill will be conducted semi-annually.

b. The following Readiness Evaluation (RE) drills will be conducted quarterly for all surface ships except LCS class which will conduct these drills once per on-hull period and once per off-hull period, not to exceed 150 days:

(1) RE-01 Conduct First Aid Drills (8 Basic Wounds): 3 departments, 3 wounds each. (MCM and PC class ships will conduct a total of 8 First Aid Drills per hull.)

(2) RE-02 Conduct Patient Transport: Watchstanders from each BDS must demonstrate proper patient transport procedures to achieve certification.

(3) RE-03 Conduct BDS Operations (N/A for PC): Each BDS is required to demonstrate proficiency in BDS operations for certification.

8. Stretcher-Bearer and Non-Medical Phone Talker Training. Stretcher-bearers and Non-medical Phone Talkers are designated personnel assigned to battle dressing stations whose primary duty is to support medical department contingencies during all conditions of readiness. They are not to have dual assignments to other watch stations during Condition I or Condition II General Quarters (GQ). Stretcher-bearers and non-medical phone talkers are cross trained to provide on-scene patient resuscitation, stabilization, and triage and possess first aid skills more advanced than those of the average crewmember. Stretcher-bearer and Non-medical Phone Talker training is required every two weeks, at a minimum, and shall be scheduled into the LRTP. Both will complete all DC training requirements and be PQS qualified as Stretcher-bearers and Non-medical Phone Talkers. (Note: LCS crews shall conduct "First Responder" training monthly when crews are disembarked from ship)

9. Rescue Swimmer First Aid Training. It is essential for command designated rescue swimmers to maintain a basic knowledge of first aid. Personnel assigned these duties must maintain current BLS for Health Care Provider certification. The Medical Department should assist in this training as available.

10. Training Aids

a. Training Gun Bag (Containing sufficient materials to support FSO-M drills).

b. Moulage Set, War Wounds (AMAL Required).

c. Manikin, CPR Training (AMAL Required).

d. Audio-visual materials.

11. Other Medical Training Requirements. Various Certification and Readiness Exercises require Medical Department participation due to the possibility of personnel casualties. Examples are the MOB-D-31-SF (Toxic Gas Drill), and the MOB-S-6SF (Man Overboard Drill).

SECTION 2 – MEDICAL DEPARTMENT PERSONNEL TRAINING

1. Medical Department In-service Training. The Medical Department will establish and maintain a vigorous training program for medical personnel. All qualifications required for medical personnel will be met within six months after reporting to the ship and verified as completed by the SMDR. Training folders will be established for each member of the Medical Department and will contain documentation of PQS completion, courses attended, certifications attained, and training sessions attended. The following specific requirements pertain to medical personnel:

a. Basic Life Support (BLS). All medical personnel shall be trained and certified as BLS provider. This certification shall remain current at all times.

b. IDC Training. All IDCs must be trained in accordance with references (h) and (r).

c. Shipboard PQS. All medical personnel will complete references (l) and (m) and any other ship specific requirements.

d. HM PQS. Appendix J is the formal Medical Department PQS to provide shipboard HMs a good working knowledge of all areas of the medical and dental operations. The following personnel (as assigned) are authorized to sign off PQS requirements: medical officers, dental officers, MSC officers (PA and MAO), nurse corps officers, IDCs, and HMs with technical NECs assigned onboard. All HMs with the exception of 8425 assigned to independent duty will complete HM PQS within six months of checking onboard.

e. Immunization. Medical Departments shall refer to Table B-1 of reference (c) for required medical training for all personnel who administer immunizations.

2. Hospital Corpsman Striker

a. The concept of the HM Striker Program is to identify and prepare eligible enlisted personnel for attendance at HM "A" School. Assignment of strikers to the Medical Department is predicated upon availability of enlisted personnel who meet the qualifications required by the MANMED Chapter 9, and the recommendation of the command's Career Development Board (CDB).

Upon selection, the Medical Department senior enlisted member shall ensure that the prospective striker meets the training required for all hands and shall further institute appropriate training in preparation for HM "A" School. Reference (j) is recommended to be completed prior to transfer to HM "A" School.

b. HM strikers shall not be assigned professional or technical responsibilities normally assigned to HMs. However, a striker may be utilized in a training capacity as directed by the SMDR. Article 7.071 of reference (n) outlines for service members the application process for admission to HM "A" School. Upon selection, the member can be placed full time in the Medical Department for training and preparation prior to transfer for schooling.

3. Pest Control Operator Training/Certification. In accordance with reference (d), all shipboard Medical Departments must have at least the SMDR and all corpsmen responsible for pest control certified as shipboard pest management specialists. If a PMT (NEC 8432) is assigned to medical, that individual will serve as the command's pest control program manager.

4. Training Resources

a. Training resources can be found at the following websites:

(1) Navy Medicine Professional Development Center (NMPDC) web site: http://www.med.navy.mil/sites/navmedmpte/courses/Pages/default.aspx

(2) Navy and Marine Corps Public Health Center (NMPCH) web site: http://www.med.navy.mil/sites/nmcphc/Pages/Home.aspx

b. For Navy Environmental & Preventive Medicine (NEPMU) support, contact:

(1) NEPMU-2, 1285 West D Street, BLDG U238, Norfolk, VA 23511; DSN: 337-6600, Comm: (757) 953-6600, Fax – (757) 953-7212. http://www.med.navy.mil/sites/nmcp/clinics/nepmu2/Pages/default.aspx

(2) NEPMU-5, 3235 Albacore Alley, San Diego, CA 92136; DSN: 526-7070, Comm: (619) 556-7070, Fax – (619) 556-7071. http://www.med.navy.mil/sites/nmcsd/nepmu5/Pages/index.htm

(3) NEPMU-6, 385 South Ave Bldg. 618 JBPHH, HI 96860; DSN: (315) 471-0237, Comm: (808) 471-0237, Fax – (808) 471-0157. http://www.med.navy.mil/sites/nmcsd/nepmu6/Pages/index.html

(4) Navy Entomology Center of Excellence, Naval Air Station Jacksonville, Bldg. 937, Box 43 Jacksonville, FL 32212-0043; DSN: 924-2424, Comm: (904) 542-2424, Fax – (904) 542-3175. http://www.nmcphc.med.navy.mil/field_activities/nece_overview.aspx

c. Officers of the Medical Department who require CEUs for licensure or board certification are encouraged to attend professional meetings or conferences to the extent permitted by available travel funds and operational considerations.

5. Emergency Response Drills for Medical Personnel. Full emergency response training drills must be conducted for all medical personnel at least quarterly. These drills will include, but are not limited to, scenarios that review BLS protocols and various traumas. On ships with an MO, these drills will also include scenarios that review advanced cardiac life support (ACLS) protocols. The SMDR evaluation should include, but is not limited to, response time, proper procedures, equipment function and familiarization, and transport. Drill sites should be varied in order to maximize response times (4-6 minutes) and demonstrate mobility. The SMDR will initiate the drill and role play as needed to support effective emergency management of the scenario. The SMDR is responsible for documenting the training. The Emergency Treatment Simulator Mannequin will be utilized if available. On ships without an MO, the IDC or Physician Supervisor of the IDC will lead, evaluate and document the drills.

6. Chemical, Biological, Radiological and Nuclear (CBRN) Training. The following materials are recommended for use in self-study and ready reference:

a. NTRP 3-11.32 - Potential Military Chemical/Biological Agents & Compounds.

b. NTRP 4-02.21 - Treatment of Nuclear and Radiological Casualties.

c. NTRP 4-02.22 - Treatment of Chemical Agent Casualties and Conventional Military Chemicals Injuries.

d. NTRP 4-02.23 - Treatment of Biological Warfare Agent Casualties.

e. NAVMED P-5041 - Treatment of Chemical Agent Casualties and Conventional Military Chemical Casualties.

f. BUMED 6470.10 (series) - Initial Management of Irradiated or Radioactively Contaminated Personnel.

g. BUMED 6470.23 - Management of Non-Ionizing Radiation Casualties.

h. Additional online courses are available on Navy Knowledge Online (NKO) at https://wwwa.nko.navy.mil.

7. Health Services Augmentation Program (HSAP) Training. HSAP refers to the augmentation of operational CRTS platforms (LHA/LHD/LPD-17 class ships) during contingency or wartime situations with active duty Navy medical and dental personnel commonly referred to as an M+1 manning augmentation and governed by references (e) and (i). Training will be conducted to familiarize HSAP personnel with their assigned platform. To support this requirement, HSAP training will be scheduled by the cognizant amphibious group medical staff and will be completed on all CRTS platforms prior to an extended deployment. A training curriculum has been developed by the staff of the Surface Warfare Medical Institute (SWMI), which actively supports the training. Ideally, HSAP training will be scheduled to occur within 180 days of deployment and will be conducted on board the same ship that will be augmented. Training will be scheduled to last a minimum of five working days and will be conducted in conjunction with underway evolutions whenever possible to enhance the training environment. Training will be supported by the amphibious group medical staff and the ship's crew to ensure that the HSAP personnel complete the training curriculum.

8. Embarked Medical Personnel Familiarization. Medical personnel from other units who are embarked onboard a surface

ship should be provided with a structured orientation to shipboard safety, operations, and organization to facilitate effective function aboard ship and promote underway personal safety. Such orientation should familiarize them with such matters as GQ, man overboard and emergency egress procedures. In addition, formal training in the ship's Medical Department layout, policies, procedures and other considerations in the delivery of shipboard medical care should be provided.

CHAPTER 3 - FISCAL/SUPPLY MANAGEMENT

Ref: (a) BUMEDINST 6470.22A CH-1, Navy Radiological System Performance Evaluation Program
(b) BUMEDINST 6710.63B, Reporting of Defective, Unsafe, or Unsatisfactory Medical and Dental Material
(c) BUMEDINST 6710.70A, Guidelines for Controlled Substances Inventory
(d) COMNAVSURFORINST 4400.1, Surface Force Supply Procedures
(e) DoD 4160.21-M, Defense Materiel Disposition Manual, August 1997
(f) NAVMED P-117, Manual of the Medical Department (MANMED)
(g) NAVMED P-5132 CH-1, Equipment Management Manual
(h) NAVSUP P-485 Volume I – Afloat Supply, Naval Supply Procedures
(i) NAVSUPINST 6710.1B, Requisitioning of Controlled Substances
(j) OPNAVINST 3120.32D, Standard Organization and Regulation of the U.S. Navy (SORM)
(k) OPNAVINST 4770.5G, General Policy for the Inactivation, Retirement, and Disposition of U.S. Naval Vessels
(l) OPNAVINST 4790.4E, Ship's Maintenance and Material Management (3-M) System Policy
(m) OPNAVINST 5090.1C CH-1, Environmental Readiness Program Manual
(n) OPNAVINST 5100.19E, Navy Safety and Occupational Health (SOH) Program Manual
(o) OPNAV P-45-113-3-99, Afloat Medical Waste Management Guide
(p) SECNAV M-5210.1, Department of the Navy Records Management Program, Records Management Manual
(q) SECNAVINST 5210.8D, Department of the Navy Records Management Program

SECTION 1 – SUPPLY AMDINISTRATION

1. General Responsibility. As directed by the CO, the command's medical SMDR, as appropriate, will be responsible and accountable for all medical material under the cognizance of the TYCOM.

2. Custody of Medical Material. The SMDR will be responsible for custody of medical supplies and equipment. Custodians of material shall not permit waste or abuse of supplies or equipment.

a. Responsibility upon Assuming Duty. SMDRs reporting to ships for duty shall, in company with the person being relieved, assure themselves of the status of material management prior to assuming duty. At a minimum, they will:

(1) Ensure that all items of durable equipment required by the AMAL are on board. Equipment must be installed into the ships 3-M system via Operational Maintenance and Management System-Next Generation (OMMS-NG)/Shipboard Non-Tactical Data Program (SNAP).

(2) Ensure that a current inventory of all supplies, location of items, and other logistics management data are accurately reflected in the SAMS/TMIP system, or TYCOM-approved data management system.

(3) Ensure that ongoing actions affecting the status of material (e.g., outstanding requisitions, outstanding surveys and outstanding repair orders), including pharmaceutical expiration dates, are properly documented and understood by the relieving SMDR.

b. Discrepancies Noted upon Relief. Discrepancies noted will be adjudicated by the CO via the letter of relief. Adjudication shall include determination of responsibility, initiation of any disciplinary or administrative action, and adjustment of accounting records and requisitions for replacement items.

3. Medical Material Requirements

a. Authorized Medical Allowance List (AMAL). The material requirements for a ship are stated in the AMAL published by the Naval Medical Logistics Command (NMLC) for each class of ship.

These listings constitute:

(1) The minimum quantity of supplies required to be onboard at all times, which may be exceeded based on usage rate of a specific item. The only exception is controlled substances. A written waiver from the Force Surgeon is required to maintain an excess of controlled substances onboard. The Medical Department does not have blanket authorization to modify the AMAL. Purchase of non-AMAL items or modification of existing equipment that would change the scope of care must be approved by the Force Surgeon. Purchase of non-AMAL, single patient specific medications is authorized and is to be evaluated on a case-by-case basis by the SMDR. IDC platforms require RMRSMO approval.

(2) For IDC platforms, items maintained outside of Sick Bay must be divided between available storerooms in order to enhance survivability in case of emergency.

b. Maintenance. For readiness assessment purposes, overall AMAL must be stocked at 90% or greater to be graded as satisfactory. Emergency AMALs (i.e., First Aid Box, Mass Casualty Box, Battle Dressing Station, MO Response Kit, IDC Response Kit, Crash Cart, Junior HM Bag, Gun Bag and First Aid Kit, Small Craft, and Dental Emergency) will be stocked at 100% at all times to be graded as satisfactory.

c. Updates. AMAL updates are periodically available on NMO. Medical Departments will ensure that the most up to date AMAL is downloaded from NMO regularly when connectivity permits regardless of FRTP cycle. In addition, AMAL changes are posted to the NMLC government website monthly and include the AMAL change codes for further explanation of an item's disposition (e.g. A1D1) https://gov_only.nmlc.med.navy.mil/default.asp.

d. Funds. Medical supplies are chargeable to OPTAR funds, citing fund code N7/U7 (CNSP), S7 (Active CNSL), or M7 (Reserve CNSL).

e. Medical equipment items with a unit price of $5,000 or more are considered investment equipment and are chargeable to OPN funds. Medical equipment over $5,000 for LHA/LHD, $2,500 for LPD/LSD and $1,500 for all other IDC ships must be approved by the TYCOM prior to purchase.

f. Changes in repair parts allowances for medical equipment resulting from AMAL changes are chargeable to the NAVSEA Coordinated Shipboard Allowance List (COSAL) allotment.

(1) Repair parts needed are generally acquired by the departments Repair Parts Petty Officer (RPPO) or the shipboard BMET through the OMMS-NG or the Authorized Parts List (APL) database. However, as a contingent for parts either not listed on the APL or require immediate delivery, the BMET or RPPO shall collaborate with either the Medical Department's supply representative or directly with the ship's Supply Department to begin the open purchase process.

(2) It is the responsibility of the BMET to research the price and availability of the required part(s) with the manufacturer as well as periodically monitor the shipment status of the part/equipment ordered.

g. Repair parts costs associated with maintenance of medical equipment are chargeable to NR/UR (CNSP), SR (Active CNSL) or MR (Reserve CNSL) OPTAR funds.

h. Recommendations for AMAL changes must be submitted via the NMLC website using the Allowance Change Request (ACR) option. Once submitted, it will be forwarded to the TYCOM for review and validation.

i. Additional requirements for material are authorized and determined as noted in the following paragraphs:

(1) Additional/Excess AMAL Augmentation. The SMDR will determine material augmentation requirements for a specific deployment from input received from available sources (e.g., usage rates, NEPMU, National Center for Medical Intelligence, theater specific requirements) unless otherwise directed by the RMR or TYCOM. The most common example of such a requirement is medication for malaria prophylaxis. Such items, except for controlled substances and durable equipment, are authorized to meet known and/or anticipated requirements pertaining to a specific deployment. They may be items not included in the AMAL or increases in quantities of items currently authorized in the AMAL. When such requirements are determined to be permanent, rather than for a specific deployment an appropriate ACR should be submitted.

(2) Spare Parts Provisioning/COSAL. These requirements are determined by NMLC and promulgated by COSAL. These items are high mortality spare parts for durable medical equipment (e.g., fuses, bulbs) which are routinely replaced during operator maintenance and/or by a BMET.

(a) Parts may be forced onboard by the APL, 3M system as planned maintenance parts or through mathematical calculations due to the replacement factor.

(b) These parts may be located in the ship's supply. In addition, if there are parts that the ship determines should be on the APL, they can submit a Feed Back Report (FBR) through Navy 311 requesting to add the part. The FBR will be evaluated by NMLC to determine if the addition is warranted.

j. Other Requirements. Some items used by the Medical Department are procured using Supply Department funds (e.g., rat traps, pest control materials and some Non-combatant evacuation operations (NEO) supplies) in accordance with reference (g).

k. A complete bulkhead to bulkhead inventory of all medical material onboard will be conducted no less than annually. A dated memorandum will be routed to the CO specifying all discrepancies discovered from the inventory with attached POA&M as necessary.

4. Medical Department Funding (Annual Budget). The SMDR shall develop a financial plan for the department based on experience and projected requirements. The SMDR shall advise the ship's supply officer and Chain of Command of these needs in advance of distribution of the quarterly allocation of funds. Pursuant to reference (d), an annual projected budget should be prepared and submitted to the supply officer for inclusion in the annual financial management plan (AFMP).

5. Operating Target (OPTAR). Pursuant to reference (d), medical/dental supplies and services have the highest priority for obligation of "other" OPTAR funds. The SMDR should be aware at all times of the status of funds projected for supporting the Medical Department. There is a direct relationship between fund accounting and material accounting. Attention to the posting of requisitions when material is ordered and when received is

essential to accurate record keeping. A file of outstanding, as well as completed, requisitions will be maintained in the Medical Department to support entries in accounting records.

6. Medical Department Equipment Funding

a. The Shipboard Equipment Replacement Program (SERP). SERP is a phased replacement lifecycle management procurement program. The goal of the program is to replace investment medical equipment, as defined in section 1.3.e, at the end of its useful life or when equipment is beyond economical repair. Funding for the program is provided by Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet.

(1) Equipment received through this program must be acknowledged as received through the following website: https://gov_only.nmlc.med.navy.mil/int_code04/SERP/.

(2) Medical Departments shall submit a SERP procurement request, Appendix K, to the TYCOM BMET no later than 1 March every year.

b. Medical Support Equipment (MSE). MSE program supports the procurement and installation of new medical technology or capability. Funding for the program is provided for by Commander, Fleet Forces Command and Commander, U.S. Pacific Fleet.

c. Urgent Replacement. In the event of an unplanned loss of equipment due to any means, and the equipment cost is less than $5,000 for LHA/LHD, $2,500 for LPD/LSD, or $1,500 for all other IDC ships, the replacement item should be purchased by the command utilizing OPTAR funds. In the event that the replacement cost exceeds the above threshold amounts, the command must submit a supply augment request to the TYCOM for funding to support the purchase and necessary installation costs of the equipment.

7. Requisitioning Standard Stock Material

a. Medical Departments shall follow the standard Navy procedures and processes as set forth by the current supply directives, including the use of Prime Vendor.

b. Report of discrepancy (SF-364) should be used for reporting shipping type (item) discrepancies and packing discrepancies attributed to the supplier or originator.

8. Requisitioning Non-Standard Stock Material. Every effort should be made to fill requirements from material carried by the Defense Medical Logistics Standard Support (DMLSS). When it is necessary to secure material from other sources, a non-standard requisition shall be prepared and submitted to the commands supply officer for procurement. The requisition should contain adequate descriptive information to permit acquisition by non-health services personnel and should give recommended sources of supply within the area of the ship's homeport or geographic area of operations.

9. Use of Re-Supply Ships. For ship types having a fleet re-supply mission, medical material is carried for issue to other ships from their cargo fill. Catalogs of fill items are available from these ships' supply officers. Use of this re-supply source is highly encouraged, especially when deployed. The receiving ship's supply officer should be consulted for requisitioning procedures, submission requirements and submission dates.

10. No-Cost Transfer of Medical Items. Transfers between forces afloat are made on the DD 1348 and will be completed by the requesting ship, according to section 5036 of reference (h).

11. Responsibility for Quality Control Surveillance of Medical Material. The SMDR shall be responsible for maintaining quality control surveillance over all medical material carried onboard. Quality control surveillance shall be consistent with directives from higher authority and specific guidance as provided herein. Medical material is to be used on a first-in, first-out basis of stock rotation unless expiration dates dictate otherwise. When an expiration date is given as month and year only, the material is considered to expire on the last day of the month.

12. Procedures for Quality Control Surveillance of the Medical Material. The following minimum procedures will be established aboard all afloat commands using the SAMS/TMIP Supply Module, or TYCOM-approved electronic system:

a. A monthly reoccurring review of supplies onboard for expired Type I material (potency dated material) to be removed from stock, survey and order replacement material prior to expiration date. Recommend utilization of the "warning requirements" application in SAMS/TMIP.

b. A monthly reoccurring review of quality control of material having an "estimated storage life", including action on extending the shelf life (to include appropriate marking), surveying and replacing material as indicated.

c. A records accounting system that adjusts promptly to reflect effects of surveys (and other dispositions), requisitions and receipts.

d. A method to identify and manage drug recalls, extensions, and suspensions of medical material.

e. A standard policy to issue and use expiration dated material on a “first to expire” basis.

f. An arrangement, where possible, to turn in dated material three months before the expiration date to an MTF in exchange for like material bearing a longer expiration period.

g. The SMDR and pharmacy technician shall subscribe to MMQC messages to ensure all drug recall, extensions and suspensions are addressed in an expeditious manner (http://www.usamma.amedd.army.mil/assets/apps/nala_qaweb/nala_index.cfm).

13. Reporting Defective or Unsatisfactory Medical Material

a. The following examples are some of the types of deficiencies in equipment and material which should be reported: systemic equipment failure, defective devices, incorrect or deficient labeling, foreign or particulate matter in liquid or solids, etc.

b. The methods on how to report discrepancies and obtain a return on the command’s purchase can be found in reference (b) and on the Defense Logistical Agency (DLA) Troop Support, Medical Supply Chain-DMMonline web site at: https://www.medical.dla.mil/registration/consent/default.aspx.

14. Shelf Life Extension Program (SLEP). The Department of Defense (DOD)/Food and Drug Administration (FDA) SLEP is used to defer drug replacement costs for date sensitive stockpiles of medical material by extending their useful life beyond the manufacturer's original expiration date. SLEP system is currently managed by Defense Medical Standardization Board (DMSB) at Fort

Detrick, Maryland. All testing for extensions is performed at FDA test facilities. Every command that maintains CBRN medications is to maintain an active account with SLEP (which can be accessed via the link below) and conduct quarterly updates of the information (https://slep.dmsbfda.army.mil/portal/page/portal/SLEP_PAGE_GRP/SLEP_HOME_NEW).

15. Survey of Medical Material. Material that has exceeded its shelf life, lost, or destroyed should be surveyed using form DD 200. Detailed instructions for conducting a survey of material is contained in chapter 5, section II of reference (h).

16. Disposal of Medical Material. All personnel are cautioned that defective or expired medical material should be disposed of in a manner as to ensure that any drug or biological is rendered non-recoverable for use and harmless to the environment. For specific procedures refer to reference (o). As stated in reference (e), "Destruction will be complete, to preclude use of the drug or any portion thereof."

a. Where appropriate, utilize the DoD Pharmaceuticals Reverse Distribution Program (DPRDP), accessible via: http://www.guaranteedreturns.com/Government.aspx.

b. If unable to effect reverse distribution, the command's Afloat Environmental Protection Coordinator should contact the Naval Station Environmental Control department at your homeport with the material safety data sheet (MSDS) specifics on the material involved. Naval Station Environmental Control will be able to remedy or access contracts to remedy disposal of material in a manner that is consistent with the homeport state laws.

17. Medical Waste Management

a. References (m) through (o) define medical waste into two categories: potentially infectious and non-infectious. The proper processing and disposal of shipboard medical waste is of particular importance due to limited storage space and lack of shore disposal facilities during deployments. Each Medical Department will establish, either as a separate instruction or as part of the SORM, official guidance for handling medical waste. Medical personnel will ensure an adequate inventory of disposal material, including containers, bags, etc., are maintained.

b. The Medical Department will establish and maintain a medical waste log in accordance with reference (o). Information maintained will include: date, type of waste, amount (volume or weight), storage location, method of disposal, tracking number, receiving activity (signature of person receiving), as well as the receiving company name.

SECTION 2 – DRUGS REQUIRING SPECIAL CUSTODIAL CARE

1. Definitions

a. Controlled Substances, AMAL. Alcohol, barbiturate, hypnotic, stimulant, narcotic and sedative medications requiring special custodial care (hereafter referred to as "controlled substances") are those designated by the symbols “C”, “R”, and "Q" appearing in the "NOTES" column of the identification list in the Federal Supply Catalog. COs may designate other substances as drugs of abuse and require security measures similar to controlled substances. Refer to chapter 21 of reference (f) for further information or clarification.

b. Controlled Substances, Non-AMAL. Units shall not procure or dispense controlled substances that are not AMAL for their platform. Exceptions to this provision may be granted in writing ONLY by the Force Surgeon. The written waiver granting authorization shall be maintained with the bulk stock records.

c. AMAL Quantity. The AMAL quantity is the authorized quantity of material required onboard at all times, and for controlled substances is the total of the bulk and working stock.

2. Security of Controlled Substances. A minimum of two safes are required for security of controlled substances. The only exceptions to this are LCS, MCM and PC platforms. Combinations of safes will be safeguarded as follows:

a. Bulk Stock Safe. Only the bulk stock custodian shall hold the combination.

b. Working Stock Safe. Only the working stock custodian shall hold the combination.

c. Recording of Combinations. A combination change envelope (SF 700) shall be used and placed in the custody of the CO or an officer designated in writing by the CO.

d. Changing of Combinations. The controlled substance safes’ combination change shall be accomplished upon change of custody, upon suspicion of compromise or every 24 months.

e. NAVMED 6710/5, Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs. NAVMED 6710/5 will be used for items in

both bulk and working stock. Accurate quality control data (i.e., manufacturer, lot number, and expiration date or manufacture date) must be annotated on each page.

3. Controlled Substance Custodians

a. Bulk Stock Controlled Substances Custodian. The bulk stock controlled substances custodian will be a commissioned officer appointed by letter with responsibilities delineated by the current CO. The bulk stock custodian will not be the working stock custodian or a member of the CSIB. NOTE: Due to the small number of crewmembers, the LCS, MCM and PC class ships are exempt from the requirement to assign a bulk stock custodian. The bulk stock custodian does not have prescription writing authority. The bulk stock custodian's duties, responsibilities and authority include:

(1) Responsibility for maintaining custody of all unissued controlled substances within the bulk stock.

(2) Familiarization with and observance of applicable portions of chapter 21 of reference (f) relating to receipt, custody, and security of controlled substances.

(3) Maintaining the necessary accounting records and documents to substantiate proper receipt and expenditure of controlled substances in custody.

(4) Ensuring that a SF 700 has been placed in the custody of the CO or their designee.

(5) Reporting directly to the CO in the performance of the above duties.

b. Working Stock Controlled Substances Custodian. The working stock custodian will be appointed by letter with responsibilities delineated by the CO. The working stock custodian will not be the bulk stock custodian or a member of the CSIB. The working stock custodian will be the pharmacy technician (NEC 8482). In the absence of a pharmacy technician the working stock custodian will be the IDC.

(1) The duties, responsibilities, and authority of the working stock controlled substances custodian will be the same as those of the bulk stock custodian, applied to the working stock.

(2) The working stock controlled substances custodian shall maintain a minimum of one unit of issue of each authorized controlled substance in the working stock safe at all times.

(3) The working stock controlled substances custodian shall report directly to the CO in the performance of the above duties.

4. Controlled Substances Inventory Board (CSIB)

a. CSIB Members. The CSIB will have a minimum of three (3) members, at least two of whom shall be commissioned officers. The senior officer will be designated as the senior member. However, more board members may be appointed at the discretion of the CO. Enlisted personnel in paygrades E-7 to E-9 may serve as the third member at the discretion of the CO. A Nurse Corps or Medical Service Corps officer can be a member provided the officer is not accountable for such substances and they do not have prescription writing privileges. A minimum of three (3) CSIB members must accomplish each inventory. On ships with an assigned crew of less than 100, one commissioned officer and one chief petty officer may constitute the board. Both members must accomplish each inventory. CSIB members shall not be involved in the direct procurement of controlled substances.

b. Training. All members must complete the required one-time CSIB training on NKO (located on the Pharmacy home page). All members will be appointed by name in writing by the current CO and the completion of training will be noted in the letter. Refer to references (c), (f), (i) and section 304.4 of reference (j) for all duties, responsibilities, authority and security procedures for the CSIB program.

5. Dispensing and Transfer of Controlled Substances. The dispensing of controlled substances for other than medical purposes is strictly prohibited. A notebook with individual substances listed shall be used for the bulk stock, working stock, and emergency breakout stock (if authorized). These records shall be retained for three years, after which they are destroyed at the beginning of a new calendar year. Example: On 1 January 2000, all controlled records and prescriptions dated through 31 December 1996 would be destroyed in accordance with references (p) and (q).

a. Procedures for Transfer from Bulk Stock to Working Stock

(1) Transfer shall be made in whole units only (e.g., bottle, box).

(2) A NAVSUP 1250 (Manual Requisition) shall be prepared in duplicate, dated, and signed by both the working stock custodian and bulk stock custodian. The original completed NAVSUP 1250 will be filed in an envelope attached to the back of the bulk stock record NAVMED 6710/5, for the drug being transferred. The duplicate of the completed NAVSUP 1250 will be attached to the working stock record NAVMED 6710/5, for the drug being transferred.

b. Procedures for Transfer from Working Stock to Bulk Stock

(1) Transfer shall be made in whole units only (e.g., bottle, box).

(2) A NAVSUP 1250 shall be prepared in duplicate, dated, and signed by both the working stock custodian and bulk stock custodian. The original completed NAVSUP 1250 will be filed in an envelope attached to the back of the working stock record, NAVMED 6710/5, for the drug being transferred. One copy of the completed NAVSUP 1250 will be attached to the bulk stock record, NAVMED 6710/5, for the drug being transferred.

c. Procedures for Transfer from Working Stock to Emergency Breakout Stock

(1) The emergency breakout stock procedure will only be used onboard ships with an MO assigned, providing 24-hour medical coverage. It will provide a minimal stock of controlled substances to the senior member of the duty section. It shall not serve as a source for filling "routine" prescriptions during duty hours.

(2) Transfer shall be made with a completed prescription blank (DD-1289) at which time a Narcotic and Controlled Drug Account Record (NAVMED 6710/1) shall be initiated.

(3) Inventory control of the emergency breakout stock shall be maintained with the Narcotic and Controlled Drug Inventory-24 hour accountability record (NAVMED 6710/4).

d. Procedures for Dispensing from the Emergency Breakout Stock

(1) Dispensing from the emergency breakout stock shall conform to the guidelines in this paragraph. A DD-1289 shall be prepared and signed by the senior member of the duty medical section. The command's MO will countersign this prescription as soon as possible. The medication will be issued to the patient and the patient will complete and sign the back of the prescription as in any controlled substance prescription. If the patient is unable to sign, it will be noted on the prescription. The front of the prescription will be annotated "issued from emergency breakout NAVMED 6710/4" (indicate the prescription number from the appropriate NAVMED 6710/4). The countersigned prescription will be attached to the appropriate NAVMED 6710/4.

(2) Once the NAVMED 6710/4 has been completed (i.e., all substances have been accounted for with attached DD-1289's), it shall be returned to the working stock custodian for inclusion in the records.

(3) Upon relieving the watch, a physical inventory of all controlled substances is accomplished between relieving senior watch-standers. The keys to the emergency breakout stock will remain in the custody of the senior medical watch-stander.

e. Procedures for Dispensing from Working Stock

(1) A DD-1289 will be prepared, dated, have the quantity dispensed, the prescription number and signature of the dispenser. Patient data will include at a minimum, full name, command, current address, telephone number and their signature acknowledging receipt of the drug item.

(2) The letter "C" will be utilized as a prefix to all controlled substances prescriptions and they will be filed sequentially.

(3) Controlled substances prescriptions will be signed by an MO or DO. In ships without an MO or DO assigned, prescriptions will be signed by the SMDR and countersigned by the CO or duly appointed commissioned officer representative (usually the executive officer, of which this appointment must be in writing).

(4) In those special cases where the controlled substances are for use by the CO, the prescriptions shall be countersigned by the duly appointed commissioned officer

representative. In NO INSTANCE shall the CO or the designated alternate sign or authorize prescriptions for controlled substances for their own personal use.

(5) Self-prescribing of medications by a health care provider is generally inappropriate and is to be avoided. If a sole-provider IDC requires prescription medication for treatment in the absence of a physician or other authorized prescriber while deployed, the administration of that medication should be documented through countersignature of the CO. In the rare event of an emergency medical condition in which the IDC is the patient requiring a controlled substance, every effort should be made to consult with a medical officer within the afloat group and/or the Numbered Fleet Surgeon before medication administration. The lowest dose and shortest duration of controlled substance that is consistent with treating the condition and providing symptom relief should be used. The presumptive diagnosis, reason for use of a controlled substance and the consultation with a medical officer, should be documented and countersigned by the CO. In addition, in order to maintain the deployable condition of the ship, the earliest possible relief (whether temporary or permanent) of the IDC patient by an alternate provider must be accomplished.

(6) SMDR prescriptions for controlled substances shall be issued only in a sufficient quantity to sustain the patient until seen by an MO or DO. In no case will more than a 10 day supply of controlled substances be prescribed.

(7) Prescriptions for controlled substances will not be issued by an IDC while in their homeport, unless an emergency situation exists and treatment will be delayed.

(8) Controlled substances are normally to be dispensed only to ship’s company. There may be certain situations in which individuals other than crewmembers may require these substances. These individuals may include people involved with civilian humanitarian operations, people aboard ship participating in a “Tiger Cruise,” people participating in the “Leaders to the Sea” Program, and other personnel aboard ship in an official capacity incident to ship’s operations. In these situations, the medical SMDR may prescribe and dispense these substances if medically warranted. In keeping with the intent and spirit of this article to restrict the use of controlled substances to eligible

individuals, controlled substances will not be issued to family members of the crew, except in the special circumstances noted above.

(9) If controlled substances are prescribed by an IDC, that record will be reviewed by their Physician Supervisor.

6. Requisitioning, Receipt, and Expenditure of Controlled Substances. The requisition, receipt, expenditure, survey, or other issuance of controlled substances is directly related to the financial management of Medical Department funds. The perpetual inventory records must be presented to the CSIB every 90 days or no later than 30 days after a transaction for comparison of total quantities contained in bulk against total quantities received and expended utilizing Medical Department funds. NMLC monitors all Navy and Marine Corps issues of controlled substances and forwards reports of discrepancies to the TYCOM for action.

SECTION 3 – MEDICAL EQUIPMENT MAINTENANCE AND REPAIR PROGRAM/3M SYSTEM

1. General. Medical equipment maintenance and repair is outlined in references (g) and (l).

2. Medical Equipment Maintenance and Repair Program. COMNAVSURFPAC/COMNAVSURFLANT ship Medical Department's shall comply with the requirements of reference (g), maintain the OMMS-NG for configuration, APL and SKED to support the 3-M program. The OMMS-NG system provides supporting BMETs with a complete unscheduled maintenance history, which is essential for proper equipment management.

a. Prepare an OMMS-NG record for all new and existing equipment required onboard by the AMAL. Equipment maintained with these records shall have an associated APL per the NMLC APL database.

b. A NAVMED 6700/3 will be maintained for the following reasons:

(1) Equipment not supported by APL.

(2) On all equipment for ships without onboard BMET.

(3) The NAVMED 6700/3 shall be used to document any unscheduled and scheduled maintenance performed on the equipment.

(4) Document any unscheduled and scheduled maintenance performed on the equipment.

c. These two types of records shall become a life cycle record for the equipment. Equipment records should match the equipment onboard.

d. Records for equipment that has been sent to disposal or transferred to another activity should be removed from the configuration.

(1) Correct APLs can be identified through the following website: https://gov_only.nmlc.med.navy.mil/int_code04/internal-code04-apl.asp.

(2) The OMMS-NG record and/or NAVMED 6700/3 shall accompany the equipment to when sent to disposal or transferred to another command.

e. In accordance with the ships 3M schedule and not less than semi-annually, a BMET will check all medical equipment items. These checks, as well as equipment repair and maintenance beyond ship's force capability, will be requested from the nearest BMET afloat, MTF, or medical equipment repair facility. The BMET shall sign the 13 week report upon completion of the scheduled maintenance.

f. Refer any problems encountered in obtaining technical assistance, arranging repair service, or implementing medical equipment maintenance programs to the RMR by e-mail, message, or telephone.

g. A Casualty Report (CASREP) is required when the medical mission is degraded due to equipment failure. CASREPs are prepared per current 3M guidelines.

3. 3M System. All Medical Department equipment is to be incorporated into the 3M system. If newly received equipment is not supported by a Maintenance Requirement Card (MRC), Medical Department shall submit a FBR to gain the correct MRC under Medical Department List of Effective Page (LOEP). Correct MRC can be identified through the following website: https://gov_only.nmlc.med.navy.mil/int_code04/internal-code04-apl.asp.

a. Until recognized by 3M, follow manufacturer's recommendations for maintenance. Once items are listed in the 3M system, the requirements for maintenance stipulated in the 3M system shall take precedence over manufacturer requirements. Recommendations for additions, deletions, and changes shall be submitted in accordance with reference (l).

b. Regular 3M maintenance **WILL NOT** be recorded on the NAVMED 6700/3. The Medical Department should annotate the "cent" sign in SKED for that check. The "cent" sign is a system mark stating that the check was satisfied by a higher authority. It also requires a flip page entry.

4. Excess Equipment Disposal

a. Obsolete or unserviceable excess material with a minimum value of $500 shall be disposed of in accordance with chapter 12-2 of reference (g). Material with a value of less than $500 shall be disposed of in a safe and responsible manner.

b. Serviceable equipment and consumable supplies considered in excess of the command's needs shall be turned in to their respective local RMR. San Diego based ships will turn in their serviceable equipment and consumable supplies to the COMNAVSURFPAC medical redistribution warehouse. Prior to material turn in, coordinate with the RMR. Equipment or consumable supplies will NOT be dropped off and left unattended outside RMR spaces or the medical redistribution warehouse at any time.

5. X-Ray Equipment. Navy medical and dental radiological systems must meet Federal standards for procurement and initial/periodic evaluation to ensure safe and proper operation. Afloat units with radiographic systems (portable or installed) shall maintain compliance with reference (a).

6. Decommissioning/Ship Retirement. Reference (k), provides a consolidated source for basic guidance concerning inactivation, retirement and disposition of naval vessels.

CHAPTER 4 - HEALTH CARE

Ref: (a) BUILDSPECS, Builder Specifications for Ships
(b) BUMEDINST 1300.2A, Suitability Screening for Individuals Nominated for Individual Augmentee and Support Assignments to Overseas Contingency Operations, and Specific Temporary Additional Duty Assignments
(c) BUMEDINST 6110.14 CH-3, Document and Reporting Individual Medical Readiness Data
(d) BUMEDINST 6120.20C, Competence for Duty Examinations, Evaluations of Sobriety, and other Bodily Views and Intrusions Performed by Medical Personnel
(e) BUMEDINST 6220.10A, Management of Human T Lymphotropic Virus Type I and II (HTLV I/II) Infection in the Navy and Marine Corps
(f) BUMEDINST 6310.11A, Sexual Assault Prevention and Response Medical-Forensic Program
(g) BUMEDINST 6320.83A, Provision of Standbys During Medical Examinations
(h) BUMEDINST 6410.9, Medical Monitoring Flight Personnel in Locations where Flight Surgeons are Not Available
(i) COMUSFLTFORCOMINST 6600.1, Dental Standard Operating Procedures (SOP) for Operational Units
(j) COMUSFLTFORCOM/COMPACFLTINST 6320.3A, Medical Screening for U.S. Government Civilian Employees, Contractor Personnel, and Guests Prior to Embarking Fleet Units
(k) DoD Instruction 6490.04, Mental Health Evaluations of Members of the Military Services of 4 March 2013
(l) NAVMEDCOMINST 5360.1, Decedent Affairs Manual
(m) NAVMEDCOMINST 6320.3B, Medical and Dental Care for Eligible Persons at Navy Medical Department Facilities
(n) NAVMEDCOMINST 6810.1, Ophthalmic Services
(o) NAVMED P-117, Manual of the Medical Department (MANMED)
(p) NAVMED P-5010, Manual of Preventive Medicine
(q) NAVMED P-5055, Radiation Health Protection Manual
(r) NAVMED P-5083, Methods for Preparing Pathological Specimens for storage and Shipment
(s) NAVPERS 15560D, Naval Military Personnel Manual
(t) NAVSUP 4440.128D, Storage and Handling of Liquefied and Gaseous Compressed Gasses and their Full and Empty Cylinders

(u) NAVSUP P-485, Volume I, II and III Ashore Supply
(v) NEHC-TM OM 6260, Medical Surveillance Procedures Manual and Medical Matrix (Edition 9)
(w) NAVAL SHIPS TECH MANUAL VOLUME 2
(x) OPNAVINST 1640.8A, Manual for the Operation and Administration for Afloat Brigs
(y) OPNAVINST 1720.4A, Suicide Prevention Program
(z) OPNAVINST 3120.32D, Standard Organization and Regulations of the U.S. Navy
(aa) OPNAVINST 3591.1F, Small Arms Training and Qualification
(ab) OPNAVINST 5100.19E, Navy Safety and Occupational Health (SOH) Program Manual
(ac) OPNAVINST 5350.4D, Navy Alcohol and Drug Prevention and Control
(ad) OPNAVINST 6400.1C, Training, Certification, Supervision Program, and Employment of Independent Duty Hospital Corpsmen (IDCs)
(ae) OPNAV P-45-113-3-99, Afloat Medical Waste Management Guide
(af) SECNAVINST 1640.9C, Department of the Navy Corrections Manual
(ag) SECNAVINST 1850.4E, Department of the Navy (DON) Disability Evaluation Manual
(ah) SECNAVINST 5210.8D, Department of the Navy Records Management Program
(ai) SECNAVINST 5211.5E, Department of the Navy (DON) Privacy Act (PA) Program
(aj) SECNAVINST 5300.28E, Military Substance Abuse Prevention and Control
(ak) SECNAVINST 6120.3 CH-1, Periodic Health Assessment for Individual Medical Readiness
(al) SECNAV M-5210.1, Department of the Navy Records Management Program, Records Management Manual

SECTION 1 – ADMINISTRATION

1. Administrative Logs and Records. The following records will be maintained in Sickbay. They will be in a book/log or kept electronic copy, and in sufficient detail to serve as a complete and permanent historical record for actions, incidents, and data. Records will be retained until disposed of pursuant to reference (ah)

a. Sick Call Log. The sick call log provides an audit trail for medical care provided to each patient. A modified sick call log should be submitted daily to the CO. Each patient's diagnosis will be noted within the context of the report. The sickcall log is a source of patient privacy breach. Protect this information and take appropriate action to ensure that protection is maintained.

b. Admissions Log. Used to note all patients that are admitted onboard the ship. Necessary patient info will include date and time of admission, patients full name, rank/rate, last four of Social Security Number, sex, age, parent command, admitting provider, initial diagnosis, discharge diagnosis, date and time of discharge and disposition at time of discharge.

c. Consultation and Follow-up Log. A data base of consultations and required follow-up care will be maintained within Sickbay.

d. Serious List/Very Serious List. In accordance with article 1770-230 of reference (s), personnel whose illnesses or injuries are of such severity as to be life threatening will be placed on the serious list or very serious list with appropriate notifications made.

e. Memorandum for the Record (MFR). The use of a MFR will now replace the previously used Medical Department Journal for accounts of events of historical significance, not otherwise recorded in other programs. The memorandum will provide a medium for recording special occurrences that might need to be reconstructed in detail at a future time. Examples of such events are those for which reference documents are removed from the ship such as serious injury or death. Recommendations made to the command that are not followed due to CO's discretion are another example. Other significant occurrences include assessments from outside sources that are not officially reported and stock inventories that are not recorded elsewhere.

The SMDR will sign each memorandum prepared. If an ADP program is utilized, a hard copy will be printed upon generating the document. Memoranda are permanent records and will be retained in accordance with reference (ah).

f. Training. Training accomplishment will be documented using the SAMS/TMIP Training Module, Relational Administrative Data Management (R-ADM) or other TYCOM approved training database. At a minimum, the documentation will include: date, topic, group receiving the training, instructor's name, number of personnel present, and the type of presentation.

g. Heat Stress. Heat Stress information will be maintained in accordance with reference (ab). The SAMS/TMIP Environmental Surveillance module, along with a "Heat Stress Binder" is the preferred method for maintaining these records. The following will be maintained and accessible:

(1) Command heat stress instruction.

(2) Copy of OPNAVINST 5100.19E, Chapter B2.

(3) A copy of the Afloat Self-Assessment (ASA) checklist/sheet.

(4) A list of all personnel trained and qualified in using the Wet, Bulb, Globe Thermometer (WBGT). Information must be provided from a TYCOM approved training database.

(5) Training rosters from all heat stress training conducted for the command (to include indoctrination rosters).

(6) List of the locations of all hanging dry bulb thermometers for the command.

(7) List of all Automated Heat Stress System (AHSS) sensor locations and equipment data (if installed).

(8) Original completed heat stress surveys signed by the CO, executive officer, chief engineer, and the SMDR and supply officer when required.

h. Hearing Conservation. Hearing Conservation information will be maintained in accordance with reference (ab). The SAMS/TMIP Environmental Surveillance module, along with a "Hearing

Conservation Binder" is the preferred method for maintaining these records. The following will be maintained within the binder:

(1) Command hearing conservation instruction.

(2) Copy of OPNAV 5100.19E, Chapter B4.

(3) A copy of the Afloat Self-Assessment (ASA) checklist/sheets.

(4) A roster of personnel who are required to be on the Hearing Conservation Program as identified by baseline and bi-annual Industrial Hygiene survey.

(5) Any personnel who have a significant threshold shift (STS) as noted on the DD 2216, with a reestablished base line.

(6) List of personnel consulted out to audiology for evaluation.

i. Refrigerator Temperature Log. Shelf life, potency, efficacy and safety of certain biologicals and medications depend on proper storage and handling procedures. Medical Departments are required to ensure proper temperatures are maintained in areas where biologicals and medications are stored. Refrigerated storage areas must be checked and recorded at least daily. In the case of multiple refrigerators, readings may be maintained on one log or individual logs, at the discretion of the SMDR.

j. X-Ray Log. If the ship has x-ray capability, the assigned X-ray technician (HM-8452) will maintain a record of studies conducted as outlined in section 2.3.

k. Laboratory Log. All ships will maintain a record of tests and studies as outlined in section 2.4.

l. Specialty Screening Log. It is recommended to maintain documentation on personnel who have been exposed to asbestos, mercury and lead. Those personnel exposed to potentially hazardous material are required to have an annual screening from Occupational Health, with a supporting SF600 entry.

m. Potable Water Log. In accordance with chapter 6 of reference (p), records concerning potable water testing will be maintained using the SAMS/TMIP Environmental Surveillance module.

n. Sterilization Log. All ships will maintain a record of sterilizations as outlined in section 3.14.

o. Medical Waste/Disposal Log. All ships will maintain a record in accordance with reference (ae).

p. Pest Control Log. In accordance with chapter 8 of reference (p), all ships will maintain a record of pest control efforts using the SAMS/TMIP Environmental Surveillance module and current NEPMU guidance.

2. Health Records

a. Privileged Communication. The health record is a legal document containing an individual's past and present medical history. The manner of custody will be such as to protect its personal nature. Health record management will be administered pursuant to chapter 16 of reference (o). The SAMS/TMIP master tickler transfer record may be used in lieu of retaining the NAVMED 6150/7. Chapter 23, section III of reference (o), reference (ii), The Privacy Act of 1974 and The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules set forth guidelines to be followed regarding the release of information from health records.

b. Health Record Verification. Medical records, with an emphasis on an accurate and complete Adult Preventative and Chronic Care Flow Sheet DD 2766, shall be verified upon receipt at the time of the PHA and prior to transfer to ensure that all required entries are contained therein. At a minimum, health records shall be verified annually by the Medical Department having custody of the record. An SF-600 entry will be made and the appropriate block will be marked on the health record jacket. NOTE: An audit of health records, where records are checked against the ship's personnel roster, will be conducted semiannually and prior to any major deployment to ensure that a medical record is onboard for each crewmember.

c. Readiness Requirements. Pursuant to reference (c), Medical Departments shall ensure all IMR and dental data is recorded in an approved electronic system for uniformed service members in the command including all new accessions.

(1) IMR consists of six elements:

(a) PHA (includes deployment health assessments)

(b) Dental readiness

(c) Readiness laboratory studies

(d) Immunizations

(e) Deployment Limiting Conditions

(f) Individual Medical Equipment

(2) Each service member's medical and SAMS/TMIP record will be documented with discrepancies be given a classification of:

(a) Fully Medically Ready. Current in all six elements.

(b) Partially Medically Ready. Lacking any readiness laboratory studies, immunizations or medical equipment.

(c) Not Medically Ready. Dental Class 3 or with a deployment limiting condition.

(d) Medical Readiness Indeterminate. Overdue PHA, PDHRA or in Dental Class 4 status.

(3) Each member must have verification of HIV testing and results of blood typing, G6PD and sickle cell in part 4 of the patient's health record and annotated on the DD 2766. There must also be documentation that DNA sampling has been accomplished. Units must verify that samples are on file with the Armed Forces Repository of Specimen Samples for the Identification of Remains (AFRSSIR). Queries can be submitted via mail or through the following website: http://www.afmes.mil/index.cfm?pageid=afdil.afrssir.database_query.

d. Sick Call Entries. A SAMS/TMIP generated SF-600 entry will be prepared for each patient reporting to sick call within 72hrs of patient encounter. The importance of proper record keeping cannot be overemphasized. A properly maintained health record is of great value to the government or to a service member in establishing entitlement to pension benefits for a service connected disability. Entries in the health record shall contain at a minimum, the date, name of ship, vital signs, complaint, and treatment rendered in the following S.O.A.P. format:

(1) S - SUBJECTIVE COMPLAINT (Patient's complaints and history)

(2) O - OBJECTIVE SIGNS (Exam findings)

(3) A - ASSESSMENT (Diagnosis)

(4) P - PLAN (Treatment, patient education and disposition)

e. Health Record Signatures. In accordance with reference (dd), a signature is required for each service member examined, treated or referred for treatment. They must print or stamp name, rate, title and National Provider Identifier (NPI). Treatment rendered by other than an IDC or MO shall be counter-signed by the SMDR. Stamped facsimile signatures will not be used on any medical form in the health record. In signing, the individual assumes responsibility for correctness of the entry. It is suggested that a rubber stamp, as in the below example, be procured for Medical Department personnel to facilitate clear entries. A stamp is required for SMDRs.

I. M. WELL, IDC, HM1, USN
NPI: 0123456789

f. Abandon Ship. If at all possible, and secondary *to* medical treatment and evacuation of casualties, make necessary arrangements to salvage the health records in the event of an abandon ship evolution. It is recommended that commands procure containers that are waterproof and provide a seal so as to minimize the chance of water damage to the records. The command name and UIC should be stenciled on the outside lid of the container along with “Medical Records”.

3. Medical Consultations

a. Patients requiring additional specialty or advanced care will be referred using an authorized electronic referral system (i.e. CHCS/ ALTHA). This technical liaison channel provides direct access for afloat Medical Department’s to the resources of shore facilities. The Medical Department will maintain a consultation log to track the status of all off-ship consultations. A consultation sheet (SF-513) may be utilized when an electronic referral system is not available or feasible.

b. The use of an MTF or non-naval health care facility should not be delayed to ensure adequate and timely resolution of health problems. In general, afloat MOs and IDCs, in consultation with their physician supervisors, should consult patients directly to the specialty clinic as needed.

c. Post-Medical Consultation:

(1) Crewmembers returning from medical consultations must receive appropriate follow-up from the units MO/IDC, who shall also assist with further medical care requirements (e.g., medications, physical therapy, follow-up appointments, etc.).

(2) Appropriate follow-up on appointment no-shows shall be conducted by the unit's SMDR. Chronic no-shows are an administrative issue and should be addressed with the chain of command.

d. Medical/Dental Consults OCONUS. In accordance with OPORD of the numbered fleet, the SMDR coordinates medical and dental services prior to all port visits. Ensure that you allow adequate time for the fleet liaison to obtain the services you are requesting. Contact can be made via e-mail, satellite communication or radio as allowed per the OPORD of the appropriate numbered fleet.

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

4. Removal from Duty for Medical Reasons. SMDRs will recommend service members for periods of medically restricted duty to the chain of command when deemed clinically appropriate. The following paragraphs are summarizing potential "medically restricted duty" status categories that are available to the SMDR when providing treatment. Article 18 of reference (o) provides a concise process for each category and should be referred to for questions.

a. Sick in Quarters (SIQ). In accordance with article 1050-190 of reference (s) and article 18-2(2) of reference (o), a member is in this status when excused from duty for treatment, or "medically directed" self-treatment, in home, barracks, or other non-hospital facilities. SIQ status should usually not exceed 72 hours, however if the enlisted MDR does not believe 72 hours will

resolve the medical condition, he or she may consult with a MO for an extension of SIQ status (total SIQ status will not exceed 14 days). An enlisted MDR must seek MO advice if the member cannot be returned to full duty after 72 hours. A recommended SIQ period from an MTF or a civilian provider should be considered as a treatment recommendation only. The SMDR will make the final disposition. Personnel placed on SIQ will be evaluated by the Medical Department prior to being returned to full duty which requires an appropriate health record entry to be made.

b. Convalescent Leave. MTFs may discharge a patient to return to his or her unit and recommend convalescent leave following significant medical treatment and/or a period of inpatient hospitalization. Convalescent leave is a recommendation by an attending physician to the command and is considered an adjunct to patient treatment. The command has approval/disapproval authority for such a recommendation. The command must evaluate each recommendation based on individual case history and operational priorities. Convalescent leave, when granted, does not count against annual leave.

c. Light Duty. Light duty is a period when the service member reports to their work space, but during the period the member is excused from the performance of certain aspects of military duties, as defined in their individual light duty write-up. The goal of light duty is to allow for appropriate clinical evaluation without causing further damage to the patient during the evaluation period. **Light duty will be ordered in periods of no more than 30 days. In no case will light duty exceed 90 consecutive days, inclusive of any convalescent leave periods.** At the end of light duty period, if the service member cannot be immediately returned to medically unrestricted duty, the service member will be referred to the MTF for a Medical Evaluation Board (MEB).

(1) Authority in Navy Medicine to convene MEBs is granted exclusively to the COs of naval medical center and naval hospitals.

(a) Operational unit surgeons or ship medical officers are **prohibited** from independently executing MEB actions, or take unilateral action to place a member on Limited Duty (LIMDU), or refer a member’s case to the Department of the Navy Physical Evaluation Board (DON PEB).

(b) If a condition is significant enough to merit a referral to an MEB is not be compatible with continued shipboard/operational service; close liaison with the chain of command and the MTF patient administration office is crucial to affect appropriate transfer (e.g. temporary duty orders on enlisted members or permanent change of station orders on officer members) for treatment.

(2) The MEB will prepare a MEBR for placement of the member on temporary duty (TLD), LIMDU or referral to a PEB for determination of the patient's fitness for continued service.

(3) In no case should a member reach their 90th day of light duty without the MTF having submitted an MEBR either placing the member on LIMDU or referring to a PEB.

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

d. Limited Duty (LIMDU). LIMDU is a disposition the MEB recommends which is similar to light duty but the major differences between the two are that, in comparison to light duty, LIMDU periods:

(1) Last longer than light duty periods.

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

(3) May necessitate the transfer of the member from the command.

(4) Does not require the consent of the members command.

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

(6) LIMDU may only be provided to a patient as the result of the actions of an MEB.

5. Referrals for Admission

a. Ships with inpatient facilities. Patients can be admitted to the ship's ward for care as deemed necessary per the MO. Appropriate chain of command notification will be made, and medical personnel will be assigned to the "ward watch" as needed. When necessary, the patient can then be transferred to a receiving inpatient facility using a locally prepared inpatient admission/disposition record. Clinical charts or abbreviated clinical records, X-rays, lab results, other pertinent data, and the health record shall accompany the patient upon transfer to other treatment facilities. Under normal circumstances, patients will not be admitted to the ward when in homeport. Patients requiring inpatient care should be referred to the nearest MTF.

(1) Documentation. All inpatient admissions staying greater than four hours, but less than 48 hours must have an Abbreviated Clinical Record (SF 539) or completed SF 600, Doctor's Orders and Progress Notes. Those inpatient admissions staying greater than 48 hours must have a completed History Part 1 (SF 504), History Parts 2 and 3 (SF505), Physical Examination (SF 506) and Doctor's Orders (SF 508) with specific call parameters. All inpatients must have at a minimum a doctor's progress note written every 24 hours. Those patients transferred from an inpatient status to a sustained stay status or patients who are considered self-care and in a convalescent leave/medical hold status must have a doctor's order written and a Chronological Record of Care (SF 600). Personnel placed on the ward having no medical conditions (Sleeper Status) do not need medical documentation, but must have senior medical officer authorization and shall not exceed a stay of greater than 24 hours.

(2) All patients needing admission to the Intensive Care Unit (ICU) will require immediate notification of the physician and Critical Care Nurse (CCN). Notification of the physician and CCN for Ward patient admission should be within an hour.

b. Ships without inpatient facilities. Patients that the IDC believes may require hospitalization will be referred to the nearest MTF or civilian medical facility for further evaluation and treatment. An escort will be provided from the patients command and preferred to be an E-5 or above. Appropriate chain of command will be notified. The IDC will consult with an MO at the nearest medical facility (MTF, shipboard or non-naval) and will complete all necessary arrangements prior to the patient being transferred from the ship. The IDC will ensure the health record and all pertinent data shall accompany the patient upon transfer to the inpatient treatment facility.

6. Treatment of Military Personnel in Non-Federal Medical Facilities

a. Inside the Continental United States (CONUS), active duty service members are not authorized to seek care outside the military health care system without prior approval, unless it is an urgent or emergent situation. Military personnel who receive inpatient or outpatient medical or dental care from civilian facilities must notify their command as soon as possible. A representative from the member's command will immediately notify the local MTF fleet liaison of any admission. Fleet Liaison will assist in handling active duty claims and payments through TRICARE. SMDRs, as well as the member, should seek guidance on local policies and consult with the supporting Fleet Liaison and Regional TRICARE facility for local procedures.

b. Outside of the Continental United States (OCONUS), civilian treatment will be obtained only in emergent situations or when coordinated care as related to a MEDEVAC. Personnel who require urgent or emergency medical treatment while OCONUS on authorized leave or liberty shall, if possible, seek care at the nearest MTF. If a facility is not available, seek the closest available care via the utilization of ISOS. The member is responsible for contacting the regional TRICARE facility within 24 hours. The member should contact the nearest command duty officer, embassy or consulate, to advise them of the situation.

7. Unreasonable Refusal of Medical, Dental or Surgical Treatment

a. The SMDR may occasionally be confronted with an active duty member who refuses to submit to recommended therapeutic measures to prevent illness or injury or to remedy a defect or condition that has interfered with his or her performance of duty. Persons refusing treatment aboard ship may be subject to administrative or disciplinary consequences. In some cases, it will be appropriate to transfer them to a MTF for further evaluation and recommendations as to disposition. Submit such cases up the immediate chain of command. Do not, under any circumstances, force unwanted medical procedures on a competent, aware individual.

b. Notwithstanding the above, medical treatment may be given with or without a member's consent in certain conditions pursuant to chapter 2-18 of reference (o). **The condition rather than the refusal of treatment should be the deciding factor for determining disposition.** In general these are:

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

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

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

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

8. Motion Sickness

a. In accordance with article 1910-120 of reference (s), enlisted members of the naval service who manifest chronic motion sickness, who do not respond to conventional prophylactic/therapeutic treatment and who are unable to perform their duties as a result should be considered for possible administrative separation from active duty.

b. The diagnosis of chronic motion sickness (ICD-9 994.6) is based on clinical presentation but must also consider the extent to which the condition has interfered with the member's performance of his or her duties. Statements from the chain of command documenting the member's performance should also be considered. The member must have a thorough examination, including evaluation by an ear, nose, and throat (ENT) specialist, to ensure that the motion sickness is not a manifestation of ENT pathology and that the member is otherwise physically qualified for duty. Members should not be transferred to a MTF for admission unless competent medical authority has determined that hospitalization is necessary for proper evaluation of the condition.

c. In the event that an enlisted member requires admission to MTF, the documentation cited above must be sent with the service member to the hospital. Enlisted members not requiring hospitalization for proper evaluation should be processed as indicated through the administrative procedures set forth in reference (s).

9. Recommendations for Discharge by Reason of Unsuitability

a. Pursuant to article 1910-120 of reference (s), enlisted personnel diagnosed as having one of the below physical or behavioral medical conditions which impair a member's performance, but do not amount to a physical disability may be processed for separation.

(1) Enuresis (bedwetting).

(2) Sleepwalking and/or Somnambulism.

(3) Dyslexia and other learning disorders.

(4) Attention Deficit Hyperactivity Disorder.

(5) Stammering or Stuttering.

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

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

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

(9) Uncomplicated alcoholism or other substance use disorder.

(10) Mental retardation.

(11) Adjustment disorders.

(12) Impulse control disorders.

(13) Sexual gender and identity disorders.

(14) Factitious disorder.

(15) Over height.

(16) Pseudofolliculitis barbae of the face and/or neck.

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

(18) Significant allergic reaction to stinging insect venom.

(19) Unsanitary habits.

(20) Certain anemia's – in the absence of unfitting sequelae – including G6PD deficiency, other inherited Anemia.

(21) Trait, and Von Willebrand's Disease.

(22) Allergy to uniform clothing or wool.

(23) Long sleeper syndrome.

(24) Hyperlipidemia.

(25) Obesity.

b. SMDRs shall utilize reference (k) in all cases of psychiatric disorders in which there is a question of mental incompetence, regardless of discharge action. All officers with these diagnoses shall have a medical board report prepared and submitted for departmental review.

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

10. Competence for Duty Examination. In cases involving possible alcohol intoxication, drug abuse, medication reactions, or other unusual exposures or circumstances, it must be determined if the individual concerned is competent to perform his or her duty. Reference (d), provides detailed instructions on procedures and forms to be used to conduct and document a competency for duty examination. Examinations will only be performed on the written request of the CO or other proper authority using NAVMED Form 6120/1, Competence for Duty Examination.

a. The examination shall be carefully and thoroughly carried out and all observations recorded because of the potential legal implications of the findings. Specimens of body fluids (i.e., blood, urine, saliva, etc.) to be used solely for the purposes of helping to establish the degree of competency shall normally not be taken unless the person is afforded all the rights of an accused under the Uniform Code of Military Justice and voluntarily agrees to provide the specimens. For exceptions to this rule, it is suggested that the ship's legal officer be contacted.

b. Regardless of whether or not body fluid specimens are obtained, a medical provider (MO or IDC) is qualified to render an opinion, based on

a clinical examination, as to whether or not the subject is under the influence of alcohol, drugs, or other incapacitating substance and whether or not the subject is fit to perform the duties of his or her rank or rate.

11. Disposition of Members Not Suitable for Shipboard Duty

a. Reference (b) provides guidance on the screening process for individuals who receive order to operational assignments.

b. If a member reports to a sea duty command who has not received a sea duty screening or is medically, surgically, or orthopedically debilitated (including wearing of cast and or use of crutches) to the extent that they are unfit for sea duty, the receiving command should prepare a message reporting that the member was improperly screened for duty. Provide members name, rank, SSN, ICD-9 code, and any amplifying information. The message should be directed to the transferring command, the transferring command's ISIC, the transferring personnel support activity and the cognizant MTF. Info addressees will include BUPERS, BUMED, TYCOM, the RMR for the prospective gaining command, and the gaining MTF.

12. Decedent Affairs Procedures

a. Initial Report. When a death occurs within a command, the SMDR shall submit, **within four hours**, a Medical Department MFR noting all available information concerning the death to the CO to comply with articles 1770-030 and 1770-040 of reference(s) for Naval personnel and chapter 3 of reference (l) for other than Naval personnel.

b. Death Certificate. Reference (o) and chapter 17 of reference (l) provide information concerning death certificates and proper submission of DD Form 2064, Certificate of Death (Overseas).

c. A short note of when and where the service member's death occurred will be noted on an SF-600 and signed by the SMDR. The health and dental records will be closed out, combined and will accompany the remains until identification and investigation is complete. The activity responsible for identification will forward the health record to the Department of Veterans Affairs (DVA) when the record is no longer required.

d. Disposition of Remains. As soon as possible, remains will be transferred to the nearest MTF for further disposition. Remains must be accompanied by the following:

(1) Medical/dental records and dental x-rays.

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

(3) Two (2) DD Form 565, Statement of Recognition, signed by shipmates who knew the deceased, if remains are recognizable.

(4) When transfer cannot be immediately accomplished, the remains will be prepared in accordance with references (l) and (r), placed in a body pouch and refrigerated at a temperature of 36-40 degrees Fahrenheit to prevent decomposition. The space used must contain no other items and must be cleaned and disinfected before reuse. Remains will be identified with waterproof tags, marked with waterproof ink, and affixed with wire ties to the right great toe and to each end of the body bag. Minimum identification will include full name, SSN, and rate.

e. Care of Personal Effects. An inventory of all the personal effects of the deceased will be made and itemized. For enlisted personnel, the inventory will be made by the division officer of the deceased and the master-at-arms. For officer personnel, two officers will accomplish the inventory. After the inventory has been completed and signed, the effects will be turned over to the supply officer for disposition.

SECTION 2 – CLINICAL HEALTH CARE

1. Responsibilities of IDCs in Commands without a Medical Officer

a. The IDC shall conduct professional and administrative duties normally performed by MO's when stationed onboard ships without an MO assigned. IDC's shall not attempt nor be required to perform, medical or surgical procedures for which they are not professionally qualified.

b. They shall make firm and appropriate recommendations to the CO whenever the service of a medical officer is required and whenever they consider the patient to be in need of professional medical care exceeding the skills and support immediately available.

2. IDCs Requiring Medical Officer Assistance/Advice. Pursuant to reference (ad) and operational circumstances permitting, the IDC shall seek consultation with an MO whenever there is a doubt about a patient's condition or treatment including the following situations:

a. Fever (oral temperature) equal to or greater than 103 degrees Fahrenheit.

b. Fever (oral temperature) greater than 100.4 degrees Fahrenheit and less than 103 degrees Fahrenheit, persistent for 48 hours.

c. Respiration greater than 28 per minute without apparent reason.

d. Pulse greater than 120 per minute without apparent reason.

e. A persistent diastolic blood pressure exceeding 105 mm/HG over a three-day period.

f. Any suspected case of hepatitis, tuberculosis, malaria, syphilis, disseminated gonorrhea, or gonorrhea second-time treatment failures.

g. Any patient with chest pain believed to be cardiac in origin or dyspepsia unrelieved by antacids.

h. Any abdominal pain associated with a fever or an elevated white count.

i. Any patient with persistent or worsening abdominal pain.

j. Any patient with hematemesis, hemoptysis, or hematochezia.

k. Any patient with sudden testicular pain where testicular torsion is a possible diagnosis.

l. Any patient with traumatic or unexplained loss of consciousness.

m. Any patient with a compromised airway. (Note: A minimally compromised airway associated with pharyngitis, other head and neck infections, or head and neck trauma may rapidly progress to a life-threatening emergency. Act expeditiously when confronted with any degree of airway compromise).

n. Any return visit within a reasonable time frame, for the same complaint that has not resolved when compliance to treatment is assured.

o. Eye injury or significant visual changes.

3. X-Ray Services. Ships with x-ray capability will maintain equipment and supplies per assigned AMALs.

a. Storage. Equipment will be properly stowed to ensure that it is secured for sea. Supplies will be stored with regard to light sensitivity or hazardous qualities. Each x-ray machine will be tested for proper performance at least every two years with results kept on file.

b. X-Ray Standard Operating Procedure (SOP). To ensure standardization of testing procedures, each ship with x-ray capability will maintain an SOP for all studies that the department is capable of conducting. Procedures will include the requirement for all x-rays to be submitted to a radiologist for professional reading.

c. Documentation. All studies conducted will be documented in an x-ray log. Entries will include, at a minimum, date, patient rank/rate, name and last four, study conducted, and results. Additionally, this log must indicate the date the film was submitted and the date the confirmation of results were received from the radiologist.

d. Radiation Health. The Medical Department is responsible for maintaining a Radiation Health Program in accordance with reference (q). The assigned x-ray technician (NEC 8451) will normally be assigned as program manager. Results and reports documented using the SAMS/TMIP Radiation Health Module. External audits will be requested through the MTF's radiology Fleet Liaison.

4. Laboratory Services. Medical Departments will maintain required laboratory equipment and supplies per assigned AMALs. The following guidelines are applicable to all ships unless otherwise indicated.

a. Storage. Equipment items will be stowed properly when not in use. Equipment intended for continued use must be properly secured to counter surfaces, bulkheads, or decks. Supplies will be stored with regard to temperature requirements and/or hazardous qualities. Refrigerated items will be stored in a biomedical refrigerator suitable for biologicals and medicinals at a temperature range of 35-46 degrees Fahrenheit. Biological reefers will have a functional audible alarm system that alerts personnel when the required temperature range is not maintained.

b. Laboratory Standard Operating Procedure (SOP). To ensure standardization of testing procedures, each ship will maintain a Laboratory SOP containing guidance for all laboratory procedures that the department is capable of conducting. The SOP also provides a valuable tool for training other members of the department.

c. Documentation. All specimens collected will be clearly labeled with patient identification data. All tests conducted will be documented in the laboratory log. Entries will include, at a minimum, date, patient rank/rate, name and last 4 of SSN, test conducted, and results.

d. Laboratory Assessment. Ships with an assigned laboratory technician (NEC 8506) will be scheduled for an annual assessment by members of a shore MTF to evaluate laboratory services. This assessment will be coordinated by the appropriate RMR as a required portion of the MRI.

5. Pharmacy Services. Medication will be stored and dispensed using the following guidelines:

a. Storage. Pharmacological supplies will be stored with regard to temperature requirements and/or hazardous qualities. Refrigerated items will be stored in a biomedical refrigerator suitable for biologicals and medicinals at a temperature range of 35-46 degrees Fahrenheit. Biological reefers will have a functional alarm system that alerts personnel outside of the space when the required temperature range is not maintained. Stock will be used and rotated with regard to expiration dates. All spaces containing drugs and medicinals will be securable to prevent unauthorized access.

b. Prescriptions/Container Labeling. All medications will be prescribed and dispensed in accordance with chapter 21 of reference (o). Medications will be dispensed in a labeled container only. Labels will include at a minimum name of ship/unit, date, patient's name, directions (e.g., two tablets every four hours), drug (e.g., Aspirin), strength (e.g., 325mg), quantity dispensed (e.g., 24 tabs), and the name of the person prescribing followed with the initials of the dispenser.

c. Administration of Antibiotics. An IDC may prescribe and administer only those antibiotics included in the ships AMAL and those non-AMAL antibiotics approved by the Force Surgeon. Strict accountability for all antibiotics will be maintained. The IDC is responsible for the proper requisitioning, receipt, custody, transfer, dispensing, loss, and procedures pertaining to use.

d. Medications Requiring Special Custodial Care. Controlled substances will be managed in accordance with chapter 3, section 2.5.e.

6. Inpatient. The ability to hold personnel in the medical spaces exists on most surface ships. On independent platforms, this capability is limited to one or two berths that can be used for short periods of time. On larger ships however, the capability is broadened by the presence of multiple MOs and enhanced ancillary services to accommodate inpatient admissions. Surgical platforms not only have a ward but also have ICU capability. The ability to deliver quality inpatient, surgical, and post-surgical health care rests on established administrative procedures, protocols, and standards of care. On ships staffed by MOs, the following areas of concern must be addressed for specialized care. These areas are not intended to be all-inclusive nor do all apply to each class of ship. Each ship may address the concerns as they apply to their individual activity.

a. Patient administration

(1) Documentation. All care provided during the inpatient stay will be documented in a separate, inpatient record using appropriate, standardized inpatient forms.

(a) Admissions >4 hours and <48 hours must have:

1. Abbreviated Clinical Record (SF 539) or complete SF600.

2. Doctor's Orders (SF508) with specific call parameters.

3. Progress Note (SF509).

4. Nursing Notes (SF510 or equivalent flowsheet).

(b) Admitted >48hours

1. History Part 1 (SF504), History Parts 2 & 3 (SF505).

2. Physical Exam (SF506).

3. Doctor's Orders (SF508) with specific call parameters.

4. Progress Notes (SF509), notations at least every 24 hours.

5. Nursing Notes (SF510 or equivalent flowsheet).

6. Narrative Summary (SF502).

(c) Sustained Stay (Convalescent Leave/Medhold Status/Sick in Quarter on Ward).

1. Doctors Order.

2. Chronological Record of Care (SF600) with evaluation by MO a minimum of every 24 hours.

(d) Pre-Operative. As per BUMED note 6320 of 4AUG09, the use of the SF 522 has been cancelled. Any procedure deemed either operative or invasive, requires documentation of consent using the DoD exception to (OF) 522 which is located at: http://www.med.navy.mil/directives/Pages/OtherForms.aspx

b. Record Maintenance

(1) Inpatient records will be reviewed for Quality Assurance by the CCN monthly when records are available.

(2) The inpatient record will be maintained onboard for two year after the discharge date and retired as in accordance with reference (ah).

c. Patient Tracking

(1) A method of patient identification and tracking will be used to ensure accurate accountability.

(2) The use of a patient status board or appropriate alternative is required.

d. Care Protocols. Specific patient care protocols must be established and reviewed periodically (but no less than biennial) to ensure that they meet current standards. Standardized Restraint, Isolation and Thrombolytic protocols can be found on the Nurse Corps Operational Subspecialty Leaders page on NKO. The following will be maintained:

(1) Patient restraint policy. Will include specific circumstances under which restraints should be used and policy for observing these patients.

(2) Patient isolation policy. Will include guidelines to protect staff and patients alike in cases of communicable/contagious diseases with emphasis on universal precautions.

(3) ACLS protocol. Will include emergency response equipment and supplies required at the scene and personnel involved in ACLS situations.

(4) Thrombolytic therapy protocol. Will be based on laboratory tests and medications currently included on the ship’s AMALs.

e. Housekeeping. Inpatient facilities have inherent requirements for cleanliness and patient comfort with special emphasis on infection control. Wards and ICUs must be kept clean and orderly to support these requirements. Appropriate infection control measures will be used per established standards of care. There must be adequate provision for the supply of linens and pajamas. Dietary needs of the patients must also be met with their level of ambulation. Upon discharge, each patient’s berth will be stripped and cleaned, including mattresses. Equipment, linen, and bedding must be disinfected with adherence to established standards for infection control.

f. Equipment and Supplies. All equipment items required by the ship's AMALs must be fully functional and required consumable supplies must be available as appropriate. Sterile supplies must not be exposed to conditions that could compromise their sterility. Specific areas of concern include:

(1) ACLS requirements including defibrillators, suction apparatus, medications and consumable supplies.

(2) Required number of beds and gurneys with orthopedic hardware and safety restraints as appropriate.

(3) ICU beds will have bedside oxygen, ventilator, suction, and IV infusion pumps.

(4) Calibrated equipment including mechanical ventilators, anesthesia machines, respiratory gas monitors, and electrosurgical apparatus.

(5) Other specialized equipment including hypo/hyperthermia and fluid warming equipment and required surgical scopes (Esophagogastroduodenoscopic, Colonscope, and Bronchoscope) with attachments.

(6) Medical refrigerators/freezers including alarms.

(7) Sterilizers including washer/sterilizers.

(8) All blood banking equipment.

7. Operating Rooms. LHA, LHD, and LPD-17 class ships, when supported by an embarked FST or other surgical support element, become surgical-capable platforms. These ships maintain multiple operating rooms, major surgical sterilization capability and blood bank capability. The following are additional areas of concern:

a. Sterilization. Surgical sets will be maintained in quantities established by the ship's AMALs and Appendix L. Sterilization shall be accomplished in accordance with sections 3.13 and 3.14.

b. Moderate Sedation Protocol. Moderate sedation involving intravenous agents are a technique requiring familiarization with its risks and complications (e.g. decreased respiratory reflexes, etc.). In addition to establishing a protocol, any clinician desiring to administer conscious sedation must be specifically credentialed to do so. Clinicians

routinely providing intravenous sedation must request clinical privileges through the credentials process, with supporting documentation indicating training or experience. A general medical officer (GMO) will not normally have had the training or experience to successfully meet the criteria for being granted this privilege.

c. For ships without a MO assigned, the closest shore MTF will provide major and minor surgical support, except in emergency conditions. It is safer for a patient to be referred to a medical facility ashore even though it may require a delay in the initiation of therapy. Emergency conditions are defined as those jeopardizing life, limb, or eye sight and are not extended to include convenience or training. These guidelines do not preclude the appropriate closure of wounds, drainage and debridement of infected skin lesions, or removal of foreign bodies (except penetrating foreign bodies of the eyes).

d. Foreign objects and tissues removed from the body of a patient (less wound debridement tissue) require pathological examination in all cases in accordance with reference (r). They are to be appropriately preserved and sent to an MTF pathology laboratory with tissue examination form (SF 515), or electronically via CHCS with the pertinent patient history and other information as may be necessary.

8. Manning of Sick Bay. A watch shall be maintained per the ship's SORM during operational evolutions potentially capable of generating casualties, at any time patients are under observation in sickbay or admitted to the ward or ICU, and at other times as designated by the CO.

9. Ophthalmic Services. Ophthalmic services, including optical inserts for protective masks, will be provided to active duty personnel in accordance with reference (n). Each crewmember that wears corrective lenses will have two (2) pairs of clear lenses and one (1) protective mask insert in their possession. DD Form 771, Eyewear Prescription, will be used for requesting all spectacles or repairs. Nonstandard lenses and frames will be fully justified under the "Special Lenses or Frames" section on the DD Form 771.

10. Periodic Health Assessment and Specialty Physical Examinations

a. Annually, all service members will receive an individualized face-to-face assessment of their health status to include the PHA components as listed reference (ak). The PHA provides the opportunity to assess changes in the health status,

especially those that could impact a member's readiness to perform military duties.

b. All physical examinations, including flight deck and NAVOSH required examinations (i.e., dome diving, explosive driver, ammunition handler, crane/fork-lift operator, etc.), will be conducted and reported in accordance with chapter 15 of reference (o), reference (v) and other appropriate Department of Transportation (DOT) guidance. Shipboard medical personnel should become thoroughly familiar with these references as they pertain to type and frequency of all officer and enlisted physicals.

11. Active Duty Women Physical Examinations and Standards. Active duty women's exams will be conducted in accordance with chapter 15-112 of reference (o). An annual health examination is recommended for every female and should be tailored to the medical and surgical history as well as the age of the patient.

12. Sick Call and Ship's Brig Sick Call

a. Sick Call. Designated sick call hours should be standard for each command with a minimum of one (1) hour per day. Times for sick call may be adjusted to fit the ship's work routine when operating under adverse or other unusual conditions thereby making the services available to each watch section. Sick call hours should be posted outside of Medical and it is recommended that they are also placed in the commands plan of the day.

b. Ship's Brig Sick Call. Certain ships and units are authorized to establish and maintain brigs. Prisoners may be confined in brigs which have been inspected and approved. Whenever the ship's brig is occupied, a ship's brig sick call shall be conducted daily by the senior hospital corpsman in the duty section. This sick call shall include a visual inspection of the sanitary condition of the brig. A medical officer, if assigned, shall conduct the sick call when the ship is underway. An entry regarding conditions found shall be made in the Sick Call Log or 8 o'clock report.

13. Alcohol and Substance Abuse

a. The U.S. Armed Forces continue to have a zero policy for drug abuse and personnel with a positive urinalysis will be separated from active duty. References (ac) and (aj) contain further guidance on programs and resources available.

b. Alcohol abuse remains a problem within the naval service. Service members suspected of alcohol abuse or an excessive use alcohol should be referred to the command DAPA for evaluation.

14. Management and Care of Patients with Altered States of Consciousness

a. Altered consciousness can be induced by abuse of alcohol and drugs, either individually or in combination. The danger of death to a person intoxicated with drugs and/or alcohol is real. Additionally, injuries can cause altered states of consciousness, often compounding the threat to an intoxicated person. Once consciousness becomes so altered that protective reflexes are impaired, medical observation becomes mandatory and chain of command attention is warranted.

b. When an individual is identified as being in an altered state of consciousness, whether that determination is made by shore patrol, Master-At-Arms (MAA), quarterdeck or shipmates, the officer of the deck (OOD) shall be notified and a MDR will be called to evaluate the patient. If in port after working hours, and when no medical personnel are on board, and a crew member is determined to have an altered consciousness, emergency medical services (EMS) should be called for the victim to be taken to the closest MTF or civilian facility.

c. In the absence of Medical Department personnel, constant supervision by a competent individual is required. The following guidelines shall be followed in the management of personnel with altered consciousness:

(1) Notify the OOD.

(2) Loosen clothing (especially in the neck area).

(3) Remove false teeth or foreign objects from the mouth.

(4) Place patient on stomach with head turned to one side.

(5) Monitor constantly for breathing pattern, chocking, swallowing of vomit, response to light-touch-noise and patient movement.

(6) Be prepared to administer cardiopulmonary resuscitation in case of respiratory and/or cardiac arrest.

(7) Transfer patient immediately, with escort, to nearest activity with a Medical Department if such transfer is feasible; otherwise, continue monitoring continuously until either relief by medical authority or full patient recovery occurs.

15. Diving Medicine. Diving related medical care is time critical and every effort shall be made to refer patients to higher echelons of care quickly. Appendix M contains information related to injuries and treatments for commonly seen accidents within the surface fleet.

16. Aviation Medicine. Appendix N contains information related to aviation medicine and aviation accidents. However, reference (h) shall be utilized when flight surgeons are not available.

a. The ships SMDR must assure that all flight personnel are physically qualified while in a flight status.

b. SMDRs are authorized to issue a NAVMED 6410/1, Grounding Notice (Aeromedical) recommendation to the CO of a squadron or officer in charge of an activity to relieve from flight duty any individual considered physically unfit for such duty. Upon issuing the grounding notice, the SMDR shall notify the cognizant flight surgeon.

c. The authority to issue a NAVMED 6410/2, Clearance Notice (Aeromedical) is the responsibility of aviation trained MOs but may be given to an IDC, physician assistant or a non-aviation trained medical officer when flight personnel are stationed in remote or isolated location where the flight surgeon is not available.

d. Aviation accidents. Information and guidance on aviation accidents are found the Naval Flight Surgeon's Pocket Reference to Aircraft Mishap Investigation.

17. Patient Berthing. CO's are responsible for maintaining the readiness of designated medical treatment spaces.

a. Personnel other than the sick or injured will not be berthed in any shipboard medical space.

b. On ships maintaining a 24-hour medical watch, the duty corpsman is authorized to sleep in sickbay but is to have a regularly assigned berthing space. Personal gear and clothing is not to be stored in sickbay.

18. Embarked Personnel. Fleet Surgical Team personnel and Medical Augmentation Personnel should be berthed commensurate with their ranks and

in keeping with the berthing of other officers on board of equivalent rank.

19. Medical Standbys. In accordance with reference (g), each Medical Department shall have written guidance for the provision of standbys to be incorporated into the MEDORM. The use of standbys is strongly recommended during sensitive or potentially compromising physical examination and required when male/female genitalia or female breasts are exposed by the examiner.

a. An MDR may request a standby with certain patients even when sensitive examinations are not being performed, including unconscious or unresponsive patients. If a patient refuses to permit the presence of a standby when the MDR believes it is necessary, the MDR must consider whether to perform the examination or to refer the patient to another source of care. The medical necessity of the care needs to be considered along with the mental competency of the patient. Events such as these should be documented; and the MDR should seek medical/legal advice.

b. As with all tasks performed in a clinical situation, the standby should receive training and education before being placed in a situation where good judgment and observation are essential. The standby should be familiar with the procedures being performed; know appropriate behavior and duties the standby is expected to perform; and know how to report an incident, should one occur.

c. Patients and MDRs should be aware of the availability of standbys, why they can be important, and how to request one. This can be done verbally, when patients are asked if they would be more comfortable if there were a standby present during the examination.

20. Allergy Immunotherapy (Allergy Shots). Allergy immunotherapy injections can only be given aboard ship in the presence of a physician with appropriate clinical privileges and resuscitative equipment and supplies necessary for the treatment of reactions, including cardiopulmonary arrest. When no such provider and/or material are on board, the injections will not be given. Only military prescribed allergy immunotherapy is authorized aboard ships. Self-administration of immunotherapy agents is not authorized.

21. Dental Care. In the absence of a dedicated Dental Department, it is the duty of the Medical Department to promote and arrange for the necessary dental treatment of the crew in accordance with reference (i).

a. All personnel will receive an annual dental examination. MDRs will arrange examinations with the nearest shore dental facility per established policies. Personnel requiring emergency dental care will be referred to the nearest ashore or afloat dental facility for treatment. After working hours, dental services are available from any nearby dental facility ashore. NAVMED 6620/2, will be utilized for all after-hours or on deployments.

b. When referral of an individual for emergency dental treatment is impossible, the IDC should accomplish palliative therapy until such time as a DO may see the patient.

c. Since IDCs do not routinely perform dental treatment, whenever possible they should seek refresher training from the local dental clinic prior to extended deployment.

d. Each command will maintain the required Authorized Dental Allowance List (ADAL).

22. Suicide Prevention. Suicide is a preventable personnel loss that impacts unit readiness, morale and mission effectiveness. Relationship disruption, substance abuse, financial problems, legal problems, and mental health problems (such as depression and Post Traumatic Stress) can interfere with individual efficiency and unit effectiveness and also increase a person's suicide risk. Preventing suicide in the Navy begins with promotion of health and wellness consistent with keeping Service members ready to accomplish the mission.

a. In accordance with reference (y), every command will have an active Suicide Prevention Program, an assigned Suicide Prevention Coordinator and suicide prevention training will be conducted on an annual basis.

b. Command-level suicide prevention and crisis action plans will be developed to provide local command-level program of awareness education, early identification and referral of at-risk personnel.

23. Mental Health

a. Referral of service member for command directed Mental Health Evaluation (MHE).

(1) The responsibility for determining whether or not referral for MHE should be made rests with the service member's commander or supervisor at the time or the referral.

(a) A senior enlisted service member may be designated by the commander or supervisor for ordering an emergency command directed evaluation (CDE).

(b) In cases involving a commissioned officer, a commissioned officer of rank senior to the officer to be referred may be designated.

(2) When a commander or supervisor, in good faith, believes that a Service member may require a non-emergency MHE, he or she will:

(a) Advise the service member that there is no stigma associated with obtaining mental health services.

(b) Refer the service member to a mental healthcare provider (MHP) providing both name and contact information.

(c) Tell the service member the date, time, and place of the scheduled MHE.

(3) When a commander of supervisor refers a service member for an emergency MHE owing to concern about potential or imminent danger to self or others, the following principles should be observed:

(a) Safety. When a service member is exhibiting dangerous behavior, the first priority of the commander or supervisor is to ensure that precautions are taken to protect the safety of the service member and others, pending arrangements for and transportation to the service member to the location of the emergency evaluation.

(b) Communication. The commander of supervisor will report to the MHP circumstances and an observation regarding the service member that led to the emergency referral either prior to or while the service member is en route to emergency evaluation.

b. Command Promotion of Care Seeking for the Maintenance of Total Well-Being.

(1) Commanders of supervisors may make informal, non-mandatory recommendations for service members under their authority to seek care from an MHP when circumstance do not require a CDE based on safety or mission concerns. Under such circumstances, the commander or supervisor will inform the service member that he or she is providing a recommendation for voluntary self-referral and not ordering the care.

(2) Commander and supervisors will demonstrate leadership and direct involvement in development of culture of total well-being of service members by providing consistent and ongoing messaging and support for the benefits and values of seeking mental health care and voluntarily-sought substance abuse education.

(3) Commanders and supervisors may educate service members with respect to additional option for assistance, including confidential counseling from family support, Military OneSource resources, consultation from chaplains, and options for obtaining assistance with financial, legal, childcare, housing, or educational issues.

(4) Commander and supervisors will not substitute alternative approaches to CDE when there is significant concern regarding a service member's safety or performance of duty or concern for the safety of others.

c. Hospitalization for Psychiatric Evaluation and Treatment. Commands shall abide by reference (k) for all issues relating to inpatient MHE.

d. Small Arms Waiver. In accordance with reference (aa), any individual with a psychiatric diagnosis for which medication is necessary, unless recommended for a waiver, will be disqualified from being issued a weapon and/or ammunition.

(1) Recommendation for a waiver must come from the prescribing mental health provider.

(2) A waiver shall not be recommended for any individual with a diagnosis of psychosis or bipolar disorder for which anti-psychotic or mood-stabilizing (including anticonvulsant) medication is necessary. Appropriate annotation of any evaluation shall be made in the service member's medical record.

(3) Small arms waivers and exceptions may be granted by the service member's CO and shall be forwarded via the chain of

command to the Bureau of Medicine and Surgery (BUMED) Office of Qualifications and Standards for review and tracking.

24. Rape/Sexual Assault. The comprehensive victim-centered management of alleged sexual assault victims requires addressing physical and psychological trauma, collection of medical forensic evidence, appropriate involvement of victim advocate, and coordination among the Sexual Assault Prevention and Response (SAPR) team members. MDRs will strictly adhere to reference (f).

25. Medical and Dental Care for Personnel other than Active Duty

a. In accordance with reference (m), individuals other than United States active duty will be seen on an emergency basis only where life saving measures will be undertaken and maintained to the ability of the shipboard medical facility. It should be understood that active duty personnel will have first priority for medical supplies and assets.

b. Other than routine medical care can be extended to non-beneficiary civilians aboard a ship when at sea for a "Family Day Cruise", "Tiger Cruise" or when that civilian is aboard in an official capacity to the U.S. government.

26. Pre-deployment Screening of U.S. Government Civilian Employees, Contract Personnel and Guests. In accordance with reference (j), civilian employees of the U.S. government and civilian contractors with an unstable chronic disease or condition that requires frequent medical monitoring and/or treatment shall not be embarked underway onboard COMNAVSURFPAC/COMNAVSURFLANT vessels.

a. DD FORM 2807 and DD FORM 2808 shall be completed within the previous 12 months and shall be submitted to the ship's SMDR no later than two months prior to deployment. In unforeseen or emergency cases, the employee will present copies of the completed DD-2807 and DD-2808 to the SMDR as soon as practicable upon arrival. The SMDR will review the documents and, if necessary, perform any additional examinations or referrals required to reach a recommendation regarding fitness for embarkation. The CO, with input from the SMDR, will make the final decision regarding fitness for embarkation in all cases.

b. If currently on medications, the individual shall bring a quantity sufficient to last through the embarked period. The individual shall contact the SMDR if any special storage is required for these medications.

c. Short-term guests, including Tiger Cruise participants, will be advised of limited shipboard medical capabilities prior to embarking and will be asked to certify their physical fitness to participate. At a minimum, such certification must specifically acknowledge that they have no medical conditions likely to be made worse by the shipboard environment and that they have an adequate supply of medications/medical devices needed for the duration of cruise.

27. Pre-confinement Physical/Screening. Pursuant to reference (af) and in accordance with reference (x), a medical screening is required of all personnel who have confinement orders. Only a credentialed provider (i.e., MO, PA or NP) can perform a confinement physical. In the event that a credentialed provider is not available, an IDC can perform the initial screening but this will need to be followed up by a credentialed providers review within 24 hours. If the service member has been awarded bread and water/diminished rations, the physical must be performed by an MO prior to commencement of the sentence.

SECTION 3 – SHIPBOARD EMERGENCY MEDICAL READINESS

1. Medical Readiness. The Medical Department will be prepared at all times for a medical emergency. When facilities are inoperable due to material casualties or personnel shortages, appropriate corrective action will be initiated and substitute support measures will be promptly defined and instituted. Sickbay must be set up to receive emergencies at all times. In addition to those medical supplies normally needed for routine sick call, a suitable area within sickbay, if not designated as a Battle Dressing Station (BDS), will be supplied and equipped to treat medical emergencies.

a. First aid supplies and equipment are distributed throughout the ship and are to be utilized by crewmembers in the event of personnel casualties during battle or emergency conditions. First aid materials should be considered a component of overall damage control readiness and highly pilferable, thus requiring optimum management and security to ensure continuous readiness.

b. Departments assigned responsibility for spaces where emergency first aid material and stretchers are installed or located are responsible for the readiness of such material. Discrepancies noted will be reported to the Medical Department. Inventory and restocking will be the responsibility of the medical department. **All emergency AMALs are required to be maintained at 100% onboard at all times.**

c. To ensure that emergency supplies are maintained in a high state of readiness, particular attention must be paid during inventories as to the material condition and potency dating of stock. Newly requisitioned supplies are to be rotated into reserve stock and older stocks utilized in sickbay in order to prevent loss through aging and deterioration of materials.

d. Potency dated material is defined as material having a specified storage period. Such items should be rotated out of emergency stock in sufficient time to allow usage prior to expiration. When expiration dates are given as month and year only, the material is considered to expire on the last day of the month specified.

e. Reference (a) lists requirements for medical and dental spaces, including requirements for emergency medical gear. This is also noted with the Medical Department INSURV check list which can be located at: http://www.spawar.navy.mil/fleet/insurv/.

2. Emergency Response Stations and Kits

a. Ships with MOs assigned will utilize the MO Resuscitation Kit. IDC Platforms will utilize the IDC Emergency Response Kit.

b. All units (except MCM, LCS and PC class ships) will also maintain the Junior HM Emergency Response Kit for each non-IDC Corpsman, with a minimum of five (5) kits for larger medical departments.

c. All emergency kits will be maintained in a continuous state of readiness, ensuring appropriate materials, quantities and quality control. Emergency kit inventory will have three parts:

(1) Inventory sheet which will list as a minimum national stock number (NSN), nomenclature, quantity, lot number and expiration date.

(2) Date of inventory sheet which will be maintained within the kit and will provide the chronological history of inventory and who conducted the inventory.

(3) SAMS/TMIP supply print out of the AMAL requirement which provides the kit requirement.

d. At least semi-annually an inventory will be conducted on all emergency kits and stations by the SMDR to ensure readiness, and should be replenished and re-inventoried after each use.

3. Battle Dressing Stations (BDS). Battle dressing stations provide alternate sites that can be used by an MDR during emergency conditions to assess and treat casualties.

a. Location

(1) BDSs will be located in areas affording maximum protection consistent with the availability of care for the wounded. BDS locations will be according to the ship class drawing.

(2) The BDS offering the best facilities for surgical procedures and care will be equipped for this purpose and designated as the Main BDS. The main BDS will have the minimum BDS AMAL and be augmented with items from other AMALs to provide for surgical procedures and definitive care after battle.

(3) Appendix O lists the number of required BDSs by ship class. Due to space limitations and small crew size, Patrol Craft (PC) class ships have no designated BDS.

b. Use of Battle Dressing Stations. On ships with separate BDSs, these locations will not be used in any manner that will interfere with the designated purpose. Specifically prohibited is use in any manner that could:

(1) Impair the primary use of the space as a BDS.

(2) Restrict ingress/egress of injured crewmembers.

(3) Compromise the maintenance and security of medical supplies and or equipment.

(4) Restrict medical department personnel from unlimited access to the spaces.

c. Outfitting. The BDS AMAL contains the minimum requirement for consumable, durable, and equipment items. The AMAL is designed to provide each BDS with supplies and equipment sufficient to provide triage, resuscitation, initial stabilization, and limited care to casualties. BDS supplies and equipment shall be maintained in a state of constant readiness, ensuring appropriate quantities, quality control, management, and security thereof. All supplies and equipment in the BDS will be reflected in a BDS inventory list. Medical Departments will adhere to reference (a) for the following items within the BDS:

(1) Furniture/Fixtures.

(2) Operating/Treatment Table. When an operating table has not been permanently installed a portable treatment table will be provided per the AMAL. Brackets for securing the table to the deck when in use must be installed and functional. Patient securing straps must be available and functional.

(3) Lighting. BDSs will have a minimum of one surgical light and four battle lanterns installed. An additional bracket flange must be provided for the alternate position of the surgical light. Additionally one general illumination fixture and two single receptacle connectors, powered by the emergency power system, will be available.

(4) Emergency Potable Water Supply. A diagram and operating instructions for the gravity fed potable water tank located within the BDS will be posted in the immediate vicinity. The tank will be labeled "DRAIN, FLUSH, AND REFILL EVERY THREE MONTHS.” It is the responsibility of the medical department to conduct this maintenance quarterly. All

emergency potable water tanks will have a bacteriological water sample test monthly to determine bacterial content.

d. Security. All pilferable items will be stored in a locked space accessible to the HM assigned to that BDS and to the duty HM for use in an emergency.

e. Route and Access Markings. On ships that have a BDS including auxiliary stations, routes leading to these stations will be marked as follows:

(1) Internal Marking. The photo luminescent paint marking system will be implemented and maintained in accordance with the INSURV Check list. The primary purpose of this system is to provide rapid emergency egress information and to identify the locations of selected damage control systems and equipment in situations involving loss of lighting.

(2) Route Access Markers. In accordance with reference (a) and chapter 079 of reference (w), labels with red letters and white background will be installed at each direct access point directing a path to the BDS. Self-adhering Red Cross decals in both photo luminescent (internal markings) and non-photo luminescent (exterior markings) available from commercial sources are authorized.

(3) When establishing and marking the routes to the various BDSs throughout the ship, the markers should be located frequently enough to enable the person following the route to have a clear view of the next marker of the route to be followed.

4. Mass Casualty Box (MCB). MCBs provide pre-positioned medical supplies for use by the Medical Department to triage and treat multiple casualties.

a. Location. Appendix O lists the number of MCBs required by ship class. They will be located at or near designated triage areas and the location will be reflected in the battle doctrine and/or SORM.

b. Outfitting. The MCB AMAL contains the minimum requirement for consumable and durable items. The AMAL is designed to provide supplies and equipment sufficient to provide triage, resuscitation, initial stabilization, and limited care in the event of a mass casualty scenario. MCB supplies shall be maintained in a state of constant readiness, ensuring appropriate quantities, quality control, management,

and security thereof. All supplies in the MCB will be reflected in a MCB inventory list. MCB supplies must be enclosed in plastic.

c. Security. To deter pilferage, all MCBs shall be secured with an anti-pilferage device rather than a lock for ease of access in an emergency. Each MCB will be secured for sea with appropriate brackets or shelves.

d. Marking. MCBs will be stenciled "MASS CASUALTY BOX" in one-inch red letters and the compartment designation in one-inch black alpha-numeric characters. Decals are a suitable alternative.

5. First Aid Boxes (FAB). First aid boxes provide a means for dispersing emergency supplies throughout the ship for use by the crew.

a. Location. Appendix O lists the minimum number of FABs required by ship class. FABs will be permanently mounted, at a minimum, in or near the below listed locations. An FAB can serve several locations if it is mounted within 100 feet of the required space.

(1) Air control spaces.

(2) Anchor handling spaces.

(3) Ship control spaces.

(4) Cargo holds and magazines.

(5) Manned communication spaces.

(6) Hangers and hanger deck bays.

(7) Manned engineering spaces.

(8) Machine shops/industrial work centers.

(9) Manned weapons spaces.

(10) Damage Control Central and all repair lockers.

(11) Major workstations, near flammable storerooms, and in major passageways.

(12) Other FABs may be mounted at the discretion of the SMDR with special attention to areas where personnel are assigned.

b. Outfitting. The FAB AMAL contains the minimum requirement for consumable and durable items. FAB contents will be divided into three equal portions and sealed in plastic. FAB supplies shall be maintained in a state of constant readiness, ensuring appropriate quantities, quality control, management, and security thereof. All supplies in the FAB will be reflected in a FAB inventory list.

c. Security. FABs will be secured with a wire seal or other anti-pilferage device that can be easily broken. Holes should not be drilled through the sides as this compromises the weatherproof integrity of the box.

d. Marking. Each FAB will be marked with a Red Cross and "FOR EMERGENCY USE ONLY" in one inch red letters. Decals are a suitable alternative.

6. Other First Aid Kits. Responsibility for custody and security will belong to the department or division to which it is issued. Medical personnel will conduct inventories at least semi-annually and will replace inventory as needed. An inventory list will be kept in all kits and will contain, at a minimum, NSN, nomenclature, quantity, quality control data, and documented dates of inventories. Each kit will be secured with an anti-pilferage device to discourage removal of supplies. The following kits are required:

a. First Aid Kit, Gun Crew (Gun Bags). Two gun bags will be maintained at each BDS and are the responsibility of the Medical Department. Contents will be encased in plastic as a liner to the canvas bag.

b. First Aid Kit, Small Craft (Boat Box). The Deck Department will maintain custodial responsibility. Kits will be placed in each small craft (i.e., captain's gig, motor whaleboat, RHIB and utility boats). To prevent water damage, the contents of these boxes should be sealed in a plastic bag before being placed in the kit.

7. Stretchers and Litters. The quantity of stretchers kept on board will be per AMAL. Determination of the type of stretcher or litter to be used for personnel casualty transfer will be based on environmental conditions and the condition of the casualty. All stretchers and litters will be stenciled with the compartment number, name of ship, and the responsible division as assigned (medical or division that owns the space). Identification data will be located so that they can be readily viewed when the stretcher is in its normal stowage position. Safety will be paramount

as such; serviceability, inspection criteria, and accountability will be in accordance with current 3M system requirements. The following standards are prescribed for stretchers and litters:

a. Handling Lines. **PERMANENTLY ATTACHED HANDLING LINES ARE NOT AUTHORIZED FOR STOKES STRETCHERS.** If the situation calls for extrication of a casualty up or down a ladder, a detachable safety or belaying line should be used on the head end of the litter only. Such a line should be 21 thread or larger manila or comparable nylon line and spliced using five (5) tucks at one end to allow attachment of a locking carabineer to facilitate attachment to the litter. The length of the safety line should be sufficient (minimum 12 feet) to work the stretcher from one deck to another and provide enough surpluses to ensure the safety of the patient and maneuverability of the stretcher. Minimum line length can be determined by identifying the longest span by which a casualty will be transported on board utilizing a handling line. This standard length of line should be used for all attached handling lines. There should be at least one (1) safety line available at each BDS for use by each assigned stretcher-bearer team.

b. Stokes Stretchers. Steel Stokes-type litters will be stowed at or near areas that facilitate their use at the discretion of the SMDR. When the width of passageways precludes safe use below decks, they should be located in open spaces where movement of casualties is possible. Location should ideally be based on accessibility and a potential for use (i.e., triage and casualty receipt areas).

(1) Four Patient Securing Straps will be attached to the lower (1/4") bar of the stretcher and coincide with the patient's chest, hips, thighs, and lower legs. Straps should be neatly stowed and easily accessible.

(2) Handling lines and patient securing straps will not be placed on Stokes stretchers located in the hangar bay and flight deck areas. These stretchers are used for mass casualty situations.

c. Litter-Splint, Extrication. These litter and spine boards, when used together, are designed to provide immobilization during patient movement in both horizontal and vertical planes. Units should be located at each BDS to facilitate use in any part of the ship on short notice. A minimum of <u>two</u> pre-cut lines should be rigged for <u>each</u> litter. For extrication, the locking carabineer attached to the primary lifting line will be attached to the "D" ring on the strap sling at the head end of the litter. The second line will be attached to one of the horizontal lift

"D" rings on the foot end of the litter to stabilize the litter during ascent. Ideally, the set of extrication lines should be stowed with the litter for ready access.

d. Underway Transfer Stokes Stretcher (Ship-to-Ship Highline). This litter is rigged and maintained by the Deck Department.

e. Litter, Rigid, Sea-Air Rescue (SAR) MEDEVAC Litter. This litter is rigged and maintained by the Deck Department.

f. Pole Litters and Litter Supports. These items will be stocked onboard CRTS per AMAL.

8. Decontamination Lockers. Stocking, inventory, labeling and route markings are the responsibilities of the Damage Control Officer/Assistant. The Medical Department will assist in procurement of 9L items that are found within the decontamination locker.

9. CBRN Force Health Protection (FHP). FHP supplies will be stocked per AMAL and TYCOM requirements. All ships will carry the below materials in amounts based on total M+1 manning at all times.

a. Stowage. Except for Pyrodistigmine bromide, which requires refrigeration to extend shelf life, supplies will be stored in divided amounts in secure locations at or near BDSs, when practical, or in storerooms ready for issue. Pyrodistigmine may be safely stored in the ship's bulk reefers providing it is readily accessible at all times. CANA is a Schedule IV controlled item, which must be kept in an appropriately secured location with controlled access. As a CBRN defense item however, it need not be included in the Medical Department's controlled substances program.

b. Responsibility. The SMDR is responsible for the quality control of FHP medications used for CBRN defense. An itemized inventory list containing the NSN, nomenclature, proper quantity required, all quality control data, and the dates of the inventory will be maintained where stored. If stored at BDSs, they may be added to the BDS inventory sheets. CBRN supplies will be inventoried at least semiannually.

c. SMDRs will ensure that all FHP CBRN medication data is entered in SLEP every 90 days and SLEP messages are maintained as they may pertain to medications currently onboard.

10. Non-Combatant Evacuation Operation (NEO) Materials. Afloat units may potentially be called upon to evacuate civilian personnel. The amphibious type ships are best suited for this type of mission but it should be understood that any unit can be called upon at any time. Specific requirements for each department are outlined in article 6.5.2 of reference (z). In addition to current AMAL items that may be used for all categories of evacuees, Appendix P specifies stock evacuation materials to be maintained on all deploying or forward deployed amphibious ships.

11. Medical Gases. The minimum quantity of oxygen to be maintained on board will be per AMAL. All medical oxygen cylinders will be tagged with a DD Form 1191, "WARNING TAG FOR MEDICAL OXYGEN" and maintained in accordance with reference (ab) and current 3M requirements. Additionally, a tag will be attached to the tank to record the date of pressure checks, pounds per square inch (PSI) reading and the initials of the person conducting the check. Oxygen tanks will be located and stowed in accordance to reference (a) and (ab). Current standards require Grad "B" shock mounting of all compressed gas cylinders, including oxygen.

a. Fitting and Handling. Oxygen cylinders fitted with regulators are considered "IN USE" for 3M purposes. At least one cylinder in the main emergency treatment area will be ready for immediate use. Fitting in other locations is at the discretions of the SMDR. Cylinders that are considered not in use or stowed will have valve convers in place. Non-ferrous wrenches will be available at all oxygen handling locations.

b. Great care must be used in handling oxygen to prevent contact of oxygen under pressure with oils, greases, organic lubricants, rubber or other flammable materials. Oxygen handling and stowage precautions, as provided in Appendix Q, will be posted in all areas of oxygen use.

c. Static Testing. In accordance with Chapter 550 of reference (w), all oxygen tanks are required to be static tested using the following criteria:

(1) Empty tanks must be hydrostatically tested prior to being refilled if five (5) years have elapsed since last hydrostatic testing.

(2) When full, tanks must be emptied and hydrostatically tested every 12 years.

12. Surgical Instrument Sets. Surgical instrument sets will be stocked per ship's AMAL. Appendix L provides the requirements for each class of ship.

a. All required trays or sets will be prepared per this instruction and maintained in sterile condition. Surgical knife blades with the foil wrapping intact and sutures packed in plastic packets are not to be steam autoclaved due to the deteriorative effect of heat on these items. Pre-sterilized items, such as knife blades and suture materials, required for packs will be attached to the exterior of the pack and included on the inventory sheet.

b. All surgical packs and sets will be plainly marked on the outside of the pack with a description of the pack, sterilization date, and expiration date. Each pack will also have an inventory list attached that can be examined without breaking the integrity of the pack.

c. It is imperative that all emergency trays be of such size that they can be re-sterilized in the ship's autoclaves. All sterilizers will be maintained and tested per current 3M requirements.

13. Sterilization Procedures

a. Steam Method. Proven through extensive research, steam sterilization is as effective as gas sterilization and is more cost effective. Shipboard sterilizers are sufficient to perform steam autoclaving of all required surgical packs; shipboard sterilization is therefore encouraged. Intensive surveillance monitoring of surgical packs has revealed that the following conditions potentially compromise sterility:

(1) Improper washing techniques.

(2) Rips, tears, or holes in cotton fabric wrappers.

(3) Deterioration of cotton fibers, which causes harborage of bacteria.

(4) Compromise of the dust cover.

b. Procedures

(1) Freshly launder linen products and replace all 6510 materials.

(2) Clean all surgical instruments properly. Ensure instruments are free of debris, rust, and corrosion. Instruments will be sterilized in the open position.

(3) Place a steam indicator strip in the middle of the pack.

(4) Double wrap with disposable wrappers or cotton wrappers as listed in the AMAL.

(5) Place date of sterilization on external indicator tape prior to sterilization.

(6) Allow pack to completely dry (approximately one hour), then immediately place in plastic dust cover (various size plastic tubing is provided by the AMAL) and seal using a heat sealing machine. Self-sealing bags may also be used.

c. Shelf-life is waived for steam sterilized packs. Packs should be opened for the annual bulkhead-bulkhead inventory if not used in the last 12 months.

14. Sterilization Log. A record of sterilization will be maintained on any ship with sterilization capability, with the following information:

a. Sterilizer number.

b. Sterilization load number. The first load of every day is one and loads are consecutively numbered thereafter for that 24-hour period.

c. List of items in the sterilization load.

d. Length of exposure time of load.

e. Temperature of sterilization for exposure.

f. Results of biological indicator testing.

CHAPTER 5 - ENVIRONMENTAL HEALTH AND PREVENTATIVE MEDICINE AFLOAT

Ref: (a) BUMEDINST 6220.12C, Medical Surveillance and Medical Event Reporting
(b) BUMEDINST 6222.10C, Prevention and Management of Sexually Transmitted Diseases
(c) BUMEDINST 6224.8A, Tuberculosis Control Program
(d) BUMEDINST 6230.15A, Immunizations and Chemoprophylaxis
(e) BUMEDINST 6250.12C, Pesticide Applicator Training and Certification for Medical Personnel
(f) NAVMED P-117, Manual of the Medical Department (MANMED)
(g) NAVMED P-5010, Manual of Naval Preventive Medicine
(h) NAVMED P-5052-26, Shipboard Pest Management Manual
(i) NAVMEDCOMINST 6230.2, Malaria Prevention and Control
(j) Naval Ships Technical Manual
(k) NEHC-TM PM 6250.1(2007), Malaria Prevention and Control
(l) NMCPHC-TM OM 6260, Medical Surveillance Procedures Manual and Medical Matrix (edition 11)
(m) NAVSEA 223-032-04/GSO dtd 2005 CD-ROM, General Specifications for Overhaul of Surface Ships (GSO)
(n) OPNAVINST 5100.19E, Navy Occupational Safety and Health (NAVOSH) Program Manual for Forces Afloat
(o) OPNAVINST 5100.23G CH-1, Navy Safety and Occupational Health Program Manual
(p) OPNAVINST 6210.2, Quarantine Regulations of the Navy
(q) SECNAVINST 5300.30E, Management of Human Immunodeficiency Virus, Hepatitis B Virus and Hepatitis C Virus infection in the Navy and Marine Corps
(r) International Health Regulations (2005) Second Edition
(s) Individual Ship Class Builder Specifications

SECTION 1 – PREVENTIVE MEDICINE

1. Responsibility. The CO is responsible for the health and physical readiness of all crewmembers. The Medical Department will assist the CO in meeting this responsibility. The SMDR shall advise the CO on conditions that adversely affect the health and well-being of the crew and make recommendations to correct these adverse conditions and ensure proper sanitation, disease prevention, and safe living conditions. References (g), (n), (o), along with this instruction, may be used as guides for environmental health, occupational health, and industrial hygiene programs and assessments.

2. Preventive Medicine Inspection/Reporting Procedures. Medical Department personnel will monitor the habitability of all shipboard spaces with special attention to overall cleanliness, sanitation practices, and pest control. Discrepancies shall be reported to the CO and cognizant Department Heads and Division Officers. Corrective action will be reported back to the medical department.

a. The following chapters of reference (g) contain specific guidance regarding shipboard functions:

(1) Chapter 1, Food Service Sanitation.

(2) Chapter 2, Sanitation of Living Spaces and Related Service Facilities.

(3) Chapter 3, Ventilation and Thermal Stress Ashore and Afloat.

(4) Chapter 6, Water Supply Afloat.

(5) Chapter 7, Waste Water Treatment and Disposal Ashore and Afloat.

(6) Chapter 8, Medical Entomology and Pest Control Technology.

b. The SMDR will make frequent informal messing/berthing walk-throughs. Although such walk-throughs should be conducted daily, the frequency may be at the discretion of the CO. Walk-throughs will be concerned with all practices and conditions

that may have an adverse effect upon the sanitation of the ship and the health of the crew. The SMDR will advise the CO in these matters accordingly.

c. The Medical Department will conduct a formal sanitation and habitability inspection no less frequently than every 90 days with a report submitted to the CO. Areas inspected will include berthing and head facilities, barbershops, potable water system, CHT/MSD system, ship's store and vending areas, laundry facilities, brig and fitness/exercise facilities. A copy will be on file in the Medical Department.

3. Sanitation Bill. The ship's SMDR shall prepare a sanitation bill and include it in the ship's directives. Excerpts from appendix D of reference (g) may be used as a guide in the preparation of this bill. Appropriate portions of the sanitation bill will be reproduced and posted in the applicable spaces.

4. Quarantine Regulations. The ship's SMDR shall keep abreast of current quarantine regulations and instructions and shall advise the CO on quarantine measures pursuant to chapter 8 of reference (f), references (g) and (p) and other applicable directives.

SECTION 2 – FOOD SAFETY

1. General. The Medical Department will monitor food service operations to ensure the protection of the crew from foodborne illness per standards provided in chapter 1 of reference (g). The Medical Department will:

a. Conduct surveillance of the storage, preparation, and serving of food and the disposal of food residues. Surveillance of food service space sanitation includes proper cleaning of equipment and utensils.

b. Conduct a food service sanitation inspection at least monthly utilizing NAVMED Form 6240/1. The report will be forwarded to the CO via the food service officer, supply officer and executive officer. Discrepancies will be noted as critical or non-critical. Discrepancies will be corrected in a timely manner and reported to the Medical Department.

c. A follow-up food service sanitation inspection utilizing NAVMED Form 6420/1 is due no later than 10 days after the initial report that denotes a critical discrepancy. This inspection will focus on the resolution of the initial critical discrepancy.

d. A complaint food service sanitation inspection is to be conducted after receipt of a verbal or written sanitation complaint regarding the food service establishment. This inspection will focus on the initial complaint.

e. Inspect subsistence items for fitness for human consumption ensuring that subsistence items are received from approved sources. All medical personnel should have a solid working knowledge of this chapter as the first line of defense against foodborne illnesses.

f. Conduct initial screening upon reporting aboard for Culinary Specialist (CS) personnel and upon assignment for FSA personnel for detection of disease or unclean habits that could result in foodborne illnesses in accordance with chapter 1(2.2) of reference (g). The health screening does not need to include a physical examination, but it should be sufficient to detect evidence of diseases that may be transmitted by food handling. Subsequent health screening (e.g., annual evaluation) is not routinely required but may be conducted at the discretion of the SMDR. It is advisable to re-screen food service personnel who

have been away from their duties for extended periods (i.e., >30 days), especially those who have traveled to foreign countries, before resumption of food service duty. All screenings shall be documented using a locally prepared special SF 600.

2. Food Safety Sanitation Training Program. Food service personnel will be properly trained/indoctrinated in food service sanitation and in carrying out their duties by qualified food service personnel in accordance with chapter 1 (2-1.2.2A) of reference (g) (NEPMUs conduct the required instructor training course for food service personnel). Medical Department personnel will maintain their qualification and monitor the food service training program using the monthly inspections to ensure that a viable program is maintained.

3. Health Standards for Food Service Personnel. No person having or suspected of having any disease in a communicable form, while a carrier of such disease, or while afflicted with boils, infected wounds, sores, or an acute respiratory infection, will work in any area of a food service facility. Any reason to suspect that a worker has contracted a communicable disease will necessitate the worker being sent to medical immediately for evaluation. A food service worker may be reinstated by medical personnel but only after the resolution of all symptoms and proper documentation on a SF 600.

4. Foodborne Illness. Foodborne illnesses are syndromes acquired by the consumption of food contaminated by disease pathogens, microbial toxins, or poisonous chemical substances. In the event of a suspected food borne illness outbreak, refer to chapter 1 (A-2) of reference (g). Immediate evaluation of the situation is necessary to avert possible crew-wide illness.

5. Routine Overhaul. If a ship is in a ROH and the ship's food service spaces are secured, an inspection of the barge food service spaces will be conducted and reported prior to use and at least monthly. The ship food service areas will be inspected and critical discrepancies corrected prior to re-opening.

SECTION 3 – WATER SUPPLY AFLOAT

1. General. Each SMDR will be thoroughly familiar with the standards listed in chapter 6 of reference (g) and will ensure that monitoring of the ship's potable water is included in the preventive medicine program. Pertinent aspects are included in this chapter for ready reference. The Medical Department will conduct monthly inspections of the potable water system and report conditions to the CO with copy to chief engineer. A written report will be included as part of the quarterly habitability inspection.

2. Water Sanitation Bill. Each ship will develop a water sanitation bill (either as part of the SORM or as a separate instruction) to meet the specific needs and conditions of the ship. This bill will be posted conspicuously in areas where potable water and associated materials are processed, treated, or stored. Chapter 6, appendix D of reference (g) contains a sample water sanitation bill that can be adapted to meet the needs of any ship.

3. Water Treatment and Halogen Residual (Bromine/Chlorine). Water from approved sources will be routinely treated by adding enough bromine to provide a residual at the end of a 30-minute contact time. Although reference (g) does not require a 0.2 parts per million (ppm) residual throughout the distribution system, a 0.2 ppm residual is desired. However, due to distance of the terminal ends of the distribution system from the potable water tank, 0.2 ppm throughout the system may not be reachable without excessively brominated water in the tanks. Assuming bacteriological monitoring has shown consistently negative results, a trace reading at terminal ends is acceptable. If water is received from an unapproved source, a source of doubtful quality, the halogen residual at point of consumption shall be a minimum of 2.0 ppm in Free Available Chlorine (FAC).

a. Water Production

(1) Distillation of harbor water is strictly prohibited except for extreme emergencies. "Emergencies" exist when vital requirements for potable water cannot be fulfilled from other sources.

(2) If an emergency exists and harbor water is distilled, sufficient halogen compound should be used to produce 2.0 ppm residual after 30 minutes at the tap. Halogenating to 5.0 ppm at the tank should produce this residual.

(3) If this halogenation does not produce the required 2.0 ppm residual, it should be increased until the required level is reached. When steaming in close proximity to other ships, (plane guarding, life guarding) precautions should likewise be taken in distilling potable water.

b. Testing for Halogen Residuals

(1) Testing will be accomplished using the DPD test or portable spectrophotometer. Testing will be accomplished before receiving water on board from any source (either shore hook-up or barge transfer) and a minimum of 30 minutes after any initial halogenation has been accomplished. Daily residual testing is mandatory while the ship is deployed or underway. Testing will be accomplished by monitoring a minimum of four sampling points that are representative of the ship's distribution system (i.e., forward, aft, mid-ships, and as far above the 0-1 level as possible). The minimum number of daily samples required is in accordance with chapter 6, table 6-9 of reference (g).

(2) Due to the routine testing conducted by public health services and preventive medicine personnel at all U.S. Naval Stations, daily testing is not required in U.S. Navy stations or ports of call within the 50 United States. When utilizing these approved water sources, testing will be conducted weekly.

(3) Regardless of the source of potable water, if there is any reason to believe contamination may occur (such as work being conducted on the ship’s potable water system) daily testing should be accomplished.

(4) All testing will be documented using the SAMS/TMIP environmental surveillance module.

c. Potable Water Connections, Hoses and Lockers

(1) Potable water fill connections are 2-1/2 inch hose valves for large ships and 1-1/2 inches for smaller ships. Fill lines for potable water will not be cross-connected with any non-potable waterline or system. When not in use, filling

connections will be closed with screw caps attached with keeper chains. Connections will be at least 18 inches above the deck with the receiving connection turned down to protect it from contamination. A warning plate bearing the inscription “POTABLE WATER ONLY” in one-inch letters will conspicuously designate filling connections. Only valve hand wheels and levers not exposed to the weather will be color-coded dark blue in accordance with reference (m).

(2) Potable water hoses will be used to transfer potable water only and for no other purpose. Hoses will be stenciled with the inscription "POTABLE WATER ONLY" at 10-foot intervals. Hoses will be kept in good condition at all times, examined monthly and removed from service when cracks develop in the lining. Cracks in lining are usually caused by normal deterioration and stress. Hoses will be stored with the ends coupled or closed with screw-type caps in padlocked, vermin proof lockers.

(3) Lockers will be identified and labeled "POTABLE WATER ONLY." Lockers will be located out of the weather, if practical, and at least 18 inches off the deck, padlocked, and vermin proof. Printed step-by-step instructions for disinfecting of potable water hoses will be conspicuously posted in the hose storage area.

(4) Sounding Rods and Tapes. The sounding rods and tapes used to measure the potable water in the storage tanks must be color-coded dark blue, labeled, or otherwise identified "POTABLE WATER USE ONLY." These tapes will be disinfected using 100 ppm free available halogen solution before each use.

4. Bacteriological Testing

a. Testing will be accomplished using the Colilert method; the required supplies are listed in the AMAL. Samples for bacteriological analysis will be collected from representative points throughout the distribution system (i.e., forward, amidships, aft, as far above the 0-1 level as possible) as well as from the BDS emergency potable water tanks and ice cube or ice makers on a rotational basis. Samples of water from potable water tanks must be collected from one quarter of potable water tanks weekly and one sample per tank monthly for emergency potable water tanks. The number of water samples collected from

the distribution system should be based on the size of the crew as pursuant to chapter 6, table 6-9 of reference (g).

b. Testing will be documented using the SAMS/TMIP environmental surveillance module. Halogen residual readings will be included with the results. Positive and negative "control test samples" will be tested each time that the bacteriological tests are performed.

c. The control tests are essential to ensure quality of the test procedure. To obtain negative control, use sterile water. A positive control may be obtained by testing 100 ml of water that has been lightly inoculated with feces; a rectal swab is recommended. The control tests are processed in the same manner as the routine water samples. No growth should result from the negative control test; the positive control should demonstrate numerous typical coliform colonies. The SMDR shall develop a financial plan for the department based on experience and projected requirements. The SMDR shall advise the ship's supply officer and CoC of these needs in advance of distribution of the quarterly allocation of funds. Pursuant to reference (d), an annual projected budget should be prepared and submitted to the supply officer for inclusion in the AFMP.

5. Calcium Hypochlorite Storage. Calcium Hypochlorite storage lockers are the responsibility of the engineering department, but the Medical Department must be aware of the location, proper mounting, and the contents of the storage locker. Improper stowage in conditions of dampness or high temperatures may lead to fire or explosion. For proper stowage requirements, refer to chapter 6 of reference (g) and chapter 670-34.9.1.2.3 of reference (j).

SECTION 4 – HABITABILITY

1. General. The need for maintaining high standards of hygiene and sanitation is fundamental to the promotion of good health and morale. The SMDR will make frequent, informal walk-through inspections of berthing areas and related service facilities to ensure habitability standards are upheld. Although such walk-throughs should be accomplished daily, the frequency should be at the discretion of the CO. Results from all habitability areas will be formally submitted to the CO at least quarterly but more frequently if necessary.

2. Barber Shop. Any space used for cutting of hair will be designated as a "Barber Shop" by the command. It will not be located in food service or berthing areas. Sanitation regulations will be posted in all barber shops. Each SMDR will become familiar with the standards of chapter 2 of reference (g). Barbers will be medically screened and determined to be free of communicable disease prior to their initial assignment on board. Annual evaluation is not routinely required. Any evidence of disease or illness will immediately be brought to the attention of the Medical Department.

3. Laundry. Laundry spaces will be maintained in a clean and sanitary condition. Sanitation regulations will be posted in all laundry spaces. Each SMDR will become familiar with the standards of chapter 2(4) of reference (g). Laundry personnel who are exposed to dry cleaning solvents must receive pre-employment and periodic physical examinations in accordance with reference (n).

4. Fitness/Exercise Facilities. Fitness/exercise facilities will be inspected for cleanliness and general sanitation practices.

5. Ship Store/Vending Areas. Ship store and vending areas will be inspected for cleanliness and general sanitation practices. Particular attention should be paid to expiration dates of food and drink products.

6. Brig. Brig inspection should be conducted in conjunction with the quarterly habitability inspection and only on vessels that maintain a brig (i.e., LHA and LHD).

SECTION 5 – INSECT AND RODENT CONTROL

1. Pest Control Procedures. Maintaining the health, welfare and morale of the crew is the primary goal in ensuring an effective and safe pest control program is in place. Each shipboard pest control operator and medical supervisor will ensure that the standards listed in chapter 8 of reference (g) and reference (h) are maintained.

a. References (g) and (h) contain detailed information on the eradication and control of cockroaches and stored product pests.

b. In accordance with reference (e), all shipboard medical departments must have at least the SMDR and all corpsmen responsible for pest control certified as shipboard pest management specialists. On ships with IDCs assigned, their certification is acceptable in lieu of a more senior non-IDC. If a Preventive Medicine Technician (NEC 8432) is assigned, that individual will serve as the pest control program manager. Seats for certification courses may be scheduled by contacting the nearest NEPMU. Certification is now valid for a four year period with a one year extension available. All personnel who maintain the certification will also participate in medical monitoring per the Medical Matrix for Organophosphate/Carbamate Compounds. Personnel are not authorized to perform pest control with pesticides if medical surveillance is not conducted.

c. Operators will use appropriate protective gear in accordance with reference (n).

d. Approved pesticides are listed on the AMAL. Use of non-AMAL pesticides must be approved by and used under the direction of NEPMU personnel and requires a written waiver by the TYCOM Force Surgeon.

e. Pest control surveys will be conducted every two weeks at a minimum. Treatments will be accomplished as needed and per published standards. All surveys, inspections, and treatments will be documented using the SAMS/TMIP environmental surveillance module.

2. Rodent Control

a. In foreign ports and non-Navy controlled U.S. ports, all ships will employ properly fitted rat guards on all lines connecting the ship to the pier. The medical department will inspect to ensure compliance with chapter 8 of reference (g).

b. The Center for Disease Control (CDC) Ship Sanitation Certificate Program (SSCP) certificate replaces the previous deratting certificate. After the SSCP inspection, authorized medical personnel shall sign, seal and issue the NAVMED 6210/1 U.S. Navy Shipboard Sanitation Control Exemption/Ship Sanitation Control Certificate. This document is issued in accordance with article 39 of reference (r). This certificate is valid for six months and should be kept current to allow for the potential of any ship to be deployed to any region worldwide with little notice. If a ship is unable to schedule re-inspection, a maximum one month extension may be provided using the NAVMED 6210/2 Notification of 30-day Extension of Ship Sanitation Exemption Control Certificate.

SECTION 6 – COMMUNICABLE DISEASES

1. General. The ship's SMDR shall be familiar with and responsible for planning, developing, and carrying out a comprehensive communicable disease program. Advice and assistance in communicable disease control can be obtained from the nearest NEPMU. The notification of communicable diseases will be reported in accordance with reference (a).

2. Sexually Transmitted Diseases (STDs). A STD program shall be conducted in accordance with references (b) and (q). Current CDC treatment guidelines located on the CDC web site at http://www.cdc.gov/std.

3. Tuberculosis Control Program. A tuberculosis control program shall be conducted in accordance with reference (c). Note: Annual PPD or other Tuberculosis Skin Testing (TST) for Fleet personnel is no longer required unless indicated by criteria outlined in the instruction.

4. Malaria. Refer to references (i) and (k) for guidance.

a. All units scheduled for deployment shall schedule a pre-deployment briefing with the cognizant NEPMU far enough in advance of deployment to allow for procurement of recommended anti-malarial agents. Units shall work with the cognizant RMR to determine a sufficient quantity of medications that should be carried.

b. Certain anti-malarial agents are contraindicated in G6PD deficient personnel. Accordingly, those persons who are traveling or deploying to a malaria-risk area must be identified and evaluated by Medical Department personnel as to evaluate the need for special chemoprophylaxis and treatment protocols.

5. Prophylactic Immunizations. An effective prophylactic immunization program shall be conducted in accordance with reference (d).

a. All immunizations, except Yellow Fever, may be given at sea or ashore at the discretion of the SMDR with the concurrence of the CO. Yellow fever immunizations on IDC ships shall only be conducted in port during normal working hours after prior notification and concurrence of the local cognizant RMR, unless an MO is present.

b. The minimum level for a health care provider to be present during all immunizations is an IDC.

c. For readiness assessment purposes, the status of crew immunizations must be greater than 90% to be graded satisfactory.

d. All health care providers will receive the occupationally appropriate vaccines.

6. Human Immunodeficiency Virus (HIV) Testing Program. Management and testing of HIV will be conducted in accordance with reference (q). In addition, specific circumstances such as needle stick, blood borne exposes, and STD evaluations may require HIV testing.

SECTION 7 – INDUSTRIAL HYGIENE AND OCCUPATIONAL HEALTH

1. General. In matters of safety, industrial hygiene, and occupational health, the ship's SMDR and safety officer shall act in an advisory capacity to the CO, department heads and other supervisory personnel. This requires knowledge of the contents and requirements in references (n) and (o).

2. Safety. Safety involves the design and control of equipment and the working environment to reduce hazards along with the training of personnel toward safe attitudes and practices. In support of the safety program, the medical department will:

a. Submit an Accident/Injury Report with a copy to the safety officer, on all injuries sustained by crew members. This includes injuries sustained at or away from the command, and if they were treated at or away from the command.

b. Complete the medical section of any JAGMAN investigations warranted.

c. Ensure all accident/injuries, including circumstances and treatment rendered, are documented in the patient's health record at the time of treatment.

3. Industrial Hygiene and Occupational Health. All levels of command will implement and manage the NAVOSH (Afloat) Program pursuant to references (n) and (o).

a. The following is a quick reference list of the major shipboard NAVOSH programs the medical department is routinely involved with:

(1) Asbestos Control Program.

(2) Heat Stress Program.

(3) Hazardous Material Control & Management Program.

(4) Hearing Conservation Program.

(5) Sight Conservation Program.

(6) Respiratory Protection Program.

(7) Radiation Protection Program (Medical Radiography).

(8) Personal Protective Clothing & Equipment.

(9) Organophosphate/Carbamate Compounds.

(10) Lead Hazard Training.

b. Volume I, Section C covers surface ship safety standards for various shipboard tasks and evolutions.

4. Surveillance Programs. The Medical Department shall conduct routine surveillance of industrial, working and living spaces per current directives and report adverse conditions potentially or actually affecting the health of the crew to the CO. The Medical Department will also assist crew members in completion of all aspects of medical surveillance screenings primarily utilizing the local occupational health office at the closest MTF. For readiness assessment purposes, a current screening of greater than 90% of the personnel in each program is required to obtain a grade of satisfactory. The major surveillance programs include:

a. Hearing Conservation Program (HCP). Personnel who are routinely exposed to noise hazards require annual audiometric testing. Program guidance is provided by section B4 of reference (n).

b. Sight Conservation. The Medical Department will work in conjunction with the safety division to ensure all aspects of sight conservation are followed. Chapter B5 of reference (n) outlines requirements of the program.

c. Asbestos Surveillance Monitoring Program (AMSP). All personnel with a history of exposure to asbestos must obtain periodic evaluation in accordance with section B1 of reference (n).

d. Lead Control. The Medical Department shall assist the safety officer with conducting lead hazard training and schedule personnel for blood lead analysis and physical examinations at shore medical activities as required for medical surveillance.

Isocyanate Exposure. Specific to personnel who routinely work with isocyanate (polyurethane) paint will be monitored utilizing section 196 of reference (l). Specific rate involved is BM and others as may be necessary.

e. Metal Fumes Exposure. Reference (n) provides welding safety guidelines. Specific to personnel who routinely conduct welding, cutting, brazing, and hot work will be monitored utilizing section 602 of reference (l). Specific rates involved are HT, MR and others as may be necessary.

f. Shipboard Sewage Systems. Medical Department Responsibilities, Marine Sanitation Devices (MSD), are outlined in chapter 7(3) of reference (g). Wastewater/Sewage workers will be monitored pursuant to section 702 of reference (l). Polio, Hepatitis A/B and Tetanus immunizations will be maintained current at all times. Specific rate involved is HT and others as may be necessary.

g. Healthcare Workers (HCW). Medical surveillance is required of all medical and dental personnel in accordance with section 719 of reference (l).

CHAPTER 6 - MEDICAL PLANNING

Ref: (a) BUMEDINST 6440.5C, Health Services Augmentation Program (HSAP)
(b) Joint Publication (JP) 3-02, "Amphibious Operations."
(c) Joint Publication (JP) 4-02, "Health Services Support."
(d) Joint Publication (JP) 4-02.2, "Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations
(e) Marine Corps Warfighting Publication (MCWP) 4-11.1, Health Service Support Operations
(f) NAVMED P-5041, Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries
(g) Navy Tactics, Techniques, and Procedures (NTTP) 1-01, The Navy Warfare Library, edition April 2005
(h) Navy Tactics, Techniques, and Procedures (NTTP) 4-02M, Patient Movement, edition May 2007
(i) Navy Tactics, Techniques, and Procedures (NTTP) 4-02.1, Medical Logistics, edition September 2012
(j) Navy Warfare Publication (NWP) 4-02, "Naval Expeditionary Health Service Support Afloat and Ashore", edition January 2008
(k) Navy Warfare Publication (NWP) 5-01 (Rev A), "Navy Planning", edition January 2007

SECTION 1 – Responsibilities

1. General. Naval exercises and operations are planned evolutions. A written strategic plan is designated an operational plan (OPLAN). In accordance to reference (k), an OPLAN is prepared by staff planning officers and is intended to provide guidance for all aspects of an operation to accomplish the stated objectives. References (a) through (j) are provided for additional information. OPLANs exist for several scenarios and are frequently updated or modified to suit changing political situations or availability of military assets. Based on the latest OPLAN, a deployment operational order (OPORD) is prepared for a ship or unit. The OPLAN and OPORD include medical appendices, which contain the information and guidance to provide medical support in an organized system during the exercise or operation.

a. Staff MOs are responsible for planning and drafting the medical appendix to the OPORD. To properly accomplish this task, they must confer on a regular basis with the staff personnel section (N1), staff intelligence section (N2), staff operations section (N3), staff logistics section (N4), and staff communications section (N6). They must further maintain close coordination with medical counterparts in the landing force to ensure both Navy and Marine Corps plans take the same direction in areas of communications, casualty evacuation, and logistical support requirements.

b. Based on the commander's concept of the entire exercise or operation, the officers preparing the medical appendix shall address the various aspects set forth below as they apply to the particular situation. Denote those actions to be carried out (ACTUAL) and those whose execution will be simulated (CONSTRUCTIVE or NOTIONAL). For basic guidance, consult Fleet, Type, Group, and Squadron effective OPORDs.

c. Factors to be addressed in the medical appendix include, as applicable:

(1) Medical scenario personnel strength, length of exercise or operation, and casualty estimate.

(2) Nature of climate, terrain, and endemic diseases in the area of operation and other conditions or hazards existing there in.

(3) Applicable preventive medicine measures required.

(4) Medical support facilities available, both U.S. military and host nation support.

(5) Assignment of responsibilities to the Amphibious Task Force command echelons and Landing Force command echelons with special attention to medical chain of command and specific CATF Surgeon and Commander, Landing Force (CLF) Surgeon responsibilities.

(6) Designation of Casualty Receiving and Treatment Ship (CRTS), Casualty Evacuation Control Ships (CECS), and arrangements for Fleet Surgical Team (FST), Medical Augmentation Program (MAP), or unit augmentation personnel, if required.

(7) Details for casualty handling and routing (medical regulating) (e.g., MEDEVAC and patient distribution control radio frequencies) for CRTS, CECS, and Beach Evacuation Station (BES) locations, and details for the appropriate triage of casualties.

(8) Evacuation policy.

(9) Medical reporting requirements (e.g., joining reports and casualty reporting requirements for actual and simulated casualties).

(10) Blood program.

(11) Medical logistics as outlined in reference (i).

(12) Decedent affairs.

(13) Training requirements for first aid and mass casualty handling.

(14) Medical intelligence from NCMI.

(15) Various annexes to the medical appendix (e.g., equipping and manning of ambulance boats, mass casualty management and reporting requirement formats).

2. Medical Augmentation. Due to multiple platforms that the Health Service Augmentation Program (HSAP) program supports, commands must utilize reference (a) to plan and request the type of team(s) or personnel required to support the operational needs of the OPLAN.

a. Fleet Surgical Teams. When deployed with an amphibious readiness group (ARG) usually aboard a flagship CRTS, an FST will be assigned to the appropriate Amphibious Squadron (PHIBRON) Commander. The PHIBRON will ensure that the FST is fully trained and capable of performing all duties assigned. The OIC of the FST shall serve as the CATF Surgeon and shall be assigned TAD to the PHIBRON Staff. The FST Medical Regulating Control Officer shall also be assigned TAD to the PHIBRON Staff. All other FST members shall be assigned TAD to the ship's Medical Department. During this period, the ship's CO shall assume line authority over FST members assigned TAD to the ship.

b. Other Augmentation. Normally, medical augments will be assigned TAD to the ship's Medical Department. Embarked medical personnel, while aboard, will integrate as part of the ship's medical department to the greatest extent possible. Types of augment teams include:

(1) Casualty Receiving Treatment Ships (CRTS) Augmentation Teams. The Medical Fleet Response Plan (MFRP) surge capacity is applicable to Budget Submitting Office (BSO) 18 Component Unit Identification Code (CUIC) HSAP personnel. There are currently 11 augmentation teams identified for the large deck amphibious ships (LHA/LHD) of the fleet.

(2) Routine Deployable. Navy medical personnel assigned to the Fleets (BSO 60 or 70) to include FST personnel that are Additional Duty (ADDU) to the local MTF. These assets are immediately available to the Fleet for deployment.

(3) Surge Ready. BSO 18 personnel assigned to CRTS CUIC BSC under the HSAP. These personnel will be available to deploy with Fleet units within 30 days of notification.

(4) Emergency Surge. Additional forces designated for further follow-on stages that are ready and capable of deploying within 120 days.

3. Landing Force. Embarked landing force medical personnel will be afforded the use of task force spaces and supplies when assigned to conduct sick call for their own troops. However, the SMDR will remain in charge of afloat medical support even if outranked by troop medical personnel.

4. Medical Joining Report. When a unit in-chops to a Task Force or Fleet area command, a Medical Joining Report will be submitted in the format requested by the Task Force/Fleet Commander. The purpose of this report is to identify total Task Force or Fleet medical assets available.

5. Medical Regulating. The area commander will establish medical regulating procedures in a specific AOR.

SECTION 2 – CASUALTY HANDLING

1. General. The team concept of Navy-Marine Corps operations extends into the medical arena. The ARG not only loads, transports, and offloads personnel and war material, it also furnishes medical support; especially during the critical phases of a landing. Until medical elements of the landing force are firmly established ashore, the CATF is responsible for evacuating casualties' seaward from the beach to designated ships for treatment and further disposition. References (b) through (f) and (h) through (j) are available to assist the CATF in conducting these operations until relieved by the ashore force.

a. During the transport and assault phases it is logical that landing force medical supplies be left intact for use ashore. This material comes in packages varying in size, ranging from the corpsman's first aid pouch to be used on the front line, to complete collecting and clearing stations including tents and vehicles. Therefore, while embarked landing force medical personnel may be assigned to conduct sick call for their own troops, they will be afforded use of task force medical spaces and supplies.

b. The SMDR remains in charge of all medical care conducted aboard the ship even if outranked by embarked medical personnel. The exercise of normal professional courtesy should prevent any misunderstandings. Embarked personnel may be called upon to assist in shipboard emergencies at any time while aboard. The foregoing indicates again the extreme importance of cooperation, professionalism and a high level of material readiness in the Force.

2. Chain of Evacuation. The beachhead is the critical transition point between responsibilities of the landing force and the task force and thus demands closest cooperation between the two for the uninterrupted flow of medical casualties seaward. The primary naval unit ashore for medical coordination is the Beachmaster Unit. This unit does not have personnel available to double as stretcher-bearers. It is the responsibility of landing force units to furnish stretcher bearers and to get casualties into medical ambulance boats and aircraft. The medical officer in charge of the beach evacuation station (BES) at the beach-head, when assured that patients are in optimal condition to be moved, requests the transportation coordinator from the

Beachmaster Unit to call in landing craft or air assets. Ordinarily, such craft are designated in the OPORD and fly the "Mike" flag to indicate same.

a. Triage of casualties is a cardinal principle in military medicine and is used all along the chain of evacuation. Patients must be evaluated and classified as to their immediate condition at each stop in the evacuation process with a goal of movement toward more appropriate, definitive treatment. Speed of evacuation is not the overriding factor. The preservation of life and limb should be of paramount importance. However, the conservation of personnel, time, facilities, and supplies in a military situation demands adherence to the principle of the greatest good for the greatest number.

b. The nature of current amphibious operations involves extensive use of MEDEVAC by helicopter directly from the landing zones to a receiving ship in a matter of minutes. Such expeditious transportation has contributed to lower morbidity and mortality rates. Triage is done aboard ship in the resuscitative or preoperative area, where many of the casualties are prepared for priority care and surgery. Killed-in-action (KIA) may be evacuated along with the living as a matter of expediency in relatively isolated amphibious operations. Facilities must be ready for proper care and preparation of remains before further transfer. Flexibility remains the keyword. The medical effort is tailored to the situation and plans modified as necessary.

c. Of ships currently in use, LHD and LHA classes are used in the CRTS role. Other task force ships possess significant medical capability. LPD 17 class ships are CRTS-capable with personnel augmentation, but do not have the capacity of the LHD and LHA classes. LPD 4 and LSD 41 classes are ships less suited for CRTS duties, but may be used for certain casualty categories at the discretion of the CATF surgeon. Patients may be retained aboard ship or returned to duty per the particular evacuation policy in force for the amphibious operation. No amphibious task force ship can match the capabilities of a hospital ship (T-AH) or fixed medical facility ashore. Therefore, serious cases are evacuated to the rear as soon as their conditions are stabilized and operational conditions permit. Ships may be called upon to transport casualties back to the continental U.S. or to staging

points ashore for air transport. For every exercise or contingency operation, read the Medical Annex Q to understand the part the medical department will play as well as the overall picture.

CHAPTER 7 - BLOOD PROGRAM

Ref: (a) NAVMED P-5101, The Technical Manual of the American Association of Blood Banks (Current Edition)
(b) NAVMED P-5120, AABB Standards for Blood Banks and Transfusion Services (Current Edition)
(c) NAVMED P-5123, Operational Procedures for the Armed Services Blood Program Elements
(d) OPNAVINST 6530.4B, Department of the Navy Blood Program

SECTION 1 – ADMINISTRATION

1. General. References (a) through (d) provide guidance on the military blood program. The blood program provides an orderly system for the collection, storage, and distribution of theater blood products during peacetime and wartime operations. Ships with surgical capability and FST personnel aboard shall maintain blood products as well as collection and transfusion supplies on board per AMAL. All other ships with an MO assigned shall maintain blood collection and transfusion materials only as required by AMAL.

2. Planning

a. Proper advance planning for blood products is of critical importance and general guidelines can be found in reference (d). Medical annexes to all OPORDs and OPLANs shall address the procurement, placement, laboratory testing, and administration of blood products. Upon deployment, operational units with blood bank or blood transfusion capability will consider the blood product requirements and will be prepared to provide support to other units.

b. Disaster Preparedness Planning. Shore-based area disaster planning is not to include any operational unit as a blood bank or blood resource, since such units must maintain operational availability and readiness for national defense at all times.

3. Responsibilities

a. Task Force Blood Program Officer (TFBPO). A TFBPO shall be appointed for every task force deployment or exercise that involves a Casualty Receiving and Treatment Ship (CRTS).

(1) If embarked, the senior MSC officer of the blood bank team shall be the TFBPO.

(2) In amphibious ready groups, the CATF surgeon shall be the TFBPO if a blood bank team is not assigned.

(3) In all other task forces, the senior MO shall be the TFBPO if a blood bank team is not assigned.

(4) In amphibious assaults, the TFBPO will coordinate blood and fluid support for the medical company ashore from the CRTS until the ships leave the AOA.

(5) Direct the procurement, storage, and use of blood products in support of the OPORD/OPLAN.

(6) Submit consolidated re-supply requests for blood components and blood bank operational reports.

b. Duties of the Senior Medical Officer. The SMO assigned to units with blood banking or blood transfusion capabilities shall:

(1) Ensure that appropriate storage facilities are in correct working order at all times.

(2) Ensure that proper handling, preparation, and type and cross-matching procedures are followed in the use of blood products.

(3) Train medical personnel in proper blood drawing, blood transfusion techniques, transfusion reactions procedures, and, if maintained aboard, handling and thawing procedures for frozen blood products.

(4) Develop and implement a viable quality control program for all aspects of blood product usage and storage.

(5) Request blood products as required from the TFBPO or, if no TFBPO is assigned, from the supporting area blood program office.

(6) Ensure standard operating procedures (SOP) are developed, maintained, and reviewed annually.

(7) Coordinate a BPO Technical Assessment Visit to promote program readiness. These assessments are required annually and sooner if unit will be deployed when regularly scheduled visit is due.

(8) Before deployment of a CRTS, ensure afloat blood product inventory and supply needs or excesses are provided to the serving area blood system director.

SECTION 2 – USAGE OF BLOOD PRODUCTS

1. Ordering Blood Products. The respective BPO is responsible for meeting blood product requirements in its respective AOR. Operational units shall use the blood report format contained in reference (d) when ordering blood products. The BPO will normally arrange air delivery of blood products to the fixed-wing airhead nearest to ships that are underway. Ships will then use organic helicopter support to transport blood products on board ships from the fixed-wing airhead. Ships operating beyond the range of helicopter support can use airdrops from fixed-wing aircraft. Coordination and arrangements will be made through the BPO.

2. Transportation of Blood Products. Blood product containers can be transported by any means possible when moving within the battle group, ship to shore or shore to ship.

a. The Air Force maintains the Expeditionary Blood Transshipment System (EBTS) at multiple air terminals in OCONUS locations as required to the CCMD. The EBTS functions as an intermediate receiving, inspecting, re-icing, storing and distributing facility for liquid and frozen blood sent from CONUS.

b. The Blood Support Detachment (BSD) is an intermediate supply point between the EBTS and the receiving platform for blood products and is used to support a specific geographical location.

3. Storage of Blood Product. Operational units in port or in steaming condition four normally will not maintain blood products with the exception of frozen blood stored aboard CRTS designated ships.

a. LPD-17, LHA and LHD class ships possess the capability to store and process frozen blood products. These classes of ships shall maintain a complete load of frozen blood products at all times in accordance with reference (d).

b. Training Units. Blood products required for training, certification, and quality control will be utilized from on-hand stocks.

c. Ships maintaining frozen blood products shall be certified prior to prolonged deployment as part of the MRI. This certification shall be coordinated by the RMR and conducted by the appropriate MTF BPO.

(1) Frozen Red Cells. Frozen red blood cells are Group 'O' cells only and may be administered to all groups/types without cross-matching, following proper protocol for deglycerolization. Rh negative frozen cells should be administered to Rh negative patients with the priority given to Rh negative females in cases of shortages. Units must be maintained at a minimum temperature of -65 degrees Celsius. Frozen red cells have an approved shelf life of 10 years.

(2) Human Serum Albumin 25%. Colloid blood component primarily used in treating burn patients. One unit of albumin for every three units of infused crystalloid is the usual ratio. Albumin, when stored under refrigeration, has a normal shelf-life of 1 year.

4. Administration of Blood Products. Under normal operating conditions, operational units shall obtain medical support from shore facilities for patients requiring blood product transfusions. Blood products administration shall only be prescribed by an MO. Units without blood transfusion capabilities shall not administer blood products. Patients in need of blood components shall be stabilized with intravenous crystalloid solutions (normal saline, Ringer’s lactate, etc.) and transported to a facility with transfusion capabilities as soon as possible.

a. The use of packed red blood cells rather than whole blood will increase the requirement for crystalloids to supplement volume expansion. A general guide to crystalloid requirements in support of acute blood loss is to replace each milliliter (ml) of estimated blood loss with three ml of crystalloid (normal saline, Ringer’s lactate, etc.).

b. Additional crystalloid will be required for infusion. Do not use crystalloid solutions containing dextrose for these purposes. Blood resources and requirements shall be assessed on at least a daily basis.

5. Return of Blood Products. When stored frozen blood products approach one-half of their shelf-life limits or are no longer needed, their return shall be coordinated with the nearest area Joint Blood Program Office (JBPO). Packing and handling procedures shall be followed in accordance with reference (a). Transportation is the responsibility of the unit in possession of the blood products.

6. Communication. All blood reports and blood shipment reports shall be sent using standard Armed Services Blood Program Office (ASBPO) approved voice, message, and/or computer generated blood report formats. Blood product request messages should be minimally classified. Information copies should be kept to a minimum and specifically required by the respective OPLAN. Messages shall be sent as IMMEDIATE because of very short blood shelf life. Blood product messages shall be formatted in accordance with reference (d). Consolidated blood bank operational reports shall be submitted to the area JBPO by TFBPO.

SECTION 3 – WALKING BLOOD BANK

1. Guidance. Pursuant to reference (c), all ships shall maintain a current, printed listing of each crewmember's blood type, Rh factor, and whether the individual is an eligible donor. When deployed, the SMDR shall be prepared to exchange lists with other ships in company in order to provide a ready cross index of available blood.

a. The blood type and Rh factor of each crewmember shall be verified as part of the medical check-in process.

b. A tickler file of blood types/Rh factors will also be maintained on all embarked personnel.

2. Procedure. A "walking blood bank" shall be utilized as a tertiary blood source when neither liquid blood products nor thawed and washed cells are available. The use of walking donors and emergency blood collections, although sometimes necessary, is not encouraged due to the lack of the capability to perform serological testing for infectious diseases. If drawn, the following procedures must be adhered to:

a. A sample of serum (minimum 1 ml) from the emergency donation must be kept for retrospective testing. The serum specimen must be kept frozen.

b. Notify the appropriate Blood Program Office (BPO) for guidance regarding follow-up testing.

c. Use the donor's SSN as the blood unit number.

d. If the emergency donation is used, the attending physician must certify in writing that the use of blood not fully tested is required to sustain the life of the patient.

APPENDIX A
ACRONYMS

ACRONYM	DEFINITION
ACLS	Advanced Cardiac Life Support
ACR	Allowance Change Request
ADAL	Authorized Dental Allowance List
AFMP	Annual Financial Management Plan
AHLTA	Armed Forces Health Longitudinal Technology
AHSS	Automated Heat Stress System
AMAL	Authorized Medical Allowance List
AO	Area of Operation
APL	Authorized Parts List
ARG	Amphibious Readiness Group
ASA	Afloat Self-Assessment
ATG	Afloat Training Group
BDS	Battle Dressing Station
BLS	Basic Life Support
BMET	Biomedical Technician
BUMED	Bureau of Medicine and Surgery
BUPERS	Bureau of Naval Personnel
CASREP	Casualty Report
CATF	Commander, Amphibious Task Force
CBRN	Chemical, Biological, Radiological and Nuclear
CCMD	Combatant Command
CCN	Critical Care Nurse
CDB	Career Development Board
CDC	Center for Disease Control
CDE	Command Directed Evaluation
CDO	Command Duty Officer
CEU	Continuing Education Unit
CHCS	Composite Health Care System
CME	Continuing Medical Education
CO	Commanding Officer
CoC	Chain of Command
COMNAVSURFLANT	Commander, Naval Surface Force Atlantic
COMNAVSURFPAC	Commander, Naval Surface Force U.S. Pacific Fleet
CONEX	Intermodal Container (ISO Container)
CONUS	Inside the Continental United States
COSAL	Coordinated Shipboard Allowance List
CRTS	Casualty Receiving and Treatment Ship
CS	Culinary Specialist
CSIB	Controlled Substances Inventory Board
DAPA	Drug/Alcohol Program Advisor
DC	Damage Control

DEERS	Defense Enrollment Eligibility Reporting System
DENEVAC	Dental Evacuation
DLA	Defense Logistical Agency
DMLSS	Defense Medical Logistics Standard Support
DMSB	Defense Medical Standardization Board
DNBI	Disease and Non-Battle Injury
DO	Dental Officer
DOD	Department of Defense
DON	Department of the Navy
DON PEB	Department of the Navy Physical Evaluation Board
DOT	Department of Transportation
DPRDP	DOD pharmaceuticals reverse distribution program
DRMS	Defense Reutilization and Marketing Service
DVA	Department of Veterans Affairs
EMS	Emergency Medical Services
ENT	Ear, Nose and Throat
ESG	Expeditionary Strike Group
FAB	First Aid Box
FAC	Free Available Chlorine
FBR	Feedback Report
FDA	Food and Drug Administration
FHP	Force Health Protection
FNDF	Forward Deployed Naval Forces
FRTP	Fleet Response Training Plan
FSA	Food Service Attendants
FSO-M	Fleet Support Operations - Medical
FST	Fleet Surgical Team
GMO	General Medical Officer
GQ	General Quarters
GMT	General Military Training
HIPAA	The Health Insurance Portability and Accountability Act of 1996
HM	Hospital Corpsman
HSAP	Health Services Augmentation Program
ICU	Intensive Care Unit
IMR	Individual Medical Readiness
INCHOP	Entering A Command Region Or Zone
ISIC	Immediate Superior in Command
ISOS	International SOS
ITT	Integrated Training Team
JQR	Joint Qualification Requirement
LCS	Littoral Combat Ship
LIMDU	Limited Duty
LOEP	List of Effective Page
LOK	Level of Knowledge
LRTP	Long Range Training Plan

MAA	Master-At-Arms
MANMED	Manual of the Medical Department
MAO	Medical Administration Officer
MCB	Mass Casualty Box
MDR	Medical Department Representative
MEB	Medical Evaluation Board
MEDEVAC	Medical Evacuation
MEDORM	Medical Department Organization Manual
MER	Medical Event Report
MEU	Marine Expeditionary Unit
MFR	Memorandum for the Record
MHE	Mental Health Evaluation
MHP	Mental Healthcare Provider
MO	Medical Officer
MRC	Maintenance Requirement Card
MRD	Medical Readiness Division
MRI	Medical Readiness Inspection
MSC	Medical Service Corps
MSDS	Material Safety Data Sheet
MSE	Medical Support Equipment
MSSP	Medical Staff Service Professional
MTF	Military Treatment Facility
MTT	Medical Training Team
NATO	North Atlantic Treaty Organization
NDRSi	Naval Disease Reporting System internet
NEC	Navy Enlisted Classification
NEO	Non-Combatant Evacuation Operations
NEPMU	Navy Environmental Preventive Medicine Unit
NKO	Navy knowledge online
NMCPHC	Navy and Marine Corps Public Health Center
NMETC	Naval Medical Education and Training Command
NMLC	Navy Medical Logistics Command
NMO	Navy Medicine Online
NPI	National Provider Number
NSN	National Stock Number
OCONUS	Outside The Continental United States
OIC	Officer in Charge
OMMS-NG	Operational Maintenance and Management System - Next Generation
OOD	Officer Of The Deck
OPLAN	Operational Plan
OPN	Other Procurement, Navy
OPORD	Operational Order
PA&I	Performance Assessment & Improvement
PB4T	Planning Board for Training
PCM	Primary Care Manager

PEB	Physical Evaluation Board
PFA	Physical Fitness Assessment
PHA	Periodic Health Assessment
PHIBRON	Amphibious Squadron
PMS	Preventive Maintenance System
PMT	Preventive Medicine Technician
POA&M	Plan of Action and Milestones
POD	Plan of the Day
PPM	Parts per Million
PQS	Personal Qualification Standards
PRD	Projected Rotational Date
PSI	Pounds per Square Inch
R-ADM	Relational Administrative Data Management
RMR	Regional Medical Representative
RMRSMO	Regional Medical Representative, Senior Medical Officer
ROC/POE	Required Operational Capability/Projected Operational Environment
ROH	Routine Overhaul
RPPO	Repair Parts Petty Officer
SAMS	Shipboard Automated Medical System
SAPR	Sexual Assault Prevention and Response
SAR	Sea-Air Rescue
SSCP	Ship Sanitation Certificate Program
SERP	Shipboard Equipment Replacement Program
SFEM	Surface Force Exercise Manual
SITREP	Situation Report
SIQ	Sick in Quarters
SLEP	Shelf Life Extension Program
SMDR	Senior Medical Department Representative
SME	Subject Matter Expert
SMMO	Ships Material and Maintenance Officer
SMO	Senior Medical Officer
SMPM	Shipboard Medical Procedures Manual
SNAP	Shipboard Non-Tactical Data Program
SOP	Standard Operating Procedure
SORM	Standard Regulations Manual
SRA	Selected Availability TAV Technical Assist Visit
TEMADD	Temporary Additional Duty
TF	Task Force
TFBPO	Task Force Blood Program Officer
TFOM	Training Figure of Merit
TD	Temporary Duty
TMIP-M	Theater Medical Information Program-Maritime
TORIS	Training and Operational Readiness Information System

TYCOM	Type Commander
USCENTCOM	United States Central Command
VBSS	Visit, Board, Search and Seizure
WBGT	Wet, Bulb, Globe Thermometer
WESS	Web-Enabled Safety System
WQSB	Watch, Quarter and Station Bill
XO	Executive Officer

APPENDIX B
SAFE TO SAIL CHECKLIST

Unit:
Date:
Inspector:

I. ADMINISTRATIVE ITEMS	< 100% = UNSAT	SAT	UNSAT	COMMENTS
a. Health records are stored in a secured space				
b. Stretcher Bearers identified and PQS qualified				
c. Medical waste management SOP in place				
d. Current Physician Supervisor Letter (non GMO ships)				
e. Current authorization to prescribe medication memorandum				
f. BLS certification for all medical providers				
g. Current StatRef onboard				
h. Ship's Sanitation Control Certification				**Expiration Date:**

SAT	UNSAT

II. EMERGENCY AMALS REQUIRED TO BE AT 100%	< 100% = UNSAT	SAT	UNSAT	COMMENTS
a. EMERGENCY RESPONSE KIT (MORK/IDC) stocked per 53/56 with current inventory documented				_____% **Last Inventory:**
b. JR HM EMERGENCY RESPONSE KIT (1 kit per 2 Jr HMs on MO ship/1 per Jr HM on IDC ship) and stocked per 55 AMAL with current inventory documented				_____% **Last Inventory:**
c. CRASH CART stocked per 54 AMAL with current inventory documeted				_____% **Last Inventory:**
1) Anti-pilferage device used				

2) ACLS algorithm current and posted				
d. FIRST AID BOXES stocked per 50 AMAL with current inventory documented				_____% **Last Inventory:**
1) Required locations adequate				
2) Properly marked				
3) Contents divided in thirds; stored in plastic				
e. FIRST-AID KIT, GENERAL PURPOSE (BOAT BOX) stocked IAW CNSF 6000.1 with current inventory documented.				_____% **Last Inventory:**
1) One per each Rhib, MWB, and Gig				
2) Contents sealed in plastic bag				

SAT	UNSAT

At least 1 BDS fully functional and ready to care for casualties (2 for L-class ships) and at least 1 Mass Casualty Box per ship class

III. OTHER EMERGENCY AMAL REQUIREMENTS	**< 100% = UNSAT**	**SAT**	**UNSAT**	**COMMENTS**
a. BATTLE DRESSING STATION (BDS) Stocked per 52 AMAL with current inventory documented				_____% **Last Inventory:**
1) Routes to BDS marked				
2) Access signs on BDS doors				
3) Surgical light & emergency lighting operable				
4) Potable water tank with diagram and valve labeling. Demonstrate alignment				
5) Surgical sink operable				
6) Operating table functionable with straps and pads				

b. OXYGEN - minimum cylinders (1 "H" and 4 "D") and corresponding regulators onboard				
1) PMS accomplished on all Oxygen cylinders				
2) "Grade B shock mounting" installed & in use				
3) Valve covers on "stowed" cylinders				
4) Non-sparking wrenches available				
5) At least 1 "in-service" cylinder ready for use. (minimum 75% full)				
6) Supplies to administer oxygen				
7) Oxygen handling and stowage precautions posted (Appendix of CNSF 6000.1)				

SAT	UNSAT

IV. LABORATORY		SAT	UNSAT	COMMENTS
a. Stocked per 32 AMAL with current inventory documented	**<80% = UNSAT**			_____% **Last Inventory:**
b. Malarial kits onboard (Required if ship is visiting endemic port(s), otherwise N/A				
c. HCG tests onboard				
d. Glucose test kit				
e. Chemistry test kit				
f. Hemo reagents and controls for QBC / Piccollo Express				
g. UA dipsticks onboard				

SAT	UNSAT

V. PHARMACY		SAT	UNSAT	COMMENTS
a. Antibiotics onboard	**<50% = UNSAT**			_____%
b. Emergency respiratory drugs onboard	**<100% = UNSAT**			_____%
c. Antidote drugs onboard	**<100% = UNSAT**			_____%
d. Moderate pain management drugs onboard	**<50% = UNSAT**			_____%
f. Designated pharmacy space can be locked				
g. Controllled Substances				
1) All controlled substances on board	**<100% = UNSAT**			_____%
2) CSIB conducted and within periodicity				

SAT	UNSAT

VI. EQUIPMENT FUNCTIONAL TEST		SAT	UNSAT	COMMENTS
a. Sterilizer				
b. AED				
c. Defibrillator				
d. Reefer temp maintained at 36 - 46 degrees Fahrenheit? Reefer log maintained per 6000.1				
e. Reefer alarm functional and audible (audible outside of Medical if not manned 24/7)				
f. Radiological equipment				
g. Infusion pump				
h. Suction apparatus				
i. EKG				
j. Piccollo Express (GMO ships)				
k. QBC STAR				

SAT	UNSAT

VII. POTABLE WATER SANITATION		**SAT**	**UNSAT**	**Comments**
a. Halogen Residual Testing supplies onboard and in sufficient quantities				
b. Bacteriological Testing supplies onboard and in sufficient quantities				

SAT	**UNSAT**

VIII. STRETCHER/LITTERS	**# Req'd per GENSPECS**	**# on board**	Proper location	**CONDITION SAT/ UNSAT**	**Comments**
a. Stokes Stretchers					
b. Sea-Air Rescue (SAR) Litters					
1) Wire Rope Assembly					
2) Sling Rescue, Helicopter with valid weight test available					**Date:**
c. Reeves Sleeve					
1) Handling Lines for litters with Locking Gate					

SAT	**UNSAT**

All sections must be graded as "**SAT**" and each line items within the section must be graded as "**SAT**" in order to be deamed medically **SAFE TO SAIL.**

TOTAL SECTIONS:	
SAT SECTIONS:	
PERCENT SAT:	
SAFE TO SAIL	

ACTION ITEMS AND COMMENTS:

APPENDIX C
TEMADD ASSIST MESSAGE TEMPLATE

R (DATE TIME GROUP)
FM (COMMAND PLAD)
TO (ISIC PLAD)
INFO COMPACFLT PEARL HARBOR HI
COMUSFLTFORCOM NORFOLK VA
COMNAVPERSCOM MILLINGTON TN
BUMED FALLS CHURCH VA
(COMNAVSURFPAC SAN DIEGO CA or COMNAVSURFLANT NORFOLK VA)
(NUMBER FLEET PLAD)
BT
UNCLAS
SECINFO/-/-//
MSGID/GENADMIN,USMTF,2008/(COMMAND PLAD)//
SUBJ/HM 8425 TEMADD ASSIST FOR (COMMAND)//
POC/(NAME)/(RANK)/UNIT:(COMMAND)/NAME:PERSONNEL
OFFICER/TEL:(123-456-7891)/EMAIL:(NAME(AT)SHIP.MIL)//
GENTEXT/REMARKS/1. REQ HM 8425 FOR TEMADD ASSIST TO (SHIP) FROM (DATE) TO (DATE).
2. (SHIP) IDC UNEXPECTED LOSS DUE TO (REASON). REQUIRE AN HM 8425 TO REPORT (DATE) DUE TO UNPLANNED LOSS AND (SHIP) UNDERWAY SCHEDULE.//
BT

APPENDIX D
PLAN OF ACTION AND MILESTONES (POA&M) FOR HULL SWAP PREPARATION OF AFLOAT MEDICAL DEPARTMENTS

1. General. The following checklist is provided to ensure a smooth transition of the Medical Departments for ships involved in hull swaps. Time frames are dependent on the hull swap progress.

2. Prior to Hull Swap

a. Six Months

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-120	Contact SPAWAR to ensure ships are running compatible SAMS/TMIP system and will be able to transfer databases.	

c. Three Months

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-90	(1) Project 3 months from sail away date and order all expiring medications.	
	(2) Initially review Medical Supply and Equipment Warning Requirements report every 30 days.	

d. Two Months

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-60	(1) Ensure a CTF/ISIC/MRD MRI is conducted using the COMNAVSURFPACINST/COMNAVSURFLANTINST 6000.2B CH-1. Take action to correct deficiencies and all critical line items before sail away date.	
	(2) Review Medical Supply and Equipment Warning Requirements.	

e. One Month

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-30	(1) Review & ensure Ships Sanitation Control Exemption Certificate is within periodicity; Schedule to renew certification prior to sail way date.	
	(2) Review Departmental PMS records/FBRs, (i.e., BIOMED Repair checks conducted.	
	(3) Review all consumable supply locations to ensure accurate accountability of on hand supply and location in SAMS/TMIP.	
	(4) Ensure all CBR and Pandemic Medicines are on hand and are accounted for in the DoD SLEP Program.	
	(5) Review Medical Supply and Equipment Warning Requirements report.	

3. During Hull Swap

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-0	(1) Contact fleet liaison at local MTF for update to medical services available.	
	(2) Review and update, as required, all medical surveillance programs to ensure protective measures are in effect.	
	(3) Arrange with local MTF pharmacy department for the transfer of bulk stock controlled substances.	
	(4) Remove emergency stock items (i.e., BDS, MCB) from the ship as required. Inventory and place in secure storage.	
	(5) Provide quarterdeck with litter and stocked First Aid Kit or Gun Bag for emergency use.	

4. Prior to End of Overhaul

a. 60 Days

TIME FRAME	TASK/DESCRIPTION	DATE COMP
	(1) Review and update crew's IMR and conduct medical records verification.	
	(2) Medical personnel and others, attend training for appropriate courses (i.e., pest control, BLS)	
	(3) Conduct inventory of all medical supplies and equipment and update medical supply records.	
	(4) Re-order supplies as needed to bring ships AMAL to 100% by completion of overhaul.	

b. 30 Days

TIME FRAME	TASK/DESCRIPTION	DATE COMP
	(1) As completion of overhaul permits, relocated supplies and equipment back aboard from locations ashore.	
	(2) Contact RMR/ISIC to schedule TAV and MRI.	

5. Post Overhaul

a. As Schedule Permits

TIME FRAME	TASK/DESCRIPTION	DATE COMP
	(1) Return all emergency stock for appropriate locations.	
	(2) Obtain reissue of the bulk stock controlled substances held at the MTF.	
	(3) Conduct operational testing after medical equipment in returned to all medical spaces from lay per 3M system.	
	(4) Update medical supplies and ensure all required data is correct.	
	(5) Re-open sickbay aboard ship, if located off ship.	
	(6) Conduct first aid training for crew training in preparation of ATG assessments and operations at sea.	
	(7) Conduct TAV and MRI.	

APPENDIX E
PLAN OF ACTION AND MILESTONES (POA&M) FOR ROUTINE OVERHAUL (ROH) PREPARATION OF AFLOAT MEDICAL DEPARTMENTS

1. General. This checklist identifies Medical Department procedures for routine overhaul. This list is not all inclusive, however is has the most common areas the SMDR needs to be aware for the overhaul process. Time frames are dependent on the overhaul progress.

2. Prior to Overhaul

a. Six Months

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-180	(1) Prepare a Pre-ROH POA&M	
	(2) Identify all required repairs to be accomplished during the ROH and submit work requests.	
	(3) Make arrangements to repaint medical spaces upon completion of these repairs.	

b. Four Months

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-120	(1) Medical personnel and supervisors of personnel that may be involved in asbestos handling attend asbestos training at MTF or NEPMU.	

c. Three Months

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-90	(1) Review ship overhaul package to determine the extent of repairs to be accomplished in medical spaces.	
	(2) Verify last MRI date and if inspection will expire while in overhaul, submit extension request through CoC.	

d. Two Months

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-60	(1) Conduct bulkhead-to-bulkhead inventories of all medical supplies and determine which items will exceed usable shelf life prior to completion of overhaul.	
	(2) Exchange identified supplies which exceed shelf life with MTF of other ships.	
	(3) Make arrangements for affected supplies and equipment to be relocated to a secure location ashore. (SHOULD BE COORDINATED WITH SUPPLY DEPARTMENT)	
	(4) If sickbay will be secured, coordinate with fleet liaison office and RMR/ISIC for temporary work space within close proximity to ship.	
	(5) Obtain from local MTF/fleet liaison office what services are provided and where they are located at.	

3. During Overhaul

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-0	(1) Contact fleet liaison at local MTF for update to medical services available.	
	(2) Review and update, as required, all medical surveillance programs to ensure protective measures are in effect.	
	(3) Arrange with local MTF pharmacy department for the transfer of bulk stock controlled substances.	
	(4) Remove emergency stock items (i.e., BDS, MCB, FAB, Gun Bag) from the ship are required. Inventory and place in secure storage.	
	(5) Provide quarterdeck with litter and stocked First Aid Kit or Gun Bag for emergency use. Maintain at 100% at all times.	

4. Prior to End of Overhaul

a. Sixty Days

TIME FRAME	TASK/DESCRIPTION	DATE COMP
	(1) Review and update crew's IMR and conduct medical records verification.	
	(2) Medical personnel and others, attend training for appropriate courses (i.e., pest control, BLS)	
	(3) Conduct inventory of all medical supplies and equipment and update medical supply records.	
	(4) Re-order supplies as needed to bring ships AMAL to 100% by completion of overhaul.	

b. Thirty Days

TIME FRAME	TASK/DESCRIPTION	DATE COMP
	(1) As completion of overhaul permits, relocated supplies and equipment back aboard from locations ashore.	
	(2) Contact RMR/ISIC to schedule TAV and MRI.	

3. Post Overhaul

a. As Schedule Permits

TIME FRAME	TASK/DESCRIPTION	DATE COMP
	(1) Return all emergency stock for appropriate locations.	
	(2) Obtain reissue of the bulk stock controlled substances held at the MTF.	
	(3) Conduct operational testing after medical equipment in returned to all medical spaces from lay per 3M system.	
	(4) Update medical supplies and ensure all required data is correct.	
	(5) Re-open sickbay aboard ship, if located off ship.	
	(6) Conduct first aid training for crew training in preparation of ATG assessments and operations at sea.	
	(7) Conduct TAV and MRI.	

APPENDIX F
PLAN OF ACTION AND MILESTONES (POA&M) FOR PRE-DEPLOYMENT PREPARATION OF AFLOAT MEDICAL DEPARTMENTS

Ref: (a) COMFLTFORCOMINST 6000.1 (series)
(b) BUMEDINST 6224.8 CH-1
(c) NAVMED P-5010 (series)
(d) BUMEDINST 6320.15 (series)

1. General. This section identifies the Medical Department pre-deployment procedures. Complete all taskings, unless otherwise specified, regardless of planned operational commitments, per reference (a).

a. 12 Months Prior Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-360	(1) Review Medical & Supply Department post deployment reports from the previous deployment.	
	(2) Validate SAMS/TMIP and R-Supply has the correct AMAL/ADAL requirements loaded (Refer to NAVMEDLOGCOM website).	
	(3) Identify Critical Medical Asset Items/Equipment (Refer to RMR/MRD).	

b. Seven Months Prior to Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-210	(1) Review operating room/intensive care unit AMAL/non-AMMAL consumable requirements and ensure on hand or ordered to be onboard NLT D-90 day.	
	(2) Conduct a bulkhead-to-bulkhead Inventory of all medical. The following info must be recorded in SAMS/TMIP or R-Supply where applicable: location, quantity, lot number, shelf life (manufacture or expiration date), and manufacturer.	

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-210	(3) Review current required instructions, publications, professional books and electronic references, order as required ensuring onboard NLT D-90 day.	
	(4) Schedule annual LAB and blood bank assessment and training NLT D-90.	
	(5) Check supplies required for blood bank, order as required to ensure onboard NLT D-90 day (See AMAL).	
	(6) Check Chemical, Biological, Radiological, Environmental (CBRNE) medications for correct quantity, expiration dates, verify data in SAMS/TMIP and SLEP for tracking purposes.	
	(7) Review requirements for Non Combatant Evacuation (NEO Ops) supplies, order as required to ensure onboard NLT D-90 day.	
	(8) Review requirements for laboratory reagents and stains; order as required to ensure onboard NLT D-90 day (See AMAL).	
	(9) Review requirements for current anti-Malaria treatment; order as required to ensure onboard NLT D-90 day (Refer to RMR and NEPMU).	
	(10) Review immunizations requirements for various AORs and order as necessary to ensure onboard NLT D-90 days (Include embarked staff in requirements review).	
	(11) Review requirements for pest control supplies (i.e., personal protection), order as required to ensure onboard NLT D-90 day.	
	12) Medical and Supply Departments coordinate budget requirement for medical equipment calibration.	

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-120	(13) Review funding requirements to support deployment.	
	(14) Review completeness of all medical emergency kits supplies and stretchers (Refer to COMNAVSURFPAC 6000.1 series instruction & AMAL).	
	(15) Ensure Appendix A of IDC Core Competencies are valid through deployment.	
	(16) Ensure Industrial Hygiene and Annual Safety Survey is scheduled if expires during deployment.	
	(17) Coordinate with local DTF to schedule appointments for all Class 3's and upcoming dental exams. (CRUDES Ships)	
	(18) Review medical records and ensure all personnel who wear spectacles have a copy of the prescription in their health record and two pairs of spectacles in their possession as well as one pair of MCU/OBA inserts.	

c. Six Months to Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-180	(1) Technical Assist Visit (Schedule with RMR).	
	(2) Schedule SAMS/TMIP, R-Supply (Force Level) shelf life management and/or TMIP training for newly reported personnel.	
	(3) Validate SAMS/TMIP and R-Supply (Force Level) has the correct AMAL/ADAL requirements loaded (Refer to NAVMEDLOGCOM website).	
	(4) Schedule and monitor crewmember appointments to specialty clinics (ortho, psych, internal medicine and etc.), separation physicals, and keep the command appraised of possible personnel losses.	

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-180	(5) Ensure Radiation Health Survey is within periodicity, as applicable.	
	(6) Review current required instructions, publications and professional books and electronic references.	
	(7) Review Mass Casualty Bill.	
	(8) Review WQSB and stretcher-bearers assignments.	
	(9) Conduct review of medical records for medical surveillance program physical examinations (i.e CHT worker, Asbestos and etc.)	
	(10) Review OPTAR funding to support deployment.	
	(11) Ensure adequate training material for maintenance of continuing education.	
	(12) Review Medical personnel certifications (BLS/ACLS/ATLS).	
	(13) Ensure adequate quantity of x-ray film is on board. Anticipate a higher usage when alternative x-ray facilities are unavailable. (AMPHIBS only)	
	(14) Ensure all personnel have a documented HIV test that will not expire during deployment.	

d. Five Months Prior to Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-150	(1) Review equipment requirements based AMAL and ADAL.	
	(2) Review AMAL/ADAL required quantities and expiration dates and order necessary supplies.	

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-150	(3) Conduct Sea/Air rescue litter training with embarked flight crew personnel.	
	(4) Schedule training classes for Medical personnel with NEPMU for STD, CBRE, Malaria Including IDCs familiarization in laboratory procedures and techniques.	
	(5) Schedule classes for non-medical personnel with NEMPU in Industrial Health classes, food service instructors, etc.	
	(6) Conduct and evaluate Mass Casualty Drill.	

e. Four Months Prior to Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-120	(1) Review requirements and conduct appropriate training to personnel assigned to: CHT handlers, Water King, Barbers and etc.	
	(2) Medical Readiness Inspection (To be completed NLT D-90).	

f. Three Months Prior to Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-90	(1) Review MEDEVAC instructions and Fleet Liaisons POC in projected AOR via ANNEX Q.	
	(2) Review inpatient procedures.	
	(3) Review completeness of all medical emergency kits supplies and stretchers.	
	(4) Schedule food service recertification/ certification classes for junior HMs, Food Service personnel, MAAs, etc.	
	(5) Schedule calibration of all equipment.	

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-90	(6) Complete all projected dental exams through deployment. (CRUDES only)	
	(7) Review non-AMAL medication requirements and submit the request to TYCOM for approval. Order as required to ensure onboard NLT D-30 day.	
	(8) Ensure crewmembers requiring non-AMAL prescriptions and medications have enough supplies onboard to last through deployment.	

g. Two Months Prior to Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-60	(1) Review SAMS/TMIP maintenance and backup procedures.	
	(2) Schedule Biomedical equipment inspection.	
	(3) Schedule pre-deployment brief from NEPMU and RMRs.	
	(4) Ensure CME/CEU training materials is onboard.	
	(5) Order crewmember specific non-AMAL medications.	
	(6) Order laboratory reagents with short shelf life.	

h. One Month Prior to Deployment.

TIME FRAME	TASK/DESCRIPTION	DATE COMP
D-30	(1) Verify stretcher-bearers and phone talkers.	_____
	(2) Verify Watch Quarter and Station Bill assignments.	_____
	(3) Ensure U.S. Navy Shipboard Sanitation Control Exemption/Ship Sanitation Control Certificate will be within periodicity during deployment with NEMPU.	_____
	(4) Order laboratory reagents with short shelf life PD+30.	_____

APPENDIX G
MASS CASUALTY BILL TEMPLATE

DEPARTMENT OF THE NAVY
USS SHIP

IN REPLY REFER TO
SHIPINST XXXX
ORIG
DD MMM YY

(NOTE: Items enclosed in brackets [ ] are added for explanatory purposes. This sample is to be used as a guide and is not all inclusive to every ship type.)

USS SHIP INSTRUCTION XXXX

Subj: MASS CASUALTY BILL

Ref: (a) COMNAVSURFPAC/COMNAVSURFLANTINST 6000.1, Shipboard Medical Procedures Manual
(b) Emergency War Surgery, NATO Handbook (2nd Revision)
(c) NAVMEDCOMINST 5360.1, Decedent Affairs Manual

Encl: (1) MEDEVAC Questionnaire {From NATOPS Manual}
(2) Mass Casualty Scenario/Individual Requirements
(3) Procedures for execution of Mass Casualty {Bridge/OOD}

1. Purpose. To establish policies and procedures for handling mass casualties in accordance with references (a) and (b).

2. Cancellation. SHIPINST XXXX [If needed]

3. Background. References (a) and (b) contain general information regarding mass casualty situations. The shipboard environment presents numerous opportunities for personnel casualty situations to occur. While a single set of guidelines cannot apply in all situations, a frame of reference is necessary to guide the crew in event of a suspected known mass casualty occurring onboard _____. This could include shipboard files, explosions, aircraft crashes on the flight deck and the possibility of the ship being used as an evacuation facility.

4. Definitions

a. Mass Casualty Situation. Severe personnel casualty situation that exceed the capabilities of the Medical Department personnel and require additional assistance from the ship's crew or other resources.

b. Casualty Scene. The area at which the casualties have occurred. This area may or may not be readily available to medical personnel trying to render initial first aid and triage. Casualties will be stabilized at this location and transported/evacuated as quickly and safely as possible to the Staging Area.

c. Staging Area. An area predetermined and established to hold casualties after immediate lifesaving first aid and initial triage has been rendered at the scene. Casualties at the staging area will continue to be triaged and receive first and supportive care as much as possible. (i.e., intravenous therapy (IV), oxygen, suturing, medications, etc.) Additionally, immediate assessment is conducted to quickly identify casualties in distress that require more definitive medical. (e.g., surgery, oral intubation, chest tube insertion, etc.) These casualties may be further transported and treated in supportive/specialized areas. (i.e., main medical, battle dressing stations, operating room medical ward, etc.)

d. Triage (Sorting). The evaluation and classification of injured personnel to establish priorities for treatment and evacuation. Triage is a continual process of patient assessment that will require constant re-evaluating and possible re-categorizing of patients at all stages of medical care. In accordance with reference (b), triage onboard _____ is sorted into [three or five] categories listed below:

[The three categories referred to in chapter 14 of reference (b) are the ones most used at the ship or unit level. The five category version is the standard NATO approach from chapter 12 of reference (b). Each ship must determine their specific capability and utilize one of the two classification formats listed below.]

[Format #1]

(1) IMMEDIATE: Those who need immediate resuscitation and surgical intervention. (e.g., shock from internal hemorrhage)

(2) DELAYED: Those who have incapacitating but not immediately life threatening injuries and are unlikely to return to duty. (e.g., fractures)

(3) MINIMAL: Those who can be promptly returned to duty. (e.g., minor soft tissue fragment wounds)

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[Format #2]

(1) Class I: URGENT. This groups requires urgent intervention if death is to be prevented. This category includes those with asphyxia, respiratory obstruction, sucking chest wounds, internal hemorrhage, most cardiac injuries and CNS wounds.

(2) Class II: IMMEDIATE. Casualties in this category present with severe life-threatening wounds that require procedures of moderately short duration. This group has a high likelihood of survival. Examples of the immediate category are: unstable chest and abdominal wounds, incomplete amputations, open fractures of long bones, white phosphorous burns and extensive second or third degree burns.

(3) Class III: DELAYED. Casualties in the delayed category can tolerate delay prior to operative intervention. When medical resources are overwhelmed, individuals in this category are held until the urgent and immediate cases are cared for. Examples include stable abdominal wounds, soft tissue wounds requiring debridement, facial wounds without airway compromise, fractures requiring operative manipulation, debridement and external fixation and most eye and CNS injuries.

(4) Class IV: MINIMAL OR AMBULATORY. This category is comprised of casualties with wounds that are so superficial that they require no more than cleansing, minimal debridement under local anesthesia, tetanus toxoid and first aid type dressings. They must be rapidly directed away from the triage area to uncongested areas where first aid and non-specialty medical personnel are available. Examples include minor burns except those involving the face, hands or genitalia. Other examples include upper extremity fractures, sprains, abrasions, and suspicion of blast injury, behavioral disorders or other obvious psychiatric disturbances.

(5) Class V: EXPECTANT. Casualties in the expectant category have wounds that are so extensive that even if they were the sole casualty and had the benefit of optimal medical resource application, their survival would still be very unlikely. During a mass casualty situation, this sort of casualty would require an unjustifiable expenditure of limited resources, resources that are more wisely applied to several other more salvageable individuals.

3

5. General Notes

a. It is essential to recognize that casualty sorting is a dynamic process. Many factors affect a decision and a significant alteration in one of them may allow the patient's category to be altered. The overall situation must be kept under review at all times.

b. Triage should be directed by an experienced medical officer, dental office or independent duty corpsman that is designated the Medical Department Representative (MDR). This person will also be designated as the triage office. If the designated triage officer is not onboard during a mass casualty situation, then their responsibilities will fall upon the next senior Medical Department person in charge.

c. It is stressed that the responsibility for initiating the use of mass casualty procedures is that of the experienced Medical Department personnel responding to the casualty scene. Medical Department personnel must be constantly aware that the situation is a finite one, and must prepare to return to conventional methods as soon as possible.

d. All Medical/Dental Department personnel will be assigned specific duties as given by the medical officer or independent duty corpsman. These duties will be assigned by name and posted on the Medical Department's Watch, Quarter and Station Bill. [Note: This bill does not list all possible positions of key personnel who may be involved in a mass casualty situation. Each ship should tailor it to their specific operational and personnel capabilities.]

6. Determining and Activating Mass Casualty Procedures. This will happen under two conditions; General Quarters (Condition One) and normal operations. Each condition of readiness will have its own circumstance for activation of mass casualty procedures and therefore requires two separate plans and procedures as follows:

a. Ships not under General Quarters (NON-GQ)

(1) Eyewitness to the casualty will:

(a) Notify Officer of the Deck (OOD) by fastest means possible, including location of casualty and numbers of personnel injured.

(b) Return and remain at casualty scene.

(c) Utilize nearest first aid box (FAB) to provide basic first aid.

(2) Officer of the Deck:

(a) Pass on the 1MC circuits immediately "**Medical Emergency! Medical Emergency in compartment (location); (number) personnel casualties reported! Medical Department personnel lay to the scene.**"

(b) If General Quarters (GQ) is sounded, due to fire, flooding, explosion or other shipboard catastrophe in which watertight integrity has been compromised and subsequent activation of repair lockers is required, refer to paragraph _____ below on GQ procedures.

(c) Notify commanding officer immediately.

(d) Dispatch messenger of the watch to main medical spaces to ensure duty corpsman is proceeding to scene.

(e) If inport, call for shore-based ambulances.

(3) Triage Officer/Medical Personnel

(a) Upon arrival at scene, assess casualties and determine if a mass casualty situation exists.

(b) If a mass casualty situation DOES NOT exists, notify OOD of situation, request and required assistance (i.e., stretcher-bearers, MAA, ambulance (inport)).

(c) If a mass casualty situation DOES exist, notify the OOD to activate the Mass Casualty Bill in accordance with enclosure (3).

(d) Conduct immediate first aid and initial triage at the scene and organize prompt evacuation and transport of casualties to the designated staging area (location).

(e) Activate emergency medical resources to support first aid treatment (i.e., Main Medical or appropriate Battle Dressing Stations (BDS), gun bags, first aid boxes, etc.).

(f) At the staging area, continue to provide first aid and triage of casualties. Detailed care and treatment will be rendered utilizing sickbay resources (i.e., surgical intervention. x-ray, etc.) and make preparation for transfer/evacuation.

(g) Brief Command Duty Officer (CDO), executive officer (XO) and commanding officer (CO) as soon as time permits.

(4) Command Duty Officer

(a) Brief the CO, XO and operations officer immediately.

(b) Proceed to the scene to provide assistance and to receive updates on the situation.

(5) Operation officer. Prepare to submit OPREP-3 Navy Blue message as directed by the CO or XO.

(6) Damage Control Assistant

(a) Open repair lockers so stretcher-bearers can obtain medical supplies (i.e., gun bas and stretcher lines).

(b) Assist in delivering mass casualty boxes to the scene and staging area.

(c) Establish safe routing from mass casualty scene to staging area and to other areas as needed. Have routes repeatedly announced over the 1MC.

(d) Ensure communication between all areas is maintained (i.e., casualty scene, staging area, BDS, bridge, quarterdeck, repair lockers, etc.).

(7) Chief Master-at-Arms

(a) Utilize MAA personnel to ensure control of scene and keep patient transportation routes clear and safe for passage.

(b) If applicable, ensure all weapons and ammunition have been removed from patients and placed in the custody of the weapons officer.

(c) Assist with control of hysterical patients.

(8) Bulk Safe Controlled Medicinals Custodian. Ensure Medical Department has access to bulk controlled medicinal's as needed.

b. Ships at General Quarters (GQ)

(1) Eyewitness to casualties

(a) Notify Damage Control Central (DCC) of location of casualties, severity of injuries and number of personnel injured.

(b) Return and remain at scene.

(c) Utilizing nearest first aid box/gun bag, provide basic first aid.

(2) Damage Control Assistant

(a) Notify bridge that multiple personnel casualties exist, provide location and routing information.

(b) Direct stretcher-bearers from BDS to the scene as tactical situation permits. Ensuring that safe routing for the stretcher-bearers to the scene and then to appropriate BDS.

(3) Keep BDS's informed as to the number and nature of injuries being evacuated from the scene utilizing 2JZ circuit, telephone or any other appropriate means.

(4) Stretcher-Bearers

(a) Lay to the scene with gun bag and appropriate stretcher.

(b) Upon arriving at the scene, assess situation and determine if mass casualty exist.

(c) If mass casualty exists, confirm with DCC and request further assistance from other repair lockers.

(d) Provide first aid to injured personnel.

(e) Update DCC with situation, request safe transit to appropriate BDS's as needed.

(f) Evacuate injured personnel to BDS's.

(g) Upon arrival at BDS notify medical personnel of extent of injuries.

(5) Medical personnel. Remain at GQ stations (BDS) and await casualties.

(6) Special Modification. Any exception would be upon the recommendation from the Medical Department representative to the commanding officer. The commanding officer may modify the existing GQ to allow for implementing procedures outline in paragraph _____, mass casualty bill for ships not under General Quarters.

7. Evacuation Priority

a. The goal of initial patient care is to stabilize the greatest number of patients by administering intravenous fluids, oxygen, resuscitation, airway and burn management, antibiotic and analgesic administration.

b. Casualties will be constantly re-evaluated under triage categories until the point of final evacuation.

8. Collection of the Dead

a. When a mass casualty occurs, the first concern of the Medical Department will be to render aid to the living. Repair party personnel will be responsible for the collection of the dead. As soon as practical, remains will be identified and Decedent Affairs procedures will be accomplished pursuant to reference (c).

b. The supply officer will supervise collection of the dead.

c. The following spaces are designated areas for collection of the dead:

(1) (location)

(2) (location)

9. Sorting for Medical Evacuation (MEDEVAC). Once the mass casualty situation onboard has stabilized; consideration for evacuation of casualties according to needs for specialized medical/surgical care should be initiated. The following priority order for evacuation is offered as a guideline:

a. Chest and neck wounds with respiratory difficulty.

b. Chest or abdominal wounds with evidence of continued internal bleeding, but with reasonable expectations of a safe arrival to higher level of care for further treatment and disposition.

c. Abdominal wounds.

d. Tourniquet cases.

e. Head and/or spinal cord injuries.

f. Burns involving 20 to 50 percent of the body surface area (BSA).

g. Fractures of major bones.

10. Transfer of Patients from Other Ships

a. No patient, by any route (helicopter, boat, etc.) should arrive without prior communication. All communication should be provider to provider. In the event of the presence of a task force surgeon, all patient transfers will be organized and arrangements made by him.

b. In the case of a MEDEVAC, all personnel items including health/dental record, service and pay record, TAD orders and all other pertinent data will be transferred with the patient.

11. Casualties Received via Flight Deck (If applicable)

a. The initial staging area for these casualties will be in the (location).

b. The Air Department or appropriate personnel shall ensure that the flight deck area is clear of all mobile equipment in the area designated for use.

c. Ensure that flight deck elevators approved for patient casualty transfer are functioning and made ready for use. (if applicable)

d. Follow mass casualty procedures as outlined in GQ and non GQ situations.

12. Casualties Received via Well Deck (If applicable)

a. The staging area for these casualties will be the (location).

b. Medical personnel will check each casualty and the standard field medical tag. When indicated, additional first aid will be rendered before instructing the stretcher-bearers where to transport the casualty for further treatment if necessary.

13. Reports. The MDR will make daily memorandum report of the following to the commanding officer:

a. Total numbers of casualties onboard

(1) Number of bed patients.

(2) Number of ambulatory patients.

b. Condition of casualties

(1) Number of casualties in satisfactory, good or excellent condition.

(2) Number of casualties in serious condition.

c. Number of casualties in critical condition.

d. Number of reported dead.

e. Number of bodies in proper storage onboard.

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MEDEVAC QUESTIONNAIRE
[This is a sample, remove or add information determined by Medical Department]

The following information is required for all MEDEVAC patients:

Name: _____ SSN: _____

Rate: _____ Age: _____ Sex: _____

Place of Departure: _____

Method of Arrival and ETA: _____ / _____

Method of Transport: (Circle one) STRETCHER AMBULATORY

Transported with: (Circle appropriate ones)

PRESSURE DRESSING FOR BLEEDING OXYGEN

ORAL AIRWAY INTRAVENOUS LINE

MEDICATIONS: _____

Brief impression of what is wrong: _____

_____

Estimate of seriousness: (Circle one)

STABLE CONDITION ACCOMPANIED BY CORPSMAN UNCONSCIOUS

Time interval since sick and injured: Days_____ Hours_____

Vital Signs: BLOOD PRESSURE _____ / _____ PULSE _____

RESPIRATIONS _____/min TEMP _____

Preliminary Evaluation Preformed by: (Circle one)

WITNESS JUNIOR CORPSMAN INDEPENDENT DUTY CORPSMAN

MEDICAL OFFICER

Enclosure (1)

SHIPINST XXXX
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MASS CASUALTY SCENARIO/INDIVIDUAL REQUIREMENTS
[This is a sample, remove or add information determined by Medical Department]

	Mass Casualties During General Quarters	Mass Casualties During Non-General Quarters
Responds to the Emergency at Scene	Stretcher-Bearers - via safe route provided by Damage Control Central	-Corpsman/Stretcher-Bearers -MAA -Witness remain on scene
Triage at Scene	Stretcher-Bearers	Corpsman
Administer First Aid at Scene	Witness at scene or Stretcher-Bearers upon arrival	Witness at scene or corpsman upon arrival
Controls Routing of Injured from Scene	DCA in DCC	DCA and on scene leader
Triage Area	Corpsman	Corpsman
Battle Dressing Station or Main Medical	Corpsman Seriously injured to main medical and minor injured to BDS via route directed by DCA	Corpsman Transport to main medical

Enclosure (2)

SHIPINST XXXX
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PROCEDURES FOR EXECUTION OF MASS CASUALTY - OOD
[This is a sample, remove or add information determined by commanding officer]

1. All scenarios

a. "MASS CASUALTY, MASS CASUALTY, MASS CASUALTY, IN COMPARTMENT (GIVE COMPARTMENT AND NOUN NAME.)"

b. "TRAIGE OFFICER AND CORPSMAN LAY TO THE SCENE."

c. "DCA OPEN ALL REPAIR LOCKERS."

d. "ALL STRETCHER-BEARERS DRAW FIRST AID SUPPLIES AND STRETCHERS FROM REPAIR LOCKER AND LAY TO THE SCENE."

e. "MASTER AT ARMS LAY TO AND SECURE THE SCENE."

f. "ALL PERSONNEL NOT DIRECTLY INVOLVED IN RESECUE OPERATIONS STAND CLEAR OF (GIVE COMPARTMENT NUMBER AND NOUN NAME.)"

2. In port scenarios

a. Call for local ambulance service immediately, providing them with location of the ship, approximate number and condition of casualties.

b. Notify the commanding officer immediately.

Enclosure (3)

APPENDIX H
MEDICAL DEPARTMENT BATTLE BILL TEMPLATE

DEPARTMENT OF THE NAVY
USS SHIP

IN REPLY REFER TO
SHIPINST XXXX
SSIC
DD MMM YY

(NOTE: Items enclosed in brackets [ ] are added for explanatory purposes. This sample is to be used as a guide and is not all inclusive to every ship type.)

USS SHIP INSTRUCTION XXXX

Subj: MEDICAL DEPARTMENT BATTLE BILL/CBRN BILL

Ref: (a) COMNAVSURFPAC/COMNAVSURFLANTINST 6000.1, Shipboard Medical Procedures Manual
(b) NAVMED P-117, Manual of the Medical Department (MANMED)
(c) NAVMEDCOMINST 5360.1, Decedent Affairs Manual
(d) NAVMED P-5041, Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries
(e) OPNAVINST 5100.19E, Navy Occupational Safety and Health (SOH) Program Manual for Forces Afloat Volume I

Encl: (1) [as needed]
(2) [as needed]

1. Purpose. The Medical Department Battle Bill is published as a guide to inform shipboard personnel about the facilities, functions, procedures, responsibilities, and policies of the Medical Department and other departments during emergency and battle conditions

2. Cancellation. [If needed]

3. Scope. The Medical Department will be prepared for emergencies at all times. A current Watch, Quarter, and Station Bill (WQSB) will be maintained with appropriate sections posted in the main medical spaces.

a. The Senior Medical Department Representative (SMDR) will not be routinely assigned duties away from the ship on any of the this ship's bills. Duties involving casualties away from the ship will be assigned to subordinate medical personnel, unless otherwise directed the commanding officer.

b. Medical department personnel will be assigned to any evolution on the Watch Stations Quarter Bill (WQSB) that would compromise their ability to meet their primary medical responsibilities and carry out their medical duties.

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4. Emergency Medical Readiness

a. Inventory. All emergency supplies and equipment will be inventoried at least semi-annually. A list of supplies and documentation of periodic inventories will be maintained at each stock location. Expired and deteriorated items will immediately replaced as necessary.

b. Surgical Sets. Surgical instrument sets required by appropriate AMALs will be maintained per reference (a), chapter 4. Sterile goods will be opened, inspected, cleaned and re-autoclaved with a periodicity approved for the specific sterilization method used and the date of expiration marked on each sterilization tape. A list of instruments and supplies required should be attached to the outside wrap of each kit.

c. Controlled Substances. Any controlled substances required as part of an emergency AMAL will not be stored in that location but will be kept in the custody of the bulk custodian until the need arises for the possible use as directed by the commanding officer. They will be issued by the bulk custodian and returned to the bulk custodian when the need no longer exists.

d. Emergency Response Kits

(1) On Medical Officer (MO) Resuscitation Kit (AMAL 53) or Independent Duty Corpsman (IDC) Emergency Response Kit (AMAL 56) [as appropriate] is to be maintained in the main treatment room and stocked per AMAL.

(2) On Junior Hospital Corpsman (HM) Emergency Response Kit (AMAL 59) is to be maintained in the main treatment room and stocked per AMAL for each non-IDC HM up to a maximum of five (5) kits.

e. Battle Dressing Stations (BDS)

(1) There are _____ BDS' onboard located at:

(a) [Location], [Frame Number]

(b) [Location], [Frame Number]

(c) [Location], [Frame Number]

2

(2) Each BDS will be stocked in accordance with AMAL 52. Material will be stocked in an easily accessible manner, in accordance with GENSPECS.

(3) Routing to all BDS's will be indicated on bulkheads and hatches by approved markings designated in GENSPECS.

(4) The WQSB will assign duties and responsibilities (by name) of medical department personnel, assigned stretcher-bearers and non-medical phone talkers.

f. Mass Casualty Boxes (MCB)

(1) There are _____ MCBs onboard located at:

(a) [Location], [Frame Number]

(b) [Location], [Frame Number]

(c) [Location], [Frame Number]

(2) Each MCB will be stocked per AMAL 51. MCBs will be located in an easily accessible space, per GENSPECS.

g. First Aid Boxes (FAB) [not applicable for PC class]

(1) There are _____ FABs onboard located at:
[may be provided as enclosure]

(a) [Location], [Frame Number]

(b) [Location], [Frame Number]

(c) [Location], [Frame Number]

(2) Each FAB will be stocked per AMAL 50. FABs will be located in spaces per GENSPECS. Additionally, they will be sealed with anti-pilferage seals and inspected monthly for pilferage. If pilferage is suspected, immediately inventory the contents and replaced missing items as required.

h. Gun Bags [not applicable for PC and LCS class]

(1) There are ____ gun bags onboard:

(a) [Location], [Frame Number]

(b) [Location], [Frame Number]

(c) [Location], [Frame Number]

(2) Two (2) gun bags are required at each BDS for each stretcher-bearer team.

(3) Each gun bag will be stocked per AMAL 57. Gun Bags will be maintained and secured with an anti-pilferage device per reference (a).

i. First Aid Kit, Small Craft (Boat Box)

(1) There are _____ boat boxes onboard stowed in the following craft:

(a) [Craft Type], [Frame Number]

(b) [Craft Type], [Frame Number]

(c) [Craft Type], [Frame Number]

(2) One (1) boat box is required for each small craft.

(3) Each boat boxes will be stocked per AMAL 58. Boat boxes will be maintained and secured with an anti-pilferage device per reference (a).

j. Stretchers

(1) There are _____ stretchers onboard located at: [may be provided as enclosure][group by type]

(a) [Location], [Frame Number]

(b) [Location], [Frame Number]

(c) [Location], [Frame Number]

(2) Stoke stretchers will be located per GENSPECS. Stoke stretchers will be equipped with securing tape (except where not authorized due to potential Foreign Object Debris (FOD) hazard) per reference (a) and current 3M procedures. Reeves type stretchers will be well dispersed and equipped with patient securing straps.

(3) A Sea-Air-Rescue (SAR) litter is located at [Frame Number], and is maintained per current 3M procedures.

4. Conditions of Readiness

a. Condition ONE/General Quarters (GQ). Refers to the ships readiness condition where the officers and crew man battle stations. The term is also used to designate the evolution in which all hands assume battle stations for fire, collision and battle. In Condition ONE, engagement with the enemy is imminent. During Condition ONE, medical department personnel will not leave assigned battle stations to treat casualties. Stretcher-bearers assigned to the BDS will respond to personnel casualties and will transport them to the appropriated BDS, as directed by the Damage Control Assistant (DCA).

b. Condition ONE ALPHA. Same as Condition ONE but applies to amphibious operations such as boat launch and recovery.

c. Condition TWO. Engagement with the enemy is probable. Medical personnel man battler stations in a condition of readiness.

d. Condition THREE. Engagement with the enemy is possible and is considered routine wartime steaming. Medical personnel must be prepared to assume the responsibilities of Condition ONE, but carry out their daily routine until otherwise directed.

e. Condition FOUR. Engagement with the enemy is not anticipated and is considered routine peacetime steaming. Medical personnel must be prepared to assume the responsibilities of Condition ONE, but carry out their daily routine until otherwise directed.

5. Order of Treatment. First aid treatment must be initiated by the crewmembers on the scene. Casualties must then be assisted or transported to the appropriate treatment location. Order of treatment includes:

a. Self-aid or Buddy Aid. Use first aid supplies as available through the ship to alleviate respiratory distress, stop hemorrhage and prevent or treat shock.

b. Stretcher-Bearers. Stretcher-bearers will relieve any crewmembers rendering aid, apply necessary first aid at the scene, return personnel with minor injuries to duty and transfer the more seriously injured to BDS'.

(1) Casualties will be transported to either the closest BDS, depending upon the capability or each BDS to handle the numbers and types of injuries sustained.

(2) All internal casualty transportation must be coordinated through Damage Control Central (DCC) to ensure safe access routes to and from Casualty Receiving Stations.

c. Battle Dressing Stations (BDS). Stabilize casualties, maintain airway, breathing, and circulation, and return as many personnel to duty as possible. Arrange for evacuation of more seriously injured casualties and removal of expired patients from the battle dressing station to designated areas as time and circumstances allow.

d. Main Battle Dressing Station. Focus initial patient care on stabilization of patients requiring airway management and/or respiratory or circulatory assistance. Resuscitate first. Then, treat according to triage precedence, remembering always that triage is a dynamic process. Give ongoing consideration to patient load, treatment requirements, personnel and material resources available, training of available assets, and availability of MEDEVAC for transferring patients to facilities offering more definitive treatment.

6. Action During Battle

a. Treat casualties in order of seriousness as noted above, temporarily treating the more serious and interrupting this treatment in order to attend to the less serious casualties who may be returned to duty.

b. Arrange for evacuation of the more serious casualties and expired patients from the BDS as time and circumstance allow. Remains of the deceased will not be evacuated through the medical system.

c. Patients with psychological symptoms are not specifically classified above. They should be separated from other casualties. These patients may require restraint or continuous one-on-one care.

7. Action Immediately after Battle

a. Continue treatment of battle casualties.

(1) Minor surgical or medical cases will be evacuated to the [Location] BDS.

(2) Major surgical or medical cases will be evacuated to the [Location] BDS.

b. Spaces assigned for collection of battle casualties:

(1) Seriously injured: [Location]

(2) Minor injuries: [Location]

(3) Psycho-behavioral cases: [Location]

c. Restore BDSs and other first aid facilities to battle readiness.

d. Report to the command officer the number of casualties and their status.

e. Arrange for transfer of serious casualties to more capable facilities, as available.

f. Casualties requiring a bed should be evacuated to [Location].

g. Care of the dead.

(1) Areas for collection, preparation, and storage will be designated by the commanding officer. These areas may be consolidated at a single location or dispersed as condition dictate.

(2) Disposition of remains will either be transfer ashore (request assistance from SOPA) or to burial at sea (can only be authorized by CNO). If remains are to be kept onboard until arrival in port, they should be refrigerated at temperatures of 36-40 degrees Fahrenheit. Refrigerators must contain no other items and must be cleaned and fumigated prior to reuse in accordance with reference (c).

h. Missing-in-Action. When death has not been established, an SF-600 will be completed giving all particulars pertaining to the presumed disappearance of the individual. The health record will be closed and handled per reference (b), article 16-9. When death is proven conclusively, procedures will be as directed in reference (c).

8. CBRN Medical Defense. Medical personnel will be thoroughly informed about medical aspects of CBRN defense and treatment and will be prepared to handle these casualties at all times. Additionally, the ships SMDR will advise the commanding officer concerning medical aspects of CBRN defense, including treatment and handling of casualties.

a. No person shall be sent to a non-contaminated area until completely decontaminated and monitored. After decontamination, casualties requiring medical care may be sent to a designated BDS.

b. There are ____ decontamination stations onboard located at:

(1) Primary: [Location] Decon Station: [Location]

(2) Secondary: [location] Decon Station: [Location]

c. Flow of personnel to decontamination stations will be directed by the commanding officer and coordinated by DCC. Access hatches leading to all decontamination stations should be clearly marked.

d. Duties of medical personnel assigned to decontamination stations are to treat the injures and to ensure, with the aid of qualified damage control personnel, that proper decontamination and monitoring procedures are carried out.

e. Personnel suspected of being contaminated are to treated and handled per reference (d).

f. Lifesaving measures must be taken immediately, but personnel providing treatment will minimize the possibility of themselves becoming contaminated. If first aid is not immediately indicated, decontamination may be accomplished prior to medical treatment.

g. Decontamination procedures will carried out as follows:

(1) All contaminated or potentially contaminated personnel will be given specific instructions of where to go for decontamination and will enter the decontamination station from the contaminated side of the station.

(2) All clothing will be removed and placed in a contaminated clothing receptacle prior to entering the decontamination station.

(3) Personnel will be monitored with dosimetry equipment and the results recorded in a radiation exposure log.

(4) Personnel will receive a soap and water wash down.

(5) Wash down will be followed by a water rinse.

(6) Monitoring will be repeated and recorded. If still contaminated, the procedure will be repeated.

(7) Once decontamination have been accomplished, decontaminated personnel will sent to the designated area for medical treatment.

(8) Deceased personnel who have been exposed to chemical or biological agents or to ionizing radiation must be monitored before transfer from the ship. Contaminated human remains will undergo routine decontamination procedures.

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9. Training Requirements. A long-range training program will be established per reference (a), chapter 2.

a. Medical training will be made available to all crewmembers and embarked personnel.

b. Hospital corpsman and strikers will pursue professional training on the job, through correspondence courses and at approved education and training functions.

c. Instruction of stretcher-bearers assigned to repair parties will be more intense than for other crewmembers and shall include familiarization with all emergency medical AMALs onboard.

d. Personnel working in electronics shall be trained in Basic Life Support (BLS) in accordance with reference (e), chapter B7.

e. Videos and other training aids for instruction should be ordered through the training officer.

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APPENDIX I
CREW MEDICAL TRAINING REQUIREMENTS

TOPIC	TARGET GROUP	PERIODICITY
Medical Programs		
Onboard Medical Services	All hands	Indoc
Shore Based Medical Services	All hands	Indoc
TRICARE Options & Procedures	All hands	Indoc
Location of Emergency Gear	All hands	Indoc
Food Safety	S-2 personnel	Annual
BLS Certification	50% of crew	24 months
Basic First Aid	All hands	Conducted during PQS qualification and FXP drills
Poisoning and Antidotes	All hands	24 months
Medical Aspects of CBRN Warfare	All hands	24 months
Health Promotion and Wellness Programs		
Suicide Awareness and Prevention	All hands	Indoc/12 months
Personal Hygiene	All hands	Indoc/24 months
Injury Prevention	All hands	24 months
Drug & Alcohol Prevention/Control	All hands	Indoc/24 months
Nutrition	All hands	Indoc/24 months
Physical Readiness	All hands	Indoc/24 months
Stress Management/Hypertension	All hands	Indoc/24 months
STD & Pregnancy Awareness	All hands	Indoc/24 months
Tobacco Cessation	All hands	Indoc/24 months
Navy Safety and Occupational Health Programs		
Asebestos	Reference OPNAVINST 5100.19E, Navy Safety and Occupational Health (SOH) Program Manual for Forces Afloat	
Heat Stress		
Hearing Conservation		
Sight Conservation		
Electrical Safety		
Lead Control		
MSD Health Hazards		

APPENDIX J

MEDICAL DEPARTMENT

PERSONNEL QUALIFICATION STANDARD (PQS)

FOR

JUNIOR HOSPITAL CORPSMAN

NAME/RATE: _____

SHIP/UNIT: _____

DATE STARTED: _____

REQUIRED COMPLETION DATE: _____

CERTIFIED BY: _____

1. Purpose. To establish a standard for basic knowledge of shipboard medical procedures and skills.

2. Objective. To give hospital corpsmen a good working knowledge and responsibilities through indoctrination and skill development in within the medical department.

3. Applicability. This PQS applies to all junior corpsmen assigned to a shipboard medical department and can be used as a training guide for hospital corpsman strikers.

4. PQS Qualifiers. The senior medical department representative (SMDR) approves all PQS qualifiers. The following personnel may be considered qualified to sign the PQS as well as other medical personnel on temporary assignment with concurrence of the SMDR.

a. Medical Officer (MO)

b. Medical Service Corps Officer (PA)

c. Nurse Corps Officer (NC)

d. Independent Duty Corpsman (IDC)

e. Technicians with appropriate NEC (i.e., Bio-med)

5. Points of Contact. Questions or recommendations for improvement of this PQS should be forwarded to:

a. For Pacific Fleet

COMMANDER
NAVAL SURFACE FORCE U.S. PACIFIC FLEET
ATTN N01H
2841 RENDOVA ROAD
SAN DIEGO CA 92155-5490

b. For Atlantic Fleet

COMMANDER
NAVAL SURFACE FORCES ATLANTIC
ATTN N02H
1430 MITSCHER AVE
NORFOLK VA 23551-2494

SECTION 1
MEDICAL DEPARTMENT ADMINISTRATION

1. Chain of Command

a. Internal/Shipboard Personnel

(1) Hospital Corpsmen _____ _____
(Signature) (Date)

(2) SMDR (MO/IDC) _____ _____
(Signature) (Date)

(3) Division Officer _____ _____
(Signature) (Date)

(4) Department Head _____ _____
(Signature) (Date)

(5) CO/XO _____ _____
(Signature) (Date)

b. External Organizations

(1) Regional Medical Representative

_____ _____
(Signature) (Date)

(2) TYCOM Force Medical _____ _____
(Signature) (Date)

(3) Regional Medical Representative

_____ _____
(Signature) (Date)

(4) BUMED _____ _____
(Signature) (Date)

2. Familiarization

a. Medical Spaces

(1) Battle Dressing Stations

	(Signature)	(Date)
(2) Operating Room	(Signature)	(Date)
(3) Medical Ward/ICU	(Signature)	(Date)
(4) Treatment Areas	(Signature)	(Date)
(5) Medical Store Rooms	(Signature)	(Date)

b. Emergency Medical Gear

	(Signature)	(Date)
(1) First Aid Box	(Signature)	(Date)
(2) Boat Box	(Signature)	(Date)
(3) Gun Bag	(Signature)	(Date)
(4) Junior HM Bag	(Signature)	(Date)
(5) IDC/MORK Bag	(Signature)	(Date)
(6) Mass Casualty Box	(Signature)	(Date)
(7) Stretchers/Litters	(Signature)	(Date)

(8) Reeves/Rescue Sleeve/SAR Litter

_____ _____
(Signature) (Date)

3. Emergency/Special Conditions

a. Watch, Quarter, and Station Bill (WQSB)

_____ _____
(Signature) (Date)

b. Emergency Conditions

(1) Battle Stations

(a) Condition I _____ _____
(Signature) (Date)

(b) Condition II _____ _____
(Signature) (Date)

(c) Condition III _____ _____
(Signature) (Date)

(2) Man Overboard _____ _____
(Signature) (Date)

(3) Abandon Ship _____ _____
(Signature) (Date)

(4) On board Medical Response

_____ _____
(Signature) (Date)

(5) Mass Casualty _____ _____
(Signature) (Date)

c. Special Conditions

(1) Flight Quarters _____ _____
(Signature) (Date)

(2) UNREP _____ _____
(Signature) (Date)

(3) Amphibious Operations _____ _____
(Signature) (Date)

(4) Landing Party _____ _____
(Signature) (Date)

4. Personnel Check-In/Check-Out procedures utilizing SAMS/TMIP

_____ _____
(Signature) (Date)

5. Health Record Maintenance and Verification

_____ _____
(Signature) (Date)

6. Required Reports. To whom the report is due and when?

a. Accident/Injury Report _____ _____
(Signature) (Date)

b. Sick Call Report _____ _____
(Signature) (Date)

c. Eight O’ Clock Report _____ _____
(Signature) (Date)

d. Water Testing Report _____ _____
(Signature) (Date)

e. Food Service Personnel Inspection

_____ _____
(Signature) (Date)

f. Habitability Report _____ _____
(Signature) (Date)

g. DNBI Report _____ _____
(Signature) (Date)

h. DEERS Immunization Report _____ _____
(Signature) (Date)

7. PHA/Screening

a. Periodic Health Assessment

_____ _____
(Signature) (Date)

b. Necessary Form for Completion

_____ _____
(Signature) (Date)

c. Screenings

(1) Food Service Personnel

_____ _____
(Signature) (Date)

(2) Flight Deck

_____ _____
(Signature) (Date)

(3) PPD Converter

_____ _____
(Signature) (Date)

(4) NAVOSH Screening (HCP/SCP/Heat)

_____ _____
(Signature) (Date)

8. Naval Correspondence

a. Preparing Memorandum for the Record

_____ _____
(Signature) (Date)

b. Preparing Naval Letters

_____ _____
(Signature) (Date)

c. Filing System (SSIC)

_____ _____
(Signature) (Date)

9. Shipboard Medical Training

a. HM In-service Training

_____ _____
(Signature) (Date)

b. All Hands Training

_____ _____
(Signature) (Date)

c. Long Range Training Plan

_____ _____
(Signature) (Date)

10. SNAP Automated Medical System (SAMS) or Theatre Medical Information Program-Maritime (TMIP)

_____ _____
(Signature) (Date)

11. Medical Inspections/Assessments

a. READ-E

_____ _____
(Signature) (Date)

b. MRI/DRI

_____ _____
(Signature) (Date)

c. INSURV

_____ _____
(Signature) (Date)

SECTION 2
SICK CALL/TREATMENT

1. Sick Call Check-In Procedures _____ (Signature) _____ (Date)

   a. Sick Call Log _____ (Signature) _____ (Date)

   b. Triage from Sick Call Log _____ (Signature) _____ (Date)

   c. Medical Standby Policy _____ (Signature) _____ (Date)

2. Reference Materials _____ (Signature) _____ (Date)

3. MO/IDC Notification Requirements

   _____ (Signature) _____ (Date)

4. S.O.A.P Notes and Health Record Documentation

   _____ (Signature) _____ (Date)

5. Physical Assessment

   a. H.E.E.N.T _____ (Signature) _____ (Date)

   b. Lungs and Chest _____ (Signature) _____ (Date)

   c. Abdomen _____ (Signature) _____ (Date)

d. Genitourinary _____ _____
(Signature) (Date)

e. Extremities _____ _____
(Signature) (Date)

f. Neurological _____ _____
(Signature) (Date)

g. Skin and Lymphatic _____ _____
(Signature) (Date)

h. Back _____ _____
(Signature) (Date)

i. Cardiovascular _____ _____
(Signature) (Date)

6. Consultation Procedures _____ _____
(Signature) (Date)

7. Follow-Up Care _____ _____
(Signature) (Date)

8. Instrument Sets

a. Minor Surgery (Suture) Packs

_____ _____
(Signature) (Date)

b. Other Packs (as applicable to ship class)

_____ _____
(Signature) (Date)

c. Sterilization

(1) Steam Sterilization _____ _____
(Signature) (Date)

(2) Alternate Methods _____ _____
(Signature) (Date)

9. Suturing

a. Instruments and Materials _____ _____
(Signature) (Date)

b. Suturing Indications & Techniques

_____ _____
(Signature) (Date)

c. Aseptic Techniques _____ _____
(Signature) (Date)

d. Wound Preparation _____ _____
(Signature) (Date)

e. Anesthesia _____ _____
(Signature) (Date)

f. Wound Closure _____ _____
(Signature) (Date)

g. Dressing _____ _____
(Signature) (Date)

h. Wound Check/Follow-Up _____ _____
(Signature) (Date)

10. Management of Intoxicated/Incapacitated Individuals		
	(Signature)	(Date)
11. Splinting and Casting		
a. Basic Materials	(Signature)	(Date)
b. Cast/Splint Types	(Signature)	(Date)
c. Cast/Splint Techniques	(Signature)	(Date)
d. Neuro/Circulation Check	(Signature)	(Date)
c. Follow-Up	(Signature)	(Date)
12. Women's Healthcare	(Signature)	(Date)
13. Sexual Assault	(Signature)	(Date)

SECTION 3
PHARMACY

1. Formulary (Generic vs. Trade Names)

_____ _____
(Signature) (Date)

2. Medication Categories

a. Anti-inflammatory Agents _____ _____
(Signature) (Date)

b. Antipyretics _____ _____
(Signature) (Date)

c. Antibiotics _____ _____
(Signature) (Date)

d. Antihistamines _____ _____
(Signature) (Date)

e. Antiemetics _____ _____
(Signature) (Date)

f. Antacids _____ _____
(Signature) (Date)

g. Antitussives _____ _____
(Signature) (Date)

h. Decongestants _____ _____
(Signature) (Date)

i. Topical Agents _____ _____
(Signature) (Date)

j. Anti-malarials _____ _____
(Signature) (Date)

3. Medication Dispensing

a. Methods of Administration

(1) Oral _____ _____
(Signature) (Date)

(2) Rectal _____ _____
(Signature) (Date)

(3) Topical _____ _____
(Signature) (Date)

(4) Intradermal Injection _____ _____
(Signature) (Date)

(5) Subcutaneous Injection

_____ _____
(Signature) (Date)

(6) Intramuscular Injection

_____ _____
(Signature) (Date)

(7) Intravenous Injection _____ _____
(Signature) (Date)

b. Contraindications/Allergies

_____ _____
(Signature) (Date)

c. Patient Identification _____ _____
(Signature) (Date)

d. DD-1289 _____ _____
(Signature) (Date)

e. Medication Labeling _____ _____
(Signature) (Date)

f. Over-the-Counter Policy _____ _____
(Signature) (Date)

g. How to use the PDR/Facts and Comparisons

_____ _____
(Signature) (Date)

h. Patient Instructions _____ _____
(Signature) (Date)

i. Breakout Locker _____ _____
(Signature) (Date)

j. Controlled Medicinals _____ _____
(Signature) (Date)

SECTION 4
LABORATORY

1. Venipuncture Techniques _____ (Signature) _____ (Date)

2. Blood/Serum Tests

   a. Complete Blood Count (CBC) _____ (Signature) _____ (Date)

   b. RPR _____ (Signature) _____ (Date)

   c. Monospot _____ (Signature) _____ (Date)

   d. Gram Stain _____ (Signature) _____ (Date)

   e. Qualitative HCG _____ (Signature) _____ (Date)

   f. Malaria Test _____ (Signature) _____ (Date)

3. Urinalysis (UA)

   a. Routine _____ (Signature) _____ (Date)

   b. Microscopic _____ (Signature) _____ (Date)

   c. HCG _____ (Signature) _____ (Date)

4. KOH Prep

_____ _____
(Signature) (Date)

5. Cultures (throat, nasal, urine and wound)

_____ _____
(Signature) (Date)

6. Normal/Abnormal Values

_____ _____
(Signature) (Date)

7. Laboratory Records

a. Chit Processing

_____ _____
(Signature) (Date)

b. Lab Log

_____ _____
(Signature) (Date)

c. Results Reporting/Health Record Filing

_____ _____
(Signature) (Date)

8. Specimen Handling

a. Universal Precautions

_____ _____
(Signature) (Date)

b. Specimen Storage

_____ _____
(Signature) (Date)

c. Specimen Disposal

_____ _____
(Signature) (Date)

d. Specimen Preservation

_____ _____
(Signature) (Date)

e. Shipping (HIV, tissue, etc.)

_____ _____
(Signature) (Date)

9. Laboratory Equipment Familiarization

_____ _____
(Signature) (Date)

SECTION 5
X-RAY

1. Familiarity with SOP	(Signature)	(Date)
2. Typical Exposures		
a. Chest X-Ray	(Signature)	(Date)
b. Extremity X-Ray	(Signature)	(Date)
c. Abdominal X-Ray	(Signature)	(Date)
d. Spinal X-Ray	(Signature)	(Date)
3. Computerized Radiography Procedures		
a. X-Ray Processing	(Signature)	(Date)
b. Result Presentation	(Signature)	(Date)
4. Archiving	(Signature)	(Date)
5. X-Ray Log	(Signature)	(Date)

SECTION 6
INPATIENT PROCEDURES

1. Ward Procedures (SOP)

a. Ward Administration	(Signature)	(Date)
b. AM care	(Signature)	(Date)
c. MO Rounds	(Signature)	(Date)
d. Meals	(Signature)	(Date)
e. Visitation Policy	(Signature)	(Date)
f. Isolation Procedures	(Signature)	(Date)
g. Medical Waste Disposal	(Signature)	(Date)
h. Restraint Policy	(Signature)	(Date)
i. Thrombolytics	(Signature)	(Date)
j. Universal Protocol	(Signature)	(Date)

2. Inpatient Records

   a. Short Form/Abbreviated Record

	(Signature)	(Date)

   b. Standard Inpatient Record

	(Signature)	(Date)

3. Doctor's Orders

   a. Verbal Orders

	(Signature)	(Date)

   b. Transcription of Orders

	(Signature)	(Date)

4. Medication Administration – Five "Rights"

   a. Right Medication

	(Signature)	(Date)

   b. Right Dosage

	(Signature)	(Date)

   c. Right Route

	(Signature)	(Date)

   d. Right Time

	(Signature)	(Date)

   e. Right Patient

	(Signature)	(Date)

5. IV Administration

   a. IV Solutions

	(Signature)	(Date)

b. Initiating IV Therapy _____ _____
(Signature) (Date)

c. Setting IV Rate _____ _____
(Signature) (Date)

d. Start Three IVs Under Supervision

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

6. EKG Procedures

a. Patient Preparation _____ _____
(Signature) (Date)

b. Lead Placement _____ _____
(Signature) (Date)

c. Machine Operation _____ _____
(Signature) (Date)

d. Recording & Reporting EKG Results

_____ _____
(Signature) (Date)

7. Equipment

a. Portable Vital Signs Monitor

_____ _____
(Signature) (Date)

b. Oxygen Equipment _____ _____
(Signature) (Date)

c. IV Infusion Pump _____ _____
(Signature) (Date)

d. Ventilators _____ _____
(Signature) (Date)

e. Use of Restraints _____ _____
(Signature) (Date)

f. BAIR Huggers _____ _____
(Signature) (Date)

g. Suction Machine _____ _____
(Signature) (Date)

h. Defibrillator _____ _____
(Signature) (Date)

i. ICU Beds _____ _____
(Signature) (Date)

j. Glucose Monitor _____ _____
(Signature) (Date)

k. Bedside Vital Signs Monitor

_____ _____
(Signature) (Date)

8. Crash Cart _____ _____
(Signature) (Date)

SECTION 7
PREVENTIVE MEDICINE

1. Potable Water Testing (Collection and Processing)

   a. Halogen Residual _____ (Signature) _____ (Date)

   b. Bacteriological Testing _____ (Signature) _____ (Date)

2. Perform HMIS Search using Computer

   _____ (Signature) _____ (Date)

3. Basic Sanitation/Habitability

   a. Food Service Areas _____ (Signature) _____ (Date)

   b. Barber Shop _____ (Signature) _____ (Date)

   c. Potable Water System _____ (Signature) _____ (Date)

   d. CHT/MSD System _____ (Signature) _____ (Date)

   e. Ship's Store/Vending _____ (Signature) _____ (Date)

   f. Laundry _____ (Signature) _____ (Date)

   g. Fitness Facilities _____ (Signature) _____ (Date)

   h. Brig _____ (Signature) _____ (Date)

   i. Berthing _____ (Signature) _____ (Date)

4. Medical Waste Management

   a. Disposal/Storage Procedures

   _____ _____
   (Signature) (Date)

   b. Log Maintenance _____ _____
   (Signature) (Date)

5. Pest Control Program

   a. Pier-side Inspection _____ _____
   (Signature) (Date)

   b. Surveying _____ _____
   (Signature) (Date)

   c. Pest Control Report _____ _____
   (Signature) (Date)

6. Food Service Personnel Inspection

   a. Culinary Specialists _____ _____
   (Signature) (Date)

   b. Food Service Attendants _____ _____
   (Signature) (Date)

7. Industrial Hygiene Survey _____ _____
   (Signature) (Date)

8. Heat Stress Program

   a. Heat Stress Monitoring PQS Completion

   _____ _____
   (Signature) (Date)

   b. WBGT Meter(s) _____ _____
   (Signature) (Date)

   c. PHEL Chart _____ _____
   (Signature) (Date)

   d. Automated Heat Stress System (AHSS) Familiarity

   _____ _____
   (Signature) (Date)

e. Reporting/Follow-Up Surveys

_____ _____
(Signature) (Date)

9. Hearing Conservation Program

a. Assignment to Program _____ _____
(Signature) (Date)

b. Issuance of Hearing Protection Devices

_____ _____
(Signature) (Date)

c. Surveillance Program _____ _____
(Signature) (Date)

10. Immunization Program

a. Requirements _____ _____
(Signature) (Date)

b. Documentation _____ _____
(Signature) (Date)

c. Cold Chain Management _____ _____
(Signature) (Date)

11. Sexually Transmitted Diseases

a. Types _____ _____
(Signature) (Date)

b. Treatment _____ _____
(Signature) (Date)

c. Follow-Up _____ _____
(Signature) (Date)

d. Documentation (Logs) _____ _____
(Signature) (Date)

e. Contact Interview _____ _____
(Signature) (Date)

12. Needle-Stick Protocol _____ _____
(Signature) (Date)

13. Tuberculosis Screening Program

_____ _____
(Signature) (Date)

14. Medical Surveillance Questionnaire

_____ _____
(Signature) (Date)

15. Tobacco Cessation _____ _____
(Signature) (Date)

SECTION 8
EMERGENCY MEDICAL READINESS AND EQUIPMENT

1. Oxygen Delivery System _____ _____
(Signature) (Date)

2. Defibrillator/Monitor _____ _____
(Signature) (Date)

3. Automatic External Defibrillator

_____ _____
(Signature) (Date)

4. Emergency Resuscitation Kit _____ _____
(Signature) (Date)

5. MO/IDC Response Kit (Location/Contents)

_____ _____
(Signature) (Date)

6. JR HM Response Kit (Location/Contents)

_____ _____
(Signature) (Date)

7. Gun Bag/Boat Box (Location/Contents)

_____ _____
(Signature) (Date)

8. Suction Apparatus _____ _____
(Signature) (Date)

9. Reeves/Rescue Sleeve/Back Board (Location)

_____ _____
(Signature) (Date)

10. SAR Liter _____ _____
(Signature) (Date)

11. At-Sea Transfer _____ _____
(Signature) (Date)

12. MEDEVAC Procedures _____ _____
(Signature) (Date)

13. BDS Locations/Contents

_____	_____
(Signature)	(Date)

14. BDS Layout

_____	_____
(Signature)	(Date)

15. MCB Locations/Contents

_____	_____
(Signature)	(Date)

16. FAB Locations/Contents

_____	_____
(Signature)	(Date)

17. Required Inventories

_____	_____
(Signature)	(Date)

18. Quality Control and Serviceability

_____	_____
(Signature)	(Date)

SECTION 9
SUPPLY

1. Authorized Medical Allowance Lists (AMAL)

_____ _____
(Signature) (Date)

2. Authorized Dental Allowance Lists (ADAL)

_____ _____
(Signature) (Date)

3. Medical Storage (Locations/Contents)

_____ _____
(Signature) (Date)

4. AMAL Change Request _____ _____
(Signature) (Date)

5. OPTAR Logs (SAMS/TMIP Module) _____ _____
(Signature) (Date)

6. NAVMED 6700/3, Equipment Maintenance Record

_____ _____
(Signature) (Date)

7. Repair Parts Petty Officer (RPPO)

_____ _____
(Signature) (Date)

8. SERP Management/Fleet Procurement Program

_____ _____
(Signature) (Date)

9. Budgets/Augments _____ _____
(Signature) (Date)

APPENDIX K
SERP EQUIPMENT LIST

UIC	SHIP	HULL	AMAL	ACTUAL NSN	AMAL NSN	NOMENCLATURE	QTY	UNIT PRICE	MODEL #	SERIAL #	INSTALLATION DATE	REPL YR
12345	BIG ONE	LPD XX	XX51	1234567890123	3210987654321	Something, really really expensive	1	$15,000.00	ABC-123	U25516-780	10/15/2005	2020

APPENDIX L
FLEET INSTRUMENT SETS MATRIX

PLATFORM	MINOR SURG	MAJOR SURG	TRACH	CHEST SURG	FX/A MPUT	LAPAR	CHEST TUBE	ENT SURG	VASC SURG	BURR HOLE
PC	1									
LCS	1									
MCM	2									
FFG	2									
DDG	2									
DDG 1000	2									
CG	3									
LCC	4	1	1							
LSD 41/49	4	1	1							
LPD 4	4	1	1							
LPD 17	34	3	3	2	5	4	3	2	2	2
LHA 6	34	3	3	2	5	4	3	2	2	2
LHA	67	6	6	2	10	8	6	3	2	4
LHD	67	6	6	2	10	8	6	3	2	4

Per XX52	4

Per XX51	1

FLEET INSTRUMENT SETS

MAJOR SURGERY SET

(NMLC REF NO. 9809**)**

NSN	NOMENCLATURE	U/I	QTY	
6515003204600	FORCEPS TOWEL BACKHAUS 5.25" LG OPP PRGS	EA	6	
6515003333100	FORCEPS DRESSING CUSHING 7" LG STR & SER TIP	EA	1	
6515003333600	FORCEPS DRESSING 5.50"LG STR AND SERR JAW	EA	2	
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLT CRV JAW	EA	10	
6515003344900	FORCEPS HEMO HALSTED DSGN 4.75-5.25" LG SLT	EA	4	
6515003345600	FORCEPS HEMO HALSTED 5"LG 0.875"JAW STR JAW	EA	10	
6515003346800	FORCEPS HEMO KELLY 5.50" LG 1" LG STR JAW	EA	4	
6515003347400	FORCEPS HEMO ROCH-OCHS 1.5-1.75" STR JAW	EA	2	
6515003351900	FORCEPS INTEST DOYEN DSGN 8.750" O/A LG BX	EA	4	
6515003352800	FORCEPS INTEST BABCOCK DSGN 6.250" O/A LG STR	EA	2	
6515003353200	FORCEPS INTEST DOYEN STR 8.75-9.25"O/A LG CRS	EA	3	
6515003373900	FORCEPS GAUZE PAD HOLD FOERSTER 9-9.75" LG	EA	1	
6515003377800	FORCEPS TISSUE ADSON 4.50" LG TWZR STR & SM	EA	2	
6515003380300	FORCEPS TISSUE ALLIS DSGN 6"LG PIVOT STR & SM	EA	2	
6515003419200	HOLDER SUT NEED HEGAR-MAYO 7" LG CENT OVAL	EA	2	
6515003447800	HANDLE SURG KNIFE DETACH BLADE SIZE 3	EA	2	
6515003609200	RETRACTOR SET GEN OPER DOUBLE END 8.5 & 8.75"	SE	1	
6515003610350	RETRACTOR GEN OPER VOLKMAN DESIGN 8.5" SIZE	EA	2	
6515003631100	SAW AMPUT SATTERLEE 8"BLADE LG 2.25"WDTH	EA	1	
6515003640520	SCISSORS GEN SURG MAYO CRVD BLD 6.50-7" LG	EA	1	
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG	EA	1	
6515003657100	SCISSORS TONSIL METZ 7" O/A LG CRVD BLADE	EA	1	
6515003866600	CANNULA ABDOM POOLE 23FR 8.75" LG FENEST	EA	1	
6515006600008	BLADE SURG KNIFE DET NO.15 CARB STL 6S	PG	1	*
6515006600010	BLADE SURG KNIFE DET NO.11 SM TANG 6S	PG	1	*
6515006600011	BLADE SURG KNIFE DET NO.10 SM TANG 6S	PG	1	*
6515011151730	SCISSORS GEN SURG METZ DISSECTING 9" LG	EA	1	
6515012080578	RETRACTOR ABDOMINAL 1″X13″	EA	2	
6515014587921	RETRACTOR ABDOMINAL 2″X13″ STRAIGHT	EA	2	
6515014587927	RETRACTOR ABDOMINAL 1.5X13″	EA	2	
6530007939570	TRAY INST CORR-RESIS STL 19.25X12.75X.75″	EA	1	
6530010324088	DRAPE SURG NONWOVEN FABRIC DISP 100 X 92″ 20S	PG	1	
7210002999610	TOWEL HAND COT 36X17″ GREEN GRAY NONDISP	EA	8	

***** Only 2 surgical blades are required for this set

FLEET INSTRUMENT SETS
MINOR SURGERY SET
(NMLC REF NO. 9806)

NSN	NOMENCLATURE	U/I	QTY	
6515002998736	HOLDER, NEEDLE HAGAR-MAYO 6"	EA	1	
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLGT CRVD JAW	EA	2	
6515003346800	FORCEPS HEMO KELLY 5.50" LG 1" LG STR JAW	EA	2	
6515003377800	FORCEPS TISSUE ADSON 4.50" LG TWZR STR & SM	EA	1	
6515003379800	FORCEPS TISSUE 5" LG TWZR STR & SM JAW SQ TIP	EA	1	
6515003417200	HOLDER SUT NEED COLLIER 5" LG STRAIGHT JAW	EA	1	
6515003447800	HANDLE SURG KNIFE DETACH BLADE SIZE 3	EA	1	
6515003651820	SCISSORS GEN SURG 5.50" LG ONE BLT & ONE SH PT	EA	1	
6515006600010	BLADE SURG KNIFE DET NO.11 SM TANG 6S	PG	1	*
6515006600011	BLADE SURG KNIFE DET NO.10 SM TANG 6S	PG	1	*
6515011190018	PROBE GEN OPER 5"LG .062" DIA SPATULATE	EA	1	

* Only 2 surgical blades are required for this set

FLEET INSTRUMENT SETS
TRACHEOSTOMY SET
(NMLC REF NO. 9801)

NSN	NOMENCLATURE	U/I	QTY	
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOS PRNG	EA	4	
6515003254400	DILATOR TRACH TROUSSEAU 5.5"LG CRVD SM	EA	1	
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLGT CRVD JAW	EA	1	
6515003345600	FORCEPS HEMO HALSTED 5"LG 0.875"JAW STR JAW	EA	1	
6515003379800	FORCEPS TISSUE 5" LG TWZR STR & SM JAW SQ TIP	EA	1	
6515003380300	FORCEPS TISSUE ALLIS DSGN 6"LG PIVOT STR & SM	EA	1	
6515003447800	HANDLE SURG KNIFE DETACH BLADE SIZE 3	EA	1	
6515003618950	RETRACTOR TRACH HUPP DSGN SHARP BLADE	EA	1	
6515003618980	RETRACTOR TRACH HUPP SHARP BLADE PT 3 PRG	EA	1	
6515003644600	SCISSORS IRIS 4-4.50" O/A LG CRVD BLD SHARP PTS	EA	1	
6515003651820	SCISSORS GEN SURG 5.50" LG ONE BLT & ONE SH PT	EA	1	
6515006600010	BLADE SURG KNIFE DET NO.11 SM TANG 6S	PG	1	*
6515006600011	BLADE SURG KNIFE DET NO.10 SM TANG 6S	PG	1	*
6515009140245	CANNULA TRACH SZ 4 W/ INT 15MM MALE ADAPT	EA	1	
6515009140248	CANNULA TRACH SZ 6 W/ INT 15MM MALE ADAPT	EA	1	
6515009140249	CANNULA TRACH SZ 7 W/ INT 15MM MALE ADAPT	EA	1	
6515011190018	PROBE GEN OPER 5"LG .062" DIA SPATULATE	EA	1	
6515009140250	CANNULA KIT TRACH SZ 8 PERM 15MM MALE ADP	EA	1	
7210002999610	TOWEL HAND COT 36X17” GREEN GRAY NONDISP	EA	4	

***** Only 2 surgical blades are required for this set

FLEET INSTRUMENT SETS
CHEST SURGERY SET
(NMLC REF NO. 9802)

NSN	NOMENCLATURE	U/I	QTY
6515000653181	FORCEPS HEMO MIXTER HALF-CRVD 6.87-7.375" LG	EA	6
6515003204600	FORCEPS TOWEL BACKHAUS 5.25" LG OPPOS PRNG	EA	6
6515003208500	CONTRACTOR RIB BAILEY DSGN DOUB-RAKE TYPE	EA	6
6515003277900	ELEVATOR PERIOS LANGENBECK DSGN 8.25" LG	EA	1
6515003279400	ELEVATOR SET PERIOS DOYEN CRV BLNT EDGE LGE	EA	1
6515003280700	ELEVATOR PERIOS 7.75" LG CRVD BLADE .625" BLDE	EA	1
6515003311300	FORCEPS BONE CUT LISTON-STILLE 10.25" LG CRVD	EA	1
6515003314800	RONGEUR STILLE DBL-JOINTED CRVD 9"LG CRAN	EA	1
6515003333100	FORCEPS DRESSING CUSHING 7" LG STR & SERR RD	EA	2
6515003333700	FORCEPS DRESSING 10" LG STR & SERR RD TIP	EA	2
6515003341400	FORCEPS GALL DUCT LAHEY DSGN 7.5"LG	EA	2
6515003359100	FORCEPS LUNG GRASP COLLIN DSGN TRIANG JAW 8"	EA	6
6515003373900	FORCEPS GAUZE PAD HOLD FOERSTER 9-9.75" LG	EA	2
6515003419800	HOLDER SUT NEED MASSON 10.5" LG STR JAW	EA	2
6515003553300	PERIOSTEOTOME ALEXAND-FARABEUF 8.25" LG	EA	1
6515003617250	RETRACTOR RIB FINOCCHIETO DSGN FENEST BLDE	EA	1
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLT PTS	EA	2
6515003657100	SCISSORS TONSIL METZ 7" O/A LG CRVD BLADE	EA	2
6515003669200	FORCEPS BONE CUT BETHUNE 13.5" LG CUPPED	EA	1
6515003746900	ELEVATOR PERIOS MATSON 9X.312" DOUB-ENDED	EA	1
6515010457158	KNIFE STERNUM LEBSCHE DSGN 10" LG PASSIV	EA	1
6515012340253	MALLET BONE SURG 7.5-11"LG 3.125"HD LG 2 PNDS	EA	1
6530007940000	TRAY INST CORR-RESIST STL 15-1/2X9-1/2X2”	EA	1
7210002999610	TOWEL HAND COT 36X17” GREEN GRAY NONDISP	EA	2

FLEET INSTRUMENT SETS
FRACTURE / AMPUTATION SET
(NMLC REF NO. 9804**)**

NSN	NOMENCLATURE	U/I	QTY
6515003225550	CURETTE MASTOID SPRATT SZ 2 SPOON SHAPE BLD	EA	1
6515003315400	RONGEUR STILLE-LUER DBL-JOINTED STR 9"LG RD	EA	1
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLGT CRVD JAW	EA	8
6515003435800	KNIFE AMPUT LISTON DSGN 10.5"LG CRV BICONCAV	EA	1
6515003631100	SAW AMPUT SATTERLEE 8"BLDE LG 2.25"WIDTH	EA	1
6515003632300	CONDUCTOR BONE CUT WIRE SAW BAILEY DSGN	EA	1
6515003632400	HANDLE BONE CUT WIRE SAW RECTANULAR	EA	1
6515003632700	SAW BONE CUT WIRE 20" LONG .040" DIAMETER	EA	1
6515011398267	RASP BONE 3" BLADE LG PUTTI STYLE DOUB-ENDED	EA	1
6515011410809	FILE BONE .5X3.5″ BLADE 9″ LG	EA	1
6530007940000	TRAY INST CORR-RESIST STL 15-1/2X9-1/2X2″	EA	1
7210002999610	TOWEL HAND COT 36X17″ GREEN GRAY NONDISP	EA	1

FLEET INSTRUMENT SETS

LAPAROTOMY SET

(NMLC REF NO. 9800)

NSN	NOMENCLATURE	U/I	QTY
6515000653181	FORCEPS HEMO MIXTER HALF-CRVD 6.87-7.375"LG	EA	4
6515002998737	HOLDER SUT NEED HEGAR-MAYO 7" LG SERR JAW	EA	2
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOS PRNG	EA	6
6515003204600	FORCEPS TOWEL BACKHAUS 5.25" LG OPPOS PRNG	EA	6
6515003333600	FORCEPS DRESSING 5.50"LG STR & SERR JAW RD TIP	EA	2
6515003333700	FORCEPS DRESSING 10" LG STR & SERR RD TIP	EA	2
6515003341400	FORCEPS GALL DUCT LAHEY DSGN 7.5"LG	EA	2
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLGT CRVD JAW	EA	12
6515003344100	FORCEPS HEMO MAYO-CARMLT 7.750 MIN 8.250 MAX	EA	2
6515003344300	FORCEPS HEMO ROCH-PEAN 6-6.50"LG 1.875" JAW LG	EA	10
6515003344900	FORCEPS HEMO HALSTED DSGN 4.75-5.25" LG	EA	6
6515003346800	FORCEPS HEMO KELLY 5.50" LG 1" LG STR	EA	12
6515003347500	FORCEPS HEMO ROCH-OCHSNER 1.875"JAW LG	EA	6
6515003349500	FORCEPS HEMO PEAN DSGN SLIGHT CRVD JAW	EA	6
6515003373900	FORCEPS GAUZE PAD HOLD FOERSTER 9-9.75" LG	EA	4
6515003377800	FORCEPS TISS ADSON 4.50" LG TWZR STR & SM JAW	EA	2
6515003379900	FORCEPS TISSUE 5.5" LG TWZR STR & SM JAW RD TIP	EA	2
6515003380300	FORCEPS TISS ALLIS DSGN 6"LG PIVT STR & SM JAW	EA	4
6515003419800	HOLDER SUT NEED MASSON 10.5" LG STR	EA	1
6515003447800	HANDLE SURG KNIFE DETACH BLADE SIZE 3	EA	2
6515003447820	HANDLE SURG KNIFE DETACH BLADE SZ4	EA	1
6515003447880	HANDLE SURG KNIFE DETACH BLADE SIZE 7	EA	1
6515003585500	RACK SUT NEED 5X1X0.4222" C/O BSE TRACT & COIL	EA	1
6515003603490	RETRACTOR ABDOM DEAVER DESIGN 1X12" SIZE	EA	1
6515003603510	RETRACTOR ABDOM DEAVER DESIGN 1.5X12" SIZE	EA	1
6515003603530	RETRACTOR ABDOM DEAVER DESIGN 2X12" SIZE	EA	1
6515003603850	RETRACTOR SET ABD RICHARDSON-EASTMAN 2S	SE	2
6515003609200	RETRACTOR SET GEN OPER DOUB-END 8.5 & 8.75"	SE	2
6515003610350	RETRACTOR GEN OPER VOLKMAN DSGN 8.5" SIZE 4	EA	2
6515003614850	RETRACTOR PERIN GELPI CRS HOOK UNIT TYPE 6.5"	EA	2
6515003620200	RETRACTOR VEIN CUSHING DSGN 8.5" CORR-RESIST	EA	2
6515003640500	SCISSORS GEN SURG MAYO DSGN 5.25-5.75" LG CRVD	EA	2
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLNT	EA	2
6515003651820	SCISSORS GEN SUR 5.50" LG ONE BLNT & ONE SH PT	EA	1
6515003656200	SCISSORS TENOTOMY STEVENS 4-4.50" O/A LG CRVD	EA	1
6515003657100	SCISSORS TONSIL METZ 7" O/A LG CRVD BLADE	EA	1
6515003866600	CANNULA ABD POOLE 23FR 8.75" LG FENESTRATED	EA	1
6515003867600	CANNULA LARYN ANG YANKAUER 9"LG 0.234-0.266"	EA	1
6515006903208	FORCEPS TISS DEBAKEY 7.75" LG TWZR STR & SERR	EA	2
6515006903223	SCISSORS GEN SURG POTTS SMITH 7.50" LG ANG HD	EA	2
6515009269193	RETRACT MASTOID WEITLANER 6.5" HK UNIT 3 PRG	EA	2

NSN	NOMENCLATURE	U/I	QTY
6515010489066	FORCEPS HEMO STORZ DSGN R ANG JAW 8.75" LG	EA	2
6515010895668	SCISSORS GEN SURG METZ DELIC DISS 11" LG CRVD	EA	1
6515011190018	PROBE GEN OPER 5"LG .062" DIA SPATULATE HAND	EA	1
6515011190787	PROBE GEN OPER 10" LG .062" DIA SPATULATE HAND	EA	1
6515011398195	RETRACTOR ABDOM KELLY 3X3.50 INCH SERR TONG	EA	2
6515011398196	RETRACTOR GEN OPER HARRINGTON 13X2.25" CRVD	EA	1
6515011398197	RETRACTOR VAGOTOMY WEINBERG 6.375X4" BLD	EA	1
6515011398407	RETRACTOR ABD RICHARDSON DSGN 9 1/8" LG BLD	EA	2
6515011398969	RETRACTOR ABD CODMAN-SHURTLEFF SZ 2.50X3.25"	EA	2
6530007940300	TRAY SURG INST 20 X 12 X 4"	EA	2
7210002999610	TOWEL HAND COT 36X17” GREEN GRAY NONDISP	EA	4

FLEET INSTRUMENT SETS

CHEST TUBE SET

(NMLC REF NO. 9808)

NSN	NOMENCLATURE	U/I	QTY	
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOS PRNG	EA	4	
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLGT CRVD JAW	EA	3	
6515003344100	FORCEPS HEMO MAYO-CARMLT 7.750 MIN 8.250 MAX	EA	2	
6515003349500	FORCEPS HEMO PEAN DESIGN SLGT CRV JAW 9"	EA	2	
6515003377800	FORCEPS TISS ADSON 4.50" LG TWZR STR & SM JAW	EA	1	
6515003419200	HOLDER SUT NEED HEGAR-MAYO 7" LG	EA	1	
6515003447800	HANDLE SURG KNIFE DETACH BLADE SIZE 3	EA	1	
6515003640520	SCISSORS GEN SURG MAYO CRVD BLADE 6.50-7" LG	EA	1	
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLNT PT	EA	1	
6515006600008	BLADE SURG KNIFE DET NO.15 CARB STL 6S	PG	1	*
6530007939945	TRAY INST CORR RESIS STEEL 10-1/2 X 8 X 2”	EA	1	
7210002999610	TOWEL HAND COT 36X17” GREEN GRAY NONDISP	EA	8	

* Only 2 surgical blades are required for this set

FLEET INSTRUMENT SETS

ENT SURGERY SET

(NMLC REF NO. 9802)

NSN	NOMENCLATURE	U/I	QTY
6515003123500	DRILL HAND BONE SMEDBERG DSGN JACOBS	EA	1
6515003417200	HOLDER SUT NEED COLLIER 5" LG ST JAW	EA	2
6515003866800	CANNULA BRAIN FRAZIER 8 FR 7.5"LG OPEN END TIP	EA	2
6515011150416	FORCEPS BONE HOLD CRVD DINGMAN 7.50" LG	EA	2
6515012132679	RONGEUR LOVE-LERRISON OVERALL JAW SZ 3/16”	EA	1
6515012460182	DRILL TWIST BONE TW DRILL PT 3” LG 0.094” DIA	PG	1
6515014467772	SCREW BONE CARROLL-GIRARA 9.9CM,TITANIUM	EA	1
6515014532159	PROBE,LACHNMAL-WILLIAMS SZ 1&2DB ENDED STR	EA	1
6515014532175	PROBE,LACHNMAL-WILLIAMS SZ 3&4 DVLE ENDED	EA	1
6515014532752	PROBE,LACHNMAL-WILLIAMS SZ 5&6 STR	EA	1
6520005196600	CURETTE ALVEO MOLT CRES BLD SZ 2 6.25-6.75" LG	EA	2
6520005196700	CURETTE ALVEO MOLT CRES BLD 2.125"L SZ 4	EA	2
6520005196740	CURETTE ALVEO MOLT CRES BLD 2.312"L BLD SZ 5L	EA	1
6520005196770	CURETTE ALVEO MOLT CRES BLD 2.125"L BLD SZ 6R	EA	1
6520005242550	ELEVATOR, ROOT #34S	EA	2
6520005243050	ELEVATOR, ROOT #301	EA	2
6520005244550	ELEVATOR, ROOT #73 MILLER	EA	2
6520005245050	ELEVATOR, ROOT #74 MILLER	EA	2
6520005323990	FORCEPS TOOTH EXTRCT #150 UP ANT BICU & RTS	EA	1
6520005324990	FORCEPS, TOOTH EXTRACT #151	EA	1
6520005419350	HANDLE, MOUTH EXAM MIRROR	EA	2
6520005551150	SCISSORS, ORAL SURG 6.75"	EA	1
6520005630650	IMPRESSION TRAY, LOW MED	EA	1
6520005631150	IMPRESSION TRAY, LOW LARGE	EA	1
6520005631650	IMPRESSION TRAY, LOW SMALL	EA	1
6520005632650	IMPRESSION TRAY, UPPER MED	EA	1
6520005633150	IMPRESSION TRAY, UPPER LARGE	EA	1
6520005633650	IMPRESSION TRAY, UPPER SMALL	EA	1
6520005842699	ELEVATOR, PERIOS MOLT #9	EA	1
6520007822648	MIRROR, MOUTH EXAM #1	EA	4
6520009357257	PLUGGER, AMALG TANNER #71	EA	1
6520011378453	RETRACT, OBWEGESER CV SZ 168	EA	1
6520011378455	RETRACT, OBWEGESER CV DOWN	EA	1
6520012109532	AWL, ORAL SURG MAX #161	EA	1
6520012109533	AWL, ORAL SURG MAX #160	EA	1
6530007940000	TRAY INST CORR-RESIST STL 15-1/2X9-1/2X2”	EA	1
7210002999610	TOWEL HAND COT 36X17” GREEN GRAY NONDISP	EA	2

FLEET INSTRUMENT SETS

VASCULAR SURGERY SET

NSN	NOMENCLATURE	U/I	QTY
6515000653181	FORCEPS HEMO MIX HALF-CRV 6.87-7.375"LG	EA	6
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOS PRNG	EA	2
6515003344900	FORCEPS HEMO HALSTED 4.75-5.25" LG SLGT CRVD	EA	8
6515003347500	FORCEPS HEMO ROCH-OCHSNER 1.875"JAW LG STR	EA	6
6515003373900	FORCEPS GAUZE PAD HOLD FOERSTER 9-9.75" LG	EA	2
6515006903198	HOLDER SUT NEED DEBAKEY 7" LG SERR JAWS	EA	2
6515006903200	HOLDER SUT NEED DEBAKEY 9" LG SERR JAWS	EA	2
6515006903208	FORCEPS TISSUE DEBAKEY 7.75" LG TWZR	EA	2
6515006903209	FORCEPS TISSUE DEBAKEY 9.5" LG TWZR	EA	2
6515006903212	CLAMP ARTY DEBAKEY-BAHN CRVD & SERR 65MM	EA	2
6515006903215	CLAMP ARTY GLOVER 9CM LG SERR STR 40MM JAW	EA	3
6515006903216	CLAMP ARTY GLOVER 9CM LG CRV SERR 40MM JAW	EA	3
6515008901682	CLAMP ARTY GLOVER 6.5CM LG CRV SER 27MM JAW	EA	2
6515008901683	CLAMP VENA CAVA SATINSKY RATCH-PAWL 10"LG	EA	2
6530007940000	TRAY INST CORR-RESIST STL 15-1/2X9-1/2X2”	EA	1
7210002999610	TOWEL HAND COT 36X17” GREEN GRAY NONDISP	EA	2

FLEET INSTRUMENT SETS

BURR HOLE SET

(NMLC REF NO. 9807)

NSN	NOMENCLATURE	U/I	QTY	
6515002998737	HOLDER SUT NEED HEGAR-MAYO 7" LG SERR JAW	EA	1	
6515003124125	BUR CRANIAL HUDSON 14MM DIA 3.812" LG 6	EA	1	
6515003345600	FORCEPS HEMO HALSTED 5"LG 0.875"JAW STR JAW	EA	10	
6515003447800	HANDLE SURG KNIFE DETACH BLADE SIZE 3	EA	1	
6515005152113	BRACE BIT BONE HUDSON 9.75" LG SNAP-LOCK	EA	1	
6515005152114	BUR CRANIAL HUDSON 9MM DIA 4.094" LG	EA	1	
6515005152115	BUR CRANIAL HUDSON 16MM DIA 3.812"LG	EA	1	
6515005152116	DRILL FLAT CRANIAL 4X0.375" CUSHING DSGN	EA	1	
6515006600011	BLADE SURG KNIFE DETACH NO.10 SMALL TANG 6S	PG	1	*

* Only 2 surgical blades are required for this set

APPENDIX M
DIVING ACCIDENTS

1. Diving Physics, Physiology and Medicine. Refer to the following portions of NAVSEA 0910-LP-106-0957, U.S. NAVY DIVING MANUAL, REVISION 6 regarding diving physics, diving physiology, diving medicine, First Aid and Hazardous Marine Creatures.

a. Volume 1, Chapter 2; Underwater Physics.

b. Volume 1, Chapter 3; Underwater Physiology and Diving Disorders.

c. Volume 5, Chapter 20; Diagnosis and Treatment of Decompression Sickness and Arterial Gas Embolism.

d. Volume 5, Chapter 21; Recompression Chamber Operation.

e. Appendix 5A; Neurological Examination.

f. Appendix 5B; First Aid.

g. Appendix 5C; Hazardous Marine Creatures.

2. Types of Underwater Breathing Methods

a. Scuba. Self-contained underwater breathing apparatus.

b. Surface Supply Diving Rigs. Breathing apparatus used: MK-21 Mod 1, KM-37 NS, MK-20 Mod 0.

c. Steinke Hood. A submarine escape appliance only.

d. Closed Circuit Underwater Breathing Apparatus (UBA). MK-16 Mod 0 and Mod 1, MK-25 Mod 0 and Mod 1, LAR-V.

3. Barotrauma during Descent. Barotrauma, or damage to body tissues from the mechanical effects of pressure, results when pressure differentials between body cavities and the hydrostatic pressure surrounding the body, or between the body and the diving equipment, are not equalized properly. Barotrauma most frequently occurs during descent, but may also occur during ascent. Barotrauma on descent is called squeeze. Barotrauma on ascent is called reverse squeeze.

a. Prerequisites for Squeeze. For squeeze to occur during descent the following five conditions must be meet. Acronym to remember condition is G.R.A.V.E.

(1) G – Gas filled space.

(2) R – Rigid walls.

(3) A – Ambient pressure change.

(4) V – Vascular penetration “Arterial/Venous blood supply”.

(5) E – Enclosed space.

b. Middle Ear Squeeze. Most common type of barotrauma (squeeze). When the eustachian tube is blocked by mucous, the middle ear meets four of the requirements for barotrauma to occur (gas filled space, rigid walls, enclosed space, and penetrating blood vessels). As the diver continues his descent, the fifth requirement (change in ambient pressure) is attained. As the pressure increases, the eardrum bows inward and initially equalizes the pressure by compressing the middle ear’s gas.

(1) Signs and Symptoms of a Middle Ear Squeeze. Upon surfacing after a middle ear squeeze, the diver may complain of pain, fullness in the ear, hearing loss, or even mild vertigo. Occasionally, the diver may have a bloody nose, the result of blood being forced out of the middle ear space and into the nasal cavity through the Eustachian tube by expanding air in the middle ear.

(2) Treatment of a Middle Ear Squeeze. Treatment consists of taking decongestants, pain medication if needed, and cessation of diving until the damage is healed. If the eardrum has ruptured antibiotics may be prescribed as well. Never administer medications directly into the external ear canal if a ruptured eardrum is suspected or confirmed unless done in direct consultation with an ear, nose, and throat (ENT) medical specialist.

c. Sinus Squeeze. Pressure is applied to the body and the passages to any of these sinuses are blocked by mucous or tissue growths, pain will soon be experienced in the affected area.

(1) Signs and Symptoms of a Sinus Squeeze. Pain produced may be intense enough to halt the diver's descent. Unless damage has already occurred, a return to normal pressure will bring about immediate relief. If such difficulty has been encountered during a dive, the diver may often notice a small amount of bloody nasal discharge on reaching the surface.

(2) Treatment of a Sinus Squeeze. Treatment is geared towards prevention; divers should not dive if any signs of nasal congestion or a head cold are evident. The effects of squeeze can be limited during a dive by halting the descent and ascending a few feet to restore the pressure balance. If the space cannot be equalized by swallowing or blowing against a pinched-off nose, the dive must be aborted.

d. Tooth Squeeze (Barodontalgia). Tooth squeeze occurs when a small pocket of gas, generated by decay, is lodged under a poorly fitted or cracked filling. If this pocket of gas is completely isolated, the pulp of the tooth or the tissues in the tooth socket can be sucked into the space causing pain. If additional gas enters the tooth during descent and does not vent during ascent, it can cause the tooth to crack or the filling to be dislodged.

(1) Signs and Symptoms of Tooth Squeeze. Tooth squeezes will usually cause pain and then immediate relief once the pressure is released.

(2) Treatment of Tooth Squeeze. The best treatment for tooth squeezes is prevention. All personnel working in pressurized environments, like diving, need to notify their dentist prior to any dental work, to identify themselves as divers. When tooth pain is first felt, stop descent and abort the dive. To continue on with the dive will cause damage to the effected tooth.

e. External Ear Squeeze. A diver who wears ear plugs, has an infected external ear canal (external otitis), has a wax-impacted ear canal, or wears a tight-fitting wet suit hood, can develop an external ear squeeze. The squeeze occurs when gas becomes trapped in the external ear canal remains at atmospheric pressure while the external water pressure increases during descent. In this case, the eardrum bows outward (opposite of middle ear squeeze) in an attempt to equalize the pressure difference and may rupture.

(1) Signs and Symptoms of External Ear Squeeze. The skin of the canal swells and hemorrhages, causing considerable pain.

(2) Treatment for External Ear Squeeze. Ear plugs must never be worn while diving. In addition to creating the squeeze, they may be forced deep into the ear canal. When a hooded suit must be worn, air (or water in some types) must be allowed to enter the hood to equalize pressure in the ear canal.

f. Thoracic (Lung) Squeeze. When a swimmer, whether performing an operational task or is recreationally spear fishing, makes a breath hold dive; the pressure in the lung becomes negative with respect to the external water pressure. An injury develops taking the form of squeeze.

(1) Signs and Symptoms of Thoracic Squeeze. Blood and tissue fluids are forced into the lung alveoli and air passages where the air is under less pressure than the blood in the surrounding vessels. This amounts to an attempt to relieve the negative pressure within the lungs by partially filling the air space with swollen tissue, fluid, and blood. Considerable lung damage results and, if severe enough, may prove fatal. If the diver descends still further, death will occur as a result of the collapse of the chest.

(2) Treatment of Thoracic Squeeze. Treatment is through administrative controls; limiting breath hold diving to controlled, training situations or special operational situations involving well-trained personnel at shallow depths.

g. Face Squeeze (Mask Squeeze). Caused by a vacuum built up between the face and a SCUBA mask or swimming goggles.

(1) Signs and Symptoms of a Face Mask Squeeze. The eye and the eye socket tissues are the most seriously affected tissues in an instance of face mask or goggles squeeze. When using exposure suits, air may be trapped in a fold in the garment and may lead to some discomfort and possibly a minor case of hemorrhage into the skin from pinching.

(2) Treatment for Face Mask Squeeze. Pressure is relief through releasing air into the mask through the nose or cracking the side of the mask or goggles on the surface, or in the water if diving, to relive the pressure built in the mask or goggles.

h. Inner Ear Barotrauma. If middle ear pressure is not equalized during descent, the inward bulge of the eardrum is transmitted to the oval window by the middle ear bones. The stapes pushes the oval window inward. Because the inner ear fluids are incompressible, the round window correspondingly bulges outward into the middle ear space. If this condition continues, the round window may rupture spilling inner ear fluids into the middle ear and leading to a condition known as *inner ear barotrauma with perilymph fistula*. Rupture of the oval or round windows may also occur when middle ear pressures are suddenly and forcibly equalized.

(1) Signs and Symptoms of Inner Ear Barotrauma. Symptoms of inner ear barotrauma usually appear abruptly during descent, often as the diver arrives on the bottom and performs the last equalization maneuver. The primary symptoms of inner ear barotrauma are persistent vertigo and hearing loss.

(a) The vertigo of inner ear barotrauma is generally described as whirling, spinning, rotating, tilting, rocking, or undulating.

(b) This sensation is quite distinct from the more vague complaints of dizziness or lightheadedness caused by other conditions.

(c) The vertigo of inner ear barotrauma is often accompanied by symptoms that may or may not be noticed depending on the severity of the insult. These include nausea, vomiting, loss of balance, incoordination, and a rapid jerking movement of the eyes, called nystagmus.

(2) Treatment for Inner Ear Barotrauma. All cases of suspected inner ear barotrauma should be referred to an ear, nose and throat (ENT) physician as soon as possible and a neurological examination should be done to rule out arterial gas embolism (A.G.E). Treatment of inner ear barotraumas ranges from bed rest with head elevation to exploratory surgery, depending on the severity of the symptoms and whether a perilymph fistula is suspected. Any hearing loss or vertigo occurring within 72 hours of a hyperbaric exposure should be evaluated as a possible case of inner ear barotrauma.

4. Barotrauma during Ascent. During ascent gases expand according to Boyle's Law. If the excess gas is not vented from enclosed spaces, damage to those spaces may result.

a. Middle Ear Overpressure (Reverse Middle Ear Squeeze). Expanding gas in the middle ear space during ascent ordinarily vents out through the eustachian tube. If the tube becomes blocked, pressure in the middle ear relative to the external water pressure increases. A diver who has a cold or is unable to equalize the ears is more likely to develop reverse middle ear squeeze.

(1) Signs and Symptoms of Middle Ear Overpressure

(a) To relieve this pressure, the eardrum bows outward causing pain. If the overpressure is significant, the eardrum may rupture. If rupture occurs, the middle ear will equalize pressure with the surrounding water and the pain will disappear. However, there may be a transient episode of intense vertigo as cold water enters the middle ear space.

(b) The increased pressure in the middle ear may also affect the inner ear balance mechanism, leading to a condition called *alternobaric vertigo of ascent*. Alternobaric vertigo occurs when the middle ear space on one side is over pressurized while the other side is equalizing normally. The onset of vertigo is usually sudden and may be preceded by pain in the ear that is not venting excess pressure.

(c) Increased pressure in the middle ear can also produce paralysis of the facial muscles, a condition known as *facial baroparesis*. In some individuals, the facial nerve is exposed to middle ear pressure as it traverses the temporal bone. If the middle ear fails to vent during ascent, the overpressure can shut off the blood supply to the nerve causing it to stop transmitting neural impulses to the facial muscles.

(d) Increased pressure in the middle ear can also cause structural damage to the inner ear, a condition known as *inner ear barotrauma of ascent*. The bulging ear drum pulls the oval window outward in the middle ear space through the action of middle ear bones. The round window correspondingly bulges inward. This inward deflection can be enhanced if the diver further increases middle ear pressure by performing a Valsalva maneuver. The round window may rupture causing inner ear fluids to spill into the middle ear space. The symptoms of marked hearing loss and sustained vertigo are identical to the symptoms experienced with inner ear barotrauma during descent.

(2) Treatment of Middle Ear Overpressure. There is no uniformly effective way to clear the ears on ascent. Do not perform a Valsalva maneuver on ascent, as this will increase the pressure in the middle ear, which is the direct opposite of what is required. The Valsalva maneuver can also lead to the possibility of arterial gas embolism. If pain in the ear or vertigo develops on ascent, the diver should halt the ascent, descend a few feet to relieve the symptoms and then continue ascent at a slower rate. Several attempts may be necessary as the diver gradually works his way to the surface. If symptoms of sustained hearing loss or vertigo appear during ascent, or shortly after ascent, it may be impossible to tell whether the symptoms are arising from inner ear barotrauma or frome decompression sickness or arterial gas embolism. Recompression therapy is always indicated unless there is 100% certainty that the condition is inner ear barotrauma.

b. Sinus Overpressure (Reverse Sinus Squeeze). Overpressure is caused when gas is trapped within the sinus cavity. A fold in the sinus-lining membrane, a cyst or an outgrowth of sinus membrane (polyp) may act as a check valve and prevent gas from leaving the sinus during ascent.

(1) Signs and Symptoms of Sinus Overpressure. Sharp pain in the area of the affected sinus results from the increased pressure. When overpressure occurs in the maxillary sinus, the blood supply to the infraorbital nerve may be reduced, leading to numbness of the lower eyelid, upper lip, side of the nose and check on the affected side.

(2) Treatment of Sinus Overpressure. The pain is usually sufficient to stop the diver from ascending. Pain is immediately relieved by descending a few feet. From that point, the diver should titrate himself slowly to the surface in a series of ascents and descents just as with a reverse middle ear squeeze. The numbness caused by blood supply to the infraorbital nerve being reduced will resolve spontaneously when the sinus overpressure is relieved.

c. Gastrointestinal Distention. This condition is caused by gas being generated in the intestines during a dive, or by swallowing air (aerophagia).

(1) Signs and Symptoms of Gastrointestinal Distention. Divers may occasionally experience abdominal pain during ascent because of gas expansion in the stomach or intestines.

(2) Treatment of Gastrointestinal Distention. These pockets of gas will usually work their way out of the system through the mouth or anus. If not, distention will occur. If the pain begins to pass the stage of mild discomfort, ascent should be halted and the diver should descend slightly to relieve the pain. The diver should the attempt to gently burp or release gas anally. Overzealous attempts to belch should be avoided as they may result in swallowing more air. Abdominal pain following fast ascents shall evaluated by a Diving Medical Officer (DMO).

5. Pulmonary Overinflation Syndromes. Pulmonary Overinflation syndromes (P.O.I.S) are a group of barotrauma-related diseases caused by the expansion of gas trapped in the lung during ascent (reverse squeeze) or over pressurization of the lung with subsequent overexpansion and rupture of the alveolar air sacs. Excess pressure inside the lung can also occur when a diver presses the purge button on a single-hose regulator while taking a breath.

a. There are two main causes of alveolar rupture

(1) Excessive pressure inside the lung caused by positive pressure.

(2) Failure of expanding gas to escape from the lung during ascent.

b. Pulmonary Overinflation from expanding gas failing to escape from the lung during ascent can occur when a diver involuntarily holds his breath during ascent. Localized pulmonary obstructions that can cause air trapping, such as asthma or thick secretions from pneumonia or a severe cold, ore other causes.

c. The conditions that bring about these incidents are different from those that produce lung squeeze and they most frequently occur during free and buoyant ascent training or emergency ascent from dives made with lightweight diving equipment or SCUBA.

6. Types of Pulmonary Overinflation. The clinical manifestations of pulmonary Overinflation depend on the location where the free air collects. In all cases, the first step is rupture of the alveolus with a collection of air in the lung tissues, a condition known as *interstitial emphysema*. Interstitial emphysema causes no symptoms unless further distribution of the air occurs. If gas enters the arterial circulation, potentially fatal arterial gas embolism may occur. Pneumothorax occurs if gas accumulates between the lung and chest wall and if accumulation continues without venting, then tension pneumothorax may result.

a. Arterial Gas Embolism (AGE). Arterial gas embolisms are caused by gas bubbles entering into the arterial circulation. Air gas embolisms can manifest during dives or entering a pressurized space, such as a chamber or pressurized space (Dome diving), where breathing is performed utilizing man carried breathing equipment. Even in brief exposures such as; time in a pressurized space or a shallow dive, like ones made in a swimming pool, have the potential of developing an air gas embolism.

(1) Signs and Symptoms of AGE. The onsets of symptoms are usually sudden and dramatic, often occurring within minutes after leaving a pressurized environment or while the environment pressure in changing back to normal surface pressure. Because the supply of blood to the central nervous system is almost always compromised, arterial gas embolisms may result in permanent neurological damage or even death unless treated with immediate recompression.

(a) Extreme fatigue, unconsciousness, paralysis, numbness, weakness, abdominal paresthesias (decreased abdominal sensorium), change in mental status, vertigo, convulsions, nausea and/or vomiting, hearing abnormalities, bloody sputum, loss of control of bodily functions, tremors, loss of coordination, numbness, vision abnormalities, personality changes, and sensation similar to that of a blow to the chest during ascent. Symptoms of subcutaneous / mediastinal emphysema, pneumothorax and/or pneumopericardium may also be present

(b) In all cases of suspected arterial gas embolism, the possible presence of these associated conditions should not be over looked. Diagnosis is usually quite evident as symptoms generally occur within minutes of surfacing.

(c) A diver who surfaces unconscious and recovers when exposed to fresh air shall receive a neurological evaluation to rule out arterial gas embolism. Victims of near-drowning who have no neurological symptoms should be carefully evaluated by a DMO for pulmonary aspiration. If pain is the only symptom, arterial gas embolism is unlikely and decompression sickness or one of the other pulmonary over inflation syndromes should be considered. Most importantly, “when in doubt”, consult your local DMO, Dive Medical Technician IDC or local dive command and speak with a Subject Matter Expert (SME) for further assistance.

(2) Treatment of AGE. Consult with the nearest recompression treatment facility and consult with the on duty US Navy Dive Medical Officer, Dive Medical Technician or Master Diver. If none are available, contact the Navy Experimental Dive Unit (NEDU) or The Navy Diving Salvage and Training Center (NDSTC). To treat a person with an arterial gas embolism, the patient needs to be transported to the nearest recompression chamber for treatment as soon as possible. If the patient is to be transported by helicopter or other unpressurized aircraft, the aircraft should be flown as low as safely possible, preferably less than 1,000 feet. Exposure to altitude results in an additional reduction in external pressure and possible additional symptom severity or other complications.

b. Mediastinal and Subcutaneous Emphysema. Mediastinal emphysema, also called pneumomediastinum, occurs when gas is forced through torn lung tissues into the loose mediastinal tissues in the middle of the chest surrounding the heart, the trachea and the major blood vessels. Subcutaneous emphysema occurs when that gas subsequently migrates into the subcutaneous tissues of the neck. Mediastinal emphysema is a pre-requisite for subcutaneous emphysema. Mediastinal/subcutaneous emphysema is caused by over inflation of the whole lung or parts of the lung due to holding breath during ascent, positive pressure breathing such as ditch and don exercises, drown proofing exercises or cough during surface swimming.

(1) Signs and Symptoms of Mediatinal and Subcutaneous Emphysema. Mild cases are often unnoticed by the diver. In more severe cases, the diver may experience mild to moderate pain under the breastbone, often described as dull ache of feeling of tightness. The pain may radiate to the shoulder or back and may increase upon deep inspiration, coughing or swallowing. The diver may have a feeling of fullness around the neck and may difficulty in swallowing. The diver’s voice may change in pitch. An observer may note a swelling or apparent inflation of the diver’s neck. Movement of the skin near the windpipe or about the collar bone may produce a cracking or crunching sound (crepitation).

(2) Treatment of Mediastinal and Subcutaneous Emphysema. Suspicion of mediastinal or subcutaneous emphysema warrants prompt referral to medical personnel to rule out the coexistence or arterial gas embolism or pneumothorax. The latter two conditions require more aggressive treatment. Treatment of mediastinal or subcutaneous emphysema with mild symptoms consists of breathing 100 percent oxygen at the surface. If symptoms are severe, shallow recompression may be beneficial. Recompression should only be carries out upon the recommendation of a DMO who has ruled out the occurrence of pneumothorax. Recompression is performed with the diver breathing 100 percent oxygen and using the shallowest depth of relief (usually 5 or 10 feet). An hour of breathing oxygen should be sufficient for resolution, but longer stays may be necessary. Decompression will be dictated by the tender’s decompression obligation.

c. Pneumothorax. A pneumothorax is air trapped in the pleural space between the lung and chest wall. It occurs when the lung surface ruptures and sir spills into the space between the ling and chest wall. These ruptures can result from a severe blow to the chest or from over pressurization of the lung.

(1) Signs and Symptoms of a Pneumothorax

(a) The onset of a simple pneumothorax is accompanied by a sudden, sharp chest pain, followed by shortness of breath, labored breathing, rapid heart rate, a weak pulse and anxiety. The normal chest movements associated with respiration may be reduced on the affected side and breath sounds may be difficult to hear with a stethoscope.

(b) The symptoms of a tension pneumothorax are similar to simple pneumothorax, but become progressively more intense over time. As the heart and lungs are displaced to the opposite side of the chest, bold pressure falls along with the arterial oxygen partial pressure. Cyanosis (a bluish discoloration) of the skin appears. If left untreated, shock and death will ensue. Tension pneumothorax is a true medical emergency.

(2) Treatment of Pneumothorax. A diver believed to be suffering from a pneumothorax must be thoroughly examined for the possible co-existence of AGE.

(a) A small pneumothorax (less than 15%) normally will improve with time as the air in the pleural space is reabsorbed spontaneously.

(b) Cases of pneumothorax that demonstrate cardio-respiratory compromise may require the insertion of a chest tube, large bore intravenous (IV)catheter, or other device designed to remove intrathoracic gas (gas around the lung). Only personnel trained in the use of these and the other accessory devices (one-way valves, underwater suction, etc.) necessary to safety decompress the thoracic cavity should insert them.

(c) A tension pneumothorax should always be suspected if the diver's condition deteriorates rapidly during ascent, especially if the symptoms are respiratory. If a tension pneumothorax is found, recompress to depth of relief until the thoracic cavity can be properly vented. Pneumothorax, if present in combination with arterial gas embolism or decompression sickness, should not prevent immediate recompression therapy. However, a pneumothorax may need to be vented as described before ascent from treatment depth. In cases of tension pneumothorax, this procedure may be lifesaving.

7. Decompression Sickness (DCS). The formation of gas bubbles formed in the bodies' tissue causing tissue damage shortly following a dive or pressure exposure. Decompression sicknesses are generally divided into two categories. Because the treatment of Type I and Type II decompression sickness may be different, it is important to distinguish between these two types. Symptoms of Type I and Type II decompression sickness may be present at the same time.

a. Type I DCS. Type I decompression sickness involves the skin, lymphatic system, muscles and joints and is not life threatening.

(1) Musculoskeletal Pain-Only Symptoms. The most common symptom of decompression sickness is joint pain. Other types of pain may occur which do not involve joints. The pain may be mild or excruciating. The most common sites of joint pain are the shoulder, elbow, wrist, hand, knee, and ankle. The characteristic pain of Type I decompression sickness usually begins gradually, is slight when first noticed and may be difficult to localize. The hallmark of Type I pain is its dull, aching quality and confinement to particular areas. It is always present at rest and is usually unaffected by movement.

(2) Cutaneous (Skin) Symptoms. The most common skin manifestation of decompression sickness is itching. Itching by itself is generally transient and does not require recompression. Cutis marmorata (marbling), may precede a symptom of serious decompression sickness and shall be treated by recompression as Type II decompression sickness. This condition starts as intense itching, progressing to redness, and then gives way to a patchy, dark-bluish discoloration of the skin. The skin may feel thickened. In some cases the rash may be raised.

(3) Lymphatic Symptoms. Lymphatic obstruction may occur, creating localized pain in involved lymph nodes and swelling of the tissues drained by these nodes.

b. Type II DCS. Type II decompression sickness (also called serious decompression sickness) involves the nervous system, respiratory system, or circulatory system. The diver may feel fatigued or weak and attribute the condition to over exertion. Even as weakness becomes more severe the diver may not seek treatment until walking, hearing, or urinating becomes difficult. Initial denial of DCS is common. For this reason, symptoms must be anticipated during the post dive period and treated before they become too severe. Type II decompression sickness may become life threatening.

(1) Neurological Symptoms. These symptoms may be the result of involvement of any level of the nervous system. Numbness, paresthesias (a tingling, pricking, creeping, “pins and needles,” or “electric” sensation on the skin), decreased sensation to touch, muscle weakness, paralysis, mental status changes, or motor performance alterations are the most common symptoms. Disturbances of higher brain function may result in personality changes, amnesia, bizarre behavior, lightheadedness, lack of coordination, and tremors. Lower spinal cord involvement can cause disruption of urinary function. Some of these signs may be subtle and can be overlooked or dismissed by the stricken diver as being of no consequence.

(2) Inner Ear Symptoms (“Staggers”). The symptoms of inner ear decompression sickness include: tinnitus (ringing in the ears), hearing loss, vertigo, dizziness, nausea, and vomiting.

(3) Cardiopulmonary Symptoms (“Chokes”). If profuse intravascular bubbling occurs, symptoms of chokes may develop due to congestion of the lung circulation. Chokes may start as chest pain aggravated by inspiration and/or as an irritating cough. Increased breathing rate is usually observed. Symptoms of increasing lung congestion may progress to complete circulatory collapse, loss of consciousness, and death if recompression is not instituted immediately.

c. Differentiating Between Type II DCS and AGE. Many of the symptoms of Type II decompression sickness are the same as those seen of AGE, although the time of on set is generally different. AGE usually occurs within 10 minutes of reaching surface ambient pressure. Since the initial treatments of these two conditions are the same and the treatment protocol is based on the response of the patient to treatment, treatment should not be delayed unnecessarily in order to come up with a diagnosis.

d. Potential risk factors associated with DCS: Include obesity, alcohol use, fatigue, dehydration, and concurrent illness. Age, temperature, and repetitive diving may contribute to DCS. Strict observance of decompression tables is a must.

e. Treatment of Type I or Type II Decompression Sickness

(1) Type I. Is treated in accordance with Figure 20-1 in Volume 5 of the U.S. Navy Diving Manual. If a full neurological exam is not completed before initial recompression, treat as a Type II symptom.

(2) Type II. Is treated with initial compression to 60 feet of saltwater (fsw) in accordance with Figure 20-1 in Volume 5 of the U.S. Navy Diving Manual. If symptoms are improved within the first oxygen breathing period, then treatment is continued on a Treatment Table 6 of the Diving Manual. If severe symptoms (e.g. paralysis, major weakness, memory loss) are unchanged or worsen within the first 20 minutes at 60 fsw, assess the patient during descent and compress to depth of relief (or significant improvement), not to exceed to 165 fsw. Treat on Treatment Table 6A from the Diving Manual. To limit recurrence, severe Type II symptoms warrant full extensions at 60 fsw even if symptoms resolve during the first oxygen breathing period.

(3) Your main objective of patients suspected of having a DCS, is getting them to a recompression chamber for further evaluation and treatment.

8. Omitted Decompression. Decompression is the function of off gassing the accumulated nitrogen in the body. Failure to off-gas (get rid of) excessive nitrogen can lead to the diver developing a dive related injury. Certain emergencies, such as uncontrolled ascents, an exhausted air supply, or bodily injury may interrupt or prevent required decompression.

a. Signs and Symptoms of Omitted Decompression. If the diver shows symptoms of decompression sickness or arterial gas embolism, immediate treatment using the appropriate recompression treatment table is essential. Even if the diver shows no symptoms, omitted decompression must be addressed in some manner to avert later difficulty.

b. Treatment for Omitted Decompression. Treatment for Omitted Decompression is found in US Navy Dive Manual, Volume 5, Chapter 20. Treatment of blow-up depends largely upon the depth of deepest decompression stop omitted, surface interval, availability of recompression chamber or not and whether a diver is symptomatic or asymptomatic.

(1) If time spent on the bottom for the particular depth was of such duration as to not require any decompression according to the US Navy Standard Dive tables, the diver should be watched closely upon arrival at the surface. If no symptoms of DCS or AGE develop, no further recompression is necessary. If symptoms do develop in the next 24 hours, IMMEDIATE recompression is necessary.

(2) If time spent on the bottom for the particular depth was of such duration as to require decompression according to the US Navy Standard Dive tables, then recompression must take place.

9. Places to Contact for Help. In the event it is necessary to seek aid, contact the closest diving facility.

a. Submarine Bases

(1) Commanding Officer, Naval Submarine Base, Box 100, Groton, CT 06349-5100 Base Information: (860) 694-4636 DSN: 694-4636.

(2) Commanding Officer, Naval Submarine Base Kings Bay 1063 USS Tennessee Avenue, Kings Bay, GA 31547-2606, Base Information: (912) 673-2000.

(3) Commanding Officer, Naval Submarine Base, 140 Sylvester Road, San Diego, CA 92106-3521, Base Information: (619) 553-1011.

(4) Commander, Naval Base Kitsap Bremerton, 1100 Hunley Road, Silverdale, WA 98315-1199, Base Information: (360) 476-3711 DSN: 439-3711.

b. Training Commands

(1) Naval Undersea Medicine Institute (NUMI), Naval Undersea Medical Institute, Box 159 NAVSUBASE NLON, Groton, CT 06349-5159, Phone: (860) 694-2876, DSN: 694-2876, E-Mail: NOMI-Info@med.navy.mil.

(2) Naval Submarine Training Center, Pacific, 1130 Bole Street Pearl Harbor, Hawaii 96676, Phone: (808) 473-0136.

(3) Deep Sea Diver Schools, NDSTC Panama City, FL. NDSTC Medical Department, 350 S. Crag Road, Panama City, FL. 32407, DSN 435-5215, Phone: (850) 235-5215.

c. Mobile Dive and Salvage Unit

(1) Mobile Dive and Salvage Unit ONE (MDSU ONE), Pearl Harbor, HI, Commanding Officer, Mobile Diving and Salvage Unit One, Building 17, Bishop Point, Pearl Harbor, Hi, 96860, Phone: (808) 471-9292, DSN (315) 471-9292.

(2) Mobile Dive and Salvage Unit TWO (MDSU TWO), Norfolk, VA. Commanding Officer, 1004 Hermitage Rd, BLDG 2052, Joint Expeditionary Base Little Creek-Ft Story, Virginia Beach, VA, 23459, Phone: (757) 462-4279.

d. Other Commands

(1) Navy Experimental Dive Unit (NEDU), Panama City, FL NAVXDIVINGU, 321 Bullfinch Road, Panama City Beach, Florida 32407-7012, Main switchboard: (850) 230-3100, NEDU FAX: (850) 234-4238.

(2) Explosive Ordnance Disposal Commands, Special Warfare Commands (SPECWAR) and Ship repair facilities (SIMA) contact your local directory.

e. Request help with dispatch. Treatment should not be delayed. Submit information per Addendum 1.

f. Evacuation. If it becomes necessary to evacuate a diver, the diver should be flown at low altitudes in a supine position on supplemental oxygen. Fluids, corticosteroids, or other supportive measures may be administered as deemed necessary by the cognizant DMO, or DMT, or other cognizant medical attendant.

10. Reporting of Diving Mishaps, Accidents and Near Accidents

a. Reporting of Diving Mishaps. A diving incident involving a qualified Navy diver and resulting in recompression treatment or 24 hours or more loss of work is considered a diving mishap.

(1) All diving data for a mishap report can be obtained from the diving supervisor of master diver who coordinated the dive.

(2) In the event of a mishap, the Naval Safety Center requires a report via message per OPNAVINST 5102.1C (Chapter 8, Appendix D) or current revision.

(3) A full narrative summary of the dive, the nature and course of clinical symptoms, and the response to treatment is documented on SF 600 of the diver’s health record. A brief note should also be made in the Special Duty Medical Abstract (NAVMED 6150/2).

b. Reporting of Diving Accidents. An accident is an unexpected event which culminates in loss of, or serious damage to, equipment or injury to personnel. Actions required in the event of an accident include:

(1) All diver-worn and ancillary/support equipment which may have contributed to the accident must be secured and shipped as outlined in the current revision of Volume 2 of the Navy Diving Manual, Appendix B.

(2) Report circumstances of the accident to Naval Sea Systems Command (NAVSEA 00C) and the Navy Experimental Diving Unit (NEDU) via message. A separate written report should be prepared using the format in the current revision of Volume 2 of the Navy Diving Manual, Appendix B

c. All fatal Navy diving accidents require a thorough and accurate investigation of the accident. Requests for autopsy should be made to the nearest naval hospital or military medical treatment facility.

11. Reporting of Near Accidents. A near accident is a situation or action that occurs during a diving evolution, which jeopardizes the safety of a diver but does not injure the diver. Such situations include equipment failure, failure to follow proper operating procedures, improper isolation of shipboard systems, unauthorized operation of shipboard equipment in the vicinity of dive operations, or work procedure discrepancies. Reporting should be done per COMPACFLTINST 5102.1A

DIVING ACCIDENT OR INJURY INFORMATION SHEET

1. Upon receipt of a telephone call concerning a diving accident or injury, carbon monoxide poisoning, gas gangrene, acute cyanide poisoning, or requests for information about diving medicine, record the following information as applicable.

a. Caller's phone number:

b. Caller's name:

c. Time of call:

d. Patient's name:

e. Patient's age: Patient's sex: Male / Female

f. Time of accident:

g. Patient's location:

h. Circumstances of injury: (i.e. diving, altitude, etc)

i. Condition of patient:

Is Patient:	Circle One
(1) Conscious	Yes or No
(2) Possibly embolized	Yes or No
(3) Ambulatory (can patient walk)	Yes or No
(4) Being Resuscitated	Yes or No
(5) IV started * *If so, what type?	Yes or No

j. Mode of transport: (Circle one)

(1) Ambulance
(2) Helicopter
(3) P.O.V.

k. ETA:

2. If this is a diving related or other type pressure exposure related injury, try to obtain additional information below unless immediate transport or patient is necessary.

a. Military or Civilian:

b. Command Name:

c. Dive History: If a military dive, use chart(s) if provided. If not, record depth/time, number of dives, and any decompression time missed (if any).

d. Has a neurological exam been done? Yes or No

Results:

3. Watch standers immediate actions required:

a. Contact the CDU/West Coast Duty Master Diver.

b. Contact the Duty Diving Medical Officer.

c. Contact the Command Duty Officer. CDO will contact:

(1) Repair Officer: HM#:
Beeper #:

(2) Executive Officer: HM#:
Beeper #:

(3) Commanding Officer: HM#:
Beeper #:

d. Recall the Duty Dive Team if directed.

e. Duty diver ready the chamber for treatment

APPENDIX N
AVIATION MEDICINE AND ACCIDENTS

1. References. SMDRs aboard ships with assigned aviation units will retain on board and familiarize themselves with the following references:

a. OPNAVINST 3710.7R, Chapter 7 – Promulgation of NATOPS General Flight and Operating Instructions.

b. OPNAVINST 3750.6Q, Chapters 6 and 7 – Naval Aviation Safety Program.

c. BUMEDINST 6410.5A, Medical Monitoring of Flight Personnel in Locations where Officers with Aviation Medicine Training are not available.

d. NAVMED P-5083 Methods of Preparing Specimens for Storage and Shipment.

e. NAVMED P-117 Manual of the Medical Department, Chapter 15, Section V.

f. NAVAIR 00-80T-67, Handbook for Aircraft Accident Investigation, Chapter 11.

g. If further guidance is required, direct liaison with the nearest facility having a Flight Surgeon assigned is encouraged. Flight Surgeons are available/on call aboard all CV/CVN platforms and at all Navy or Marine Corps Air Stations.

2. Removal and Return to Flight Status. It is the responsibility of SMDRs aboard ships with assigned aviation units to establish a close working relationship with the officer in charge (OIC) or the assigned aviation unit. The OIC will be kept informed of the medical status of all aircrew members reporting for sick call.

a. NAVMED 6410/1, Grounding Notice. The authority to issue a grounding notice has been expanded to include the appropriate medical department representative on independent duty.

b. NAVMED 6410/2, Clearance Notice. The authority to issue a clearance notice returning aircrew members to duty involving flying, has been expanded to include non-aviation trained MOs, HMs holding NEC 8425 (IDC), NEC 8406 (Aerospace Medicine Technician) and 8409 (Aerospace Physiology Technician) who have completed the basic or refresher course in aviation medicine at a Naval School of the Health Sciences. In cases where aircrew members have been grounded for over ten days, they must be examined by a medical officer trained in aviation medicine before returning to duty involving flying.

(1) In cases where non-aviation trained MOs or qualified HM issue a clearance notice, a message or verbal concurrence must be obtained from a flight surgeon, AVME or AVMO before the aircrew member can resume duty involving flying.

(2) Under no circumstances will an aircrew member be issued a clearance notice while on medication without concurrence from a MO trained in aviation medicine.

3. Aircraft Accident. Certain actions should be taken by medical department personnel aboard ships not having Flight Surgeons assigned prior to the on-scene arrival of an Aircraft Mishap Board (an investigation team which includes a Flight Surgeon). The below information is intended to provide the shipboard SMDR with information and procedures necessary to assist an investigating flight surgeon with an aircraft accident mishap investigation.

a. Specimen Collection. The collection of specimens applies to all survivors, whether injured or not, and should be done as soon as possible. It is important to realize that these specimens are not for legal use and have the same status as a privileged statement. Routine procedures required for aircrew following an aircraft accident, with specimens obtained as soon as possible, are:

(1) Blood Alcohol. Prepare arm with soap and water or betadine scrub (not alcohol swab). Draw one large purple-top stoppered tube. Label: FOR BLOOD ALCOHOL, patient’s name, rank, service number, unit attached, and the date and time specimen obtained. Place specimen with blood alcohol form in laboratory freezer.

(2) Carbon Monoxide. Draw one purple-top tube and fill tube as full as possible, being careful not to let air into the tube. Attach label with: Carbon monoxide specimen, patient's name, rank, service number, unit attached, and the date and time specimen obtained. Place specimen in refrigerator.

(3) Hemoglobin and Hematocrit. Draw one full purple-top tube and perform tests in the laboratory. Label tube in detail as above and store in the refrigerator.

(4) ALIQUOT. Draw two large red-top tubes, allow clotting, spin down, draw off 8 ml or serum and place in red-top tube. Label in detail as with other specimens and place in freezer for possible future studies. Retain for 90 days.

(5) Blood Sugar. Draw on grey-top tube, label as previously indicated, and place in refrigerator.

(6) Urine Sample. Obtain at least 75 ml or urine, if possible, and perform routine urinalysis in the laboratory. Label specimen in detail and save remainder in refrigerator for drug screen if ordered by flight surgeon.

(7) Extra Tubes. Draw two large red-top tubes and place in laboratory refrigerator with detailed labels for additional tests that may be ordered by the flight surgeon.

(8) Total Specimens saved in refrigerator or freezer

(a) Large Red-top (5) – 2 with serum only in freezer (1 with 4 ml) (1 with 8 ml to be kept for 90 days).

(b) Purple-top (3) – refrigerator.

(c) Grey-top (1) – refrigerator.

(d) Urine Specimen – 75 ml minimum.

b. Scene Survey. One of the primary responsibilities of medical personnel present at the scene of an accident is to quickly survey the casualties involved and notify the nearest medical facility. This will permit personnel at that medical facility to take necessary steps to receive the casualties.

(1) Where practical, sketches and photographs should be made to include the location of the wreckage and position of remains. After the previous has been accomplished, those fatally injured should be placed in rubberized remains bags. Where possible, the exact location of the body or parts shall be marked and identification tags be placed on the markers as well as on the pouch in which the remains are placed. All flight gear on the body or on body parts shall be left on the remains and handled as little as possible. Any other flight gear should be packaged separately and sent with the body to the nearest naval medical facility. A thorough search of the area surrounding the body should be undertaken by a search party in order to locate all remains, equipment and personal belongings. An emergency treatment tag, with appropriate notations, should be tied to each body. Bodies should be identified by number until definite identification can be established.

(2) It is important that no information regarding the identity of the victims or the nature of the casualties be released to the press or to any unauthorized civilians except by personnel listed in OPNAVINST 3750.6Q.

c. Remains Recovery. In general, COMNAVAIRLANT or COMNAVAIRPAC should be consulted about any problems in the handling of remains. Funds are available for the recovery of remains if it is necessary to employ civilian equipment or labor. For example, if a pilot is in the cockpit of an aircraft in shallow water, the involved command through the TYCOM, may secure civilian equipment to recover the body. In many cases it may be necessary to recover the body before tissue change can destroy evidence which might be revealed through histopathological investigation.

d. Specimen Handling. Freezing techniques are used for the preparation of sections for immediate diagnosis, for certain histochemical procedures and for preparation of materials required in toxicological studies. In aircraft accidents toxicological examinations are performed only at the Armed Forces Institute of Pathology. Prompt collection of fresh tissue is essential to protect it against chemical or mechanical change. Chemical preservations invalidate results of toxicological analysis; therefore no fixing fluid (for example formalin) should ever be used. Formalin-fixed tissue should never be packed in the same container with frozen material. Refrigeration with dry ice is the prescribed method of preservation and rapid transportation is of the utmost importance.

e. Preparation and Packing of Specimens. Under ideal conditions tissue specimens for toxicological examination will be collected under the supervision of the pathologist performing the autopsy and will consist of the following: liver, brain, kidney, lung, bone marrow, blood, urine, and stomach contents. Precautions shall be taken to prevent contamination of specimens during the course or the autopsy. Thorough toxicological examination requires approximately 250 to 500 grams of brain, liver, kidney, and lung; 100 ml of blood; and all urine submitted. Red bone marrow and lung tissue are especially useful in cases where disintegration of soft tissue has occurred. In the field conditions are often less than ideal. In order to aid the pathological examination, any tissue located should be forwarded without attempting to identify it. Use the following basic guidelines in preparing tissue specimens for shipment:

(1) Individual tissue specimens (e.g., brain, liver, etc.) should be placed in separate plastic bags. To obtain the quantity of material required it may be necessary to distribute the individual specimens among several latex rubber or plastic bags.

(2) Blood and bodily fluids will be shipped in latex rubber bags. All air should be carefully evacuated prior to closing the bag by knotting or other means. As an added precaution, this bag should be enclosed in a second bag.

(3) Use heavy polyethylene plastic bags (.005 or .006 gauge) or latex rubber bags (condoms) as individual specimen containers. Place the specimen in the plastic or rubber bags, evacuate as much air as possible from the bag, and then heat-seal the bag, knot it, or securely fasten it with a rubber band. As an added precaution, the tissue bag should be enclosed in a second bag in which a tag with all identifying data is also placed. It is recommended that only paper labels be used in identifying frozen specimens, as plastic labels may contaminate the specimen and cause false readings. Heat-seal or fasten the second bag as indicated above, and prepare the package for shipment. DD Forms 1322 (Aircraft Accident Autopsy Report), 1323 (Toxicological Examination-Request and Report), and any other available information should be sealed in a separate plastic bag and forwarded with the specimen.

(4) It is imperative that frozen specimens and dry ice not be packed in sealed cans or any type of container which will not permit the escaping gas to pass through its walls. Dry ice is formed under tremendous pressure. It requires approximately 230,000 ml of carbon dioxide under pressure to form one pound of dry ice. The pressure created inside a sealed container is a hazard and the container may burst. Do not enclose dry ice in a thermos bottle unless holes are drilled through the stopper of the thermos.

(5) When packing for shipment, the specimen and protocols (DD Forms 1322 and 1323) should be placed in a stout cardboard box filled with pieces of dry ice and enough filler (sawdust, Styrofoam, or suitable packing) to fill and insulate the box. The box should be large enough to accommodate eight to ten pounds of dry ice for a shipping time (23 to 36 hours) and should be sealed with tape, then wrapped in several layers of heavy paper. A plastic insulated box is available in the Federal Stock Catalogue.

f. Addressing of Specimens. The packing box containing specimens for toxicological examination should be labeled, "FRAGILE – RUSH – SPECIMENS FOR TOXICOLOGICAL EXAMINATION (AIRCRAFT ACCIDENT)" and forwarded by military or commercial air freight to the Director, Armed Forces Institute of Pathology (AFIP), Washington, DC 20306. Correct destination should be clearly written to ensure prompt delivery. Send a message (TWX) notifying AFIP of: (1) time of arrival, (2) airline, and (3) flight number and airport. Place telephone number of AFIP on outside of package and ask carrier to call when material arrives. AFIP telephone numbers are: (202) 782-2100 and DSN 662-2100. Mark "Frozen Tissue" on package.

(1) The following table has been prepared to guide personnel preparing fresh tissue specimens being shipped for toxicological studies. The table gives the estimates for outside temperature, the number of hours in transit, and the amount of dry ice needed to protect the specimen until its arrival at the final destination.

OUTSIDE TEMPERATURE	TRANSIT TIME (hours)	WEIGHT OF SPECIMEN (pounds)	AMOUNT OF DRY ICE (pounds)
Below 50F	72	2	5
	48	3	4
	24	4	3
50-80F	72	2	5
	48	3	4
	24	3	4
80-100F	72	1	6
	48	2	5
	24	3	4
Over 100F	72	Not recommended for shipments over 48HRS	
	48	1	6
	24	2	5

(2) If dry ice is not available, continue to package and label as directed above. Freeze the tissue and arrange to transport the tissue specimens as expeditiously as possible to another refrigeration station until it can be delivered to the nearest naval medical facility. A chain of custody should be maintained to ensure prompt delivery and to minimize the possibility of loss or undue delay which may allow the specimens to deteriorate.

APPENDIX O
EMERGENCY MEDICAL REQUIREMENTS

SHIP CLASS	NUMBER OF BATTLE DRESSING STATIONS	NUMBER OF MASS CASUALTY BOXES	NUMBER OF FIRST AID BOXES
CG	2	1	50
DDG	2	1	40
FFG	2	1	20
LCC	3	4	63
LCS	0	2	16
LHA	4	7	80
LHA (6 Class)	4	11	90
LHD	4	9	95
LPD (4 Class)	4	5	65
LPD (17 Class)	3	5	65
LSD (41 & 49 Classes)	3	4	63
MCM	1	1	10
PC	0	1	0

APPENDIX P
NON-COMBATANT EVACUATION OPERATION (NEO) MATERIALS

The Medical Department is responsible for maintaining the following:

COG	NSN	NOMENCLATURE	U/I	LHA/LHD	LPD/LSD
9L	6505-01-0011-1464	Amoxicillin for Oral Susp, 250mg/5ml	BT	12	6
9L	6505-01-144-5318	Erythro Ethylsucc & Sulfisox for Oral Susp	BT	12	6
9L	6505-01-201-3458	Acetaminophen Oral Susp, .160gms/5ml	BT	12	6
9L	6505-01-237-0561	Electrolyte Solution Oral 8's (Pedialyte)	CS	4	2

The Supply Department is responsible for maintaining the following:

COG	NSN	NOMENCLATURE	U/I	LHA/LHD	LPD/LSD
(Locally procured)		Diaper, Disposable, 36s	PG	30	15
(Locally procured)		Baby Oil, 1/2 Pint	EA	15	8
(Locally procured)		Baby Food, Assorted, 24s	PG	18	9
(Locally procured)		Baby Formula Powder, 1/4 lb CN	CN	20	10
9D	7210-01-286-0983	Towel	EA	300	200
9G	8520-00-129-0803	Soap, Toilet, 4 oz	PG	5	2
9L	6530-00-619-8315	Cap, Nursing Bottle Nipple Protection, 12s	PG	4	2
9L	6530-00-722-0107	Bottle, Nursing, 8 oz 36s	PG	1	1
9L	6530-00-722-0115	Nipple, Nursing Bottle, Rubber, 12s	PG	12	6
9L	8415-01-156-3561	Belt, Sanitary Pad Holder, 12s	PG	3	2

APPENDIX Q
OXYGEN HANDLING AND STOWAGE PRECAUTIONS

1. Oxygen cylinders will be hydrostatically tested at a minimum of twelve years.

2. Never permit oil, grease or readily flammable materials to come in contact with oxygen cylinders, valves, regulators, gauges or fittings.

3. Never lubricate regulators, fittings or gauges with oil or other flammable substances.

4. Never handle oxygen cylinders or equipment with oily hands, greasy gloves or rags.

5. Always clear the particles of dust and dirt from cylinder valve openings by slightly opening and closing the valve before applying any fitting to the cylinder.

6. Open the high-pressure valve on the oxygen cylinder before bringing the equipment to the patient.

7. Open the cylinder valve slowly, with the face of the regulator gauge away from all personnel.

8. Never drape an oxygen cylinder with any material such as hospital gowns, masks or caps.

9. Never use oxygen fittings, valves, regulators or gauges for anything other than oxygen.

10. Never mix gases of any type in any cylinder; oxygen or other.

11. Always use oxygen from a cylinder through a pressure regulator.

12. Never attempt to use regulators that need repair or have valves that do not work properly.

13. Defective oxygen equipment should always be repaired or replaced by the manufacturer or his authorized agent.

14. All medical oxygen cylinders will be tagged with a DD Form 1191, “WARING TAG FOR MEDICAL OXYGEN”

15. Comply with all PMS and BUILDSPEC requirements for handling and storage.