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COMNAVAIRFORINST 6000.1B
N01H

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COMNAVAIRFOR INSTRUCTION 6000.1B

From: Commander, Naval Air Forces

Subj: SHIPBOARD MEDICAL PROCEDURES MANUAL

1. Purpose. To promulgate a consolidated guide to medical department procedures for Commander, Naval Air Forces (COMNAVAIRFOR) aircraft carriers (CVN).

2. Cancellation. COMNAVAIRFORINST 6000.1A.

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

4. Summary of Changes

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

(1) Chapter 2 directs to COMNAVAIRFORINST 1650.15N for amplifying information on computation for the Blue "M" award.

(2) Chapter 3 replaces the Fleet Readiness Training Plan (FRTP) with the new Optimized Fleet Response Plan (OFRP) and references COMNAVAIRFORINST 3500.20E for crew certification.

(3) Chapter 5 provides an update to reflect submission of lessons learned business rules and an updated list of minimum required standard operating procedures (SOP). Chapter 5 also removes Navy Medicine Online for submission of lessons learned, as well as TRICARE contact information and directs to download current TRICARE contact information from the link provided prior to each underway. Directs to Naval Military Personnel Manual (MILPERSMAN) articles 1910-120 and 122, and current international classification of disease (ICD) codes for the list of medical conditions under which enlisted personnel may be medically separated.

(4) Chapter 6 reflects current theater medical information program maritime (TMIP-M) capabilities.

(5) Chapter 7 reflects updated medical hold policy.

(6) Chapter 8 changes the duration for chronic medications for deployment. The controlled substances section refers to the COMNAVAIRFOR; Commander, Naval Surface Force, U.S. Pacific Fleet (COMNAVSURFPAC); and Commander, Naval Surface Force Atlantic (COMNAVSURFLANT) controlled substances SOPs for the management of controlled substances in medical and dental departments to include administration, security, material management, and Controlled Substances Inventory Board (CSIB) procedures. The laboratory section includes the new Clinical Laboratory Improvement Program (CLIP) policy.

(7) Chapter 10 is extensively revised and provides information in accordance with the Manual of Medical Department (MANMED) Navy Medicine (NAVMED) P-117 chapter 15-103 for nuclear field duty examinations and standards.

(8) Chapter 11 addresses the new electronic catalog (ECAT) process.

(9) Chapter 14 updates small craft requirements.

(10) Chapter 15 revised the title for carrier strike group (CSG) force surgeon to CSG surgeon.

(11) Chapter 18 directs to OPNAVINST 5100.19F for amplifying information with various occupational health and safety programs. In addition, changes reflect the proper name of the responsible agency for conducting initial audiograms.

(12) Chapter 19 addresses the requirement for specialty peer review for certified registered nurse anesthetist (CRNA). Updated requirement for utilization of the DoD web-based Joint Patient Safety Reporting System.

(13) Appendix B provides the new individual medical readiness (IMR) checklist.

(14) Appendix J updates surgical procedure forms.

(15) Appendix K updates the list of banned abbreviations and symbols.

(16) Appendix O updates CVN authorized medical allowance list (AMAL) lists and requirements.

(17) Appendix P updates medical department training requirements and Navy Enlisted Classification naming.

(18) Appendix Q updates small craft first aid requirements.

(19) Appendix W updates new requirements for inpatient record review.

(20) Appendix X updates new requirements for CRNA record review.

b. Changes and additions to this instruction are anticipated. It is to be emphasized that the contents of this instruction are intended to serve as functional guides, not restricting the initiative or discouraging the resourcefulness of individuals. Recommendations for changes increasing the effectiveness of this manual are encouraged and should be forwarded through the administrative chain of command and COMNAVAIRFOR (N01H).

c. Basic references throughout this instruction are revised or canceled continually. Stock numbers of medical material change frequently. Each senior medical officer (SMO) is responsible for assuring such changes are posted as they occur.

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

6. Records Management

a. Records created as a result of this instruction [notice, change transmittal], regardless of format or media, must be maintained and dispositioned for the standard subject identification codes (SSIC) 1000, 2000, and 4000 through 13000 series per the records disposition schedules located on the Department of the Navy/Assistant for Administration (DON/AA), Directives and Records Management Division (DRMD) portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx . For SSIC 3000 series dispositions, please refer to part III, chapter 3, of Secretary of the Navy Manual 5210.1 of September 2019.

b. For questions concerning the management of records related to this instruction [notice, change transmittal] or the records disposition schedules, please contact your local records manager or the DON/AA DRMD program office.

7. Review and Effective Date. Review and Effective Date. Per OPNAVINST 5215.17A, COMNAVAIRPAC N6 will review this instruction annually around the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, DoD, SECNAV, and Navy Policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will automatically expire 10 years after effective date unless reissued or canceled prior to 10-year anniversary date, or an extension has been granted.

K. R. WHITESELL

Releasability and distribution:
This instruction is not cleared for public release and is available electronically via the COMNAVAIRPAC SP portal: https://cpf.navy.deps.mil/sites/cnap/default.aspx.

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CHAPTER 1
INTRODUCTION

1. Mission. The medical department is charged with the responsibility for the prevention and control of disease and injury, and the treatment of the sick and injured. The SMO must consult with and advise the CVN CO and the CSG commander in all matters affecting the health of the crew, embarked personnel, or others as the mission dictates. To accomplish this mission, medical personnel must keep themselves informed of planned operations and anticipate any demands that may be placed upon them.

2. Purpose. This is the third edition of the shipboard medical procedures manual. This guide is intended to serve as basic information to standardize operations and provide a guide and planning tool during and beyond preparations for major deployments. It can also be used as a ready reference for situations encountered in the day-to-day function of a CVN's medical department. This instruction cannot cover every situation that may be encountered in a CVN or CSG medical department and therefore is considered a guideline that should be applied with common sense and real-time consultation as required. Type commander (TYCOM) force medical departments are available, at all times, for consultation and assistance through the entire spectrum of operations.

3. Concept of Operations

a. CVN medical departments are focused on the primary mission of providing routine, primary care and emergency response to the ship's crew. In addition, the evolving operational environment has necessitated a response to events outside normal operational boundaries (e.g. humanitarian assistance and disaster response). The introduction of joint force integration to include joint tactics, techniques, and procedures requires medical departments to adopt standardized practices and understand required capabilities across the operational spectrum.

b. Medical departments must focus on OFRP requirements defined in COMNAVAIRFORINST 3500.20E while executing medicine with the NAVMED P-117, and this instruction. Departmental training and preparation will culminate in a fully ready, joint force capable unit. Training and preparation are intended to protect the health of the crew, maintain individual medical readiness, provide primary care, and provide first response, forward resuscitation, and theater hospitalization. All duties are performed in accordance with required operational capability (ROC) and projected operational environment (POE).

4. Distance Support Concepts for Health Services. Distance support concepts will continue through direct care system support to units pierside and deployed (i.e. through consultation services provided by continental United States (CONUS) and outside continental United States (OCONUS) military treatment facilities (MTF), digital radiography, and virtual reach back via the world wide web).

a. TMIP-M. The TMIP-M is currently installed on all CVNs. This framework will host the functionality of maritime medical modules (MMM). Pierside medical care is also enhanced through Citrix access to MTF Armed Forces Health Longitudinal Technology Application (AHLTA) and Composite Health Care Systems (CHCS). This capability will precede the eventual movement to an electronic medical record.

b. Teleradiology. Teleradiology capability will continue as currently defined with radiology information systems and picture archiving and communication systems (PACS). These systems are currently in place and allow radiology reports to be read and results fed back to the ship for disposition.

5. Acronyms. A list of definitions for acronyms contained in this instruction may be found in appendix A.

CHAPTER 2
FORCE MEDICAL

2-1. Organization

1. Role of Force Medical

a. COMNAVAIRFOR is responsible for standardized policy that prepares Naval Aviation units for deployments. The mission of COMNAVAIRFOR is manning, personnel, training, equipping, and inspecting units to ensure readiness. COMNAVAIRPAC and COMNAVAIRLANT medical and dental personnel are combined at the force level for policy only. COMNAVAIRFOR Force Surgeon will represent COMNAVAIRPAC or COMNAVAIRLANT consensus medical or dental policy to Bureau of Medicine and Surgery (BUMED); COMNAVAIRFOR; Commander, U.S. Pacific Fleet (COMPACFLT); and Commander, U.S. Fleet Forces Command (COMUSFLTFORCOM). Operational execution and title 10 responsibility flows through the line chains of command.

b. TYCOM force surgeons and force dental officers are staff advisors to the line and are available for professional or administrative assistance to subordinate operating units. Force medical's role is to:

(1) Ensure provision of well-trained, effective medical departments on board CVNs through medical and administrative supervision.

(2) Provide coordination of staffing, training, and equipment for CVN medical departments, including technical review of the AMAL.

(3) Review healthcare providers' credentials, clinical privileges, and provide guidance and oversight for quality assurance programs. COMNAVAIRPAC and COMNAVAIRLANT Force Surgeons are the BUMED and COMUSFLTFORCOM designated privileging authority for their respective TYCOM.

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

(5) Conduct medical readiness inspections (MRI), medical assist visits (MAV), individual medical readiness inspections (IMRI), and any other inspections required by higher authority.

(6) Consolidate input on current and future issues facing the fleet and promulgate as required.

(7) Provide oversight for aeromedical and other health service activities on board CVNs and facilitate coordination with supporting MTF in the provision of health care.

2. Force Medical Staff. The optimal force medical staff may include the following personnel contingent on current staff funding:

TITLE	LOCATION
COMNAVAIRFOR/COMNAVAIRPAC Force Surgeon	San Diego, CA
COMNAVAIRFOR Deputy Force Surgeon	San Diego, CA
COMNAVAIRLANT Force Surgeon	Norfolk, VA
COMNAVAIRLANT/PAC Medical Admin Officer	Norfolk, VA
COMNAVAIRPAC Force Nurse	San Diego, CA
COMNAVAIRLANT Force Nurse	Norfolk, VA
COMNAVAIRPAC Force Mental Heatlh Professional	San Diego, CA
COMNAVAIRPAC Force Radiation Health Officer	San Diego, CA
COMNAVAIRLANT Force Radiation Health Officer	Norfolk, VA
COMNAVAIRLANT/PAC Environmental Health Officer	Norfolk, VA
COMNAVAIRPAC Force Corpsman	San Diego, CA
COMNAVAIRLANT Force Corpsman	Norfolk, VA
Medical Services Professional	San Diego, CA
Squadron Readiness Corpsman	San Diego, CA
Logistics Readiness Corpsman	San Diego, CA
Logistics Readiness Contract	Norfolk, VA

In addition, depending on manning, the TYCOM may have other resources, which may be utilized by shipboard medical departments. These resources include:

a. COMNAVAIRLANT. Aerospace Physiologist and Aero Medical Safety Officer (Code N453) and Industrial Hygiene Officer (Code N454).

b. COMNAVAIRPAC. Industrial Hygiene Officer (Code N454) and Aerospace Physiologist (Code N453, additional duty from BUMED M3B3).

3. Force Medical Points of Contact. Communication between CVN medical departments and the TYCOM force surgeons is essential. TYCOM force surgeons and members of their staff can be contacted via phone, e-mail, or fax at any time. Current telephone and e-mail addresses for staff members are promulgated quarterly.

4. Chain of Command. Medical department administrative and operational control relationships clearly follow those of the ship or line. The administrative connection to COMNAVAIRPAC and COMNAVAIRLANT force medical continues throughout the deployment cycle.

5. Force Medical Publications. COMNAVAIRFOR force medical publishes periodical newsletter for aeromedical professionals entitled BONES. The newsletter is an official

publication and contains articles of interest to the aeromedical community written by the TYCOM staff and selected guest authors, content from Naval messages and other items of interest, reference materials, and contact lists. Copies of BONES must be maintained for reference by each shipboard medical department.

2-2. Credentials Review and Privileging

1. Privileging Authority. To practice in the Navy, health care providers must be privileged according to current Defense Health Agency (DHA) policy for all DoD components and Military Health System (MHS). The Director of DHA has the ultimate responsibility in the establishment, direct implementation of, and ensure compliance with standards and procedures required by the DHA Procedure Manual (PM) 6025.13. The privileging authority remains delegated to each service leadership, DHA Market Director for the Navy is the Surgeon General of the Navy, until full functionality of the DHA is established. Privileging authority for the operational forces has been delegated to the force surgeon, COMUSFLTFORCOM and again one level lower to COMNAVAIRPAC and COMNAVAIRLANT Force Surgeons. Credentials review and privileging are accomplished according to DHA-PM 6025.13, COMUSFLTFORCOM/COMPACFLTINST 6320.2A, COMNAVAIRFORINST 6320.2 and as directed by COMUSFLTFORCOM/COMNAVAIRPAC/COMNAVAIRLANT Force Surgeons. Once a medical staff appointment with clinical privileges is granted by a privileging authority, a provider is eligible to request to provide health care services at all other DON and DoD medical commands using the inter-facility credentials transfer brief (ICTB).

2. Credentials Review Committee (CRC). The role, responsibilities, and membership of the CRC are outlined in the DHA-PM 6025.13 volume 3, enclosure 3, COMUSFLTFORCOMINST/ COMPACFLTINST 6320.2A, and COMNAVAIRFORINST 6320.2. The CRC provides a review of the credentials prior to privileging, quality assurance of the medical records, and case review as required. Recommendations for privileging from the CRC are forwarded to their respective, COMNAVAIRPAC or COMNAVAIRLANT Force Surgeon for action. The CRC also has a role to enhance medical care by developing clinical practice guidelines, evaluating, and improving the processes of delivering medical care in the operational environment.

3. Medical Executive Committee (MEC). COMUSFLTFORCOM/COMPACFLTINST 6320.2A outlines the responsibilities of the COMUSFLTFORCOM MEC. MEC oversees the credential review and privileging process, provides support to TYCOM surgeons to include TYCOM specific policy and procedure review, and reviews and provides recommendations to the COMUSFLTFORCOM Fleet Surgeon on adverse privileging actions. MEC will also review privileging applications for TYCOM surgeons and numbered fleet surgeons.

4. Clinical Privileging Requirements

a. All licensed clinical providers reporting for permanent duty to COMNAVAIRFOR commands must apply for privileges in accordance with COMNAVAIRFORINST 6320.2. After

receipt of the provider's application, the electronic individual credentials file (e-ICF) and all supporting documents, the medical service professional (MSP) reviews and verifies the applicant's credentials. The MSP will then, forward the electronic application package to the assigned levels of credentials reviewer committee and then to the privileging authority for final approval. Notification of privileges granted is sent to the provider through the Joint Centralized Credentialing Quality Assurance System (JCCQAS) and the provider replies by acknowledging the approval. The MSP forwards a copy of the approved privileges to the unit SMO for notification and to include in the provider's command activity file (CAF).

b. Temporary additional duty (TAD) personnel will be granted permission to exercise their clinical privileges using an ICTB, as stated in paragraph 6 of this chapter. For providers under the same privileging authority, in the case of squadron flight surgeons of COMNAVAIRFOR units, a copy of their current privileges will be provided to the SMO of the receiving unit to include in their temporary CAF.

c. Operational Medicine Training Requirements

(1) All active medical and allied health providers are responsible for maintaining current basic life support (BLS) certification in accordance with the current military training network (MTN), DoD, and BUMED standards.

(2) Prior to arrival at an aviation unit or command, advanced life support (ALS) training is required of all medical corps officers, physician assistants (PA), nurse corps (NC) officers, and independent duty corpsmen (IDC). Subject to operational commitments, medical officers reporting without ALS or BLS certifications are required to obtain training at the earliest opportunity. Continued currency or re-certification of ALS is required in accordance with BUMEDINST 1500.15F.

(3) Advanced trauma life support (ATLS) training is required of all shipboard medical corps officers and PAs. Medical providers reporting without ATLS training are required to attend a local ATLS program or the combat casualty care course (C-4) at the earliest opportunity. Continued currency and re-certification of ATLS is required in accordance with BUMEDINST 1500.15F.

5. Electronic-Individual Credential File (e-ICF)

a. e-ICFs are maintained at COMUSFLTFORCOM for COMNAVAIRLANT-based units and at COMNAVAIRFOR for COMNAVAIRPAC-based units. An electronic copy of all credentials is maintained in JCCQAS, a web-based credentialing database. A duplicate hard copy of the entire file is no longer required and maintained on board. However, credentialing CAF will be maintained by the unit SMO, or by his designated credentials coordinator, for each

provider on board. The file will contain a copy of the electronically approved application for privileges (snapshot) to include a list of core and non-core privileges granted and other requirements listed in paragraph 7 of this chapter. It is the responsibility of each provider to apply for privileges and forward to the MSP any updated, new, or changed documents, and certifications during their assignment to a COMNAVAIRFOR unit. The provider is responsible for providing accurate and current evidence of professional qualifications. The MSP's mailing address is:

(1) For COMNAVAIRLANT-based units:
Commander, U.S. Fleet Forces Command (N01H)
1562 Mitscher Ave STE 250, Norfolk, VA 23551-2487
The MSP can be reached at DSN 836-5929 or commercial (757) 836-5929.

(2) For COMNAVAIRPAC-based units:
Commander, Naval Air Forces (N01H)
Box 357051, NAS North Island
San Diego, CA 92135-7051
The MSP can be reached at DSN 735-1148 or commercial (619) 545-1148.

6. Inter-facility Credential Transfer Brief (ICTB). Providers from other privileging authorities must be privileged by their parent command. A document containing the information required in granting privileges in accordance with DHA-PM 6025.13 must be forwarded from the permanent command to COMUSFLTFORCOM (N01H) for COMNAVAIRLANT units and COMNAVAIRFOR (N01H) for COMNAVAIRPAC units for processing and referral to the appropriate privileging authority for granting of clinical privileges (see paragraph 5a (1) and (2) of this chapter for the appropriate addresses). The MSP will request an ICTB for reserve component providers from the Centralized Credentialing and Privileging Directorate of the Bureau of Medicine and Surgery Detachment (BUMED-CCPD), Jacksonville, Florida. The TYCOM privileging authority is tasked with the responsibility of granting clinical privileges based on the information provided in the ICTB. When approved, the staff appointment letter and supporting privileging documents will be forwarded, granting permission for the provider to exercise privileges during their assignment to a COMNAVAIRFOR unit.

7. Submission of Performance Appraisal Report (PAR) and Compliance with Professional Practice Evaluations. A PAR is required upon renewal of privileges every two years, renewal after year of initial appointment with privileges, detachment from COMNAVAIRFOR, and for all periods of clinical care exceeding four days for TAD or deployed providers. Clinical competency must be addressed on the PAR in Section 9 for core privileges and each supplemental privilege granted in section 10. The PAR must be submitted as soon as possible to the appropriate MSP (COMNAVAIRLANT to COMUSFLTFORCOM and COMNAVAIRPAC to COMNAVAIRFOR), prior to the departure of the provider being evaluated and 45 days prior to privilege expiration. The PAR becomes part of the e-ICF by uploading a complete signed copy in the documents section. Failure to submit PARs in a timely manner may result in a delay

of privileges. Focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) will be completed and maintained on each provider aboard CVNs in the CAF. An FPPE is required for all privileged providers new to COMNAVAIRFOR units and should be completed within three months but not to exceed six months. An OPPE must be completed on each provider at least every six months on the first of October and first of April for the preceding six months period not to exceed eight months. FPPE and OPPE compliance will be evaluated during MRI.

Note: SMO PAR, FPPE, and OPPE must be forwarded to their respective TYCOM, COMNAVAIRLANT or COMNAVAIRPAC Force Surgeon, for signature.

2-3. Inspections, Certifications, and Assist Visits (ICAV)

1. Crew Certification. Crew certification is the process by which the CSG commander or immediate superior in command (ISIC), supported by COMNAVAIRPAC, COMNAVAIRLANT, and the Afloat Training Group (ATG), ensures a ship is ready to proceed safely to sea with a qualified crew. At the ISIC's request, force medical will assist with crew certification visits. Crew certifications (phases 1, 2, and 3) are conducted on board all COMNAVAIRFOR ships upon completion of new construction or after a maintenance period, as required. Chapter 3 of COMNAVAIRFORINST 3500.20E provides additional information regarding crew certification. Training assessment cards (TAC) provide a checklist and scoring tool that identifies specific criteria for medical department crew certification visit.

2. Medical Readiness Inspection (MRI)

a. The MRI is a comprehensive, formal administrative and material inspection conducted by force medical to determine the readiness (C-status) of the medical department. It is intended to assess whether the medical department is manned, equipped, and trained to carry out its assigned functions and tasks, and whether it is "ready for tasking or deployment." It includes a determination of whether the medical department is responsively complying with directives from higher authority. The MRI occurs at least once in accordance with OFRP and is usually conducted approximately 3 months prior to deployment. The periodicity of MRIs will be adjusted based on changes in the OFRP. In accordance with COMNAVAIRFORINST 3500.20E and COMNAVAIRFORINST 1650.15N, the MRI is part of the Blue "M" and Battle Effectiveness (Battle "E") awards.

b. Force medical will conduct an MRI of each COMNAVAIRFOR CVN. A standardized assessment guide used by inspection teams to conduct the MRI is updated annually and can be obtained from their respective TYCOM. The checklist is comprised of six sections:

(1) Section A – Administration and Training

(2) Section B – Supplies and Equipment

(3) Section C – Emergency Medical Preparedness

(4) Section D – Ancillary Services

(5) Section E – Force Health Protection

(6) Section F – IDC Program Management

c. Each section, as well as the overall inspection, will be assigned a C-status based upon the following criteria:

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

(2) Overall MRI C-status is determined by averaging the percentage scores of sections A through F. C-status assignment is as follows:

(a) C-1	Fully Ready	>=90%
(b) C-2	Substantially Ready	>=80%
(c) C-3	Marginally Ready	>=75%
(d) C-4	Not Ready	<75%

d. The senior evaluator will verbally debrief both the SMO and the CO at the conclusion of the inspection. A final written report containing the MRI checklist and written comments from the inspection team will be forwarded to the ship's CO from the TYCOM. Items identified as C-3 or C-4 in the report will be followed up by the inspection team to ensure they are corrected prior to deployment.

3. Individual Medical Readiness Inspection (IMRI)

a. The purpose of this inspection is to determine and validate the level of medical readiness of the ship's personnel and to evaluate the effectiveness of the periodic health assessment (PHA) program and birth month recall program. Force medical will conduct this inspection on an annual basis aboard each CVN. This inspection may be conducted concurrent with a regularly scheduled MRI. If no MRI is scheduled for the calendar year, a separate IMRI will be conducted. The inspection will consist of a review of a minimum of 120 randomly selected records (TMIP and hard copy medical records). Areas to be reviewed and scored include the PHA, dental readiness, medical readiness immunizations, medical readiness laboratory studies, individual medical equipment, and deployment limiting conditions. Other areas to be reviewed at the force surgeon's discretion include audiograms, occupational health physicals, women's

health exams, and annual health record verification. The current IMRI checklist is attached as appendix B. This checklist is updated annually. Check with TYCOM for the current version.

b. Medical department shall assess all personnel annually. In addition, personnel checking in and out of a command must process through the medical department. The IMRI has been proven to be effective in maintaining and monitoring overall medical readiness. The program requires command-wide support.

c. To facilitate annual assessments, all personnel must report to medical annually during their respective birth month. SECNAVINST 6120.3A details IMR and the PHA process. See chapter 2, section 3, paragraph 4 of this instruction for information regarding the PHA.

d. The ship is considered medically ready when the crew reaches the cumulative percentage of 90 on the IMRI, as determined by the percentage of fully medically ready Sailors.

e. Department heads will be notified prior to the beginning of each birth month of personnel requiring annual medical readiness verification. Department heads will also be notified of personnel failing to complete their birth month medical evaluation and verification. Each department aboard the ship must appoint a birth month recall liaison representative to facilitate the completion of all medical requirements.

f. The TMIP must be used to track and manage all medical readiness and immunization requirements for all command personnel. Using the IMR, PHA, and basic medical requirement indicators (e.g., immunizations, tuberculin skin test, human immunodeficiency virus (HIV), deoxyribonucleic acid, audiogram, PHA, and annual record verification), a monthly summary of the overall crew medical readiness will be generated and reported in the monthly medical quality assurance report.

g. Pre-deployment health assessment, post-deployment health assessment, and post-deployment health reassessment will be conducted in accordance with current directives and instructions (DoDI 6490.03, Deployment Health, 11 Aug 06) or any updated version.

4. PHA

a. According to DoDI 6025.19, the PHA is one of six components of IMR. The Navy supporting directives are detailed in SECNAVINST 6120.3A.

b. The purpose of the PHA is to consolidate medical, occupational health, and risk screening services; medical record review; preventive counseling; and risk communication under one annual assessment for all active duty service members.

c. All service members will receive their PHA on an annual basis preferably during their birth month. Commands may elect to follow another mechanism of assuring annual assessment.

d. Documentation of the PHA will be placed on the DD Form 2766 and NAVMED Form 6120/4. Units are encouraged to utilize programs to populate an electronic version of DD Form 2766. Additionally, program guidance or best practice examples are available from the Navy and Marine Corps Public Health Center website, https://www.med.navy.mil/sites/nmcphc/epi-data-center/Pages/periodic-health-assessment.aspx.

5. Site Visit. A site visit request is an informal readiness assessment, which focuses on a specific area or areas for improvement in preparation for an MRI. The subject matter expert (SME) usually conducts the site visits in the specific areas requested. An informal debrief will be provided to the SMO. A site visit can be requested at any time. Arrangements may be made by e-mail to the COMNAVAIRPAC or COMNAVAIRLANT force surgeons, or to the assigned TYCOM's SMEs. A site visit may be conducted at the discretion of the COMNAVAIRPAC or COMNAVAIRLANT force surgeons at any time.

6. Medical Assist Visit (MAV)

a. This form of readiness assessment focuses on identifying areas for improvement in preparation for an MRI. A written debrief will be provided to the SMO. The CO or executive officer (XO) may also be provided a verbal or written debrief if desired, or if the inspecting senior evaluator deems it necessary. The MAV should be scheduled no more than 90 days prior to an MRI. Arrangements may be made, with the approval of the ship's CO, by e-mailing COMNAVAIRPAC or COMNAVAIRLANT force surgeons.

b. Individual sub-sections of the MAV that are fully ready (C-1) may, at the discretion of the respective force surgeon, count toward the MRI and not be re-inspected. Sections, which are not fully ready, will be inspected during the subsequent MRI.

7. Battle "E" Required Sub-Event

a. The COMNAVAIRFOR CVN Battle "E" competition is designed to measure and recognize the level of battle effectiveness through superior performance and readiness by each carrier and its respective departments. The competition is based on a calendar year. Eligibility for the overall Battle "E" and departmental awards demands demonstrated operational excellence in addition to superior achievement during inspections, certifications, assessments, and qualifications, and training events conducted throughout the competitive cycle. See COMNAVAIRFORINST 1650.15N for explanation of calculation.

b. Ships should coordinate with TYCOM and ATG teams to take advantage of SMEs to grade Battle "E" required sub-events during training or assessment visits. Additional instructions of a general nature follow:

(1) Battle "E" required sub-event grading must be graded by ATG or an external agency approved by the TYCOM in accordance with COMNAVAIRFORINST 3500.20E. Observers

must be carefully chosen based on seniority, technical background, and experience and must not be assigned to the ship or its associated air wing.

(2) Battle "E" required sub-event scoring for all Battle "E" events must be conducted per applicable TACs to the major combat operations (MCO) standard. Battle "E" required sub-events will be calculated using the most recent 'P' score reported by an authorized external assessment agency (e.g. ATG or CSG (if authorized by the TYCOM)). Completion of Battle "E" required sub-events must be reported to the TYCOM via naval message.

(3) Ships in an operational status for 180 days or more must complete all required exercises. Battle "E" required sub-events not completed during the competitive cycle will be scored "zero" unless waived by the TYCOM. A request for waiver must not be submitted prior to the fourth quarter of the competitive cycle and will require justification that all means were exhausted in accomplishing the requirement. CSG endorsement will indicate efforts expended to assist the ship in obtaining opportunity, observers, or services to meet the requirement. If the TYCOM grants the waiver, the event will be computed as an average of the grade submitted by other competitors (fleet average). If the event is not waived, it will be considered incomplete and will be scored "zero" and counted accordingly in the computation for relative standing. Except in unusual circumstances, waiver request received by the TYCOM later than 15 days after completion of the competitive cycle will be disapproved.

(4) Carryover of Unit Level Training (ULT) Events and ICAV Scores. Due to the structure and timing of the OFRP, ships will not always conduct ULT events or receive inspections and certifications (not counting re-inspections) normally factored into calculations each calendar year. In these instances, scores from the previous cycle completion will be carried over provided they remain within the periodicity specified in the training and readiness (T and R) matrix and applicable governing instructions.

8. Other Major CVN Inspections and Assessments. The following lists other inspections, or assessments conducted during the OFRP for all CVNs:

Inspection or Assessment	Inspectors	Directives
Command Assessment of Readiness and Training (CART) CART I - Conducted prior to ship's return from deployment. Internal event to assess the inter-deployment period. A proposed schedule of major events and comprehensive training plan are developed. CART II - Appraisal of readiness for training by the CO, ISIC, and ATG with TYCOM support after the ship's FRP maintenance period.	ATG or TYCOM	COMNAVAIRFORINST 3500.20E

Inspection or Assessment	Inspectors	Directives
Tailored Ships Training Availability (TSTA) TSTA I through III- Intensive training periods following CART. The final evaluation period (FEP) is held during the last three days of TSTA III.	ATG or TYCOM	COMNAVAIRFORINST 3500.20E
Pre-critical Reactor Safeguards Examination Conducted on CVNs only prior to initial criticality of newly installed reactor core.	Director, Naval Nuclear Propulsion	
Post-overhaul Reactor Safeguards Examination (PORSE) Conducted on CVNs only prior to initial reactor operation during shipyard availability.	Naval Nuclear Propulsion Examining Board	COMNAVAIRFORINST 3540.5
Operational reactor safeguards examination (ORSE) Conducted on CVNs only within one year of last pre-critical or PORSE and within 3 months of the anniversary of the last ORSE.	Naval Nuclear Propulsion Examination Board	COMNAVAIRFORINST 3540.5
Inspection and Survey (INSURV) Conducted every five years. Determine and report ship's fitness for further service and identify material conditions which limit capability to carry out assigned missions.	Board of Inspection and Survey	OPNAVINST 4730.5R
Crew Certification Conducted following shipyard periods greater than six months.	ATG or TYCOM	COMNAVAIRFORINST 3500.20E
Radiological Affairs Support Program (RASP) inspection Conducted every 3 years. Inspection of aircraft intermediate maintenance department (AIMD) Radiation (RAD) health program.	Radiological Affairs Support Office (RASO)	NAVSEA 04 NAVMED P-5055 NAVSEA S04020-AA-RAD-010
Flight deck certification Flight deck physical examinations and hospital corpsman (HM) personnel qualification standard (PQS) as flight deck observer.	TYCOM	COMNAVAIRFOR INST 3500.71C NAVMED P-117, 15-65
Nuclear Propulsion Mobile Training Team (NPMTT)	Air or Sub TYCOMs	NAVMED P-5055 COMNAVAIRFOR INST 6470.5

Inspection or Assessment	Inspectors	Directives
Training and assessment audits of RAD health program on CVN only. Conducted prior to ORSE or PORSE.		

2-4. Battle "E" Departmental Award

1. Medical Department Award (Blue "M"). The Blue "M" is awarded annually for outstanding medical readiness. It is awarded each calendar year based upon prior fiscal year data. Multiple recipients are possible. The Blue "M" is one of the departmental awards that count towards the overall CVN Battle "E" award.

2. Blue "M" CVN Award Computation. Criteria for determining awarding of the Blue "M" can be found in COMNAVAIRFORINST 1650.15N.

CHAPTER 3
AIRCRAFT CARRIER EMPLOYMENT TRAINING CYCLE

3-1. Background

1. OFRP. The OFRP was designed to meet the requirements of the fleet training continuum. The OFRP is a flexible and scalable approach to training, which is managed by TYCOM during the maintenance and basic phase and by COMUSFLTFORCOM and COMPACFLT during the integrated and sustainment phases. The OFRP aligns Navy capabilities and missions, in support of combatant commander and Navy requirements. OFRP requirements are defined through fleet training instructions. The OFRP ensures naval capabilities are aligned with mission essential tasks and potential operational tasking. A complete explanation of the OFRP, including diagrams that explain the OFRP events, is outlined in COMNAVAIRFORINST 3500.20E, chapter 3.

2. Forward Deployed Naval Force (FDNF). The ORFP ensures naval capabilities are aligned with mission essential tasks and potential operational tasking. By nature of location, the FDNF CVN has different training opportunities available compared to CONUS units. Forward deployed operations tempo (OPTEMPO) affords opportunities to maintain tactical proficiency through dedicated training events in conjunction with regional and exercise commitments. Therefore, the FDNF CVN remains within the sustainment phase and complies with the requirements of this phase as specified in T and R matrix in support of the overarching Commander, U.S. SEVENTH Fleet training plan. FDNF training is discussed in detail in chapter 8 of COMNAVAIRFORINST 3500.20E.

3-2. Maintenance

1. Guidelines for Depot Level Maintenance Availability

a. Introduction. Availability periods for maintenance and modernization are a routine experience for the ship. A short (three to six months) shipyard period poses a significant distraction to the function of the medical department. A long (one to three years) shipyard period may necessitate relocation of the medical department off-ship to a floating accommodation facility (FAF) and result in the complete redesign or reconstruction of departmental spaces. The preparation requirements for shipyard periods begin long before the ship conducts a berth shift to the shipyard. Planning 6 to 12 months ahead of time (three or more fiscal years in the case of complex over-haul or refueling complex over-haul (RCOH) due to the requirement for early dedication of significant financial and material resources) is essential for a successful availability period. Advance liaison with the ship's maintenance manager is essential to ensuring the inclusion and prioritization of medical department deferred maintenance and alteration actions in the current ship's maintenance project. Refer to OPNAVINST 4790.4F for guidance on the submission of deferred maintenance actions via the ship's maintenance action form, OPNAV Form 4790/2K. Medical department planning personnel must be knowledgeable

with the Organizational Maintenance Management System-Next Generation (OMMS-NG). The work package is derived from this system and it tracks all work during the yard period.

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

c. Medical Surveillance Programs

(1) General. During any shipyard period, there will generally be an increase in personnel placed in the hearing conservation, sight protection, and respiratory protection programs. The industrial hygiene officer (IHO) should identify personnel that, due to yard status, may fall into a different or additional occupational health surveillance programs. Personnel should receive appropriate physical examinations prior to arriving in the shipyard. Personnel requiring specific physical examinations must be identified by the IHO, based on their evaluation of work center functions and process data. Most medical surveillance programs will continue during the yard period as identified in the industrial hygiene baseline survey. However, special or additional physical examinations may be required for unique overhaul requirements such as asbestos rip outs and gasket repairs, lead-based paint removal, ventilation duct cleaning, void rehabilitation teams, fire watch teams, and habitability improvement. Good communication between departments is essential, both at the leading chief petty officer (LCPO) and department head levels. Department organization must identify Sailors exposed to hazards and referred or recalled by the medical department for care. Continuous monitoring by birth month recall and keeping TMIP rosters and follow-up of "no-shows" are essential for maintaining a successful program.

(2) Hearing Conservation. The ship’s audiometric booth should be certifiable for in port, flight operations and “at-sea”. Usually, the ship’s audiometric booth is not certifiable while in the shipyard. Excessive noise on the hangar bay makes it almost impossible to perform audiograms. If possible, arrangements should be made with shipyard personnel to avoid noisy or vibrating machinery from being placed directly over medical spaces. Refer to the IHO or the local MTF for support services.

(3) Collecting Holding and Transfer (CHT) and Potable Water Supply Problems. CHT and potable water services are occasionally interrupted. It is wise to have a contingency plan if these services are disrupted, such as, a plan for the availability and access to water from other locations for proper hand washing. If accessible, the potable water tank located in the main battle dressing stations (BDS) can also be utilized. Potable water supplied onboard should

continue to be tested for halogen residual and bacterial contamination by preventive medicine technicians.

(4) Preventive Medicine Inspections. The CO and department heads should be advised that certain sanitation and habitability inspections might be reduced or not conducted as spaces are being reworked or are inaccessible.

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

2. Healthcare During Availability

a. Continue to provide the full range of health care for ship's company, except for inpatient care. Medical sick call, routine appointments, and physical examinations continue, and may increase, due to the stress of the shipyard environment. Consultations to MTFs continue to require management and may be more difficult, since shipyards may be far from the supporting MTF. The medical response teams (MRT) continue to be important for crew and worker safety, but patients will usually be turned over to shore facilities for treatment. Advance liaison with any shipyard health care assets should include discussions about maintaining medical control of medical emergencies on the ship and procedures for turning over a patient to responding medical personnel. Advance liaison with the local MTF for ancillary services support should also be considered if necessary.

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

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

d. MRT Emergencies and Deep Extrications. Most deep rescue victims provide unique rescue circumstances. Coordination with the damage control assistant (DCA) to obtain deep rescue drill training prior to entering the shipyard is prudent. A team, as designated by the ship’s standard organization regulations manual (SORM), must be formed with the necessary expertise, to include riggers, and other required personnel according to chapter 14, section 2, paragraph 7d. Each medical department watchstanding team must have one staff member trained to provide

medical support and assistance in the event of a deep rescue extrication. Additional coordination will need to be established with the local emergency medical system.

e. Reactor Work and Effect on Main Medical and Dental. During reactor refueling, the entire health service department will be completely removed to allow access to the reactors. Health care will be provided onboard the FAF. Extra effort may be required to maintain IMR, occupational health surveillance programs, and ship-wide support programs. The shipyard has teams that respond to nuclear contamination incidents. Ship's force will need to coordinate efforts with the shipyard's response teams.

f. Medical Department Maintenance and Modernization

(1) Shipyard Liaison and Tracking of Maintenance Actions. Establish liaison with the availability project team and work centers performing ship's force maintenance actions in medical spaces. Interface, on a regular basis, with shipyard personnel who are performing maintenance and alterations. Ensure accurate tracking and timely follow-up of all medical department maintenance actions. Even with persistent daily tracking, be prepared for numerous delays. Ensure maintenance actions have been screened for accuracy and reviewed by the medical department representative (normally the departmental Material and Maintenance Management (3M) system assistant) prior to close-out or acceptance. Once accepted, any further action to repair or replace faulty equipment or perform additional work will, most likely require additional expenditure of scarce funds. Any action that causes a work stoppage may have similar effects.

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

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

(4) Anticipating Potential Problems. Anticipating work in other areas of the ship may impact work done (or not done) in medical department spaces (e.g., hot work being done in spaces above, below, or adjoining medical spaces could cause resulting damage to existing decks, paint, equipment, etc.; or work being done by shipyard personnel in medical spaces may delay medical department rehabilitation efforts until completed). Equipment not properly prepared or protected for storage or subjected to unexpected environmental conditions may

become irreparably damaged and require force medical assistance for emergent procurement action. This equipment damage should be preventable if proper inactive equipment maintenance (IEM) procedures are followed, in accordance with OPNAVINST 4790.4F, and the equipment is properly secured or protected. Unexpected shipyard delays may result in medical moving back on board the ship immediately preceding the ship's departure from the yards. This delay may allow little time for spaces to set up, cleaned, and stocked for return to sea. Also, anticipate the potential for the AMAL to become severely depleted during an availability period, especially if supplies are moved off the ship and expired shelf life items have not been routinely surveyed and reordered. A complete AMAL will be required when the ship leaves the shipyard and returns to normal operations.

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

(1) Equipment and Supplies. In preparation for going into the shipyard for RCOH, the medical department will be required to package, inventory, sort, and remove all equipment and supplies for storage, redistribution, or disposal. The majority of the medical department will be required to conduct this event. Equipment and supplies will be transferred to temporary storage (if pending FAF availability), long term warehouse storage (anything that will be returned to the medical spaces when the department is put back together at the end of RCOH), or Defense Reutilization Management Office (DRMO) for disposal. Ensure proper IEM procedures are followed, in accordance with OPNAVINST 4790.4F, for equipment that will be inactivated for periods of prolonged idleness (i.e., equipment designated for long-term storage). Ensure proper accounting for all emergency supplies distributed throughout the ship such as first aid boxes (FAB), mass casualty boxes, and report on the monthly quality assurance report as directly by TYCOM.

(2) Medical and Dental Care

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

(b) Emergency Care. At least one MRT will be maintained on board for the provision of emergency care. Emergency care will be coordinated with the shipyard and regional emergency medical system.

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

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

(1) 12 Months Prior to Entering the Yard

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

(b) Thoroughly review OPNAVINST 5100.19F and OPNAVINST 5100.23G CH-1 requirements for the hearing conservation program, respiratory protection program, lead medical surveillance, isocyanates, CHT systems and spills, heat stress program, asbestos medical surveillance program, polychlorinated biphenyls, and other programs.

(c) As appropriate be involved in overhaul issues.

(2) 9 to 12 Months Prior to Entering the Yard

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

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

(c) Train LCPOs, division officers (DIVO), and department heads in the requirements for different occupational health programs.

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

(3) 6 to 9 Months Prior to Entering the Yard

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

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

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

(4) 3 to 6 Months Prior to Entering the Yard. Construct database for assigned personnel.

(5) 0 to 3 Months Prior to Entering the Yard

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

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

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

(d) Try to arrange "one stop" occupational health physical examinations and ensure that the medical officer is allotted adequate time to see personnel using appointments.

3. Crew Certification. Crew certification is the process by which the ship's ISIC, supported by the TYCOM and the ATG, ensures the crew is qualified and the carrier is ready to proceed safely to sea following a maintenance or new construction. Crew certification, fast cruise, sea trials, and shakedown evolutions are outlined in chapter 3 of COMNAVAIRFORINST 3500.20E**.**

CHAPTER 4
ORGANIZATION AND PERSONNEL

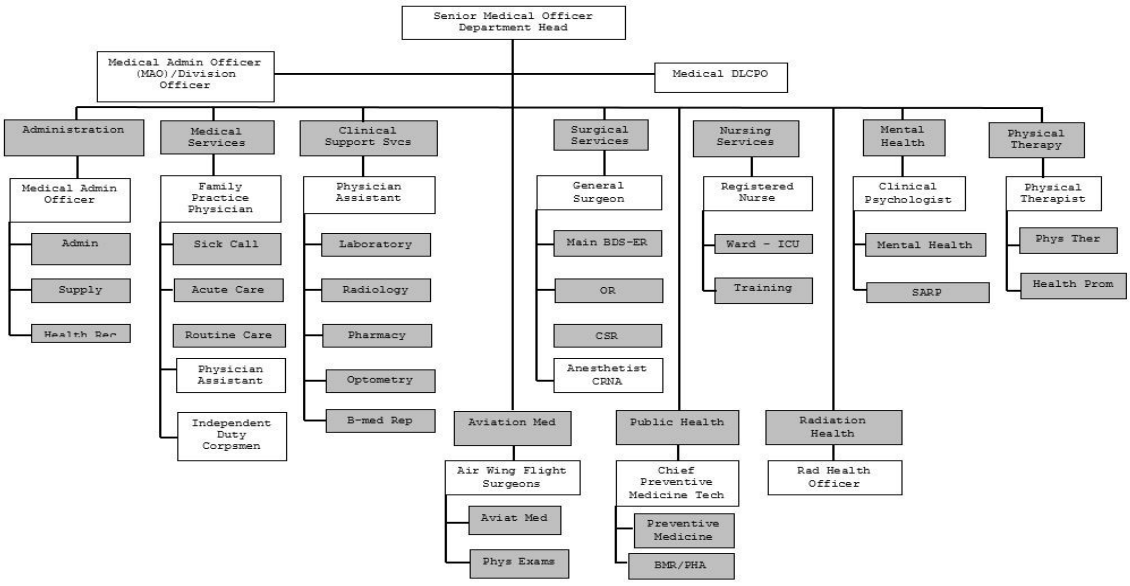
1. Medical Department Organization

a. The ship's medical department organization must be documented in the ship's SORM or in a departmental SOP and must delineate the organization, chain of command, duties, and responsibilities of each functional area or significant position within the medical department. This document will include job descriptions for all medical department personnel.

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

c. The ship's medical department organization guidance should contain a diagram outlining the organizational relationships that exist within the department and the chain of command. Figure 4-1 shows a recommended medical department organization chart. Medical providers performing patient care services have responsibility for the work done in their sections; however, the coordination of watch bills, training and disciplinary functions necessitates coordination between the various divisions. The medical administrative officer and department leading chief petty officer (DLCPO) generally accomplish this coordination. The DLCPO, as the senior enlisted member of the department, remains as the de facto primary mentor and career counselor to all enlisted assigned to the medical department. It is important for supervisors to work together to ensure the efficient, effective deployment of staff and to contribute to fitness reports and evaluations.

Figure 4-1 Recommended Medical Department Organization.



2. Manning. Manning for each ship's medical department may be found within the activity manning document (AMD). This document lists all billets and associated subspecialty codes and Navy Enlisted Classification (NEC) codes for both officer and enlisted personnel. A listing of typical billets authorized for CVN medical departments may be found in appendix C. All unplanned losses of medical department personnel must be reported to the TYCOM force medical office (refer to section 7 of this chapter) for requesting TAD medical personnel support). A monthly review should be completed and any shortfalls should be reported to TYCOM force medical the third week of each month. This will allow TYCOM force medical to prioritize billets with TYCOM N1.

3. Duties, Cognizance, and Qualifications

a SMO and Carrier Strike Group Surgeon. The head of the medical department aboard a CVN must be a designated flight officer preferably board-certified in aerospace medicine and a designated naval flight surgeon. In addition to those general duties prescribed by Navy Regulations for a department of the crew, conducting inspections incident thereto and advising the CO as to the hygiene, habitability, sanitation, and safety matters within his or her purview which affect the command. SMO must additionally be responsible for the administrative and material readiness of the medical department. The SMO reports to the CO in matters related to the health or well-being of the crew, keeping the XO appropriately informed. The SMO reports to the XO in matters related to the administration of the medical department and reports to the embarked flag or chief of staff in health matters of CVN strike group cognizance. The SMO must:

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

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

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

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

(5) The medical department will ensure that supplies and equipment are ordered, inspected, and accounted for. (see chapter 11, which outlines these responsibilities)

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

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

(8) Report to the embarked flag or chief of staff for additional duties as CSG surgeon. Areas of interest are medical intelligence; disease, outbreaks, and emerging infectious disease in the area of responsibility (AOR); fatigue operations; and chemical, biological, radiological, nuclear, and explosives (CBRNE) threats. National Center of Medical Intelligence (NCMI), formerly known as Armed Forces Medical Intelligence Center must be utilized in preparation for deployment and during deployment to receive unclassified, for official use only, classified, secret, and top secret intelligence.

(9) Establish policies and procedures for the administration of the medical department in accordance with current directives.

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

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

(12) Ensure appropriate medical monitoring of personnel exposed to environmental hazards as identified by the safety department.

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

(14) Prepare the initial drafts of fitness reports for all officers assigned to the medical department, including input to the carrier air wing (CVW) commander for air wing flight surgeons (when embarked).

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

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

(17) Comply with decedent affairs and relevant guidance, in accordance with NAVMEDCOMINST 5360.1.

(18) Ensure preventive medicine technicians (PMT) provide training in shipboard pest control procedures for selected medical and supply department personnel and maintain a pest control program.

(19) Per OPNAVINST 3120.32D, ensure medical department personnel are assigned only to duties related to patient care or to the administration of directly related facilities. This does not preclude assignment as a member of courts-martial, audit, inventory, interview boards, and, if workload permits, duties that are required for warfare specialty qualifications.

(20) When appropriate, obtain samples or specimens to detect the possibility of biological attack and advise and assist the damage control assistant (DCA) in decontamination resulting from biological agents.

(21) When directed, perform competence for duty examinations and report the findings to the CO.

(22) Ensure all medical equipment and supplies that comprise AMALs are maintained on board and submit AMAL change requests (ACR) to TYCOM for any additions or deletions.

(23) Consult with the senior dental officer on patients requiring joint medical and dental care.

(24) Maintain an effective health promotion program, emphasizing preventive medicine practices to reduce the risk of illness and disease and improve the overall wellness of the ship's crew and their families.

(25) Assign the following collateral duties to specific medical department officers:

(a) Overseas screening program coordinator.

(b) Exceptional family member program coordinator.

(c) Health promotion program coordinator (assigned in writing by the CO).

(d) Quality assurance coordinator (QAC).

(e) Quality assurance physician advisor (QAPA).

(f) Professional credentials coordinator.

(g) Patient contact representative.

(h) IDC physician supervisor (coordinate with COMNAVAIRLANT and COMNAVAIRPAC force surgeons and privileging authority MSP).

(i) Infection control officer.

(j) Bloodborne pathogen program coordinator.

b. Ship's Surgeon. The ship's surgeon must be a medical corps officer who has completed residency training in general surgery, and holds an active staff appointment with clinical privileges in general surgery. The ship's surgeon reports directly to the SMO. The surgeon is responsible for the evaluation and management of all patients with potential surgical pathology. The ship's surgeon may also serve as the ward medical officer. When in port for extended periods of time, the ship's surgeon must work at a local MTF with surgical services in order to maintain his or her surgical skills. The surgeon will report back to the ship at least one week prior to any underway periods. The surgeon is responsible for obtaining appropriate clinical privileges coordinated through the medical services professional (MSP) of the appropriate Privileging Authority (COMUSFLTFORCOM or COMNAVAIRFOR) by requesting an ICTB submitted to the local MTF to apply for privileges. These duties must not interfere with the surgeon's primary responsibility to the CVN. Specifically, the ship's surgeon must:

(1) Assist the SMO in the performance of his or her duties and make recommendations concerning surgical policies, standards, and practices in the functioning of the medical department.

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

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

(4) Supervise the functioning of the operating room and all phases of care for surgical and trauma patients.

(5) Ensure the emergency room and operating room are in a constant state of readiness to receive casualties from any disaster aboard the ship or from other sources.

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

(7) Support medical department mission accomplishment by assuming additional duties as assigned by the SMO. These additional duties may include the following:

(a) Be present during sick call in the department and available for consultation.

(b) Stand on-call duty as assigned by the SMO or departmental watch coordinator.

(c) Assist with education of medical departmental staff by supporting educational efforts during drills to include: general quarters, mass casualty, and medical response drills.

c. Anesthesia Provider. The anesthesia provider may be either a medical corps anesthesiologist, or a nurse corps certified registered nurse anesthetist (CRNA) assigned TAD from a designated MTF to support CVN underway periods if no provider is assigned on the authorized manning document. The anesthesia provider reports to the SMO. Specifically, the anesthesia provider must:

(1) Provide general anesthesia or monitored anesthesia care for all elective and emergency operative cases requiring anesthesia.

(2) Provide consultation regarding the perioperative care of patients, including intensive care unit (ICU) management and pain control issues.

(3) Report to the medical department (or on scene) for all medical emergencies. Assist with airway management during emergency resuscitation of patients.

(4) Ensure all anesthesia equipment and supplies are in working order and well maintained. Assemble and maintain an airway kit for ease of use during rapid sequence intubations.

(5) Assist oral surgeon with cases requiring procedural sedation.

(6) The SMO may assign the anesthesia provider secondary duties to support medical department mission accomplishment. These secondary duties, however, must not interfere with the anesthesia provider's primary duties to provide anesthesia care and respond to airway emergencies while underway. The additional duties may include:

(a) Be available during sick call for consultation.

(b) Stand departmental duty within the provider's scope of practice.

(c) Assist with education and development of medical departmental staff by conducting lectures and supporting educational efforts during drills.

d. Family Medicine Physician (FP). The FP must be a medical corps officer who has completed a residency in family medicine and holds an active staff appointment with clinical privileges in family medicine, operational, and primary care medicine. The FP may serve as the ward medical officer in the place of the ship's surgeon as determined by the SMO. The FP reports directly to the SMO. Specifically, the FP must:

(1) Serve as sick call supervisor, overseeing the professional treatment and care of the sick and injured as directed by the SMO. The FP will see sick call patients and see all patients that are referred to their level of care by other providers.

(2) Provide recommendations concerning policies, standards, and practices of the medical department.

(3) Be assigned as the direct supervisor of the PA and hospital corpsmen (HM) engaged in direct patient care, including, when appointed, serving as physician supervisor for IDC personnel. Perform all functions of the designated physician supervisor in accordance with OPNAVINST 6400.1C.

(4) Keep the SMO informed as to the condition of all patients under their immediate care and consult with the SMO, psychologist, physical therapist, and ship's surgeon regarding their professional treatment as needed.

(5) Oversee and provide quality assurance in support of the sick call screeners program (SCSP).

(6) Serve as quality assurance physician advisor (QAPA) as referenced in chapter 19, section 4, paragraph f of this instruction.

(7) Assist the general surgeon to ensure the emergency room is in constant state of readiness to receive casualties from aboard the ship or from other sources.

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

e. Medical Administrative Officer (MAO). The MAO must be a medical service corps officer (health care administrator). The MAO reports directly to the SMO. The MAO must assist the SMO in the details of medical department administration and must be designated in writing by the CO. Specifically, the MAO must:

(1) Evaluate the effectiveness of the medical department's administrative policies, methods, and procedures and advise the SMO as appropriate.

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

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

(4) Subject to the approval of the SMO, administer leave for the medical department.

(5) Prepare the medical department's watch, quarter, and station bill (WQSB) in coordination with ship's nurse and DLCPO.

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

(7) Ensure the safeguarding and authorized disposition of all medical department classified correspondence and publications assigned to his or her custody.

(8) Supervise the maintenance of health records.

(9) Supervise the procurement, stowage, preservation, and issue of medical department supplies and materials.

(10) Serve as the controlled medicinal bulk stock custodian for controlled substances on the ship. Assume direct custody of narcotics and other controlled substances and personally supervise the condition, safekeeping, and economical expenditure of these items.

(11) Supervise the departmental 3M program.

(12) Serve as the ship's health benefits advisor and supervise the ship's Tricare program.

(13) Assume responsibility for ensuring comprehensive health records screening in support of the command security program, if directed.

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

f. Ship's Nurse. The ship's nurse must be a nurse corps officer with subspecialty training and experience in critical care nursing (subspecialty code 1960). The nurse will serve as nursing supervisor for the medical department and as the department's training officer. The ship's nurse reports directly to the SMO. Specifically, the ship's nurse must:

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

(2) Assist health care providers in the professional treatment and care of the sick and injured. Report to the ward medical officer on matters relating to inpatient care.

(3) Be designated as the medical training team (MTT) leader as set forth in COMNAVAIRFORINST 3500.20E.

(4) Maintain ship's crew BLS education as either BLS program administrator or affiliate faculty. Maintain BLS instructor or instructor-trainer qualifications.

(5) Be designated as the department's quality assurance coordinator, ship's patient safety manager, and be responsible for quality assurance and risk management matters as set forth in chapter 19, section 4, paragraph e, of this instruction.

(6) Participate in health promotion education of ship's crew, assisting the ship's health promotion program coordinator as applicable.

(7) Coordinate basic shipboard first aid and rescue (SFAR) injuries, buddy aid and stretcher-bearer training of the ship's crew.

(8) Ensure that supplies are stocked in adequate amounts and that all equipment is in operating order in the ward and ICU. If discrepancies are noted, immediately route findings through MAO for action.

(9) Serve as the crash cart coordinator for the ship. Supervise the daily checks and monthly inventories.

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

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

g. PA. The PA must be a medical service corps officer clinical care specialist who possesses PA core privileges. The PA reports directly to the SMO. The PA works under the supervision and direction of the FP or a credentialed physician clinical supervisor appointed in writing by the privileging authority. Guidelines for utilization of PAs are set forth in detail in COMNAVAIRFORINST 6320.2. Specifically, the PA must:

(1) Keep his or her physician supervisor informed as to the condition of all patients under his or her immediate care and consult with other physicians in regards to treatment as required.

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

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

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

h. Clinical Psychologist (CP). The CP must be a medical service corps officer clinical care specialist who possesses CP core privileges. The CP reports directly to the SMO. Specifically, the CP must:

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

(2) Maintain close clinical liaison with supporting MTF mental health services.

(3) Maintain clinical responsibility for all services provided by the substance abuse rehabilitation program (SARP) director and the psychiatric technician.

(4) Support and employ operational stress reduction programs (i.e., suicide awareness, anger management, domestic or blue on blue violence, post-traumatic stress disorder, etc.) throughout the deployment cycle.

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

i. Physical Therapist (PT). The PT must be a medical service corps officer clinical care specialist who possesses a current state license in physical therapy. They must possess physical therapy core privileges. The PT reports directly to the SMO. Specifically, the PT must:

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

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

(3) Serve as the health promotion program coordinator (designated in writing by the CO).

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

j. Radiation Health Officer (RHO). The RHO must be a medical service corps officer health care scientist who has been trained in the RHO program. The RHO reports directly to the SMO. The RHO must perform duties as directed in COMNAVAIRPAC / COMNAVAIRLANTINST 6470.5.

k. Air Wing Medical Department. CVW medical providers remain under the primary administrative control of the air wing commander while embarked but must be under the cognizance of the SMO as fully integrated members of the ship's medical department. At all times, the CVW and CVN medical departments will work together in a collegial and mutually supportive manner. It is expected that 50 percent of the CVW medical provider’s time should be utilized in direct support of the CVW. In addition, they must perform such duties as the SMO may direct, including routine medical department watch-standing assignments in support of the ship or CVW mission.

(1) CVW flight surgeons are required to be medical corps officers who have completed an internship, post-internship aeromedical, or flight surgeon training, and have been designated as a Naval Flight Surgeon. In addition, they must hold an active staff appointment with clinical privileges in flight surgery, operational and primary care medicine.

(2) Aviation Physician Assistants (APA). CVW aviation physician assistants are required to be medical service corps officers who have completed the flight surgeon training course and have been designated as a Naval Aviation Physician Assistant. In addition, they must hold an active staff appointment with clinical privileges as a physician assistant as well as physician assistant-flight medicine. APAs must have a physician supervisor assigned in writing. This supervisor is typically one of the CVW flight surgeons.

(3) Specifically, CVW medical providers must:

(a) Provide medical care and treatment of CVW personnel and assist in the treatment of ship's company personnel.

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

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

(d) Recommend to the CVW commander or squadron commander suspension from flying or other appropriate action whenever, in their judgment, pilots or aircrew are not fit to undertake flight duties without risk to the success of the mission or to the flight crew and themselves.

(e) Recommend to squadron COs and the CVW commander additional measures that may contribute to flight safety.

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

(g) Frequently consult with the SMO, CVW commander, and squadron commanders and keep them informed on all matters relative to the health and welfare of CVW personnel, particularly those in actual control of aircraft.

(h) Request, when appropriate, a local board of flight surgeons to determine eligibility of flight status of personnel whose physical or psychological well-being is in question.

(i) Maintain oversight of assigned squadron HMs, and ensure that the IMR of squadron personnel is maintained.

l. Medical DLCPO. The DLCPO is the primary assistant to the SMO in the administration, supervision, and training of the medical department enlisted personnel, while instilling good order and discipline. The DLCPO reports directly to the SMO. The DLCPO must also perform as the medical DIVO in the absence of the medical DIVO. Specifically, the DLCPO must:

(1) Assist in the assignment of enlisted personnel to various duties for which the department is responsible and to exercise overall supervision of all enlisted personnel.

(2) Be responsible for the professional growth and development of all enlisted personnel assigned to the medical and dental departments.

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

(4) Assist the MAO and nurse in preparing and maintaining the WQSB.

(5) Prepare the watch and liberty lists for medical department enlisted personnel. Subject to the approval of the SMO administer liberty for the medical department enlisted.

(6) Inspect all medical department spaces daily, with the exception of battle dressing stations (BDS), which must be inspected weekly. These inspections will address the general material condition, cleanliness and preparedness to conduct clinical procedures in these spaces. Completion of these inspections, and any discrepancies noted, will be documented in the medical department journal (duty log).

(7) Directly supervise the performance of LCPOs.

(8) Coordinate with CVW LCPO regarding HM assignments to ensure squadron requirements are met with ample opportunities to rotate to different areas of the medical department for training. Coordination between the medical DLCPO and CVW LCPO to achieve mutual support for both the CVN and CVW is critical.

(9) When embarked on board the CVN, the CVW LCPO will report to both the CVW flight surgeon and CVN medical DLCPO.

(10) The DLCPO is the senior HM aboard the CVN and will ensure coordination and cross-training of all HMs between the medical and dental departments, (i.e., dental, lab, pharmacy, X-ray, flight deck, etc.). This includes the assignment of a surgical technician to support oral surgery services.

(11) Supervise the maintenance of health records.

(12) Supervise the inspection and replenishment of FABs, mass casualty boxes, BDS, and other emergency medical kits.

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

m. Substance Abuse Rehabilitation Program (SARP) Director. SARP director provides drug or alcohol abuse assessment, consultation, education, outpatient treatment, intensive outpatient treatment, residential treatment, and continuing care services for personnel attached to the CVN and subordinate units embarked. The senior certified Navy Drug and Alcohol Counselor assigned to the medical department must be designated as the SARP director. The SARP director must be a graduate of the Navy Drug and Alcohol Counselor School (to include the director's seminar) and hold the requisite NEC for their billet. The SARP director reports directly to the CP and works closely with the Command Drug and Alcohol Program Advisor (DAPA). The CP supervises all activities of SARP and the preceptor program as the SARP director.

n. Division Leading Petty Officer (LPO). Normally, the senior HM within each division must be designated the division LPO and must assist the DLCPO in the administration, training, and overall supervision of the personnel of each division.

o. Independent Duty Corpsman (IDC). IDC is a specially trained HM to manage health programs and provide primary care under indirect supervision on shore, at sea, and on mission deployment. Certified by their privileged physician supervisor, the IDC can practice under indirect supervision on board the CVN and other ships with IDCs within the CSG. In the event of a CSG IDC unplanned loss, the carrier IDC must be the first option for IDC coverage. Refer to OPNAVINST 6400.1D for IDC delivery of health care.

(1) Maintain certification and perform all functions of an IDC in accordance with OPNAVINST 6400.1D.

(2) Supervise the maintenance of FABs, mass casualty boxes, BDS, and other emergency medical kits, as directed.

(3) Serve as a member of the MTT. Assist with the basic SFAR injuries, buddy aid, and stretcher-bearer training of the ship's crew. Assist with the preparation and submission of medical training drill packages.

(4) Serve as a member of the medical response team (MRT).

p. Hospital Corpsman (HM). HMs must perform duties as prescribed by the CO, SMO, clinical supervisor, and other competent authority, and must be assigned to only those duties as allowed by the Geneva Convention and the Standard Organization and Regulations of the U.S. Navy. HMs must perform clinical duties according to COMNAVAIRFORINST 6320.3. HMs assigned to the inpatient ward must complete a job qualification standards for personnel assigned

duties on the inpatient ward. Operating room technicians will spend 50 percent of their time working in the operating room of the local MTF while in port. Whenever possible, the surgical technicians should work with the ship's surgeon in the operating room and should also work a wide variety of surgical cases in order to maintain and enhance their skills.

q. Professional Apprenticeship Career Track (PACT) Program. Previously called "strikers", this new program codifies existing policies and supersedes all prior policy guidance. PACT Sailors will use career waypoints – PACT designation (C-WAY – PACT designation) module to apply for rating entry, see MILPERSMAN 1306-611. The Navy PACT Program requires an initial four-year active obligation, and in return, guarantees initial apprentice skill training and a career development plan with viable career opportunities for Sailors who maintain eligibility. The PACT Program provides a required general workforce to support operational readiness and is designed to enlist Sailors into a monitored, general apprenticeship program that provides apprentice-level formal and on-the-job training, leading to a viable career field within two years on board their permanent duty station (PDS). PACT Sailors in receipt of an initial accession contract into one of the three tracks must meet the established minimum requirements for their chosen track, must observe and/or assist and will ALWAYS be under direct supervision when conducting any patient care procedures. They must receive education and training in patient privacy, Health Insurance Portability and Accountability Act (HIPAA), Personal health information (PHI) prior to assignment of any duties in the medical department. Selection and use of PACT Sailors as standbys during medical examinations will be in accordance with COMNAVAIRFORINST 6320.1. Additional training guidance is provided in chapter 13, section 2, paragraph 6, of this instruction.

4. Watchstanding

a. In homeport, a BLS medical response capability is the minimum medical capability that must be maintained on board the ship at all times. The duty medical officer (physician) may be ashore on weekends, or after normal working hours, but must be in contact via telephone or any other available communication means at all times. Significant cases should be discussed by telephone with the duty medical officer and all patient treatment entries must be cosigned on the next working day. Each CVN medical department must have a written protocol that defines "significant" cases that require contact with the duty medical officer. Emergency cases may warrant immediate referral to the nearest emergency room if the duty medical officer cannot be reached in a timely manner.

b. In ports other than homeport, the CVN medical department must maintain the capability to provide all of its usual medical services. Specifically, the department must maintain routine outpatient, inpatient and advance life support (ALS) medical response capabilities on board. A duty medical officer must be on board at all times, unless a waiver of this requirement has been specifically granted by the TYCOM. Except in emergencies, all medical department officers will only stand duty in the medical department. This policy does not interfere with standing watches to achieve warfare qualifications or competitive fitness report ranking as long as the

medical officer can be released immediately to respond to an emergency, and they are not assigned as the primary duty medical officer.

c. Except in emergencies, all HMs should perform medical duties and watches strictly within the confines of providing medical care.

d. During flight quarters, the flight deck BDS must be manned by two "flight deck-qualified" HMs at all times. During underway periods, this responsibility must be shared equitably by the organic medical department HMs and the CVW HMs.

5. Watch Quarter and Station Bill (WQSB). A current WQSB must be conspicuously posted within the medical department. The bill must identify assignments for conditions of normal operations, general quarters, mass casualty, MRTs, sea and anchor, contaminated injured sailor, abandon ship, and man overboard. All medical department personnel and personnel assigned to medical watch stations (including stretcher-bearers and phone talkers specified in chapter 14, section 1, paragraph 1, of his instruction) must be listed on the WQSB.

6. Medical Personnel from Embarked Units

a. Flight Surgeons

(1) Embarked CVW. Whenever a CVW is embarked, all air wing flight surgeons will accompany the wing aboard and report to the SMO upon arrival for duty in accordance with COMNAVAIRFORINST 6000.2. CVW flight surgeons remain under the primary administrative and operational control of the CVW commander but are responsible to the SMO and strike group surgeon for medical matters. Flight surgeons will stand duties and watches as assigned by the SMO.

(2) Carrier Qualifications. The ship's complement will be augmented with at least one flight surgeon in support of each CVN qualification period. Under normal conditions, flight surgeons from units participating in CVN qualifications will embark with their respective units. When squadrons cannot provide the required flight surgeons, the appropriate COMNAVAIRLANT or COMNAVAIRPAC force surgeon's office will be informed in time to institute appropriate action. COMNAVAIRPACINST 1301.9A/COMNAVAIRLANTINST 1301.6G apply.

b. Hospital Corpsman (HM). Whenever a CVW is embarked, all CVW squadron HMs will accompany their respective squadrons aboard. In accordance with COMNAVAIRFORINST 6000.2, they will report to the CVW senior flight surgeon. Squadron HMs are expected to work with the CVN medical department in a mutually supportive manner, assist with departmental duties and be integrated into the medical department watchbill. Squadron HMs will continue to fulfill their responsibilities to their parent squadron for various operational, medical, dental, and administrative matters (i.e. squadron readiness meetings or functions). When embarked,

squadron HMs must store all squadron personnel medical records in the medical department's medical records room and the squadron HMs will be responsible for maintaining their respective squadron's readiness. The ship's medical DLCPO may provide performance evaluation input to the CVW flight surgeon or LCPO for squadron HMs. Search and rescue (SAR) medical technicians will remain assigned to squadrons, thus allowing them to stand ready-duty SAR alert, medical evacuation (MEDEVAC), aircrew duties, and maintain squadron readiness.

c. CSG HM. The CSG HM reports directly to the CSG staff. While embarked, the CSG HM will coordinate with the medical DLCPO and MAO to manage medical movement and plans operations and medical intelligence officer (POMI) activities within the CSG. CSG HM will conduct renewal of performance assessments during sustainment in accordance with COMNAVAIRFOR 3400.20E.

7. TAD and Temporary Additional Duty (TEMADD) Medical Personnel Support. Active duty support is occasionally needed for short-term coverage. Support for a longer term may also be necessary to bridge a gap between an unplanned loss and the arrival of a permanent replacement. Except in emergencies, a three-month advance notice is required. TAD support may also be available through the use of reserve component assets. Requests for reserve component support must be submitted as far in advance as possible. Requests for TAD or TEMADD medical support must specify a required onboard arrival time of no later than 24 hours prior to the ship getting underway to allow for unexpected travel delays. Medical providers must ensure an ICTB is forwarded to appropriate TYCOM force surgeon's office.

a. Anesthesia and General Surgeon. During every underway, according to the required operational capabilities (ROC) and projected operating environment (POE), general surgeon and anesthesia coverage is required, unless assigned on the AMD. Anesthesia support is provided by a designated anesthesia department at a specific BUMED MTF, according to BUMED (Code M3/5 C) with the exception of the Ford class who are permanently assigned on AMD. A general surgeon is permanently assigned on the CVN AMD. General surgery coverage is via permanent change of station orders to each operational CVN. Because some surgeons do not have the opportunity to complete boards before arriving to the CVN, a planned absence of the ship's surgeon may be necessary. Surgical specialty boards usually occur during the August time frame and oral boards are usually in October. A proactive inquiry should be made before a new surgeon reports aboard to determine if they will need to take their boards. If confirmed, a request for TAD support must be initiated, as far in advance as possible, to ensure general surgery coverage during all underway periods.

(1) Three months prior to a desired coverage period, the CVN will send an unclassified Naval message (i.e., not mentioning ship's movement, specific underway periods, or other operational security information) to COMNAVAIRPAC and COMNAVAIRLANT, as appropriate, identifying the required specialty, dates of coverage needed, and ship's point of contact.

(2) Annual coverage for anesthesia during planned absences is coordinated via unclassified naval message to COMNAVAIRPAC and COMNAVAIRLANT, as appropriate, indicating anticipated dates of TAD coverage due no later than 1 July of each year.

(3) COMNAVAIRPAC and COMNAVAIRLANT will coordinate with COMUSFLTFORCOM and BUMED, via the appropriate chain of command, to ensure that each CVN has anesthesia coverage during all required periods.

(4) The responsible MTF will supply and fund TAD anesthesia support to the homeport of the designated CVN.

(5) Close follow up of all requests will ensure that anesthesia support personnel are identified well in advance of each underway period.

(6) It should be noted that new general surgeons may come directly from civilian residencies and will need significant transition support to include military identification issuance and in-processing support.

(7) Appendix D provides sample TAD support request message templates.

b. Request for Support (RFS). Medical department support (other than general surgery and anesthesia) is requested via the TYCOM. Direct requests to MTFs are not authorized. Requests should be initiated at a minimum of three months prior to the dates required (except in the case of an emergency or unplanned loss). See appendix D for sample messages. When available, contact via phone or e-mail must be made with force medical prior to initiating any request to allow TYCOM to utilize internal resources, if available. Requests for TAD support to cover planned absences must be submitted with as much lead time as possible. Significant advance notice also improves the opportunity to utilize reserve assets to support the identified requirement.

Note: If a reservist is identified to fill the requirement, ensure coordination with the ship's reserve liaison officer (RLO) for logistics requirements and the assignment of a billet control number (BCN) as well as the credentialing staff at their respective TYCOM MSP. The requesting CVN will be responsible for providing funding data to the supporting command.

c. Enlisted

(1) Permanent Loss

(a) Notification of enlisted requirements as a result of unplanned loss is accomplished through the submission of the enlisted manning inquiry report (EMIR). EMIR guidance is delineated in the MILPERSMAN 1306-108. This article establishes a Navy-wide EMIR for

personnel shortages having a significant effect on unit readiness. Units will submit an EMIR message report to Navy Personnel Command (NAVPERSCOM), Enlisted Personnel Readiness and Support Branch (PERS-4013) on the occasion of an enlisted personnel manning concern meeting the criteria outlined below. To qualify for submission as an EMIR, the personnel shortage should meet one of the following criteria:

1. Current on board or projected on board manning in the applicable rating or closed loop and transitory NEC is below Navy Manning Plan or billets authorized, whichever is less.

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

3. In the opinion of the CO, the personnel shortage has a significant effect on unit readiness.

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

(c) Ensure submission of an EMIR is coordinated with the ship's personnel office. EMIR messages are submitted to COMNAVPERSCOM MILLINGTON TN//PERS-4013XX with information addressee copy to the TYCOM (Personnel and Force Medical) COMPACFLT PEARL HARBOR HI, and COMCOMUSFLTFORCOM NORFOLK VA.

(2) Temporary Loss. Before RFS messages are forwarded to COMUSFLTFORCOM or PERS 4013 for action, notification of enlisted requirements as a result of a temporary unplanned loss will be made via message to the TYCOM (personnel and force medical). When available, contact via phone or e-mail must be made with force medical prior to initiating any request. Other TYCOM assets will be utilized whenever possible.

d. Reserve. Medical department personnel reservists may be available to provide fleet support. Any requirement for reserve support must be coordinated with the ship's RLO prior to submitting a request via TYCOM to BUMED. The RLO needs to be aware of all embarked reservists and has the responsibility for coordinating logistics and the assignment of a BCN for each requirement. Requests for reserve support will be submitted to BUMED (code M3F and M10) with information addressee copy to the TYCOM (force medical and reserve liaison).

8. Off-duty Remunerative Civilian Employment

a. MILPERSMAN 5370-010 establishes policy for all members of the Naval service with regard to off-duty or outside employment.

b. Privileged Providers. DHA-PM 6025.13, COMUSFLTFORCOM/COMPACFLTINST 6320.2, and COMNAVAIRFORINST 6320.2, HA policy memorandums 96-050 and 97-019 MANMED article 1-22 (22 Aug 1998) provide policy for off-duty remunerative professional civilian employment, including self-employment, of active duty Navy medical department officers. No Navy medical department officer on active duty may engage in any off-duty remunerative employment without first obtaining the endorsement of the CO and approval from COMNAVAIRPAC or COMNAVAIRLANT Force Surgeon. The local command has the primary responsibility for control of off-duty employment by Navy medical department officers. Appendix E must be used to submit requests to the privileging authority for approval and submit quarterly reports.

CHAPTER 5
ADMINISTRATION

5-1 Records, Reports, and References

1. Manuals, Documents, and Instructions

a. Organizational Document. According to chapter 4, section 1, paragraph 1, the organization of each medical department must be documented in a ship's SORM or in a departmental SOP. The document must define the chain of command and delineate duties and responsibilities of each functional area or significant position within the medical department.

b. SOP Manuals. Work centers within the medical department must establish an SOP manual providing detailed step by step information on the daily routine and how to conduct each procedure or function. The cognizant work center supervisor must review the SOPs annually, updated as necessary, submitted to the MAO for review, and submitted to the SMO for approval. SOPs are a valuable tool to initially provide medical department staff with pertinent information to successfully complete medical department training requirements, and for periodic review thereafter, for refresher training. The SMO must approve each SOP by signature on the cover page; the SMO and each member assigned to that work center must review the SOP annually and document said review by their signature and date on the signature page in the SOP. SOPs are to be used as references and not as a substitute for training. SOPs are required, at a minimum, for the following work centers:

Administration	Radiology
Clinical Psychology	SARP
Laboratory and Blood Bank	Training
Operating Room (including Anesthesia)	Treatment Room
Pharmacy and CSIB	Ward and ICU
Physical Examinations	Birth Month Recall and IMR
Physical Therapy	Sick Call
Radiation Health	Force Health Protection Defense

2. Records and Logs. Records and logs may be in an electronic, book, or log form and in sufficient detail to serve as a complete and permanent historical record for actions, incidents, and other recorded data. Electronic logs are permitted only if daily, weekly, and monthly backup copies are maintained in order to minimize the chance of data loss. The following records and logs must be maintained within the medical department:

a. Medical Department Daily Journal (Duty Log). Each ship must maintain a medical department daily journal. The journal will contain a complete history of the medical department. It must indicate personnel admitted to or discharged from the ward, reports of personnel casualties, injuries, and deaths, inspection of fresh provisions, ship drills, brig visits, sanitation

inspections, and all other occasions of medical significance. The journal must be routed through the DLCPO, reviewed daily by the MAO, and signed by the SMO. If the journal is maintained electronically, a hard copy will be printed daily and signed by the SMO. The journal is a permanent record and must be retired in accordance with SECNAVINST 5210.8E.

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

c. Consult Log. A consult log must be kept to track the specialty consult process. Follow-up is needed to ensure patients receive appointment The ordering provider needs to review the completed SF-513 (military), DD Form 2161 (civilian), or documented in Composite Health Care System (CHCS). The following tracking elements will be incorporated in the log: patient name, last four, division, consulted specialty and working diagnosis, date submitted, consult date, consult returned and reviewed by the ordering provider.

d. Pathological and Biopsy Specimen Log. A pathological and biopsy specimen log is to be maintained with documentation that all patients have been notified of their pathology results, and that the ordering provider has reviewed the results and the results are filed in the patient's medical record. This log is to be maintained for two years and retired in accordance with SECNAVINST 5210.8E.

e. Operating Room Log. An operating room log is to be maintained with documentation for each surgery performed in the operating room. This log will contain the patient's name, date, procedure, surgeon, anesthetist, type of anesthesia, pre-op or post-op diagnosis, and pathology specimens obtained.

f. Training Log. A training log is to be maintained to document all lectures and training periods conducted in accordance with the training program for ship's company and medical department personnel. All drills are to be documented in this log. A muster sheet is to be maintained on file for each lecture given. If training is documented in the ship's Relational Administration Data Management Application (R-ADM) database, this will suffice for this requirement.

g. Bulk Controlled Medicinals Record. The bulk custodian will maintain and retain the bulk controlled medicinal record, with a copy kept in the medical department.

h. Working Stock Controlled Medicinals Record. The working stock custodian will retain and maintain the controlled medicinal record, with a copy kept with the bulk controlled medicinal custodian.

i. Potable Water Log. Daily chlorine water testing as well as weekly bacteriological water testing is required to be recorded in the log. The potable water log in TMIP will be used to meet this requirement.

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

k. Ancillary Service Logs. Records of all laboratory tests and x-ray studies performed and prescriptions dispensed (including over the counter medications) must be maintained in accordance with chapter 8, section 1, paragraphs 1-5; section 2, paragraph 4 (a-b); and section 3, paragraph 1 (a-d), of this instruction.

l. Sterilization Log. A sterilization log must be maintained in accordance with chapter 8, section 5, paragraph 2 (a-f), of this instruction.

m. Medical Waste Disposal Log. A medical waste log must be maintained to include the following elements: date, type of waste, amount (number of boxes, volume or weight), storage location, method of disposal, date of disposal, tracking number, and receiving activity with signature of recipient. Ensure use of DD Form 1348-1A for transfer of waste to shore facilities. Refer to chapter 17 for additional information.

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

o. Equipment Maintenance Record. A NAVMED Form 6700/3 will be maintained on all medical and dental equipment. All equipment will also be included in the Organizational Material Management System-Next Generation (OMMS-NG) system.

3. Health Records

a. Privileged Communication. The health record is a legal document, containing an individual's past and present medical history. The health record is the property of the U.S. Government, not the individual. The manner of custody will be such as to protect its personal nature. Administration and management of health records will be in accordance with MANMED, chapter 16. The Privacy Act of 1974, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and SECNAVINST 5211.5F govern release of health records information. MANMED, chapter 23, section III, sets forth release guidelines. The service treatment records (STR) should not be allowed to leave the medical department, except

as needed to facilitate consultative medical care. Medical department personnel have a legal responsibility to secure protected medical and personally identifiable information and to ensure that any dissemination of that information is made in accordance with applicable law and regulations.

b. Verification. Health records must be maintained according to chapter 16 of the MANMED and other relevant directives. They must be verified annually, during the annual PHA, and upon receipt or transfer of ships personnel. Deficient items should be corrected or be marked to identify the need for completion. Upon verification, the appropriate block will be marked on the health record jacket. A biannual physical audit of health records (wall-to-wall inventory) shall be conducted to ensure each crew members' records are on board. This verification must also include verification that TMIP or medical readiness reporting system (MRRS) data accurately reflects the health status of the crew.

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

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

(2) O – OBJECTIVE SIGNS (Exam findings).

(3) A - ASSESSMENT (Diagnosis).

(4) P - PLAN (Treatment, disposition, follow-up, and patient education). The PLAN section of a note will include the specific follow-up time.

d. All signatures in the hard copy health record will be in black ink. The name, rank or rating, profession or corps (e.g., MC), and service of the medical department representative making entries in the health record will be typed, neatly printed, or stamped under the signature. Stamped facsimile signatures will not be used on any medical form in the health record. In signing, the individual assumes responsibility for the accuracy and completeness of the entry. Electronic health record (EHR) entries will be in accordance with provided templates.

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

4. Filing and Records Retirement. Correspondence and files should be complete, orderly, and in compliance with SECNAVINST 5210.8F. Records, logs, and correspondence should be

disposed of in accordance with SECNAVINST 5210.8F. Supporting homeport MTF should be consulted in order to appropriately retire an STR. Supplemental information can be found in BUMED notice 6150 dated 12 October 2018, NAVADMIN 187/14, and ALNAV 066/16 or latest iterance.

5. Reports.

a. Daily Reports

(1) Morning Report of Sick and Injured. This report must be submitted by the senior medical department representative (SMDR) on a daily basis, via the chain of command, to the CO. This report must contain, at a minimum, the following:

(a) Individuals recommended to be placed sick in quarters (SIQ).

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

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

(d) Individuals injured within the preceding 24 hours.

(e) Patients MEDEVAC'd to other facilities.

(f) Patients transferred from other facilities.

(2) Eight O'clock Report. This report must be submitted by the SMDR, in the format specified by the command to the CO via the XO.

b. Weekly Reports

(1) Status Report. When the ship is underway, a status report is required to be sent to TYCOM force medical on a weekly basis. This report should be e-mailed to the TYCOM force surgeons and must contain, at a minimum, the following:

(a) Period covered.

(b) Inpatient admissions.

(c) Surgical procedures.

(d) Documented new pregnancies.

(e) MEDEVACs.

(f) Sexual Assault Medical Forensic Exams (SAMFE).

(g) Other significant events. Any incident that could result in higher authority interest should be reported immediately to the force surgeon via e-mail, naval message or telephone. These events must also be included in the next weekly status report.

(2) Medical Record Data Transmission. Even if using the TMIP communicator application to automatically upload IMR data. TMIP data is automatically uploaded to Navy Medicine Online at least weekly or manually as needed.

c. Monthly Reports

(1) TYCOM Quality Assurance Report. The TYCOM quality assurance report is a required monthly report. Each month's report must be submitted to the TYCOM no later than the 15th of the following month. The CO's signed copy must follow no later than the last working day of the month.

d. Quarterly Reports. Controlled substances inventory report; the CSIB must conduct an inventory at least every 90 days, in accordance with current BUMEDINST 6710.70 series, MANMED article 21-24, and controlled substances SOP. The inventory will be unannounced and a controlled substances inventory report must be submitted to the CO for approval. The controlled substances inventory report must be prepared and submitted by the senior member of the CSIB after each inventory. This report must list each item in stock, together with its strength and unit of issue. The report must show the amount on hand from the previous report, quantity received, quantity expended, and balance on-hand. The audit will include cross-checking a representative sample of health records to ensure orders for controlled substances are properly documented in the visit note.

e. Situational Reports

(1) Medical Event Report (MED Form 6220-3). In accordance with BUMEDINST 6220.12C, medical event reports will be created and submitted via TMIP or equivalent. Reportable medical events and specific time frames for reporting are listed in enclosure (2) of BUMEDINST 6220.12C.

(2) Summary Record of Tuberculosis (TB) Contact Investigation. The command initiating the contact investigation must prepare and maintain summaries of the investigation. Summary records are required for the initial investigation and the three-month follow-up investigation. Records must be retained on file for at least three years and in accordance with enclosure (3) of BUMEDINST 6224.8C.

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

(4) Operational Report (OPREP)-5, medical input is provided every 24 hours while underway and is written in a format delineated by the CO.

(5) Department turnover report must be provided as delineated by the command or higher authority.

6. Cruise Report and Lessons Learned Brief

a. Cruise Report. Upon the completion of a deployment of 90 days or greater, a cruise report must be submitted to the force surgeon using the template provided in appendix F. This report must be submitted no later than 30 days after return from deployment.

(1) The cruise report is an important document to record unusual, unplanned, and non-routine events that occurred before and during a deployment. This information is valuable to assess operational readiness and those support personnel who have not deployed to a particular area of operation. Succinct, worthwhile observations that can be submitted to the Navy Lessons Learned System is the intent of this report. Items that may warrant mention include: port calls, available medical facilities, significant incidence of disease, equipment maintenance, supply lag time, etc.

(2) While a narrative format is acceptable to capture individual staff experiences, appendices summarizing recommended AMAL change requests (ACR), inpatient admissions, MEDEVACs, and key lessons learned must be included in the report. At a minimum, the top 5 lessons learned must be submitted in the following format:

(a) Topic.

(b) Observation.

(c) Discussion.

(d) Recommendation.

b. Observations must be approved by the cognizant commander (i.e. CVN, CSG issues etc.) and submitted to TYCOM force surgeon electronically.

7. Injury Reporting

a. The Manual of the Judge Advocate General (JAGMAN), part E of chapter 2, requires a line of duty determination in every injury resulting in physical inability of a member of the naval service to perform his or her duties for a period in excess of 24 hours or where a permanent disability may result. Refer to the ship's legal officer and the JAGMAN for specific guidance.

Completion of the line of duty determination is not normally a medical department function unless the injury occurred within medical department spaces or involved a member of the medical department.

b. Medical department personnel must initiate a local injury report upon initial notification or treatment of any injured crewmember. This report must include the diagnosis, treatment, circumstances and disposition of the patient. The original report must be forwarded to the CO via the safety department, with additional copies to those departments and divisions as directed.

c. For personnel casualty reporting messages, refer to MILPERSMAN 1770-030 and BUMEDINST 5360.1 (Decedent Affairs Manual).

8. Books, Publications, Instructions, and Notices

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

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

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

d. In addition to the references required in COMUSFLTFORCOMINST 6820.1, the following references are required to be held by medical departments aboard CVNs:

(1) Fundamentals of Aerospace Medicine (current edition) by DeHart.

(2) U.S. Naval Flight Surgeon's Manual (Out of print. Retain if onboard).

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

(4) Current AMAL and formulary.

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

(6) Digital reference material as provided by BUMED and/or TYCOM.

(7) Current issue of BONES.

9. Medical Research Aboard Aircraft Carriers

a. All requests to conduct medical research onboard COMNAVAIRFOR vessels, or utilizing COMNAVAIRPAC and COMNAVAIRLANT personnel, must be referred to the cognizant force surgeon for review after approval of the research protocol by an institutional review board (IRB). IRB approval for COMNAVAIRPAC CVNs will normally be granted through the Naval Health Research Center or Naval Medical Center San Diego. Institutional Review Board (IRB) approval for COMNAVAIRLANT CVNs will be granted through Naval Medical Center Portsmouth. A copy of the research proposal and documentation of IRB approval must accompany all requests to conduct research. Requests will also include the following:

(1) Brief description of the research proposal.

(2) IRB approval.

(3) Source of funding for the research.

(4) Dates the research is to be conducted.

(5) Extent of support requested from ship (i.e. recruitment of subjects, advertising, space needed, staff support, etc.).

(6) Any expenses that may be incurred by the ship to support the study.

(7) Statement indicating that subjects' privacy will be protected.

(8) Research point of contact information.

b. Once TYCOM force medical has reviewed the research proposal, an endorsement will be drafted and forwarded to the ship's CO for review. TYCOM endorsement implies the research proposal has been reviewed and the IRB has been approved. In addition, the TYCOM must believe that the proposal research has potential value to the future health and welfare of the operational forces. See appendix G for a sample research request and endorsement.

c. Upon receipt of the research request and TYCOM endorsement, the SMO, in coordination with the principal investigator (PI), will brief the CO regarding aspects of the study and its impact on the ship. Once permission has been granted by the CO, the medical department may liaise directly with the PI to conduct the research study.

d. No medical research may be conducted without specific written approval of the research protocol by the TYCOM.

5-2. Off-ship Medical Care

1. Senior Officer Present Afloat and Ashore (SOPA) Instruction. SOPA instructions are delineated in each ship's homeport. The SMO must review and ensure compliance with the medical section of the local SOPA instruction.

2. TRICARE. Under TRICARE active duty personnel are assigned to a primary care site according to their unit identification codes (UIC) and duty station location. Active duty personnel stationed on board naval vessels are assigned to their ship as their primary care site. The primary care manager (PCM) will provide all routine care. PCMs will direct active duty members to a military or, in rare instances a civilian hospital or clinic, when specialty care is needed. It is important to keep the crew informed of TRICARE rules and regulations as well as how to access medical care while traveling on authorized leave or TAD.

3. Medical Consultations

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

b. Request for Consultation. Patients requiring additional consultation services at other medical facilities will be referred using either a SF-513 (military), DD Form 2161 (civilian), or electronic referrals such as the CHCS. The medical department will maintain a tickler system to track the status of all off-ship consultations. The following guidelines are general in nature and the consultation process may vary depending on the policies of the MTF in each geographic area.

(1) Each ship will develop and implement a comprehensive program for tracking and managing off-ship consultations. The process must include informing the patient of appointment scheduling and consultation procedures and ensure patients make required appointments in a timely manner. In addition, the process will include informing the patients' chain of command of scheduled appointments to ensure they are kept, facilitate transportation if required, and consultation results are received back to the ship and are reviewed by the ordering provider.

(2) Whenever possible, an electronic consultation should be used. An authorized CHCS or AHLTA remote connection can be used to request consultation services; otherwise a properly prepared consultation sheet (SF-513) will accompany each patient referred for consultation. Contact the supporting Navy MTF's operational forces medical liaison office for local policy. The request for consultation must include a summary of the patient's history (i.e. condition, complaints, treatment administered to date, and results of the regimen) and any other information

that may be of value to the provider completing the consultation. X-rays, laboratory reports, and other pertinent information should also accompany the patient.

(3) Coordination with operational forces medical liaison officers (MLO) at medical and dental treatment facilities is mandated by COMNAVAIRFOR to ensure proper, adequate, and timely resolution of medical support problems.

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

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

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

4. Non-military Outpatient Health Care

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

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

5. Claims for Treatment of Military Personnel in Non-Federal Medical Facilities. The process for submitting claims for payment of civilian health care bills varies by the location of the ship. The following paragraphs define the various processes based on geographic location:

a. At Homeport. When bills are incurred for civilian care of active duty members while in homeport, the bills are to be forwarded to the designated active duty claims representative for the TRICARE region where the ship is homeported. The claim form, DD Form 2642, must be completely filled out and accompanied by an itemized bill from the treating provider(s) or medical facility. Reasons for not utilizing military medical facilities should be indicated on the DD Form 2642. Data on this form must be clear and contain sufficient information upon which

to make a decision regarding payment of the claim. If necessary, attach a memorandum explaining in detail why federal facilities were not used. If the care was for an injury that was from an accident or was related to off-duty employment, a "statement of personal injury – possible third party liability", DD Form 2527, must be submitted as well. Contact information can be located online https://www.tricare.mil. Current TRICARE contact information should be available during underway periods.

b. Away from Homeport but not Deployed. When civilian medical bills are incurred by active duty members away from homeport, but not deployed (underway for less than 30 days), those bills should be collected and submitted to the TRICARE region processing office for the geographic region in which the ship is homeported.

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

(1) Deployed to an Area with No MTF Support. The Assistant Secretary of Defense for Health Affairs has awarded the TRICARE Overseas Program (TOP) to International SOS to assist with foreign payments for urgent or emergent medical care and MEDEVAC assistance in areas without host nation TRICARE contracts. When operating in areas supported by the TOP contract, this should be used as the primary method of obtaining required civilian care. When such care is coordinated through International SOS, there will be no billing to the ship. The TRICARE Global Remote Overseas (TGRO) contract is limited to urgent or emergent care and should not be used for routine consultations. If it is necessary to get a routine consultation in an area supported by the TOP contract, International SOS can provide recommended sources to receive care, even if that care is not covered under the contract. In those cases, the ship is responsible for paying any associated bills. Contact information can be located online https://www.tricare-overseas.com. Current TRICARE Overseas and International SOS contact information should be available during underway periods

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

6. Medical Evacuation (MEDEVAC)

a. General

(1) The fleet concept of medical care requires the full utilization of all resources "organic" to the command and task force prior to transfer ashore. However, since treatment capability afloat is often constrained by ship design and manning, patient transfer may be necessary and plans and procedures must exist to accomplish this procedure safely. Transfer of casualties or patients is an inherently dangerous procedure. In all cases, a risk to benefit ratio must be determined to decide the best course of action to serve the patient under the present operational, geographic and environmental factors. The transfer of a patient has two major components; uninterrupted continuity of care and selection of a proper transportation platform. Determination of the necessary appropriate medical support personnel, supplies and equipment must be accomplished in an expeditious and complete manner. Continuity of care requires a direct combination of professional evaluation and information between the sending, transporting, and receiving providers.

(2) For specific guidance refer to the theater in-chop message and by reviewing the Annex Q of the respective numbered fleet surgeon's homepage. Appendix H of this instruction contains a detailed MEDEVAC checklist for use in managing the MEDEVAC process.

(3) Each CVN medical department must develop and publish a MEDEVAC checklist consisting of all required procedures, actions and notifications, customized for the ship's command structure and geographic AOR. Physician to physician contact by transferring and receiving facilities must be accomplished prior to transfer if possible. An SF 600 entry documenting all aspects of care and the reasons for transfer must be entered into the health record.

(4) A MEDEVAC request message must be sent to the receiving medical treatment facility to document all MEDEVACs. At a minimum, the COMUSFLTFORCOM and COMPACFLT Fleet Surgeon, CNAP or CNAL Force Surgeon, CSG commander and fleet commander must be made information addressees on this message and any messages concerning medical emergencies occurring at sea. The message format can usually be found in the theater in-chop message. If the patient originally came from another ship or submarine, the parent command must be informed of their status. Additionally, if the patient is from a submarine, notify the submarine's group commander and TYCOM as well.

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

(6) The responsibility for patients being transferred to another activity for transportation and/or treatment rests with the CO of the transferring command until the patient, with all necessary records and belongings, is safely delivered to the receiving medical facility. Prior to

transfer, the transferring command is also responsible for ensuring the receiving command are fully informed as to the condition of all patients transferred, including mental competency and disciplinary status.

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

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

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

(c) All patients and escorts (medical and non-medical attendants) who must travel to the hospital for appointments or admission will be issued a 30-day funded TEMADD orders. The exception to this requirement is if the ship is in the port serviced by the hospital. In ports other than homeport, if the ship must depart and the patient will remain for evaluation or treatment, funded orders must be issued to the patient prior to the ship's departure. The parent unit must provide notification to the designated MTF prior to patient movement and have a discharge plan for the patient should the unit depart from the port servicing MTF. The appropriate block must be checked to allow the medical facility to send the patient to another facility for further evaluation if indicated.

(8) Patients sent for evaluation of suicidal ideation, gestures, or threats must have a non-medical escort who will remain with the patient until released by the examining psychiatrist or psychologist. This escort should be at minimum an E-4 or at least the same rank of the patient whichever is senior, refer to the appropriate numbered fleet operational orders (OPORD) for guidance. This escort does not need to be a member of the medical department.

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

c. Transfers to Veterans Administration Hospitals. The health record of a patient transferred to a VA hospital must be forwarded to the appropriate authority. Prior to forwarding the record, an entry must be recorded on a SF 600 reflecting the name and location of the VA hospital to which the patient has been transferred in accordance with MANMED, chapter 16.

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

e. Transfers to Hospitals of Foreign Nations

(1) When a service member is hospitalized at a medical facility of a foreign nation, an entry must be made in the health record. However, this entry must not be designated as an official transfer document. The health record must be retained on board until the patient either returns to duty or is transferred to another U.S. naval vessel or U.S. military activity. Copies of appropriate medical pages will accompany the patient. Upon departure of the vessel from port, the health record will be delivered to the CO or designated representative for inclusion with the member's service record and forwarding to the nearest U.S. Embassy or Consulate. The Embassy or Consulate must be furnished with a complete history of the reason for hospitalization and must be requested to coordinate with the hospital, with intent towards having the member properly cared for. Upon the member's recovery, the Embassy or Consulate must arrange for the member's transportation, with records, to the nearest U.S. naval activity. Refer to MANMED, article 16-37 for further details.

(2) In every case where fleet personnel are admitted to a foreign medical facility, the CO will designate a mature, responsible officer or petty officer as MLO. The MLO will establish and maintain close liaison between the medical facility, the patient's attending physicians and the ship's SMO. The command must submit a personnel casualty report (hospitalization in a foreign medical facility) if the ship must sail and leave the patient and MLO at the facility. As soon as the patient's condition will allow, medical evacuation will be coordinated with the appropriate commands.

(3) The patient's command, when in the port where the service member is hospitalized, will ensure the patient is visited daily by a member of the medical department and a daily status report will be provided to the CO.

7. Patient Administration

a. Administrative procedures for admitting patients to the inpatient ward or ICU must abide by the requirements noted in chapter 7, section 10, of this instruction and be logged in the medical department journal (duty log).

b. Personnel whose illnesses or injuries are of such severity as to be considered life threatening (as defined by MILPERSMAN 1770-010) will be placed on the serious list or very serious list, with appropriate notifications made as required.

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

d. MTF may discharge a patient to return to his or her unit and recommend convalescent leave. Convalescent and sick leave are recommendations by an attending physician to the patient's command and are considered as adjuncts to patient treatment. The command has final approval or disapproval authority for such recommendations. The command must evaluate each recommendation based on individual case history and operational priorities. Convalescent and sick leave, when granted, do not count as annual leave. COs of naval hospitals or commanders of Naval Medical Centers may grant convalescent leave without consulting the patient's parent command according to MILPERSMAN Article 1050-180. In case of conflict over MTF recommendations it is best to discuss the recommendation with the consultant.

8. Decedent Affairs

a. General. Responsibilities of COs and medical officers regarding deaths are set forth in the following:

(1) U. S. Navy Regulations, 1990, Article 0815.

(2) BUMEDINST 5360.1 Decedent Affairs Manual.

(3) MCO P 3040.4E Casualty Procedures Manual.

b. Reports and notifications are outlined in the following:

(1) MANMED, Chapter 17.

(2) MILPERSMAN Section 1770.

(3) MCO P3040.4E.

c. To assure orderly compliance with current procedures in the event of deaths occurring onboard ship and deaths of personnel away from their parent command, medical departments must maintain "death portfolios", containing a procedure check-off list and all pertinent forms. Appendix I is a sequential, step-by-step procedure that will assist in the timely submission of reports, messages, letters, forms, etc. by the command.

d. At least five "death portfolios" must be available in the medical department, at all times, and are to be provided to the cognizant action officer when the need arises.

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

f. Decedent Affairs Procedures

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

(2) Medical department journal (duty log). An entry will be made in the journal recording all available information concerning the death.

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

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

(5) Disposition of Remains. As soon as possible, remains will be transferred to the nearest Naval or Armed Forces Medical Facility for further disposition. Command representatives, (e.g. safety, legal and Naval Criminal Investigative Service), should be consulted to ensure all investigative protocols are met. Remains must be accompanied by the following:

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

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

(c) Two DD Form 565s, Statement of Recognition, signed by shipmates who knew the deceased, if remains are recognizable. In all cases, refer to the Decedent Affairs Manual, NAVMEDCOMINST 5360.1 regarding requirements for death certificates to accompany remains. When transfer cannot be immediately accomplished, the remains will be prepared in accordance with NAVMED P-5083, placed in a body pouch and refrigerated at a temperature of 36-40 degrees Fahrenheit or 2.2-4.4 Celsius to prevent decomposition. The space used must contain no other items and must be cleaned and disinfected before reuse. Remains will be identified with waterproof tags, marked with waterproof ink and affixed with wire ties to the right great toe and to each end of the body bag. Minimum identification will include the full

name, patient identifier, and rate. The Decedent Affairs Manual contains complete information and guidelines.

5-3. Miscellaneous

1. Disposition of Members Who Refuse Medical Treatment

a. Medical departments may occasionally be confronted with an active duty member who refuses to submit to recommended therapeutic measures to prevent illness, injury or to remedy a defect or condition that has interfered with their performance of duty. Persons refusing treatment aboard ship may be subject to administrative or disciplinary consequences. In some cases, it will be appropriate to transfer the patient to a military treatment facility for further evaluation and recommendations as to disposition. The medical board process, if warranted, is detailed in MANMED, article 18-11. Submit cases up the immediate chain of command.

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

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

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

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

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

Note: MANMED Articles 18-4(2)(g) and 18-12(3)(j)(6) provide guidance concerning disposition of personnel who refuse medical, surgical, or dental care or related diagnostic studies. The condition, rather than the refusal of treatment, should be the deciding factor for determining disposition.

c. Command directed psychological examinations must be conducted in accordance with DoD Instruction 6490.04, DoD Instruction 6490.4, and DoD Directive 6490.1.

2. Recommendations for Discharge by Reason of Unsuitability

a. The recommendation for separation by reason of unsuitability or unsatisfactory performance due to personality disorders and disorders of intelligence should be only made in those cases in which a member has demonstrated unsuitability by unsatisfactory performance of duty or repeated disciplinary problems. The patient must demonstrate a personality disorder or

other non-psychotic mental disorder as diagnosed by a psychiatrist or clinical psychologist. A recent change in administrative separation processing is that, prior to separating a Sailor with a personality disorder, the case must be reviewed by Navy Medical Forces Pacific for COMNAVAIRPAC or Navy Medical Forces Atlantic for COMNAVAIRLANT (see BUMEDNOTE 6000 Serial M3/5/E08UGEN-016191c dated 19DEC2008).

b. Enlisted personnel diagnosed having a medical condition as listed in MILPERSMAN 1910-120 and 122 and current ICD codes, may be processed for separation in accordance with MILPERSMAN section 1900, SECNAVINST 1910.4B, and MANMED chapter 18.

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

4. Berthing of Non-Patient Personnel in Medical Spaces. There will be no non-patient personnel assigned berthing in medical department spaces.

CHAPTER 6
MEDICAL INFORMATION SYSTEMS

1. General

a. Medical information systems provide vital support for the management of the medical department. These systems are evolving rapidly and can dramatically improve the provision of care to the Sailors and Marines aboard our ships. The medical department is supported by the ship's combat systems officer (CSO) and the hardware and software provided must be approved for operation on the ship's local area network (LAN). Each individual program to be installed on the LAN must have a sponsor, be a program of record and have completed LAN compatibility and security testing. All software must be certified as a Naval Information Warfare Center (NIWC) approved product. All questions concerning the installation of a specific program should be addressed to the ship's combat systems department and TYCOM force medical.

b. Any computer that is provided to the medical department, as part of a medical equipment system, must not be re-utilized as a computer work station or removed from the equipment system. This requirement is intended to keep users from swapping their current computer with one of higher quality that is part of a medical equipment system.

2. Theater Medical Information Program (TMIP). TMIP is the medical department information system developed by DoD for all deployed forces. This program contains an electronic medical records system, armed forces health longitudinal technology application-theater (AHLTA-T) for deployed forces, and ship specific required maritime medical modules (MMM). It also employs a data transfer system that transmits data off the ship that updates medical readiness and eventually EHR. All medical personnel should be proficient in using the TMIP.

a. MMM is the current multi-user database application that is used to automate the medical department's administrative functions. Use of the following six modules is mandatory for all CVN medical departments:

(1) The master tickler tracks immunizations, physicals and other monitoring programs.

(2) The radiation health module is the only software application currently approved by BUMED to track radiation exposure data.

(3) The occupational health and environmental health module tracks water testing, heat stress, and pest control data.

(4) The supply module provides management of the medical department AMALs, including medical consumable, pharmaceutical supplies, and durable medical equipment. It automates updating the AMALs from NAVMEDLOGCOM via the SAILOR website, refer to paragraph 3, and provides inventory tracking and re-order of medical supplies. It also tracks

inventory and location of medical equipment in the medical department. This module of TMIP is used to manage the ship's medical storerooms.

(5) The health services module is used to track medical workload. This function must be used to capture all workload provided by the medical division including care provided to the carrier air wing personnel when embarked.

(6) The system management section is used to create TMIP accounts and control the level of access to the information contained in the program, and maintains system integrity.

Note: Use of the TMIP medical record, training management and periodic duties modules is optional.

b. To ensure a complete database of all on board personnel, embarked CVW squadrons will continue to maintain, monitor, and update their unit's medical readiness utilizing medical readiness reporting system or authorized applicable database for squadrons.

c. The information contained in TMIP is protected by encryption technology and must be maintained on a ship's server. A member of the medical department must be designated and trained as the TMIP administrator. All users must be entered into the system using the systems management module. Use is password protected and each user should only be granted access to those modules necessary for the completion of assigned tasks. Passwords are not to be shared with other individuals. The system manager's password must be provided to the ship's CMS or security manager for emergency access.

3. Theater Medical Information Program (TMIP) Maintenance. Maintenance of the TMIP server, and the data contained therein, must be accomplished in accordance with the following MRCs: (48 QX23 N), (68 QX21 N), and (48 QX22 N). The Full MMM backup should be saved to a network share or other secure location for redundancy. A minimum of seven MMM back-ups are required to be maintained by medical to provide a safe, redundant data repository in the event it is necessary to restore the system.

Note: TMIP maintenance is normally performed by the ship's Combat Systems Department. Open communication between Medical and Combat Systems is paramount to ensure accurate and timely completion of backups.*

a. TMIP Support. Submit a Navy 311 request for service ticket, include TMIP in the subject of the request. Provide TYCOM with service ticket number and any and all updates pertaining to TMIP issues. TMIP support is available from:

(1) SPAWAR Acquisition Integrated Logistics Online Repository (SAILOR) website: https://sailor.navy.mil.

(2) For Atlantic and Pacific Fleet Units: NIWC ATLANTIC or NIWC PACIFIC
Website: Navy 311: https://www.public.navy.mil/navwar/navy311/pages/home.html

Email: Navy311@navy.mil
Message: NAVY THREE ONE ONE NORFOLK VA
Phone: COMM (855) NAVY-311, DSN 510-628-9311, option 0

4. Remote Access to MTF. CVNs may be able to remotely access the supporting MTF's CHCS or AHLTA server via the internet (Citrix). Firewall clearances must be negotiated with the ship's combat systems department and the MTF's information systems manager. Use of such systems to submit electronic consults, obtain electronic medical record entries, laboratory and pathology results and order consults, lab tests, and radiology studies from the supporting MTF is encouraged.

Note: Access to these systems require submission for site specific SAAR-N forms.

5. Telemedicine. Telemedicine is the business practice of exchanging clinical information in electronic format between remote locations to facilitate clinical diagnosis, treatment, consultation or referral for the purpose of delivering medical services. The word "telemedicine" has been broadly applied in the medical field. CVN Medical Department providers are encouraged to use telemedia technology of communication, as available, to assure the highest quality of care for the patients served by the department. Examples of telemedicine are:

a. A telephone consult between providers, or a provider and a patient for the purpose of delivering medical services.

b. A request for medical consultation through email, with or without data attachments.

c. A video teleconference for the purpose of conducting a patient visit or consult between providers, or provider and patient.

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

e. The online reference of an electronic medical library for the purpose of medical consultation or making a clinical diagnosis.

f. Faxed or scanned images of medical record data transmitted between two MTFs or commands.

6. Medical Data System Manager. Each ship must designate one person in the medical department to be the medical data system manager, who must be responsible to:

a. Grant access to medical data systems.

b. Arrange and track training of personnel in the use of the medical data systems.

c. Serve as department information security official.

CHAPTER 7
CLINICAL SERVICES

7-1. MRT

a. The MRT is an excellent method of extending emergency room medical expertise and equipment to a patient outside the medical department during the first critical minutes following an accident or injury, such as electrical shock, asphyxiation, cardiac arrest, etc. The MRT is designed for the treatment of one or two patients and is not intended for utilization in mass casualty situations. Therefore, all COMNAVAIRFOR ships will develop and establish two MRTs in a manner that best suits the needs of the medical department and the ship. The names of MRT members must be posted on the WQSB.

b. MRT must be composed of a minimum of four personnel, all of which must be HMs. An MRT must be present aboard ship at all times; exceptions to this policy require specific approval by the ship's CO. The MRT must be able to provide, at a minimum, BLS level of care after hours while the ship is in homeport. While the ship is at sea, or in foreign ports where a provider's presence is required aboard, the MRT is expected to be able to provide ALS level of care once the provider is present at the scene or in direct communication with the MRT while en route. At the discretion of the SMO, the IDC may serve as the provider for the MRT. Also, ALS training for assigned corpsmen is highly encouraged.

c. While at sea or in a foreign port, the second MRT must muster in the main medical spaces when a medical emergency is called away.

d. MRT drills must be conducted according to the frequency specified in COMNAVAIRFORINST 3500.20E. At a minimum, each of the two MRTs should be drilled on a monthly basis. Actual responses may count as a drill; as long as; the event was a bona fide medical emergency, the MRT response time was immediate, and the care rendered was deemed satisfactory in accordance with the SMO, or the MTT leader.

e. Hand-held-radios, allowing for instantaneous communication between the MRT and the medical department, have proven invaluable in rendering quality emergency medical care. At least one hand-held radio must be carried by the MRT during all medical emergencies. Hand-held radios are not authorized for use in reactor department spaces. As such, the medical and reactor departments need to develop an effective alternative form of communication.

2. MRT Equipment

a. Each MRT must have a full set of emergency medical equipment. Members of the MRT must at a minimum carry the following equipment:

(1) Oxygen, suction bag-valve-mask device.

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

(3) Defibrillator or Automatic External Defibrillator (AED).

(4) Tamper sealed drug bag with full ALS capability (syringes, laryngoscope, endotracheal tubes, etc.)

b. Additional equipment may include a stretcher, if not transported to the scene by stretcher bearers.

c. Once on scene, should it be determined that a higher level of care is warranted, MRT personnel will radio the medical department to request the assistance of a medical officer (if one is not on scene), or for further medical officer guidance.

d. MRT bags and equipment must be inventoried on a daily basis during medical duty section turnover and after each use. Written documentation is required. (see chapter 14, section 2, paragraph 7d of this instruction, for requirements on deep access rescue).

3. Crash Carts

a. Three complete crash carts must be maintained within medical and dental department spaces. One must be located within the treatment room, one in the ICU, and one in the operatory dental space. Additionally, the anesthesia cart should be stocked with emergency drugs and ALS algorithms for emergency situations in the operating room. Each crash cart will be stocked in accordance with appendix O (AMAL 3054, 3254), and will reflect the contents according to current COMNAVAIRFORNOTE 6000.

b. During an availability period, at least one crash cart must be maintained in the designated main medical space. If dental procedural sedation is preformed, an additional crash cart must be located in the dental operatory space.

c. On a monthly basis and after every use, crash carts must be inspected with attention paid to medication expiration dates. A tamper seal must be used to ensure the cart has not been opened between uses. Crash carts must be checked daily to ensure that a numbered, tamper proof seal is intact. Defibrillators, suction units, and oxygen tanks on the crash carts must be checked on a daily basis in accordance with preventive maintenance schedule (PMS) procedures and the manufacturer's recommendation. Written documentation of these inspections and checks is required.

4. Beach Guard Medical Support

a. Whenever the ship sets up a beach guard it must be manned with medical personnel constituting the medical beach guard. The mission of a medical beach guard is to supply BLS level of care capability, first aid, and safety screening of personnel before transiting to the ship. At a minimum, one HM with voice communication capability to the ship (i.e., mobile phone or hand-held radio) is required. Communication between the duty HM and ship's duty physician will be tested at the beginning of each duty section. The medical beach guard must be equipped with a junior emergency response kit (JERK). Other equipment and personnel must be available in accordance with local environmental conditions and host nation medical resources. Medical beach guard personnel must be briefed on the contact numbers for shore medical facilities and ambulance services, guidance for when to contact the duty medical officer, when to delay transit to the ship and when to divert patients to shore facilities.

b. Refer to ship's instruction on management of intoxicated personnel.

5. Sick Call

a. Sick call must be held at those times designated by the CO. Sick call should be adjusted to fit the ship's work routine when operating under adverse or other unusual conditions so as to make the services available to each watch section.

b. Each patient reporting to sick call must have an entry made in the health records. Entries made in the health record must be legible and contain the date, name of ship, vital signs, complaint, and treatment rendered in "SOAP" format. All sick call medical record entries must be signed and include the printed name, rank, corps, and service of the health care provider or electronically signed in the electronic medical record as appropriate.

c. All non-physician health care providers who function in sick call evolutions must comply with COMNAVAIRFORINST 6320.3. A credentialed health care provider or IDC must countersign all health record entries of patients seen by sick call screeners.

d. The health services module should be used to generate the sick-call log of all patients seen by the medical department.

e. Brig Sick Call. Brig sick call must be conducted twice daily when any prisoners are being detained in the brig. Brig sick call must include an inspection of the sanitary conditions of the brig. The senior HM in the duty section must hold brig sick call. A medical department journal entry documenting brig sick call is required. A medical officer must be designated as the brig medical officer, and must be informed of any medical issues or treatment provided to prisoners.

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

(1) An HM must immediately seek medical officer advice if it is anticipated that the member cannot be returned to full duty after 72 hours due to unresolved illness.

(2) The SIQ or light duty chit will contain, at a minimum, the following:

(a) Limitations described as specific as possible;

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

(c) the specified time and place of follow-up;

(d) any special instructions to the patient, and

(e) a patient signature block for the patient to acknowledge his or her understanding.

6. Treatment Room. The treatment room, which also functions as the main BDS, must remain open and manned continuously, except under specific approval from the ship's CO. The function of the treatment room is as an emergency room during routine evolutions and as a BDS during general quarters. It must be appropriately stocked as a BDS as determined by the SMO. The treatment room must have the following equipment available and in working order at all times:

a. Operating Room (OR) table.

b. OR lighting.

c. Medical oxygen.

d. Suction.

e. Crash cart.

f. Defibrillator.

g. Vital signs monitor.

h. Sharps containers.

i. Main BDS supplies.

7. Surgery

a. Surgical Services. The risk of traumatic injury and severe illness aboard ship makes the availability of surgical services essential. Surgical services aboard, while of the highest quality available, cannot always match the capabilities of shore-based facilities. Therefore, a risk-benefit analysis should be undertaken prior to commencing any surgical endeavor. This is not intended to prohibit the performance of minor surgery or emergency surgery where the delay incident to transfer of the patient would introduce a disproportionate risk and or where safe and reasonable surgical capability exists.

b. Action. Medical and dental officers are directed, whenever surgical (including maxillofacial) procedures are contemplated, to carefully evaluate the aforementioned factors and to use the following guidelines:

(1) It is not advisable to perform procedures on board ship while in port where more capable shore-based surgical capabilities exist. Exception can be made for minor procedures under local anesthesia.

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

(3) At sea, SMOs must discuss with the CO the command's policy with respect to surgery and notification of the patient's chain of command prior to performing an elective surgical procedure. The ship's CO must be notified immediately of all emergency (unscheduled) surgical procedures.

(4) The SMO is charged with the responsibility for all patient care. Explicit approval from the SMO (usually after consultation with the chain of command) is required prior to performance of any major surgical procedure requiring the use of more than local anesthesia.

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

c. See appendix J for recommended forms to prepare in support of elective surgery.

8. General Anesthesia

a. General Anesthesia. General anesthesia administered aboard CVNs must be administered only by an anesthesia provider. General anesthesia is discouraged for elective surgical procedures when other methods of anesthesia are available.

b. Absence of an Anesthesia Provider. In the absence of an anesthesia provider, general anesthesia will be administered only in actual emergency situations required to save life and limb. The ship's surgeon and SMO will determine if general anesthesia is required in the absence of a privileged anesthesia provider. The oral surgeon may administer general anesthesia in emergent situations.

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

d. The an anesthesia provider will be responsible for developing and updating the carrier instruction on procedural sedation.

9. Intensive Care Unit (ICU).

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

b. ICU Beds. The ICU must have three beds, to include monitors and other necessary ICU equipment, unless specifically waived by the force medical officer. Whenever a patient requiring intensive care monitoring occupies an ICU bed, a nurse or medical officer must be present within the main medical spaces. Additionally, a qualified health care worker will be present in the ICU at all times whenever a patient is admitted to the ICU.

c. Notification. All patients admitted to the ICU are to have notification procedures accomplished as specified in section 10 of this chapter.

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

10. Inpatient Care and Ward Management

a. The ship's surgeon or family medicine provider will be assigned in writing as the ward medical officer. The ward medical officer will be responsible to the SMO for medical care and documentation thereof, including oversight of admissions, discharges, and daily patient rounds. The ward medical officer must ensure that the SMO is informed of all admissions. Admitting privileges to the ward or ICU are limited to TYCOM-privileged medical officers. A CP with the appropriate clinical privileges may admit and manage mental health patients. However, a medical officer with admitting privileges must be involved as a consulting specialist. This is to ensure medical officer involvement in a mental health admission to rule out a medical basis for mental status changes, prescribe medications as needed, and to ensure consistency of inpatient documentation. If medications are recommended, a privileged medical officer must sign orders. Other privileged providers (e.g. PAs, physical therapists, nurse practitioners) may assist and manage inpatient care, but a physician must countersign all notes and orders.

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

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

(2) The minimum manning which must be maintained while the inpatient ward is open for admissions is a medical corps officer and an HM. Only trained and competent HMs will be assigned to inpatient care duties, and they will be assigned such watch sections to ensure the ward is adequately manned 24 hours a day while the ward is in operation.

(3) The minimum number of ward beds required on a NIMITZ class CVN is 51. Specific configuration is 40 general ward bed, eight quiet room beds (usually this will be configured as two 4-bed quiet rooms), and three ICU beds. The minimum number of ward beds on a FORD class CVN is 44. Specific configuration is 32 general ward beds, nine quiet room beds, usually configured as three 3-bed quiet rooms and three ICU beds. Temporary reconfiguration of ward spaces is authorized so long as at least one quiet room or isolation room is always available for patient quarantine and all beds are available for use during a mass casualty situation. Patient care and privacy must always be the priority over office space.

(4) A review of the patient’s profile, medication administration record, daily nursing flowsheet, and progress notes must be conducted and documented, verified by the SMO during daily beside rounds. Care must be taken to ensure that meals are served on time, medications are

administered, and other treatments are given as directed. Vital signs must be obtained at scheduled intervals, and laboratory specimens and x-rays will be obtained as ordered by the attending provider. All abnormal results will be promptly reported to the ship's nurse or duty medical officer. The inpatient chart shall be properly maintained and legible. Timely documentation is of the utmost importance.

(5) Vital signs must be taken and documented at least every 12 hours while a patient is admitted to the ward. All abnormal results will be promptly reported to the ship's nurse or duty medical officer.

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

(a) Patient's DIVO notified.

(b) The personnel officer must be notified about all patients whose illnesses or injuries are of such severity as to be life threatening (as defined by MILPERSMAN section 1770). Such patients will be placed on the serious list or very serious list with appropriate notifications made to next of kin (NOK) as required.

(c) CO and XO notified.

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

(7) Controlled Substances. Written procedures are required for the handling and dispensing of controlled substances as directed by MANMED, chapter 21. When an admitted patient is prescribed a controlled substance, the medication will be dispensed from the pharmacy. If multiple doses of controlled substances are dispensed at once, they will be maintained in a locked cabinet on the inpatient ward or ICU. The storage and record of receipts and expenditures of these medications must be in accordance with chapter 21 of MANMED, and chapter 8, section 1, paragraph 10, of this instruction.

(8) Inpatient Chart

(a) All patients (medical and dental) requiring ongoing treatment or observation must be admitted to the ward. The highest possible quality of medical care must be administered with

a clear record of care and an audit trail for routine review of patient care practices. Formal written admission procedures in accordance with standard Navy medical practices, utilizing a formal chart, will be followed. Required documentation is found on the inpatient record review form, appendix W, the abbreviated medical record (SF 539) is authorized in lieu of the SF 504, SF 505, and SF 506 for use aboard COMNAVAIRFOR vessels if admission is less than 48 hours.

(b) Upon acceptance of an individual for admission in the ward, for whatever reason, the SMO must be immediately notified and fully informed. The medical officer ordering admission (or consulting physician if admitted by the ship's CP) must assume full responsibility for the well-being of that patient until care is appropriately concluded or the patient is formally transferred to the care of another physician.

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

(d) Upon discharge or release from medical department cognizance, a copy of the narrative summary (SF 502) and the operative report (SF 516) if applicable, must be placed in the patient's outpatient medical record. The discharge summary must contain the following:

(1) Admission diagnosis.

(2) Discharge diagnosis.

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

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

(5) Duty status.

(6) Condition of patient on discharge.

(e) According to BUMEDINST 6550.7A, patient notes or orders created by a CRNA do not require physician co-signature.

c. Medical Hold (MEDHOLD). The unique nature of medical care in the shipboard environment is clearly recognized. A deployed ship does not have the luxury of discharging a patient to convalescent leave or to a shore-based transition care unit. On occasion, ward beds are used for patients who would not otherwise require hospitalization. Due to the difficulty

encountered using shipboard ladders and other potentially hazardous environmental conditions, some patients may be better cared for in the medical department. The close proximity of the galley, combined with the facilities on the ward, allow recovering patients to provide self-care in a controlled environment. MEDHOLD is not an alternative for admission. Patients must not be placed in a MEDHOLD status if they require vital signs, or other nursing care. MEDHOLD patients must be capable of self-care.

(1) The SMO has a clear obligation to provide safe and proper medical care, regardless of the medical reason for accepting a patient for berthing in the ward. Medical transition company (MTC) is for sick or injured patients that do not require inpatient care but have multiple appointments per day or per week and need to be close to the hospital to attend those appointments. It is not an automatic acceptance, MTC has criteria that has to be met in order to accept patients and does not allow automatic acceptance. Refer to MTF operational forces medical liaison (OMFL) for specific criteria.

(2) The medical department is responsible for all personnel residing in medical spaces. The medical department must account for these individuals for mustering purposes. Non-patient berthing on the ward is prohibited (see chapter 5, section 3, paragraph 4, of this instruction).

11. Physical Examinations. The medical department is responsible to ensure all necessary physical exams are available, completed and submitted as required in a timely fashion in accordance with the MANMED and other agencies dictating specifics (DoD Medical Examination Review Board, National Aeronautics and Space Administration, etc.). All required follow-ups, recalls and resubmission should be completed in a timely manner. All laboratory and radiographic results must be reviewed and initialed by a licensed clinical provider.

12. Aviation Medicine

a. All aviation medicine procedures will be accomplished in accordance with COMNAVAIRFOR M-3710.7 and chapter 15, section 65 of the MANMED. Direct oversight of operations, including review of physical examinations, waivers, and submissions will be the role of the SMO and CVW flight surgeons as directed by the SMO.

b. The flight deck BDS will be manned in accordance with ship's policy by trained and competent personnel, and in accordance with chapter 4, section 4, par d. The SMO, or assigned CVW flight surgeons, must provide oversight of flight deck BDS operations.

13. Substance Abuse Rehabilitation Program (SARP). The SARP serves to prevent and treat alcohol abuse and dependence. The SARP director reports clinically to the CP, and administratively to the medical DLCPO and medical DIVO. The SARP should work closely with the command's DAPA to ensure expeditious evaluation and treatment as necessary. The SARP must be run and services provided in accordance with BUMEDINST 5353.4B, to include

preceptor and reporting requirements. "Performance indicator surveys" must be distributed and collected from all patients.

14. Clinical Psychology.

a. Clinical psychology services are an effective asset to the medical department and crew on a platform with an inherently stressful environment. The various preventive and treatment options made available should serve to improve working conditions and morale, as well as reduce the need for administrative separations and MEDEVACs for mental health reasons.

b. The CP will report to the SMO, and follow all applicable instructions and directives, including COMNAVAIRFORINST 6320.3, non-physician health care providers. The quality assurance program applies to assigned CP.

c. CP must be well integrated into the medical department and ship's crew and provide high quality care within the parameters of their credentials. In addition, the CP will run ship-wide health promotion programs to include stress management, anger management, and suicide prevention and provide SARP oversight.

d. Psychiatric technicians will report clinically to the assigned CP.

e. The CP may manage mental health admissions to the medical ward and ICU that do not require medication if they have the required clinical privileges. If medications are involved supervision by a medical officer is required.

f. The CP will be responsible for developing and updating the CVN instruction on critical incident stress debriefing and on the management of personnel with suicidal ideation.

15. Physical Therapy (PT)

a. PT services are an effective asset to the medical department and crew on a deploying warship and industrial complex. The various preventive and treatment modalities made available should serve to prevent injuries, decrease lost work days, improve morale and decrease the need for MEDEVACs due to musculoskeletal injuries.

b. The physical therapist will report to the SMO and follow all applicable directives and instructions, including COMNAVAIRFORINST 6320.3, non-physician health care providers. The quality assurance program applies to assigned physical therapists.

c. The physical therapist must be well integrated into the medical department and crew and provide high quality care within the parameters of their credentials. The physical therapist should be utilized in health promotion (e.g., healthy back, injury prevention, etc.) and other activities as assigned by the SMO.

d. Physical therapy technicians will report clinically to the physical therapist.

e. Medical ward and ICU admissions related to musculo-skeletal injuries, while followed closely by the physical therapist, must be made by a medical officer.

f. The physical therapist must be responsible to the SMO for currency and maintenance of PT supplies and equipment.

16. Women's Health Issues

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

b. At the required annual health maintenance examination for women, the provider can determine periodicity of follow on cervical cytology testing based on history, age and previous cytology results. An annual health maintenance form is required for all active duty women. The annual examination will be performed in accordance with MANMED Article 15-112.

c. Due to inherent delays in receiving cervical cytology results during deployments, all attempts should be made to complete cervical cytology testing prior to deployment. Every effort will be made to provide patients with their results within 30 days.

d. The references for the pregnancy policy are OPNAVINST 6000.1D. The following policy will be followed for all CVN pregnant service members:

(1) May continue to serve aboard a ship until the 20th week of pregnancy, while in port or during short underway periods, provided an evacuation capability exists and the time for medical evacuation is less than six hours to a treatment facility capable of evaluating and stabilizing obstetric emergencies. This requirement includes TAD orders. The six-hour rule is not intended to allow pregnant service members to operate routinely at sea, but rather to provide the CO flexibility during short underway periods. A service member discovered to be pregnant while underway or deployed should be transferred ashore as soon as possible given the constraints of the ship's location, current mission, next port call, health of the service member, and unborn child(ren), etc.

(2) Should not deploy with or be assigned to units that are deploying from notification of pregnancy through 12 months following delivery and release from their provider. Under no circumstance should a pregnant Service member remain onboard past the 20th week of pregnancy.

17. Clinical Instructions. Each CVN must develop written guidance for handling the following events:

a. Management of Alleged Rape Victims. Plans, policies, and procedures must be developed and implemented in a shipboard instruction in accordance with OPNAVINST 1752.1C and BUMEDINST 6310.11A.

b. Management of Intoxicated Personnel. Although not all inclusive, the following checklist represents the minimum criteria that should be established in the management of intoxicated personnel:

(1) Shipboard guidelines for command duty officers (CDO) on handling intoxicated personnel.

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

(a) Beach guard HM guidelines in foreign ports.

(b) Ward management.

(3) Documented training for all medical department personnel for screening intoxicated personnel.

c. Competence for Duty Examinations. Competence for duty examinations will be performed according to BUMEDINST 6120.20C. The purpose of competence for duty examinations is to determine whether an individual who shows signs of intoxication to medications, alcohol, or illicit drugs, is competent to perform duty to operate a motor vehicle, or to perform other official functions or risk the safety of themselves or others. The CO, XO, CDO, or department head must give the authority and signature for requesting a competence for duty examination, as delegated by the CO. Unless laboratory testing is specifically requested, a clinical evaluation should suffice in determining competence. Competence for duty examinations must be performed by a medical privileged provider and completed on NAVMED Form 6120/1.

d. Management of Personnel with Suicidal Ideation. Personnel with suicidal ideation must be managed in accordance with BUMEDINST 6520.2. Plans, policies, and procedures must be developed and implemented through a specific shipboard instruction.

e. Critical Incident Stress Debriefing. Early intervention and counseling has proven very effective when contact with the patient is initiated early after a significant event or disaster. Each ship must make plans for debriefing critical incidents including the use of indigenous assets, and off-ship assets such as Special Psychiatric Rapid Intervention Team.

f. Procedural Sedation. Each carrier medical department is required to develop guidelines for the use of IV sedatives. Ensure that dental patients who are intended to recover on the ward are included in the policy.

CHAPTER 8
ANCILLARY SERVICES

8-1 Pharmacy

1. General

a. This section establishes policy for general operation of the pharmacy and provides additional guidance for management of controlled substances stocks and prescriptions.

b. Pharmacy services will be provided to active duty personnel of the CVN, CVW, CSG, and other eligible beneficiaries as directed by the SMO according to MANMED chapter 21.

c. The SMO is responsible for maintaining appropriate security of all pharmacy spaces and stocks. Access to the pharmacy spaces will be limited to the bare minimum needed to run the day-to-day operations of the pharmacy. In general, access to pharmacy spaces must be limited to the MAO, the pharmacy technician (or qualified designated on the job training HM covering during the pharmacy technician's absence) and the current medical department duty officer (MDDO).

d. The pharmacy technician must ensure the smooth operation of the pharmacy, manage the department's formulary, and oversee prescription dispensing and pharmacy procedures as defined in MANMED chapter 21 and this instruction.

2. Prescription Dispensing Policies and Limitations. The following is a listing of policies pertaining to the operation of pharmacies on board CVNs. These policies are the most frequently asked about and are a common cause of concern. It is not intended as a listing of all policies and procedures relating to the pharmacy. Refer to MANMED, chapter 21, for additional information.

a. Patients must be required to present military identification (ID) (or appropriate photo ID for non-active duty personnel) prior to receiving any medications dispensed from the pharmacy. Positive ID will be confirmed for all patients prior to dispensing or administering medications while in an inpatient status.

b. Prescriptions from civilian providers must not be filled on board. CVN providers will not countersign, initial, or rewrite civilian prescriptions. An appropriate evaluation and medical record entry must be made prior to prescribing medications on the advice of a civilian provider.

c. Providers are specifically prohibited from prescribing or furnishing a controlled substance to themselves or members of their immediate family.

e. Telephoned or verbal prescriptions will not be accepted.

f. Prescriptions will not be dispensed by mail (exception is via the TRICARE Mail Order Pharmacy (TMOP) as it is not part of the CVN medical department).

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

g. The maximum non-controlled drugs that can be dispensed at one time is a 90-day supply. However, birth control pills and hormonal replacement therapy (e.g., Premarin and Provera) can have a maximum quantity of 180 days of supply. The maximum quantity for schedule II-V pharmaceuticals is a 14-day supply unless the prescription is cosigned by the SMO.

h. All dispensed medications must be labeled properly with an appropriate health record entry in accordance with MANMED, chapters 16 and 21.

i. A log will be maintained of all medications dispensed (either paper or electronic). With the implementation of the TMIP, this function is included and a separate log is only required if TMIP is not functional.

j. All medications dispensed after normal working hours must be prepared by the duty corpsmen and will be verified by the MDDO prior to dispensing to the patient. The verification must ensure that the proper drug, strength, and quantity are dispensed. Additionally, the reviewer will ensure that all lot number and expiration date information are properly documented on DD Form-1289. Both the department duty officer and the reviewer will sign the DD Form 1289.

3. CVN Formulary

a. The CVN formulary is defined by the current AMAL and is published by NAVMEDLOGCOM and distributed electronically through their website.

b. In addition to this formulary, each ship may develop a local formulary addendum, listing any additional medications (non-AMAL) stocked aboard ship. This local formulary addendum must be published and made available to all medical and dental providers with authorization to prescribe medications. Any local formulary additions must be approved by the SMO and are the sole responsibility of the individual ship to obtain. No additional funding will be provded for locally approved, non-AMAL medications.

d. IDCs may independently prescribe all formulary medications except as follows:

(1) Controlled substances.

(2) Any other medications and/or fluids restricted by the ship's SMO or respective TYCOM.

(3) Any prescriptions for the above may be recommended by the IDC, but must be authorized and written by a privileged provider prior to administration.

d. COMNAVAIRPAC and COMNAVAIRLANT force medical, with input from the fleet on an annual basis, will review and update the formulary. It is based on the DoD joint core formulary. It is designed to provide for the ongoing acute care for patients and to be prepared for contingencies that may be expected during deployment. It is not designed to supply all ongoing chronic medication needs for members served by the CVN medical department.

4. Prescription Requirements. Prescriptions must be written in ink, or typewritten on an original DD Form 1289, DoD prescription or a NAVMED Form 6710/6, poly prescription. TMIP pharmacy module fulfills these requirements. Each prescription must show the following:

a. Patient's full name and date of birth.

b. Date prescription was written.

c. Full name of drug, form of drug, dosage size, or strength written in the metric system and quantity to be dispensed. Prescriptions should be written using the generic medication name.

d. Complete directions for the patient. "Take as directed," in most circumstances, is not considered adequate instruction and must be avoided. Instructions to the patient must not include terminology contained on the Joint Commission list of "Do Not Use" list of abbreviations and notations, listed in Appendix K.

e. Refill authorization. If none, specify "no refills".

f. The legibly printed, typed, or stamped name of the provider, and the provider's original signature.

g. Prescriptions not meeting these requirements will be returned to the provider by the pharmacy technician for correction prior to dispensing the medication to the patient.

h. Additional requirements for controlled substances include:

(1) Prescriptions for controlled substances filled off the ship also require the provider's United States Drug Enforcement Agency (DEA) number and branch of service to be on file.

(2) Prescriptions for controlled substances must be written in ink, or typewritten on DD Form 1289, DoD Prescription. NAVMED Form 6710/6 is not authorized for controlled substances. Duplicated, carbon, photographic, pre-printed, rubber-stamped, or

"addressographed" orders are also not valid prescriptions for controlled substances. TMIP pharmacy module fulfils these requirements.

(3) No controlled substance prescriptions will be filled unless there is a bonafide signature card on file in the pharmacy for the physician or dentist, PA, or nurse practitioner writing the prescription.

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

(5) Erasure or line-outs on prescriptions for controlled substances are prohibited and will not be dispensed.

i. These prescription requirements remain in effect as back up requirements when TMIP is unavailable. Providers will then use CHCS for pharmacy items and the signature requirement will be fulfilled by the electronic order entry signature. However, if a patient must have a prescription filled in a community pharmacy, the provider is required to write a traditional prescription and sign it as required by 21 CFR 1306.05(d).

5. Controlled Substances

a. Definition. Alcohol, barbiturates, hypnotics, stimulants, narcotics, and other substances requiring special custodial care are collectively called controlled substances. Controlled medicinals are defined as a drug or other substance determined by the Director, DEA, Department of Justice, to be designated schedule symbols II, III, IV, or V, as defined in the controlled substances act, effective 1 May 1971, and other items requiring security storage.

b. Refer to the COMNAVAIRFOR, COMNAVSURFPAC, and COMNAVSURFLANT controlled substances SOP for the management, security, and disposal of excess quantities or deteriorated items of controlled substances in medical and dental departments.

c. Additional guidance for the disposal of excess quantities or deteriorated control substances can be found in chapter 11, section 14, paragraphs (a to c), of this instruction.

d. In accordance with chapter 5, section 1, paragraph 1 (a and b) of this instruction, the medical department will maintain the most up-to-date controlled substances SOP in appendix L.

6. Controlled Substances Inventory Board (CSIB). Refer to the COMNAVAIRFOR, COMNAVSURFPAC, and COMNAVSURFLANT controlled substances SOP for CSIB procedures and examples of the appointment letters in appendix L.

7. Reports. Refer to appendix L for examples of CSIB report letters.

8. Controlled Substance Break-out Lockers

a. The purpose of the break-out locker stock is to provide providers on duty or working in the ICU, ward, OR, or dental operatory with timely access to controlled substances for use in their work sections. The SMO will specify the quantity and type of controlled substances held in the break-out locker stock.

b. In order to maintain a clear and concise audit trail, all controlled medicinals for break-out use must be accompanied by a properly prepared narcotic and controlled drug account record (NAVMED Form 6710/1). Entries on the NAVMED Form 6710/1 must have corresponding substantiating entries on the medication administration record (MAR), NAVMED Form 6550/8, and on the nursing notes (SF 510) of the inpatient record. The doctor's orders must also indicate the date, time and quantity ordered and the date and time the medication is to be discontinued. Additionally, each locker must maintain a controlled drug log containing the NAVMED Form 6710/1 and narcotic and controlled drug inventories (NAVMED Form 6710/4) secured with the contents of the locker. All break-out lockers must be maintained under lock and key with access only to those persons designated by the SMO in writing.

c. Transfer and Dispensing of Controlled Medicinals

(1) Transfer from working stock to and from break-out lockers:

(a) Small quantities of controlled substances may be transferred from the pharmacy working stock to the break-out lockers. Appropriate security will be provided according to COMNAVAIRFOR, COMNAVSURPAC, and COMNAVSURFLANT controlled substances SOP.

(b) Transfer from working stock to break-out lockers, or vice versa, will follow the same procedures as outlined in MANMED, chapter 21 and will be documented on the NAVMED Form 6710/5 for the bulk stock and on the NAVMED Form 6710/1 used to track the break-out locker stock.

(2) Dispensing from break-out stocks. Dispensing from the pharmacy break-out lockers after normal pharmacy hours will be made only on a properly prepared and signed prescription form DD Form 1289 following the following procedures:

(a) Administration of controlled substances from the break-out lockers must have a documented order by the provider. Record usage on NAVMED Form 6710/1 at the specified location and locked up in the break-out locker. Entries will be made in the patient's record as appropriate.

(b) Physicians and dentists may sign prescriptions for schedule II through V controlled medications. PAs and nurse practitioners can prescribe schedule II through V

controlled medications, if within their scope of practice. IDCs attached to COMNAVAIRFOR units may not prescribe controlled medications.

(c) The break-out locker custodian must ensure all appropriate entries are made on the NAVMED Form 6710/1 and NAVMED Form 6710/4, for each break-out locker during their watch. The custodian of the working stock must ensure the accuracy and completeness of all pertinent DD Form 1289s and NAVMED Form 6710/1. SMOs, or their appointed representatives, must assure the accuracy and completeness of all NAVMED Form 6710/4s by visual and physical accounting when deemed necessary.

(d) Upon relieving the watch, a physical inventory of the pharmacy emergency break-out locker is accomplished between the off-going and on-coming MDDO. A third party must witness the count. The keys to the pharmacy emergency break-out locker in the pharmacy must remain in the custody of the MDDO.

9. Force Health Protection (FHP) Material. Controlled medications held on board as integral components of the FHP block AMAL, will be kept under lock and key and placed in the custody of the bulk custodian. Appropriate entries will be made in the custodian's records and will be monitored by the CSIB. At the discretion of the CSIB chair, bulk quantities of FHP controlled substances may be stored in pilfer proof packaging and may be inventoried as a single block on the quarterly CSIB report. Full inventories should be accomplished upon transfer of the bulk custodian or at least annually.

10. Dispersal of Controlled Medicinals Prior to Combat or Emergency Situations. Planning is an important factor. The decision to distribute controlled medicinals to BDS safes rests with the CO. This action must be considered when a combat or emergency situation is imminent. The custodian or SMO should have written guidance defining distribution procedures and responsibilities in the event controlled medicinals need to be dispersed for an emergency situation or combat. Each ship must develop plans and simulate disbursal and retrieval of morphine and other controlled substances as determined by the SMO during each general quarters or mass casualty drill. Policies for the actual distribution of controlled substances during actual general quarters or mass casualty emergencies must be included in the battle bill.

11. Over the Counter Medications (OTC). In order to expedite the treatment of minor injuries and illnesses, an OTC Medication Program is authorized aboard aircraft carriers. The list of OTC medications will be reviewed, approved and documented. No HM may hand out medications that are not on this SMO-approved OTC list. See appendix L for a sample CVN OTC patient instruction form.

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

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

c. OTC medications dispensed will be entered into the patient's medical record, and an OTC log must be maintained to prevent abuse of the service. Entry into the patient's medical record is required to document the encounter.

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

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

12. AMAL Additions and Deletions. As therapeutic modalities change, the medications on the AMAL need to be updated. Several factors determine which medications are stocked on board. The TYCOM force surgeons determine what is authorized on the AMAL based upon level of care, specialty advisor recommendations, prime vendor contracts, and DoD pharmacoeconomic board input. Any staff, medical or dental officer, can request that a drug be added or deleted from the AMAL by providing written justification, to include drug, nomenclature, cost, and clinical benefit. This justification must take into account that the AMAL change will apply to all aircraft carrier medical departments. The ordering of controlled drugs not listed on the AMAL requires prior approval by the appropriate force surgeon. Refer to chapter 11 for AMAL change request procedures.

13. Pre-deployment Medication Analysis and Reporting Tool (P-MART)

a. The DHA pharmacy operations division provides operational forces with a medication management tool called P-MART. Upon receiving an alpha roster of Sailors aboard the ship, this tool can provide a medication use profile for each Sailor. The profile includes medications obtained at any MTF, the TMOP, and all TRICARE retail pharmacies. In addition, the profile can be viewed based on type of medication including high risk, chronic, etc.

b. To request a P-MART analysis for your unit or to seek assistance, contact the P-MART team at dha.jbsa.pharmacy-ops.mbx.pass-dmt@mail.mil or call the pharmacy analytics support section (PASS) at 1-866-275-4732, option 1 and ask for a data management team member. Additional instructions may also be found under "P-MART", subheading "How to Get a P-MART Analysis", at https://health.mil/PMART.

14. Chronic Medications for Deployment. All personnel on chronic medications must obtain an initial supply of their medications (up to 180 days) in support of the length of the scheduled deployment prior to leaving home port. There are two methods for receiving these medications:

a. Request a full deployment duration supply (up to 180 days) from the local MTF.

b. Obtain an initial supply of medications from the TMOP. If member is unable to obtain the entire deployment length worth of medications due to TMOP prescription quantity restrictions, be sure the individual is counseled to use their shipboard address for receipt of refills and that medication refills are requested with enough lead time during the deployment to arrive in theatre before running out of their current supply. Complete the TMOP patient registration and prescription submission process at least 14 days prior to deployment in order to obtain the initial prescription prior to departure. TMOP should also be used for any non-formulary chronic use prescriptions. Deployment refill process:

(1) Prior to deployment, the service member must set up an account with TMOP as follows:

(a) Go to www.express-scripts.com/TRICARE.

(b) Login or select "create an account" to register.

Note: ID number is the member's complete social security number

(c) Provide an e-mail address that can be accessed while deployed

(d) Member should use their current address (where they are now) and will use the website to update their address and to order refills when deployed.

(e) After the member deploys, they will get reminder emails from TMOP reminding them to update their TMOP online registration with a current mailing address (which may include Army Post Office (APO) or Fleet Post Office (FPO)) and to order refills of medication via the member's online account. TMOP will only fill medications as requested by the service member and will send the medication to the address provided when the medication was ordered.

Note: The average shipping time to an in-theater address is approximately 3-4 weeks.

(f) Service members may obtain additional detailed instructions via https://www.express-scripts.com/TRICARE/tools/deployedrx.shtml.

1. Under "Deployment Prescription Program (DPP)" select "DoD Deployment/Prescription Program Beneficiary Brochure"

2. Contact TMOP DPP: toll-free 1-855-215-4488, commercial 1-480-438-8344, available 24 hours a day, 7 days a week. E-mail DeployedPrescriptionProgram@express-scripts.com.

(2) Prescriber's Registration for the Deployment Prescription Program. Prescribers providing medications to deploying military personnel may register for individual access to the

DPP by e-mailing deployedprescriptionprogram@express-scripts.com and requesting access to the DPP secure server for prescription upload.

(a) The following information will be required:

1. Requestor's Name

2. Rank

3. Military e-mail address

4. Clinical status (for example, MD, PA, NP, RPh)

5. Country of origin or ship name

(b) Once an account has been created, the prescriber will be sent an e-mail with a user ID and temporary password (user IDs and passwords are case-sensitive). The DPP account may be activated by:

1. Going to https://dpp.express-scripts.com

2. Enter the user ID and password received in the email from express scripts DPP and click log-in.

3. After logging in, change the temporary password by re-entering the temporary password in the "current password" box and subsequently entering a new password in the "new password" box.

4. Passwords must contain one of each: upper-case letter; lower-case letter; number (0 to 9); and special character.

5. Click save changes

(c) The prescriber may now utilize the DPP secure server to obtain and complete a DPP prescription form to prescribe medication(s) for deploying service members, which will need to be filled out should the member require additional medication once deployed in theater.

1. The DPP prescription form can be found in the support docs folder on the DPP secure server.

Note: If submitting a prescription for a member that is deploying to the United States Central Command (CENTCOM) AOR please review modification 13 to USCENTCOM individual deployment policy at https://www.express-scripts.com/

TRICARE/tools/deployedrx.shtml as a waiver may be required. If the member is not deploying to the CENTCOM AOR please note on the DPP form the AOR, if known, so that the processing of the prescription will not be delayed in any way pertaining to a waiver.

2. The form can be completed electronically and must include:

a. A complete APO/FPO address.

b. Authorizing signature and credentials of prescriber. Schedule III-V medications require a handwritten signature; digital signatures will not be accepted.

Note: Prescriptions for schedule II medications must be mailed with an original handwritten signature (no photocopies) to: Express Scripts, P.O. Box 52012, Phoenix, AZ 85072-2012.

(d) Prescribers may alternately submit prescriptions to the TMOP DPP via:

1. Fax at 1-877-327-8038, the cover sheet must indicate fax origin number of pages and sender's contact information.

2. U.S. Mail (Note: Required for CII prescriptions) as noted above.

(e) Additional detailed instructions may be obtained via:

1. https://www.express-scripts.com/TRICARE/tools/deployedrx.shtml, under "Deployment Prescription Program (DPP)" select "DoD Deployment Prescription Program Provider Brochure".

2. Contact TMOP DPP:

a. Phone: toll-free 1-855-215-448 or commercial 1-480-438-8344, available 24 hours a day, 7 days a week.

b. E-mail: DeployedPrescriptionProgram@express-scripts.com.

(f) In the event of an urgent order the medical privileged provider can call in a prescription to express scripts directly at:

1. CONUS: 1-877-283-3858.

2. OCONUS: 1-602-225-0005 ext. 436914.

c. Smoking cessation products can be ordered in conjunction with the smoking cessation program. Requirements for these products need to be coordinated in advance with the command tobacco cessation coordinator.

d. OTC medications are NOT part of the TRICARE pharmacy benefit through home delivery. Exceptions: Prilosec, Claritin, Claritin D, Zyrtec, Zyrtec D, and fexofenadine.

e. Contact Information

(1) TMOP toll-free 1-855-215-448 or commercial 1-480-438-8344, available 24 hours a day, 7 days a week.

(2) E-mail at deployedprescriptionprogram@express-scripts.com.

(3) Mail: Express Scripts, P.O. Box 52012, Phoenix, AZ 85072-2012.

8-2. Laboratory

1. Reporting of Laboratory Results

a. Laboratory Log. A log of all laboratory tests performed must be kept (utilization of TMIP is encouraged), containing at a minimum the following information: name, patient identifier last 4 (or successor identifier), date, test performed, technician. A separate log must be maintained for all specimens sent off the ship for testing, including the basic information listed above plus the following: Facility submitted to, date sent, date results received, and result. A copy of the laboratory results will be maintained by the laboratory for two years. The TMIP-M laboratory system will meet these documentation requirements.

b. Filing of Laboratory Results. All performed laboratory test results must be entered into the medical record (hard copy or EHR) in a timely fashion after review by a medical provider. Documentation of this review must be accomplished by the provider placing their initials on the lab chit.

2. Blood Bank

a. The carrier blood bank program is optional; however, carrier medical departments choosing to use this program, must comply with the requirements listed below.

b. The carrier blood bank program authorizes the CVN to deploy with up to 20 units (usually five to eight units) of packed type O-Negative red blood cells. A deployment requiring this level of blood support is for a duration of 30 days or greater.

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

d. Coordinate OCONUS re-supply requests via message to the closest Area Joint Blood Program Office, U.S. naval hospital, or other designated blood supply source five to ten days before arrival or close transit. Blood supply source locations will be designated by the Combatant Command Joint Blood Program Office in coordination with the Navy component command depending on the area of operation.

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

3. Walking Blood Bank (WBB)

a. General. Every effort should be made to use other intravenous solutions, when feasible, in place of whole blood for resuscitation. However, whole blood transfusions may be required in an emergency situation. The WBB will be used in a mass casualty situation, when the refrigerated blood supply (if available) has been exhausted. Procedures for processing WBB donors as well as activation or utilization procedures for the WBB must be contained in the medical department WBB SOP manual.

b. Organization. The SMO will designate a medical or dental officer to be the WBB officer (WBBO). The WBBO will report the status of the WBB to the general surgeon on at least a monthly basis, or more frequently, as determined by the general surgeon. The general surgeon will exercise overall program management responsibility and will provide guidance and direction to the WBBO as necessary. The general surgeon will report the status of the WBB to the SMO prior to any underway periods.

c. Donors. A minimum of 300 people or at least 10 percent of the ship's company will be enrolled and eligible to donate. WBB donors should only be used in a true emergency when the delay necessary to transfer a patient to a shore-based medical facility would be detrimental to a critical patient. Personnel must be screened by the medical department and determined to be healthy to qualify as a donor. They must meet all screening criteria to include the following: have a normal temperature, be free of acute respiratory disease and can be determined from the donor's history, and free of disease transmissible by blood transfusion (e.g, viral hepatitis, malaria, syphilis, HIV, etc.). DD Form 572 will be completed and updated prior to each major deployment (30 days or greater) but no less than annually, by each member of the WBB. It is highly encouraged that the medical department coordinate a series of ship-wide blood drives with the local MTF blood bank, prior to deployment so that a complete serological and virological screening can be performed on as many WBB donors as possible. However, separate serological or virological testing is not required.

d. Aircrew personnel will be handled in accordance with COMNAVAIRFOR M-3710.7.

e. Donor File. The WBBO must establish and maintain a listing of all personnel eligible as blood donors. This file must include the person's full name, rate, rank, DOD ID, division, projected rotation date, telephone extension and blood type. The file must be updated on a monthly basis.

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

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

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

(a) For COMNAVAIRLANT CVNs, the address and phone number is: Laboratory Medicine Service Line & Fleet Forces Command Liaison, Naval Medical Center Portsmouth, 620 John Paul Jones Circle, Portsmouth, VA 23708-2197; COMM: 757-953-1617/DSN 377-1617.

(b) For COMNAVAIRPAC CVNs, the address and phone numbers are: Director Western Area Blood Systems, Head Blood Bank, Naval Medical Center San Diego, 34800 Bob Wilson Drive, San Diego, CA 92134-5000; COMM: 619-532-9240/DSN 522-9240

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

h. The WBB will be exercised during mass casualty drills at least once every 120 days. Blood samples will be obtained from three volunteer personnel: one "recipient" and two potential donors. Ensure one of the "donors" is of the same blood type as the "recipient". A type and screen (T&S) will be run on the three samples as well as an immediate spin crossmatch between the simulated recipient and both donor samples (demonstrating both a match and a mismatch). Results of this exercise, including number of WBB respondents, time required to conduct the testing, and the results of the T&S and crossmatch will be maintained in a log tracking WBB activity. The log and all associated documentation must be available for inspection at the health services readiness inspection.

4. Laboratory Services

a. It is imperative that all CVNs with laboratory capabilities comply with the current Clinical Laboratory Improvement Program (CLIP) policy and SOP. CLIP requirements include individual unit registration, biennial inspection (technical assist visit (TAV)), and biennial compliance certification. TYCOM will coordinate TAVs with the MTF for a CVN. A copy of the laboratory assessment, with documentation of corrective action, must be kept on file within the ship's medical department.

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

(1) Assign a technical consultant to the ship.

(2) Conduct a biennial inspection using the current fleet laboratory assessment form. A copy of the form will be provided by the technical consultant. The assessment results will be submitted to the SMO, who is responsible for taking corrective action as required. A copy will be maintained in the supporting MTF laboratory.

(3) Provide laboratory training as required.

(4) Establish internal proficiency testing as needed.

(5) Review documentation validating the precision of instrumentation and accuracy of laboratory results.

(6) Verify the ability to perform all shipboard laboratory procedures.

8-3. Radiology

1. Radiology Services

a. Medical department radiology services provide plain film x-rays of the head, thorax, abdomen, extremities, and portable ultrasound. Dental x-rays are performed at the dental department.

b. Plain films are processed by computed radiography (CR), a method of capturing a radiographic image on a phosphorous plate, which is inserted into and is processed through a digital laser reader that produces a digital image. The image is then transferred to a picture archiving communications system (PACS) to store the images, display images, and then is transmitted from the ship to Walter Reed National Military Medical Center, Bethesda, for interpretation by radiologists.

c. Dental x-rays are processed as digital images and are stored on the ship.

d. The medical department is equipped with ultrasound equipment capable of color flow Doppler ultrasound for intra-abdominal pathology and pelvic pathology. The family physician and general surgeon may be trained to operate the ultrasound and provide interpretation as part of their non-core privileges.

2. Quality Assurance (QA). Regardless of the imaging method used, radiographs will be monitored on an ongoing basis for quality by a member of the medical staff. A complete log must be kept listing all x-ray exposures, and must contain the following elements: date of exposure, patient name, patient identifier, type of study, technician name, ordering provider, date sent for radiologist review, date returned from radiologist review, and verification that radiologist result is placed in the outpatient chart. A retake rate of less than seven percent is considered acceptable for x-ray technicians and less than eight percent for OJT trained hospital corpsmen. If the retake rate exceeds these thresholds, then the monthly QA report will document what corrective actions have been taken (e.g. training) to reduce the retake rate.

3. Reporting of Radiology Results. SMOs must ensure that the results of radiology studies performed are entered into the medical record in a timely fashion after review by a medical provider. Documentation of this review must be accomplished by the provider placing their initials on the x-ray report or TMIP-M radiology module can fulfill these requirements when provider acknowledges the results in the EHR.

4. Disposition of X-Ray Studies. Shipboard x-ray studies must be maintained on board for five years. After that time, they may be disposed of in accordance with SECNAVINST 5210.8F.

5. Digital Radiology System

a. A CR system has been installed on all CVNs. CR systems are composed of three major components: x-ray machine, CR system, and the PACS. The functions of each component are listed in table 8-1.

X-Ray Machine	CR System	PAC System
•Generates x-ray beam •Exposes patient to create image on a cassette	•Extracts and digitizes the image from the cassette •Creates image •Digitizer and computer to process images	•Collects and stores the images •Displays the images •Transmits the image to MTF for reading

Table 8-1 CVN Computer Radiography Configuration

b. Support, repair, and maintenance procedures for the CR system are provided via a two-tier process as listed below:

(1) Tier 1 Support Ship. The ship's bio-medical equipment technician (BMET) evaluates the situation and attempts to fix the problem.

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

(b) Software. If the ship's automated data processing (ADP) staff have attended CR system administrator training, the ADP staff may attempt to restore the system to its original configuration. CR software or application configuration issues cannot be addressed by the ship's combat system department (CSD) administrator. Such issues need to be routed directly to the Navy Telemedicine Business Officer and Telemedicine Technical Support Center (TTSC) for timely assistance, in accordance with manufacture warranty, which states that only certified maintenance technicians can configure software.

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

(a) Assistance through references or troubleshooting via the vendor's website.

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

c. Approved Parts List (APL). NAVMEDLOGCOM and NAVICP-M are responsible for developing the CR APL. NAVICP-M will complete the APL process and ensure the approved (populated or non-populated) APL is introduced to the CVN weapons system file and the class configuration manager.

6. X-Ray Equipment Performance Evaluation. BUMEDINST 6470.22B provides guidelines regarding diagnostic x-ray equipment. Of particular note, each medical and dental x-ray machine requires performance testing every two years. Contact the supporting MTF radiation safety department to schedule the testing. Retain all copies of performance testing on board for three years. Operation of x-ray equipment without a current letter of certification requires a waiver from the TYCOM.

7. Teleradiology (TR)

a. General. TR involves the electronic transmission of digitized x-ray images from one location to another for interpretation by a radiologist. The purpose of TR is to provide timely expert x-ray interpretation to the remotely located health care provider to facilitate clinical management and thus improve patient care.

b. CVNs using the medical website server will transmit via MEDWEB and the reports will be generated back to the carrier via the MEDWEB server. In general, this is a rapid process. CVNs using the Radworks server will transmit using a MEDWEB IP address. The x-ray reports are encrypted and sent back via the internet to a common access card-enabled computer terminal in the carrier medical department for download. This is a slower process that is bandwidth constrained.

c. The specific procedures for obtaining interpretations via electronic communications are dependent upon the urgency of the need, whether immediate (STAT) or routine. The provider requesting x-ray interpretation will determine the level of urgency, using the following guidelines:

(1) Stat Interpretation. The radiograph and pertinent medical history should be sent by the most expeditious means available. The TR interpretation site will provide a report by telephone (if possible) and will generate an electronic interpretation within four hours of receipt of the x-ray image and notification of the stat TR request.

(2) Routine Interpretation. CD-R files can be mailed via CD to designated MTF weekly for interpretation when bandwidth is limited or not available for routine studies. The site requesting interpretation will transfer digitized x-rays to a CD-R using a “lossless” compression or uncompressed format on a weekly or bi-weekly schedule, depending on volume, urgency, and mail routing availability. To avoid duplication, send only files that have not been previously transmitted for stat interpretations. The TR interpretation site will send an electronic report or mail a paper report within one week of receipt of the x-ray studies.

e. Communication. Effective communication between transmitting referral sites and the consultation sites is crucial to the success of TR. Ships should communicate with the MTF regarding the volume of radiographs being sent via mail (on CD-R) or electronically so the MTF can efficiently integrate them into their workload. Additionally, specific information on how to access resources, including telephone numbers, e-mail addresses, points of contact (POC), and internet interfaces, must be readily available to all participants and should be acquired and tested before the ship gets underway.

f. Documentation. Documentation includes providing timely permanent reports for the individual patient’s medical record, local temporary image back-up, permanent storage (archive) of the digital (filmless) x-ray images, and accurate workload captured.

(1) Reports. The MTF providing the interpretation will generate a report for permanent documentation in the patient's medical record. The facility receiving the TR service is responsible for ensuring that a report is received for every image and that the report is entered into the patient's medical record. The requesting site and the MTF consultation center providing study interpretations must coordinate business rules to ensure the reports are delivered electronically or by regular mail, depending on the communication capabilities and/or limitations of the medical sites.

(2) Archives. CVN medical departments must backup the image and report files locally, and are required to maintain the image files on board for five years.

g. TR Quality Processes. Each CVN requesting TR services will establish an SOP to:

(1) Monitor x-ray quality,

(2) Ensure timely delivery of images to the MTF by TR electronic direct transmission or CD-R removable media,

(3) Maintain temporary local backup libraries until the MTF has received and reported the final interpretation, and

(4) Enter the final report into the patient's medical record. Problems with service will be addressed with the TR coordinator at the MTF.

(5) Address problems with service with the TR coordinator at the MTF.

8-4. Optometric Services

1. General

a. Optometric services will be provided to active duty personnel of the uniformed services in accordance with SECNAVINST 6810.1.

b. Spectacle prescription, DD Form 771, must be used for requesting spectacles or repairs. Special requests will be documented in the "special lenses or frames" block. Examples are tinted lenses due to topside watches, or frames of choice (FOC).

c. Under the FOC Program

(1) The CVN medical department is responsible for:

(a) Overseeing the ordering and maintenance of the required supplies to support the FOC Program.

(b) Fabricating FOC eyeglasses for CVN personnel, the embarked CVW, and the deployed CSG.

(2) CVN supply petty officers are responsible for ordering current authorized FOC supplies through the electronic catalogue or through open purchase from authorized vendors, Rochester optical, 1260 Lyell Ave., Rochester, NY, 14606, phone (800)820-6616, https://rochesteroptical.com. or Randolph Engineering Eyewear, 26 Thomas Patten Drive, Randolph, MA 02368, phone (800) 541-1405, https://www.randolphusa.com.

(3) FOC supply related questions may be directed to the COMNAVAIRFOR force medical supply and logistics POC at (619) 545-1148, DSN 735-1148.

(4) FOC program technical guidance may be obtained from the Naval Ophthalmic Support and Training Activity by calling (757) 887-7600 Ext: 1, DSN: 953-7600 Ext: 1, or by email at nostra-customer-service@mail.mil.

d. According to SECNAVINST 6810.1, air controllers or flight deck personnel must not be issued flight goggles. Flight deck personnel should be issued spectacles in accordance with paragraph 2-4, of the above instruction. However, under the FOC program they may choose to receive one pair. Note that tinted lenses are authorized for flight deck, air controller personnel, and others whose duties require them to stand topside watches.

e. HMs qualified to perform refractions, must have a page 13 entry signed by the SMO and filed in the individual's personnel record. Aviator refractions should be countersigned by a CVW flight surgeon or SMO.

f. Optometry supplies (frames and lens blanks) may be received by CVN medical departments on a no-cost basis from Naval Opthalmic Support and Training Activity (NOSTRA). CVN desiring to receive such supplies must report optometric production metrics to NOSTRA on a monthly basis via email no later than the 15th of each month. The spreadsheet format for reporting optometric production metrics is available in electronic format from NOSTRA.

8-5. Sterile Processing of Equipment and Supplies

1. Event-related Sterilization. Sterilization of surgical, dental, and patient care equipment and supplies is a critical element in infection control and patient safety. CVN medical departments must utilize an event related sterilization program. Studies have demonstrated that once an object is sterile it will remain so until its protective wrapping is compromised. A pathogen is presumed to have been introduced if the integrity of the protective wrapping has been compromised. Therefore, sterility is related to an event vice being related to time. The requirements of the CVN central sterilization and reprocessing are covered in the joint

COMNAVAIRFOR and COMNAVSURFOR shipboard central sterilization and reprocessing SOP. Maintain a current copy on board.

a. Steam Sterilization. Sterile processing of equipment and supplies for surgical procedures and patient care must be by steam sterilization.

b. Liquid Chemical Sterilization. Endoscopic equipment including items that are sensitive and may be damaged by heat and pressure will be sterilized using the STERIS sterilizer. In the event the Steris sterilizer is non-functioning, chemical high-level disinfection with items such as CIDEX-OPA may be utilized temporarily until the unit is operational.

c. Standard sterile processing procedures as outlined in paragraphs below will be adhered to for steam, liquid chemical sterilization, and high-level disinfection procedures.

d. Standard sterile processing procedures will be followed, to include: proper hand washing, strict cleanliness of the processing room, controlling traffic through the processing room, no use of rubber bands, and not carrying sterile items under arms or in unsanitary containers. Double wrappers are required. If linen wrappers are used, an extra blue polyethylene wrapper must be added. Both of these wrappers are in the AMAL. In addition, if the item is to be stored outside of the main BDS, it must be plastic wrapped with a double heat seal. For single items, double peel pack with a double heat seal is authorized. In all cases, ensure proper drying and cooling to prevent rust and contamination from condensation.

e. After an item has been sterilized, it must be labeled with a sticker, which states, "STERILE Unless Package Opened or Damaged, Check Before Use." The sticker must also be labeled with the date sterilized and the batch number. A sterilization log must be kept and will contain the date processed, item sterilized, batch number, temperature of sterilizer, amount of time sterilized, and biological indicator results. Biological indicators should be run daily but, at a minimum, will be run once a week.

f. Sterile items should be stored in closed cabinets whenever possible. Otherwise, they will be stored on open shelves and must not be within 12 inches of the deck or overhead. Sterile items must not be stored within two inches of walls or bulkheads unless they are properly lined and in good repair. Under no circumstances will sterile items be stored next to bulkheads that have been known to form condensate. Sterile items that will be stored on open shelves for more than one year require dust covers. Ideal storage conditions are 64-72 degrees Fahrenheit with 35-70 percent humidity. Under these conditions the heat-sealed plastic cover will provide the necessary protection for sterile items. Sterile items exposed to temperature above 80 degrees Fahrenheit, or humidity greater than 80 percent must be re-sterilized. Each space where sterile gear is stored on open shelves will be cleaned at least weekly. Sterile gear will be rotated so that the oldest gear will be used first. New items are placed in the back, and old items are placed in the front.

g. Sterile items must be inspected before use. They will also be inspected during the semi-annual BDS and mass casualty box inventories. Look for damage to the outer wrapper. Damage is defined as a hole or tear in the package, wet or moist package, dropped on floor, unsealed or broken seal, resealed with tape, or otherwise compromised. Damaged items must be re-sterilized. When in doubt, remove the package from service and submit it for re-sterilization.

h. After each extended availability period in excess of 90 days, all sterile gear will be opened, inventoried, and re-sterilized. This requirement conducted is for equipment accountability purposes.

2. Sterilization Records. A record of sterilizer use must be maintained, and must include the following information:

a. Sterilizer number or ID.

b. Sterilization load number in the format DDMMMYY-## (i.e. 23JAN01-01). The first load of every day is load # 01, and loads are consecutively numbered thereafter for that 24-hour period.

c. List of items and packs in the sterilizer load.

d. Length of exposure time of load.

e. Maximum temperature of sterilization for exposure.

f. Results of biological indicator testing with each load.

3. Sterilizer Testing

a. In addition to maintenance, in accordance with PMS requirements, all sterilizers on CVNs will be tested (at a minimum) on a weekly basis with a biological indicator. A bowie-dick test should be run with the first cycle every day or at least weekly if the sterilizer has not been used. Follow the manufacturer's directions for processing the biological test. Ensure that testing is completed on all sterilizers, and not just the steam sterilizers.

b. Results of testing are to be recorded in the sterilization record and will be maintained for a minimum of two years

CHAPTER 9
RADIATION HEALTH PROTECTION

1. General. The requirements of the Carrier Radiation Health program are covered in COMNAVAIRPAC/COMNAVAIRLANTINST 6470.5.

CHAPTER 10
NUCLEAR FIELD DUTY

1. General. Nuclear field duty (NFD) involves work in the Naval Nuclear Propulsion or Nuclear Weapons Programs. A high degree of reliability, alertness, and good judgment is required in order for operations to be conducted safely and to maintain the integrity and accountability of these critical programs. It should be noted that NFD is not the same as occupational exposure to ionizing radiation (ionizing radiation work). While all nuclear field personnel must also be qualified as ionizing radiation workers, not all ionizing radiation workers are nuclear field personnel. Examples of the latter category are medical radiology personnel and industrial radiographers. The requirements for NFD examinations and standards are outlined in MANMED P-117, chapter 15-103.

2. Nuclear Field Duty. The SMO assisted by the RHO and the MAO is responsible for NFD qualifications. The NFD program is administered in accordance with the above instructions, which are directly from NAVMED P-117 chapter 15-103. For cases which NAVMED P-117, chapter 15-103 does not address, contact the COMNAVAIRPAC or COMNAVAIRLANT Radiation Health Officer or BUMED for assistance. Appendix M provides a template for NFD disqualification and waiver packages.

CHAPTER 11
MEDICAL SUPPLY AND EQUIPMENT

1. General. This chapter is a complete revision from the previous guidance and should be reviewed in its entirety. Since medical supply and equipment requirements evolve dynamically causing medical instructions to change frequently, each medical department is expected to post such changes as they are issued. The SMO is overall responsible for the medical department AMALs. The SMO will ensure all non-emergency AMALs remain at or above 90 percent readiness, and all emergency AMALs remain at 100 percent.

Note: Procurement of non-AMAL items is not authorized, without the approval of TYCOM force surgeon. This includes equipment, consumables, medications, and controlled substances not listed on the AMAL. The SMO may request to procure non-AMAL items, however, this requires prior written approval by the TYCOM force surgeon.

2. Organization. The medical department supply team is responsible for the timely reorder and requisition of all medical supplies and equipment. The MAO, DLCPO, and medical department repair parts petty officer (RPPO) will form the medical department supply team.

a. MAO and DLCPO. The MAO must be appointed as the supply team manager and the DLCPO must be appointed as the deputy supply team manager. These team members will act as primary liaisons between the medical and supply departments.

b. Medical Department RPPO. Each CVN medical department must assign a medical department RPPO (E-5 or above) to act as the medical material manager. The medical department RPPO will report directly to the MAO and DLCPO. If a logistics support person is assigned to the medical department, they will assist the RPPO.

c. Miscellaneous Supply Team Members. Additional team members that assist the medical department supply team are the pharmacy technician (PHARM tech), the BMET, and the PMT.

3. Medical Supply Program Management Assignments. Prior to being assigned any supply and medical equipment management duties, the below end users must gain familiarization and/or complete training as follows:

a. MAO, DLCPO, and RPPO. The MAO, DLCPO, and RPPO must have account access, and know-how to the use the following programs and reference material:

(1) TMIP (Must request access).

(2) Shelf-Life Extension Program (SLEP) (Must register for account).

(3) ECAT Trading Partner Account (Must register for "Approver" access).

(4) U.S. Army Medical Materiel Center, Europe (USAMMCE) (Must register for account access).

(5) Navy Assemblage Information Logistics System (NAILS) website.

(6) NAVMEDLOGCOM Home (MIL/GOVT) website.

(a) NAILS

(b) Fleet allowance parts list information.

(c) Device codes and life expectancy.

(d) Shipboard equipment replacement program (SERP).

(e) SERP, MSE, and TAH procurement status Fleet Procurement Program (FPP).

(7) Medical material quality control (MMQC) messages, medical material information (MMI) messages (Must request to receive notifications).

(8) Navy Medicine Online (NMO) website (Must register for readiness access).

(9) Shipboard Medical Procedures Manual chapters: 2, 5; 8; 11; 17; and 18.

(10) Medical master catalog (MMC) (Must request access via Defense Medical Materiel (DMM) Online).

b. PHARM Tech. The PHARM tech must have account access and know how to the use the following programs and reference material:

(1) TMIP (Must request access).

(2) SLEP (Must register for account).

(3) ECAT Trading Partner Account (Must register for "Approver" access).

(4) NAILS website.

(5) Pharma Logistics (Must register for account).

(6) MMQC messages and MMI messages (Must request to receive notifications).

(7) Shipboard Medical Procedures Manual chapters: 2; 5; 8; 11; 17; and 18.

c. BMET. The BMET must have account access/know how to use the following programs and reference material:

(1) TMIP (Must request access).

(2) NAVMEDLOGCOM Home (MIL/GOVT) website.

(a) NAILS

(b) Fleet allowance parts list information.

(c) Device codes and life expectancy.

(d) SERP.

(e) SERP, MSE, and TAH procurement status FPP.

(3) MMQC messages and MMI messages (Must request to receive notifications).

(4) Shipboard Medical Procedures Manual chapters: 2, 5, 8, 11, 17, and 18.

d. PMT. The PMT must have account access/know how to use the following programs and reference material:

(1) Vaccine Information and Logistics Systems (VIALS) via NAVMEDLOGCOM website (Must register for account access).

(2) Shipboard Medical Procedures Manual chapters: 2, 5, 8, 11, 17, and 18.

4. Medical Supply and Equipment Programs. Medical supplies and equipment are requisitioned and or maintained through the use of various online supply programs.

a. TMIP. The TMIP material management module is utilized to maintain a continuous inventory of all supplies and equipment onboard.

b. SLEP. Utilized to test the extension of large amounts of high cost pharmaceuticals (primarily 3005 AMAL Force Health Protection medications). Each ship is required to register a primary SLEP coordinator and one alternate SLEP coordinator (Primary: PHARM tech alternate: RPPO) or other designated personnel (PMT). The SLEP coordinators are required to validate/update all SLEP on-hand quantities every 90 days via the SLEP website. The PHARM tech must also monitor e-mail message traffic for SLEP notices and actions, and comply with

DoD/FDA system instructions regarding suspending, testing, destroying or re-labeling of extended material. When lots are sent out for testing purposes, the testing phase can take up to 18 months to complete and the test results are sent via e-mail from Defense Medical Standardization Board (DMSB). Training will be provided by TYCOM.

c. Prime Vendor Trading Partners Account Via ECAT. The prime vendor trading partners account accessed via the ECAT System, streamlines medical and surgical supply procurement options. ECAT is a net-centric ordering, distribution, and payment system providing the DoD and other Federal customers access to multiple manufacturer and distributor commercial catalogs.

d. MMC. The MMC application provides users the ability to execute product searches and product souring requests against the MMC. The MMC Web Application includes a sophisticated product search capability that will assist users in finding products that they are interested in. Once found, users can immediately execute a sourcing action for one or more of the products of interest that will return a list of executable sources for the product to their associated Department of Defense Activity Address Code (DoDAAC). This souring results set identifies source program (e.g., prime vendor, ECAT, readiness ECAT) and includes product ordering numbers Prime Vendor Online (PVON), National Distribution Center (NDC), as well as pricing available to that customer. The application also provides product information, National Stock Numbers (NSNs) associated to a given product, equivalent products based on first data bank and supply line classification and product identifier cross references (manufacture part number to PVON to vendor catalog number).

e. NAILS. Provides listing of most current CVN AMAL items.

f. Operational Forces Support. Utilized to manage medical equipment via the NAVMEDLOGCOM website. Under the “operations forces support” tab the following programs and documents are accessible:

(1) Fleet Allowance Parts List Information. Complete listing of equipment APLs.

(2) Device Codes and Life Expectancy. Complete listing of medical equipment device codes and average life expectancy.

(3) SERP. Annual medical equipment requests for items over $5,000 that are replaced utilizing fleet funding.

(4) SERP, MSE, and TAH Procurement Status Also Known as FPP. Utilized to document the receipt of SERP equipment received by the unit ordered via the SERP program. Allows the fleet to have visibility of all requirements with the SERP program. Additionally, tracks SERP buys from contract awarding to shipment to the unit. Immediately after new equipment is received, receipt acknowledgement is entered by the BMET in FPP.

g. MMQC and MMI Messages. Utilized to control medical and dental products through quality deficiency reporting.

h. SAILOR. Utilized to download TMIP AMAL quarterly updates for all CVN assemblages. The medical department will coordinate with their ship Information Technology Department to complete quarterly installations.

i. VIALS. VIALS is NAVMEDLOGCOM web application that manages seasonal influenza vaccine distribution and status information for the naval hospitals, the fleet, and Navy and Marine Corps reserve units.

j. Pharma Logistics. Cardinal Health has teamed up with Pharma Logistics, a nationally recognized pharmaceutical returns company, to offer a hassle-free returns program. CVNs can now process expired, unsalable products through pharma logistics and receive credits towards the purchase of pharmaceuticals.

5. AMAL. The medical material requirements for CVNs are listed in each AMAL that can be referenced via the NAILS option on the NAVMEDLOGCOM website. Each ship must maintain all AMALs and ensure all non-emergency AMALs remain at or above 90 percent readiness and all emergency AMALs remain at 100 percent readiness.

a. Fleet AMAL Taxonomy. AMALs are numbered with assigned platform specific numbers. The first two digits identify the platform. (ex. 3023-CVN Nimitz Class ship, 3223-CVN Ford Class ship). The last two digits identify the functional area (ex. 3023-ICU CVN Nimitz Class, 3223-ICU CVN Ford Class).

b. Non-emergency AMALs. The AMALs are considered non-emergency AMALs are 3005/3205 through 3036/3236 and must be maintained at 90 percent readiness at all times unless authorized to deviate from this practice in writing by the TYCOM force surgeon.

c. Emergency AMALS. The AMALs are considered emergency AMALs are 3050/3250 through 3058/3258 and must be maintained at 100 percent readiness at all times unless authorized to deviate from this practice in writing by the TYCOM force surgeon. These AMALs are stocked and maintained in accordance with the annually published CVN Battle Readiness Gear Sets Notice (COMNAVAIRFORNOTE 6000) as partial quantities due to limited space, etc. A copy of this documentation is kept on file at the TYCOM force surgeon's office and a copy must be kept on file onboard the ship as an MRI inspectable item.

d. AMAL Assemblage Codes. Since medical supply and equipment requirements evolve dynamically, AMAL items are in constant fluctuation and can change on a quarterly basis. When AMAL items change, they are given replacement prioritization codes that instruct the end user on when and how to replace them.

(1) The following table is an explanation of AMAL codes:

Table 11-1 AMALs Assemblage Codes

CODE	EXPLANATION
A0	Added to allowance list. New items should be added to stocks as soon as practical using ships OPTAR funds.
A1	Added to allowance list. Field activities are to order this as a replacement item after stock of the corresponding deleted item have been exhausted or are no longer usable.
A2	Technical Operational Budget (TOB) funded item. Initial outfitting item added to allowance list. Military strip requisition should be forwarded by ship's supply department for procurement citing NAVSEA OPN Medical/Dental TOB funding.
A3	Added to allowance list. Field activities are to order this item immediately to replace stocks of the corresponding deleted item.
A4	Added to allowance list. Material will be processed and delivered to ship at the discretion of COMUSFLTFORCOM/NAVSEA.
A5	Added to allowance list. No procurement action is necessary. Administrative change in NSN, nomenclature, unit of issue, standardization action, etc.
D0	Deleted from allowance list without replacement; field activities are not authorized to carry this item. Contact TYCOM for disposition instructions.
D1	Deleted from allowance list. Field activities are to retain and use the item until stock has been exhausted or is no longer usable.
D3	Deleted from allowance list. Field activities are to dispose of the item immediately.
D5	Deleted from allowance list. No procurement action necessary. Administrative change for NSN, nomenclature, unit of issue, standardization action, etc.
NQ	Quantity Change made for this NSN. Code indicates new allowance quantity. If this represents a quantity increase, activities are to order the additional quantities at the discretion of COMUSFLTFORCOM /NAVSEA. If there is a quantity decrease, activities are to use existing stock until they reach the new (decreased) level, until stock of the deleted item has been exhausted, or until stock is no longer usable.

e. Non-AMAL Items for Deployment Operations. In the event a deployment operation requires the use or procurement of non-AMAL items (i.e. consumables, medications, controlled substances) the following is required: the MAO must prepare on command letterhead a detailed memorandum containing the NSNs, nomenclature descriptions, quantities required, and appropriate justification substantiating the need for these items. The SMO must sign the memorandum and forward to the TYCOM force surgeon for review/approval. This written documentation must be kept onboard for two years and is an MRI inspectable item.

6. AMAL Custody and Inventory Periodicity. The MAO and DLCPO in conjunction with the RPPO are responsible to the SMO for the custody and inventory of medical material and equipment and must not permit waste or abuse of medical supplies and equipment. When a

change in manning occurs with the SMO or DLCPO, an inventory must be completed and documented prior to turnover in the medical supply bulkhead-to-bulkhead log. All inventories are to be documented and will be maintained onboard for two years as a MRI item.

a. In company with the outgoing SMO and DLCPO, the new SMO and DLCPO must review the status of the medical department AMALs prior to assuming duty. At a minimum, this procedure must:

(1) Ensure a bulkhead-to-bulkhead inventory has been conducted of all AMALs on-hand.

(2) Ensure all non-emergency AMALs are at or above 90 percent readiness and all emergency AMALs are at 100 percent readiness. These materials must be on-hand and not on order.

(3) Ensure all material expiring in the next 120 days has been identified and placed on order.

(4) Ensure the most current version of TMIP is installed and being utilized on the medical department computers.

(5) Ensure a complete equipment inventory is accomplished and reconciled. All discrepancies will be identified and investigated prior to departure.

b. Inventory Periodicity. AMAL and equipment items must be inventoried at least annually. This may be accomplished by a one-time bulkhead-to-bulkhead inventory or by inventorying 10 percent of line items each month. Local spot-checks must be conducted daily in storerooms and workspaces. To maintain AMAL inventory accuracy, it is imperative that the most current version of TMIP is installed and utilized. As an MRI inspectable item, daily, weekly, and monthly database back-ups must be conducted and stored on an authorized government external storage device. In addition to the annual requirement, it is highly recommended nine months prior to a planned deployment, a bulkhead-to-bulkhead inventory is conducted. All findings and solutions should then be documented on a memorandum and forwarded to the CO and TYCOM Force Surgeon to establish a supply Plan of Action & Milestones (POA&M) for deployment preparations.

7. Medical Funding. The budget submission of the medical OPTAR should be calculated by taking into consideration the ship's schedule, the average of the OPTAR amounts for the previous three years, and consideration for inflation. These amounts are not intended to limit the maximum/minimum obligations for requirements.

a. OPTAR Log. The OPTAR log is a ledger style accounting for all supply requisitions. The TMIP supply module has an OPTAR log and is the preferred method to track supply

requisitions. If the use of TMIP is not feasible, or if the command requires the use of another medium, this requirement must be waived.

b. Report 21. The report 21 is a report generated by the supply department that shows requisition status and actual cost of individual items. This report is used like a bank statement to reconcile and balance the OPTAR log.

c. Embarked Units. Medical supply and equipment usage for all embarked units has been calculated into the organic minimum quantity on board operating amounts for all AMALs. Therefore, separate funding is not provided by the ship or TYCOM to augment medical supplies or equipment for embarked units. All embarked units on board CVNs will draw medical consumables and use medical equipment on board within the medical department.

d. Open Purchases. An open purchase is accomplished by completing and submitting a NAVSUPP Form 1149 or by using the command's impact card. The impact card can be used similar to a credit card for purchases under $3,500. Specific guidelines exist for the use of an impact card. Contact your supply department for guidance on the use of these cards.

e. Medical Equipment Purchases. All medical equipment required by AMAL that has a cumulative cost over $5,000 will be replaced utilizing fleet funding via SERP. All equipment required by AMAL that has a cumulative cost below $5,000 is to be procured through the ship's regular OPTAR funds. CVNs will notify the TYCOM force surgeon's office prior to requesting third party support to perform specific maintenance, calibration, or certifications for medical equipment to avoid unauthorized third party vendor commitments. Once approved by the TYCOM force surgeon's office, these maintenance contracts will be funded from the ship's OPTAR. Individual visits are funded by submitting a NAVSUPP Form 1149 open purchase document. Specific pieces of equipment that may require this level of support are: anesthesia equipment, chemistry analyzer, computed radiography unit, ventilators, and the audiometry booth.

8. Medical Supply Tracking and Requisition Methods

a. Medical Supply Tracking. To track various supply requisitions, the supply department publishes a monthly material obligation verification (MOV) report. The supply department forwards this list to the medical department to validate receipt of material ordered. The RPPO then validates the list for accuracy and must report all outstanding requisitions greater than 30 days to the MAO or DLCPO for further action. The SMO will then sign the MOV and return to the supply officer.

b. Requisition methods. Medical supplies are requisitioned using multiple procurement methods based on the operational status of the ship and type of material. Below is a list of various requisition requirements and recommendations:

(1) Pier side. When CVNs are pier side for an extensive amount of time, it is highly recommended that all medical materials be requisitioned through their prime vendor trading partner account via ECAT. Materials requisitioned this way are likely delivered within 48-72 hours via the Defense Logistics Agency (DLA) warehouse where the ship is stationed. It is imperative that the MAO, DLCPO, and RPPO establish solid lines of communication with their local DLA representative to ensure the timely movement of medical material from the warehouse to the ship. R-Supply, MILSTRIP, and MILSTRAP can still be utilized to requisition medical material while pier sides, however shipping times are historically slower when utilizing this requisition method.

(2) Underway. When CVNs are deployed, it is highly recommended that medical materials are requisitioned using the below methods in the following order to expedite delivery of items:

(a) U.S. Army Medical Materiel Center, Europe (USAMMCE). USAMMCE provides expedited medical logistic support to warfighters in European Command (EUCOM), African Commnand (AFRICOM), Central command (CENTCOM), and to the Department of State. Prior to deployment, it is highly recommended that the RPPO register for a USAMMCE account and use this as the primary method to procure medical materials while deployed.

(b) R-Supply, MILSTRIP, and MILSTRAP. It is highly recommended that the R-Supply, MILSTRIP, and MILSTRAP methods be used as a secondary option to procure all items on the AMAL that have a NSN as this is a slower procurement method than using USAMMCE. When ordering through R-Supply, MILSTRIP, and MILSTRAP, it is important to note medical material will be delivered to the medical department based on the priority code it was given at the time of requisition. As such, RPPOs must ensure all medical material items are requisitioned with a “777” or “999” code and assigned a requisition priority code of either “3” or “5”. Specific guidance on the priority of requisitions may be found in the R-Supply, MILSTRIP, and MILSTRAP manual, and the NAVSUP P-485.

9. Controlled Substance Requisitions. According to COMNAVAIRFORINST 4440.2C, chapter 4, section 406: “schedule II-V narcotics are not permitted to be ordered from a prime vendor by the supply department. Instead, all controlled substances must be ordered by the medical department using a standard R-Supply, MILSTRIP, and MILSTRAP requisition method."

Note: Only the bulk custodian is authorized to sign for receipt of controlled medicinals arriving on board.

10. Vaccination Requisitions

a. Annual Influenza. On an annual basis, the influenza vaccinations are procured using VIALS. PMTs must be responsible for submitting the annual influenza requests during the

second quarter of the current fiscal year through the VIALS's website in accordance with the annual Naval Administration publication so that they may be delivered and administered to patients during the first quarter of the following fiscal year. Once quantities have been requested, the PMT must notify the MAO or DLCPO of the completion and in turn reports to the TYCOM force surgeon's office in preparation of the upcoming influenza vaccination process.

b. Requisition of Vaccinations other than Influenza. All other vaccinations are requisitioned through R-Supply, MILSTRIP, MILSTRAP, or prime vendor trading partners via ECAT.

11. Medical Material Quality Control (MMQC). Each CVN must maintain a strict quality control program for all medical material onboard. This must consist of frequent inspection, examination, and shelf-life material management procedures.

a. Shelf-Life Management. The following procedures will be established to maintain shelf-life management:

(1) Material must be issued and used according to shelf-life on a "first in, first out" basis.

Note: Potency dated material is material having a definitive storage period (expiration date). When an expiration date is given as a "Month/Year" (MM/YYYY), the material is considered to expire on the last day of the month. Material must be inspected regularly and estimated shelf-life must be recorded. Any material that has shelf-life extensions must be labeled and replaced as indicated. To avert accidental usage, expired material must be re-ordered, removed from stock prior to expiration dates, and properly disposed as soon as possible.

(2) A records accounting system that adjusts promptly to reflect the results of material requisitions, receipts, and dispositions. Material must be regularly inspected.

(3) A records accounting system that tracks SLEP test results on force health protection material.

(4) A records accounting system that tracks MMQC messages. The system must document actions taken or not applicable on each MMQC message received. This documentation must be kept on file for two years, either electronically on a government approved storage device or by keeping a hard copy binder. It is highly recommended that the PHARM tech sign up to receive MMQC messages, as most of the items recalled tend to be medications centric.

12. Reporting Defective Medical Supplies. Upon the receipt or discovery of defective or unsatisfactory medical material, CVNs must suspend all stocks involved from issue and use. Materials received with less than six months of shelf-life remaining must be sent back to the vendors for refund and/or exchanges.

a. Material Complaints. Reports must be made in accordance with the provisions of BUMEDINST 6710.63C. Material complaints are categorized into three sub groups as follows: category I, category II, and category III. Copies of reports must be provided to the TYCOM force medical offices on both coasts. Prior to submission of any report, the inadequacy or unsuitability of the item must be thoroughly evaluated by medical, supply, and/or maintenance personnel. Only items that are considered to be injurious or unsatisfactory due to inherent characteristics must be reported. Items involving idiosyncrasies or sensitivities or individual patients must not be reported. For material purchased through prime vendor trading partners, users must follow the existing vendor's material returns guidelines as published.

(1) Category I Complaints. This includes equipment determined to be harmful or defective to the extent that use has already or may cause death, serious injury, or illness. Category I complaints must be sent via priority message to the DLA Troop Support. Telephone calls are acceptable, followed by a written detailed supply deficiency report (SDR).

(2) Category II & III Complaints. Category II complaints include material or medical items, other than equipment, suspected of being harmful, defective, deteriorated, or otherwise unsuitable for use. Category III complaints include equipment determined to be unsatisfactory due to malfunctions, design, or defects caused by faulty material, workmanship, quality inspection or performance. Both category II and category III complaints require original and four copies of the SDR to the DLA Troop Support. One additional copy of the report must be furnished to both the NAVMEDLOGCOM, Fort Detrick, Maryland, MD; and DMSB, Fort Detrick, Frederick, MD.

(3) Pharma Logistics. All CVNs are required to register an account with Pharma Logistics in order to return expired, damaged, or excess products (dependent on the manufactures return policy, they can be awarded credits for return). Credits issued can only be used to purchase pharmaceuticals and must be used within 90 days of issue, however can be extended up to 180 days for deployed units via TYCOM request. The PHARM tech can contact the Pharma Logistics pharmaceutical program representative to help identify which products intended for disposal are actually returnable for credit. Pharma Logistics can be reached via telephone at (888) 729-7427, business hours Monday to Friday, 0700hrs-1600hrs, central time; website: www.pharmalogistics.com.

13. Disposal of Medical Material (Medicinals). All medical department personnel are cautioned that medical material should be disposed of in a manner as to ensure the medical material is rendered non-recoverable for use and harmless to the environment.

a. As stated in DoD Manual 4160.21-M, Defense Utilization Disposal Manual, "Destruction will be complete, to preclude use of the drug or any portion thereof." Security of all medicinals must be maintained to ensure inaccessibility by non-medical personnel. The following guidelines must be used when disposing of medicinals:

(1) Tablets, Capsules, Powders. Remove from the original container, crush or break tablets and capsules, and flush into the sewage system. Flush in small quantities to ensure that you do not plug the sewage piping system.

(2) Injectables and Parenterals. Remove the stoppers from the bottle, injectors, or open vials as directed, then express contents into the sewage system. Dispose of needles in sharps container.

(3) Auto Injectors. Offload in bulk as medical waste.

(4) Biologicals. Whether dried or suspended in liquid, these materials must be:

(a) Incinerated,

(b) Injected with enough sterilizing agent to kill the live biological agent, or

(c) Pressure steam sterilized.

Note: If one of the latter two procedures is used, the sterilized contents of the containers should be emptied into the sewage system and the containers disposed of in a bio-hazard bag. At no time must medicinals be disposed of over-the-side, in whole or in part.

b. Each pharmacy will maintain a "survey and destruction log" for non-controlled substances. The log will indicate:

(1) Name,
(2) Nomenclature,

(3) NSN,

(4) Lot number,

(5) Manufacturer,

(6) Expiration date,

(7) Amount,

(8) Date,

(9) Method of destruction, and

(10) Signature of PHARM tech.

c. Survey and destruction of controlled substances, narcotics, and alcohol must follow the guidelines of chapter 8, section 1, paragraph 5 of this instruction.

d. Destruction of the above materials should be accomplished in a well ventilated and secure area. In addition, when working with liquid substances subject to absorption through the skin, the wearing of goggles and neoprene rubber gloves is required followed by thorough hand washing in every case.

14. Disposal of Excess Quantities or Deteriorated Controlled Substances. Excess or deteriorated quantities of controlled substances requiring special custodial care will be disposed of according to MANMED, chapter 21, the Afloat Medical Waste Management guide (OPNAV P-45-113-3-99) and chapter 17, section 3, paragraph 6, of this instruction.

a. For forces afloat, medical waste is classified by OPNAVINST 5090.1D, chapter 22 as either infectious or non-infectious medical waste that are managed in accordance with OPNAV P-45-113-3-99.

b. Pharmaceutical Items Offload. Naval stations are subject to federal, state and local regulations for medical waste management and disposal. As the naval station is typically the receiver for offloaded material, it is important to contact the homeport environmental office prior to offloading any pharmaceutical Items. If a medical product meets federal or local jurisdiction hazardous waste criteria, and is not classified as a biohazard, sharp, or pharmaceutical, the waste is disposed by the receiving shore activity as a hazardous waste and not as a medical waste.

c. The following procedures should be followed when the ship's SMO has determined that excess pharmaceuticals need to be offloaded:

(1) Where appropriate, utilize the DoD Pharmaceuticals Reverse Distribution Program accessible through pharmalogistics website.

(2) If unable to effect reverse distribution, request the ship's afloat environmental protection coordinator to contact the base environmental office at ship's homeport with the MSDS specifics on the material involved. Base environmental will be able to access contracts already in place to dispose of the material in a manner that is consistent with the homeport state laws and avoid potential violations and fines for the U.S. Navy.

CHAPTER 12
FACILITIES AND EQUIPMENT MAINTENANCE

1. Medical Equipment Maintenance and Repair Program

a. COMNAVAIRFOR CVNs will comply with COMUSFLTFORCOM/ COMPACFLTINST 4235.7 and OPNAVINST 4790.4F for equipment management and maintenance policies. Maintenance and repair of medical and dental equipment is the responsibility of the BMET as supervised by the MAO, and DLCPO.

(1) When new equipment arrives on board, it must be entered into the OMMS-NG and 3M/PMS Schedule (SKED) to update the ship's records. A separate entry must be submitted to remove the old unit. This provides an accurate listing in the Ship's Master System Weapons File and the Configuration Data Manager's Database – Open Architecture (CDMD-OA) database. It also drives spare parts provisioning through the Coordinated Shipboard Allowance List (COSAL) system. These procedures are all defined in OPNAVINST 4790.4F. To submit to the 3M coordinator, provide the APL and Allowance Equipage List (AEL) numbers for the new piece of equipment. These numbers can be obtained from the NAVMEDLOGCOM web page at http://www-nmlc.med.navy.mil/. Once logged in using the MIL/GOVT link, click the operational forces link and then choose APL from menu selection on the left. This page also offers all accompanying BMET information pertaining to the equipment AMALs (SERP, APLs, NSN search) and required information for documentation.

(2) To update the maintenance procedures, a feedback report is submitted to the 3M coordinator to add the new piece of equipment and remove the old one from the ship's maintenance program. Follow the manufacturer's recommendations for preventive maintenance until the actual PMS cards arrive.

(3) A NAVMED Form 6700/3, medical and dental equipment maintenance record, is required for all equipment with a value of $5,000 and above. This record provides documentation for all unplanned but performed maintenance and additionally provides inspectors a quick method of checking for equipment updates and efficiencies of BMET program management ability for units.

(4) If mission essential equipment malfunctions, and is beyond the BMET's ability to repair it, the ship (MAO and BMET) must contact the TYCOM for assistance and if necessary, the MAO submits a CASREP in accordance with OPNAVINST 4790.4F. Contact the ship's maintenance manager for assistance in submitting the CASREP. Ensure that Force Health Services, COMUSFLTFORCOM/COMPACFLT Health Services, and NAVMEDLOGCOM are informed on the CASREP message. The COMUSFLTFORCOM/COMPACFLT SERP's account supports medical equipment CASREPs according to COMUSFLTFORCOM/ COMPACFLTINST 4235.7. NAVMEDLOGCOM will assist in coordinating a qualified BMET or a company technician to conduct repairs.

(5) Equipment that is no longer serviceable or being upgraded may be sent to DRMO for reutilization or disposal. Maintain disposal records in equipment files for a minimum of two years.

2. Medical Material Requirements

a. Coordinated Shipboard Allowance List (COSAL). The COSAL is an authoritative document that lists:

(1) The equipment or components verified by ship's configuration and logistics support information system configuration data manager (CDM) to be installed on a ship to perform its operational mission.

(2) The repair parts and special tools required for the operation, overhaul, and repair of equipment or components.

b. Allowance Parts List (APL) and Allowance Equipage List (AEL). Spare parts and consumables required to support medical equipment are listed on the APL and AEL. APL and AELs:

(1) Are developed and managed by NAVMEDLOGCOM and are submitted to the NAVICP-M to establish COSAL support.

(2) List the technical characteristics of a particular piece of equipment to include logistic and supply information.

(3) Identify all maintenance repair parts associated with the equipment. Each repair part listed has potential to fail during normal operation and is a possible allowance item; however, only those with a sufficiently high predicted failure rate, an actual replacement rate, and items required for planned maintenance or safety of the ship's personnel or mission will be authorized and listed in the COSAL. Force medical, in conjunction with force supply, will review and designate items that will be carried at all times.

3. Radiation Protection Survey and Equipment Performance Test of Diagnostic X-Ray Equipment.

a. References. BUMEDINST 6470.22A change-1 provides guidelines regarding diagnostic x-ray equipment. Of particular note, each medical and dental x-ray machine requires performance testing every two years. A list of approved surveyors may be obtained from NAVMEDLOGCOM and Navy and Marine Corps Public Health Center (NMCPHC). Retain all copies of performance testing on board for three years. Operation of x-ray equipment without a current letter of certification requires a waiver from the TYCOM force medical. (See chapter 8, section 3, paragraph 6).

4. Oxygen Handling and Storage

a. At least one oxygen cylinder must be available for ready use in the main BDS, OR, and the ICU (i.e., with regulators installed at all times). When activating the remaining BDSs, oxygen regulators will be installed on the working oxygen cylinder and checked to ensure availability of an adequate supply of oxygen. If a BDS is secured from use for extended period of time, regulators should be removed and stowed safely to prevent inadvertent tank bleed-down. Note that installing regulators will change the frequency of PMS pressure checks.

b. Oxygen cylinders should be mounted off the deck and stowed according to grade B shock mounting and OPNAVINST 5100.19F. Oxygen cylinders will be mounted in permanent storage racks. Once a cylinder is placed into service, the person using the cylinder must modify the "Full/In Use/Empty" tag (DD Form 1191 or equivalent) to indicate the fact that the cylinder has been placed into service. When empty, the tag will be changed to indicate the tank is empty.

c. Empty cylinders are to be filled at the earliest opportunity and must never be stored in the racks provided for full cylinders. Cylinders will be filled to capacity, and kept ready for immediate use.

d. The following oxygen handling and stowage regulations, based on those of the Compressed Gas Association (http://www.cganet.com/), must be observed and posted in each area where medical oxygen tanks are used or stored.

(1) Oxygen cylinders, meeting 3A or 3AA Department of Trnasportation standards, must be hydrostatically tested and stamped in accordance with Naval Ship’s Technical Manual (NSTM) Chapter 550.

(2) Never permit oil, grease, or readily flammable materials to come in contact with oxygen cylinders, valves, regulators, gauges, or fittings.

(3) Never lubricate regulators, gauges or fittings with oil, organic lubricants or other flammable substances.

(4) Never handle oxygen cylinders or equipment with oily hands, greasy gloves or rags.

(5) Always clear the particles of dust and dirt from cylinder valve openings by slightly opening and closing the valve before applying any fitting to the cylinder.

(6) Open the high-pressure valve on the oxygen cylinder before applying the equipment to the patient.

(7) Open the cylinder valve slowly, with the face of the regulator gauge away from all personnel.

(8) Never drape an oxygen cylinder with any materials such as hospital gowns, masks, or caps.

(9) Never use oxygen fittings, valves, regulators, or gauges for anything other than oxygen.

(10) Never mix gases of any type in an oxygen bottle or any other cylinder.

(11) Always use a pressure regulator to administer oxygen from a cylinder.

(12) Never attempt to use regulators that need repair or have valves that do not work properly.

(13) Defective oxygen equipment should always be repaired, or replaced by the manufacturer or their authorized agent.

Note: All oxygen cylinders must have a medical warning tag (DD Form1191 or equivalent) affixed.

5. SERP Fleet Medical Equipment Acquisition and Maintenance

a. SERP. SERP is the process employed to modernize major fleet medical equipment. For CVNs, items required by the AMAL that have a cumulative cost over $5,000 are replaced utilizing fleet funding. All SERP equipment items are managed by predetermined life cycles. The status of contracts for replacement equipment can be checked by the BMET via FPP website. Immediately upon receipt of all newly received equipment, the BMET must be report this information on the monthly QA report. Additionally, the BMET will acknowledge receipt via the FPP website. The BMET will also ensure all required SERP equipment is entered in the ship's 3M or PMS SKED and OMMS-NG database along with supporting APLs to update the ship's records via a feedback report to the 3M coordinator. This is to ensure repair parts, periodic maintenance, and support is available for these critical pieces of equipment. A separate entry must be submitted to remove old equipment in SKED and OMMS-NG.

b. SERP Acquisition Requirements and Annual Inventory. All BMETs are to maintain and annual validated SERP inventory on file with the TYCOM force surgeon's office to allow for proper planning and funding. All BMETs will annually validate the condition of their SERP equipment and submit a SERP replacement request list to the TYCOM force surgeon's office to ensure future funding is available to replace end of life cycle medical equipment. It is important to note, procurement for SERP equipment is based on budgetary constraints, therefore, emergent buys due to equipment casualties or major repairs may result in reprioritizing and redistribution of funding after submission of the annual SERP requests have been received. Emergent buys will take precedence over other existing requirements.

c. SERP Major Medical Equipment Installations. Equipment that requires major installation (i.e., audio booth, x-ray systems, etc.) needs to be planned for and conducted during shipyard maintenance periods. All departments need to ensure they plan major installs during these maintenance periods, to include OMMS-NG entries requesting the installation.

6. Medical Equipment CASREP Procedures. If mission essential equipment malfunctions and is beyond the BMET's ability to repair it, the MAO or DLCPO must contact the ship's maintenance manager for assistance in submitting a casualty report (CASREP) in accordance with OPNAVINST 4790.4F, and documented in the monthly QA report. Additionally, the MAO or DLCPO will immediately notify TYCOM force surgeon's office, COMUSFLTFORCOM, COMPACFLT, and NAVMEDLOGCOM. When mission essential equipment malfunctions and has not reached its life cycle expectancy, it may be replaced as long as documentation on the NAVMED Form 6700/3 medical and dental equipment maintenance record show that repairs have exceeded the current monetary value of the equipment. The BMET will coordinate with the TYCOM force surgeon's office and NAVMEDLOGCOM to coordinate repairs or replacement of the equipment. The COMUSFLTFORCOM and COMPACFLT SERP's account supports medical equipment CASREPs in accordance with COMUSFLTFORCOM/COMPACFLTINST 4235.7.

CHAPTER 13
MEDICAL TRAINING

13-1. General

1. Long and Short-range Training Program

a. In accordance with COMNAVAIRFORINST 3500.20E, the medical department is required to maintain a long-range training plan (LRTP) that includes pertinent events such as exercises, courses of instruction, drills, GMT, lectures, seminars, inspections, and assist visits. The LRTP should be projected for a minimum of 12 months into the OFRP. The medical department should ensure that all crew-related medical training requirements are included in the LRTP and publicized in the ship's LRTP to ensure the crew are aware of training opportunities available.

b. From the LRTP, a short-range training plan (SRTP) is to be prepared for the department. This schedule should cover a period of about three months. The SRTP should include exercises, drills, and lectures. Refer to COMNAVAIRFORISNT 3500.20E for a sample SRTP.

2. Medical Department Required Training

a. Required training for individual medical department personnel is outlined in appendix P. The medical department training officer and the ship's training officer will track these requirements through R-ADM application and/or the Fleet Training Management and Planning System (FLTMPS). Specific training requirements (i.e., SWMDOIC, firefighting, etc.) must be completed en route to the ship or shortly after the member reports onboard pending course availability. Members will receive training credit for attending an equivalency program as outlined in FLTMPS.

b. As outlined in appendix P, all medical department staff will maintain current certification in BLS and use of the AED. A qualified BLS instructor-trainer will serve as the director/affiliate faculty for the program. The program director or affiliate faculty will ensure all aspects of training, monitoring and evaluation are conducted according to the military training network (MTN), and in accordance with current DoD and BUMED guidelines. Refer to section 4, paragraph 2, of this chapter for additional requirements related to BLS training.

c. In addition, training on the below topics must be provided to all medical department personnel:

(1) Annual HIPAA.

(2) Bloodborne Pathogens. Annual training regarding the hazards and protective

measures to prevent transmission of disease due to blood and human body fluids according to current BUMED directives.

(3) Annual infectious medical waste training according to BUMEDINST 6280.1C.

(4) Team Strategies and Tool to Enhance Performance and Patient Safety (TeamSTEPPS). Training must be completed at least quarterly, or as often as needed, to ensure that all medical personnel have completed training within three months of reporting on board.

(5) Command Instructions. Training must be conducted and documented at least once during the current OFRP, or as often as needed, to ensure that all medical personnel are familiar with the command policies and required actions for the following:

(a) Management of intoxicated personnel.

(b) Needle sticks.

(c) Management of rape and alleged rape cases.

(d) Competence for duty examinations.

(e) Management of personnel with suicidal ideation.

(f) Critical incident stress debriefing.

(g) Restraints.

(6) General Military Training (GMT). Required yearly GMT courses will be completed according to current guidelines. GMT courses completed in a lecture or classroom setting need to be entered into the FLTMPS via the ship's training officer in order for the staff member to receive credit for completion.

(7) Radiation Protection Training. All personnel must receive radiation protection training commensurate with their duties and according to federal regulations, DON directives, Radiological Controls for Ships (NAVSEA S9213-33-MMA-000/(V)), and the Radiation Health Protection Manual (NAVMED P-5055).

3. Optional Training Opportunities. The fundamentals of critical care support (FCCS) is listed to enhance awareness. This opportunity requires command funding, which may vary pending CVN location. Medical department staff are highly encouraged to attend the FCCS training offered by the Society of Critical Care Medicine (SCCM). The course is designed primarily for providers who do not routinely work in a critical care setting but may be called upon to use critical care skills until a patient can be transferred to an ICU setting or another higher level of

care. The course provides a review of critical care basics to include an in-depth segment on ventilator management. The course is offered periodically at Naval Medical Center San Diego and Naval Medical Center Portsmouth. Additional civilian training locations and dates can be accessed at the following SCCM website: www.sccm.org/education/fccs_courses/index.asp

4. Training Aids. The following items should be available to assist in the medical department's training efforts:

a. Moulage set, simulated wounds, or injuries.

b. Manual of Preventive Medicine (NAVMED P-5010).

c. Manual of the Medical Department (NAVMED P-117).

d. Resuscitation training manikins.

e. AED trainer.

f. Patient and rhythm simulator for defibrillator.

13-2. HM Training

1. Training of HM. The SMO is responsible for all medical care rendered on board the CVN. It is his/her responsibility to ensure that HMs are trained and competent to perform the tasks assigned. Specific utilization of HMs is outlined in COMNAVAIRFORINST 6320.3, Non-Physician Health Care Providers. Training requirements are shown in appendix P.

2. Personnel Qualification Standards (PQS). The SMO must develop a local training and certification program for duties as an HM. This program must follow the guidelines for a job qualification requirement (JQR).

3. Sick Call Screener Program (SCSP).

a. The SCSP must be accomplished in accordance with BUMEDINST 6550.9B.

b. Each HM who functions as a non-physician health care provider, in accordance with the sick call screener instruction, must be certified by the SMO prior to evaluating or treating patients.

4. Hospital Corpsman Skills Basic Program (HMSB). BUMEDINST 1510.23D established standard requirements for basic skills competencies and ongoing maintenance of medication administration, IV therapy (including insertion), venipuncture, hemorrhage control and hemostasis, and patient assessment. Corpsmen checking into the medical department as their

initial permanent duty station must demonstrate competencies in these areas to satisfy the requirements of BUMEDINST 1510.23D, and prior to enrolling in SCSP in accordance with BUMEDINST 6550.9B.

5. Rotation of Hospital Corps Personnel. The SMO must provide for the rotation of HM personnel through assignments in order to ensure thorough indoctrination in all phases of their duties. (Refer to OPNAVINST 3120.32D change-1 chapter 7 and OPNAVINST 3500.34G. Many areas, (i.e., lab, pharmacy, x-ray, and others) may need to be covered through OJT. While there is no requirement to have a certified technician operating in these areas at all times, OJT HMs will be expected to deliver the same standard of care. The SMO is responsible for developing and implementing additional safeguards to ensure quality patient care is maintained. Each CVN should benefit from their training and expertise by rotating and training additional HMs to cover each ancillary service. The overall benefit is a medical staff that is much more capable and experienced. Additionally, a service may have to be covered by an OJT tech if a designated technician becomes an unplanned loss. It must be recognized, however, that use of OJT Corpsmen to cover in high-risk areas (e.g. Pharmacy) constitutes an increased risk of adverse events.

6. Professional Apprenticeship Career Track (PACT) Program. Previously called "strikers", this new program codifies existing policies and supersedes all prior policy guidance. PACT Sailors will use Career Waypoints – PACT designation (C-WAY – PACT designation) module to apply for rating entry, see MILPERSMAN 1306-611. The Navy PACT Program requires an initial four-year active obligation, and in return, guarantees initial apprentice skill training and a career development plan with viable career opportunities for Sailors who maintain eligibility. The PACT Program provides a required general workforce to support operational readiness and designed to enlist Sailors into a monitored, general apprenticeship program that provides apprentice-level formal and OJT, leading to a viable career field within two years on board their permanent duty station (PDS). The Hospital Corps Strikers Program is a PACT program that was established in order to maintain an adequate number of HMs by allowing volunteers from the fleet to enter a apprenticeship level on-the-job training that exposes them to the HM rate. Only those personnel who possess the requirements as specified by current instructions and are highly motivated to become HMs should be selected and recommended for assignment to Class "A" Hospital Corpsman school. Strikers do not have to be assigned to the medical department in order to be recommended for Hospital Corpsman school, although this is highly desirable. When assigned, they should be rotated throughout the department in order to ascertain their capabilities prior to requesting assignment to Hospital Corpsman school. PACT Sailors in receipt of an initial accession contract into one of the three tracks must meet the established minimum requirements for their chosen track. PACT must observe and/or assist and will ALWAYS be under direct supervision when conducting any patient care procedures. They must receive education and training in patient privacy, HIPAA, PHI prior to assignment of any duties in the medical department. Selection and use of strikers PACT Sailors as standbys during medical examinations will be in accordance with COMNAVAIRFORINST 6320.1. Additional training guidance is provided in section 1, paragraph 2, of this chapter.

7. IDC Continuing Education. According to OPNAVINST 6400.1D, IDCs are required to complete a minimum of 15 continuing education units (CEU) annually. This requirement is met during the first year after graduating from IDC school. Future CEU requirements may be fulfilled by attending the annual Joint Air Force/Navy Armed Forces Operational Medical Symposium. TYCOM fully endorses supporting IDC participation in this conference when OPTEMPO permits. This conference provides a comprehensive review of all subject matter within an IDC specialty of medicine. There are other methods of obtaining CEUs besides resident courses. Articles in professional association journals and other publications offer continuing medical education (CME) credit for reading an article and answering related questions. Refer to the OPNAVINST 6400.1C and COMNAVAIRFORINST 6400.1 for further guidance and funding requests. Funding for operational forces is available through Navy Medicine Professional Development Command (NMPDC).

8. Enlisted Aviation Warfare Specialist (EAWS), Enlisted Surface Warfare Specialist (ESWS), and Enlisted Information Warfare Specialist (EIWS) Programs

a. EAWS Program. COMNAVAIRFORINST 1414.2B establishes policy and guidelines for the EAWS Program. EAWS is the primary warfare specialty for enlisted personnel assigned to a squadron, ship, or afloat staff under the cognizance of Naval Air Forces.

b. ESWS Program. OPNAVINST 1414.9A and COMNAVSURFORINST 3502.1D change-1 establish policy and guidelines for the ESWS Program. This warfare specialty is considered a secondary specialty for all medical department enlisted personnel permanently assigned to a CVN.

c. EIWS designation signifies that an eligible Sailor has achieved a level of excellence and proficiency in information warfare (IW). COMNAVCYBERFORINST 1414.1 establishes policy and guidelines for the EIWS program. Personnel assigned to a squadron, ship, or afloat staff are expected to qualify in the primary warfare mission of the unit embarked. EIWS qualification may only be obtained through the formal qualification program set forth in the COMNAVCYBERFORINST 1414.1 and is considered a secondary specialty for all medical department personnel.

d. All medical department enlisted personnel may enroll into the ESWS or EIWS program upon completing their EAWS Program.

9. Non-resident Training Courses. Navy Education and Training Professional Development Center (NETPDC) publishes NAVEDTRA 12061, “Catalog of Nonresident Training Courses” which is available on My Navy Portal.

10. Senior Enlisted Leadership Training Continuum

a. Advanced Medical Department Enlisted Course (AMDEC). The AMDEC is a three unit course in the medical department Enlisted Learning Continuum. The course is designed to introduce medical department and other enlisted personnel assigned to Navy medicine commands to the organization, structure, business practices, and operational policies of the Navy medical department. The course is part of the Navy E-Learning curriculum.

b. Executive Medical Department Enlisted Course (EMDEC). The EMDEC is the second course in the medical department senior enlisted leader's learning continuum. This course is designed to prepare medical department senior enlisted personnel for increased responsibilities as senior enlisted leaders who understand the "practice and business" of Navy medicine in both the operational and MTF settings. This course is offered at NMPDC.

13-3. Officer Training

1. Surface Warfare Medical Department Officer (SWMDO) Designation. COMNAVSURFPAC/COMNAVSURFLANTINST 1412.8B contains the standards and procedures for Navy medical department officers to qualify as a SWMDO. A medical department officer must not be required to become part of any shipboard watch bill to pursue qualification as a SWMDO; and qualification must not interfere with the duties assigned in the medical department.

2. Continuing Medical Education (CME). BUMED funding may be obtained to support required CME. Procedures to submit for BUMED and NMPDC funding are contained in BUMEDINST 5050.6A.

3. Correspondence Courses. Officers are encouraged to take advantage of this training opportunity. Most of the courses grant CME or CEU credit upon satisfactory completion of the course.

4. Leadership, Education, Analysis, Development, Sustainment (LEADS) (formerly known Joint Medical Executive Skills Institute). In 1992, Congress mandated that commanders of MTFs possess certain administrative competencies before assuming their command positions. In 1996 and in 1998, that guidance was expanded to include prospective deputy commanders, lead agents, and managed care coordinators. Forty competencies in eight major areas have been identified and make up the professional skills list. In addition to overseeing the 40 competencies, LEADS publishes a catalog of executive medical courses offered by each service and the DoD. The catalog describes available courses taught within the Military Healthcare System and identifies which of the 40 competencies each course covers.

5. Navy Medical Department Officer's Learning Continuum

a. Basic Readiness Officer Course (BROC). The BROC is the first course in the Navy Medical Department Officer's Learning Continuum. The purpose of the BROC is to increase junior officer awareness for all aspects of naval medicine including: MTF operations; operational medicine and health service support; and homeland defense. All those in ranks O-1 to O-3 are required to complete this online course, which is available on My Navy Portal.

b. Advanced Readiness Officer Course (AROC). The AROC is the second course in the Navy Medical Department Officer's Learning Continuum. This course is designed to prepare medical department officers at the O-4 to O-5 level for increased responsibilities as senior officers and leaders who understand the "practice and business" of Navy medicine in both the operational and MTF settings. This course is offered at NMPDC in Bethesda, Maryland.

13-4. Crew Training

1. Training of Non-medical Personnel

a. COMNAVAIRFOR considers that a comprehensive program in first aid, self-aid, buddy-aid and the medical aspects of CBR warfare is essential to maintaining a high level of combat readiness. Such training is recognized as a potentially critical factor for casualty reduction and in minimizing adverse effects on combat effectiveness in modern warfare. Training of this nature will enhance the successful management of mass casualties in any disaster, whether in peace or war.

b. The shipboard first aid injuries that are trained are as follows: puncture or penetrating wound, sucking chest wound, abdominal evisceration, massive hemorrhage with amputation, laceration, fractures, burns, hypothermia, heat stress, electrical shock, and smoke inhalation. The ship's crew should receive basic first aid training, cardio pulmonary resuscitation (CPR), and stretcher-bearer training, at every available opportunity such as during command indoctrination, GQ drills, and on a routine basis aligned with the LRTP.

c. The SMO will ensure a continuing, standardized, regularly scheduled program of instruction for the officers and crew in first aid, self-aid, and the medical aspects of CBR warfare. Utilization of shipboard information, training, and information television (SITE TV) is encouraged.

2. BLS Training

a. Information on current CPR and health care provider courses are available from local chapters of the MTN, local MTFs, and the MTN website at https://info.health.mil/edu/MTFDIV/MTN/SitePages/Home.aspx or:

Military Training Network for Resuscitative Medicine
Uniformed Services University of the Health Sciences
F. Edward Hebert School of Medicine
4301 Jones Bridge Road, Bethesda, MD 20814-4799
Commercial (301)-295-0964, DSN 295-0964

b. The medical department must:

(1) Have a qualified BLS instructor-trainer on board to serve as program director or affiliate-faculty and effectively manage an approved BLS program, with appropriate documentation. Additionally, it is recommended that the department maintain a minimum of five BLS instructors to support BLS training requirements for the crew. In addition to the ship's nurse, it is recommended that IDCs obtain BLS instructor certification as part of this minimum requirement. The purpose is to ensure that the IDCs are prepared to conduct BLS instruction should they be required to backfill one of the smaller ships attached to the CSG.

(2) Incorporate CPR/AED training into the command indoctrination for all hands, and ensure periodic courses are available to the crew.

(3) Maintain current healthcare provider qualifications, at a minimum, for all medical department personnel.

(4) Provide CPR/AED qualification for the following groups:

(a) Minimum of 50 percent of personnel in the electrical and electronic associated ratings.

(b) All gas-free engineers designated as rescue personnel for engineers working in confined spaces.

(c) All members of CVN master-at-arms force and brig personnel, to include personnel TAD from other departments.

(5) Individual departments are responsible for maintaining crewmembers' qualifications and ensuring currency.

3. Advanced Training of Repair Party, Stretcher Bearer Personnel, and Boat Crews. The training program for these personnel must include all subjects applicable to the crew, with special emphasis and additional training in first aid procedures, methods of resuscitation, self-aid in chemical warfare, casualty evacuation, and transportation of casualties. The names and assignments of stretcher-bearers must be posted on the medical department WQSB.

4. Medical Training Team (MTT)

a. All CVNs will establish a MTT. This team will be responsible to the SMO for the proper training of medical personnel and ship's company in all aspects of first aid, medical response team performance, war wound, and mass casualty treatment. Paragraph 3 of this chapter outlines the mission area training exercises as required by COMNAVAIRFORINST 3500.20E.

b. The MTT will be comprised of personnel with the requisite knowledge, background, and training to facilitate medical training. The team leader will be the ship's nurse, leading a team made up of at a minimum, one medical officer, a departmental chief petty officer, and one independent duty hospital corpsman (IDC). MTT members will be PQS qualified and designated in writing by the CO or his designated approving authority. Either the MTT leader or the medical department LCPO will also be a member of the DCTT.

c. In order to facilitate collaboration and integration among all the ship's training teams, it is recommended that each member of the MTT carry a secondary training team assignment. For example, one MTT member would also be assigned to the air department training team. This secondary assignment fosters improved communication between the training teams by offering consistent MTT presence during drill planning and at drill briefs and debriefs.

d. The MTT will observe, grade and critique all medical exercises and report the results to the head of department. Members of the MTT will utilize TAC cards for grading when carrying out their training drills prior to any medical drill/evolution the MTT Leader will conduct a brief, utilizing a drill package that outlines the objective of the drill, timeline, personnel assignments, safety concerns (utilizing ORM), and lessons learned (from previous drills). Following each drill, MTT will debrief Sailors on station, and conduct a drill debrief with all MTT and other drill team members involved. The drill package and de-brief will be routed to the SMO for review and/or higher authority depending on ship's requirements.

CHAPTER 14
BATTLE READINESS

14-1. General Quarters (GQ).

1. Battle Bill. Each carrier will have a ship's medical department battle bill or instruction that addresses the location and quantity of emergency medical supplies located throughout the ship. It must also outline the roles and responsibilities of medical department personnel during emergency and special evolutions. A sample battle bill is provided in appendix Q.

2. Battle Dressing Stations (BDS).

a. A minimum of six BDSs must be maintained and must be located in areas affording maximum protection consistent with the availability of care for the injured. The BDS contained within the medical department must be classified as the primary (main) BDS. Since it is co-located with the operating room and has ancillary support, it is best suited to care for the critically injured.

b. In addition to the main BDS, a minimum of five additional BDSs are required for CVN type ships: one forward, one aft, two auxiliary BDSs, and one in close proximity to the flight deck.

c. BDSs must not be utilized as auxiliary storerooms. Stowage of personal gear within the BDS is prohibited.

d. Each BDS will maintain adequate operational readiness equipment to include a potable water tank with gravity feed piping, proper lighting and a secured table suitable for the treatment of casualties.

e. A roster of all assigned BDS personnel must be maintained in each BDS to include stretcher bearers and phone talkers. All BDS personnel must be incorporated into the medical department's WQSB.

f. In accordance with NWP 3-20.31 and COMNAVAIRFORINST 3500.20E, a minimum of one corpsman, four stretcher-bearers, and a phone talker will be assigned to support each BDS; and a minimum of one corpsman and four stretcher bearers will be assigned to support each repair locker. Stretcher-bearer personnel may be provided from damage control (DC) personnel or from outside the DC organization. Ships must have as many personnel trained to function as stretcher- bearers as deemed necessary to handle mass casualties. They must be trained in advanced first aid and casualty handling techniques and must be capable of training other crewmembers in self-aid and buddy-aid pertaining to the SFAR. Each stretcher-bearer team must be equipped with a first aid kit gun crew (gun bag).

g. All HMs will be assigned GQ stations in a BDS, a repair locker, or in main medical. In the event of significant battle casualties, main medical must remain fully functional. This requires the lab, x-ray, pharmacy, and the ward to be fully staffed.

3. Maintenance and Rotation of Supplies. Provisions must be made for permanent stowage and adequate security of medical supplies at the BDSs. The SMO must ensure that each BDS is equipped with the necessary miscellaneous items (e.g., flashlights, head and hand lanterns, batteries, etc.). Prescribed surgical packs must be readily available and serviceable should the need arise. SMOs must inspect these facilities and supplies upon reporting for duty, and are encouraged to recommend changes to the TYCOM on the basic contents of the sterile packs and associated supplies. Additional supplies may be added to the minimum requirements if approved by the SMO. If added, they will be included on the inventory and managed the same as the required items. An inventory list must be kept of all emergency medical supplies dispersed throughout the ship. Rotation of shelf life supplies is mandatory. Newly requisitioned supplies are to be rotated into reserve stock and older stock utilized in sick bay. This process provides the opportunity for use prior to expiration. Defective material will be surveyed and destroyed in accordance with current directives.

4. Additional Supplies for BDS. The AMAL 3052/3252 contains the minimum requirements for BDSs on all CVNs. A complete inventory of all BDSs must be accomplished semi-annually, and the inventory list signed and dated at the time the inventory is conducted. The replacement of material must occur as part of the regular semi-annual inventory. Items that will expire prior to the next scheduled inventory must be replaced during the inventory.

5. BDS Accessory Items. The following accessory items must be maintained in a state of operational readiness in each BDS:

a. Lighting. BDSs must have at least one surgical light and four relay type toggle switch battle lanterns installed.

b. Oxygen. Each BDS must have the capability to administer oxygen and oxygen cylinders must be available for ready use. When the space is occupied, at least one tank will be set-up with a regulator installed, a face mask and one resuscitator. Each BDS will have two "H" cylinders and four "D" cylinders. One "H" cylinder and one "D" cylinder may be in an "in-use" status. All other tanks must be full. The BDS in-use tanks must not be allowed to fall below 1000 PSI unless treating actual casualties.

c. Water Supply. Provisions for potable water supply for BDSs must comply with ship's design and class specifications. A diagram and operating instructions for the gravity fed potable water system must be posted in the immediate vicinity. The potable water gravity tank must be labeled "drain, flush, and refill every three months." It must be the responsibility of the medical department to empty, flush, and refill the emergency fresh water tanks. All tanks must have water samples taken monthly to determine chlorine and bacterial content in accordance with

current 3M and preventive medicine directives. The date and result of the most recent chlorine residual and bacteriological test must be posted on or near the potable water tanks.

6. Route and Access Markings

a. Routes to BDSs must be marked on interior and exterior bulkheads throughout the ship in accordance with the NSTM, volume 2, chapter 079.

b. Each hatch and door leading directly to a BDS must be fitted with a metal label plate with the inscription "ACCESS BATTLE DRESSING STATION" engraved thereon in 1/2 inch letters and filled with red baked enamel.

c. When establishing and marking the routes to the various BDSs throughout the ship (interior and exterior), the markers must be located frequently enough to enable the person(s) following the route to have a clear view of the next marker.

7. Surgical Packs and Trays. Surgical instrument trays, anesthesia trays, minor surgical sets, suture sets and items that are routinely stocked at BDSs must be prepared in accordance with this instruction.

a. Specific trays or sets must be prepared and maintained sterile. Surgical knife blades are to be included with surgical instrument trays with the foil wrapping intact to prevent rusting. Sutures packaged in plastic packets are desirable, but are not to be autoclaved due to the deteriorating effect of heat to plastic. Paper foil wrapped sutures may be autoclaved. Assorted suture materials will be made readily available and must be armed with a needle. Pre-packaged sterile knife blades and suture materials can be placed in the plastic dust cover with the sterile packs. A piece of tape should be placed on the outside of the plastic cover indicating the expiration date of the suture material inside.

b. The following sterile packs and trays must be maintained, sterilized, and located in each BDS. See chapter 8, section 5 of this instruction for guidelines on event related sterilization.

REQUIRED PACKS FOR BATTLE DRESSING STATIONS		
Nomenclature	U/I	QTY
Tracheotomy Tray *	EA	1
Chest Tube Tray *	EA	1
Minor Instrument Set *	EA	4
Sterile Linen Pack	EA	1
Sterile Sheet Pack	EA	2

(See Appendix R for set definitions)

Note: * May be replaced with AMAL disposable kits in accordance with current COMNAVAIRFORNOTE 6000.

14-2. First Aid Boxes (FABS), First Aid Gun Bags, and Portable Supplies

1. General

a. Ship's personnel must understand the lifesaving value of the emergency medical supplies and facilities located throughout the ship. They must also be instructed not to open these supplies and spaces except in actual emergencies. FABs, gun bags, and mass casualty boxes are to be marked with a red cross (each bar to be 2" X 6"). However, manufacturer applied red crosses are acceptable until they are no longer legible.

b. Maintenance and Security of Supplies. Supplies stored in emergency medical units (i.e., FAB, mass casualty boxes, gun bags, etc.) must be protected from weather and pilferage. The contents will be wrapped in clear plastic bags or reusable bag. All first aid kits that are intended for use by the crew will be sealed with a plastic anti-pilferage seal or anti-tamper tape that can be broken with little effort. The medical department will conduct semi-annual inspections/inventories of emergency medical kits, and signed, dated entries will be made on the inventory list of each emergency kit. Locations of all emergency medical kits will be listed in the medical department battle bill for easy location. All sets will have a list of the contents and an inventory signature page in each individual set. The signature page will list more than one inventory to document a history of inventory.

2. FAB

a. FAB (NSN 1H 2090-00-368-4792) will be stocked in compliance with appendix O (AMAL 3050/3250) and distributed throughout the ship in accordance with the ship’s medical department battle bill. The minimum number of FAB for all CVN ships is 90. The recommended location for these boxes is contained in appendix Q (sample medical department battle doctrine) and appendix S; however, these locations may be altered as necessary to better meet the needs of the individual ship. The location of each FAB will be documented in the medical department battle bill.

b. FABs will be maintained in accordance with appendix Q of this instruction. Each FAB will be marked with a red cross (2" X 6") and labeled "For Emergency Use Only."

c. Each first aid kit will be stocked in accordance with appendix O (AMAL 3050/3250) and will reflect the contents according to current COMNAVAIRFORNOTE 6000. The contents will be divided into three equal portions to represent three separate first aid kits and will be sealed in a reusable bag.

3. First Aid Kit Gun Crew (Gun Bags)

a. Each repair party locker and BDS will be provided one gun bag for utilization by each stretcher-bearer team. The location of each gun bag will be documented in the medical battle bill.

b. Each gun bag will be maintained in accordance with appendix Q of this instruction.

c. Each gun bag will be stocked in accordance with appendix O (AMAL 3057/3257) and will reflect the contents according to current COMNAVAIRFORNOTE 6000.

4. Mass Casualty Boxes. Mass casualty boxes provide portable medical supplies in the event of a mass casualty. Refer to current COMNAVAIRFORNOTE 6000 and appendix O (AMAL 3051/3251) for contents.

5. Junior Emergency Response Kit (JERK). Each carrier will maintain a minimum of five JERK units to support special evolutions such as sea and anchor detail, and underway replenishment. They will be maintained as outlined in appendix Q of this instruction. Refer to appendix O (AMAL 3055/3255), and will reflect the contents according to current COMNAVAIRFORNOTE 6000.

6. Small Crafts and Life Raft First Aid Kits

a. Each small craft must be provided one boat box (NSN 8115-01-656-8316). They will be maintained as outlined in appendix Q of this instruction. Refer to appendix O (AMAL 3058/ 3258), and will reflect the contents according to the current COMNAVAIRFORNOTE 6000. Life rafts must be provided with life raft first aid kit, (NSN 6545-00-168-6893). Contents in these kits are maintained according to Federal Supply Code class 6545, components of sets, kits and outfits (class-6545-IL, volume 2).

b. All small craft first aid kits must be inspected semi-annually by medical department personnel and maintained in accordance with appendix Q of this instruction. The components of these small craft first aid kits must be encased in plastic bags before placement in the first aid kit containers. These kits will be listed in the medical department battle bill.

c. Life raft first aid kits will be inspected in conjunction with the regular PMS. They do not require inventory by medical department personnel and will be under the supervision of deck department. However, the medical department will provide assistance and supplies in the re-stocking of used and expired inventory.

7. Stretchers and Litters

DESCRIPTION	MINIMUM QUANTITY
Litter, Folding, Rigid, Pole (Army Pole Litters or Mass Casualty/Decontamination Litters)	28
Litter, Rigid, Sea-Air, MEDEVAC (Sea-Air Rescue (SAR) Rigid Collapsible stretcher)	2
Litter, Rigid, Stokes	80
Litter-Splint, Extrication (Rescue or Reeves Sleeve II)	24
Sling, Rescue Helicopter	2
Wire Rope Assembly (Trail line Assembly or Extraction line)	2
Handling Lines with Snap Hooks	24

a. The type and quantity of the various stretchers must be maintained according to CVN AMALs and this instruction, and will be listed in the medical department battle bill. The recommended location for the stretchers is contained in appendix Q and appendix S, however, these locations may be altered as necessary to better meet the needs of the individual ship. Consideration will be given to the nature of extrication required when selecting the type of stretcher for that area of the ship. Stretchers will not normally be stowed in locked spaces that are difficult to access. Determination of the type of stretcher or litter to be used for personnel casualty transfer must be based on the condition of the casualty and environmental factors; however, safety must remain a paramount consideration.

b. Serviceability, inspection criteria, and accountability for all stretchers or litters must be in accordance with the current 3M system. All stretchers or litters will be stenciled with the ship's name, hull number, and compartment location. Stenciling must be located in such an area that it can be readily viewed when the stretcher and litter is in its normal storage position. Locations and types of all stretchers and litters will be included in the medical department's battle bill.

c. Handling lines will be maintained in BDSs, repair lockers, and with the MRT gear. One will be available with each litter-splint, extrication (rescue or reeves sleeve II). They will consist of at least 25 feet of line, and must have a snap-hook or locking d-ring spliced to one end of the line with a minimum of five tucks on the splice. If a modern synthetic double-weave line is used, it will be tied to the ring with a bowline and two half hitches. Handling lines must be maintained in a pouch for easy stowage and transport. The purpose of the handling line is to belay a patient in a litter down a ladder. Historically, the lines spliced on a stretcher were difficult to maintain and became a significant trip hazard after they were used. If a patient must be transported down a ladder, the line will be removed from the pouch, snapped onto the stretcher, and then re-stowed at the bottom of the ladder. Handling lines with a pouch are commercially available through emergency medical services (EMS) distributors. The locking d-rings and snap-hooks must be rated for a minimum breaking strength of 5,000 pounds.

d. Deep Access Rescue and Extrication

(1) It is not normally the function of the medical department to rig the extrication equipment for rescue from a deep space or void. Riggers have the requisite knowledge to perform this hazardous evolution safely. Each ship will designate and train a shipboard extrication team who will rig and maintain the equipment necessary to extricate the patient, while the medical personnel treat the patient and prepare them for transport in the appropriate litter.

(2) Handling lines of sufficient circumference and length will be provided to permit efficient and safe handling. 1/2" nylon handling lines or equivalent synthetic lines are required.

(a) The line must be of sufficient length to allow the litter to be lowered into the required space with enough line remaining to pass through the pad eye or block over the hatch and take three turns around a stanchion.

(b) An additional line of suitable length must be available for attachment to the lower end of the litter to stabilize it during the extrication process.

(c) The shipboard extrication team must maintain both lines along with any other specialized equipment.

e. Sea-Air Rescue (SAR) Litters. NTTP 3-50.1 requires at least two SAR MEDEVAC litters for boat and deck recovery be maintained aboard CVNs. NTTP 3-50.1 also requires a trail line assembly (also known as wire rope assembly or extraction line) and a rescue litter sling assembly (also known as sling, rescue helicopter) when using these litters for a SAR helicopter or deck recovery. Assemblies must be ordered separately. Refer to appendix O for details. The medical department is responsible to maintain SAR litters in a state of readiness at all times.

f. Army pole litters (also known as litter, folding, rigid pole, or decontamination and mass casualty litters) are to be utilized for moving patients on the ward and to support mass casualty requirements. They must not be utilized to transport patients up or down ladders.

14-3. Chemical, Biological and Radiological (CBR) Preparedness.

1. CBR Defense Responsibility

a. The SMO must ensure all providers have a thorough knowledge of CBR medical treatment regimens. Courses are available through the local environmental preventive medicine unit, on-line and through other government agencies. The following are recommended for self-study and references:

(1) NSTM 070 Radiological Recovery of Ships After Nuclear Weapons Explosions.

(2) J3OP-US258 Emergency Medical Preparedness Response Course (EMPRC) Clinician Course or J3OP-US260 Emergency Preparedness Response Course (EPRC) Operator Responders Course.

(3) NAVPERS 10899 B, Disaster Control (Ashore and Afloat).

(4) NWP 3-20.31 Surface Ship Survivability.

(5) NSTM 470 Shipboard biological warfare (BW) and chemical warfare (CW) defense and countermeasures.

(6) NAVMED P-5041, Treatment of Chemical Agent Casualties.

(7) NAVMED P-5042, Treatment of Biological Agent Casualties.

(8) BUMEDINST 6470.10B, Initial Management of Irradiated or Radioactively Contaminated Personnel.

(9) Medical Management of Biological Casualties Handbook by U.S. Army Medical Research Institute of Infectious Diseases, Ft. Detrick MD (current edition).

(10) Medical Management of Chemical Casualties Handbook by U.S. Army Medical Research Institute of Chemical Defense, Aberdeen Proving Grounds (current edition).

2. CBR Defense Bill. The SMO must be familiar with the ship's CBR defense bill, which establishes CBR defense organization within the ship's damage control organization. The CBR defense bill will outline the battle and administrative responsibilities of the medical department during and after CBR attack.

3. CBR Defense Material

a. FHP supplies will be stocked according to AMAL 3005/32005 and TYCOM requirements. Ships and operating units must provide adequate protective measures for Nerve Agent Auto-Injector (ATNAA) to prevent loss from pilferage or misuse. Except for pyrodistigmine bromide, which requires refrigeration to extend shelf life, adequate storage is considered to be a locked cabinet, locked medical locker, or locked storeroom that is not readily accessible to all hands. Controlled medicinals included in the FHP AMAL will be included in the SLEP program and will be required to be inventoried every 90 days. The entire stock of the controlled medicinal can be secured with tamper evident seals to allow for quick inventory. When the ship is cruising in condition III or higher, the FHP AMAL block must be distributed to each BDS. A plan for distribution of CBR defense medications must be developed by each carrier and documented in the ship’s battle bill and ship’s CBR defense bill.

4. Decontamination Stations. Personnel decontamination stations must be established in accordance with NWP 3-20.31, NSTM 470, and BUMEDINST 6470.10B. CBR defense materials are required by BUMEDINST 6470.10B and are defined in appendix O. The medical department must provide them in the indicated quantity and they must be stowed in a suitably mounted cabinet or chest near each decontamination station. Semi-annual inventories of decontamination stations will be documented and signed. Dated entries must be made on the inventory list of each decontamination locker.

5. BW and CW Medical Material

a. The FHP medical consumables block will be stocked in accordance with appendix O.

b. Specific medications and treatment protocols may be found in the references listed in paragraph 14301.

c. Medical and supply departments must coordinate custody and appropriate storage (secure refrigeration as required, etc.).

d. Careful attention must be paid to the SLEP, in coordination with the TYCOM, by the designated custodian of the block.

14-4. BW Agent Confirmatory Laboratory Guidance

1. General. To provide guidance to naval units outfitted with confirmatory laboratories for use of equipment described herein and for receiving, sampling, testing, reporting, packaging and transport of suspected BW samples. Guidance pertains to all deployed ship platforms currently outfitted with confirmatory labs aboard. The confirmatory laboratory uses highly reliable polymerase chain reaction (PCR) technology to confirm or discount presumptive hand held assay (HHA) results. Testing a presumptive HHA sample with a second independent method leads to a very high level of certainty for sample identification. This uniquely layered approach to bio-defense leads to highly reliable BW agent identification.

2. Definitions.

a. PCR Testing. Confirms the presence of the deoxyribonucleic acid (DNA) of a specific BW agent. PCR equipment is deployed as part of the confirmatory laboratory.

b. PCR Instrument – Lightcycler or R.A.P.I.D. Laboratory instrument used to conduct PCR testing.

c. Dirty Area. The dirty area is the portion of the confirmatory laboratory where positive control standards and suspect samples are prepared for PCR testing.

d. Clean Area. The portion of the confirmatory laboratory where PCR reagents and negative controls are prepared for PCR testing.

e. PCR Reagents. Materials required for PCR testing.

f. Quality Control Program. Monthly testing program established to maintain the proficiencies of PCR trained laboratory technicians.

g. Reachback. Protocols established to contact subject matter experts at the biological defense research directorate (BDRD). Reachback is the definitive third component of the Navy's robust layered approach to BW agent detection.

h. Biosafety Cabinet (BSC). Specialized laboratory equipment used to keep potentially biohazardous materials isolated. Confirmatory laboratories utilize the BSC to safely manipulate suspect BW agent samples.

i. Receiving Party. Person or persons responsible for receiving and transporting suspect package to its next destination.

3. Environmental Sampling. COMNAVAIRFOR CVNs are outfitted with environmental sampling protocols and equipment to sample for the presence of aerosolized BW agents and suspicious powders and liquids in letters and parcels. Upon the detection of a suspect BW agent, Navy units are trained in the proper procedures to safely package and ship a sample of the suspect BW agent to the nearest confirmatory laboratory. All CVNs have received confirmatory testing capabilities. These capabilities include the confirmatory PCR laboratory equipment, microbiology area and HHA capabilities. The confirmatory laboratory is staffed to deliver a second opinion on a positive environmental sample or a suspicious letter and parcel sample.

4. Confirmatory PCR Laboratory Set Up

a. The confirmatory PCR laboratory consists of five components. These components include a clean area, a dirty area, a BSC, a PCR instrument (either a R.A.P.I.D. or a Lightcycler), and a set of reagents and standards. The clean area must be set up in an area where potential biological sample contaminants are not present. All reagents and negative PCR control standards are set up in the clean area. The dirty area may be set up in the standard medical laboratory. Positive controls and samples are set up in the dirty area. The BSC is co-located with the dirty area. While manipulating suspect samples within the BSC, in order to prevent DNA contamination of the clean and dirty areas, the PCR instrument must be set up in a separate area from the clean or dirty areas. The reagents and standards must be stored in a manual defrost freezer maintained at negative 20 degrees Celsius. Freeze or thaw cycles are detrimental to these reagents and standards.

b. Confirmatory microbiological laboratory consists of standard plating techniques for bacterial samples.

c. An HHA is repeated in the confirmatory laboratory setting. This verifies the HHA result from the field.

5. Confirmatory Laboratory Operations Upon Notification of Inbound Presumptive BW Agent Samples. The SMO directs PCR qualified laboratory technician to prepare for receipt of samples, and to prepare the confirmatory laboratory. The SMO initiates reachback communication with BDRD.

6. Receiving Presumptive BW Agent Package

a. Commander of an affected unit utilizes chain of command to arrange for safe transport of decontaminated package containing the presumptive BW agent sample to the carrier lab. The CVN CO alerts the lab that a suspect package is inbound.

b. The lab prepares for receipt of suspect package.

c. Suspect package is received, while maintaining chain of custody procedures.

d. Receiving party escorts suspect package to confirmatory laboratory for testing while maintaining chain of custody procedures.

e. The SMO or lab tech receives package while maintaining chain of custody procedures.

f. Confirmatory lab tech opens BW agent package within BSC and ensures integrity of sample container. The primary container is removed, decontaminated with a hype-wipe, and the sample is prepared for testing.

g. Lab tech runs confirmatory tests including HHA, PCR, and microbiological analysis as appropriate.

7. Confirmatory Laboratory Testing and Responses for Negative HHA

a. If receiving a suspicious letter or parcel sample with a previously negative HHA test result:

(1) The SMO instructs confirmatory lab tech to repeat a complete HHA panel to verify negative HHA result, perform microbiological analysis on blood agar or MacConkey's media as available, and conduct PCR testing. Conduct reachback for specific agent test procedures.

(2) Results of all confirmatory tests will be verified via reachback consultation with BDRD.

(3) The SMO directs medical monitoring of "at-risk" personnel until lab clears sample (i.e. no growth on blood agar or MacConkey's media after the appropriate time period and/or PCR testing negative) or as deemed appropriate by the SMO (No clinical cases observed following an anticipated agent-specific incubation period).

(4) If sample is determined negative by confirmatory testing:

(a) Alert chain of command of negative result.

(b) Chain of command issues follow-on messages as appropriate.

(c) Chain of command will determine further treatment of the sample(s) and follow-on action. If sample is shipped from the confirmatory laboratory, package as a class 6.2 infectious substance but label and ship as an "environmental sample". Engage local shipping experts for further detail.

(5) If sample is determined positive for a BW agent by confirmatory laboratory testing:

(a) The SMO directs medical treatment appropriate to BW agent detected. Since multiple agents could be present in a positive sample, engage reachback subject matter experts at BDRD for instruction on additional testing of the sample.

(b) Chain of command issues follow-on messages as appropriate.

(c) Chain of command will determine further treatment of the sample(s) and follow-on action. If sample is shipped, package and ship as a class 6.2 infectious substance. Engage local shipping experts for further detail.

8. Confirmatory Laboratory Testing and Responses for Positive HHA

a. If confirmatory laboratory is receiving a sample that has tested positive via the HHA:

(1) The SMO directs the laboratory technician to conduct confirmatory tests including a complete HHA panel, PCR testing for the BW agent identified, and microbiological analyses (as available) for the BW agent identified. Since multiple agents could be present in a positive sample, engage reachback SMEs at BDRD for instruction on additional testing of the sample.

(2) The SMO directs medical monitoring of "at-risk" personnel until lab clears sample (i.e. No growth on blood agar or MacConkey's media after 72 hours and PCR testing negative) or as deemed appropriate by SMO (No clinical cases observed following an anticipated agent-specific incubation period).

(3) If Lab confirms presence of BW agent, the SMO reports positive results and recommends appropriate medical course of action to the CO.

(4) If after consultation with BDRD reachback, the confirmatory laboratory determines that the sample is negative (i.e. No BW agent detected):

(a) The SMO reports negative result to the CO.

(b) CO initiates appropriate follow on message traffic.

(c) Chain of command will determine further treatment of the sample(s) and follow-on action. If sample is shipped, package as a Class 6.2 Infectious Substance but label and ship as an "Environmental Sample." Engage local shipping experts for further detail.

9. PCR Quality Control Program

a. PCR quality control reagents (unknown samples) are deployed to confirmatory laboratories.

b. Confirmatory laboratories are instructed to conduct PCR quality control testing on a monthly basis.

c. PCR quality control testing consists of periodically analyzing a set of unknowns, and completing the BW report form. Send results via unclassified internet to BDRDBW@nmrc.navy.mil for reachback analysis and confirmation.

10. Certification of Confirmatory Laboratory Biological Hoods

a. The BDRD of the Naval Medical Research Center (NMRC) requires that the biological hoods of the confirmatory labs on Navy ships be certified annually.

b. Certification may be obtained by civilian contractor. Contact the TYCOM force medical for specific guidance.

11. Technical Reachback POC Information

a. Contact:

NMRC, BDRD watch stander pager numbers:
Primary (877) 243-1528
Secondary (877) 243-1531
STU III DSN 285-7509 COM: 301-319-7509
EMAIL: NIPR: BDRDBW@NMRC.NAVY.MIL; SIPRNET:

BDRD.OPS@INTECWASH.NAVY.SMIL.MIL
CLASSIFIED MESSAGE TRAFFIC PLAD: NAVMEDRSCENTER SILVER SPRING MD
NMRC OFFICER OF THE DAY
DSN: 285-9053
COM: (301) 526-1649

b. Inform the NMRC OOD that you need the BDRD watch stander paged; provide contact information to the OOD.

12. Confirmatory Laboratory Inventories

a. Inventory checklists are included in the Dirty and Clean laboratory boxes.

b. Questions regarding inventory components may be addressed through reachback to BDRD.

14-5. Mass Casualty Planning

1. Definition of Mass Casualty. The mass casualty bill must be activated any time personnel casualties exceed the capabilities of the medical department personnel on the scene. In this situation, all of the medical personnel and material resources will need to be mobilized in an effort to render aid to the greatest number of casualties possible. The keys to successful execution of the mass casualty bill are flexibility, good communication, sound leadership, and efficient utilization of resources to return the greatest number of personnel to full duty, resulting in quality care to the greatest number of remaining casualties. Although triage will vary according to the ship's tactical situation and the total number of casualties sustained, the categories remain consistent. There should be no hesitancy in calling "Mass Casualty" as this action mobilizes many functional areas of the ship in addition to Medical (i.e. dental, supply, weapons, AIMD, air department, and security). The exact method of notification should be outlined in the Mass Casualty Bill. The medical department must develop, implement, and regularly review the Mass Casualty Bill. Mass casualty drills are required, and the periodicity is outlined in the COMNAVAIRFORINST 3500.20E.

2. Triage Categories. Triage is necessary in order to determine priority for treatment as well as returning the greatest number of personnel to full duty. Depending upon the tactical situation, emphasis will be placed predominantly on the immediate category or on the walking wounded category. Assignment of a triage category is a continuously evolving process and should be repeated frequently, and, at a minimum, following each intervention. The triage categories are:

a. Immediate (Red). Life or limb-saving measures are required in order to have any reasonable expectation for survival.

b. Delayed (Yellow). Cases in which some surgical intervention will be required, but can be safely delayed until after the Immediate category have been treated.

c. Minimal (Walking Wounded) (Green). Those who not only can ambulate without assistance to receive care, but who can be tended to most rapidly and then returned to their duty station.

d. Expectant (Black). Those whose injuries are so severe that survival is either not expected or would consume so many personnel and material resources that many other casualties would suffer as a consequence.

Note: Triage categories may be assigned differently depending upon the total number of casualties suffered, the number and expertise of medical providers, the amount of medical supplies, and the urgency with which casualties must be returned to duty. Depending upon the situation, it may be more important to retain a large number of casualties in the holding area where the surgeon and anesthesia provider are able to assist multiple casualties, rather than getting the first case to the operating room.

3. Mass Casualty Areas. The exact location of the following areas will vary depending upon the location of the casualties and the nature of the event resulting in the casualties, in addition to what tactical evolution the ship is in at the time. If the ship is in flight operations, the prime consideration will be to clear the flight deck expeditiously without contributing further foreign object debris (FOD) hazards. The primary triage evolution can be accomplished by rapid movement of casualties to another location with movement of minimal, if any, supplies onto the flight deck.

a. Initial Triage and Collecting Area. This area may be one in the same, and merely be an area for collecting as many casualties as possible before movement to a safe location (i.e. deck edge elevator prior to movement to the hangar bay). If this area is on the flight deck, it may be just one or two HMs performing initial triage and informing other department personnel of the nature and extent of injuries. Depending upon the situation a flight surgeon and one or two HMs will be in the flight deck BDS to render aid to walking wounded (to expeditiously return them to full duty) or possibly render the beginning of ATLS protocols.

b. Triage Area. This area is the first location where a concerted triage effort is conducted, and depending upon timing and numbers, the first ATLS measures. The primary triage officer should be located here. Walking wounded should be directed to the designated treatment area, often an auxiliary BDS or a separate location in the hangar bay. Expectant and deceased casualties should be moved to other locations in the hangar bay.

c. Holding Area. This area is the area where the greatest amount of care can be rendered to the greatest number of casualties with the fewest personnel because of the open spaces. This area is for the gathering of casualties for definitive resuscitation and temporary observation prior

to orderly movement to the main BDS. Often, this area will be the forward or aft mess decks on the second deck. One should not rush to move large numbers of casualties to the main BDS because the configuration in the main BDS is such that it takes more providers to render care in that area. Depending upon the total number of casualties, you may move two or three of your most critical casualties plus a surgical case to the main BDS. Remember, you cannot afford to commit too many personnel to just a few casualties if the total casualty count is high.

d. Main BDS. All litter casualties will eventually be moved to this location. Walking wounded casualties will be treated and returned to duty to support the ships evolution.

4. Location of Providers. Distribution of providers is as critical as distribution of supplies and utilization of space. The location of all providers for mass casualty response must be listed in the WQSB. Resist the temptation to commit yourself or other providers to a hazardous location. Personnel resources are limited and the medical department cannot afford to have any of them become casualties themselves. Crash fire and rescue personnel, other fire fighters, and repair locker personnel are trained in the recovery, extraction, and removal of casualties. Stretcher bearers will then bring the casualties to the providers. Dental officers will assist in triage or in treatment of casualties as appropriate. Because the greatest amount of care can be provided to the greatest number of casualties in the holding area, this area may be the best location for initial utilization of the general surgeon, oral surgeon, and anesthesia provider. Like all other facets of the mass casualty scenario, distribution of personnel must remain flexible and well thought out in terms of safety and effectiveness.

5. Mass Casualty Supplies**.** Seven mass casualty sets will be used to provide mass casualty medical supplies. These sets will be stocked in accordance with appendix O (AMAL 3051/3251). These sets must be strategically pre-staged and remain portable to support a variety of contingencies. The seven mass casualty sets should be maintained with one in each hangar bay, two on the forward mess decks, and two on the aft mess decks. These locations may be altered as necessary to better meet the needs of the individual and the ship. These supplies must be inventoried as outlined in appendix Q of this instruction. The supply petty officer must work closely with the supply department to rapidly replenish the supplies once they are depleted from the mass casualty sets and other locations.

6. Communication. Each CVN must establish an effective mass casualty communication system that allows for alternate methods of communication in the event that the primary means is lost through an equipment casualty. Hand held radio systems are the most efficient and are preferred over sound powered phones or messengers; however, all three methods of communication should be drilled. The number and type of casualties is critical for efficient management of the situation, and must eventually be reported to the chain of command. The SMO must retain a capability of overseeing the entire evolution and an understanding of the "big picture." This understanding is necessary in order to apply his/her expertise and experience to the overall directing of events. The SMO should assign a qualified officer or Chief Petty Officer to Damage Control Central for communications control and medical coordination, without compromising

access to bulk narcotics. This individual accumulates casualty information and directs the flow of casualties, personnel, equipment, and supplies throughout the ship. They determine safe routes based on information from the DCA and provide casualty information to the damage control officer. They are the "controllers" of the flow of casualty care and medical responses throughout the ship.

7. Preparation. Planning for a wide variety of scenarios is key to being well prepared. Although history has taught us to plan for the flight deck or hangar bay mishap, there are numerous other events and locations that could produce mass casualties, at sea or in port. The medical department and ship's personnel should train for as many variations as possible. Although the Mass Casualty Bill is not executed during GQ, plan for the management of numerous casualties during GQ, and for the eventual movement of casualties as the situation evolves or the ship stands down from GQ. A script cannot possibly be written for every possible situation. Shipboard personnel must practice as many different scenarios as possible and create order out of chaos through effective communication and efficient utilization of resources.

CHAPTER 15
CARRIER STRIKE GROUP OPERATIONS

1. Carrier Strike Group Surgeon (CSGS) Responsibilities**.** The CVN SMO must be designated as the CSGS. The CSGS is the senior medical authority afloat and advises the strike group commander on all matters pertaining to the health care of the strike group. The CSGS must become familiar with the role of JTF surgeon and joint force maritime component commander surgeon responsibilities and how to fit into CSG staff prior to any underway periods (see NTTP 3-32.1, Navy Tactics, Techniques, and Procedures Maritime Operations Centers). This role has become important in CSG and CVN joint force integration and in contingency operations; the SMO, MAO and others may be tasked to act as a JTF Surgeon cell. SMOs should consult with COMNAVAIRPAC or COMNAVAIRLANT if additional forces are required. It is highly recommended that at the first sign of standing up a JTF surgeon cell that the CSGS request O-6 Medical Service Corps/POMI augment.

2. Medical Liaison with Ships in Strike Group**.** Carrier Medical Departments must provide medical support for the entire CSG while underway and as needed/required outside the strike group. Support within the strike group is facilitated if all parties are fully cognizant of each other's capabilities and general operating procedures. Ships in company have called upon CVN Medical Departments for assistance in a variety of circumstances, including:

a. Operational emergencies involving personnel casualties.

b. Medical and surgical consultative services.

c. Dental support.

d. Supply, x-ray and laboratory services.

e. Evacuation services.

f. Preventive medicine and epidemiological support.

g. Optician support.

h. Medical equipment repair support.

i. Mental health and substance abuse consultation, evaluation, and treatment.

j. IDC support.

3. Strike Group Pre-deployment Planning**.** To optimize medical support within the CSG, all COMNAVAIRFOR CVN medical departments, prior to commencement of strike group operations or operational deployments, must accomplish the following:

a. Establish communications between the carrier and commands in company at least 30 (preferably closer to 90) days prior to Composite Training Unit Exercises or deployment.

b. Hold pre-deployment briefs to assure the understanding and coordination of mission requirements and CSG policies and procedures by medical representatives of all participating units. The CSGS must provide sufficient notice and lead time to allow attendance by all medical department representatives at these work-up phase meetings. At a minimum, the following issues should be discussed: medical and dental capabilities within the CSG, quality assurance, medical intelligence, MEDEVAC procedures, grounding, and clearing of flight crew personnel and medical guard ship duty.

c. Physically visit, whenever possible, medical departments of ships, which will be in company.

d. Invite medical department representatives of commands, which will be in company to visit the CVN medical department for indoctrination.

e. Provide a written protocol describing, at a minimum:

(1) Regular communication forums including NIPR, SIPR (chat is highly recommended), and POTS contact numbers. Underway it is highly advisable for the CSGS to have a fireside SIPRNET chat several nights a week to discuss CSG medical issues/patients.

(2) Medical and dental services available and capabilities.

(3) Procedures for patient referral or transfer.

(4) Other information as desired by the CVN medical department, such as medical supply material carried on board.

(5) Indoctrination on helicopter MEDEVAC methods, limitations, hazards, and environment. Additionally, ascertain whether the sending ship is capable of receiving a helicopter on deck.

(6) The information should also be provided to additional ships, which join the task force or operational group during the deployment.

4. Surface Force IDC Process Improvement**.** During CSG operations, a medical officer must periodically embark upon the IDC-manned strike group ships. Program process improvement

review and oversight rests with the COMNAVSURFOR; however, if requested, the CVN medical department may conduct process improvement reviews and assist with any difficult medical cases. COMNAVSURFOR has directed CSG monthly QA reports be copied to the CVN SMO for situational awareness.

5. Pre-deployment Checklist**.** All medical departments will utilize the checklist in appendix T when preparing for deployment.

6. Maritime Operations Center (MOC) Functions**.** In contingency operations, the SMO for limited periods may be required to function as the MOC surgeon. The functions listed below are provided as a basic outline line of responsibilities:

a. Advise the commander concerning the following:

(1) The health of the force, such as disease and non-battle injury/battle injury rates.

(2) Prevention and protection measures and procedures.

(3) Health surveillance, including medical, occupational, and environmental.

(4) The treatment and evacuation of all eligible personnel.

b. Ensure membership and required medical liaison relationships to appropriate headquarters, codes and organizations, specifically the JTF cell, and teams to coordinate FHP and health services support (HSS) issues.

c. Assist subordinate commands in identifying FHP and HSS requirements and ensuring FHP and HSS is provided and maintained.

d. Oversee all aspects associated with the medical Navy Mission Essential Tasks (NTA 4.12) to ensure optimal health readiness of the population at risk, to include U.S. forces and other eligible personnel.

e. Prepare and/or be prepared to execute Annex Q (Medical Services) for operational plans /operational orders in coordination with the HSS cell.

CHAPTER 16
HEALTH PROMOTIONS AND WELLNESS

1. General

a. Health Promotion and Wellness (HPW) is a combination of health education and related organizational, physical, emotional, social, spiritual, mental wellness and health care interventions designed to improve or protect health. An HPW program should encourage healthy lifestyles, increase organizational and individual readiness, and concentrate on increased healthy lifestyle choices by identifying and minimizing health risk behavior and disabilities.

b. It is estimated that individual behaviors and environmental factors account for at least 70 percent of all premature deaths in the U.S. Unhealthy lifestyles are the major underlying cause for many of the health problems in the U.S. population, pose a huge social and economic burden, and decrease mission readiness by decreasing deployability and performance levels. Examples of unhealthy lifestyles include misuse of drugs and alcohol, tobacco use, poor nutrition, sedentary lifestyle, preventable injuries, sexual irresponsibility, mismanagement of stress and anger, suicide attempts and interpersonal violence.

c. The CO is responsible for ensuring that a command HPW program is implemented. The command HPW program must promote optimal wellness through various educational and intervention programs.

d. Program requirements for COMNAVAIRFOR ships are outlined in COMNAVAIRFORINST 6100.1. Additional information on health promotion programs can be found in OPNAVINST 6100.2A and BUMEDINST 6110.13A.

e. The medical department plays a key role in the establishment and overall maintenance of the command HPW program.

2. HPW Program Goals

a. Available to all crew/staff.

b. High participation and satisfaction rate.

c. Increase awareness of healthier lifestyles and behaviors.

d. Improve readiness.

e. Increase command fitness.

f. Assist in risk reduction.

g. Encourage individual responsibility.

h. Enhance productivity and morale.

i. Improve quality of life.

j. Emphasize healthy people leading indicators, such as

(1) Physical activity

(2) Overweight and obesity

(3) Tobacco use

(4) Substance abuse

(5) Responsible sexual behavior

(6) Mental health

(7) Injury and violence

(8) Environmental health

(9) Immunizations

(10) Access to health care

3. Health Promotion Coordinator Qualifications**.** The health promotion coordinator (HPC) must:

a. Possess a genuine interest in HPW and increase crew awareness of HPW topics for a healthy lifestyle.

b. Be a non-smoker.

c. Maintain height/weight standards and be physically fit.

d. Be paygrade E-7 or above and appointed in writing.

4. Courses for Health Promotion Coordinator (HPC)

a. Contact the NMCPHC and the local MTF/clinic for courses on HPW programs.

b. The HPC must attend the three-day Navy Health Promotion Advanced Course given by NMCPHC.

c. It is recommended that the HPC should attend the combined Population Health & Health Promotion and Wellness Conference sponsored by NMCPHC, Navy Occupational Health, and Preventive Medicine held annually.

d. Utilize the Health Promotion toolbox and additional program guidance offered at NMCPHC's website at: http://www.nmcphc.med.navy.mil.

5. HPW Program Marketing

a. A yearly calendar of events/classes must be published and distributed throughout the ship. This calendar must contain the health promotion events sponsored by the ship and the local area hosts when pier side. Many classes are taught in the local area that the ship can utilize. Contact the force environmental health officer (EHO) or the local MTF, Fleet and Family Support Center, area Navy Environmental Preventive Medicine Unit (NEPMU) or clinic Health Promotion Department for more information.

b. The ship's closed-circuit TV should be used to air the events calendar and show educational videos on the different health promotion programs.

c. Conduct health fairs to expose the crew to current health topics and allow them to interact with health care professionals on an informal basis. Contact the local NEPMU for info and help with the health fairs.

d. The ship's newspaper, Plan of the Week/Day, bulletin boards, notes, brochures, pamphlets, newsletters, and promotion posters should be used to promote the command's HPW program.

6. Program Self Evaluation

a. The HPC must oversee a health assessment on each command member at least annually. This assessment is to ensure that the HPW program is meeting the needs of the crew. To conduct the assessment, the Health Risk Appraisal (HRA) form or the Health Assessment Review Tool can be used. For the fleet, the HRA is normally used. To obtain information on the following go to the NMCPHC web site: http://www.nmcphc.med.navy.mil/. The local supporting NEPMU can assist in compiling the HRA data sheets.

b. The HPC should develop a survey or evaluation form that can be used to evaluate the HPW classes given at the command. At the end of all HPW classes, a survey should be provided to participants in order to evaluate and make changes to improve the class. All class participants should be encouraged to fill out an evaluation form/survey.

7. Health Promotion Award**.** NMCPHC administers the Surgeon General's Blue "H" Award for command excellence in HPW. For more information, including the specific criteria for the Blue "H" Award, contact NMCPHC (www.nmcphc.med.navy.mil).

CHAPTER 17
PREVENTIVE MEDICINE, ENVIRONMENTAL HEALTH, AND DEPLOYMENT HEALTH SURVEILLANCE

17-1. General

1. Introduction**.** This chapter addresses policies that promote and maintain the health, welfare, and comfort of the personnel stationed aboard COMNAVAIRPAC and COMNAVAIRLANT CVNs. The SMO is responsible for implementing preventive medicine, occupational medicine, deployment health and environmental health programs and advising the CO of all conditions affecting the health of the crew. These include:

   a. IMR and PHA

   b. Communicable disease control and the immunization-tracking program

   c. TB control and surveillance program

   d. Food safety program

   e. Potable water and ice surveillance program

   f. CHT system and solid waste surveillance

   g. International health regulations

   h. Pest control program

   i. Habitability

   j. Medical waste program

   k. Bloodborne pathogen program

   l. Heat stress program

   m. Deployment health surveillance program

2. Inspections and Reports

   a. Inspections

      (1) The SMO or preventive medicine representative must conduct routine sanitation and

habitability inspections to identify health threats and other detrimental conditions that are potentially degrading to the health and wellbeing of the ship's crew.

(2) Findings must be documented and reported to the CO with copies provided to cognizant department heads, DIVOs or LCPOs.

(3) Inspection frequency is determined by published guidelines and instructions, CO's direction, potential health risk for illness or injury, and/or degree of compliance with published health standards.

b. Preventive Medicine/Occupational Health Reporting

(1) Pertinent aspects from the preventive medicine and occupational health program will be submitted in the monthly medical QA report. The monthly report format for the occupational health and preventive medicine information is maintained at the TYCOM and a copy is available upon request.

(2) The compliance goal for each program area is set forth by higher authority. An overall compliance equal to or greater than 90 percent is the ultimate goal. The MRI, Section E, and FHP is the assessment tool for program compliance. Additionally, the monthly QA report monitors program compliance throughout the calendar year. Programs should have the ability to actively improve and measure program compliance and properly explain deficiencies, shortfalls and corrective actions.

17-2. Preventive Medicine

1. Disease Reporting

a. The Medical Event Report (MER) is the primary method of reporting various medical events, including communicable diseases, injuries and outbreaks, to the chain of command and appropriate health authorities. Reporting requirements and guidelines for MERs are provided in BUMEDINST 6220.12C.

b. Commands are required to report to applicable military, local, state, federal, and international health authorities. The TYCOM force EHO as well as the local MTF preventive medicine department and area supporting NEPMU can also offer assistance and advice.

c. Submit routine MERs using the NMCPHC's NDRSi Website or TMIP as reportable event(s) are suspected or confirmed. If suspected, ensure follow up with necessary information to close the event. Urgent MERs must be reported within 24 hours of suspected diagnosis followed up by a final MER when diagnosis is confirmed. Specific reporting timeframes for each reportable disease are contained in BUMEDINST 6220.12C. TMIP-generated medical event reports may be acceptable to health authorities for commands that do not have adequate

internet access. Always verify these procedures depending on where you are operating to ensure proper communicable disease reporting to the correct authorities. In addition, a step by step guide to submit files through NMO is available at http://www.nmcphc.med.navy.mil/PreventiveMedicine/diseasesurveillance/medeventreporting.aspx. Technical assistance is also available through the help desk at 757-953-0954 or ndrs@nmcphc.med.navy.mil.

d. Special emphasis concerning AOR requirements. If you are in doubt of FHP guidance or AOR Annex Q direction depending on location (e.g. COCOM, service component and or numbered fleet), notify the cognizant NEPMU via telephone and/or e-mail or contact the TYCOM force EHO at 757-836-6317 for guidance if available.

e. The medical department sick call log must be reviewed daily for tracking potential disease trends and follow-up on reportable diseases and injuries.

2. Communicable Disease Control and Surveillance

a. Immunizations

(1) Ship's company and embarked squadron personnel must be immunized and re-immunized, as applicable, in accordance with BUMEDINST 6230.15B. Squadron personnel should be fully immunized by their cognizant shore-based MTF prior to deployment. In the event that significant numbers of squadron personnel embark not fully immunized, the specifics of the immunization shortfall should be reported to the appropriate CNAP or CNAL force medical staff in the monthly QA report.

(2) Preventive medicine must provide program oversight to ensure that required immunizations are administered and documented correctly. Medical personnel administering immunizations must receive annual training in the current policies and procedures.

(3) Adhere to established immunization tracking requirements.

(a) Immunization documentation. Immunizations will be recorded including all the required data fields at the time of service on the Adult Immunization Record, NAVMED 6230/4 (rev 10-2007), or TMIP generated DD 2766 and filed in the medical record. NAVMED 6230/4 is also available at: http://www.med.navy.mil/directives/ExForms/NAVMED%206230-4%20(10-2007).pdf. Each medical record must contain a current NAVMED 6230/4 or TMIP generated DD 2766. Standard Form 601, immunizations record, containing previous immunizations must be retained, but must not be used for recording current immunizations. Immunizations must also be recorded at the time and point of service (where the immunization is given), in TMIP when available. Immunizations listed on the DD 2766 must be fully documented in TMIP, as the DD 2766 print out does not list all immunization information required by the

U.S. FDA and the National Vaccine Liability Act. Requirement is to document immunizations once in the medical record and once in TMIP.

(b) Electronic transfer of all immunization data is required weekly to the Navy Medicine Medical Information Systems Support Activity via the NMO website. This requirement is in addition to data that is transferred via TMIP communicator.

(c) Accurate documentation in the database and individual medical records is critical. Entries for each vaccine or toxoid administered need to be entered on NAVMED 6230/4. Include the following information: date given, manufacturer, lot number, dose given, and route of administration. The provider's name, address, and title also needs to be included.

1. Cold chain management is critical. Proper storage and shelf life requirements must be closely monitored. If in doubt always check the vaccine (product) package insert for specifics.

2. The temperature of all refrigerators used to store vaccines must be checked and documented twice a day. Stay vigilant in monitoring vaccine products. This is critical for quality control and preserving supplies.

b. Tuberculosis (TB) Control Program

(1) Navy policies governing TB control, treatment, and case management are detailed in BUMEDINST 6224.8C. Specific program guidance may be obtained from either the TYCOM or the cognizant NEPMU.

(2) All operational personnel must have a Latent TB Infection Screening (LTBI) administered after receipt of orders to a commissioned vessel. All previous TB Skin Test (TST) reactors must show documentation of successful completion of LTBI treatment regimen. If a person gives an undocumented history of LTBI treatment for a previous positive TST or other laboratory test, perform a TST and treat in accordance with BUMEDISNT 6224.8C. Document successful treatment for LTBI in the medical record. No additional LTBI testing or chest radiograph is required unless otherwise indicated. All ship personnel must be evaluated annually during the PHA using NAVMED 6224/8 Interim Tuberculosis Exposure Risk Assessment, to determine TB exposure history and risk of acquiring TB. This must be documented in the individual medical record. Following the initial TST, subsequent evaluations will be conducted via TB questionnaire/survey in accordance with BUMED 6224.8C.

(3) A PMT must evaluate all individuals with a TST induration greater than 5 mm to determine if their test is positive. A medical officer or PA must see all reactors prior to instituting a course of Isoniazid (INH) preventive therapy. A second opinion is required from a preventive medicine physician or infectious disease specialist if an initial reactor who meets the guidelines of BUMEDINST 6224.8C is not started on INH.

(4) Patients placed on INH therapy must be seen monthly by preventive medicine until successful completion of treatment as prescribed in BUMEDINST 6224.8C. Consideration should be given to directly observed therapy on a semi-weekly basis as a tool to maximize compliance. A final follow-up visit is also required after the completion of INH therapy and the patient is placed in the annual follow-up program.

(5) Tracking for TB control program. TMIP must be used to track all newly identified reactors, monthly INH follow-up, and previous reactors (annuals). A desktop guide is available and should be incorporated into the SOP. This standardizes data entry, program reports, and annual summary report.

c. Sexually Transmitted Disease (STD) Program

(1) Navy guidance for the diagnosis and treatment of STDs is provided in BUMEDINST 6222.10C. The most current Centers for Disease Control and Prevention (CDC) treatment guidelines must be available and utilized for STD patient management and treatment.

(2) An STD control program report (log or database) must be maintained to track the overall management of patients being assessed, evaluated and treated for STDs. TMIP serves as the management tool for this program requirement.

(3) All STD patients must be directed to preventive medicine for contact interviews to fulfill various reporting requirements in accordance with BUMEDINST 6220.12C and BUMEDINST 6222.10C. TMIP provides the necessary data fields to track patient follow-ups, Hepatitis B vaccine series, and MER submissions. Creating an ad hoc report in TMIP by selecting these fields that match your data input enables production of a current STD control report, useful in determining control measures that need to be undertaken.

(4) A MER must be submitted for any case of chlamydia, gonorrhea, syphilis (all stages), and/or hepatitis B. Section 2, paragraph 1, of this chapter, details MER guidance.

(5) All patients evaluated for a STD must be tested for syphilis and HIV. Hepatitis B virus (HBV) vaccine will be administered (if not previously vaccinated) to all patients evaluated for a STD in accordance with the current CDC treatment guidelines. When STD patients return for their third dose of the HBV vaccine (i.e., 6 months) they should also be offered follow-up HIV testing.

d. Rabies Prevention and Animal Bite Control

(1) Follow guidance in accordance with SECNAVINST 6401.1B and BUMEDINST 6220.12C. In addition, cognizant NEPMU or local MTF preventive medicine department must be contacted for current treatment protocols and guidance with various reporting requirements, methods, and forms reportable in accordance with BUMEDINST 6220.12C.

(2) All animal bite cases must be individually evaluated for possible rabies vaccine administration. In most cases, rabies vaccine should be administered when patients cannot provide adequate information to health or animal control authorities to locate the suspect animal. Utilize DD-2341 dated October 2007 for documentation.

e. Malaria Prevention and Control

(1) Chemoprophylaxis and treatment protocols are defined in the current edition of the Navy Medical Department Pocket Guide to Malaria Prevention and Control, NEHC-TM PM 6250.1 and NAVMEDCOMINST 6230.2. BUMEDINST 6230.16A

(2) Medical intelligence sources, such as the NCMI or their MEDIC CD-ROM product, provide information on current malaria threats and recommendations. Chemoprophylaxis drug quantities and shelf life must be verified prior to deployment and integrated into mission planning. The current AMAL may not have adequate quantities to cover an extended period in a malaria threat area.

f. Hand Washing Techniques and Control

(1) In order to minimize the spread of communicable diseases through direct and non-direct hand contact, the usage of waterless hand sanitizers must be implemented. These products do not replace proper hand washing techniques. They provide a portable or semi-permanent solution to help combat potential spread of communicable disease.

(2) Waterless hand washing stations should be staged at various key locations throughout the ship and must be conspicuously mounted to the bulkhead. The following locations are recommended:

(a) Entrance to all galley food service lines

(b) Snack food vending stations

(c) Medical spaces (to include patient waiting areas)

(d) Liberty brows (ideally, to be used primarily during foreign port call visits)

(e) Gym facilities

(f) Any other area as deemed necessary by the Senior Medical Officer

(3) The Supply Department will be responsible to ensure that adequate supplies are present for the waterless hand washing stations. During their scheduled inspections, Preventive Medicine will inspect the hand washing stations for functionality and will conduct appropriate

awareness training on proper hand washing, personal hygiene, and ship sanitation. Individual departments that have installed waterless hand sanitizer stations are responsible for keeping them stocked.

(4) Design and manufacturer of the waterless hand sanitizing stations must be left to the discretion of the Supply Department with guidance from the SMO. Specific guidance may be obtained from either the TYCOM Force EHO or the Navy and Marine Corps Public Health Center.

3. Medical Intelligence and Health Threat Briefs

a. Information concerning endemic diseases and vectors in potential ports of call is available from NEPMUs and Navy and Marine Corps Public Health Center Intranet. Phone numbers and website addresses are as follows:

UNIT	COMM	DSN	FAX	WEB ADDRESS
NEPMU 2	(757) 953-6600	377-6600	(757) 953-7212	http://www.med.navy.mil/sites/nepmu2/Pages/default.aspx
NEPMU 5	(619) 556-7070	526-7070	(619) 556-7071	http://www.med.navy.mil/SITES/NMCPHC/NEPMU-5/Pages/default.aspx
NEPMU 6	(808) 473-0555	(315) 473-0555	(808) 473-2754	http://www.med.navy.mil/sites/nmcPHC/nepmu-6/pages/default.aspx
NECE JAX	(904) 542-2424	942-2424	(904) 542-4324	http://www.med.navy.mil/sites/nmcphc/nece/pages/default.aspx
Army Public Health Center	(800) 222-9698	584-4375	(410) 436-7301	https://phc.amedd.army.mil/topics/envirohealth/Pages/default.aspx

17-3. Environmental Health

1. Food Safety

a. Applicability. This section applies to galleys, bake shops, meat processing areas, sculleries, food storage spaces, mess decks, ice cream and soda messes, first class petty officer messes, chief petty officer messes, wardrooms, CO and flag messes, vending machines and other areas where food is stored, prepared, served or consumed.

b. Responsibilities

(1) The SMO or the PMT will conduct a formal food service sanitation inspection of each food service space at least once a month.

(2) All cited critical violations must be corrected at the time of the inspection or within ten days of initial inspection. Formal inspection reports must be routed via the chain of command to the CO.

(3) Informal walk-through assessments are highly encouraged. A minimum of weekly walk-through assessments of the galleys and wardrooms should be conducted.

c. Communicable Disease Occurrences

(1) If a communicable disease outbreak occurs which has a direct impact on food service operations, (e.g. gastroenteritis (GE) or norovirus) the SMO will notify the CO and the supply department to inform them of the health threat.

(2) In order to minimize and mitigate the spread of disease via respiratory discharge and hand contact, the following processes will be imposed:

(a) Self service at the galleys will cease (exception would be for wrapped or prepackaged food items and beverage stations). All food will be dispensed by galley personnel until disease threat has been confined as determined by the SMO.

(b) Hand-rails of ladder wells will be disinfected by wiping them with a sanitizing solution. Hand-rails should be wiped at least twice a day until disease rates have lowered.

(c) Preventive medicine will regularly monitor hand washing stations to enforce and educate the crew on the significance of hand washing. They will properly educate the crew concerning hand washing techniques.

d. References. The Manual of Naval Preventive Medicine, Chapter 1 (NAVMED P-5010-1) and NAVSUP Pubs 421 and 486 are the Navy basic guidance documents. In addition, the most current version of the FDA's "Food Code" (http://www.fda.gov/food/foodsafety/retailfoodprotection/foodcode/default.htm) provides a frequently cited reference source for established food safety principles and practices.

e. Medical Screening. All personnel working in foodservice must be initially evaluated by medical personnel. A screening questionnaire will be administered and completed by all foodservice workers prior to commencing duties in any food preparation area per NAVMED P-5010-1.

f. Training

(1) All foodservice workers must receive a minimum of four hours of food safety and sanitation training. Temporary foodservice workers (less than 30 days) must receive a minimum of two hours training.

(2) Any foodservice worker designated as a supervisor or person in charge must meet the requirements as cited in OPNAVINST 4061.4.

(3) Preventive medicine staff must provide oversight for the food safety and sanitation training program. If galley personnel conduct food service training, preventive medicine staff should routinely audit the training sessions to determine the validity and effectiveness of the training curriculum. Foodservice management personnel and/or the PMTs will conduct training of foodservice workers. Additionally, training support for foodservice workers designated as supervisors or a person in charge can also be supported by local NEPMUs.

2. Potable Water Sanitation

a. Responsibility

(1) Each ship must have a Water Sanitation Bill that delineates all policies and procedures for the provision and monitoring of potable water.

(2) The reactor officer is responsible for supply and treatment of potable water.

(3) The SMO is responsible for conducting a comprehensive medical surveillance program of the potable water system including adequacy of disinfection procedures, collection of samples for bacteriological analysis, and daily halogen residuals from the potable water distribution system.

b. References. NSTM chapter 531 and 533; Manual of Naval Preventive Medicine, Chapter 6 (NAVMED P-5010-6); BUMEDINST 6240.10C.

c. Surveillance

(1) Preventive medicine must conduct a comprehensive potable water system inspection on a quarterly basis. The inspection should include a review of deck risers, hoses, and hose lockers, sounding tubes, sounding tapes, halogen storage, batch chlorination procedures and the brominators, chlorinators or electrolytic disinfectant generators as applicable. A search for submerged potable water outlets and other existing or potential cross-connections must be included. A copy of the inspection must be routed via the chain of command to the CO.

(2) Daily halogen residuals must be taken from 12 sampling sites, which are varied and represent all parts of the potable water distribution system. Reactor departments will be notified daily of the sampling results. Free available chlorine (FAC), total chlorine residuals or total bromine residuals will be maintained as prescribed by current directives. “Trace” halogen residuals may be permitted underway and in CONUS but must be supported by consistently negative bacteriological test results. If no trace is detectable, or if positive bacteriological tests occur, action must be taken to determine the cause and correct any system problems. Daily

halogen residuals may be reduced to once per week while monitoring bacteriological quality of potable water when the ship is connected to shore potable water supply in homeport.

(3) Bacteriological quality of potable water and ice must be tested weekly, unless otherwise noted, following the procedures provided in NAVMED P-5010-6. Sampling sites must conform to the following:

(a) Water samples from 12 sites that are varied and represent all parts of the distribution system.

(b) Water samples from 1/4 of all potable water tanks.

(4) Monthly

(a) Ice samples from all operating ice making/dispensing machines.

(b) Emergency potable water tanks/BDSs.

d. A water log within TMIP must be maintained that documents the source and location the sample was taken from and the results of all daily halogen and all weekly bacteriological testing.

e. A weekly potable water bacteriological testing report that documents location and test results must be submitted to the CO.

f. Training. Engineering personnel responsible for processing, treatment and distribution of potable water are encouraged to attend a one-half day basic or refresher Water Sanitation Afloat Class (COIB-322-2120) offered on-line at Navy E-learning course. The ship's PMTs should provide the training if it is not accessible.

3. Collection, Holding and Transfer (CHT) System and Solid Waste Surveillance

a. Responsibilities. The engineering officer is responsible for operating and maintaining the CHT system. The SMO is responsible to ensure all CHT personnel are trained in the medical aspects of marine sanitation devices and for conducting periodic medical surveillance inspections of the CHT system.

b. References. OPNAVINST 5090.1D establishes Navy policy concerning environmental and natural resource protection. NAVMED P-5010-7 and NSTM, chapter 593 provide guidelines concerning safe and efficient operation of the CHT system.

c. Surveillance. Preventive Medicine must conduct a comprehensive CHT system inspection on a quarterly basis. The inspection should include a review of pump rooms, comminuted spaces, spill lockers, and deck risers for safety, health, and sanitation concerns. A copy of the inspection must be routed via the chain of command to the CO.

d. Medical Screening. All CHT workers should be tracked via TMIP and properly evaluated. The best practice is to coincide this with the PHA process. Ensure immunization status is reviewed annually and keep a current roster of all personnel who have been screened and trained to respond to CHT spills. This should be maintained in preventive medicine and tracked as a type of physical exam in TMIP.

e. Training

(1) Preventive medicine must provide annual training to all personnel who operate or maintain the CHT system and its components as well as personnel assigned to clean up CHT spills. The topics should include, but not be limited to: infectious diseases associated with human waste, the hazards of hydrogen sulfide and other gases, personal hygiene, personal protective equipment, and proper clean-up of spills and disinfection procedures.

(2) Engineering personnel responsible for the operation, maintenance and clean-up of spills are encouraged to complete the course in Health Aspects of Marine Sanitation Devices via the Navy E-Learning website.

f. Solid Waste Collection Sites. Preventive medicine must inspect all solid waste collection and processing sites for overall cleanliness and sanitation on a monthly basis. All plastic waste processing areas must also be included in the monthly sanitation inspection.

4. Pest Control Program and International Health Regulations

a. Responsibilities

(1) The medical department is responsible for performing pest surveys and conducting or supervising safe pest control operations. An integrated pest management approach must be followed and the indiscriminate use of pesticides is prohibited.

(2) PMTs and all medical department personnel who assist with pest control must maintain current Shipboard Pest Management Certification.

(3) All PMTs must also maintain current DoD Category 8 Pest Control certification per BUMEDINST 6250.12D.

(4) The supply department is responsible for funding and procuring pest control supplies and equipment and preparing their spaces properly for pesticide application.

(5) Other departments requiring pesticide applications must ensure their spaces are prepared properly for the pesticide treatment.

(6) The SMO should contact the regional NEPMU to determine any unique host nation entry requirements prior to making a port visit.

b. References. OPNAV 6210.2A provides quarantine regulations. OPNAVINST 6250.4C establishes Navy policy for implementing pest management programs. The Manual of Naval Preventive Medicine, Chapter 8 (NAVMED P-5010-8) and the Navy-Wide Shipboard Pest Control Manual (Navy Entomology Center for Excellence (NECE) publication) discuss Navy policies for a safe and effective pest control program. BUMEDINST 6250.12D establishes procedure for pesticide applicator training and certification for medical department personnel.

c. International Health Regulations (Ship Sanitation Control Exemption Certificate (SSCEC) or Ship Sanitation Control Certificate (SSCC)).

(1) Follow BUMEDINST 6210.4 for program guidance to comply with international health regulations. Ships must maintain their U.S. Public Health Seal until further notice.

(2) Deployable vessels must maintain a current SSCEC or SSCC. To be valid, the certificate must have been issued within the preceding six months. Ships must obtain inspection and certification from another command; self-inspection and certification is not authorized.

(3) This service is available through U.S. quarantine stations in major ports of the U.S., including Puerto Rico and the Virgin Islands, and by NEPMUs, NECE, naval hospitals, and ships with qualified professionals as detailed in BUMEDINST 6210.4. Should operational commitments preclude obtaining a SSCEC or SSCC inspection prior to expiration of the current certificate then one 30-day extension may be granted by the issuing authority.

d. Surveillance and Treatment

(1) Monthly surveys of all food storage and service areas are required to actively search for signs of insect infestations. Active infestations will require frequent follow-up. All incoming provisions also need to be assessed for potential insect infestation. A comprehensive surveillance program will include the use of sticky traps and flushing agents.

(2) A pest control log within TMIP will be utilized and maintained. The application documents all investigations, surveys, pesticide applications and treatments. It provides the user management tools to analyze and troubleshoot problem areas.

(3) In the event of an insect or rodent infestation, the ship's certified pest control personnel must initiate prompt and appropriate control measures. TYCOM force EHO must be notified. NEPMUs or NECE should be contacted for technical assistance as needed.

(4) The application of pesticides without correcting sanitation discrepancies and eliminating insect harborages is not approved, as it is ineffective in achieving long-term control over pests.

e. Pest Control Training

(1) OPNAVINST 6250.4C states that medical personnel can be trained to apply pesticides aboard ship. Individuals certified in shipboard pest control are restricted to using only those procedures, equipment, and pesticides approved for shipboard use. Annual certification training is required for all medical personnel who procure and apply standard stock pesticides. The NEPMUs and NECE provide this training.

(2) Additionally, Environmental Protection Agency Pesticide Applicator Category 8 certification must be maintained by PMTs as part of their basic 8432 NEC qualification per BUMEDINST 6250.12D. The certification is initially issued upon graduation from PMT "C" School and is effective for three years. Recertification can be attained at any point before the three years expires by either attending a recertification course sponsored by NECE, either in Jacksonville, Florida or an authorized regional course. This course is also offered every year at the NMCPHC conference. NECE is authorized to extend the expiration date by 12 months if operational commitments interfere with recertification efforts. If an individual's certification has expired, the member must repeat the entire Pesticide Applicator course. There are no exceptions since this training certification process must comply with strict federal EPA pesticide regulations.

(3) Medical and supply department personnel are selectively encouraged to assist with the pest control program, under the supervision of a PMT, by attending a one-day Shipboard Pest Management Course (CANTRAC Course B-322-1075) offered by NEPMUs.

5. Habitability Inspections

a. Responsibilities. The SMO or preventive medicine representative must conduct periodic sanitation inspections of berthing areas, heads, shower rooms, laundry, dry cleaning plants, confinement facilities (brig), gymnasiums, barbershops, and ship stores. The CO must be advised of conditions that are harmful to the health and morale of the crew.

b. References. Shipboard habitability standards are prescribed in OPNAVINST 9640.1C. The Manual of Naval Preventive Medicine, Chapter 2 (NAVMED P-5010-2) provides guidelines concerning sanitation of living spaces and related facilities.

c. Inspections

(1) All berthing spaces and heads are required to be inspected for general sanitation and cleanliness on a quarterly basis. The inspection plan should focus on a randomly selected sample

of berthing compartments and heads by the medical department under the supervision of preventive medicine.

(2) Barbershops, the ship's laundry and dry cleaning plant (if applicable), the ship's store, gymnasium, and the ship's brig are to be inspected on a quarterly basis.

d. Medical Screening. All barbers and laundry workers must be medically screened and have current immunizations prior to commencing their duties. The supervisor of the laundry facility must maintain copies of the certifications and each barber must display their medical certificate at their workstation

6. Infectioius Medical Waste Management Program

a. Applicability. Infectious medical waste requires special handling, sterilization, storage and disposal by medical department personnel.

b. Responsibilities. The CO must ensure that no medical materials are disposed of in a manner that poses a risk or perception of a risk to public health and welfare or the marine environment. Disposal of medical materials must also comply with existing state and local regulations or Status of Forces Agreements (SOFA).

c. References. OPNAV P-45-113-3-99 (Afloat Medical Waste Management Guide) supplements and implements the policies established for shipboard medical waste as either infectious or non-infectious medical waste to be managed in accordance with chapter 22 of OPNAVINST 5090.1B (Navy Environmental and Natural Resources Program Manual) and BUMEDINST 6280.1C (Management of Regulated Medical Waste).

d. State Medical Waste Requirements

(1) In port, potentially infectious medical waste from ships must be delivered to a designated Navy Branch Medical Clinic or turned over to an authorized PWC contractor.

(2) Listing specific rules and regulations for every county, state and country where COMNAVAIRFOR maintains a homeport would be impractical due to the extent, complexity, and propensity to change of those requirements. Nevertheless, each CVN must ensure compliance with its respective municipalities' regulations regarding disposal of medical waste. Local guidance must be obtained from the supporting MTF, NEPMU or PWC Environmental staff.

e. Foreign Countries. For foreign countries, the packaging, handling, storage, transportation, treatment and disposal of infectious waste must be consistent with standards to protect public health and the environment as prescribed by applicable SOFAs and international

agreements. If no SOFA or international agreement exists, infectious waste must be disposed of as specified by the cognizant fleet commander.

f. Record Keeping. Tracking, storage and disposal of shipboard infectious medical waste will be recorded in the Shipboard Medical Waste Storage and Disposal Record.

g. Program Oversight. Preventive medicine will evaluate overall compliance with the Medical Waste Program on a monthly basis.

CHAPTER 18
OCCUPATIONAL HEALTH AND SAFETY

18-1. General

1. Introduction

a. Background. The safety and health of Navy personnel is an integral responsibility of the command and is achieved through the integration of safety and health into all aspects of naval operations. The NAVOSH program will be carried out through the chain of command, with assistance from safety and health personnel. Specific emphasis is required by supervisory personnel to ensure NAVOSH hazards are identified and corrected, and that personnel are aware of hazards associated with their work and the means to prevent accidents and illnesses.

b. Purpose. The core of the NAVOSH program is training and the identification, risk assessment, mitigation, elimination and control of safety and health hazards. The occupational health element is primarily concerned with more insidious health effects, which are usually produced by long term (chronic) exposures to toxic chemicals and materials or harmful physical agents (e.g., noise, radiation, etc.) and the treatment of work-related injuries. The occupational health program element is divided into two major subspecialties – industrial hygiene and occupational medicine. Each of these subspecialties has, as one of its major functional components, a long-term surveillance program.

(1) Industrial hygiene involves the surveillance of the work place and the anticipation, recognition, identification, evaluation, and control of any health hazards.

(2) Occupational medicine focuses on the medical surveillance of personnel potentially exposed to the hazards identified during the industrial hygiene work place evaluation, and the diagnosis and treatment of occupational injuries and illnesses.

c. Responsibility. The safety department is responsible for the overall NAVOSH program (COMNAVAIRFORINST 5100.3). All medical surveillance and examination requirements are the responsibility of the Medical Department.

2. Command Occupational Health Inspections

a. OPNAVINST 5100.19F requires that a baseline industrial hygiene survey be conducted for each ship. An update of the baseline survey is necessary when system, equipment, or load out changes significantly affect the onboard hazard and/or risk. This survey is the essential risk management tool. As part of the operational risk management responsibilities, the CO is required to identify potential hazards, assess the risks presented by the hazards, and provide controls to prevent exposures to personnel. Deterioration of existing controls, modifications, and additions to shipboard processes and equipment will occur over time. An update of the industrial

hygiene survey is required at least every two years to address all changes that may have occurred. A more limited survey to address specific concerns is available at the discretion of the CO. Examples of changes that could significantly affect the on-board hazard and/or risk are as follows:

(1) New or modified equipment or processes.

(2) Introduction of new hazardous chemicals and/or harmful physical or biological agents.

(3) Deterioration of existing controls (e.g., ventilation) which degrades over time.

(4) Some of these changes would be the expected result of a shipyard availability period and COs may consider requesting industrial hygiene assistance from their supporting NEMPU following a major availability.

b. The baseline and periodic industrial hygiene surveys will be conducted by the assistant safety/IHO assigned to the CVN. The CVN IHO may request assistance from their respective TYCOM force IHO, supporting regional IH plan or area NEPMU.

c. The safety department must provide the medical department a copy of the baseline and periodic industrial hygiene survey, including specific medical surveillance requirements. The medical department will permanently maintain copies of all baseline and subsequent industrial hygiene surveys and perform occupational health exams to meet medical surveillance requirements.

d. The medical department may request industrial hygiene to evaluate or re-evaluate any work procedures or processes suspected as occupational hazards based on health complaints, diagnosis, accident and injury reports, and/or non-battle injury data.

3. Workplace Monitoring

a. The IHO must conduct workplace monitoring as indicated by the baseline or periodic industrial hygiene survey. If the IHO is unable to accomplish the work place monitoring, their respective TYCOM force IHO will be notified and assistance will be arranged.

b. The medical department must be responsible for reviewing heat stress surveys from engineering and non-engineering spaces prior to submission to the CO/XO.

4. Medical Surveillance

a. General

(1) The safety department has the primary responsibility to inform department heads of operations identified in the industrial hygiene survey, which may potentially expose personnel to health hazards.

(2) Occupational medical surveillance examinations are designed to produce specific information upon which decisions may be based regarding the adequacy of administrative, engineering and personal protective measures and controls used to prevent hazardous exposures, and to verify that personnel have not received dangerous exposures to chemical, physical, radiological or biological hazards.

(3) The medical department will provide surveillance examinations as required by OPNAVINST 5100.19F for those work centers identified by the safety department as requiring medical surveillance. Medical department will utilize the Medical Matrix Manual and PC Matrix program developed by the NMCPHC. This program produces standardized occupational health exam SF 600 overprints and is available at: http://www.med.navy.mil/sites/nmcphc/Documents/oem/medical-matrix-11.pdf.

(4) It is the responsibility of the individual's department to ensure the individual presents to the Medical Department for examinations. The safety and medical departments will coordinate and monitor compliance.

b. Medical Surveillance Examinations

(1) The latest IH survey identifies departments and divisions that perform processes that present industrial health hazards. Thus, the individuals within these departments and division will be subject to various medical surveillance programs linked to their occupation. The Medical Department must coordinate with DIVOs to identify and maintain a current roster of individuals occupying those positions. The medical department is then responsible for entering these people into the appropriate medical surveillance program and performing the appropriate occupational health medical examination(s).

(2) The results of all occupational health medical surveillance examinations must be reviewed by an appropriately privileged medical provider to ensure that all aspects of the examination have been completed, and that appropriate actions have been initiated for all abnormal examination results. The medical department will track all occupational health medical examinations in TMIP.

18-2. Occupational Health Programs

1. Personnel Protective Equipment

a. General. Operations for which respiratory protection or protective eyewear are required must be identified during the industrial hygiene survey. A listing of operations for which

respirators are required, and the types of respirators required for each must be provided to department heads and maintained by the safety department for TYCOM, INSURV review or other applicable inspection process.

b. Respirator User Medical Screening

(1) Individuals required to use respirators must be identified in the industrial hygiene survey. The individual's department is responsible for the presentation of the individual for medical examination. The safety department serves as the respirator program manager (RPM) and will be responsible for the program's management.

(2) Personnel who are required to use respirators that are certified by National Institute for Occupational Safety and Health (NIOSH) or Mine Safety and Health Administration (MSHA) must be scheduled for a medical evaluation to screen for the presence of limiting conditions.

(3) The medical privileged provider's evaluation of suitability of the individual examinee for respirator use must be based on knowledge of the workplace and tasks and results of the medical evaluation. The medical provider must classify the examinee in a category and report those findings to the responsible DIVO on the medical clearance request found in OPNAVINST 5100.19F with a copy to the RPM.

c. Sight Conservation Program

(1) The safety department, as part of the industrial hygiene survey, must provide a list of all eye hazardous areas and processes to the responsible department. All personnel, prior to the onset of exposure to eye-hazardous processes or operations or those exposed as a result of an emergency, must be referred for a sight screening examination. It is the responsibility of the individual's department to identify individuals at risk and send those individuals to the medical department. The safety department will oversee the Sight Conservation Program.

(2) The medical department must validate the prescription and facilitate procurement of required prescription safety glasses.

(3) Issue and maintenance of sight protective equipment must be in accordance with OPNAVINST 5100.19F.

2. Hearing Conservation Program

a. General. The definitive source documents for hearing conservation are DODINST 6055.12, OPNAVINST 5102.1D, and OPNAVINST 5100.19F. They provide guidance for the establishment and implementation of an occupational noise control and hearing conservation

program elements. The goal is to prevent occupational hearing loss and assure auditory fitness for duty of all navy personnel.

b. Audiometry. Personnel exposed to potentially hazardous noise must receive periodic hearing testing to assess the effectiveness of noise reduction measures and personal protective equipment.

(1) Reference Audiogram. All military personnel must have a reference audiogram. OPNAVINST 5100.19F requires that reference audiograms be recorded on DD Form 2215 (NSN 0102-LF-002-2150). The audiogram performed at the Military Entrance Processing Station (MEPS) may not be used as a reference audiogram or transcribed to a DD Form 2215.

(2) Monitoring Audiogram

(a) Procedures for conducting monitoring hearing tests are outlined in detail in OPNAVINST 5100.19F. Monitoring audiograms must be recorded on DD Form 2216 (NSN 0102-LF-002-2160).

(b) The monitoring audiogram must be compared to the most current reference audiogram to determine if a significant threshold shift (STS) has occurred. Procedures for STS evaluations are outlined in OPNAVINST 5100.19F, VOL 1, Appendix B4-A.

Note: all permanent threshold shifts are reported in accordance with with OPNAVINST 5102.1D CH-2.

c. Audiometric Test Booths. The IHO must annually certify the audiometric booth according to NMCPHC Technical Manual, TM-6260.51.99-2 dated September 2008. Coordinate with the 3M A-1 for annual maintenance, and for further program support visit NMCPHC website.

d. Personal Hearing Protection Devices

(1) Personnel working in or entering designated hazardous noise areas or utilizing noise hazard tools or equipment must have hearing protective devices available at all times, and wear them without consideration of duration of exposure. A qualified professional must document exceptions to this requirement.

(2) Every effort must be made to issue personnel hearing protective devices suited to the location and duration of usage following the guidance contained in OPNAVINST 5100.19F, VOL I, Appendix B4-D.

e. Training

(1) The medical department must provide training to all personnel included in the hearing conservation program relative to hearing conservation prior to working in noise hazardous areas or with noise hazardous equipment annually and/or during required training stand-downs as applicable. Initial training topics include:

(a) The elements and rationale for hearing conservation including the effects of noise on hearing.

(b) Designated noise hazardous areas and equipment.

(c) Proper use and maintenance of hearing protective devices, including the advantages and disadvantages of each type of device.

(d) The necessity for periodic hearing testing, and a description of test procedures.

(e) Mandatory requirement to wear assigned protective equipment, and the administrative actions that may result from failure to comply.

(f) Off duty hearing health hazards.

(g) The effects of hearing loss on career longevity, promotion, and retention.

(h) Communication in high noise environments.

(2) Refresher training for the hearing conservation enrolled personnel will be performed in conjunction with the annual audiogram.

f. Record Keeping. The medical department must maintain a current roster of personnel who routinely work in designated noise hazardous areas and must update this roster semi-annually. They must also retain documentation of initial and refresher training for everyone in the hearing conservation program. Additionally, they must also upload audiometric information utilizing the Defense Occupational Health Readiness System-Hearing Conservation (DOEHRS-HC) as directed by the regional occupational audiologist.

3. Heat Stress Monitoring Program

a. Responsibilities. The medical department is responsible for performing heat stress surveys as assigned by the CO. The industrial hygiene survey should identify and include heat stress areas as hazards. Reactor and Engineering departments are responsible for monitoring and surveying their own spaces. Medical provides monitoring and surveying for other departments. A command instruction is required and provides additional details.

b. References. OPNAVINST 5100.19F and NAVMED P-5010, chapter 3 provide guidance for the implementation of the heat stress program.

c. Surveys

(1) The medical department must assess individual spaces for heat stress conditions and stay times when dry bulb (DB) temperatures exceed the following limits:

(a) Physiological Heat Exposure Limit (PHEL) I through III

1. Watch/work length 4 hours or less DB ≥ 100 degrees F

2. Watch/work length greater than 4 hours DB ≥ 90 degrees F

(b) PHEL IV through VI DB ≥ 85 degrees F

(2) All medical department personnel who perform heat stress surveys must be appropriately trained and competent in the operation and calibration of wetbulb globe thermometers (WBGT).

d. Record Keeping. The medical department must maintain a complete file of all heat stress survey reports performed during the previous 12 months and enter these surveys into the appropriate TMIP module. In addition, the medical department must periodically audit non-medical departmental heat stress monitors and provide necessary direction to ensure satisfactory performance.

e. Required Reports or Inquiries. All heat stress related injuries must be reported on Heat Injury Report forms (NAVMED 6500/1). This form must be signed by the CO and forwarded to NMCPHC with a copy to the appropriate COMNAVAIRPAC/COMNAVAIRLANT force medical office. Additionally, an Accident and Injury report should be generated in TMIP and routed to the safety department to ensure appropriate data entry into the Web Enabled Safety System. If a heat injury results in one or more lost workdays, a mishap report (Report Control Symbol OPNAV 5102-1) must be submitted in accordance with OPNAVINST 5102.1D.

f. Training. According to OPNAVINST 5100.19F, all personnel receive heat stress training upon reporting aboard and annually thereafter. This training covers heat stress health hazards and related injuries.

4. Bloodborne Pathogen Program

a. Applicability. A bloodborne pathogen program is required for all commands that have personnel who potentially have an occupational exposure to bloodborne pathogens. All medical and dental department personnel aboard ship are considered potentially exposed to bloodborne

pathogens. In addition, security personnel and others who can reasonably anticipate occupational exposure to blood must be included in this monitoring program. These individuals and the particular function must be identified in the ship's bloodborne pathogen instruction.

b. Responsibilities

(1) Each CVN is required to have a written Bloodborne Pathogen Control Plan which is reviewed annually. The command is responsible for providing appropriate personal protective equipment.

(2) The infection control officer must serve as the bloodborne pathogen program coordinator, and should be familiar with procedures and practices to reduce bloodborne pathogens.

c. References. OPNAVINST 5100.19F and BUMEDINST 6280.1C.

d. Exposures

(1) An exposure incident review procedure must be implemented. These procedures must be reviewed annually to identify processes or mechanisms leading or conducive to exposures. This review should continue to yield and develop better courses of action to prevent future bloodborne pathogen exposure.

(2) In the event of a bloodborne pathogen exposure, such as a needlestick, the victim and the source patient need to be screened and evaluated. Included in this evaluation would be screening for both HIV and HBV.

(3) Guidance for initiating chemoprophylaxis is contained in Appendix U. The CDC should be consulted for the latest information and any updates to treatment protocols. Additionally, there is a CDC telephone hotline available at (888) 448-4911.

(4) Personnel who receive an occupational exposure to known HIV infected blood or other body fluids must be evaluated promptly and must start chemoprophylaxis. Treatment should be initiated within one to two hours and no later than 72 hours. If treatment is initiated, a DoD infectious disease physician must be consulted. Do not delay treatment if timely contact of an infectious disease physician is not possible. A MER must be submitted in the event of an occupational exposure requiring chemoprophylaxis initiation and an accident and injury report should also be completed and routed to the safety department.

(5) A physician's written opinion and record of counseling regarding the risk of developing a bloodborne pathogen disease must be placed in the patient's health record. There must also be a documented medical follow-up within six months.

(6) Each incident requires that a permanent individual case file be maintained by the medical department with all supporting documentation. Additionally, a safety department accident and injury report must be initiated following any used needlestick or sharps injury (as mentioned above in section (4)).

e. Training. Initial and annual training must be provided to individuals identified in the command's bloodborne pathogen instruction and training must be documented and entered into R-ADM.

f. Medical Screening. Medical and dental department personnel must be screened annually to ensure that they have received the HBV vaccine and are current for Measles Mumps Rubella, bi-annual HIV screening, and annual Latent TB Infection screening.

5. Asbestos Management Program (AMP)

a. According to OPNAVINST 5100.19F, the medical department representative will determine placement of personnel in the AMP using the NMCPHC medical surveillance procedures manual and medical matrix.

b. An updated Medical Surveillance Questionnaire, OPNAV 5100/15, must be obtained from all personnel reporting aboard. A determination as to the placement of the individual in the AMP must be indicated in Part II of the Medical Surveillance Questionnaire. Personnel placed on the AMP at any time in their career must remain in the AMP for the duration of their career in the Navy.

c. Asbestos medical surveillance examinations must be conducted in accordance with OPNAVINST 5100.19F.

6. Lead Medical Surveillance Program (LMSP)

a. Personnel are included in the LMSP when industrial hygiene surveys indicate that they perform work or are likely to be in the vicinity of an operation which generates airborne lead concentration at or above the action level more than 30 days a year. The program includes:

(1) Pre-placement medical evaluation prior to assignment involving potential exposures to lead that equals or exceeds the action level.

(2) Follow-up medical evaluation on blood lead analysis.

(3) Notification of personnel concerning the results of their blood lead levels.

(4) Counseling of individuals with abnormalities detected during medical evaluation.

(5) Removal of personnel from work with exposure to lead in certain specified situations.

b. Personnel who are expected to be assigned to duties, or likely to be in the vicinity of an operation involving exposure to lead concentrations greater than 30 micrograms lead per cubic meter of air (mcg/m^3), as an 8-hour time-weighted average (TWA), for more than 30 days per year, must be scheduled for a pre-placement medical evaluation in accordance with the current OPNAVINST 5100.19F.

c. Personnel who are or may be exposed to 8-hour TWA concentrations of lead greater than 30 mcg/m^3 for more than 30 days in accordance with year must be scheduled for blood lead monitoring every six months. They must be scheduled for blood lead monitoring every two months when their blood lead levels exceed 30 mcg/dL of whole blood. The medical surveillance requirements for personnel will be based on industrial hygiene evaluations. Identification of personnel at risk and requiring medical surveillance is the responsibility of the cognizant department head in consultation with the safety department. Responsibility for the presentation of the individual to the medical department for evaluation is the responsibility of the individual's department.

d. An individual must be medically removed from lead work if their blood lead concentration equals or exceeds 60 mcg/dL or the average of the last three blood lead concentrations equals or exceeds 50 mcg/dL.

(1) Blood lead concentrations of personnel medically disqualified for lead work must be monitored monthly until the individual's last two consecutive results are below 40 mcg/dL. At this point the individual may be medically requalified for lead work.

(2) When an individual's blood lead concentration is between 30 and 40 mcg/dL, blood lead concentrations must be monitored every two months until the last two consecutive blood lead test results are less than 30 mcg/dL.

e. Follow-up medical evaluations must be conducted in accordance with with OPNAVINST 5100.19F for all personnel found to have a blood lead concentration at or above 30 mcg/dL.

Note: The Medical Surveillance Procedures Manual and Medical Matrix provide Form 161 as the examination form.

f. An IH evaluation must be requested of the safety department to determine the cause and necessary corrective action of each blood lead level at or above 30 mcg/dL.

g. Removal from the LMSP is indicated when an individual's current work no longer requires the individual to perform a lead-exposed job. The IHO should make this assessment.

CHAPTER 19
QUALITY ASSURANCE AND RISK MANAGEMENT

1. Policy. Despite the constraints of the operational environment, COMNAVAIRPAC/ COMNAVAIRLANT is committed to providing the highest quality health service support to our forces. Every attempt will be made to provide the same standard of care available in the Navy's shore based MTF and clinics. We fully support the principle that the quality of health care is steadily improved through effective programs of QA, risk management, continuing education, and utilization review. By analyzing unsatisfactory outcomes and changing processes which lead to those problem outcomes, the quality of care will improve and, most importantly, desirable outcomes will be achieved. This can be confirmed when the care rendered is measured against clinically valid, measurable and predetermined criteria. A pattern of serious and/or frequent patient care errors will be handled in accordance with BUMEDINST 6320.67A, change 1.

2. Scope. This program is applicable to all health care services and health care providers assigned to COMNAVAIRPAC/COMNAVAIRLANT medical departments.

3. QA Program Objectives

a. Evaluate the quality and appropriateness of patient care on an ongoing basis.

b. Identify at least one process improvement initiative project annually and provide progress reports via the Opportunity Summary List section of the monthly QA report. A final outcome report must be submitted on the initiative to the TYCOM force medical detailing the improvements in the process and the benefits and the cost. COMUSFLTFORCOM/ COMPACFLT process improvement initiatives will also be tracked.

c. Reduce risk to patients and staff thereby reducing exposure to liability.

d. Document the resources required to maintain acceptable standards of patient care services.

e. Communicate important QA/RM information to effect sound clinical management and decision-making at all levels of care.

f. Integrate, track and trend QA/RM data to identify problems that require focused review or intervention.

g. Support clinical privileging and certification requirements in accordance with chapter 2, section 2, paragraph 4 of this instruction.

h. Identify education and training requirements for both staff and patients.

i. Participate in COMNAVAIRPAC/COMNAVAIRLANT medical QA TELCONs or VTCs for sharing of QA initiatives and lessons learned across the TYCOM.

j. Conduct ongoing patient satisfaction surveys. An example of a patient satisfaction form is found in Appendix V.

4. Organization and Responsibility

a. TYCOM surgeon. The force surgeon is responsible for implementing and maintaining the QA program and must:

(1) Establish policy for the medical department's QA programs aboard CVNs.

(2) Review and monitor the implementation of QA programs and provide technical assistance as required.

b. The COMUSFLTFORCOM MEC is composed of the senior medical and dental department officers for all TYCOMS in the Norfolk area. The COMNAVAIRFOR MEC must be composed of the COMNAVAIRPAC/COMNAVAIRLANT force surgeons and dentists, COMNAVAIRFOR Force Surgeon, COMNAVAIRFORRES Force Surgeon, and SMEs as necessary. The MEC duties are defined in BUMEDINST 6010.13.

(1) Conduct assist visits and MRIs to monitor the QA program.

(2) Review monthly CVN QA Reports, weekly deployed CVN SITREPS, and routine correspondence such as preventive medicine reports.

c. CVN COs. The COs are ultimately responsible for their ship's medical QA program and must ensure that it is in keeping with TYCOM requirements as set forth in this instruction.

d. SMO. The SMO must ensure overall QA program implementation, and will appoint, in writing, a QA coordinator (QAC) and a QA physician advisor (QAPA). In addition, the SMO must:

(1) Establish a QA committee to lead the medical department QA activities. These include monitoring, evaluation and improvement of health care processes, conducting peer reviews, and investigating health care practice variance reports. Membership must include the SMO and all health care providers, the Medical Professionals Credentials Coordinator, the QAC, and others as designated by the SMO. This committee must meet at least monthly.

(2) Act as chairperson of the QA committee.

(3) Schedule QA committee meetings monthly, or more often if necessary.

(4) Review and approve the agenda for the monthly meetings.

(5) Designate in writing a patient contact representative.

e. QA Coordinator. Responsibilities of the QAC include:

(1) Collect all data to complete the monthly QA report and submit through the chain of command for review and approval. A new template will be distributed by the TYCOM each calendar year.

(2) Electronically send monthly QA report to appropriate TYCOM force medical by the 15th of the month following the period of the report.

(3) The command endorsed copy of the monthly QA report is to be sent via e-mail or fax to TYCOM by the end of the month following the period of the report and a copy maintained in the department. Discard after five years in accordance with SECNAVINST 5210.8E.

(4) Prepare agenda for monthly meetings and submit to SMO for review and endorsement.

(5) Coordinate review of medical records and assist the QAPA in assigning each provider with a designated number of records to review based on total number of new patient visits for the month.

(6) Track medical department QA projects and initiatives.

(7) Coordinate distribution of patient satisfaction surveys during all medical visit encounters (Appendix V) and report results in monthly QA report.

f. QA Physician Advisor (QAPA). Responsibilities of the QAPA include:

(1) Principal advisor to the SMO and other health care providers on matters related to health care Process Improvement.

(2) Assist the QAC in data collection, assign each provider a designated number of records to review based on the total number of new patient visits for the month, ensure the required number of provider records are reviewed, and track problem resolution.

(3) Review and endorse the monthly QA report.

g. Patient Contact Representative. An effective patient contact program monitors the patient's healthcare service experience. The medical department must have a patient contact representative as designated by the SMO. The patient contact representative(s) must:

(1) Routinely solicit comments from patients utilizing the written survey in appendix V to determine patient satisfaction.

(2) Utilize other means to obtain patient feedback such as focused interviews, informal conversations, and other forums as deemed appropriate to collect information on patient satisfaction.

(3) Participate in the monthly QA committee meeting and ensure patient satisfaction results are provided in the monthly QA committee meeting minutes to the TYCOM.

5. Medical Records Review

a. Review of the inpatient and outpatient medical records must include participation by all healthcare providers, nursing staff, and medical records personnel. The medical record review must include:

(1) Adequacy of the records as a primary document reflecting the care and treatment of the patient.

(2) Adequacy of the record as a medico-legal document.

(3) Timely completion of the record.

(4) Confidentiality, custody and proper release of information from the record.

(5) Standardization and use of medical record forms.

(6) Appropriate use of symbols and abbreviations, including signature with name, rank, corps, and service stamped or neatly printed below the signature.

(7) Legibility.

(8) In order to obviate multiple record data entries only one entry is required in either TMIP, MRRS, hard copy medical record or the EHR – (TMIP M/AHLTA). However, all IMR items must be documented in the medical treatment record (Form 6150/20).

b. Inpatient Medical Records Review.

(1) All active duty military inpatient medical records must be maintained as outlined in the MANMED, Chapter 16.

(2) All inpatient medical records must be reviewed upon patient discharge using the Inpatient Record Review Form (appendix W). The ship's nurse will perform these record reviews, submit to the SMO for signature and forward to TYCOM force nurse as directed.

c. Provider Records Review.

(1) All active duty military outpatient medical records must be maintained as outlined in the MANMED, Chapter 16.

(2) It is recommended that the following routine be carried out at the end of each month:

(a) The number of new patient encounters is determined for each provider.

(b) The number of records to be reviewed is determined by multiplying each provider's new patient encounters total by 10 percent and rounding up to the next whole number. For example, if the PA saw 143 new patients during the month, 15 of those records are to be reviewed.

(c) A medical records technician must randomly "pull" the designated number of records for each provider.

(d) The QAC or QAPA distributes the "pulled" records to the providers so that there is fair and equal distribution and also ensures that each provider does not review their own records.

(e) The medical/dental records will be reviewed using the Provider Record Review Forms contained in appendix X. These forms are intended for review of privileged providers. In addition to the form for general outpatient records, specialized forms are provided for CPs, PTs, and CRNAs.

(f) Due to the nature of their specialties, the PT and CP records will benefit from specialty peer review when the ship is in homeport, peer review from other CVN medical department's PTs or CPs should be utilized, when available. If no other CVN is available, arrangements should be made to have peer review at the local MTF. When the ship is at sea or deployed, the SMO will conduct these reviews. The PT's records must be reviewed using the PT record review form and the CP's records must be reviewed using the CP record review form contained in appendix X.

(g) CRNAs will benefit from specialty peer review when the ship is in homeport, peer review from other CVN medical department's CRNA should be utilized, when available. Then, if no other CVN is available, arrangements should be made to have peer review at the local MTF. When the ship is at sea or deployed, the SMO will conduct these reviews. Records to be reviewed must include outpatient procedures using procedural sedation and operative procedures

performed in the operating room. The CRNAs records must be reviewed using the CRNA record review form contained in appendix X.

6. Patient Safety Reporting Procedures. Patient safety reports (PSR), constitute process improvement documents and are protected from disclosure under 10 U.S.C. 1102. PSRs capture information on events that negatively impact clinical care. They allow the medical department staff to identify trends, which may then lead to action to reduce those events. As such, their intent is to identify the cause for the process variance and provide recommendations for remedial action and must not be used for disciplinary action. CVNs will utilize the DoD web-based Joint Patient Safety Reporting (JPSR) System for patient safety reporting. If the system is unavailable (e.g. required maintenance, unit lack of connectivity), personnel will use the offline reporting form, then, transcribe the information into the electronic system as soon as possible. Offline forms must be properly labeled and safeguarded.

a. The QAC will serve as the PSM for the CVN.

b. Patient safety reportable events are unexpected events (i.e. death, medication error, needlestick injury, loss of power, repair or supply problems, etc.) that diminish the department's ability to maintain routine clinical operations. It is important that anyone can submit a PSR. Upon notification of the event, the PSM will ensure that a PSR is generated that outline the details of the incident to include: date, time, location, patient diagnosis, provider and a description of relevant circumstances surrounding the incident. The PSM will review the initial comments related to the incident.

c. Upon completion of the review by the PSM, the report will be forwarded to the QAPA who will comment on the variance and assign a category to the incident.

d. Upon completion of review by the PSM and QAPA, the report will be forwarded to the SMO for review, comment and recommendations.

e. The QA committee will discuss the case and formulate recommended actions to be taken. All remedial actions will be included in the report.

f. Once this process has been completed, TYCOM PSM will review and close out the report. The number of the PSR for the calendar year will be included in the PSR section of the monthly QA committee meeting minutes and forwarded to the TYCOM. For incidents resulting in serious untoward effects (i.e. death, disability, ICU admission, etc.) notify the respective force surgeon immediately.

g. Once received by the TYCOM all reports submitted for the month will be reviewed during MEC meetings.

APPENDIX A
ACRONYMS

3M	Material and Maintenance Management System
ALS	Advanced Life Support
ACR	AMAL Change Request
ADP	Automated Data Processing
AED	Automatic External Defibrillator
AEL	Allowance Equipage List
AHLTA	Armed Forces Health Longitudinal Technical Application
AIMD	Aircraft Intermediate Maintenance Department
AMP	Asbestos Management Program
AMDEC	Advanced Medical Department Enlisted Course
AMDOC	Advanced Medical Department Officer Course
AMAL	Authorized Medical Allowance List
AMSO	Aerospace Medical Safety Officer
AOR	Area of Responsibility
APL	Allowance Parts List
ATG	Afloat Training Group
ATLS	Advanced Trauma Life Support
ATO	Air Transport Officer
BDS	Battle Dressing Station
BDRD	Biodefense Research Development
BLS	Basic Life Support
BMET	Biomedical Repair Technician
BSC	Biosafety Cabinet
BUMED	Bureau of Medicine and Surgery
CART	Command Assessment of Readiness and Training
CASREP	Casualty Report
CBR	Chemical, Biological, Radiological
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosives
CDC	Center for Disease Control
CDM	Configuration Data Manager
CDMD-OA	Configuration Data Manager's Database-Open Architecture Database
CHT	Collection, Holding, and Transfer
CITRIX	Internet System
CNAL	Commander, Naval Air Force, Atlantic
CNAP	Commander, Naval Air Force, U.S. Pacific Fleet
CME	Continuing Medical Education
COH	Complex Over-Haul
COMNAVAIRFOR	Commander Naval Air Forces (CNAF)
COMNAVAIRLANT	Commander Naval Air Force Atlantic (CNAL)
COMNAVAIRPAC	Commander Naval Air Force U.S. Pacific Fleet (CNAP)

COMPACFLT	Commander U.S. Pacific Fleet
COMPTUEX	Composite Training Unit Exercise
COMUSFLTFORCOM	Commander, U.S. Fleet Forces Command
CONUS	Continental United States
CRNA	Certified Registered Nurse Anesthesia
COSAL	Coordinated Shipboard Allowance
CP	Clinical Psychologist
CRC	Credentials Review Committee
CSG	Carrier Strike Group
CSIB	Controlled Substances Inventory Board
CVW	Carrier Air Wing
DB	Dry Bulb
DC	Damage Control
DCA	Damage Control Assistant
DEA	Drug Enforcement Administration
DHA	Defense Health Agency
DLA	Defense Logistics Agency
DLCPO	Department Leading Chief Petty Officer
DMSB	Defense Medical Standardization Board
DNA	Deoxyribonucleic acid
DoD	Department of Defense
DON	Department of the Navy
DPP	Defense Procurement Plan
DRI	Dental Readiness Inspection
DRMO	Defense Reutilization Management Office
EAWS	Enlisted Aviation Warfare Specialist
EHO	Environmental Health Officer
EHR	Electronic Health Record
EMIR	Enlisted Manning Inquiry Report
EMDEC	Executive Medical Department Enlisted Course
ESWS	Enlisted Surface Warfare Specialist
FAB	First Aid Boxes
FAC	Free Available Chlorine
FAF	Floating Accommodation Facility
FCCS	Fundamentals of Critical Care Support
FHP	Force Health Protection
FLTMPS	Fleet Training Management and Planning System
FOD	Foreign Object Debris
FPPE	Focus Professional Performance Evaluation
GMT	General Military Training
GQ	General Quarters
HIPAA	Health Insurance Portability and Accountability Act
HM	Hospital Corpsman

HPC	Health Promotion Coordinator
HPW	Health Promotion and Wellness
HSS	Health Service Support
ICD	International Code of Diseases
ICF	Individual Credential Files
ICU	Intensive Care Unit
ICTB	Inter-facility Credential Transfer and Privileging Brief
ID	Infectious Disease
IDC	Independent Duty Corpsmen
ICAV	Inspections, Certifications, Assessments, and Visits
IEM	Inactive Equipment Maintenance
IHO	Industrial Hygiene Officer
IMR	Individual Medical Readiness
IMRI	Individual Medical Readiness Inspection
INSURV	Board of Inspection and Survey
ISIC	Immediate Superior in Command
ISOS	International SOS
IV	Intravenous
JAGMAN	The Manual of the Judge Advocate General
JCCQAS	Joint Centralized Credentialing Quality Assurance System
JERK	Junior Emergency Response Kit
JQR	Job Qualification Requirement
JTF	Joint Task Force
LAN	Local Area Network
LCPO	Leading Chief Petty Officer
LEADS	Leadership, Education, Analysis, Development, Sustainment
LMSP	Lead Medical Surveillance Program
LPO	Leading Petty Officer
LRTP	Long Range Training plan
LTBI	Latent Tuberculosis Infection
MAO	Medical Administrative Officer
MANMED	Manual of the Medical Department
MAV	Medical Assist Visit
MDDO	Medical Department Duty Officer
MCO	Major Combat Operations
MEC	Medical Executive Committee
MEDEVAC	Medical Evacuation
MEDHOLD	Medical Hold
MER	Medical Event Report
MILSTRAP	Military Standard Transaction Reporting and Accountability Procedures
MILSTRIP	Military Standard Requisitioning and Issue Procedures

MLO	Medical Liaison Officer
MMR	Measles Mumps Rubella
MMQC	Medical Material Quality Control
MOC	Maritime Operations Center
MRI	Medical Readiness Inspection
MRT	Medical Response Team
MSP	Medical Services Professional
MTC	Medical Transition Company
MTF	Military Treatment Facility
MTN	Military Training Network
MTT	Medical Training Team
NAILS	Navy Assemblage Information Logistics System
NAVICP-M	Naval Inventory Control Point Mechanicsburg
NAVMED	Manual of Navy Medicine
NAVMEDLOGCOM	Naval Medical Logistics Command
NAVOSH	Navy Occupational Safety and Health
NAVSEA	Naval Sea Systems
NCIS	Naval Criminal Investigative Service
NEC	Navy Enlisted Classification
NECE	Navy Entomology Center of Excellence
NEPMU	Navy Environmental Preventive Medicine Unit
NFD	Nuclear Field Duty
NIWC	Naval Information Warfare Center
NMRC	Naval Medical Research Center
NMPDC	Navy Medicine Professional Development Center
NMCPHC	Navy and Marine Corps Public Health Center
NOBC	Navy Officer Billet Code
NOK	Next of Kin
NOSTRA	Naval Ophthalmic Support and Training Activity
NSN	National Stock Number
NSTM	Naval Ships Technical Manual
NWP	Naval Warfare Publication
OCONUS	Outside Continental United States
OFRP	Operational Forces Reporting Plan
OJT	On-the-Job Training
OMMS-NG	Organizational Material Management System-Next Generation
OOD	Officer of the Deck
OPPE	Ongoing Professional Performance Evaluation
OPTEMPO	Operations Tempo
OR	Operating Room
ORSE	Operational Reactor Safeguards Examination
PA	Physician Assistant
PACS	Picture Archiving and Communication System

PACT	Professional Apprenticeship Career Track
PAR	Performance Appraisal Report
PCM	Primary Care Manager
PCR	Polymerase Chain Reaction
PDS	Permanent Duty Station
PHA	Periodic Health Assessment
PHEL	Physiological Heat Exposure Limit
PHI	Protected Health Information
PIA	Planned Incremental Availability
PLM	Performance Evaluation Input
P-MART	Pre-deployment Medication Analysis and Reporting Tool
PMS	Planned Maintenance System
PMT	Preventive Medicine Technician
POC	Point of Contact
POM	Preparation for Overseas Movement
POMI	Plans Operations and Medical Intelligence
PORSE	Post-Overhaul Reactor Safeguards Examination
POTS	Plain Old Telephone System
PQS	Personnel Qualification Standards
PPV	Pharmaceutical Prime Vendor
PT	Physical Therapist
PWC	Public Works Center
QA	Quality Assurance
QAC	Quality Assurance Coordinator
QAPA	Quality Assurance Physician Advisor
RAD	Radiology
R-ADM	Relational Administration Data Management Application
RASP	Radiological Affairs Support Program
RCOH	Refueling Complex Over-Haul
RFS	Request for Support
RIS/PACS	Radiology Information Systems/Picture Archiving and Communication System
RLO	Reserve Liaison Officer
RM	Risk Management
ROC/POE	Required Operational Capabilities/Projected Operating Environment
RPM	Respirator Program Manager
RPPO	Repair Parts Petty Officer
SAR	Search and Rescue
SARP	Substance Abuse Rehabilitation Program
SCCM	Society of Critical Care Medicine
SCSP	Sick Call Screeners Program
SCOOP	Ship Coordinated Offload/Outfitting Plan
SDR	Supply Deficiency Report (SDR

SERP	Shipboard Equipment Replacement Program
SFAR	Shipboard First Aid and Rescue
SIPR	Secured Internet Protocol Router
SIQ	Sick In Quarter
SKED	Schedule
SLEP	Service Life Extension Program
SMDR	Senior Medical Department Representative
SME	Subject Matter Expert
SMO	Senior Medical Officer
SOFA	Status of Forces Agreement
SOP	Standard Operating Procedure
SOPA	Senior Officer Present Afloat/Ashore
SORM	Ship's Organization Regulations Manual
SRTP	Short-Range Training Plan
SSCC	Ship Sanitation Control Certificate
STD	Sexually Transmitted Disease
STS	Significant Threshold Shift
SWMDO	Surface Warfare Medical Department Officer
TAD	Temporary Additional Duty
TAV	Technical Assist Visit
TB	Tuberculosis
TEMADD	Temporary Additional Duty
TMIP-M	Theater Medical Information Program Maritime
TMOP	TRICARE Mail Order Pharmacy
TOB	Technical Operation Budget
TR	Teleradiology
TST	Tuberculosis Skin Test
TSTA	Tailored Ships Training Availability
TWA	Time Weighted Average
TYCOM	Type Commander
ULT	Unit Level Training
USAMMCE	U.S. Army Medical Materiel Center, Europe
WBB	Walking Blood Bank
WQSB	Watch, Quarter, and Station Bill
VIALS	Vaccine Information and Logistics Systems
XO	Executive Officer

APPENDIX B
INDIVIDUAL MEDICAL READINESS CHECKLIST

INDIVIDUAL MEDICAL READINESS INSPECTION
Health Record Worksheet

Ship/Squadron: _____ Date: _____ Inspector: _____

	Records Reviewed														
Requirements	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Actual**		**Possible**
Last 4 SSN															
1. PHA (Birth Month +/- 30d)														/	12
2. Deployment Limiting Cond														/	12
3. Dental Readiness														/	12
4. Individual Medical Equip														/	12
5. Readiness Lab Studies	X	X	X	X	X	X	X	X	X	X	X	X			
a. Blood Type/RH														/	12
b. G6PD														/	12
c. Sickle Cell Trait														/	12
d. DNA														/	12
e. HIV (every 2 years)														/	12
6. Immunizations	X	X	X	X	X	X	X	X	X	X	X	X			
a. Hep A(x2)/TWINRIX(x3)														/	12
b. Hep B(x3)/TWINRIX(x3)														/	12
c. Influenza (annually by 1Jan)														/	12
d. MMR (2 Doses)														/	12
e. Poliovirus (IPV/OPV)														/	12
f. Tetanus (Td/TDap q10 yrs)														/	12
Medical Readiness Category														/	180

Medical Readiness Scoring:

Fully Ready (FR):_____ All Components (1-6) are good. Partially Ready (PR):___Lacking Labs, Imms or Med Equip.

Not Ready (NR): ____Deploy Limit Condition or Dental Class 3. Indeterminate (I):____Dental Class 4, Missing/expired PHA.

Non-IMR Items													Actual		Possible
a. Anthrax (if Req, 2 or more)	/	/	/	/	/	/	/	/	/	/	/	/		/	
b. Smallpox (if Req)														/	
c. Typhoid (every 2 years)														/	12
d. Yellow Fever (every 10 yrs)														/	
e. TB Risk Screen /Converter FU														/	12
f. HCP Audiogram (if Req)														/	
g. PDHA/PDHRA (if Req)														/	
h. Well Woman Exam														/	
i. HREC Verified (annually)														/	12
Comments:														/	

INDIVIDUAL MEDICAL READINESS INSPECTION

Health Record Worksheet

Ship/Squadron: _____ Date: _____ Inspector: _____

Records Reviewed															
Requirements	1	2	3	4	5	6	7	8	9	10	11	12	Actual		Possible
Last 4 SSN															
1. PHA (BM +/- 30d)	Current, Complete (VA Screening, Med Equip noted, etc.), Signed by Provider													/	
2. Deploy Limit Cond	Noted on PHA, LIMDU documentation, etc. (Valid for Squadrons)													/	
3. Dental Readiness	Noted on DD2766, section 10; in DREC, on PHA, or listed on readiness report.													/	
4. Individual Med Equip	Noted on DD2766 (Allergies= Red Tags; Glasses), PHA, etc.													/	
5. Blood/Labs	Noted on DD2766, section 10 and/or NAVMED 6150/20 Problem Summary List.														
a. Blood Type/RH	Noted on DD2766, section 10 and/or NAVMED 6150/20 Problem Summary List.													/	
b. G6PD	Noted on DD2766, section 10 and/or NAVMED 6150/20 Problem Summary List.													/	
c. Sickle Cell Trait	Noted on DD2766, section 10 and/or NAVMED 6150/20 Problem Summary List.													/	
d. DNA	Noted on DD2766, section 10 and/or NAVMED 6150/20 Problem Summary List.													/	
e. HIV (q2y)	Required every 2 years.													/	
6. Immunizations	Recorded on NAVMED 6230/4, Adult Immunization Record (and previous SF 601)														
a. Hep A(x2)/TWINRIX(x3)	DoD Requirement per BUMEDINST 6230.15B													/	
b. Hep B(X3)/TWINRIX (x3)	Series should be completed if started per BUMEDINST 6230.15B													/	
c. Influenza (annually by 1Jan)	DoD Requirement per BUMEDINST 6230.15B													/	
d. MMR (2 Doses)	DoD Requirement per BUMEDINST 6230.15B													/	
e. Poliovirus (IPV/OPV)	DoD Requirement per BUMEDINST 6230.15B													/	
f. Tetanus (Td/TDap q10 yrs)	Navy Requirement for Operational Forces per BUMEDINST 6230.15B													/	
Medical Readiness Category	**Indicate lowest state of readiness as indicated from columns above**													/	

Medical Readiness Scoring:

Fully Ready (**FR**): All Components (1-6) are good.

Partially Ready (**PR**): Lacking Labs, Imms or Med Equip.

Not Ready (**NR**): Deploy Limit Condition or Dental Class 3.

Indeterminate (**I**): Dental Class 4, Missing or expired PHA.

Non-IMR Items													Actual		Possible
a. Anthrax (if Req)	Regional Required per BUMEDINST 6230.15B													/	
b. Smallpox (if Req)	Regional Required per BUMEDINST 6230.15B													/	
c. Typhoid (every 2 years)	Regional Required per BUMEDINST 6230.15B													/	
d. Yellow Fever (every 10 yrs)	Regional Required per BUMEDINST 6230.15B													/	
e. HCP Audiogram (if Req)														/	
f. TB Risk Screen /Converter FU	Annual screening required per BUMEDINST 6224.8A													/	
g. PDHA/PDHRA (if Req)	NAVADMIN 002/13, OPNAV INSTRUCTION 6100.3														
h. Well Woman Exam														/	
i. HREC Verified (annually)														/	
Comments:														/	

APPENDIX C
GENERAL CVN MEDICAL DEPARTMENT MANNING

Description	SUB SPEC	AQD	Grade/ Rate/ Desig	NEC/NOBC
PREVMED AERO	15A1J	6AG	2102H	0163
GENERAL SURGEON	15C0J		2100I	0214
CRITICAL CARE NURSE	1960R		2900J	0904
HEALTH CARE ADMIN	1801S		2300J	0800
PHYSICIAN ASSISTANT	1893E		2300J	0113
FAMILY PRACTITIONER	16Q0J		2100J	0108
CLIN PSYCHOLOGIST			2300J	
PHYS THERAPIST			2300J	
RAD HEALTH			2300J	
NRS ANESTH	1972P		2900J	
HOSPITAL CORPSMAN			HMCS	0000 LCPO
DRUG & ALCH COUNS			CPO	L40A Drug and Alcohol Counselor
DRUG & ALCH INTERN			PO1	L39A Drug and Alcohol Counselor Intern
HOSPITAL CORPSMAN			HMC	L12A Prev Med Tech
HOSPITAL CORPSMAN			HM1	L08A Biomed/Dent Rep
HOSPITAL CORPSMAN			HM1	L12A Prev Med Tech
HOSPITAL CORPSMAN			HM1	L10A Surf IDC
HOSPITAL CORPSMAN			HM1	L05A Rad Hlth Tech
HOSPITAL CORPSMAN			HM1	L04A Aero Med Tech
HOSPITAL CORPSMAN			HM2	L31A Med Lab Tech
HOSPITAL CORPSMAN			HM2	L24A Behav Hlth Tech
HOSPITAL CORPSMAN			HM2	L20A PT Tech
HOSPITAL CORPSMAN			HM2	L19A Optician
HOSPITAL CORPSMAN			HM2	L12A Prev Med Tech
HOSPITAL CORPSMAN			HM2	L10A Surf IDC
HOSPITAL CORPSMAN			HM2	L04A Aero Med Tech
HOSPITAL CORPSMAN			HM3	0000 Gen Duty HM
HOSPITAL CORPSMAN			HM3	L31A Adv Lab Tech
HOSPITAL CORPSMAN			HM3	L23A Surg Tech
HOSPITAL CORPSMAN			HM3	L22A Pharmacy Tech
HOSPITAL CORPSMAN			HM3	L17A Adv X-Ray Tech
HOSPITAL CORPSMAN			HM3	L05A Rad Hlth Tech
HOSPITAL CORPSMAN			HM3	0000 Gen Duty HM
HOSPITAL CORPSMAN			HM3	0000 Gen Duty HM
HOSPITALMAN			HN	0000 Gen Duty HM

HOSPITALMAN	HN	0000 Gen Duty HM
HOSPITALMAN	HN	0000 Gen Duty HM
HOSPITALMAN	HN	L23A Surg Tech
HOSPITALMAN	HN	0000 Gen Duty HM
HOSPITALMAN	HN	0000 Gen Duty HM
HOSPITALMAN	HN	0000 Gen Duty HM
HOSPITALMAN	HN	0000 Gen Duty HM
HOSPITALMAN	HN	0000 Gen Duty HM

Note: * Validate manning in accordance with your current AMD.

APPENDIX D
TAD SUPPORT REQUEST MESSAGE

********** (CLASSIFICATION AS REQUIRED) **********

R 211200Z FEB 18
FM USS (YOUR SHIP)
TO TYCOM (COMNAVAIRLANT or COMNAVAIRPAC as appropriate)
INFO COMFLTFORCOM or COMPACFLT as appropriate)
BT
UNCLAS (OR CLASSIFIED AS REQUIRED) //N01331//
MSGID/GENADMIN//
SUBJ/REQUEST FOR GENERAL SURGEON SUPPORT// (OR AS APPROPRIATE)
GENTEXT/RMKS/1. REQUEST GENERAL SURGEON SUPPORT FOR THE FOLLOWING PERIOD: 10-12APR18. SURGEON WILL NEED TO MEET THE SHIP BY 08APR18. (OR MEMBER IS INSTRUCTED TO REPORT ONE DAY PRIOR TO ANY UNDERWAY PERIOD)
2. NORMALLY ASSIGNED SURGEON WILL BE INVOLVED WITH NATIONAL BOARDS REVIEW and EXAM.
3. REQUEST ASSIGNED PERSONNEL RECEIVE THE FOLLOWING INFORMATION:
(A) LONG SLEEVED SHIRTS ARE REQUIRED TO BE WORN WHEN UNDERWAY. LEATHER SHOES/BOOTS (STEEL-TOED) ARE REQUIRED.
(B) PERSONNEL ON SPECIALIZED MEDICATIONS SHOULD BRING SUFFICIENT QUANTITIES FOR THE DURATION OF ANY UNDERWAY PERIOD.
(C) LIBERTY ATTIRE POLICY PROHIBITS T-SHIRTS AND REQUIRES THAT PERSONNEL DEPARTING ON LIBERTY PRESENT A NEAT AND MODEST APPEARANCE.
4. PLEASE ENSURE INTERFACILITY CREDENTIALS TRANSFER BRIEF (ICTB), PER BUMEDINST 6320.66, IS FWD TO (APPROPRIATE TYCOM) ON ALL YOUR TAD PERSONNEL.
5. MISSION JUSTIFICATION. GENERAL SURGEON AUGMENTATION ADDRESSES A TEMPORARY SHORTFALL IN ORGANIC MEDICAL CAPABILITY ONBOARD (YOUR SHIP)
6. POC: LT MAO A. MAO, MSC, USN; CVN ## TITLE; COMM: (XXX)XXX-XXXX; EMAIL: MAO.A.MAO(AT)@CVN##.NAVY.MIL.//
BT
#0001
NNNN

Note: Customize this message to meet individual ship's requirements, be aware that this is only a request, and it may not be executed. The TYCOM will determine if temporary assets are available within the TYCOM. If the assets are not available, TYCOM will forward an endorsement of the message for approval and action. The TYCOM will forward surgeon requests to U.S. Fleet Forces Command who will task BUMED to support. Requests for other TAD support will be addressed directly to BUMED with an info copy to U.S. Fleet Forces Command.

APPENDIX E
OFF-DUTY CIVILIAN PROFESSIONAL EMPLOYMENT REQUEST

Requests to perform off-duty civilian professional employment and quarterly report will be submitted in the following formats (NAVMED FORM 1610/1 (rev.6/2011) is available online):

PRIVACY ACT STATEMENT

Authority: 10 U.S.C. 5013, Secretary of the Navy; CNICINST 5230.1, Total Workforce Management Services; OPNAVINST 3440.17, Navy Installation Emergency Management Program. Purpose**:** Allows human resources specialists, administrative support personnel, and supervisors to manage their entire workforce. Routine uses: In addition to those disclosures generally permitted under 5 U.S.C. 552a (b) of the Privacy Act of 1974, these records contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a (b) (3) as follows. The DoD Blanket Routine Uses set forth at the beginning of Department of Navy compilation of systems of records notices apply to this system. Disclosure**:** Voluntary. However, failure to provide the requested information may result in failure to receive consideration for application.

Section A.

Date: _____

From: _____
(Name, rank/grade,)

To: COMNAVAIRPAC/COMNAVAIRLANT Force Surgeon

Via: (1) Authorized Representative of Proposed Employer
(2) Commanding Officer, _____

Subj: OFF-DUTY EMPLOYMENT OF ICO: _____
(Insert Full Name and Prospective Job Title)

Ref: (a) 5 U.S.C. Section 5536
(b) DOD 5500.7-R, Chapter 8
(c) ASD (HA) Policy Memo 96-050 (Health Care Providers)
(d) ASD (HA) Policy Memo 97-019 (Dental Care Providers)
(e) MANMED Article 1-22, as amended by BUMED Notice 6000 of 22 Aug 98
(f) COMNAVAIRFORINST 6320.2
(g) DOD 6025.13-R

1. Per references (a) through (g), I request permission to engage in off-duty employment as set forth below:

a. My proposed employer: _____

b. My proposed off-duty employment start date is: _____

c. My proposed worksite location: _____

d. My proposed worksite telephone number: _____

e. My proposed work hours: _____

f. My proposed duties include: _____

_____

_____

g. I do/do not have permission to engage in other previously authorized off-duty employment (state details on separate sheet, if applicable).

2. I acknowledge the following limitations on my off-duty employment and have explained them to my proposed employer.

a. The site of my off-duty employment must be located within 2 hours travel time, by land, of the site of my military duties.

b. I must have a period of at least 6 hours between the end of my off-duty employment and the start of my military duties and must not work more than 16 hours per continuous 7-day period without specific approval of my commanding officer.

c. As part of my off-duty employment, I must not assume primary responsibility for the medical or dental care of any patient on a continuing basis.

d. My off-duty employment must not be performed on military premises; involve expense to the Federal Government; or involve use of military personnel or supplies.

e. As a military member, I may be required to respond immediately to calls for military duty.

f. I am responsible for complying with all requirements to practice in the civilian community, such as state licensing, Drug Enforcement Administration certification, and personal medical liability coverage requirements.

g. I must take annual leave for any obligations (e.g., court appearances or testimony before a compensation board) arising out of off-duty employment when these obligations require

absence during duty hours. There is no guarantee that the leave request will be approved by my command.

h. I must not refer patients from the military treatment facility to my prospective employer's facility.

i. I must not solicit or accept a fee directly or indirectly, and my prospective employer must not charge, for my care of a Department of Defense (DOD) healthcare beneficiary (i.e., member, retired member, or dependent of such member) of the Uniformed Services. TRICARE payments must be disallowed in any claim from a TRICARE provider in those instances when a Navy healthcare provider renders services to such a person, for the services provided by the Navy healthcare provider. This restriction does not apply to dental services provided to CONUS enrollees of the TRICARE Family Member Dental Plan. TRICARE payments for services I provide a DOD health care beneficiary during my off-duty employment must be disallowed.

3. I acknowledge my understanding of my off-duty employment limitations in accordance with references (a) through (g), and by my signature hereby attest to my compliance with same.

_____
Provider Signature/Date

Section B**.**

From: Authorized Representative of Proposed Employer
To: COMNAVAIRPAC/COMNAVAIRLANT Force Surgeon

Subj: OFF-DUTY EMPLOYMENT OF ICO: _____
(Insert Full Name and Prospective Job Title)

1. I am the Authorized Representative of _____
(Insert Full Name and Prospective Job Title)

2. I have read and accept the foregoing limitations, including the compensation and availability limitations, on the off-duty employment of _____
(Insert Full Name and Prospective Job Title)

3. I certify that this facility will not seek payment from a DoD beneficiary, TRICARE, or the Federal Government for health care provided by the subject named provider to DoD beneficiaries except for dental services provided to Continental United States enrollees of the TRICARE Family Member Dental Plan.

4. I further certify that the off-duty employment of the subject named provider will not negatively impact the civilian community and practices.

_____
Signature

_____
Name/Title/Date

_____
Employer's Organization Name

_____
Contact Phone Number(s)

Section C.

From: Commanding Officer, _____
To: COMNAVAIRPAC/COMNAVAIRLANT Force Surgeon

Subj: COMMAND ENDORSEMENT IN SUPPORT OF REQUEST TO ENGAGE IN OFF-DUTY EMPLOYMENT ICO: _____
Name/Primary Duty Title

1. On the basis of review of SNO's military performance and in light of this Command's current OPTEMPO, SNO's request to engage in off-duty employment is hereby recommended for approved / disapproved. (circle one)

2. SNO has been reminded that a favorable recommendation from this Command does not constitute an approval to commence off-duty employment. Final authority to initiate off-duty employment must occur upon receipt of COMNAVAIRPAC/COMNAVAIRLANT Force Surgeon approval.

3. SNO has been directed, that upon final authorization to engage in off-duty employment, to report all off-duty hours associated with this request to the COMNAVAIRPAC / COMNAVAIRLANT Force Surgeon, on a fiscal quarter basis, using the current Off-Duty Professional Employment Quarterly Report template. In addition, via formal written Navy correspondence, SNO has been directed to report any untoward outcomes and potential or real malpractice claims within 30 days to the COMNAVAIRPAC / COMNAVAIRLANT Force Surgeon.

_____
Signature/Date

Section D.

From: COMNAVAIRPAC/COMNAVAIRLANT Force Surgeon
To: Provider _____

Subj: REQUEST TO ENGAGE IN OFF-DUTY EMPLOYMENT

1. On the basis of your Command's recommendation, your noted satisfactory completion of all required training and certification elements and satisfactory performance of all assigned duties, your request to engage in off-duty employment is hereby approved/disapproved. (circle one)

2. In the performance of your authorized off-duty employment, you are directed to comply with all COMNAVAIRFOR Health Services instructions, prevailing health care practice guidelines and related directives.

3. You are reminded that this authorization may be revoked, at any time, as recommended by your Command, as a result of recommendations by the Executive Committee of the Medical Staff (ECOMS), as dictated by mission requirements or by me.

_____
Signature/Date

COMNAVAIRPAC/COMNAVAIRLANT Off-Duty Professional Employment
Quarterly Report

Date: _____

From: _____
(Authorized off-duty employment provider name)
To: COMNAVAIRPAC/COMNAVAIRLANT Force Surgeon
Via: Designated Authorized Representative of Off-Duty Employer

SUBJ: OFF-DUTY EMPLOYMENT QUARTERLY REPORT

Ref: (a) COMNAVAIRFORINST 6320.2

1. Per reference (a), the following is submitted:

a) Employment Location _____

NOTE:
(1) Must match the employer information indicated on original approved request
(2) A separate form must be submitted for each authorized employer

MONTH	HOURS WORKED

2. I hereby certify that I understand the off-duty employment policies, restrictions and reporting requirements stipulated under reference (a) and that I am in compliance.

_____
Provider Signature/Date

Civilian Employer Certification:

1. I hereby certify that the off-duty employment hours posted above are accurate for the indicated period.

_____
Signature/Date

_____
Name and Title Date

CNAP/CNAL Force Surgeon Certification:

1. On the basis of identified employer certification and previously approved off-duty employment, I hereby certify that the identified Health Care Provider remains in compliance with reference (a).

_____
Signature/Date

_____
Name and Title Date

Copy to:
CNAP/CNAL Privileging Authority
File

APPENDIX F
CRUISE REPORT TEMPLATE

Utilize Navy Lessons Learned (NLL) format and when complete submit to TYCOM.

I. Introduction – Synopsis by SMO of highlights of deployment (good and bad). Kudos to staff may be imparted in this paragraph and the concluding paragraph, but we recommend these comments not be incorporated in the body.

II. Lessons Learned from Staff-Comments from all officers and key departmental leaders to include:

Senior Medical Officer	LCPO
Senior Dental Officer/Principal Asst	Preventive Medicine Tech
Medical Admin Officer/Admin PO	Drug and Alcohol Counselor
Oral Surgeon	Lab Tech
General Surgeon	OR Tech
Family Medicine Physician	Pharmacy Tech
Ship's Nurse	Radiology Tech
Clinical Psychologist/Tech	Optometry Tech
Radiation Health Officer/Tech	Aviation Medicine Tech
Physical Therapist	Independent Duty Corpsman
Physician Assistant	Repair Parts Petty Officer
Senior Flight Surgeon	CRNA or Anesthesiologist

III. Conclusion – Brief Synopsis by SMO with concluding remarks.

IV. Appendices

a. Recommendations for ACRs – Please include in this appendix a consolidated list of recommended ACRs for any medical/dental equipment, supplies or pharmaceuticals that you recommend for addition, deletion or change.

b. Admissions and MEDEVACS: – Please include a "top 10 list" by ICD-XX code (please specify diagnosis) for the following:

Inpatient admissions
Outpatients
Incoming MEDEVACS
Outgoing MEDEVACS

c. Lessons Learned for Action – Please identify key items for action in this cruise report in the following format:

Topic
Observation
Discussion
Recommendation

Note: *Submission of Cruise Report is due to the TYCOM force surgeon NLT thirty days after the ship returns to Homeport. Waiver for extension of this deadline must be submitted through the COMNAVAIRFOR Force Surgeons.

APPENDIX G
RESEARCH REQUEST AND ENDORSEMENT

Requests with TYCOM review/endorsement to conduct research aboard COMNAVAIRFOR carriers will be submitted to the ship in the following format:

6010
Date

From: Principal Investigator, *Study Name/Institution*
To: Force Surgeon, Commander, Naval Air Force, Atlantic/U.S. Pacific Fleet

Subj: RECRUITMENT OF SUBJECTS ABOARD COMNAVAIRLANT/PAC ASSETS FOR *(STUDY NAME AND INSTITUTE CONDUCTING THE STUDY)*

1. Request permission to recruit active duty military, as subjects for a research study conducted by (*Name of Research Institute)* at or aboard COMNAVAIRFOR assets from (start date) to (end date).

2. The research study to be conducted is funded by (State the funding source) and is in collaboration with (include names of any collaborating institutes). The rest of this paragraph should be used to provide a general statement of the intent of the study and an overview of the tools/background to be used to collect the study data.

3. This paragraph should outline the method the research team will use to collect the data and the impact it will have on the ship and its crew. It should be in general terms, not scientific jargon, and provide enough information to allow the chain of command to determine if it will permit the study to be performed aboard.

4. This paragraph should ensure the privacy of the data and if any feedback from the study will be provided to the participating individuals. It should also include a statement of the planned use of the data (i.e. This study will be used to compile normative data along age and gender lines to establish a military normative baseline).

5. This study is IRB approved (packet available on request) by (state the IRB institute(s) and funding agency. Include a statement of who approves recruitment into the study. No expenses will be incurred by COMNAVAIRFOR ASSETS in support of this study.

6. For additional information, please contact (Principal Investigator) at (XXX)XXX-XXXX or Email:xxxxxxxx@xxxx.xxx

B. INVESTIGATOR

6010
Ser N01H/XXX

From: Commander, Naval Air Force, Atlantic/U.S. Pacific Fleet
To: Commanding Officer, USS (COMMAND Name)

Subj: RECRUITMENT OF SUBJECTS ABOARD COMNAVAIRLANT/PAC ASSETS FOR *(STUDY NAME AND INSTITUTE CONDUCTING THE STUDY)*

Ref: (a) IRB approval and Review for Protection of Human Research Volunteers from Research Risks
(b) Research Institutes funding data

Encl: (1) Request for recruitment of subjects on board COMNAVAIRLANT/PAC CVN XX
(2) Additional supporting documents

1. COMNAVAIRLANT/PAC code N01H has reviewed (Study Institute) research proposal (brief statement of the proposal intent). We endorse consideration of this proposal to recruit active duty subjects on board COMNAVAIRLANT/PAC CVNs.

2. This study has met our requirements for funding and has been reviewed and approved by the following Human Subject Institutional Review Board: List the IRB Institutes.

3. Support for this research effort from the ship would include providing a liaison, appropriate space to recruit and perform the test and authorizing personnel time to participate. The (Study Center) research team is looking to recruit roughly XXX subjects. Test time per subject is XXXX. Subject identifiers will not be included in the data and results will only be presented in aggregate preserving subject confidentiality.

4. Encourage your consideration of this proposal to recruit subjects for the study aboard your ship. POC is CDR P. I. Investigator at (XXX) XXX-XXXX.

FORCE SURGEON
By direction

APPENDIX H
MEDICAL EVACUATION PROTOCOL AND CHECKLIST

Sample SOP:

Ref: (a) COMNAVAIRFORINST 6000.1B
(b) COMNAVAIRFORINST 4630.12A
(c) AIR FORCE INSTRUCTION 41-307
(d) Fleet OPORD Annex Q

Encl: (1) Flight Surgeon's Aeromedical Patient Evaluation
(2) Sample MEDEVAC Message
(3) MEDEVAC Evacuation Checklist
(4) MEDEVAC Equipment and Supply Checklist
(5) MEDEVAC via COD

1. Purpose. To establish administrative protocol for conducting MEDEVACS while underway.

2. Discussion. The decision to MEDEVAC a patient rests with the command, customarily based on the recommendation of the Senior Medical Officer (SMO). It is essential to communicate with every key person when initiating administrative procedures once the decision is made to MEDEVAC. It is also essential to carefully plan and prepare for adequate supplies, equipment, paperwork and liaison with the receiving facility to ensure smooth patient movement from Medical Department to aircraft to higher echelon of care. Any patient transported off the ship while the ship is not tied to a pier will be considered a MEDEVAC and must be accounted for as a form of regulated patient movement. While there are instances when a patient is sent ashore for tests or consults only with the expectation that they will return to the ship for follow on care they should be treated as a MEDEVAC for accountability purposes. For these cases the applicable portions of this chapter should be followed, i.e. patients sent for studies or consults need not necessarily be given TAD orders for 30 days, have any medical attendants nor require any equipment. These types of patients were previously considered passengers transported via lifts of opportunity without an accounting within the medical system for their movement. Even though these patients are ambulatory and are being seen for outpatient procedures, studies or consults they still need to be regulated by medical personnel via a MEDEVAC message and should have follow up reporting as required by higher authority. Under no circumstances should a special flight or transport be arranged solely for these consultative MEDEVACS.

3. Classification. MEDEVACS are prioritized based on patient acuity into the following categories:

a. Urgent – Requires MEDEVAC within hours. Flight ops may need to be interrupted to expedite the MEDEVAC.

b. Priority – Requires MEDEVAC in the next 24 hours.

c. Routine – MEDEVAC in the next three days.

d. Space Available/Consultation- Routine movement of a patient for the purpose of obtaining additional clinical studies or consultation not available on the ship but that is of low enough priority to be able to wait for the next lift of opportunity. These patients are outpatients expected to return to the ship following their consultation/study and must be regulated as patient movement but do not require en route medical care. From a flight manifest perspective these patients will be viewed as a passenger but will be accounted for in medical as a regulated patient movement with an appropriate MEDEVAC message sent for accounting purposes.

4. Procedures

a. Outbound:

(1) Contact the nearest Military Treatment Facility (MTF) or Civilian Emergency Room for an accepting physician. If unable to reach by phone, e-mail the Operational Forces Medical Liaison (formerly known as Fleet Medical Liaison) of the respective MTF with the patient's name, rate, DOD ID, command, diagnosis, and the estimated time of arrival.

Note: In areas where ISOS is operational, (e.g., Singapore, Malaysia, Australia, etc.) contact ISOS directly.

(2) Contact the patient's command, DIVO and/or LCPO, to inform them of the member being MEDEVAC'd, and obtain from them any personal items the patient may need prior to transport.

(3) Contact the Air Transfer Office (ATO), to manifest the patient and any medical attendant(s) on the flight. If a medical attendant is necessary, contact the Duty Flight Surgeon to ready him/herself for the impending MEDEVAC. He/she must assemble the personal flight gear and brief the patient on in-flight procedures.

Note: Only flight certified personnel must accompany patients on MEDEVACS unless the patient acuity warrants additional attendants (i.e. nurse, corpsman).

(4) In the event of an emergency situation, notify the Air Operations Officer or Primary Flight Control, to schedule a MEDEVAC flight whether by Helo or COD.

(5) If the patient is non-ambulatory, notify the following:

(a) Flight Deck Control Officer (Handler) - to clear an area on the flight deck for transporting the patient to the aircraft.

(b) Ordnance Handling Officer (OHO) – to coordinate the use of the upper stage weapons elevator (Engineering Department for stores elevator).

(c) Security –to secure a route (notify 30 minutes prior to transfer).

(d) Flight Deck BDS –to alert flight deck corpsmen to anticipated time of MEDEVAC departure. (ensure flight deck corpsmen are standing by and ready to provide transport assistance from the arriving elevator to the aircraft).

(6) If time permits, complete all necessary paperwork, (enclosures (1) and (2)) for the patient and medical attendant so it can accompany both to their ultimate destination. Fully funded TAD orders will be provided for the patient and attendant to cover travel and per diem for a period of 30 days. Under the remarks section, indicate "SNM needs definitive medical care".

Note: Do not hold up the MEDEVAC in an emergency. Documents can be mailed at a later time.

(7) Before leaving Main Medical, make sure the patient has his/her military identification card, clothing to cover the time period of the patient's temporary detachment, verification of Individual Force Protection Brief (in Fifth Fleet AOR), funded orders, personal effects, consults/medical record, and a small amount of cash and/or credit card for incidental expenses.

(8) If the patient and attendant have a passport, ensure they accompany the patient/attendant, to and from the ship, in cases of travel that may involve foreign countries. If the patient or attendants do not have passports, inform appropriate fleet liaison so they may initiate State Department contacts as needed.

(9) Track the patient's movement/treatment through the MEDEVAC system via message traffic and/or e-mail, requesting frequent updates from the receiving MTF. This information must be included on the Morning Report. Enclosure (2) is a sample MEDEVAC message sent immediately after the patient leaves the ship. Check your local Fleet OPORD on specific guidance for drafting this message.

(10) Utilize enclosures (3) and (4) as guidelines while executing a MEDEVAC. These will ensure all the necessary paperwork, equipment, and supplies accompany the patient en route to the receiving facility.

b. Inbound:

(1) Same as for outbound, except for the following:

(a) CDC will normally contact the Medical Department with the MEDEVAC information, usually obtained from the ship on INMARSAT or radio. Information on the patient may be limited, such as only whether he/she is ambulatory and a provisional diagnosis.

(b) Upon notification of an inbound MEDEVAC, contact the Duty Medical Officer (DMO) and SMO. It may be necessary for the DMO/SMO to talk to the sending ship directly, in CDC, to get more definitive clinical information. Get the estimated time of arrival (ETA) and try to ensure the patient comes with at least 30 days funded orders and advanced per diem, to support possible follow-on MEDEVAC to a higher echelon of care, if necessary.

(c) Notify the Flight Deck BDS of the incoming MEDEVAC and inform them of the MEDEVAC's ETA. Have them stand-by to provide assistance with patient movement down to Medical.

(d) If the patient is on a stretcher, notify flight deck control to clear the flight deck in order to transport the patient to the second deck. Also notify ordnance control that the patient is on a stretcher and request that one of the elevators be manned up.

(e) Notify security to have at least two MAAs stationed to clear the passageway to be used (usually the port side) for patient movement to Main Medical.

(f) Send a message to patient's parent command, info their TYCOM (and COMNAVAIRPAC or COMNAVAIRLANT) on the patient's arrival and status/diagnosis via ICDM code(s).

Note: Remember, immediate action is necessary to achieve a good MEDEVAC process and outcome. Do not delay patient transport to complete administrative procedures.

c. MEDEVAC via COD – In addition to the steps outlined in paragraph 4a, the below administrative steps must be followed:

(1) Liaison with aircrew personnel to configure the aircraft in order to accommodate any non-ambulatory patients. Enclosure (5) provides guidelines for the recommended placement of the stretcher, supplies and equipment in preparation for catapult launch.

Note: The Stokes litter is the only authorized litter for transporting patients during a catapult launch.

(2) Ensure the aeromedical patient evaluation form (enclosure (1)) has been filled out prior to the MEDEVAC.

(3) The Senior Medical Attendant and/or SMO will brief the aircraft commander on the condition of the patient and any special considerations required for the flight.

Date

MEMORANDUM

From: Senior Medical Officer, USS XXXX XXXXXXXXX (CVN ##)
To: Aircraft Commander, VRC- XX or HS-XX

Subj: FLIGHT SURGEON'S AEROMEDICAL PATIENT EVALUATION

1. Patient information:

   a. Name:

   b. CMD/Dept/Div:

2. Patient's condition able to tolerate the forces of a catapult launch? **YES/NO**

3. Medical attention required? **YES/NO**

4. Non-medical escort required (e.g. for mental health patient)? **YES/NO**

5. Any precautions regarding contagious diseases or other special considerations? **YES/NO**

6. Comments: _____
_____
_____
_____
_____

I. M. SMO

Enclosure (1)

Sample MEDEVAC Request

R 210130Z FEB 18 (CURRENT ZULU TIME)
FM USS NEVERSAIL
TO ADMINSUPU SWA BAHRAIN//60//
INFO COMFIFTHFLT//014//
COMCARGRUFIVE
COMSEVENTHFLT
COMNAVAIRFOR SAN DIEGO CA/N01H
BUMED//
BT
UNCLAS//N06000//
MSGID/USS NEVERSAIL/-/MONTH//
AMPN/SUBJ/MEDEVAC REQUEST//REF/A/DOC/COMFIFTHFLT OPORD 100-95//
AMPN/APP. 3 TO ANNEX D/MEDEVAC MSG//
RMKS/1. PRECEDENCE: (URGENT-Requires MEDEVAC within hours; PRIORITY-Requires MEDEVAC in the next 24 hours; ROUTINE-MEDEVAC in the next three days; ROUTINE WITH SPECIAL REQUIREMENTS-Patients who are non-ambulatory, with casts, or other fixtures)
2. LITTER/AMBULATORY
3. RANK/RATE
4. AGE
5. SEX
6. WEIGHT
7. MEDICAL SPECIALTY (MED, ORTHO, PSYCH, ETC.)
8. ICD-CODE
9. SPECIAL EQUIPMENT REQUIREMENTS (CATHETER, CAST, 02, IV, ETC.)
10. PERMANENT DUTY STATION
11. VITALS:
    A. TEMP:
    B. PULSE:
    C. RESP:
    D. B/P:
12. MEDICATIONS
13. BRIEF HISTORY
14. ATTENDING PHYSICIAN/MEDICAL DEPARTMENT REPRESENTATIVE
15. TELEPHONE/INMARSAT
16. ATTENDANT (NMA)
    A. NAME
    B. GRADE
    C. AGE

Enclosure (2)

D. SEX
E. WEIGHT
F. RELATIONSHIP TO PATIENT IF APPLICABLE
17. OTHER: If you have movement planned, provide details. E.g. "plan movement of patient on C-2 flight from Fujairah to Bahrain on 22 Feb 18, ETA 1200Z."//
BT

USS ALWAYS AT SEA (CVN XX)

MEDICAL EVACUATION (MEDEVAC) CHECKLIST

Patient Name:	Unit:	Date:	MEDEVAC #:

Points of Contact List

Duty Flight Surgeon		Flight Deck BDS	
Ship's CO		Flight Deck Control	
Ship's XO		Cognizant HOD	
HEC		TFCC	
Strike OPS		TAO	
Gun Boss		DESRON COS; CAG or DCAG	
Ordnance Control		TYCOM	

Referring Clinician

1	Contact SMO and MAO	Complete ☐
2	Contact receiving physician at MTF (with assist of MAO as needed)	Complete ☐
3	Give name of receiving physician and hospital location to MAO	Complete ☐
4	Prescribe transport meds for patient	Complete ☐
5	Fill out consultation form	Complete ☐
6	Finish paperwork (History and Physical, orders, etc.)	Complete ☐
7	Ensure patient and/or attendant knows the plan (receiving MD, location)	Complete ☐

Nurse

1	Coordinate with clinician for enroute meds/equipment	Complete ☐
2	Copy all orders and paperwork	Complete ☐
3	Give the COPIES of the orders/paperwork and the ORIGINAL CHART to the flight surgeon for transport to MTF (We keep the ORIGINALS of the orders/paperwork)	Complete ☐
4	Give medications and equipment to the flight surgeon (medications the clinician ordered).	Complete ☐
5	Gather the patient chart, the copies of the orders/paperwork, and contact information; place with the patient	Complete ☐

6	Check: a. Clothes/bag with essential belongings packed and available in the Medical Department? If no, contact Medical LCPO b. TAD orders? If no, contact MAO c. Direct the patient to bring medical record back from MTF? d. Ensure patient has: contact information, phone number of main medical, instructions post evaluation	Complete ☐ Complete ☐ Complete ☐ Complete ☐

MAO

1	Establish communications with hospital for clinician	Complete ☐
2	Notify ATO	Complete ☐
3	Complete ATO request	Complete ☐
4	Complete Aeromedical clearance	Complete ☐
5	Ship's Company: TAD orders full cost 30 days – Training Officer	Complete ☐
6	For CVW personnel: TAD orders full cost 30 days – Squadron AO	Complete ☐
7	Landing zone preparation COD: coordinate beach detachment transport HELO: coordinate MTF landing pad preparations	Complete ☐
8	Instruct patient in reporting procedures post release	Complete ☐
9	Write and send notification message	Complete ☐

LCPO

1	For ship's company, notify CMDCM	Complete ☐
2	For embarked personnel, notify CMDCM	Complete ☐
3	For ship's company, notify cognizant LCPO	Complete ☐
4	Notify originating unit/department of need for sea bag	Complete ☐
5	Form a team to transport patient from medical to ATO staging area or Flight Deck BDS	Complete ☐

Flight Surgeon

1	For CVW personnel: a. Notify Squadron CO/XO b. Notify CAG or Deputy CAG	Complete ☐
2	Check Aeromedical suitability	Complete ☐
3	Ensure records and appropriate gear onboard for transport	Complete ☐
4	Advise on, and assist with, transportation of patient from medical to aircraft to receiving hospital (as necessary.)	Complete ☐
5	Ensure receiving clinician receives medical documentation / records	Complete ☐

Flight Deck BDS

1	SMO should brief flight deck medical and Flight Deck Control on the upcoming MEDEVAC, time, etc. All transportation via any elevators should have been arranged prior to times of transport and briefing.	Complete ☐
2	Receive notice from Main medical about the patient with all patient information, status, and expected time for departure.	Complete ☐
3	Notify flight deck control and Handler about patient and expected time and route of patient movement to flight deck, including whether ambulatory, whether the upper stage elevator will be used, etc.	Complete ☐
4	Gather flight deck stretcher-bearers for transport and have them standing by at the proper location.	Complete ☐
5	Make sure all necessary equipment is ready to go or gather any additional equipment that may be required.	Complete ☐
6	Patient should be received and escorted by either ATO to Flight deck BDS or by an escort from Medical, which does a turnover with a flight deck HM.	Complete ☐
7	When patient arrives, give them a flight deck safety brief, time of departure, and address concerns they may have or issues we need to address with them.	Complete ☐
8	Notify Flight Deck Control and Handler that the patient has arrived and is standing by in Flight deck BDS. Flight deck control should be notified on the status and condition and any special instructions that may be needed or required from the flight deck HM.	Complete ☐
9	Flight deck HM's will ensure that all gear and patient belongings go with the patient, and ensure that the patient is stable and ready for transport.	Complete ☐
10	Once cleared for transport, 1 or 2 flight deck HM's will escort the patient with flight deck stretcher bearers to the COD or HELO, and ensure that they are secured and all safety precautions are taken and that any special equipment…(O2, Meds, etc) are secured and with the patient.	Complete ☐
11	Once the patient is loaded and secured, Flight Deck Medical will notify Handler and Flight Deck Control that the patient has been turned over to the COD or HELO Crew. Flight Deck Medical will call Main Medical and give a final status that the patient has been turned over and is departing.	Complete ☐

MEDEVAC EQUIPMENT/SUPPLY CHECKLIST

The following checklist should be reviewed prior to MEDEVAC and tailored to the patient's personal needs.

Pre Flight

AIRWAY ❑ Laryngoscope blades/handles ❑ ETTs ❑ Oral/nasal airways ❑ Stylet ❑ KY jelly ❑ Nasogastric tubes ❑ Tongue blades ❑ Rapid Sequence Intubation Medications ❑ ALS bag/Meds
BREATHING ❑ Nasal Cannula ❑ Face mask ❑ Non-rebreather ❑ Sterile water for inhalation ❑ Nebulizer setup ❑ Ambubag ❑ Oxygen extension tubing ❑ Ventilator Circuit ❑ Suction tubing ❑ Yankauer
CIRCULATION ❑ IV pump tubing QTY____ ❑ Regular IV tubing QTY____ ❑ IV fluids_____ QTY____ ❑ IV start supplies: ❑ -18G catheter (2), ❑ -20G catheter(2) ❑ -alcohol pads (5), ❑ -opsite (5), ❑ -clean 2x2's (10) ❑ -1" tape (2) ❑ -Tourniquet ❑ Needles (18G, 21G) ❑ Syringes (3cc, 5cc, 10cc)

Enclosure (4)

DRESSINGS ❑ Kerlix ❑ Sterile 4x4's ❑ Clean 4x4's ❑ Bandaids
MISCELLANEOUS SUPPLIES ❑ Trash Bags ❑ Non-sterile gloves ❑ Sterile gloves ❑ Sharps Container small self-contained ❑ Sheets QTY _____ ❑ Blankets QTY_____ ❑ Pillow ❑ Cargo Straps QTY_____3 per patient/ multiple for equip ❑ Urinal/Bedpan ❑ Flashlight
EQUIPMENT ❑ IV Pump QTY_____ ❑ Defibrillator/Monitor ❑ Spare batteries for defibrillator ❑ Stethoscope ❑ Sphygmomanometer ❑ Pulse-ox handheld ❑ Impact Ventilator ❑ Impact Suction machine ❑ "D" Cylinders and O2 regulators ❑ Stokes basket or Litter ❑ Litter for equipment with collapsible handles ❑ Bandage scissors

MEDEVAC VIA COD

- Reference (c) is a comprehensive Air Force Instruction that outlines aeromedical standards of care for fixed wing aircraft.
Refer to this instruction for guidance pertaining to the impact of altitude changes for various patient conditions.

- Follow MEDEVAC checklists as outlined in Enclosures (3) and (4).

- Once notified of emergent MEDEVAC, aircraft commander will reconfigure aircraft removing 2-3 rows of aft seating to give medical attendants space to provide care. Configuration time will take approximately 30 to 60 minutes.

Pre-Launch

- Patient is placed in a horizontal position in a Stokes litter and secured in the aft end of the aircraft. Ensure adequate hearing and eye protection as well as padding and blankets for patient comfort. The litter will be placed at a 45 degree angle abutting the aft seating stanchions so that the patient is facing the forward end of the aircraft (see figure 1). This will help minimize physiological stresses on the patient during the catapult launch. Aircrew will secure the patient for launch.

- Medical attendants will be seated in the first row of seats immediately aft of the patient in preparation and through launch (see figure 1).

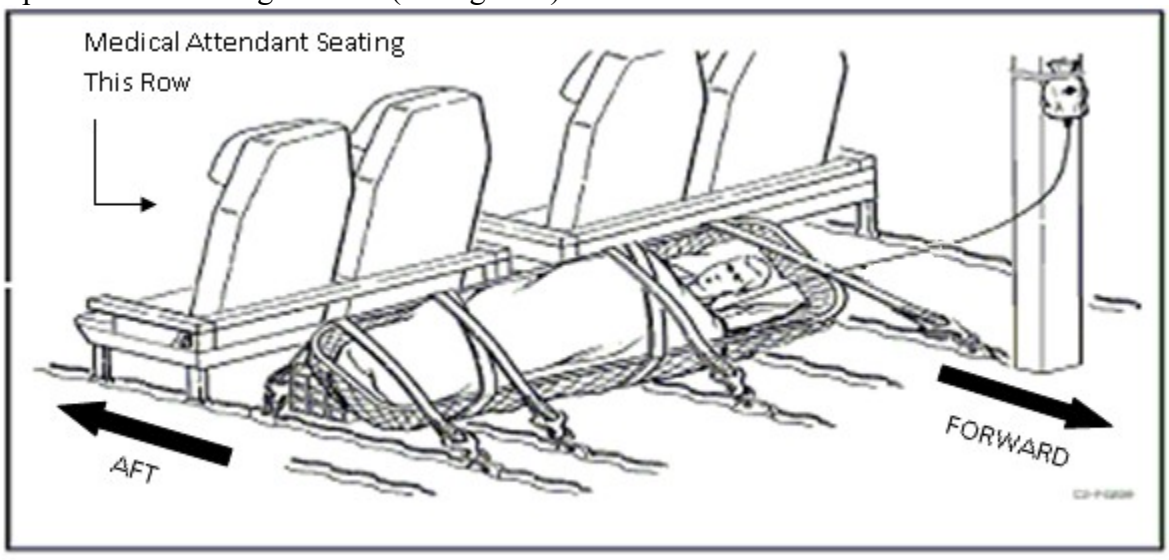


Figure-1: Positioning Stokes for catapult launch. Note that seats in the medevac COD aircraft face aft.

Enclosure (5)

- All gear will be secured by aircrew in accordance with aircraft Standard Operating Procedures

- The O2 cylinders will be secured inside the cage. Be prepared to have an extended length, reinforced, oxygen hose to connect to the ventilator and extended length circuitry to connect to the patient.

- The ventilator will be secured to the D-ring on the deck of the aircraft on the patient's left side where it can be easily manipulated by medical attendants if necessary.

- Monitoring equipment (Defibrillator) will be secured to the deck of the aircraft facing the aft end of the aircraft in order that medical attendants can easily visualize patient vital signs.

- IV bags will be secured as illustrated in Figure 1. An inflated pressure bag may be applied to maintain adequate flow of IVFs. Be sure to adjust the pressure as necessary for changes in altitude. An IV pump, if used, will be secured in an upright position to the outside of the Stokes stretcher to ensure ease of manipulation by medical attendants.

- The ACLS transport bag with supplies will be secured in the cage until after the launch.

Post-Launch

- Upon approval of the aircraft commander, the Stokes litter will be re-secured to the deck of the aircraft in a horizontal position. Aircrew will remove supporting seat stanchions and maximize working space for medical attendants if necessary.

- Additional supplies and equipment may be removed from the cage and conveniently hung or placed on the floor of the aircraft to render care.

Landing

- Aircraft crew will ensure the Stokes litter is secured flush with the deck.

- All non-essential supplies and equipment removed during flight will be secured in the cage per aircraft crew.

APPENDIX I
DECEDENT AFFAIRS

CONTENTS OF THE "DEATH PORTFOLIO"

1. The following items are to be maintained in each "Death Portfolio" Check List for Completion of Death Procedures:

a. Brief Summary of Decedent Affairs Program benefits when NOK prepares own arrangements

b. Sample Receipt for Remains of the Deceased Letter

c. Remains Identification Tag

CHECK LIST FOR COMPLETION OF DEATH PROCEDURES				
Name (Last, First, Middle)				
Rate/Rank		Patient ID		
Division/Squadron				
Time/Date of Death				
			YES	NO
Notify CO (Medical Officer)				
Notify XO (Medical Officer)				
Notify Disbursing Officer (Personnel Officer)				
Notify NCIS Agent (OOD/Medical)				
Information provided to Personnel Officer: Initiates priority Personnel Casualty Report message to BUPERS				
Death Certificate drafted (Medical Officer) **CONUS: Civil Death Certificate **OCONUS: DD 2064				
Complete two DD 565 Statement of Recognition				
Remains tagged and wrapped (Medical Department)				
Receipt for remains obtained (if civilian, funeral home picks up remains aboard ship)				
Information provided for appropriate entries in ship's log (Medical)				
Inventory personal effects (Division Officer)				
** Signed copy of NAVSUP 29 sent with effects				
** Signed copy of NAVSUP 29 retained on file				
Complete ten (10) copies of DD 2064 or Civil Death Certificate for distribution (Medical Department)				
Certified copy of civil death certificate obtained (if applicable)				

(Personnel/Casualty Assistance Calls Officer)		
CO's letter of condolence to NOK (BUPERSMAN 4210140) (Personnel Office)		
Terminate Health Record (Medical Department)		
Terminate Service Record (Personnel Office)		
Initial brief to escort (Personnel Officer/Medical Admin. Officer)		
Provide copy of escort manual to escort (Personnel Officer/Medical Admin. Officer)		

SAMPLE RECEIPT FOR REMAINS OF THE DECEASED LETTER

From: (Full name and business address of civilian mortuary)
To: Commanding Officer, USS ALWAYS SAIL, Norfolk, Virginia

Subj: RECEIPT FOR REMAINS

1. Receipt is acknowledged of the remains of the late

_____
Full name, rank/rate, service/file number of deceased)

_____
(Signature of mortuary representative)

_____
(Printed full name and position of representative signing receipts)

WITNESS:

_____
(Signature of command representative)

_____
(Printed rank/rate, name and position)

APPENDIX J
SAMPLE SURGICAL FORMS

1. Major Surgical Procedure. The following forms are examples and will be used to document a major surgical procedure:

a. Universal Protocol for Operative Procedures (See page J-3)

b. Modified Duty Authorization Chit (See page J-4)

c. Elective Surgery Memorandum (See page J-5)

d. Consent Form: DoD Exception to OF 522

e. Informed Consent Note: Use SF-509

f. History and Physical: Use SF-504, SF-505, and SF-506) or Abbreviated Medical Record: Use SF-539

g. Doctor's Orders: Use SF-508

2. Minor Operative Procedure: The following forms will be used to document a minor surgical procedure:

a. Universal Protocol for Bedside Procedures (See page J-6)

b. Minor Operative Procedure Report (See page J-7)

c. Consent Form: DoD Exception to OF 522

3. Upper GI Endoscopic Procedure. The following forms will be used to document an upper GI endoscopic procedure:

a. Universal Protocol for Operative Procedures (See page J-6)
or Universal Protocol of Bedside Procedures (See page J-3)

b. Upper GI Endoscopy Report (See page J-8)

c. Modified Duty Authorization Chit (See Page J-4)

d. Elective Surgery Memorandum (See page J-5)

e. Consent Form: DoD Exception to OF 522

f. History and Physical: Use SF-504, SF-505, and SF-506) or Abbreviated Medical Record: Use SF-539

g. Doctor's Orders: Use SF-508

4. Lower GI Endoscopic Procedure. The following forms will be used to document a lower GI endoscopic procedure:

a. Universal Protocol for Operative Procedures (See page J-6) or Universal Protocol of Bedside Procedures (See page J-3)

b. Lower GI Endoscopy Report (See page J-9)

c. Modified Duty Authorization Chit (See page J-4)

d. Elective Surgery Memorandum (See page J-5)

e. Consent Form: Use SF-522

f. History and Physical: Use SF-504, SF-505, and SF-506) or Abbreviated Medical Record: Use SF-539

g. Doctor's Orders: Use SF-508

5. Vasectomy Procedure. The following forms will be used to document a vasectomy procedure:

a. Universal Protocol of Bedside Procedures (See page J-6)

b. Modified Duty Authorization Chit (See page J-4)

c. Elective Surgery Memorandum (See page J-5)

d. Consent Form: Use SF-522

e. Surgical Sterilization Counseling Form (See page J-10)

f. Vasectomy Operation Report (See page J-11)

g. Informed Consent Note: Use SF-509

h. History and Physical: Use SF-504, SF-505, and SF-506) or Abbreviated Medical Record: Use SF-539

i. Doctor's Orders: Use SF-508

6. Anesthesia documentation examples

a. Pre-Operative Questionnaire and Assessment

b. Intraoperative Anesthesia Record: Use OF 517

c. Recovery Room Record: Use NAVMED 6320/16

UNIVERSAL PROTOCOL CHECKLIST FOR OPERATIVE PROCEDURES

This form will be used in with DoD Exception to OF 522 in accordance with policies set forth in COMPACFLTINST/COMFLTFORCOMINST 6320.16A

PRE-PROCEDURE VERIFICATION PROCESS

Yes □ Operational setting conducive to performing procedure
Yes □ Patient verbalized two personal identifiers *OR* N/A □

Yes □ Patient unable to verbalize; identity confirmed via _____ N/A □

Yes □ Consent form completed and signed by patient, provider, and witness

Yes □ All required paperwork complete and with correct patient identification information

Yes □ Radiologic image(s) present, identified as patient's, and displayed N/A □

Yes □ Pathology report(s) present, identified as patient's, and reviewed N/A □

Yes □ Biopsy report(s) present, identified as patient's, and reviewed N/A □

Yes □ Correct implant present N/A □

Yes □ All required equipment present, fully functional, and with sufficient power source for entire procedure

Site Marking

Yes □ Site verified with patient (If patient not included, state reason: _____)
Yes □ Site marked N/A □

Time Out (Immediately Before Procedure)

Yes □ All team members verify correct patient/site/procedure
Yes □ Correct patient position

Printed Name: _____
Date/Time Signature: _____

Patient Identification:

USS XXX (CVN-XX)
MEDICAL DEPARTMENT

MODIFIED DUTY AUTHORIZATION CHIT

This is a recommendation to your Division Officer/Department Head. You must take this form to Your Division before commencing Modified Duty or SIQ status. Misuse or fraudulent use of this chit may result in disciplinary action. Unless otherwise directed, all Modified Duty chits expire in 72 hours. SIQ recommendations must be reviewed by a Medical Officer every 24 hours except as noted below. Following is an example Modified Duty Authorization Chit.

Date

From: Medical Department USS CARRIER (CVN XX)
To: Department Head/Division Officer, Division X

Subj: MODIFIED DUTY ICO (RANK/RATE NAME)

1. The above named individual is recommended for (select one):

(a)__ Sick in Quarters for ___ hours.

(b)__ Modified Duty for ___ days with the following recommendations (select all that apply).

__ Standing not to exceed _____ hours in a 4-hour period.
__Walking not to exceed _____hours in a 4-hour period.
__ No running
__No squatting
__ No kneeling
__ No carrying anything greater than ____ pounds
__ No pushing/pulling anything greater than ____ pounds
__ Other: _____

3. This change of full duty status begins on (date/time) and expires on (date/time).

4. When SIQ is recommended for more than 24 hours, the member is responsible for mustering with their Department/Division.

5. SIQ chits issued by Hospital Corpsmen after normal working hours will expire the following day.

I have read and understand the above SIQ/Modified Duty policies fully and will comply with them.

_____

Patient's name Signature Date

_____

Medical Dept Rep Signature Date

MEMORANDUM

Date

From: Ship's Surgeon, CVN-XX
To: Department Head, Any Department, CVN-XX

Subj: REQUEST FOR ELECTIVE SURGERY ICO [MEMBER NAME]

Ref: (a) COMNAVAIRFORINST 6000.1B

1. Per reference (a), this memo is submitted for your approval.

2. [Member Name] has requested elective surgery that is tentatively scheduled for [date/time] pending Department Head approval.

3. This procedure may require placement on Sick in Quarters for ____ hours or admission to the Medical Ward for ____ days (one-line through if not applicable). If the loss is unacceptable, please indicate a suitable date range on your endorsement.

_____
SURGEON

FIRST ENDORSEMENT

From: Department Head, Any Department, CVN-XX
To: Ships Surgeon, CVN-XX

1. Approved/Disapproved.

2. If disapproved, an acceptable date range for rescheduling is: _____ to _____.

_____
DEPARTMENT HEAD

UNIVERSAL PROTOCOL CHECKLIST FOR BEDSIDE PROCEDURES

This form will be used with DoD Exception to OF 522 in accordance with policies set forth in COMPACFLTINST/COMFLTFORCOMINST 6320.16A

PRE-PROCEDURE VERIFICATION PROCESS

Yes □ Operational setting conducive to performing procedure

Yes □ Patient verbalized two personal identifiers *OR* N/A □

Yes □ Patient unable to verbalize; identity verified via _____ N/A □

Yes □ Consent form completed and signed by patient, provider, and witness

Yes □ All required paperwork complete and with correct patient identification information

Yes □ All required equipment present, fully functional, and with sufficient power source for entire procedure N/A □

Yes □ All necessary supplies available and not expired

Yes □ Correct type and concentration of local anesthetic present

Yes □ Correct type and sufficient amount of suture material present N/A □

Site Marking

Yes □ Site verified with patient (If patient not included, state reason: _____)
Yes □ Site marked N/A □

Time our (Immediately before procedure)

Yes □ All team members verify correct patient/site/procedure

Printed Name: _____

Name/Date/Time Signature: _____

Patient Identification:

USS XXX (CVN XX)
MEDICAL DEPARTMENT
MINOR OPERATIVE PROCEDURE REPORT

DATE: _____

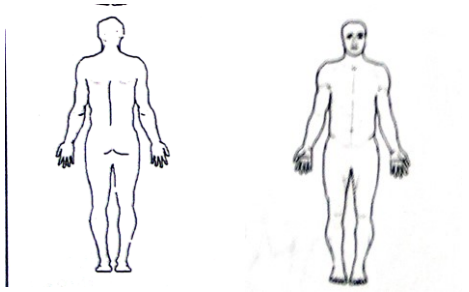
HISTORY: _____
_____
_____

PHYSICAL FINDINGS: _____
_____
_____

PREOP DIAGNOSIS: _____

PROCEDURE: Excision of _____

POST OP DIAGNOSIS: _____ Epidermal Inclusion Cyst
_____ Lipoma
_____ Fat Necrosis
_____ Nevi
_____ Other: _____



SURGEON: _____

ANESTHETIC: 1% Lidocaine w/Epinephrine 0.25% Marcaine

PROCEDURE: The lesion was identified by inspection by inspection and palpation. The skin surrounding the lesion was prepped and draped in standard sterile fashion. Local anesthetic was infiltrated in the skin and subcutaneous tissue. After adequate analgesia was assured:

_____ an incision was made over the mass. The mass was sharply excised from the subcutaneous fat and passed off as a specimen. The wound was inspected and no residual mass was identified.

_____ an elliptical incision was made to include the lesion and a 1 to 2 mm border of normal skin. The full thickness of skin was sharply excised from the underlying fat. The lesion was passed off as a specimen.
Adequate hemostasis was observed.

The skin edges were re-approximated with: _____
The incision was dressed with: ____ Bacitracin/bandaid ____ steri-strips ____ gauze.
The patient tolerated the procedure well. He/she was given the following instructions: to keep the incision clean and dry; may shower in 24 hours; return to Medical if any redness, drainage, swelling, or bleeding occurs; return for suture removal in _____ days, and take Tylenol as needed for discomfort.

Signature of Surgeon: _____Date: _____Time:_____

Addressograph

USS _____ (CVN-___)
MEDICAL DEPARTMENT

UPPER GI ENDOSCOPY REPORT

Patient: _____

Date: _____ Time: _____

Endoscopist: _____
_____

Indication: _____
_____
_____
_____

Premedication: _____
_____

Findings: _____

Oral Cavity/Hypopharynx: _____
_____
_____

Esophagus: _____
_____
_____

Stomach:_____
_____

Duodenum: _____
_____
_____

Photos: _____
_____

Diagnosis: _____
_____

Recommendations: _____
_____
_____
_____

_____ _____
Endoscopist's Signature Date

Addressograph

USS_____(CVN _____)
MEDICAL DEPARTMENT

COLONOSCOPY/SIGMOIDOSCOPY REPORT

Patient: _____

Date: _____ Time: _____

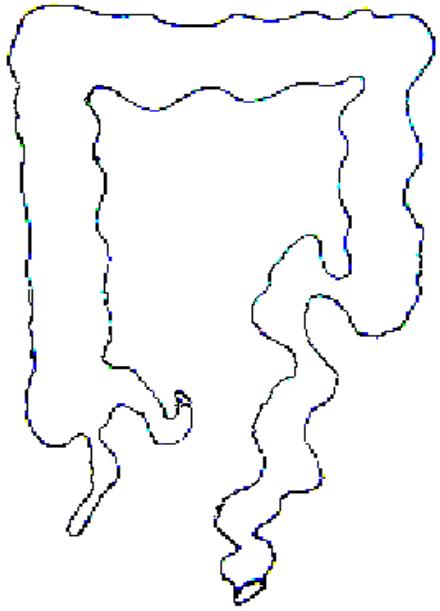
Endoscopist: _____

Indication: _____
_____
_____

Premedication: _____
_____

Findings: _____
_____
_____

Appendicular orifice: _____
_____



Anal Canal: _____
_____
_____

Rectosigmoid: _____
_____
_____

Descending Colon: _____
_____
_____

Transverse Colon: _____
_____
_____

Ascending Colon:
_____
_____
_____

Photos: _____
_____
_____

Specimens:
_____
_____

Diagnosis:_____
_____
_____

Recommendations:_____
_____
_____
_____

_____ _____
Endoscopist's Signature Date

Addressograph

SURGICAL STERILIZATION COUNSELING FORM

(To be printed on STANDARD FORM 600)

USS_____ (CVN _____)
MEDICAL DEPARTMENT

COUNSELING NOTE:

I am a ____ year old male, father of ____ children, and I desire a vasectomy for elective, permanent sterilization.

I have received information verbally and in writing describing the indication for elective, permanent sterilization, alternative forms of birth control, potential risks and complications (including, but not limited to, pain, bleeding, infection, and failure of the procedure to obtain the desired, permanent sterilization), and post procedure precautions and wound care instructions.

In addition, I have been briefed on the need to continue using alternative forms of birth control until my semen has been analyzed and found to be free of sperm on two occasions, at least six weeks and/or 15 ejaculations, following the vasectomy.

PATIENT: _____Date:_____ WITNESS: _____Date:_____

This ____ year old male, father of _____ children, desires a vasectomy for elective, permanent sterilization. I have described the procedure, its permanent nature, and potential complications of pain, bleeding, infection, and failure of the procedure to provide permanent sterility.

VASECTOMY SCHEDULED FOR (MM/DD/YY): _____

COUNSELING PHYSICIAN: _____

USS_____(CVN _____)
MEDICAL DEPARTMENT

VASECTOMY OPERATION REPORT

PREOPERATIVE DIAGNOSIS: Undesired Fertility DATE: _____

OPERATIVE PROCEDURE PERFORMED: Bilateral Trans-Scrotal Vasectomy

SURGEON: _____ ASSISTANT: _____

TECHNICIAN: _____

ANESTHETIC: _____ OPERATIVE DIAGNOSIS: SAA

DESCRIPTION OF PROCEDURE: The scrotum was prepped and draped in the usual sterile manner. The vas deferens were isolated subcutaneously in the scrotum. The skin and spermatic cord were infiltrated with local anesthetic solution. A 1cm skin incision was made down to the spermatic cord, and the vas was isolated from the surrounding tissue. The vas was then grasped with an Allis Clamp and delivered through the skin incision. The vas was then further isolated and skeletonized with a hemostat. A 1cm segment of the vas was sharply excised. Each specimen was then placed in a labeled specimen cup filled with Buffered Formalin, and forwarded to the Pathology Department at _____.

Additional Steps in the Procedure:

1. Number of skin incisions: _____
2. Hemostasis was obtained with: ____ Suture ligation. ____ Cautery ____ Pressure.
3. The ends of the vasa were:
   ___ Ligated with _____ suture.
   ___ Clipped with Titanium liga clips.
   ___ Cauterized.
   ___ Buried in separate fascial layers.
   ___ Folded over and secured with _____ suture.
4. The skin incision(s) were:
   ____ Closed with suture.
   ____ Closed by hemostat pressure.
5. The incision(s) was/were dressed with:
   ____ Bacitracin ointment.____ Xeroform gauze. ____ Plain gauze.

COMMENTS: The patient was instructed that he is NOT INFERTILE and to continue using Birth Control methods until a NEGATIVE semen analysis result is obtained (AZOOSPERMIA), following 6 weeks and/or 15 ejaculations. Use of a Jock Strap is recommended; place an Ice

Pack on the affected area for the first 24 hours; take only Tylenol 325mg (2 tabs every 4 hours) as needed for pain. Post-operative instructions were given orally and in a written form.
MODIFIED DUTY RECOMMENDED: Patient assigned 48 hours SIQ with 14 days light duty.

SIGNATURE OF SURGEON: _____ DATE: _____

Addressograph

APPENDIX K

ABBREVIATION "DO NOT USE" LIST

ALERT! Fleet Banned Abbreviations and Symbols

The abbreviations, dose designations, and symbols listed below have been formally identified as frequently misinterpreted and involved in harmful medication errors. DO NOT USE these error-prone terms in verbal or written documentation. Remove the terms from educational materials; medication administration carts, labels, and records; medication storage areas; and pre-printed orders, pathways, and protocols.

Do Not Use Term	Intended Meaning	Potential Misinterpretation	Use Instead
°	Hour	0 (zero)(e.g., q2° misinterpreted as q20)	"h", "hr", or "hour"
Ø	Null sign, zero	4 (four), 6 (six), 8 (eight), or 9 (nine)	"0" (zero), "zero", describe intent using whole words
<, ≤, >, ≥	Less than, less than or equal to, greater than, greater than or equal to	Opposite of intended, used incorrectly (<10 misinterpreted as 40)	Entire term (e.g., "less than")
@	At	2 (two)	"at"
&	And	2 (two)	"and"
+	Plus, and	4 (four)	"and"
/ (slash mark)	Separate 2 doses or indicate "per"	1 (one)(e.g., 25 units/10 units misinterpreted as 25 units and 110 units)	"per" for the word reference and to separate doses
Abbreviations for medication names	e.g., HCTZ, MgSO4, MS, MSO4, Nitro, NTG	Misinterpreted due to similar abbreviations for many medications	Complete medication names (e.g., "Morphine Sulfate", "Nitroglycerin")
Abbreviations with a period following the abbreviation (e.g., mg. or mL.)	e.g., mg, mL	Unnecessary period misinterpreted as "1" if poorly written	Term without a terminal period
AD, AS, AU	Right ear, left ear, both ears	Wrong ear or administered in eye(s)	Entire term (e.g., "right ear")
Apothecary units (e.g., drams, grains, minims, ounces, and their abbreviations)	Pharmaceutical measures	Confused with metric units and numbers, unfamiliar to many professionals	Metric system units
BT	Bedtime, between	"BID" (twice daily)	Entire intended term
cc	Cubic centimeter	"u" (units)	"mL" (preferred over "ml") or "milliileter(s)"
D/C	Discharge or discontinue	Incorrect action (medications discontinued when intended discharge meaning followed by a medication list)	Entire intended term
Drug name and dose run together (especially problematic for medication names that end in lower case "l")(e.g., Inderal40 mg, Tegretol300 mg)	e.g., Inderal 40 mg, Tegretol 300 mg	Inderal 140 mg, Tegretol 1300 mg	Place adequate space between the medication name, dose, and unit of measure
hs, HS	At bedtime/hours of sleep, half-strength	Unintended meaning	Entire intended term
j/d	One daily	tid, TID	"one daily" or "1 daily"
IJ	Injection	Intrajugular or IV (intravenous)	"injection"
IN	Intranasal	IM (intramuscular) or IV (intravenous)	"intranasal" or "NAS"
IU, I.U.	International unit	IV (intravenous) or 10 (ten)	"international unit"
Large doses without properly placed commas (e.g., 100000 units)	100,000 units	10,000 units, 1,000,000 units	Use commas for dosing units at/above 1,000 or spell out number for readability (e.g., "100 thousand")
µg	Microgram	mg resulting in 1,000-fold overdose	"mcg" or "micrograms"

APPENDIX L

CONTROLLED MEDICINALS - SAMPLE LETTERS AND OTC MEDICATION REQUEST

CONTROLLED MEDICINALS BULK STOCK CUSTODIAN APPOINTMENT LETTER

Date

From: Commanding Officer, USS
To: LT Mao A. Mao, MSC, USN

Subj: APPOINTMENT AS BULK STOCK CUSTODIAN FOR CONTROLLED MEDICINALS

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1B
(c) COMNAVAIRFOR/COMNAVSURFPAC/COMNAVSURFLANT Controlled Substances Standard Operating Procedures

1. You are hereby appointed as Bulk Stock Custodian for controlled medicinals on board this ship, as defined in references (a), (b) and (c).

2. You must read and become familiar with parts of references (a), (b) and (c) which concern your duties as Bulk Custodian.

3. You must maintain the necessary accounting records and documents as set forth in reference (a) to show the proper receipt and expenditure of items in your custody.

4. You must ensure that the proper security is maintained for items in your custody, and that the combination of the safe containing the bulk stock items is changed at least every six months in accordance with reference (c).

5. An inventory of all drugs in your custody will be held by the Controlled Substance Inventory Board (CSIB) appointed for this purpose every 90 days or more frequently, if necessary.

6. Ensure that a Combination Change Envelope (SF 700) has been used and placed in the custody of the CO or a designated officer.

_____
SIGNATURE (Commanding Officer)

Copy to:
Medical Department File
Commanding Officer's file

Senior member of the CSIB

I have read and understand the provisions of references (a), (b) and (c).

_____

SIGNATURE (Bulk Custodian)

CONTROLLED MEDICINALS WORKING STOCK CUSTODIAN APPOINTMENT LETTER

Date

From: Commanding Officer, USS
To: (name of appointee)

Subj: APPOINTMENT AS WORKING STOCK CUSTODIAN FOR CONTROLLED MEDICINALS

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1B
(c) COMNAVAIRFOR/COMNAVSURFPAC/COMNAVSURFLANT Controlled Substances Standard Operating Procedures

1. You are hereby appointed as Working Stock Custodian for the controlled medicinals on board this ship, as defined in references (a), (b) and (c).

2. You must read and become familiar with parts of references (a), (b) and (c) which concern your duties as Working Stock Custodian.

3. You must maintain the necessary accounting records and documents as set forth in reference (a) to show the proper receipt and expenditure of items in your custody.

4. You must ensure that the proper security is maintained for items in your custody and that the combination of the safe containing the working stock items is changed at least every six months in accordance with reference (c).

5. An inventory of all drugs in your custody will be held by the Controlled Substance Inventory Board (CSIB) appointed for this purpose every 90 days or more frequently, if necessary.

6. Ensure that a Combination Change Envelope (SF 700) has been used and placed in the custody of the CO or a designated officer.

_____
SIGNATURE (Commanding Officer)

Copy to:
Medical department file
Commanding officer's file
Senior member of the CSIB
Appointee

CONTROLLED MEDICINALS INVENTORY BOARD APPOINTMENT FORM LETTER

Date

From: Commanding Officer, USS NEVERSAIL (CVN XX)
To: A Commissioned Officer (Other than the Bulk Stock Custodian)

Subj: APPOINTMENT AS SENIOR MEMBER OF THE CONTROLLED SUBSTANCES INVENTORY BOARD

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1B
(c) COMNAVAIRFOR/COMNAVSURFPAC/COMNAVSURFLANT Controlled Substances Standard Operating Procedures

1. You are hereby appointed as Senior Member of the Controlled Substance Inventory Board (CSIB) as described in Article 21-24(1)(b) of reference (a). In addition, (A Commissioned Officer) and (another member E-7 or above) will serve as members of this board.

2. All members must become thoroughly familiar with the parts of references (a), (b) and (c) which concerns the duties of the CSIB and complete CSIB training in accordance with reference (c).

3. You will cause a physical inventory to be held of all narcotics, alcohol, alcoholic beverages and other controlled medicinals on board this ship at least every 90 days in compliance with references (a), (b) and (c). A written report of each inventory conducted must be promptly submitted to the CO as required by Article 21-47 of reference (a).

4. In your report to the CO, you must include the following information:

a. Discrepancies noted in checking all receipt and expenditure vouchers, prescriptions (DD Form 1289) and NAVMED 6710/5, perpetual inventory forms, showing the receipt and expenditure of all drugs inventoried. Losses, thefts, or irreconcilable differences must be reported in accordance with Article 21-25 of reference (a).

b. If all prescribed accounting records were properly prepared as set forth in references (a), (b) and (c).

c. f seals on the closures of vials, bottles and other containers inspected were damaged or tampered with.

d. Security of spaces where inventoried drugs are stowed and recommendations, if any, to enhance the security of such spaces.

e. Any item which shows signs of damage, expired potency date, or deterioration. Recommend action for disposal of any such item listed in accordance with Article 21-26 of reference (a).

SIGNATURE (Commanding Officer)

Copy to:
Each Board Member
Medical department file
Commanding officer's file
Appointee

CONTROLLED MEDICINALS INVENTORY REPORT FORMAT

Date

From: Senior Member, Controlled Substances Inventory Board
To: Commanding Officer, USS NEVER SAIL (CVN XX)

Subj: CONTROLLED INVENTORY REPORT (BULK OR WORKING STOCK); FOR THE MONTH OF

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21

1. Per with reference (a), a controlled medicinal inventory was conducted with the following results:

Drug Name	Unit of Issue	Strength	Amount Remaining Last Report	Quantity Received	Quantity Expended	Balance On Hand

2 Discrepancies noted are as follows: (either state "none" or list each discrepancy with a corresponding explanation.)

SENIOR MEMBER

Copy to:
Board members
Bulk/Working Stock Custodian

CVN-XX MEDICAL DEPARTMENT MEMORANDUM

Date

From: Controlled Substances Bulk Custodian, USS NEVERSAIL (CVN XX)
To: Commanding Officer, USS NEVERSAIL (CVN XX)
Via: (1) Senior Medical Officer, USS SAIL (CVN XX)
(2) Executive Officer, USS SAIL (CVN XX)

Subj: AUTHORIZATION TO DISPOSE OF EXPIRED CONTROLLED SUBSTANCES

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1B
(c) COMNAVAIRFOR/COMNAVSURFPAC/COMNAVSURFLANT Controlled Substances Standard Operating Procedures

1. Per references (a), (b) and (c), request authorization to dispose of the following expired controlled substances:

DRUG NAME/ DOSAGE	QUANTITY	EXP	LOT #

2. Upon approval, I will properly dispose of the medications with at least one member of the Controlled Substances Inventory Board (CSIB) as a witness.

3. Upon completion of the disposal of all medications listed above, a memorandum will be forwarded stating the personnel involved in the process, their signatures, date of when it occurred, and method of disposal.

A. C. ULATER

Commanding Officer: APPROVED/DISAPPROVED (PLEASE CIRCLE)

CO Signature: _____ Date: _____

CVN-XX MEDICAL DEPARTMENT MEMORANDUM

Date

From: Controlled Substances Bulk Custodian, USS SAIL (CVN XX)
To: Commanding Officer, USS SAIL (CVN XX)
Via: (1) Senior Medical Officer, USS SAIL (CVN XX)
(2) Executive Officer, USS SAIL (CVN XX)

Subj: COMPLETION OF EXPIRED CONTROLLED SUBSTANCES DISPOSAL

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1B
(c) COMNAVAIRFOR/COMNAVSURFPAC/COMNAVSURFLANT Controlled Substances Standard Operating Procedures
(d) Reference the memo requesting Authorization to Dispose of Expired Controlled Substances

1. The following medications were disposed of in accordance with references (a) through (d):

DRUG NAME/ DOSAGE	QUANTITY	EXP	LOT #	DATE	BULK	CSIB	METHOD

2. I certify that the following medications have been disposed of properly and record of this disposal will be kept for 2 years.

A. C. ULATER

CSIB Member Name: _____

CSIB Member Signature: _____ Date: _____

CSIB Member Name: _____

CSIB Member Signature: _____ Date: _____

CO Name: _____

CO Signature: _____ Date: _____

Copy to:
Board members
Bulk/Working Stock Custodian

SAMPLE OTC PHARMACY PROGRAM
(Customize according to SMO's direction)

MEDICAL DEPARTMENT USS _____ CVN XX FPO AE _____

OVER-THE-COUNTER MEDICATION REQUEST
(Please Print Clearly)

PATIENT'S NAME: _____ DOD ID: _____

J-DIAL: _____ ALLERGIES: _____

SYMPTOMS BEING TREATED: _____

By signing, I certify the following:

1. I understand that the medication is for use in minor illnesses or conditions and that if symptoms worsen or do not improve within 48 hours, I should be seen by a medical provider.

2. I am NOT pregnant. I am NOT on Flight Status at the time.

3. I also understand that this service is available to me only TWICE PER MONTH.

4. If I become dizzy, drowsy, or suffer from any other undesirable side effects, I will discontinue the medication and report to the Medical Department.

5. Up to (3) items may be selected, but NO MORE THAN ONE ITEM FROM EACH CATEGORY.

SIGNATURE AND DATE: _____

PAIN/FEVER	TOPICALS
( ) Tylenol 325mg (12 tabs)	
	( ) Chapstick
( ) Motrin 200mg (12 tabs)	( ) Hydrocortisone 1% Cream
( ) Aspirin 325mg (12 tabs)	( ) Sunscreen
SORE THROAT	**ANTACIDS**
( ) Cepacol Lozenges (9 tabs)	( ) Maalox Suspension
COUGH/CONGESTION	**ANTIFUNGALS**
( ) Humabid LA #12 tabs	( ) Antifungal Foot Powder

( ) Mycelex 1% Cream

UPSET STOMACH/DIARRHEA	SEA SICKNESS
( ) PeptoBismol #12 tabs	( ) Meclizine 25mg (12 tabs)

ANTIHISTAMINES/DECONGESTANT

( ) Phenylephrine 10mg (12 tabs)

PARENT COMMAND (CHECK BOX)

ϒ CVN XX	ϒ CCG X	ϒ CVW X	ϒ SEAL TEAM X
ϒ HS X	ϒ VAQ XXX	ϒ VAW XXX	ϒ VF XX
ϒ VFA XX	ϒ VFA XXX	ϒ VMFA XXX	ϒ VS XX

ϒ OTHER (specify TAD, CVNXX, etc)_______

APPENDIX M

NUCLEAR FIELD DUTY SAMPLE LETTER

6470
Ser #XXX
DD MMM YY

From: Commanding Officer, USS YOUR SHIP (CVN XX)
To: Deputy Chief of Naval Operations (N133D2)
Via: (1) Commander, Naval Air Force Atlantic/U.S. Pacific Fleet (N01H)
(2) Chief, Bureau of Medicine and Surgery (M3/5OM2)
(3) Commander, Naval Personnel Command (PERS 403)

Subj: REQUEST FOR DISQUALIFICATION FROM/WAIVER FOR NUCLEAR FIELD DUTY ICO ETN1 JOHN Q. SAILOR, USN

Ref: (a) NAVMED P-117, Manual of the Medical Department
(b) [List Other Pertinent Directives (i.e. OPNAVINST 5355.5B, NAVMED P-5055, OPNAVINST 1540.41B, etc.)]
(x) Last reference

Encl: (1) SMO Summary Memo dtd DD MMM YY
(2) NAVMED Form 2808, Report of Medical Examination dtd DD MMM YY
(3) NAVMED Form 2807-1, Report of Medical History dtd DD MMM YY
(4) Other supporting documentation. (e.g. SF 600s, Report of Psychological Evaluation, specialty consults, etc.)

1. Per references (a) through (x), ET1 JOHN Q. SAILOR was evaluated by Lieutenant Commander Hitchcock, USS YOUR SHIP (CVN XX) Clinical Provider, and was found "not fit" for Nuclear Field Duty due to a diagnosis of whatever the condition is (e.g. ET1 JOHN Q. SAILOR has been diagnosed with major depressive disorder and has been prescribed psychotropic medication.)

2. Per reference (a), request BUMED find ET1 JOHN Q. SAILOR disqualified from Nuclear Field Duty. Enclosures (1) through (x) are submitted for your review. A waiver of the standards is or is not recommended.

3. Point of contact is S. M. Officer, who may be reached at (123) 456-7890 or DSN 123-7890 or email: smo@cvnxx.navy.mil.

I. M. THE CO

APPENDIX N

AMAL CHANGE REQUEST (ACR)

NSN:
NOMENCLATURE:
CHECK ONE: ☐ Add ☐ Replace ☐ Delete with Replacement ☐ Delete W/O Replacement
NEW OR REPLACEMENT NSN and COMMON NAME:
NEW OR REPLACEMENT NOMENCLATURE:
(If this item is a piece of equipment, provide the information below. If available, a copy of the company catalog/item sheet should be forwarded with the ACR)
MANUFACTURER NAME:
ADDRESS:
PHONE:
MODEL #: PART #: CAT #:
JUSTIFICATION FOR CHANGE:
AMAL(S) AFFECTED:

APPENDIX O

REQUIRED AMALS AND SUPPLIES

1. The following AMALs will be maintained:

TITLE	AMAL	REQD
Force Health Protection	3005/3205	1
Consumables Storeroom	3012/3212	1
Controlled Med Bulk Stock	3013/3213	1
Equipment	3015/3215	1
Operating Room	3021/3221	1
ICU/Ward	3023/3223	1
BMET	3025/3225	1
Preventive Medicine	3030/3230	1
Radiology	3031/3231	1
Laboratory	3032/3232	1
Pharmacy	3034/3234	1
Optometry	3035/3235	1
Physical Therapy	3036/3236	1
First Aid Box. See current COMNAVAIRFORNOTE 6000 for exact QTY	3050/3250	90 min
Mass Casualty Box. See current COMNAVAIRFORNOTE 6000 for exact QTY	3051/3251	7 sets
Battle Dressing Station. See current COMNAVAIRFORNOTE 6000 for exact QTY	3052/3252	6 spaces
Crash Cart. See current COMNAVAIRFORNOTE 6000 for exact QTY	3054/3254	3 carts
JERK. See current COMNAVAIRFORNOTE 6000 for exact QTY	3055/3255	5 bags
Gun Bag. See current COMNAVAIRFORNOTE 6000 for exact QTY	3057/3257	16 bags
Boat Box. See current COMNAVAIRFORNOTE 6000 for exact QTY	3058/3258	2 boxes

CBR Decontamination Locker contents:

NSN	NOMENCLATURE	U/I	QTY
5120-00-545-4268	Retrieving Tool, Magnetic	EA	1
6505-00-480-7216	Aluminum Hydroxide Gel 12 oz	BT	2
6505-01-072-3623	Magnesium Sulfate, 8 oz	BT	2
6505-00-246-0142	Water for Irrigation	BT	8

NSN	NOMENCLATURE	U/I	QTY
6510-00-782-2698	Sponge, Surg, 4" X 4", 8 Ply	PG	2
6510-00-890-1371	2" Surgical Tape	PG	1
6510-00-890-1370	3" Surgical Tape	PG	1
6508-00-852-6597	Soap, Antiseptic, Cake	EA	200
6515-01-234-6838	Applicator, DispSq Tip 100's	PG	2
6530-00-772-5935	Brush, Surgical Scrub, Nylon	EA	50
8520-00-550-6417	Soap, Grit, 4.5 oz., Cake	EA	50
8520-00-965-2109	Cleaner, Hand Anti-Microbial Laundry Detergent	TU	2
6530-00-075-6636	Specimen Cup, Urine, 500s, PG	EA	20*
6505-01-496-4916	Potassium Iodide Tablets 130MG 14s	PG	6000**
8520-01-346-9200	Skin Cleanser, Waterless	PG	1***

Note: * Package contains 500 urine cups with additional items; distribute 20 cups each to each DECON station.

Note: ** Distribution is one package per crewmember. Maintain entire quantity in Supply until needed. This requirement is applicable to nuclear powered vessels only.

Note: *** Contains 24 4OZ bottles.

Additional Items:

NSN	NOMENCLATURE	U/I	QTY
6530-01-504-9051	Litter, Folding, Rigid Pole	EA	28
6530-01-187-0104	Litter, Rigid, Sea-Air, Medical EVAC	EA	2
6530-01-315-4784	Liter, Rigid, Stokes	EA	80
6530-01-477-8525	Litter-Splint, Extrication (Rescue or Reeves Sleeve II)	EA	24
1670-01-226-5300	Sling, Rescue Helicopter	EA	2
4010-01-312-4854	Wire Rope Assembly(Trail Line Assembly) (Extraction Line)	EA	2
6545-01-459-1115	First Aid Kit, Small Craft	EA	*
	Handling Lines with Snap Hooks	EA	24

APPENDIX P

MEDICAL DEPARTMENT TRAINING

DIVISION M

The following training courses are required based on the billet assigned. See end of appendix for course descriptions.

BSN	TITLE	DESG GRADE RATE RATING	PRI NOBC NEC	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE
002010	SENIOR MED OFFICER	2102H	0163	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	CNL-FB-1.0	ALS	ATLS	
002020	NRS ANESTH	2900I	0952	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	ALS			
002030	GEN SGN	2100I	0214	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	B6A-2300	ALS	ATLS	B-6A-1013
002040	SHIP'S NURSE	2900J	0904	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	ALS	FS01	TNCC	B6A-2301
002050	PHYS THERAPIST	2300J	0873	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	HPW	B6A-2301		
002055	RAD HEALTH OFFICER	2300J	1825	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	B6A-2301			
002060	CLIN PSYCH	2300J	0851	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	B6A-2301			
002070	MED ADMIN OFFICER	2300J	0800	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B6A-2301	Pt Admin	Supply
002080	PHYSICIAN ASST	2300J	0113	BLS, TEAM STEPPS	SAMFE	J3OP-US258	J-495-0416	ALS	ATLS	B6A-2301	

BSN	TITLE	DESG GRADE RATE RATING	PRI NOBC NEC	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE
002090	FAMILY PRACTITIONER	2100J	0102	BLS, TEAM STEPPS	SAMFE	J3OP-US258	J-495-0416	B-6A-2300	ALS	ATLS	
002110	DRU&ALC COUNS	CPO	L40A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416				
002120	DRU&ALC COUNS INTERN	PO1	L39A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416				
002130	HOSPCORPS LCPO	HMCS	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	CSS-3MM-030	TMIP	CNL-FB-1.0	
002140	HOSPCORPS PMT	HMC	L12A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	B-322-1075	B-322-2101	TMIP	AUDIO
				NMCPHC-HC-1.0		CSFE-OAM-1.0	NMCPHC-HAS-1.0	NMCPHC-WSA-1.0		NMCPHC-HAMSC-1.0	
002160	HOSPCORPS PMT	HM1	L12A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	B-322-1075	B-322-2101	TMIP	AUDIO
				NMCPHC-HC-1.0		CSFE-OAM-1.0	NMCPHC-HAS-1.0	NMCPHC-WSA-1.0		NMCPHC-HAMSC-1.0	
002240	HOSPCORPS PMT	HM2	L12A	BLS, TEAM STEPPS		J3OP-US260 CBRNE-O	J-495-0416	B-322-1075	B-322-2101	TMIP	AUDIO
				NMCPHC-HC-1.0		CSFE-OAM-1.0	NMCPHC-HAS-1.0	NMCPHC-WSA-1.0		NMCPHC-HAMSC-1.0	
002150	HOSPCORPS BMET	HM1	L08A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	SUPPLY	CSS-3MM	TMIP	
002170	HOSPCORPS IDC	HM1	L10A	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	FSO1	B-300-0033	ALS	B-300-4010
002250	HOSPCORPS IDC	HM2	L10A	BLS, TEAM STEPPS		J3OP-US258	J-495-0416	FSO1	B-300-0033	ALS	B-300-4010
002180	HOSPCORPS RAD HLTH	HM1	L05A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP			

BSN	TITLE	DESG GRADE RATE RATING	PRI NOBC NEC	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE
002190	HOSPCORPS AMT	HM1	L04A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	NMCPHC-HC-1.0	AUDIO	
002260	HOSPCORPS AMT	HM2	L04A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	NMCPHC-HC-1.0	AUDIO	
002200	HOSPCORPS MLT	HM2	L31A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	6H-F3/311-F3			
002280	HOSPCORPS MLT	HM3	L31A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	6H-F3/311-F3			
002210	HOSPCORPS BHT	HM2	L24A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP			
002220	HOSPCORPS PT	HM2	L20A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP			
002230	HOSPCORPS OPTIC	HM2	L19A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP			
002290	HOSPCORPS SURG	HM3	L23A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	FSO1	TMIP		
002370	HN SURG TECH	HN	L23A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	TCCC		
002300	HOSPCORPS PHARM	HM3	L22A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP			
002310	HOSPCORPS XRAY	HM3	L17A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP			
002320	HOSPCORPS RAD HLTH	HM3	L05A	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP			
002270	HOSPCORPS GEN DUTY	HM2	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		

BSN	TITLE	DESG GRADE RATE RATING	PRI NOBC NEC	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE	COURSE
002330	HOSPCORPS GEN DUTY	HM3	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002340	HOSPCORPS GEN DUTY	HM3	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002350	HOSPCORPS GEN DUTY	HM3	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002360	HOSPCORPS GEN DUTY	HM3	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002380	HN GEN DUTY	HN	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002390	HN GEN DUTY	HN	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002400	HN GEN DUTY	HN	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002410	HN GEN DUTY	HN	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002420	HN GEN DUTY	HN	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		
002430	HN GEN DUTY	HN	0000	BLS, TEAM STEPPS		J3OP-US260	J-495-0416	TMIP	B-300-4010		

NOTE: Repair Parts Petty Officer (collateral duty) also requires supply training.

COURSE CIN AND TITLES

CIN	COURSE
J-495-0416	SHIPBD FIRE FIGHTING
B-322-1075	SHIPBD PEST MGMT
B-322-2101	FOOD SAFETY MGR
FSO1	BLS INSTRUCTOR
B-300-0033	REFRESHER TRAINING FOR IDC
B-6A-2301	SURFACE WARFARE MED DEPT OFFICER INDOC COURSE (SWMDOIC)
B-6A-2300	SURFACE WARFARE MEDICAL OFFICER INDOCTRINATION COURSE (SWMOIC)
B-6A-1013	TRAUMA REFRESHER COURSE FOR SURGEONS (TRCS)
J3OP-US258 (EMPRC)	EMPRC CLINICIAN COURSE
J3OP-US260 (EPRC)	EPRC OPERATOR RESPONDERS COURSE
NMCPHC-HC-1.0	HEARING CONSERVATION PROGRAM
NMCPHC-HSA-1.0	HEAT STRESS AFLOAT
NMCPHC-WSA-1.0	WATER SANITATION AFLOAT
NMCPHC-HAMSD-1.0	HEALTH ASPECTS OF MARINE SANITATION DEVICES
ES-OAM-001 (OAM-001)	OVERVIEW OF ASBESTOS MANAGEMENT PROGRAM
CSS-FSFSS-010-1.0	FOOD SAFETY AND FOOD SERVICE SANITATION
CNL-FB-1.0	FLEET BUSINESS: THE NAVY BUSINESS AND FISCAL PRACTICES COURSE
TNCC	TRAUMA NURSING CORE COURSE
TMIP	NIWC TMIP COURSE No associated CIN
SUPPLY **	PROGRAM SUPPORT TEAM OR SUPPLY DEPARTMENT
CSS-3MM-030	3M MAINTENANCE MGR – OMMS NG
BLS	BASIC LIFE SUPPORT (BLS) No associated CIN
ALS	ADV LIFE SUPPORT (ALS) No associated CIN
ATLS	ADV TRAUMA LIFE SUPPORT (ATLS) No associated CIN
AUDIO	AUDIOMETRIC TECH SCHOOL (AUDIO) No associated CIN

CIN	COURSE
HPW	HEALTH PROMOTION AND WELLNESS COURSE THROUGH NMCPHC
TEAMSTEPPS	Team STRATEGIES and TOOL to ENHANCE PERFORMANCE and PATIENT SAFETY
SAMFE	SEXUAL ASSAULT MEDICAL FORENSICS EXAMINER COURSE (SAMFE)
B-300-4010	TACTICAL COMBAT CASUALTY CARE PROVIDER (TCCC)
6H-F3/311-F3	JOINT BIOLOGICAL AGENT DETECTION SYSTEM (JBAIDS)
B-6I-0002	PATIENT ADMINISTRATION COURSE

Note: ** Visit https://www.pst.govapps.com to reserve a seat for PST training.

APPENDIX Q

SAMPLE MEDICAL DEPARTMENT BATTLE DOCTRINE

USS SAIL INSTRUCTION 6101.1

Subj: Medical Department Battle Doctrine

Ref: (a) COMNAVAIRFORINST 6000.1B
(b) COMNAVAIRFORNOTE 6000
(c) Authorized Medical Allowance List (AMAL)

1. Purpose. To promulgate guidance on the facilities, functions, procedures, responsibilities and policies of the Medical Department and other departments for emergencies and battle in accordance with references (a) and (b).

2. Scope

a. Location of Battle Dressing Stations

(1) Six Battle Dressing Stations (BDS) are maintained onboard this ship and are located as follows:

(a) Main (Sick Bay) 1 142 1 L

(b) Forward Enlisted Dining Facility (FWD EDF) 1 114 1 L

(c) Aft (AFT EDF) 1 184 1 L

(d) Flight Deck 04 144 0 L

(e) Forward (Auxiliary) 03 44 0 L

(f) Aft (Auxiliary) 03-163 0 L

(2) Routing to all Battle Dressing Stations will be indicated on bulkheads and hatches by approved markings designated in General Specifications for ships of the United States Navy.

b. Assignments of specific duties of Medical/Dental Department personnel and stretcher bearers assigned to the Battle Stations, must be assigned by name to the Watch, Quarter and Station Bill:

(1) Medical Department personnel must not be assigned duties away from the ship or on any of the Ship's Bills except for extreme emergencies. Duties involving casualties away from the ship must be assigned to Medical Department personnel only if directed by the CO.

(2) The Medical Department must be prepared for emergencies at all times. The Watch, Quarter and Station Bill must be kept current and visibly posted in sick bay. All personnel of the Medical Department must be continually instructed and familiarized with his/her station and prescribed duties. This bill must be kept current at all times.

(3) General Quarters (GQ): General Quarters are the assigned battle stations of the officers and crew for fire, collision, and battle.

(a) Condition ONE: Engagement with the enemy is imminent. Medical Department personnel will not leave assigned battle stations to treat casualties; all casualties will be brought to the nearest Battle Dressing Station for treatment.

(b) Condition TWO: Engagement with the enemy is probable. Medical Department personnel man battle stations in a condition of readiness.

(c) Condition THREE: Engagement with the enemy is possible. Medical Department personnel must be prepared to assume the responsibilities of Condition ONE, but carry out their daily routine until otherwise directed.

c. Preparation of the Medical Department for Emergencies or Battle.

(1) Each BDS will be equipped with the supplies and equipment as outlined in references (b) and (c).

(a) A list of medical supplies at each station will be posted in the BDS and the medical supplies will be maintained, inspected, and inventoried every six months to ensure readiness.

(b) The supplies in BDSs must be carried in the "on hand" column on the stock record cards. These items are reserve stock and should be rotated into the working stock prior to expiration date. When taken from reserve stock, these items are to be reordered and replaced.

(c) Deteriorated items must be replaced as required.

(d) Controlled substances, narcotics, and barbiturates that are carried as reserve stock must not be routinely stored in the Battle Dressing Stations, but under the custody of the Bulk Custodian until the need arises for their possible use as directed by the CO. They must be issued by the Bulk Custodian, and must be returned to the Bulk Custodian when the need no longer exists.

(e) Sterile goods, if sealed in plastic in accordance with Event-Related Sterilization guidelines are subject to re-sterilization only upon damage to the outer packaging. The date of sterilization will be placed on each package. Tape Sterilization Indicator System (NSN 6530 01 628 0667) must be used. Prepackaged sterile or disposal knife blades and suture materials can be placed in the plastic dust cover with the sterile packs. A piece of tape should be placed on the outside of the plastic dust cover and marked to indicate the expiration date of the suture material inside. A list of contents containing the NSN, nomenclature, and quantity must also be attached to the outside of all sterile packs. A list of surgical instruments and supplies required for surgical kits is contained in reference (c).

(2) Mass Casualty Boxes must be stocked in accordance with AMAL 3051 and maintained in the same manner as the supplies and equipment stored in Battle Dressing Stations. A list of supplies must be posted inside each Mass Casualty Box. The locations are as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(3) First Aid Boxes: AMAL 3050/3250

(a) There are (number) wall type, weather proofed First Aid Boxes on the ship (minimum 90). Each box is located as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(b) A list of the required contents of these boxes is outlined in references (b) and (c). A list of the supplies must be posted inside each box.

(c) The First Aid Boxes must be maintained in the same manner as the supplies and equipment stored in the Battle Dressing Stations and Mass Casualty Boxes. They must, however, be sealed with anti-pilferage tape or breakable plastic seals and inspected routinely for pilferage.

(d) Inspection and inventory of these boxes must be conducted semi-annually to replace deteriorated items and replenish. In the event boxes are entered, they will be inventoried and replenished immediately.

(4) Junior Emergency Response Kits (JERK, AMAL 3055/3255) must be maintained as follows:

(a) A total of (number) kits will be maintained in medical spaces (minimum 5).

(b) Items must be replaced immediately as used.

(c) Kits will contain an inventory list and will be inventoried at least semi-annually to replace deteriorated items and replenish as necessary.

(5) Gun Bags (AMAL 3057/3257)

(a) There are 16 Gun Bags located as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(b) They must be maintained in accordance with reference (b) and (c). These bags are not to be used routinely, but maintained for emergency use only. One gun bag will be in each repair locker and one in each BDS for use by the stretcher bearers.

(6) Stretchers

(a) (number) Stokes (minimum 80), (number) Reeve's Sleeve with back boards (minimum 24), and (number) Army Pole Litters (minimum 28) must be well dispersed about the ship. Their locations and use must be an item of instruction to all members of the crew.

(b) Location of Stokes Litters is as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(c) Location of Reeve's Sleeves are as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(d) Location of Army Pole Litters is as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(7) Small Craft Boat Boxes (AMAL 3058/3258).

(a) There are (number) Small Craft Boat Boxes (NSN 8115-01-656-8316), one located in each Small Craft.

(b) A list of the required contents of these boxes is outlined in references (b) and (c). A list of the supplies must be posted inside each box.

(c) The contents in the Small Craft Boat Boxes must be enclosed in plastic bags. Boxes will contain an inventory list and will be inventoried at least semi-annually to replace deteriorated items and replenish as necessary.

d. Order of First Aid and Treatment

(1) First aid treatment must be initiated by the crewmember(s) on the scene and assist injured personnel to treatment facilities whenever possible.

(2) Stretcher Bearers will relieve the crewmember(s), rendering necessary first aid on the scene of the casualty, return the minor injuries to duty, and transfer the more serious casualties to Battle Dressing Stations.

(3) Self-aid or Buddy aid. Use available aid supplies in kits, boxes, etc., to stop hemorrhage, prevent or treat shock, alleviate respiratory distress, and assist injured personnel to treatment facilities.

(4) Battle Dressing Stations:

(a) Primary duty: To return as many casualties to duty as quickly as possible.

(b) To separate casualties not immediately returnable to duty and provide for their continuous care.

e. Action During Battle

(1) Triage and treatment of casualties will focus on returning the greatest number of casualties to duty, while judiciously using time and resources to save life, limb and eyesight.

(2) Arrange for evacuation of more serious casualties and expired patients from the Battle Dressing Station, as time and circumstances allow.

f. Action Immediately After Battle

(1) Continue treatment of battle casualties.

(2) Restore Battle Dressing Stations and first aid facilities to battle readiness.

(3) Arrange for transfer of serious casualties to medical treatment facilities.

(4) Report to the CO the number of casualties and their status.

(5) The deceased should be collected, prepared and stored.

(a) The following locations have been designated for storage of remains:

COMPARTMENT NUMBER	NAME OF SPACE

(b) If the remains are to be kept until arrival in port, they should be placed in cold storage.

(1) Cold storage spaces must contain no other items and must be cleaned and decontaminated prior to reuse. Refer to Decedent Affairs Manual.

(2) Remains must be kept at a temperature of 36 40 degrees Fahrenheit to prevent decomposition.

(3) The following refrigerated spaces have been designated for storage of remains (Note: Indicate a primary and secondary storage refrigerator):

COMPARTMENT NUMBER	NAME OF SPACE

(6) Casualties Requiring Surgical or Medical Care

(a) Minor surgical or medical cases must be evacuated to the [INSERT LOCATION(S)] Battle Dressing Station.

(b) Major surgical or medical cases must be evacuated to the Main Battle Dressing Station, or designated alternate location.

(7) Spaces Assigned for Collection of Battle Casualties.

(a) Seriously injured: (LOCATION)

(b) Minor injuries: (LOCATION)

(c) Psychiatric: (LOCATION)

(8) Disposition of Battle Fatalities (See Decedent Affairs Manual, BUMEDINST 5360.1).

(a) Transfer remains ashore (Request assistance from SOPA).

(b) Burial at sea (Refer to Decedent Affairs Manual, Chapter 8 1).

(9) Disposition of Missing Battle Casualties.

(a) When death has not been established, a SF 600 will be completed giving all particulars pertaining to the presumed disappearance of the individual. The health record must be closed and handled in accordance with NAVMED P 117, Chapter 16.

(b) When death is proven conclusively, procedures must be as directed by BUMEDINST 5360.1.

g. CBR Medical Defense

(1) Location of Decontamination Stations

(a) Forward Decontamination Station: _____

(b) Aft Decontamination Station: _____

(2) Flow of personnel to Decontamination Stations must be directed by the CO and coordinated by Damage Control Central.

(3) Access hatches leading to all Decontamination Stations must be clearly marked.

(4) Organization of Medical Care for Contaminated Personnel

(a) No person must be sent to a non-contaminated area until completely decontaminated and monitored to ensure decontamination.

(b) After decontamination, injured persons, or persons requiring other medical care, may be sent to the designated Battle Dressing Station.

(5) Medical Department personnel must be thoroughly informed on medical aspects of CBR defense and treatment of casualties.

(a) The Senior Medical Officer must advise the CO concerning medical aspects of CBR defense, including treatment and handling of casualties.

(b) Duties of Medical Department personnel assigned to decontamination stations are to treat the injured and ensure, with the aid of qualified damage control personnel, that proper monitoring and decontamination procedures are carried out.

(6) The Senior Medical Officer must ensure the Decontamination Station medical supplies and equipment are readily available. Decontamination station medical supplies are located at:

COMPARTMENT NUMBER	NAME OF SPACE

(7) Life saving measures may be taken immediately, but personnel providing treatment should minimize the possibility of becoming contaminated. If first aid is not immediately indicated, decontamination must be accomplished prior to medical treatment.

(8) Ionizing Radiation Casualties. Treatment and handling of radiation casualties will be in accordance with current instructions.

(9) Care of the Deceased.

(a) Deceased personnel who have been exposed to ionizing radiation must be monitored before transfer from the ship.

(b) Radioactive human remains will have routine decontamination procedures completed.

3. Training of Crew, Stretcher Bearers, Food Handlers, and Assigned Medical Department Personnel. A long-range training schedule for the officers and crew must be prepared by the Medical Department and filed with the Training Officer. From this program, the Training Officer must assign training periods by division and it must be published weekly in the Plan of the Day.

a. A training log must be maintained indicating date, subject matter, number present, division attending, and instructor's name. All training must be recorded in the Medical Department Daily Journal.

b. All Hospital Corpsmen and PACT sailors must have on the job training, completed correspondence courses, and studied the Handbook of the Hospital Corps.

c. Instruction of stretcher bearers must be more intense than for other crew members, and must include familiarization and use of all medical material in the gun bags and BDSs as applicable.

d. Training aids for instruction must be ordered through the Training Officer.

_____

(Signature)

APPENDIX R

SURGICAL INSTRUMENT SET REQUIREMENTS

PLATFORM	MAJ SURG	MIN SURG	TRACH	CHEST	FX / AMP	LAP	CHEST TUBE	ENT	VASC	BURR HOLE
CVN	4	12	4	2	2	4	4	2	2	2
EACH BDS (If disposable consumables are not available)		4	1	1						

MAJOR SURGERY SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515002998736	HOLDER SUTURE NEEDLE HEGAR-MAYO 6” LG SERRATED CARB TUNGSTEN JAW	EA	41.32	1
6515002998737	NEEDLE HOLDER MAYO-HEGAR TUNGSTEN CARBIDE 7INL	EA	32.91	1
6515003204600	FORCEPS BACKHAUS TOWEL 5 1/4INL	EA	7.11	6
6515003333100	FORCEPS DRESSING CUSHING 7" LG STR & SERRATED RD TIP SLENDER MDL	EA	44.66	1
6515003333600	FORCEPS DRESSING 5.50"LG STRAIGHT AND SERRATED JAW ROUND TIP CRS	EA	13.59	2
6515003343800	FORCEPS KELLY ARTERY CURVED 5 1/2INL	EA	30.78	10
6515003344300	ROCH-PEAN HEMOSTAT	EA	8.87	2
6515003344900	FORCEPS HALSTED MOSQUITO CURVED 5INL	EA	9.05	4
6515003345600	HALSTED MOSQUITO FORCEPS 5	EA	7.62	10
6515003346800	FORCEPS KELLY ARTERY STRAIGHT 5 1/2	EA	11.27	4

6515003347400	FORCEPS HEMO ROCHESTER-OSCHNER 1.5-1.75" STR JAW 6.25-6.75" LG	EA	14.36	2
6515003349500	FORCEPS PEAN CURVED 9INL	EA	18.56	2
6515003351900	FORCEPS INTESTINAL DOYEN DESIGN 8.750" O/A LG BOX LOCK JOINT CRS	EA	231.64	4
6515003352800	FORCEPS INTESTINAL BABCOCK DESIGN 6.250" O/A LG STR BOX LOCK CRS	EA	14.19	2
6515003353200	FORCEPS INTESTINAL DOYEN STRAIGHT 8.75-9.25"O/A LG CRS BOX LOCK	EA	229.31	3
6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	23.90	1
6515003377800	FORCEPS ADSON TISSUE1X2 TEETH W/TYING PLATFORM 4 3/4INL	EA	6.78	2
6515003380300	FORCEPS TISSUE ALLIS DSGN 6"LG PIVOTED STRAIGHT & SMOOTH JAW CRS	EA	10.15	2
6515003447800	HANDLE SURGICAL BLADE # 3 GRADUATED	EA	5.89	2
6515003603850	RICHARDSON RETRACTOR SMALL	SE	25.07	2
6515003609200	RETRACTOR SET GENERAL OPERATING DOUBLE END 8.5 & 8.75" BLADES	SE	29.60	1
6515003610350	RETRACTOR GENERAL OPERATING VOLKMAN DESIGN 8.5" SIZE 4 PRONG CRS	EA	41.04	2
6515003640520	SCISSORS MAYO	EA	14.98	1
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLUNT PTS 1.626" CUT LG	EA	14.13	1
6515003657100	SCISSORS TONSIL METZENBAUM CURVED LIGHTWEIGHT 7INL	EA	67.36	1
6515003867600	SUCTION TUBE YANKAUER W/FINGER VALVE CHROME	EA	31.40	1
6515006198219	HOLDER SUTURE NEEDLE WEBSTER 5” LG STR JAW LOCK HDL L TWT MDL CRS	EA	33.94	1
6515006600008	BLADE SURG KNIFE DET NO.15 CARBON STEEL U/W 3 3L 7 9 HANDLE 6S	PG	0.91	2

6515006600010	BLADE SURGICAL #11 STAINLESS STEEL STERILE	PG	6.59	2
6515006600011	BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.65	2
6515011151730	SCISSORS GEN SURGERY METZENBAUM DISSECTING 9" LG CRVD BLADE CRS	EA	43.75	1
6515011398407	RETRACTOR RICHARDSON GRIP HANDLE 3/4X1 IN 9 3/4INL	EA	23.17	1
6530010324089	DRAPE SURGICAL NONWOVEN FABRIC DISPOSABLE 6FEET LG 44IN WIDE 20S	PG	43.56	1
6530007939570	TRAY INSTRUMENT CORROSION-RESISTING STEEL 19.25X12.75X.75 INCHES	EA	31.50	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.35	8
MINOR SURGERY SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515002998736	HOLDER, NEEDLE HAGAR-MAYO 6"	EA	16.04	1
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLIGHTLY CURVED JAW STR HDL CRS	EA	10.77	2
6515003346800	FORCEPS HEMO KELLY 5.50" LG 1" LG STRAIGHT JAW BOX LOCK CRS	EA	8.87	2
6515003377800	FORCEPS TISSUE ADSON 4.50" LG TWEEZER STRAIGHT & SMOOTH JAW CRS	EA	7.60	1
6515003379800	FORCEPS TISSUE 5" LG TWEEZER STRAIGHT AND SMOOTH JAW SQ TIP CRS	EA	2.50	1
6515003417200	HOLDER SUTURE NEEDLE COLLIER 5" LG STRAIGHT JAW BOX LOCK CRS	EA	16.15	1
6515003447800	HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 3 NARROW NOSE	EA	1.98	1
6515011190018	PROBE GEN OPER 5"LG .062" DIA CRS SPATULATE HANDLE BULBOUS TIP	EA	3.55	1

6515003651820	SCISSORS GEN SURG 5.50" LG ONE BLUNT AND ONE SHARP BLADE PT CRS	EA	10.33	1
6515006600010	BLADE SURG KNIFE DET NO.11 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	0.72	2
6515006600011	BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.31	2
6515011190018	PROBE GEN OPER 5” .062” DIA CRS SPATULATE HANDLE BULBOUS TIP	EA	4.90	1
6530015785539	DRAPE SURGICAL GENERAL SURGERY 2 PLY GREEN NONSTERILE REUSABLE 2	PG	32.93	1
TRACHEOTOMY SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515003343800	DILATOR TRACHEAL TROUSSEAU 5.5"LG CURVED SMOOTH STRAIGHT HDL	EA	120.71	1
6515003345600	FORCEPS KELLY ARTERY CURVED 5 1/2INL	EA	30.78	2
6515003345600	FORCEPS HALSTED MOSQUITO CURVED 5INL	EA	9.05	1
6515003377800	FORCEPS ADSON TISSUE 1X2 TEETH W/TYING PLATFORM 4 3/4INL	EA	6.78	2
6515003379800	FORCEPS TISSUE 5" LG TWEEZER STRAIGHT AND SMOOTH JAW SQ TIP CRS	EA	24.17	1
6515003380300	FORCEPS TISSUE ALLIS DSGN 6"LG PIVOTED STRAIGHT & SMOOTH JAW CRS	EA	10.15	1
6515002998736	NEEDLE HOLDER MAYO-HEGAR NARROW JAW TUNGSTEN CARBIDE 6INL	EA	179.94	1
6515003447800	HANDLE SURGICAL BLADE # 3 GRADUATED	EA	5.98	1
6515003618950	RETRACTOR TRACHEAL HUPP DESIGN CRS SHARP BLADE POINT STR HANDLE	EA	23.27	1
6515003618980	RETRACTOR TRACHEAL HUPP CRS SHARP BLADE POINT 3 PRONG QUANTITY	EA	24.97	1

6515003644600	SCISSORS IRIS 4-4.50" O/A LG CRVD BLADE SHARP POINTS FNGR RING	EA	4.06	1
6515003651820	SCISSORS GEN SURG 5.50" LG ONE BLUNT AND ONE SHARP BLADE PT CRS	EA	5.34	1
6515003867600	SUCTION TUBE YANKAUER W/FINGER VALVE CHROME	EA	31.40	1
6515003866800	SUCTION TUBE FRAZIER ANGLED 8FR 4 1/4INL	EA	23.81	4
6515006600010	BLADE SURGICAL #11 STAINLESS STEEL STERILE	PG	0.72	2
6515006600011	BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.65	2
6515011190018	PROBE GEN OPER 5” LG .062 DIA CRS SPATULATE HANDLE BULBOUS TIP	EA	4.90	1
6530007939945	TRAY INSTRUMENT CORROSION RESISTING STEEL 10-1/2 X 8 X 2 INCHES	EA	34.08	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.35	4
CHEST SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515000653181	FORCEPS HEMO MIXTER HALF-CURVED 6.87-7.375"LG 1.625-1.875"JAW	EA	78.73	6
6515003204590	FORCEPS BACKHAUS TOWEL 5 1/4INL CLAMP CRS	EA	8.50	6
6515003208500	BAILEY CONTRACTOR ADULT PRONGED BLADE	EA	7.11	6
6515003277900	ELEVATOR PERIOSTEAL LANGENBECK DESIGN 8.25" LONG BLUNT EDGE CRS	SE	134.28	1
6515003279400	ELEVATOR SET PERIOSTEAL DOYEN CURVED BLUNT EDGE LGE .25" W BLADE	EA	67.98	1
6515003280700	ELEVATOR PERIOSTEAL 7.75" LG CURVED BLADE .625" BLADE WIDTH CRS	EA	39.70	1
6515003311300	FORCEPS BONE CUTTING LISTON-STILLE 10.25" LG CURVED DOUBLE CRS	EA	59.46	1

6515003314800	RONGEUR STILLE CRS DBL-JOINTED CURVED 9"LG CRANIAL BONE FORCEPS	EA	472.39	1
6515003333100	FORCEPS DRESSING CUSHING 7" LG STR & SERRATED RD TIP SLENDER MDL	EA	33.13	2
6515003333700	FORCEPS DRESSING 10" LG STRAIGHT & SERRATED RD TIP HEAVY MDL CRS	EA	13.59	2
6515003341400	FORCEPS GALL DUCT LAHEY DESIGN 7.5"LG CRS BOX LOCK JOINT TYPE	EA	16.82	2
6515003359100	FORCEPS LUNG GRASPING COLLIN DESIGN TRIANGULAR JAW 8" O/A LG CRS	EA	229.31	6
6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	106.43	2
6515003447820	HANDLE SURGICAL BLADE #4	EA	5.68	4
6515003419800	HOLDER SUTURE NEEDLE MASSON 10.5" LG STRAIGHT JAW BOX LOCK CRS	EA	17.10	2
6515003553300	PERIOSTEOTOME ALEXANDER-FARABEUF 8.25" LG CURVED F/RIB SURGERY	EA	17.92	1
6515003617250	RETRACTOR RIB FINOCCHIETO DESIGN CRS FENESTRATED BLADE MEDIUM	EA	42.37	1
6515003640520	SCISSOR MAYO STRAIGHT 6 3/4INL	EA	14.98	2
6515003657100	SCISSORS METZENBAUM CURVED LIGHTWEIGHT 7INL	EA	35.59	2
6515003669200	RIB SHEARS BETHUNE 13.5” LG STEEL SINGLE JOINTED SCREW LOCK TYPE	EA	249.52	1
6515003746900	ELEVATOR PERIOSTEAL MATSON 9X.312” DOUBLE-ENDED BLUNT BLADE	EA	114.06	1
6515006600011	BLADE SURG KNIFE DET NO. 10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	6.59	2
6515010457158	KNIFE STERNUM LEBSCHE DSGN 10” LG PASSIVATED NONGLARE FINISH CRS	PG	47.04	1

6515011535806	SUCTION INSTRUMENT YANKAUER W/O CONTROL VENT W/72”SUCT TUBING 20S	BX	422.31	1
6515012340253	MALLET BONE SURGERY CRS 7.5-11"LG 3.125"HEAD LG 2 POUNDS	EA	22.70	1
6530007940000	TRAY INSTRUMENT CRS16.75X9.25X2.50 INCHES RECTANGULAR	EA	62.44	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.35	2
FRACTURE- AMPUTATION SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515003225550	CURETTE MASTOID SPRATT SIZE 2 SPOON SHAPE BLADE SOLID RIGID CRS	EA	87.30	1
6515003277900	ELEVATOR PERIOSTEAL LANGENBECK DESIGN 8.25” LONG BLUNT EDGE CRS	EA	67.98	1
6515003279400	ELEVATOR SET PERIOSTEAL DOYEN CURVED BLUNT EDGE LGE .25”W BLADE	SE	39.70	
6515003280700	ELEVATOR PERIOSTEAL 7.75” LG CURVED BLADE .625” BLADE WIDTH CRS	EA	59.46	1
6515003311300	FORCEPS BONE CUTTING LISTON-STILLE 10.25” LG CURVED DOUBLE CRS	EA	472.39	1
6515003315400	RONGEUR STILLE-LUER DBL-JOINTED STR 9"LG RD END JAWS BONE SURG	EA	541.85	1
6515003343800	FORCEPS KELLY ARTERY CURVED JAW 5 1/2INL HDL CRS	EA	30.78	8
6515003435800	KNIFE AMPUTATING LISTON DESIGN 10.5"LG CURVED BICONCAVE HANDLE	EA	130.95	1
6515003631100	SAW AMPUTATING SATTERLEE 8"BLADE LG 2.25"WIDTH F/LGE BONE SAWING	EA	61.83	1
6515003632300	CONDUCTOR BONE CUTTING WIRE SAW BAILEY DESIGN STEEL OVERALL	EA	71.43	1
6515003632400	HANDLE GIGLI SAW STRULLY LOOP PR	EA	73.89	1

6515003632700	SAW BONE CUTTING WIRE 20" LONG .040" DIAMETER WITHOUT HANDLE CRS	EA	9.25	1
6515003634100	CUTTER RING COMPLETE	EA	74.77	1
6515011398267	RASP PUTTI DOUBLE ENDED FLAT CURVED UP/SIDEWAYS 10 1/2INL	EA	208.03	1
6515011410809	FILE, BONE 1/2X3-1/2IN BLADE 9IN LG	EA	91.03	1
6530009140238	TRAY INSTRUMENT CRS16.75X9.25X2.50 INCHES RECTANGULAR	EA	48.03	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.35	1
LAPAROTOMY SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515000653181	FORCEPS HEMO MIXTER HALF-CURVED 6.87-7.375"LG 1.625-1.875"JAW	EA	78.73	4
6515002998737	NEEDLE HOLDER HEGAR-MAYO TUNGSTEN CARBIDE 7INL	EA	32.91	2
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	8.50	6
6515003204600	FORCEPS BACKHAUS TOWEL 5 1/4INL	EA	7.11	6
6515003333600	FORCEPS DRESSING 5.50"LG STRAIGHT AND SERRATED JAW ROUND TIP CRS	EA	13.59	2
6515003333700	FORCEPS DRESSING 10" LG STRAIGHT & SERRATED RD TIP HEAVY MDL CRS	EA	11.83	2
6515003341400	FORCEPS GALL DUCT LAHEY DESIGN 7.5"LG CRS BOX LOCK JOINT TYPE	EA	53.57	2
6515003343800	FORCEPS KELLY ARTERY CURVED 5 1/2INL	EA	30.78	12
6515003344100	FORCEPS HEMO MAYO-CARMALT 7.750 MIN 8.250 MAX O/A LG CRS	EA	66.78	2
6515003344300	FORCEPS HEMO ROCHESTER-PEAN CURVED 6 1/2INL	EA	8.87	10
6515003344900	FORCEPS HALSTED MOSQUITO CURVED 5INL	EA	9.05	6
6515003346800	FORCEPS KELLY ARTERY STRAIGHT 5 1/2INL	EA	11.27	12

6515003347500	FORCEPS ROCHESTER-OCHSNER STRAIGHT 7 1/4INL	EA	53.00	6
6515003349500	FORCEPS PEAN CURVED 9INL	EA	18.56	6
6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	23.90	4
6515003377800	FORCEPS ADSON TISSUE 1X2 TEETH W/TYPING PLATFORM 4 3/4INL	EA	6.78	2
6515003379900	FORCEPS TISSUE 5.5" LG TWEEZER STRAIGHT & SMOOTH JAW RD TIP CRS	EA	4.51	2
6515003380300	FORCEPS TISSUE ALLIS DSGN 6"LG PIVOTED STRAIGHT & SMOOTH JAW CRS	EA	10.15	4
6515003419800	HOLDER SUTURE NEEDLE MASSON 10.5" LG STRAIGHT JAW BOX LOCK CRS	EA	150.02	1
6515003447800	HANDLE SURGICAL BLADE # 3 GRADUATED	EA	5.89	2
6515003447820	HANDLE SURGICAL BLADE #4	EA	5.68	1
6515003447880	HANDLE SURGICAL BLADE SIZE# 7	EA	7.61	1
6515003585500	RACK SUTURE NEEDLE 5X1X0.4222" C/O BASE TRACT & COIL WIRE SPRING	EA	18.25	1
6515003603490	RETRACTOR DEAVER STANDARD HANDLE 1IN 12INL	EA	131.54	1
6515003603510	DEAVER RETRACTOR MEDIUM	EA	35.13	1
6515003603530	RETRACTOR DEAVER STANDARD HANDLE 2IN 12INL	EA	35.01	1
6515003603850	RETRACTOR RICHARDSON-EASTMAN SET OF 2	SE	25.07	2
6515003609200	RETRACTOR SET GENERAL OPERATING DOUBLE END 8.5 & 8.75" BLADES	SE	29.60	2
6515003610350	RETRACTOR GENERAL OPERATING VOLKMAN DESIGN 8.5" SIZE 4 PRONG CRS	EA	41.04	2
6515003614850	RETRACTOR PERINEAL GELPI CRS HOOK UNIT TYPE 6.5" SELF RETAINING	EA	42.37	2
6515003620200	RETRACTOR VEIN CUSHING DESIGN 8.5" CORROSION RESISTING STEEL	EA	69.84	2

6515003640500	SCISSORS GEN SURG MAYO DSGN 5.25-5.75" LG CURVED BLADE BLUNT PTS	EA	6.29	2
6515003640920	SCISSORS MAYO STRAIGHT 6 3/4INL	EA	14.43	2
6515003651820	SCISSORS GEN SURG 5.50" LG ONE BLUNT AND ONE SHARP BLADE PT CRS	EA	5.34	1
6515003656200	SCISSORS STEVENS TENOTOMY CURVED RIBBON HANDLE HEAVY 3 3/4INL	EA	35.59	1
6515003657100	SCISSORS METZENBAUM CURVED LIGHTWEIGHT 7INL	EA	67.36	1
6515006903208	FORCEPS DEBAKEY TISSUE TAPERED 2MMW TO 1.5MMW 7 3/4INL	EA	34.91	2
6515006903223	SCISSOR POTTS-SMITH 60DEG 7 1/2INL	EA	106.21	2
6515009269193	RETRACTOR MASTOID WEITLANER 6.5" HOOK UNIT TYPE 3 VS 4 PRONGS	EA	47.30	2
6515010489066	FORCEPS HEMOSTATIC STORZ DSGN R ANG JAW 8.75" LG 52MM JAW LG CRS	EA	79.86	2
6515010895668	SCISSORS GEN SURG METZENBAUM DELICATE DISSECTING 11" LG CRVD CRS	EA	81.15	1
6515011398195	RETRACTOR ABDOMINAL KELLY 3X3.50 INCH SERR TONGUE PASSIVATED CRS	EA	99.44	2
6515011398196	RETRACTOR HARRINGTON 7IN BLADE 2 1/2IN BLADE WIDTH 12 1/2INL	EA	104.65	1
6515011398197	RETRACTOR VAGOTOMY WEINBERG 6.375X4" BLADE ONE SIZE HOLLOWED CRS	EA	58.18	1
6515011398407	RETRACTOR RICHARDSON GRIP HANDLE 3/4X1IN 9 3/4INL LG BLADE 1X0.75" CRS	EA	23.17	2
6515011398969	RETRACTOR BALFOUR COMPLETE SLIDE FENESTRATED 2 ½ AND 3 1/2IN LATERAL 10 3/4IN SPREAD 3 1/4IN W BLADE CRS	EA	605.43	2
6515011470203	TIP SUCTION YANKAUER WITHOUT CONTROL VENT FLEXIBLE STRAIGHT TIP 6F TUBING STERILE	PG	75.60	1
6515012080578	RETRACTOR RIBBON MALLEABLE 1INW 13INL	EA	27.85	1

6530007940300	TRAY, SURG INSTRUMENT 20-5/8 X 12-5/8 X 4 IN CORROSION RESISTING STEEL	EA	62.44	2
6530013137781	SURGICAL PACK DISPOSABLE STERILE LAPAROTOMY TYPE 10S	PG	142.95	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	4
CHEST TUBE SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	8.50	4
6515003343800	FORCEPS KELLY ARTERY CURVED 5 1/2INL	EA	30.78	3
6515003344100	FORCEPS HEMO MAYO-CARMALT 7.750 MIN 8.250 MAX O/A LG CRS	EA	66.78	2
6515003349500	FORCEPS PEAN CURVED 9INL	EA	18.56	2
6515003377800	FORCEPS ADSON TISSUE 1X2 TEETH W/TYING PLATFORM 4 3/4INL	EA	6.78	1
6515003419200	NEEDLE HOLDER HEGAR-MAYO JAW TUNGSTEN CARBIDE 6INL	EA	179.94	1
6515003447800	HANDLE SURGICAL BLADE # 3 GRADUATED	EA	1.98	1
6515003640520	SCISSORS MAYO CURVED BLADE 6 3/4INL	EA	14.98	1
6515003640920	SCISSORS MAYO STRAIGHT BLADE 6 3/4INL	EA	14.43	1
6515006600008	BLADE SURG KNIFE DET NO.15 CARBON STEEL U/W 3 3L 7 9 HANDLE 6S	PG	0.91	1
6515006600011	BLADE SURG KNIFE DET NO. 10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.65	1
6530007939945	TRAY INSTRUMENT CORROSION RESISTING STEEL 10-1/2 X 8 X 2 INCHES	EA	34.08	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.35	4
ENT SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515003417200	HOLDER COLLIER 5INL	EA	44.94	2

6515003478400	MIRROR LARYNGEAL CRS PLAIN GLASS .437” DIAMETER TYPE II SIZE 00	EA	17.30	1
6515003478500	MIRROR LARYNGEAL SIZE 1 TYPE II .625”DIA 8.5”HDL PLAIN GLASS	EA	18.23	1
6515003478600	MIRROR LARYNGEAL .75”DIA 8.5”HDL TYPE II SIZE 3 PLAIN GLASS	EA	17.91	1
6515003478700	MIRROR LARYNGEAL .938”DIA 8.5”HDL TYPE II SIZE 5 PLAIN GLASS	EA	17.92	1
6515003866800	SUCTION TUBE FRAZIER ANGLED 8FR 4 1/4INL	EA	23.81	2
6515011150416	FORCEPS BONE HOLDING CRVD DINGMAN 7.50" LG SERRATED JAW TYPE CRS	EA	209.70	2
6515011428219	DRILL TWIST BONE JACOBS 5” LG 0.094” DIA TWIST DRILL PT CRS 6S	PG	293.32	1
6515014532159	PROBE LACHRYMAL WILLIAMS SZ 1&2 SS DBL ENDED STR	EA	51.85	1
6515014532175	PROBE LACRIMAL WILLIAMS SILVER CYLINDRICAL SIZE 3-4	EA	51.85	1
6515014532752	WILLIAMS LACHRYMAL PROBE SIZE 5 AND 6	EA	51.85	1
6515012132679	RONGEUR LOVE-LERRISON STAINLESS STEEL OVERALL JAW SZ 3/16 IN	EA	956.97	1
6520005196600	CURETTE ALVEOLAR MOLT CRES BLADE SZ 2 6.25-6.75" LG	EA	51.81	2
6520005196700	CURETTE ALVEOLAR MOLT CRES BLADE 2.125"L SZ 4 6.25 - 6.75"L	EA	59.16	2
6520005196740	CURETTE ALVEOLAR MOLT CRES BLADE 2.312"L BLADE SZ 5L	EA	59.16	1
6520005196770	CURETTE ALVEOLAR MOLT CRES BLADE 2.125"L BLADE SZ 6R	EA	35.48	1
6520005242550	ELEVATOR, ROOT #34S	EA	52.97	2
6520005243050	ELEVATOR, ROOT #301	EA	29.52	2
6520005244550	ELEVATOR, ROOT MILLER NO 73 CRS BLADE 6.125INCHES LONG	EA	47.62	2
6520005245050	ELEVATOR, ROOT #74 MILLER	EA	59.41	2
6520005323990	FORCEPS TOOTH EXTRACTING #150 UPPER ANTERIORS BICUSPIDS & ROOTS	EA	79.072	1

6520005324990	FORCEPS, TOOTH EXTRACT #151 LOWER ANTERIORS BICUSPIDS & ROOTS	EA	69.42	1
6520005419350	HANDLE, MOUTH EXAMINING MIRROR CRES O/A FINISH 4.5-4.75”LG	EA	9.89	2
6520005551150	SCISSORS, ORAL SURGICAL DEAN CRES 6.5-7.0”LG FINGER RING GRIP	EA	52.29	1
6520005842699	ELEVATOR, PERIOSTEAL MOLT #9 CURVED BLADE DBL ENDED 7.25” LENGTH	EA	37.28	1
6520011378453	RETRACT, ORAL OBWEGESER 12 BY 60 MM CURVED UPWARDS	EA	90.04	1
6520011378455	RETRACT, ORAL OBWEGESER CURVED DOWNWARDS NO 167 70X14MM CRES	EA	56.76	1
6520012109532	AWL, ORAL SURG MAX #161 F/PER-ALVEOLAR & PER NASAL WIRING	EA	143.15	1
6520012109533	AWL, ORAL SURGERY MANDIBULAR AWL NO 160 SLIGHTLY CURVED	EA	156.47	1
6520015015479	MIRROR MOUTH EXAMINING CRS FRONT REFLECTIVE SURFACE SIZE 5 12S	PG	45.59	1
6530009140238	TRAY INSTRUMENT CRS16.75X9.25X2.50 INCHES RECTANGULAR	EA	48.03	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.35	2
VASCULAR SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515000653181	FORCEPS HEMO MIXTER HALF-CURVED 6.87-7.375"LG 1.625-1.875"JAW	EA	78.73	6
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	8.50	2
6515003344900	FORCEPS HALSTED MOSQUITO CURVED 5INL	EA	9.05	8
6515003347500	FORCEPS ROCHESTER-OCHSNER STRAIGHT 7 1/4INL	EA	53.00	6

6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	23.90	2
6515003447800	HANDLE SURGICAL BLADE #3 GRADUATED	EA	5.89	1
6515006903198	HOLDER SUTURE NEEDLE DEBAKEY 7" LG SERRATED TUNGSTEN CARB JAWS	EA	75.79	2
6515006903200	NEEDLE HOLDER CARDIOVASCULAR TUNGSTEN CARBIDE 9 1/4INL	EA	123.82	2
6515006903208	FORCEPS DEBAKEY TISSUE TAPERED 2MMW TO 1.5MMW 7 3/4INL	EA	34.91	2
6515006903209	FORCEPS DEBAKEY TISSUE TAPERED 2MMW TO 1.5MMW 9 1/2INL	EA	47.69	2
6515006903212	CLAMP ARTERY DEBAKEY-BAHNSON CURVED & SERRATED 65MM JAW 10" O/A LG	EA	159.08	2
6515006903215	CLAMP ARTERY GLOVER 9CM LG SERRATED STRAIGHT 40MM JAW LG BULLDOG	EA	222.92	3
6515006903216	BULLDOG GLOVER CURVED 4CML JAW	EA	89.67	3
6515006903223	SCISSOR POTTS-SMITH 60DEG 7 1/2INL	EA	106.21	2
6515008901682	CLAMP ARTERY GLOVER 6.5CM LG CURVED SERRATED 27MM GLOVER CVD SER	EA	92.80	2
6515008901683	FORCEPS SATINSKY VENA CAVA ATRAUMATIC JAWS 2IN JAW LENGTH 10 3/8	EA	185.96	2
6530009140238	TRAY INSTRUMENT CRS16.75X9.25X2.50 INCHES RECTANGULAR	EA	48.03	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.35	2
BURR HOLE SET				
NSN	NOMENCLATURE	UI	UPRICE	QTY
6515002998737	NEEDLE HOLDER MAYO-HEGAR TUNGSTEN CARBIDE 7INL	EA	32.91	1
6515003124125	BRACE HUDSON BUR CRANIAL HUDSON 14MM	EA	148.51	1
6515003345600	FORCEPS HALSTED MOSQUITO STRAIGHT 5INL JAW CRS BOX LOCK	EA	7.62	10
6515003447800	HANDLE SURGICAL BLADE # 3 GRADUATED	EA	1.65	1

6515005152113	BRACE BIT BONE HUDSON 9.75" LG SNAP-LOCK PASSIVATED	EA	883.28	1
6515005152114	HUDSON BURS 9MM DIAMETER	EA	69.28	1
6515005152115	BUR CRANIAL HUDSON 16MM DIA 3.812"LG BALL HEAD 8 FLUTE CRS	EA	143.65	1
6515005152116	BRACE HUDSON CUSHING PERFORATING DRILL 3/8 IN CUTTER DIAMETER	EA	129.63	1
6515006600011	BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.65	2

SURGICAL ATTIRE PACK			
NSN	NOMENCLATURE	UI	QTY
6532002998613	CAP, OPERATING, SURGICAL, LARGE	EA	3*
6532002999630	TROUSERS, OPERATING, SURGICAL, MEN'S MEDIUM	EA	3*
6532002999634	SHIRT, OPERATING, SURGICAL, MEN'S MEDIUM	EA	3*
STERILE LINEN PACK			
NSN	NOMENCLATURE	UI	QTY
6530002994905	WRAPPER, STERILIZATION, GREEN, 24"	EA	1
6532000836535	GOWN, OPERATING, SURG., GREEN, LARGE	EA	3*
7210002999610	TOWEL, HAND, GREEN	EA	3
STERILE SHEET PACK			
NSN	NOMENCLATURE	UI	QTY
6530009264905	WRAPPER, STERILIZATION, GREEN, 24"	EA	1
7210000811417	SHEET, BED, COTTON-POLYESTER WHITE	EA	2

APPENDIX S

RECOMMENDED LOCATIONS FOR FIRST AID BOXES AND LITTERS

1. The following locations are recommended for placement of First-Aid Boxes and Reeves Sleeve Litters. Each ship may modify this listing to reflect the actual locations in their ship and include those locations in the ship's Battle Bill.

a. First Aid Boxes:

QTY	COMPARTMENT	NAME	FRAME	PORT /STBD
1	010-167-1-C	ECM EQUIPMENT RM		
1	01-0-1-Q	CAPSTAN MACH RM	0-1	STBD
1	01-13-0-Q	WINDLASS RM	13-27	CL
1	01-133-2-Q	ELECTRICAL SVC SHOP	133-138	PORT
1	01-175-2-Q	AIR FILTER CLEANING	175-180	PORT
1	01-230-4-Q	IC SHOP NO 3	230-235	STBD
1	02-118-5-Q	AVION SHOP NO 11		
1	02-121-1-L	AVION WORK SPACE		
1	02-92-1-Q	AIR FILTER CLEANING		
1	02-K-0-Q	FORECASTLE		
1	03-148-2-Q	FLAG GALLEY		
1	03-160-3-Q	CO GALLEY		
1	03-170-0-Q	CARRIER ATC CTR		
1	03-190-0-Q	ARRESTING GEAR		
1	03-195-0-Q	ARRESTING GEAR		
1	03-195-3-Q	AVIATION ARRESTING		
1	03-199-1-Q	AUTO STANCHION		
1	03-200-4-Q	AUTO STANCHION		
1	03-210-0-Q	ARRESTING GEAR		
1	03-84-0-Q	ELECTRIC SV EQUIPMENT		
1	03-84-13-Q	AVIATION LAUNCH		
1	07-160-3-Q	FLAG PLOT	160-165	STBD
1	07-167-3-Q	RADAR RM NO 3	167-170	STBD
1	08-175-1-Q	RADAR RM NO 4	175-180	STBD
1	1-127-0-Q	HANGAR BAY NO 2	127-180	CL
1	1-179-0-Q	HANGAR BAY NO 3	179-235	CL
1	1-230-1-Q	SUN WORK CENTER	230-237	STBD
1	1-235-01-Q	AVN JET ENGINE SHOP	235-255	CL
1	1-54-8-Q	PIPE SHOP	54-64	PORT
1	1-58-2-Q	AVN ORD	54-64	PORT
1	1-64-0-Q	HANGAR BAY NO 1	64-127	CL

1	2-165--0-Q	CREW GALLEY	165-175	CL
1	2-172-0-Q	BAKERY	172-180	CL
1	2-175--2-Q	LOAD CTR SWBD RM NO 8	175-180	PORT
1	2-180-5Q	CAPSTAN MACH RM NO 2	180-185	STBD
1	2-190-1-Q	WR GALLEY NO 2	190-198	STBD
1	2-247-2-E	STEERING GEAR RAM NO 2	247-255	STBD
1	2-257-1-Q	CAPSTAN MACH RM	257-259	STBD
1	2-257-2-Q	CAPSTAN MACH RM	257-259	PORT
1	2-84-0-Q	CREW GALLEY	84-96	CL
1	3-101-2-Q	REACTOR INSTR & MAINT	101-107	PORT
1	3-133-0-Q	LS WPN ELEV NO 5	133-138	CL
1	3-133-1-Q	ACFT ELEV MACH RM NO 2	133-180	STBD
1	3-138--0-Q	LS WPN ELEV NO 6	138-143	CL
1	3-138-1-Q	AMIDS WPN ELEV HYD PUMP	138-141	CL
1	3-165-1-Q	METALSMITH MACH SHOP	165-180	CL
1	3-198-1-Q	ACFT ELEV MACH RM NO 3	200-225	STBD
1	3-200-0-Q	ACFT ELEV MACH RM NO 4	210-215	CL
1	3-210-0-Q	CPO GALLEY	210-215	CL
1	3-235-0-Q	LAUNDRY	235-245	CL
1	3-235-4-Q	DRY CLEANING	235-245	PORT
1	3-247-1-E	STEERING RM PWR RM NOl	247-255	STBD
1	3-247-2-E	STEERING RM PWR RM NO2	247-255	PORT
1	3-94-2-Q	MARINE PRESS SHOP	94-96	PORT
1	3-96-5-Q	AFT ELEVA MACH RM NO 1	96-123	STBD
1	4-1 80--2-O	PRINT SHOP	180-190	PORT
1	4-113--0-Q	FWD IC GYRO	113-118	STBD
1	4-113--3-E	REACTOR FILL PUMP RM	113-118	STBD
1	4-119--2-E	SWBD RM NO 1	119-128	PORT
1	4-128-0-M	UNIV ORD MAG	128-138	CL
1	4-138-0-M	UNIV ORD MAG	138-148	CL
1	4-148-0-E	REACTOR RM NO 2	148-150	CL
1	4-165-2-E	REACTOR FILL PUMP RM	165-170	PORT
1	4-171 -1-E	SWBD RM N0 2	171-180	STBD
1	4-171--0-Q	AFT TC GYRO RM	171-180	CL
1	4-174-2-Q	REACTOR PLANT PERS DECON	173-180	PORT
1	4-235--0-Q	LAUNDRY	235-245	CL
1	4-247-1-E	STEERING GEAR RAM NO 1	247-255	PORT
1	4-64-0-M	UNIV ORD MAG	54-74	CL
1	4-74-0-M	UNIV ORD MAG	74-84	CL
1	4-84-0-M	UNIV ORD MAG	84-96	CL
1	4-I 65-1-Q	DECONTAMINATION LAUNDRY		

1	5-128-0-M	UNIV WPNS MAG	138-148	CL.
1	5-54-0-M	UNIV WPNS MAG	55-63	CL
1	5-84-0-M	UNIV WPNS MAG READY SVC	84-98	CL
1	6-54-0-M	UNIV WPNS MAG	54-64	CL
1	6-84-0-M	UNIV WPNS MAG	84-96	CL
1	7-113-0-E	MAIN MACH RM NO 1	113-128	CL
1	7-128-0-M	UNIV WPNS MAG	128-138	CL
1	7-148-1-E	COOLANT TURB GEN RM NO 2	148-165	STBD
1	7-148-4-E	REACTOR AUX RM NO 2	148-165	PORT
1	7-165-0-E	MAIN MACH RM NO 2	165-180	CL
1	7-190-0-E	PUMP RM	192-200	CL
1	7-25-0-E	AIR CONDITIONING MACH RM		
1	7-44-0-E	PUMP ROOM NO 1	44-62	CL
1	7-64-0-E	PUMP ROOM NO 2	64-74	CL
1	7-74-0-M	UNIV WPNS MAG	74-84	CL
1	7-84-0-M	UNIV WPNS ASSY AREA	84-96	CL
1	7-96-1-E	COOLANT TUR GEN NO 1	96-113	STBD
1	7-96-4-E	REACTOR AUX RM NO 1	96-113	PORT

b. Reeves Sleeve Litters:

QTY	COMPARTMENT	NAME
1	03-10-2-Q	REPAIR 7F
1	03-175-13-Q	REPAIR 7B
2	03-18-2-L	FWD AUX BDS
1	03-220-9-Q	REPAIR 7A
2	03-225-4-L	AFT AUX BDS
2	04-165-3-L	FLIGHT DECK BDS
1	1-143-2-L	REPAIR 1B
1	1-225-5-L	REPAIR 1A
1	1-69-2-L	REPAIR 1F
2	2-109-1-L	MAIN BDS
1	2-160-2-Q	REPAIR 5
2	2-213-1-L	AFT BDS
1	2-220-2-L	REPAIR 3
1	2-34-2-L	REPAIR 2
2	2-89-1-L	FWD BDS
1	2-99-2-Q	REPAIR 4
2	2-109-1-L	MRT BAGS
1		DENTAL

APPENDIX T

PRE-DEPLOYMENT/DYNAMIC FORCE EMPLOYMENT CHECKLIST

PRE-DEPLOYMENT CHECKLIST	
SIX MONTHS PRIOR TO SCHEDULED DEPLOYMENT	**COMPLETED**
Check levels of supplies and equipment and initiate procurement action to bring levels to AMAL or Usage Rate, whichever is greater. Specific requirements for the area of deployment should be identified & requisitioned.	**[ ]**
Formulate plans for accelerated in-service training programs with specific emphasis upon needs for deployment such as Pharmacy, Laboratory, Operating Room, X-ray and Preventive Medicine, Ward Procedures, Intensive Care, etc. Specifically designate instructor subject areas & accumulate updated lesson plans, training films and tests.	**[ ]**
Formulate a training program in first aid emergency procedures for crew.	**[ ]**
Request quotas, as required, for the following schools: 1) Shipboard Water Sanitation (Medical & Engineering) 2) Food Sanitation, Basic and Refresher (Supply) 3) Food Sanitation, Supervisor level (Medical & Supply) 4) Shipboard Pest Control Training/Certification (Medical & Supply) 5) Understanding and Controlling Sound and Noise (Medical) 6) Audiometric Certification	 **[ ]** **[ ]** **[ ]** **[ ]** **[ ]** **[ ]**
Ensure all pest control operations are certified.	**[ ]**
FIVE MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Commence accelerated in-service training programs for medical personnel.	**[ ]**
Commence accelerated first aid training for ship's crew; ensure that squadrons are doing the same for their personnel.	**[ ]**
FOUR MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Systematically review assignments and responsibilities to ensure each individual is specifically trained to perform each functio the published JQR.	**[ ]**
Ascertain name and qualifications of squadron medical personnel deploying and establish means of direct communications.	**[ ]**
Monitor supplies ordered and received. All immunization materials, bulk and staple items should be on board and stored.	**[ ]**

Follow-up on all outstanding requisitions and upgrade the priority as necessary.	
Obtain a roster of all Strike Group medical personnel and conduct initial meeting for planning deployment	**[ ]**
THREE MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Order spectacles and gas mask inserts as required for crew. Each crewmember wearing glasses must have two pairs of glasses and one pair of gas mask inserts prior to deployment. Ideally, shipboard optical supplies should be reserved for use during extended deployments or emergencies.	**[ ]**
Query P-MART to obtain an inventory of chronic medication requirements. Begin arrangements for obtaining deployment medications from TMOP or local MTF.	**[ ]**
Conduct a TMIP validation of all onboard AMAL allowance percentages to include shelf life expiration. Document all findings in the Medical Department Daily Journal and submit report to TYCOM for review. Re-order as necessary, and make appropriate changes to the same, as re-supply is accomplished.	**[ ]**
Review IMR status of CVN and CVW, and develop a plan to reach 95 percent (the sum of Fully Ready and Partial Ready) prior to deployment.	**[ ]**
Review and monitor the food handlers training program as required by OPNAVINST 4061.4.	**[ ]**
Conduct survey on all anesthesia and intensive care equipment and ensure that required calibrations will not expire during the upcoming deployment.	**[ ]**
Supporting Anesthesia provider to inventory and review anesthesia equipment and supplies.	**[ ]**
Contact the Force EHO to obtain medical intelligence, to verify current vaccination and review force health protection requirements for anticipated AORs and ports of call.	**[ ]**
The bio-medical repair technician must conduct function checks, document findings, and perform required repair service or PMS on all medical equipment. Ensure all necessary replacement parts and test equipment are on board, and calibrations are accurate.	**[ ]**
Maintain effective liaison with Medical Departments of prospective CSG elements.	**[ ]**
TWO MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Monitor supplies ordered and received. All bulk and staple items should be on board and stored. Follow-up on non-receipted supplies and update priorities as necessary.	**[ ]**
Remind ship's personnel through POD and/or e-mail announcements to order their prescribed medications through the mail order pharmacy.	**[ ]**
Contact a Navy Environmental and Preventive Medicine Unit for pre-deployment brief.	**[ ]**
ONE MONTH PRIOR TO DEPLOYMENT	**COMPLETED**

Ensure current Ship's Sanitation Control Exemption Certificate or Control Certificate as specified by International Health Regulations is onboard.	**[ ]**
Procure, on emergency basis, items and services required to put all medical equipment in reliable operational condition.	**[ ]**

APPENDIX U

POST EXPOSURE PROPHYLAXIS PROTOCOL

1. Algorithm. Review and follow steps (a) through (f).

a. Immediate Exposure Site Action. Flush/clean the blood borne pathogen contact area using soap and water (for wounds or skin sites), water (for the nose, mouth, mucous membranes, or skin), or water and saline (for the eyes) for at least FIVE minutes.

b. Known Source HIV Testing. Determine, if possible, if the known source is HIV positive or negative to guide the post-exposure prophylaxis (PEP) initiation decision. The HIV testing method must produce rapid results yet not delay PEP initiation if warranted; the Ora-Quick Rapid HIV Test (with test stand and positive/negative controls) is cu11·ently the fleet selected method . Units without testing capability will medevac the exposed individual to a site with testing capability. If the source patient is unknown, immediately obtain expert consultation (refer to section 1d below) to determine the optimal course of action.

(1) Known Source is HIV Negative. HIV PEP is not recommended. However, if acute seroconverting illness or the conversion window period is suspected, prescribe a HIV PEP regimen containing 3 (or more) antiretroviral medications (refer to section 4c below for regimens) AND immediately obtain expert consultation (refer to section 4d below) to determine the optimal course of action. The exposed patient must begin the PEP regimen as soon as possible (within hours) after exposure and continue the regimen for 4 weeks.

(2) Known Source is HIV Positive. Prescribe a HIV PEP regimen containing 3 (or more) antiretroviral medications (refer to section 4c below for regimens). The exposed patient must begin the PEP regimen as soon as possible (within hours) after exposure and continue the regimen for 4 weeks. Obtain expert consultation (refer to section 1d below).

c. HIV PEP Medication Regimens

(1) Preferred combination. raltegravir (Isentress) 400mg 1tablet by mouth twice daily AND emtricitabine 200mg/tenofovir 300mg disoproxil fumarate (Truvada) 1 tablet by mouth once daily. These medications are currently included on authorized medical allowance lists.

(2) Alterative combination. dolutegravir (Tivicay) 50mg 1 tablet by mouth once daily AND emtricitabine 200mg/tenofovir 300mg disoproxil fumarate (Truvada) 1 tablet by mouth once daily.

(3) If the exposed individual delays exposure reporting more than 72 hours, is pregnant, has serious co-morbid disease (including chronic HBV, chronic kidney injury with eGFR less

than 60, and drug interactions), and/or has known toxicity to PEP medications, immediately obtain expert consultation (refer to section 1d below) to dete1mine the optimal course of action.

d. Numbered Fleet Surgeon and Expert Consultations

(1) Communicate the event utilizing the respective OPORD Annex Q including contacting the appropriate numbered fleet surgeon if HIV PEP is indicated due to the medical evacuation requirement.

(2) Obtain expert Infectious Disease consultation if HIV PEP is indicated, HIV PEP indication is uncertain, or confounding variables exist. Recommended contacts are:

(a) Navy Blood borne Infection Management Center (NBIMC) Infectious Disease Specialist at (301) 295-5246 (Monday through Friday 0800-1600 ET only).

(b) Walter Reed National Military Medical Center Infectious Disease Specialist at Pager (866) 296-4913 PIN# 250-0329 (available 24/7).

e. Medical Evacuation for Follow Up. If HIV PEP is prescribed, initiate urgent medical evacuation of the exposed individual to a DoD shore MTF for time sensitive evaluation, counseling, and additional testing. Specialty care should begin within 72 hours of source exposure whenever possible. Provide patient with adequate medication for a minimum of 5 days of travel. Plan for long term follow up including testing and drug toxicity monitoring.

f. Patient Safety/Risk Management Report. Initiate a report and route it to the respective TYCOM Force Surgeon to review processes, which may require support to prevent additional exposures.

APPENDIX V

SAMPLE PATIENT SATISFACTION SURVEY

USS EVERSAIL (CVN XX) PATIENT SATISFACTION SURVEY

Name (Optional): _____ Date: _____

Rank: _____ Age: _____ Gender (circle one): M F

What was the reason for your visit (circle one)? BMR Physicals Sick Call Pharmacy
Av Med X-Ray Lab PMT PT Mental Health Rad Health Med Records

Other (please specify) _____

What provider(s)/technician(s) did you see? _____

How would you rate today's medical visit?

Completely Satisfied	Somewhat Satisfied	Undecided	Somewhat Dissatisfied	Completely Dissatisfied
☐	☐	☐	☐	☐

Was there anything we could have done better?_____
_____

Other comments, good or bad: _____
_____

Would you like to be contacted by the Patient Representative? Yes No. If yes, include name at the top.

APPENDIX W

INPATIENT RECORD REVIEW FORM

USS AIRCRAFT CARRIER (CVN XX) INPATIENT RECORD REVIEW	
Record Identifier	
All forms must be legible, fully completed, dated, timed, and signed with stamped/printed name.	
	Y = YES N= NO NA = NOT APPLICABLE
Patient Information (full name, date of birth and patient identifier) on All Documents	
Privacy Act Present & Signed	
SF 502 – Narrative Summary *	_____/(uploaded into OutPt Record)_____
SF 539 Abbreviated Medical Record Or SF 504 History - Part 1 SF 505 History- Parts 2 and 3 SF 506 Physical examination	
SF 508 Doctors Order	
SF 509 Progress Notes	
Shift Nursing flowsheet completion/SF 510 Nursing Notes	
NAVMED 6550/8 Medication Administration Record	
12 Hour/24 Hour Chart Checks completed (as applicable)	
NAVMED 6550/12 Patient Profile	
SF 508 verified by RN w/date and time noted	
Corpsman documentation co-signed by RN	
Discharge orders and patient education noted	
OPERATIVE PROCEDURE	_____ N/A ___ YES
OF 522 Request for Administration of Procedures	
Universal Protocol Checklist for Operative Procedures	
NAVMED 6320/16 Recovery Room Record	
OF 517 Anesthesia Medical Record	
SF 516 Operative Record*	_____/(uploaded into Out Pt Record)_____
* Upload SF 502 AND SF 516, as applicable Record Review Summary Comments: Reviewer: _____ Name/Signature/Date: _____ Senior Medical Officer: _____ Name/Signature/Date: _____	

❑ Documentation is Appropriate **If Checked, Return Form to QAC**	❑ Documentation Needs Improvement **If Checked, Review with Appropriate Individual**

APPENDIX X

PROVIDER RECORD REVIEW FORMS

USS AIRCRAFT CARRIER (CVN XX) OUTPATIENT RECORD REVIEW					
PROVIDER: PERIOD COVERED:					
Record Identifiers					
	Y = YES **N** = NO **NA** = NOT APPLICABLE				
The Following are Documented:					
Date & Time of Entry					
Provider's Printed Name, Rank & Corps					
Provider's Signature					
Chief Complaint or Purpose of Visit					
Objective Findings					
Diagnosis or Medical Impression					
Studies Ordered & Results, i.e., labs, x-rays					
Therapies Administered					
Disposition					
Patient Education & Instructions					
All Entries are Legible					
The Following are Appropriately Addressed:					
Vital Signs					
History & Physical					
Diagnostic Modalities					
Diagnosis & Therapy					
Consultations					
Record Review Summary Comments: Reviewer: _____ Name/Signature/Date: _____					
❑ Treatment Appropriately Documented and Legible ❑ Treatment Consistent with Standard of Care **If Above Boxes Checked, Return to QAC**			❑ Documentation Incomplete or Illegible ❑ Treatment Deviates from Established Practice **If Above Boxes Checked, Submit to SMO for Review**		

Senior Medical Officer Review	
❑ No Action Needed → Return Form to QAC	❑ Action Needed → Review with Provider
Comments:	
SMO _____ Name/Signature/Date: _____	
Provider _____ Name/Signature/Date: _____	

USS AIRCRAFT CARRIER (CVN XX) CLINICAL PSYCHOLOGIST RECORD REVIEW						
PROVIDER: PERIOD COVERED:						
Record Identifier						
Y = YES **N** = NO **N/A** = NOT APPLICABLE						
INITIAL REPORT						
Sufficient Identifying Data						
Inclusion of the Following: Referral Question						
History						
Mental Status						
Diagnosis						
Treatment Plan						
Adequate History to Include Drug & Alcohol Use						
Mental Status Includes Suicide & Homicide Status						
If Suicidal, Assessment Includes Past Attempts & Determination of Current Risk						
Sufficient Documentation to Support Diagnosis						
History Consistent with Diagnosis						
Treatment Plan Consistent with Diagnosis						
Treatment Plan Meets Standard of Care						
Referral Question Appropriately Answered						
Safety Issues Adequately Addressed (Harm to Self or Others, Domestic Abuse)						
Physical Pain Assessment Documented						
PROGRESS NOTES						
Significant Events are Documented						
Changes in Symptoms are Documented						

Changes in Diagnosis are Consistent with Documentation					
Mental Status & Diagnosis are Documented or Statement of No Change					
Treatment Plan Meets Standard of Care					
TERMINATION NOTE					
Course of Treatment is Adequately Documented					
Initial & Termination Diagnosis are Stated					
Termination of Case was Appropriate					
Trainee Involvement Appropriately Documented					

Record Review Summary
Comments:

Reviewer: _____ Name/Signature/Date: _____

❑ Treatment Appropriately Documented and Legible ❑ Treatment Consistent with Standard of Care **If Above Boxes Checked, Return to QAC**	❑ Documentation Incomplete or Illegible ❑ Treatment Deviates from Established Practice **If Above Boxes Checked, Submit to SMO for Review**

Senior Medical Officer Review

❑ No Action Needed → Return Form to QAC	❑ Action Needed → Review with Provider

Comments:

SMO _____ Name/Signature/Date: _____

Provider _____ Name/Signature/Date: _____

USS AIRCRAFT CARRIER (CVN) XX PHYSICAL THERAPIST RECORD REVIEW						
PROVIDER: PERIOD COVERED:						
Record Identifier						
Y = YES **N** = NO N/A = NOT APPLICABLE						
Date & Time of Entry						
Subjective Information (Including Age & Gender)						
DOI/DOS or Onset of Symptoms						
Chief Complaint or Purpose of Visit						
What Aggravates or Eases Symptoms						
Patient's Goals/Functional Limitations						

Tests & Measures Performed						
Assessment Appropriate to History & Objective Exam						
Plan Appropriate to Assessment/Goals? -Interventions including but not limited to these core privileges (refer patients to other providers, authorize light duty- 30 days, SIQ-24 hours, apply manual therapy including to spinal joints, etc.)						
Goals in Measurable Terms with Time Frame						
At Least 1 Goal Written in Functional Terms						
Plan for Follow-up or Discharge Written						
Pain Level Noted on Each Note						
Patient Education Noted						
All Entries Legible						
Provider Signature & Stamp Present						

Record Review Summary
Comments:

Reviewer_____ Name/Signature/Date: _____

❑ Treatment Appropriately Documented and Legible ❑ Treatment Consistent with Standard of Care **If Above Boxes Checked, Return to QAC**	❑ Documentation Incomplete or Illegible ❑ Treatment Deviates from Established Practice **If Above Boxes Checked, Submit to SMO for Review**

Senior Medical Officer Review

❑ No Action Needed → Return Form to QAC	❑ Action Needed → Review with Provider

Comments:

SMO _____ Name/Signature/Date: _____

Provider _____ Name/Signature/Date: _____

USS AIRCRAFT CARRIER (CVN) XX CERTIFIED REGISTERED NURSE ANESTHETIST RECORD REVIEW					
PROVIDER: PERIOD COVERED:					
Record Identifier					
Y = YES N = NO N/A = NOT APPLICABLE					
Date & Time of All Entries					
All Entries Legible					
Provider Signature & Stamp Present					
Allergies noted on all forms					
Consent of Anesthesia Complete OF522 Request of Anesthesia					
Pre-Operative Screening/Assessment Complete					
Previous Medical Surgical History					
Social History					
Review of Systems					
Physical Exam with preop vital signs					
Lab/Rad/Tests					
Preop Diagnosis documented					
Anesthetic Plan					
Anesthesia Flowsheet complete:					
All applicable entries made to ensure Standard of Care met					
Narcotic medication administration and wasted noted					
Surgery Enter room time noted					
Surgery Exit room time noted					
Surgery Time out noted					
Surgery Start time noted					
Surgery Stop time noted					
PACU Temp >36C					
Narcotic administration and waste noted on NAVMED 6550/4 (if applicable)					

<table>
<tr><td colspan="2">Records to be review must be outpatient procedures using procedural sedation and operative procedures performed in the operating room.
Record Review Summary
Comments:

Reviewer _____ Name/Signature/Date: _____

_____</td></tr>
<tr><td>❑ Treatment Appropriately Documented and Legible
❑ Treatment Consistent with Standard of Care
If Above Boxes Checked, Return to QAC</td><td>❑ Documentation Incomplete or Illegible
❑ Treatment Deviates from Established Practice
If Above Boxes Checked, Submit to SMO for Review</td></tr>
<tr><td colspan="2">Senior Medical Officer Review</td></tr>
<tr><td>❑ No Action Needed → Return Form to QAC</td><td>❑ Action Needed → Review with Provider</td></tr>
<tr><td colspan="2">Comments:

SMO _____ Name/Signature/Date: _____

Provider_____ Name/Signature/Date: _____</td></tr>
</table>