



COMDTNOTE 6000
April 18, 2003
CANCELLED:
April 19, 2004

COMMANDANT NOTICE 6000

Subj: CH-18 TO MEDICAL MANUAL, COMDTINST M6000.1B

1. PURPOSE. This Notice publishes revisions to Medical Manual, COMDTINST M6000.1B. Intended user of this directive are all Coast Guard Units that maintain Medical Manuals.
2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of Headquarters units, Assistant Commandants for directorates, Chief Counsel and special staff offices at Headquarters shall ensure compliance with the provisions of this Notice. Internet Release Authorized.
3. DIRECTIVES AFFECTED. Medical Manual, COMDTINST M6000.1B.
4. SUMMARY. Newly revised material and editorial changes are denoted by a line or bolded print and line, on the outside of the page. Enclosure (1) summarizes the substantial changes throughout the Medical Manual. Medical Manual COMDTINST M6000.1B, CH-18 is provided as enclosure (2).
5. PROCEDURES. No paper distribution will be made of this Manual. Official distribution will be via the Coast Guard Directives System CD-ROM, the Information and Technology G-CIM website at <http://cgweb.uscg.mil/g-s/g-si/g-sii/newcis.htm> or <http://cgweb.uscg.mil/g-c/g-ccs/g-cit/g-cim/directives/welcome.htm> and the Department of Transportation Website <http://isddc.dot.gov/>. The G-CIM website electronic version will also be made available via the Commandant (G-WK) Publications and Directives website (see # 7, below).

a. Remove and insert the following pages

Remove

Insert

Chapter 1 CH-16

Chapter 1 CH-18

Chapter 2 CH-17, pg 9-10

Chapter 2 CH-18, pg 9-10

Chapter 2 CH-16, pg 17-18

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B	1	1	15	1	15	1	1	15	1	1	1	6	1	1		1	10	1	1	1	1	1	1	1	1	
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NON-STANDARD DISTRIBUTION:

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Chapter 3 CH-17, pg i-iv
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Chapter 13 CH-18
Chapter 14 CH-18, pg 9-13

6. POLLUTION PREVENTION CONSIDERATIONS: Pollution Prevention considerations were examined in the development of this directive and have been determined to be not applicable.
7. FORMS AVAILABILITY. All forms listed in this Manual with the exception noted in this paragraph are available from stock points listed in the Catalog of Forms, COMDTINST 5213.6. Local reproduction authorized for History and Report of OMSEP Examination CG-5447, Periodic History and Report of OMSEP Exam CG-5447 and the M&E Collection Log CG-5544. Some forms referenced in this Manual are also available on SWSIII Jet Form Filler. Web links to forms in .pdf format have been provided on the Pubs and Directives page; <http://www.uscg.mil/hq/g-w/g-wk/g-wkh/g-wkh-1/Pubs/Pubs.Direct.htm>.

/S/

JOYCE M. JOHNSON
Director of Health and Safety

- Encl (1) Summary of substantial changes
(2) CH-18 to Medical Manual, COMDTINST M6000.1B

CH-18 to Medical Manual, COMDTINST M600.1B

CHAPTER 1	
1-B-15-a.(1)(b)	Fixed format only.
1-B-16-b.(3)(c) 1-7	Revised <u>1</u> through <u>7</u> to clearly define what form is needed for an IMB/DMB.
1-B-18-a. (1)(2)(3) & (4)	Revised entire section on Health Benefits Advisors (HBA)
1-B-18-c.(1)&(2)	Inserted TRICARE web sites.
1-B-21-b.	Provides new guidance for non-rates and TAD personnel that are placed in CG Clinics/Sickbays for a short period of time.
1-B-21-d.(2)	Provides new guidance for volunteer health care providers.
1-B-21-f.	Provides new guidance for health care providers who are members of the Auxiliary and American Red Cross.
1-B-21-g.(7)	Inserted Privacy Act and HIPAA for volunteer orientation requirements.
	Chapter 1 has been re-formatted and re-issued in its entirety.
CHAPTER 2	
2-A-6-a.(1)	Revised paragraph (1) to state: Any expenses incurred in obtaining elective care or follow-up care at USMTFs is the responsibility of the member.
2-B-1-a.	Revised paragraph to reflect Reserve Policy Manual.
2-F-2-b.	Updated current statute.
2-F-2-c.	Updated current statute.
CHAPTER 3	
3-A-7-e.(1)(d)	Provides new guidance covering protocols for applicants requiring physicals exams for service academies, ROTC, and USUHS.
3-A-7-h.	Revised annual physical exam requirement to include selected reserve.
3-A-7-j.	Revised quinquennial physical to include selected reserve.
3-A-7-l.(6)	Provides clarification for convening a Medical Board.
3-A-7-m	Edited MLC (kma) to MLC (k)
3-C-8-e.(7)	Revised wording and changed (carefully recorded) to (averaged)
3-C-20-b.(6)	Removed section for Cholesterol Testing.
3-C-20-b.(6)(a)	Requires Serological Test for aviation and diving candidate physicals.
3-C-20-b.(6)(e)	Revised paragraph to bring current syphilis reporting requirements.
3-C-20-d.(1)(e)	Removed sub section (e) ECG no longer required for applicants for service academies.
3-C-21-a.&b.(2)&(c)	Revised section, clarified measurement of height, weight, and frame size, utilizing metric and english system.
3-C-22-k.	Revised paragraph inserted text to include authorization of the Randot and Titmus test for measuring depth perception.
3-D-10-c.(1)	Revised paragraph to match DoD Instruction.

3-E-5	Provides guidance for CG active duty members apply for CG Direct Commissioning Program
3-F-1-c.	Revised paragraph and removed (temporarily).
3-F-2	Inserted new text at the end of paragraph concerning HIV infection.
3-F-16-c.	Revised paragraph to clarify <u>Mood Disorders</u> and inserted new text.
3-F-21	Fixed format. Removed text concerning complications or residuals.
3-G-6-a.(1)	Inserted new guidance concerning cardiovascular Wolff-Parkinson-White (WPW) Syndrome.
3-G-6-a.(5)	Inserted new paragraph referencing ALCOAST 157/02, Navy Flight School Eligibility for Individuals who have had PRK.
3-G-8-a.	Inserted new guidance at the end of the paragraph for Aircrew Candidates: Cycloplegic refraction and anthropometric measurements are not indicated. A chest x-ray is required within the previous 3 years.
CHAPTER 4	
4-A-2-a.(1)&(2)	Revised paragraph to clarify order of forms in the Health Record
4-A-2-a.(6)(b)5&6	Inserted 5 & 6 to this section to clarify order of forms in Dental Record
4-B-6-b.(2)	Revised sentence to define "NA" Not Applicable
4-B-6-c(46)(d)	Updated reference for HIV antibody testing.
4-B-30 and 31	Added (30 & (31). This section gives guidance how to fill out CG-5447 History and Report of OMSEP Examination and CG-5447A Periodic History and Report of OMSEP Examination
4-C-3-b.(1)&(2)	Revised numbering system for permanent dentition.
4-C-3-c.(2)(c)	Updated paragraph adding follow-up exams for previously rendered treatment.
4-C-3-c.(3)(a)	Updated this section to meet DoD Memorandum Policy on Standardization of Oral Health and Readiness Classification dtd (Jun 4, 2002)
4-C-3-c.(4)(g)5	Revised paragraph to include ceramics and resins.
4-C-3-c.(4)(g)8	Revised paragraph to include acrylic.
Section III (3)	Updated paragraph to include all dental materials used intraorally shall be identified.
	Operation, Conditions, or Treatment: Updated abbreviations
4-C-6-c.	Updated guidance concerning lost Dental Records.
4-C-7	Updated guidance for Special Dental Record entries.
4-C-8-a.	Inserted tattoos, and piercings to paragraph.
4-D-2-a.(1)(b) & (c)	Added the SF-513 Consult Sheet and NAVMED 6660 Periodontal Screening to right side of Dental Record
4-D-b.(1)	Updated guidance for dental anesthesia.
	Chapter 4 (text) section will be re-issued do to format change
Enclosure (1)	Added CG-5447 History and Report of OMSEP Examination and CG-5447A Periodic History and Report of OMSEP Examination forms.

CHAPTER 8	
8-A-2-b.	Increased equipment purchase to \$1500.00 for CG Clinics, and over \$500 for units with HS's assigned.
CHAPTER 10	
10-A-1-e.(7)	Revision of sentence to read: Oversees the following responsibilities of collateral duty pharmacy officers who:
10-A-2-c.	Revised paragraph to meet standards in COMDTNOTE 6570, Pharmacy Quality Assurance.
10-A-9.b.(1)	Removed reference to CG Core Formulary
10-A-9-b.(5)(a)	Removed reference to CG Core Formulary
CHAPTER 12	
12-A-2-b.(1)	Revised text directing an employee occupationally expose for OMSEP exposure or hazards 30 or more days per year.
12-A-2-b.(5)	Added new sub-paragraph (5), SOP enrollment guidelines.
12-A-3-a.(1)	Revised paragraph updating CG 5447 and CG 5447A
12-A-3-b.	Updated paragraph describing duties and responsibilities of the SEHO.
12-A-4	Updated this paragraph including the recommendation of removing a member from OMSEP program through the Commanding Officer.
12-A-5-e.(1)	Revised paragraph to include Classification of Diseases ICD.
12-B-1	Revised paragraph updating provider's responsibilities.
12-B-2-b.(1) through (4)	Added new section describing the OMSEP Periodic Examination, and the CG Form 5447A.
12-B-2-c.(3)	Revised paragraph updating current standards for HAZMAT response personnel.
12-B-2-d.(1)(a)	Added new text to include end of exposure requirements.
12-B-2-d(2)(a)	Revised paragraph to implement requirements for completion of CG-5447.
12-B-2.(2)(c)	Inserted new paragraph describing requirements for the Separation Letter. Note: This letter was formatted with fill-able Adobe.
12-B-2-e	Inserted new text recommending medical officer authority for shorter intervals between OMSEP exams.
12-B-3-b.	Added new section to explain new CG-5447A
12-B-3-i.	Inserted new text describing format of OMSEP Separation Letter. (Figure 12-B-4) This letter was formatted with fill-able Adobe.
12-B-4-a. (3)	Revised dB to 25.
12-C-7-b.(3)	Revised paragraph to reflect change in dB to 25.
12-C-7-d.(1)(b)	Updated decibels to current standards.
12-C-7-d.(2)	Revised paragraph to reflect changes in STS
12-C-7-d.(7)(d)	Added new paragraph describing reporting requirements.
12-C-13	Unspecified removed, in it's place Bloodborne Pathogens.
	Chapter 12 will be re-issued. Of particular interest, all Exposure Protocols have been reformatted.

CHAPTER 13	
	M&E's removed from chapter
13-B-2	Inserted (Unrestricted, Active) to this section
Figure 12-B-1	Inserted I. Health Care provider BLS
13-H-3	Revised paragraph concerning M&E's
13-H-4	Revised requirements for M&E's
13-H-5-f.	Revised paragraph to specify M&E follow-up.
Figure 13-H-1	Updated Monitoring and Evaluation Report
Figure 13-H-2	Replaced M&E Collection Log CG-5544
13-J-8-b.(4)	Updated paragraph, inserted reference to current OSHA standards regarding personal protective garments.
13-J-10	Updated paragraph, inserted reference to current OSHA standards concerning labels.
13-J-12-c.(3)	Added new sub-section (3); references OSHA standards concerning Bloodborne Pathogens.
	Chapter 13 will be re-issued.
CHAPTER 14	
14-B-2.c(2) through (5)	Added new text to this section to provided current guidance for DANCAS,

CHAPTER 1
ORGANIZATION AND PERSONNEL

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CHAPTER 1. ORGANIZATION AND PERSONNEL

Section A - Organization.

1. Mission of the Coast Guard Health Services Program.
 - a. The Health Services Program supports Coast Guard missions by providing quality health care to maintain a fit and healthy active duty corps, by meeting the health care needs of dependents and retirees to the maximum extent permitted by law and resources, and by providing authorized occupational health services to civilian employees.
2. Director of Health and Safety.
 - b. Mission. The mission of the Director of Health and Safety is to:
 - (1) serve as advisor to the Secretary of Transportation;
 - (2) serve as advisor to the Commandant; and
 - (3) develop and implement the Coast Guard's overall health care program.
 - c. Duties and Responsibilities. Under the general direction and supervision of the Commandant, Vice Commandant, and the Chief of Staff, the Director of Health and Safety shall assume the following duties and responsibilities:
 - (1) serve as Program Director (PD) for the Health Services Program (G-WKH), and the Safety and Environmental Health Program (G-WKS);
 - (2) act as advisor to the Commandant in providing counsel and advice on:
 - (a) health care issues affecting operational readiness and quality of life in the Coast Guard;
 - (b) interdepartmental and interservice agreements for health care of Coast Guard personnel;
 - (c) the significance of legislative matters affecting the Coast Guard Health Services and Safety and Environmental Health Programs; and
 - (d) important developments in the Department of Defense and the Department of Health and Human Services which affect the Coast Guard Health Services and Safety and Environmental Health Programs;
 - (3) serve as advisor to the Secretary in developing and implementing departmental national defense emergency medical, health, and sanitation policies and plans (except those involving civil aviation) and such other advisory services that may be required or requested;
 - (4) plan, develop, and administer a comprehensive, high quality health care program (quality is defined as the desired level of performance against established standards and criteria) for all authorized beneficiaries;
 - (5) plan, develop and administer a comprehensive program for the prevention of illness and injury of Coast Guard personnel and dependents, to reduce losses, and protect the environment in Coast Guard working facilities and living

spaces/by establishing and maintaining adequate safety and environmental health standards for aircraft, vessel, shore facilities, and motor vehicle; providing information and encouragement to beneficiaries for personal wellness programs and providing healthy and pleasing meals at Coast Guard dining facilities;

- (6) administer TRICARE Management Activity (TMA), including the appropriation of funds, on behalf of the Coast Guard as provided in the Dependents Medical Care Act and regulations pursuant thereto;
- (7) monitor and protect the health of personnel attached to the Coast Guard through the Occupational Medical Surveillance and Evaluation Program (OMSEP);
- (8) direct the administration of funds in those appropriations or allotment fund codes under the control of the Office of Health and Safety, including furnishing total budget estimates and apportionment or allotment recommendations to the Chief of Staff;
- (9) advise responsible offices concerning establishing physical standards for military duty and special operational programs;
- (10) procure and recommend assignments to the Commander, Coast Guard Personnel Command (CGPC), and review the performance of Public Health Service personnel detailed to the Coast Guard;
- (11) provide professional health care guidance to all health services personnel;
- (12) maintain liaison with the Public Health Service, the Department of Veterans Affairs, the Department of Defense, and other Federal agencies and serve on interservice boards and committees as appointed;
- (13) set policy and guidelines for the subsistence program;
- (14) provide technical advice to operating program managers;
- (15) set policy and guidelines for health care quality assurance; and act as the Governing Body for Coast Guard health care;
- (16) set policy and guidelines for the Alcohol Abuse Prevention program; and
- (17) serve as a member of the Human Resources Coordinating Council.
- (18) administer the Coast Guard Emergency Medical system.
- (19) Public Health Service. The responsibility of the Public Health Service for providing physicians, dentists, and other allied health personnel support to the Coast Guard is set forth in 42 USC, 253. These personnel are provided on a reimbursable basis and are subject to Coast Guard regulations and the Uniform Code of Military Justice (UCMJ).

3. Health and Safety Division, Maintenance and Logistics Commands MLC (k).

a. Mission. The mission of MLC (k) is to:

- (1) interpret and implement health care policies as set forth by the Commandant;
- (2) develop and implement the Coast Guard's overall Health Services, and Safety and Environmental Health Programs for the Area; and
- (3) serve as Health Care Advisor to Commander, Maintenance and Logistics Command.

b. Functions and Responsibilities. Under the direction and supervision of the Commander, Maintenance and Logistics Command (MLC), the Chief, Health and Safety Division shall:

- (1) act as Medical Advisor to the Area commander in providing counsel and advice on:
 - (a) interagency and interservice agreements for health care of Coast Guard personnel;
 - (b) the significance of legislative matters affecting the Coast Guard health care program; and
 - (c) important developments in the Department of Defense which affect the Coast Guard health care program.
- (2) serve as advisor to the Area commander in developing and implementing national defense emergency medical, health, and sanitation policies and plans;
- (3) plan, develop, and administer a comprehensive health care program for all beneficiaries;
- (4) develop health services mobilization requirements and support documents;
- (5) review and act on requests for contract health care services;
- (6) act as contract technical representative in reviewing health care contract proposals;
- (7) administer the health care quality assurance program;
- (8) administer the Safety and Environmental Health Programs;
- (9) administer the Alcohol Abuse Prevention program;
- (10) develop and implement pharmaceutical support services;
- (11) be responsible for providing funding for direct health care expenditures;

- (12) be responsible for the general oversight of health care budgets;
 - (13) be responsible for the oversight of general clinic policy to include setting standards for clinic operations and prioritizing of clinic functions;
 - (14) designate clinics as catchment area patient management sites;
 - (15) maintain liaison with U. S. Public Health Service, the Department of Veterans Affairs and the health departments of the Department of Defense and other Federal agencies within you area of responsibility; and
 - (16) be responsible for the general oversight of the subsistence program by providing assistance to Coast Guard units (ashore and afloat) to ensure the maintenance of high quality food service operations.
- c. In addition, the MLC (k)s shall have the right, in coordination with unit commanding officers, to detail health services personnel (officer and enlisted, Coast Guard and Public Health Service) for special assignments including meeting short-term staffing needs.
4. Responsibilities of Commands with Health Care Facilities. Unit commanding officers shall be responsible for:
- a. oversight of clinic procurements;
 - b. ensuring adherence to policies, military regulations and general administrative procedures,
 - c. funding for administrative and non-health care expenditures for clinics;
 - d. maintenance, repair and general support of clinic facilities;
 - e. ensuring compliance with action items required by quality assurance site surveys;
and
 - f. working with the appropriate MLC in fostering quality, productivity, and operating efficiencies.

Section B - Personnel.

1. General Duties of Medical Officers. The principal duty of medical officers is to understand and support the operational missions of the Coast Guard. Medical Officers include Physicians, Physician Assistants (PA/PYA), and Nurse Practitioners (NP) who are members of the Coast Guard or Public Health Service detailed to the Coast Guard. Medical officers are required to have appropriate certification or licensure while assigned to the Coast Guard. Physicians must have an unrestricted state license to practice medicine. See 1-B-11 for nurse practitioner and physician assistant credential requirements. Civilian medical practitioners (under contract to the Coast Guard or GS employees) assigned to a medical treatment facility are considered medical officers to the limits defined by the language of their contract and/or job description. Civilian medical practitioners who have a contract with the Coast Guard to see patients in their private offices are not considered medical officers for the purpose of this instruction.
 - a. General Responsibilities.
 - (1) Medical officers must keep informed in all fields of general and military medicine and shall:
 - (a) ensure the fitness for unrestricted worldwide duty of active duty personnel;
 - (b) provide health care for all eligible beneficiaries as authorized by applicable laws and regulations;
 - (c) make appropriate referrals of eligible beneficiaries following existing policy and regulation;
 - (d) treat sick and injured personnel;
 - (e) prevent and control disease;
 - (f) promote health;
 - (g) give advice on such matters as hygiene, sanitation, and safety;
 - (h) recommend duty status of active duty personnel and Coast Guard civil service employees;
 - (i) ensure that each patient is notified of results of all PAP smears, mammograms, biopsies, pregnancy tests, and all tests that are abnormal or whose results indicate a need to initiate or change treatment.
 - (j) thoroughly understand all operational missions of the unit, units within the local area, and the human factors involved in performing them;
 - (k) ensure that personnel are physically and psychologically fit for duty and attempt to learn of any unusual circumstances which might adversely affect their proficiency;

- (l) maintain an active interest and participate in the local unit's safety program, assist the safety officers in planning, implementing, and coordinating the unit safety program, and advise the command on safety issues;
 - (m) be thoroughly familiar with the types of personal protective and survival equipment carried at the unit. Assist the engineering officer in maintaining and issuing the equipment, and be familiar with the Rescue and Survival System Manual, COMDTINST M10470.10 (series);
 - (n) actively participate in the unit physiology training program to ensure that personnel are capable of coping with the hazards of mission performance by presenting lectures and demonstrations which include, but are not limited to:
 - 1 fatigue
 - 2 emergency medicine,
 - 3 survival,
 - 4 disorientation,
 - 5 night vision,
 - 6 stress, and
 - 7 drug and alcohol use and abuse.
 - (o) ensure that HSs who participate in EMT operations maintain their certification, knowledge and Health Services skills in EMT operations, physiology;
 - (p) provide Health Services refresher training on emergency procedures; and
 - (q) participate in a program of continuing education in operational medicine including familiarity with information published for other branches of the Armed Forces.
- (2) Medical officers act as medical members in physical disability evaluation cases.
 - (3) Medical officers are responsible for advising commanding officers on: health status of personnel; nutritional adequacy, food handling and preparation; heating, ventilation, and air conditioning; housing; insect, pest, and rodent control; water supply and waste disposal; safety; items sold in exchanges, commissaries, and other CGES facilities; the physical fitness of personnel; and immunization standards.
- b. Physical Examinations. Medical officers shall conduct physical examinations in accordance with Section 3-C of this Manual and in cases involving disability evaluation be guided by the Physical Disability Evaluation System, COMDTINST

M1850.2 (series), and the Department of Veterans Affairs Publication, Physician's Guide for Disability Evaluation Examinations.

- c. Reports to Command. Report injuries to, or deaths of, personnel; damage, destruction, or loss of health services department property; and any other important occurrence, to the officer of the day or other command official for entry into appropriate log. Report any suspected child/spouse abuse to the commanding officer, family advocacy representative, and local law enforcement/child protective agency in accordance with Family Advocacy Program, COMDTINST 1750.7 (series), and other local, state, or Federal law. Report patients in serious or critical condition to the commanding officer or officer of the day, together with the information needed to notify the next of kin. Death imminent procedures are contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series).
- d. Educational Measures. Conduct health education programs, including disseminating information about preventing disease and other subjects pertaining to hygiene and sanitation.
 - (1) Sexually Transmitted Diseases. Conduct or supervise the instruction of personnel regarding sexually transmitted diseases and advise them of the associated dangers.
 - (2) First Aid Instruction. Conduct or supervise a program which will ensure knowledge and ability in first aid.
 - (3) Occupational Medical Surveillance and Evaluation Program (OMSEP). Conduct or supervise a program to indoctrinate personnel in the various aspects of occupational health and the OMMP.
 - (4) Human Immunodeficiency Virus (HIV). Conduct or supervise the instruction of personnel regarding (HIV) and advise them of the associated dangers.
 - (5) Wellness. Conduct or supervise a program to emphasize the importance of life-styles in maintaining health.
 - (6) Human Services. Conduct or supervise the instruction of Health Services personnel to ensure they are aware of all the services available to maintain a state of well being for personnel.
- e. Cooperation With Other Agencies. Cooperate with Federal, state, and local agencies for preventing disease, reporting communicable diseases, and collecting vital statistics.
- f. Designated Supervising Medical Officer (DSMO). Medical officers assigned as "designated supervising medical officer" (DSMO) will assume clinical responsibility for the treatment provided by each health services technician in their clinic for whom they are responsible. Assignments shall be made in writing and signed by the DSMO's commanding officer. Clinical supervision and accountability is defined as follows:

- (1) during normal clinic hours, HS consultation with the DSMO as determined by that medical officer, review 20 percent of each day's new patient encounters seen only by the HS, and review 100 percent of all patient encounters seen only by the HS who return with no improvements. (Ideally these reviews would include the patient's presentation to the medical officer.) The DSMO shall countersign all records reviewed.
 - (2) outside normal clinic hours, direct or telephone consultations as determined by the DSMO or duty MO; and, the following working day, a review of 100 percent of all visits seen only by the HS. The DSMO or duty MO shall countersign all records reviewed.
- g. Designated Medical Officer Advisor (DMOA). Health Services Technicians on independent duty (IDTs) shall have a "designated medical officer advisor" (DMOA) identified. The DMOA shall provide professional advice and consultation to the IDT. The cognizant MLC (k) shall apportion units with IDTs to units with medical officers attached. The cognizant MLC (k) shall make changes as necessary and forward such information to the affected units and Commandant (G-WKH). At the unit level, assignments shall be made in writing (addressed to the DMOA) and signed by the DMOA's commanding officer, with copies to the IDT unit and the cognizant MLC (k). Assignment letters shall be addressed to the specific individuals involved, and new letters shall be issued following a change of DMOA or IDT. Professional advice and consultation, in this instance, is defined as follows:
- (1) Telephone or radio consultation regarding specific cases as necessary between the HS and the DMOA. This does not preclude consultation between the HS and another Coast Guard medical officer, a medical officer of the Army, Navy, Air Force, or USPHS, or a physician under contract to the Coast Guard whose contract provides for such consultations; and
 - (2) Treatment record review: At the end of each quarter, the commanding officer of the independent duty HS or his designee (cannot be the HS) shall select at random 15 health records which have at least one entry made by the HS during the previous quarter. For each of these records, copies shall be made of all SF 600 entries during the quarter. Copies of the SF-600's shall be sealed in an envelope and marked for the **DMOA's Eyes Only**. The copies are then forwarded to the DMOA for review. The DMOA shall review these record entries according to established criteria for record review at his/her facility. Each record entry (copy) shall be annotated "reviewed," dated, and stamped with the DMOA's name and pertinent comments concerning the record entry. One copy of the reviewed record entries shall then be returned to the HS via the unit's commanding officer. A second copy of the reviewed entries shall be retained by the DMOA. Both the HS and DMOA copies shall be retained at the respective commands for a period of three years, for MLC review during QA site surveys. The record review shall be discussed with the HS in the

quarterly phone contact between the DMOA and the HS. The DMOA is encouraged to provide input to the unit CO or XO regarding the professional performance of the independent duty HS.

- (3) Review of MLC quality assurance site survey reports for the independent duty site: The DMOA and HS shall review the MLC quality assurance site reports for the site. They shall collaborate on the required written plan of corrective actions which must be submitted to the MLC following the site survey. The DMOA should also consult with the unit commanding officer regarding the findings of the survey report.
2. Duties of Senior Medical Officers. The senior medical officer attached to a unit is responsible to the commanding officer of the unit for the provision of health services. In addition to the general duties of a medical officer, the senior medical officer is responsible for:
 - a. performing those duties as prescribed in Coast Guard Regulations, COMDTINST M5000.3 (series) if designated by Commander, Coast Guard Personnel Command (CGPC) as division chief;
 - b. advising the commanding officer of any deleterious environmental health factors;
 - c. supervising any assigned PYA/PAs and NPs including, on a monthly basis, random review for approximately five percent of the PYA/PA/NP's charts for adequacy and appropriateness of treatment rendered;
 - d. in the absence of a pharmacy officer, maintaining antidotes for narcotics and poisons and ensuring only properly trained personnel are assigned to the pharmacy;
 - e. acting as the commanding officer's representative on local emergency planning boards, and, during emergencies or disasters, furnishing advice to the commanding officer, formulating plans, and helping civilian authorities meet health care needs;
 - f. managing the quality of health care services provided;
 - g. maintaining liaison with the hospital commander or senior medical officer of nearby (75 miles) USMTF's;
 - h. acting as quality assurance technical supervisor for all contracted health services;
 - i. ensuring efficient and effective use of all assigned medical officers and civilian consultants;
 - j. preparing, through training and experience, health services technicians for independent duty assignments;
 - k. recommending to the command a designated supervising medical officer (DSMO) for each HS who provides medical treatment to patients; and
 - l. convening medical boards as appropriate in accordance with Chapter 3, Physical Disability Evaluation System, COMDTINST M1850.2 (series)
 - m. ensuring that all ancillary service areas (e.g., laboratory, radiology, etc.) maintain adequate policy and procedures manuals;

- n. in conjunction with the MLC, providing professional oversight and establishing qualifications standards and privileging for assigned personnel, including contract, reserve and student providers;
 - o. assigning personnel and ensuring position and billet descriptions are accurate and that credentials and privileging requirements are met;
 - p. within general Coast Guard and unit guidelines, determining the priority and range of services for each beneficiary group;
 - q. maintaining liaison with counterparts in MTF, USTF, VA and private sector facilities;
 - r. preparing performance appraisals for assigned staff;
 - s. reviewing and ensuring accuracy of Clinic Automated Management System (CLAMS) and other statistical and informational reports;
 - t. ensuring that appropriate training is conducted on a regularly scheduled basis;
 - u. ensuring active participation and compliance with the Quality Assurance Program;
 - v. ensuring strict adherence to current infection control procedures and standards;
 - w. keeping the division chief informed;
 - x. other duties assigned by the Chief, Health Services Division.
3. Duties of Flight Surgeons. In addition to fulfilling the general duties of medical officers, flight surgeons must:
- a. thoroughly understand all operational missions of the aviation unit and participate as a flight crew member as required on MEDEVACS and to meet the requirements as set forth in the Coast Guard Air Operations Manual, COMDTINST M3710.1 (series);
 - b. be familiar with the operational missions of other Coast Guard units in the local area;
 - c. obtain a general understanding of the flight characteristics of the aircraft assigned to the unit and be thoroughly familiar with the human factors involved in pilot and crew member interaction with the aircraft;
 - d. be familiar with the Air Operations Manual, COMDTINST M3710.1 (series), with specific emphasis on Chapter 6, Rescue and Survival Equipment; Chapter 7, Flight Safety; and the sections of Chapter 3 (Flight Rules) dealing with protective clothing and flotation equipment;
 - e. ensure that aviation personnel are physically and psychologically fit for flight duty and attempt to learn of any unusual circumstances which might adversely affect their flight proficiency, this includes getting acquainted with each pilot and crew member;
 - f. make recommendations to the commanding officer concerning the health status of aviation personnel, and in particular, only a flight surgeon or aviation medical officer (AMO) shall issue “up” chits, except as noted in Section 3-G-2;

- g. maintain an active interest and participate in the air station flight safety program and assist the flight safety officer in planning, implementing, and coordinating the station flight safety program, and advising the command on the aeromedical aspects of flight safety;
 - h. participate as the medical member of Aircraft Mishap Analysis Boards and, when so assigned, be responsible for completing the Medical Officer's Report in accordance with Chapter 2 of Safety and Environmental Health Manual, COMDTINST M5100.47 (series);
 - i. be thoroughly familiar with the types and uses of personal pro-protective and survival equipment carried on aircraft at the unit [The flight surgeon shall assist in inspecting the equipment, shall advise the engineering officer and aviation survival members in maintaining and issuing the equipment, and shall be familiar with Rescue and Survival Systems Manual, COMDTINST M10470.10 (series)];
 - j. actively participate in the unit aviation physiology training program to ensure that aviation personnel are capable of coping with the hazards of flight by presenting lectures and demonstrations which include, but are not limited to:
 - (1) fatigue,
 - (2) emergency medicine,
 - (3) survival,
 - (4) disorientation,
 - (5) night vision,
 - (6) reduced barometric pressure,
 - (7) crash injury avoidance,
 - (8) stress, and
 - (9) drug and alcohol use and abuse.
 - k. advise the command on MEDVAC operations:
 - l. ensure that HSs who participate in aviation operations maintain their knowledge and skills in aeromedical physiology, and provide refresher training lectures and demonstrations to emergency medical technicians (EMTs) and health services technicians on emergency medical procedures; and
 - m. participate in a program of continuing education in aviation medicine including familiarity with information published for flight surgeons by other branches of the Armed Forces.
4. General Duties of Dental Officers. The principal duty of dental officers is to support the Coast Guard operational mission by determining each member's fitness for unrestricted duty on a worldwide basis. Coast Guard dental officers are assigned to perform duties as

general dental officers. Exceptions will be authorized in writing by Commander, Coast Guard Personnel Command (CGPC).

a. General Responsibilities.

- (1) Coast Guard dental officers must stay informed in all fields of general and military dentistry and be responsible for:
 - (a) ensuring the fitness for unrestricted duty of active duty personnel on a worldwide basis;
 - (b) providing dental care for all eligible beneficiaries as authorized by applicable laws and regulations (ensure non-enrollment in United Concordia or Delta Dental before providing covered services);
 - (c) preventing and controlling dental disease (this includes performing dental prophylaxis);
 - (d) promoting dental health;
 - (e) referring eligible beneficiaries for dental treatment per MLC (k) SOP;
 - (f) prioritizing the delivery of dental care to meet Coast Guard unit operational readiness requirements;
 - (g) ensuring that patients with gingivitis or periodontal disease have the opportunity to receive follow up care;
 - (h) ensuring that results of all biopsies are received and reviewed by a dentist to ensure that the appropriate action is taken;
 - (i) ensuring that when dental externs are assigned to the clinic, that a protocol is developed detailing lodging and subsistence arrangements, types of procedures allowed, available population to be treated and supervising dental officer responsibilities. The protocol must be signed by the Commanding Officer and provided to all participating dental schools;
 - (j) ensuring that procedures for handling medical emergencies within the dental clinic are clearly written and emergency drills are practiced periodically; and

b. Dental examinations. Dental officers shall conduct the dental examination portion of physical examinations in accordance with Chapter 3 of this Manual. Dental examinations shall be conducted as soon as practical on personnel who report for duty so as to determine the need for dental treatment and to verify their dental records. Annual Type 2 dental examinations shall be conducted on all active duty personnel collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).

c. Care of Mass Casualties. Dental officers shall be qualified to perform first aid procedures in order to treat or assist in treating mass casualties.

- d. State Licensure. While assigned with the Coast Guard, dental officers are required to have an unrestricted state license to practice dentistry.
 - e. Continuing Education. Participate in a program of continuing training in operational medicine/dentistry including familiarity with information published for other branches of the Armed Forces.
5. General Duties of Senior Dental Officers. The senior dental officer is responsible for:
- a. performing duties outlined in Coast Guard Regulations, COMDTINST M5000.3 (series) if designated by Commander, Military Personnel Command as division chief;
 - b. conducting an organized preventive dentistry and dental health education program for all eligible beneficiaries;
 - c. preparing, through training and experience, health services technicians for independent duty assignments;
 - d. overseeing the preparation of reports, updating the dental clinic policy and procedures manual, and maintaining records connected with assigned duties;
 - e. overseeing the overall working condition, cleanliness and infection control of the dental clinic, which includes sterilization procedures, dental supply, equipment, publications maintenance, and the establishment of a preventive maintenance program for dental equipment and supplies;
 - f. maintaining custody, security, and records of the dispensing of dental stores including all controlled substances and poisons under the cognizance of the dental branch, and maintaining antidotes for narcotics and poisons;
 - g. issuing prescriptions for, and supervising the dispensing of controlled substances used in the dental branch;
 - h. maintaining custody, security, and records of precious metals dispensed and ensuring that precious metals are reclaimed as required and necessary forms are filed with the Department of Treasury;
 - i. managing the quality of dental care services provided;
 - j. in conjunction with the MLC (k), providing professional oversight and establishing qualifications standards and privileging for assigned personnel, including contract, reserve and student providers;
 - k. assigning personnel and ensuring position and billet descriptions are accurate and that credentials and privileging requirements are met;
 - l. within general Coast Guard and unit guidelines, determining the priority and range of services for each beneficiary group;
 - m. maintaining liaison with counterparts in MTF, USTF, VA and private sector facilities;

- n. preparing performance appraisals for assigned staff;
 - o. and reviewing and ensuring accuracy of CLAMS and other statistical informational reports;
 - p. ensuring that appropriate training is conducted on a regularly scheduled basis;
 - q. ensuring active participation and compliance with the Quality Assurance Program.
 - r. ensuring strict adherence to current infection control procedures and standards;
 - s. keeping the division chief informed;
 - t. other duties assigned by the Chief, Health Services Division.
6. General Duties of Chief, Health Services Division. The Chief, Health Services Division will:
- a. act as an advisor to the commanding officer regarding all health related matters;
 - b. under the unit executive officer, carry out the plan of the day as it pertains to the Health Services Division;
 - c. ensure that clinic performs Supporting Clinic duties for units designated by the cognizant MLC in their area of responsibility (AOR) IAW this instruction, cognizant MLC Instructions and SOP, and other pertinent directives. These duties include but are not limited to the following:
 - (1) Ensure the medical/dental readiness of all active duty personnel within their area of responsibility. This includes the review of health records and correction of deficiencies issues such as:
 - (a) Immunizations
 - (b) physical examinations
 - (c) annual dental exams
 - (d) HIV testing
 - (e) DNA specimen submission
 - (f) tuberculosis testing
 - (2) Provide pharmacy oversight to designated units via collateral duty Pharmacy Officer.
 - (3) Provide prime vendor pharmaceutical services to designated units via collateral duty Pharmacy Officers.
 - (4) Provide prime vendor medical/surgery services to designated units.
 - (5) Ensure that a Designated Medical Officer Advisor program is in place for designated units. This should include CPR/Lifesaver training to designated individuals.

- (6) Provide physical examination review (approval/disapproval) to designated units.
 - (7) Ensure that health care delivery is provided in a timely manner to units for which a clinic is designated as their primary management site.
 - (8) Provide health benefits advice to designated units.
 - (9) Assist with nonfederal medical and nonfederal dental preauthorization processing for designated units.
 - (10) Assist with nonfederal invoice processing for designated units.
 - (11) Assist with the timely completion of Medical Boards.
- d. ensure the medical/dental readiness of all active duty personnel within their area of responsibility;
 - e. review the division AFC-30 and AFC-57 budget submittals;
 - f. be responsible for the allocation of resources (personnel, funds, space, and equipment) within the division;
 - g. when directed by the command, represent the division at staff meetings and ensure timely dissemination of the information to division personnel;
 - h. prepare performance appraisals as appropriate and ensure that performance evaluations for all health services personnel are prepared and submitted in accordance with current directives;
 - i. review all division reports;
 - j. be responsible for the division training program, including rotation of personnel assignments for training and familiarization, in the health care delivery system;
 - k. oversee clinic policies, procedures and protocols for compliance with this Manual, COMDTINST M6000.1B, MLC Instructions and S.O.P, and other pertinent directives;
 - l. provide oversight with regard to applicable Federal, state, and local statutes and regulations;
 - m. seek opportunities for cost reduction and enhancement of patient care through billet conversions, resource sharing, contracting, etc.;
 - n. designate a clinic Quality Assurance Coordinator and ensure that the QA program is carried out;
 - o. proctor student extern programs;
 - p. proactively support and promote the command wellness program;
 - q. participate in health care initiatives with local/regional DOD delivery systems, under Headquarters and MLC guidance;

- r. oversee and promote work-life issues pertaining to health care;
 - s. ensure strict compliance to current infection control procedures and standards;
 - t. serve as chair of the Patient Advisory Committee;
 - u. oversee DSMO and DMOA programs;
 - v. in coordination with their respective MLC (k), establish their clinic as a Patient Management Site for units within their area of responsibility;
 - w. And perform other duties as directed by the Commanding Officer.
7. General Duties of Pharmacy Officers. While assigned with the Coast Guard, pharmacy officers are required to have an unrestricted state license to practice pharmacy. Pharmacy officers shall ensure that medications are acquired, stored, compounded, and dispensed according to applicable Federal laws in their primary and collateral duty clinics. This includes the direct supervision and management of the following:
- a. dispensing and labeling of all drugs, chemicals, and pharmaceutical products;
 - b. maintaining signature files for all health care providers;
 - c. providing patient-oriented pharmaceutical services including monitoring for appropriate drug therapy, allergies, therapeutic duplication, and medication interactions. Significant patient interactions should be documented on the SF-600;
 - d. providing verbal and written patient medication counseling when appropriate;
 - e. maintaining routinely stocked items at levels consistent with anticipated usage between regularly scheduled procurements of pharmacy supplies and determining the most effective expenditure of funds;
 - f. ensuring that security measures are instituted to prevent unauthorized entrance into the pharmacy or misappropriation of pharmacy stock;
 - g. receiving, safeguarding, and issuing all controlled substances as the command-designated custodian of controlled substances;
 - h. ensuring adequate quality control of all pharmaceuticals locally compounded;
 - i. maintaining current drug information files and a reference library of pertinent textbooks and professional journals;
 - j. implementing the decisions of the Pharmacy and Therapeutics Committee and serve as secretary of that committee;
 - k. inspecting monthly all clinic stocks of drugs and biologicals;
 - l. developing and maintaining a formulary for local use by medical and dental officers;
 - m. informing the clinical staff of new drug information, policy changes, or other pertinent data on drugs;
 - n. participate in a program of continuing education in pharmacy or related fields;

- o. maintaining, updating, and documenting monthly inspections of poison antidote and emergency drug supplies;
 - p. providing technical advice to the unit concerning drug testing, substance abuse, and other pharmaceutical matters;
 - q. providing guidance and advice to the medical staff on current immunization requirements,
 - r. servicing as a resource for designated therapeutic categories of medications as they relate to the Coast Guard Health Services Allowance Lists, Core formulary, HS Drug Formulary and other drug lists, and.
 - s. participate in a program of continuing training in operational medicine/pharmacy including familiarity with information published for other branches of the Armed Forces.
8. Maintenance and Logistics Command Pharmacy Officers. Under the general direction and supervision of the Chief, Quality Assurance Branch, MLC, the MLC pharmacy officer shall:
- a. plan, develop and implement, within the resources available, an MLC-wide pharmacy quality assurance program to:
 - (1) review and evaluate the delivery of pharmaceutical services in support of mission operations, implement established policies pertaining to pharmaceutical services, and recommend appropriate changes, and
 - (2) monitor pharmacy operations, via quality assurance site visits, financial monitoring, and other workload indicators to ensure optimum utilization of personnel and financial resources.
 - b. plan and administer the acquisition and distribution of pharmaceuticals:
 - (1) review, analyze, and recommend the most efficient and cost effective means for providing pharmaceutical services throughout the Area, including the financial resources to be allocated to each operating facility under MLC oversight;
 - (2) monitor the procurement of controlled substances by Coast Guard units within the Area;
 - (3) provide to MLC (kqa) a system for the random monitoring of drugs procured from nonfederal sources.
 - c. serve as pharmaceutical consultant on pharmacology, pharmacy, and drug utilization and provide technical pharmacy expertise, assistance, and advice to the MLC Commander and command elements within the Area;
 - d. provide guidance and advice regarding the evaluation, training, and justification for pharmacy personnel to meet operational needs of units within the Area;

- e. provide liaison or representation to regional Federal and professional pharmacy groups and committees; and
- f. administer and monitor the collateral duty assignments of pharmacy officers in their respective Area.

9. Environmental Health Officers.

- a. Duties: Environmental health officers are responsible for recognition, evaluation, and control of biological, chemical, physical, and ergonomic factors or stresses arising from the environment which may cause sickness, impaired health and well-being, or significant discomfort and inefficiency, property damage, or which could adversely affect the Coast Guard's industrial hygiene, pest management, radiological health, and sanitation. Specific responsibilities can include:
 - (1) planning, budgeting, implementing and directing an environmental health program to support commands within their geographic area of jurisdiction.
 - (2) conducting environmental health audits of Coast Guard facilities and operations in order to detect health hazards and noncompliance with applicable safety and environmental health laws, regulations, standards, and procedures. Facilities and operations include:
 - (a) work environments;
 - (b) storage, handling, treatment, and disposal of hazardous materials and hazardous waste;
 - (c) storage, handling, treatment, and disposal of infectious medical waste;
 - (d) food preparation, service and storage operations;
 - (e) solid wastes storage, handling, treatment, and disposal;
 - (f) pest management operations;
 - (g) potable water treatment, storage and distribution systems;
 - (h) waste water collection, treatment, and disposal system;
 - (i) housing facilities;
 - (j) ionizing radiation sources;
 - (k) non-ionizing radiation sources;
 - (l) recreational facilities;
 - (m) health care facilities;
 - (n) child care facilities;
 - (o) laundry and dry-cleaning operations; and
 - (p) barber shop operations

- (3) providing technical assistance to units to abate deficiencies identified by the environmental health officer during the audit.
 - (4) monitoring ongoing hazard abatement actions to ensure that identified hazards are being eliminated promptly.
 - (5) providing environmental health training to commands within their jurisdiction.
 - (6) providing technical assistance to units on request to identify and abate health risks.
 - (7) reviewing engineering plans and specifications for new facilities and modifications to existing facilities to ensure conformance with environmental health standards and practices.
 - (8) serving as technical advisor to commands within their jurisdiction.
 - (9) initiating and conducting special health risk assessment studies.
 - (10) maintaining liaison with Federal, state, and local government agencies concerning environmental health for commands within their jurisdiction.
 - (11) advising commands when medical monitoring data indicates the possibility of occupationally-induced or aggravated disease and investigating possible causes so that corrective measures can be initiated.
 - (12) providing consultation, advice, and training on the occupational medical monitoring program to Coast Guard commands within their area of jurisdiction.
 - (13) enrolling personnel in the OMSEP when they meet the criteria of occupational exposure as defined in paragraph 12-A-2.
 - (14) disenrolling personnel from the OMSEP when they do not meet the criteria of occupational exposure as defined in paragraph 12-B-4.
- b. Reports. Environmental health officers shall submit reports to the appropriate MLC (k) about environmental health conditions observed during their surveys.
- c. Duty Limitations. Environmental health officers shall carry out all management functions required to operate the safety and environmental health program within their AOR. They may be required to perform only those technical duties for which they are trained. They may represent health services at various staff meetings in matters relating to the management and budgetary aspects of their assignment. They will be primarily responsible for special studies as in the case of monitoring chemical spill response and enforcement personnel. They will be responsible to the Commander, MLC (k) for proper implementation of the safety and environmental health program.
10. Clinic Administrators. Officers, Chief Warrant Officers (experience indicator 19), or senior enlisted personnel assigned to manage and administer health care facilities.

- a. Under the direction of the Chief, Health Services Division, manage the administrative functions required to operate the health care facility. The Clinic Administrator will not be required, nor attempt, to perform clinical duties for which he/she is not trained.
- b. General Responsibilities. The Clinic Administrator will:
 - (1) plan, supervise, and coordinate general administration of the health services facility;
 - (2) prepare, submit, manage, and exercise fiduciary control and accountability over the health services division AFC-30 and AFC-57 funds;
 - (3) provide fiscal oversight over the acquisition of equipment and supplies;
 - (4) maintain a planned program of equipment maintenance and replacement;
 - (5) provide physical security of health services division supplies and pharmaceuticals;
 - (6) maintain liaison with other local agencies (military and civilian) in all health care related matters;
 - (7) provide resources to assist medical and dental officers in emergency care of the sick and injured when necessary;
 - (8) prepare the disaster preparedness plan as it relates to the health services division;
 - (9) prepare the heavy weather bill as it relates to the health services division;
 - (10) seek opportunities for cost reduction and enhancement to patient care through billet conversions, resource sharing, contracting, etc.;
 - (11) serve as an advisor to the chief, health services division on all administrative matters;
 - (12) oversee the supervision of enlisted personnel assigned to the health services division;
 - (13) ensure that correspondence, reports, and records comply with appropriate instructions (i.e. Paperwork Management Manual, Coast Guard Correspondence Manual, etc.);
 - (14) maintain an adequate health services division reference library;
 - (15) train subordinates, conduct classes, instruct enlisted personnel in their duties, and supervise their study of regulatory and professional publications and courses for advancement in rating;
 - (16) participate in a program of continuing education in Health Care Administration;
 - (17) assist beneficiaries with health benefits information;

- (18) enforce standards of appearance and conduct of health services division personnel;
- (19) ensure that accurate, appropriate data is submitted to the CLAMS information system, CHCS system, etc.;
- (20) oversee clinic rotation assignments of Health Services Technicians;
- (21) implement clinic policies, procedures, and protocols, for compliance with Coast Guard regulations, the Medical Manual, MLC INST/SOP, and other pertinent directives;
- (22) ensure compliance with all applicable Federal, state, and local statutes, together with the medical, dental and pharmacy officers;
- (23) oversee and promote work-life issues pertaining to health care
- (24) serve as assistant chair for the Patient Advisory Committee;
- (25) ensure that enlisted personnel evaluations for members assigned to the health services department are prepared and submitted in accordance with the Coast Guard Personnel Manual;
- (26) provide administrative oversight in the areas of NONFED health care, contracts, and BPAs;
- (27) ensure that health care invoices are processed in accordance with MLC INST/SOP;
- (28) ensure that physical examinations comply with current standards;
- (29) promote and administer the unit's environmental sanitation program (in the absence of an environmental health officer); and
- (30) oversee the unit's Occupational Medical Surveillance and Evaluation Program (OMSEP), in the absence of an environmental health officer.

11. Physician Assistants (PA/PYA(s)) and Nurse Practitioners (NP).

- a. General Responsibilities. PA/PYA(s) and NP(s) responsibilities are defined in Section 1-B-1. Under the supervision of the senior medical officer they are subject to the duty limitations listed below.
- b. Duty Limitations.
 - (1) Senior Medical Officers (SMO) of units with mid-level providers (physician assistants or nurse practitioners) assigned shall assign clinical duties and responsibilities to each provider and shall be accountable for the actions of those providers.
 - (a) To determine the extent of oversight required, SMOs shall be guided by this section, the provider's clinical training and previous experience, by personal observation, and Chapter 13-C, Clinical Privileges.

- (b) The SMO may delegate supervisory responsibility to another staff physician or certified mid-level provider (mentor). A copy of this delegation shall be filed in the non-certified provider's Professional Credentials File (PCF).
 - (c) Physicians responsible for supervising mid-level providers shall perform and document reviews of at least five percent of the mid-level provider's charts each calendar month for accuracy of diagnosis and appropriateness of treatment rendered.
- (2) Physician assistants who are not certified by the National Commission on Certification of Physician Assistants (NCCPA), recent graduates who have not taken or passed the NCCPA examination, and nurse practitioners who have not taken or passed a specialty board examination offered by the pertinent nurse practitioner certifying organization, shall practice in Coast Guard facilities only under the following conditions:
- (a) all health record entries shall be co-signed by a licensed or certified provider by the end of the next working day;
 - (b) all prescriptions, except for those on the Coast Guard HS formulary, shall be co-signed by a licensed or certified provider by the end of the next working day;
 - (c) when a supervisory provider is not present at the unit, noncertified mid-level providers shall be restricted to providing medical care, except for emergencies, to active duty members only;
 - (d) noncertified mid-level providers may stand clinic watches providing a standby licensed or certified provider is available via telephone to discuss any questions or concerns; and,
 - (e) with the exception of operational emergencies, noncertified mid-level providers are not eligible for independent TAD assignments at locations where a supervisory provider is not present.
- c. Nothing in this section limits PA/PYA's or NP's access to any available source of information or advice during an emergency.

12. TRICARE Management Activity-Aurora (TMA) Liaison Officer.

- a. Responsibilities. The Coast Guard TMA liaison officer maintains liaison between TRICARE and Commandant (G-W) on matters of policy, operations, and program administration. This function will not involve the responsibility for formulating department policies. Departmental policies will continue to be developed by members of the liaison group for the Uniformed Services Health Benefits Program.
- b. Duties.
 - (1) Specific Duties. Specific duties include, but are not limited to the following:

- (a) coordinate and assist, as necessary, in preparing and submitting uniform workload data for use in budgetary programming at departmental level;
 - (b) ensure timely notification to Commandant (G-W) concerning changes in TRICARE operational or administrative procedures;
 - (c) identify gaps in the TRICARE information program and recommend solutions;
 - (d) represent Coast Guard viewpoints on matters relating to TRICARE operational and administrative procedures;
 - (e) assist in developing future TRICARE information programs;
 - (f) keep the Coast Guard informed of problem areas relating to service beneficiaries and service health care facilities, where appropriate, and recommend changes which will benefit the TRICARE operation; and
 - (g) monitor purchases of high-cost equipment for use by TRICARE beneficiaries and make recommendations concerning future purchases as opposed to rental.
- (2) Duties within TMA Liaison Division.
- (a) Investigate and respond to Presidential, Congressional, and beneficiary inquiries and complaints. Investigate and respond to inquiries concerning eligibility.
 - (b) Make public presentations concerning program benefits to various groups.
 - (c) Prepare special studies relating to program activities.
 - (d) Serve as liaison representative for USPHS, DVA, and NOAA.
- (3) Other Duties. Participate in contract performance appraisal visits to the fiscal administrators. This function involves a comprehensive review and evaluation of the operations of the civilian agencies which, under contract, administer the program within each region.

13. Health Services Technicians.

- a. Rating Structure. The rating structure for health services technicians is contained in Group VIII, Enlisted Qualifications Manual, COMDTINST M1414.8 (series).
- b. General Duties of Health Services Technicians.
 - (1) The primary purpose of a health services technician is to provide supportive services to medical and dental officers and primary health care in the absence of such officers. In accordance with Paragraph 7-5-4, Coast Guard Regulations, COMDTINST M5000.3 (series), health services technicians shall not be detailed to perform combatant duties.

- (2) In particular, health services technicians are responsible for all administrative aspects of health care and health record maintenance for both their command and subordinate commands without health services personnel attached. Geographically separate subordinate commands will retain responsibility for security (i.e. physical custody) of health records. In addition to the military duties common to all enlisted personnel, health services technicians perform health services department functions, such as:
- (a) respond to calls for emergency medical assistance or evacuations (MEDEVACS);
 - (b) maintain appointments and appointment records;
 - (c) perform occupational medical monitoring duties;
 - (d) render first aid;
 - (e) perform tentative diagnosis and emergency treatment (In doing so, appropriate drugs, oral or injectable, may be administered as required in emergency situations to prevent or treat shock or extreme pain. In all other incidents where injection of controlled substances is required, permission must be obtained from a physician prior to administration. In either case, the commanding officer shall be notified immediately and entries shall be made in the patient's health record.);
 - (f) provide nursing care where trained;
 - (g) provide definitive treatment;
 - (h) provide prophylactic treatments;
 - (i) instruct crew members in first aid and oral hygiene;
 - (j) prepare materials (including sterile instruments) and medications for use;
 - (k) maintain military readiness of the health services division by complying with the appropriate Health Services Allowance List;
 - (l) perform administrative procedures in health care matters, maintain health and dental records current in all aspects;
 - (m) adhere to regulations, instructions, and control of precious metals, controlled substances, and poisons;
 - (n) exercise responsibility for all equipment and stores placed in their charge, and exercise personal supervision over their condition, safekeeping, and economic expenditure;
 - (o) maintain cleanliness of all health services spaces;
 - (p) provide services as a health benefits advisor; and
 - (q) assist in the processing of nonfederal health care requests and invoices.

- (3) Each HS who provides medical treatment to patients at a Coast Guard clinic staffed by one or more medical officers shall have a medical officer from that facility assigned in writing as his/her designated supervising medical officer (DSMO). The DSMO shall assume responsibility for all clinical treatment provided by the HS. Each independent duty HS, and HSs assigned to clinics without a medical officer, shall have a medical officer assigned in writing as his/her "Designated Medical Officer Advisor" (DMOA), to provide professional advice and consultation when needed. Refer to 1-B-1.f. and 1-B-1.g. for further details concerning DSMO/DMOA. Health services technicians assigned to units without a medical officer shall provide only "first response" emergency care to non-active duty personnel.
- (4) Care shall be taken during medical examinations which involve chest, genital, and rectal areas to afford maximum privacy and minimum exposure of the patient. An attendant of the same gender as the patient may be requested by the patient during examination or treatment. Health services technicians are authorized to conduct examinations to include: auscultation, palpation, percussion, and visual inspection as indicated by the medical complaint. Exceptions to the above are:
 - (a) health services technicians shall not perform:
 - 1 routine digital examinations of the prostate;
 - 2 routine examinations through instrumentation of the urethra; or
 - 3 routine gynecological examinations.
 - (b) such routine examinations shall be referred to a medical officer. In situations where no medical officer is readily available and such examination is necessary to provide emergency care, the health services technician is authorized to do so. If the HS and patient are of different gender, an attendant of same gender as the patient shall accompany the patient during the examination or treatment.
- (5) Participate in a course of continuing education, either clinical or administrative, through correspondence courses, resident courses, etc.

14. Health Services Technicians - Dental (HSDs).

- a. The primary responsibility of HSDs is to provide chairside assistance to dental officers.
- b. Additional duties include:
 - (1) Cleansing, sterilization, maintenance, and preparation of dental instruments;
 - (2) Cleansing, disinfecting, and maintenance of dental equipment and dental operatories;
 - (3) Preparing of dental materials;

- (4) Assessing, referral, and treatment (under direct supervision of a dental officer) of common dental conditions;
 - (5) Charting dental conditions;
 - (6) Maintaining dental records;
 - (7) Exposure and development of dental radiographs;
 - (8) Providing oral hygiene instruction;
 - (9) Taking impressions and fabricating study models; and
 - (10) Performance of emergency intervention as necessary.
- c. HSDs may be assigned to supplement HS duty sections, HSDs may not stand watch independently.

15. Independent Duty Health Services Technicians.

a. Duties.

(1) General Duties.

- (a) Health services technicians on independent duty perform the administrative duties and, to the extent for which qualified, the clinical duties prescribed for medical officers of vessels and stations. (See Coast Guard Regulations, COMDTINST M5000.3 (series) and Section 1-B of this Manual.) They shall not attempt nor be required to provide health care for which they are not professionally qualified. They shall provide care only for active duty personnel, however they may provide care to non-active duty patients on an emergency basis. The filling of prescriptions for other than active duty personnel shall be strictly limited to emergency situations and to authorized stock on hand under the allowance list for the unit. They may, under the guidance set forth in Paragraph 10-A-6-h. of this Manual, establish non-prescription medication handout programs for eligible beneficiaries.
- (b) Health services technicians shall not be detailed to perform combatant duties in accordance with Paragraph 7-5-4, Coast Guard Regulations, COMDTINST M5000.3 (series).
- (c) In accordance with the Personnel Manual, COMDTINST M1000.6 (series), commanding officers are authorized to use health services technicians for general duties except noted below:
 - 1 Health services technicians shall not be used for duties that require bearing arms (except for the limited purposes allowed by the Geneva Convention for their own defense or protection of the wounded and sick in their charge) even though the bearing of arms may be purely ceremonial.

2 Health services technicians shall not be used for combat duties that are unrelated to health care or administration.

(2) Specific Duties.

- (a) Sanitation of the Command. Make daily inspections to ensure that appropriate sanitation practices are maintained.
- (b) Health of Personnel. Establish and maintain a system for determining those who need immunizations, tuberculin tests, X-rays, dental services, and routine physical examinations. The system shall include all return appointments requested by physicians or dentists from outside referrals requested by the command.
- (c) Care of Sick and Injured. Hold daily sick call. Diagnose and treat patients within capabilities. When indicated, refer cases to facilities where medical or dental officers are available or, if this is not practical, obtain help and advice by radio or other expeditious means.
- (d) Procurement, Storage, and Custody of Property. All parts of the Health Services Allowance List (HSAL) Afloat, COMDTINST M6700.6(series), and Health Service Allowance List Ashore, COMDTINST M6700.5 (series) contain information needed for ordering and procuring supplies. The HSAL also contains procedures for storage and custody of property.
- (e) Reports. Prepare and submit reports required by Chapter 6 of this Manual and other directives.
- (f) Health Records. Maintain health records as required by Chapter 4 of this Manual. Ensure that all treatment records and/or consults from outside referrals are obtained and placed in the health record. In addition, ensure that each patient is notified of all physical exams, consultations, and diagnostic tests (i.e., pap smears, mammograms, biopsies, x-rays, etc.) performed at any facility prior to filing in the health record.
- (g) Training. Prepare and carry out a program for training non-medical personnel in first and self-aid, personal hygiene, sexually transmitted disease prevention, medical aspects of CBR warfare, cardiopulmonary resuscitation, etc., as part of the unit's regular training program.
- (h) Other Duties. As assigned by the commanding officer.

b. Reporting Procedures.

- (1) Policy. Upon reporting for independent duty, the health services technician shall consult with the commanding officer and executive officer to determine their policies regarding health care and the administration of the health services department.

- (2) **Inventory.** Obtain the unit Health Services Allowance List and inspect the inventory of all health services department equipment, supplies, and publications. Initiate action for repair, survey, or replenishment of equipment, supplies, and publications. Verify inventory records and check logs of controlled substances. Report any discrepancies to the commanding officer without delay. Amplification of requirements and procedures is contained in Chapters 8 and 10 of this Manual.
 - (3) **Health Records.** Check health records against the personnel roster. Any missing records should be accounted for or requested from previous duty stations. If records cannot be accounted for within one month's time, open a new health record. Check health records for completeness, and if not current, obtain and enter all missing information to the fullest extent possible. (See Chapter 4 of this Manual for instructions pertaining to health records.)
 - (4) **Operational Readiness.** Ascertain the state of operational readiness of the health services department and advise the commanding officer. Operational readiness refers to the immediate ability to meet all health care demands within the unit's capabilities.
- c. **Responsibilities.** The commanding officer is responsible for the health and readiness of the command. The health services department is charged with advising the commanding officer of conditions existing that may be detrimental to the health of personnel and for making appropriate recommendations for correcting such conditions. Meticulous attention to all details and aspects of preventing disease must be a continuing program. It is imperative that shipboard and station sanitation and preventive health practices be reviewed constantly in order that any disease promoting situation may be discovered immediately and promptly eradicated.
- d. **Routines.**
- (1) **Daily Routines.**
 - (a) **Sickcall.** Hold sickcall daily at a time prescribed by the commanding officer.
 - (b) **Binnacle List.** Prepare the unit Binnacle List and submit it to the commanding officer. (See section 6-B of this Manual for instructions pertaining to the Binnacle List.)
 - (c) **Inspections.** The following shall be inspected daily:
 - 1 coffee messes;
 - 2 living spaces;
 - 3 heads and washrooms;
 - 4 fresh provisions received (particularly milk and ice cream);
 - 5 scullery in operation;

- 6 drinking fountains;
 - 7 garbage disposals;
 - 8 sewage disposals;
 - 9 water supplies;
 - 10 and industrial activities. (See Chapter 7 of this Manual and the Food Service Sanitation Manual, COMDTINST 6240.4(series)).
- (d) Testing of Water. Perform water tests for chlorine/bromine content daily outside of CONUS and at all units that make or chlorinate/brominate their own water and record the results in the Health Services Log. Consult the Water Supply and Wastewater Disposal Manual, COMDTINST M6240.5 (series).
 - (e) Cleaning. Health services department spaces shall be cleaned daily and all used instruments cleaned and stored until sterilization can be accomplished.
- (2) Weekly Routines.
- (a) Health Services Logs. A health services log shall be kept by all activities and shall be submitted to the commanding officer for review, approval, and signature. Section 6-B of this Manual contains the information needed for maintaining the log.
 - (b) Inspections. Conduct sanitation inspection of the ship or station with emphasis on food service, living spaces, and sanitary spaces, specifically including food handlers, refrigerators and chill boxes, and galley spaces and pantries. Submit a written report to the commanding officer and make an appropriate entry in the health services log.
 - (c) Training. Conduct training in some aspect of health care or treatment unless required more frequently by the commanding officer or other directive.
 - (d) Hold field day.
 - (e) Resuscitators. Inspect and test resuscitators to ensure proper functioning. Record results in the health services log.
- (3) Monthly Routines.
- (a) Reports. Submit all required health services monthly reports, outlined by Chapter 6 of this Manual and other appropriate directives.
 - (b) Inspection of Battle Dressing Station Supplies. Monthly, inspect battle dressing station supplies to ensure adequate and full inventory. Check sterile supplies and re-sterilize every six months (refer to Health Services Allowance List Afloat, COMDTINST M6700.6 (series)). Replace

expired or deteriorated supplies and materials. Enter an appropriate entry in the health services log indicating that the inspection was conducted and the action taken.

- (c) First Aid Kits. Inspect hinges and hasps to ensure that they are free from rust, corrosion, or excessive paint.

(4) Quarterly Routines.

- (a) Inventory of Controlled Substances. The Controlled Substances Inventory Board shall conduct an inventory, as required by Chapter 10 of this Manual, and submit a written report of the findings to the commanding officer.
- (b) Reports. Submit all required health services reports as outlined in Chapter 6 of this Manual and other appropriate directives.
- (c) Inventory. Conduct a sight inventory of all health services consumable supplies/equipment as required by Chapter 8 of this Manual and the Health Services Allowance List.
- (d) First Aid Kits. Inspect the contents to ensure adequate and full inventory. Replace expired and deteriorated supplies and materials. Make an appropriate entry in the health services log.

16. Coast Guard Beneficiary Representatives at Uniformed Services Medical Treatment Facilities (USMTF).

- a. Duties. Health Services Technicians may be detailed to duty as representatives at USMTF's where the Coast Guard patient workload warrants. The purpose of these assignments is to ensure, for active duty personnel:

- (1) that Coast Guard authorities are provided prompt and current information concerning the status of Coast Guard personnel being treated;
- (2) that Coast Guard personnel being treated receive necessary command administrative support;
- (3) that the USMTF use the patient's Coast Guard health record and that entries are made in it or on forms that are filed in it; and
- (4) that necessary health records and forms either accompany the patient or are forwarded to the command having custody of the health record.

- b. Responsibilities. The representative is responsible for the following:

- (1) Notification of Patient Status. It is essential that the representative keep cognizant command levels advised of the status of Coast Guard patients admitted for inpatient treatment. The following procedures shall be used:
 - (a) notify commands, by the most expedient means possible, within 24 hours of admission or discharge of members of their command.

- (2) Health Record Entries. The representative is responsible for ensuring that all information concerning inpatient hospitalization, (e.g., admissions, operative summaries, discharge summaries) which is required to be entered in the health record, is furnished to the command which maintains the patient's health record. The representative shall also make the USMTF aware that all entries or forms associated with outpatient medical and dental activity must be entered in the patient's Coast Guard health record.
- (3) Copies of Forms. The USMTF is responsible for completing and furnishing at least one copy of the following forms to the representative. The representative is responsible for preparing any additional copies needed.
 - (a) Inpatient hospitalizations:
 - 1 SF-502, Narrative Summary (or other discharge summary form), and
 - 2 Operative summary if surgery was done.
 - (b) Physical examinations:
 - 1 DD-2808, Report of Medical Examination.
 - 2 DD 2807-1, Report of Medical History.
 - 3 ANY specialty reports obtained pursuant to the physical examination.
 - (c) Initial (IMB) and Disposition Medical Boards (DMB):
 - 1 NAVMED 6100/1, Medical Board Report Cover Sheet for IMB/DMB;
 - 2 Current DD-2808, Report of Medical Examination for IMB;
 - 3 Current DD-2807-1, Report of Medical History for IMB;
 - 4 Current SF-502, Narrative Summary for IMB/DMB;
 - 5 ANY specialty reports obtained pursuant to the physical examination for IMB/DMB;
 - 6 CG-4920, Patient's Statement Regarding the Findings of the Medical Board, signed by the patient for IMB/DMB;
 - 7 The command endorsement, Line of Duty/Misconduct Statement (if any), and members rebuttal (if any) should normally be done at/by the command for IMB/DMB.
- (4) Liaison and Assistance. The representative shall:
 - (a) Maintain liaison between the Coast Guard units in the area and the USMTF as follows:
 - 1 Clinical services to obtain timely appointments for Coast Guard personnel;

- (5) Notify applicants and program managers of the status and qualifications of applicants.
- (6) Provide copies of medical examinations and medical information to the various programs on applicants until they are no longer eligible.
- (7) Provide copies of medical examinations and medical information to eligible applicants as requested.

18. Health Benefits Advisors (HBA).

- a. Responsibilities. Individuals designated as Health Benefits Advisors (HBAs) at CGMTFs are responsible for advising and assisting beneficiaries concerning their health benefits. This individual shall:
 - (1) keep current on the multiple health and dental care programs and options available to Active Duty, Selected Reserve, retirees and their family members such as: TRICARE, Uniformed Services Family Health Benefits Program (USFHBP), Retiree Dental Program, TRICARE Dental program, etc.
 - (2) advise all beneficiaries on matters pertaining to healthcare benefits, including;
 - (a) obtaining Nonavailability Statements and using the local appeal system for Nonavailability Statements,
 - (b) obtaining prior authorization for specialty care under TRICARE prime and,
 - (c) educating Prime enrollees on access standards for Acute, Routine and Specialty healthcare.
 - (3) advise TRICARE beneficiaries on the relationship between TRICARE, Department Veterans Affairs(DVA) programs, Social Security, Medicare, insurance provided through employment, and the effect of employment and private insurance on benefits available under TRICARE:
 - (a) stress availability of TRICARE and explain financial implications of using non-participating providers,
 - (b) provide beneficiaries the names and addresses of participating providers of the specific services the beneficiary requires, and
 - (c) caution beneficiaries to verify that the provider participates in TRICARE at the time of service and they are accepting new patients;
 - (4) coordinates TRICARE problem cases with MLC and TRICARE contractors;
 - (5) assist all beneficiaries in properly completing TRICARE enrollment and claim forms;
 - (6) serve as a single point of contact for all health benefits programs available to active duty and retired members and their dependents;

- (7) provide information and assistance based upon personal, written, or telephone inquiries concerning healthcare benefits;
 - (8) keep beneficiaries informed of changes within the various programs, e.g., legislative changes affecting benefits available or other policy/procedures impacting upon the usage of civilian medical care. Provides for an ongoing program of lecture services, informational seminars, and group counseling to various beneficiary groups, service clubs, retirement briefings, etc.;
 - (9) maintains liaison with local providers and encourages them to increase their acceptance of the TRICARE program, and
 - (10) maintains liaison with cognizant MLC, and unit collateral duty HBAs in local area.
- b. Training.
- (1) Individuals designated as HBAs must be trained in TRICARE benefits, exclusions, claims preparation, processing, cost sharing formulas, eligibility criteria, and alternatives to TRICARE.
 - (2) Training Schedule.
 - (a) Requests for attendance at the TRICARE course should be submitted via the Chain of Command to the CG TRICARE Liaison Officer at TMA-Aurora.
 - (b) TRICARE course registration form is available at <http://www.TRICARE.osd.mil>. This form may be submitted electronically or by mail.
 - (3) TMA-Aurora Liaison Staff Seminars. The Liaison Office at TMA-Aurora provides seminars for large beneficiary groups, e.g., recruiter, career counselor, etc. Arrangements for seminars should be made directly with CG Liaison.
 - (4) Funding. Training requests for the TRICARE course will be funded by the cognizant unit.
- c. Sources of Reference Materials. HBAs shall acquire and become familiar with specific reference materials on Federal and nonfederal health programs. Specifically, as TRICARE policies change, the HBA shall maintain an updated reference library through distribution channels as outlined below:
- (1) TRICARE Information: TRICARE Web Site: www.tricare.osd.mil
 - (2) TRICARE Publications: TRICARE Smart Site: www.tricare.osd.mil/smart
 - (3) Beneficiaries can check their own claim status and eligibility at www.mytricare.com
 - (4) TRICARE Claim Forms (DD-2642, OCT93)
Now available at Website: <http://www.TRICARE.OSD.MIL> or by contacting:

Stock Point: Navy Publications and Forms Center
5801 Tabor Avenue
Philadelphia, PA 19120
U/I: PD

- (5) Referral for Civilian Medical Care (DD-2161).
May be printed locally by accessing CG Standard Workstation III, Jetform
Filler Database or by contacting:

Stock Point: Navy Publications and Forms Center
5801 Tabor Avenue
Philadelphia, PA 19120
U/I: PD

- (6) Fiscal Intermediary Distribution by Region. Fiscal Intermediary Newsletter

- (7) Local Community. Local Publication - Social Services Directory

19. Dental Hygienists. Dental hygienists are licensed graduates of American Dental Association accredited schools of dental hygiene. Whether contract or active duty providers, they are authorized to treat beneficiaries in Coast Guard dental clinics under the oversight of a dental officer. Restrictions on the degree of required oversight and the scope of services vary from state to state.

- a. In the interests of standardization, quality assurance, and risk management, dental hygienists in Coast Guard health care facilities shall, in most circumstances, treat patients only when a dental officer is present for duty at the command. At the discretion of the SDO, and in the interest of expediency, this guideline may be overridden if each of the following conditions is met on each patient:
- (1) Only active duty members are treated;
 - (2) A medical officer is present in the building;
 - (3) Patients' Periodontal Screening and Recording (PSR) scores are 10 or less; and
 - (4) The licenses of the SDO and dental hygienist are not jeopardized by this action.
- b. In every case, patients must receive a Type 2 examination by a dental officer no more than six months prior to treatment by a dental hygienist.
- c. The Senior Dental Officer (SDO), or a staff dental officer designated by the SDO, shall review no fewer than 5% of the dental hygienist's patients for completeness of plaque/deposit removal and damage to hard/soft tissues. The responsible dental officer shall document these reviews in the patients' dental records.
- d. The scope of the dental hygienist's services shall be governed by either the state in which the license is held or the state in which the clinic is located, whichever is more restrictive, and shall be itemized in the clinic's Standard Operating Procedures (SOP).

- e. In some cases the state license may contain an addendum certificate which “privileges” the dental hygienist to administer injections of local anesthesia under the direct oversight of a licensed dentist. If the state in which the clinic is located also allows this, then the dental hygienist may deliver local anesthesia under the direct oversight of the dental officer. In all cases, the dental hygienist must possess specific credentials from the state of licensure allowing him/her to administer local anesthesia. “Direct oversight” shall mean that the dental officer personally has authorized the dental hygienist to administer local anesthesia to the specific patient being treated at the specific time (i.e., “blanket approvals” are not authorized). The dental officer shall be physically present in the clinic while local anesthesia is administered by the dental hygienist. While direct oversight does not require the dental officer to be physically present in the dental hygienist’s operatory, the dental officer must be in the clinic and be capable of responding to an emergency immediately.
20. Red Cross Volunteers. Red Cross Volunteers (ARC) are persons who have completed a formal training program offered by a Red Cross Chapter and have a certificate of successful completion. Red Cross training is a screening and educational tool that enables individuals with an interest in helping others to function as supervised medical assistants in the clinic.
- a. Responsibilities. Red Cross Volunteers are responsible for scheduling their time in the clinic with clinic staff, accepting supervision, and carrying out activities mutually agreed upon by themselves and the clinic. These duties must fall within the scope of duties for which Red Cross training has prepared the volunteer. Duties may include: patient transport via gurney or wheelchair within the clinic; assessing and properly recording temperature, respiratory rate, heart rate, and blood pressure; acting as a chaperone during exams or treatment; assisting in specialty areas, i.e., laboratory (with appropriate additional training and supervision); answering telephones, filing and other clerical duties; cleaning and wrapping instruments.
- b. Supervision. Supervision of Red Cross volunteers is the responsibility of the Clinic Administrator and may be delegated.
- c. Orientation. Each volunteer must have an initial orientation to the clinic documented. Orientation shall include at least the following topics:
- (1) Fire Safety,
 - (2) Emergency procedures (bomb threats, mass casualty, power outages, hurricanes/tornadoes),
 - (3) Universal precautions and infection control,
 - (4) Proper handling of telephone emergency calls,
 - (5) Phone etiquette, paging, proper message taking,
 - (6) Patient Bill of Rights and Responsibilities, to include confidentiality, and chaperone duties in accordance with Chapter 2-J-3-b of this Manual.

21. Volunteers.

- a. Volunteer health care workers (HCW) who are not health care providers and who are members of the U. S. Public Health Service (USPHS), Department of Defense (DOD) or Coast Guard Auxiliary (AUX) shall work under the supervision of clinic staff and will provide support services that include but are not limited to: patient transport via gurney or wheelchair within the clinic, assessing and recording vital signs, acting as a chaperone during examination or treatment, clerical duties such as answering telephone or filing, cleaning and wrapping instruments, etc.
- b. Coast Guard non-rate, (active/reserve) who wish to learn more about the HS rating by participating in clinical activities prior to applying/attending HS “A” school are considered volunteers and must follow the same guidelines set forth in Chapter 1-B-21-b. and g. of this Manual. Additionally, written documentation that the member has received/understood instructions concerning items listed in 1-B-21-g.(1) through (7), must be signed by the Clinical Supervisor/Administrator and counter signed by the Senior Medical Officer. Additional requirements include:
 - (1) Priority should be given to the non-rate (active/reserve) who is on the HS “A” school list. Other non-rate (active/reserve) personnel will be considered by the Clinic Supervisor/Administrator on a case-by-case basis.
 - (2) All non-rates (active/reserve) must obtain written approval by their department supervisor prior to being assigned to the medical department.
 - (3) The non-rate (active/reserve) must be supervised at all times within the clinic by a senior HS1/HS2 and may not provide independent patient care.
 - (4) The non-rate (active/reserve) will not to be utilized as part of the HS clinical duty rotation schedule, and must work during normal clinical hours Monday-Friday while assigned to the clinic. This clinical participation will not preclude non-clinical duties or assignments.
 - (5) Non-rates (active/reserve) aboard cutters must be directly supervised by the ships “HS” and follow the same guidelines in Chapter 1-B-21-b. and g. Written documentation as stated in 1-B-21-g. must be signed by the “XO” and “HS”.
- c. TAD “none medical personnel” who are assigned to medical will follow the same guidelines in Chapter 1-21-g., and will not be utilized in the delivery of patient care.
- d. Health care providers who are members of the USPHS or DOD and volunteer to work in Coast Guard clinics for up to fourteen days per year will not be required to apply to G-WK for clinical privileges.
 - (1) Volunteer providers in this category will submit a copy of a current active state license, copy of current clinical privileges and a current CPR card to the local clinic when they report in. They will also complete a request for clinical privileges appropriate to their category and submit to the local SMO/SDO.

Volunteer providers can also submit a Credentials Transfer Brief in lieu of their license and CPR card.

- (2) For all categories of volunteer health care providers, only one active, unrestricted license from a state or U.S. Territory is required. Volunteers are authorized to work in any Coast Guard clinic in any state or territory even if they are not licensed in that jurisdiction.
 - (3) The SMO/SDO will evaluate the clinical privileges requested and by signing the request will authorize the provider to perform those health care services.
- e. Health care providers who are members of the USPHS or DOD and volunteer to work in Coast Guard clinics for more than fourteen days per year will be required to apply for clinical privileges from G-WK as described in Chapter 13-B and C of this Manual.
- f. Volunteer health care providers who are members of the Auxiliary, American Red Cross (ARC), university medical treatment facilities, as well as volunteer providers who are not affiliated with any organization, will be required to apply for clinical privileges from G-WK, IAW with protocols described in the Medical Manual, COMDTINST M6000.1(series), Chapter-13-B and C will be required to satisfy the same standards for credentialing and privileging that are required for active duty health care providers in the Coast Guard. Volunteer providers will work under the direct or indirect supervision of Coast Guard clinic providers.
- g. Each volunteer must have an initial orientation to clinic standard operating procedures which must be documented and must include at the minimum:
- (1) Fire safety
 - (2) Emergency procedures (e.g., bomb threats, mass casualty, power outages, hurricanes/tornadoes)
 - (3) Universal precautions and infection control
 - (4) Proper management of telephone calls, emergency calls
 - (5) Telephone etiquette, paging, taking messages
 - (6) Patient sensitivity and confidentiality
 - (7) Privacy Act and HIPAA

- (2) Coast Guard health care facilities are not required to provide such information under the law. Clinics may elect to provide standardized information to patients on request. Information given out shall conform to the implementing laws of the state in which the clinic is located. Clinics providing such information shall notify patients of its availability either by posted notice or via patient handout materials.
- (3) Clinic staff members usually do not have the required training and experience to advise patients on the legal issues concerning creation of advance directives. Patients shall be referred to the appropriate source of legal support, e.g., command or district legal officers.
- (4) Clinic staff members, where allowed by state law, may serve as witnesses to advance directive signatures.
- (5) Advance directive documents shall be held by the member and/or the member's next of kin. Advance directive documents shall not be filed in the member's health record since health records are not universally available 24 hours a day, seven days a week, for reference by a treating hospital.

5. Elective Surgery for Pre-Existing Defects.

- a. General. In many medical/dental procedures undertaken to correct defects that existed prior to entrance (EPTE) into the Service, the likelihood of return to full duty is questionable. In addition, such cases have often resulted in long periods of convalescence with subsequent periods of limited duty, outpatient care, and observation which render the Government liable for benefits by reason of aggravation of these defects.
- b. Criteria. The following conditions must be met before attempting surgical correction of an EPTE defect.
 - (1) It interferes with the member's ability to perform duty.
 - (2) The procedure being considered is an accepted one, carries a minimal risk to life, and is not likely to result in complications.
 - (3) There should be a 90 percent chance that the procedure will correct the defect and restore the member to full duty within a reasonable time (three months) without residual disability. If the defect does not meet the above conditions and the member is, in fact, unfit to perform the duties of grade or rate, action shall be taken to separate the member from the Service.
- c. Discussion. Whether elective medical/dental care should be undertaken in any particular case is a command decision which should be decided using the above guidelines. In questionable cases, the member may be referred to a medical board for final decision prior to undertaking elective treatment for an EPTE defect.

6. Elective Health Care.

- a. Medical/Dental treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the Coast Guard. If the member's condition does not interfere with their ability to perform duty, the treatment shall be considered elective.
- (1) Elective care may be obtained, if available, from USMTF's. **Any expenses incurred in obtaining elective care or follow-up care at USMTFs is the responsibility of the member.**
 - (2) If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.
 - (3) Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's health record must contain a SF-600 entry detailing:
 - (a) the personnel action to be taken by the command regarding the granting of absence;
 - (b) that the service member was counseled regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local Coast Guard primary care facility, or if there is no near by Coast Guard primary care facility, then the cognizant MLC (k) via phone. SF-600 will be faxed to the cognizant MLC (k) for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.
 - (c) that the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard health record, including initial evaluation, treatment plan, progress notes, and follow-up care.
 - (4) Members shall understand that once they have received an elective treatment or procedure, they may be adversely effected for present or future assignments or specialized duty. For example, Laser In-situ Keratomileusis (LASIK) is disqualifying for divers, aviation personnel, and landing signal officers (LSO).

7. Other Health Insurance (OHI)

- a. General. In some situations a member may desire to utilize their spouses' health insurance (OHI) to obtain health care outside of the Military Health Care System. Whether elective health care or all other areas of health care, this decision has an impact on the command and possibly on a member's access to the Physical Disability Evaluation System (PDES).
- b. Criteria. The following conditions must be met before utilizing a spouse's health insurance or OHI,

Section B - Health Care for Reserve Personnel.

1. Care at Uniformed Services Medical Treatment Facilities.

- a. Authority for Reserve Personnel. Section 2-A of this Manual contains the authority for medical care. Information concerning Reserve incapacitation benefits and reporting procedures is contained in the Reserve Policy Manual, COMDTINST M1001.28(series).
- b. Application for Care. A member of the Coast Guard Reserve may be admitted to USMTFs upon written authorization from an appropriate Coast Guard authority (e.g., Commanding Officer's letter, Notice of Eligibility, or appropriately endorsed orders).
- c. Definitions. The following definitions apply throughout this section:
 - (1) Active duty means full-time duty in a Uniformed Service of the United States. It includes duty on the active list, full-time training duty, annual training duty and attendance, while in the service, at a school designated as a service school by law or by the Secretary of the Uniformed Service concerned.
 - (2) Active Duty for Training is defined as full-time duty in a uniformed service of the United States for training purposes.
 - (3) Inactive Duty Training.
 - (a) Duty prescribed for reservists by the Secretary concerned under 37 USC 206 or any other provision of law.
 - (b) Special additional duties authorized for reservists by an authority designated by the Secretary concerned and performed by them on voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.
 - (4) Disability. A temporary or permanent physical impairment resulting in an inability to perform full military duties or normal civilian pursuits.
 - (5) Employed. Reservists are employed on duty during the actual performance of duty, while engaged in authorized travel to or from active duty for training, and while on authorized leave or liberty.
 - (6) Line of Duty. An injury, illness, or disease shall be deemed to have been incurred in line of duty, if a reservist at the time of debilitating incident is performing active duty or active duty for training, or is on authorized leave or liberty, provided the disability is not the result of misconduct.
- d. Injury Incurred in Line of Duty. A member of the Coast Guard Reserve who is ordered to active duty or to active duty for training, or to perform inactive duty training, for any period of time, and is disabled in line of duty from injury while so

employed is entitled to the same hospital benefits as provided by law or required in the case of a member of the regular Coast Guard. For the purpose of these benefits, a member who is not in a pay status is treated as though receiving the pay and allowances to which entitled if serving on active duty.

- e. Disease Incurred in Line of Duty While on Active Duty. A member of the Coast Guard Reserve who is ordered to active duty for training for a period of more than 30 days, and is disabled while so employed, is entitled to the hospital benefits as are provided by law or regulation in the case of a member of the regular Coast Guard. An exception is that a member of the Coast Guard Reserve ordered to perform involuntary active duty for training under the provision of 10 USC 270 is only eligible for the limited medical benefits described below, following termination of the training duty period.
- f. Illness or Disease Contracted in Line of Duty in Peacetime. A member of the Coast Guard Reserve who, in time of peace, becomes ill or contracts a disease in line of duty while on active duty for training or performing inactive duty training is entitled to receive medical, hospital, and other treatment appropriate for that illness or disease. The treatment shall be continued until the disability resulting from the illness or disease cannot be materially improved by further treatment. Such a member is also entitled to necessary transportation and subsistence incident to treatment and return home upon discharge from treatment. The treatment may not extend beyond ten weeks after the member is released from active duty, except:
 - (1) upon an approved recommendation of a medical board or
 - (2) upon authorization of the MLC (k), based on a physician's certification that the problem is a continuation of that for which the member was initially treated, and that benefit will result from further treatment. Refer to Section 11-B-3 of the Reserve Administration Policy Manual, COMDTINST M1001.28(series), for specific instructions regarding the extension of medical treatment beyond 10 weeks for those who are receiving treatment under a Notice of Eligibility (NOE).
- g. Injury or Disease En Route to or from Active Duty. A member of the Coast Guard Reserve is authorized medical care for an injury or disease incurred while en route to or from active duty, active duty for training, or inactive duty for training.
- h. Injury or Disease Not in Line of Duty. A member of the Coast Guard Reserve is not entitled to medical care for an injury or disease not incurred in the line of duty.
- i. Pregnancy. Pregnancy in the Coast Guard, COMDTINST 1900.9, contains guidance regarding pregnancy and reserve members. Use of reserve servicewomen who are pregnant for ASWAC assignment is not encouraged. Reserve servicewomen may accept Special Active Duty for Training (SADT) with the understanding that duty must be completed by the 24th week of gestation.

- (3) name and age of the proposed adoptive child or court-ordered ward; and
 - (4) a copy of the court order, legal decree, or other applicable instrument issued by a court or adoption agency which indicates the child has been placed in the house for adoption or with the intent to adopt, or the court order granting guardianship of the ward to the service member and any amounts of income to which the ward is entitled.
- c. Upon approval, the respective uniformed service will issue a letter of authority for care in one or more of their USMTFs located in the United States. This letter is the only authority for care (since designees are not DEERS-eligible) and must be presented (or on file) when seeking authorized care. These letters have expiration dates and may require the sponsor to request to reissue.
- d. When there is a need for medical care outside the United States, the sponsor should contact the nearest USMTF requesting humanitarian consideration. The Service Secretaries have limited authority for designation of beneficiaries outside the United States.

Section F - Health Care for Other Persons.

1. Members of the Auxiliary.

- a. Authority for Care of Auxiliary Members. Basic authority for health care for members of the Auxiliary injured while performing Coast Guard duty is contained in 14 USC 832. Section 5.59 of Chapter 1, Title 33, CFR, states: "When any member of the Auxiliary is physically injured or dies as a result of physical injury incurred while performing patrol duty or any other specific duty to which he has been assigned, such member or his beneficiary shall be entitled to the same benefits as are now or as may hereafter be provided for temporary members of the Coast Guard Reserve who suffer physical injury incurred in the line of duty. Members of the Auxiliary who contract sickness or disease while performing patrol duty or any other specific duty to which they have been assigned shall be entitled to the same hospital treatment as is afforded members of the regular Coast Guard." Claims for Auxillary healthcare shall be submitted to:

U. S. Department of Labor
OWCP Special Claims Branch (District 25)
800 North Capitol Street, NW, Room 800
Washington, DC 20211

- b. Compensation Under Federal Employee's Compensation Act (FECA) Program. See the Detail of Civilian Employees, COMDTINST M12300.7 (series).

2. Temporary Members of the Reserve.

- a. Composition of the Reserve. The Coast Guard Reserve is a component part of the United States Coast Guard and consists of two classes of reservists: Regular and Temporary. Temporary members of the Reserve may be enrolled for duty under such conditions as the Commandant prescribes, including but not limited to part-time and intermittent active duty with or without pay, and without regard to age. Members of the Auxiliary, officers and members of the crew of any motorboat or yacht placed at the disposal of the Coast Guard, and persons (including government employees without pay other than compensation of their civilian positions) who by reason of their special training and experience are deemed by the Commandant qualified for such duty. The Commandant is authorized to define the powers and duties of temporary reserves, and to confer upon them, appropriate to their qualifications and experience, the same grades and ratings as are provided for regular members of the Reserve.
- b. Authority for Care of Temporary Reservists. "14 U.S.C. 707(2002)", contains authority for health care and/or compensation of temporary reserves under conditions set forth therein.

- c. Care at Coast Guard Expense. 14 U.S.C. 707(d) states: "A temporary member of the Reserve, who incurs a physical disability or contracts sickness or disease while performing a duty to which the member has been assigned by competent authority, is entitled to the same hospital treatment afforded a member of the Regular Coast Guard."
 - d. Compensation Under Federal Employee Compensation Act (FECA) Program. See Detail of Civilian Employees, COMDTINST M12300.7(series)
3. Members of Foreign Military Services.
- a. General. Members and dependents of foreign services assigned or attached to a Coast Guard unit for duty or training (such as Canadian Exchange Officers) or who are on active duty with a foreign military unit within the United States (such as the crew of a vessel being taken over at the Coast Guard Yard under the Military Assistance Program) are eligible for inpatient health care at DoD MTF's provided by US Code: Title 10, Section 2559. As there are several categories of foreign service members for whom medical care benefits vary, both for themselves and their dependents, if any doubt exists as to eligibility for health care and the authorized sources from which it can be obtained, contact Commandant (G-WKH) for advice.
 - b. Care at Uniformed Services Medical Treatment Facilities. Members of foreign military services and their dependents who are eligible, therefore, shall be provided inpatient health care at DoD MTFs upon request of the member's commanding officer or consular official, or by application of the member or dependent upon presentation of proper identification.
4. Federal Employees.
- a. Benefits Under Federal Employees Compensation Act (FECA) Program. All Federal Employees assigned to Coast Guard vessels, e.g., National Marine Fishery Service (NMFS), Drug Enforcement Agents, etc., are civilian employees of the United States Government, and as such, are entitled to health care and compensation under FECA. See Detail of Civilian Employees, COMDTINST M12300.7 (series).
 - b. Care Aboard Ship and Outside CONUS. Federal Employees may be given medical care while serving with the Coast Guard in a locality where civilian health care is not obtainable, such as on board a Coast Guard vessel or outside the United States. Outpatient and inpatient care may be provided at Navy medical facilities outside CONUS, if reasonably accessible and appropriate nonfederal medical facilities are not available.
5. Seamen. Sick and disabled seamen may receive emergency health care aboard Coast Guard vessels.

6. Nonfederally Employed Civilians Aboard Coast Guard Vessels.

- a. Authority for Care. There is no statute which either prohibits or authorizes the Coast Guard to provide health care to civilians while aboard Coast Guard vessels. There is no objection to furnishing emergency health care, but routine care should not be furnished. When these civilians are aboard Coast Guard vessels for relatively lengthy periods, the commanding officer must determine what treatment is to be given.
- b. Responsibility. Commanding officers of vessels deployed for extended periods shall ensure that nonfederally employed civilians who are carried aboard Coast Guard vessels under their cognizance are physically capable of withstanding the trip contemplated and that they are free from medical conditions which could cause an interruption of the vessel's mission. Nonfederally employed civilians must furnish such evidence from a physician at no expense to the Coast Guard or Federal Government.

CHAPTER 3

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- (5) if PCS transferring to a foreign country [refer to 3-C.20.b(9)(b)], HIV antibody test must have been conducted within the past 6 months with results noted prior to transfer;
- (6) if an evaluatee is enrolled (or will be enrolled based on new assignment) in the Occupational Medical Surveillance and Evaluation Program (OMSEP), ensure appropriate periodic/basic examination is performed.

e. Applicant.

- (1) Commissioning Programs. A physical examination is required for applicants for entry into the Coast Guard as follows:
 - (a) Coast Guard Academy: DODMERB physical examination within 24 months;
 - (b) Officer Candidate School: MEPS physical within 24 months of entry date, except:
 - 1 Coast Guard personnel on active duty may obtain the physical examination at a USMTF within 24 months of entry date, and
 - 2 Members of other Armed Services may submit a physical examination from a USMTF provided the examination has been performed within the past twelve (12) months and is as complete as a MEPS physical examination.
 - (c) Direct commission: MEPS physical within 24 months of entry date or oath of office for Ready Reserve Direct Commission, except aviation programs, where examination by a uniformed service flight surgeon or AMO is required within 12 months of entry date.
 - (d) Applicants for service academies, ROTC scholarship programs, and the Uniformed Services University School of Health Sciences (USUHS) are authorized to utilize MTFs for their initial physical examination and additional testing if necessary. (Office of Assistant Secretary of Defense Health Affairs, OASD (HA) policy memo 9900003/Physical Examinations for ROTC Applicants (notal)).
 - 1 Applicants for entry into these program and prospective flight personnel should be treated as mission related priorities with scheduling precedence associated with priority group 1.
 - 2 Scheduling of physical examinations, additional tests and evaluations are to be conducted in a timely manner.
- (2) Aviation. An aviation physical examination is required for applicants for training in all categories of aviation specialties. This physical examination is valid for 24 months for Class II applicants and 12 months for pilot applicants.
- (3) Diving. A physical examination is required for all applicants for duty involving diving, and is valid for twelve months.

- f. Pre-Training Screening Examinations. A screening examination is required within 1 week of reporting to the Coast Guard Academy, Officer Candidate School, Direct Commission Officer orientation, or the Recruit Training Center. This screening examination shall be sufficiently thorough to ensure that the person is free from communicable and infectious diseases, and is physically qualified. The results of this examination shall be recorded on an SF-600 and filed in the health record.
- g. Retired Members Recalled to Active Duty. A physical examination is required for retired personnel who are recalled to active duty. This physical examination is valid for twelve months. A physical examination performed for retirement may be used for recall providing the date of recall is within six months of the date of the physical examination.
- h. Annual. An annual physical examination is required on all active duty and selected reserve personnel who are 50 years of age or older and all air traffic controllers.
- i. Biennial.
 - (1) Biennial physical examination is required every 2 years after initial designation, until age 48, for the following:
 - (a) all aviation personnel (except air traffic controllers); and
 - (b) all Landing Signal Officers (LSO).
 - (2) The biennial exam will be performed within 90 days before the end of the birth month. The period of validity of the biennial physical will be aligned with the last day of the service member's birth month. (Example: someone born on 3 October would have August, September, and October in which to accomplish his/her physical. No matter when accomplished in that time frame, the period of validity of that exam is until 31 October two years later.)
 - (3) This process of aligning the biennial exam with the birth month is a new process effective immediately. In order to phase in this process the valid period of future biennial exams may be extended up to a total of thirty months (6 months from the current valid date) to align the valid date with the birth month. (See Table 3-A-1).
 - (a) Example 1: A member with an October birth month accomplishes biennial exam in May 2000 (previously valid until May 2002). Biennial exam is now valid until October 2002 (29 months total) to allow the member to align biennial exam with birth month.
 - (b) Example 2: A member with a June birth month accomplishes a biennial exam in October of 1999 (previously valid until October 2001). Biennial exam is now valid until June 2001 (20 months total) to allow the member to align biennial exam with birth month.
 - (4) The requirement to perform a biennial exam will not be suspended in the event of training exercises or deployment. Aircrew with scheduled deployment during their 90 day window to accomplish their biennial exam may accomplish their biennial exam an additional 90 days prior and continue with the same

valid end date. This may result in a member having a valid biennial for 30 months. Members unable to accomplish a biennial exam prior to being deployed will be granted an additional 60 days upon return in which to accomplish their physical. Align subsequent biennial exam with the aircrew member's birth month using Table 3-A-1.

- (5) Additionally, a comprehensive physical may be required during a post-mishap investigation, FEB, or as part of a work-up for a medical disqualification.
- (6) Personnel designated as aircrew are expected to maintain a biennial exam schedule regardless of current aviation duty status.

Table-3-A-1

Number of months for which a biennial exam is valid

Birth Month	Month in which last biennial exam was given											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
JAN	24	23	22	21	20	19	30	29	28	27	26	25
FEB	25	24	23	22	21	20	19	30	29	28	27	26
MAR	26	25	24	23	22	21	20	19	30	29	28	27
APR	27	26	25	24	23	22	21	20	19	30	29	28
MAY	28	27	26	25	24	23	22	21	20	19	30	29
JUN	29	28	27	26	25	24	23	22	21	20	19	30
JUL	30	29	28	27	26	25	24	23	22	21	20	19
AUG	19	30	29	28	27	26	25	24	23	22	21	20
SEP	20	19	30	29	28	27	26	25	24	23	22	21
OCT	21	20	19	30	29	28	27	26	25	24	23	22
NOV	22	21	20	19	30	29	28	27	26	25	24	23
DEC	23	22	21	20	19	30	29	28	27	26	25	24

Notes:

Read down the left column to the examinee's birth month; read across to month of last biennial exam; intersection number is the maximum validity period. When last biennial exam was within the 3 month period preceding the end of the birth month, the validity period will normally not exceed 27 months. When the last biennial exam was for entry into aviation training, for FEB, post-accident, post-hospitalization, etc., the validity period will range from 19 to 30 months. Validity periods may be extended by 1 month only for completion of an examination begun before the end of the birth month.

- j. Quinquennial/Quinquennial Diving. A physical examination is required every five (5) years after entry on all active duty and selected reserve personnel, within 30 days of their birth dates starting at age 25 through age 50, and for all personnel maintaining a current diving qualification (also note "Other" in item #15.c. of DD-2808). Quinquennial physical examinations are also required for:
- (1) reserve officers assigned to the Individual Ready Reserve (IRR) who are on a promotion list.
 - (2) Officers in 3-A-7.e.(1)(a) and (b) above must have a current approved physical examination documented by PMIS data base entry prior to being promoted (i.e., a quinquennial physical examination within the last 5 years).
- k. Occupational Medical Surveillance and Evaluation Program (OMSEP). Those individuals who are occupationally exposed to hazardous substances, physical energies, or employed in designated occupations must undergo physical examinations as required by Chapter 12 of this Manual.
- l. Miscellaneous Physical Examinations.
- (1) Retention. This examination is done at the direction of the commanding officer when there is substantial doubt as to a member's physical or mental fitness for duty.
 - (2) Pre-confinement Physical Screening. In general, personnel who are presented for this screening, who do not require acute medical treatment or hospitalization, are fit for confinement. Cases where a member requires more than routine follow-up medical care, or has certain psychiatric conditions, that may make them unfit for confinement, should be discussed with the chief medical officer (or his/her representative) at the confining facility. Personnel requiring detoxification for alcohol or drug dependency are not fit for confinement; however, members that have been detoxified or that may require rehabilitation alone are fit for confinement. This screening shall be recorded on an SF-600 (per FIGURE 3-A-1) and, together with a copy of the last complete and approved Report of Physical Examination (DD-2808) and Report of Medical History (DD-2807-1), shall be submitted to the Reviewing Authority.
 - (3) Post Confinement Physical Examination. Ensure a separation physical examination has been completed prior to the member departing the confining facility. The separation physical shall meet the standards of section 3-F and must be approved by the appropriate MLC(k).
 - (4) Reservists. A district commander may require any reservist attached to a command within that area to undergo a complete physical examination if reasonable doubt exists as to the reservist's physical or mental fitness for duty.
 - (5) Non-Fitness for Duty Determination Physical Examinations. The Chief of Health Services retains the authority and responsibility to determine capability and capacity to conduct non-fitness for duty physical examinations for all eligible beneficiaries.

- (6) **Medical Boards.** Medical Boards are convened to evaluate the present state of health and fitness for duty of any active duty/selected reserve member. Chapter 1-16-b.(3)(c) of this Manual outlines required forms for this process.
- m. **Annual Command Afloat Medical Screening.** Officers and enlisted personnel scheduled to assume command afloat shall undergo a medical screening prior to assignment. The initial screening may be conducted by a medical officer where applicable, or an HS not in the prospective chain of command of the member being screened. Thereafter, all commanding officers and officers-in-charge of afloat units will have an annual command afloat medical screening. This screening will also be performed by a medical officer where available, otherwise, the screening may be performed by a Health Services Technician who IS NOT in the chain of command of the person being screened. The screening process will include a medical history completed by the member, a visual acuity check, blood pressure measurement, and a thorough review of interval history in the member's health record. Results are to be recorded using the format in Figure 3-A-2. The medical screening form (Figure 3-A-2) and a copy of the last approved DD-2808 and DD-2807-1 shall then be forwarded to the appropriate MLC (k) for review. The MLC (k) will approve or disapprove the screening using section 3-F (retention standards) as the guiding directive. If a question arises as to the fitness of the individual, the MLC (k) may request additional information from the examining unit. If the MLC (k) is unable to render a decision as to the fitness for command, the entire command afloat screening package will be forwarded to Commandant (G-WKH) for final action. The reviewed form shall be returned to the member's command for filing in the member's health record.
- n. **Dental Examinations.** Annual Type II dental examinations are required for all active duty assigned to commands collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).
8. **Waiver of Physical Standards.**
- a. **Definition of Waiver.** A waiver is an authorization to change a physical standard when an individual does not meet the physical standards prescribed for the purpose of the examination.
- (1) Normally, a waiver will be granted when it is reasonably expected that the individual will remain fit for duty and the waiver is in the best interests of the Coast Guard. A service member will not be granted a waiver for a physical disability determined to be not fit for duty by a physical evaluation board approved by the Commandant. In these cases, the provisions for retention on active duty contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and the Personnel Manual, COMDTINST M1000.6 (series) apply.
- (2) If a member is under consideration by the physical disability evaluation system, no medical waiver request shall be submitted for physical defects or conditions described in the medical board. All waiver requests received for conditions described in the medical board will be returned to the member's unit without action.

- (3) A waiver of a physical standard is not required in a case where a Service member's ability to perform on duty has been reviewed through the physical disability evaluation system and the approved finding of the Commandant is fit for duty.
- b. Authority for Waivers. Commander CGPC-epm (enlisted), CGPC-opm (officers), and CGPC-rpm (reserve) have the sole authority to grant waivers. The decision to authorize a waiver is based on many factors, including the recommendations of the Chief, Office of Health and Safety; the best interest of the Service; and the individual's training, experience, and duty performance. Waivers are not normally authorized but shall be reviewed by Commander (CGPC) for the following:
 - (1) original enlistment in the regular Coast Guard of personnel without prior military service;
 - (2) appointment as a Cadet at the Coast Guard Academy; and
 - (3) training in any aviation or diving category specialty.
 - c. Types of Waivers.
 - (1) Temporary. A temporary waiver may be authorized when a physical defect or condition is not stabilized and may either progressively increase or decrease in severity. These waivers are authorized for a specific period of time and require medical reevaluation prior to being extended.
 - (2) Permanent. A permanent waiver may be authorized when a defect or condition is not normally subject to change or progressive deterioration, and it has been clearly demonstrated that the condition does not impair the individual's ability to perform general duty, or the requirements of a particular specialty, grade, or rate.
 - d. Procedures for Recommending Waivers.
 - (1) Medical Officer. A medical officer who considers a defect disqualifying by the standards, but not a disability for the purpose for which the physical examination is required, shall:
 - (a) enter a detailed description of the defect in Item 77 of the DD-2808; and
 - (b) indicate that either a temporary or permanent waiver is recommended.
 - (2) Command/Unit Level. When the command receives a Report of Medical Examination (DD-2808) indicating that an individual is not physically qualified, the command shall inform the individual that he/she is not physically qualified. The individual shall inform the command via letter of his/her intentions to pursue a waiver. The medical officer is required to give a recommendation on whether the waiver is appropriate and if the individual may perform his/her duties with this physical defect. This recommendation shall be completed on an (SF-502) Narrative Summary. A cover letter stating the command's opinion as to the appropriateness of a waiver, the individual's

previous performance of duty, special skills, and any other pertinent information, shall accompany the medical officers report. The waiver request package shall be forwarded directly from the member's unit to Commander CGPC-epm or opm, or Commandant (CGPC-rpm) as appropriate.

- e. Command Action on Receipt of a Waiver Authorization. A command receiving authorization from the Commander CGPC-epm/opm/rpm for the waiver of a physical standard shall carefully review the information provided to determine any duty limitation imposed and specific instructions for future medical evaluations. Unless otherwise indicated in the authorization, a waiver applies only to the specific category or purpose for which the physical examination is required. A copy of the waiver authorization shall be retained in both the service and health records for the period for which the waiver is authorized. Copies of future DD-2808's for the same purpose shall be endorsed to indicate a waiver is or was in effect.

9. Substitution of Physical Examinations.

- a. Rule for Substitution of Physical Examinations. In certain circumstances, a physical examination performed for one purpose or category may be substituted to meet another requirement provided the following criteria are met:
 - (1) the examinee was physically qualified for the purpose of the previous examination and all the required tests and recommendations have been completed;
 - (2) the DD-2808 used for substitution bears an endorsement from the Reviewing Authority or Commandant (G-WKH), as appropriate, indicating that the examinee was qualified for the purpose of the previous examination;
 - (3) there has been no significant change in the examinee's medical status since the previous examination;
 - (4) a review of the report of the previous examination indicates that the examinee meets the physical standards of the present requirement;
 - (5) the date of the previous examination is within the validity period of the present requirement; and
 - (6) all additional tests and procedures to meet the requirements of the current physical examination have been completed.
- b. No substitutions are authorized for the following physical examinations:
 - (1) enlistment;
 - (2) pre-training; and
 - (3) applicants for or designated personnel in special programs (aviation, diving, Academy).
- c. Procedures for Reporting Substitution. Substitutions of a physical examination shall be reported by submitting a copy of the DD-2808 and DD-2807-1 being used to meet the present requirements with the endorsement illustrated in FIGURE 3-A-1, parts A, B, and C. Retain a copy of the substitution endorsement in the health record.

FIGURE 3-A-1 (revised 02/02)

MODIFIED PHYSICAL EXAMINATION FOR:			
SUBSTITUTION/OVERSEAS ASSIGNMENT/SEA DUTY/PSU HEALTH SCREENING			
This form is subject to the Privacy Act Statement of 1974.			
A. EVALUEE DATA			
LAST NAME - FIRST NAME - MIDDLE INITIAL		RATE/RANK	SOCIAL SECURITY NUMBER
UNIT		EXAMINING FACILITY	
PURPOSE OF EXAMINATION	TRANSFER/DEPLOYMENT LOCATION	DATE	
B. HEALTH HISTORY (completed by examinee)			
1. Would you say your health in general is:		<input type="checkbox"/> Excellent	<input type="checkbox"/> Good
		<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
2. Do you have any medical or dental problems or concerns?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Do you have any health related duty limitations?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Could you be pregnant? (females request HCG if needed)		<input type="checkbox"/> N/A	<input type="checkbox"/> Unknown
		<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Are you taking prescription medications? (request refills if needed)		<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. During the past year, have you sought or required counseling or mental health care?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
7. Explain any "fair, poor, yes, or unknown" responses: _____			
8. Have you been hospitalized since your last physical? Yes / No. If (Yes) explain. _____			
I certify that responses above are true: (signature of examinee) _____			
C. PHYSICAL EXAMINATION REVIEW (current approved physical examination required)			
9. Date and type of current approved physical examination: _____			
10. Status of recommendations or further specialist examination: _____			
11. Summary of significant health history since last physical examination: _____			
D. HEALTH RECORD REVIEW			
12. Have routine gynecologic (pap) examinations been completed in past year? (females)		<input type="checkbox"/> N/A	<input type="checkbox"/> No
		<input type="checkbox"/> No	<input type="checkbox"/> Yes
13. Does examinee have two pair of glasses? (if required to correct refractive error)		<input type="checkbox"/> N/A	<input type="checkbox"/> No
		<input type="checkbox"/> No	<input type="checkbox"/> Yes
14. Does PSU examinee have a gas mask insert? (if required to correct refractive error)		<input type="checkbox"/> N/A	<input type="checkbox"/> No
		<input type="checkbox"/> No	<input type="checkbox"/> Yes
15. Has DNA sampling been completed and documented? (once per career)		<input type="checkbox"/> No	<input type="checkbox"/> Yes
16. Has G-6-PD screening been completed and documented? (once per career)		<input type="checkbox"/> No	<input type="checkbox"/> Yes
17. Are immunizations up-to-date and meet requirements for destination?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
18. Has an HIV AB test been drawn in the past 6 months? (foreign country PCS only)		<input type="checkbox"/> N/A	<input type="checkbox"/> No
		<input type="checkbox"/> No	<input type="checkbox"/> Yes
19. Are malaria chemoprophylaxis, PPD, and special health concern requirements met?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Contact the Center for Disease Control and Prevention at http://www.cdc.gov for information.			
20. Has a Type 2 dental examination been completed in the past year and is examinee "Class 1 or 2"?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
21. Explain any "no" answers: _____			
E. SIGNATURE AND APPROVAL/DISAPPROVAL			
Medical Officer signature/stamp: _____		Date: _____	
Dental Officer signature/stamp: _____		Date: _____	
Reviewing/approving authority: _____		<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	

7. Ocular Motility (Item 26 of DD-2808).
- a. Ascertain the motility of the eyeballs by testing for binocular eye movement (ductions and versions) in the cardinal positions of gaze. If any abnormalities are suspected, verify with the cover/uncover test.
 - b. Observe if the eyes move together and whether there is loss of motion in any direction (paralysis or paresis), or absence of muscle balance, whether latent (heterophoria) or manifest (strabismus). Have the examinee look at a test object and alternately cover and uncover one eye leaving the other uncovered and observe the movement, if any, in each eye. In heterophoria movement occurs only in the eye that is covered and uncovered; on being covered, it deviates and on being uncovered, it swings back into place to take up fixation with the other eye that has remained uncovered.
8. Heart and Vascular System (Item 27 of DD-2808).
- a. General. In direct light, have the examinee stand at ease, with arms relaxed and hanging by sides. Do not permit the examinee to move from side to side or twist to assist in the examination, as these maneuvers may distort landmarks: and increase muscular resistance of the chest wall. Examine the heart by the following methods: inspection, palpation, auscultation, and when considered necessary, by mensuration.
 - b. Inspection. Begin from above and go downward, with special reference to the following:
 - (1) any malformation that might change the normal relations of the heart;
 - (2) pulsations in the suprasternal notch and in the second interspaces to the right and left of the sternum;
 - (3) character of the precordial impulse; or
 - (4) epigastric pulsations.
 - c. Palpation. First palpate to detect thrills over the carotids, thyroid glands, suprasternal notch, apex of the heart, and at the base. Use palms of hands in palpating and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the examinee stoop and throw the shoulders slightly forward, thus bringing the heart into the closest possible relation with the chest wall. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Place the palm of one hand over the heart and fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate to determine the degree of tension or compression of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered.
 - d. Auscultation. In auscultating the heart, bear in mind the four points where the normal heart sounds are heard with maximum intensity:

- (1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.
- (2) Tricuspid area, junction of the fifth right rib with the sternum. Here the first sound is distinct.
- (3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.
- (4) Mitral area, fifth interspace to left of sternum. Here the first sound is most clearly heard.

e. Blood Pressure.

- (1) Only the sitting blood pressure is required.
- (2) Other positions required only if sitting blood pressure exceeds **159/90**. (**140/90** for aviation personnel).
- (3) Take the sitting blood pressure with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure.
- (4) Personnel recording blood pressure must be familiar with situations that result in spurious elevation. A medical officer shall repeat the determination in doubtful or abnormal cases and ensure that the proper recording technique was used.
- (5) Artificially high blood pressure may be observed as follows.
 - (a) If the compressive cuff is too loosely applied.
 - (b) If the compressive cuff is too small for the arm size. Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual, this may require an "oversize" cuff.
 - (c) If the blood pressure is repetitively taken before complete cuff deflation occurs. Trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure.
- (6) At least five minutes of rest should precede the blood pressure recording. Due regard must be given to physiologic effects such as excitement, recent exercise, smoking or caffeine within the preceding thirty minutes, and illness.
- (7) No examinee shall be rejected based on the results of a single recording. If 2 out of the 3 positions exceed **159/90**, the disqualifying blood pressures will be rechecked for 3 consecutive days in the morning and afternoon of each day and **averaged**. The first determination shall be recorded in Item 58 and the repeat determinations in Item 73 of DD-2808.

20. Laboratory Findings.

a. Required Tests. Personnel undergoing physical examinations are required to have the following tests performed, except where obtaining them is not possible or expeditious, or incurring charges for them is not authorized. In such cases, these tests shall be obtained at the first duty station where facilities are available. The normal values listed below are for guidance. Abnormal laboratory values alone are not disqualifying; however, the causative underlying condition may be. Minimal deviations may not require further evaluation and this should be noted as NCD (not considered disqualifying) in item 74 by the examiner. Normal variants should be noted as such.

b. Hematology/Serology.

- (1) Hematology. Perform a hematocrit (HCT) or hemoglobin (HGB) on all examinees. Perform other hematological studies only as indicated.
- (2) Red Blood Cell Measurements.
- (3) Hemoglobin - Males 13-18 gm/100ml
- (4) Females 11.7-16 gm/100ml
- (5) Hematocrit - Males 40-54%, Females 35-47%

If any of these parameters are abnormal, an RBC and indices shall be done. Normal indices are:

RBC- Males	4.3 to 6.2 million
Females	3.8 to 5.4 million
MCV-	82-92 cubic microns
MCH-	27-32 picograms
MCHC -	30-36%

- (6) Serological Test for Syphilis (RPR/STS).
 - (a) Required for all aviation and diving candidate physicals.
 - (b) Unless there is a documented history of adequately treated syphilis, all examinees testing positive shall have repeat testing three or more days later. Ensure that at the time of obtaining serum the examinee neither has, nor is convalescing from, any acute infectious disease or recent fever. If available at no charge, the facilities of local or state health departments may be used for performing serological tests. Examinees with a history of treated syphilis should have declining or low titer positive reaction.
 - (c) If the second test is positive then obtain an FTA/ABS. If the FTA/ABS is positive, further evaluation may be required to determine the appropriate therapy.

- (d) Several conditions that are known to give false RPR/STS are infectious mononucleosis, malaria, yaws, pinta, chicken pox, infectious hepatitis, immunization, and atypical pneumonia. The cause of a false positive serological test for syphilis should be explored since many diseases giving a false positive are also disqualifying.
 - (e) New diagnosis of syphilis requires disease reporting per local governmental requirements and IAW Chapter 7-B-3 of this Manual.
- (7) Sickle Cell Preparation Test. Applicants for aviation and diving training shall be tested for sickling phenomenon, if not previously tested. Evaluate positive sickledex results by a quantitative hemoglobin electrophoresis. Greater than 40 percent Hbs is disqualifying for aviation and diving. Once the test has been completed, the results will be filed in the health record and recorded on the Problem Summary List. The test need never be repeated.
- (8) HIV Antibody.
- (a) The most recent HIV antibody test date will be recorded in item #49 of the DD-2808 (Report of Medical Examination), on the DD Form 2766, Item 10.h. (Adult Preventive and Chronic Care Flow Sheet), and under Remarks on the SF-601 (Immunization Record). Epidemiological information concerning HIV infection will be monitored by Commandant (G-WKH) and the policy concerning routine testing will be revised as necessary.
 - (b) HIV antibody testing is required as follows (see COMDTINST. 6220.1A):
 - 1 All applicants for regular or reserve programs for enlistment, appointment, or entry on active duty;
 - 2 Candidates for officer service (direct commission, OCS, Academy, MORE, etc.) as part of pre-appointment or pre-contract physical examination;
 - 3 Cadets at the Coast Guard Academy as part of the physical examination prior to commissioning;
 - 4 All Coast Guard members who have not had at least one documented HIV antibody test in the last **five** years;
 - 5 All members with PCS orders to a foreign country, within six months prior to transfer;
 - 6 During the clinical evaluation of the patients at high risk of HIV infection being seen for other sexually transmitted diseases or as part of prenatal examinations; and

- 7 Patients being referred to Level II/III alcohol/drug treatment programs must be tested for HIV immediately prior to entering such a program;
- 8 Newly identified tuberculin reactors.
- (c) Accession testing will usually be performed through MEPS examination centers. Other required testing can be done through DOD MTFs or designated Coast Guard HIV Antibody Testing Centers. Other required testing will be done through designated Coast Guard-wide HIV contract laboratory, Viomed laboratories. Commanding Officers may arrange testing with the laboratory directors at local uniformed services medical facilities (USMTFS) or qualified local civilian laboratories, only with the permission of, and prior coordination with, MLC(k). Record keeping and reporting requirements must be met. Liaison with the Department of Defense indicates that there are no prohibitions to testing Coast Guard personnel at these facilities. Contact Commander, MLC(k) for permission to use USMTFS or local civilian facilities to arrange methods for reporting results.
- (d) Members who are confirmed HIV antibody positive or indeterminate by Western Blot, by the Coast Guard-wide contract laboratory, will have a second confirmatory specimen drawn and submitted for analysis to the same Coast Guard-wide contract laboratory.
- (e) Members who are confirmed HIV antibody positive by the second confirmatory Western Blot, by the Coast Guard-wide contract laboratory, will be referred to a DOD MTF with the capability to perform a complete evaluation. Contact the respective MLC (k), and they will assist in making arrangements for the evaluation. Ensure that both the medical and dental records accompany the member to the DOD MTF for the evaluation. A narrative summary of this evaluation shall be obtained by the referring medical officer, who shall notify G-WKH via MLC(k) upon receipt. Initiate a Disease Alert Report IAW Chapter 7 of this Manual.
- (f) Once a member has been confirmed HIV positive, arrange immediate medical and social services counseling, using available Coast Guard, DOD, or civilian resources to ensure that the member understands the clinical implications of the positive test, the purpose of subsequent medical evaluation, and the policies in this instruction.
- (g) Members who are confirmed HIV antibody positive shall receive counseling. The individual's command will provide medical and supportive counseling to the member if this has not already been provided by the evaluating facility.

- (h) All information surrounding the individual's physical condition is strictly confidential. Only key personnel, with a verifiable "need to know" such as the individual's commanding officer, should be informed of the HIV status.
- (i) Coast Guard medical officers requiring HIV antibody testing for clinical diagnosis should direct the Coast Guard HIV Antibody Testing Center to send a shipment to the Coast Guard-wide contract laboratory immediately. Results should ordinarily be available within 48 hours via electronic mail or telephone from Commandant (G-WKH).
- (j) HIV antibody testing required by members of other uniformed services (active duty or reserve), or by specific agreement with other Federal agencies (e.g., Department of State), must be performed through a Coast Guard HIV Antibody Testing Center.
- (k) Voluntary testing and counseling of dependents, retirees, and civilian employees must be performed through a Coast Guard HIV Antibody Testing Center.

c. Chest X-ray (Item 52 of DD-2808).

- (1) Will be accomplished as part of the physical examinations for application for aviation or diving programs. Chest X-rays previously performed within eighteen (18) months of application, with normal results, are acceptable if there is no change in clinical presentation.
- (2) Will not be performed for routine screening purposes without a prior clinical evaluation and a specific medical indication. The senior medical officer may authorize an exception to this policy when there are obvious medical benefits to be gained by routine screening x-ray examination (e.g., Asbestos Medical Surveillance Program). Such exceptions should be authorized only after careful consideration of the diagnostic yield and radiation risk of the x-ray study, as well as other significant or relevant costs or social factors. X-ray examinations will not be ordered solely for medical-legal reasons.

d. Electrocardiogram (Item 52 of DD-2808).

- (1) Electrocardiograms (ECG) shall be accomplished routinely on the following individuals:
 - (a) those in whom medical history or clinical findings are suggestive of cardiac abnormalities;
 - (b) examinees with a sitting pulse rate of less than 50 or more than 100;
 - (c) examinees who are 40 years old or older;

- (d) applicants for aviation and diving training and all designated personnel every four (4) years until age 40, then biennially. For designated aviation personnel on physical examinations where no EKG is required, place the date and results of the last EKG in block #52 (Other) of DD-2808; and
 - (2) All student and designated aviation personnel shall have an ECG on file in their health record.
 - (3) All tracings will be compared to the baseline reading in the health record, if one is present. If significant changes are present, obtain a cardiac consultation. A report of the consult shall be submitted for review along with the DD-2808. It is imperative then that proper techniques for recording the ECG be followed.
 - (a) The routine ECG will consist of 12 leads, namely standard leads 1, 2, 3, AVR, AVL, AVF, and the standard precordial leads V1 through V6.
 - (b) Take care to properly place the precordial electrodes. It is important that the electrodes across the left precordium are not carried along the curve of the rib but are maintained in a straight line. Be particular in placing the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Do not smear electrode paste from one precordial position to another. Include a standardization mark on each recording.
- e. Urinalysis. A urinalysis is required on all physical examinations. The urine shall be tested for specific gravity, glucose, protein, blood, leukocyte esterase, and nitrite by an appropriate dipstick method. A microscopic examination is required only if any of these dipstick tests is abnormal.
- (1) Specific Gravity. Normal values are 1.005-1.035. Specific gravity varies with fluid intake, time of day, climate, and medication. As a rule, elevation of the specific gravity reflects only the state of hydration, while a low specific gravity may reflect kidney disease. In evaluating abnormalities, a repeat is generally sufficient, provided the factors above are considered and explained to the individual. Where possible, the repeat should be a first morning specimen which is usually the most concentrated.
 - (2) Glucose. Any positive test is abnormal. A false positive for glucose may occur in individuals who take Vitamin C or drink large quantities of fruit juice. As soon as practical after discovery of the glycosuria, obtain a fasting blood glucose. If glycosuria persists or if the fasting blood glucose exceeds 125 mg/100 ml, evaluate the individual for diabetes.
 - (3) Protein. A trace positive protein is often associated with a highly concentrated (specific gravity 1.024 or greater) early morning specimen and is considered normal and need not be repeated. A one plus or greater protein, or a trace positive in the presence of a dilute urine, should be evaluated by a 24-hour specimen (normal range 10-200 mg protein/24 hours).

- (4) Microscopic.
 - (a) Normal: 0-5 WBC
0-5 RBC (clean catch specimen)
occasional epithelial cells (more may be normal
in an otherwise normal urinalysis)
no casts occasional bacteria
 - (b) Pyuria usually indicates an infection or improper collection techniques. Appropriate follow-up is required, including repeat after the infection has cleared.
 - (c) Hematuria may normally occur following heavy exercise or local trauma and as a false positive in menstruating females. It always requires evaluation with the minimum being a repeat showing no hematuria.
 - (d) Casts, heavy bacteria, other organisms, and abnormal cells require further evaluation.

f. PAP Test (Item 52 a. of DD-2808).

- (1) A PAP test is required at the following times on female members:
 - (a) on the pre-training physical examination at time of initial entry into the Coast Guard;
 - (b) every two years, if on extended active duty; and
 - (c) with quinquennial examinations, for reserves.
- (2) PAP tests and pelvic examinations (by civilian or military practitioners) that have been performed within one year of periodic examinations are acceptable. In any case, results of the pelvic examination and PAP test will be recorded in Item 52 a. The practitioner is responsible for communicating the result of the PAP smear (either positive or negative) to the patient.
- (3) To reduce false-negative smears, endocervical sampling shall be done using a cytobrush, provided no contraindication is present (as in pregnancy or cervical stenosis). Laboratories to which smears are sent for interpretation must, as a matter of routine, indicate on their reports whether endocervical sampling was adequate. Where endocervical cell sampling is reported as inadequate, the smear shall be repeated.

g. Pulmonary Function Test (PFT). Perform a PFT on all OMSEP examinations and when clinically indicated.

- (1) Screening spirometry should not be performed if the subject:

- (a) is acutely ill from any cause;
 - (b) has smoked or used an aerosolized bronchodilator within the past hour;
 - (c) has eaten a heavy meal within the previous two hours; or
 - (d) has experienced an upper or lower respiratory tract infection during the past three weeks.
- (2) Explain the procedure to the subject.
 - (3) Instruct the subject to remove any tight clothing or dentures and to sit or stand comfortably in front of the spirometer. The chin should be slightly elevated with the neck slightly extended. The use of a nose clip is recommended.
 - (4) Tell the subject to take the deepest possible inspiration, close mouth firmly around the mouthpiece and without further hesitation, blow into the apparatus as hard, fast, and completely as possible. Active coaching throughout the entire duration of the forced expiration must be done to elicit maximum subject effort. Positioning of the lips around the mouthpiece should be checked.
 - (5) After two practice attempts, three further tracings should be recorded. If the technician believes that the subject has not made a full inspiration prior to the forced expiration, not put forth a maximal effort, or not continued expiration sufficiently long, that particular tracing should be repeated. Repeat attempts marred by coughing. The variation between the largest and smallest FVC of three satisfactory tracings should not exceed 10%.
 - (6) From the three satisfactory tracings, the FVC, FEV₁, and FEV₁/FVC% should be determined. Use the highest FVC and FEV₁ in the calculations regardless of the curve(s) on which they occur. The tracing itself should also be maintained as part of the medical record.
 - (7) If the tests are baseline studies, determine the predicted values and calculate the subject's percent of the predicted normal, and transcribe results on the record sheet. In non-Caucasians, the predicted FEV₁ and FVC should be multiplied by 0.85 to adjust for ethnic differences. No correction factor is necessary for the FEV₁/FVC%.
 - (8) If the tests are follow-up studies, comparison should be made with the previously recorded highest value for each test. This highest value may not necessarily have occurred during baseline tests.
 - (9) Verify any abnormalities in either baseline or follow-up pulmonary functions by repeating spirometry in two weeks. If abnormalities persist, clinical assessment by a physician qualified to evaluate chest disease is essential. In males, a 30 millimeter annual decline in FEV₁ and 25 millimeters FVC can be attributed to normal aging. In females, it is 25 millimeters in both the FEV₁ and FVC. PFT. Abnormal functions are present when:

- (a) FEV-1 or FVC is less than 80% of predicted;
- (b) FEV-1/FVC% is less than 69%;
- (c) decline in the FEV-1 or FVC greater than 8%;
- (d) decrease in the FEV-1/FVC% greater than 6%; and
- (e) see the following:

**SPIROMETRIC
GUIDELINES**

	OBSTRUCTIVE DISEASE FEV-1/FVC	RESTRICTIVE DISEASE FCV% FCV PREDICTED
NORMAL	> 0.69	> .80
MILD TO MODERATE	0.45 -0.69	0.51-0.80
SEVERE	< 0.45	<0.51

- h. Special Tests. In some cases, information available should be supplemented by additional tests or diagnostic procedures (eye refractions, x-rays, repeated blood pressure readings, etc.), in order to resolve doubts as to whether the examinee is or is not physically qualified. If facilities are available to perform such tests at no cost, they should be obtained as indicated in individual cases. Otherwise, applicants for original entry in the Service will be required to obtain such tests at their own expense, if they desire further consideration.
- i. Laboratory Values (OMSEP). All laboratory values not previously discussed but that accompany a physical examination (e.g., chemistry profiles, etc.) must have accompanying normals for the laboratory that performed the tests.
- j. Mammography. Mammography is required for Coast Guard active duty and reserve females beginning at age 40 and at ages 44, 48, 50, 52, 54, 56, 58, 60, and 62. Clinical findings, family history, and other risk factors may dictate that a mammogram be done at times other than those indicated in this screening schedule. Results should be documented on the routine physical exams. Mammograms done between the required screening ages can be used to satisfy the periodic requirement. This judgment is left to the practitioner. If mammography is not done at the required ages, the reason must be supplied in item 73 of the DD-2808 and should include date and result of the last mammogram. Practitioners are responsible for communicating mammography results (either positive or negative) to the patient.

- k. Glucose-6-Phosphate Dehydrogenase (G-6-PD). Qualitative testing (present or not) for G-6-PD deficiency is required at all accession points (TRACEN Cape May, Academy, RTC Yorktown). All other Coast Guard members with no record of testing shall be tested prior to assignments afloat or to malaria-endemic areas. The results of testing shall be annotated on the DD-2766 Adult Preventive and Chronic Care Flowsheet. Once testing is accomplished, it need never be repeated.

21. Height, Weight, and Body Build.

- a. Height. Measure the examinee's height in both meters and to the nearest inch, without shoes.
- b. Weight.
 - (1) Weights are with underwear/undergarments only.
 - (2) Weigh the examinee on a standard set of scales calibrated and accurate. Record the weight both kilograms and pounds. Do not record fractions of pounds, such as ounces.
- c. Frame Size. Using a cloth tape, measure the wrist of the dominant hand, measure all the way around from lateral to medial styloid process. Measure in centimeters and inches including fraction of inches.
- d. Body Fat Percentage. Determined by MEPS.

22. Distant Visual Acuity and Other Eye Tests.

- a. Distant Visual Acuity, General. Visual defects are one of the major causes for physical disqualification from the armed services. Methods of testing vision have varied greatly among the armed services and from place to place in each Service. Consequently, visual test results are not always comparable. An examinee presenting for examination at one place might be qualified for visual acuity, while at another place, disqualified. Although this is an undesirable situation, no practical solution, such as prescribing standards for equipment and conditions (room size, ventilation, paint colors, room illumination, etc.), is available to the Coast Guard as the examinations are obtained from various sources over which the Coast Guard has no control. It is therefore imperative that examiners be especially painstaking to obtain the most accurate results possible.
- b. Examination Precautions.
 - (1) Make every effort to conduct the examination when the examinee is in normal physical condition. Follow the examination routine in the order prescribed in the following instructions. Record the vision for each eye when determined so that errors and omissions will be avoided.
 - (2) It may be extremely difficult to obtain an accurate measure of visual acuity. Bear in mind that individuals who are anxious to pass visual acuity tests may resort to deception. Similarly, other individuals may attempt to fail a visual acuity test to avoid undesirable duties. Hence, be prepared to cope with either

possibility in order to uncover and recognize visual defects without the cooperation of the person being tested.

- (3) Refer uncooperative examinees to a medical officer.

c. Examination Procedures.

- (1) In order to obtain a more valid evaluation, inform examinees that contact lenses will not be worn during the evaluation and for 72 hours before. Orthokeratotic lenses shall be removed for 14 days or until vision has stabilized for 3 successive examinations.
- (2) If the examinee wears glasses, they must be removed before entering the exam room. Test each examinee without unnecessary delay after entering the examining room. In order to prevent personnel from memorizing the charts, permit only one examinee to view the test charts at a time. Keep examinees awaiting testing out of hearing.
- (3) Direct the examinee to a line that is 20 feet from the test chart. Hold an occluder so that it covers the examinee's left eye. Instruct the examinee to keep both eyes open and not to squint. The occluder must not be pressed against the eyeball or lids or any part of the eye being shielded, but, should be held in contact with the side of the nose. The eye shielded by the occluder should be left open in order to avoid pressure and to discourage squinting. A rigid occluder, constructed of a material such as wood, translucent plastic, or metal, of a design to discourage cheating shall be used to shield the eye not being tested.
- (4) Direct the examinee to begin with the first line and to read as many lines as possible. (Watch the examinee, not the chart that is being read. Hold the occluder so the examinee cannot peep around it. The most frequently used method of increasing visual acuity is to squint. This will not be permitted. Some examinees with astigmatism will be able to read the letters better by tilting the head to one side; do not allow this. Another well-known method used to pass a visual acuity test is to obtain eyedrops beforehand that contract the pupil; suspect this if the pupils are unusually small.)
- (5) Record the smallest line read with no errors on the chart from the 20 foot distance as the vision for the right eye (0.D.).
- (6) Test the visual acuity for the left eye (0.S.), preferably using a different chart, record in the same manner.
- (7) Test the visual acuity for both eyes (0.U.), preferably with a third chart, record in the same manner.
- (8) Test an examinee who wears glasses again with them on. Follow the same procedure as without glasses.
- (9) When there is suspicion that the examinee has memorized a chart, a different chart should be used or the letters on the chart should be read in reverse order.

- (10) The examinee is expected to read letters promptly. No precise time limit should be applied, but 1 or 2 seconds per letter is ample.
 - (11) An examinee who fails a letter should not be asked to read it again. If a rapid reader makes an obviously careless mistake, caution the examinee to "slow down" and repeat the test using another chart.
 - (12) Some examinees give up easily. They may need encouragement to do their best; however, do not coach them.
 - (13) The effects of fatigue may make a certain amount of retesting necessary. In questionable cases, one retest should be given not less than the day after the initial test.
- d. Armed Forces Vision Tester (AFVT). Visual acuity may also be determined with the (AFVT) which consists of two rotating drums holding illuminated slides for testing various facets of vision. The examinee observes the distance slides looking slightly downward with the instrument set and also observes the near slides looking downward at a greater angle. The handles on the side of the instrument rotate the drums to change the slides. Beneath the eye pieces there is a lever that operates an occluder so that each eye can be tested separately. In the case of the slides for muscle balance and stereopsis, the two eyes must be tested together and the occluder should be centered so it occludes neither eye. A scoring key is provided with the instrument. The following slides are available:
- (1) Rear Drum (Distance Testing).
 - (a) Slide 1 - Vertical Phorias.
 - 1 The right eye sees a set of numbered steps, the left sees a dotted line. With both eyes open the examinee is asked which step the dotted line intersects. Interpretation: step 1, 2 prism diopters of left hyperphoria; step 2, 1.5 left hyperphoria; step 3, 1.0 left hyperphoria; step 4, 0.5 left hyperphoria; step 5, orthophoria; step 6, 0.5 prism diopters of right hyperphoria; step 7, 1.0 right hyperphoria; step 8, 1.5 right hyperphoria; step 9, 2.0 right hyperphoria.
 - 2 Detecting Malingerers: i.e., if known that a score of 5 is normal, the examinee could feign a normal phoria. To avoid this, a pair of VARIABLE PRISMS is provided, by which the examiner can raise either the right or the left eye image. The prisms are mounted within the viewing box. The extent of prismatic deviation is governed by the position of two control handles.
 - 3 The correct score--and the only score recorded--is that obtained when both control handles of the VARIABLE PRISM are pushed inward as far as they will go. This is known as the SCORING POSITION. Moving the left handle outward from this position

moves the left eye image downward and outward. Similarly, moving the right handle outward moves the right eye image downward and outward.

- 4 The maximum amount of downward shift provided by each control corresponds to four steps. Moving the right handle outward to its extreme position therefore will change the apparent location of the dotted line from step 1 to step 5, for example, from 6 to above 9, etc. Moving the left control handle outward to its extreme position similarly will change the apparent location of the dotted line from step 5 to step 1, or from step 8 to step 4, etc. Vary the location of the right or left control handle, each time asking the examinee to report the location of the dotted line. Only the answer obtained when both handles are in the SCORING POSITION gives the examinee's test score.
- (b) Slide 2 - Horizontal Phorias.
- 1 The examinee's right eye sees a row of numbered dots, the left eye sees an arrow, with the occluder in the open position, ask the examinee to which numbered dot the arrow is pointing.
Interpretation: The reporting value minus 11 equals prism diopters of exophoria; 11 minus the reported value equals the prism diopters of esophoria.
 - 2 DETECTING MALINGERERS: By means of the VARIABLE PRISM previously mentioned, the right and left eye images can both be shifted outward a maximum of seven dots. To produce this outward shift without a downward shift, in this test both control handles are moved outward simultaneously by the same amount. When both handles are shifted as far out as they go, the apparent position of the arrow is moved seven dots to the left, giving a score seven below the true score.
 - 3 As in previous test, the correct score and the only score recorded is that obtained when the control handles are in the SCORING POSITION.
- (c) Slides 3 and 3A - Visual Acuity. With both eyes uncovered the examinee sees a jumble of letters. With one eye covered, the uncovered eye cannot see the letters intended for the opposite eye.
- (d) Slides 4 and 4A - Visual Acuity, Large Letters. Separate charts for the left and right eye.
- (e) Slides 5 and 5A - Stereopsis. Six groups of horizontal lines, five circles to a line. The groups are numbered A to F. In each horizontal row of circles, one circle stands out closer to the examinee. The degree of

difficulty increases from A to F. The examinee calls the circle that stands out. Passing score: There must be no misses in groups A through D. Caution: Ensure that neither eye is inadvertently left occluded when this test is being given. Both eyes must be able to see the circles in order for any stereopsis to occur.

- (2) Front Drum (Near Testing).
 - (a) Slide 6 - Vertical Phorias. Same as slide 1, only this is a near test.
 - (b) Slide 7 - Horizontal Phorias. Same as slide 2, except subtract 13.
 - (c) Slide 8 - Near Visual Acuity. This is given in Snellen notations.
 - (d) Slide 9 - Near Visual Acuity, Large Letters.
- e. Score recording. Record vision test scores as a fraction in that the upper number is the distance in feet from the chart and the lower number is the value of the smallest test chart line read correctly. Thus, a person reading at a distance of 20 feet, the 30 foot test chart line is given a score of 20/30. 20/20 indicates that a person reads at a distance of 20 feet the test chart line marked 20. Similarly, 20/200 means a person can read at a distance of 20 feet only the test chart line marked 200.
- f. Refraction.
 - (1) Eye refractions are required:
 - (a) when applying for flight training (SNA) (This must include cycloplegic.); and
 - (b) when visual acuity falls below 20/20 in either eye (near or distant).
 - (2) Subsequent refractions are required only if the visual acuity deteriorates further.
 - (3) If a cycloplegic is used during the course of refraction, then the examinee must wear dark glasses until the effects disappear. The installation of 1 drop into each eye of 1% solution of pilocarpine hydrochloride in distilled water after completing the examination will constrict the pupil and thus relieve the photophobia.
- g. Near Vision. Test near vision on all examinees and record results in Item 61 of DD-2808 using Snellen notations. The examinee should be positioned so that the light source is behind him/her and the near vision test card is well illuminated. The examiner shall instruct the examinee to hold the test card exactly 14 inches/35.5 cm in front of their eyes (measure from the inner aspect of the lower eyelid [corner of the eye] to the face of the card to ensure accurate distance). Test each eye separately. Note the smallest line of type that the examinee is able to read with each eye. Record near vision both with and without corrective lenses if glasses are worn

or required. Record corrections worn in Item 73. See the chart below for conversion from the various near point letter nomenclatures to Snellen notations.

CONVERSION TABLE FOR VARIOUS NEAR POINT LETTER NOMENCLATURE

Standard Test Chart	Snellen English Linear	Snellen Metric	Jaegar
14/14	20/20	0.50	J-1
14/17.5	20/25	.62	J-2
14/21	20/30	.75	J-4
14/28	20/40	1.00	J-6
14/35	20/50	1.25	J-8
14/49	20/70	1.75	J-12
14/70	20/100	2.25	J-14
14/140	20/200		

- (b) 18 plate test set. Examinee must correctly read at least 14, excluding demonstration plates.
 - (c) 15 plate test set. Examinee must correctly read 10 plates.
- k. Depth Perception. Required for all aviation personnel and when medically indicated. The AFVT is the most commonly used method of testing depth perception. When this instrument is not available, the Randot (random Dot Circles Test) and the Titmus (Titmus Graded Circles Stereoacuity Test) are authorized alternatives to measure depth perception. If the examinee fails any of the aforementioned tests, use a Verhoeff Stereopter. Results obtained with the Verhoeff are final in resolving all cases of questionable depth perception.
- (1) Findings.
 - (a) AFVT. An error in group A, B, C, or D is disqualifying.
 - (b) Verhoeff. Failure to correctly report eight out of eight in two of three trials is disqualifying.
 - (2) Operating the Verhoeff.
 - (a) As a preliminary, show target #2 (the second target down when the instrument is upright) at about 40 centimeters and bring it nearer if necessary. This will acquaint the examinee with what is to be observed and at the same time determine whether there is at least a distance, however short, that can be judged correctly.
 - (b) Show one or two positions at close range to the examinee to clearly demonstrate that one rod is always at difference from the other two. Point out that the size of the rods is not a clue to the relative distance. The examinee is now ready for the test.
 - (c) Hold the apparatus 1 meter from the examinee.
 - (d) Eight different rod relations are possible and all eight are shown.
 - (e) Keep the device centered as a frontal plane normal to the subject's binocular visual midline. To avoid helpful extraneous cues it is highly important to hold the device steady, and particularly not to rotate it on its vertical axis. It is also important not to permit the subject to move the head.
 - (f) Do not expose the target window while the device is being placed in position or the sets are changed. A convenient method of manipulation is to grasp the device over the target window with the left hand, place the desired set into position with the right hand, then grasp the device below with the right hand and expose the target window by moving the left

hand up or down. Thus while the target window is exposed, the device is supported by both hands of the examiner.

- (g) The instructions to the subject are: "Report the nearest strip and the farthest strip, unless they all appear to be at the same distance, referring to the strips as 'left,' 'middle,' and 'right'." Only the report concerning the one strip out of plane (farther or nearer than the other two that are in the same plane) is to be considered.

1. Field of Vision.

- (1) Except for aviation personnel, special tests for field of vision are not required unless medically indicated.
- (2) Procedure.
 - (a) Face the examinee at a distance of 2 feet.
 - (b) Close right eye and instruct the examinee to close left eye and focus right eye on your left eye.
 - (c) Bring fingers in from the periphery, midway between you and the examinee.
 - (d) Instruct the examinee to say when and how many fingers seen.
 - (e) Test all cardinal points.
 - (f) Repeat test for the left eye.
 - (g) Any evidence of abnormality should be given study on the perimeter.
- (3) Normals.
 - (a) Temporally - 90° .
 - (b) Superotemporally - 62° .
 - (c) Superiorly - 52° .
 - (d) Superonasally - 60° .
 - (e) Inferonasally - 55° .
 - (f) Inferiorly - 70° .
 - (g) Inferotemporally - 85° .

hand is compared with the normal hand (nondominant is 80 percent of dominant grip).

10. Lower Extremities (see 3-D-11). The causes for rejection for appointment, enlistment, and induction are as follows:
 - a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in EXHIBIT 3-F-1.
 - (1) Hip. Due to disease(726.5) or injury (905.2).
 - (a) Flexion to 90 degrees (minimum).
 - (b) No demonstrable flexion contracture.
 - (c) Extension to 10 degrees (beyond 0 degree).
 - (d) Abduction to 45 degrees.
 - (e) Rotation - 60 degrees (internal and external combined).
 - (2) Knee. Due to disease (726.7) or injury (905.4).
 - (a) Full extension compared with contralateral.
 - (b) Flexion to 90 degrees.
 - (3) Ankle. Due to disease (726.7) or injury (905.4).
 - (a) Dorsiflexion to 10 degrees.
 - (b) Plantar flexion to 30 degrees.
 - (c) Eversion and inversion (total to 5 degrees).
 - (4) Subtalar. Due to disease (726.7) or injury (905.4).
 - (a) Eversion and inversion total to 5 degrees.
 - b. Foot and ankle.
 - (1) Absence of one or more small toes (895). If the function of the foot is poor, or running or jumping is prevented; absence of a foot (896) or any portion thereof except for toes as noted herein.
 - (2) Absence of great toe(s) (895). Loss of dorsal and/or planter flexion if the function of the foot is impaired (905.4).
 - (3) Deformities of the toes. Either acquired (735) or congenital (755.66), including polydactyly (755.02), that prevents the wearing of military footwear, or impairs walking, marching, running, or jumping. That includes hallux valgus (735).

- (4) Clubfoot and/or Pes Cavus (754.5). If stiffness or deformity prevents foot function or wearing military footwear.
- (5) Symptomatic Pes planus. Acquired (34) or congenital (754.6) or pronounced cases with absence of subtalar motion.
- (6) Ingrown toenails (703). If severe.
- (7) Planter Fasciitis (728.7). If persistent.
- (8) Neuroma (355.6). Confirmed condition and refractory to medical treatment, or will impair function of the foot.

c. Leg, knee, thigh, and hip.

- (1) Loose or foreign bodies in the knee joint (717.6).
- (2) Physical findings of an unstable or internally deranged joint (717.9). History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.
- (3) Surgical correction of any knee ligaments (P81), if symptomatic or unstable.
- (4) History of congenital dislocation of the hip (754.3). Osteochondritis of the hip (Legg-Perthes Disease) (732.1), or slipped femoral epiphysis of the hip (732.2).
- (5) Hip dislocation (835). Dislocation within 2 years before examination.
- (6) Osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4). If symptomatic.

d. General.

- (1) Deformities (905.4), disease, or chronic pain (719.4) of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life; or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty.
- (2) Shortening of a lower extremity (736.81), resulting in a noticeable limp or scoliosis.

11. Miscellaneous Conditions of the Extremities. (see 3-D-9 and 3-D-10). The causes for rejection for appointment, enlistment, and induction areas follows:

a. Arthritis.

- (1) Active, subactive, or chronic arthritis (716).
- (2) Chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree, that has interfered with the following of a physically active vocation in civilian life or that prevents the satisfactory performance of military duty.

- (c) Endodontics. The need for endodontic intervention on seven or more canals is disqualifying.
- (d) Maxillary and Mandibular Bones. Malunited fractures of maxillary or mandibular bones and deformities of maxillary or mandibular bones interfering with mastication or speech are disqualifying. The presence of extensive necrosis or osseous lesions requiring surgical intervention are also disqualifying.
- (e) Oral Tissues. Extensive loss of oral tissues that would prevent the replacement of missing teeth with a satisfactory prosthetic appliance is disqualifying. Unresolved oral inflammatory diseases are disqualifying. Hypertrophic, hyperplastic, or leukoplakic conditions of the soft tissue of the oral cavity may be disqualifying and will be considered on a case-by-case basis.
- (f) Periodontal Disease. The presence of advanced periodontal disease is disqualifying.
- (g) Serviceable Teeth. A sufficient number of teeth, natural or artificial, in functional occlusion to assure satisfactory incision, mastication, and phonation are required. The minimum requirement is edentulous upper and lower jaws corrected by full dentures. A requirement for placement of a prosthesis to meet the above requirements is disqualifying.
- (h) Temporomandibular Joint. Current symptoms and/or history of chronic temporomandibular joint dysfunction is disqualifying (see also section 3-D-16.b).

4. Commissioning of Officer Candidates.

- a. The physical examination given upon arrival at OCS precludes the need for a commissioning physical examination providing there has been no intervening change in physical status and a visual acuity and color perception examination are given prior to actual commissioning.
- b. The physical standards for commissioning are the same as for enrollment as an officer candidate. Final determination as to physical fitness for commissioning is made by the Commandant.

5. Coast Guard Direct Commission Program. Physical standards for Coast Guard active duty member's (CWO's, enlisted) that apply for the Direct Commission program are the same as for retention of officers in the regular Coast Guard. (refer to Section F of this Manual for the standards). Physical standards for all other applicants are the same as for enrollment of officer candidates.

6. Direct Commission in the Coast Guard Reserve.
 - a. Nonaviator. The physical examination and standards for direct commission in the Reserve are the same for enrollment of officer candidates, except that Ready Reserve Direct Commission (RRDC) examinations must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).
 - b. Aviator. Candidates for direct commission in the Reserve as aviators must obtain an aviation physical examination from a currently qualified uniformed services flight surgeon or AMO within the last 12 months. The candidate must meet the standards for Class I, contained in section 3-G.
7. Direct Commission of Licensed Officers of U. S. Merchant Marine.
 - a. Physical Examination. Two physical examinations are required: a preliminary physical at the time of the written examination; and a pre-appointment physical examination taken by successful candidates within six months of actual commission. The physical examination must be conducted by a medical officer of the uniformed services on active duty. Final determination of physical fitness will be made by the Commandant.
 - b. Physical Standards. The physical standards for direct commission of Licensed Officers of the U. S. Merchant Marine are the same as for enrollment of officer candidates. All these standards must be met without waiver.
8. Appointment to Warrant Grade.
 - a. Physical Examination. A complete physical examination is required within 12 months prior to appointment to Warrant Officer, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).
 - b. Physical Requirements. The physical standards for appointment of Coast Guard members to Warrant Officer are the same as for retention of officers in the regular Coast Guard. (refer to Section 3-F of this Manual for the standards). Physical standards for all other applicants are the same as for enrollment of officer candidates.

Section F- Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions.

- a. Scope. This section establishes specific physical standards applicable to all personnel (regular and reserve) for:
 - (1) enlistment/reenlistment of prior service USCG personnel within 6 months of discharge from active duty in the Regular Coast Guard;
 - (2) retention;
 - (3) overseas duty; and
 - (4) sea duty.
- b. Physical Examinations. Physical examinations should be conducted by at least one medical and one dental officer of the uniformed services or by contract physician/dentist.
- c. Fitness for Duty. Members are ordinarily considered fit for duty unless they have a physical impairment (or impairments) that interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties. Active duty or selected reserves on extended active duty considered permanently unfit for duty shall be referred to an Initial Medical Board for appropriate disposition.

2. Use of List of Disqualifying Conditions and Defects. This section lists certain medical conditions and defects that are normally disqualifying. However, it is not an all-inclusive list. Its major objective is to achieve uniform disposition of cases arising under the law, but it is not a mandate that possession of one or more of the listed conditions or physical defects (and any other not listed) means automatic retirement or separation. If the member's condition is disqualifying but he/she can perform his/her duty, a waiver request could be submitted in lieu of immediate referral to an Initial Medical Board. If the request is denied, then an Initial Medical Board is required. The only exception is HIV infection, which may not require waiver or referral to IMB if the member continues to fully perform duties. (see Chapter 3- F-22 of this Manual)

3. Head and Neck.

- a. Loss of substance of the skull. With or without prosthetic replacement when accompanied by moderate residual signs and symptoms.
- b. Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

4. Esophagus, Nose, Pharynx, Larynx, and Trachea.

a. Esophagus.

- (1) Achalasia. Manifested by dysphagia (not controlled by dilation), frequent discomfort, inability to maintain normal vigor and nutrition, or requiring frequent treatment.
- (2) Esophagitis. Persistent and severe.
- (3) Diverticulum of the esophagus. Of such a degree as to cause frequent regurgitation, obstruction and weight loss, that does not respond to treatment.
- (4) Stricture of the esophagus. Of such a degree as to almost restrict diet to liquids, require frequent dilation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

- (1) Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.
- (2) Stenosis of the larynx. Causing respiratory embarrassment upon more than minimal exertion.
- (3) Obstruction edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

c. Nose, Pharynx, Trachea.

- (1) Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting and concomitant severe headaches.
- (2) Sinusitis. Severe and chronic that is suppurative, complicated by polyps, and does not respond to treatment.
- (3) Trachea. Stenosis of trachea that compromises airflow to more than a mild degree.

5. Eyes.

a. Diseases and Conditions.

- (1) Active eye disease. Or any progressive organic disease regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual field so that:
 - (a) distant visual acuity does not meet the standards; or
 - (b) the diameter of the field of vision in the better eye is less than 20°.
- (2) Aphakia, bilateral. Regardless of lens implant(s).
- (3) Atrophy of optic nerve.
- (4) Glaucoma. If resistant to treatment, or affecting visual fields, or if side effects of required medications are functionally incapacitating.

- y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity.
 - z. Scleroderma. Generalized, or of the linear type that seriously interferes with the function of an extremity or organ.
 - aa. Ulcers of the skin. Not responsive to treatment after an appropriate period of time or if interfering with satisfactory performance of duty.
 - bb. Urticaria. Chronic, severe, and not amenable to treatment.
 - cc. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.
 - dd. Other skin disorders. If chronic, or of a nature that requires frequent medical care or interferes with satisfactory performance of military duty.
15. Neurological Disorders.
- a. Amyotrophic sclerosis, lateral.
 - b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.
 - c. Atrophy, muscular. Progressive muscular atrophy.
 - d. Chorea. Chronic and progressive.
 - e. Convulsive disorders. (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) Following a seizure, the member is NFFD, and will remain unfit until he/she is controlled with medications with no seizures for twelve months. A medical board is not required if the convulsive disorder is well controlled.
 - f. Friedreich's ataxia.
 - g. Hepatolenticular degeneration.
 - h. Migraine. Manifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment.
 - i. Multiple sclerosis.
 - j. Myelopathy transverse.
 - k. Narcolepsy, cataplexy, and hypersomnolence.
 - l. Obstructive Sleep Apnea. when not correctable by use of CPAP or surgical means.
 - m. Paralysis, agitans.

- n. Peripheral nerve conditions.
 - (1) Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.
 - (2) Neuritis. When manifested by more than moderate, permanent functional impairment.
 - o. Syringomyelia.
 - p. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance loss of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.
16. Psychiatric Disorders. (see section 5-B concerning disposition)
- a. Disorders with Psychotic Features. Recurrent psychotic episodes, existing symptoms or residuals thereof, or recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.
 - b. Affective disorders; anxiety, somatoform, or dissociative disorders. Persistence or recurrence of symptoms sufficient to require treatment (medication, counseling, psychological or psychiatric therapy) for greater than 6 months. Regardless of the length of treatment, any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see “Personnel Manual, COMDTINST M1000.6 (series) for further guidance”.
 - c. Mood disorders. Bipolar disorders or recurrent major depression. All other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization, or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than 6 months. Prophylactic treatment requiring more than one drug, or associated with significant side effects (such as sedation, dizziness or cognitive changes) or frequent follow-up that limit duty options. **(Prophylactic treatment with medication may continue indefinitely as long as the member remains asymptomatic following initial therapy).** Any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see “Personnel Manual, COMDTINST M1000.6 (series) for further guidance.”
 - d. Personality; sexual; factitious; psychoactive substance use disorders; personality trait(s); disorders of impulse control not elsewhere classified. These conditions may render an individual administratively unfit rather than unfit because of a physical impairment. Interference with performance of effective duty will be dealt with through appropriate administrative channels (see section 5-B).

(5) required chronic anti-coagulant, other than aspirin, such as Coumadin.

20. Tumors and Malignant Diseases.

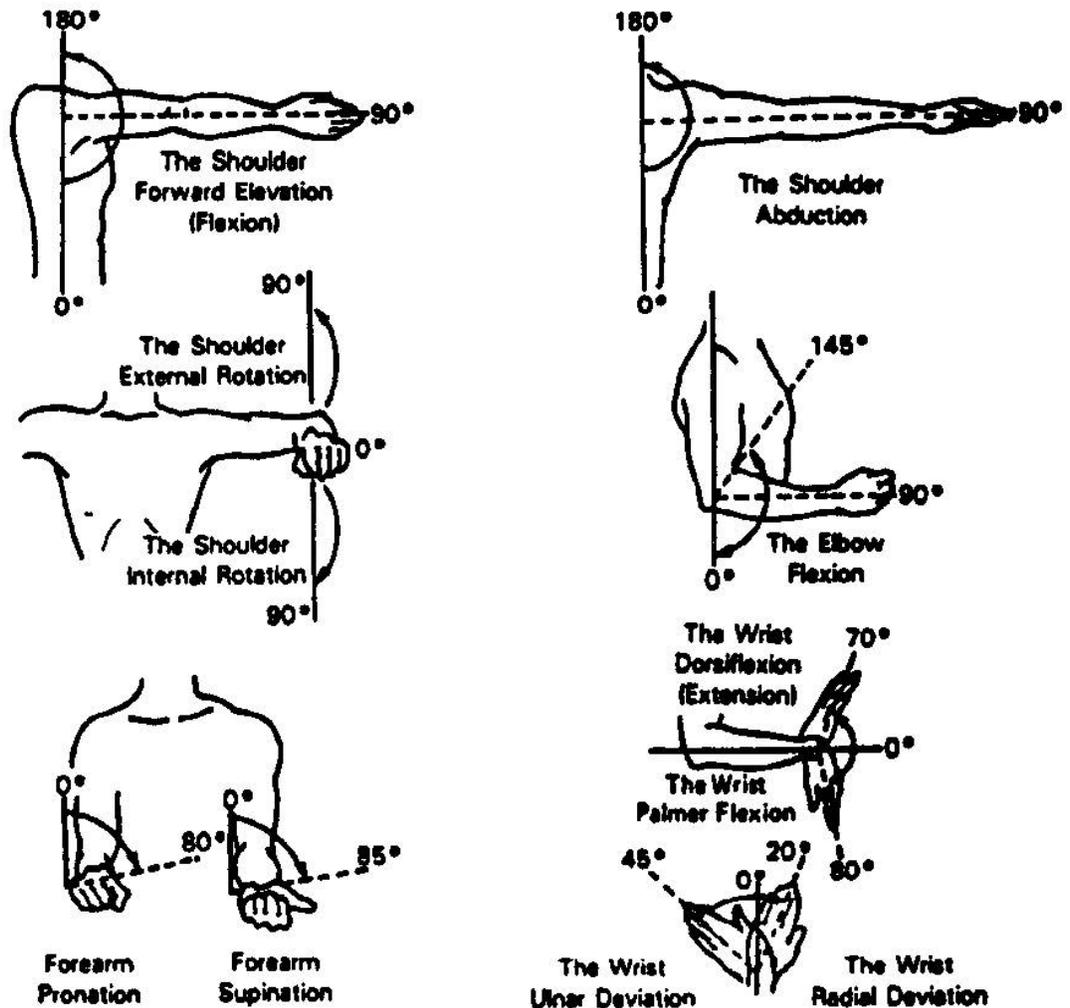
- a. Malignant Neoplasms. Which are unresponsive to therapy or when the residuals of treatment are in themselves disqualifying under other provisions of this section or in individuals on active duty when they preclude satisfactory performance of duty.
- b. Neoplastic Conditions of Lymphoid and Blood Forming Tissues. Render an individual unfit for further military service.
- c. Benign Neoplasms. Except as noted below, benign neoplasms are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment are unfit only if their condition precludes satisfactory performance of military duty. However, the following normally render the individual unfit for further military service:
 - (1) Ganglioneuroma; or
 - (2) Meningeal fibroblastoma. When brain is involved.

21. Sexually Transmitted Disease. Complications or residuals of such chronicity or degree of severity that the individual is incapable of performing useful duty.

22. Human Immunodeficiency Virus (HIV). A member who is discovered to be HIV positive (infected with HIV) by confirmatory testing is not world-wide deployable. An HIV positive member who continues to fully perform his duties is fit for duty ashore. After the member has been initially evaluated at the appropriate DoD MTF per Chapter 3, Section C, Paragraph 20.b.(9)(e) of this manual, the supporting medical officer shall obtain a copy of the written narrative detailing the member's medical condition and forward it to G-WKH via the cognizant MLC(k). The Narrative shall be marked **confidential**. G-WKH will advise CGPC that the member is not worldwide deployable but will not forward information as to the members diagnosis. Determination of duty assignments shall than be made by CGPC Assignments Officers cognizant of the members duty restriction. The member's supporting medical officer shall obtain copies of the **ANNUAL** medical evaluation narratives from the appropriate DoD MTF and submit them (marked as confidential) to G-WKH via MLC(k). A medical board shall be initiated when progression of the disease adversely impacts the member's ability to perform his duties. Taking medication for HIV disease is not necessarily in itself reason to initiate a medical board.

23. Transplant recipient. Any organ or tissue except hair or skin.

**3-F - EXHIBIT 1
MEASUREMENT OF ANKYLOSIS AND JOINT MOTION
UPPER EXTREMITIES**



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid position (0°) between pronation and supination when the thumb is uppermost.

- e. Height. Minimum 157.4 cm (62 inches). Maximum 198 cm (78 inches).
- f. Chest. Any condition that serves to impair respiratory function may be cause for rejection. Pulmonary function tests are recommended to evaluate individuals with a history of significant respiratory system problems.
- g. Cardiovascular System. Cardiac arrhythmia, heart murmur, or other evidence of cardiovascular abnormalities shall be carefully studied. Evidence of organic heart disease, rhythm disturbances or vascular diseases, if considered to impair the performance of flying duties, is cause for rejection.
- h. Teeth. The following are disqualifying:
 - (1) Any carious teeth that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.
 - (2) Any dental defect that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.
 - (3) Fixed active orthodontic appliances require a waiver from CGPC (opm or epm). (fixed retainers are exempts).
 - (4) Routine crown and temporary dental work is not disqualifying for aviation missions. Recommend that temporary crowns be cemented with permanent cement like polycarboxylate or zinc oxyphosphate cement until the permanent crown is delivered. Recommend temporary grounding of 6-12 hours after procedures. Such work may be disqualifying for deployment.
- i. Distant Visual Acuity. Distant visual acuity shall be not less than 20/200 in either eye and if less than 20/20 must be correctable to 20/20 with standard lenses. When the visual acuity of either eye is less than 20/20 correction shall be worn at all times while flying.
- j. Oculomotor Balance. The following are disqualifying:
 - (1) esophoria greater than 10 prism diopters;
 - (2) exophoria greater than 10 prism diopters;
 - (3) hyperphoria greater than 1.5 prism diopters;
 - (4) prism divergence at 20 feet and 13 inches is optional. These tests shall be accomplished only on designated aviators who have sustained significant head injury, central nervous system disease, or who have demonstrated a change in their phorias.
- k. Eyes. Any pathologic condition that may become worse or interfere with proper eye function under the environmental and operational conditions of flying disqualifies. History of radial keratotomy is disqualifying.

- l. Near Visual Acuity. Uncorrected near vision (both eyes) shall be not less than 20/200 correctable to 20/20, with correction worn in multivision lenses while flying if uncorrected near vision is less than 20/40 in either eye.
 - m. Color Vision. Normal color perception is required.
 - n. Depth Perception. Normal depth perception is required. When any correction is required for normal depth perception it must be worn at all times.
 - o. Field of Vision. The field of vision for each eye shall be normal as determined by the finger fixation test. When there is evidence of abnormal contraction of the field of vision in either eye, the examinee shall be subjected to perimetric study for form. Any contraction of the form field of 15° or more in any meridian is disqualifying.
 - p. Refraction. There are no refractive limits.
 - q. Ophthalmoscopic Examination. Any abnormality disclosed on ophthalmoscopic examination that materially interferes with normal ocular function is disqualifying. Other abnormal disclosures indicative of disease, other than those directly affecting the eyes, shall be considered with regard to the importance of those conditions.
 - r. Ear. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. A perforation or evidence of present inflammation is disqualifying. The presence of a small scar with no hearing deficiency and no evidence of inflammation, does not disqualify. Perforation, or marked retraction of a drum membrane associated with chronic ear disease, is disqualifying.
 - s. Sickle Cell Preparation Test. Quantitative hemoglobin electrophoreses greater than 40% HGs is disqualifying.
5. Standards for Class 1R. Physical requirements for service are the same as for Class 1, except:
 - a. Age 50 or older, or
 - b. Have a waiver (temporary or permanent) of physical standards that forbids unrestricted flight.
 6. Candidates for Flight Training.
 - a. Standards. Candidates for flight training shall meet all the requirements of Class 1, with the following additions or limitations:
 - (1) Cardiovascular.
 - (a) Candidates with accessory conduction pathways (Wolff-Parkinson-White (WPW), other ventricular pre-excitation patterns) are CD. No waiver is recommended for candidates with this condition.

- (b) Candidates with WPW Syndrome who have had definitive treatment via Radio Frequency (RF) ablation with demonstrable non-conduction on follow-up Electrophysiologic Studies (EPS) are considered for waiver on a case-by-case basis.
 - (c) Asymptomatic candidates: When incidentally noted accessory bypass tracts, proven incapable of sustained rapid conduction as demonstrated by EPS, is discovered in a candidate, the candidate (if asymptomatic), will be considered qualified. In general, EPS is not recommended in asymptomatic individuals.
- (2) Height. Candidates for Class I training must also satisfy the following anthropometric requirements: Refer to figure 3-G-1 through figure 3-G-4 for guidelines on measurements.
- (d) **sitting height:** 33 inches to 40.9 inches. Record in parentheses in Item 73, DD-2808 (SH _____), see figure 3-G-1 for proper measurements;
 - (e) **sitting eye height:** 28.5 inches or greater. Record in parentheses in Item 73, DD-2808 (SEH _____), see figure 3-G-2 for proper measurements;
 - (f) **thumb tip reach:** 28.5 inches or greater. Record in parentheses in Item 73, DD-2808 (TTR _____), see figure 3-G-3 for proper measurements;
 - (g) **buttock-knee length:** 21 inches to 27.9 inches. Record in parentheses in Item 73, DD-2808 (BKL _____), see figure 3-G-3 for proper measurements;
 - (h) **add:** sitting eye height (SEH) and thumb tip reach (TTR), 57 inches or greater. Record in parentheses in Item 73, (SEH + TTR = _____).
- (3) Uncorrected distant visual acuity must be not less than 20/50 each eye and correctable 20/20 each eye. Uncorrected near visual acuity must be not less than 20/20 each eye (may be waiverable).
- (4) While under the effects of a cycloplegic, the candidate must read 20/20 each eye. The following are disqualifying:
- (a) total myopia greater than (minus) -2.00 diopters in any meridian;
 - (b) total hyperopia greater than (plus) +3.00 diopters in any meridian;
 - (c) astigmatism greater than (minus) -0.75 diopters; (Report the astigmatic correction in terms of the negative cylinder required.)
 - (d) the purpose of this cycloplegic examination is to detect large latent refractive errors that could result in a change of classes during an aviation career. Therefore, the maximum correction tolerated at an

acuity of 20/20 shall be reported. Cycloplegics reported as any other acuity, e.g., 20/15 will be returned.

- (5) The Coast Guard will consider sending candidates to Navy Flight School who have had photorefractive keratectomy, (anterior corneal stromal surface laser ablation with no stromal flap), and meet all of the enrollment criteria. Candidates must have demonstrated refractive stability as confirmed by clinical records. Neither the spherical or cylindrical portion of the refraction may have changed more than 0.50 diopters during the two most recent postoperative manifest refractions separated by at least one month. The final manifest shall be performed no sooner than the end of the minimum waiting period (3 or 6 months depending on the degree of preoperative refractive error). The member must have postoperative uncorrected visual acuity of at least 20/50 correctable with spectacles to at least 20/20 for near and distance vision. Detailed enrollment criteria may be obtained by contacting CGPC-opm-2.

- (6) Hearing. Audiometric loss in excess of the limits set forth in the following table is disqualifying:

FREQUENCY	500	1000	2000	3000	4000
EITHER EAR	30	25	25	45	55

- (7) Personality. Must demonstrate, in an interview with the flight surgeon, a personality make-up of such traits and reaction that will indicate that the candidate will successfully survive the rigors of the flight training program and give satisfactory performance under the stress of flying.
- (8) Chest x-ray. Aviation trainees must have had a chest x-ray within the past three years.
- (9) Report of Medical History (DD-2807-1). In addition to the normal completion of the DD-2807-1, the following statement shall be typed in block 29 and signed by the applicant: "I certify that I do not now use, nor have I ever used, contact lens for any purpose, and that I am not aware that my uncorrected vision has ever been less than 20/50." If the applicant cannot sign this statement, include a full explanation by the examining flight surgeon, and an ophthalmology consultation.

b. Reporting.

- (1) The importance of the physical examination of a candidate should be recognized not only by the examining flight surgeon but also by health services personnel assisting in the procedure and preparing the report. Candidates often come from a great distance or from isolated ships. If the examination cannot be completed in one working day, seek the commanding officer's help in making it possible for the candidate to remain available for a second working day. Careful planning should keep such cases to a minimum. If a report, upon reaching Commandant (G-WKH), is found to be incomplete and must be returned, the candidate will suffer undue delay in receiving orders and in some

cases will be completely lost to the Coast Guard as a candidate. The preparation of the DD-2808 in the case of a candidate requires extreme care by all concerned.

- (2) In a report of the examination of a candidate, rigid adherence to set standards is expected. The examining officers are encouraged to use freely that portion of the report that provides for "remarks" or "notes." Comments made under "remarks" are the examiner's opinion. Information from any source may be molded into an expression of professional opinion. A final recommendation of the examiner must be made. When such recommendation is not consistent with standards set by Commandant (G-K) the examiner shall note that fact on the form under "remarks" or "notes" and a reasonable explanation made. When space on an DD-2808 is inadequate, use a Continuation Sheet (SF-507).

7. Requirements for Class 2 Flight Officers.

- a. Flight Officer Candidates. Flight officer candidates shall meet the standards for Class 1 except that depth perception is not required.
- b. Designated Flight Officers. Flight officers shall meet the standards for flight officer candidate except that uncorrected distant visual acuity must be not less than 20/400 in either eye and shall be correctable to 20/20.

8. Requirements for Class 2 Aircrew.

- a. Aircrew Candidates. Unless otherwise directed by Commander CGPC-epm, personnel will not be permitted to undergo training leading to the designation of aircrewmembers unless a flight surgeon/aviation medical officer has found them physically qualified for such training. Should it be desirable, for exceptional reasons, to place in training a candidate who does not meet the prescribed physical standards, the commanding officer may submit a request for a waiver, with the DD-2808 and DD-2807-1, to Commandant (CGPC), justifying the request. Aircrew candidates shall meet the standards for Class 1, except that minimum height is 152.5 cm/60 inches and uncorrected distant visual acuity must be not less than 20/100 each eye, correctable to 20/20 each eye. Cycloplegic refraction and anthropometric measurements are not indicated. A chest x-ray is required within the previous 3 years.
- b. Designated Aircrew. Aircrew shall meet the standards for Class 1, except the minimum height is 152.5 cm/60 inches.

9. Requirements for Class 2 Medical Personnel.

- a. Flight Surgeon (FS)/Aviation Medical Officer (AMO)/FS Candidates. While assigned to a Duty Involving Flight Operations billet, FS/AMOs shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).
- b. Aviation MEDEVAC Specialists (AMS)/AMS Candidates. Aviation MEDEVAC Specialists (Health Services technicians (HS) who are assigned to flight orders),

shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).

10. Requirements for Class 2 Technical Observers. The term "technical observer" is applied to personnel who do not possess an aviation designation but who are detailed to duty involving flying. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. They shall meet the standards prescribed for general duty. These personnel are not required to undergo a physical examination for flying provided a complete physical examination, for any purpose, has been passed within the preceding 60 months and intervening medical history is not significant. The physical examination need not be conducted by an FS/AMO. Technical observers who are required to undergo egress training must have a current (general purpose) physical examination and a status profile chit indicating "OK DIF/Dunker/Chamber."
11. Requirements for Class 2 Air Traffic Controllers. Air traffic controllers, tower controllers, and ground control approach operators shall meet the general physical standards for Class 1, except:
 - a. Articulation. Must speak clearly and distinctly without accent or impediment of speech that would interfere with radio communication. Voice must be well modulated and pitched in medium range. Stammering, poor diction, or other evidence of speech impediments, that become manifest or aggravated under excitement are disqualifying.
 - b. Height. Same as general service.
 - c. Visual Acuity.
 - (1) Candidate's visual acuity shall be no worse than 20/100 for each eye correctable to 20/20 each eye and the correction shall be worn while on duty.
 - (2) Personnel already designated shall have distant visual acuity no worse than 20/200 each eye correctable to 20/20 each eye and the correction shall be worn while on duty.
 - (3) Air traffic controllers whose vision becomes worse than 20/200 either eye may not engage in the control of air traffic in a control tower but may be otherwise employed in the duties of their rating.
 - d. Depth Perception. Normal depth perception is required.
 - e. Heterophoria. The following are disqualifying:
 - (1) esophoria or exophoria greater than 6 prism diopters; and
 - (2) hyperphoria greater than 1 prism diopter.
12. Requirements for Landing Signal Officer (LSO).
 - a. Physical Examinations for Landing Signal Officer (LSO).

- (1) Candidates. Officer and enlisted candidates for training as LSO's shall have a physical examination prior to the training leading to qualification. LSO duties for flight deck require stricter visual acuity standards than those for general duty in the Coast Guard. Examination by a FS/AMO is not required.
 - (2) Reexamination. Biennial reexamination is required of all currently qualified LSO's.
- b. Physical Standards for LSO's. In addition to the physical standards required for officer and enlisted personnel, the following standards apply:
- (1) Distant Visual Acuity. The uncorrected distant visual acuity shall be no worse than 20/200 in each eye and must be correctable to 20/20 in each eye. If the uncorrected distant visual acuity is less than 20/20 in either eye, corrective lenses must be worn while performing LSO duties.
 - (2) Depth Perception. Normal depth perception is required.
 - (3) Color Vision. Normal color perception is required.

13. Contact Lenses.

- a. Class 1 personnel may be authorized by their local flight surgeon to wear contact lenses while flying, provided the following conditions are met:
- (1) Only gas permeable disposable soft lenses may be used.
 - (2) The lenses are to be removed during the hours of sleep.
 - (3) The lenses are disposed of after 2 weeks of use.
 - (4) All prescribed optometry follow-up visits are adhered to. After routine safe use has been established and documented by the prescribing optometric authority, an annual optometric recheck is the minimum required. A copy of the record of any visit to an eye care professional will be furnished by the member to the local flight surgeon for review and placement in the member's health record.
 - (5) Following any change in the refractive power of the contact lens, the member must be checked on the AFVT to ensure that Coast Guard Class I standards for acuity and depth perception are met. In addition, the flight surgeon shall document that there is no lens displacement, when user moves his/her eyes through all 8 extreme ranges of gaze.
 - (6) Contact lens case, saline for eye use, and an appropriate pair of eyeglasses are readily accessible (within reach) to the lens wearer while in-flight.
 - (7) Contact lens candidate submits request to the command agreeing to abide the above conditions.
 - (8) The flight surgeon authorizes use of contact lenses after ensuring that such use is safe and the user fully understands the conditions of use. This authorization expires after one year. Initial and any annual re-authorizations shall be documented by an entry in the health record.

- (9) Contact lens use is not a requirement for aviation operations. The decision to apply for authorization is an individual option. Accordingly, lens procurement and routine optometric care related to contact lens use at government expense are not authorized.
- b. The optional wearing of contact lenses by Class 2 personnel performing duty involving flying and by air control personnel in the actual performance of their duties is authorized under the following circumstances:
- (1) Individuals are fully acclimated to wearing contact lenses and visual acuity is fully corrected by such lenses;
 - (2) Individuals wearing contact lenses while performing flight or air control duties have on their person, at all times, an appropriate pair of spectacles;
 - (3) A flight surgeon has specifically authorized the wearing of contact lenses while performing flight or air control duties (An entry shall be made on SF-600 in the individual's health record authorizing wearing of contact lenses.); and
 - (4) Wearing contact lenses while performing aviation duties is an individual option. Accordingly, procuring contact lenses at government expense is not authorized.

Figure 3-G-1

Sitting Height

Purpose

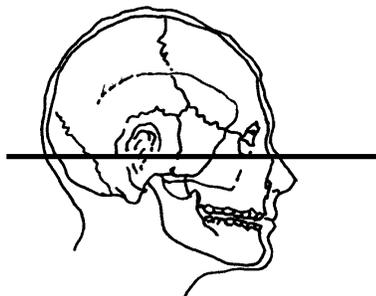
This measurement is important in the design and layout of work stations occupied by Navy personnel. Controls must be placed in numerous locations, and the minimum acceptable space between the helmet and the canopy of cockpits must be considered.

Equipment Required

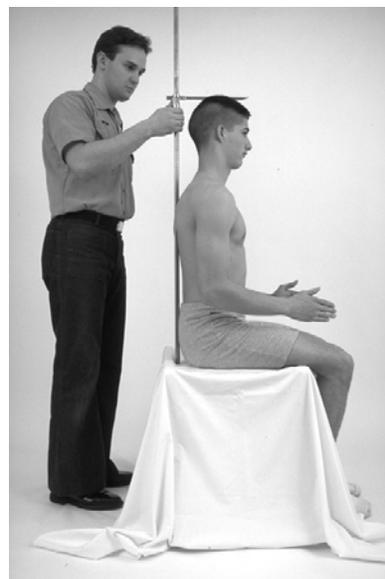
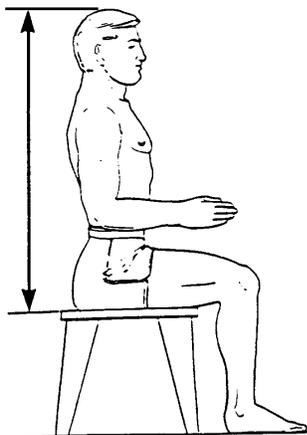
Anthropometer

Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel, and the knees are flexed 90° with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the top of the head with an anthropometer. The shoulders and upper extremities should be relaxed. Measure at the maximum point of quiet respiration.



NOTE: Measurements are to be taken to the nearest eighth of an inch. The measurement should be taken at least twice. If there is a large variation between the two measurements, recheck the body position and repeat measurements.

Eye Height, Sitting

Purpose

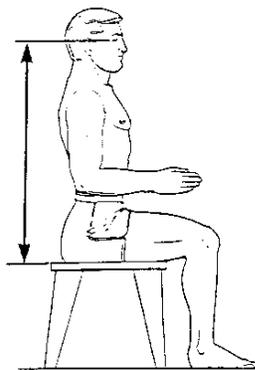
Sitting Eye Height plays a decisive role in instrument panel layout, viewing angles, and seat adjustment, since the pilot must have optimum vision both inside and outside of the cockpit.

Equipment Required

Anthropometer

Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel and the knees are flexed 90° with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the corner or angle formed by the meeting of the eyelids on the outer corner of the right eye with an anthropometer.



NOTE: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.

Thumbtip Reach

Purpose

This measurement is important in the design and layout of work stations occupied or used by Navy personnel. Thumbtip reach is particularly useful for the placement of controls in various locations within cockpits.

Equipment Required

Wall-mounted linear scale.

Measurement Procedure

1. The subject stands erect in a corner looking straight ahead with the feet together and heels 7.87 inches (20 cm) from the back wall.
2. With the buttocks and shoulder placed against the wall, the right arm and hand (palm down) are stretched horizontally along the scale while the thumb continues along the horizontal line of the arm with the index finger curving around to touch the pad at end of the thumb.
3. The subject's right shoulder is held against the rear wall. The horizontal distance from the back wall to the tip of the right thumb is measured.



NOTE 1: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.

Buttock-Knee Length

Purpose

This measurement is usually associated with ejection seat clearance and threshold values between the knee and the glare shield (or canopy bow).

Equipment Required

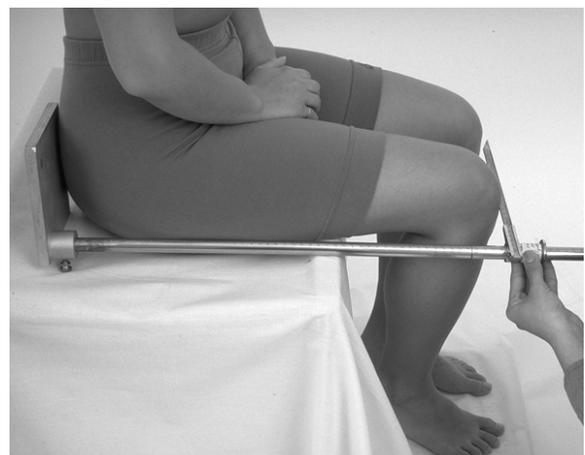
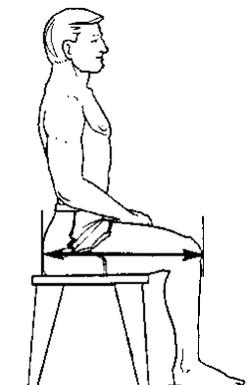
Anthropometer

Measurement Procedure

1. While the subject sits erect, draw a landmark on the bottom tip of the right knee cap. The subject's thighs should be parallel, with the knees flexed at 90°. The feet should be in line with the thighs, and lying flat on the surface of a footrest or the floor.



2. The anthropometer is placed flush against the buttock plate at the most posterior point on either buttock, and the anterior point to the right knee is measured with an anthropometer.



NOTE 1: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.

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CHAPTER 4. HEALTH RECORDS AND FORMS

Section A - Health Records.

1. Purpose and Background.

- a. The health record is the chronological medical and dental record of an individual while a member of the Coast Guard or the Coast Guard Reserve. The primary reasons for compiling a health record are listed below.
 - (1) To develop an accurate clinical history that will help in future diagnosis and treatment.
 - (2) To protect the Government, the individual concerned, and the individual's dependents. It may be used in adjudicating veterans claims by making permanently available in a single record all entries relative to physical examinations, medical and dental history, preliminary to entry and throughout the individual's entire Coast Guard career. This is accomplished by opening or maintaining medical and dental records:
 - (a) upon entry into the Service;
 - (b) as required to maintain concise, yet complete, records during period of service; and
 - (c) at time of separation.
 - (3) To facilitate appraisal of the physical fitness or eligibility for benefits by making the information contained in the health record available to Coast Guard selection boards, disability evaluation system, Board of Correction of Military Records, for income tax purposes, and for claims to the Department of Veterans Affairs.
 - (4) To furnish a basis for collecting statistical information.
 - (5) To identify deceased persons through dental records when other means are inadequate.
- b. As an individual's service career progresses, the health record increases in value to the Government, the individual, and the individual's family and dependents. Accuracy, therefore, is of the utmost importance in making entries, including entries regarding minor ailments or injuries which appear trivial at the time, but which must be recorded to protect the Government and the individual.

2. Contents of the Health Record.

- a. Each member's health record shall consist of CG-3443 (Health Record Cover) with medical records and dental records arranged as follows:
 - (1) SECTION I - HISTORY OF CARE. All forms in this Section shall be arranged in the following order, (a) being the top and (g) being the bottom. Additionally, the forms should be grouped by date with the most recent on top. Do not separate corresponding forms DD-2808 and DD-2807-1.

- (a) Adult Preventive and Chronic Care Flowsheet Form DD 2766
 - (b) Consultation Sheet SF-513
 - (c) Narrative Summary Clinical Resume * SF-502
 - (d) Report of Medical Examination DD-2808 (Rev. Jan 03), and Report of Medical History DD2807-1 (Rev. Jul 01)
 - (e) History and Report of OMSEP Examination Form CG-5447 (Rev.03/03), and Periodic History and Report of OMSEP Examination CG-Form 5447A (03/03)
 - (f) Report on or Continuation of *, ** SF-507
 - (g) Medical Board Report Cover Sheet * NAVMED 6100/1
- (2) SECTION II - RECORDS OF CARE. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (a) being the top and (b) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (a) Chronological Record of Care SF-600
 - (b) Emergency Care and Treatment SF-558
- (3) SECTION III - RADIOLOGICAL REPORTS. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (a) being the top (b) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (a) Radiographic Consultation Request/Report SF-519A
 - (b) Medical Record-Radiographic Reports SF-519
- (4) SECTION IV - LABORATORY REPORTS AND ECG REPORTS. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (a) being the top (b) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (a) Clinical Record - Laboratory Reports SF-514
 - (b) Clinical Record - Electrocardiographic Record SF-520
- (5) SECTION V - MISCELLANEOUS. All forms in this Section shall be arranged in the following bottom (a) to top (i) sequence.
- (a) Chronological Record of Service CG-4057
 - (b) Special Duty Medical Abstract * NAVMED 6150/2
 - (c) Record of Occupational Exposure to Ionizing Radiation * DD-1141
 - (d) Occupational Health Surveillance Questionnaire * CG-5197
 - (e) Syphilis Record * SF-602

- (f) Request for Administration of Anesthesia and for Performance of Operations and other Procedures * SF-522
 - (g) Hearing Conservation Program microprocessor test result strips taped or stapled to the SF-514 Clinical Record-Laboratory Reports form. DD-2215 Reference Audiogram, and DD-2216 Hearing Conservation Data Sheet, will also be placed in section V, in sequential order under the SF 514 "Hearing Conservation Program" form.
 - (h) Eyewear Prescription DD-771
 - (i) Immunization Record SF-601
- (6) SECTION VI - DENTAL RECORD AND INTERNATIONAL VACCINATION RECORD. All forms in this Section shall be arranged in the following bottom (a), to top (b) sequence.
- (a) International Certificate of Vaccination PHS-731
 - (b) U.S. Coast Guard Dental Record CG-3443-2
 - 1 Sensitivity Sticker * PHS-2410
 - 2 Dental Health Questionnaire CG-5605
 - 3 Health Record - Dental -- (Continuation) * SF-603A
 - 4 Health Record - Dental SF-603
 - 5 NAVMED 6660 Periodontal Chart
 - 6 SF-522 Request for Anesthesia

Note:

* --- When required

** -- SF-507's are attached to and filed after the form they continue

*** - Optional Form

- b. File forms of the same number in their assigned sequence, with the most recent on top of each previous form, e.g., SF-600 dated 94/02/15 is filed on top of SF-600 dated 94/02/14.
- c. Record all dates on the Health Record Cover in the following sequence (all numerals): year/month/day (e.g., 51/02/07).
- d. Reports, including laboratory, X-ray, and consultations, shall be reviewed and initialed by the responsible MO, DO, PA/PYA or NP before they are filed in the health record.
- e. The health record is a legal document. As such, legibility of all information is essential. Patient ID information shall be typed, printed, or stamped. All entries shall be neat and legible. All signatures shall be accompanied by the stamped or typed name and rank of the practitioner.

3. Opening Health Records.

a. General.

- (1) A health record will be opened at the recruiting office for each individual upon entry into the Coast Guard.
- (2) A new health record will be opened upon reenlistment of personnel with prior USCG service when such enlistment is not effected the day following discharge. In all cases, request the individual's health record covering prior military service from the National Personnel Records Center, St. Louis, MO.
- (3) Other Specific Occasions for Opening Health Record.

<u>OCCASSION</u>	<u>OPENED BY</u>
Officer appointed from civilian	First duty station
Reserve Officer	Unit where procured
Cadet	Academy
Retired Personnel recalled to Active Duty	First duty station
Original Record Lost or Destroyed	Responsible Custodian

4. Terminating Health Records.

a. General Instructions.

- (1) Upon discharge without immediate reenlistment or enlistment in the Coast Guard Reserve, or retirement, forward the health record (Medical Personnel Data Record or MED PDR) to the servicing PERSRU within 2 days of the member's separation. **DO NOT GIVE THE ORIGINAL HEALTH RECORD TO THE MEMBER UPON FINAL SEPARATION.** Cite the reason for separation on the reverse side of Chronological Record of Service (form CG-4057). The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC-adm3) or Commandant (G-RSM-3) for Reservists. (See Section 4-B-27 for additional requirements for CG-4057.) Health record documents are not filed in the HQ PDR. They will be returned to the unit if received by Commander, (CGPC adm-3) in error.
- (2) Discharge for immediate reenlistment at the same unit, revocation of appointment as a temporary officer to continue on active duty in permanent status, or retirement with continuation of active duty are not termination of service.
- (3) When a health record is terminated and the dental record is not available for inclusion therein, forward a letter of explanation with the health record.

- b. Release from active duty (RELAD) with concurrent transfer to the Coast Guard Reserve or discharge from active duty with immediate enlistment in the Coast Guard Reserve. Upon RELAD, forward the health record (MED PDR) to the servicing PERSRU within 2 days of the member's separation. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to District (rs) in which the member will reside after separation.
- c. Disappearance, Other Than Desertion. Whenever an individual disappears and the facts regarding such disappearance are insufficient to justify a conclusion of death, enter a complete account of the circumstances on an SF-600 in the health record. Do not terminate the health record until final disposition.
- d. Desertion.
 - (1) When an individual is officially declared a deserter, enter an explanatory note on SF-600. Forward the health record (MED PDR) to the servicing PERSRU within 2 days of determination of deserter. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC) or Commander (CGPC-rpm) for Reservists.
 - (2) Upon return of a deserter to his/her own command, a physical examination shall be performed and recorded on the DD-2808. Retain the original for incorporation into the health record, and forward a copy to Commander (CGPC) or Commander (CGPC-rpm) for Reservists with a request for the deserter's health record.
- e. Discharge of Personnel Convicted by Civilian Authorities. When the Commandant directs the discharge of personnel convicted by civilian authorities, the commanding officer will make arrangements for their physical examination, to be recorded on an DD-2808. In the event no medical officer is available, obtain a statement signed by the warden of the penitentiary or reformatory that the person to be discharged from the Coast Guard is physically and mentally qualified for discharge and is not in need of hospitalization. The warden's statement, accompanied by the terminated health record, will be forwarded with the closed out service record.
- f. Discharge of Courts-Martial Prisoners Confined in Federal Penitentiaries, Reformatories, and the Naval Disciplinary Command. When the Commandant directs the discharge of a courts-martial prisoner confined in a Federal penitentiary, reformatory, or the Naval Disciplinary Command, the command to which the prisoner has been administratively assigned shall arrange with the warden for physical examination of the prisoner. Results of this physical examination will be entered on the DD-2808 and signed by the medical officer of the designated penal institution. The command to which the prisoner has been administratively assigned will terminate the health record, using the information furnished on the DD-2808 and the account of medical, dental, and first aid treatments supplied by the penal institution. The terminated health record, DD-2808, and the resume will then be forwarded with the closed out service record.

- g. Retired Personnel (Includes Temporary Retirement). Upon notification of retirement, make an entry on CG-4057 under "Remarks" indicating place, date, and category under which retired. The command having custody of the health record will sign the CG-4057 and forward it to the command having administrative control of the member for inclusion in the closed out service record.
 - h. Cadets. When a cadet's service is terminated, the health record will be terminated and forwarded to the Cadet Record Office, for processing. Following this procedure, the record will be forwarded to the Registrar's Office and held until the departing cadet's class graduates. When this occurs, the record will be forwarded to the Federal Personnel Records Center, St. Louis, MO. This includes cadets who graduate from the Academy but do not accept or are not tendered a commission.
 - i. Officers (Reserve) to Inactive Duty and Officers (Regular) who Resign to Accept a Reserve Commission. In the case of reserve officers being released to inactive duty and regular officers who resign and accept a commission in the reserve, the health record will be terminated.
 - j. Death. Upon notification of death, make an entry on CG-4057 under "Remarks" indicating place, time, date, and a short explanation of the circumstances surrounding death. A commissioned officer will sign the CG-4057 and then deliver it and the terminated health record to the commanding officer (no later than the day following death) for inclusion in and transmittal with the member's service record to Commander (CGPC) or Commander(CGPC-rpm).
5. Custody of Health Records.
- a. General Responsibilities.
 - (1) Health records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). Health record custody and security requirements are applicable to all documents which contain health information, whether or not filed in the health record, such as Inpatient Medical Records and mental health treatment records. Disposal of all health record documents shall be in accordance with Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).
 - (a) Since health records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).
 - (b) Except as contained in the Privacy and Freedom of Information Acts Manual, the information contained in health records shall not be disclosed by any means of communication to any person, or to any agency unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

- (2) Health records shall be retained in the custody of the Chief, Health Services Division of the unit to which the individual is attached. At units where there is no medical officer attached, the health record will become the responsibility of the executive officer in accordance with Coast Guard Regulations, COMDTINST M5000.3(series), who may delegate custody to the senior health services department representative. At units without a health services technician the custody of the health record is the responsibility of the unit's executive officer. Maintenance of these health records may be delegated to health services personnel of another unit (e.g., groups, support centers, etc.). **At no time shall individual members keep or maintain their own health record.** If there is a need to check out a health record for an appointment at another health care facility, the health record custodian shall have the member complete and sign the health record receipt form (NAVMED 6150/7). The health record custodian shall place the record in an envelope, hand it to the member, and tell the member to return the record as soon as possible following the appointment. The envelope used for record transportation shall bear a printed request reminding outside providers to treat the contents as confidential, and requesting providers to include copies of their consultations or case notes for placement in the health record. The responsibilities contained herein are also applicable to Reserve components.
- (3) Individuals may examine their own health record in the presence of a health services department representative, providing:
 - (a) such examination does not interrupt the unit's scheduled mission, and
 - (b) there is no information contained therein that would be detrimental to the individual's mental well-being, as determined by the member's attending physician.
- (4) Health records are subject to inspection at any time by the commanding officer, executive officer, duly appointed counsel in the case of formal hearings, or duly appointed Coast Guard officials who are conducting authorized investigations. Such inspections will be conducted in the presence of a health services department representative to aid in the interpretation of information contained in the health record.
- (5) Health services personnel making entries in health records shall ensure all entries, including signatures, are neat and legible. Signature information shall include the stamped or printed name and grade or rate of the signer. Facsimile signature stamps may only be used on the PHS-731 and the SF-601.
- (6) If an erroneous entry is made in a health record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

- (7) Health services personnel are responsible for the completeness of the entries made on any medical or dental form while the health record is in their custody. No sheet shall be removed from the health record except under conditions specified in this Manual.
- (8) Members are not authorized to write in, alter, remove documents from, or otherwise change their health record or its contents. Request for changes to health record contents shall be made in accordance with procedures contained in Chapter 16 of the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3.

6. Transfer of Health Records.

- a. When active duty or reserve personnel are transferred, The Chief Health Services Division, his designee, the Executive Officer, or the senior Health Services department representative will make the necessary entries in the health record and ensure that the current health record, dental record (SF-603) and Certificate of Vaccination (PHS-731), if applicable, are properly completed.
- b. A DD-877 shall be initiated for each record transferred. The DD877 shall be attached to the front cover of the record. The health record will be forwarded to the Coast Guard clinic or Independent Duty Health Services Technician servicing the gaining unit. **Send records using a service that provides a tracking number, such as Priority Mail, Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical.** (See Article 4-D-7.c. of this Manual for policy regarding transfer of Clinical Records of dependents.)
- c. Transfer to Federal Penitentiaries, Reformatories, or the Naval Disciplinary Command. A letter of transmittal and a copy of the health record shall accompany a member who is being transferred under sentence of a courts-martial (who has not been or will not be discharged immediately) to a penal institution for execution of the unexpired sentence. The original health record, with a letter of transmittal stating the name of the penal institution to which the prisoner is being transferred and the length of the sentence, shall be forwarded to the command to which the member has been administratively assigned which shall maintain the health record until the prisoner has been discharged from the Service. A copy of the letter of transmittal shall also be forwarded to Commander (CGPC).

7. Creating an Additional Volume.

- a. Due to chronic medical conditions, long narrative summaries, medical boards, etc., the record may fill to capacity which may cause the loss or damage to new records.
- b. Procedures for creating a second volume:
 - (1) Obtain a new Health Record (CG-3443) and transcribe the information from the original jacket.
 - (2) Write "VOLUME II" in bold print in the lower left corner of the new jacket cover. Insert forms required by this chapter.

- (3) Write "VOLUME I" in bold print in the lower left corner of the original jacket cover.
- (4) Transfer all documents pertaining to current or chronic illness to the new record.
- (5) Remove the most recent SF-600 from VOLUME I and place it in VOLUME II. Insert a blank SF-600 on top of the remaining forms in VOLUME I and draw a diagonal line across the page. Enter the following on this line:

CLOSED. NO FURTHER ENTRIES IN THIS RECORD. REFER TO
VOLUME II.
- (6) Insert the most recent Report of Medical Examination (DD-2808) and the Report of Medical History (DD-2807-1) into VOLUME II.
- (7) Transcribe the immunization and HIV test date information onto a blank SF-601 and insert it in the appropriate section of VOLUME II.
- (8) Place the original Problem Summary List (NAVMED 6150/20) into VOLUME II and a copy of this form in VOLUME I with the annotation, "CLOSED. NO FURTHER ENTRIES.", below the last entry.
- (9) Place the original Chronological Record of Service (CG 4057) in VOLUME II and a copy in VOLUME I.

8. Lost, Damaged, or Destroyed Health Records.

- a. If a health record is lost or destroyed, a complete new health record shall be opened by the unit health record custodian. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing health record should be recovered, any additional information or entries in the replacement record shall be inserted in the old record.
- b. Health records which become illegible, thus destroying their value as permanent records, shall be restored and duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Take particular care in transcribing the date on DD-2808 into the new record as such information may be required by the Department of Veterans Affairs to determine the individual's right to pension or other Federal benefits. Stamp or mark "DUPLICATE" on the cover of the new record. Explain the circumstances necessitating the duplication on an SF-600. Forward health records replaced by duplicate records to CGPC-adm-3.

9. Accuracy and Completeness Check.

- a. Upon transfer of an individual, the health record custodian at both the detaching unit and the receiving unit shall inspect the health record for accuracy and completeness, in accordance with the following guidelines:

- (1) that all immunizations are up-to-date (See Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series));
 - (2) that PPD screening is current in accordance with Section 7-D of this Manual;
 - (3) that all required audiograms are completed, especially on personnel involved in the hearing conservation program;
 - (4) that required forms have been properly completed and are in the correct order;
 - (5) that all deficiencies in physical requirements shall be scheduled for correction, all missing forms shall be replaced, and all other clerical or administrative errors corrected; and
 - (6) that all OMSEP requirements are met.
- b. The health record custodian shall ensure that all identified deficiencies are corrected immediately. Appointments shall be scheduled and the individual's supervisor notified of the need to correct deficiencies as soon as possible.
- c. Upon separation of the individual from the Service, the unit terminating the health record will inspect the health record, correct all errors, fill in omissions, and make sure the patient identification information is completed on all forms.

Section B - Health Record Forms.

1. **CG-3443 (Health Record Cover).** See Encl (1), pg.4-1. Each patient's health record shall be maintained in a CG-3443 (Health Record Cover). The CG-3443 shall be completed according to the following instructions:
 - a. Last Name. Record in all capital letters.
 - b. Given Name(s). Record given name(s) in full without abbreviations. If the individual has no middle name or initial then use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s) record each initial in quotation marks. When "Jr." or "II" or other similar designations are used they shall appear after the middle name or initial.

DOE John Buck Jr.

Surname First Name Middle Name

- c. Beneficiary. Enter the appropriate beneficiary code to describe the patient (enter "20" for active duty members).
 - (1) 01 to 19 - Dependent children in order of birth
 - (2) 20 - Sponsor
 - (3) 30 - Spouse
 - (4) 31-39 - Unremarried former spouse
 - (5) 40 - Dependent mother (active duty)
 - (6) 45 - Dependent father (active duty)
 - (7) 50 - Dependent mother-in-law (active duty)
 - (8) 55 - Dependent father-in-law (active duty)
 - (9) 60 - Other dependents
 - (10) 80 - Humanitarian (non-eligible)
 - (11) 90 - Civilian employee
 - (12) 99 - Other eligible
- d. Sponsor's Social Security Number. Enter.
- e. Blood Type and Rh Factor. Enter the blood-type and Rh factor in the appropriate boxes. Use utmost caution when recording this information. If not known, complete a blood-type and Rh factor test as required.
- f. Special Status. Check the appropriate block to indicate whether the individual is in aviation or diving status, has a waiver, requires occupational monitoring, or has an allergy.
- g. Date of Birth. Enter year, month and day (e.g., 51/02/07).

- h. Local Use. Use the spaces provided below the sensitivity sticker location for local use information such as rank, unit, etc. as needed.
- 2. CG-5266 (Drug Sensitivity Sticker).
 - a. General. Form CG-5266 should be initiated for anyone having documented history of sensitivity or hypersensitivity to specific drugs, serums, or vaccines, including PPD converters. Other non-drug allergies should be indicated on this form only if they will affect potential therapy (e.g., egg yolks). Every effort shall be made to verify the reported sensitivity and to confirm that it is allergic in nature.
 - b. Detailed Instructions.
 - (1) Prepare two originals. (One each for the health and dental records.)
 - (2) List the name of each drug, serum, vaccine, or anesthetic indicated on the DD-2766 Adult Preventive and Chronic Care Flowsheet.
 - (3) Affix the CG-5266 vertically to the indicated location on the health record cover (form CG-3443) and vertically to the lower left corner on the front of the dental record cover (CG-3443-2).
- 3. DD2766 (Adult Preventive and Chronic Care Flowsheet Form). See Encl (1), pg 4-2.
 - a. General. The Adult Preventive and Chronic Care Flowsheet Form documents significant/chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing, screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exam, etc), and chart audits. In-house training sessions should be conducted prior to the implementation of this form.
 - b. Detailed Instructions. DD2276 should be inserted as the first page of the medical record and all sections completed by the health care provider with the following guidelines exceptions:
 - (1) Information from previous Problem Summary Lists should be copied and updated onto the DD2276 as it is placed in the health record.
 - (2) If the patient is not allergic to any drugs, indicate NKDA (no known drug allergies), in block 1.a.
 - (3) Sections 8.a., 10.e. and 10.i. are not required to be completed.
 - (4) Use a pencil to darken the circles on Section 7, Screening Exam.
 - (5) The medical officer should enter the date and location of every deployment the member participates in Section 11, Pre/Post Deployment History. Pre and post deployment questionnaires are documented in Section 11 for participants in DOD deployment.

4. **SF-600 (Chronological Record of Medical Care)**. See Encl (1), pg 4-6.

a. **General**.

- (1) This form provides a current, concise, and comprehensive record of a member's medical history. Properly maintained, the SF-600 should: aid in evaluating a patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of health care received. The SF-600 shall be continuous and include the following information as indicated: complaints; duration of illness or injury, physical findings, clinical course, results of special examinations; treatment; physical fitness at time of disposition; and disposition. The SF-600 also serves as the patient's prescription from which pharmacy services are provided.
- (2) When a new SF-600 is initiated, complete the identification block with the name (last, first, middle initial), sex (M or F), year of birth, component (active duty or reserve), service (USCG, USN, USA, etc.), Social Security Number, and the member's grade/rate and organization at the time the form is completed.
- (3) File SF-600's on the right side of the medical record with the most current SF-600 on top.
- (4) Enter sick call entries on SF-600 in the following SOAP format

SOAP METHOD OF SICK CALL WRITE UPS

S: (Subjective).

cc: (Chief Complaint) sore throat, cough, diarrhea, etc.

hpi: (History Present Illness) onset of symptoms, all problems, review of symptoms

pmh: (Past Medical History) any related problems in past that may be present with chief complaint

fh: (Family History) any diseases, chronic/acute, possibly related to present complaint

all: (Allergies) any known allergies to drugs/medications, etc.

O: (Objective).

First visual assessment/evaluation of the patient's general appearance: limping, bleeding, doubled over, etc.

PE: All results of physical exam, vital signs, lab, x-ray, and any other study results.

A: (Assessment).

Imp: (Impression, Diagnosis) includes R/O (rule out)

NOTE: THIS IS TO INCLUDE, AFTER IMPRESSION, WHAT YOU ARE GOING TO DO NOW AND WHY--SUCH AS, SUTURING, TOURNIQUET, ETC.

P: (Plan).

List of medications given, lab, x-ray, special studies ordered, duty status, return appointments, referrals, etc.

- (5) The entries for all treatments shall be complete with regard to place, date, problem number (if appropriate), number of sick days, diagnosis of all conditions for which treated and signature of individual furnishing treatment. Note all facts concerning the origin of the disease, pregnancy status, symptoms, course, treatment, and if a conflicting opinion is expressed subsequently by the same, or another medical officer, fully state the reason for such change. The record need not be voluminous, but it shall be thorough, concise, clearly phrased, and complete in each case. All entries, including signatures, must be legible.
- (6) When a member is injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's health record, the record custodian shall ascertain the facts in the case and make the necessary entries on SF-600. Discuss and document the instructions given to the patient. Include the intended treatment and, as appropriate, possible alternative treatments, possible complications, and long term prognosis. Information regarding previous treatments should be entered giving the following: date, place, and full details of treatment; laboratory reports; x-ray results; etc. The following shall also be entered:
 - (7) "Date:
"Transcribed From Official Records.
Signature/Rate Duty Station of Transcriber"
- (8) When an individual is required to carry the PHS-731, enter a statement of acknowledgment on the SF-600.
- (9) When an individual is diagnosed as having a Sexually Transmitted Disease (STD) make an entry to record that an interview was conducted and that the following was discussed with the patient:
 - (a) symptoms,
 - (b) complications,
 - (c) treatments, and contacts.

5. Treatment at Other Than Unit Assigned. When an activity furnishes sick call treatment to an individual whose health record is not available, an entry shall be made on a new SF-600 and forwarded to the individual's duty station for inclusion in the health record.
6. DD-2808 (Report of Medical Examination). See Encl (1), pg. 4-7.
 - a. Purpose. The DD 2808 is used to record physical examination results to determine whether an examinee does, or does not, meet the standards established for the type of physical examination administered (i.e., initial enlistment, officer programs, retention, release from active duty, diving, aviation, retirement, etc.). The SF-88 is no longer applicable.
 - b. Preparation.
 - (1) When Prepared. DD-2808 shall be prepared and submitted to the reviewing authority whenever a complete physical examination is required.
 - (2) Required Entries. Certain groups of personnel are required to meet physical standards somewhat different from other groups. Accordingly, the use of all the spaces or use of the same spaces on the DD-2808 is not necessarily required for reporting the results of the various categories of physical examinations. If a certain item of the medical examination is required and facilities for accomplishing it are not available, an entry "NFA" (No Facilities Available) shall be made in the appropriate space. An entry "NE" (Not Evaluated) shall be made in the appropriate space for any item of the clinical evaluation (Items 17-42) which was not evaluated. For other items listed on the DD-2808 which were not required for a particular category of physical examination, an entry "NI" (Not Indicated) or "NA" (Not Applicable), shall be made in the appropriate space. Reference should be made to other provisions of Chapter 3, which prescribe the nature and scope of each physical examination and indicate the applicability of items of the DD-2808 to the particular program. Unless otherwise indicated by such provisions, the minimum requirements for completing the DD-2808 are:
 - (a) All Examinations. Items 1-44, 45-63, 66, and 71a, shall be completed for all physical examinations, if facilities are available. Item 41, shall be completed for all female personnel.
 - (b) Aviation Personnel. Additionally, Items 64, 65, and 66-70 and 72b shall be completed for physical examinations of aviation personnel.
 - (3) A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the final recommendation. Before signing and forwarding, the examiner shall review the completed DD-2808 for completeness and accuracy. Failure to do so reflects significantly on the examiner's clinical and/or administrative attention to detail. Remember that the reviewing authority does not have the advantage of a direct examination

and must rely on the examiner's written record and appropriate additional information in arriving at a decision.

c. Details for Entries on DD-2808.

- (1) **Item 1: Date of Examination.** Enter date in format - 02Aug15.
- (2) **Item 2: Social Security Number.** Enter the nine digits of their SSN.
- (3) **Item 3: Last Name.** Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)."
- (4) **Item 4: Home Address.** Enter the evaluatee's present residence and not the home of record.
- (5) **Item 5: Home Telephone Number.** NA
- (6) **Item 6: Grade.** Use official abbreviation of the current grade or rate. Example: HSCS; LTJG. If not a service member, enter "civilian."
- (7) **Item 7: Date of Birth.** (e.g.57Sep04).
- (8) **Item 8: Age.** Enter age.
- (9) **Item 9: Sex.** Mark one or the other of the boxes.
- (10) **Item 10: Race.** Mark the box next to the racial or ethnic group of which member belongs.
- (11) **Item 11: Total Years of Government Service.** Enter years and months (e.g., 06 yrs 04 mo's).
- (12) **Item 12: Agency.** Enter the OPFAC number of the unit to which the examinee is attached.
- (13) **Item 13: Organization and UIC/Code.** List name of ship or station to which the examinee is assigned. Initial entry into Service; enter recruiting office concerned.
- (14) **Item 14a: Rating or Specialty.** NA
- (15) **Item 14b: Total Flying Time.** Aviators only or NA.
- (16) **Item 14c: Last six months.** Aviators only or NA.
- (17) **Item 15a: Service.** Mark a box next to appropriate service.
- (18) **Item 15b: Component.** Mark a box next to appropriate component.

- (19) **Item 15c: Purpose of Examination.** Mark the box and corresponds to the appropriate purpose(s) of the examination. If not listed, mark “Other,” and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms “flight physical,” “diving physical,” or “aviation physical.” Rather, use specific terms such as “Class I Aviation,” “Candidate for Flight Training,” “Class II Aircrew,” “Dive Candidate,” “Quinquennial Diving,” etc. Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program. When necessary, continue under Item 73, Notes.
- (20) **Item 16: Examining Facility or Examiner.** For civilian or contract physician, enter the full name and address. For USMTF, enter only the facility name, city and state in which located.
- (21) **Item 17-42: Clinical Evaluation.** Check each item in appropriate column.
- (a) **Item 35:** Is continued on lower right side (Feet), circle appropriate category.
- (22) **Item 43: Dental Defects and Disease.** For an oral examination as part of an accession physical, record whether or not the applicant is ‘Acceptable’ or ‘Not Acceptable’. Refer to the standards described in Chapter 3 Section D-5 Physical standards for enlistment, appointment, and induction. Enter disqualifying defects in detail in Item 73. Record the Dental Classification. Refer to Chapter 4 Section C-3-c for definitions of dental classes. For routine physical examinations, record only the Dental Classification. When oral disease or dental defects are discovered on examination of active duty member personnel, suitable recommendations will be made for instituting corrective measures. A copy of form SF-603, Dental Record does not need to be attached to the DD-2808.
- (23) **Item 44: Notes.** Describe every abnormality from Items 17-43 in detail. Enter pertinent item number before each comment. Continue in Item 73 and use Continuation Sheet (SF-507), if necessary.
- (24) **Item 45: Laboratory Findings.** Enter all laboratory results in quantitative values.
- (a) **Urinalysis.** Enter specific gravity and results of albumin, sugar and if required, microscopic tests in the indicated spaces.
- (b) **Item 46: Urine HCG.** If applicable.
- (c) **Item 47: H/H.** Enter either the hematocrit or the hemoglobin results.
- (d) **Item 48: Blood Type.** If applicable.
- (e) **Item 49: HIV.** Enter date drawn only in the results section.

- (f) **Item 50: Drugs Test Specimen ID Label.** NA
 - (g) **Item 51: Alcohol.** NA
 - (h) **Item 52: Other.** Enter all other tests performed and their results which are not indicated on the form and which were performed in connection with the physical examination (e.g., sickle cell test, PAP test, PPD, EKG, Chest X-ray results, etc.). The results will be continued in Item 73 or on Continuation Sheet (SF 507), if necessary. If provided on the lab report, include "normal" range values for all tests performed by a civilian or military lab. Use quantitative values and avoid vague terms such as "WNL" or other such qualitative forms.
- (25) **Item 53: Height.** Measure without shoes and record to the nearest one-half centimeter ((one-half inch)
 - (26) **Item 54: Weight.** Measure with the evaluatee in under garments and record results to the nearest kilogram (pound).
 - (27) **Item 55: Min Weight-Max weight, Max BF%.** NA
 - (28) **Item 56: Temperature.** Leave Blank. NI
 - (29) **Item 57: Pulse.** Record the actual pulse rate.
 - (30) **Item 58: Blood Pressure.** Record the actual value in numerals for both systolic and diastolic.
 - (31) **Item 59: Red/Green.** NA
 - (32) **Item 60: Other Vision Test.** If applicable.
 - (33) **Item 61: Distant Vision.** Test and record using the Snellen scale. Record vision in the form of a fraction and in round numbers, that is 20/20, 20/40, not 20/20-2 or 20/40-3.
 - (34) **Item 62: Refraction.** Enter the lens prescription when the evaluatee wears (or requires) lenses for correction of visual acuity. Do not enter the term "lenses."
 - (35) **Item 63: Near Vision.** Test and record using the Snellen scale. (See item 61).
 - (36) **Item 64: Heterophoria.** Enter when indicated.
 - (37) **Item 65: Accommodation.** Enter when indicated.
 - (38) **Item 66: Color Vision.** Color Vision. Enter the test used and the results.

- (a) Farnsworth Lantern. Record the results as "Passed FALANT" or "Failed FALANT" followed by the fraction of correct over total (i.e., 9/9 or 17/18).
 - (b) Pseudoisochromatic Plates (PIP). Record results as "Passed PIP" or "Failed PIP" followed by the fraction of correct over total (i.e., 12/14 or 14/14).
 - (c) Enter "Passed on record" or "failed on record" if the results of a previous PIP or FALANT examination are available on record for review.
- (39) **Item 67: Depth Perception.** When indicated, enter test used in left portion of Item 67.
- (a) AFVT. In the appropriate space in the right-hand portion of Item 65, record the letter designation of the highest group passed (i.e., Passed F).
 - (b) Verhoeff. In the appropriate space in right-hand portion of Item 34, record perfect score as 16/16.
- (40) **Item 68: Field of Vision.** Enter when indicated.
- (41) **Item 69: Night Vision.** Enter when indicated.
- (42) **Item 70: Intraocular Tension.** When indicated, enter the results in millimeters of mercury.
- (43) **Item 71: Audiometer.** Required on ALL physical examinations. Use ANSI 1969 standards, do not use ISO or ASA standards.
- (a) **Item 71a:** Current
 - (b) **Item 71b:** If applicable.
- (44) **Item 72a: Reading Aloud Test.** If applicable.
- (45) **Item 72b: Valsalva.** When indicated mark either SAT or UNSAT.
- (46) **Item 73: Notes and Significant or Interval History.** Use this space for recording items such as:
- (a) any pertinent medical history;
 - (b) summary of any condition which is likely to recur or cause more than minimal loss of duty time;
 - (c) wrist measurements;
 - (d) most recent HIV antibody test date (see Chapter 3-C-20.b.(9) of this Manual);
 - (e) date of PPD and results; and
 - (f) Preventive Medicine stamp per Use of Preventive Medicine Stamp, COMDTINST 6200.11(series), for exams originating in Coast Guard sickbays and clinics.

- (47) **Item 74a: Examinee's Qualification.** State whether or not the examinee is qualified for the purpose of the examination. If the purpose for the examination is an IMB or DMB, state whether or not the examinee is qualified or not qualified for retention and to perform the duties of his/her rank/rate at sea and foreign shores.
- (48) **Item 74b: Physical profile.** Leave blank.
- (49) **Item 75: I have been advised of my disqualifying condition.** If indicated, have evaluatee sign and date.
- (50) **Item 76: Significant or Disqualifying Defects.** Leave Blank
- (51) **Item 77: Summary of Defects and Diagnoses.** List ALL defects in order to protect both the Government, and evaluatee, in the event of future disability compensation claims. All defects listed which are not considered disqualifying shall be so indicated by the abbreviation NCD (Not Considered Disqualifying). When an individual has a disease or other physical condition that, although not disqualifying, requires medical or dental treatment clearly state the nature of the condition and the need for treatment. If a medical or dental condition is disqualifying, and treatment is scheduled to be completed prior to transfer to overseas or sea duty, indicate the date the member is expected to be fully qualified, e.g., "Dental appointment(s) scheduled, patient will be class I (dentally qualified) by (date)". **Leave Profile Serial, RBJ, Qualified, and Waiver blocks blank.**
- (52) **Item 78: Recommendations.** Indicate any medical or dental recommendations. Specify the particular type of further medical or dental specialist examination indicated (use SF-507, if necessary).
- (53) **Item 79: MEPS Workload.** Leave Blank.
- (54) **Item 80: Medical Inspection Date.** Leave Blank.
- (55) **Item 81-84: Names and Signature of Examiners.** The name, grade, branch of Service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign using ballpoint pen or ink pen (black or blue-black ink only) in the appropriate section. Do not use facsimile signature stamps. When attachment sheets are used as a supplement or continuation to the report, they shall be serially number (both sides); however, indicate only the actual number of attached sheets in the bottom right **block 87** on DD-2808.
- (56) **Item 85: Administrative Review.** The person who reviews the PE for accuracy, prior to submitting for approval shall sign and date.
- (57) **Item 86: Waiver Granted.** Leave Blank.
- (58) **Item 87: Number of attached Sheets.** Fill in with appropriate number of forms attached.

7. **DD-2807-1 (Report of Medical History)**. See Encl (1), pg. 4-7.
- a. **Purpose**. DD-2807-1 provides a standardized report of the examinee's medical history to help the examiner evaluate the individual's total physical condition, and to establish the presence of potentially disabling conditions which are not immediately apparent upon physical examination. In preparing the form, encourage the examinee to enter all medical problems or conditions experienced, no matter how minor they may be. The examiner must investigate and evaluate all positive medical history indicated on the form.
 - b. **Preparation and Submission of DD-2807-1**. Prepare and submit DD-2807-1 with all physical examinations except: Periodic OMSEP and Substitution/Overseas/Sea Duty Modified Physical Examination.
 - c. **Preparation Procedures**. DD-2807-1 shall be prepared by the examinee and the examining medical officer.
 - (1) The examinee shall furnish a true account of all injuries, illnesses, operations, and treatments since birth. False statements or willful omissions in completing the DD-2807-1 may result in separation from the Service upon arrival at the Academy, Recruit Training Center, Officer Candidate School, or later in the individual's career.
 - (2) A copy of the DD-2807-1 must be included in the member's health record. Entries must be printed, in the examinee's and examiner's own handwriting, using either ball-point pen or ink pen (black or dark blue). Pencils or felt-tip pens will not be used. Information in the numbered blocks on the form will be entered in the following manner:
 - (a) **Item 1: Last Name, First, Middle Name**. SMITH, Hannibell H. Record the surname in all capital letters. Record the given name(s) in full, without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial within quotation marks. If the individual has no middle name, enter the letter "(n)" in parenthesis. Designations such as "Jr." or "II" will appear after the middle name or initial or after "(n)" if there is no middle name.
 - (b) **Item 2: Social Security Number**. Enter SSN.
 - (c) **Item 3: Enter date format** –2001Sep04.
 - (d) **Item 4a: Home Address**. Enter the evaluatee's present residence and not the home of record.
 - (e) **Item 4b: Home Telephone**. Enter home phone number.
 - (f) **Item 5: Examining Location and Address**. For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.

- (g) **Item 6a: Service.** Mark a box next to the appropriate service.
- (h) **Item 6b: Component.** Mark a box next to the appropriate component.
- (i) **Item 6c: Purpose of Examination.** Mark a box next to the appropriate purpose(s) of the examination. If not listed, mark “Other” and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms “flight physical,” “diving physical,” or “aviation physical.” Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program.
- (j) **Item 7a: Position.** Use official abbreviation of current grade or rate, branch of the Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCM, USCG; LTJG, USCGR; HSC, USCG (RET); HS3, USCG (TEMPRET). If not a Service member, enter "civilian."
- (k) **Item 7b: Usual Occupation.** List current occupation.
- (l) **Item 8: Current Medications.** List all current medications including over the counter meds.
- (m) **Item 9: Allergies.** List any allergies to insect bites/stings, foods medicine or other substances.
- (n) **Item 10 to 28.** Check appropriate box.
- (o) **Item 29: Explanation of “Yes” Answer(s).** Describe all “yes” answers from section 10-28. Include date(s) of problems, name of doctor(s), and /or hospitals(s), treatment given and current medical status.
 - 1 Append Item 29 to include: The statement to present health and a list of medications presently being taken by the examinee. For individuals receiving examinations more frequently than quinquennial, there is often little change in the medical history from year to year. As an alternative to having the examinee complete Section 10-28 of the DD-2807-1 at a periodic examination, the following statement may be entered in Item 29 and initialed by the person undergoing the examination.
 “I have reviewed my previous Report of Medical History and there have been no changes since my last medical examination, except as noted below.” _____(initials)
- (p) **Item 30. Examiner’s Summary and Elaboration of all Pertinent Data.** Prior to performing the physical examination, the examiner will review the completeness of the information furnished on the DD-2807-1. When this is done, summarize the medical history under

(Item 30a. Comments) as outlined below and then sign the form. If additional space is needed, use Continuation Sheet, SF-507.

- (q) Do not use the term "usual childhood illnesses"; however, childhood illnesses (those occurring before age 12) may be grouped together enumerating each one. Incidents, other than those occurring in childhood, shall have the date recorded rather than the examinee's age. Do not use "NS" or "non-symptomatic" for items of history. Use "NCNS," "No Comp., No Seq." after items of recorded history where applicable. Elaborate on all items of history answered affirmatively except "Do you have vision in both eyes". The following specific questions shall also be asked on examination for initial entry into the Coast Guard, and for aviation and diving duty applicants:

- 1 "Is there a history of diabetes in your family (parent, sibling, or more than one grandparent)?"
- 2 "Is there a history of psychosis in your family (parent or sibling)?"
- 3 "Do you now or have you ever worn contact lenses?"
- 4 "Do you now or have you ever used or experimented with any drug, other than as prescribed by a physician (to include LSD, marijuana, hashish, narcotics, or other dangerous drugs as determined by the Attorney General of the United States)?"
- 5 "Have you ever required the use of an orthodontic appliance attached to your teeth or a retainer appliance? Month and year last worn? Are they still necessary?"
- 6 "Are there any other items of medical or surgical history that you have not mentioned?" All affirmative answers to the above questions shall be fully elaborated in Item 25. Negative replies to the above questions shall be summarized as follows: "Examinee denies history of psychosis, use of drugs, history of wearing of contact lenses, requirement for any orthodontic appliance, all other significant medical or surgical history; family history of diabetes." A rubber stamp or the overprinting of this information in Item 25 is recommended.

- (3) Distribution. Attach the original DD-2807-1 to the original DD-2808 and submit to reviewing authority. A copy of the DD-2807-1 and DD-2808 shall be kept on file at the unit pending the return of the approved DD-2807-1 and DD-2808. After review and endorsement, the reviewing authority shall forward the original DD-2807-1 and DD-2808 to the members parent command for insertion into the members health record.

8. [**SF-558 \(Emergency Care and Treatment\) \(Rev 9-96\)**](#). See Encl (1), pg. 4-13. This form provides a comprehensive yet concise record of emergency health care. It shall be used whenever an individual receives emergency treatment. Detailed instructions for completing the form are as follows:

- a. Patient's Home Address or Duty Station. Complete all blocks in this section.
- b. Arrival. Record the date and time the patient arrived at the clinic or emergency room for care.
- c. Transportation to Facility. Record the name of the ambulance company or unit that transported the patient for care, if appropriate. If patient was not transported by ambulance or other emergency vehicle, enter "N/A".
- d. Third Party Insurance. List detailed insurance if known by patient. If potential third party liability exists, forward a copy of SF-558 to Commandant (G-WRP-2). Note: Disregard DD2568 in chart, enter N/A).
- e. Current Medications. List all medications patient is presently taking.
- f. Allergies. Record any substance or drug to which the patient has a known or suspected allergy. If none, enter "NKA" (No Known Allergy).
- g. Injury or Occupational Illness. Most fields. When, refers to date injury was sustained. Where, refers to location injury occurred. How, refers to what happened (briefly).
- h. Emergency Room Visit. Self-Explanatory.
- i. Date of Last Tetanus Shot. Self-Explanatory.
- j. Chief Complaint. Record a brief description of why the patient is seeking health care.
- k. Category of Treatment. If Condition is Result of Accident/Injury. Check the block that best describes the patients' condition upon arrival.
 - (1) Emergent. A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.
 - (2) Urgent. A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.
 - (3) Non-Urgent. A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute
- l. Vital Signs. Take and record all vital signs. Indicate the time vitals were taken. Use 24-hour clock annotation i.e. 0215.
- m. Lab Orders and X-Ray Orders. Self-Explanatory, check appropriate box.
- n. Orders. List orders given by provider. Record all medications, appointments made. Or any other follow-up plans.
- o. Disposition. Check appropriate box. Ensure patient understands this section.
- p. Patient/Discharge Instructions. Be specific. Ensure patient understands instructions given.

- q. Patients Signature and Date. Have the patient or person accompanying the patient sign the form. This signature only acknowledges that instructions were given to the patient.
 - r. Time Seen by Provider. Record the time when the patient received treatment. Use 24-hour clock annotation i.e. 0215.
 - s. Test Results. Record results of tests ordered on patient.
 - t. Provider History/Physical. Self-explanatory, use standard S.O.A.P. format.
 - u. Consult With. List all individuals that on-scene provider received medical advice from. Example Dr. Richard Smith.
 - v. Diagnosis. Record patient diagnosis.
 - w. Providers Signature and Date. The medical officer or other health care provider shall sign and date the form.
 - x. Codes. List all ICD-9 codes applicable to the patient.
 - y. Patients' Identification. Ensure all patient identification information is entered.
9. DD-2215 Reference Audiogram. Place form in section V of the Health Record.
10. DD-2216 Hearing Conservation Data. Place form in section V of the Health Record.
11. Audiogram Results. The Microprocessor will generate a legal archival test result strip, which shall be fastened to a separate SF-514, Clinical Record-Laboratory report form, dedicated to this purpose and filed under section V of the Health Record. Label this SF-514 "Hearing Conservation Program" across the bottom.
- a. All test result strips shall be placed sequentially onto form SF-514 in left to right formation overlapping 2/3 of the last audiogram.
12. SF-502 (Narrative Summary). See Encl (1), pg.4-15. SF-502's are used for a variety of purposes, such as:
- a. to summarize the important facts about a patient's hospitalization;
 - b. to summarize the findings of a medical board; or
 - c. to report the results of a Board of Flight Surgeons.
- If received subsequent to the individual's discharge from the hospital, it shall be inserted in the health record immediately upon receipt.
13. NAVMED 6100/1 (Medical Board Report Cover Sheet).
- a. The NAVMED 6100/1 is used in preparing a medical board. A copy of the NAVMED 6100/1 and the complete medical board shall be inserted into the individual's health record.
 - b. Detailed instructions for preparing and distributing this form are contained in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

14. **SF-513 (Consultation Sheet)**. See Encl (1), pg 4-16.
- a. **Purpose**. SF-513 is used whenever a patient is referred to another facility for evaluation.
 - b. **Detailed Instructions**. Complete the form as follows:
 - (1) To. Facility or department to which the patient is being referred.
 - (2) From. Unit referring the patient.
 - (3) Date of Request. Self-explanatory.
 - (4) Reason for Request. Specify the reason for referring the patient, i.e., chest pains, infected sebaceous cyst, etc.
 - (5) Provisional Diagnosis. Self-explanatory.
 - (6) Doctor's Signature. Must be signed by a medical officer, dental officer, or health services department representative. Accompanying this signature should be the qualifying degree of the individual requesting the consult.
 - (7) Approved. Leave Blank.
 - (8) Place of Consultation. Check the appropriate block.
 - (9) Emergency/Routine. Check the appropriate block.
 - (10) Identification No. Enter the patient's SSN.
 - (11) Organization. Enter patient's branch of service.
 - (12) Register No. If inpatient, enter the appropriate register number. If outpatient, leave blank.
 - (13) Ward No. If outpatient enter "OP." If inpatient, enter appropriate ward number.
 - (14) Patient's Identification. Enter the appropriate patient identification information.
 - (15) The remainder of the form is completed by the consultant.
 - c. **When the consultation sheet (SF-513) is completed and returned by the consultant, the following actions are required:**
 - (1) Originator shall review and sign the SF-513;
 - (2) Originator shall complete a Visit Profile sheet (CG-5460B) as directed by Use of Clinic Automated Management System (CLAMS), COMDTINST 6010.18(series) for later entry into CLAMS; and
 - (3) The SF-513 shall then be filed in the appropriate dental or medical section of the health record.

15. **SF-520 (Electrocardiographic Report)**. See Encl (1), pg.4-17.
- a. Purpose. SF-520 is used to report the results of all electrocardiograms.
 - b. Detailed Instructions. The individual performing the electrocardiogram shall complete the form as follows:
 - (1) Previous ECG. Check appropriate block
 - (2) Clinical Impression. Reason why the electrocardiogram was requested, e.g., chest pain, physical examination, etc.
 - (3) Medication. Enter any medications that the patient is taking.
 - (4) Emergency/Routine. Check appropriate block.
 - (5) Bedside/Ambulant. Check appropriate block.
 - (6) Age. Enter patient's age as of last birthday.
 - (7) Sex. Enter "M" or "F," as appropriate.
 - (8) Race. Leave blank.
 - (9) Height. Enter to nearest one-half centimeter (one-half inch).
 - (10) Weight. Enter to the nearest kilogram (pound).
 - (11) B.P. Enter recumbent blood pressure.
 - (12) Signature of Ward Physician. Signature of medical officer ordering the electrocardiogram.
 - (13) Date. Date the ECG was performed using appropriate format.
 - (14) Register No. Enter patient's social security number.
 - (15) Ward No. Enter "OP" (outpatient) or appropriate ward no.
 - (16) Patient's Identification. Enter the appropriate patient identification information.
 - (17) The remainder of the form is completed by the medical officer evaluating the electrocardiogram.
 - c. The baseline ECG shall be appropriately marked "Baseline ECG."
16. **SF-515 (Tissue Examination)**. See Encl (1), pg.4-18.
- a. Prepare a SF-515 whenever a tissue specimen is forwarded to a laboratory for examination.
 - b. Ensure patient's identification information is completed.
17. **SF-541 (Gynecologic Cytology)**. See Encl (1), pg.4-19.
- a. Prepare a SF-541 whenever a vaginal or cervical smear (PAP test) is forwarded to a laboratory for examination.

- b. Ensure patient's identification information is completed.
18. **SF-514 (Laboratory Reports)**. See Encl (1), pg.4-20.
- a. This is a display form for mounting graphic reports, automated printout reports, or printed reports associated with special equipment.
 - b. Attach the laboratory reports to the indicated spaces with the most recent on top.
 - c. Ensure patient's identification information is completed.
 - d. Clinical Record - Laboratory Report Display (SF-545). May be used in lieu of SF-514. This is a display form for mounting laboratory requests and report forms. When a patient will require the same type of test several times, a separate display sheet shall be used for each type of test. In low use situations, the various test result forms should be mounted on alternate strips 1, 3, 5, and 7.
 - (1) The following Standard Forms should be mounted serially on strips 1, 2, 3, 4, 5, 6, and 7:
 - (a) Chemistry I (SF-546),
 - (b) Hematology (SF-549),
 - (c) Urinalysis (SF-550), and
 - (d) Serology (SF-551).
 - (2) The following Standard Forms be mounted on alternate strips 1, 3, 5, and 7:
 - (a) Chemistry II (SF-547);
 - (b) Chemistry II (Urine) (SF-548);
 - (c) Parasitology (SF-552);
 - (d) Spinal Fluid (SF-555); and
 - (e) Immunohematology (SF-556).
 - e. In many instances there will be a mixed assortment of Standard Forms to be mounted in a patient's chart and obviously these should be mounted in the most practical sequence.
 - f. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the SF-545. A check mark in the space in the lower right corner identifies the name of the laboratory forms that are displayed on this sheet or indicates that a variety or assortment of forms is displayed on the sheet.
19. **SF-545a - Clinical Record - Laboratory Report Display** for SF-553, SF-554, and SF-557. This is a display form for mounting Microbiology I, Microbiology II, and miscellaneous forms for inclusion in the health record. It may be used, when indicated, in addition to SF-514.

20. SF-546 - 557 (Laboratory Requests).

- a. SF-546 (Chemistry I). Used to request most blood chemistry tests. Fill in the identification data as described previously. The specimen source information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER. The names of the blood chemistry tests are listed individually on this form. At the bottom of the list there is provision for ordering a battery or profile of tests. When requesting the identifying names of the battery or profile of tests must be written into the space provided. There is also space for writing in the names of other tests not specifically listed.
- b. SF-547 (Chemistry II). Used to request blood gas measurement, T3, T4, serum, iron binding capacity, glucose tolerance, and other chemistry tests. Fill in the identification data as described previously. The specimen source information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER.
- c. SF-548 (Chemistry II, Urine). Used to request chemistry tests on urine specimens. The specimen interval information is given by checking the box marked 24 HOURS or by specifying information in the position marked OTHER.
- d. SF-549 (Hematology). Used to request routine hematology tests. The specimen source information is given by checking box marked VEIN, the box marked CAP for capillary, or by specifying information in the position marked OTHER.
- e. SF-550 (Urinalysis). Used to request urinalysis tests, including routine urinalysis with microscopic examination. The specimen source information is given by checking the box marked ROUTINE or by specifying information in the position marked OTHER. (Note that routine urinalysis may be ordered by simply placing an "X" in front of the word MICROSCOPIC in the requesting section.) The space marked PSP is for requesting and reporting phenolsulfonphthalein measurements. The space marked HCG is for requesting and reporting measurements of human chorionic gonadotropin.
- f. SF-551 (Serology). Used to request tests that measure serum antibodies, including tests for syphilis.
 - (1) The space marked RPR is for requesting and reporting measurements of the Rapid Reagent Card Test for Syphilis
 - (2) The space marked TA is for requesting and reporting measurements of the Latex Fixation Test for Thyroglobulin Antibodies.
 - (3) The space marked COLD AGG is for requesting and reporting of Cold Agglutinins.
 - (4) The space marked ASO is for requesting and reporting Antistreptolysin 0 titers.
 - (5) The space marked CRP is for requesting and reporting measurements of C Reactive Protein.

- (6) The space marked FTA-ABS is for requesting and reporting for fluorescent treponemal antibody-absorption test.
 - (7) The space marked FEBRILE AGG is for requesting and reporting measurements of Febrile Agglutinins.
 - (8) The space marked COMP FIX is for requesting and reporting Complement Fixation Tests. The name of the specific antibody should also be written in this space.
 - (9) The space marked HAI is for requesting and reporting Hemagglutination Inhibition Tests. The name of the specific antibody should also be written in this space.
- g. SF-552 (Parasitology). Used to request tests for intestinal parasites, malaria and other blood parasites, as well as most test on feces. Fill in identification data as described previously.
- h. SF-553 (Microbiology I). Used to request most bacteriological isolations and sensitivities.
- (1) The type of the patient's infection, according to origin, is indicated by checking one of the boxes in the space marked INFECTION in the upper right area of the form.
 - (2) The examination requested is indicated by checking either the box marked SMEAR, SENSITIVITY, CULTURE, or COLONY COUNT.
 - (3) The report of the examination is written or stamped on the form by the laboratory personnel.
 - (4) The names of the bacteria identified or isolated are listed in the space marked PREDOMINANT ORGANISM(S).
 - (5) The sensitivity listing and results are stamped or written in the space marked SENSITIVITY.
- i. SF-554 (Microbiology II). Used to request tests for fungi, acidfast bacillus (TB), and viruses.
- (1) The type of infection according to origin is indicated by checking one of the boxes in the space marked INFECTION.
 - (2) The examination(s) requested is checked in the sections for fungus test or AFB tests or viral cultures.
 - (3) The test results are stamped or written on the form by the laboratory personnel.
- j. SF-555 (Spinal Fluid). Used to request most spinal fluid tests.
- k. SF-556 (Immunohematology). Used to request blood grouping, typing, and blood bank tests.

1. SF-557 (Miscellaneous). Used to request and report tests such as electrophoresis and assays of coagulation factors, which are not ordered on other laboratory forms.
 - (1) Fill in the identification data as described previously.
 - (2) The specimen source is specifically described in the space marked SPECIMEN SOURCE.
 - (3) Write the name of the test requested in the request section of the form.
21. SF-519 (Radiographic Reports). See Encl (1), pg.4-21.
 - a. This is a display form for mounting Radiographic Reports (SF-519-A). Attach the SF-519-A to the indicated spaces, with the most recent report on top.
 - b. Use SF-519-A to request x-ray examinations. All patient data must be completed as indicated. Ensure that examinations requested are in standard terms or abbreviations. ALL pertinent clinical history, operations, physical findings, pregnancy status, and provisional diagnoses must be recorded in the appropriate space. This information is needed by the radiologist in order to render a proper interpretation of the film.
 - c. Complete the required patient's identification information.
22. DD-771 (Eyewear Prescription). See Encl (1), pg.4-22. Type DD-771 for clarity and to avoid errors in interpretation, using the following format:
 - a. Date. Enter as follows, 22 JAN 87, etc.
 - b. Order Number. Enter unit identifying number, issued by NOSTRA or Top Gun Fantasy Ray Ban, above the order number block. Complete order number block if desired.
 - c. To. Appropriate fabricating facility.
 - d. From. Enter complete unit address of unit ordering the eyewear.
 - e. Name, Service Number/Social Security Number. Enter as ALBERT, Michael W. HSC 123-45-6789.
 - f. Age. Self-explanatory.
 - g. Unit and Address. Enter complete mailing address of unit to which individual is attached. If retiree, use the individual's home or mailing address.
 - h. Active Duty, etc. Check appropriate block.
 - i. USA, USN, etc. Check appropriate block.
 - j. Spectacles. Check appropriate block.
 - k. Aviation Spectacles. Use this block only when ordering aviation frames. Check as appropriate:

- (1) N-15 tinted lenses;
 - (2) Coated lenses (coated with an anti-glare compound) are not authorized for Coast Guard personnel.
- l. Other. Leave blank.
 - m. Interpupillary Distance. Copy directly from patient's Prescription, previous DD-771, or SF-600.
 - n. Eye Size. As above. (Not required for aviation goggles)
 - o. Bridge Size. As above. (Not required for aviation goggles)
 - p. Temple Length and Style. As above. (Not required for aviation goggles)
 - q. Number of Pairs. Enter the number of pairs requested.
 - r. Case. Enter the number of cases requested.
 - s. Single Vision.
 - (1) Sphere. Copy directly from individual's prescription, previous DD-771, or SF-600 (+1.00, -1.25, etc.). Prescriptions are filled in multiples of 0.25 diopters only.
 - (2) Cylinder. As above, except that prescriptions or multivision lenses must be in "minus cylinder" form, (-0.50, -0.75, etc.).
 - (3) Axis. Copy directly from individual's prescription, previous DD-771, or SF-600. The axis must contain three (3) digits such as: 180, 090, 005, etc.
 - (4) Decentration. Need not be completed unless specified as a part of prescription.
 - (5) Prism. As indicated on individual's prescription, previous DD-771, or SF-600.
 - (6) Base. As above.
 - t. Multivision. If the individual needs multivision lenses (bifocals, trifocals, etc.) then the prescription must be in minus cylinder form.
 - u. Special Lenses or Frames. This block is used for special instructions or justification for aviation spectacles, or nonstandard lenses, and frames, etc.
 - (1) When replacement eyewear is ordered from a prescription extracted from the health record, enter the following entry in this block: "REPLACEMENT ORDER: PRESCRIPTION FROM REFRACTION PERFORMED ON DATE."
 - (2) When eyewear is ordered for recruits, enter the following entry in this block: "RECRUIT - PLEASE EXPEDITE."
 - (3) When tinted lenses are ordered for non-aviation personnel, enter a written justification in this block. "Tinted lenses STATE JUSTIFICATION."

- (4) When nonstandard temples or frames are ordered, enter type frame or temple requested, and justification:
 - (a) Riding Bow Cables, (Justification);
 - (b) Adjustable Nose Pads, (Justification).
 - (5) When an individual's pupillary distance is less than 60 mm it must be verified and an entry placed in this block: "PD of ____ verified and correct."
 - v. Signature of Approving Authority. Shall be signed by the senior medical officer, designated representative, or the commanding officer where no medical officer is present.
 - w. Signature of the Prescribing Officer. Shall be signed by the medical officer or person performing the refraction. When this is not possible, i.e., examination obtained from a civilian source, transcribed from the health record, etc., the person transcribing the information shall sign as prescribing officer. Flight surgeons may sign prescriptions as both the prescribing and approving authority.
23. **SF-601 (Immunization Record)**. See Encl (1), pg.4-23.
- a. All prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food and allergies, and blood typings shall be recorded on SF-601 and also on the PHS-731. The recordings shall be continued on the current record until additional space is required under any single category.
 - b. In such cases, insert a new SF-601 in the health record and retain the old SF-601. Concurrently, make a thorough verification of the entries and bring all immunizations up-to-date. Replacement of the current SF-601 is not required because of change in grade, rating, or status of the member concerned.
 - c. The name of the individual administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or a rubber stamp used. Signatures on SF-601 are not required. However, in the event of their use, make sure they are legible.
 - d. The individual administering the immunizations is responsible for completing all entries in the appropriate section, including required entries on reactions.
 - e. Enter information concerning a determined hypersensitivity to an immunization or vaccine under "Remarks and Recommendations". Type appropriate entries (such as HYPERSENSITIVE TO TYPHOID) in capitals. Enter "HIV antibody testing done (enter date(s))".
 - f. For Yellow Fever vaccine, record the origin and batch number.
24. **SF-602 (Syphilis Record)**. See Encl (1), pg. 4-25.
- a. This form shall be prepared and inserted in the health record for each person for whom a confirmed diagnosis of syphilis or any of its complications or sequela has been established.

- b. The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation and the repeated performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in Section II of SF-602.
25. **DD-1141 (Record of Occupational Exposure to Ionizing Radiation)**. See Encl (1), pg.4-27.
- a. Requirements. The custodian of the medical records shall prepare and maintain as DD-1141 for each person occupationally exposed to ionizing radiation. Enter all exposures in rems.
 - b. Recording Procedures.
 - (1) Initial Determination of Accumulated Dose.
 - (a) In the initial preparation of DD-1141, obtain complete reports of previous exposure. For each period in which the individual was engaged in activities where occupational exposure was probable, and no record, or only an incomplete record of exposure during the period can be obtained, assume that an occupational exposure of 1.25 rems was incurred per quarter of each calendar year or fraction thereof.
 - (b) In cases where the nature of the radiation is unknown, assume gamma radiation.
 - (c) If an individual was exposed at more than one facility, calculate the cumulative exposures and record them in Items 7 through 12 as appropriate. Enter the sum of the whole body exposure in Item 13, and a statement regarding the sources of that information in Item 16, REMARKS.
 - (2) Current Record.
 - (a) Quarterly, make appropriate entries on each individual's DD-1141 from the exposure records received from the Public Health Service Contractor.
 - (b) Maintain separate DD-1141 to record exposures other than whole body, with appropriate descriptions under Item 16, REMARKS.
 - c. Completion Instructions.
 - (1) Item 1. Leave blank.
 - (2) Item: 2. Enter last name, first name, and middle initial. If the combination of last name and first name exceed 19 spaces, enter last name and initials only.
 - (3) Item 3. Enter SSN.
 - (4) Item: 4. Enter in not more than 10 spaces, rate, grade, title or position the individual is currently holding. Use standard service abbreviations: i.e., CAPT; HSCS; HSI; etc. Abbreviate civilian occupation titles as needed; i.e.,

Radiological Physicist to Rad Physic; Radiation Physiologist to Rd Physiol;
Electrical Welder to Elec Wldr; etc.

- (5) Item 5. Enter date of birth: i.e., 4 SEP 87.
 - (6) Item 6. Enter name of activity or unit.
 - (7) Items 7 & 8. "Period of Exposure." Enter the day, month, and year: i.e., 1 MAR 87.
 - (8) Items 9-12. "Dose This Period." Enter radiation dose received this period to three decimal places: i.e., 02.345rem. Use five digits including zeros as necessary for all entries.
 - (a) Item 9. Enter skin dose (soft) which includes low energy gamma and x-ray of less than 20 KVE effective energy and beta radiation. Total skin dose is the addition of columns 9 and 12.
 - (b) Item 10. Enter gamma and x-ray dose greater than 20 KVE effective energy in REM.
 - (c) Item 11. Enter neutron dose in REM.
 - (d) Item 12. Enter sum of items 10 and 11.
 - (9) Item 13. Add item 12 to previous item 13; enter total in item 13.
 - (10) Item 14. Enter permissible dose calculated from the age formula $5(N-18)$ REM, where N equals the present age in years.
 - (11) Item 15. Recorder certify entries by initial.
 - (12) Item 16. Enter other pertinent information such as known exposure from internally deposited radioactive material or from any external radioactive sources. Describe briefly any activity or assignment bearing a potential for exposure and estimate dose-time relationships, if feasible. If this form is used for other than whole body and skin of whole body, specify the use; i.e., hands and forearms, feet and ankles, thyroid, etc. When recorded dose is not obtained from film badge readings, specify whether estimates were obtained from pocket dosimeters, area or air monitoring, bioassay, etc.
26. [CG-4057 \(Chronological Record of Service\)](#). See Encl (1), pg 4-28.
- a. Purpose. Use this form:
 - (1) to maintain a chronological record of assignments for each active duty member of the Coast Guard;
 - (2) as a statement of agreement or disagreement with the assumption of fitness for duty upon separation from the Coast Guard; and
 - (3) to terminate the health record.
 - b. Chronological record of assignments. Prepare original only. Record the member's full name in all capitals, together with the Social Security Number. Make entries

each time a member leaves or returns from PCS, TAD, or hospitalization at a unit different than the one to which currently assigned.

- c. Agreement or disagreement with the assumption of fit for duty at the time of separation. Members not already in the physical disability evaluation system, who disagree with the assumption of fitness for duty at separation shall indicate on the reverse of form CG-4057. They shall then proceed as indicated in paragraph 3-B-5. of this Manual. Members who agree with the assumption shall check the box indicating agreement. This is a health services department responsibility when there is a health services department representative attached; otherwise it becomes a personnel action.
 - d. Terminating the health record. The reverse side of the form is also used to terminate a member's health record upon definite separation from active service. The date of termination is the effective date of separation. Make appropriate entries giving the reason for termination, the date of termination and the grade and signature of the responsible commissioned officer in the bottom portion of the form. Additionally, an entry, signed by the member whose health record is being terminated, acknowledging the receipt of a copy all available NAVMED 6150/20's, a copy of separation examination if done (either DD-2808 or SF-600 entry), a signed copy of the CG-4057, and the PHS-731 shall be made in the Remarks section of the CG-4057.
 - e. This form is also used to notify the individual of the possibility of certain disability benefit entitlements from the Department of Veterans Affairs after separation.
 - f. If either side of the CG-4057 is filled, the reverse side shall have a line drawn diagonally through it in red and a second CG-4057, marked "Supplement" at the top, started.
27. NAVMED 6150/2 (Special Duty Medical Abstract). See Encl (1), pg. 4-30.
- a. General. The purpose of the NAVMED 6150/2 is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performing special duty, such as aviation and diving. The object of the special duty examination, and the instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performing a special duty. Therefore, accuracy and content of information are essential in reporting information applicable to these categories.
 - b. Entries.
 - (1) Record entries upon completion of each physical examination and completion of designated special training. When a previously qualified member is suspended from special duty for physical reasons, enter the period of suspension and reason therefore on the NAVMED 6150/2.

- (2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers.

28. PHS-731 (International Certificate of Vaccination).

a. General.

- (1) Prepare PHS-731 for each member of the Coast Guard (for reserve personnel when ordered to Active Duty for Training). This form shall be carried only when performing international travel or when reporting for Active Duty for Training. When not required for either of the preceding reasons, the completed certificate shall be retained in the individual's health record. Appropriate entries shall be made on PHS-731 and SF-601 when immunizations are administered.
- (2) A reservist not on extended active duty who plans international travel either under official orders or privately, may request that the appropriate district commander (r) furnish a PHS-731 for this purpose. The reservist shall return the PHS-731 to the district commander (r) when travel is completed.
- (3) When properly completed and authenticated, the PHS-731 contains a valid certificate of immunization for international travel and quarantine purposes in accordance with World Health Organization Sanitary Regulations.
- (4) All military and nonmilitary personnel performing international travel under Coast Guard cognizance shall be immunized in accordance with Commandant Instruction 6230.4 (series) and shall have in their possession a properly completed and authenticated PHS-731.

b. Detailed Instructions.

- (1) Stamp or type the following address on the front of PHS-731:
Commandant (G-WK)
U. S. Coast Guard
2100 Second St., S.W.
Washington, DC 20593-0001
- (2) Enter data by hand, rubber stamp, or typewriter.
- (3) Enter the day, month, and year in the order named (i.e., 4 SEP 87).
- (4) Record the origin and batch number for yellow fever vaccine.
- (5) Entries for cholera and yellow fever must be authenticated by the Department of Defense Immunization Stamp and the actual signature of the medical officer. Other immunizations may be authenticated by initialing. Entries based on prior official records shall have the following statement added:
"Transcribed From Official Records."

- c. Remove the PHS-731 from the health record and give it to the individual upon separation from the Service.
29. **CG-5214 (Emergency Medical Treatment Report)**. See Encl (1), pg. 4-32.
- a. **Purpose**. CG-5214 provides a multiple copy record of all emergency medical care rendered by Coast Guard personnel outside of a clinic or sickbay. All care rendered by crews of Coast Guard emergency vehicles must be documented with a CG-5214.
 - (1) Part 1, Copy to Patient. This copy shall be placed in the patients' health record if available.
 - (2) Part 2, Copy to Receiving Unit. This copy shall be given to the hospital, clinic, or EMS crew assuming responsibility for patient care.
 - (3) Part 3, Copy to Triage Officer. In multi-casualty incidents, this copy shall be given to the triage officer to account for the patients' treatment priority and status. Otherwise, this copy shall be kept on file at the clinic or sickbay.
 - (4) Part 4, (hard copy) to Commandant (G-WKH-1). This copy shall be forwarded to Commandant (G-WKH-1) using the mailing label on the reverse side.
 - b. **Preparation and Submission of CG-5214**. The form provides an accurate account of the patient's injury or illness, and a detailed report of all treatments rendered en route to a receiving facility. If possible, the report should be completed during the transport phase. Detailed instructions for completing the CG-5214 are as follows:
 - (1) Victim Identification.
 - (a) Item 1: Name. Enter last, first, and middle initial.
 - (b) Item 2: Sex. Check one.
 - (c) Item 3: Estimated Age. Enter in years or months.
 - (2) Description of Incident.
 - (a) Item 4: Date. Enter date incident occurred.
 - (b) Item 5: Type of Incident. Check one and give pertinent details under "Nature of Emergency/Mechanism of Injury".
 - (c) Item 6: Time on Scene. Enter (using 24 hour clock).
 - (d) Item 7: Time of Incident. Enter (using 24 hour clock).
 - (e) Item 8: Location. Enter exact geographical area.
 - (3) Observation of Victim. Stick-Man figure: Place applicable injury letter code over injured area.
 - (4) Skin. Circle applicable number.
 - (5) Vital Signs. Note time observed (24 hour clock).
 - (6) Level of Consciousness. Check only one per time observed.

- (7) Pupils. Check only one per time observed.
- (8) Pulse. Place numerical value under rate and check appropriate space for quality.
- (9) Breathing. Place numerical value under rate and check appropriate space for quality.
- (10) Blood Pressure. Enter systolic and diastolic values under applicable time.
- (11) Temperature. Circle either oral or rectal and enter in numerical value.
- (12) Mast. Beside "Mast BP" enter blood pressure values. Circle applicable compartments inflated.
- (13) Triage Information. Circle one of the following:
 - (a) Priority I: Patients with airway and/or breathing problems, cardiac arrest, uncontrolled bleeding or controlled bleeding with symptoms of shock, severe head or abdominal injuries, and severe medical problems to include possible heart attack, severe burns, and severe poisonings.
 - (b) Priority II: Patients with less serious burns, multiple fractures, potential C-Spine injuries without shock, or medical conditions of a less serious note.
 - (c) Priority III: Patients with obvious minor injuries or patients who are obviously dead or mortally wounded.
- (14) Medications. List any medications the patient is currently taking.
- (15) Allergies. List any known allergies for the patient.
- (16) Medications Administered. Note the time, dosage, and route of administration for any medications administered to the patient.
- (17) Rescuer Information.
 - (a) Item 10: Name. Enter last, first, and middle initial.
 - (b) Item 11: Level. Circle appropriate certification level.
 - (c) Item 12: Unit. Rescuer's assigned unit.
 - (d) Item 13: OPFAC#. Enter.
 - (e) Item 14: rescue Vehicle. Identity of the responding vehicle, vessel, or aircraft.
 - (f) Item 15: Receiving Unit. Hospital, EMS vehicle, or clinic assuming responsibility for patient care.
 - (g) Time Patient Transferred. Enter (24 hour clock).

30. [DD877 \(Request for Medical/Dental Records or Information\)](#). See Encl (1), pg. 4-33.
- a. Purpose. The DD 877 is a self-carboning triplicate form that is used to forward health and clinical records between clinics and units as well as to request records from clinics, units, or MTFs.
 - b. General. This form shall be initiated and included with health and clinical records as directed in Chapter 4-A-6. And 4-D-7. Of this Manual
 - c. Detailed Instruction.
 - (1) Each DD877 must have all boxes completed.
 - (2) In all instances when a DD877 is initiated, remarks concerning the reason for sending the record, the name of the gaining unit for the member/ sponsor and a request for action will be included on the form. When preparing a DD877 for a record to be forwarded, place the following in section 9., REMARKS: "Health {clinical} record for this member (family member) is forwarded to you for appropriate filing. Member (sponsor) assigned to (insert gaining unit name)."
 - (3) For members entering the inactive reserve, enter the following in section 9, remarks: "**member entering inactive reserve in your district**. Per Medical Manual, COMDTINST M6000.1(series), Chapter 4-B-4.b.,this health record is forwarded for appropriate action."
 - (4) A copy of the DD877 will be retained at the unit sending the record for 6 months after the record is mailed, then may be discarded.
31. [CG-5447 \(History and Report of OMSEP Examination\)](#) See Encl (1), pg 53.
- a. The CG 5447 is used to biennially update the Occupational Medical Surveillance and Evaluation Program. Demographic and identification information is vital to maintaining the database. CG 5447 will allow better tracking of personnel currently enrolled in OMSEP. Complete the form as follows:
 - (1) **Item 1: Last Name**. Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)".
 - (2) **Item 2: Grade/Rate/Rank**. Use official abbreviation of the current grade or rate, branch of service, class and status; i.e., regular, reserve, or retired, and if active or inactive. Example: HSCS, USCG; SN, USCG (TEMPRET); ETCM, USCG (RET). If not a service member, enter "civilian."
 - (3) **Item 3: SSN**. Enter the Social Security Number.

- (4) **Item 4: Date of Exam.** Enter date in format e.g.04Sept03.
- (5) **Item 5: Home Address.** Enter home address in full (where examinee presently resides).
- (6) **Item 6: Work/duty phone.** Enter phone number beginning with area code. Include extension (if any), e.g., (xxx)-xxx-xxxx, ext xxxx.
- (7) **Item 7: Unit Name and location.** Enter unit, ship or station to where examinee is assigned.
- (8) **Item 8: Home phone.** Enter phone number beginning with area code. Include extension (if any), e.g., (xxx)-xxx-xxxx, ext xxxx.
- (9) **Item 9: Unit OPFAC#.** Enter OPFAC number of unit to which examinee is attached.
- (10) **Item 10: Unit Zip Code:** Enter unit's 5-digit zip code, e.g., 20593.
- (11) **Item 11: Date of Birth & Age.** Enter date followed by age in parentheses, e.g., 3Mar48 (54).
- (12) **Item 12: Sex.** Enter appropriate letter: (M) male or (F) female.
- (13) **Item 13: Race or Ethnicity.** Enter a one character designator to identify the examinee's racial or ethnic group:
 - (a) 1-Black (Negro);
 - (b) 2-Hispanic (includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or other Spanish origin or culture regardless of race);
 - (c) 3-American Indian (including Alaskan Natives);
 - (d) 4-Asian (including Pacific Islanders); or
 - (e) 5-All others (e.g., White/Caucasian, etc.)
- (14) **Item 14: Occupational or usual duties.** Describe all primary duties, positions or billet assignments, (e.g. inspector, electrician, ASM).
- (15) **Item 15: Examining Facility Name & Location.** For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.
- (16) **Item 16. Purpose of Examination.** Mark appropriate box. If uncertain ask for assistance.
- (17) **Item 17. Years in Occupation.** List number of years in present position or job title.
- (18) **Item 18-24. (Part 1-Section 1-Occupational History).** Mark appropriate box Yes (Y) or No (N) as indicated.

- (19) **Item 25. (Part 1-Section 1-Occupational History).** Explain all Yes (Y) answers to question 18-24 above.
- (20) **Item 26. (Part 1-Section II-Family History).** Mark appropriate Yes (Y) or No (N) as indicated.
- (21) **Item 27. (Part 1-Section III-Social History).** Mark appropriate box Yes (Y) or No (N) as indicated. Where indicated, please enter the number that best approximates the amount of tobacco products consumed/used by the examinee. If examinee does not consume tobacco products but is frequently exposed to second hand smoke (home; social group) please describe in Item 33 below.
- (22) **Item 28. (Part 1-Section III-Social History).** Mark appropriate box Yes (Y) or No (N) as indicated. Where indicated, please enter the number that best approximates the amount of alcoholic beverages consumed/used by the examinee.
- (23) **Item 29. (Part 1-Section III-Social History).** Mark appropriate box Yes (Y) or No (N) as indicated. Explain all YES answers.
- (24) **Item 30 (Part 1-Section IV – Personal Health History).** Mark appropriate box Yes (Y) or No (N) as indicated.
- (25) **Item 31. (Part 1-Section IV – Personal Health History).** Mark the one box that best describes the examinees present health status.
- (26) **Item 32. (Part 1-Section IV – Personal Health History).** Mark appropriate box Yes (Y) or No (N) as indicated.
- (27) **Item 33. (Part 1-Section IV – Personal Health History).** Enter comments and explain all Yes (Y) responses to questions 27-32.
- (28) **Examinee must sign and date form.**
- (29) **Item 34. (Part 1-Occupational Exposure History).**
- (a) Column 1 - In chronological order list all known/documented exposures, including those occurring in prior employments.
 - (b) Column 2 - Enter the date of the known exposure, e.g. year/day/month.
 - (c) Column 3 - Enter the name of the place where exposure is known to have occurred.
 - (d) Column 4 – List the type (if any) for protective equipment in use during the documented exposure
- (30) **Examinee must sign and date form.**
- (31) **Part 2 - Medical Officer Section.**
- (a) **Item 1-4.** Same as Part 1 Items 1-4 first page. Provider must enter.

- (b) **Item 5. Examining Facility Name & Location.** For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.
- (c) **Item 6. Enter the phone number of facility/medical provider** performing the examination. Include area code and seven-digit number and extension, if indicated e.g. (xxx) xxx-xxxx extension xxx.
- (d) **Item 7. Surveillance Protocols.** Mark the indicated box for each of the examinee's documented exposure protocols for which an examination was performed. For a *separation/termination examination* make sure to include ALL documented exposure protocols (past and present) for which surveillance was performed.
- (e) **Item 8. Occupational related diagnosis.** List ALL occupationally related diagnosis, e.g., asbestosis; leukemia, mesothelioma).
- (f) **Item 9. Respirator Wear.** Mark appropriate box.
- (g) **Item 10. Conclusions.** Mark appropriate box.
- (h) **Item 11. Next OMSEP Examination.** For a regular schedule exam at the default time mark the space for "12 months". You may enter any specific time interval (of less than 12 months) under space marked "Other".
- (i) **Item 12.** Enter appropriate date when examinee was notified of examination results. This is a **mandatory** requirement.
- (j) **Item 13.** Provider should utilize this space to expand on all aforementioned diagnosis, to provide recommendations on follow-up care, and advise on future testing or procedures.
- (k) **Medical provider must print name, sign and date form in space provided.**

32. **CG-5447A (Periodic History and Report of OMSEP Examination).** See Encl (1), pg 57.

- (1) The CG-5447 A Periodic History and Report of OMSEP Examination is to be used for all scheduled periodic examinations. The member should review the last/previous OMSEP examination prior to completing this form.
- (2) **Items 1-10.** Follow the same guidelines for part 1, CG-5447, Chapter 4-B-30-a.(1)-(7).
- (3) **Item 11.** Follow the same guidelines in Item 15 part 1, CG-5447, Chapter 4-B-30-a.(15).
- (4) **Item 12. Last OMSEP Exam.** Enter date of last OMSEP Initial/periodic or separation examination on record.

- (5) **Item 13. Present Exposure Protocols.** Enter all documented exposure protocols for which examinations are scheduled.
- (6) Any changes since the **last** examination should be listed and describe in the “comments” area indicated for each of the particular sections. If no changes have occurred the member need only check the “no change “ box, as indicated, for each of the particular sections.

Section 1- Occupational History

Section 2- Family History

Section 3- Social History

Section 4- Personal Health History

Occupational Exposure

- (7) **Health Care Provider Review.** The medical officer is responsible for reviewing the completed CG-5447A and accompanying laboratory and radiological study results (if any), as well as making any final recommendations. The medical officer **MUST** enter all appropriate comments in the “recommendations” space, including any additional studies, follow-up examinations or consultations. The medical provider **MUST** also initial the appropriate boxes indicating the review of any laboratory studies or radiological procedures performed as part of this examination.
- (8) The medical officer **MUST** provide name and signature as well as date the CG-5447A (in the spaces provided) indicating the examinee was notified of any results and recommendations. When finalized the CG-5447A is to be placed into the member’s medical record.
- (9) **Note:** If no changes have been reported by the examinee since the last examination and laboratory studies or radiological procedures (if any) are all within normal parameters, the designated health services technician (HST) may review and initial (sign and stamp) the completed CG-5447A **after** discussing the results with the cognizant medical officer and obtaining approval. The HST must make the following notation: “discussed and approved by medical officer” below the signature block. This allowance is intended primarily for situations where the cognizant medical officer is geographically separated and travel to/from the units negatively impacts unit operations.

Section C - Dental Record Forms.

1. **CG-3443-2 (Dental Record Cover).** See Encl (1), pg. 4-34.
 - a. Open a CG-3443-2 for each individual upon arrival at a training center or initial entry into the Coast Guard or Coast Guard Reserve. When an individual on the retired list returns to active duty, submit a request for a copy of the closed out dental record to Commandant (G-PIM). Whenever the original record is lost or destroyed, a new dental record shall be opened immediately. The dental record shall be kept in the Health Record Cover (CG-3443) of each individual.
 - b. All dental forms and radiographs will be contained in the Dental Record.
 - c. Detailed Instructions.

- (1) Surname. Record the surname in all capital letters.

DOE

SURNAME

- (2) Given name(s). Record in full without abbreviation. If the individual has no middle name or initial then record the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are used, they shall appear after the middle name or initial.

DOE JANE ANN

SURNAME First Name Middle Name

- (3) Social Security Number (SSN). Enter Social Security Number.
- (4) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.), and the year: i.e., 4 SEP 49.
- (5) Change in Grade or Rate. Enter as they occur.
- (6) Blood Type. Enter the individual's blood type in the appropriate box. If not known, perform a blood type test.
- (7) RH Factor. Enter the individual's RH factor in the appropriate box. If not known, perform an RH factor test.
- (8) Drug Sensitivity Sticker. When required, affix the Drug Sensitivity Sticker (CG-5266) to the lower left corner of the front of the Dental Record Cover. Do not cover other identification data. **See Encl (1) pg. 4-34.**
- (9) Dental Radiographs.

- (a) **Dental Bitewing Radiograph Storage.** Bitewing radiographs shall be stored in the standard stock 5-year x-ray card (FSC# 6525-00-142-8732). This shall replace the single bitewing x-ray card (FSC# 6525-00-817-2364). X-ray film is mounted in the x-ray card with the raised dot side of the film on the **front** side of the card.
2. **NAVMED 6600/3 (Dental Health Questionnaire).** See Encl (1), pg. 4-35.
- a. **General.** CG-5605 will help the dental officer detect any present or past health problem (i.e., positive Human Immunodeficiency Virus (HIV)) that might interfere with definitive dental treatment. All positive answers from the health history section must be followed up by the dental officer for impact on health care and so annotated on the CG-5605 and the SF-603A.
- b. **Detailed Instructions.** Insert the Dental Health Questionnaire as the first page of the dental record. Patients shall fill out a new Dental Health Questionnaire at least annually, or when information changes. Maintain the two most recent forms in the dental record with the current CG-5605 on top.
- (1) **Chief Complaint.** Have the patient enter the problem they are presently having.
- (2) **Check and Sign.** Have the patient enter yes/no in each box of the history. The signature indicates the authenticity of the history.
- (3) **Summary of Pertinent Findings.** Include baseline BP reading.
3. **SF-603 (Dental Record).** See Encl (1), pg. 4-36.
- a. **General.** The Dental Record is a continuous history and must contain accurate and complete entries of dental examinations and treatments. Each entry shall clearly indicate the name of the dental officer conducting the examination and/or rendering the treatment. Dental hygienists or other auxiliary personnel providing care shall also follow this requirement. Each dental officer is personally responsible for ensuring that all entries are properly recorded.
- b. **Numerical Classification for Record Purposes.** Chart markings have been standardized so that dental conditions, treatments needed, and treatments completed may be readily identified. This facilitates efficient continuity of treatments and may establish identification in certain circumstances.
- (1) Use the following numbering system for permanent dentition starting with the maxillary right third permanent molar as tooth #1:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- (2) Use the following numbering system for deciduous dentition starting with the maxillary right second deciduous molar as tooth A:

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

- (3) Indicate a supernumerary tooth by placing "s" in the location of the supernumerary tooth and in the remarks section enter a statement that the examinee has a supernumerary tooth.
- (4) Indicate deciduous and supernumerary teeth on the SF-603 in SECTION I, Part 5 (Diseases, Abnormalities, and Radiographs) and enter a statement in the remarks section of Section 5.

c. Detailed Instructions.

SECTION I. DENTAL EXAMINATION

- (1) Purpose of Examination. To assess the oral health status of cadets, officer candidates and enlisted recruits upon initial entry into the Coast Guard, and to provide periodic (but at least annual) examinations of active duty personnel. Enter an "X" in the appropriate box. Mark the "Initial" box for the dental examination made upon entrance into the Coast Guard. All other examinations fall under the "Other" category and shall be identified: i.e., "Academy", "Reenlistment", etc.
- (2) Type of Examination. Enter an "X" in the proper box of item 2, "Type of Exam."
- (a) Type 1, Comprehensive Examination. Comprehensive hard and soft tissue examination, which shall include: oral cancer screening examination; mouth-mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; panoramic or full-mouth periapical, and posterior bitewing radiographs as required; blood pressure recording; and when indicated, percussive, thermal, and electrical tests, transillumination, and study models. Included are lengthy clinical evaluations required to establish a complex total treatment plan. For example, treatment planning for full mouth reconstruction, determining differential diagnosis of a patient's chief complaint, or lengthy history taking relative to determining a diagnosis. Use S.O.A.P. format to record the results of a Type 1 examination.
- (b) Type 2, Oral Examination (annual or periodic). Hard and soft tissue examination, which shall include: oral cancer screening examination; mouth mirror and explorer examination with adequate natural or artificial illumination; periodontal screening; appropriate panoramic or intraoral radiographs as indicated by the clinical examination; and blood pressure recording. An appropriate treatment plan shall be recorded. This type is the routine examination, which is normally performed one time per treatment regimen per patient, unless circumstances warrant another

- complete examination. Use S.O.A.P. format to record the results of Type 2 examination.
- (c) Type 3, Other Examination. Diagnostic procedure as appropriate for: consultations between staff; observation where no formal consult is prepared; certain categories of physical examination; and emergency oral examination for evaluation of pain, infection, trauma, or defective restorations **and follow-up exams for previously rendered treatment.**
 - (d) Type 4, Screening Evaluation. Mouth mirror and explorer or tongue depressor examination with available illumination. This includes the initial dental processing of candidates without necessarily being examined by a dentist, or other dental screening procedures.
 - (e) If not specified by this Manual, it shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient. However, Type 3 and Type 4 examinations are not adequate to definitively evaluate the oral health status of patients. When the dental officer determines that a comprehensive periodontal examination is to be accomplished, use the Navy Periodontal Chart, NAVMED 6660/2 (3-90).
- (3) `Dental Classification of Individuals. Dental classifications are used to designate the health status and the urgency or priority of treatment needs for active duty personnel. Use the following guidelines and criteria for the classification of patients. When a criterion for a specific condition is not listed, the dental officer shall evaluate the prognosis for a dental emergency and assign the appropriate classification.
- (a) **Class I (Oral Health):** Patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are worldwide deployable.
 - (b) **Class II:** Patients with a current dental examination, who require non-urgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Class 2 are worldwide deployable. Patients in dental class 2 may exhibit the following:
 - 1 Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient.
 - 2 Interim restorations or prostheses that can be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials for which protective cuspal coverage is indicated.
 - 3 Edentulous areas requiring prostheses but not on an immediate basis.
 - 4 Periodontium that:

- a requires oral prophylaxis.
 - b Requires maintenance therapy.
 - c Requires treatment for slight to moderate periodontitis and stable cases of more advanced periodontitis.
 - d requires removal of supragingival or mild to moderate subgingival calculus.
 - 5 Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal.
 - 6 Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployment up to six months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.
 - 7 Temporomandibular disorder patients in remission. The provider anticipates patient can perform duties while deployed without ongoing care and any medications or appliances required for maintenance will not interfere with duties.
- (c) **Class III:** Patients who require urgent or emergent dental treatment. Class 3 patients normally are not considered to be worldwide deployable.
 - 1 Treatment or follow-up indicated for dental caries, symptomatic tooth fracture or defective restorations that cannot be maintained by the patient.
 - 2 Interim restorations or prostheses that cannot be maintained for a 12-month period.
 - 3 Patients requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months.
 - a Acute gingivitis or pericoronitis.
 - b Active progressive moderate or advanced periodontitis.
 - c Periodontal abscess.
 - d Progressive mucogingival condition.
 - e Periodontal manifestations of systemic disease or hormonal disturbances.
 - f Heavy subgingival calculus.

- 4 Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication, or acceptable esthetics.
 - 5 Unerupted, partially erupted, or malposed teeth with historical, clinical or radiographic signs or symptoms of pathosis that are recommended for removal.
 - 6 Chronic oral infections or other pathologic lesions including:
 - a. Pulpal, periapical, or resorptive pathology requiring treatment.
 - b. Lesions requiring biopsy or awaiting biopsy report.
 - 7 Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (e.g., drain or suture removal) until resolved.
 - 8 Acute Temporomandibular disorders requiring active treatment that may interfere with duties.
 - (d) **Class IV:** Patients who require periodic dental examinations or patients with unknown dental classifications. Class 4 patients normally are not considered to be worldwide deployable.
- (4) Priority of Dental Treatment. To further indicate priority of treatment within a class, the following groupings shall be used when necessary (listed in order of decreasing priority).
 - (a) Group 1. Coast Guard active duty personnel in receipt of orders to sea, overseas, or combat duty.
 - (b) Group 2. Coast Guard active duty personnel upon return from sea, overseas, or combat duty.
 - (c) Group 3. Other Coast Guard personnel.
 - (d) Group 4. Active duty personnel of other Services assigned to duty with the Coast Guard.
 - (e) Group 5. Active duty personnel of other Services.
 - (f) Missing Teeth and Existing Restorations.
 - (g) Markings shall be made on examination chart as follows:
 - 1 Missing Teeth. Draw a large "X" on the root(s) of each tooth that is not visible in the mouth.
 - 2 Edentulous Mouth. Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.

- 3 Edentulous Arch. Make crossing lines, each running from the uppermost aspect of one third molar to the lowest aspect of the third molar on the opposite side.
 - 4 Amalgam Restorations. In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape, and block solidly.
 - 5 Nonmetallic Permanent Restorations (**includes ceramics and resins**). In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape.
 - 6 Gold Restorations. Outline and inscribe horizontal lines within the outline.
 - 7 Combination Restorations. Outline showing overall size, location, and shape; partition and junction materials used and indicate each, as in "4." above.
 - 8 Porcelain **and acrylic** Post Crowns. Outline the crown and approximate size and position of the post(s).
 - 9 Porcelain Veneers. Outline each aspect.
 - 10 Acrylic Resin Jacket Crowns. Outline each aspect.
 - 11 Fixed Bridges. Outline each, showing overall size, location, teeth involved and shape by the inscription of diagonal lines in abutments and pontics.
 - 12 Removable Appliances. Place an "X" through the missing tooth, place a line over replaced teeth and describe briefly in "Remarks."
 - 13 Root Canal Fillings. Outline canal filled and black in solidly.
 - 14 Apicoectomy. Draw a small triangle apex of the root of the tooth involved, the base line to show the approximate level of root amputation.
 - 15 Drifted Teeth. Draw an arrow from the designating number of the tooth that has moved; the point of the arrow to indicate the approximate position to which it has drifted. Under "Remarks" note the relationship to the drifted tooth in respect to occlusion.
- (h) If an individual is appointed or enlisted with dental defects which have been waived, the defects shall be described fully in the dental record under "Remarks" (Section I).
- (i) The examining dental officer shall sign, date, and record the place of examination where indicated.

- (5) Diseases, Abnormalities, and Radiographs.
- (a) Markings on the examination chart of Diseases, Abnormalities, and Radiographs shall be made as follows:
- 1 Caries. In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location and shape, and block in solidly.
 - 2 Defective Restoration. Outline and block in solidly the restoration involved.
 - 3 Impacted Teeth. Outline all aspects of each impacted tooth with a single oval. Indicate the axis of the tooth by an arrow pointing in the direction of the crown.
 - 4 Abscess. Outline approximate size, form, and location.
 - 5 Cyst. Outline the approximate form and size in relative position of the dental chart.
 - 6 Periodontal Disease. Inscribe a horizontal continuous line on the external aspect of root(s) involved in a position approximating the extent of gingival recession or the clinical depth of the pocket. If known, indicate the position of the alveolar crest by a second continuous line in relative position to the line indicating the gingival tissue level.
 - 7 Extraction Needed. Draw two parallel vertical lines through all aspects of the tooth involved.
 - 8 Fractured Tooth Root. Indicate fracture with a zigzag line on outline of tooth root.
- (b) A statement regarding hypersensitivity to any other drug known to the person for whom a Dental Record is prepared shall be entered under "Remarks." (Example: HYPERSENSITIVITY TO PROCAINE)
- (c) Complete items A through E.
- (d) The examining dental officer shall sign, date, and record the place of examination where indicated.
- (e) NOTE: Section I, Subsections 4 and 5 of SF 603 are used to record findings of initial and replacement examinations. These charts shall not be altered thereafter.

SECTION II. PATIENT DATA

- (1) Patient Data. Complete items 6 through 14 as indicated.

SECTION III. ATTENDANCE RECORD

- (1) Restorations and Treatments (Completed during service) (Item 15).
 - (a) Record restorations or treatments provided a patient after the initiation of a Dental Record on the chart "Restorations and Treatments" of Section III, in accordance with the following:
 - 1 Carious Teeth Restored. In the diagram of the tooth involved, draw an outline of the restoration showing size, location and shape, and indicate the material used. Amalgam restorations would be outlined and blocked in, composite resin restorations outlined only, etc.
 - 2 Extractions. Draw a large "X" on the root(s) of each tooth extracted.
 - 3 Root Canal Fillings. Outline each canal filled on the diagram of the root(s) of the tooth involved and block it in solidly.
 - 4 Apicoectomy. Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of tooth amputation.
 - 5 Bridge and Crowns. Outline and fill in as specified above.
 - 6 Removable Appliances. Place a line over numbers of replaced teeth and give a brief description under "Remarks."
 - 7 Unrecorded Operations and Conditions. Operations performed by other than Coast Guard dental officers subsequent to the original examination will be indicated by the dental officer discovering the condition just as if they had been done by a Coast Guard dental officer. Make appropriate entries indicating the nature of the treatment and adding the abbreviation "CIV" or other abbreviation as the case may be. The date entered will be the date of the discovery.
 - 8 Other. Similarly, note operations known to have been performed by Coast Guard dental officers whose identity is not recorded, except use the abbreviation "CGDO." The date entered shall be the date the operation is discovered. Account for teeth which are shown as missing in the chart, Missing Teeth and Existing Restorations, and which have erupted subsequently, by an entry in the following manner: "1 and 32," eruption noted, date, and signature of dental officer making the notation. Record other conditions of comparable importance in a similar manner.
 - (b) Record a series of treatments for a specific condition not producing lasting changes in dental characteristics by entering of initial and final treatment dates (i.e., POT daily 1 AUG 87 thru 5 AUG 87 or Vin Tr. twice daily 1 AUG 87 thru 10 AUG 87).

- (c) Authenticate each entry in this record by a written entry in the spaces provided under "Services Rendered."
- (2) Subsequent Disease and Abnormalities (Item 16). Chart subsequent conditions, in pencil only, using the instructions in Chapter 4-C.3.(6). Once treatment is completed and documented in item 17, erase pencil entry in item 16 and permanently transfer in ink to item 15 (Restorations and Treatments).
- (3) Services Rendered (Item 17). The accuracy and thoroughness in recording patient histories and treatment progress notes are essential elements in the diagnosis and treatment of the dental patient. In addition to the conventional listing of the tooth number and procedure, **all dental materials used intraorally shall be identified.** Use trade names where possible. This includes, but is not limited to; bases and liners, metallic and nonmetallic restorative materials, denture frameworks and bases, impression materials, medicaments, and anesthesia. Record prescribed medications.
- (a) Standard S.O.A.P. format. The S.O.A.P. format shall be used to document all sickcall and emergency dental treatments, to document Type 1 and Type 2 examinations, and to record the results of the examination of patients in preparation for comprehensive treatment planning. S.O.A.P. format is not required to document ongoing delivery of treatment, which has been previously planned. All entries are to be on the SF-603/603-A, item 17. The S.O.A.P. format uses a problem-oriented record as a tool in management of patient care. The acronym is derived from the first letter of the first four record statements as follows:
- 1 **"S" Subjective data.** This data includes the reason for the visit to the dental clinic, and if appropriate, a statement of the problem (chief complaint "in the words of the patient") and the qualitative and quantitative description of the symptoms appropriate to the problem.
 - 2 **"O" Objective data.** A record of the type of examination and the diagnostic aids, including the ordering of radiographs, and the actual clinical findings, x-ray results, or laboratory findings appropriate to the problem. This is to include all the provider's findings such as carious teeth, inflammation, periodontal status, pocket depths, blood pressure measurement, etc.
 - 3 **"A" Assessment.** This portion is the assessment of the subjective data, objective data, and the problem statement which leads the provider to a diagnosis, e.g., "needs" (existing conditions or pathoses).

- 4 **"P" Plan.** This is the plan of treatment to correct or alleviate the stated problems or needs, irrespective of the treatment capability of the dental treatment facility. Include recommended treatment and, as appropriate, possible complications, alternative treatment, and prognosis with and without intervention. Include consultations, a record of the specific treatment performed, pre- and postoperative instructions, prescriptions, and any deviations from the original treatment plan.
- (b) The following classification of tooth surfaces are listed in order of precedence and shall be used in connection with recording restorations of defective teeth:

Surface	Designation
Facial (Labial) (Anterior teeth)	F
Buccal (Posterior teeth)	B
Lingual	L
Occlusal (Posterior teeth)	O
Mesial	M
Distal	D
Incisal (Anterior teeth)	I

- (c) Use combinations of designators to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of the left mandibular cuspid; 30-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.

Surface	Designation
Mesial-Occlusal	MO
Distal-Occlusal	DO
Mesial-Incisal	MI
Distal-Incisal	DI
Occlusal-Facial	OF
Occlusal-Lingual	OL
Incisal-Facial	IF
Incisal-Lingual	IL
Mesial-Occlusal-Distal	MOD
Mesial-Occlusal-Facial	MOF

Mesial-Occlusal-Lingual	MOL
Mesial-Incisal-Distal	MID
Mesial-Incisal-Facial	MIF
Mesial-Incisal-Lingual	MIL
Distal-Occlusal-Facial	DOF
Distal-Occlusal-Lingual	DOL
Mesial-Occlusal-Distal-Facial	MODF
Mesial-Incisal-Distal-Facial	MIDF
Mesial-Occlusal-Distal-Facial-Lingual	MODFL
Mesial-Incisal-Distal-Facial-Lingual	MIDFL

- (d) The use of abbreviations is not mandatory but is desirable for purposes of brevity in view of the limited space available in the dental record for recording services rendered. Whenever there is a possibility of misinterpretation due to the use of abbreviations, dental operations shall be written in full. When abbreviations are used, they shall conform to the following:

Operation, Condition, or Treatment	Abbreviation
Abrasion	Abr.
Abscess	Abs.
Acrylic	Acr.
Adjust (ed)(ment)	Adj.
Amalgam	Am.
Anesthesia	Anes.
Apicectomy	Apico.
Bridge (denotes fixed unless otherwise noted)	Br.
Calcium Hydroxide	CaOH
Calculus	Calc.
Cavity Varnish	C.Var.
Cement	Cem.
Complete Denture (full unless otherwise noted)	CD.
Composite Resins	Comp. Res.
Crown	Cr.

Deciduous	Decid.
Defective	Def.
Drain.	Drn.
Equilibrate (action)	Equil.
Eugenol	Eug.
Extraction	Ext.
Fluoride	Fl.
Fracture(s)	Frac.
General	Gen.
Gingival (itis) (state type in parenthesis).	Ging.
Gutta percha	G.P.
Impacted (ion)	Imp.
Impression	Impr.
Maxillary	Max.
Mandibular	Mand.
Periapical	PA.
Pericoronitis	P-Cor.
Periodontitis	Perio.
Porcelain	Porc.
Post Operative Instructions Given	POIG.
Post Operative Treatment	POT.
Prepared (ation)	Prep.
Prophylaxis	Prophy.
Reappoint (ment)	Reappt.
Recement (ed)	Recem.
Reduce (d)	Red.
Removable Partial Denture	RPD.
Sedative (ation)	Sed.
Sequestrum	Seq.
Surgical	Surg.
Suture (s)(d)	Su.

Treatment (ed)	Tx.
Zinc Chloride	ZnCl.

(4) Space is provided in the lower right margin under Section III for the patient's name which is for convenience in filing in the dental record. Record the last name in capital letters. Do not abbreviate any part of the name.

4. SF-603-A (Dental Continuation).

a. General. Use a SF-603-A whenever the original SF-603 becomes filled or when the record cannot be satisfactorily brought up-to-date by entries on the appropriate chart.

b. Detailed Instructions.

(1) Enter individual's name and SSN in the space provided on the right margin of both the front and backside of the form.

(2) Number the continuation sheet in the upper right corner following the phrase "DENTAL-Continuation." Thus, the earliest SF-603-A is labeled "DENTAL-Continuation #1" and subsequent sheets are labeled "DENTAL-Continuation #2", "DENTAL-Continuation #3", etc.

(3) File the SF-603-A forms on top of the SF-603 form in reverse chronological order, i.e., the most recent on top.

5. SF-513, Consultation Sheet.

a. Purpose. SF-513 shall be used whenever a patient is referred to another facility for evaluation or treatment.

b. Detailed Instructions. Complete the form as detailed in paragraph 4-B-14.b.

6. Lost Dental Records.

a. Forward "stray" dental records, disposition of which cannot be determined, to Commandant CGPC-adm-3 with a letter of explanation.

b. When a Dental Record is missing, prepare a new record. Prominently mark the Dental Record Cover (CG-3443-2) and the Health Record, Dental (SF-603) "REPLACEMENT." Request the old Dental Record from the individual's last unit or Commandant CGPC-adm-3.

c. In case a lost Dental Record is recovered, **incorporate the replacement record into the original record.**

7. Special Dental Records Entries. When dental treatment is refused, make an appropriate entry on the SF-603/603-A, **signed by both the dental officer and patient.**

8. Dental Examination Requirements.

a. Any peculiarities or deviations from normal are particularly valuable for identification purposes and shall be recorded on SF-603 under "Remarks." Abnormalities such as erosion, mottled enamel, hypoplasia, rotation, irregularity of

alignment and malocclusion of teeth, presence of supernumerary teeth, denticles, Hutchinson's incisors, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palatinus and torus mandibularis, **tattoos, piercings**, embedded foreign bodies and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion shall be simply and clearly described. Dentures and other removable dental appliances shall also be described under "Remarks".

- b. When all teeth are present, and free of caries or restorations, take special effort to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, make an entry to that effect on SF-603 under "Remarks."
 - c. Inquire about the patients' tobacco use during routine dental examinations and document. Advise users of the health risks associated with tobacco use, the benefits of stopping, and where to obtain assistance in stopping if available. Advise all pregnant tobacco users of the health risks to the fetus.
 - d. Oral hygiene and periodontal status at time of examination shall be recorded. Upon initial examination, complete items 5A-5C, SF-603, with additional comments placed in "Remarks" if needed. For all subsequent examinations, describe oral hygiene level and periodontal status in item 17 of SF-603/603-A.
 - e. For all patients 16 years of age or older, blood pressure readings shall be taken and recorded on the CG-5605 and the SF-603/603A at initial and subsequent dental examinations.
1. Recording of Dental Treatments on SF-600. Make entries of dental treatment on SF-600 when the patient is on the sick list and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or dental significance may be made when appropriate.

Section D - Clinical Records.

1. Purpose and Background. The Clinical Record (CG-3443-1) is the chronological medical and dental record of a nonactive duty beneficiary (dependent or retiree) eligible for health care at a Coast Guard facility. The primary reasons for compiling a clinical record are:
 - a. To develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result.
 - b. To protect the Government, the individual concerned, and the individual's dependents: It may be used;
 - (1) to provide, plan and coordinate health care;
 - (2) to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies;
 - (3) to compile statistical data; for research; to teach health services personnel;
 - (4) to determine suitability of persons for service or assignments;
 - (5) to adjudicate claims and determine benefits; for law enforcement or litigation;
 - (6) to evaluate care provided; and
 - (7) to evaluate personnel and facilities for professional certification and accreditation.
 - c. To aid in identifying deceased persons when other means may be inadequate.
2. Contents of Clinical Records.
 - a. Each clinical record shall consist of CG-3443-1 with dental and medical records arranged in the following bottom to top sequence:
 - (1) Right Side - Dental: CG-3443-2 Dental Record Cover* with CG-5266 (Drug Sensitivity Sticker)*, containing the following:
 - (a) SF-522, Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures*
 - (b) SF-513 Consultation Sheet
 - (c) NAVMED 6660 Periodontal Screening
 - (d) SF-603, Dental Record - Continuation*
 - (e) SF-603A, Dental Record*
 - (f) CG-5605, Dental Health Questionnaire*
 - (2) Right Side - Medical:
 - (a) PHS-731, International Certificate of Vaccination*, attached to the lower right corner of the inside of the Clinical Record Cover

- (b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*
- (c) SF-507, Continuation Sheet**
- (d) SF-602, Syphilis Record*
- (e) SF-601, Immunization Record*
- (f) DD-771, Spectacle Order Form*
- (g) SF-520, Electrocardiographic Report*
- (h) SF-519, Radiographic Reports
- (i) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display*)
- (j) SF-541, Gynecologic Cytology*
- (k) SF-515, Tissue Examination*
- (l) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*
- (m) SF-513, Consultation Sheet*
- (n) SF-502, Narrative Summary*
- (o) CG-5447, Occupational Medical Surveillance and Evaluation Program*
- (p) DD-2807-1, Report of Medical History*
- (q) DD-2808, Report of Medical Examination*
- (r) SF-558, Emergency Care and Treatment
- (s) SF-600, Chronological Record of Medical Care
- (t) DD-2766, Adult Preventive and Chronic Care Flowsheet Form
- (u) CG-5266, Drug Sensitivity Sticker*

* When required

** SF-507's are attached to and filed after the form is continued

- b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 89 on top of SF-600 dated 20 MAY 86.
 - c. Enter all dates on Clinical Record forms, including the Clinical Record Cover, in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.
3. Extraneous Attachments. In order to ensure that the clinical record is an accurate, properly documented, concise and dependable record of the medical and dental history of the individual, keep extraneous attachments to a minimum. When they are necessary, file them beneath all other forms.

4. Opening Clinical Records. Open a Clinical Record when an eligible non-active duty beneficiary initially reports to a Coast Guard health care facility for treatment.
5. Terminating Clinical Records. The Clinical Record shall be terminated four years after the last record entry. Make an entry on SF-600 explaining the circumstances under which the record was terminated. Forward the record to:

Dependent Records:

National Personnel Records Center
GSA (Civilian Personnel Records)
11 Winnebago Street
St. Louis, MO 63118-4126

Military Records:

National Personnel Records
Center (MPR)
9700 Page Avenue
St. Louis, MO 63132-5100

6. Custody of Clinical Records.
 - a. Clinical Records shall be retained in the custody of the Chief, Health Services Division of the unit providing care. At times when there is no medical or dental officer, the clinical record will become the responsibility of the senior health services department representative.
 - b. The name, grade, or rate of the health care provider making entries in clinical records shall be typed, stamped, or printed under their official signatures. Do not use facsimile signature stamps.
 - c. If an erroneous entry is made in a Clinical Record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.
 - d. Each health care provider is responsible for the completeness of the entries they make on any medical or dental form in the Clinical Record.
 - e. Nothing shall be removed from the Clinical Record except under conditions specified in this Manual.
7. Safekeeping of Clinical Records. Clinical Records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).
 - a. Since Clinical Records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).
 - b. Except as contained in the The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3(series), the information contained in Clinical Records shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

8. Transfer of Clinic Records.

- a. When dependents of active duty personnel accompany their sponsor to a new duty tation, the Chief, Health Services Division, his designee, the Executive Officer, or the senior health services department representative shall ensure that the “TRANSFERRED TO” line of the health Record Receipt form, NAVMED 6150/7, is completed in accordance with Chapter 6-B-5 of this Manual.
- b. A DD 877 shall be initiated for each record transferred. **Send records using a service that provides a tracking number, such as Priority Mail Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical**, to the Coast Guard clinic serving the gaining unit. Express mail and Federal Express should be used only when absolutely necessary and not as a general rule. In instances where the family member will not be located near a Coast Guard Clinic, the record may be mailed to the appropriate MTF. This form can be located on the internet at; <http://web1.whs.osd.mil/ICDHOME/DD-0999.htm>
- c. If the family members will no longer receive care through a military primary care manager, the family member may be given a copy of the clinical record contents to carry with them. The original clinical record will be retained at the clinic serving the unit where the sponsor was last assigned.
- d. Clinics will give family members written information containing address and POC information to facilitate requests for record copies after transfer. All requests for clinical record copies must be in writing. The family member may request that a copy of the record be forwarded to their new care provider once they arrive at the new location, or they may request that the original record be forwarded to their new military primary care manager once they arrive at the new location. In these cases, the clinic shall send a copy of the clinical record contents to the care provider within 10 working days of receipt of the written request. If the clinic cannot comply with this requirement for some reason, the family member will be notified within 10 working days of the request of a projected date when the record copy will be available.
- e. In any instance where there is concern about potential loss of the clinical record, or that its contents may become unavailable to the treating clinic or its provider, the Clinic Administrator or the Chief, Health Services Division shall direct that copies of parts or all of the clinical record shall be made and retained at the clinic.
- f. Originals and copies of clinical records shall be retained and subsequently archived in accordance with directions contained in the Paperwork Management Manual, COMDTINST 5212.12(series).

9. Lost, Damaged, or Destroyed Clinical Records.

- a. If a Clinical Record is lost or destroyed, the unit which held the record shall open a new record. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing Clinical Record is recovered, insert in it any additional

information or entries from the replacement record, then destroy the replacement record cover.

- b. Clinical Records which become illegible, thus destroying their value as permanent records, shall be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record became illegible. The new record shall be stamped or marked "DUPLICATE" on the cover. The circumstances necessitating the duplication shall be explained on the SF-600. Forward Clinical Records replaced by duplicate records to the National Personnel Records Center.

10. Clinical Record Forms.

- a. CG-3443-1 (Clinical Record Cover). See Encl (1), pg 4-40.

- (1) General. The Clinical Record Cover is used whenever a Clinical Record is opened on dependents or retirees.

- (2) Detailed Instruction's:

- (a) Last Name. Record the last name in all capital letters.

SMITH

- (b) Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

SMITH, Helen (n)

Last Name First Name Middle Name

- (c) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 3 FEB 77.

- (d) Social Security Number. Enter sponsor's SSN.

- (e) Status. Check the appropriate block; i.e., Retiree USCG, Dependent USPHS, etc.

- (f) Other. Use this block to indicate special status or other information useful for either proper monitoring of the patient or for aid in identifying the patient or record.

- (g) Occupational Monitoring. Indicate the reason for occupational monitoring if monitoring is required.

- (h) Med-Alert. Check this block to indicate that the patient has a medical problem that must be considered in rendering treatment; i.e., allergy, diabetes, cardiac problems, etc. Describe the specific medical problem within the medical record on Problem Summary List, NAVMED 6150/20.

11. [SF-522 \(Authorization for Anesthesia, Operations, etc.\)](#). See Encl (1), pg. 4-41.
 - a. Complete SF-522 describing the general nature of the procedure and have the patient sign prior to administering anesthesia (local or general) except for dental anesthesia. Also, complete SF-522 prior to administering immunizing agents **and dental surgical procedures such as exodontia, root canal therapy, and periodontal surgery**.
 - (1) Insert the form immediately behind Consultation Sheet (SF-513) or as indicated in Section 4-D-2.

Section E - Employee Medical Folders.

1. Purpose and Background. The Employee Medical Folder (EMF), (SF-66 D), is the chronological medical record of Federal employees eligible for health care at Coast Guard facilities. These are the primary reasons for compiling an EMF.
 - a. Develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of care rendered, including diagnosis, treatment, and end result.
 - b. To protect the Government and the individual concerned.
 - c. The information in the EMF is routinely used: to provide, plan and coordinate health care; to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies; to compile statistical data; for research; to teach health services personnel; to determine suitability of persons for service or assignments; to adjudicate claims and determine benefits; for law enforcement or litigation; to evaluate care provided; and to evaluate personnel and facilities for professional certification and accreditation.
2. Custody of Employee Medical Folders (EMF's).
 - a. EMF's are the property of the Federal government handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).
 - (1) Since EMF's contain personal information of extremely critical or sensitive nature, they are considered class III records according to The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), requiring maximum security (high security locked cabinets or areas). Except as contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), the information contained in the EMF shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the responsibility of the requester to obtain the consent.
 - b. EMF's shall be retained in the custody of the medical officer of the unit at which the individual is employed. At no time shall individual employees keep or maintain their own records.
 - c. Individuals may examine their EMF in the presence of a health services department representative, providing it does not interrupt the scheduled mission of the unit and there is no information contained therein which would be detrimental to the individual's mental well-being.
 - d. Health services personnel making entries in EMF shall ensure that all entries, including signatures, are neat and legible. Signature information shall include the name and grade or rate. Do not use facsimile signature stamps.

- e. If an erroneous entry is made in an EMF, draw a diagonal line through the complete entry. Make an additional entry showing wherein and to what extent the original entry is in error.
 - f. Health services personnel are responsible for the completeness of the entries made on any form while the EMF is in their custody. No sheet shall be removed from the EMF except under conditions specified in this Manual.
 - g. Health services personnel shall ensure that, if EMF's are located in the same office as the Official Personnel Folder (OPF), the records are maintained physically apart from each other.
3. Contents of the Employee Medical Folders.
- a. Each medical folder shall consist of SF-66 D (Employee Medical Folder) with medical records arranged in the following bottom to top sequence:
 - (1) Left Side Dental: Leave blank.
 - (2) Right Side - Medical:
 - (a) PHS-731, International Certificate of Vaccination*, attached to the lower right corner of the inside of the EMF
 - (b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*
 - (c) SF-507, Continuation Sheet**
 - (d) CG-5447, Occupational Medical Surveillance and Evaluation Program*
 - (e) SF-602, Syphilis Record*
 - (f) SF-601, Immunization Record*
 - (g) DD-771, Spectacle Order Form*
 - (h) SF-520, Electrocardiographic Report*
 - (i) SF-519, Radiographic Reports
 - (j) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display*)
 - (k) SF-541, Gynecologic Cytology*
 - (l) SF-515, Tissue Examination*
 - (m) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*
 - (n) SF-513, Consultation Sheet*
 - (o) SF-502, Narrative Summary*
 - (p) DD-2807-1, Report of Medical History* DD-2808, Report of Medical Examination*

- (q) SF-558, Emergency Care and Treatment*
 - (r) SF-600, Chronological Record of Medical Care
 - (s) CG-5357, Outpatient Record
 - (t) DD-2766, Adult Preventive and Chronic Care Flowsheet
 - (u) CG-5266, Drug Sensitivity Sticker*
 - (v) * When required
 - (w) ** SF-507's are attached to and filed after the form is continued.
- b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 87 on top of SF-600 dated 20 MAY 86.
 - c. Enter all dates in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.
4. Accountability of Disclosures. The accountability of disclosure of records, as required by the Privacy Act of 1974, will be maintained in accordance with Chapter 8, of COMDTINST M5260.2 (series). The information will be retained for five years after the last disclosure or for the life of the record, whichever is longer.
 5. Opening Employee Medical Folder. Open an EMF when an eligible Federal employee initially reports for treatment.
 6. Terminating Employee Medical Folders. Terminate the EMF in accordance with the Coast Guard Paperwork Management Manual, COMDTINST 5212.12 (series). Make an entry on SF-600 explaining the circumstances under which the folder was terminated.
 7. Transferring to Other Government Agencies. When transferring an EMF to other agencies, complete a Request for Medical/Dental Records or Other Information (DD-877).
 8. Lost, Damaged, or Destroyed Employee Medical Folders.
 - a. If an EMF is lost or destroyed, the unit which held the record shall open a complete new Employee Medical Folder. Stamp or mark "REPLACEMENT" on the cover. If the missing folder is recovered, insert in it any additional information or entries from the replacement folder, then destroy the replacement folder.
 - b. EMF's which become illegible, thus destroying their value as permanent records, will be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Stamp or mark "DUPLICATE" on the new record cover. Document the circumstances necessitating the duplication on an SF-600. Forward EMF's replaced by duplicate records to the National Personnel Records Center.

9. **SF-66 D (Employee Medical Folder)**. See Encl (1), pg. 4-42. Detailed instructions are:

a. Last Name. Record the last name in all capital letters.

BROOKS

b. Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

BROOKS Cecilia (n)

Last Name First Name Middle Name

c. Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 8 JUN 62.

d. Social Security Number. Enter SSN.

Section F -Inpatient Medical Records.

1. Purpose and Background.

- a. Certain Coast Guard health care facilities have the capability and staffing to provide overnight care. Overnight care is defined as any period lasting more than four hours during which a beneficiary remains in the facility under the care or observation of a provider. By definition, overnight care may last less than 24 hours or it may last several days. Overnight care is utilized when a patient's condition or status requires observation, nursing care, frequent assessment, or other monitoring.
- b. Inpatient Medical Records (IMRs). Facilities providing overnight care shall create an Inpatient Medical Record (IMR) separate from the Health Record for the purpose of recording and preserving information related to the overnight care. The IMR shall be assembled as soon as a person is identified as needing overnight care. The IMR shall contain the following forms in a TOP TO BOTTOM sequence:
 - (1) Inpatient Medical Record Cover Sheet and Privacy Act Statement. See Encl (1), pg 4-43.
 - (2) SF-508, Doctor's Orders (most recent on top)
 - (3) SF-506, Clinical Record/Physical Exam
 - (4) SF-502, Narrative Summary
 - (5) SF-509, Doctor's Progress Notes (most recent on top)
 - (6) SF-511, Vital Signs Record
 - (7) SF-514, Laboratory Report Display
 - (8) SF-519, Radiologic Reports
 - (9) Patient Care Kardex
 - (10) Medication Kardex
 - (11) SF-513, Consultation sheet
 - (12) Miscellaneous forms (e.g., audiograms)
- c. Abbreviated Inpatient Medical Records (AIMRs). For patients who receive overnight care lasting 24 hours or less, an Abbreviated Inpatient Medical Record (AIMR) shall be created. The AIMR shall consist of at least an Inpatient Medical Record Cover Sheet, Privacy Act Statement, and an DD-2770, Abbreviated Medical Record form. SF-545, Laboratory Reports; SF-519, Radiologic Consultation Reports; Kardexes; and other forms may be included at the discretion of the clinic. The AIMR shall be maintained while in use, completed, stored, and retired following the same requirements as listed for IMRs below.
- d. During the time that the patient is receiving care, the IMR may be maintained in a loose-leaf binder, clipboard, or other convenient device, at the facility's discretion. Devices should be chosen and maintained so that the privacy of the patient

information contained therein is protected at all times. Keeping or storing the record at the patient's bedside is discouraged for privacy reasons.

- e. Once the patient is released from overnight care, providers shall have 48 hours to complete their notations in the record (excluding dictated entries). All laboratory, radiologic and consultation forms shall also be included in the IMR within 48 hours of the patient's release from overnight care.
 - f. Dictated entries shall be entered in the medical record within 7 days of discharge. The record may be held in medical records and flagged as needing a dictated entry.
 - g. After all notations, lab reports, radiology reports and consultations have been entered into the IMR, the IMR forms shall be placed in a bifold paper jacket (form CG-3443-1), and secured via a two prong device. The medical records staff is responsible for ensuring that the documents are in the correct order and are stored properly.
2. Maintenance and Storage. IMRs are the property of the Federal Government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance concerning these acts is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). All requirements and directions for handling and storing IMRs also apply to AIMRs.
 - a. Since IMRs contain personal information of an extremely critical or sensitive nature, they are considered to be Class III records requiring maximum security (high security locked cabinets or areas). IMRs shall be stored in well ventilated and sprinklered areas. Fire-resistant cabinets or containers shall be used for storage whenever possible.
 - b. IMRs shall be retained at the health care facility which created the record. IMRs will not be transferred with personnel who change duty stations. Copies of the IMR may be given to the individual if such a request is made in writing, or may be released to other persons, e.g., physicians or hospitals, if the patient requests or authorizes such release in writing. All release requests and authorizations will be inserted into the IMR cover.
 - c. IMRs will be retained at the creating health care facility for two (2) years after the date the patient is released from overnight care.
 3. Disposition of IMRs. The IMR will be forwarded to the National Personnel Records Center (NPRC) as described in Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series), two years after the date the patient was released from inpatient care. The NPRC requirements must be met in order for the NPRC to accept the records.
 - a. Records must be sent in prescribed standard cubic foot cartons. [See Encl \(1\), pg.4-45](#). Cartons are available from the General Services Administration Federal Supply Service (FSS). The FSS stock number is NSN 8115-00-117-8344. All non-standard cartons will be returned at the expense of the originating organization.

- b. NPRC does not accept accessions of less than one cubic foot. Small amounts shall be held until a volume of one cubic foot or more is reached.
 - c. Print the accession number on each box, starting in the upper left hand corner [See Encl \(1\), pg. 4-45](#) . Mark the front of the box only. The accession number consists of the RG, which is always 26 for the Coast Guard, the current FY in which the records are being shipped, and a four digit number assigned by NPRC (see 4-F-3.j. for SF-135 preparation). Mark the front of the box only. Ensure that the information printed on the box is not obscured in any way, and that removal of tape or other sealing materials will not remove vital information.
 - d. Number each box consecutively, e.g., 1 of 8, 2 of 8, 3 of 8,,8 of 8; or 1/8, 2/8, 3/8...8/8, in the upper right hand corner. See Encl (1), pg. 4-45 for placement.
 - e. Records shall be arranged in each storage box either alphabetically or numerically. Print the identifier of the first and last record/folder that is contained in the box on the center front of each box as shown in Encl (1), pg. 4-45.
 - f. Enclose in the first box of each accession one copy of the SF-135 and any alphabetical or numerical listing needed to reference the records.
 - g. Ship records together so they arrive at the NPRC at the same time. Shipments of 10 cubic feet or more shall be palletized as shown in [Encl \(1\), pg. 4-46](#).
 - h. Records must be shipped within 90 days of being assigned an accession number. Failure to ship within 90 days will void the accession number.
 - i. Each clinic that transfers IMRs to NPRC must keep a master list (hard copy) of the records sent. The master list must be retained at the clinic for a period of 50 years.
 - j. All shipments to NPRC must be accompanied by SF-135, Records Transmittal and Receipt form. The transmittal form must include the name on the record and the individual's social security number. The accession number elements include the RG which is always 26 for the Coast Guard, the current FY during which the record is shipped, and the 4 digit sequential number assigned by NPRC. Also include the date sent. Complete SF-135 preparation and submission instructions are contained in the Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).
4. Inpatient Medical Record Forms and Required Entries.
- a. SF-508, Doctor's Orders. See Encl (1), pg 4-47.
 - (1) Purpose. SF-508 is used to record written and verbal orders of the medical or dental staff; record that nurses have noted orders; record automatic stop dates for medications and time limited treatments; and record the RN review of orders which shall be performed every 24 hours.

(2) Preparation

- (a) When Prepared. SF-508 shall be used to communicate doctor's orders for all persons admitted to the medical facility inpatient area.
- (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.
 - 2 The date and time at which the order is written by the provider will be listed under the start column. If a verbal order is received, the date and time at which the order was received will be noted by the person who received the order in the start column. All verbal orders must be countersigned by the admitting provider on the next working day.
 - 3 Certain orders may be defined as time limited, e.g., complete bedrest for 24 hours, tilts q 8 hours X 3, etc. In addition, the facility shall define the length of time between renewal of orders for medications, treatments, etc. For orders which are time limited, the date and time when the order expires shall be noted under the stop column.
 - 4 All doctor's orders shall be listed on the form under drug orders. Orders shall be printed clearly in black ink. Only approved abbreviations shall be used. Nursing staff and/or health services technicians are required to contact the provider who wrote the order if there are any questions or difficulty encountered in reading the written order.

b. [SF-506, Clinical Record/Physical Exam](#). See Encl (1), pg. 4-48.

- (1) Purpose. SF-506 is part of the inpatient medical record. It is used to record information obtained from physical examinations.
- (2) Preparation. When Prepared. SF-506 shall be prepared when a patient is admitted to the medical facility.
 - (a) Required Entries.
 - 1 Patient identification information may be written in or printed using a patient identification card.
 - 2 Fill in the date that the exam is conducted in the upper left corner. The patient's self reported height may be used. Patients shall be weighed accurately on the day of admission and the weight entered as present weight. Vital signs to include temperature, pulse and blood pressure are recorded in the appropriate boxes. Rectal temperatures shall be identified by an "R" after the temperature reading. Axillary temperatures in adults are unreliable and will not be used.

following the day of surgery is post-op day one. Post-op days shall be numbered consecutively thereafter.

- 4 The month in which the patient is admitted shall be written on the fifth line, first column. The year shall be completed by writing in the correct numerals after "19" on the fifth line.
 - 5 The calendar date on which the patient is admitted shall be written in on the line next to the word day, e.g., if the patient is admitted on 3 June, the hospital day is one, and a "3" is written on the line next to the word day.
 - 6 The hour at which the vital sign measurements are to be made are noted in the spaces next to the word hour. Use 24 hour clock notations, e.g., 11 p.m. is 2300, etc.
 - 7 Once vital signs have been measured, they shall be recorded on the form using the symbols for pulse and temperature. Symbols are placed in the columns, not on the brown dotted lines.
 - 8 Blood pressure measurements are written in the spaces to the right of the words "blood pressure". The first measurement made after midnight is written in the top left column, the second is written below it. The first measurement made after noon is written in the top box in the right side column, the second below that, etc. Blood pressure may also be represented by x marks placed at the systolic and diastolic measurements corresponding to the scale for pulse measurements.
 - 9 Other vital signs measurements or intake and output measurements may be written in the spaces on the lower part of the form, or a local overprint/stamp may be used.
 - 10 Both sides of the form will be used. If the second side of the form is used, the word "continued" will be clearly written on the bottom of the first page.
- e. SF-514, Laboratory Reports.
- (1) Purpose. SF-514 is part of the inpatient medical record. It is used to keep laboratory report forms neat, in proper order, make them easily accessible to caregivers, and stores them as part of the inpatient medical record. SF-545, Clinical Record - Laboratory Report Display may be used in lieu of SF-514.
 - (2) Preparation.
 - (a) When Prepared. SF-514/SF-545 shall be prepared when a patient is admitted to the inpatient medical area.
 - (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.

- 2 Reports (or chits) may be attached to the form using either the self adhesive on the back of the chit, or by neatly placing a strip of clear adhesive tape horizontally across the top of the report, so that the lower half of the tape strip is touching the chit and the upper half is sticking to the SF-514/SF-545.
- f. SF-519, Radiologic Consultation Reports.
- (1) Purpose. SF-519 is part of the inpatient medical record. It is used to collect radiological reports for easy access by caregivers and to store the reports with the inpatient medical record.
 - (2) Preparation.
 - (a) When Prepared. SF-519 shall be prepared when a patient is admitted to the inpatient medical area.
 - (b) Required Entries. Reports shall be attached to the form using the self stick adhesive on the back of the report or clear adhesive tape.
- g. DD-2770 (replaces SF 539) Abbreviated Medical Record. See Encl (1), pg. 4-52.
- (1) Purpose. DD-2770 is used to record history, exam findings, patient progress, doctor's orders, vital signs, output, medications and nurse's notes for patients requiring overnight care who remain 24 hours or less.
 - (2) Preparation.
 - (a) When Prepared. DD-2770 may be used for any overnight care patient for whom total stay is anticipated to be 24 hours or less. If length of stay exceeds 24 hours, a full IMR must be initiated to provide proper documentation of the patient's stay. The DD-2770 shall be prepared when a short stay patient is admitted to the inpatient medical area.
 - (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.
 - 2 History, chief complaint, and condition on admission must be documented in the top box on page one. Date of admission shall be noted here also.
 - 3 Physical examination findings shall be noted in the center box on page one. Physical exam findings shall be completely noted and appropriate to the condition. Deferred exams, such as rectal exams, shall be noted as such.
 - 4 The patient's progress over the 24 hour period between admission and discharge will be noted by the medical officer in the third box on page one. Date of discharge and final diagnosis shall be noted here also.

- 5 The physician shall sign the form in the box provided and use a printed ink stamp to clearly mark his/her name, rank, and SSN. The date the form is signed shall be written in the box provided next to the signature.
- 6 The location of the clinic or dispensary, for example, Dispensary TRACEN Cape May, shall be written or stamped in the box marked organization.
- 7 Doctor's orders shall be written only in the space provided on page two. Each order group written shall be dated and signed. A printed ink stamp shall be used by medical officers to mark name, rank, and SSN. All medical and dental orders given during the patient's stay must be recorded. A second page should be started if the number of orders exceeds space available on one page.
- 8 Vital sign measurements shall be recorded in the spaces provided with the date and time of each notation. Bowel movements and urine output are noted in the columns marked stools and weight.
- 9 Medications administered and brief notes regarding the patient's condition shall be made in the nurse's notes area. Medication name, dose, route, and time given shall be recorded for each dose of medication administered. Each notation shall be signed with the name, military rank, or title for civilians, e.g., RN or LPN, of the person making the note.

Section G – Mental Health Records.

1. Active duty: Complete mental health assessments and visits will be done in an IMB, DMB or traditional psychiatric evaluation format and recorded on SF-600, SF-513, IMB, DMB, or typed psychiatric evaluation forms as appropriate. Active duty episodic visits and routine appointments will be recorded on SF-600 in SOAP format. The Objective (“O”) section would include mental status observations and any other pertinent physical findings. Records of active duty mental health assessments and visits will be kept in the main health record (CG-3443). An additional separate mental health record may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner’s office. New patients would be evaluated IAW traditional psychiatric evaluation.
2. Non- Active duty: Separate records of mental health care may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner’s office. Alternatively, the mental health practitioner may elect to keep records of visits in the dependent or retiree’s main based record (CG-3443-1). Should the practitioner elect to maintain a separate office based record for non-active duty patients, the main health record (orange jacket) must include, at a minimum, the diagnosis in the problem summary listing, current psychiatric medications on the SF-600, and lab work ordered by the mental health provider. New patients would be evaluated IAW traditional psychiatric evaluation. Episodic and follow up visits would be recorded in a SOAP format.
3. Psychiatric evaluation format: The psychiatric evaluation shall include, at a minimum: patient information, chief complaint, history of present illness, past history (psychiatric symptoms, diagnoses, and care medical illness, surgeries, current medications, allergies, alcohol & drug history), personal history, family history, mental status exam, assessment (DSM-IV), prognosis, and plan. Included in all assessments and other visits as appropriate will be an estimation of potential for harm to self or others. In addition, notes should contain sufficient information to establish that the criteria for any new DSM based diagnosis are met.
4. Custody of Mental Health Records: Records kept in the mental health practitioner’s office are property of the CG and copies should be available to other civilian practitioners or agencies at the patient’s request. These records should also be available to other CG providers, as part of an official records review process, and as directed in Section 4.A.5. of this Manual.

HISTORY AND REPORT OF OMSEP EXAMINATION

PART 1 *(This form is subject to the Privacy Act Statement of 1974)*

1. LAST Name, First Name, Middle Initial:		2. Grade/Rate/Rank:	3. SSN:	4. Date of Exam:
5. Home Address (apt#, Street#, street name, city, state, zip):		6. Work/duty phone:	7. Unit Name and location (city & state):	
		8. Home phone:	9. Unit OPFAC#:	10. Unit Zip Code:
11. Date of Birth & Age:	12. Sex (M or F):	13. Race or Ethnicity:	14. Occupation or usual duties (describe):	
15. Examining facility name & location (City & State):		16. Purpose of Examination: <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Exit/Separation		
17. How many years have you worked in this occupation?				

Section I. OCCUPATIONAL HISTORY (patient must complete)

18. Are you exposed to any of the following hazards in your present job, Yes or No?

Y N <input type="checkbox"/> <input type="checkbox"/>	Entry into closed spaces (tanks, voids)	Y N <input type="checkbox"/> <input type="checkbox"/>	Extreme cold/heat	Y N <input type="checkbox"/> <input type="checkbox"/>	Bodily fluids, or infectious agents
<input type="checkbox"/> <input type="checkbox"/>	Vibration (jackhammer)	<input type="checkbox"/> <input type="checkbox"/>	Metals (Lead fumes, other)	<input type="checkbox"/> <input type="checkbox"/>	Mental or emotional stress
<input type="checkbox"/> <input type="checkbox"/>	Chemical (liquid, vapor, gas)	<input type="checkbox"/> <input type="checkbox"/>	Dust (sawdust, asbestos dust fibers)		

19. Do you wear any of the following on your present job, Yes or No?

Y N <input type="checkbox"/> <input type="checkbox"/>	Earplugs or muffs	Y N <input type="checkbox"/> <input type="checkbox"/>	Full-face respirator	Y N <input type="checkbox"/> <input type="checkbox"/>	Welding face-mask	Y N <input type="checkbox"/> <input type="checkbox"/>	Other, list below in item 25.
<input type="checkbox"/> <input type="checkbox"/>	Dust mask	<input type="checkbox"/> <input type="checkbox"/>	Air-line respirator	<input type="checkbox"/> <input type="checkbox"/>	Rubber gloves		
<input type="checkbox"/> <input type="checkbox"/>	Half-face respirator	<input type="checkbox"/> <input type="checkbox"/>	Safety glasses	<input type="checkbox"/> <input type="checkbox"/>	Protective body suit		

Y N <input type="checkbox"/> <input type="checkbox"/>	20. Have you had any difficulty wearing your protective clothing or equipment? (If you don't need to wear any, answer "no")
<input type="checkbox"/> <input type="checkbox"/>	21. Have you had any work-related illness or injury?
<input type="checkbox"/> <input type="checkbox"/>	22. Have you been limited in your work for health reasons?
<input type="checkbox"/> <input type="checkbox"/>	23. Have you left or changed jobs due to health reasons?
<input type="checkbox"/> <input type="checkbox"/>	24. Do you have hobbies or outside activities, which would expose you to any of the hazards listed in 18, above? If yes explain.

25. If you marked "Yes" to any questions from items 19-24, explain in this section.

Section II. FAMILY HISTORY (patient must complete)

26. Have any blood relatives (mother, father, brother, sister, grandparents, aunts, uncles, children) had any of the following problems?

Y N <input type="checkbox"/> <input type="checkbox"/>	Anemia, blood disease, or bleeding tendency	Y N <input type="checkbox"/> <input type="checkbox"/>	Eye trouble or blindness
<input type="checkbox"/> <input type="checkbox"/>	Asthma, hayfever, allergies	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy, fits, or convulsions
<input type="checkbox"/> <input type="checkbox"/>	Birth defects or multiple miscarriages	<input type="checkbox"/> <input type="checkbox"/>	High blood pressure, stroke
<input type="checkbox"/> <input type="checkbox"/>	Cancer, leukemia, or other malignancy	<input type="checkbox"/> <input type="checkbox"/>	Kidney trouble (stones or kidney failure)
<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Lung troubles cystic fibrosis, bronchitis, emphysema
<input type="checkbox"/> <input type="checkbox"/>	Hearing problem, deafness	<input type="checkbox"/> <input type="checkbox"/>	Other disease or family condition, if so list:

HISTORY AND REPORT OF OMSEP EXAMINATION

PART 1, (con't) Section III. SOCIAL HISTORY (patient must complete)

<p>27. Cigarettes/pipe/cigar smoking history.</p> <p>Do you smoke cigarettes/cigars or a pipe now? Y N</p> <table style="margin-left: auto; margin-right: auto;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> <p>If NO: Did you ever smoke cigarettes/pipes or cigars?</p> <p>If you smoked before, when did you stop?</p> <table style="margin-left: auto; margin-right: auto;"> <tr><td style="width: 100px; height: 20px;"></td></tr> </table> <p>How many years have you smoked?</p> <p>How many cigarettes/cigars or pouches per week?</p> <p style="padding-left: 20px;">If YES: How many years have you smoked?</p> <p>How many cigarettes/cigars or pouches per week?</p>											<p>28. Alcohol use history.</p> <p>Do you drink any alcoholic beverages (beer, wine, liquor)? Y N</p> <table style="margin-left: auto; margin-right: auto;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> <p>If YES: How many glasses of wine per week? _____</p> <p>How many ounces of liquor per week? _____</p> <hr/> <p>29. Do you use any recreational drugs?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, list here.</p>		

Section IV. PERSONAL HEALTH HISTORY (patient must complete)

30. Have you recently had or do you have any of the following symptoms or complaints, yes or no?

<table style="margin-left: auto; margin-right: auto;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>									<p>Lumps you can feel</p> <p>Trouble concentrating</p> <p>Nosebleeds</p> <p>Pain or swelling in neck</p>	<table style="margin-left: auto; margin-right: auto;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>											<p>Infertility or miscarriages</p> <p>Birth defects in your children</p> <p>Anemia (low blood)</p> <p>Easy bruising or bleeding</p>

31. In general, would you say your health is (**check one**):

Excellent
 Very Good
 Good
 Fair
 Poor

32. List any Noise Exposure:

<p>Hearing Conservation Program (HCP)</p> <table style="margin-left: auto; margin-right: auto;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> <p>Firearm use</p> <p>Motor Racing</p> <p>Power tool use</p> <p>Head Set use</p> <p>Music/Concerts</p> <p>Lawnmower/Other</p>															<p>History</p> <table style="margin-left: auto; margin-right: auto;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> <p>Chronic ear Infections</p> <p>Ear Drum Rupture</p> <p>Ear/Head Surgery</p> <p>Hearing Aid use</p> <p>Ringling of ears</p> <p>Difficulty Hearing</p>														

33. Additional space for comments and explanations of your "YES" answers:

All information provided will be handled in accordance with the Privacy Act requirements, and will not be otherwise disclosed.

I hereby certify that I have reviewed the foregoing information supplied by me, and that it is true and complete to the best of my knowledge.

Signature of patient:	Date:
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HISTORY AND REPORT OF OMSEP EXAMINATION

PART 2 MEDICAL OFFICER'S SECTION

1. LAST Name, First Name, Middle Initial (of patient):	2. Grade/Rate/Rank (of patient):	3. SSN (of patient):	4. Date of Exam:
--	----------------------------------	----------------------	------------------

5. Examining facility or examiner and address:	6. Facility phone #: ()
--	--------------------------

7. Surveillance protocols followed (check all that apply):

<input type="checkbox"/> Asbestos	<input type="checkbox"/> Chromium compounds	<input type="checkbox"/> Lead	<input type="checkbox"/> Respiratory sensitizers	<input type="checkbox"/> Solvents
<input type="checkbox"/> Alcohol or drug abuse	<input type="checkbox"/> Nutrition (low-fat/salt)	<input type="checkbox"/> Stress reduction	<input type="checkbox"/> Breast / testicular self-exam	<input type="checkbox"/> HCP
<input type="checkbox"/> Benzene	<input type="checkbox"/> Pesticides	<input type="checkbox"/> Resp wear	<input type="checkbox"/> Haz-Waste	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Unspecified				

8. List only occupational-related diagnoses by ICD code number and name: (If no exact corresponding ICD code is available, use the closest code to the related diagnosis.)

ICD Code	Diagnosis	ICD Code	Diagnosis

9. Respirator wear.

This examinee is medically approved for respirator wear. (Comment on any restrictions or limitations.)

Is not approved for respirator wear.

10. CONCLUSIONS:

This examinee does have medical conditions which limit his/her performance of duties (Specify any limitations.)

Does not have any conditions which limit his/her performance of duties.

11. Next OMSEP examination should be in: 12 months Other:

12. Examinee was informed about the results of this examination _____ (date).

13. Recommendations:

Printed or typed name/rank and degree of examining medical officer.	Signature of examining medical officer.	Date:
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PERIODIC HISTORY AND REPORT OF OMSEP EXAMINATION

1. LAST Name, First Name, Middle Initial:	2. Grade/Rate/Rank:	3. SSN:	4. Date of Exam:
5. Home Address (apt#,Street#, street name, city, state, zip):	6. Work/duty phone:	7. Unit Name and location (city & state):	
	8. Home phone:	9. Unit OPFAC#:	10. Unit Zip Code:
11. Examining facility name & location (City & State):	12. Date of Last OMSEP Exam:	13. Present Exposure Protocols:	

Review each section of the last CG 5447 (History and Report of OMSEP Examination). If there has been any changes to any section please list the item and how it has changed.

Section I. OCCUPATIONAL HISTORY	
COMMENTS:	<input type="checkbox"/> No Change

Section II. FAMILY HISTORY	
COMMENTS:	<input type="checkbox"/> No Change

Section III. SOCIAL HISTORY	
COMMENTS:	<input type="checkbox"/> No change

Section IV. PERSONAL HEALTH HISTORY	
COMMENTS:	<input type="checkbox"/> No Change

OCCUPATIONAL EXPOSURE	
COMMENTS:	<input type="checkbox"/> No Change

HEALTH CARE PROVIDER REVIEW							
RECOMMENDATIONS:	<table style="width: 100%;"> <tr> <td style="width: 80%;">Lab Results Reviewed</td> <td style="width: 20%; text-align: center;">Initial</td> </tr> <tr> <td>X-ray Results Reviewed</td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td>Other:</td> <td style="text-align: center;"><input type="text"/></td> </tr> </table>	Lab Results Reviewed	Initial	X-ray Results Reviewed	<input type="text"/>	Other:	<input type="text"/>
Lab Results Reviewed	Initial						
X-ray Results Reviewed	<input type="text"/>						
Other:	<input type="text"/>						

Health Care Provider, (<i>print or type</i>):	Health Care Provider Signature:	Date:
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CHAPTER 8. RESOURCE MANAGEMENT

Section A - Resource Management. The Health Services Program has three resource management levels.

1. Unit.

- a. A unit's commanding officer (CO) is charged with ensuring all unit aspects operate effectively and efficiently. For units with health care facilities, this means using personnel, funds, equipment, expendable supplies and materials, health care spaces, and external health care providers economically and efficiently. The CO oversees all health care equipment maintenance. Commanding officers will ensure management of command resources provides the best amount of care to all eligible beneficiaries at the least cost to the Government.
 - (1) In general, care provided in Coast Guard clinics is more cost-effective than any other source's. The fixed cost of physical plant, staff, and equipment is divided by the number of beneficiaries served; thus, the more care provided, the lower the cost per visit. Therefore, units should set goals to provide the maximum amount of care possible. Achieve these goals by operating properly staffed clinics at times most convenient to beneficiaries, scheduling to decrease the time patients wait, efficiently managing health care providers' valuable time, and publicizing the availability of services to beneficiaries in the surrounding communities.
 - (2) If the current level or mix of resources is inefficient, the commanding officer will report this fact through the chain of command and recommend corrections. Timeliness is extremely important in dealing with changes in resource requirements. Good resource planning should address these needs long before it becomes necessary for a unit commanding officer to deny care to any authorized beneficiary due to lack of resources.
- b. The unit commanding officer directly controls the unit's financial plan or budget, including unit health care resources. Monthly the CO reports medical and dental workloads, operating targets, adjustments to the targets, and actual expenditures to Commandant (G-WKH) on the unit's Health Services Statistical Report. From an oversight or management review perspective, repeated or recurring amounts of unit Fund Code-57 (AFC-57) moneys dedicated to health care are the "base" funds. COs must justify additional unit operating funds above this base solely on the criterion of increased workloads.
- c. The unit commanding officer will review all uses of unit funds and reallocate funds during the current fiscal year. The unit commanding officer must first inform the chain of command before he or she can reduce the amount of care the unit's clinic provides to eligible beneficiaries. The CO will report the circumstances supporting the decision and identify what resources are required to ensure normal health care facility operations through the end of the fiscal year. The District or Maintenance

and Logistics Commander's Budget Review Board (for district or MLC units respectively) will address these current fiscal year AFC-57 unit requests.

2. Maintenance and Logistics Command (MLC). Maintenance and Logistics Commands administer the health services program in their respective area of responsibility. Administrative functions include:
 - a. Approving and funding care non-Federal and Department of Veteran's Affairs sources provide;
 - b. Approving or disapproving requests to procure health care equipment costing more than \$1500.00 for units with CG Clinics/AFC-57 funding and over \$500.00 for sickbays with HS's assigned/AFC-57 funding;
 - c. Approving clinic budgets. Each clinic's parent command shall submit a zero-based AFC-57 direct care funding request to the appropriate MLC (k) through the chain of command. This request should include predicted equipment procurement requests to Commandant (G-CBU) using the automated ATU budget process according to current directives. The MLC request should include a line item for each clinic, proposed equipment funding, and an estimate of non-Federal care cost.
 - d. Targeting AFC 57 and AFC 73 funds to pay for Department of Defense for all health care the Army, Navy, Air Force, TRICARE and USTF programs provided to Coast Guard beneficiaries.
3. Headquarters.
 - a. Commandant (G-WK) obtains health services program resources from the budget process for these purposes:
 - (1) Targeting AFC-57 funds to the MLC (k)s to pay for all non-Federal and VA medical care provided in each region;
 - (2) Targeting AFC-57 funds to the MLC (k)s to acquire health care equipment; and
 - (3) Targeting AFC-57 funds to allotment target units in response to budget requests the MLC (k)s submit.
 - b. Commandant (G-WK) is also the program manager for replacing, expanding, or creating health care facilities with Acquisition, Construction, and Improvement Appropriation funds and works with Commandant (G-A) and the MLC's Facilities Design and Construction Center staffs on plans and layouts.

Section B - General Property Management and Accountability

1. Basic Policies. The Director of Health and Safety:
 - a. Establishes procedures to manage and account for health care material pursuant to the personal property management policies contained in the Property Management Manual COMDTINST M4500.5A;
 - b. Directs and coordinates the health care supply system;
 - c. Determines requirements for health care material; and
 - d. Establishes allowance lists, advises, and assists field units.
2. Physical Property Classifications. Property is divided into two categories: real property and personal property. Health care material is personal property and is accounted for in accordance with Property Management Manual COMDTINST M4500.5A
3. Property Responsibility and Accountability.
 - a. Clinic administrators are responsible and accountable for the property their facilities use. Additionally, they serve as the health services finance and supply officer.
 - b. In the absence of a clinic administrator, the senior commissioned health services department representative acts as the property custodian.
 - c. If health services technicians only are assigned to a facility, the senior health services technician acts as the property custodian.
4. Expending Property Unnecessarily. All persons having custody of health care property shall avoid any unnecessary expenditures of such property within their authority's limits and shall prevent such expenditures by others.
5. Stock Levels, Reorder Points, and Stock Limits.
 - a. General. Stock levels, reorder points, and stock limits discussed below apply to all health care facilities, especially those at major shore units such as the Academy, ISC Alameda, and Training Center Cape May. These large facilities with multiple components (e.g., pharmacy, laboratory, dental clinic, etc.) need to maintain a greater stock depth to serve their clientele. COMDTINST M4500.5A (series) contains overall supply policy and procedures.

- b. Terms.
- (1) Operating Stock. That quantity of material on hand needed to meet daily operating needs during the interval between delivery of replenishments.
 - (2) Safety Stock. That amount of inventory in addition to operating stock needed to sustain operations if deliveries are delayed or demands unexpectedly heavy.
 - (3) Reorder Point. Low Limit. Both terms mean the predetermined inventory level for a specific item at which it is reordered.
- c. Stock Inventory and Transactions. All health care facilities shall maintain sufficient amounts of stock to prevent out-of-stock conditions. To do so, maintain stock inventory and transaction records, either electronically (on computer) or by using stock cards, inventory records, etc.
- (1) Generally, health services supply activities at facilities with multiple components are authorized one month's safety stock. Experience may prove this level is not adequate for certain items or in certain circumstances. These units are authorized to maintain more a larger supply if and wherever exceptional circumstances dictate. Establish procedures to ensure reviews of stock records periodically to identify items reaching a low limit (reorder point) or the authorized allowance and quantity and to revise low limits if current usage so indicates.
 - (2) Ships and small shore units may use the minimum quantities indicated in the Health Services Allowance List to establish reorder points. If the list does not indicate a minimum allowance, e.g., for "optional" items, establish reorder points for commonly used items based on current usage rates. Do not order excessive quantities of material.
 - (3) When a ship receives orders to deploy or a station notice of a change in operating conditions that may require additional material, promptly review authorized allowance quantities to replenish critical items in time for the deployment or operational change.
 - (4) Pharmacies procuring drugs through prime vendor systems (either directly or through pharmacy officer staffed clinics) should try to stock one-month quantities of regularly used items. Ongoing inventories of these limited quantities are not required except where applicable for controlled substances. Pharmacies shall "sight inventory" monthly before ordering.
6. Transferring and Loaning Property. Written approval is required from Commandant (G-WKH) to loan health care property to any state, community, organization, or private individual. Property or transferred to other military units is at the commanding officer's discretion. Obtain custody receipts in such instances. Use NAVSUP 460, Equipment Stock Card and Custody Record, or a local form for local transactions and DD-1149 to transfer property from one activity to another.

CHAPTER 10

PHARMACY OPERATIONS AND DRUG CONTROL

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CHAPTER 10. PHARMACY OPERATIONS AND DRUG CONTROL

Section A - Pharmacy Administration

1. Responsibilities.

- a. The person designated in writing as responsible for the pharmacy is accountable to the Chief, Health Services Division, or the executive officer for properly storing and dispensing drugs, record keeping, and maintaining a pharmacy policy and procedures manual.
- b. The person in charge of the pharmacy shall acquire, store, compound, and dispense medications according to applicable Federal laws (principally Title 42, United States Code [42 USC] and Title 21, Code of Federal Regulations [21 CFR]) and observe the highest standards of professional practice and established pharmaceutical procedures.
- c. Through medical administration persons responsible for daily pharmacy operations shall request adequate funding to provide the level of pharmaceutical care required in Section 10.A.2.c.
- d. Health Services Division Chiefs shall ensure that all short-term, interim, or temporarily assigned pharmacy personnel have successfully completed Quality Assurance Guide (QAIG) #41 (Pharmacy Watchstander Qualification Guide(PWQG)) and that all regular assigned pharmacy personnel have completed pharmacy technician “C” school training. These minimum standards of qualifications must be documented in the training file of all pharmacy watchstanders. The PWQG does not replace the requirement for “C” school trained pharmacy technicians, but will assist clinic personnel in becoming more productive members of the Coast Guard health services team and in doing so further enhance the mission of the Coast Guard clinics.
- e. Pharmacy officer collateral duty oversight shall be provided for all clinics and sickbays that do not have pharmacy officers assigned. A Pharmacy Officer Collateral Duty Program shall be administered by the cognizant Maintenance and Logistic Command (k), who shall:
 - (1) Determine cost requirements for the pharmacy officer collateral duty program and submit funding requests to Commandant (G-WKH) in the annual operating summary of budget estimates (CG-4144) process.
 - (2) Provide direction and funding to pharmacy officers for matters relating to assignments in pharmacy officer collateral duty program.
 - (3) Develop work plans which specifies units for which the pharmacy officer is responsible.
 - (4) Ensure that visit schedule will be:

- (a) the most cost effective;
 - (b) feasible to maintain responsibilities at the unit where the pharmacy billet is assigned; and
 - (c) coordinated with the unit commanding officer possessing the billet.
- (5) Establish the content and frequency of a reporting system for pharmacy officers on assignment and provide a copy of this report to the unit commanding officer where the billet is assigned.
- (6) Ensure that rating officers of pharmacy officers on assignment in the pharmacy collateral duty program obtain input for completing the USPHS Commissioned Officers' Effectiveness Report from the other units where the pharmacy officer provides oversight.
- (7) Oversees the following responsibilities of collateral duty pharmacy officers who:
- (a) Report to the Chief, Health Services Division of the unit to which they are assigned.
 - (b) Follow the established chain of command.
 - (c) Serve as a member of the Pharmacy and Therapeutics Committee, and assist those units to which they are assigned with developing and maintaining a drug formulary. This formulary shall be standardized to provide a list of medications stocked in the "therapeutic category" format.
 - (d) Provide direct assistance for all aspects of the Pharmaceutical Prime Vendor Program.
 - (e) Assist each unit in eliminating or minimizing the purchase of medication through nonfederal sources by using formulary process and redistributing medication as needed.
 - (f) Develop an inventory of limited use pharmaceuticals/pharmaceutical supplies for distributing to each unit.
 - (g) Serve as the point of contact for redistribution of medication that are due to expire or are in excessive supply.
 - (h) Identify special order medication, label them for each patient and assure that they are not considered formulary items. These should be marked for a specific patient only and removed when the patient no longer requires them.

- (i) Analyze and develop the most cost effective methods for providing non-formulary medication for chronic conditions.
- (j) Provide oversight to the health services technician(s) who normally operate the unit pharmacy and assist in dispensing operation as required.
- (k) Provide and document in-service training to the clinic staff.
- (l) Review all pharmacy operations and policies including controlled substance activities.
- (m) Assist the unit in preparation for MLC Quality Assurance Surveys.
- (n) Submit a report of the content and frequency established by MLC (k).

2. Prescribers.

a. Authorized prescribers include:

- (1) Medical officers and dental officers as defined in this Manual's Sections 1.B.1. and 1.B.4.;
- (2) Civilian physicians employed by the Coast Guard;
- (3) HSs may prescribe drugs listed in the Coast Guard Health Services Technician Formulary, COMDTINST 6570.1 (series). While performing isolated duty at LORAN stations or underway, HSs may prescribe additional drugs listed in Health Services Allowance List, Part 2 (Vessels), COMDTINST 6700.6(series). HSs in these situations should seek medical advice if available; and
- (4) Civilian physicians, dentists, and allied health care providers (nurse practitioners, physician assistants, optometrists, etc.) as authorized by State law in their licensing jurisdiction to write prescriptions in practicing their profession.

b. Prescriptions by uniformed service physicians and dentists, other than Coast Guard, shall be honored when ever possible. For example, Department of Defense prescription policies (TRICARE/TRI SERVICE) shall be considered/observed to the fullest extent possible within the scope of the primary care nature of Coast Guard Health Care facilities. Prescriptions by these providers shall be written on the prescription forms authorized by their service.

c. Prescriptions for eligible beneficiaries from licensed civilian physicians, dentists, or podiatrists shall be honored for products on the clinic's formulary. Clinic formularies shall be established based on **Department of Defense Basic Core Formulary (BCF) guidelines** and the prescribing habits of the providers assigned to that clinic.

- (1) For those Coast Guard clinics with a pharmacy officer permanently assigned, the BCF contains the minimum drugs that each pharmacy must have on its formulary and provide to all eligible beneficiaries.
 - (2) For those Coast Guard clinics without a pharmacy officer permanently assigned, there is no requirements to stock the entire contents of the BCF. Military practitioners or contract providers shall not countersign civilian prescriptions nor shall civilian prescriptions be rewritten during cursory outpatient visits with the intent of authorizing the prescription for dispensing at the facility.
 - (3) In the case of multiple strength BCF drugs, all strengths need not be stocked but all prescriptions for that agent will be filled, regardless of strength.
 - (4) If additional funding is required for specific, high cost drugs, it shall be requested via the AFC-57 budget process via the cognizant MLC(k).
- d. Authorized prescribers shall not prescribe controlled medications for themselves and/or their family members. If such medication is required and no other prescriber is assigned to the facility, the commanding officer or executive officer shall approve and countersign each prescription before the prescriber fills it.

3. Prescriptions.

- a. Prescriptions written by Coast Guard physician's assistants and nurse practitioners may be filled at the facility where written or at a neighboring MTF as permitted by local prescribing policy. Prescriptions written by health services technicians shall be filled only at the facility where written. Coast Guard clinics may agree among themselves to honor another Coast Guard clinic's physician assistants' or nurse practitioners' prescriptions if stock shortages so necessitate. Other Coast Guard facilities may honor Coast Guard physician assistants' and nurse practitioners' refills (for other than controlled substances) if the patient presents his or her health care record containing the original entry.
- b. Accept telephoned and oral prescriptions only in emergencies. The prescriber must write and sign the prescription as soon afterwards as possible. A clinic may choose to accept FAXed prescriptions provided it receives the original prescription before dispensing the medication.
- c. Health Services Technicians shall not contact civilian prescribers to resolve prescription problems but return the problem prescription to the patient and explain why he or she cannot dispense it. The HS may provide the names of suggested available products to the patient. Professional supervisors (pharmacy officers or senior medical officers) may authorize, via the Pharmacy Policy and Procedures Manual, pharmacy technicians to make telephone contact with civilian prescribers to resolve problems. All authorized telephone transactions will be clearly defined; those transactions not listed shall be unauthorized.

- d. Prescriptions shall be personalized. If more than one member of a family is prescribed the same drug, a separate prescription blank must be used for each member
 - e. Items prescribed must treat conditions within the normal scope of professional practice and the ethics of the prescriber.
 - f. Prescriptions for medications to treat cosmetic conditions (baldness, wrinkles, etc.) and for weight loss will not be honored nor shall medications for these conditions be stocked at Coast Guard facilities.
 - g. Do not fill prescriptions for animals other than those the Government owns.
 - h. If a physician assistant has clinical privileges at a local DOD facility, he or she may use its prescription form to write prescriptions to be filled at that facility, provided the form contains the statement "To be filled only at [insert designated DOD facility]."
 - i. The prescriber's facility has the responsibility to procure and dispense all medications its staff members (including in-house contract prescribers) prescribe. In the rare event a patient must carry a prescription elsewhere for dispensing, the prescriber shall write the facility's name in addition to the other required information on the form.
 - j. Providers are tasked with the cost-effective use of medications. Commandant (G-WKH) maintains a list of and prescribing guidelines for selective medications, listed in Figure 10-A-2. Clinics shall ensure in-house prescriptions meet the requirements to use these items cost-effectively.
4. Prescribing in the Medical Record.
- a. At all clinics and sickbays, prescribe medications on an SF-600 in the medical record, or when appropriate, SF-558, Emergency Care and Treatment. The medical record thus becomes a more comprehensive repository for all patient health information and also ensures the pharmacy staff has access to the necessary clinical information (age, weight, allergies, lab values, vital signs, etc.) to provide complete pharmaceutical care. In clinics that maintain dental records separately, the dental staff may use prescription forms.
 - b. Procedures.
 - (1) Document (S.O.A.P. format) the patient visit on an SF-600 or SF-558 in the chart. Under the "Plan" section list the drug name, strength, directions, quantity, and refills. Start each new drug entry on a new line (examples: "HCTZ 50 mg, #1 tab po QD #90 RF X 1"; "Clonidine 0.1 mg, #1 tab po BID #180 RF X 1"). If prescribing for a dental condition, label the SF-600 section "Dental Rxs" and list the same information required here and in 10-A-4.b.(2).
 - (2) In the "Plan" section, state a disposition to assist pharmacy staff in coordinating quantities of all chronic medications until the next appointment.

Complete the entry with the authorized prescriber's signature (examples: RTC PRN; F/U appt. 10 days; RTC 3 months).

- (3) The terms chronic and maintenance medications are synonymous. A maintenance medication is defined as any medication used to treat a chronic condition. The term "maintenance" implies that a prescriber and patient have gone through a dosage titration process and have determined that the patient should be "maintained" on an effective dose of a medication that is well tolerated. Ultimately, the individuals in a position to make such a determination are the patient and the prescriber. The standard quantity issued for chronic conditions is a 90-day supply. If it is necessary to deviate from this amount, prescribe quantities in 30-day increments (30, 60, 90, etc.) if possible. If pharmacy staff in consultation with the prescriber deem it advantageous to the patient due to travel, deployment, operational commitments, packaging, etc., they may dispense larger quantities.
- (4) Pharmacy staff shall completely draw a single horizontal line through errors or changes and conspicuously write "Error" next to the item. The person changing the entry shall initial the change or error. Return incorrect or incomplete entries to the prescriber for revision.
- (5) Pharmacy staff shall write the prescription number or put the multi-part strip label on the SF-600 and initial to identify the person who prepared the prescription.
- (6) Pharmacy staff shall write the manufacturer's name, lot number, and expiration date to the right of the drug prescription (not required with CLAMS OR CHCS). Sickbays not on CLAMS OR CHCS also shall maintain a drug dispensing log containing prescription number, patient's name, patient's SSN, drug name, drug manufacturer, and lot number. Retain this log for record purposes for 3 years.
- (7) For refills, pharmacy staff shall note the date, pharmacy identity and "Rx Refill" on the SF-600, followed by medication name, quantity, original prescription date, manufacturer's name, lot number, expiration date, and remaining refills. If processing through CLAMS OR CHCS, the only required information is the pharmacy identity, current date and medication name. The pharmacy staff member charting the refill shall initial the entry. The use of personal stamps to further identify pharmacy personnel is encouraged. Any other services (counseling, vital signs, etc.) provided to the patient shall also be noted in the medical record. See Figure 10-A-1 for examples.
- (8) In addition to the SF-600 or SF-558 entry, written prescriptions are required for all controlled substances or cases where a prescription must be taken to another pharmacy.
- (9) All prescriptions generated from sources outside the clinic shall be filled or refilled using CLAMS OR CHCS or the procedures specified in this Chapter and maintained on file in the pharmacy. The pharmacy need not maintain a health care record if the patient receives only basic pharmaceutical care from the facility.

5. Signatures. No prescription or order shall be filled unless it bears the signature of an individual authorized to write prescriptions. All prescriptions shall be imprinted/stamped with the prescriber's name, rank, and professional discipline (MD, DDS, HS2, etc.). Prescriptions for controlled substances shall also provide the social security number of the prescriber or DEA number. Pharmacy personnel shall maintain signature examples for in-house and contract prescribers. Professional judgment shall be used to verify authenticity of prescriptions from other sources.
6. Dispensing.
 - a. The pharmacy shall serve as the source of supply from which clinics or satellite activities normally obtain required pharmaceuticals and related supplies. In addition, the pharmacy dispenses required, authorized preparations directly to patients.
 - b. Except for OTC program items, the pharmacy shall dispense all stocked items only on receiving a properly written, verified prescription. If pharmacy staff receive an illegible prescription or question its authenticity, dosage, compatibility, or directions to the patient, staff shall obtain clarification from the prescriber before dispensing the medication(s).
 - c. Clinics shall have a system (computerized, written, etc.) in place to ensure they can obtain prescriptions in case of a product recall.
 - d. Clinics shall submit all pertinent patient adverse reactions or product quality problems on the FDA MEDWATCH system on FDA Form 3500. Obtain MEDWATCH forms and information from the FDA at 1-800-FDA-1088.
 - e. When dispensing medication, the dispenser shall identify the patient and ensure his or her eligibility.
 - f. Use child-resistant containers to dispense all prescription legend medications except nitroglycerin, which is dispensed in the original container. The practitioner or patient may specifically request a conventional closure; a practitioner must so indicate on the prescription order. If the patient requests such a closure, enter a statement so saying on the back of the prescription; have the patient sign it. When refilling prescriptions, the pharmacy must ensure the safety closure still functions and the label is legible before dispensing in the original container.
 - g. Prescriptions (except for controlled substances-see 10-B-4.c.) may be refilled when authorized by the prescriber. The maximum quantity shall be a year's supply of medication. No prescription shall be refilled after more than one year from the date it was written. **PRESCRIPTIONS SHALL NOT BE REFILLED FROM THE LABEL ON THE CONTAINER ONLY.**
 - h. Coast Guard clinics are encouraged to establish non-prescription medication programs under the following guidelines:
 - (1) Commanding Officer of Coast Guard units assigned health care personnel may elect to operate a nonprescription drug program. Units not staffed with an HS, may operate a nonprescription medication program if quarterly oversight

(direct visit) is provided by a Coast Guard clinic or supporting Independent Duty HS. Units electing to offer a nonprescription drug program shall inform their respective MLC, and verify that they will operate within these guideline.

- (2) All Coast Guard health care facilities shall make condoms available to beneficiaries even if they elect not to offer a nonprescription drug program. Condoms shall be made available to beneficiaries under 18 years of age unless specifically forbidden by law.
- (3) Items available shall be limited to those specifically identified in the Nonprescription Medication Program section of the “Core” Formulary (COMDTINST 6570.2A) Units may elect not to offer every product from this list but shall not select products other than those listed.
- (4) A beneficiary family shall be limited to a maximum of two items per week from the program. Occasionally, it may be necessary to extend this limit due to family size. Pharmacy and Therapeutics Committees (if available) and collateral duty pharmacy officers shall provide guidance and monitor any such extensions.
- (5) Items shall only be available during normal operating hours of the facility.
- (6) Pharmacy or sick bay personnel shall monitor the program for perceived overuse. Individuals suspected of this shall be referred to a medical officer and may have their access to this privilege denied.
- (7) All products must be dispensed in the Manufacturer’s FDA approved packages with required instructions and warnings. Other locally packaged items are not authorized. Local Pharmacy and Therapeutics Committees may develop supplemental information on sheets to provide additional dosage or drug information to the patient.
- (8) Nonprescription drug program items shall not be dispensed to pregnant patients or non active duty beneficiaries under 18 years of age. Local flight surgeons, via the Pharmacy and Therapeutics Committee, shall determine which products may be acquired by personnel on flight status.
- (9) Facilities offering this service shall keep quarterly statistics as to the quantity of items dispensed and the dollar value expended. This figure shall be separated from regular pharmacy workload statistics and not be counted as a prescription number. Only those items which have been dispensed by a written prescription shall be counted in the facility prescription number totals.
- (9) The Patients are responsible for providing an authorized identification card to verify their eligibility.
- (10) To receive a nonprescription item, patients must sign a log request form which certifies the following:
 - (a) “I do not wish to see a physician or other health care provider for advise before receiving these medications. I understand that the medication is for minor illness or conditions and that if symptoms worsen or persist longer than 48 hours, the person for whom this medication is intended should be seen by a health care provider.

- (b) “I am not pregnant or under 18 years of age (unless active duty). If on flight status, I understand that I am only authorized to receive over-the-counter items approved by the flight surgeon.
 - (11) Individuals suspected of returning for medication for a non-resolving problem shall be referred to a medical officer for evaluation.
 - (12) The log sheet or request form shall also contain the date, patient’s name, and the name and quantity of the item(s) received.
 - (13) Beneficiaries requesting medical advice that, in the opinion of the pharmacy or sick bay personnel, is beyond their expertise, shall be referred to the medical officer.
 - (14) Funding for independent duty HS assigned units (vessel, groups, etc.) deciding to offer this service shall be from their unit’s AFC-30 account.
- i. When the pharmacy is closed, a medical or dental officer, or a person so authorized, may dispense medication from a locked cabinet or locker containing pre-packaged or limited supplies of after-hours medications. These drugs are dispensed under the same procedures required when the pharmacy is open, including appropriate labeling and complete as an entry in the health record.
Do not fill prescriptions from civilian prescribers from the after-hours locker except for emergency pain medications and/or antibiotics to treat acute infection.
 - j. Bulk items for use in the clinic may be issued on authorized prescription forms or locally approved requisition forms.
 - k. A sign shall be posted outside of the pharmacy in a highly visible location stating “Please inform our pharmacy staff if you are breast feeding or may be pregnant.” Clinic pharmacies shall maintain a written drug information system (USP, CHCS, etc.) to provide information to patients when appropriate.
 - l. Coast Guard pharmacies staffed with one pharmacy technician or HS generally dispense an average of 75 prescriptions per day. Clinics with a pharmacy officer and HS can be expected to average 150 prescriptions per day. These workload expectations account for "background" clinic and pharmacy activities (collateral duties, OTC program, bulk issues, etc.).
 - m. Pharmacies shall adhere to applicable state laws governing generic dispensing of civilian prescriptions. Civilian prescribers may provide the facility with a written statement giving "blanket approval" to dispense generics for their prescriptions.
 - n. Dispense drug samples only through the pharmacy; they must have proper labeling and child-resistant containers. A system shall be maintained to recall sample products should such action become necessary.
7. Labeling.

- a. A label will be prepared for each prescription dispensed to individuals and will be securely affixed to the container prior to dispensing. The label or appropriate auxiliary labeling will show as a minimum:
- (1) facility identity, including pharmacy address and telephone number;
 - (2) consecutive identifying number;
 - (3) prescriber's name;
 - (4) definite, concise directions to the patient;
 - (5) drug name and strength, unless prescriber directs otherwise;
 - (6) amount dispensed;
 - (7) patient's first and last name;
 - (8) initials of person typing the prescription label;
 - (9) the legend "**KEEP OUT OF THE REACH OF CHILDREN**" on all prescription labels;
 - (10) date prescription filled;
 - (11) indication of refills;
 - (12) expiration date (for liquid antibiotics);
 - (13) the legend "**CAUTION: FEDERAL LAW PROHIBITS THE TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM IT WAS PRESCRIBED**" (for controlled substances only);
 - (14) any necessary supplemental or auxiliary labels.
- b. If prescription contents are for external use only or require further preparation(s) for use (shaking, dilution, temperature adjustment, or other manipulation or process) include appropriate directions on the label or affix an additional label to the container. If liquid preparations for external use are poisonous, affix a "poison" label to the container. If medicines prescribed for internal use are poisonous, use sound judgment whether to label them "poison" based on the finished preparation's potency in each case.
- c. Medicinal preparations compounded or packaged in the pharmacy for subsequent issue will be identified and labeled with the full generic name, except that trade or brand names may be used provided trade or brand name product actually is in the container. The manufacturer's name, lot number, and expiration date, if any, will be shown on the label.
- d. Drug issued to clinics for subsequent reissue to outpatients shall be adequately labeled in the pharmacy.
- e. All multiple dose injectable vials shall be dated upon opening. Expiration will normally be thirty days unless:
- (1) the product is expensive and manufacturer's information guarantees the product is usable beyond 30 days, or

(2) product information indicates a shorter expiration date.

8. Drug Stock.

- a. The person responsible for the pharmacy's daily operations must authorize all orders procuring medications. The clinic finance officer shall verify funds are available for all procurements. For prime vendor requisitions, verify funds availability before entering the "ZOA" document entry in the Automated Requisition Management System (ARMS), not prior to the order being submitted to the prime vendor.
- b. The Defense Personnel Support Center is the primary source of medications for either the "Depot" system or prime vendor contracts. Use other Federal sources (Perry Point IHS Depot, Federal Supply Schedules, MLC-negotiated purchase agreements, etc.) may be used when, due to price or service advantages, it is determined to be the most cost-effective procurement method to meet the needs of the unit. Drug procurement from retail sources shall be done only when absolutely required for urgent patient needs and when other, less costly, sources cannot meet this need.
- c. Only those items that have been licensed and approved by the Food and Drug Administration (with the exception of vitamins with an established RDA) are authorized for use in Coast Guard health care facilities. Coast Guard health care facilities shall not purchase or dispense "herbal supplements" or "dietary supplements".
- d. In storage, separate external use medications from internal use medications and ophthalmic and otic preparations. Caustic acids such as glacial acetic, sulfuric, nitric, concentrated hydrochloric, or oxalic acid shall not be issued to clinics, but shall be stored in separate lockers, clearly marked as to contents. Methyl alcohol shall not be stored, used, or dispensed by the pharmacy.
- e. Store flammable drugs according to accepted fire safety regulations.
- f. Use solid-core doors with 1-inch (minimum), throw key-operated, dead-bolt locks shall be used for all pharmacy and medical supply areas. On "Dutch" doors, both sections shall have this type lock.
- g. Remove from stock drugs under testing in the FDA/DOD Shelf Life Extension Program; label them with the project number until results are received. While pending, use these items only in emergencies. Upon return of results, items should be destroyed or marked with new expiration dates and returned to stock. Oral contraceptives, ophthalmics, otics, and inhaler medications should not be extended. These items may be used, while pending, results, to offset medical allowance list requirements.
- h. The pharmacy shall maintain, in the pertinent clinic areas, an adequate supply of emergency medications, poison antidotes, and the poison control center telephone number. Containers for these items shall be closed with break-away seals to prevent

the unreported removal of items. The outside of the container shall contain an inventory list containing the expiration dates of dated items.

- i. Where feasible, pharmacies shall establish borrowing policies with local Government or civilian pharmacies to cover temporary supply shortfalls. The person responsible for the pharmacy shall maintain a log of items loaned or borrowed, and review and initial the log weekly to ensure prompt replacement of all items.

9. Pharmacy and Therapeutics Committee.

- a. This is a mandatory advisory committee in all Coast Guard health service treatment facilities having assigned medical officers. It should meet regularly, but at least four times a year. The committee is composed of, but not limited to the following: at least one physician, one dental officer, a pharmacy officer (when available), and a representative from medical administration. The chairman shall be a physician member. When a pharmacist is assigned, he or she is the secretary of this committee.

- b. The committee is an advisory group on all matters relating to the acquisition and use of medications. Its recommendations are subject to the approval of the Chief, Health Services Division. The basic responsibilities of this committee are to:

- (1) Use the Department of Defense Basic Core Formulary (DoD BCF) as guidance to develop and maintain a clinic drug formulary as specified in 10-A-2.c.; the group reviews new and deletes unnecessary items.
- (2) Maintain a health service technician formulary selected from products authorized by the Coast Guard Standardized Health Services Technician Formulary;
- (3) Ensure the unit formulary does not include items based primarily on civilian prescriber demand;
- (4) Prevent unnecessary therapeutic duplications of formulary products;
- (5) Conduct an ongoing review of all non-formulary items the pharmacy procures and dispenses. To accomplish this, the clinic and/or P&T committee lists:
 - (a) A list of all clinic formulary items not currently in the DoD BCF;
 - (b) A list of all special order items and the number of patients for whom procured (add special order items procured for seven or more patients to the unit formulary);
- (6) Conduct an ongoing drug usage evaluation (DUE) program for selected medications;
- (7) Monitor the facility's controlled drug prescribing and usage;
- (8) Review pharmacy policies and procedures as necessary;
- (9) Monitor the quality and accuracy of prescriptions and patient information the pharmacy provides and enacts any quality assurance measures it deems

necessary (double checks, etc.) to ensure pharmacy quality and availability of services; and

- (10) Reviews any adverse reaction or product quality reports (VAERS or MEDWATCH) before any drugs or vaccines are released.
- c. Minutes shall be prepared for each meeting and approved by the Chief, Health Service Division.

FIGURE 10-A-1

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
NEW PRESCRIPTIONS (WITH CLAMS):			
08 Aug 91	P:O Rxs:	HCTZ 50 MG, *1 TAB QD, RFX1	#1842
0930		Clonidine 0.1 MG, *1 TAB BID, RFX1	#180 #1843
			MJ
		(2) F/U 6 months	
			CDR J. James M.D. John James
NEW PRESCRIPTIONS (WITHOUT CLAMS):			
08 Aug 91	P:O Rxs:	HCTZ 50 mg, *1 Tab QD, RFX1	#1842
0930		Clonidine 0.1 mg, *1 Tab BID, RFX1	#180 #1843
			Barr/Exp 6/91/Lt #624833
			AT/18A23/AS
			CDR JOHN JAMES M.D.
REFILL PRESCRIPTIONS (WITH CLAMS):			
06 Nov 91	Rx R.Fill:	Rfx #1842 (HCTZ) #1843 (Clonidine)	MJ
1415			
REFILL PRESCRIPTIONS (WITHOUT CLAMS):			
06 Nov 91	Rx R.Fill:	Rx #1842 (HCTZ) *90, NR	
1415		Barr / Exp 6/91 / Lt #624833	MJ
		Rx #1843 (Clonidine 0.1 MG) *180, NR	
		BI / Exp 6/95 / Lt #18A23	
OVER			
PATIENT'S IDENTIFICATION (Use this space for Mechanical Properties)			
RECORD MAINTAINED AT: USCG Headquarters Clinic			
PATIENT'S NAME (Last, First, Middle Initial): Flyer Joseph R.		SEX: M	
RELATIONSHIP TO SPONSOR:		STATUS: A/D	RANK/GRADE: CDR
SPONSOR'S NAME:		ORGANIZATION: STA ALEXANDRIA	
DEPT./SERVICE: CG	ISSN/IDENTIFICATION NO.: 000-00-0000	DATE OF BIRTH: 10 JAN 49	

FIGURE 10-A-2: PRESCRIBING GUIDELINES FOR EXPENSIVE MEDICATIONS

DRUGS INCLUDED	GUIDELINES
1. Cholesterol and Lipid Lowering Agents	
Lovastatin and other similar agents to reduce cholesterol and lipid levels	<p>Patients prescribed these products shall have:</p> <p>A. Documented hyperlipidemia confirmed by at least one of these baseline laboratory values:</p> <ol style="list-style-type: none"> 1. Fasting Total Serum Cholesterol > 240 mg/dl 2. Fasting serum LDL > 160 mg/dl or > 130 mg/dl if risk factors present 3. Fasting HDL < 35 mg/dl 4. Fasting Serum Triglyceride Levels > 250 mg/dl
2. Antibiotics	
Amoxicillin and Potassium Clavulanate (Augmentin), Azithromycin (Zithromax), Cefaclor (Ceclor), Cefixime (Suprax), Cefuroxime (Ceftin), Ciprofloxacin (Cipro), Clarithromycin (Biaxin), Erythromycin/Sulfasoxazole (Pediazole)	<p>Limit use of these and other more costly antibiotics to patients who have unsuccessfully taken more traditional, less expensive antibiotics or where culture and sensitivity testing confirms organism sensitivity. Use these drugs for initial therapy only if Sanford's <i>Guide to Antimicrobial Therapy</i> indicates they are the primary agent of choice.</p>
3. Smoking Cessation Aids	
Nicotine gum and patches (any manufacturer), and other products used for smoking cessation	<p>Behavioral modification is the primary method of smoking cessation; do not prescribe smoking cessation aids to patients without proof of ongoing participation in a "recognized" program that consists of regularly scheduled patient interaction with a smoking cessation facilitator. Do not prescribe smoking cessation products for anyone who continues to smoke after the initial two weeks of therapy.</p>
4. Antihistamines	
Fexofenadine (Allegra), Loratadine (Claritin)	<p>All patients prescribed these products shall have:</p> <ol style="list-style-type: none"> 1. Previously documented failure to obtain relief of symptoms with at least one antihistamine or one antihistamine-and-decongestant combination or documented history of intolerance to antihistamines' sedative effects. 2. A consulting physician's prescription for unresolved allergy problems. 3. Current aircrew qualification with documented allergies.

CHAPTER 12

OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

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CHAPTER 12. OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

Section A - General Requirements.

1. Description.

- a. The work environment and occupational activities inherent to Coast Guard missions can expose personnel to health hazards with the potential for disease or injury. The Occupational Medical Surveillance and Evaluation Program (OMSEP) is designed to identify work related diseases or conditions, through baseline and periodic examinations, at a stage when modifying the exposure or providing medical intervention could potentially arrest disease progression or prevent recurrences. The fundamental purpose of this program is to identify pre-existing health conditions, provide risk specific periodic screenings, and monitor clinical laboratory tests and biologic functions suggestive of work related environmental exposures. All OMSEP enrollees receive periodic physical examinations, in accordance with Occupational Safety and Health Administration (OSHA) requirements, for the duration of their health hazard exposure or end of their employment. Individuals are released from active surveillance at the end of their exposure. In accordance with OSHA regulations, the OMSEP personnel tracking database containing the name, social security number, billet or occupation code, applicable examination protocols, and next physical examination due date remains active for an additional 30 years.
- b. The OMSEP is the physical examination process for the Coast Guard's Occupational Health Program. The guidance for this program is outlined in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series). OMSEP replaces the present version of the physical exam process described in the SEH Manual as the Occupational Medical Monitoring Program (OMMP).

2. Enrollment.

- a. Coast Guard Medical Surveillance Action Level: The medical surveillance action level (MSAL) is the level of worker exposure, determined by workplace sampling, at or above which occupational medical surveillance examinations will be performed. The Coast Guard MSAL will be 50% of the most stringent of the current OSHA permissible exposure limit (PEL), or, the most current American Conference of Governmental Industrial Hygienists (ACGIH) Threshold Limit Value (TLV).
- b. Determination of Occupational Exposure.
 - (1) An employee is considered occupationally exposed for OMSEP purposes if an exposure or hazardous condition is likely to occur **30 or more days per year**. Documentation of the exposure must meet the following criteria: quantitative work-site sampling measurements indicate hazard levels at or above the MSAL or that the exposure can reasonably be determined, in the absence of quantitative sampling, to exceed the MSAL.
 - (2) Quantitative sampling is the primary and definitive means to characterize workplace health hazards, although personal sampling measurement is preferred to workplace sampling. Coast Guard Safety and Environmental Health Officers (SEHOs) using guidance contained in the Safety and Environmental Health

Manual, COMDTINST M5100.47 (series) will generally perform this function. SHEOs will normally characterize workplaces by frequency of exposure, type of exposure, and risk groups.

- (3) Certain occupations or exposures may require surveillance by federal statutes, DOT regulations, or Safety and Environmental Health Manual, COMDTINST M5100.47 (series) without regard to the 30-day exposure threshold.
 - (4) Competent environmental health authority is considered to be the cognizant SEHO but the authority may be delegated to other recognized and approved personnel with the necessary technical training and abilities. Qualitative assessments must be based on expected type, frequency, mode, and duration of hazard exposure, and are considered temporary until validated by quantitative means.
 - (5) **Unit Directives and/or Standard Operating Procedures (SOP's)- enrollment guidelines and monitoring criteria developed and approved, at the unit level, by ALL cognizant parties (Health Services Division; Safety and Environmental Health; Industrial Hygiene-Unit Command) are acceptable so long as they comply, with the enrollment criteria set forth in Section A-2, b (1-4) above.**
- c. Enrollment Criteria: Recommendations for enrollment are based on specific job assignments and the level of worker exposure. This process is initiated at the unit level and must be finalized by the IH or cognizant SEHO, with recommendations from the supervising medical officer (if necessary), before forwarding to Maintenance and Logistics Command (MLC (k)) via the OMSEP database (see section 12-A-3-(a)-3). Personnel will be enrolled in the OMSEP if either of the following criteria are met:
- (1) Personnel identified as occupationally at risk/exposed to hazardous chemicals or physical agents at levels documented or reasonably determined to be above the CG Medical Surveillance Action Level (MSAL) for that hazard,
 - (2) Personnel actively engaged for 30 or more days per calendar year in the following occupations will be enrolled in OMSEP, unless an IH investigation determines individuals are not exposed to toxic chemicals or physical hazards: resident inspectors, pollution investigators, marine safety (general), port safety (general), vessel inspectors or marine investigators; and fire fighters.
 - (3) Note: New OMSEP enrollees may be considered for enrollment under the guidelines of the Hazardous Waste Protocol, which provides the most thorough surveillance for those with unknown hazardous risks and no prior history of exposures. However, the unit IH or cognizant SEHO may recommend enrollment using the medical surveillance protocol considered most appropriate.

3. Reporting Requirements.

a. Examination Reports:

- (1) Required forms: OMSEP Initial/Baseline and Exit/Separation physical examinations require completion of the most current version of CG Form 5447 (7-02) in addition to forms DD-2808 and DD-2807-1. **Periodic examinations require completion of the most current version of the CG Form 5447A(07-02) and any Acute Exposure requires completion of the Acute Exposure**

Information Form. Other OMSEP specific forms and their uses are presented in Chapter 4 of this Manual.

- (2) Record keeping: OMSEP personnel records will be handled in the same manner as other medical records (see Chapter 4 of this Manual) with the following exceptions: all x-ray, laboratory test, and related reports of examinations or procedures done for OMSEP purposes, as well as the medical record cover, shall be clearly labeled "OMSEP." All OMSEP examination reports, including all laboratory data, must be entered into the individual's health record and maintained in accordance with OSHA regulations. The member's medical record custodian will maintain all OMSEP medical records on file for the duration of employment. Upon separation or retirement, all records concurrently labeled "OMSEP" will be maintained, for an additional 30 years, as required by OSHA regulations [29 CFR 1915.1120].
 - (3) OMSEP database: MLC (k) will maintain an electronic database of all OMSEP enrollees based on enrollment information provided by the local units and will be accessible to the commands in accordance with privacy act requirements. The OMSEP personnel tracking database should include, at a minimum, the member's name, social security number (SSN), billet or occupation code, applicable examination protocols, and next physical examination due date. The handling of all data in the OMSEP database will comply with Privacy Act requirements.
 - (4) Substitutions: OMSEP examination forms may not be substituted for other examination forms. If another examination is anticipated/required, (i.e. FLIGHT, RELAD) at the same time as the OMSEP examination the appropriate forms for each particular examination should be provided to the examiner so they may be completed at the same time. Duplicate laboratory tests are not required, so long as all specific tests and procedures required for each exam are completed and reported.
 - (5) Exposure data records: Any available exposure data, from workplace surveys, industrial hygiene personal or area monitoring, material safety data sheets, or assigned IH/SEHO other appropriate sources, will be provided by OMSEP coordinator to the examining medical officer as part of the examination packet. These data should be supplied by the local unit, in coordination with the supporting industrial hygienist, prior to the examination. The protocols in Section 12-C, in addition to OSHA regulations, specify what exposure surveillance data must be maintained and made available to the examining medical officer.
- b. Individual units, in coordination with the cognizant SEHO, are responsible for creating and managing a roster of all OMSEP enrollees, **and providing this information to the designated medical officer (DMOA)/clinic and MLC (k)'s. This information may be accessed at any time through the database. No written reports are required.**
 - c. Sentinel Occupational Health Event Reporting: The occurrence of a new illness or disease, which is likely associated with an occupational exposure or condition, may be considered a "sentinel event." Such an event may serve as a warning signal that the quality of preventive measures may need to be improved. In order to facilitate timely intervention, the initial diagnosis of any such diseases must be reported IAW Section 7-B of this Manual. A complete list of reportable occupational diseases is found in Figure 7-B-2.

4. Medical Removal Protection. It is the responsibility of the commanding officer to assure a safe and healthy working environment. The finding of a work-related illness or injury, which could be further exacerbated by continued exposure to a workplace hazard or condition, requires immediate evaluation to determine whether the worker must be at least temporarily removed from further exposure. A recommendation to remove the member should be made **to the unit's Commanding Officer** by the examining medical officer **in coordination with the cognizant SEHO**. (see section 12-B-4-b.)
5. Roles and Responsibilities. The OMSEP is part of a larger and more comprehensive surveillance process requiring the coordinated effort of various district units and local commands working to secure the safety and health of Coast Guard workers. Key personnel have been identified as essential in maintaining a sound occupational health prevention program. Following is a description of their expected roles and responsibilities in this process: NOTE: For the purposes of this Chapter all references to employees, workers, personnel will be assumed to be part of the ONE CG TEAM concept. Rules, regulations, and directives apply equally to ALL unless otherwise specified.
 - a. Units/Commands: Each unit must appoint an OMSEP coordinator, usually the Safety Coordinator (SC) or the Safety and Occupational Health Coordinator (SOHC), or Independent Duty Corpsman. Even if units are under one servicing clinic, the unit is still required to appoint an OMSEP coordinator. The OMSEP coordinator is responsible for updating the database of OMSEP enrollees, ensuring OMSEP examinations are completed in a timely fashion, and ensuring all available exposure data is available to the medical officer at the time of the OMSEP examination.
 - b. MLC (k): MLC (k)'s will ensure that SEHO work-site monitoring and reporting is completed and entered into the appropriate database. Additionally they will provide oversight to the local units ensuring the accuracy and completeness of the OMSEP personnel database. The MLC (k)'s medical officers will provide oversight over the physical examination consultation and referral process. MLC (k)'s will also provide indicated guidance and or training to HS personnel on examination practices and procedures.
 - c. SEHOs: SEHOs are required to review all requested OMSEP enrollments from the unit OMSEP Coordinators. SEHOs will approve or disapprove requested enrollments through the on-line database. Disapprovals need to be explained to the requesting unit. To substantiate enrollments, SEHOs are required to conduct and update quantitative and/or qualitative IH assessments of their units' workplace environment. SEHOs are required to have these written assessments available to the medical officer for review, if requested, to determine the appropriate medical surveillance protocol to use. SEHOs are also required to provide training and day-to-day consultation with their unit OMSEP Coordinators on database management, enrollment criteria and reporting requirements.
 - d. Commandant (G-WKS): Commandant (G-WKS) will provide planning, development, and expertise on occupational health issues. G-WKS is responsible for policy making, procedural decisions, and ensuring currency of Chapter 12 of the Medical Manual with OSHA standards. The G-WKS occupational medicine medical officer will provide support on physical examination problems and review all diagnosed occupational health

related abnormalities encountered by the on-site provider, will be provided to onsite providers. G-WKS is the final authority on decisions of any OMSEP related problems.

e. Medical Officer's Responsibilities:

- (1) Medical Diagnosis coding. The examining medical officer is responsible for explaining and/or following any abnormalities through to a resolution. All diagnoses made must be appropriately coded **using the International Classification of Diseases (ICD), clinical modification's most current revision**. ICD codes should be noted in parentheses next to the diagnosis on the examination report and be reported to the fifth digit.
- (2) Written assessment or opinion. Whenever a physical exam is performed, the examining medical officer must include the following information in writing as part of the record of each examination. This information should be included in the appropriate blocks.
 - (a) The occupationally pertinent results of the medical examination.
 - (b) An opinion about adequacy of the information available to support any diagnosed occupational disease(s), if appropriate.
 - (c) Any recommended limitations to the employee's assigned work.
 - (d) A statement that the employee has been informed about the results of the examination. (see Section 12-B-3-j.)
 - (e) Any additional written information required by the protocols listed in Section 12-C.

f. Medical Administrators:

- (1) Support. Medical Administrators are responsible for providing administrative assistance on all OMSEP related matters. This support should extend to :
 - (a) All units within the designated AOR.
 - (b) Contracted medical providers and their respective facilities.
 - (c) IDT's.
- (2) OMSEP report/worksite data. Medical Administrators should interact with OMSEP coordinators within their AOR to ensure currency of the roster of enrollees and ensure that work-site information is received in a timely manner. Worksite exposure information, reported history of past exposures and Material Safety Data Sheets (if needed) should precede the physical examination to give the medical officer ample time to reach an educated decision.
- (3) Physical Examinations/Medical Records. The Medical Administrator is responsible for the following clinic functions in support of OMSEP:
 - (a) Timely scheduling of physicals.

- (b) Providing qualified technicians to perform the indicated laboratory and radiological procedures.
 - (c) Ensuring proper calibration of equipment, and
 - (d) Compliance with quality assurance standards.
- g. Civilian Employees: Civilian OMSEP enrollees may be entitled to services provided by Coast Guard medical facilities should a determination be made by the Safety and Environmental Health Officer and confirmed by a medical provider, that an adverse health condition resulted from a work place exposure. Employees are expected to report and explain any illnesses or injuries resulting from exposure sources outside their primary duty station or from other non-occupational settings. Should a determination of an injury or illness, resulting from an exposure at the workplace, be made by a medical provider, civilian appropriated fund employees should contact their servicing civilian Command Staff Advisor (CSA) for assistance in making a claim with the Department of Labor. Non-appropriated fund employees (NAF) should contact their immediate supervisor and/or personnel liaison office. The services provided by the Coast Guard facilities will be only to establish an occupationally-related illness/injury. Further medical care should be provided by the civilian employee's health care provider.
- h. Others: In the event of an emergency situation with heavy exposure (e.g., fire, spill), 24-hour assistance is available from the Agency for Toxic Substances Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-498-0210.

Disease Registry (ATSDR) at the Centers for Disease Control and Prevention.
Call 404-639-0615-6360.

LIST OF ABBREVIATIONS

ACGIH	American Conference of Governmental Industrial Hygienists
ALT	Alanine aminotransferase
AST	Aspartate amino transferase
BUN	Blood urea nitrogen
CBC	Complete blood count
CNS	Central nervous system
CXR	Chest x-ray
DOT	Department of Transportation
EL	Excursion limit (OSHA mandated maximal “safe” airborne concentration of a substance)
FVC	Forced vital capacity
FEV-1	Forced expiratory volume at one second
ICD-9	International Classification of Diseases, (coding system for medical diagnoses.)
IH	Industrial hygiene or industrial hygienist
LDH	Lactic dehydrogenase
MCV	Mean corpuscular volume
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin concentration
MLC (k)/(kse)	Maintenance and Logistics Command: (k)-medical; ((kse)-safety & environmental health.
MO	Medical officer (physician, physician’s assistant or nurse practitioner)
MSAL	Medical surveillance action level (Defined in 12-A-3)
OMSEP	Occupational Medical Surveillance and Evaluation Program
OSHA	Occupational Safety and Health Administration
PEL	Permissible exposure limit (The OSHA mandated TWA airborne exposure limit)
PFTs	Pulmonary function tests

LIST OF ABBREVIATIONS (continued)

RBC	red blood cell
SC	Safety Coordinator
SEHO	Safety and Environmental Health Officer
SOHC	Safety and Occupational Health Coordinator
STEL	Short-term exposure limit (The maximal “safe” airborne concentration of a substance)
STEL/C	Short-term exposure limit/ceiling (maximal “safe” airborne concentration of a substance)
STS	Significant threshold shift
TB	Tuberculosis
TLV	Threshold limit value (ACGIH) (The TWA airborne concentration of a substance)
TST	tuberculin skin test (Mantoux)
TWA	time-weighted average
U/A	Urinalysis

Section B - Administrative Procedures.

1. General: All medical examinations and procedures required under the OMSEP shall be performed by or under the supervision of a licensed medical officer and an accredited laboratory shall perform all laboratory tests. Timely completion and monitoring of scheduled examinations is essential in identifying work related health hazards and any specific health effects. All tests required as part of an OMSEP examination should be completed prior to and the results made available to the health care provider at the time of the physical examination. This requirement may be waived if travel or time costs make separate visits impractical. **The provider is required to review, approve (sign), and explain any abnormalities. Any unexplained, examination finding, laboratory abnormality, or test result must be referred to a certified Occupational Health Clinic/provider for further evaluation.**
2. Examination Types.
 - a. Initial/baseline. Baseline examinations are required before placement in a specific job in order to assess whether the worker will be able to do the job safely, to meet any established physical standards, and to obtain baseline measurements for future comparison. Each baseline examination shall consist of all of the elements specified under the appropriate surveillance protocol(s) in Section 12-C. [Table 12-B-1](#) also summarizes the required forms and tests for a baseline examination under each of the surveillance protocols. In the event that the employee is being monitored under more than one protocol, each unique form or test need only be completed once for a particular examination.
 - (1) An initial examination is required for all employees prior to employment. The employee may not be exposed to a potential health hazard until the physical examination is completed. In the event of scheduling delays, this requirement may be waived, if the employee completes ALL the necessary laboratory tests specified under the appropriate surveillance protocol(s). The physical examination must still be completed at the earliest possible date, but not beyond 30 days after the initial date of employment. Longer delays will require temporary removal. Workers who transfer from operational to administrative positions on a frequent basis during the same duty assignment may, with medical officer approval, receive a periodic physical vice a complete baseline examination upon re-entering the hazardous work site.
 - (2) All employees must have an initial physical examination prior to reassignment to any position with an occupational health hazard exposure as defined in Section 12-A-2-b. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.
 - b. Periodic.
 - (1) **Periodic examinations are generally provided at twelve-month intervals, though under some protocols, the period between examinations may vary. Once enrolled in the OMSEP periodic examinations will be performed at the required interval for the duration of the health hazard. Members being monitored under more than one exposure protocol need to complete the CG-5447A, Periodic History and Report of OMSEP Examination form only once during a particular examination. The member should review the last CG**

5447, History and Report of OMSEP Examination form on record and annotate any changes, which may have occurred since the last examination. Each periodic examination shall consist of all of the elements specified under the appropriate surveillance protocol(s). (Section 12-C. and Table 12-B-1).

- (2) **Any OMSEP enrollee actively monitored, identified as a risk of exposure to a new health hazard requiring additional protocols, must complete all the required laboratory tests and procedures specified under the appropriate surveillance protocol(s). The employee must also complete the CG-5447A (Periodic History and Report of OMSEP Examination). The employee may not be placed at risk of exposure until the examination is completed. This requirement is subject to the stipulation described above in Section 12-B-1.**
- (3) Employees who transfer from operational to administrative positions on a frequent basis may, with medical officer approval, receive a periodic physical examination vice a complete exit (end of exposure) examination. This does not preclude a complete exit/separation examination upon the end of employment.
- (4) **Laboratory tests are required for most exposure protocols as part of the periodic surveillance examination. Laboratory tests are usually performed in accordance with the specific protocol. (Section 12-C. and Table 12-B-1). Members being monitored under more than one exposure protocol need to have similar laboratory test (i.e. CBC; U/A; Chem panel) performed only once during a particular examination. The medical provider may perform additional tests as often and as deemed necessary.**

c. Acute Exposure.

- (1) An acute health hazard exposure examination is required, when the applicable short-term exposure limit (STEL) ceiling limit of the substance(s) in question is exceeded. The requirement applies whether or not the employee exhibits any overt symptoms of acute exposure. Specific requirements, if any, for an acute exposure examination are found under the protocols in Section 12-C.
- (2) An acute health hazard exposure examination is required if the employee exhibits any adverse effects following an acute exposure to a suspected hazardous substance. If the substance(s) is identified, an examination should be performed following the specific protocol(s) for that substance(s). In the event no specific substance is identified, an examination should be directed according to the "Hazardious Waste" examination protocol and presenting symptoms. The Acute Chemical Exposure Information form (Figure 12-B-1) should be used to collect and organize information when an acute exposure occurs. The information on this form must accompany the employee to his/her examination.
- (3) All HAZMAT response personnel with a documented exposure event, including Coast Guard Strike Team members and firefighters, must complete an Acute Chemical Exposure Information form (Figure 12-B-1) at the end of each HAZMAT response. Special attention must be provided to the type, duration and degree of toxicity of the agent(s) encountered as well as the type of contact (inhalation, skin absorption, ingestion). The type of PPE utilized, type of respirator (if any), and protective clothing worn should also be noted. **This information is to be reviewed by the cognizant medical provider before entering into the medical record. Based on this information as well as any additional**

information from the exposure event, the medical provider may choose to direct an acute health hazard exposure examination. Specific requirements, if any, are found under the protocols in Section 12-C.

- d. Exit/Separation (Employment/Exposure). Exit exams are designed to assess pertinent aspects of the worker's health when the worker leaves employment or when exposure to a specific hazard has ceased. Results may be beneficial in assessing the relationship of any future medical problem to an exposure in the workplace. Exit physical examinations must be completed within 30 days of the last day of exposure or employment. The worker may not be re-assigned to a hazardous area once the examination is completed. In the event the worker is exposed to a hazardous substance, after completing the examination, ALL laboratory tests required by the specific protocol for that particular substance must be repeated (see [Table 12-B-1](#) and Section 12-C). The following conditions also apply:
- (1) End of Exposure:
 - (a) OMSEP enrollees assigned to a non-hazardous work environment but likely to be assigned to a designated area later in their **career should receive an end of exposure examination including completion of the CG-5447A (Periodic History and Report of OMSEP Examination)**.
 - (b) Individuals enrolled in the OMSEP, with exposures to known carcinogens or agents with prolonged latency periods for disease development (e.g., asbestos, benzene), will receive an end of exposure exam including completion of the CG-5447A upon reassignment to non-hazardous area and continue to receive periodic annual physicals according to the designated protocol(s). These individuals will be monitored for the duration of their Coast Guard career unless the responsible supervising medical officer or other cognizant medical authority determines such monitoring is not required.
 - (2) End of Employment:
 - (a) OMSEP enrollees permanently separating from Coast Guard employment should receive an end of employment examination, **including completion of the CG-5447 (History and Report of Examination Form) specified laboratory tests and procedures and any required consultations and referrals**.
 - (b) At the time of the examination the member's permanent home of record and phone number must be secured for notification of any abnormalities. A copy of the member's occupational health history, including all potential exposure agents, severity and duration of exposure, and any recommendations on future protocol testing or examinations, must be placed in the member's medical record. A personal copy should also be provided to the member. (see Section 12-B-3-j).
 - (c) **All members must be provided with a personal copy of the "Separation Letter" in addition to the one placed in the member's medical record. Upon request, the member should also be provided with a copy of the "Medical Officer's Report," part 2 of the CG-5447.**

- e. Timing of next examination. The default interval between examinations is one year for all protocols except respirator wear and prior (not current) exposure to asbestos, in which case the default interval is five years. However, **a medical officer may recommend for any individual patient a shorter interval between examinations than the default period, if such is medically indicated**. Any recommendation on the timing of the next examination should be included as part of the physician's written assessment.
3. Use of OMSEP Forms.
- a. CG Form 5447 (03-03) (History and Report of OMSEP Examination). This form must be completed whenever an OMSEP (**initial or separation**) physical examination is required, except when only annual hearing conservation program is needed. Ensure that the examinee and medical officer identifying information are accurately recorded, including phone numbers. All history sections on the CG-5447 must be completed.
- b. CG Form 5447A (03/03) (Periodic History and Report of OMSEP Examination). **This form must be completed whenever a periodic OMSEP physical examination is required. The examinee must review the last CG-5447 form or record and note any changes, which may have occurred since the last examination. If there have been no changes during the interval from the last examination, the examinee should mark the appropriate box in each of the sections.**
- c. OSHA Respirator Medical Evaluation Questionnaire-(mandatory). This questionnaire is to be completed by any worker who is to be issued a respirator or assigned to a task that may require a respirator.
- d. CG-5140 (Audiometric Biological Calibration Check). This form is to be used to record calibration of the audiometric equipment.
- e. DD Form 2215 (Reference Audiogram). This form is used to record initial audiometric test results.
- f. DD Form 2216 (Hearing Conservation Data). This form is used to record the results of periodic and follow-up audiometry for individuals routinely exposed to hazardous noise. This form should be preceded by a reference audiogram (DD Form 2215 or other record) already on file in the individual's health record.
- g. Notification of Summary Results. A sample of this form is provided in (Figure 12-B-2). A photocopy or a locally generated form may be used to provide the required notification to the enrollee of the results of his/her OMSEP examination.
- h. Acute Exposure Information Form. This form is used to record the results of any unexpected exposures and for verification of notification of the appropriate agencies. A sample of this form is provided in (Figure 12-B-1).
- i. Separation Letter. This letter serves as notification of the member's documented exposure(s) while serving in the US Coast Guard. It provides the nature and levels of exposure(s), if known, and the medical provider's comments and recommendations. **A sample letter is found as (Figure 12-B-4), and can be completed from this Manual. Copies of this letter should be placed in the official health record and also provided directly to the member.**

- j. Patient Notification. The medical officer is responsible for notifying the patient of any and all abnormalities found or diagnoses made, whether or not they are occupationally related or simply an incidental finding. Notification must be made within 30 days of completion of the examination and should be documented as a medical record entry (Figure 12-B-2).

4. Medical Removal Standards

- a. The following abnormal laboratory findings during an OMSEP examination mandate immediate removal of the employee from further workplace exposure to the hazard listed, pending resolution of the abnormality or a determination that the abnormality is not due to a workplace exposure. The medical officer should coordinate all medical removal recommendations with the cognizant SEHO before forwarding to the commanding officer (CO).
 - (1) Benzene (any of the following):
 - (a) The hemoglobin/hematocrit falls below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.
 - (b) The thrombocyte (platelet) count varies more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.
 - (c) The leukocyte count is below 4,000 per mm³ or there is an abnormal differential count.
 - (2) Lead: A blood lead level at or above 40µg/100 ml of whole blood.
 - (3) Noise: A loss of hearing of ≥ 25 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz), compared with the current reference audiogram.
 - (4) Organophosphate pesticides: cholinesterase level at or below 50% of the pre-exposure baseline.
- b. Pregnancy is not a reason for automatic medical removal from the workplace. A decision to remove or restrict a pregnant woman must be based on sound clinical judgment after careful consideration of the workplace environment and the woman's physical capabilities. The woman's pre-natal health care provider (obstetrician) should be apprised early of any/all potential hazards and safety precautions available.

5. Reporting of Examination Results

- a. Coast Guard medical officers will have 30 days from completion of the examination to meet all medical officer responsibilities in Section 12-B-4.
- b. Contractual providers, IDTs, and other detached HSS/units must forward all OMSEP examination questions, problems, and any unresolved matters, with accompanying supporting information, to the assigned CG medical officer for review within 15 days of receipt (includes the examination and any additional testing or consultations).
- c. All records must be forwarded to the record custodian upon compliance with Sections 12-B-6- (a) and 12-B-6 (b) above.

**Table 12-B-1
REQUIRED FORMS AND TESTS FOR VARIOUS OMSEP EXAMINATIONS**

Exam Type Exposure Protocol	Initial/Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
ASBESTOS	CG-5447 * OSHA Resp. Quest. DD-2808 / DD-2807-1 * (a) Stool Guaiac PFTs / "B" Reader CXR / CBC / Multichem panel / U/A w/micro	CG-5447A * (a) Stool Guaiac PFTs / "B" Reader * (b) CXR CBC / Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 Stool Guaiac PFTs / "B" Reader CXR / CBC / Multichem panel U/A w/micro OSHA Respiratory Questionnaire	Acute Exposure Form	N/A
BENZENE	CG-5447 DD-2808 / DD-2807-1 CBC w/diff / Platelet count / RBC / Indices / Multichem panel U/A w/micro	CG-5447A CBC w/diff / Platelet count / RBC / Indices / Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 CBC w/diff / Platelet count / RBC / Indices / Multichem panel U/A w/micro	Urinary phenol CBC w/diff / Platelet count / RBC / Indices Acute Exposure Form	Only under special circumstances. Contact G-WKS-3
CHROMATES	CG-5447 DD-2808 / DD-2807-1 CXR / PFTs / CBC Multichem panel U/A w/micro	CG-5447A PFTs / CBC Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 CXR / PFTs / CBC Multichem panel U/A w/micro	Acute Exposure Form	N/A
HAZARDOUS WASTE	CG-5447 DD-2808 / DD-2807-1 Vision Screening CXR / PFTs / CBC w/diff Multichem panel U/A w/micro	CG-5447A Vision Screening PFTs / CBC w/diff Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 Vision Screening CXR / PFTs / CBC w/diff Multichem panel U/A w/micro	Acute Exposure Form PFTs / CBC w/diff Multichem panel U/A w/micro * (c) Heavy Metal Screen	Only under special circumstances. Contact G-WKS-3

- Notes:
- ◆ OSHA Medical Evaluation Respiratory Questionnaire. DD Form 2493-1/2493-2 Asbestos Report may be required at medical DoD facilities.
 - ◆ * (a) only if patient is age 35+ or otherwise clinically indicated.
 - ◆ * (b) B-reader chest x-rays will be done at periodic examinations according to the following schedule:

Years since last exposure	Age of examinee		
	15 to 35	36 to 45	over 45
0-10	Every 5 yrs	Every 5 yrs	Every 5 yrs
Over 10	Every 5 yrs	Every 2 yrs	Annually

- ◆ * (c) Heavy metal screen includes blood lead, cadmium, mercury, and arsenic levels.

Table 12-B-1 (con't)
REQUIRED FORMS AND TEST FOR VARIOUS OMSEP EXAMINATIONS

Exam Type Exposure Protocol	Initial/Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
LEAD	CG-5447 DD-2808 / DD-2807-1 Blood lead & ZPP CBC w/diff Multichem panel U/A w/micro	CG-5447A Blood lead & ZPP CBC w/diff Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 Blood lead & ZPP CBC w/diff Multichem panel U/A w/micro	Acute Exposure Form Blood lead & ZPP CBC w/diff Multichem panel U/A w/micro	Blood ZIPP
NOISE	DD Form 2215 CG-5447 DD-2808 / DD-2807-1	DD Form 2216	DD Form 2216 CG-5447 DD-2808 / DD-2807-1	Acute Exposure Form DD Form 2216	N/A
PESTICIDES	CG-5447 DD-2808 / DD-2807-1 Blood Cholinesterase, twice / PFTs / CBC w/diff / Multichem panel / U/A w/diff	CG-5447A *(d) Blood Cholinesterase PFTs / CBC w/diff Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 *(d) Blood Cholinesterase PFTs / CBC w/diff Multichem panel U/A w/micro	Acute Exposure Form *(d) Blood Cholinesterase PFTs	* (d) Blood Cholinesterase
RESPIRATORY SENSITIZERS	CG-5447 DD-2808 / DD-2807-1 PFTs / CBC w/diff Multichem panel U/A w/micro	CG-5447A PFTs / CBC w/diff Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 PFTs / CBC w/diff Multichem panel U/A w/micro	Acute Exposure Form PFTs	N/A
SOLVENTS	CG-5447 DD-2808 / DD-2807-1 CBC w/diff Multichem panel U/A w/micro	CG-5447A CBC w/diff Multichem panel U/A w/micro Biological moni-toring (if possible)	CG-5447 DD-2808 / DD-2807-1 CBC w/diff Multichem panel U/A w/micro	Acute Exposure Form Specific blood or urine tests for specific solvents.	Specific blood or urine tests specific solvents. (see Section 12- C-11.d.)
RESPIRATOR WEAR (only)	CG-5447 ** OSHA Resp Quest	** ORQ (update)	** OSHA Resp Quest	N/A	N/A

Note: ◆ ***(d)** Blood Cholinesterase only required if exposure includes organophosphate and/or carbamate pesticides.
 ◆ ****** Respiratory: OSHA Respiratory Questionnaire, this form is provided at the unit level (worksites), (Reference Section 12-C-9).

Table 12-B-1 (con't)
REQUIRED FORMS AND TESTS FOR VARIOUS OMSEP EXAMINATIONS

Exam Type Exposure Protocol	Initial/Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
TUBERCULOSIS	CG-5447 DD-2808 / DD-2807-1 * (e) Tuberculin skin test (TST)	CG-5447A * (e) Tuberculin skin test (TST)	CG-5447 DD-2808 / DD-2807-1 * (e) Tuberculin skin test (TST)	Acute Exposure Form * (e) Tuberculin skin test (TST)	N/A
BLOODBORNE PATHOGENS	CG-5447 DD-2808 / DD-2807-1 CBC Multichem panel U/A w/micro	CG-5447A CBC Multichem panel U/A w/micro	CG-5447 DD-2808 / DD-2807-1 CBC Multichem panel U/A w/micro	Acute Exposure Form CBC Multichem panel U/A w/micro	Only under special circumstances. Contact G-WKS-3

NOTES:

- ◆ *(e) Personnel with a history of reactive tuberculin skin tests should be monitored for development of symptoms of active TB. A CXR should be done only if the skin test is newly reactive.

**Figure 12-B-1
ACUTE EXPOSURE INFORMATION FORM**

This form is subject to the Privacy Act Statement of 1974

Last Name, First Name, Middle Initial: _____	SSN: _____	Date: _____	Time: _____
ONE FORM FOR EACH EXPOSURE			
Name of chemical exposed to: _____			
Chemical Abstract Services (CAS) number, if known: _____			
Physical form: <input type="checkbox"/> Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Gas/Vapor <input type="checkbox"/> Aerosol			
Chemical form: <input type="checkbox"/> Acid <input type="checkbox"/> Alkali <input type="checkbox"/> Organic Solvent <input type="checkbox"/> Heavy Metals			
Modes or routes of exposure: <input type="checkbox"/> Inhalation <input type="checkbox"/> Ingestion <input type="checkbox"/> Skin <input type="checkbox"/> Other _____			
Exposure duration: <input style="width:200px; height:20px;" type="text"/> _____			
Brief description of the incident: _____			
Observed symptoms: _____			
Associated injuries: _____			
Personal protective equipment used: _____			
Notify District/ISC Safety & Environmental Health Officer, cognizant MLC (kse), and G-WKS-3.			
Further guidance received: _____			
Contact ATSDR emergency response line at 404-498-0210 to obtain further guidance.			
ATSDR guidance: _____			
Attach Material Safety Data Sheet (MSDS) and shipping manifest to this form, if available.			
Reviewing Authority Signature: _____			Date: _____

FIGURE 12-B-2

OMSEP

NOTIFICATION OF SUMMARY RESULTS

Date of Examination: _____

Patient: _____ SS#: _____

Address: _____

Phone #

Reference. (a) Medical Manual, COMDTINST M6000.1(series).

1) An environmental health evaluation has determined that you may have been exposed to the following health hazards at your workplace:

2) Your physical examination was conducted in accordance to reference (a).

There **ARE** / ARE **NOT** abnormalities in your physical examination and laboratory testing.

NOTED ABNORMAL PHYSICAL FINDINGS OR LABORATORY TESTS	RESULT/INTERPRETATION

3) Additional comments on your Occupational Medical Surveillance and Evaluation physical

Name and Title of Health Care Provider: _____

Signature of Health Care Provider: _____

Date: _____

Figure 12-B-4

U.S. Department of
Homeland Security



United States
Coast Guard

United States Coast Guard

Staff Symbol: _____

PH: _____

FAX: _____

6120

Date: _____

MEMORANDUM

From: _____
Senior Medical Representative

To: _____

Subj: NOTIFICATION OF TERMINATION FROM THE OMSEP PROGRAM

Ref: MEDICAL MANUAL, COMDTINST M6000.1(series)

1. You have been enrolled in the Coast Guard's Occupational Medical Surveillance and Evaluation Program (OMSEP). During the past _____ years you received periodic physical examinations based on Occupational Health Safety Organization (OSHA) protocols for the following known potentially hazardous exposures:

2. Your occupational (work-related) history also indicates suspected exposure to the following agents:

3. At the time of your EXIT/SEPARATION medical examination you were found to be in good health with no evidence of occupational induced disease. However, it is recommended that you continue to receive medical examinations on a periodic basis on age indicated guidelines. In addition, the periodicity of the examination should be modified to allow for adequate detection and prompt intervention on disease processes resulting from the latent effects of occupational hazardous substances. Your medical provider should follow OSHA mandated recommendations, for the aforementioned hazardous substances, in determining the frequency and level of care you require.

4. Any questions relating to this member's occupational health history can be obtained by contacting the U.S. Coast Guard's Office of Safety and Environmental Health at # 202-267-1883.

Section C - Medical Examination Protocols.

1. General.

- a. The following protocols follow the same format. Each contains a brief description of the hazard and its possible effects; the conditions required for an individual to be surveyed under that protocol; information which must be provided to the examining medical officer; specific requirements of the history and physical, including laboratory tests and special procedures; and any additional written requirements on the part of the examining medical officer. The protocols are summarized in Figures 12-C-1 through 12-C-12. Copies of these figures may be locally reproduced. The unit OMSEP coordinator should complete the information in the first eight blocks at the very top, and the appropriate protocol summary figure(s) should be provided to the examining medical officer with the examination packet.
- b. Multiple protocols for a single individual. In the event that an individual is being monitored on more than one protocol (e.g., asbestos and noise), the final examination packet must include each of the required items for each of the protocols. However, each required form or test need only be completed once.
- c. Past exposure. Personnel who have a documented history of workplace exposure to known carcinogens, but who are not currently exposed, shall be offered an annual medical examination, according to this protocol until end of employment. Undergoing this examination is strictly voluntary.

2. Asbestos (Figure 12-C-1).

- a. Exposure effects. Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent. There is a synergistic effect between asbestos exposure and cigarette smoking, so that the risk of lung cancer is roughly ten times greater in asbestos-exposed workers who smoke as opposed to nonsmoking asbestos-exposed workers. The primary route of exposure is inhalation, though ingestion of fibers may also occur.
- b. Required surveillance.
 - (1) All personnel with current employment exposure to airborne asbestos, who meet the MSAL criteria in Section 12-C-2- (4) below, shall undergo medical surveillance. These personnel shall be included in the OMSEP and be examined according to the protocol in Section 12-C-2.d below. Medical examinations shall be provided upon enrollment and at least annually thereafter, throughout the duration of exposure or until end of employment, whichever comes first. Under current Coast Guard policies for management of asbestos, very few non-shipyard workers should be currently exposed at or above the PEL or EL.
 - (2) Construction worker standard. The OSHA standard for asbestos applies to, but is not limited to, workers who demolish, remove, alter, repair, maintain, install, clean up, transport, dispose of, or store asbestos containing materials.
 - (3) The current MSALs are based on the OSHA exposure standard for shipyards [29 CFR 1915.1001].

- (a) For other than shipyard and construction workers, medical surveillance is required for those employees who are or will be exposed at or above the PEL as an 8 hour time-weighted average, or above the EL averaged over 30 minutes, regardless of the number of days of exposure.
- (b) For shipyard and construction workers, medical surveillance is required for those workers:
 - 1 Who remove any asbestos-containing materials, or who perform repair and maintenance operations in which asbestos-containing materials are likely to be disturbed, if such work is performed for a combined total of 30 or more days per year, regardless of fiber levels;
 - 2 Who are exposed at or above the PEL or EL for a combined total of 30 or more days per year; or
 - 3 Who are required to wear positive pressure respirators while performing asbestos-related work, regardless of the number of days respirators are worn.
- c. Information to medical officer. The following information must be provided to the examining medical officer, by the OMSEP coordinator, prior to the examination taking place:
 - (1) A copy of the OSHA asbestos standards [29 CFR 1915.1001], with appendices D and E.
 - (2) A description of the affected employee's duties as they relate to the employee's exposure.
 - (3) The employee's representative exposure level or anticipated exposure level.
 - (4) A description of any personal protective or respiratory equipment used or to be used.
- d. Examination protocol.
 - (1) Each initial, periodic, and exit examination shall include, as a minimum:
 - (a) A medical and work history. Emphasis should be placed on the member's history of tobacco use (smoking), and associated symptoms of dyspnea on exertion, recurrent epigastric discomfort, pleuritic chest pains or unexplained cough.
 - (b) Completion of the OSHA Respiratory Medical Evaluation Questionnaire Appendix C to RP Standard 29CFR 1910.134. Note: additional information on asbestos reporting guidelines may be found at www.osha.gov.
 - (c) A complete physical examination of all systems, with emphasis on the respiratory system, the cardiovascular system, and digestive tract.

- (d) A stool guaiac test, if the patient is age 35 or over.
- (e) PFTs, including FVC and FEV1.
- (f) Routine screening labs, including a CBC, multichemistry panel (including glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and U/A with microscopic.
- (g) A postero-anterior (PA) CXR, in accordance with the schedule and interpretation requirements in Section 12-C-2-d(2) below;
- (h) Any other tests or procedures deemed appropriate by the examining physician, including specialty consultations.

(2) Chest x-ray requirements:

- (a) A PA CXR shall be performed at the initial examination and then according to the following schedule:

<u>Years since</u>	<u>Age of examinee</u>		
<u>First exposure</u>	<u>15 to 35</u>	<u>36 to 45</u>	<u>over 45</u>
0 to <u>10</u>	Every 5 yrs.	Every 5 yrs.	Every 5 yrs.
Over 10	Every 5 yrs.	Every 2 yrs.	Annually

- (b) A PA chest-x-ray shall be performed at the exit examination.
- (c) All CXRs shall be interpreted and classified in accordance with a professionally accepted classification system and recorded following the format of the CDC/NIOSH (M) 2.8 form. A B-reader or a board eligible/certified radiologist using the ILO-U/C International Classification of Radiographs for Pneumoconiosis references shall only do the interpretation.
- (d) Assistance in obtaining the location of the nearest B-reader is available from MLC (k).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the examining physician must address the following in writing:

- (1) Any detected medical conditions placing the employee at increased risk of health impairment from further asbestos exposure.
- (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.
- (3) Employee notification of the results of the examination and any medical conditions resulting from asbestos exposure that might require follow-up.
- (4) Employee notification of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

3. Benzene (Figure 12-C-2).

a. Exposure effects. Benzene exposure can cause central nervous system depression, leukemia, aplastic anemia, and dermatitis. The primary route of exposure is inhalation of vapors, though skin absorption may also occur. Within the Coast Guard, most benzene exposure occurs among marine inspectors and oil spill responders.

b. Required surveillance.

(1) The Coast Guard MSALs are based on the OSHA action level and PEL standards. Enrollment in the OMSEP is required for all personnel:

(a) who are or may be exposed to benzene at or above the current average exposure action level 30 or more days per year,

(b) who are or may be exposed to benzene at or above the current short-term exposure action level 10 or more days per year, or

(c) who served as resident inspectors, pollution investigators, marine safety officers, port safety officers, vessel inspectors, or marine investigators prior to 1990. These personnel are considered to have been exposed at/or above the MSAL unless otherwise documented.

(2) In addition to routine surveillance requirements above, if an employee is exposed to benzene in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs. after the exposure, and an acute exposure examination will be performed within 72 hrs. of the exposure. Such an examination must contain a urinary phenol test on the collected urine specimen.

c. Information to medical officer. The following information must be provided to the examining physician, by the OMSEP coordinator, prior to the examination taking place:

(1) A description of the affected employee's duties as they relate to the employee's exposure.

(2) The employee's representative exposure level or anticipated exposure level.

(3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed history which includes:

1 past occupational exposure to benzene or any other hematological toxins, at work or at home;

2 a family history of blood dyscrasias, including hematological neoplasms;

- 3 a personal history of blood dyscrasias, including genetic hemoglobin abnormalities, bleeding abnormalities, abnormal function of formed blood elements; and of renal or liver dysfunction;
 - 4 history of exposure to ionizing radiation;
 - 5 smoking history, alcohol usage history, and all medicinal drugs routinely taken;
 - 6 any current history of headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, or weight loss.
- (b) a complete physical examination, (Ensure the patient is examined for mental status changes, dermatitis, and pallor.);
 - (c) a CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC);
 - (d) a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;
 - (e) any other tests or procedures deemed appropriate by the examining physician.
- (2) Each acute exposure examination shall include, as a minimum:
- (a) a brief summary of the nature of the exposure and investigation of any symptoms or complaints;
 - (b) a total urinary phenol level (mg/L) or a urinary phenol adjusted for urinary creatinine (mg/g creatinine), plus a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC). Plasma folate and B12 levels to rule out megaloblastic anemia if the MCV is elevated.
 - (c) any other test or procedure deemed appropriate by the examining physician may be performed, if available. Coast Guard medical providers are encouraged to contact G-WKS for advise and consultation in selecting the most applicable test or procedure. Alternatively, medical providers may contact any certified Occupational Health clinic provider, available in the local community.
 - (d) If either the total urinary phenol level is below 50 mg phenol/L of urine, or the urinary phenol adjusted for urinary creatinine is less than 250 mg/g creatinine, and the CBC is normal, no further testing is required. Otherwise, contact Commandant (G-WKS-3) for further requirements.

- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the following must be addressed in writing by the examining medical officer:
 - (1) Any detected medical conditions, which would place the employee's health at greater than normal risk of material impairment from exposure to benzene.
 - (2) The medical officer's recommended limitations upon the employee's exposure to benzene or upon the employee's use of protective clothing or equipment and respirators.
 - (3) A statement that the employee has been informed by the medical officer of the results of the examination and any medical conditions resulting from benzene exposure which require further explanation or treatment.
- 4. Chromium Compounds (Figure 12-C-3).
 - a. Exposure effects. Hexavalent chromium compounds are known human carcinogens. They may also cause dermatitis, skin ulceration, occupational asthma, and nasal septum perforation. The primary routes of exposure are percutaneous absorption and inhalation. Chromates may be found in certain metal alloys, paints, and masonry cements. Within the Coast Guard, most chromate exposure is from the use of chromium containing paints.
 - b. Required surveillance. The Coast Guard MSALs are based on the ACGIH threshold limit values (TLVs). Medical surveillance is required for all personnel who are or may be exposed to chromium IV compounds at or above the current exposure action level 30 or more days per year.
 - c. Information to medical officer. The following information must be provided by the OMSEP coordinator to the examining physician prior to the examination taking place:
 - (1) A description of the affected employee's duties as they relate to the employee's exposure.
 - (2) The employee's representative exposure level or anticipated exposure level.
 - (3) A description of any personal protective or respiratory equipment used or to be used.
 - d. Examination protocols. Each routine initial, annual (periodic), and exit examination must include:
 - (1) A detailed history, which includes:
 - (a) Past and current occupational exposures to chromate, asbestos, or any other pulmonary carcinogens at work or at home;
 - (b) Smoking history and alcohol usage history;
 - (c) Any past or current history of dry skin, skin ulcers—usually painless, nosebleeds, asthma, shortness of breath, wheezing, or cough;

- (2) A directed physical examination, with attention to the skin, mucous membranes, and respiratory tract, both upper and lower (ensure the patient is examined for erosion of the nasal mucosa and septum, respiratory rhonchi, dermatitis, and cutaneous ulcers);
 - (3) A CBC, multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a U/A with microscopic;
 - (4) PFTs (including FVC & FEV₁);
 - (5) A PA CXR **only** for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);
 - (6) Any other tests or procedures deemed appropriate by the examining physician.
- e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:
- (1) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.
 - (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.
5. Hazardous Waste (Figure 12-C-4).
- a. Exposure effects. The OSHA medical surveillance protocol for hazardous waste operations and emergency response (HAZWOPER)[29 CFR 1910.120] involves medical surveillance for potential exposure to numerous metals and chemicals, usually in uncontrolled spill, fire, disposal situations. Therefore, there are no specific exposure effects to describe.
 - b. Required surveillance.
 - (1) Routine medical surveillance is required for employees involved in hazardous waste operations when any of the following conditions are met:
 - (a) Exposure or potential exposure to hazardous substances or health hazards at or above the MSAL for that substance (as defined in Section 12-A-4), without regard to the use of respirators or personal protective equipment, for 30 or more days per year.
 - (b) All hazardous waste operation employees who wear a respirator for 30 or more days per year or as required under Section 12-C-9.
 - (c) All employees who are injured, become ill, or develop signs or symptoms due to possible overexposure involving hazardous substances or health hazards from an emergency response or hazardous waste operation.
 - (d) Members of HAZMAT response teams, including all Coast Guard Strike Team members and firefighters.

- (2) In addition to routine surveillance requirements above, if an employee is exposed to a hazardous substance above the Coast Guard MSAL in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs after the exposure, and an acute exposure examination will be performed within 72 hrs of the exposure.
- c. Information to medical officer. The examining medical officer shall be provided, by the OMSEP coordinator, one copy of the OSHA HAZWOPER standard [29 CFR 1910.120] and its appendices, plus the following specific information:
- (1) A description of the employee's duties as they relate to the employee's exposures.
 - (2) The employee's exposure levels or anticipated exposure levels.
 - (3) A description of any personal protective equipment used or to be used, including any respirators.
 - (4) Information from previous medical examinations of the employee which is not readily available to the examining physician.
- d. Examination protocols.
- (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
 - (a) A medical and occupational history which includes:
 - 1 past and current occupational exposure to hazardous chemicals, metals, dusts, fumes, and heat stress;
 - 2 any history of heat illness, allergies, sensitivities, or physical abnormalities;
 - 3 current medications, and immunization history;
 - 4 smoking history, and alcohol usage history;
 - 5 a complete review of organ systems.
 - (b) A complete physical examination with attention to the skin, eyes, nose, throat, and respiratory, cardiovascular, genitourinary, and neurologic systems;
 - (c) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC);
 - (d) A multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;
 - (e) PFTs (including FVC & FEV1);

- (f) Vision screening;
 - (g) A PA CXR only for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);
 - (h) Any other tests or procedures deemed appropriate by the examining physician. (Consider a stool guaiac and/or electrocardiogram, if indicated by age or physical findings).
- (2) Each acute exposure examination shall include, as a minimum:
- (a) A brief summary of the nature of the exposure and investigation of any symptoms or complaints;
 - (b) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic;
 - (c) PFTs (including FVC & FEV1);
 - (d) Appropriate biological monitoring tests (e.g., blood metal screen) depending on the exposure in question. Contact Commandant (G-WKS-3) for further information and requirements.
- e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:
- (1) Whether the employee has any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from work in hazardous waste operations or emergency response, or from respirator use.
 - (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.
 - (3) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.
6. Lead (Figure 12-C-5).
- a. Exposure effects. In adults, excessive lead exposure can cause hypertension, anemia, peripheral neuropathy, encephalopathy, spontaneous abortions in women, and decreased fertility in men. The primary route of exposure in adults is inhalation of lead containing dust or fumes. Most exposure in the Coast Guard occurs during removal of previously applied lead-based paint coatings, or during environmental recovery of previously discarded lead-acid batteries. Some welders may be exposed to lead fumes.
 - b. Required surveillance. The Coast Guard MSAL is based on the OSHA PEL standard for shipyards [29 CFR 1915.1025]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to lead at or above the current exposure action level for 30 or more days per year.

- c. Information to medical officer. The OMSEP coordinator shall provide the medical officer with one copy of the OSHA lead standard [29 CFR 1915.1025] and its appendices, plus the following specific information:
- (1) A description of the employee's duties as they relate to the employee's exposure.
 - (2) The employee's exposure level or anticipated exposure levels to lead and to any other toxic substance (if applicable).
 - (3) A description of any personal protective equipment used or to be used, including any respirators (if known).
 - (4) Prior blood lead determinations.
 - (5) Information from previous medical examinations of the employee which is not readily available to the examining physician. This includes all available prior written medical opinions concerning the employee.
- d. Examination protocols.
- (1) Biological monitoring or "blood lead only" examinations must be provided to each employee exposed at or above the OSHA action level (currently TWA of 30 mg/ m³ air) **every six months**. Otherwise, only annual examinations must be performed, unless an employee's blood lead level is found to be elevated at or above 40 mg/100 ml of whole blood.
 - (2) Each routine initial, periodic, exit, and acute exposure examination shall include, as a minimum:
 - (a) A detailed work history and a medical history, with particular attention to:
 - 1 past lead exposure (occupational and non-occupational);
 - 2 personal habits (smoking, handwashing after work and before eating);
 - 3 past and current gastrointestinal, hematological, renal, cardiovascular, reproductive, and neurological problems.
 - (b) A complete physical examination with particular attention to:
 - 1 ocular fundi, teeth, gums, hematological, gastrointestinal, renal, cardiovascular, and neurological systems;
 - 2 blood pressure (must be recorded);
 - 3 pulmonary status should be evaluated if respiratory protection is to be used. (see Section 12-C-9).
 - (c) The following routine laboratory tests:
 - 1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology;
 - 2 blood lead level and zinc protoporphyrin (must be performed by a laboratory licensed by the CDC for proficiency in blood lead testing);

- (b) Every effort should be made to schedule the reference audiogram on civilian workers in order to avoid conflicts with assigned duties; military personnel shall receive their reference audiogram at initial entry training.
 - (c) Testing to establish a reference audiogram shall be preceded by at least 14 hours without exposure to workplace noise. Hearing protectors that attenuate workplace noise below a TWA of 85 dBA, may be used to meet this requirement, in place of exclusion from the noisy workplace.
- (3) Exit audiograms: shall be conducted on all employees, previously enrolled in the “hearing conservation program”, if it is determined the employee no longer works in a designated “hazardous noise area,” unless that employee is moving to another Coast Guard position that also involves work in such areas. However, if the employee’s audiogram shows hearing losses (compared to the reference audiogram) **equal to or greater than 25 dB** in the speech frequencies (500 - 3000 Hz) the employee must continue to receive annual audiograms until end of employment.
- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with a description of the employee’s duties as they relate to the employee’s exposure, the dB level of the hazardous work area and a description of any personal protective equipment used or to be used (e.g., earplugs or earmuffs).
- d. Examination protocols.
- (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include completion or updating of the indicated physical examination forms (i.e. CG 5447 or CG 5447A) and audiometric testing data (audiogram). All audiometric testing shall:
 - (a) Be performed by a licensed or certified audiologist, otolaryngologist, or other physician; or by a technician who is certified by the Council for Accreditation in Occupational Hearing Conservation. A technician who performs audiometric tests shall be responsible to an audiologist, otolaryngologist, or other physician. Standard instructions shall be given to individuals before testing.
 - (b) Be conducted in a testing environment with background octave band SPLs not greater than **21 dB** at 500 Hz, **26 dB** at 1000 Hz, **34 dB** at 2000 Hz, **37 dB** at 4000 Hz, and **37 dB** at 8000 Hz. The test environment shall be surveyed annually to ensure these levels are not exceeded.
 - (c) Include pure tone, air conduction, and hearing threshold examinations of each ear at the test frequencies of 500, 1000, 2000, 3000, 4000, and 6000 Hz.
 - (d) Be performed on audiometers conforming to the most current calibration specifications of the American National Standards Institute (ANSI). Audiometers currently in operation must receive annual electroacoustic calibration to maintain certification.

- (e) Occur on audiometers that have received a functional operations check before each day's use for specifications in the OSHA Occupational Noise Exposure standard [29 CFR 1910.95]
 - (f) Be recorded on DD Form 2215 (Reference Audiogram), or DD Form 2216 (Hearing Conservation Data), or equivalent locally reproduced versions as appropriate.
- (2) Significant Threshold Shift (STS). Transcribe the reference audiogram test results into the "Reference Audiogram" spaces on the DD Form 2216, Hearing Conservation Data (or equivalent). The reference levels are subtracted from the current levels at 2000, 3000, and 4000 Hz. The differences in hearing levels calculated at 2000, 3000, and 4000 Hz are added together and divided by three, for each ear. STS exists if the resulting average hearing loss in either ear is greater than or equal to ± 10 dB [29 CFR 1910.95]. Additionally, any change of **± 15 dB** at 2000, 3000, or 4000 Hz in either ear shall constitute an STS. Results shall be recorded on DD Form **2216 (or equivalent) as the "Reference Audiogram" results under the appropriate heading "Left" for left ear and "Right" for right ear. (Note: The National Institute for Occupational Safety and Health (NIOSH) age corrections shall NOT be applied when determining STS. (see Figure 12-C-13, Audiometric Threshold Shift Evaluation)**
- (3) A follow-up audiogram shall be conducted when an individual's audiogram shows an STS, in either ear, relative to the current reference audiogram. Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. An audiologist, otolaryngologist, or other knowledgeable physician shall perform the evaluation and determine if the noise-induced STS is/is not work-related or has/has not been aggravated by occupational noise exposure.
 - (4) When a negative STS (improvement in hearing threshold from the reference audiogram) is noted on the periodic audiogram, one 14-hour noise-free follow-up test is required. That may be administered on the same day as the periodic test. The results of the follow-up test may be used to create a re-established reference audiogram.
 - (5) When a positive STS (decrease in hearing threshold from the reference audiogram) is noted on the periodic audiogram, two consecutive 14-hour noise-free follow-up tests **must** be administered to confirm if the decrease in hearing is permanent. The follow-up exams may not be performed on the same day as the periodic audiogram. The results of the second follow-up test may be used to reestablish a reference audiogram, if the required medical evaluation validates the existence of a permanent noise induced threshold shift (see Section 12-3-d.(3) above). If the results of the first follow-up test do not indicate an STS, a second follow-up test is not required.
 - (6) A new reference audiogram shall replace the original reference audiogram when the medical evaluation confirms that the STS noted during the annual and follow-up audiograms is permanent. The original reference audiogram shall be retained in the patient's medical record.

- (7) Acute exposure examinations (formerly called the Detailed Surveillance Program). These examinations are designed to observe any dynamic hearing loss, to identify those who demonstrate unusual noise sensitivity, or to monitor personnel acutely exposed to unprotected high levels of noise (impulse >140dBA).
- (a) The initial acute exposure examination shall consist of all elements described in Sections 12-C-7.d. (1)-(6), above. Additional follow-up audiograms will be performed at 30 and 90 days, or at more frequent intervals at the discretion of the medical officer.
 - (b) If any of the follow-up audiograms demonstrate an average loss of no more than 10 dB in 2000, 3000, and 4000 Hz in either ear, when compared to the revised reference audiogram, hearing may be considered stable. The reference audiogram (per Section 12-C-7-d (5) and (6)) remains the audiogram against which further testing is compared. The individual is returned to annual monitoring.
 - (c) If these reevaluation audiograms exhibit a loss greater than an average threshold of 10 dB in 2000, 3000, and 4000 Hz in either ear when compared to the revised reference audiogram, the individual must be referred to an otolaryngologist for a consultation. Final disposition will depend on the consultant's diagnosis and recommendations.
 - (d) **Reporting requirements: In accordance with OSHA's Occupational Illness and Reporting Requirements effective January 1, 2003, the following rule applies: Any threshold shifts (+/- 10dB in either ear) that results in a total of 25dB level of hearing loss above audiometric zero, averaged over the 2000, 3000, and 4000 frequencies must be recorded and reported as a hearing loss case. Since most audiometers are designed to provide results referenced to audiometric zero no other calculations are required. NOTE: Any such event must be reported as a mishap in accordance with Chapter 3 of the Safety and Environmental health Manual, COMDTINST M5100.47(series).**
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the medical officer must do the following:
- (1) The employee shall be notified in writing within 21 days, when an audiologist or a physician confirms a threshold shift is permanent. Such determination must be entered in the employee's medical record.
 - (2) Supervisors shall be notified, in writing, that the worker has experienced a decrease in hearing. Release of medical information must conform to privacy act requirements.
 - (3) Document that the patient was counseled concerning the potential seriousness of repeated unprotected exposures to excessive noise and provided additional information on hearing protection and avoidance of hazardous noise exposures.

8. Pesticides (Figure 12-C-7).

- a. Exposure effects. There are over 1,200 chemical compounds currently classified as pesticides. However, this surveillance protocol is primarily concerned with only two classes of pesticides: organophosphate and carbamate insecticides, and chlorophenoxyacetic acid herbicides. Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase and they cause parasympathetic nervous system hyperactivity (miosis, urination, diarrhea, defecation, lacrimation, salivation), neuromuscular paralysis, CNS dysfunction (irritability, anxiety, impaired cognition, seizures, coma), peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy. In the past, some chlorophenoxyacetic herbicides were contaminated with dioxins during manufacture.
- b. Required surveillance. The Coast Guard MSALs for carbaryl, chlorpyrifos, malathion, parathion, 2,4, -D, and 2,4,5,-T are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to any identified pesticide at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year.
- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:
 - (1) A description of the employee's duties as they relate to the employee's exposure.
 - (2) The employee's exposure level or potential exposure level to any pesticides.
 - (3) A description of any personal protective equipment used or to be used, including any respirators.
- d. Examination protocols.
 - (1) Biological monitoring or "RBC cholinesterase only" examinations must be provided at least every six months to each employee exposed to organophosphate or carbamate pesticides at or above the MSAL. If an employee's RBC cholinesterase activity is found on any testing to be less than 80% of the pre-exposure baseline, the frequency of biological monitoring will be increased to at least every three months during the application season. Non-seasonal, acute exposures will be monitored at a frequency determined by the supervising medical officer based on exposure information data.
 - (2) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
 - (a) A detailed work history and a medical history, with particular attention to:
 - 1 past and current exposure to pesticides or other chemicals (occupational and non-occupational);
 - 2 smoking and alcohol use history;

- (1) Any detected medical conditions, which would place the employee's health at increased risk from exposure to identified pesticides or from respiratory wear.
- (2) Counseling on the possible increased risk of health impairment from working with certain pesticides, in the event that the employee was found to have skin disease, chronic lung disease, or abnormalities of the central or peripheral nervous system that could directly or indirectly be aggravated by such exposure.

9. Respirator Wear ([Figure 12-C-8](#)).

- a. Exposure effects. The OSHA medical surveillance protocol for respirator wear is a means to assess the effectiveness of respiratory protection among exposed workers. Periodic examinations are required to assess continued fitness for duties and to assess whether the present respiratory protection program provides adequate protection against illness. Respirators are often extremely uncomfortable to wear for long periods. Workers with asthma, claustrophobia, angina, and other conditions may not be able to wear respirators effectively. The worker should be questioned for a history or symptoms of past and current exposures to hazardous chemicals; fumes and dusts; smoking and alcohol use histories; wheezing or abnormal breath sounds; clubbing; and cardiac arrhythmia.
- b. Required surveillance.
 - (1) Initial Medical Determination. An initial/baseline examination will be performed at the time of assignment to a job requiring respirator wear. Before an employee may be issued a respirator or assigned to a task that may require a respirator, that worker must complete a mandatory OSHA Respirator Medical Evaluation Questionnaire. This questionnaire will be provided, at the local unit by the cognizant SEHO, to all workers expected to require the use of a respirator. This questionnaire serves as the initial medical examination. A health care professional (nurse, nurse practitioner, physician assistant, and physician) must review this questionnaire to determine if a follow-up medical examination is required. Independent duty technicians (IDT'S) are authorized to review the questionnaire but must refer any positive responses on questionnaire (or any other concerns) to the supervising medical officer for further review. Any employee who gives a positive response to any questions among questions 1-8 in section two of the questionnaire shall be subject to a follow-up medical examination. This examination will determine whether the worker is physically and mentally capable of performing the work and using a respirator [29 CFR 1910.134].
 - (2) Additional Medical Evaluation and Medical Examination.
 - (a) Additional medical examinations maybe required to assess continued fitness for duties involving respirator wear. The following conditions will dictate the need for a follow-up evaluation:
 - 1 The member reports signs and symptoms related to the ability to use a respirator;
 - 2 The health care provider, supervisor, or respirator program coordinator informs the command of the need for evaluation;

- 3 Observations are made during fit testing, respirator use, or program evaluation that indicate the need for evaluation;
 - 4 When changes in workplace conditions such as physical work effort, protective clothing or climate conditions result in substantial increase in physiological burden;
 - 5 A member's scheduled quintennial physical examination.
 - (b) Periodic physical examinations will be provided at least once every five years. The periodic physical examination requires a review and update of the respirator questionnaire. A health care provider must review the questionnaire to determine the need for a follow-up examination. A follow-up medical examination is required for anyone with positive responses to questions 1-8 in section two of the questionnaire.
 - c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:
 - (1) A description of the employee's duties as they relate to the employee's respirator wear.
 - (2) The employee's exposures or potential exposures to any hazardous chemicals or physical agents.
 - (3) A description of the respirator(s) used or to be used.
 - d. Examination protocol. Each routine (non-acute exposure) initial and periodic examination shall include, as a minimum the completion of the mandatory OSHA Respirator Medical Evaluation Questionnaire.
 - e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:
 - (1) Any detected medical conditions that would place the employee at increased risk of material impairment of the employee's health from respirator use.
 - (2) Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).
 - (3) Note: As a general rule, anyone with documented respiratory impairment of moderate to severe degree (FEV_1 or $FVC < 70\%$ of predicted) should not be routinely approved to wear a respirator.
10. Respiratory Sensitizers (Figure 12-C-9).
- a. Exposure effects. Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).

- b. Required surveillance. The Coast Guard MSALs for formaldehyde, toluene diisocyanate, and vanadium, are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to any identified respiratory sensitizer at or above the MSAL (as defined in Section 12-A-2) for 30 or more days per year. In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.
- c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:
 - (1) A description of the employee's duties as they relate to the employee's exposure.
 - (2) The employee's exposure level or anticipated exposure level to any respiratory sensitizers.
 - (3) A description of any personal protective equipment used or to be used, including any respirators.
- d. Examination protocols.
 - (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
 - (a) A detailed work history and a medical history, with particular attention to:
 - 1 past and current exposure to respiratory sensitizers (occupational and non-occupational);
 - 2 smoking history;
 - 3 any symptoms of eye, nose, or throat irritation;
 - 4 chronic airway problems or hyperactive airway disease; and
 - 5 allergic skin conditions or dermatitis.
 - (b) In the event that the employee is not required to wear a respirator and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a system specific physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used. (see Section 12-C-9).
 - (c) The following routine laboratory tests:
 - 1 a CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;
 - 2 PFTs (including FVC & FEV₁).
 - (d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CXR, bronchial provocation tests).

- (2) Each acute exposure examination shall include, as a minimum:
 - (a) A medical and work history with emphasis on any evidence of upper or lower respiratory problems, allergic conditions, skin reaction or hypersensitivity, and any evidence of eye, nose, or throat irritation.
 - (b) A directed physical examination with attention to the respiratory system.
 - (c) PFTs (including FVC & FEV1).
 - (d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, bronchial provocation tests).
 - e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:
 - (1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure to identified respiratory sensitizers, or from respirator use.
 - (2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.
11. Solvents ([Figure 12-C-10](#)).
- a. Exposure effects. There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when considered as an admittedly broad group. These effects are skin disorders (acute irritant dermatitis, chronic eczema), acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma), and chronic CNS effects (chronic solvent intoxication, neurobehavioral abnormalities, cognitive dysfunction). Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic to humans; benzene being a notable exception (see Section 12-C-3, above). In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).
 - b. Required surveillance. The Coast Guard MSALs for ethylene glycol, methyl ethyl ketone, VM & P naphtha, and xylene are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to any identified hazardous solvent at or above the MSAL (as defined in Section 12-A-2) for 30 or more days per year. An acute exposure examination is required in the event of any documented overexposure (above the TLV or STEL) to a solvent or any presumed overexposure where symptoms are present. In the case of an acute overexposure, an appropriate urine or blood specimen should be collected as soon as possible after the overexposure incident.
 - c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

- (1) A description of the employee's duties as they relate to the employee's exposure.
- (2) The employee's exposure level or potential exposure level to any solvents.
- (3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

- (1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:
 - (a) A detailed work history and a medical history, with particular attention to:
 - 1 past and current exposure to solvents (occupational and non-occupational);
 - 2 smoking history and alcohol use history;
 - 3 any symptoms of dry skin, skin irritation, or dermatitis;
 - 4 any CNS symptoms, including headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, difficulty concentrating, mood changes, or confusion;
 - 5 a review of symptoms with attention to the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems.
 - (b) A system specific physical examination, with attention to the skin and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).
 - (c) The following routine laboratory tests:
 - 1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC); and
 - 2 a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic.
 - (d) Consideration should be given to biological monitoring tests for ongoing overexposure to certain solvents, if specimens can be obtained in a timely manner during the exposure period. For non-acute exposures, a timely manner generally implies that the specimen be obtained at the end of a work shift or the end of a workweek.
 - 1 For toluene, measure urinary hippuric acid, at the end of a full work shift.

- b. Required surveillance. Employees who are occupationally exposed to active TB cases will be enrolled in the OMSEP and undergo annual screening for tuberculosis. See section 7-D-3 of this Manual, Tuberculosis Screening Program, for complete details. In the Coast Guard, medical personnel and personnel involved in alien migrant interdiction operations (AMIO) are at potential risk for exposure to active TB cases.
- c. Information to medical personnel. In order to assess whether the employee should remain under active surveillance for TB exposure, the OMSEP coordinator must provide the examining medical officer with the following information:
 - (1) A description of the employee's duties as they relate to the employee's exposure.
 - (2) The employee's exposure level or potential exposure level active TB cases.
 - (3) A description of any personal protective equipment used or to be used.
- d. Examination protocols.
 - (1) Routine screening for exposed individuals is covered in section 7-D-3.
 - (a) Personnel with a history of non-reactive tuberculin skin tests will receive annual skin testing. Routine skin testing does not require an examination by a medical officer.
 - (b) Personnel with a history of reactive skin test(s) will be monitored for development of symptoms of active TB (cough, hemoptysis, fatigue, weight loss, night sweats) annually. A health services technician or a medical officer may complete such monitoring. Routine annual CXRs will not be done.
 - (2) Evaluation of personnel with newly reactive tuberculin skin tests or suspected active TB is covered in section 7-D-4. A medical officer shall perform a physical examination and obtain a complete medical history in such personnel. A CXR should be done.
- e. Specific written requirements. Requirements for recording routine skin test results are covered in Section 7-D-3-c. In addition, medical personnel should make a written recommendation as to whether continued annual TB surveillance is required.

13. Bloodborne Pathogens (Figure 12-C-12).

- a. Exposure effects. Bloodborne pathogens are defined as any pathogenic microorganism present in the blood of humans, which are able to cause human diseases. COMDINST 6220.8, Prevention of Bloodborne Pathogens (BBP) Transmission, includes definitions, prevention and control measures, and applicability, as well as discussing vaccination policy, and post exposure prophylaxis. Further instructions are found in Chapter 13 of this Manual which covers approved work practices and training requirements including discussions in Universal Precautions. The primary Bloodborne Pathogens (BBP's) include **Human Immune Deficiency Virus (HIV), Hepatitis B (HBV), and Hepatitis C (HCV).**

b. Required surveillance.

- (1) Bloodborne Pathogen exposure surveillance is based on OSHA guidelines (29 CFR 1910.1030). Enrollment in OMSEP is required for all workers who reasonably anticipate contact with BBP's as a result of their duties. Determination of exposure must be based on the definition of occupational exposure without regard to personal protective equipment. Exposures should be listed according to:
 - (a) Jobs in which all workers have occupational exposure (i.e. lab personnel) and,
 - (b) Jobs where only some of the workers may be exposed (i.e. alien migrant operations). In these circumstances all the specific tasks and / or procedures potentially causing the exposure must be clearly listed.
- (2) All BBP enrollees will be entered into the OMSEP database for proper identification. Monitoring and post-exposure prophylaxis will be done in accordance with any reported or suspected acute exposure (see Figure 12-C 12), and guidelines found in Chapter 13 of this manual.

c. Information to medical personnel. Since the potential for infectivity of patient's blood and body fluids is not routinely known, it is essential that all workers conform **to blood and body fluid precautions**, regardless of any lack of evidence of infectiousness. Acute viral hepatitis is a serious operational problem, which has significantly altered the course of many military operations. According to established classification acute hepatitis is a self-limited liver injury of <6 months duration and chronic hepatitis represents a hepatic inflammation >6 months. The usual course is six to 10 days of acute symptoms associated with a variable rise in ALT/AST and bilirubin. The common clinical presentation includes the symptom complex of anorexia, nausea, right upper quadrant pain and tenderness, hepatomegaly, and jaundice. Specific Bloodborne Pathogens are discussed in further detail:

- (1) **Hepatitis B - (HBV)**, also known as "serum" hepatitis, is less of a risk for endemic outbreaks than other hepatitis viruses but is also less amenable to prophylactic measures. Serologic evidence precedes clinical symptoms by approximately 1 month. Hepatitis B is the leading cause of liver-related deaths from cirrhosis and hepatocellular carcinoma worldwide; is especially frequent in drug abusers, male homosexuals, and chronic dialysis patients; 5% to 10% of adults in the US have had the disease; and 10% develop a chronic carrier state and constitute an infectious pool. Important serological markers to follow include: HB_sAg, HB_eAg, HB_cAg, HB_sAb, HB_eAB and HB_cAb. The AST and ALT should also be evaluated at monthly intervals following their initial rise and decline.
 - (a) **Hepatitis B surface antigen (HBsAg) is found in acute illness** and becomes positive 1 to 7 weeks before clinical disease. It remains positive 1 to 6 weeks after clinical disease and in chronic carrier states. Blood-containing HBsAg is considered potentially infectious.

- (b) **Hepatitis B antibody (Anti-HBs)** is an antibody against the surface antigen of hepatitis B and appears weeks to months after clinical illness. The presence of this antibody confers immunity and indicates prior disease (if hepatitis B core antibody positive) or vaccination (if hepatitis B core antibody negative).
 - (c) **Anticore antibody (Anti HBe)** appears during the acute phase of the illness and its presence can be used to diagnose acute HBV infection especially in the "window period" when both HBsAg and HbsAb may be undetectable. Presence of HBeIgM denotes acute infection and IgG appears chronically. The latter may be protective against reinfection.
 - (d) **Hepatitis B e antigen (HBeAg)** is a mark of infectivity both acutely and chronically.
 - (e) **Those who are hepatitis B carriers or have chronic active hepatitis will be HBsAg positive.**
- (2) **Hepatitis C - (HCV)**, formerly Non A- Non B hepatitis, is responsible for most cases of post-transfusion hepatitis and presents a significant risk for the development of hepatocellular carcinoma. It accounts for 20% to 40% of acute hepatitis in the United States. Hepatitis C also causes 90% of post transfusion hepatitis. The virus has an extremely high mutation rate and is thus not easily neutralized by the body's antibody response. Acute infection is usually asymptomatic; with 20% of patients developing jaundice, and 75% of those infected developing chronic disease. **HCV** hepatitis, to date, has no serological markers that have been exclusively associated with blood transfusions, making this a diagnosis of exclusion based on the appropriate clinical setting. Most patients with hepatitis C have a history of intravenous drug abuse. Other risk factors include history blood transfusion, tattoos, alcohol abuse and cocaine snorting. Epidemiological evidence suggests that it can be transmitted sexually with risk of transmission increasing with duration of a relationship but with a very low incidence (<5%).
- (a) Diagnostic serologic tests that probe for antibodies produced in response to several viral antigens are now available for the diagnosis of hepatitis C. These tests are highly sensitive and specific. If testing low risk populations, RIBA (recombinant immunoblot assay) test should be obtained since the ELISA has a higher false-positive rate.
 - (b) Polymerase chain reaction (PCR) can detect minute quantities of HCV RNA present in blood as early as 1-2 weeks after infection. Qualitative PCR tests detect as few as 100 HCV RNA copies, and quantitative tests detect a lower limit of 500-2000 copies.
 - (c) Genetic heterogeneity of HCV identifies at least 6 distinct genotypes (with numerous subtypes). Different genotypes have geographic and epidemiological differences, and they are good predictors of response to interferon.

(3) **Human Immunodeficiency Virus - (HIV)**, is a retrovirus, which was recognized as an infectious cause of an unusual immunodeficiency syndrome, which is transmitted, in a similar mode to that of hepatitis B virus. Has been recognized as major public health problem for men and women, with between 5 and 10 million persons infected worldwide. It can be acquired through intimate homosexual or heterosexual contact, by receiving infected blood or blood products, or by inoculation via needles contaminated with infected blood (IV drug use, tattooing, etc). There is also good evidence that transmission via open skin wounds exposed to infected blood or saliva occurs, though such transmission is rare. The diagnosis is based on recognition of clinical symptoms in an at risk population and appropriate serological screening procedures:

- (a) **Clinical diagnosis:** Some patients experience a flu-like illness when initially infected, but often there are no symptoms. A very variable, prolonged period may pass in which there are no signs or symptoms as immunosuppression proceeds. When the immune system is sufficiently impaired, infections with various organisms usually not pathogenic occur. The clinician should be attentive to signs of global dementia that occur in the absence of an opportunistic infection of the CNS. This appears to be a direct consequence of HIV viral infection and precedes any other clinical manifestation in between 10 and 25 percent of infected patients who develop AIDS. Initially, there are mild cognitive defects involving judgment and memory, which progress to a severe global dementia.
- (b) **Serological diagnosis:** HIV ab test (western blot) serves as the screening tool during routine medical evaluations. This is a commercially available enzyme immunoassay (EIA) test. The median interval between infection and seropositivity is estimated at three months. Results are considered reactive only when a positive result is confirmed in a second test.

d. Examination protocols. Each examination should, as a minimum:

- (1) Follow the post exposure guidelines found in Chapter 13 of this manual.
- (2) Ascertain source and exposed person's HCV exposure and immune status.
- (3) Follow up any suspicious laboratory findings with a detailed work and medical history giving particular attention to:
 - (a) Past and present history of exposures to BBP's.
 - (b) Smoking and alcohol use history.
 - (c) Any symptoms of skin irritation, bleeding or recurrent dermatitis.
 - (d) Any CNS symptoms, including headaches, nausea, vomiting, dizziness, weakness, and disorientation.
 - (e) A review of the immunologic and hematopoietic systems.

- (f) A system specific physical examination with attention to the skin, mucous membranes, respiratory, and nervous system including a mental status evaluation.
 - (g) The following laboratory tests: CBC, and WBC counts with differential, CD4 counts, immunoglobulins, platelet counts, liver enzymes and hepatitis profile and a multichemistry panel (including glucose, BUN, total protein and creatinine) and urinalysis.
- (4) Provide a complete review of the medical record to confirm documentation of compliance with indicated immunizations and completion of baseline laboratory studies before assignment to specific tasks or procedures with potential risk of exposure.
- e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:
- (1) Any other medical conditions, which could place the worker at greater than normal risk.
 - (2) The periodicity of the next evaluation and/or referral to the appropriate specialty clinic.
 - (3) The recommended duty limitations, hygiene care and infectious disease precautions.
 - (4) The exposure risk (unprotected exposure) for HIV, HBV and HCV.
 - (5) **“Universal Precautions”**- defined as an approach to infection control where all human blood and body fluids are treated as if known to be infectious for blood borne pathogens. Specimens that entail "universal precautions" are all excretions, secretions, blood, body fluid, and any drainage. Personnel should protect themselves from contact with these specimens by using the appropriate barrier precautions to prevent cross-transmission and exposure of their skin and mucous membranes, especially the eyes, nose, and mouth. See Chapter 13 of this Manual for further guidance.

Figure 12-C-1

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
Examination Protocol for Exposure to: ASBESTOS			
IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS	
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2802/DD-2807-1 DD Form 2493-1 or OSHA Respiratory Disease Questionnaire (Part1) optional	
Periodic	<input type="checkbox"/> <input type="checkbox"/>	DD Form 2493-1 or OSHA Respiratory Disease Questionnaire (Part2) optional CG 5447A Periodic History and Report of OMSEP Examination	
Acute Exposure	<input type="checkbox"/>	Acute Exposure Form	
All types (except acute exposure)	<input type="checkbox"/> <input type="checkbox"/>	Complete blood count (CBC); multichemistry panel (includes liver function tests, BUN , creatinine); urinalysis with microscopic (U/A). Pulmonary function tests (FVC & FEV1)	
All types	<input type="checkbox"/> <input type="checkbox"/>	Physician's notification regarding examination results. (Final action.) Chest x-ray (PA) with "B-reader" or board certified radiologist evaluation at initial exam then per table:	
YEARS SINCE FIRST EXPOSURE- X-rays			
	Age 15-35	Age 36-45	Age>45
0-10	Every 5 years	Every 5 years	Every 5 years
Over 10	Every 5 years	Every 2 years	Every year
To the examining medical officer: <ul style="list-style-type: none"> ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes. ◆ Ensure that the patient is questioned about the following history or symptoms: smoking history, dyspnea on exertion, cough, pleuritic pain, heartburn or epigastric pain. (See OSHA Respiratory Disease Questionnaire.) ◆ Ensure that the patient is examined for the following possible signs: clubbing, basilar rales ◆ You must address the following four items in writing: 1) whether the employee has any detected medical conditions placing him/her at increased risk of health impairment from further asbestos exposure; 2) any recommended limitations on use of personal protective equipment; 3) that the employee has been informed by you of the results of the examination and any medical conditions resulting from asbestos exposure that require follow-up; 4) that the employee has been informed of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking. ◆ Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent. ◆ Asbestos was used in shipbuilding until the 1970s. Exposure among OMSEP participants is mostly associated with repair and overhaul of vessels built prior to that time ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms. 			
Reviewing Authority Signature:			DATE:

Figure 12-C-2

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
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Examination Protocol for Exposure to: BENZENE

IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2802/DD-2807-1
Periodic	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination
Acute Exposure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Urinary phenol. (Only immediately after acute exposure) Blood or breath benzene level (optional-if available) CBC w/Diff Acute Exposure Form
All types	<input type="checkbox"/>	Physician's notification regarding examination results. (Final action.)
All types (except Acute Exposure)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC). Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, GGT, LDH, and alkaline phosphatase) U/A/ with microscopic

To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: smoking history, headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, weight loss.
- ◆ Ensure that the patient is examined for the following signs: mental status changes, dermatitis, pallor.
- ◆ Benzene exposure causes CNS depression, leukemia, aplastic anemia, and dermatitis.
- ◆ The employee should be medically removed from the workplace if any of the following are noted on the exam:
 - ▶ The hemoglobin/hematocrit is below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.
 - ▶ The thrombocyte (platelet) count has dropped more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.
 - ▶ The leukocyte count is below 4,000 per mm³ or there is an abnormal differential count.
- ◆ Benzene is commonly associated with petrochemical manufacturing. Exposure among OMSEP participants is generally related to marine vessel inspection or disaster response (oil spill, fire). Commercial gasoline is about 3% benzene.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

Reviewing Authority Signature:

DATE:

Figure 12-C-3

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
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Examination Protocol for Exposure to: CHROMATES

IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1 Chest x-ray (PA)
Periodic	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination
Acute Exposure	<input type="checkbox"/>	Acute Exposure Form
All types (except acute exposure)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Complete blood count (CBC) Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) U/A with microscopic
All types	<input type="checkbox"/> <input type="checkbox"/>	Physician's notification regarding examination results. (Final action.) Pulmonary function tests (FVC & FEV1).

To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: smoking history, shortness of breath, wheezing, cough, dry skin, skin ulcers.
- ◆ Ensure that the patient is examined for the following signs: erosion of nasal mucosa and septum, respiratory rhonchi, dermatitis, cutaneous ulcers.
- ◆ Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- ◆ Chromium exposure causes lung cancer, dermatitis, skin ulcers, and nasal septum perforation.
- ◆ Chromic acid may cause acute burns or irritation to skin, eyes, and upper respiratory tract. Inhalation may cause acute epiglottitis, laryngospasm, pneumonitis, and pulmonary edema.
- ◆ Some chromium compounds cause occupational asthma.
- ◆ Chromium compounds are commonly associated with steel and chemical manufacturing. Exposure among OMSEP participants is generally related to working with chromium containing paints.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

Reviewing Authority Signature:	Date:
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Figure 12-C-4

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
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Examination Protocol for Exposure to: HAZARDOUS WASTE

IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2802/DD-2807-1 Chest x-ray (PA)
Periodic	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination
Acute Exposure	<input type="checkbox"/> <input type="checkbox"/>	Blood lead and/or heavy metal screen, if indicated. Acute Exposure Form
All types (except acute exposure)	<input type="checkbox"/>	Vision screening (distant and near)
All types	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pulmonary function tests (FVC & FEV ₁). CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC). Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) U/A with microscopic Physician's notification regarding examination results. (Final action)

To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: smoking history, weight loss, headache, visual disturbances, difficulty concentrating, decreased attention span, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, shortness of breath, anemia.
- ◆ Ensure that the patient is examined for the following signs: gingivitis, sialorrhea, tremor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, respiratory rhonchi and hyperresonance, dermatitis, edema.
- ◆ Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- ◆ The hazardous waste protocol involves medical surveillance for effects of exposure to a variety of heavy metals and chemical compounds. Neurotoxicity, pulmonary disease, dermatitis, and cancer are possible effects of excessive exposures to hazardous wastes.
- ◆ The top ten most hazardous substances found are: Lead; arsenic; mercury; benzene; vinyl chloride; cadmium; polychlorinated biphenyls; benzo(a) pyrene; chloroform; benzo (b) fluoranthene.
- ◆ OMSEP participants monitored under this protocol are primarily members of HAZMAT and spill response teams, firefighters, and marine safety inspectors. Individual, specific exposure histories are often ill defined. If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

Reviewing Authority Signature:

Date:

Figure 12-C-5

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
Examination Protocol for Exposure to: LEAD			
IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS	
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2802/DD-2807-1	
Periodic	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination	
Acute Exposure	<input type="checkbox"/>	Acute Exposure Form	
All types	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood lead and zinc protoporphyrin (ZPP) / erythrocyte protoporphyrin (EP) CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology. Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase, and uric acid) U/A with microscopic Physician's notification regarding examination results. (Final action.)	
<p>To the examining medical officer:</p> <ul style="list-style-type: none"> ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes. ◆ Ensure that the patient is questioned about the following history or symptoms: past lead exposure, smoking history, abdominal pain and cramping, joint and extremity pain, difficulty concentrating, irritability, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, anemia, and infertility. ◆ Ensure that the patient is examined for the following signs: hypertension, papilledema, gum "lead lines", pallor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, extensor motor weakness. ◆ Lead exposure can cause fatigue, anemia, arthralgias and myalgias, peripheral motor neuropathy, neurobehavioral disturbances and encephalopathy, acute abdominal pain, gout and gouty nephropathy, acute and chronic renal failure, spontaneous abortions, and male infertility. ◆ If the blood lead level is greater than 40 µg/100 g of whole blood, the employee must be medically removed from any workplace exposure. ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms. ◆ ZPP/EP assays are used as a complement to BLL testing. ZPP/EP assay is not sufficiently sensitive at lower BLLs and thus are not a useful screening test. ZPP/EP elevated in jaundice, iron diff anemia and hemolytic anemias. 			
Reviewing Authority Signature:			Date:

Figure 12-C-6

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
Examination Protocol for Exposure to: NOISE			
IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS	
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2802/DD-2807-1 DD Form 2215 or equivalent locally reproduced version.	
Periodic	<input type="checkbox"/> <input type="checkbox"/>	CG 5447A Periodic History and Report of Examination DD Form 2216 or equivalent locally reproduced version.	
Acute Exposure	<input type="checkbox"/>	Acute Exposure Form	
All types	<input type="checkbox"/> <input type="checkbox"/>	Physician's notification regarding examination results. (Final action.) DD Form 2216 or equivalent locally reproduced version.	
To the examining medical officer: <ul style="list-style-type: none"> ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes. ◆ A significant threshold shift (STS) exists if the average change in hearing from the reference audiogram at 2000, 3000, and 4000 Hz is greater than or equal to ± 10 dB in either ear. ◆ Additionally, any change of ± 15 dB at 1000, 2000, 3000, or 4000 Hz in either ear constitutes an STS. ◆ Do not apply the National Institute for Occupational Safety and Health (NIOSH) age corrections when determining STS. ◆ Follow-up audiograms must be conducted when an individual's audiogram shows an STS relative to the current reference audiogram in either ear. When a positive STS (decrease in hearing threshold) is noted, two 14-hour noise-free follow-up tests must be administered to confirm that the decrease in hearing is permanent. When a negative STS (improvement in hearing) is noted, one 14-hour noise-free follow-up tests must be administered. ◆ Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. That evaluation must be performed by an audiologist, and otolaryngologist, or other knowledgeable physician. ◆ If, compared with the current reference audiogram, a loss of hearing of ≥ 25 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz) is noted, the employee must be medically removed from further workplace exposure. ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms. 			
Reviewing Authority Signature:		Date:	

Figure 12-C-7

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
Examination Protocol for Exposure to: PESTICIDES			
IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS	
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2802/DD-2807-1 Blood cholinesterase level, two specimens at least 24 hrs. apart	
Periodic	<input type="checkbox"/> <input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination Blood cholinesterase level, if current exposure involves organophosphate or carbamate pesticides	
Acute Exposure	<input type="checkbox"/> <input type="checkbox"/>	Acute Exposure Form Blood cholinesterase level, if current exposure involves organophosphate or carbamate pesticides	
All types	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pulmonary function tests (FVC & FEV1) CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC) Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase. U/A with microscopic Physician's notification regarding examination results. (Final action.)	
<p>To the examining medical officer:</p> <ul style="list-style-type: none"> ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes. ◆ Ensure that the patient is questioned about the following history or symptoms: past and current exposures to pesticides, smoking and alcohol use history; eye, nose or throat irritation; cough; nausea, vomiting, diarrhea or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; allergic skin conditions or dermatitis. ◆ Ensure the patient is examined for the following possible signs: dermatitis, meiosis, rhinitis, mental status changes Pulmonary system must be examined if respiratory protection is used. ◆ If the cholinesterase level is at or below 50% of the pre-exposure baseline, the employee must be medically removed from any further workplace exposure. ◆ Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase. They cause parasympathetic nervous system hyperactivity, neuromuscular paralysis, CNS dysfunction, peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy. ◆ Arterial blood gases and chest radiography are useful in cases of inhalation exposure or respiratory compromise. Metabolites of organophosphates can be detected in urine up to 48 hrs after exposure though testing is available only from reference laboratories. ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms. 			
Reviewing Authority Signature:			Date:

Figure 12-C-8

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
Examination Protocol for Exposure to: RESPIRATOR WEAR			
IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS	
Initial/Baseline or Separation	<input type="checkbox"/>	OSHA Respiratory Medical Evaluation Questionnaire	
Periodic	<input type="checkbox"/>	OSHA Respiratory Medical Evaluation Questionnaire (update).	
All types	<input type="checkbox"/>	Physician's notification regarding examination results. (Final action)	
<p>To the examining medical officer:</p> <ul style="list-style-type: none"> ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes. ◆ This protocol applies to all employees required to wear a respirator in the course of their work. ◆ Ensure that the patient is questioned about the following history or symptoms: past and current exposures to hazardous chemicals, fumes, and dusts; smoking and alcohol use history; any history of claustrophobia, asthma, angina, syncope, and other respiratory or cardiovascular disease. ◆ Ensure the patient is examined for the following possible signs: wheezing or other abnormal breath sounds, clubbing, and cardiac arrhythmias. ◆ You must address whether the employee as any detected medical conditions which would place him or her at increased risk of material health impairment from the required respirator use. Consider whether the employee's health will allow him or her to tolerate respirator wear. <ul style="list-style-type: none"> ▶ Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree (FEV1 or FVC <70% of predicted) should not be routinely approved to wear a respirator. Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold). ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms. 			
Reviewing Authority Signature:			Date:

Figure 12-C-9

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
Examination Protocol for Exposure to: RESPIRATORY SENSITIZERS			
IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS	
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1	
Periodic	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination	
Acute Exposure	<input type="checkbox"/>	Acute Exposure Form	
All types	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pulmonary function tests (FVC & FEV1) CBC (complete blood count) Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) U/A (dipstick sufficient) Physician's notification regarding examination results. (Final action)	
To the examining medical officer: <ul style="list-style-type: none"> ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes. ◆ Ensure that the patient is questioned about the following history or symptoms: past and current exposures to respiratory sensitizers, smoking history; eye, nose or throat irritation; cough; asthma or other chronic airway problems; allergic skin conditions or dermatitis. ◆ In the event that the employee is not required to wear a respirator, and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a directed physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used. ◆ Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride). ◆ In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures. ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms. 			
Reviewing Authority Signature:			Date:

Figure 12-C-10

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
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Examination Protocol for Exposure to: SOLVENTS

IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS
Initial/Baseline or Separation	<input type="checkbox"/> <input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
Periodic	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination
Acute exposure	<input type="checkbox"/> <input type="checkbox"/>	Acute Exposure Form Specific blood or urine tests for specific solvents
All types (except acute exposure)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pulmonary function tests (FVC & FEV1) CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC). Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase) U/A with microscopic
All types	<input type="checkbox"/>	Physician's notification regarding examination results. (Final action)

To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ Ensure that the patient is questioned about the following history or symptoms: past and current exposures to solvents, smoking and alcohol use history; allergic skin conditions, dry skin, or dermatitis ; eye, nose or throat irritation; headache, nausea, vomiting, dizziness, vertigo; fatigue, weakness, irritability, depression, difficulty concentrating, or impaired short-term memory; and numbness, tingling, or weakness in the extremities.
- ◆ Ensure the patient is examined for the following possible signs: dermatitis, peripheral neuropathy, cognitive dysfunction, and mental status changes.
- ◆ If the particular solvent exposure is well characterized and specific laboratory tests are available, biological monitoring should be considered.
- ◆ Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- ◆ There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when taken as a broad group. These effects are skin disorders, and acute and chronic CNS effects. Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic in humans; benzene being a notable exception.
- ◆ In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

Reviewing Authority Signature:

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Figure 12-C-11

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Date:	Patient Name:	SSN:	Unit:
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Examination Protocol for Exposure to: TUBERCULOSIS

IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS
Initial/Baseline or Separation (with no history of prior reactive skin test)	<input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination
	<input type="checkbox"/>	DD-2808/DD-2807-1
	<input type="checkbox"/>	PPD tuberculin skin test (TST)
Newly reactive TST	<input type="checkbox"/>	Enter results on SF 601 and PHS 731
	<input type="checkbox"/>	Chest x-ray
Acute Exposure	<input type="checkbox"/>	PPD tuberculin skin test (TST)
	<input type="checkbox"/>	Acute Exposure Form
Periodic follow-up on reactive TST	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination
All types	<input type="checkbox"/>	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- ◆ You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- ◆ For personnel with a prior history of a reactive TST, ensure the patient is questioned about the following symptoms of active TB: fever, night sweats, weight loss, cough, and hemoptysis. This questioning may be completed by a nurse or health services technician.
- ◆ See section 7-D of the Medical Manual for full information on the tuberculosis control program.
- ◆ Forward a copy of all test results to the unit OMSEP coordinator.
- ◆ If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

Reviewing Authority Signature:

Date:

Figure 12-C-12

This form is subject to the Privacy Act Statement of 1974

Date:	Patient Name:	SSN:	Unit:
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Examination Protocol for Exposure to: BLOODBORNE PATHOGENS

IF EXAM TYPE IS		DO or COMPLETE THESE ITEMS
Initial/Baseline or Separation	<input type="checkbox"/>	CG-5447 History and Report of OMSEP Examination
	<input type="checkbox"/>	HIV ab test (western blot)
Periodic	<input type="checkbox"/>	CG 5447A Periodic History and Report of OMSEP Examination
Acute Exposure	<input type="checkbox"/>	Acute Exposure Form
All types	<input type="checkbox"/>	CBC (complete blood count) / WBC and differential / Platelet count
	<input type="checkbox"/>	Multichemistry panel (including total protein, liver enzymes, BUN and creatinine, bilirubin and alkaline phosphatase)
	<input type="checkbox"/>	Hepatitis profile, HBV ab, HCV ab, CD4 count, HBV sag/sab
	<input type="checkbox"/>	CXR
	<input type="checkbox"/>	Physician's notification regarding examination results. (Final action)

To the examining medical officer:

- ◆ Establish safe practice rules: "Universal Precautions"- defined as an approach to infection control where all human blood and body fluids are treated as if known to be infectious for bloodborne pathogens. Specimens that entail "universal precautions" are all excretions, secretions, blood, body fluid, and any drainage. Laboratory personnel should protect themselves from contact with these specimens by using the appropriate barrier.
- ◆ In the event of any indication or suspicious results from lab tests/X-ray procedures:
 - ◆ Follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
 - ◆ Ensure the patient is questioned about his/her general medical and work history, including: social habits, blood donations, use of drugs or medications, and a complete review of systems.
 - ◆ Notify chain of command while adhering to privacy act requirements.
 - ◆ Ensure the patient is examined for any of the following signs: gingivitis, dermatitis, open (weeping or bleeding) skin lesions, shortness of breath, loss of memory, fatigue, mood lability, paresthesias, anemia.
- ◆ Provide a complete review of the medical record to confirm documentation of compliance with indicated immunizations and completion of baseline laboratory studies before assignment to specific tasks or procedures with potential risk of exposure.

Reviewing Authority Signature:	Date:
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CHAPTER 13

QUALITY ASSURANCE

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CHAPTER 13. QUALITY ASSURANCE

Section A - Quality Assurance Plan

1. Purpose.

The Commandant and Chief, Office of Health and Safety are committed to providing the highest quality health care to Coast Guard beneficiaries. The Health Services Quality Assurance Program (QAP) described here establishes policy, prescribes procedures, and assigns responsibility for Quality Assurance (QA) activities at Coast Guard health services facilities. It is intended to function as an integral component in a Total Quality Management (TQM) system aimed at achieving patient satisfaction by using quantitative methods to continuously improve the health services program. It is essential that the QAP integrates into the Coast Guard's overall TQM concept to improve the health care delivery system at all organizational levels. The Office of Health and Safety, Maintenance and Logistics Commands, unit commanding officers, health care providers, and patients must cooperate to ensure successful implementation of the TQM concept in the health care arena.

2. Background.

Health care QA includes monitoring and evaluating performance against generally accepted medical and dental standards to improve performance. For QA activities to be successful, health care providers and managers must directly involve themselves in the on-going process of monitoring, evaluating, and reviewing records, etc., to allow effective adjustments at the local level. For many years, Coast Guard health care facilities have conducted QA activities, usually as a normal outgrowth of conforming with this Manual's directives and the consequence of Coast Guard practitioners' good medical and dental practices. However, until 1988, no attempts were made to standardize QA activities among all Coast Guard health care facilities to ensure consistently high-quality performance. Formal QA mechanisms were lacking and documentation was sketchy. Since Maintenance and Logistics Commands were established in 1987 and the Quality Assurance Branch was reorganized in 1989 in the Office of Health and Safety, a concerted effort has been made to develop a Coast Guard-wide QA program designed to address quality-of-care issues at our facilities. The program has been tailored the program to Coast Guard medical and dental practices and incrementally phased it in over an extended time period. This dynamic program continues to evolve in an ever-changing health care environment. Directives will be amended as necessary.

3. Applicability and Scope.

All Coast Guard health care facilities with medical or dental officers assigned shall have a QAP to organize efforts to achieve and document quality health care for eligible

beneficiaries. The QAP described here contains the essential elements required at all Coast Guard facilities and assigns responsibilities for program initiatives. All active duty, reserve, and civilian health care providers treating patients at Coast Guard clinics must participate in on-going monitoring and evaluation processes designed to assess the quality and appropriateness of the services they provide.

4. QAP Objectives.

- a. Communicate important QA information to enable sound clinical and management decision-making at all organizational levels.
- b. Review credentials; approve privileges.
- c. Establish criteria to certify clinics and ensure facilities attain and sustain compliance with established standards.
- d. Systematically monitor health services to identify opportunities to improve patient care, implement corrective actions when required.
- e. Integrate, track, and analyze QA information to identify significant patterns that may require additional review or intervention.
- f. Identify and justify resources required to maintain acceptable patient care standards.
- g. Conduct safety and infection control surveillance.
- h. Identify, assess, and decrease risk to patients and staff, thereby reducing liability exposure.
- i. Identify educational and training requirements and assure satisfactory education and training standards are established and maintained.
- j. Establish and maintain adequate systems to monitor and assess patient satisfaction; respond to patient and command concerns about access and quality of care.

5. Definitions.

- a. Quality. The desired level of performance as measured against generally accepted health care standards.
- b. Quality Health Care. According to the Joint Commission on Accreditation of Healthcare Organizations, quality is the prompt, well-documented, effective, efficient, and appropriate organization and delivery of care which maximizes the probability of positive outcomes and minimizes the probability of negative outcomes. Additionally, Coast Guard health care also must meet these criteria:
 - (1) Consistent with Coast Guard policies, guidance, and Medical Manual directives;
 - (2) Consonant with practices in the applicable professional community; and
 - (3) Perceived by beneficiaries as caring, competent, and effective.

- c. Quality Assurance. Those functions which attempt to ensure the desired level of performance by systematically documenting, monitoring, evaluating, and, where necessary, adjusting health care activities. These functions' goal is to improve clinical performance and patient care by striving to meet established high standards.
 - d. Professional Oversight. Monitoring and evaluating services provided by Coast Guard health care personnel and non-Federal providers, including, among others, technical guidance and assistance, peer review, resource utilization review and QA site surveys conducted by Maintenance and Logistics Commands to ensure compliance with the Coast Guard Health Care QAP.
 - e. Governing Body. The agency that has ultimate authority and responsibility for establishing policy, maintaining quality patient care, and providing organizational management and planning.
6. Organizational Responsibilities. See Figure 13-A-1.
- a. Chief, Office of Health and Safety.
 - (1) Establish at all Coast Guard health care facilities a comprehensive QAP which meets industry standards such as those published by the Joint Commission on the Accreditation of Health Care Organizations or similar independent accrediting organizations (the MLC implements the QAP);
 - (2) Govern Coast Guard health care facilities, with delegated responsibilities to the Chief, Health Services Division at each facility.
 - (3) Establish and promulgate health care policy, including professional performance standards against which quality can be measured;
 - (4) Establish and promulgate productivity and staffing standards for the health services program;
 - (5) Conduct periodic Quality Assurance Meetings for Headquarters and MLC QA staffs to coordinate and implement program policy at all organizational levels;
 - (6) Review credentials and grant privileges for all Coast Guard medical and dental officers;
 - (7) Establish criteria for Coast Guard clinic certification and, based on MLC site surveys, certify those facilities meeting established standards;
 - (8) Develop and promulgate the Quality Assurance Implementation Guide; and
 - (9) Identify education and training requirements and assure satisfactory standards are established and maintained. Coordinate and fund continuing professional education for all health services personnel.

b. Maintenance and Logistics Commands.

- (1) Ensure the Commandant's Health Care QA Program is executed at the field level;
- (2) Periodically conduct QA site surveys of all health services facilities in their area in accordance with Section 13.F. provisions. Based on survey findings, recommend clinic certification status to Commandant (G-WK) in accordance with Section 13.G. provisions; pay customer assistance visits when necessary;
- (3) Develop and maintain standard operating procedure manuals and/or health services support program guides necessary to provide operational guidance for clinic activities;
- (4) Develop and maintain Quality Assurance Checklists for QA site surveys;
- (5) Perform utilization review of clinic expenditures, staffing, equipment, supplies, and facilities; review and process all requests for non-Federal medical care from units in its jurisdiction; and
- (6) Provide technical and professional advice regarding health services to units, as required.

c. Commanding Officers.

- (1) Ensure the unit actively pursues health services QAP standards;
- (2) Appoint in writing an individual to serve as Health Services Quality Assurance Coordinator in accordance with Paragraph 13.A.6.e.;
- (3) Appoint health services staff members to serve on a Health Services Quality Assurance Focus Group in accordance with Paragraph 13.A.6.f.; and
- (4) Send copies of QA Focus Group meeting minutes to cognizant MLC (K).

d. Chief, Health Services Division. Represents the Governing Body locally for Quality Assurance and related activities.

e. Health Services QA Coordinator.

- (1) The Health Services QA Coordinator should be a senior health services staff member with these characteristics:
 - (a) demonstrates the ability and motivation to provide and ensure quality health care;
 - (b) knows the requirements of the Medical Manual, COMDTINST M6000.1 (series);
 - (c) communicates well both in writing and orally;
 - (d) well versed in delivering Coast Guard health care and supports the goals of health care quality assurance; and

- (e) is an E-6 or above.
- (2) The Health Care QA Coordinator fulfills these responsibilities:
 - (a) Directs Health Services QA Focus Group activities;
 - (b) Implements the health care QA program locally by identifying and coordinating resolution of health care QA problems;
 - (c) Develops and promulgates an annual QA calendar which sets the agenda for all QA activities at the unit, including among other activities QA Focus Group meetings and all monitoring and evaluation functions; and
 - (d) Other health care QA functions as necessary.
- (3) The Chief, Health Services Division or Clinic Administrator may be appointed as the Health Services QA Coordinator. However, this is not recommended in larger clinics since these two individuals are expected to provide necessary management expertise and clinical guidance in conducting the health care QA program and effecting any required program adjustments. The Health Services QA Coordinator's relationship to the Chief, Health Services Division is advisory.

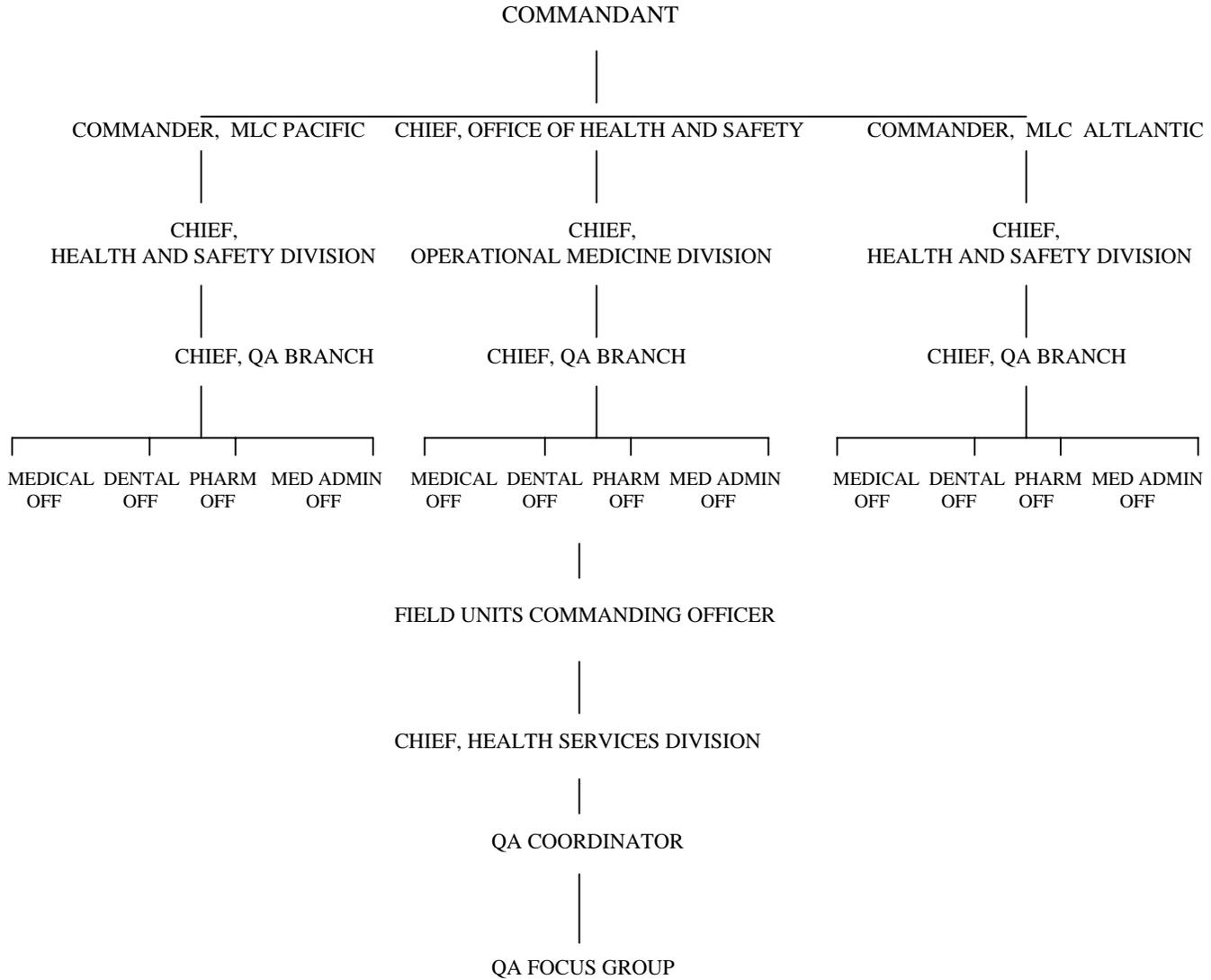
f. Health Services QA Focus Group.

- (1) The Health Services QA Focus Group shall consist of three to 15 members, depending on unit size, including both enlisted members and officers who broadly represent the health care services provided at that unit.
- (2) Members will include at least a medical or dental officer, a clinic supervisor, and department representatives, e.g., pharmacy, physical therapy, x-ray, laboratory, etc. If desired, the Health Care QA Focus Group at small units may operate as a "Committee of the Whole" of all staff members.
- (3) The Health Services QA Focus Group advises the Chief, Health Services Division about the quality of the facility's health care and performs these functions:
 - (a) Identifies and resolves problems which affect the quality of health care delivery at the facility (The Chief Health Services Division may delegate investigating and resolving a particular QA problem to the staff member responsible for the clinical area where the problem has been identified, e.g., laboratory, patient reception, etc.).
 - (b) Ensures all required health services committee meetings are held according to the provisions of the Coast Guard Medical Manual, MLC standard operating procedures and operational guides, and local instructions, including, among others, the Pharmacy and Therapeutics Committee and Patient Advisory Committee.

- (c) Uses existing USCG standards, MLC QA checklists, and monitoring and evaluation exercises to monitor and evaluate the quality of services delivered both in-house and by contract providers.
 - (d) Performs systematic, documented reviews of health records for compliance and adherence to Medical Manual standards and MLC standard operating procedures, health and safety support program guides, and QA checklists.
 - (e) Solicits and monitors patient perceptions and satisfaction by surveys and questionnaires.
 - (f) The Health Care QA Focus Group shall meet at least quarterly and more often as local needs dictate. The clinic will maintain these meetings' original minutes; forwarding copies of the minutes along with monitoring and evaluation reports through the chain of command for the cognizant MLC (K) and Commandant (G-WKH) to review.
7. Confidentiality Statement. All documents created under authority of this instruction are health services quality assurance records and part of the Coast Guard's QAP. They are confidential and privileged under 14 USC 645 provisions. Releasing health services QA documents is expressly prohibited except in limited circumstances listed in 14 USC 645.
8. QAP Review and Evaluation. The Chief, Office of Health and Safety will annually review and evaluate the QAP. The review will reappraise the QA Plan and incorporate comments from the Commanders of the Maintenance and Logistics Commands on implementation activities at field units during the preceding year.
- a. By 30 November annually MLC Commanders shall provide to Commandant (G-WK)a written QA Review and Evaluation Report addressing these topics during the previous fiscal year:
 - (1) Summary of clinical certifications and accreditations;
 - (2) Summary of significant clinical problems identified;
 - (3) Summary of peer review activities;
 - (4) Recommended QAP modifications; and
 - (5) MLC QA Plan for upcoming calendar year.
 - b. By 31 January annually the Chief, Office of Health and Safety will issue to all units a written QA report addressing these topics:
 - (1) Summary of clinical certifications and accreditations during past fiscal year;
 - (2) Summary of significant clinical problems identified during past year;
 - (3) QAP modifications for the current fiscal year; and
 - (4) QA Plan for the current fiscal year.

FIGURE 13-A-1

ORGANIZATIONAL CHART FOR QUALITY ASSURANCE PROGRAM



Section B – Credentials Maintenance and Review

1. Background. Commandant (G-WK) is responsible for ensuring health care providers in Coast Guard facilities are competent and capable. Verifying medical or dental officer qualifications is essential to assure providers are prepared for the scope of practice for which they are employed. To maintain quality health care the credentials review process must be effective. Primary sources must certify as valid certain credentials, including qualifying professional degree(s), license(s), graduate training, and references before a provider may practice independently in Coast Guard health care facilities. All candidates for USCG employment, USCG civil service employees, assigned USPHS commissioned corps officers, and contract providers who provide direct patient care in Coast Guard health care facilities will comply with this chapter's provisions as applicable. The credentials shall be reviewed for each medical or dental officer appointed to a position providing patient care. Clinical responsibilities will be assigned based on this review.
2. Definitions.
 - a. Contract Provider. An individual physician, dentist, physician assistant or nurse practitioner, other than uniformed services personnel, who provides care in a Coast Guard health services facility under a contractual agreement with the Coast Guard.
 - b. Credentials. Documents constituting evidence of education, clinical training, licensure, experience, clinical competence and ethical behavior.
 - c. Credentials Maintenance. Filing, updating, modifying or completing files or documents about practitioner credentials.
 - d. Credentials Review. The process of checking a practitioner's verified credentials and other supporting documents to evaluate potential assignments, assign or rescind clinical privileges, or take administrative or personnel actions.
 - e. Dental Officer. A U.S. Public Health Service (USPHS) commissioned officer assigned to the Coast Guard, who is a graduate of an accredited school of dentistry and holds a valid, current state license to practice dentistry.
 - f. Intake Credentials Verification. The process of verifying a practitioner's license, education, training, and competence before initial assignment or employment.
 - g. License (Current, Unrestricted, Active). A certificate issued by one of the 50 states, District of Columbia or U.S. Territories (Guam, Puerto Rico, Virgin Islands) that permits a person to practice medicine, dentistry, or other allied health profession.
 - h. Medical Officer. A commissioned USCG or USPHS officer assigned to the Coast Guard who has graduated from an accredited educational institution and is currently licensed as a physician or nurse practitioner; or a physician assistant holding valid certification from the National Association on Certification of Physician Assistants.

- i. Primary Source Verification. Verification of a credential with an individual or institution possessing direct knowledge of the validity or authenticity of the particular credential.
 - j. Provider. A person granted individual clinical privileges to diagnose and treat diseases and conditions, including physicians, dentists, physician assistants, nurse practitioners, podiatrists, optometrists, and clinical psychologists.
3. Pre-selection Credentials Review.
- a. Commandant (G-WKH) PHS liaison officer in cooperation with the PHS Division of Commissioned Personnel (DCP) shall perform a pre-employment review and verify minimum standards before appointing Commissioned personnel. The DCP also screens individuals and certain credentials as part of the commissioning process. Coast Guard procedures are designed to complement the DCP's; the Coast Guard may alter its policies as DCP modifies them.
 - b. The cognizant MLC or local command by direction shall perform a pre-employment review of and verify Civil Service employees, contractors providing care in Coast Guard health care facilities, and students.
 - c. To review and verify student credentials, obtain a letter from the school stating the student is in good academic standing. Document malpractice coverage arrangements through an appropriate affiliation agreement. (Student Extern Programs, COMDTINST 6400.1 (series).
4. Practitioner Credentials File (PCF). Commandant (G-WKH-2) shall initiate and maintain PCFs for all Civil Service and Uniformed Service licensed practitioners for the entire length of their employment or service. Persons unable or unwilling to provide required information may be disqualified for employment or accession. These files must contain this information:
- a. A current curriculum vitae accounting for all time since the qualifying degree was received.
 - b. Copies of qualifying educational degrees (diploma, certificate) needed to perform clinical duties with the documents' primary source verification; see Section 13-B-6.
 - c. Copies of required postgraduate training certificates for the area of work; for example, internship, residency, fellowship, nurse practitioner or physician assistant training, and primary source verification of these documents' authenticity.
 - d. Copies of state licenses for all states in which the practitioner is licensed (active or inactive), current renewal certificates, and Educational Commission for Foreign Medical Graduates (ECFMG) certification if the practitioner graduated from a

medical school not in the Continental U. S., Hawaii, Alaska, or from a medical school not accredited by the American Association Liaison Committee on Medical Education in Puerto Rico. The practitioner must attach a statement of explanation for lapsed state licenses or those subject to disciplinary action. The primary source must verify all licenses or renewal certificates.

- e. Copies of specialty board and fellowship certificates with primary source verification of these documents.
 - f. Proof of current (within one year) competence, i.e., two letters of reference for initial appointment and a description of recent clinical privileges held (practitioner's supervisor must note concurrence with and approval of privilege performance).
 - (1) The official reviewing letters of reference is authorized to contact the author of the letters to verify authorship and authenticity of letters. The official is also authorized to request a second letter of reference from an author when the first letter is deemed unclear. The official reviewing a letter of reference is authorized to contact the author via telephone in cases in which the author declines to respond in writing. In such cases, the official will document in a telephone log the site, date, time, identity of call participants and a detailed description of the conversation.
 - g. A statement explaining any involvement in malpractice cases and claims, including a brief review of the facts about the practitioner's involvement.
 - h. A statement about any hospitals', licensing boards', or other agencies' disciplinary action.
 - i. A copy of current certification in Cardiopulmonary Resuscitation from the American Heart Association or American Red Cross.
 - j. Copies of all current and prior Drug Enforcement Agency (DEA) registration, as appropriate.
 - k. National Practitioner Data Bank (NPDB) query.
5. Documentation.
- a. Documents will be placed into a U. S. Coast Guard Training Record (CG-5285) folder. Commandant (G-WKH-2) will maintain files in a locked cabinet. PCFs and their contents are Class III (maximum security) records and protected from disclosure under the Privacy Act. Do not release documents in the PCF to any other individual or entity unless the provider has given express written permission.

b. Place documents in the six-section folder are as follows:

- (1) Section One: Coast Guard clinical privilege documents.
- (2) Section Two: Reference letters.
- (3) Section Three: Adverse actions, malpractice documents, proof of malpractice coverage, statements about adverse information or malpractice claims.
- (4) Section Four: Copies of CPR certification cards, continuing education certificates (CME), other military or civilian courses other than initial qualifying degree.
 - (a) By 31 December **every other year**, each provider shall submit a summary of CME completed during the **prior 2 years** to Commandant G-WKH-2.
 - (b) The CME summary will be in the form of a list in tabular format and will include the name of the course, date taken, sponsoring organization and CME earned.
 - (c) Providers who are members of the professional organizations that maintain transcripts can submit a transcript in lieu of a summary of CME.
- (5) Section Five: JCAHO-accredited hospital letter on admitting privileges, privileges granted by other or previous institutions, curriculum vitae.
- (6) Section Six: Copies of license(s), diploma(s) or degree certificates, ECFMG certificate (if applicable), Internship certificate, Residency Certificate, Fellowship documents, and Board Certification. Primary sources must verify all documents in Section Six.

c. See Figure 13-B-1 for a list of required documents by provider category.

6. Verification.

- a. To verify education, training, licensure or registration, certification, ECFMG and board certification, obtain either an original letter from the educational institution or certifying body attesting to successful completion of specialty training, or verify by telephone call between the Coast Guard representative and educational institution or specialty board. Record telephone verification on the document itself and on official letterhead signed and dated by the person making the call. Place all verification documents with their source documents in PCF Section Six.

- b. Commandant (G-WKH) will verify uniformed services persons before appointment.
- c. Before selection of Civil Service and contract providers, there will be a verification of education, training, licensure, experience, certification or registration, and current competence.
- d. To verify experience and current competence requires at least two recommendation letters from appropriate sources as listed below. Commandant (G-WKH-2) or the appropriate MLC shall receive direct letters from the person providing the reference. Verify descriptions of recent clinical privileges as above.
 - (1) A letter either from the hospital chief of staff, clinic administrator, professional head, or department head if the individual has professional or clinical privileges or is associated with a hospital or clinic; or
 - (2) A letter from the director or a faculty member of the individual's training program if he or she has been in a training program in the previous two years; or
 - (3) A letter from a practitioner in the appointee's discipline who is in a position to evaluate the appointee's peer and a professional association or society association (mandatory if the appointee is self-employed).

7. Contract Provider Credentials Review.

- a. All contract providers who perform any part of their work in a Coast Guard health care facility will submit credentials documents to the appropriate MLC per Paragraph 13.B.6. above and MLC SOPs.
- b. The contracting officer will verify documents.
- c. At the contracting officer's request, MLC (K) will perform a technical review of the providers' credentials.

8. Reverification.

- a. These credentials are renewable and will be primary source on renewal: License, PA certification, Board certification, and contract providers' malpractice coverage. Reverify contract providers' credentials at contract renewal.
- b. Reverify these credentials by original letter or telephone contact. The person making the call will record telephone contact on the document and by a separate, signed memorandum.

9. National Practitioner Data Bank.

- a. Commandant (G-WK) possesses sole authority to report to the National Practitioner Data Bank. Commandant (G-WKH-2) is designated as the appropriate entity for National Practitioner Data Bank queries. Coordinate all queries for patient care providers through this branch.
- b. A reply from the NPDB is not required before the practitioner begins providing services. However, any provider whose credential verification is not fully completed will be considered to have a conditional appointment until all credentials are verified as required.

FIGURE 13-B-1

REQUIRED CREDENTIALS BY PROVIDER CATEGORY

	A	B	C	D	E	F	G	H	I	J	K
Physicians	X	X	X	X	X	X	X	X	X	X	X
General Practice Physicians*	X	X	X	X		X	X	X	X	X	X
Dentists	X	X	X	X			X	X	X	X	X
Physician Assistants	X	X	X	X			X	X	X		X
Nurse Practitioners	X	X	X	X			X	X	X		X
Optometrists	X	X		X			X	X	X		X
Physical Therapists	X	X	X	X			X	X	X		X
Dental Hygienists	X	X		X			X	X	X		X

- A. Current curriculum vitae
- B. Copies of qualifying educational degrees
- C. Copies of required postgraduate training certificates for the area of work; for example, internship, residency, fellowship, nurse practitioner or physician assistant schooling
- D. Copies of state license(s)
- E. Copies of specialty board certification and fellowship certificates
- F. Proof of current competence, recent clinical privileges
- G. Proof of malpractice coverage (contractors only)
- H. Statement explaining malpractice claims, other adverse actions
- I. Health Care Provider BLS**
- J. DEA certification
- K. NPDB query

* General Practitioners. Physicians who have completed one year of Graduate Medical Education (Internship) and have not completed a full residency in a medical specialty.

Section C – Clinical Privileges

1. Purpose. Granting individual clinical privileges to independent practitioners providing services in health care organizations is an essential component of quality assurance. Clinical privilege granting and rescinding activities define the organization's scope of care and services available to patients. The privileging process is directed solely and specifically at providing quality patient care; it is not a disciplinary or personnel management system. However, privileging actions may accompany administrative or judicial actions or engender them. Granting and rescinding clinical privileges is highly confidential, and must be conducted according to strict rules to prevent improper or prejudiced actions. This section establishes processes and procedures to grant and rescind clinical privileges. These provisions fall outside the scope of Administrative Investigations Manual, COMDTINST M5830.1 (series).
2. Background. Commandant (G-WK) is responsible for planning, developing, and administering a comprehensive, high-quality health care program which must ensure the persons providing care have appropriate, verified licenses, education, and training. Coast Guard health care practitioners must adhere to commonly accepted standards for treatment and therapeutic modalities. In the Coast Guard, adherence to accepted standards is achieved by rigorous quality assurance (QA) and providers' peer reviews.
3. Definitions.
 - a. Abeyance. Temporarily assigning a provider to non-clinical duties while an internal (focused) or external review or investigation is conducted.
 - b. Clinical Privileges. Type of practice activities authorized to be performed in the facility, within defined limits, based on the providers' education, professional license as appropriate, experience, current competence, ability, judgment, and health status.
 - c. External Review. Administrative, non-judicial, or criminal investigations initiated by entities other than the Coast Guard health services program.
 - d. Focused Review. An internal administrative mechanism to evaluate information about clinical care or practice. Coast Guard health services officers conduct focused reviews as part of the quality assurance program.
 - e. Full Staff Privileges. Unrestricted privileges as defined by "Clinical Privileges" above, reevaluated and renewed every two years.
 - f. Peer Review. Review by an individual (or individuals) who possesses relevant professional knowledge or experience, usually in the same discipline as the individual under review.
 - g. Privileging. The process through which providers are given the authority and responsibility to make independent decisions to diagnose illnesses and/or initiate, alter, or terminate a regimen of medical or dental care.

- h. Professional Review Committee. A committee appointed by Commandant (G-WK), composed of the Deputy Director of Health and Safety (G-WKd) and the Chiefs of the Operational Medicine Division (G-WKH), Operational and Clinical Medicine (G-WKH-1), and Quality Assurance Branch (G-WKH-2) or their designees. At least two physicians and one dentist shall be members.
 - i. Provider. For this chapter, an individual granted clinical privileges to independently diagnose and treat diseases and conditions. Physicians, dentists, physician assistants, nurse practitioners, podiatrists, optometrists, and clinical psychologists are provider disciplines within the Coast Guard health services program.
 - j. Provisional Clinical Privileges. Initial privileges, generally effective 365 days from issue date, Commandant (G-WK) grants providers when they begin practice in the Coast Guard health services program or earn a new or changed clinical privilege. New Coast Guard providers are eligible for full staff privileges after successfully completing one year of provisional privileges.
 - k. Expiration of Credentials. It is ultimately the responsibility of the provider to ensure that all credentials required for clinical privileges are renewed prior to their expiration dates. If any credential required for clinical privileges is allowed to expire, the provider may have clinical privileges suspended or terminated. This will remove the provider from direct patient care and may also render the provider ineligible to receive any special pay for clinical duties while the provider is in this status.
4. Applicability and Scope. All military and salaried civilian, and contract civilian Coast Guard health care providers shall have clinical privileges assigned. Health services personnel (other than providers) who function under a standard job or position description or standard protocol, policies, and procedures, or who must consult with another provider before or during medical or dental treatment will not receive clinical privileges.
5. Clinical Privileges.
- a. General.
 - (1) Commandant (G-WK) will grant clinical privileges based on education, specific training, experience, license or certification status, and current competence. He or she shall consider facility, support staff, equipment capability, etc. limitations which may prevent a provider from conducting certain activities. Commandant (G-WK) shall assign or require providers to perform professional duties *only* if their education, training, and experience qualifies them to perform such duties. Commandant (G-WK) also shall consider the provider's health status and ability to treat coworkers and patients with dignity and respect (i.e., the presence or absence of good interpersonal skills and "bedside manner") when granting privileges.

- (2) At defined intervals the provider shall use form CG-5575, Request for Clinical Privileges, to initiate a request for clinical privileges. Chief, Health Services Division (HSD) shall recommend whether to approve or disapprove clinical privileges and submit the recommendation to Commandant (G-WK) through MLC (K). The Professional Review Committee shall review the privileges requested and recommend a response to Commandant (G-WK). The actions of the Professional Review Committee will not be considered final until Commandant (G-WK) approves them.
- (3) Absence of clinical privileges must not delay treatment in an emergency—a situation in which failure to provide treatment or hospitalization would result in undue suffering or endanger life or limb. In such cases the providers are expected to do everything in their power to save the patient's life or treat the condition.
- (4) On transfer, the gaining Chief, Health Services Division shall evaluate the provider's clinical privileges to determine whether to continue all previously granted privileges, or whether the facility, patient population, or other factors require adjusting privileges. If a change is indicated, the provider shall submit a revised request for privileges form as delineated below for the Professional Review Committee's review and approval.
- (5) (5) When providers in the Coast Guard are assigned TAD, Commandant (G-WKH-2) shall transmit a copy of the provider's clinical privileges to the host SMO/SDO who will evaluate the privileges and advise the provider which if any privileges will be restricted at that site. When assigned TAD to a clinic that is accredited by JCAHO, AAAHC or other external accrediting agencies, Commandant (G-WKH-2) will also transmit a credentials transfer brief (CTB) to the host command.
- (6) (6) When providers from DoD are assigned TAD to Coast Guard clinics, their parent command shall transmit a copy of their clinical privileges as well as a CTB to the host command prior to their arrival. The SMO/SDO will determine if any of the privileges will be restricted.

b. Procedures.

- (1) Commandant (G-WKH) will inform new Coast Guard providers they must request provisional clinical privileges in writing before accession to active duty or formal employment. New Coast Guard providers shall send written requests for provisional clinical privileges to Commandant (G-WKH) by facsimile or mail at least 45 days before accession. Privilege requests for persons already employed by or assigned to the Coast Guard shall be forwarded by mail for facsimile (FAX) to Commandant (G-WKH) through the cognizant MLC (k) for Professional Review Committee action.
- (2) Providers do not require Professional Review Committee approval before reporting for duty. Until credentials review is completed and privileges are

granted, new providers may deliver care under supervision, i.e., peers shall oversee the provider's work by reviewing monthly a random sample of at least 5% of the provider's charts. Any problems detected during this review will be documented in writing and copies given to the provider. Providers who fail to have the deficiencies corrected in 60 days may have their privileges restricted.

- (3) Provisional clinical privileges are effective for one year. When granting provisional privileges, the risks associated with the activities for which a new provider seeks privileges and the frequency with which he or she performs the procedures shall be considered.
- (4) Privilege request documents, Professional Review Committee actions, and any other documents relating to the granting, maintaining, reviewing or rescinding clinical privileges will be maintained in the individual provider's credentials file.
- (5) The Chief, HSD shall evaluate the provider's provisional privileges after one year. Providers may apply for full staff privileges after one year of successful performance.
- (6) The Professional Review Committee will evaluate full staff privileges every two years. Providers will submit written privilege requests to Commandant (G-WKH) through MLC(kqa) 90 days before privileges are due for renewal.

c. Routine Operations of the Professional Review Committee (PRC)

- (1) The Quality Assurance (QA) Division, Commandant (G-WKH-2) will have the responsibility of monitoring and administering the granting of clinical privileges for all health care workers (HCW'S) in the Health and Safety Program that require the formal granting of clinical privileges in order to perform their duties.
 - (a) Commandant (G-WKH-2) will maintain a Practitioner Credentials File (PCF) for HCW's in the CG Health and Safety Program that will be used for granting clinical privileges.
 - (b) The local QA Coordinator at each field unit will have the responsibility of maintaining a list of the expiration dates of all significant documents required to grant clinical privileges as stipulated in Section 13-B and will notify the HCW when these documents are within 90 days of expiration.
 - (c) It is ultimately the responsibility of the HCW to take appropriate actions to prevent these documents from expiring and to ensure that current documents are entered in the PCF.
 - (d) Commandant (G-WKH-2) will also monitor the expiration dates on these documents and will coordinate through the local QA coordinators.

- (e) The Professional Review Committee (PRC) will make recommendations to Commandant (G-WK) on the granting of clinical privileges.
 - (f) The PRC will routinely review requests for clinical privileges for HCWs upon reporting to new CG duty stations and every 2 calendar years.
 - (g) The PRC can also be convened by Commandant (G-WK) to review PCF's for situations other than the routine review of clinical privileges. This is described further in section 13-C-5-d.
- (2) Commandant (G-WKH-2) will conduct a preliminary review of the requests for clinical privileges as well the entire PCF'S selected to be presented before the PRC.
 - (3) Commandant (G-WKH-2) will forward requests for clinical privileges as well as the PCF'S to the cognizant Program Coordinators who will evaluate the PCF'S and decide if they should be presented before the PRC or if further information or action is required before being submitted before the PRC.
 - (4) After Commandant (G-WK-2) and Program Coordinators have decided which records will be presented to the PRC, Commandant (G-WKH-2) will prepare an agenda and will schedule a PRC meeting.
 - (5) The PRC will included:
 - (a) Commandant (G-WKd) as President of the PRC
 - (b) At least 2 physicians
 - (c) At least 1 dentist
 - (d) At least 1 PA or NP
 - (e) 1 member of Commandant(G-WKH-2), non-voting, to act as recorder
 - (f) Other members of Commandant (G-WKH-2)
 - (6) The PRC will evaluate each PCF and can recommend any of the following actions for each case:
 - (a) Grant all requested privileges.
 - (b) Revoke all current privileges or certain specific privileges.
 - (c) Restrict all current privileges or certain specific privileges.
 - (d) Suspend all current privileges or certain specific privileges.
 - (e) Hold in abeyance all current privileges or certain specific privileges.

- (f) Monitor or supervise of performance of clinical privileges.
 - (g) Request that any decision regarding privileges be deferred until more information is submitted to the PRC.
 - (h) Maintain or modify current privileges while more information is forthcoming or an investigation is being conducted.
 - (i) Request a document focused review or other type of internal investigation.
 - (j) Request an external review or investigation.
 - (k) Other actions as dictated by circumstances.
- (7) In accordance with the terminology adopted by the National Practitioner Data Bank (NPDB) and Federal Credentialing Program (FCP), an adverse privileging action is considered to be any action that revokes, restricts or suspends current privileges for over 30 days.
 - (8) The PRC will vote on each case but the decision to approve or reject a recommendation for a privileging action will be made by WKd..
 - (9) The PRC will forward its recommendations for privileging actions in the minutes of the meeting to Commandant (G-WK) via: Commandant (G-WKH-2), Commandant(G-WKH), and Commandant (G-WKH), and Commandant (G-WKd)
 - (a) Commandant (G-WK) will prepare the minutes for each meeting of the PRC.
 - (b) The minutes will specific the privileging action recommended.
 - (c) In the case of a recommendation by the PRC for an adverse privileging action or any privileging action less than granting full privileges requested, the minutes will specify the reasons or justification for that recommendation.
 - (10) After Commandant (G-WK) receives the minutes, Commandant (G-WK) will make a decision on how to act on the recommendations of the PRC.
 - (a) In cases where the PRC has recommended the granting of full privileges and Commandant (G-WKd) concurs, the request for Clinical Privileges will be submitted to Commandant (G-WK) for final approval.
 - (b) In cases where the PRC has recommended an adverse privileging action or a status less than the granting of all clinical privileges requested and

Command (G-WK) may forward the case to General Legal Counsel, Commandant (G-LGL) for a legal opinion prior to taking action.

- (11) In cases that have been forward to Commandant (G-LGL) for a legal opinion regarding the intended privileging action, Commandant (G-WK) will have 3 working days to make the final decision on how to act after receiving the results of the legal opinion.
 - (a) Commandant (G-WK) will attempt to contact the HCW by telephone and inform about the action.
 - (b) Commandant (G-WK) will forward a letter to the HCW by mail.
 - (c) Commandant (G-WK) will inform the relevant MLC(k) or MLC(m) by letter.
 - (d) MLC will notify the local command and the Chief, Health Services Division,
- (12) In cases where Commandant (G-WK) requests a document or focused review or investigation prior to acting on the recommendations of the PRC, MLC will have the responsibility of organizing and funding this activity and coordinating with the local command.
 - (a) The officer or team conducting the inquiry will be convened within 10 working days after MLC has received written notification from Commandant (G-WK)
 - (b) Within 5 working days after MLC has received written notification from Commandant (G-WK), the local Commanding Officer and the Chief, Health Services Division will be notified of the identity of the officer or team conducting the inquiry.
 - (c) The inquiry will be completed within 3 working days after it has been initiated.
 - (d) Before departing, the officer or team will brief the local Commanding Officer and the Chief, Health Services Division on the findings and recommendations.
 - (e) When the review or investigation has been completed, the officer or team conducting the inquiry will forward a written report of their findings and recommendations to MLC within 10 working days.
 - (f) MLC will forward the results to Commandant (G-WK) within 5 working days After receiving it.

- (13) After receiving written notification from Commandant (G-WK) of the enactment of an adverse privileging action that does not grant full privileges, if the HCW has 30 calendar days to contact Commandant (G-WK) in writing to request a hearing
- (14) After receiving written notification from Commandant (G-WK) of the enactment of an adverse privileging action or a privileging action that does not grant full privileges, if the HCW does not request a hearing within 30 calendar days, it will be presumed that the HCW accepts and will comply with the privileging action.

Commandant (G-WK) will make the decision to notify the NPDB in the case of an adverse privileging action.

- (a) The Coast Guard Health and Safety Program is considered a health care entity under the Health Care Quality Improvement Act of 1987.
 - 1 Health care entities are requires to report any adverse privileging action that is enacted for over 30 calendar days for all physicians and dentists.
 - 2 Health care entities are not required to report adverse privileging actions for other HCW'S
- (b) Commander (G-WK) will make the final decision to report adverse privileging actions
- (c) Commandant (G-WKH-2) will submit the report to the NPBD when directed by Commandant (G-WK) in accordance with current NPDB

d. Non-Routine Privileging Actions.

- (1) The objective of a non -routine privileging action is to affect a change in clinical privileging that is motivated by an urgent set of circumstances that precludes waiting for the routinely schedule evaluation for clinical privileges by the PRC.
- (2) In these cases, the local command will normally initiate a request for modification or termination of clinical privileges based on events at the local field unit level.
 - (a) The request will be in the form of a letter from the local command MLC(k).
- (3) The letter must describe in detail the exact circumstances leading up to the decision to request a modification or termination of clinical privileges.

- (4) The letter must identify the individuals who initiated the complaint or action and every member of the staff and chain of command who had any involvement in the case.
 - (a) In extreme cases, the local command may elect to communicate immediately with MLC(k) by telephone. However this must be followed by the issuance of a letter
 - (b) Local commanding officers may have questions or concerns about providers and under what circumstances requests for restrictive actions should be made.
- (5) The local command should use the cognizant MLC(k) as the POC for these queries.
- (6) Requests for information guidance can be made via telephone, electronic or written correspondence.
- (7) MLC(k) will evaluate the request from the local command and will have up to 5 working days to determine what action will be taken including:
 - (a) No action.
 - (b) Request more information from the local command.
 - (c) Immediate action such as placing the HCW in abeyance.
 - 1 Normally Commandant (G-WK) will make the decision to hold the privileges of the HCW in abeyance.
 - 2 Incases where circumstances are extreme MLC(k) may temporarily hold the privileges in abeyance and then contact Commandant (G-WK) as soon as possible.
 - (d) Convening a document or focused review.
 - (e) Submitting the case for disposition to Commandant (G-WK).
- (8) If MLC (K) determines that a document or focused review is indicated, an officer or team will be on site within 10 working days if the decision.
 - (a) The HCW will notified of the decision as soon as possible by telephone and this will be followed by a letter from MLC (k) to the HCW describing the circumstances that led to this action.

- (b) The local Commanding Officer and Chief, Health Service Division will be appraised of the identity of the officer or team that will be convened for the document or focused review within 5 working days after the decision to convene has been made.
 - (c) The review will be completed within 3 working days after it has been initiated.
 - (d) The officer or team will brief the local a Commanding Officer as well as the Chief, Health Services Division on the findings and recommendations.
 - (e) The officer or team will forward a written report on the findings and recommendations to MLC(k) within 10 working days after the review has been concluded.
- (9) MLC(k) will review the findings and recommendations of the document or focused review and will determine what action to take within 5 working days including:
- (a) No action.
 - (b) Request more information from the local command.
 - (c) Forward the written report from the document or focused review to Commandant (G-WK) for disposition with recommendations from MLC(k)
- (10) After receiving the written report if the document or focused review and the recommendations from MLC(k), Commandant (G-WK) will decide what action to take within 5 working days including:
- (a) No action.
 - (b) Request for more information.
 - (c) Forward the report from the document or focused review with recommendations from the MLC(k) to the PRC and convene an impromptu meeting with instructions to make recommendations to Commandant (G-WK) on the issue of privileging for this particular case.
 - 1 The PRC will convene within 5 working days.
 - 2 The PRC will vote on the case but the decision to enact a privileging action will made by WKd.

- (c) Commandant (G-WKH-2) will submit the report to the NPDB when directed by Commandant (G-WK) in accordance with current NPDB protocols.

e. Hearing Process

- (1) After receiving written notification from Commandant (G-WK) of the enactment of an adverse privileging action or a privileging action that does not grant full privileges, the HCW has 30 calendar days to contact Commandant (G-WK) in writing to request a hearing.
- (2) Commandant (G-WK) has 10 working days to convene a hearing committee after receiving request from the HCW for a hearing.
 - (a) Commandant (G-WK) will notify MLC that a hearing has been requested.
 - (b) Normally hearings will be schedule at Commandant (G-WK) unless otherwise specified.
- (3) A hearing committee will consist of at least three Coast Guard Public Health Service (CG/PHS) officers with the rank of Lieutenant Commander or above and a representative Commandant (G-LGL) to act as legal advisor. At least two of the CGPHS officers on the hearing committee will have board specialties the same as the provider requesting the hearing. Each (CGPHS) officer will have one vote.
 - (a) The HCW will bear all expenses of transporting witnesses or legal advisors.
 - (b) The HCW has the right to:
 - (c) Have an attorney or legal advisor present who can provide legal advice to the HCW. The legal advisor will not participate directly in the proceedings.
 - (d) To record of the proceedings.
 - (e) To call and cross-examine witnesses.
 - (f) To present relevant written evidence.
 - (g) To submit a written statement at the conclusion of the hearing.
- (4) The hearing committee will convey its findings in a written report within 3 working days after the conclusion of the hearing to Commandant (G-WK).
- (5) Commandant (G-WK) will have 3 working days to act on the findings of the hearing.

- (a) Commandant (G-WK) will attempt to contact the HCW by telephone and inform about the results of the hearing and the action to be taken
- (b) Commandant (G-WK) will forward a letter to the HCW by mail.
- (c) Commandant (G-WK) will inform the relevant MLC(k) or MLC(m) by letter.
- (d) MLC will notify the local command and Chief, Health Services Division.

Section D - Quality Assurance Checklists.

1. Background. The MLC Health and Safety Divisions develop and maintain Quality Assurance Checklists, which detail in question-and-answer format the essential criteria against which to assess the quality of health services. These criteria are derived from primarily from the Coast Guard Medical Manual and MLC Standard Operating Procedures and Health and Safety Support Program Guide. MLC commanders will make every effort to ensure uniformity among MLC Checklists to the extent permitted by regional command policies.
2. Usage. QA Checklists will be used primarily to assess compliance with quality assurance standards, which may focus on structure, process, or outcome measures of quality care. Their design will allow clinics and sick bays to self-assess performance by answering the series of questions the checklist poses. Compliance with checklist standards will be scored on a percentage basis. Resulting scores will determine each clinic's certification status.
 - a. Key Elements. Because of their critical nature and importance governing quality of care, certain clinic checklist items will be designated "key elements." Complying with key elements is essential for clinic success. A high degree of conformity with key elements will be required to certify a clinic.
 - b. Elements. "Elements" are certain other checklist items of a less critical (but still important) nature than key elements. Required compliance for clinic certification is lower for elements than for key elements.
 - c. Information Items. The checklist also contains a number of questions included for informational purposes only and not scored for certification.
3. Amendments. The MLC is responsible for Checklist amendments and may amend its Checklist at any time based on policy changes, program requirements, or suggestions and recommendations from clinic personnel or Commandant (G-WK). QA checklists are "living documents" and expected to change regularly to reflect changes in clinic operations and policy. Therefore, clinics will be given updated checklist copies long before QA site surveys.

Section E – Quality Assurance Implementation Guide (QAIG)

1. Background. The QAIG is a series of exercises designed to assist commands to meet Health Services QA Program requirements. Serving as a guideline, the QAIG minimizes the QA program administrative requirements by providing direction and, in many cases, templates for addressing critical QA issues. The exercises often eliminate the need for each clinic to develop its own policies and procedures by providing generic frameworks clinics can adapt to local conditions. In some cases, clinics may be required to submit evidence of completing an exercise to the MLC Health and Safety Division for data evaluation purposes.
2. Responsibilities.
 - a. COMMANDANT (G-WKH) develops as many as 10 exercises per year on critical QA issues for inclusion in the QAIG. The MLCs distribute the exercises.
 - b. COMMANDER, MLC (K) ensures exercises are distributed to appropriate commands for clinic personnel to complete and also reviews each facility's QAIG during quality assurance site surveys.
 - c. Unit QA Coordinators ensure staff promptly complete all QAIG exercises and maintain a complete, up-to-date QAIG.

Section F- Quality Assurance Site Survey.

1. Procedures. All Coast Guard health care facilities are subject to periodic QA site surveys designed to assess compliance with QA checklist elements, and in the case of clinics, to attain Commandant (G-WK) certification; see Section 13-G. MLC Health and Safety Divisions conduct clinic site surveys in accordance with Coast Guard Clinic Certification Program requirements. MLCs survey independent duty sick bays according to schedules promulgated by the MLC. Facilities will be given notice at least eight weeks before the scheduled survey date regarding survey format and schedule and include with the notice the current QA Checklist against which performance is to be evaluated. MLCs will make every effort to schedule QA site surveys during time periods that allow maximum clinic staff participation.
2. Survey Format. The MLC site survey team will conduct all surveys according to this format:
 - a. On arrival brief the Commanding Officer.
 - b. Review on-site clinic or sick-bay procedures and spaces according to QA checklist.
 - c. Health Records Review.
 - (1) Review selected records for documentation as required by QA checklist and verify accuracy of clinic data collection.
 - (2) Review selected records for pertinent diagnosis and care (see Section 13.I., Peer Review).
 - d. Review clinical monitoring and evaluation program.
 - e. Clinic All-Hands Meeting to review the QA site survey team's preliminary findings and solicit clinic staff's suggestions and recommendations for improvement. Feedback from the staff is encouraged on the Quality Assurance Program and the staff may present problems for troubleshooting with MLC QA Staff. A training component focusing on Quality Assurance and its incorporation into the Coast Guard's total quality management philosophy may be included
 - f. Clinical services review with branch heads (e.g., medical services, dental services, pharmacy, etc.).
 - g. Brief Senior Medical Officer, Senior Dental Officer, and Medical Administrative Officer.
 - h. Brief Commanding Officer.
3. Survey Report. Commander, MLC (k) will provide a written QA site survey report to the Commanding Officer within six weeks after the completed survey. Clinics which are determined to be performing at a level below that required for certification will receive the survey report or interim action report within two weeks of the site survey and will be re-survey within 180 days according to Section 13-G provisions. The report will consist

of an executive summary of major survey findings, an itemized account of facility performance measured against QA checklist elements, corrective actions required, and for clinics, certification status based on parameters described in the clinic certification program in Section 13-G. Commanding Officers must provide a written plan for corrective action to Commander, MLC (k), within 45 days of receiving the written evaluation. MLC (k) personnel will be available to assist all facilities in meeting program requirements.

4. Customer Assistance Visits. Customer assistance visits are interim, abbreviated visits by MLC (kqa) staff members. Units may request or MLC (k) initiate them to review compliance with applicable clinic regulations and offer assistance in meeting regulatory requirements.

Section G - Coast Guard Clinic Certification and Accreditation

1. Clinic Certification Program.

- a. Background. Commandant (G-WK) must certify all Coast Guard clinics with assigned medical and dental officers to provide health services. Clinic certification is based on complying with standards set forth in the Medical Manual, COMDTINST M6000.1 (series), and MLC Quality Assurance (QA) Checklists. Commandant (G-WK) certifies facilities based on the results of Quality Assurance site surveys conducted by Maintenance and Logistics Commands.
- b. Responsibility.
 - (1) Unit. The unit commanding officer is responsible for ensuring the command's health care facility complies with standards set forth in the Coast Guard Medical Manual and MLC QA Checklists and for meeting the minimum requirements set forth for clinic certification.
 - (2) Maintenance and Logistics Command. Chief, Health and Safety Division is responsible for developing and coordinating QA Checklists and periodically conducting Quality Assurance Site Surveys at facilities in their area of responsibility. These surveys will assess compliance with existing directives and recommend the facility's certification status based on survey results.
 - (3) Headquarters. Chief, Office of Health and Safety coordinates and directs the certification program, issues certificates to certified clinics, adjudicates appeals, and promulgates appropriate standards governing Coast Guard providers' delivery of health care and policies on managing and operating Coast Guard health care facilities.
- c. Certification Standards.
 - (1) Certified. Commandant (G-WK) will certify clinics complying with at least 90% of both key elements and all other elements on the QA Checklist. Clinics must earn re-certification every three years.
 - (2) Provisionally Certified. Commandant (G-WK) will provisionally certify clinics complying with at least 80% of key elements and at least 80% of all other elements on the QA Checklist. MLC Health and Safety Divisions will annually re-survey provisionally certified facilities until they attain full certification.
 - (3) Not Certified. A facility failing to achieve either certification or provisional certification under this Section's provisions will be subject to a follow-up MLC QA site survey within 180 days after notice of non-certification. During this remedial period, the MLC will assist the facility to promptly address QA survey discrepancies and may impose restrictions limiting the scope of services the facility can provide. The facility must request a follow-up survey during this period. If the facility does not receive at least provisional certification.

- (4) MLC will notify the Commanding Officer the health care facility is not certified by letter through the chain of command and detail appropriate specific restrictions on care delivery in that facility.
 - (a) The Commanding Officer shall submit weekly message reports of progress attained in eliminating disqualifying discrepancies to the cognizant MLC (k), with an information copy to Commandant (G-WKH), through the chain of command.
 - d. Notice of Certification Status. The Maintenance and Logistics Command will send each surveyed facility a copy of the survey report and recommendations for corrective action within 6 weeks of the site survey. If a facility is not certified, the MLC(k) will send the survey report or an interim action report within two weeks of the site survey. Certified and provisionally certified facilities will receive certificates which they are to display prominently within.
 - e. Appeal of Certification Status. A Unit Commanding Officer (CO) may appeal the certification status awarded as a result of the MLC Quality Assurance site survey within 30 days of the site survey report date. The Commanding Officer appeals in writing to Commandant (G-WK) through the chain of command; the appeal must specify the particular disputed QA checklist elements and reasons for the appeal. The CO must not base the appeal on corrective actions taken after the QA site survey or local misinterpretation of QA checklist elements or Medical Manual guidelines. Commandant (G-WK) will consider the appeal and render a final verdict on certification status within 30 days of receiving the appeal.
2. Clinic Accreditation Program.
- a. All Coast Guard-certified health care facilities with four or more medical officers assigned are expected to pursue accreditation from an external accrediting organization. The cognizant MLC and G-WKH must approve pursuit of this accreditation. Once a clinic achieves full or provisional external accreditation, that facility will automatically receive Coast Guard certification and be required to maintain external accreditation. A non-scored MLC QA survey will also be performed to ensure compliance with Coast Guard regulations and compliance with G-WK quality assurance program standards.
 - b. The respective Maintenance and Logistics Command will provide any technical and professional assistance the health care facility requires to prepare for external accreditation. On the command's letter request, Commandant G-WK will provide funding for external accreditation surveys through the respective MLC (K).
3. Laboratory Certification. All ashore medical facilities that test human specimens to provide information to diagnose, prevent, and/or treat any disease or assess a human being's health must comply with the regulations for laboratory testing as stated in the Clinical Laboratory Improvement Amendments of 1988 (CLIA), administered by the Department of Health and Human Services.

Section H- Monitoring and Evaluation Program

1. Background. Monitoring and Evaluation (M&E) is an on-going program that examines important areas of clinical care and assesses how well the facility provides that care. The Joint Commission of the Accreditation of Health Care Organizations describes M&E as the "heart" of quality assurance, a process of continuously seeking areas of potential improvement in the health care delivery system. Participants identify areas of care needing improvement, implement actions to improve care, and continually monitor these areas to ensure the improvements are effective and the quality of care satisfactory.
2. Responsibilities.
 - a. Commandant (G-WKH-2) will monitor and update the M&E program as appropriate.
 - b. Commander, Maintenance and Logistics Commands (k) shall review each facility's M&E log during Quality Assurance site surveys.
 - c. Unit QA Coordinators shall ensure the Quality Assurance Focus Group (QAFG) performs on-going M&E according to schedule. They shall retain logs or their equivalent on file for three years for MLC QA site survey teams to review.
3. Implementation. The Monitoring and Evaluation Report Form (Figures 13-H-1) is the basic instrument documenting Coast Guard clinics' M&E. Each clinic will complete a separate form for each aspect of care monitored.
4. Monitoring and Evaluation Process.
 - a. Monitoring. Units may select any appropriate exercise from the M&E QAIG each quarter, or develop their own exercises to address unit-specific issues. Units must record exercises they developed on Figures 13-H-1, and obtain cognizant MLC (k) approval. All selected exercises must address high-risk, high-volume, or problem-prone clinic procedures.
 - b. Submit M&E Reports to the QAFG prior to the last work day of each quarter. Therefore, start collecting data for each exercise at the beginning of each quarter.
 - c. Follow-Up Reports.
 - (1) Studies Meeting Thresholds. The facility must follow up each initial M&E Report in 6 months with a follow-up report (Figure 13-H-1, Section 8).
 - (2) Studies Not Meeting Thresholds. The facility must produce a follow-up report 3 months after the initial report, and every 3 months thereafter until it meets that threshold(s).
 - d. Use the M&E Data Collection Log, CG-5544 (Figure 13-H-2), to evaluate health records or other information sources for compliance with the indicator criteria. Record each record reviewed as meeting or not meeting the indicator. Retain completed logs on file for three years for MLC QA site survey teams to review.

5. Monitoring and Evaluation Report Forms (Figure 13-H-1). M&E report forms contain ten (10) sections: Sections 1 through 7 on the front and Sections 8 through 10 on the back.
 - a. Aspect of Care (Section 1). If the M&E program is to be meaningful, it must focus on clinical issues that have the greatest potential to affect our patients: high-volume, high-risk, or problem-prone aspects of care.
 - b. Clinical Indicator (Section 2). A component of care which shall be measured to determine compliance with standards. Commandant (G-WKH-2) establishes clinical indicators with suggestions from MLCs (k) and the professional staff at all clinics.
 - c. Thresholds for Evaluation (Section 3). Evaluate compliance with indicator criteria. If the evaluation does not meet a threshold, then the QAFG or its designee(s) must investigate the aspects of care and recommend specific action(s) for improvement.
 - d. Data Collection Methodology (Section 4). M&E exercises' data collection processes are designed to be simple. Any staff member can collect the data. One method is to review clinical records for specific indicator criteria, which are assessed as either "met" or "not met" and recorded accordingly. The "not met" column on the Data Collection Log allows the data collector to identify the specific unmet criteria, so follow-up action can be started.
 - e. Evaluation Report (Section 5). Calculate the percentage of reviewed cases that meet and do not meet the indicator criteria and enter results
 - f. Recommended Action (Section 7). The QAFG must act on completed M&E Reports. If the M&E does not meet a threshold, the QAFG must recommend action(s) to improve this aspect of care. Action specifically taken to improve an indicator is necessary, (Note: Follow-up in three months is not a corrective action).
 - g. Follow-Up Reports (Sections 8-10). Generate either 3 or 6 months after the initial report by completing Section 8 on the M&E Report Form reverse. If possible, the same person responsible for the initial report should prepare the follow-up report. In some cases, a clinic may need to continue a quarterly M&E of a particular aspect of care indefinitely. Use Form Sections 9 and 10 for this purpose.

USING THE MONITORING AND EVALUATION SCHEDULE AND CLINICAL ASPECTS OF CARE LISTING

Each clinic shall monitor at least **one** clinical aspect of care each quarter. Clinics shall select an aspect of care from the M&E QAIG, or an optional exercise specific to a clinic issue.

Submit completed M&E reports to the Quality Assurance Focus Group (QAFG) before the last work day of each quarter. Data collection for each exercise should begin on the first day of each quarter to allow time to collect and evaluate a representative data sample before the end of the quarter. It is recommended that the QAFG assign responsibility for each exercise before the start of each quarter, so that person may collect data promptly. Whenever possible, the same person responsible for the initial M&E report also should generate follow-up reports.

FOLLOW-UP REPORTS

For studies that meet thresholds:

Each initial M&E report must be followed six months to one year later by a follow-up report depending on the nature of the indicator being monitored.

For studies that do not meet thresholds:

A follow-up report is required three months after the initial report and every three months after that, until the evaluation meets thresholds.

Record follow-up reports on the M&E Report Form reverse in Sections 8, 9, and 10.

USING THE M&E DATA COLLECTION LOG, CG-5544

Use this form or a locally produced equivalent to evaluate health records or other information sources for compliance with the indicator criteria. Record each health record reviewed as meeting or not meeting the indicator. M&E Report Section 2 lists indicator criteria, signify unmet indicator criteria by marking the log's appropriate column (e.g., (a), (b), etc.).

Retain completed logs or equivalent on file for three years for MLC QA site survey teams' review.

Figure 13-H-1

OPTIONAL

MONITORING AND EVALUATION REPORT

Facility _____ QA Coordinator _____

1. Aspect of Care	
2. Indicator	
3. Threshold	
4. Data Collection Methodology	
5. Evaluation Report	% Meeting _____ % Not Meeting Indicator Criteria _____
6. Evaluator	Name: _____ Date Evaluated _____
7. Recommended Action	<p style="text-align: center;">_____ / _____ Signature Date</p>

Figure 13-H-1 (Reverse)

<p>8. 3 to 6-Month Follow-up Report</p>	<p>Evaluation Criteria: _____ % Meeting _____ % Not Meeting _____ Continue M&E _____ Discontinue M&E</p> <p>Recommended Action:</p> <p>_____ / _____ Signature Date</p>
<p>9. 3 to 6-Month Follow-up Report</p>	<p>Evaluation Criteria: _____ % Meeting _____ % Not Meeting _____ Continue M&E _____ Discontinue M&E</p> <p>Recommended Action:</p> <p>_____ / _____ Signature Date</p>
<p>10. 3 to 6-Month Follow-up Report</p>	<p>Evaluation Criteria: _____ % Meeting _____ % Not Meeting _____ Continue M&E _____ Discontinue M&E</p> <p>Recommended Action:</p> <p>_____ / _____ Signature Date</p>

Facility _____
 Aspect of Care _____
 Data Collector _____ Date _____

Figure 13-H-2 M & E COLLECTION LOG

Facility _____
 Aspect of Care _____
 Data Collector _____

	Date	Case Identification	INDICATOR (A-E Not Met)						Date	Case Identification	INDICATOR (A-E Not Met)				
			Met	A	B	C	D				E	Met	A	B	C
1								26							
2								27							
3								28							
4								29							
5								30							
6								31							
7								32							
8								33							
9								34							
10								35							
11								36							
12								37							
13								38							
14								39							
15								40							
16								41							
17								42							
18								43							
19								44							
20								45							
21								46							
22								47							
23								48							
24								49							
25								50							

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TOTAL NUMBER	MET	NOT MET
PERCENTAGE		

SECTION I - PEER REVIEW PROGRAM.

Text to come.

Section J - Infection Control Program (Exposure Control Plan).

1. Background.

- a. A standard set of infection control strategies is essential to prevent transmitting infectious diseases. Because history, physical examination, and/or readily available laboratory tests cannot identify all infected patients, use these procedures when providing health care to any patient to prevent transmitting infectious agents.
- b. Health services personnel (officers, enlisted, and civilian) and emergency medical technicians (EMTs) may be exposed to infection through direct contact, droplets, or aerosols from a wide variety of microorganisms in their patients' blood, secretions, excretions, and other body fluids. Direct contact may transmit infection by contaminated instruments (e.g.; needle sticks). Everyone has the potential to transmit infectious diseases to others. All health services personnel and emergency medical technicians must know how infectious diseases spread and take appropriate precautions.
- c. While Coast Guard health services personnel and emergency medical technicians must be seriously concerned with the risk of exposure to human immunodeficiency virus (HIV), the risk of contracting other infectious diseases, such as hepatitis B virus (HBV), is much greater. HBV infection can result in serious physical debilitation and adversely affect a practitioner's ability to provide health care. Once infected, a person also poses a potential risk to future patients as an HBV infection "carrier." Infection control practices that prevent HVB transmission also prevent HIV transmission. Since 1982 a safe, effective vaccine to prevent Hepatitis B has been available; it stimulate active immunity against HBV infection and provides over 90% protection against the virus for 7 or more years after vaccination.

2. Policy.

- a. Health services personnel will adhere to infection-control principles, general hygiene measures, and the Center for Disease Control and Prevention's (CDC's) "universal precautions" to prevent transmitting infectious disease between themselves and their patients.
- b. Hepatitis B vaccination is mandatory for all Coast Guard health services personnel and recommended for emergency medical technicians. Civilian administrative staff and E-8 and E-9 Health Services Technicians filling administrative positions are exempt; however, these personnel are encouraged to receive Hepatitis B vaccination. EMTs and clinic administrative personnel declining to receive HBV vaccination must sign this statement on an SF-600, and it shall be retain in the individual's health record:

I understand due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated **free** with

Hepatitis B vaccine. However, I now decline Hepatitis B vaccination. I understand by declining this vaccine, I continue to risk acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series free.

- c. Emergency medical technicians will adhere to the “universal precautions” described in Chapter 13-K-3.
 - d. Under the OSHA Blood-Borne Pathogen (BBP) Standard, all health services administrative and clinical personnel are occupationally exposed. All clinics shall provide the health care professional responsible for vaccinating employees with Hepatitis B vaccine a copy of the OSHA BBP Standard.
3. Universal Precautions.
- a. Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, care providers must consistently use blood and body-fluid precautions with all patients, including those in emergency care settings in which the risk of blood exposure is greater and the patient’s infectious status usually is unknown. CDC currently recommends the “universal blood and body-fluid precautions” approach or “universal precautions.”
 - (1) All health care workers will routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when anticipating contact with any patient’s blood or other body fluids. Personnel will wear gloves to touch patients’ blood and body fluids, mucous membranes, or broken skin; to handle items or surfaces soiled with blood or body fluids; and to perform venipuncture and other vascular access procedures. Personnel will change gloves after contact with each patient. Personnel will wear masks and protective eyewear or face shields during procedures likely to generate blood droplets or other body fluids to prevent exposure to oral, nasal, or optic mucous membranes. Personnel will wear gowns or aprons during procedures likely to generate blood splashes or other body fluids.
 - (2) If contaminated with blood or other body fluids, personnel immediately will wash hands and other skin surfaces thoroughly. All persons shall wash their hands after completing activities likely to expose them to BBPs and remove protective clothing before leaving the work area.
 - (3) All health care workers will take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures or when cleaning used instruments, disposing of used needles, and handling sharp instruments after procedures. To prevent needle stick injuries, personnel will not by hand directly recap needles, purposely bend or break them, remove them from disposable syringes, or otherwise manipulate them. After using disposable syringes and needles, scalpel blades, and other sharp items, personnel will dispose of them by placing them in puncture-resistant containers located as close to the use area as practical. The Coast Guard does not authorize using reusable needles.

- (4) Although research has not definitively implicated saliva in HIV transmission, it is prudent to use mouthpieces, resuscitation bags, or other ventilation devices instead of mouth-to-mouth resuscitation. These devices must be available for use in areas where the need for resuscitation is predictable.
 - (5) Health care workers who have exuding lesions or weeping dermatitis will not provide any direct patient care or handle patient care equipment until the condition resolves.
 - (6) Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas with a reasonable likelihood of occupational exposure to BBPs.
 - (7) Personnel shall not keep food and drink in refrigerators, freezers, shelves, drug storage areas, or cabinets or on countertops or benchtops where blood or other potentially infectious materials are present.
 - (8) Personnel shall perform all procedures involving blood or other potentially infectious materials in a manner that prevents droplets of these substances from splashing, spraying, splattering, and generating.
 - (9) Pregnant health care workers apparently do not face greater risk of contracting HIV infection than non-pregnant health care workers; however, if a health care worker develops HIV infection during pregnancy, the infant risks infection due to prenatal or perinatal transmission. Therefore, pregnant health care workers will thoroughly learn and strictly adhere to universal precautions to minimize the risk of HIV transmission.
- b. Implementing universal blood and body fluid precautions for all patients eliminates the need for the “Blood and Body Fluid Precautions” isolation category CDC previously recommended for patients known or suspected to be infected with blood-borne pathogens. Personnel will use isolation precautions as necessary if they diagnose or suspect associated conditions, such as infectious diarrhea or tuberculosis.
4. Precautions for Invasive Procedures. The universal blood and body fluid precautions listed above and those listed below shall be the minimum precautions for all invasive procedures, defined as surgical entry into tissues, cavities, or organs; repair of major traumatic injuries in an operating or delivery room, emergency department, or out-patient setting, including both physicians’ and dentists’ offices; a vaginal delivery; manipulating, cutting, or removing any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.
- a. All health care workers who participate in invasive procedures routinely shall take appropriate barrier precautions to prevent skin and mucous membrane contact with all patients’ blood and other body fluids. Personnel shall wear gloves and surgical masks for procedures that commonly generate droplets, splash blood or other body fluids, or generate bone chips, such as those using rotary dental instrumentation. Personnel shall wear gowns or aprons made of materials that provide an effective barrier during invasive procedures likely to splash blood or other body fluids. All

health care workers who perform or assist in vaginal deliveries shall wear gloves and gowns when handling the placenta or infant until after they remove blood and amniotic fluid from the infant's skin and during post-delivery care of the umbilical cord.

- b. If a glove is torn, cut, or punctured, the wearer will remove it, re-scrub, and put on a new glove as promptly as patient safety permits. The needle or instrument involved in the incident shall also be removed from the sterile field.
5. Precautions for Medical Laboratories. Blood and other body fluids from all patients will be considered infectious. To supplement the universal blood and body fluid precautions listed above, these following precautions are recommended for health care workers in clinical laboratories.
- a. All blood and body fluid specimens shall be placed in a well-constructed, labeled container with a secure lid to prevent leaking during transport, taking care when collecting each specimen to avoid contaminating the container's exterior or the laboratory form accompanying the specimen.
 - b. All persons obtaining or processing blood and body fluid specimens (e.g., removing tops from vacuum tubes) shall wear gloves. Personnel shall wear masks and protective eyewear if they anticipate contact with mucous membrane with blood or body fluids, change gloves, and wash hands after completing specimen processing.
 - c. For routine procedures such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, personnel shall use biological safety cabinets (Class I or II) whenever performing procedures with a high potential for generating droplets, including activities such as blending, sonicating, and vigorous mixing.
 - d. Use mechanical pipetting devices to manipulate all liquids in the laboratory. *Never pipette by mouth.*
 - e. Use needles and syringes only in situations in which no alternative exists. Personnel will follow the *recommended* universal precautions to prevent needle injuries.
 - f. Decontaminate laboratory work surfaces with an appropriate chemical germicide after spilling blood or other body fluids and completing work activities.
 - g. Decontaminate contaminated materials (including gauze pads) used in laboratory tests before reprocessing or place such materials in bags and dispose of them according to institutional policies for disposing of infectious waste.
 - h. Decontaminate scientific equipment contaminated with blood or other body fluids with an appropriate chemical germicide and clean such equipment before repairing it in the laboratory or transporting it to the manufacturer.

- i. All persons shall wash their hands after completing laboratory activities and remove protective clothing before leaving the laboratory.
6. Handling Biopsy Specimens. Generally, personnel must put each specimen in a sturdy container with a secure lid to prevent leaking during transport and take care when collecting specimens to avoid contaminating the container's exterior. If the outside of the container is visibly contaminated, clean and disinfect it or place it in an impervious bag before delivery to the appropriate destination for examination
7. Using and Caring for Sharp Instruments and Needles.
 - a. Personnel will consider sharp items (needles, scalpel blades, dental burs, and other sharp instruments) potentially infectious and handle them with extreme care to prevent unintentional injuries.
 - b. Personnel must place disposable syringes and needles, scalpel blades, anesthetic carpules and other sharp items in closable, leak-proof, puncture-resistant containers. Cardboard containers are not appropriate for this purpose. To prevent unintentional needle stick injuries, personnel will not by hand directly recap disposable needles, purposefully bend or break them, remove them from disposable syringes, or otherwise manipulate them after use.
 - c. If multiple injections of anesthetic or other medications from a single syringe are required, personnel may use these techniques in lieu of directly recapping by hand:
 - (1) Use an approved shielding device specifically designed to recap safely (e.g., "On-Guard").
 - (2) Use the "scoop" recapping technique. Affix the empty needle sheath to a flat surface and "scoop" it onto the exposed needle. A hand does not touch the sheath until the needle is securely inside.
 - (3) Use a hemostat to recap by securing the empty sheath well away from the health care worker's hand.
 - d. All Coast Guard Health Care Units shall establish a needle stick protocol; see Section 13-J-13. If a needle stick occurs, the affected person shall report the accident to his or her immediate supervisor, who will document the incident in a memorandum to the Chief, Health Services Division or health services department head, with a copy to the affected person. The memorandum will detail the needle stick's time, date, and circumstances and any medical treatment received. The Chief, Health Services Division or health services department head shall ensure the established needle stick protocol is observed in all cases.
8. Infection Control Procedures for Minor Surgery Areas and Dental Operatories.
 - a. Medical History. Always obtain a thorough medical history. For dental procedures, have the patient complete a Dental Health Questionnaire, NAVMED 6600/3, as Section 4-C requires. Amplify this information by asking the patient specific questions about medications, current illnesses, hepatitis, recurrent illness,

unintentional weight loss, lymphadenopathy, oral soft tissue lesions, results of last HIV test, or other infections. Completely review the individual's health record or consult with a physician if the history reveals active infection or systemic disease.

b. Using Protective Attire and Barrier Techniques.

- (1) Health care workers will consider all patients' blood, saliva, and other body fluids infectious. To protect themselves and patients, personnel must always wear gloves when touching:
 - (a) blood;
 - (b) saliva;
 - (c) body fluids or secretions;
 - (d) items or surfaces contaminated by the above; and
 - (e) mucous membranes.
- (2) Further, personnel must completely treat one patient, if possible, and wash and re-glove hands before performing procedures on another patient. Repeatedly using a single pair of gloves is not allowed; such use can produce defects in the glove material, which reduce its effectiveness as a barrier to microorganisms. Additionally, when gloves are torn, cut, or punctured, the wearer immediately must remove them, thoroughly wash his or her hands, and put on new gloves before completing minor surgical or dental procedures.
- (3) Personnel shall wear surgical masks and protective eyewear or a chin-length plastic face shield. Personnel shall change masks after lengthy examinations or procedures, most especially after any, which produce spatter. Patient protective eyewear shall be provide during all treatment procedures likely to splash or spatter blood, saliva, gingival fluids, or foreign objects. Personnel will use rubber dams, pre-procedural mouth rinsing, high-speed evacuation, and proper patient positioning, when appropriate, to minimize droplet generation and spatter in the dental operator.
- (4) When examining or treating any patient personnel must wear smocks, gowns, or laboratory coats. **When engaging in procedures where there is potential exposure to bodily fluids, personnel must wear scrubs. If wearing reusable garments, the clinic shall have the garments laundered by one of two methods: 1) laundry service, or 2) in-house washer and dryer that is used SOLELY for contaminated laundry. Contaminated laundry, including scrubs, shall be placed and transported in bags labeled or color-coded in accordance with OSHA Regulation, Bloodborne Pathogens Standards, 1910.1030(g)(1)(i).** Personnel shall change **garments** at least daily, when visibly soiled, or after any surgical procedure. All treatment team members must wear long-sleeved gowns or smocks during all surgical procedures **and those procedures** employing rotary instrumentation.

c. Washing and Caring for Hands.

- (1) Personnel must always wash hands after removing gloves between patient treatment contacts, after touching inanimate objects blood or saliva likely has contaminated, and before leaving the minor surgery area or dental operator because gloves knowingly or unknowingly may become perforated during use. These perforations allow bacteria to enter and multiply rapidly beneath the glove material.
- (2) Whenever possible wash hands at sinks that provide hot and cold water through a single mixing valve and preferably readily accessible to the treatment room or operator. After scrubbing, rinse hands in cool water to reduce the likelihood and severity of latex reactions.
- (3) For certain routine dental procedures, such as examinations and non-surgical techniques, hand-washing with plain soap is adequate, since soap and water will remove transient microorganisms. For surgical procedures, personnel must use an antimicrobial surgical hand scrub. Clinics may need to stock non-allergenic soap for allergic individuals.
- (4) Health services personnel who have exuding lesions or weeping dermatitis must refrain from all direct patient care and handling patient-care equipment until the condition resolves.

d. Sterilizing and Disinfecting Dental Hand Pieces, Ultrasonic Scalers, and Dental Units.

- (1) After each use with each patient, personnel will sterilize dental hand pieces (including high-speed, low-speed components used intraorally and ultrasonic scalers) because the device may aspirate a patient's blood, saliva, or gingival fluid into the hand piece or waterline. Clinics should purchase sufficient numbers of autoclavable hand pieces to meet this requirement. Dry heat is the recommended method of sterilizing dental burs.
- (2) Because water retraction valves within dental units may aspirate infectious materials back into the hand piece and water line, check valves must be installed to reduce the risk of transferring infectious material. To physically flush out contaminants run high-speed hand pieces and discharge the water into a sink or container for 3 minutes at the beginning of each day and 30 seconds between patients. Additionally, flush high-speed hand pieces with a 1:10 hypochlorite solution for 3 minutes at the end of each week.
- (3) Disinfect all dental unit surfaces with a suitable chemical germicide between patients or cover such surfaces during use. Use impervious backed paper, aluminum foil, or clear plastic wrap to cover surfaces difficult or impossible to disinfect (e.g., light handles or x-ray tube heads). Remove the covering while gloved, discard the covering, remove used and don fresh gloves, and then recover with clean material after each patient.

- (4) Dental laboratory personnel will observe infection control protocols. They will thoroughly, carefully clean blood and saliva from material used in the mouth (e.g., impression materials, occlusal registrations), especially before polishing and grinding intra-oral devices. They will clean and disinfect contaminated materials, impressions, and intra-oral devices before handling them in the dental laboratory and before putting them in a patient's mouth. They will disinfect laboratory instruments (e.g. spatulas, knives, and wax carvers), plastic benches, chucks, handles, switches, tubing, air hoses, and lab hand pieces every day. Rubber mixing bowls require overnight immersion to disinfect. Workstations, including exposed equipment, drawers, work surfaces, and sinks, require weekly surface disinfecting. Because of the increasing variety of dental materials used intra-orally, dental providers should consult with manufacturers about specific materials' stability in disinfecting procedures.
 - (5) Use sterile saline or sterile water as a coolant or irrigator when performing surgical procedures involving cutting soft tissue or bone.
- e. Dental Radiology Sterilization and Disinfecting Procedures.
- (1) Film-Holding and –Aiming Devices. When practical, heat-sterilize film-holding and –aiming devices between patients. For those items unable to withstand heat sterilization, use a chemical sterilant. Immerse for 6 to 10 hours depending on the sterilant manufacturer's instructions. If sterilization is not practical, immerse these items in chemical disinfectant between patients according to manufacturer's instructions.
 - (2) Panoramic Unit Bite Blocks. Use disposable bite block covers between patients. If disposable covers are not available, treat bite blocks similarly to film-holding devices.
 - (3) Handling Intra-oral Film Packets. Place intra-oral film removed from a patient's mouth directly into a disposable container such as a paper cup or towel for transfer to the darkroom. Discard wrappers directly into a refuse container or into a disposable towel to prevent contaminating the darkroom counter.
 - (4) X-ray Chair. Between patients wipe arm- and headrests with a chemical surface disinfecting solution. If using paper or plastic headrest covers, replace them after each patient.
 - (5) Intra-oral X-ray Tubehead and Exposure Buttons. Wipe these items with a surface disinfectant or cover them after each patient visit. Do not allow disinfectant liquid to leak into the tubehead seams or the exposure button switch.

9. Sterilizing and Disinfecting.

- a. Instrument Categories (Spaulding Classification). The Spaulding Classification defines as critical instruments that normally penetrate soft tissue, teeth, or bone (e.g., forceps, scalpels, bone chisels, scalers, surgical burs, etc.). They must be heat-sterilized after each use. Instruments not intended to penetrate soft or hard tissues

(e.g., amalgam carvers, plastic instruments, etc.) but which may come into contact with tissues are semi-critical and also should be heat-sterilized after each use. If heat sterilization is not possible, semi-critical instruments must receive chemical sterilization. Non-critical instruments never contact tissue. Sterilization is recommended for non-critical instruments, but high-level disinfection is acceptable.

b. Instrument Preparation.

- (1) Initially Storing Contaminated Instruments. Immerse contaminated instruments in a container of soapy water immediately after use or completing the patient visit.
- (2) Cleansing Instruments. Instruments must be cleansed for sterilization to be effective. Cleanse them using an ultrasonic cleaner according to the manufacturer's instructions. Hand-scrubbing instruments is prohibited. Persons who cleanse instruments must wear heavy-duty ("Nitrile") rubber utility gloves to reduce the risk of injury. Inspect instruments for cleanliness before preparing them for packaging.
- (3) Packaging and Wrapping Instruments. Depending on intended use, wrap or package most instruments individually or in sets. Packaging in metal or plastic trays reduces set-up time; instruments and other materials arranged systematically are more convenient. Package size and sterilization method generally determine the best wrapping material, most commonly paper, plastic, nylon, cloth, or combinations of these materials. Seal packages by heat, tape, and self-sealing methods. Wrap instruments loosely to allow the sterilizing agent to circulate freely throughout the pack. Pack scissors, hemostats, and hinged instruments in the open position so the sterilizing agent can reach all parts. When wrapping in an easily punctured material, cover the tips of sharp instruments with 2 x 2 gauze or cotton roll. If using plastic or nylon sterilization tubing, the pack should be approximately 20% larger than the longest instrument to allow the inside air to expand when heated. Clear tubing is relatively puncture-resistant and enables rapid identification of contents. When using cloth to wrap critical items, use a double thickness. Date all packs.

c. Heat Sterilization.

- (1) The best way to minimize cross-contamination is to sterilize all instruments that can withstand sterilizing conditions. The most practical, dependable sterilization method, heat, when appropriate, is preferable to chemical means. These are the most common heat sterilization techniques:
 - (a) Steam Vapor Under Pressure Sterilizer (Autoclave). Steam vapor under pressure is an excellent sterilization method. Moist heat kills the bacteria by causing their proteins to denature and coagulate within the microbial cell. The steam's high temperature, not the pressure, kills the microorganisms. Steam can rust cutting edges made of carbon steel; however, antirust agents reduce this process.

- (b) Chemical Vapor Under Pressure Sterilizer (Chemiclave). This sterilizer uses chemical vapor under pressure and kills bacteria in much the same manner as the steam sterilizer. It is an excellent sterilization method. Because chemical vapors are less corrosive than steam, they do not dull sharpened instruments. Chemical vapor sterilizers use a specific mixture of formaldehyde, alcohols, ketone, acetone, and water. If the manufacturer's recommended chemical solution is not available, distilled water may be used for a short time. Use chemical solutions only once. A disadvantage of the chemical vapor sterilizer is the residual chemical vapor that escapes into the air when the chamber door is opened. While non-toxic and non-mutagenic, its odor can be objectionable. Allowing the sterilizer to cool for at least 20 minutes before opening will significantly reduce the residual vapor level. A commercial purging system that reduces residual vapor levels is available.
- (c) Dry Heat Sterilizer. Dry heat kills bacteria by an oxidation process. Dry heat sterilization will not corrode instruments, but dry heat sterilizers can destroy metal instruments' temper and melt solder joints if not monitored properly. Some dry heat units are not able to sterilize large trays and require special wrapping and bagging materials. For these reasons, dry heat sterilization is not recommended for critical instruments, and should be monitored carefully and used judiciously with semi-critical and non-critical instruments. Because sterility is destroyed as soon as items are touched or left open to the environment, do not place loose instruments in dry heat sterilizers. Wrap and bag all instruments; they must remain wrapped or bagged until used.

d. Sterilization Monitoring.

- (1) Chemical Indicators. External and internal chemical indicators provide a quick visual check to verify instruments have been exposed to elevated temperatures. They do not guarantee the instruments are sterile. External chemical indicators (autoclave tape or sterilizing bags with heat-sensitive printing) identify at a glance which instruments have been processed but show only the outside of the pack was exposed to an elevated temperature. An external chemical indicator must be on every pack processed. If using see-through packages, a chemical indicator placed inside the pouch is acceptable. Internal chemical indicators, available in strips, cards, or labels, react to time/temperature/sterilizing agent combinations.
- (2) Biological Spore Monitors (BSM). Bacterial spores resist heat destruction better than do vegetative forms of bacteria and viruses. Therefore, the spores are used to verify a sterilizer's effectiveness. Place them in the most challenging area of the load being tested and wrap the pack in the usual fashion. Monitor all chemical vapor, water vapor, and dry heat sterilizers with a spore test either weekly or each cycle, whichever is less frequent.

- (a) These systems require a either medical laboratory service or an in-house incubator to incubate the test spore. Dry heat sterilizers require an alternate system using a glassine envelope with enclosed spore strips. Regardless of the system used, document spore monitoring, including identification test date, test results, and operator, and maintain the records for two years.
- (b) If a spore monitor tests positive (spores are still alive), check the sterilizer for proper use and function and repeat the spore test. Items need not be recalled because of a single positive spore test. However, do not routinely use the unit in question until after obtaining a second test. If the second test also is positive, the unit requires service or repair. When the unit is returned to use, perform a spore test to ensure the unit is in proper operating condition.
- (3) Storage and Shelf Life. Store sterile instruments and packs in a cabinet or drawer to reduce contact with aerosols and dust. Handle them as little as possible before using them. Instrument pack life varies according to wrapping material as follows:

Metal or Plastic Container	30 days
Paper Wrap	30 days
Cloth (Double Thickness)	2 months
Nylon, Plastic, or Plastic-Paper Combination (Tape Sealed)	6 months
Nylon, Plastic, or Plastic-Paper Combination (Heat Sealed)	12 months

Rewrap and resterilize outdated packs or packs suspected of being contaminated. Rotate packs to use the oldest ones first. Keep loose (unwrapped or unpacked) instruments to an absolute minimum as their sterility cannot be ensured. Recycle loose reusable instruments through a sterilizer at least once every two weeks. Disinfect drawers and instrument holders containing loose instruments monthly.

- e. Chemical Sterilization and High-Level Disinfection. Although heat is the preferred sterilization method, certain instruments and plastics will not tolerate heat sterilization and require chemical sterilization or high-level disinfection. These disinfectants destroy microorganisms by damaging their proteins and nucleic acids. Most formulae contain 2% glutaraldehyde and come in two containers. Mixing the proper amounts from each container activates the solution. Sterilization monitors cannot verify glutaraldehyde sterilization. The solution is caustic to the skin, so use forceps or rubber gloves to handle instruments immersed in glutaraldehyde and *always* follow manufacturer's directions *carefully*. Label each container of fresh

solution with an expiration date. Uninterrupted immersion for 7 to 10 hours in a fresh glutaraldehyde solution usually will achieve sterilization; uninterrupted immersion for 10 minutes will kill most pathogenic organisms, but not spores. Heavily soiled or contaminated instruments render glutaraldehydes ineffective. Debride instruments thoroughly to disinfect effectively. Glutaraldehydes are not recommended for surface disinfection.

f. Surface Disinfection.

- (1) Extraordinary efforts to disinfect or sterilize environmental surfaces such as walls, floors, and ceilings generally are not required because these surfaces generally do not transmit infections to patients or health care workers. However, routinely clean and remove soil from them.
- (2) After contamination, wipe all other treatment room surfaces such as countertops, dental chairs, light units, exam tables, and non-sterile objects in the operating field with absorbent toweling to remove any extraneous organic material, and then disinfect them with a suitable chemical germicide. Personnel shall wear heavy-duty (“Nitrile”) rubber utility gloves when applying surface disinfectants. Many different chemical disinfectants possessing varying degrees of effectiveness are available. The following three surface disinfectants are recommended.
 - (a) Iodophor. Iodophor compounds contain 0.05 to 1.6% iodine and surface-active agents, usually detergents, which carry and release free iodine. Iodophor’s antimicrobial activity is greater than that of iodine alone: 10 to 30 minutes of contact produces intermediate levels of disinfection. Iodophors are EPA-approved as effective when diluted 1:213 with water. Because iodine’s vapor pressure is reduced in iodophor, its odor is not as offensive. In addition, iodophors do not stain as readily as iodine.
 - (b) Phenolics. In high concentrations, phenolic compounds are protoplasmic poisons. In low concentrations, they deactivate essential enzyme systems. As disinfectants, phenolics are usually combined with a detergent; 10 to 20 minutes of contact produces disinfection. Phenolics are less corrosive to treated surfaces.
 - (c) Sodium Hypochlorite. Sodium hypochlorite is thought to oxidize microbial enzymes and cell wall components. A 1:10 dilution of 5.25% sodium hypochlorite in water produces a solution which disinfects at an intermediate level in 10 minutes. Sodium hypochlorite solution tends to be unstable, so prepare a fresh solution daily. It possesses a strong odor and can harm eyes, skin, clothing, upholstery, and metals (especially aluminum).

(3) Chemical Disinfectants Not Recommended For Use.

- (a) Alcohol. Alcohol is bacteriocidal against bacterial vegetative forms by denaturing cellular proteins. Diluted in water, a 70 to 90% solution is more effective than a more concentrated solution. Alcohol's disadvantages are: (1) rapid evaporation, (2) lack of sporicidal or viricidal activity, and (3) rapid inactivation by organic material. Since alcohol interferes with proper surface cleansing, it has no place in the disinfection protocol.
- (b) Quaternary Ammonium Compounds. In the past, benzalkonium chlorides and other "quats" were used as disinfectants because they were thought to be safe and inexpensive and have low surface tension. Their biocidal activity breaks down the bacterial cell membrane, producing an altered cellular permeability. As a group, these compounds have serious deficiencies. Being positively charged, they are attracted to not only bacteria but also to glass, cotton, and proteins, which decrease their biocidal activity. Common cleaners', soaps', and other compounds' negatively charged ions neutralize "quats." Research has shown some "quats" support the growth of gram-negative organisms. Quats are ineffective against most spore formers, the Hepatitis B virus, and the tubercle bacillus.

10. Laundry. Although research has identified soiled linens as a source of large numbers of certain pathogenic microorganisms, the risk of linens actually transmitting disease is negligible. Wearing gloves while handling soiled linen is recommended. Handle it as little as possible and with minimum agitation to prevent gross microbial contamination of the air and persons handling the linen. Carefully check linen for sharps objects and remove them before washing. Bag all soiled linen where used; do not sort or rinse it in patient care areas. **Contaminated laundry, including scrubs, shall be placed and transported in bags labeled or color-coded in accordance with OSHA Regulation, Bloodborne Pathogens Standards, 1910.1030(g)(1)(i).**

11. Cleaning and Decontaminating Blood or Other Body Fluid Spills. Use an EPA-approved germicide or recommended surface disinfectant agent to promptly clean all blood and blood-contaminated fluid spills. Health care workers must wear gloves. First remove visible material with disposable towels or other appropriate means that prevent direct contact with blood. If anticipating splashing, wear protective eyewear and an impervious gown or apron that provides an effective barrier to splashes. Next decontaminate the area with disinfectant solution or an appropriate EPA-approved germicide. Clean and decontaminate soiled cleaning equipment or put it in an appropriate container and dispose of it according to clinic policy. Use plastic bags clearly labeled as containing infectious waste to remove contaminated items from the spill site. Remove gloves; then wash hands.

12. Infectious Waste.

- a. Epidemiological evidence does not suggest most clinic waste is any more infectious than residential waste. However, public concern about the risk of medical wastes must not be ignored. Identifying wastes for which special precautions are necessary include those wastes which potentially cause infection during handling and disposal and for which special precautions appear prudent, including sharps, microbiology laboratory waste, pathology waste, and blood specimens or products. While any item that has touched blood, exudates, or secretions potentially may be infectious, it is usually not considered practical or necessary to treat all such waste as infectious. Materials containing small amounts of blood, saliva, or other secretions such as tainted gauze pads, sanitary napkins, or facial tissues are not considered infectious waste. Generally, autoclave or incinerate infectious waste before disposing of it in a sanitary landfill. Infectious waste autoclaving standards are different from normal sterilization standards. Carefully pour bulk blood, suctioned fluids, excretions, and secretions down a drain connected to a sanitary sewer. Or for materials capable of it, grind and flush such items into sanitary sewers (some states prohibit this practice).
- b. The Environmental Protection Agency classifies health care facilities as generators of infectious waste based on the weight of waste generated. Coast Guard classification is based on facility type. All Coast Guard clinics are considered generators. Each Coast Guard health care facility must have a written infectious waste management protocol consistent with state and local regulations in the unit's area.
- c. Biohazard warning labels shall be affixed to regulated waste containers; refrigerators, and freezers containing blood or other potentially infectious material; and other containers used to store, transport, or ship blood or other potentially infectious materials with these exceptions:
 - (1) Substitute red bags for labels on regulated waste bags or containers. OSHA believes red bags protect personnel because they must comply with OSHA BBP Standard Paragraph (g)(2)(iv)(M), which requires training personnel to understand the meaning of all color coding.
 - (2) Individual containers of blood or other potentially infectious materials placed in a labeled container during storage, transport, shipment or disposal.
 - (3) **Contaminated laundry, including scrubs, shall be placed and transported in bags labeled or color-coded in accordance with OSHA Regulation, Bloodborne Pathogens Standards, 1910.1030(g)(1)(i).**

13. Managing Exposures (Needle Stick Protocol)

- a. Exposure.
 - (1) An exposure occurs if a health care worker comes in contact with blood or other body fluids in one of these ways:

- (a) Parenteral—through a needle stick or cut;
 - (b) Mucous membrane—from a splash to the eye or mouth;
 - (c) Cutaneous—contact with large amounts of blood or prolonged contact with blood when the health care worker’s exposed skin is chapped, abraded, or afflicted with dermatitis.
- (2) All individuals so exposed shall report the exposure to their immediate supervisor, who will document the incident in a memorandum detailing the exposure’s time, date, and circumstances and any medical treatment received to the Chief, Health Services Division or health services department head, with a copy to the exposed person. The QA coordinator or his or her designee also will retain a copy and ensure all required follow-up treatment and testing is documented. The Chief, Health Services Division or health services department head shall ensure that the following this management protocol is adhered.
- (3) After an exposure, obtain the source person’s consent, making sure to follow local laws governing consent for testing non-active duty source persons and incompetent or unconscious persons. At a location where appropriate pre-test counseling is available for the source person, draw a blood sample and test it for Hepatitis B Surface Antigen (HbsAg) and Human Immunodeficiency Virus (HIV) antibody. Provide the source person post-test counseling and treatment referrals. Inform the exposed person of the source person’s test results and applicable laws and regulations on disclosing the source person’s identity and infectious status. It is extremely important all persons who seek consultation for any HIV-related concerns receive appropriate counseling from a USMTF or other medical facility capable of providing this service.
- (4) All clinics shall ensure the health care professional evaluating an employee after an exposure incident has this information:
- (a) A copy of the OSHA BBP Standard,
 - (b) A description of the exposed employee’s duties as they relate to the exposure incident,
 - (c) Documentation of the route(s) of exposure and circumstances under which exposure occurred,
 - (d) Results of the source individual’s blood tests, if available; and all records on the employee’s appropriate treatment, including vaccination.
- (5) The SMO shall obtain and give the exposed person a copy of the evaluating health care professional’s written opinion within 15 days after the evaluation is complete.
- (6) Figure 13-J-1 presents a sample needle stick injury flow sheet.

b. Hepatitis B Virus Post-exposure Management.

- (1) For a worker exposed to a source individual found to be positive for HbsAg:
 - (a) The exposed worker who has not previously received Hepatitis B vaccine will receive the vaccine series. A single dose of Hepatitis B immune globulin (HBIG) if it can be given within 7 days of exposure is also recommended.
 - (b) Test the exposed worker who has previously received Hepatitis B vaccine for antibody to Hepatitis B surface antigen (anti-HBs). If the antibody level in the worker's blood sample is inadequate (i.e., less than 10 SRU by RIA, negative by EIA) give the exposed employee one dose of vaccine and one dose of HBIG.
- (2) If the source individual is negative for HbsAg and the worker has not been vaccinated, the worker shall receive Hepatitis B vaccination.
- (3) If the source individual refuses testing or cannot be identified, the unvaccinated worker should receive the Hepatitis B vaccine series. Consider administering HBIG on an individual basis if the source individual is known or suspected to be at high risk of HBV infection. At his or her discretion the responsible medical officer will manage and treat as needed previously vaccinated workers who are exposed to a source who refuses testing or is not identifiable.

c. Human Immunodeficiency Virus Post-exposure Management.

- (1) If a worker is exposed to a source individual found positive for HIV infection or who refuses testing, counsel the exposed worker about the risk of infection and evaluate him or her clinically and serologically for evidence of HIV infection as soon as possible after the exposure. In view of the evolving nature of HIV post-exposure management, the health care provider must be well informed of current Centers for Disease Control (CDC) guidelines on this subject.
 - (a) Advise the exposed worker to report and seek medical evaluation for any acute febrile illness occurring within 12 weeks after exposure. Such an illness, particularly one characterized by fever, rash, or lymphadenopathy, may indicate recent HIV infection.
 - (b) After the initial test at the time of exposure, retest seronegative workers 6 weeks, 12 weeks, and 6 months after exposure to determine whether HIV transmission has occurred. During this follow-up period (especially the first 6 to 12 weeks after exposure, when most infected persons seroconvert), exposed workers must follow CDC recommendations to prevent transmitting HIV, including refraining from blood donation, informing health care workers rendering treatment of his or her status, and using appropriate protection during sexual intercourse. During all phases of follow-up, it is vital to protect worker confidentiality.

- (2) If the source individual's tests are seronegative, perform a baseline testing of the exposed worker with optional follow-up testing 12 weeks later if the worker desires or the health care provider recommends it. After the initial test at the time of exposure, at the responsible medical officer's discretion, retest consenting seronegative source individuals at 12 weeks and 6 months afterward.
- (3) If the source individual cannot be identified, decide appropriate follow-up on an individual basis. All workers concerned they have been infected with HIV through an occupational exposure should undergo serologic testing.
- (4) Follow CDC recommendations for preventing HIV and HBV transmission to patients during exposure-prone procedures, defined as those invasive procedures with a recognized risk of percutaneous injury to health care workers.
 - (a) All health care workers shall adhere to universal precautions. Health care workers with exuding lesions or weeping dermatitis shall refrain from all direct patient care. Health care workers shall comply with current CDC guidelines for disinfecting and sterilizing equipment and supplies.
 - (b) All health care workers performing exposure-prone procedures shall know their HIV and HBV status.
 - (c) All health care workers who are HIV or HBV positive shall refrain from performing exposure-prone procedures.

14. Training Personnel For Occupational Exposure. All Health Services Divisions or Branches will inform and train personnel in occupational exposure initially on assignment and annually thereafter. Personnel who have taken appropriate training within the past year need receive additional training only on subjects not previously covered. The training program shall contain at least these elements:

- a. An accessible copy and explanation of the regulatory text of this standard (Federal Register 56 (235):64175, December 6, 1991 [29 USC 1910.1030]).
- b. A general explanation of the epidemiology and symptoms of bloodborne diseases.
- c. An explanation of bloodborne pathogen transmission modes.
- d. An explanation of the exposure control plan outlined in Section 13-J.
- e. An explanation of the appropriate methods to recognize tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- f. An explanation of methods to reduce or prevent exposure, such as barrier techniques, and their limitations.
- g. Information on the types and properly using, locating, removing, handling, decontaminating, and disposing of personal protective equipment.

- h. An explanation of the basis for selecting personal protective equipment.
- i. Information on the Hepatitis B vaccine, including efficacy, safety, administration, and benefits. This vaccination is mandatory for all Health Services Technicians except E-8 and E-9 personnel in administrative positions. It is recommended and available for EMTs and E-8 and E-9 Health Services Technicians in administrative positions.
- j. Information on appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and available medical follow-up described in Section 13-J-13.
- l. Information on the post-exposure evaluation and follow-up the SMO or designee is required to provide for the employee after an exposure incident.
- m. An explanation of the signs, labels, and/or color coding required for sharps and biohazardous materials.
- n. A question-and-answer period with the person conducting the training session.

Figure 13-J-1

SAMPLE NEEDLESTICK INJURY FLOWSHEET
(CONFIDENTIAL)

Health Care Worker's Name: _____

Source's name, status, and contact information (if known):

Date of Incident: _____

Type of Exposure (check one)

- Needle stick, cut, or puncture wound with contaminated instrument
- Splash to the eye or mouth
- Contact with large amounts of blood when the exposed skin is chapped, abraded, or afflicted with dermatitis
- Other: _____

	NO	YES
Have consent to test and pretest information been given?		
Is source test positive for HBV?	(2)	(next)
Is Health Care Worker (HCW) vaccinated for hepatitis?	(2)	(next)
HCW Hepatitis B surface antigen (anti-HBs) adequate (i.e., more than 10 SRU by RIA, positive by EIA)?	(3)	(next)
Less than 7 days since exposure?	(7)	(4)
Is source test positive for HIV?	(5)	(1)(6)

ACTION TAKEN

1. Post exposure counseling
2. Initiate and complete HBV vaccination series
3. Give one dose of HBV vaccine
4. Give one dose of HBIG
5. HIV testing (baseline, optional 12 weeks)
6. HIV Testing (baseline, 6 weeks, 12 weeks, 6 months)
7. No action required

SENT TO QA COMMITTEE: _____

Section K - Risk Management Program

1. Purpose. The risk management program supports quality medical care by identifying, analyzing, and preventing actual and potential risks to patients and staff. The program provides mechanisms to detect and prevent accidents and injuries and reduces the cost of claims and loss of other resources.
2. Background. Risk management programs are most effective if they are prospective, preventive, and comprehensive. All staff members, beneficiaries, contract providers, and volunteers shall be aware of risks in the clinical environment and act safely and responsibly to implement program requirements. Risk management activities are not limited to claims activities but examine all instances of actual and potential risk or loss.
3. Definitions.
 - a. Medical Incident: An adverse or unexpected medical outcome resulting in death or significant morbidity.
 - b. Occurrence: Any event or situation in which there is an actual or potential injury or patients or staff raise a significant complaint or concern about treatment delivered.
4. Informed Consent.
 - c. Background. Every person, with a few exceptions, has the right to be examined and treated only in the manner they authorize. This individual prerogative is based on the concept a competent patient has the right to make informed decisions about health care. Consent for health care must be informed, voluntary, competent, and specific, and is clearly an important issue in quality patient care. The objective of informed consent is improved patient-provider communication in non-emergent situations, which should result in patients' realistic expectations about the nature of treatment and the expected outcome, and reduced liability for the government. Clear documentation demonstrating the patient was properly informed is necessary to protect the patient, the provider, and the government. Although patients must be informed of treatment options, military members who refuse treatment necessary to render them fit for duty (including immunization) are subject to separation and/or disciplinary action (see Chapter 2-A-4-b.).
 - d. Responsibilities.
 - (1) Chief, Health Services Division (CHSD): The CHSD must publish facility-specific implementing instructions that ensure providers carry out the spirit and intent of this Section. The CHSD and cognizant MLC should monitor compliance with consent policies and procedures as a regular part of medical and dental records review.
 - (2) Health Care Providers: Responsible health care providers must counsel patients before treatment and document receiving the patient's informed consent.

- e. Types of Consent. Consent may be expressed or implied.
- (1) Expressed Consent: This type of consent is obtained by open discussion between the provider and patient and must include a statement the patient consents to the proposed procedure. Expressed consent may be oral or written.
 - (a) Oral Consent. Except where this regulation specifically requires written consent, oral consent is sufficient authorization for treatment. However, oral consent is difficult to prove. If a health care provider receives oral consent to treatment, he or she must document it by an entry in the treatment record. Consent received from competent authority by telephone is a form of oral expressed consent; a person not directly involved in the patient's care should witness such consent; and it must be documented by an entry in the treatment record.
 - (b) Conditions Requiring Written Consent. Document written consent by having the patient sign forms authorizing treatment and including an entry in the treatment record that discusses the requirements outlined in Paragraph 13-K-4. Except in emergencies, written consent is required for these situations:
 - 1 All surgical procedures (including, among others, placing sutures, incision and drainage, removing a foreign body(s), cauterizing, removing wart(s), injecting medications into a joint(s), etc.)
 - 2 Invasive tests and procedures to diagnose and treat disease or remove tissue specimens (e.g., biopsies), except routine phlebotomy.
 - 3 Anesthesia, except local dental anesthesia.
 - 4 Dental procedures other than routine restorative dentistry.
 - 5 Genitourinary procedures including vasectomies, IUD insertion or removal, etc.
 - (2) Implied Consent. Implied consent is derived from the patient's conduct even if he or she does not communicate specific words of consent. Assume implied consent only if one can reasonably presume the patient knows the risks, benefits, and alternatives to treatment. For example, a patient's presence at dental sick call is implied consent for a dental exam. Never accept implied consent to treatment involving surgical therapy or invasive diagnostic procedures except in emergencies.
- f. Emergencies. Consent before treatment is not necessary when immediate treatment is required to preserve life or prevent deterioration of the patient's condition. The provider will document the existence and scope of the emergency and describe the events precluding obtaining consent.

- g. Who May Consent. Generally, competent adult patients who have the capacity to manage their own affairs who present themselves for treatment have the authority to consent. If a patient is incompetent due either to statutory incompetence (e.g., a minor) or mental impairment, then it must be determined who the individual with legal capacity to consent and obtain his or her consent before examining or treating the patient. Laws defining minors and to what they may legally consent differ by state. The law of the state where the facility is located governs legal capacity to consent. Each clinic will develop a policy for treating minors.
- h. Information To Provide. The provider must advise the patient of the nature of his or her condition; describe the proposed treatment in terms the patient can understand; and explain the material risks and expected benefits of the proposed treatment course, available alternative health care options, and the option of non-treatment. A material risk is one a reasonable person likely would consider significant in deciding whether to undertake therapy and is a function of the likelihood of occurrence, the severity of the injury it threatens to cause, and existing reasonable alternatives. A provider is not required to explain risk that are considered extremely remote unless the patient requests an explanation or the potential adverse consequences are so grave a reasonable person in the patient's particular circumstances would consider the risk important.
- i. Informing the Patient. Health care providers will provide information in a manner that allows a patient of ordinary understanding to intelligently weigh the risks and benefits when faced with the choice of selecting among the alternatives or refusing treatment altogether. Health care providers must communicate in language one can reasonably expect the patient to understand. Although open discussions between the responsible health care provider and the patient should be the standard, each department may develop internal methods to acquaint patients with the benefits, risks, and alternatives to procedures requiring consent. In some departments, prepared pamphlets or information sheets may be desirable.
- j. Documentation. Regardless of the method used to inform the patient or the form of consent (oral or written), the provider must document the disclosure and the patient's reactions in the medical or dental record. It is highly recommended progress notes even if the patient has signed a preprinted "consent" form. Progress notes written to document disclosing information to the patient will be specific about the information provided. The notes must specifically enumerate risks, alternative forms of treatment, and expected benefits the provider discussed with the patient. Use SF 522, "Request for Administration of Anesthesia and for Performance of Operations and Other Procedures," to document consent in all surgical, anesthetic and reproductive procedures other than local dental anesthesia and routine restorative dentistry.
- k. Witness to Consent. All consent forms require a witness's signature. The witness may be a health care facility member who is not participating in the procedure or treatment. Patients' relatives are not acceptable as witnesses. The witness confirms the patient signed the form, not that he or she received all relevant information.

1. Duration of Consent. Consent is valid as long as no material change in circumstances occurs between the date the patient consented and the procedure or treatment date. Obtain new consent if a material change in circumstances occurs, for example the provisional diagnosis changes. If more than seven (7) days elapse between the date the patient signed the consent and the date treatment begins, provider and patient must re-sign, re-initial, and re-date the consent form. A new consent is not required for each stage in a series of treatments for a specific medical condition, e.g., repeated application of liquid nitrogen to warts.
5. Occurrence Monitoring and Reporting. (To be developed).
6. Medical Incident Monitoring and Reporting.
 - a. Definition. In the Coast Guard's Health Services Program, a medical incident is an event involving an unexpected death or permanent disability of a patient to whom Coast Guard health services personnel have rendered health care. The event is not reviewed to place blame or discipline those involved, but rather to assess the health care process(es) involved and identify potential areas for improvement. The Coast Guard uses the resulting recommendations to determine health care policy, personnel, equipment, and training needs to prevent future adverse health care outcomes. A single event may result in initiating a Mishap Board as the Safety and Environmental Health Manual, COMDTINST M5100.47 (series), requires and a legal investigation conducted concurrently with a medical incident review of the same event (e.g., a vessel collision with injuries). In most cases however, a medical incident review will occur solely within a Coast Guard health care facility or with medical or dental services rendered its only issue.
 - b. Reporting Procedure. Within 24 hours after a medical incident occurs, the command shall submit copy(s) of SF-558, Emergency Care and Treatment Report , and/or SF-600 for events occurring within the clinic and/or CG-5214, Emergency Medical Treatment Report, for events occurring outside the clinic to the appropriate MLC (k). Clearly mark "Incident Report" in large print across the top of these forms. Stamp or print this statement on the top of each document: "This is a medical quality assurance document. It is protected by Federal law (14 USC 645)." MLC (k) shall send copies of the documents to Commandant (G-WKH) within three days of receipt.
 - c. Review Procedure. On receiving one of the three forms, MLC (k) or Commandant (G-WKH), if appropriate, shall review the document(s); verify the event meets the Paragraph 13-K-6-a criteria for an incident; determine whether an on-site medical review shall be conducted; and designate a single point of contact at MLC (k) or Commandant (G-WKH).
 - (1) If MLC (k), or Commandant (G-WKH), determines a medical incident review is unnecessary, they shall notify the command by letter within 10 working days of the event and send a copy of the letter to Commandant (G-WKH).
 - (2) If conducting an on-site medical incident review, MLC (k) or Commandant (G-WKH), as appropriate, shall notify the involved command as soon as possible and designate an officer to conduct a review or convene a panel of

qualified professional staff, including a member of the involved facility, to review all aspects of the incident. To ensure confidentiality, the panel shall consist of only the designated facility point of contact and the persons MLC (k) or Commandant (G-WKH) appoint.

- d. The incident review officer or panel shall request and review all relevant documents and reports, interview personnel as required, and when the review is complete, submit a written letter report with this information on the incident to Commandant (G-WKH) through the cognizant MLC (k) (see Paragraph 13-K-6-e below):
- (1) Synopsis. A brief summary of the incident and injuries and/or fatalities involved.
 - (2) Factual Information. Factual information and data about the incident and personnel involved shall consist of at least these topics:
 - (a) History. The chronological order of any significant events preceding, during, and after the incident, including any written logs or transcripts of radio logs substantiating this chronology, such as the SF-558, CG-5214, or SF-600.
 - (b) Injuries. Describe each injury, or in the case of fatalities, the cause of death. Include autopsy findings when available.
 - (c) Professional qualifications of all persons who delivered health care, including all recent applicable training and certificates (e.g., ACLS, BLS, EMT, HS, etc.).
 - (d) Equipment Performance. List all pertinent medical equipment used during the incident and any failures due to mechanical malfunction, operator error, inadequate training, or other factors. Describe whether equipment involved was maintained or serviced according to manufacturers' specifications.
 - (3) Analysis and Conclusions. The individual's or panel's hypothesis of the circumstances surrounding the event, emphasizing the health care aspect, developed using all available information and including a brief conclusion about the health care rendered and how it contributed to the event's outcome.
 - (4) Recommendations. Recommended modifications to policy, personnel staffing, equipment, training, or any other health care delivery system aspect which might improve to avoid similar incidents in the future.
- e. Routing Incident Review Reports. The cognizant MLC (k) shall send the completed report to Commandant (G-WKH) for review and appropriate action.

Section L- Training and Education

1. Definitions.

- a. ACLS (Advanced Cardiac Life Support): Sponsored by the American Heart Association (AHA), this 16-hour program (8 hours for recertification) emphasizes cardiac-related diagnostic and therapeutic techniques and grants a completion certificate valid for two years on completion. An ACLS certificate of completion recognizes a person completed the course and does not in any way authorize him or her to perform skills taught there. ACLS also sometimes refers to the cardiac component of Advanced Life Support.
- b. Advanced Life Support (ALS): A general term applied to pre-hospital skills beyond the basic life support level including, among others, EKG interpretation, medication administration, and advanced airway techniques.
- c. Basic Life Support (BLS): Rudimentary pre-hospital skills including CPR, bleeding control, splinting, patient assessment, oxygen administration, etc., associated with the basic level emergency medical technician.
- d. Cardio-Pulmonary Resuscitation(CPR): A program sponsored by the AHA and American Red Cross which, on completion, grants certificates of completion for 1 to 2 years. The course curriculum includes basic skills (airway maintenance and cardiac compression) necessary to sustain heart and brain function until advanced skills can be administered.
- e. Emergency Medical Technician (EMT): A general term referring to the certification of pre-hospital care providers routinely recognizes at three skill levels (EMT-Basic, EMT-Intermediate, EMT-Paramedic), but functions performed at each level vary significantly by jurisdiction. When the term EMT is used alone, assumes it refers to the EMT-Basic level, which performs BLS skills.
- f. Paramedic: An individual certified by the National Registry of Emergency Medical Technicians as an Emergency Medical Technician-Paramedic (NREMT-P) or certified by a local governing body to perform ALS procedures under a physician's license.

2. Unit Health Services Training Plan (In-Service Training).

- a. Clinics, sickbays, and independent duty health services technicians must have an on-going in-service training program aimed at all providers with emphasis on the Health Services Technicians' professional development. It is expected of clinic staff members attending outside training to share new information with other staff members. In-service training sessions allow clinics to ensure issues of clinical significance are presented to their staff.

- b. In-service training must include these topics, among others:
 - (1) Quality Assurance Implementation Guide Exercises;
 - (2) Annual review of clinic protocols on suicide, sexual assault, and family violence;
 - (3) Patient satisfaction issues;
 - (4) Patient sensitivity;
 - (5) Emergency I.V. therapy;
 - (6) Pneumatic anti-shock garment (MAST) review;
 - (7) Emergency airway management;
 - (8) Cardiac monitor and defibrillator familiarization;
 - (9) Cervical spine immobilization and patient transport equipment;
 - (10) Emergency vehicle operator's training (where operated);
 - (11) Section 13-K infection control policy and procedures.

- c. The Chief, Health Services Division, must designate in writing a Health Services Training Coordinator (HSTC) who coordinates clinic in-service training, distributes a quarterly training schedule, and maintains the unit's health services training record. The HSTC's responsibilities include these:
 - (1) Establishes and maintains a Health Services Training Record to document all training conducted within the clinic. Records should include presentation outline, title, program date, name of presenter, and list of attendees. Maintain training records for 3 years from the date on which training occurred.
 - (2) Ensures all emergency medical training is documented in the individual's Coast Guard Training Record (CG-5285) for credit toward the 48-hour National Registry EMT continuing education requirement.
 - (3) Maintains a Training Record section that records personnel certifications including CPR, ACLS, EMT, and flight qualifications, including expiration dates and copies of the current certificate. The HSTC should ensure assigned personnel obtain recertification before current certificates expire.

3. Emergency Medical Training Requirements.

- a. All active duty, civilian, and contract civilian personnel working in Coast Guard clinics and sick bays shall maintain current BLS certification at the health care provider level (AHA "C" Course or equivalent).

- b. Every Health Services Technician who participates in SAR or MEDEVAC operations must be a currently certified EMT. At least one currently certified EMT will staff Coast Guard emergency vehicles. Unit commanding officers shall ensure HSs are trained in sufficient numbers under Section 13-M-3.h to meet this requirement.

- c. At least one medical officer per clinic will maintain current ACLS certification.
 - d. Only licensed or certified physicians, nurse practitioners, physician assistants, or Nationally Registered advanced life support providers (EMT-P and EMT-I) will perform ALS procedures, except as Section 13-L-3.e stipulates. Paramedics may perform functions authorized by their certifying jurisdiction's protocols with written medical officer authority.
 - e. Other than those permitted in the Standardized Health Services Technician Formulary, (COMDTINST 6570.1), an HS in SAR or MEDEVAC situations may provide ALS procedures and medications only if his or her supervising medical officer authorizes such provision in writing and assumes responsibility for those procedures and medications. In emergencies, the supervising medical officer may so authorize by radio.
 - f. Other than those described in Sections 13-L-3.d and 13-L-3.e, persons who have completed an ACLS course should note certification means only they have completed the course and does not convey a license to perform any skill. Individuals completing ACLS courses shall serve as a clinic resource on current standards for pre-hospital care in training and equipment areas.
 - g. Emergency vehicles shall be equipped to provide basic life support (BLS) only. The clinic shall maintain equipment (monitor-defibrillator, advanced airway kit etc.) and medications to provide ALS services at in a reserve status and add them when necessary if authorized ALS providers are available.
 - h. To obtain required EMT training (basic course or recertification), commands shall use local military sources if available. Usually most public service training agencies or community colleges offering training can accept Coast Guard personnel. If the required training is not available from a civilian or military source within a 50-mile radius, commands may use other cost-effective training sources. Submit requests through the chain of command to Commandant (G-WKH) with these items:
 - (1) CG-5223, Short-Term Resident Training Request;
 - (2) SF-182, Request, Authorization, Agreement and Certification of Training;
 - (3) Requests for training outside a 50-mile radius which incur per diem expense require the unit commanding officer's or officer-in-charge's statement local training sources are unavailable.
4. Health Services Technician "A" School.
- a. The Office of Personnel and Training operates the 20-week introductory course for Health Services Technicians, including the Emergency Medical Technician (EMT) course, at TRACEN Petaluma. As program manager, Commandant (G-WKH) provides professional comments to the TRACEN on curriculum and qualifying requirements. Commandant (G-PRF) controls HS "A" School personnel quotas. The Training and Education Manual, COMDTINST M1500.1 (series), outlines selection requirements and procedures.

5. Health Services Technician "C" Schools.

- a. Due to the specialized nature of health care, the Coast Guard requires health services technicians to complete training in medical specialty fields such as aviation medicine, preventive medicine, medical and dental equipment repair, physical therapy, eye specialist, laboratory, radiology, pharmacy, and independent-duty specialties. The usual sources are Department of Defense training programs.
- b. Selection for HS "C" Schools is based on qualification code requirements for HS billets at clinics and independent duty sites as specified in personnel allowance lists. Secondary selection criteria include command requests, personnel requests, and deficiencies noted on MLC Quality Assurance Site Surveys.
- c. HS personnel should submit a CG-5223, Short-Term Resident Training Request, with Command endorsement to Commandant (G-WKH) through the appropriate chain of command. Commandant (G-WKH) must receive this request at least 45 days before the training convening date.
- d. HS personnel wishing to pursue "C" school training in courses of 20 weeks or longer require a permanent change of duty station coordinated by Military Personnel Command (CGPC). Submit requests on CG-3698A, Assignment Data Form, to Military Personnel Command (CGPC-emp).

6. Continuing Education Programs.

- a. All U.S. Public Health Service Officers and Coast Guard physician assistants must maintain active professional licenses and/or certification to practice their professional specialty while assigned to the Coast Guard. Licensing and/or recertification requirements often demand continuing professional education, which enhances the practitioner's skills and professional credentials.
- b. The Office of Health and Safety attempts to fund one continuing education course annually for all licensed health services professionals. The program coordinator for an applicant's professional specialty must approve all training requests. Generally training should provide at least six documentable continuing education credits per day pertinent to the applicant's Coast Guard billet. Personnel should obtain training at the nearest possible geographic location.
- c. Medical and dental officers' licensing and certification exams will not be funded as continuing education. Coast Guard-sponsored Physician Assistant (PA) programs' graduates may request funding for examination fees (primary care only), travel to the testing site nearest their current duty station, and per diem associated with obtaining initial certification from the National Commission on Certification of Physician Assistants. The Coast Guard funds this one-time exception because it sponsors the PA training program and requires certification for employment. PAs may take the recertification examination in conjunction with the annual physician assistant conference. Travel and per diem will be authorized as annual CME. The member pays recertification examination fees.

- d. Except for Health Service Technician "C" School applicants, Health and Safety Program personnel requesting continuing education must follow these procedures:
- (1) Each person requesting training must complete CG-5223, Short-Term Resident Training Request, with proper endorsements.
 - (2) Accompany each training request with course literature (e.g., a descriptive brochure) or a brief written description.
 - (3) Submit SF 182, Request, Authorization, Agreement and Certification of Training (10 parts) with proper endorsements if using a government purchase order to pay tuition or fees.
 - (4) Send all completed forms to Commandant (G-WKH) for processing. Send one information copy of the Short Term Training Request to the appropriate Maintenance and Logistics Command, Quality Assurance Branch.
 - (5) Training requests must arrive at Commandant (G-WKH) *8 weeks* before the anticipated training convening date. Coast Guard Training Quota Management Center (TQC), Portsmouth, VA, processes approved requests and issues orders.

7. Long-Term Training Programs.

- a. Long-Term Post-graduate Training for Medical Officers (Physicians, Physician Assistants, and Nurse Practitioners). This 1- to 2-year program for medical officers principally emphasizes primary care (family practice, general internal medicine, and pediatrics). Consideration may be given for non-primary care specialties such as occupational health, public health, and preventive medicine. Training in orthopedics is a potential option for mid-level practitioners only. The Health Services Program Manager will consider non-primary care post-graduate medical training only when needed. Applicants also must have applied to their chosen training program and meet its requirements before requesting training. Applicants should have served with the Coast Guard Health Services Program for at least 2 years for each year of training received. For physician applicants, highest consideration will be given first to those who have not completed an initial medical residency. Commandant (G-WKH) has more information.
- b. Advanced Dental Training Programs. This 2-year program provides dental officers advanced training in general dentistry, enabling them to give more effective, comprehensive dental care to Coast Guard beneficiaries. The Department of the Navy, Naval Medical Command, Bethesda, MD, conducts the training, designed to qualify dental officers to meet the American Dental Association and Federal Services Board of General Dentistry requirements for specialty board examination. Dental officers chosen for this program are expected to pursue board certification. For program prerequisites and applications procedures, see the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series).
- c. Health Services Administration. This program provides instruction in facility and personnel management, program planning, cost containment, quality assurance, third-party payment and liability, and medical-legal issues. The program provides

training at the undergraduate (bachelor's degree) level for Chief Warrant Officers and senior enlisted HS personnel (Medical Administrators) and post-graduate (master's degree) level for officers in grades O-2, O-3, and O-4. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

- d. Physician Assistant Program. Conducted at the U.S. Intra-service Physician Assistant Program, Fort Sam Houston TX, this program trains Coast Guard personnel interested in becoming Physician Assistants. Program graduates receive a baccalaureate degree from the University of Nebraska. If they meet eligibility requirements, graduates are offered a direct commissions as ensigns as described in the Personnel Manual, COMDTINST M1000.6 (series), Article 1.A.7. Each year three Coast Guard students are selected for training based on Service needs. Training at other institutions is not authorized. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

Section M - Patient Affairs Program

1. Patient Sensitivity.

- a. The Coast Guard considers patient sensitivity issues of paramount importance in delivering health care. Important issues in this area include medical record confidentiality, privacy during medical examination and treatment, respect for patient concerns, and enhancing the patient's perception of the quality of services delivered.
- b. All clinics shall conduct continuing patient sensitivity training. The "Treat Everyone As Myself" (TEAM) Program, developed by the U.S. Navy and Service Quality Institute available through each MLC Health and Safety Division, is the recommended course. It provides the structure for an internal review of patient-provider interaction and suggestions on ways to improve this relationship.

2. Patient Advisory Committee (PAC).

- a. The Coast Guard's health services program provides primary health care to a wide array of beneficiaries authorized by law and regulation. Medical Treatment Facilities (MTFs) often are unaware of their population's health problems until patients voice complaints or criticisms to the command. To enable beneficiaries to express their concerns, a PAC must be available to open lines of communication between health care providers and care recipients.
- b. Each Coast Guard MTF shall establish a PAC and specify criteria for committee functions. PACs shall include one officer and one enlisted member not assigned to the clinic; an active duty representative from each Coast Guard command in the clinic's service area; an active duty representative from each of the other uniformed services using the MTF; a retired representative; and an active duty dependent representative from both officer and enlisted communities.
- c. MTF shall conduct PAC meetings at least quarterly.
- d. The Chief, Health Services Division or his or her designee shall chair the meeting. Meeting minutes shall include recommended actions and an attendance list; and will be forwarded to the commanding officer with a copy to each PAC member. Specific PAC objectives include:
 - (1) Advise the Chief, Health Services Division on the range of services the beneficiary population requires;
 - (2) Serve as a communications link between the MTF and the beneficiaries the members represent;
 - (3) Serve as a patient advocacy group to assure all patients are accorded their rights as described in the Commandant's Patient Bill of Rights and Responsibilities;

- (4) Assist the Chief, Health Services Division in advising patients of their responsibilities as described in the Commandant's Patient Bill of Rights and Responsibilities;
- (5) Assist the Chief, Health Services Division in establishing patient education programs; and
- (6) Advise the Chief, Health Services Division on the acceptability and convenience of the services provided.

3. Patient Satisfaction Assessment.

- a. Assessing patient satisfaction through patient satisfaction surveys has become an effective, efficient method to investigate and measure the quality of the Coast Guard health care delivery system from the patient's perspective.
- b. A patient satisfaction survey form shall be available to every patient who receives care at a Coast Guard facility.
- c. Satisfaction surveys will be conducted annually for all patient visits during a randomly selected one-week period.
- d. Locally prepared patient satisfaction surveys are authorized for use.
- e. Patient satisfaction survey results shall be provided to the quality assurance focus group for discussion and action and documented in meeting minutes. Survey results shall report and recommended actions to the unit commanding officer.
- f. Persons distant from a Coast Guard clinic can comment about care received from civilian providers by sending a mail-in Maintenance and Logistics Command survey form available from unit Health Services Technicians.

4. Patient Grievance Protocol.

- a. The Coast Guard expects health services personnel to maintain a professional attitude at all times. Our goal to provide the highest quality health care within allotted resources to all beneficiaries with the least personal inconvenience. Despite our best efforts, occasionally a patient will be dissatisfied with the care received.
- b. Whenever possible individuals with grievances should seek out or be referred to the clinic supervisor, health benefits advisor (HBA), or clinic administrator (CA) for complaint resolution before leaving the clinic. Refer written or telephone complaints to the appropriate clinic staff member. At a minimum, the complainant shall be given the name of his or her unit Patient Advisory Committee representative and advise the complainant of the time and place of the next PAC meeting.
- c. If the clinic supervisor, HBA, or CA cannot resolve the complaint, he or she shall refer the complainant to the senior medical or dental officer as appropriate.
- d. Refer the complainant to the commanding officer or higher authority only if the patient believes the clinic or PAC has not resolved the complaint.

- e. MLC (kqa) shall review concerns reported on forms mailed to the Maintenance and Logistics Command for quality assurance purposes, action, or referral to an appropriate level for resolution and follow up.
5. Congressional Inquiries.
- a. Occasionally, circumstances arise in which beneficiaries exercise their right to solicit assistance from their elected Congressional Representative to resolve their complaint with the Coast Guard health care system.
 - b. The Coast Guard maintains a Congressional liaison staff to direct inquiries to the appropriate Headquarters office that can best address the issue and respond satisfactorily. Normally Commandant (G-WK) replies to health care problems.
 - c. Congressional inquiries require a complete investigation of the circumstances surrounding the issues the beneficiary addresses. To this end, the command, health care facility, and individuals involved must supply supporting documentation and/or statements to assist in the investigation.
6. Patient Bill of Rights and Responsibilities. Each Coast Guard health care facility shall conspicuously display the Commandant's "Patient Bill of Rights and Responsibilities."

- (f) **Periodic Duties:** This module provides supervisory personnel with a method to schedule, assign and track the completion of assigned tasks.
 - (g) **System Management:** This module maintains unit specific information, user table maintenance, and system utilities.
- c. Dental Common Access System (DENCAS).
 - (1) The Dental Common Access System is an enterprise-wide, world class e-business system that functions seamlessly between ship and shore to provide a complete picture of Navy and Coast Guard personnel dental readiness. DENCAS also provides an accurate, real-time, comprehensive administrative reporting system. The dental data is centralized in a single database for query by authorized staff over the NIPRNET. The DENCAS system is designed with security features that prevent unauthorized access, data transmission interception, and alteration. Navy Dental Treatment Facilities (DTF) and Coast Guard dental clinics are able to access dental data on individual active duty members from either service. However, summary dental data for each clinic is only available to their respective commands.
 - (2) **Commanding officers are directed to ensure that Active Duty and Selected Reserve (SELRES) members assigned to their units comply with the medical/dental requirements of Chapter 3 of this manual. In an attempt to gain a more accurate assessment of dental readiness, commanding officers shall ensure that every member assigned to their unit have documented in DENCAS all dental exams and a current Dental Class status.**
 - (3) Definitions.
 - (a) **Modules:** Particular functional features of the DENCAS system.
 - (b) **DMD – Dental Management Data. These are the dental procedure codes representing provider productivity.**
 - (c) **NMIMC:** Naval Medical Information Management Center. Responsible for DENCAS application support.
 - (4) **DENCAS Access Levels.**
 - (a) **DTF User: This access level allows users to maintain patient dental and demographic information.** It automatically updates Dental Class status, recall appointment intervals, documents dental treatment needs, allows for the transfer of patient dental data, tracks dental provider information, and records DMD (dental productivity) data. Additionally, this module can generate a variety of dental reports.

- 1 DTF User access should be granted to dental clinic staff members and Independent Duty Corpsmen. DTF Users must enter DENCAS data in a timely manner in order to ensure accurate dental readiness reports and patient information.**
 - 2 Results from dental examinations completed by civilian, Army, and Air Force providers should be recorded on the SF 603 and DD Form 2813. The original DD Form 2813 should be maintained in the member's dental record. Units without an assigned Independent Duty Corpsman should send a copy of the DD Form 2813 to their respective MLC(k) to be transcribed into DENCAS.**
- (b) **DTF Admin User – This access level provides the same functionality as the DTF user. In addition, DTF Admin Users may issue and revoke DTF User certificates from personnel within their areas of responsibility (AOR).**
 - (c) **Command User:** Command User functions are designed for use by the **Maintenance and Logistics Commands (MLC) to review dental information on active duty members within their respective geographic AOR.** This module displays the current dental readiness and dental health statistics for each command within their AOR. Command Users have access to the reports concerning individual patient dental class, recall appointments, and treatment needs. **In addition, DMD data for each provider and dental clinic is available.**
 - (d) **Corporate User:** This access level provides patient and DMD reports for all Coast Guard active duty members and Coast Guard dental clinics to the Coast Guard Headquarters Office of Health Services.
 - (e) **External User:** This module provides access to a number of useful reports on the real-time status of dental health within the External User's own command. When an External User first logs on to DENCAS, the Home Page displays the current status of dental readiness and dental health for the External User's own customer command. With a click on any of the report links on the page, the External User can view reports summarizing dental class, exam recall, members requiring routine dental care, and members requiring urgent dental care. **Local commands (external customers) can obtain access to this level by contacting their respective MLC(k) or G-WKH-3. DTF Admin Users may also grant access.**

- (f) **System Management:** This access level provides for system setup, table maintenance, and maintains system-related information such as user access, password configuration, and the access log. Responsibility for this module is shared between NMIMC and the Coast Guard Office of Health Services.

(5) **Modules.**

- (a) **Patient Information:** DENCAS is designed to only track Coast Guard active duty and selected reserve (SELRES) members. The following guidance should be followed in order to facilitate accurate and consistent data entry and reports in DENCAS:
 - 1 Patient information (i.e., dental class, treatment needs, and exam date) should be recorded in DENCAS for only Coast Guard active duty and SELRES members. Entering patient information for dependents, retirees, and Department of Defense service members will result in errors in the dental readiness and exam compliance reports.
 - 2 DENCAS classifies patients as either “deployed” or “non-deployed”. Active duty members are classified as “deployed” and SELRES members as “non-deployed”. The Coast Guard uses this classification to separate active duty member patient information data from SELRES member data.
 - 3 Dental Class IV will be used to record that active duty and SELRES members do not have a dental exam on file in DENCAS or they are overdue for a dental exam.
 - 4 Patients with treatment needs marked as "urgent" should be classified as Dental Class III.
 - 5 Use of the "patient transfer" function should be kept to a minimum. All patient transfers will be done automatically by means of a monthly DEERS data import by the DENCAS system administrator.
- (b) **Provider:** Provider productivity data should be entered under Dental Management Data (DMD) module for all categories of patients. Current Dental Terminology (CDT) codes are used to record all procedures.
 - 1 Dental procedure code “A9999” should be used to record each patient visit.

2 A Daily Dental Procedures log sheet should be maintained for each provider to record on paper all completed dental procedures. This log sheet is available as CG-6019, Daily Dental Procedures form on the Commandant (G-WK) website. Completed log sheets should be kept on file in the dental clinic for three years.

d. Third Party Collections Program: Other Health Insurance (OHI).

- (1) The United States Coast Guard is required by law to collect money from all third party insurance payers for the cost of medical services provided to military beneficiaries. This requirement, under Title 10 of the United States Code, Section 1095 is known as the Third Party Collection Program (TPC).
- (2) This program applies to family members and retirees who have health insurance coverage other than TRICARE, Medicare or Medicaid. Commanding Officers and Chiefs of Health Services will ensure that clinic staffs market the program and educate eligible beneficiaries based on guidelines provided by Commandant (G-WKH) program manager.
- (3) Each CG clinic will follow guidelines established by the Office of Health Services for documenting in CHCS any Other Health Insurance information non-active beneficiaries may have and facilitate the recovery of health care costs by adhering to guidelines provided by Commandant (G-WKH) program manager.

Section C - Medical Readiness System (MRS).

To be developed pending implementation of a functional system.