Army Report
Lyster Army Health Clinic
Fort Rucker, Alabama
OSC File Number DI-11-1358
December 2, 2011

Redacted Version

DEPARTMENT OF THE ARMY
OFFICE OF THE ASSISTANT SECRETARY
MANPOWER AND RESERVE AFFAIRS
111 ARMY PENTAGON
WASHINGTON, DC 20310-0111

DEC -2 2011

Special Counsel Carolyn N. Lerner
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1730 M Street, N.W., Suite 218
Washington. D.C. 20036-4505

RE: Whistleblower Investigation-Lyster Army Health Clinic, Department of Preventive Medicine, Fort Rucker, Alabama (Office of Special Counsel File Number DI-11-1358)

Dear Ms. Lerner:

In accordance with Title 5, United States Code (USC), Section 1213(c) and (d), the enclosed report is submitted in response to your referral of information requesting an investigation of allegations and a report of findings in the above referenced case.

The Secretary of the Army (SA) has delegated his authority to me, as agency head, to review, sign, and submit to you the report required by Title 5, USC, Section 1213(c) and (d). [TAB A].

The Department of the Army (DA) has enclosed two versions of its Report. The first version of the Report contains the names and duty titles of military service members and civilian employees of the DA. This first version is for your official use only, as specified in Title 5, USC, Section 1213(e); we understand that, as required by that law, you will provide a copy of this first version of the Report to the whistleblower, the President of the United States and the Senate and House Armed Services Committees for their review. Other releases of the first version of the Report may result in violations of the Privacy Act[1] and breaches of personal privacy interests.

The second version of the Report has been constructed to eliminate references to privacy-protected information and is suitable for release to all others as well as the regulations that require protection as noted above. We request that only the second version of the Report be made available on your web-site, in your public library, or in any other forum in which it will be accessible to persons not expressly entitled by law to a copy of the Report.

[1] The Privacy Act of 1974, Title 5, USC, Section 552a.

INFORMATION INITIATING THE INVESTIGATION

By letter dated March 28, 2011, the Office of Special Counsel (OSC) referred to the Secretary of the Army (SA) specific allegations made by the Whistleblower against Lyster Army Health Clinic (LAHC), Department of Preventive Medicine, Fort Rucker, Alabama that form the basis of this investigation and report. Generally, the Whistleblower alleged that the Department of Preventive Medicine at LAHC required her to perform advanced medical tasks that she was not trained or certified to carry out, thereby creating a substantial and specific danger to the patients' health and safety. Specifically, the Whistleblower alleged the following:

1. She was hired in August 2010 after responding to a vacancy announcement for a Community Health Nurse (CHN) posted by LAHC. The OSC letter noted that "While [the Whistleblower], who does not have any higher level graduate education or advanced public health training, was not authorized to perform the advanced functions of a Community Health Nurse, she did meet the requirements of the published vacancy announcement."

2. As a Registered Nurse (RN) with an Associate's Degree in nursing, she was immediately assigned advanced nursing duties[2] beyond the scope of her training and experience. Specifically, she was responsible for ordering and interpreting sexually transmitted infection (STI), tuberculosis, and hepatic liver enzyme tests, and refilling prescriptions for Isoniazid, an antibiotic used to treat tuberculosis.

3. The Whistleblower informed her supervisors, Occupational Health Physician, Supervising Preventive Medicine Physician and Chief of Preventive Medicine that as an RN, she was not qualified to perform these advanced tasks, but was told that the tasks were part of the required job duties of a CHN. When the Whistleblower continued to object to refilling the Isoniazid prescriptions and performing the hepatic liver enzyme and tuberculosis tests, and fully refused to perform STI tests, on the grounds that she lacked the requisite training, she was threatened with disciplinary action.

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[2] During the OSC's investigative stage prior to its forwarding the Whistleblower's allegations to the Secretary of ht Army, the OSC requested that OGC provide the name and contact information of an Army subject matter expert who could discuss the general education, training, experience and licensure requirements for a Community Health Nurse, and in particular address the issue of whether a Community Health Nurse requires an advanced nursing degree. OGC referred OSC to,Chief, Policy and Programs Branch, Civilian Human Resources Division, Headquarters, U.S. Army Medical Command (MEDCOM). In his statement prepared for this Report, Chief, Policy and Programs Branch addressed this matter and testified to the following: "3. On or about early March 2011, I was contacted by the Office of Special Counsel and asked several generic questions related to distinguishing the various types of nursing occupations, to include nursing assistants, licensed vocational nurses / licensed practical nurses (LVN/LPN), registered nurses (RN), and advanced practice registered nurses (APRN). To the best of my recollection, during our discussion, I reviewed AR 40-68, para. 7-4a(2) which listed CHNs as APRNs. I also advised that APRNs are required to possess a Master's Degree or higher, and in many cases required certification as to a specific specialty.
4. Since that time, I have reviewed the Office of Personnel Management (OPM) Position Classification Standard for Nurse Series, GS-0610, dated 8 Jun 1977 which describes the requirements for RN positions throughout the federal government. It is used to establish the occupational series, title, and grade level of each RN position. When I reviewed the specific specializations and titles of RNs, I found that the CHN specialty can be classified at an entry level beginning above the grade of GS-07. Therefore, CHNs do not necessarily fall under the classification of APRNs." [TAB Q, Statement of Chief, Policy and Programs Branch, paragraphs 3-4].

4. At the insistence of Chief, Preventive Medicine Clinic and Supervising Preventive Medicine Physician and despite her misgivings, the Whistleblower ordered liver enzyme tests, interpreted the test results, and refilled prescriptions for Isoniazid for approximately ten to twelve patients per month between August 2010 and January 2011. She contended that given her lack of training and experience in providing advanced medical services, this posed a significant danger to the health and safety of patients because should she misinterpret liver enzyme test results and fail to detect abnormal liver activity, the continued prescription of Isoniazid could result in severe liver damage.

The OSC found that these allegations constitute a substantial and specific danger to public health and safety under 5 U.S.C. § 1213(a)(1).

CONDUCT OF THE INVESTIGATION

On April 8, 2011, the SA forwarded the OSC referral to the Commander, U.S. Army Medical Command (MEDCOM), and directed him to conduct an investigation into the allegations referred to the Secretary by the OSC. This referral was appropriate because MEDCOM provides healthcare oversight and control of all medical centers and medical treatment facilities and activities in the Army, with the exception of field units, as provided for under AR 40-1, *Composition, Mission, and Functions of the Army Medical Department*. [TAB B].

In addition, on April 8, 2011, the Department of the Army Office of General Counsel (OGC) forwarded the SA's directive to the MEDCOM Office of the Staff Judge Advocate to assist the MEDCOM commander in taking appropriate action and initiating the requested investigation. The Secretary directed the MEDCOM Commander to initiate an investigation into the allegations referred to him by the OSC. In addition to the investigation, the SA directed that the Commander ensure that appropriate corrective action is initiated.

On May 6, 2011, Brigadier General (BG) Joseph Caravalho, Jr. Commander, Southern Regional Medical Command (SRMC) appointed the Regional Nurse Executive, SRMC, as an Investigating Officer (IO) [TAB D-1], under the provisions of AR 15-6, *Procedures for Investigating Officers and Board of Officers,*[3] with a mandate to investigate the allegations forwarded by the OSC. BG Caravalho directed The Investigating Officer to investigate and determine the following:

a. What are the educational, licensing, training and experience requirements for a Community Health Nurse (CHN)?

b. Are there published federal guidelines or Army regulations regarding the educational, licensing, training and experience requirements for CHN? If so, what are they?

[3] AR 15-6 promulgates guidelines for Army administrative investigations. Army commands and organizations frequently appoint investigating officers under provisions of AR 15-6 to investigate all manner of allegations and concerns. [TAB C].

c. Are there published federal guidelines or Army regulations for duties of a Community Health Nurse at a military treatment facility? If so, what are they?

d. Did LAHC Department of Preventive Medicine know of federal guidelines or Army regulations pertaining to the educational, licensing, training and experience requirements and duties of a Community Health Nurse at a military treatment facility?

e. Did LAHC's vacancy announcement for the Community Health Nurse include the proper educational, licensing, training and experience requirements and duties of a CHN?

f. Did the Whistleblower, who was selected to fill the CHN position at LAHC possess the requisite educational, licensing, training and experience to be a CHN?

g. Did the Whistleblower have knowledge of the requisite educational, licensing, training, and experience requirements to be a CHN when she accepted the job?

h. If so, did she inform LAHC selecting officials prior to accepting the position that she did not have the requisite educational, licensing, training and experience to fulfill the position?

i. Did the Whistleblower knowingly misrepresent her qualifications or training during the selection process for the position of CHN or any time thereafter?

j. Are the duties the Whistleblower was directed to perform as the LAHC CHN, to wit: the responsibility to order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to refill prescriptions for Isoniazid, fall within duties only a CHN with the requisite educational, licensing, training and experience can perform?

k. Were the above listed responsibilities/duties (order and interpret STI, tuberculosis and hepatic enzyme tests and refill Isoniazid prescriptions) specifically defined in the position description or the vacancy announcement?

l. What duties listed in the position description does the Whistleblower have the requisite educational, licensing, training, and experience requirements to perform?

m. When did the Whistleblower inform her supervisors, Occupational Health Physician Supervising Preventive Medicine Physician and/or Chief of Preventive Medicine or anyone else in the Whistleblower's supervisory chain of command that she did not possess the requisite educational, licensing, training, and experience requirements to perform the duties that they required of her?

n. Once informed of her lack of requisite educational, licensing, training or experience, did Supervising Preventive Medicine Physician, Chief, Preventive Medicine Clinic, or anyone else in the Whistleblower's supervisory chain of command knowingly direct her to continue to perform duties for which she was not properly trained or qualified to perform?

o. Did Supervising Preventive Medicine Physician, Chief, Preventive Medicine Clinic, or anyone else in the Whistleblower's supervisory chain of command threaten her with adverse or disciplinary action if

she did not continue to perform any duties, to include ordering and interpreting STI, tuberculosis and hepatic enzyme tests and refilling Isoniazid prescriptions, that she should not perform due to the lack of requisite educational, licensing, training and experience requirements?

p. Has the Whistleblower been disciplined or received any adverse actions as a result of informing her supervisors that she should not be performing duties of a CHN?

q. Was any patient injured as the result of the Whistleblower's actions performing the duties required by Supervising Preventive Medicine Physician, Chief, Preventive Medicine Clinic, or anyone else in the Whistleblower's supervisory chain of command?

r. Do the acts of Supervising Preventive Medicine Physician, Chief, Preventive Medicine Clinic, or anyone else in the Whistleblower's supervisory chain of command requiring her to perform these duties constitute a substantial and specific danger to public health or safety?

Upon review of the Investigating Officer's appointment papers as the AR 15-6 IO, DA OGC recommended that an additional issue be addressed by the IO. Consequently, on June 13, 2011, Major General (MG) M. Ted Wong, the successor in command to BG Caravalho as Commanding General, SRMC,[4] issued a second appointment memorandum to the Investigating Officer to provide information on one additional matter [TAB D-2]: to describe the differences in laymen's terms between various types of nurses, such as Registered Nurse (RN), Licensed Practical Nurse (LPN) and a CHN.

On November 16, 2011, the IO completed the Report of Investigation (ROI). During the course of the investigation, the Investigating Officer interviewed the complainant, the Whistleblower; the supervisors named in the complaint, Supervising Preventive Medicine Physician, Staff Physician, Preventive Medicine Clinic, LAHC; and Chief, Preventive Medicine Clinic, LAHC; Deputy Commander for Nursing at LAHC; Chief, Department of Pharmacy at LAHC; and Occupational Health Nurse, former CHN at LAHC. In addition, the IO several Army subject matter experts, specifically, the Former Nurse Corps Public Health Consultant to The Surgeon General (TSG)[5], and currently the Chief, Wounded Warrior Division, Joint Task Force National Capital Region Medical, Walter Reed National Military Medical Center Bethesda, Maryland for his expertise on the education, licensing, training, experience and scope of practice for CHNs in the U.S. Army MEDCOM, Chief, Policy and Programs Branch, Civilian Human Resources Division, Headquarters, U.S. Army Medical Command (MEDCOM); and the Chief, U.S. MEDCOM Quality Management Division.

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[4] The SRMC had a change of command and BG Caravalho "rotated out" and MG Wong assumed command of SRMC.

[5] TSG has a consultant program in the various specialty areas. TSG selects a person for a specified period to be his consultant in that area. The United States Army Surgeon General Consultant Program home page provides the following description of this program:"The Surgeon General's Consultant Program consists of a Chief Consultant, and 137 specialty consultants from all AMEDD corps - medical, dental, veterinary, nurse, medical service and medical specialist. Consultants to The Surgeon General serve as subject matter experts in their field, assist in the maintenance of high standards of professional practice, contribute to the development of educational programs for the advancement of AMEDD officers, and provide essential liaison with leaders in medical and related professions." Hence, with respect to the Former Nurse Corps Public Health Consultant to TSG, his title was "Public Health Nursing Consultant to the Army Surgeon General and the Northern Regional Medical Command." He was also the "Chief of Public Health Nursing and Deputy Chief of Preventive Medicine at Walter Reed Army Medical Center."

The IO also gathered all relevant information and documentation from the Whistleblower and Chief, Preventive Medicine Clinic that they possessed regarding the Whistleblower's hiring action, the Standard Operating Procedures (SOPs) and training protocols for the Preventive Medicine Clinic at LAHC, and records related to any alleged disciplinary action taken against the Whistleblower.

BACKGROUND

To facilitate a better understanding of the facts and circumstances associated with the whistleblower's allegations to the OSC and to permit a more knowledgeable assessment of the testimonial and documentary evidence collected from all of the witnesses, it is important to understand MEDCOM's mission and functional relationships with supporting organizations.

U.S. Army Medical Command (MEDCOM) Mission

The Surgeon General (TSG) of the U. S. Army serves in a dual role as both the U.S. Army Surgeon General and MEDCOM Commander. MEDCOM provides medical, dental, and veterinary capabilities to the Army and designated Department of Defense (DoD) activities. TSG is responsible for the development, policy direction, organization, and overall management of an integrated Army-wide health services system. [See Army Regulation 40-1, *Composition, Mission, and Functions of the Army Medical Department*, dated July 1, 1983, paragraph 1-6, [TAB B]. Among many other functions, MEDCOM provides medical and dental care worldwide; coordinates Army health services for Army, civilian, and Federal health care resources in a given health service area; and conducts health care education, training and studies. The Commander, MEDCOM, directs all active duty Army health services activities involved in providing direct health care support within the prescribed geographical limits of responsibility; designates missions and levels of care to be provided by subordinate military treatment facilities; and determines manpower staffing standards and levels of staffing. [AR 10-87, *Army Commands, Army Service Component Commands, and Direct Reporting Units*, dated September 4, 2007 paragraphs 15-2d and 15-3d. [TAB E].

In his role as Commander, MEDCOM, TSG exercises oversight and control of all medical centers and medical treatment facilities and activities in the U.S Army, with the exception of field units. Regional Medical Commands (RMCs) are major subordinate commands (MSCs) of MEDCOM and are multi-state command and control headquarters that allocate resources, oversee day-to-day management, and promote readiness among military treatment facilities in their geographic areas. [See AR 10-87 Chapter 15, TAB E]. Lyster AHC is funded by and receives operational oversight and guidance from MEDCOM through the Southern Regional Medical Command.

Lyster Army Health Clinic

An Army Health Clinic (ACH) is a Military Treatment Facility (MTF) staffed and equipped to provide ambulatory health services to eligible personnel. An ACH also performs non-therapeutic activities related to the health of the personnel served including physical examinations, immunizations, medical administration, and Preventive Medicine services. It normally has general radiology, laboratory, and pharmacy capabilities and may offer specialty care in one or more of the subspecialties of medicine. Services provided depend on the availability of space and facilities and the capability of the assigned professional staff. MEDCOM Regulation 10-1. [TAB F].

Lyster AHC provides primary care and ancillary services to a military population that consists of active duty service members, their families, a large retiree population and their family members. The clinic, fully accredited by the Joint Commission on Accreditation of Healthcare Organizations is located at Fort Rucker, Alabama.

The facility is dedicated to the memory of General (Dr.) Theodore C. Lyster, a veteran of the Spanish-American War, who pioneered aviation medicine. General Lyster, one of the first to recognize the medical problems peculiar to flight, is known as the father of aviation medicine in America. Fort Rucker serves as the headquarters for Army Aviation and the U.S. Army Aviation Center of Excellence which trains military, civilian, and international personnel in aviation and leadership skills, integrates Army aviation warfighting doctrine and requirements as determined by the Department of Defense Joint Capabilities Integration Development System, manages available resources, and sustains our commitment to the well-being of Soldiers, civilians, retirees, and families.

The Preventive Medicine Clinic[6] is one of approximately a dozen clinics at Lyster AHC. [See Lyster Organization Chart, TAB G]. The Preventive Medicine Clinic has five departments: (1) Community Health Nursing, [7] (2) Wellness Center/Health Promotion, (3) Environmental Health, (4) Occupational Health, and (5) Industrial Hygiene. The Community Health Nursing (CHN) Department provides education and counseling to beneficiaries on Sexually Transmitted Infection, Latent Tuberculosis Infection, Infectious Disease, and HIV. The CHN department also serves at the Health Consultant for Child and Youth Services, the Special Needs Accommodation Process (SNAP). The CHN department is responsible for studying, monitoring and controlling diseases in the local population, especially regarding all blood-borne pathogens, communicable diseases and sexually transmitted infections. In addition, the CHN department provides classes to units and civilian employees on post on the following subjects: Sexually Transmitted Infections (STI), Human Immunodeficiency Virus (HIV), Infectious Diseases, Blood-borne Pathogens, Communicable Diseases, and Child and Youth Services Educational Programs.

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[6] Several witnesses refer to the Preventive Medicine Clinic as the Preventive Medicine Department or the Preventive Medicine Service. Additionally, the organizational chart at TAB G refers to it as the Preventive Medicine Department. For purposes of this Report, all three references refer to the same organizational element at LAHC.

[7] the Whistleblower was a Community Health Nurse in the Community Health Nursing Department of the Preventive Medicine Clinic.

LICENSURE AND THE FEDERAL PRACTICE OF MEDICINE GOVERNING STATUTORY AND REGULATORYAUTHORITIES

The information that follows provides both an overview of the nursing profession and the governing statutory, regulatory, and policy authorities that govern the practicing nursing health care provider at a federal medical/health facility.

NURSING

Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human responses; and advocacy in health care for individuals, families, communities, and populations. (The American Nurses Association (ANA).

The ANA states there are six essential features of professional nursing:

1. Provision of a caring relationship that facilitates health and healing,
2. Attention to the range of human experiences and responses to health and illness within the physical and social environments,
3. Integration of objective data with knowledge gained from an appreciation of the patient or group's subjective experience,
4. Application of scientific knowledge to the processes of diagnosis and treatment through the use of judgment and critical thinking,
5. Advancement of professional nursing knowledge through scholarly inquiry, and
6. Influence on social and public policy to promote social justice.

OVERVIEW OF NURSING SPECIALTIES

In the IO's Report of Investigation, the IO provided the following description regarding the various nurse specialties in response to one of the inquiries posed to him by the AR 15-6 Appointing Authority:

Licensed Practical (or Vocational) Nurse (LPN/LVN): LPNs provide direct patient care in hospitals, doctors' offices, nursing homes, long-term care facilities and outpatient home health care under the supervision of an RN or physician. An LPN's tasks include taking blood pressure, pulse and temperature. LPNs administer immunizations, change dressings, clean and bandage wounds, administer medication and monitor patient condition. The training program for LPNs is for one year, usually at a community college or vocational/technical college. After successful completion, LPN students receive either a diploma or certificate. In order to be licensed as an LPN, students must then pass the NCLEX-PN national licensing examination.

Registered Nurse (RN): RNs provide direct patient care but are less likely to carry out tasks of a Licensed Practical Nurse (LPN), such as taking temperatures and giving immunizations. RNs responsibilities are broader, such as developing and enacting a patient care plan, as well as, managing and assigning tasks to LPNs and Nurse Assistants. RNs also have greater opportunities for professional growth in a wide range of specialties. RN students train for at least two years to earn an associate's degree or four years to earn a Bachelor of Science degree. The nursing program is usually offered at a community college or a traditional four year college of arts and sciences. RN student training is rigorous, both in a classroom and clinical setting to prepare students for leadership roles in the nursing profession. Upon graduation, students must pass the NCLEX-RN national licensing examination to be licensed as an RN.

Community Health Nurse (CHN): CHNs complete the same education requirements stated above for an RN. CHNs then can elect to specialize in a field of nursing that is a continuing and comprehensive practice involving preventive, curative, and rehabilitative care. The philosophy of community health is based on the belief that care directed to the individual, the family, and the group contributes to the health care of the population as a whole. The Community Health Nurse is not restricted to the care of a particular age or diagnostic group. Participation of all consumers of health care is encouraged in the development of community activities that contribute to the promotion, education, and maintenance of good health. These activities require comprehensive health programs that pay special attention to social and ecologic influences and specific populations at risk. Training for this specialty can be gained via formal course work or on the job training. (It should be noted that as a result of comprehensive review of the relevant Army regulatory authorities to the nursing health care practitioners that occurred during the Army's investigation into the Whistleblower's allegations, it was discovered that CHNs had been erroneously included under paragraph 7-4a in AR 40-68 [TAB H] that describes APRNs. Rather, CHNs are **not** Advanced Practice Registered Nurses and do **not** require a higher level graduate education or advanced public health training).[8]

Advanced Practice Registered Nurse (APRN): AR 40-68, paragraph 7-4a(1) [TAB H] defines the four specific nursing specialties that are considered advanced practice nurses; these include: Certified Nurse Midwife's (CNMs); Certified Registered Nurse Anesthetist (CRNA); Clinical Nurse Specialists (CNSs); and Nurse Practitioners (NPs). The thread common thread to all APRN roles is that they require a "master's or doctorate level education and advanced knowledge and clinical competency to provide health care in a defined area of specialization."

STATUTORY AND REGULATORY AUTHORITIES

Title 10, United States Code (USC) Section 1094, requires independently practicing health care professionals in the Military Health System (MHS) to possess an unrestricted license, unless the requirement is waived due to unusual circumstances. 10 USC 1094 provides: "A

[8] In her statement, the Chief, U.S. Army MEDCOM Quality Management Division, Headquarters and the proponent of AR 40-68 stated that "The placement of CHNs under the description of APRNs in AR 40-68, paragraph 7-4a(2) is inaccurate and confusing. CHNs are not APRNs and should not be placed under para. 7-4." Chief, U.S. Army MEDCOM Quality Management Division added that upon the next revision or AR 40-68, this correction will be incorporated into the revision and CHNs will be removed from paragraph 7-4a.

person under the jurisdiction of the Secretary of a Military Department may not provide healthcare independently as a healthcare professional . . . unless the person has a current license to provide such care. In the case of a physician, the physician may not provide healthcare as a physician under this chapter unless the current license is an unrestricted license that is not subject to limitation on the scope of practice ordinarily granted to other physicians for a similar specialty by a jurisdiction that granted the license."

A state may not enforce licensing requirements against an individual performing duties for the federal government where those licensing requirements would give the state licensing board "virtual power of review" over a federal determination of the individual's competency. If a federal agency hires employees or contractors pursuant to a federal regulation instructing the agency to determine competency by various criteria, a state licensing law imposing an additional or separate criteria is in conflict with the federal regulatory scheme, and is therefore preempted under the Supremacy Clause of the U.S. Constitution.

The governing Department of Defense regulatory framework for regulating DoD health care professionals is Department of Defense (DoD) 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation*, dated June 11, 2004. [TAB I]. The following relevant provisions provide working definitions for some of the key terms used in this Army report.

DL1.1.7. Credentials. The documents that constitute evidence of appropriate education, training, licensure, experience, and expertise of a healthcare practitioner.

DL1.1.16. Healthcare Practitioner. Synonymous with "healthcare professional." Any physician, dentist, or healthcare practitioner of one of the professions whose members are required to possess a professional license or other similar authorization. These include DoD healthcare personnel who are physicians, dentists, registered nurses, practical nurses, physical therapists, podiatrists, optometrists, clinical dieticians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD(HA).

DL1.1.17. Healthcare Provider. Military (Active or Reserve component) and civilian personnel (Civil Service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens within the scope of his or her license, certification, or registration. This category includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD(HA).

DL1.1.23. License. A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide healthcare within the scope of practice for a discipline. The stages of license

are as follows:

DL1.1.23.1. Current. Active, not revoked, suspended, or lapsed in registration.

DL1.1.23.2. Valid. The issuing authority accepts, investigates, and acts upon quality assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.

DL1.1.23.3. Unrestricted. Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. An unrestricted license must allow the provider unabridged permission to practice in any civilian community in the jurisdiction of licensure without having to take any additional action on her/his license.

DL1.1.24. Licensed Independent Practitioner. Any individual permitted by law and by the organization to provide care, treatment and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. This term is equivalent to Healthcare Provider. (See DL1.1.17.)

With respect to the interplay between federal and state licensing requirements, DoD 6025.13-R, paragraph C4.2.1.1, states, "As directed by 10 U.S.C. 1094(d) .... notwithstanding any State law regarding the licensure of healthcare professionals, a licensed healthcare professional who is a member of the Armed Forces may practice the member's profession in any State, regardless of whether the practice occurs in a healthcare facility of the Department of Defense, healthcare facility of the Veterans Administration, a civilian facility affiliated with the Department of Defense, or any other authorized location as long *as the individual is practicing within the scope of federal duties*. (Emphasis supplied) These licensure requirements also apply to federal civilian employees and contractors not just active duty healthcare professionals. [TAB H, AR 40-68, paragraph 4-3a].

Other relevant regulatory provisions are derived from Army regulations and the Office of Personnel Management (OPM). The relevant Army regulation, AR 40-68, *Clinical Quality Management,* provides that RNs must have a current, valid, *unrestricted* license from a State. Additionally, OPM has established standards for civilian positions. [TAB H, AR 40-68, paragraph 4-4a]. State level requirements may change, but requirements related to licensure of Army Medical Department (AMEDD) health care personnel (military/civilian) will at all times comply with current OASD (HA) guidance. [TAB H, AR 40-68, paragraph 4-4a]. Health care personnel (military/civilian) employed by the Federal Government will abide by the practice requirements imposed by their State of licensure to the fullest extent possible. [TAB H, AR 40-68, paragraph 4-4a(2)]. However, compliance with State requirements shall not interfere with the individual's performance of assigned duties/responsibilities in the specified discipline within the Federal sector. [TAB H, AR 40-68, paragraph 4-4a(2)].

EXPLANATION OF THE U.S. ARMY PRIVILEGING AND DELEGATION PROCESS UNDER AR 40-68

Clinical privileging is defined by Army Regulation as "The process whereby a health care provider is granted, based on peer and department head recommendations, the permission and responsibility to provide specified or delineated health care within the scope of his or her license, certification, or registration. Clinical Privileges define the scope and limits of practice for individual providers and are based on the capability of the health care facility, the provider's licensure, relevant training and experience, current competence, health status and judgment." [TAB H, AR 40-68, Glossary, Section II – Terms]. Army Regulation (AR) 40-68, Chapter 7 provides the general information and specific professional requirements related to each category of privileged provider (military and civilian). It details the list of privileged providers, to include (but not limited to) the following nursing providers: Advanced Practice Registered Nurse (ARPN), Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Nurse Practitioner (NP). [TAB H, AR 40-68, paragraph 7-1a]. **Community Health Nurses (CHNs) are not named as a category of healthcare providers that require privileging. Although the list is not all inclusive, the defined group of ARPNs established under AR 40-68, paragraph 7-4a(1) includes CNMs, CRNAs, CNSs, and NPs but not CHNs which is consistent with the grouping under Chapter 7 that CHNs are neither privileged providers nor ARPNs. [TAB H, AR 40-68, paragraph 7-4a(1); See also footnote 5 that discuss CHNs in AR 40-68].**

AR 40-68, Chapter 9 provides guidance distinguishing between health care providers that require privileging and health care personnel that may function without clinical privileges. Specifically, "Health care practitioners who function independently to initiate, alter, or terminate a regimen of medical care must be privileged."[TAB H, AR 40-68, paragraph 9-2a]. However, "Members of the healthcare staff who function under a standard job description in the performance of their duties – *utilizing practice guidelines or standard policies and/or procedures* – do not require clinical privileges. Department/service chiefs are responsible for the ongoing assessment of the competence of personnel to safely perform assigned duties." [TAB H, AR 40-68, paragraph 9-2b].

AR 40-68, Chapter 5 provides guidance regarding the competency assessment, delegation and supervision of healthcare personnel within the Army medical treatment facilities (MTFs). Chapter 5 begins with a general overview of the requirement for competency of all staff members within an MTF. Specifically, it provides, "Competence is the ability of a staff member to apply decision-making, psychomotor, and interpersonal skills at the level of knowledge expected of his/her current duty position. Highly competent performance by members of the organization is predicated on a variety of factors to include: a carefully structured new employee orientation, ongoing education and training opportunities, and formalized evaluation processes." [TAB H, AR 40-68, paragraph 5-1a]. Competency assessment is required of all health care personnel involved in providing health care. Health care personnel, both privileged and non-privileged, are required to maintain the requisite competencies associated with the duty position that they are assigned. [TAB H, AR 40-68, paragraph 5-1b(2)].

AR 40-68, Chapter 5 also provides for the delegation of privileged task, function or

process to a competent *non-privileged* professional. Specifically, "Delegation transfers to a competent individual the authority to perform a selected patient care task in a given situation. Typically, delegation involves the licensed or privileged professional allowing a specified patient care activity, which is within his or her own scope of practice, to be performed by the unlicensed assistive personnel (UAPs), an RN/LPN, or other non-nursing personnel. The authority to perform the task is passed to another but the professional responsibility and accountability for the overall care provided, and for associated patient outcomes, remains with the delegating individual." [TAB H, AR 40-68, paragraph 5-2a]. The regulatory guidance provides that it is the responsibility of local leadership to ensure that all healthcare providers to whom patient care tasks and procedures have been delegated are assessed as to individual competency; that competency-based orientation is provided; and that individual duties are based on demonstrated knowledge, skill and technical proficiency. [TAB H, AR 40-68, paragraph 5-2e].

Additionally, all health care personnel are provided supervision of their clinical performance to ensure the competence and skill of those providing health care and services. [TAB H, AR 40-68, paragraph 5-3]. Supervision may be direct or indirect. [TAB H, AR 40-68, paragraph 5-3b]. Direct supervision requires that the supervisor be involved in the decision-making process either verbally or by being physically present through all or a portion of care. [TAB H, AR 40-68, paragraph 5-3b(1)(b)]. Indirect supervision involves retrospective review by the supervisor of selected records and/or observation of the results of the care provided. Criteria for indirect supervisory review relates to quality of care, quality of documentation, and the staff member's scope of practice. [TAB H, AR 40-68, paragraph 5-3b(1)(a)]. Supervisors of non-privileged health care personnel must complete periodic clinical performance evaluations that address the individual's demonstrated abilities and competency to perform the duties, responsibilities, expectations and components of his/her position. The individual's improvement or lack of improvement related to documented performance limitations/inadequacies are assessed and addressed in each written evaluation. [TAB H, AR 40-68, paragraph 5-3c(3)(b)].

USE OF CLINICAL PRACTICE GUIDELINES BY COMMUNITY HEALTH NURSES

Clinical Practice Guidelines (CPGs) are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. CPGs define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients. These guidelines are primarily for use by clinicians--physicians, nurses, and other health professionals in clinical practice. The statements contain recommendations that are based on evidence from a rigorous systematic review and synthesis of the published medical literature. Clinical care decisions and specific therapeutic interventions on the part of the provider are based, in part, on CPGs; nationally recognized standards of care/practice; current professional clinical references; and other relevant regimens, guidelines, or policies, as appropriate. These serve as a framework for practice and are the basis for the specific clinical privileges requested by the individual provider and for periodic performance review and evaluation activities. [TAB H, AR 40-68, paragraph 7-2].

Under Army Regulation (AR) 40-68, *Clinical Quality Management*, Community Health Nurses (CHNs) function in an expanded role using CPGs approved by the local military treatment facility's (MTF's) Executive Committee of the Medical Staff (ECMS) and the Deputy Commander for Nursing (DCN). These CPGs, SOPs, and protocols are created from information contained in Department of the Army Pamphlet (DA Pamphlet) 40-11, *Preventive Medicine*, dated July 22, 2005,[9] [TAB J, DA Pamphlet 40-11], and the references contained within, as well as information from the U.S. Army Public Health Command. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature, but he/she does not independently initiate, alter, or discontinue any medical treatment. [TAB H, AR 40-68, paragraph. 7-4a(2)].

A similar approach to the Army's use of Clinical Practice Guidelines, SOPs and other protocols is the State of California's reliance on such supplementing documents. The State of California, Board of Registered Nursing Scope of Practice Guidelines provides "[t]he means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the organized health care system in which it is to be used." [TAB L, California, Board of Registered Nursing, "An Explanation of the Scope of RN Practice Including Standardized Procedures, p. 2]. Given that the working environment at issue is a federal medical facility, the operative guidelines are those applicable from OPM, DoD and Army.

OVERVIEW OF THE ALLEGATIONS, SUMMARY OF THE EVIDENCE OBTAINED FROM THE INVESTIGATION, AND AGENCY DISCUSSION

Overview of the Allegations

The Whistleblower made the following allegations regarding being required to perform advanced medical tasks by the Department of Preventive Medicine at LAHC that she was not trained or certified to carry out, thereby creating a substantial and specific danger to the patients' health and safety. The following allegations were referred by OSC to the SA for investigation:

OSC-Referred Allegation 1:

The Whistleblower was hired in August 2010 after responding to a vacancy announcement for a Community Health Nurse (CHN) posted by LAHC. The OSC letter noted that "While [the Whistleblower], who does not have any higher level graduate education or advanced public health training, was not authorized to perform the advanced functions of a Community

[9] DA Pamphlet 40-11 [TAB J] defines the programs and services within the medical functional area of preventive medicine; identifies Army publications that delineate functions and contain the detailed instructions, guidance, and procedures necessary for implementing the policies and responsibilities outlined in Army Regulation (AR) 40–5 [TAB K]; and provides detailed preventive medicine functions, instructions, guidance, and procedures not published in other Army documents.

Health Nurse, she did meet the requirements of the published vacancy announcement."

OSC-Referred Allegation 2:

As a Registered Nurse (RN) with an Associate's Degree in nursing, she was immediately assigned advanced nursing duties beyond the scope of her training and experience. Specifically, she was responsible for ordering and interpreting sexually transmitted infection (STI), tuberculosis, and hepatic liver enzyme tests, and refilling prescriptions for Isoniazid, an antibiotic used to treat tuberculosis.

OSC-Referred Allegation 3:

The Whistleblower informed her supervisors, Occupational Health Physician, Supervising Preventive Medicine Physician and Chief of Preventive Medicine, that as an RN, she was not qualified to perform these advanced tasks, but was told that the tasks were part of the required job duties of a CHN. When the Whistleblower continued to object to refilling the Isoniazid prescriptions and performing the hepatic liver enzyme and tuberculosis tests, and fully refused to perform STI tests, on the grounds that she lacked the requisite training, she was threatened with disciplinary action.

OSC-Referred Allegation 4:

At the insistence of Chief, Preventive Medicine Clinic and Supervising Preventive Medicine Physician and despite her misgivings, the Whistleblower ordered liver enzyme tests, interpreted the test results, and refilled prescriptions for Isoniazid for approximately ten to twelve patients per month between August 2010 and January 2011. She contended that given her lack of training and experience in providing advanced medical services, this posed a significant danger to the health and safety of patients because should she misinterpret liver enzyme test results and fail to detect abnormal liver activity, the continued prescription of Isoniazid could result in severe liver damage.

Summary of the Evidence Obtained from the Investigation

Overview

All of the evidence gathered during the subject investigation indicates that based on her education, licensing, training and 37 years of experience as a nurse, the Whistleblower was hired to perform the full range of duties that are appropriate for a nurse at the GS-0610-11 level. She was not asked to perform tasks contrary to her nursing licensure program under the State of California nor asked to perform tasks beyond the scope of a duly licensed practicing registered nurse (RN) employed at a federal medical facility. Although the Whistleblower may have had other expectations when accepting the CHN position at LAHC, the duly legal / authorized clinical tasks that she was expected to perform were common practice within the Army Medical Command (MEDCOM) and were defined by protocols/SOPs systematically developed within Army guidelines established in accordance with Army regulation. Although the Whistleblower's expectations for the CHN position she accepted at LAHC are unclear, it is clear that LAHC reasonably expected that with 37 years as a licensed RN with extensive experience with public health nursing, the Whistleblower was very well qualified to perform the clinical duties of the

CHN position. The preponderance of the evidence presented throughout the investigation clearly supports this conclusion.

Given the nature of the Whistleblower's allegations, it is important to stress that the clinical duties that she was required to perform were *not* "advanced" nursing duties requiring an advanced degree to perform but were duties commonly performed by an RN in a military medical facility with established protocols. CHNs have the same educational and licensing requirements as RNs but specialize in a field of nursing that is a continuing and comprehensive practice involving preventative, curative and rehabilitative care. CHNs do *not* require privileging but work under delegated authority of a licensed / privileged provider to perform selected patient care within that provider's scope of practice using protocols/SOPs. The realities of how medical services are delivered at medical facilities, under both State and federal guidelines, are that medical facilities, which provide medical services to hundreds if not thousands of patients of all ages and ailments, employ a pyramid-like structure of health care professionals that include a smaller number of physicians who are supported by a larger number of staff, including nurses, in order to leverage the physician's care and assistance across a larger patient population. Nurses play a vital role in delivering medical care based upon their professionalism and expertise that compliment the professionalism and expertise of the attending physicians. The evidence summarized below reflects the symbiotic relationship between the duties of the physician and their supporting nurses and other medical personnel.

All of the witnesses germane to the allegations were interviewed by the IO. Each witness interviewed in the context of the AR 15-6 investigation initiated to address the allegations referred to the SA by the OSC was asked to respond to a set of questions that were developed by the Investigating Officer to solicit specific information to address the 19 questions he was directed to answer by the Appointing Authority. Since the complainant was identified, the Investigating Officer began with an interview of the Whistleblower. Similar questions were then addressed with the Whistleblower's supervisors at the Preventive Medicine Clinic: Chief, Preventive Medicine Clinic; Supervising Preventive Medicine Physician, and Deputy Commander for Nursing at LAHC. The Investigating Officer also interviewed two other employees working at LAHC that had relevant information: Occupational Health Nurse, former CHN at LAHC that was responsible for the training / orientation of the Whistleblower, and Chief, Department of Pharmacy. In addition to these witnesses, the Investigating Officer also interviewed the Former Public Health Nurse Consultant to The Surgeon General (TSG) for his expertise on the education, licensing, training, experience and scope of practice for CHNs in the U.S. Army MEDCOM. Lastly, two other individuals provided statements to clarify several issues that surfaced during the review of the ROI: Chief, Policy and Programs Branch, Civilian Human Resources Division, Headquarters, U.S. Army MEDCOM for his expertise on civilian personnel issues within U.S. Army MEDCOM and, Chief, U.S. Army MEDCOM, Quality Management Division (QMD) for her expertise in AR 40-68, "Clinical Quality Management" as QMD is the proponent of this regulation.

The IO investigated each of the allegations made by the Whistleblower regarding her duties and whether or not they were beyond the scope of the educational, licensing, training and experience of a CHN. The AR 15-6 ROI clearly reflects that the Whistleblower had the requisite educational, licensing, training and experience to be a CHN as a licensed RN with an Associate's

Degree and 37 years of nursing experience. Further, the IO found that the duties she was assigned, specifically, ordering and interpreting sexually transmitted infection (STI), tuberculosis, and hepatic enzyme tests, and refilling prescriptions for Isoniazid were *not* "advanced nursing duties" that were beyond the scope of practice of a CHN as she had alleged.

All of the testimonial and documentary evidence gathered by the IO during the AR 15-6 investigation reflects that the duties assigned to the Whistleblower were well-established in Clinical Practice Guidelines (CPGs) and were within the scope of practice for a nurse with the Whistleblower's extensive training and experience as a Registered Nurse. Finally, the ROI and its supporting record evidence support the conclusions that (1) the Preventive Medicine Clinic's CPGs were within the practice standards established under Army Regulation as well as the California Board of Registered Nursing, and (2) no patient injury occurred and never posed or constituted a danger to the public health and safety.

Documentary and Testimonial Evidence Gathered During the Investigation concerning the LAHC Preventive Health Clinic

Statement of the Whistleblower, Complainant

The Whistleblower made a sworn statement on May 17, 2011 confirming her allegations that the vacancy announcement did not address the "*specific duties*" hat she was asked to perform at LAHC regarding the ordering of medication refills and lab tests under her name as provider or diagnosing and treating Sexually Transmitted Infections (STIs) or Sexually Transmitted Diseases (STDs), tuberculosis and hepatic enzyme tests. [Tab M, Statement of the Whistleblower, p. 1, Answers 1 and 6]. She stated that she was very "forthright" about her credentials, education and experience with the selection officials, pointing out that there were notes made on her resume to reflect that they were aware of her not having CHN or Occupational Health Nursing certification or experience and only possessing an Associate's degree. [Tab M, Statement of the Whistleblower, Answer 3]. Further, the Whistleblower testified that those who interviewed her and with whom she dealt with after she was hired "knew that I didn't have Pubic Health Certificate, was not advanced practice nurse and did not have work experience or training as a public health nurse/community health nurse." [Tab M, Statement of the Whistleblower, Answer 4]. The Whistleblower testified that the vacancy announcement read

> "as if it was a job with providing patient education, counseling and coordination of health programs for child youth services. There was nothing in the Vacancy Announcement that mentioned that I would be prescribing medication under [her] name or provider, ordering lab tests and x-rays under my name as provider or diagnosing and treating sexually transmitted diseases as a provider. I had basic knowledge of Public Health, experience in patient education, crisis counseling and coordinating programs." [Tab M, Statement of the Whistleblower, Answer 2].

She further stated that she advised her supervisors, Chief, Preventive Medicine Clinic and Supervising Preventive Medicine Physician, that she should not be ordering medication or ordering labs without a physician's order; "that if this was the job, they needed a nurse practitioner". Hence, she stated that ordering medication was outside the scope of her practice. [Tab M, Statement of the Whistleblower, Answers 8 and 13].

Additionally, the Whistleblower stated that she

> "had education and experience to train.....and at one time had a preliminary vocation teaching credential for health course design, implementation and evaluation. I was able to plan and coordinate health services to assist families. I had the education and experience for conducting health education activities revolving around group interaction. I had experience working with patients with active tuberculosis, HIV/AIDS, epidemiological diseases and STI/STDs in the emergency room and operating room only. I was able to deliver training at all levels and evaluate training. I was able to deliver training at all levels and evaluate training. I had experience and training to give crisis counseling and gain cooperation of patients who were afraid, resistant, suspicious or noncompliant with public health directives." [Tab M, Statement of the Whistleblower, Answer 7].

She stressed that on many occasions that she asked Supervising Preventive Medicine Physician to interpret the hepatic enzyme results as she could not because it was outside the scope of her practice. [Tab M, Statement of the Whistleblower, Answer 8]. The Whistleblower was concerned that she was not a nurse practitioner and did not feel comfortable performing the tasks she was being asked to perform including those related to the hepatic enzyme, latent tuberculosis, and STD/STIs) [Tab M, Statement of the Whistleblower, Answers 8 and 9] and that "it was not safe practice for soldiers" to be seen by a non-practitioner in that "they deserved the right to a medical exam by a practitioner." [Tab M, Statement of the Whistleblower, Answer 9]. On December 28, 2010, she wrote an e-mail to Deputy Commander for Nursing and the Deputy Commander for Clinical Services (DCCS), regarding her concerns and telling them that ordering labs and medication refills was not in her scope of practice. [Tab M, Statement of the Whistleblower, Answer 10]. The Whistleblower received a letter of warning on January 4, 2011 "stating that I would be fired if I did not comply. The letter also had reference to the possibly insubordination for talking with the pharmacist." [Tab M, Statement of the Whistleblower, Answer 11].

Regarding her being required to continue to perform duties that were a substantial and specific danger to public health or safety, the Whistleblower provided the following:

> "In my experience and my knowledge as a registered nurse of 37 years, it is standard of practice that registered nurses are not qualified to perform the duties of prescribing medication and ordering specific labs without a doctor's direct order. The orders for medication and labs must have the doctor's name as prescribing or ordering doctor on the ordering slips. In many states, nurse practitioners and physician assistants are not allowed to prescribe medication or order labs without a physician's supervision or a physician checking their charts and signing their names as approving the order. Registered nurses are not trained to diagnose and treat patients and it is not in their scope of practice. Further training is needed as a nurse practitioner. . . .

I did not have the requisite training as a nurse practitioner and was not qualified to perform the duties of prescribing refills of medication, ordering hepatic enzymes and interpreting the results nor diagnosing and treating patients. Exhibit F-8 application for nurse practitioner furnishing number and DEA for prescribing medications clearly shows that one must be trained as a nurse practitioner with a Board approved Pharmacology course and a minimum of 520 supervised hours of prescribing by a physician.

I was a substantial and specific danger to the public health and safety of patients for whom I was told to diagnose, treat and prescribe medications, as I was unqualified, unskilled and untrained. I did not possess the requisite educational, licensing, training and experience requirements required for diagnosing and treating patients, ordering labs and interpreting them and ordering refills of a liver toxic medication such as INH as an independent practitioner....

Simply reading material from the CDC website does not make me an expert and I was never tested for my competency or knowledge. Patients with STD/STIs need to be examined by a provider because they may not verbalize all of their symptoms and could have something else going on health wise. I also have no idea about what medications to prescribe for STD/STIs." [Tab M, Statement of the Whistleblower, Answer 13].

Statement of Supervising Preventive Medicine Physician, LAHC

Supervising Preventive Medicine Physician made a sworn statement on May 17, 2011. He did not participate in the hiring and interview process of the Whistleblower, but he stated unequivocally that a licensed, registered nurse would have the requisite education, training, and experience to be able to perform functions related to ordering and interpreting STI, Tuberculosis, and Hepatic Enzyme tests and to refill prescriptions for INH, "and/or the ability to learn how to do them as a professional nurse."

One of the first responsibilities that the Whistleblower had was to care for latent tuberculosis patients. The patients were referred to her by other health care professionals secondary to positive PPD tests indicating the possible presence of latent tuberculosis. Her job was to perform the initial health care interview with the patient, taking a medical history specific to possible exposure to tuberculosis. The following sequence of events to be performed by the LAHC CHN was provided for in the protocol signed and authorized by the Department Head, Preventive Medicine, and Supervising Preventive Medicine Physician personally, as the supervising preventive medicine physician:

"The CHN, per protocol, would order a chest x-ray and hepatic blood enzyme tests. She would fill out the defined latent tuberculosis documentation, and based upon the history she received, make a recommendation for treatment, including the use of isoniazid therapy. The patient would then make an appointment with me, at which time I would review the history, lab and x-rays, perform the indicated physical examination and review the recommendations from the CHN. Based upon this, if indicated, I would begin isoniazid treatment and write the

initial prescription for 30 days of isoniazid (INH). Per protocol, arrangements would be made for the CHN to re-evaluate the patient in 4 weeks to access for signs and symptoms of INH toxicity, and to order hepatic blood tests. If the patients has signs of symptoms of liver toxicity, and/or the liver test values are above the acceptable upper limits, the CHN refers the patient back to the prescribing provider. If there is no evidence of liver toxicity by interview or lab work, the protocol authorizes the CHN to provide a 30 day prescription for INH. The patient interview with the CHN re-occurs every 30 days, with the liver tests performed again only at the 3 month visit after initiating the treatment. At these interviews, if there are no findings indicative of liver toxicity, the CHN is authorized through the protocol to provide an additional 30 day prescription for INH. If there is evidence of liver toxicity, the CHN refers the patient back to the initial prescribing provider. This continues for a total treatment period of nine months, at which time the patient is appointed with the initial prescribing physician to access completion of the treatment."

At the time of the Whistleblower's first encounter with a referred patient for this condition, she stated that she would like to perform the assessments with Supervising Preventive Medicine Physician to gain working experience with these evaluations. He fully agreed to supervise and at that time, he advised her that she needed to become familiar with the Center for Disease Control (CDC) documents regarding the evaluation, diagnosis and treatment for latent tuberculosis. He then gave her the link to the CDC website and some of the relevant documents. Based on her training and credentials as an RN, Supervising Preventive Medicine Physician "fully expected" that she would have the ability to understand the CDC documents, apply the information to her patients, and quickly learn the initial patient interviews and evaluations that she did with Supervising Preventive Medicine Physician. However, after several patient encounters, it became apparent to Supervising Preventive Medicine Physician that she was having challenges in grasping the basic knowledge regarding latent tuberculosis. Without equivocation, Supervising Preventive Medicine Physician's expectation was that "a registered nurse with her training and experience would be able to quickly understand and apply the specific clinical information to patients.

After a period of observing the Whistleblower with patients that began in October 2010, Supervising Preventive Medicine Physician went to Chief, Preventive Medicine Clinic regarding his concerns in early December 2010 of the Whistleblower's lack of abilities. He concluded it might be easier for him to just do the initial evaluations by himself and not involve the Whistleblower, as it was becoming too time consuming. After he expressed his concerns with Chief, Preventive Medicine Clinic, she stated that she would work with the Whistleblower regarding these latent tuberculosis patients. Subsequently, the Whistleblower no longer asked him to assist with initial interviews. The Whistleblower consulted with him periodically on patients having their 30-day follow-ups, and to the best of Supervising Preventive Medicine Physician's knowledge, she followed the protocols.

Regarding the ordering and interpreting of Sexually Transmitted Infections (STIs) or Sexually Transmitted Diseases (STDs), the plan to initiate this process with the Whistleblower began in late December 2010. Supervising Preventive Medicine Physician testified that at that time, she "vehemently rejected the proposition when presented by Chief, Preventive Medicine Clinic and refused to perform these evaluations in accordance with the signed and authorized protocols." To Supervising Preventive Medicine Physician's knowledge, the Whistleblower has never performed these evaluations. Supervising Preventive Medicine Physician was present when Chief, Preventive Medicine Clinic

gave the Whistleblower the letter of warning on January 4, 2011 and the Whistleblower abruptly left without further discussion. Supervising Preventive Medicine Physician has not seen the Whistleblower since that date.

Lastly, Supervising Preventive Medicine Physician testified that no patient was injured as a result of the Whistleblower's actions; however, some of the latent tuberculosis patients lost a short period of continuing care after she left on January 4, 2011. This did not result in any adverse effects to these patients regarding their treatment. Further, none of the patients the Whistleblower cared for with latent tuberculosis developed active tuberculosis which could have been a threat to public safety and none were in danger for their health or safety as the authorized protocol was followed. Further, Supervising Preventive Medicine Physician testified that the Whistleblower never evaluated any patients with STIs nor was she presented with any patients with this issue.

Statement of Chief, Preventive Medicine Clinic

Chief, Preventive Medicine Clinic provided a sworn statement on May 17, 2011 with an explanation that "[t]here are no specific or specialized educational or training requirements for a CHN. The only requirement for licensing is to be a Registered Nurse." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 1]Chief, Preventive Medicine Clinic testified that the position required "[e]xperience or exposure in any one or more related Community or Public Health programs or situations such as Home Health, Emergency Preparedness, Health Promotion, Occupational Health and Safety, Communicable diseases, bioterrorism, teen pregnancy, environmental hazards, chronic diseases, marketing research, awareness through media, and working in any capacity of health outside of the hospital environment dealing with individuals, families, groups, or entire communities and populations." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 1]. Chief, Preventive Medicine Clinic testified that the Whistleblower did possess the requisite educational, licensing, training, and experience to be a CHN as she "holds a registered Nurse's license from the State of California and has had several years experience with related Public Health Programs such as Disaster Preparedness, American Red Cross, Population Health, Evacuations, etc." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 6].

Chief, Preventive Medicine Clinic very clearly remembered the completeness and thoroughness of the Whistleblower's' interview regarding exactly what were the duties of a CHN at LAHC. Chief, Preventive Medicine Clinic testified that during the Whistleblower's interview, "she restated on several different occasions when answering our questions that she had a clear understanding of the experience requirements for the CHN position as she read the vacancy announcement verbatim." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 7]. Prior to accepting the position, the Whistleblower never stated that she did not possess the requisite qualifications to fulfill the CHN position and neither had any of the selecting officials determined that she did not possess the requisite qualifications. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 8]. Chief, Preventive Medicine Clinic testified that "[o]n the contrary, she impressed the interview panel with having researched our organization (LAHC) prior to the interview which indicated she was a higher caliber candidate because most interviewees would not go to such lengths, also, she spoke extensively of what she had to offer for the position and the programs." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 8].

Regarding the requirements that CHNs are required to follow when performing their duties, Chief, Preventive Medicine Clinic testified that according to AR 40-68, Chapter 7, "individual MTF's

establish local Standard Operating Procedures (SOP's) and protocols which describe a Community Health Nurse's role and responsibility to carry out the functions of these programs and mission." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 2]. Further, Chief, Preventive Medicine Clinic explained that "[a]ll military treatment facilities, being federal establishments have published Standard Operating Procedures (SOPs) and Protocols based on Army Regulations which address the functions, roles and responsibilities and duty performance expectations for the CHN" and provided representative SOPs used at LAHC. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 3; and TABs N-11, N-12, and N-13, Protocols/SOPs provided by Chief, Preventive Medicine Clinic]. Additionally, Chief, Preventive Medicine Clinic stated that the LAHC Department of Preventive Medicine "uses the federal guidelines including Army regulations to develop the position description for CHN's, for establishing Standard Operating Procedures and Protocols pertaining to the mission requirements in Preventive Medicine Programs such as STD's, HIV, Latent Tuberculosis Surveillance, Child Development Centers, Tobacco Cessation, etc." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 4].

According to Chief, Preventive Medicine Clinic's testimony, the duties the Whistleblower was directed to perform, to wit, responsibility to order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to refill prescriptions for Isoniazid (INH) fell within the scope of practice for CHNs as provided for by the governing SOPs and protocols that dictated the responsibilities of the CHN which were based on and fell within the scope of practice for RNs under MEDCOM policy and Army Regulation. Chief, Preventive Medicine Clinic stated that though these duties were not specifically defined in the vacancy announcement, they were generally referred to in the position description under "preventive therapy" and "knowledge of infectious diseases and sexually transmitted diseases." [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 11].

Chief, Preventive Medicine Clinic stressed during her testimony that the Whistleblower never lacked the educational, licensing, training or experience to perform her duties. As a matter of fact, Chief, Preventive Medicine Clinic testified that the Whistleblower had initialed all the documentation provided earlier for her training and orientation in the programs pertaining to CHNs. Chief, Preventive Medicine Clinic unequivocally testified that there was no doubt that the Whistleblower was directed to perform her duties according to what she was hired to do and for which she was qualified to performed. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 13]. The Whistleblower was first counseled informally with a joint and participative discussion regarding performance of her duties according to the SOP for STI's and Tuberculosis Surveillance. When she verbalized that she refused to perform those duties, Chief, Preventive Medicine Clinic checked with Human Resources (HR) personnel for guidance on follow-up courses of action. The Whistleblower received two written counseling statements regarding the expectations for her to perform her duties as a CHN in accordance with HR guidance.

The Whistleblower informed Chief, Preventive Medicine Clinic of her concerns around December 21-22, 2010. When the Whistleblower verbalized concern that performing such duties would jeopardize her license, Chief, Preventive Medicine Clinic immediately contacted her supervisor, Deputy Commander for Nursing. She then had all of the protocols / SOPs reviewed by the Public Health Command to ensure that they were aligned with other standard MTF practices. Chief, Preventive Medicine Clinic then checked with the Consultant for the California Board of Registered Nursing and received confirmation that the duties contained

in the LAHC protocols / SOPs were within the scope of practice for any RN. Chief, Preventive Medicine Clinic then met with the Whistleblower and the department group, to include Supervising Preventive Medicine Physician and Occupational Health Nurse, to advise the Whistleblower that the duties contained in the MTF protocols were within the scope of her practice and she need not worry about her license. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 12].

Regarding the issue of ordering prescriptions in her own name, Chief, Preventive Medicine Clinic testified that the Whistleblower sent an e-mail to Chief, Preventive Medicine Clinic's supervisors regarding ordering medication refills. She advised that she had gone to the Chief of Pharmacy to have him remove her name. Chief, Preventive Medicine Clinic stated that the Whistleblower had never advised her of the concerns about ordering refills for INH, and that had the Whistleblower advised her of that particular concern, she would have resolved that issue immediately by having Supervising Preventive Medicine Physician's name being the default on all prescriptions as the Preventive Medicine Physician. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 12].

Chief, Preventive Medicine Clinic stated that at no time was any patient injured as a result of the Whistleblower's actions; however, there is evidence that the Whistleblower neglected to document on follow-up cases. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 16]. Further, Chief, Preventive Medicine Clinic testified that the actions taken by Chief, Preventive Medicine Clinic and other supervisors at LAHC Preventive Medicine Clinic did not constitute a substantial and specific danger to public health or safety. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 17]. Moreover, the oral and written counseling statements the occurred between Chief, Preventive Medicine Clinic and the Whistleblower and a Memorandum of Warning that Chief, Preventive Medicine Clinic issued to the Whistleblower were done pursuant to the advice and guidance of the LAHC Human Resources Office and in accordance with the Army Table of Penalties. [TAB N, Statement of Chief, Preventive Medicine Clinic, Answer 14].

Statement of Deputy Commander for Nursing, LAHC

The Deputy Commander for Nursing provided a sworn statement on May 18, 2011 wherein she advised that all vacancy announcements are prepared by the Civilian Personnel Advisory Center and include all licensure and education requirements for the position under recruitment. Regarding the specific requirements for the position at issue, Deputy Commander for Nursing testified that the educational, licensing, training and experience requirement for a CHN were "at a minimum, the individual must have a nursing degree from an accredited college or university and a valid registered nurse license from within the United States. While experience in community health nursing is not a requirement, it is preferred. However, training can be conducted once hired." She confirmed that the Whistleblower did possess the minimum educational and licensure requirements as well as experience to be a CHN. Further, when the offer of employment was made to the Whistleblower, neither the hiring official nor anyone else at LAHC received any questions from the Whistleblower regarding the requisite qualifications for the CHN position prior to the Whistleblower accepting the position.

The Deputy Commander for Nursing testified that the Whistleblower's duties were well within the scope of practice of the CHN position as the Whistleblower worked under the guidance of a physician at all times in case there were any questions. Further, though some of the responsibilities were not specifically defined in the position description or vacancy announcement, Deputy Commander

for Nursing stated that they were addressed during the Whistleblower's job orientation and training. Further, Deputy Commander for Nursing testified that the Whistleblower informed Chief, Preventive Medicine Clinic of her concerns regarding performance of duties within the first couple of months of employment. When LAHC was notified, they contacted both the California Board of Nursing and the Army Public Health Nursing Consultant and Chief Nurse, Public Health Command, regarding the Whistleblower's concerns regarding her scope of practice.

The Deputy Commander for Nursing testified that the Whistleblower has not been disciplined or received any adverse actions as a result of her reluctance to perform the duties she expressed concerns over. Administratively, the Whistleblower was placed on Leave Without Pay status due to her absence from work and having no annual or sick leave available. While Deputy Commander for Nursing is aware of some delay in management regarding the Whistleblower's assigned patients pending coverage by another department employee, she is not aware of any negative patient outcomes related to this delay. As part of the Risk Management Committee, Deputy Commander for Nursing would have been aware as any issues regarding patient safety would be addressed by this committee. Lastly, according to the Deputy Commander for Nursing, at no time was there a substantial or specific danger to public health as a result of any actions by the Whistleblower's supervisory chain of command.

Statement of Chief, Department of Pharmacy, LAHC

The Chief, Department of Pharmacy provided a sworn statement on May 18, 2011 and provided information regarding his participation on the interview process with the Whistleblower. He stated that he was the observer during the interview process when the Whistleblower and others were telephonically interviewed for the position of CHN at LAHC. He was not a voting member. During the interview process, the Whistleblower presented herself as someone fully qualified to fill the position of CHN at Lyster

Regarding the issue of ordering medication refills for INH, the Chief, Department of Pharmacy testified to the following:

> "[a] far as the pharmacy was concerned, the Whistleblower was licensed and credentialed to renew prescriptions for INH. Therefore, the Whistleblower was allowed to put into CHCS new prescriptions for INH using her name as the prescribing provider. The Whistleblower came to me and asked me for a report listing all of the prescriptions put into CHCS using her name as the prescribing provider. I ran a report from CHCS for the information she asked for, but [he] did not forward this report to her or anyone else. This report was deleted within 3 weeks by CHCS. This report was not retained by me."

Statement of Occupational Health Nurse, Former CHN, LAHC

Occupational Health Nurse provided sworn statements on May 18, November 8, and November 28, 2011. Occupational Health Nurse was previously the CHN at LAHC before taking her current position as the Occupational Health Nurse at LAHC.[10] Generally, Occupational Health Nurse acknowledged that the general

[10] Occupational Health Nurse was the Whistleblower's immediate predecessor as LAHC's CHN. She accepted a position as a GS-0610-12/ Occupational Health Nurse at LAHC which created the vacancy that the Whistleblower was hired to fill.

duties of a LAHC CHN included ordering and interpreting STI tests, ordering Isoniazid refills, and interpreting lab (hepatic enzyme) tests based on protocols initiated and approved by a physician. Occupational Health Nurse pointed out that "[t]hese are not duties of only a CHN with requisite educational, licensing, training and experience. All of the lab tests return with an interpretation. If a test interpretation from the lab list the test as abnormal, the physician is available for consultation/medical decisions." However, as a nurse, Occupational Health Nurse explained that the CHN is expected to perform nurse duties which are assistive to the responsibilities assigned to physicians such as those explicitly cited in the vacancy announcement to which Occupational Health Nurse applied and her position description, including those documents' references to "providing comprehensive public health/community health nursing and communicable disease control (also stated sexually transmitted diseases). Communicable disease control would include skills/knowledge within the scope of practice of a registered nurse."

Occupational Health Nurse provided detailed testimony regarding the full spectrum of duties that comprise the day to day activities for a CHN at LAHC, none of them out of the ordinary.

> "Planned, implemented, evaluated health education classes for active duty soldiers, their commanders, military and civilian supervisors and their staff, health care workers, and other eligible populations with the goal of maximizing assimilation of information and encouraging behavioral change. Provided counseling and education to families affected by or associated with HIV. Counseled families and individuals, to include those who were HIV antibody positive or had sexually transmitted diseases (STD) and their contacts, regarding disease transmission and concerns of daily living. Assisted with the epidemiological investigation of HIV/STD positive persons and contacts using interview techniques and data collection methods as required. Documented information obtained using approved format (AHLTA) and within the parameters of confidentiality. Planned and coordinated health services to assist individuals and families with complex problems involving family disruption and compliance with a medical regime associated with HIV disease. Made referrals to other Military Treatment Facilities (MTF), civilian health agencies, and special agencies in support of disease control and contact assistance. Provided nursing intervention to include individual and group counseling about identified life style health risks and their control (e.g., smoking cessation). Served as Child and Youth Services (CYS) consultant. Cooperated with and assisted CYS with health concerns (was available for specific concerns on children; conducted monthly inspections; conducted classes on health, medication, and communicable disease for staff). Participated on the Special Needs Resource Team. Participated in operation of Tuberculosis Control Program [interviewed cases and contacts, ordered/monitored protocol labs, ordered preventive therapy (refill medications) based on standard protocol, and followed-up]. Participated in the epidemiological investigation of communicable diseases. Ordered standard protocol labs for STDs. Conducted health education activities, which revolved around group interaction (e.g., sexually transmitted disease prevention classes for soldiers) and individual counseling for STD positive individuals."

Occupational Health Nurse testified that she was on the selection committee in the hiring action of the Whistleblower. Occupational Health Nurse testified that "the Whistleblower made the statement in the interview she thought she would be able to perform the duties discussed." From a review of the Whistleblower's resume and the conduct and full participation of the Whistleblower in a very interactive interview, Occupational Health Nurse unequivocally stated that she found her to have the requisite education, licensing, training and experience to be to a successful CHN at LAHC when she accepted the CHN position. Occupational Health Nurse testified that the educational, licensing, training and experience requirements for a CHN are to have a registered Nurse Degree (an Associate Degree at a minimum), a Registered Nurse licensure; and Basic Life Support training.

Once the Whistleblower entered on duty as the LAHC CHN, Occupational Health Nurse had regular contact with the Whistleblower since Occupational Health Nurse was assigned to train and orient the Whistleblower on the policies and procedures for CHNs at LAHC. However, "the Whistleblower was not successful in grasping all the policies, procedures, responsibilities and duties" she was required to perform." Occupational Health Nurse stated that the purpose of the orientation phase of a new CHN is to utilize "an Initial Competency Assessment, a one-one-one physical orientation, competency calendar (for documentation of the orientation/training provided), and I had developed a checksheet" to capture this information.[1] [TABs N-6, Initial Competency Assessment form, and N-5, Orientation & Competency Calendars for September and October].

In her testimony, Occupational Health Nurse described in detail the following process for evaluating and reviewing the competency assessment of the specific duties and responsibilities of the CHN at LAHC:

> "The process for evaluating and reviewing the competency assessment is a one-on-one hands-on process. For the Whistleblower, I reviewed and demonstrated everything verbally. The Whistleblower took notes for how to do EVERYTHING step by step, then she was given a demonstration with patients (policies and procedures required), then the Whistleblower was expected to give a return back demonstration. However, as mentioned, the Whistleblower was not successful with demonstrating the required competencies and skills of a LAHC CHN. The self assessment was completed by the Whistleblower. The orientation (discussion and demonstration of required skills/competencies of a LAHC CHN) was over a month long, and she still did not have competency validation (ability to perform safely) of required skills for a LAHC CHN." (Emphasis in original)

Occupational Health Nurse also testified with respect to the Whistleblower's Competency Assessment checklist, she initialed those tasks that were completed by the Whistleblower, some of the line items were to be completed by the Chief of Preventive Medicine, Chief, Preventive Medicine Clinic, while few were not applicable to the Whistleblower. Thus, the checklist on the competency assessment contains entries that reflect successful completion by the Whistleblower

[1] In a follow-up statement on November 28, 2011, Occupational Health Nurse clarified that the Initial Competency Assessment form was developed by Chief, Preventive Medicine Clinic, and that Occupational Health Nurse primarily used the Competency & Orientation Calendars during the Whistleblower's training & orientation. Because it has been over a year since she had contact with the Whistleblower, Occupational Health Nurse no longer has the other training "checklist" she referenced in her November 8, 2011 statement.

while other line tasks were left blank reflecting that the Whistleblower never completed those competency assessment tasks.

Regarding the Whistleblower's concerns regarding performing certain tasks being outside her scope and practice, Occupational Health Nurse responded, "If an individual has an RN licensure, this indicates you have a standard skill set and knowledge. The Whistleblower demonstrated she did not have a basic RN skill set by stating she would lose her license if she followed a standard protocol (ordering standard protocol labs, etc.). No one can provide a nurse training for every circumstance – a nurse must have critical thinking/problem solving abilities which the Whistleblower did not demonstrate." Further, Occupational Health Nurse stressed, "the Whistleblower only wanted to perform certain duties . . . and if it was a duty she DID NOT desire to do, then she claimed she was not provided training or it was out of the scope of her licensure." (Emphasis in the original).

Summary of the Evidence in Response to the OSC Referred Allegations

After a review of all relevant information and evidence, the IO, found all four allegations to be unfounded. Specifically, in response to the Whistleblower's allegations, he found:

1. There is ample federal and State guidance related to the qualifications to be a Community Health Nurse (CHN).

In determining the educational, licensing, experience and training requirements for a CHN, the IO reviewed the California Board of Registered Nursing's "Explanation of the Scope of RN Practice, Including Standardized Procedures" [TAB L-1]; AR 40-68, *Clinical Quality Management*, Rapid Action Revision (RAR) May 22, 2009 [TAB H]; the Vacancy Announcement [TABs M-1 and N-19]; and the Position Description [TABs M-2 and N-20]. Additionally, the IO interviewed the Former Public Health Nursing (PHN) Consultant to The Army Surgeon General and currently the Chief, Wounded Warrior Division, Joint Task Force National Capital Region Medical, Walter Reed National Military Medical Center Bethesda, Maryland.

The federal and State guidelines are provided as attachments to this report and clearly establish the minimum educational, licensing, experience and training requirements for CHNs, as follows:

a. **Educational and Licensure Requirements.** The educational and licensing requirements for a CHN are the same as for a Registered Nurse (RN) in all 50 States: either a Bachelors or Associates degree from a program accredited by the National League for Nursing or the Commission on Collegiate Nursing Education (CCNE), or accepted by the U.S. Secretary of Education. As long as a nurse has obtained a license through the RN licensing board, there is nothing to indicate what degree is required for being licensed.

The licensing requirements for a CHN vary by state, but according to the National Council of State Boards of Nursing, the minimum requirements for an RN are (a) graduation or verification of completion and eligibility for graduation from a state-approved nursing program;

(b) Passage of the National Council Licensure Examination (NCLEX); and (c) Self-report of any and all criminal convictions, chemical dependencies, and functional deficits.

AR 40-68, paragraph. 4-4a(1) [TAB H] provides that health care providers/professionals, to include RNs, "must possess and maintain a current, active, valid, and *unrestricted* license from a U.S. jurisdiction before practicing independently within the scope of practice for their specialty. ...The Office of Professional Management (OPM) has established the minimum qualification requirements for comparable civilian positions by employee classification series and grade level in its Qualification Standards Handbook for General Schedule Positions." [TAB H, p. 13]. The vacancy announcement for CHN at Lyster Army Health Clinic (LAHC) provided the basic requirements for the position: "Degree or diploma from a professional nursing program approved by the legally designated State accrediting agency AND Registration: Applicants must have active, current registration as a professional nurse in a State, District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States." [TABs M-1 and N-19].

b. **Experience Requirements.** The Vacancy Announcement provided that "[a]pplicants must possess one (1) year of specialized experience to the GS-09 grade level." [TABs M-1 and N-3]. According to Former Nurse Corps Public Health Consultant to TSG, "For civilian [CHNs], every attempt is made to hire someone with at least some experience, even if it is with a civilian public health department. Naturally, this is not always possible, and in those instances, we take applicants with a wide variety of experiences. Obviously, every attempt is made to interview these people ahead of time and communicate what the duties are, to ensure that they understand the differences between public health nursing and other types of nursing, such as medical-surgical." Neither AR 40-68 nor the California Board of Registered Nursing provide for a minimum experience level to be a CHN. The IO found that experience requirements are based on the specific position and Clinical Practice Guidelines (CPGs) established at the individual Army installation.

c. **Training Requirements.** The training requirements for a CHN for entry level mirror those for RNs. Although there are training programs provided by the U.S. Army MEDCOM for Army Nurse Corps officers, on the job (OJT) is the primary means of training public health nurses such as the Whistleblower. Further, in accordance with AR 40-68, paragraph 5-1a, the Army requirements provide that "Highly competent performance by members of the organization is predicated on a variety of factors, to include: a carefully structured new employee orientation, ongoing education and training opportunities, and formalized evaluation processes." [TAB H, p. 17]. AR 40-68, paragraph 7-4a(2) provides that CHNs "function in an expanded role using CPGs approved by the EMCS [Executive Committee of the Medical Staff] and DCN [Deputy Commander for Nursing]." [TAB H, p. 27]. The California Board for Registered Nursing provides that the authority for RNs to perform in a medical / clinical function is standardized procedures developed through collaboration among RNs, physicians and administrators in the "organized health care system" where it is used. "Organized health care systems" are defined by California statute to include, "licensed health facilities, clinics, home health agencies, physicians' officers, and public or community health services." [TAB L-1, p. 2, Standardized Procedures for Medical Functions]. LAHC falls within this definition.

With respect to the use of the CPGs, the IO found that "CPGs are protocol driven standard operating procedures (SOPs) that provide specific practice guidance for health care professionals

to address individual practice situations. There were specific CPGs that were obtained during this investigation related to the duties of CHNs at LAHC [TABs N-11, N-12, and N-13] which include: Community Health Nursing Isoniazid (INH) Chemoprophylaxis Program; Refill (INH) Chemoprophylaxis Therapy by Community Health Nurses (CHNs); Sexually Transmitted Diseases (STD) Patient Management Procedures; and the Tuberculosis Program. These CPGs outline the nursing and physician responsibilities and detailed instructions on ordering lab tests, duration of treatment and what to do in the case of abnormal findings."

The IO found that the above requirements, as elaborated upon by Chief, Preventive Medicine Clinic's testimony, were incorporated into the LAHC vacancy announcement which contained specific sections outlining the "Basic Qualification Requirements" for the Community Health Nurse position. These educational, licensing, training and experience requirements comply with AR 40-5 and AR 40-68 as outlined in the LAHC CPGs. Specifically, the "Major Duties" outlined in the announcement included:

(1) Assists in the coordination and implementation of a comprehensive Community Health Nursing Program for Fort Rucker.

(2) Community health nursing is a synthesis of nursing practice and community health principles applied to promoting, preserving, and/or restoring the health of military personnel, their families, and the retired military community through community assessment, adult and child health care, chronic and communicable disease control, health education, referrals, follow-up and liaison activities.

(3) Assesses individual's health status based on responses to health risk questionnaires, and clinical determination of height, weight, blood pressure, and glucose/cholesterol readings.

(4) Participates in operation of Tuberculosis Control Program (cases, contacts, follow-up, preventive therapy).

2. The Whistleblower had the requisite educational, licensing and experience to be a Community Health Nurse in the Preventive Medicine Clinic, LAHC.

The requisite educational and licensing requirements for a CHN are the same as for an RN. The Whistleblower was a licensed RN in the State of California and had 37 years of experience as a nurse. The requisite training and experience was properly described in the vacancy announcement as follows:

> SPECIALIZED EXPERIENCE: In addition to meeting the basic requirements above, applicant must possess *1 year specialized experience* equivalent to the next lower grade level GS-09, which equipped the applicant with comprehensive knowledge of an extensive range of public health nursing theories, principles and procedures to provide specialized services to persons with infectious disease or chronic disease of public health importance. Knowledge of human growth and development and the interrelatedness of host, agent, and environmental factors when maintaining individual and community health. Skills to perform crisis intervention with patient and family in

a stressful environment in order to provide support and consolation concerning disease process. *Ability to independently assess the need, design program goals and objectives,* develop quality assurance monitors in support of the program goals and to set program priorities based on community need. *Knowledge of infectious diseases, sexually transmitted diseases and diseases interfering with the body's normal immune system*, especially as related to AIDS and the HIV viruses. (Emphasis added)

The Whistleblower's resume indicates that she did possess the requisite educational, licensing, training, and experience to be a Community Health Nurse at LAHC. As previously discussed, the entry level educational requirements for an RN include a two-year Associate Degree which the Whistleblower possessed. [TABs M-3 and N-18]. Chief, Policy and Programs Branch, Civilian Human Resources Division reviewed the Whistleblower's job application on file and determined that the Whistleblower "is highly qualified for this Community Health Nurse (CHN) position at Lyster Army Health Clinic (LAHC), Fort Rucker, Alabama." [TABs M-3 and N-18; see also TAB Q, Statement of Chief, Policy and Programs Branch, p.1, paragraph 2]. The Whistleblower had an Associate's Degree from Purdue University (1974) and she was a licensed RN, California Board of Registered Nursing. Her training included Medical Management of Chemical and Biological Casualty (2003); International Committee Red Cross Course for Health Emergencies in Large Populations (Johns Hopkins University 2002), as well as other specialized training related to public health. [TABs M-3 and N-18].

The vetting process for this position involved several levels of scrutiny to include the Civilian Personnel Office at Fort Rucker, the Preventive Medicine Clinic at LAHC and a telephonic panel interview. The Whistleblower's varied experience working with public health in addition to working as an Emergency Room nurse during several periods from 1978 to 2003 gave the Whistleblower the requisite specialized training for the GS-11 CHN position at LAHC. [TABs M-2 and N-20]. Her resume included experience as an Occupational Health Nurse / Monitor for Raytheon Technical Services in 2007; Public Health Analyst for Department of Health and Human Services from 2006 to 2007; and as a Supervisory Nurse for the National Disaster Medical System, Disaster Medical Assistance Team from 1997 – 2007. Her resume also included experience as a Sexual Assault examiner and trainer. [TABs M-3 and N-18]. Furthermore, Chief, Preventive Medicine Clinic testified that "she impressed the interview panel with having researched our organization (LAHC) prior to the interview which indicated she was a higher caliber candidate because most interviewees would not go to such lengths, also, she spoke extensively of what she had to offer for the position and the programs." [TAB N, Statement of Chief, Preventive Medicine Clinic, p. 2, Answer 8].

Although the Whistleblower's statement during the investigation claimed that "the selecting officials were aware of my not having a Community Health Nurse or Occupational Health experience or certification and only possessing an Associate's Degree in Nursing," the CHN position did not require certification or an advanced degree.[12] [TAB M, Statement of the Whistleblower, p. 1]. The Whistleblower had the requisite education and licensure to be a CHN

[12] As discussed at Footnote 8 above, Chief, U.S. Army MEDCOM Quality Management Division testified that "[t]he placement of CHNs under the description of APRNs in AR 40-68, paragraph 7-4a(2) is inaccurate and confusing. CHNs are not APRNs and should not be placed under para. 7-4." Chief, U.S. Army MEDCOM Quality Management Division stated that upon the next revision or AR 40-68, this correction will be incorporated into the revision and CHNs will be removed from paragraph 7-4a."

because the requisite educational and licensure requirements were the same as an RN. Further, the Whistleblower was hired based on her specialized experience, as detailed in her resume [TABs M-3 and N-18] and as stated in the memorandum requesting approval to set the rate of pay for the Whistleblower above the minimum rate because of her superior qualifications [TAB O, p. 1].[13] According to her resume, the Whistleblower had been practicing as an RN since 1978 and had over 10 years of experience as a Supervisory Nurse for the National Disaster Medical System, Disaster Medical Assistance Team.

Based on a review of the Whistleblower's experience, the hiring officials believed that "the Whistleblower brings to the civilian workforce extensive experience as well as training and education in the career field. Her experience and education make her very well qualified for this position." As a result of the Whistleblower's qualifications, the hiring officials not only felt she met the qualifications for an entry-level CHN, but based on the Whistleblower's prior position as a GS-11, Step 10, she was hired at LAHC above the grade posted in the announcement. [TAB O-1, p. 1]. In order to hire her above the grade posted in the announcement, the LAHC Commander had to approve an advance in-hire rate to have her entry pay increased from Step 1 to Step 10. This resulted in an increase in her salary of $17,220.00. In addition to the advance in-hire rate, the Whistleblower also received a relocation incentive of $16,418.00 at the time she was hired. The total amount that the Whistleblower received above the entry level salary for the position was $33,638.00. [TAB Q, Statement of Chief, Policy and Programs Branch, p. 4].

3. All of the duties that the Whistleblower was asked to perform, to include ordering and interpreting sexually transmitted infection (STI), tuberculosis, and hepatic liver enzyme tests, and refilling prescriptions for Isoniazid, an antibiotic used to treat tuberculosis were established in written protocols / standard operating procedures (SOPs) within the Preventive Medicine Clinic at LAHC as part of the major duties established by LAHC for the Tuberculosis Control and Sexually Transmitted Disease programs which were referred to in both the vacancy announcement and position description[14].

There were two vacancy announcements for the CHN position at LAHC: 1) the vacancy announcement provided by the Whistleblower (Announcement No. SCEG09508786) was open from June 11, 2009 to June 24, 2009 [TAB 6a] and 2) the vacancy announcement provided by Chief, Preventive Medicine Clinic (Announcement No. MD-DHL-09-1466) was open from August 7, 2009 to September 7, 2009 [TAB 8t].

With respect to the Duties described in Announcement No SCEG09508786, the relevant portions are:

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[13] Army regulations allow for this advanced salary rate to be used when approved by the Medical Treatment Facility (MTF) Commander upon request based on a candidate's superior qualifications based on training and experience.

[14] The Whistleblower's complaint was centered around the vacancy announcement and what expectations she had coming into the job based on it. However, the specific clinical duties, i.e. ordering and interpreting sexually transmitted infection (STI), tuberculosis, and hepatic liver enzyme tests, and refilling prescriptions for Isoniazid, were required as part of the overall duties required as part of the operation of the Tuberculosis Control and Sexually Transmitted Disease programs at the Preventive Medicine Clinic at LAHC. Regardless of the Whistleblower's expectations, the position that she was hired for was as a nurse. Therefore, it is entirely reasonable to expect that there were be clinical duties required of the position and these duties were implied tasks as part of the overall position requirements in the operation of the Community Health Nursing Department.

> "Assists with the epidemiological investigation of HIV positive persons. Counsels families and individuals, to include those who are HIV positive and their contacts, regarding disease transmission. . . . Assists in the coordination and implementation of a comprehensive Community Health Nursing Program. *Participates in operation of Tuberculosis Control Program. . . .* Assess individual health status." (Emphasis added) [ROI, Response to Question e, p. 6; TABs 6a and 8t]

With respect to the Major Duties described in Announcement No. MD-DHL-09-1466, the relevant portions are:

> "Assists in the coordination and implementation of a comprehensive Community Health Nursing Program for Fort Rucker. Community Health nursing is a synthesis of nursing practice and community health principles applied to promoting, preserving, and/or restoring the health of military personnel, their families, and the retired military community through community assessment, adult and child health care, chronic and communicable disease control, health education, referrals, follow-up and liaison activities. Provides counseling and education to families affected by or associated with HIV. *Assesses individual's health status based on responses to health risk questionnaires, and clinical determinations of height, weight, blood pressure, and glucose / cholesterol readings.* Serves as Child and Youth Services (CYS) consultant. *Participates in operation of Tuberculosis Control Program (cases, contacts, follow-up, preventive therapy).*" (Emphasis added). [See TABs M-2 and M-20].

Chief, Policy and Programs Branch, Assistant Chief of Staff for Human Resources, Office of the Surgeon General, reviewed the personnel documents related to this case. Upon review, Chief, Policy and Programs Branch explained that the Whistleblower was hired through the OPM direct hire appointment authority.[15] However, it should be noted that the overall duties for the position at LAHC Preventive Health Clinic described in the position description (PD) are more pertinent to this case because the Whistleblower was not hired as a result of either vacancy announcement, as both closed in 2009. The Whistleblower was interviewed and selected for the CHN position by the hiring officials in July 2010. Additionally, Chief, Policy and Programs Branch provided:

> Although the specific duties stated above were not explicitly delineated in the PD, such tasks are not required to be explicitly stated in a PD or vacancy announcement under the OPM Position Classification Standard. PDs established under OPM guidance are not intended to capture or delineate all tasks or all duties expected to be performed by an incumbent; instead they are intended to capture paramount grade-controlling major duties and to identify the knowledge, skills, and abilities essential to satisfactorily perform the duties of the position. Beyond the general requirements for the PD,

[15] The Office of Personnel Management government-wide direct hire appointment authority allows an agency to hire on-the-spot for five medical occupations, to include Registered Nurses, without regards to veteran's preference on the basis that the agency is exercising such appointment authority to fill a hard-to-fill position due to severe shortage of candidates or meeting a critical hiring need for the agency.

supervisory officials have the authority to assign duties to for each position within the scope of the overall job description as mission requirements dictate. . . .

Other than the Position Description and Vacancy Announcement, management officials have other opportunities to define the required duties of a position being filled through the interview process, while assigning performance objectives to the new hire, and through the initial orientation of the new employee. In this case, LAHC established an Initial Competency Assessment form to be used during orientation. It is appropriate and expected that during the interview and selection process, while developing performance objectives, and completing the Initial Competency Assessment that discussions would focus on required duties of the position and defining the expectations to the new hire." [TAB Q, Statement of Chief, Policy and Programs Branch, p. 4].

The clinical duties that the Whistleblower alleged she was not qualified to perform were directly related to the Tuberculosis Control and Sexually Transmitted Disease programs which were referenced in both vacancy announcements[16]. Furthermore, there were three specific CPGs related to the duties of CHNs at LAHC to include (and which in turn, were applicable for the Whistleblower to follow). They are: (1) "Prescribing Isoniazid (INH) Chemoprophylactic Therapy by Community Health Nurses"; (2) "Sexually Transmitted Diseases (STD) Patient Management Procedures"; and (3) "Tuberculosis Program". These CPGs outline the nursing and physician responsibilities and detailed instructions on ordering and interpreting lab tests, ordering medication refills of INH, duration of treatment and what to do in the case of abnormal findings.

Specifically:

(1) "Prescribing Isoniazid (INH) Chemoprophylactic Therapy by Community Health Nurses" describes the policies and procedures for eligibility, monitoring and refill of INH therapy in consultation with the Preventive Medicine physician. [TAB N-11].

(2) The "Sexually Transmitted Disease (STD) Patient Management Procedures" protocol provides guidance to health care providers at LAHC who, through their duties, participate in the medical and administrative management of clients suspected or confirmed to have an STD. As part of this protocol, CHNs are required to "Order the minimum laboratory tests listed under Diagnostic Protocol 6c(1) for all walk in suspect STD clients and investigative contacts at the Preventive Medicine Clinic. When labs are ordered, a clinic appointment for the individual must be made with their primary health care provider." [TAB N-12].

(3) The "Tuberculosis Program" SOP provides the Preventive Medicine Service (PMS) procedures for evaluation and follow-up of individuals with positive reactions to Tuberculin Skin Tests (TSTs) and individuals who are a close or other than close contact to a case of tuberculosis. Under this protocol, all CHNs in the PMS are required to order the following laboratory tests: (a) Posterior, Anterior, and Lateral (PA/LAT) chest x-ray (CXR), (b) Liver function test (LFT) – Alkaline phosphatase (ALK Phos), Lactate Dehydrogenase (LDH), Total Bilirubin, Aspartate

[16] See Footnote 14 above.

aminotransferase (AST) and Alanine aminotransferase (ALT), and (c) Complete Blood Count (CBC), Urinalysis, and HIV testing. [TAB N-13].

4. The protocols / SOPs in place at the Preventive Medicine Clinic at LAHC met the standards under Army guidance set forth by the Public Health Command and the Whistleblower was authorized under the California Board of Registered Nursing to work under established military protocols while assigned to a military treatment facility.

Chief, Preventive Medicine Clinic testified that the Preventive Medicine Clinic used federal guidelines, including AR 40-5 and AR 40-68 to develop the SOPs / protocols discussed above. Chief, Preventive Medicine Clinic also testified that "[w]hen the Whistleblower verbalized concern that by performing such duties would jeopardize her license, I immediately checked with my supervisor, Deputy Commander for Nursing, I had the SOP's and protocols [detailed above] reviewed by the Public Health Command to ensure they were aligned with other standard MTF practices, and I received direct confirmation by a Consultant of the Board of Nursing in the State of California that the duties fell within the scope of practice for any RN." [TAB N, Statement of Chief, Preventive Medicine Clinic, p. 5]

Chief, Preventive Medicine Clinic provided the IO the confirmation e-mail she received from the California Nursing Education Consultant (NEC) for the Board of Registered Nursing (BRN) which stated, "When a CA licensed RN is doing the functions specified in the military protocol as a military staff, he/she can perform the functions in the assigned setting. However, the same RN, outside of the assigned setting and the military role, must be bound by the CA NPA [Nursing Practice Act] as specified in the BPC [Business and Professional Code] section 2725[17]." [TAB N-14, p. 1].

5. As long as written protocols, e.g., Clinical Practice Guidelines or Standard Operating Procedures (SOPs) are in place, CHNs can perform in an expanded role, to include ordering and interpreting lab tests and ordering re-fills of prescriptions, within the scope of practice as RNs.

<u>Scope of CHN Practice Under Federal Regulations.</u>

The scope of practice of CHNs within the Medical Treatment Facility is established under AR 40-68. Specifically, AR 40-68, 7-4a(2) provides, "Community health nurses (CHNs) function in an expanded role using clinical practice guidelines (CPGs) approved by the ECMS [Executive Committee of the Medical Staff] and the DCN [Deputy Commander for Nursing]. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature,

[17] "Section 2725 of the BPC provides the Legislative intent: Practice of nursing defined as follows:

(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. . . . It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. . . .

(c) "Standardized procedures," as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 . . . through collaboration among administrators and health professionals including physicians and nurses.

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 . . ." [TAB L-5, Business and Professional Code, Chapter 6, Nursing, p. 8].

but he/she does not independently initiate, alter, or discontinue any medical treatment. Likewise, the scope of practice of occupational health nurses (OHNs) typically includes CPG or protocol-based patient interventions. In selected circumstances, either the CHN or OHN may be assigned duties or functions for which clinical privileges are deemed appropriate." [TAB H, p. 27].

In determining the scope of practice for a CHN under the Army guidelines, the IO also interviewed Former Nurse Corps Public Health Consultant to TSG who provided the following information regarding the tasks which would properly be within the scope of duties for a CHN:

"(1) **Responsibility to order and interpret sexually transmitted infection (STI).**

...the ability to order and interpret laboratory tests for STI. This would depend on the institution.[18] If so, it would be written into the protocols that are approved by the medical staff. These protocols are evidence-based, and are essentially algorithm-type of documents. Frankly, this is an area that we frequently have been asked to support. When a person has symptoms of any kind, whether influenza, ankle pain, or painful urination, they should go to their regular place of medical care and seeks treatment. STDs are something that a primary care manager is trained to take care of. Part of that training includes awareness that STDs are a public health matter, and should be referred to the preventive medicine department, specifically the public health nurse. Our role is not diagnosis and treatment, but ensuring that the public health concerns with the aforementioned condition have been adequately addressed. That includes contact tracing and reporting. It also includes ensuring that the individual received the proper treatment in accordance with the CDC guidelines. If, for example, someone sees their regular doctor for gonorrhea, and he or she orders the appropriate bacteriological studies, but neglects to request an HIV test, the public health nurse will usually "fill in the blanks", based on the medical-staff approved protocols (which are based on published CDC guidelines). If any of those things are positive, and it comes back to the public health nurse, that person should be communicating that information to the provider...

(2) **Tuberculosis and hepatic enzyme tests.**

While individuals with latent tuberculosis infections have their initial treatment prescribed by providers, the initial workup does include an interview to identify risks, and while the individual has come to us from another clinic in most cases, and therefore may have already had chest radiographs requested, we also can put in a request for those. While nationally, only a PA chest x-ray is necessary, some of the physicians overseeing our practice have stated their preference for both PA and lateral. We are here to support the provider, and run the clinic according to the doctor's orders. While baseline hepatic enzymes are no longer recommended on all individuals, if, during the course of the air intake interview, an individual is identified at being at risk for hepatotoxicity (if there liver is challenged with

[18] A Military Treatment Facility, such as a Medical Center, Army Community Hospital, Health Clinic, etc.

hepatotoxic drugs, such as Isoniazid), we are supposed to request the baseline hepatic enzymes, and follow them closely during the course of the individual's therapy...

(3) **Re-fill prescriptions for Isoniazid (INH).**

Refills only, not the initial prescription, which can only be done by a licensed independent practitioner. And the refills are only for anti-tuberculin medications, not others, such as STD treatments."

As discussed in above, AR 40-68 allows for the delegation of privileged tasks, functions or processes to a competent nonprivileged provider. Specifically, "delegation transfers to a competent individual the authority to perform a selected patient care task in a given situation. Typically, delegation involves the licensed or privileged professional allowing a specified patient care activity, that is within his or her own scope of practice, to be performed by the unlicensed assistive personnel (UAPs), an RN/LPN, or other nonnursing personnel. The authority to perform the task is passed to another but the professional responsibility and accountability for the overall care provided, and for associated patient outcomes, remains with the delegating individual." [TAB H, AR 40-68, paragraph 5-2, p. 21]

In his testimony, Former Nurse Corps Public Health Consultant to TSG explained the practice of delegation related to CHNs that each CHN "is supposed to operate under protocols approved by the medical staff at their facility. Their practice is overseen by a licensed independent practitioner, typically a physician, and typically the chief of preventive medicine." Such was the case for the Whistleblower in that Supervising Preventive Medicine Physician stood in that capacity vis a vis the Whistleblower's practice. AR 40-68 also provides that it is the responsibility of local leadership to ensure that all healthcare providers to whom patient care tasks and procedures have been delegated are assessed as to individual competency; that competency-based orientation is provided; and that individual duties are based on demonstrated knowledge, skill and technical proficiency. [TAB H, AR 40-68, paragraph 5-2, p. 21]. This requirement was met at LAHC through the protocols/SOPs established a LAHC for CHNs in the Preventive Medicine clinic as discussed by Supervising Preventive Medicine Physician and Chief, Preventive Medicine Clinic in their statements. [TAB N, Statement of Chief, Preventive Medicine Clinic, p. 3, Answer 10].

Although the Whistleblower provided references to several Army Regulations (AR 40-3, paragraph 11-11b, 14-9, Individuals Authorized to Order Lab Tests; AR 40-3, paragraph 11-11, Personnel Authorized to Write Prescriptions; AR 40-68, paragraph 4-4, Note (2), Abiding by Practice Requirements of State licensure; and AR 40-68, paragraph 5-3, Supervision of Practice, the Whistleblower's reference to these provisions are not relevant to her duties which were established under protocols / SOPs. As discussed above, the Whistleblower was not privileged but working under delegated authority by Supervising Preventive Medicine Physician and her duties were established not by privileging provisions under AR 40-68 but by the standard protocols/ SOPs developed at LAHC. As Chief, Preventive Medicine Clinic explained in the "Memorandum of Warning" to the Whistleblower on 4 January 2011, "Army Public Health Nurses do not practice under a Privilege-base but a Protocol-based Practice." [TAB N-2].

<u>Scope of CHN Practice Under CA Board of Registered Nursing Guidelines.</u>

In addition, the IO reviewed the California Board of Registered Nursing's "Explanation of the Scope of RN Practice, Including Standardized Procedures" regarding the scope of practice of a CHN under their respective licensing and privileging requirements. The California Board of Registered Nursing (BRN) distinguishes Public/Community Health nurses as either certified Public Health Nurses who require a certificate from the BRN [TAB L-4, Advanced Practice Certificate, p. 2] or non-certified who work as RNs. As the Whistleblower was not a certified CHN under California directives, the IO only addressed the scope of practice of RNs under the California Board of Registered Nursing. [TAB L-1, "An Explanation of the Scope of RN Practice Including Standardized Procedures," pp. 1-4]. Under the California BRN licensure guidelines, non-certified CHNs must adhere to the standards contained in the "Explanation of the Scope of RN Practice including Standardized Procedures." This document does not give prescriptive detail on what tasks can and cannot be done, but instead allow an RN to practice beyond their "normal scope of practice" when working under "written standardized procedures developed by nursing, medicine and administration in an organized health care system after the RN has been evaluated and approved as having met the educational and experience requirements specified in the procedure." [TAB L-1, "An Explanation of the Scope of RN Practice Including Standardized Procedures," p. 3].

Although the Whistleblower provided reference to "Instructions for Applying for a Nurse Practitioner Furnishing Number," [TAB M-8] the strict requirements set forth under California Business and Professional Code (BPC) for standardized procedures by Organized Health Care Systems under California law and regulation do not apply to the federal government. The IO interviewed Chief, Preventive Medicine Clinic regarding the issue of the Whistleblower's concerns regarding the scope of practice under her State licensure, and she testified that based on her research and consultation with the California BRN, the CPGs developed by LAHC are consistent with the State's scope of practice guidelines.

Chief, Preventive Medicine Clinic testified that when the Whistleblower expressed concerns with working outside her scope of practice when performing certain tasks, that she requested guidance from the Board of Registered Nursing Consultant regarding whether an RN registered in California hired and working for the military is legally protected and bound to practice nursing under military protocols. [TAB N, Statement of Chief, Preventive Medicine Clinic, p. 3, Answer 12] She received a response back from Nursing Education Consultant (NEC), California BRN, that it was difficult to do a comparison of the SOPs at LAHC under California regulation because "[t]he rules under which army staff work are different than that of RNs in CA who practices within the NPA [Nursing Practice Act]. Since the NPs [Nurse Practitioners] obtained the furnishing authority, the Board has moved away from RNs managing medications using standardized procedures." [TAB N-14, p. 2]. The California Nursing Education Consultant, however, then sent a follow-up e-mail to Chief, Preventive Medicine Clinic and Deputy Commander for Nursing on 7 January 2011 that "As federal employees, military staff needs to abide by the federal rules, and if federal rules are in conflict or require the staff (RN) to do beyond the scope allowed in the CA NPA, as long as the federal employee functions within the policies of the federal agency, the staff may do so and would not be disciplined by the BRN." [TAB N-14, p.1].

Chief, Preventive Medicine Clinic advised the Whistleblower in the "Memorandum of Warning" on January 4, 2011, "According to the California Board of Registered Nurses, Example A (Process Protocol) page 7-21 clearly states,

'nurses may perform the following functions within their training specialty are and consistent with their experience and credentialing: assessment, and treatment of episodic illnesses, chronic illness, contraception, and the common nursing function of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies, recommending diets, and referring to specialty clinics when indicated. Standardized procedure functions such as managing medication regimens, are to be performed in (list area, i.e. short appointment clinic." [TAB N-2, pp. 1-2]

Chief, Preventive Medicine Clinic also forwarded the follow-up e-mail that California Nursing Education Consultant sent to her and Deputy Commander for Nursing, referenced above, to the Whistleblower via e-mail on January 13, 2011 with the note, "[The Whistleblower], As you requested, please see the message below. Let me know if you have any questions." [TAB N-1] Although the Whistleblower never returned to work after January 4, 2011, the e-mail from California Nursing Education Consultant was forwarded (and received by the Whistleblower) prior to her complaint to the OSC. The response from the State of California advising that the Whistleblower could perform the duties that LAHC had assigned to her to perform did not allay the Whistleblower's perceptions.

Finally, the IO interviewed Occupational Health Nurse, the previous CHN at LAHC, regarding the duties and responsibilities of the CHN at LAHC. She outlined the CHN duties at LAHC that are consistent with above stated information in terms of scope of practice and the expectation to perform protocol driven nursing functions, i.e., the responsibility to order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to refill prescriptions for Isoniazid.

6. In addition to established protocols, the Preventive Medicine Clinic at LAHC had a carefully structured orientation and training program for CHNs, and it was the Whistleblower's failure to cooperate with the established protocols and training program and not the LAHC command that led to the negative impact on the Whistleblower's performance of her assigned duties.

Although the issue of training is disputed by the Whistleblower who asserts that she was not properly trained, the IO found that the Preventive Medicine Clinic at LAHC had a structured orientation and training program for CHNs which included the Senior System Civilian Evaluation Report Support Form [TAB N-4], Orientation and Competency Calendars [TAB N-5] and an Initial Competency Assessment Form [TAB N-6]. The IO found that there was a discrepancy between the Whistleblower and her supervisors, Chief, Preventive Medicine Clinic and Supervising Preventive Medicine Physician as to what tasks were within her scope of practice. Despite the best efforts of the staff, to include counseling on the requirement to complete the required training for new CHN personnel on October 5, 2010, the Whistleblower never completed the the Initial Competency Assessment. The IO found that the Whistleblower believed that the tasks mentioned in her compliant were of a nature that she deemed only appropriate for a nurse practitioner to perform; thus, there was no need for her to be trained to perform these tasks.

The Whistleblower's first day at LAHC was August 30, 2010. On September 7, 2010, the Initial Competency Assessment tool was initiated. The Initial Competency Assessment contains all of the required duties for CHNs in the Preventative Health Clinic, LAHC, to include ordering appropriate labs

and chest x-rays, refilling medication if indicated, and referring abnormal findings to designated provider (which implies a requirement to interpret lab tests). [TAB N-6]. Although the Whistleblower completed the self assessment portion, the orientation (preceptor initials & date) and the competency validation by supervisor (signature & date) were not completed. Due to unpredictability of opportunities to perform certain tasks, there was no hard date to complete this assessment; however, the normal standard for completion was within 2-6 months after employment. Due to the Whistleblower's unwillingness to perform the specified tasks and the events leading to her being absent from work, the Competency Assessment could not be completed.

On September 17, 2010, the Senior System Civilian Evaluation Report Support Form was initiated and the first face-to-face counseling session conducted. It detailed the Whistleblower's duties as a CHN, specifically "[r]esponsible for the coordination and implementation of the installation Sexually Transmitted Diseases, HIV Awareness Program and Latent Tuberculosis Surveillance." [TAB N-4]. On 5 October 2010, approximately one month after initiation of orientation & training with the Initial Competency Assessment tool, Chief, Preventive Medicine Clinic counseled the Whistleblower to outline the expectations with regards to the directive training of new CHN personnel. Specifically, Chief, Preventive Medicine Clinic stressed that the Whistleblower was "expected to complete training with [Occupational Health Nurse] on the assigned programs of Community Health Nursing" which included completion of the "initial competency assessment" form regarding the duties related to the management of latent TBI, HIV, STI and other epidemiological cases. [TAB N-7].

During the AR 15-6 investigation, the IO interviewed both Occupational Health Nurse and Supervising Preventive Medicine Physician regarding the Whistleblower's training as a CHN. Occupational Health Nurse's described the training process as follows:

> "The process for evaluating and reviewing the competency assessment is a one- on-one hands-on process. For the Whistleblower I reviewed and demonstrated everything verbally. The Whistleblower took notes for how to do EVERYTHING step by step, then she was given a demonstration with patients (policies and procedures required), then the Whistleblower was expected to give a return back demonstration. However, as mentioned above the Whistleblower was not successful with demonstrating the required competencies and skills of a LAHC CHN. The self assessment was completed by the Whistleblower. The orientation (discussion and demonstration of required skills/competencies of a LAHC CHN) for the Whistleblower was over a month long, and she still did have competency validation (ability to perform safely) of required skills for a LAHC CHN.

Occupational Health Nurse emphasized that the Whistleblower had significant gaps in her ability to assimilate and execute the duties of the CHN at LAHC because "the Whistleblower only wanted to perform certain duties . . . and if it was a duty she DID NOT desire to do, then she claimed she was not provided training or it was out of the scope of her licensure." She added that training and assistance were offered several times, but were rejected by the Whistleblower.

Supervising Preventive Medicine Physician testified that one of the first responsibilities that the Whistleblower had was to care for latent tuberculosis patients. The sequence of events to be performed by the LAHC CHN was provided for in the protocol signed and authorized by the Department Head, Preventive Medicine and Supervising Preventive Medicine Physician. At the time of the

Whistleblower's first encounter with a referred patient for this condition, she requested to perform the assessments with Supervising Preventive Medicine Physician's supervision and he agreed. During his initial supervision, he advised her that she needed to become familiar with the Center for Disease Control (CDC) documents regarding the evaluation, diagnosis and treatment for latent tuberculosis. He then gave the link to the CDC website and some of the relevant documents.

Based on her training and credentials as an RN, Supervising Preventive Medicine Physician fully expected that she would have the ability to understand the CDC documents, apply the information to her patients, and quickly learn the initial patient interviews and evaluations that she did with Supervising Preventive Medicine Physician. However, after several patient encounters, it became apparent to Supervising Preventive Medicine Physician that the Whistleblower was having challenges in grasping the basic knowledge regarding latent tuberculosis. After a period of observing the Whistleblower with patients, Supervising Preventive Medicine Physician went to Chief, Preventive Medicine Clinic regarding his concerns regarding the Whistleblower's lack of abilities. After he expressed his concerns with Chief, Preventive Medicine Clinic, the Whistleblower consulted with him periodically on patients having their 30-day follow-ups, and to the best of Supervising Preventive Medicine Physician's knowledge, she followed the protocols.

Regarding the ordering and interpreting of STIs, the plan to initiate this process with the Whistleblower began in late December 2010. At that time, she vehemently rejected the proposition when presented by Chief, Preventive Medicine Clinic and refused to perform these evaluations per the signed protocols. To Supervising Preventive Medicine Physician's knowledge, the Whistleblower has never performed these evaluations. Supervising Preventive Medicine Physician testified that he was present when Chief, Preventive Medicine Clinic gave the Whistleblower a "Memorandum of Warning" on January 4, 2011 for failure to observe written SOPs for "Sexually Transmitted Diseases Patient Management Procedures, LAHC Regulation No. 40-544." The warning was provided as a result of an incident which occurred on December 23, 2011 when the Whistleblower expressed concerns regarding her understanding of the scope of practice for ordering labs or medications which were "absolute and adamant that under no circumstances would [the Whistleblower] comply with this Standard Operating Procedure." [TAB N-2, Statement of Chief, Preventive Medicine Clinic, p. 1].

The "Memorandum of Warning" also addressed the e-mail sent by the Whistleblower to Chief, Preventive Medicine Clinic; Deputy Commander for Nursing, and the Deputy Commander for Clinical Services, and Supervising Preventive Medicine Physician regarding her refusal to comply with the LAHC regulations for ordering lab tests for patients who have not been prior examined by a physician or equivalent and her refusal to order INH refill medications as directed under the LAHC SOPs. [TAB N-2, Statement of Chief, Preventive Medicine Clinic, p. 1]. Chief, Preventive Medicine Clinic explained that based on the Whistleblower's concern, Chief, Preventive Medicine Clinic immediately took the SOP to the DCN and patient care services for guidance. It was confirmed that "the LAHC Regulation had been approved by the deputy officials and had not discretionary guidelines or was written outside of the federal guidelines for safe medical practice according to the military, Department of Defense, civilian or private rule." [TAB N-2, Statement of Chief, Preventive Medicine Clinic, p. 1]. Chief, Preventive Medicine Clinic also advised that she researched the California Board of Registered Nursing guidelines and contacted the regional consultant for the Board of Registered Nursing to verify the that "Army Public Health Nurses do not practice under a Privilege-base but a Protocol-based Practice" and that the duties performed under the SOPs were within scope of practice under California guidelines and in compliance with MEDCOM policies and procedures. [TAB N-2, Statement of Chief, Preventive Medicine Clinic, pp. 1-2].

Although the "Memorandum of Warning" contained language that failure to perform her duties may result in the initiation of formal disciplinary action, paragraph 4 also explained that "[t]his document will **not** be forwarded for inclusion in your Official Personnel Folder, but will be maintained in your organizational employee record folder. It will be used to support future actions prompted by any recurrence of behavior referenced herein." [TAB N-2, p. 2]. However, the Whistleblower refused to sign the counseling statement which is her prerogative in actions such as this.

The IO noted that subsequently, after she received the January 4, 2011 the Whistleblower was in a Leave Without Pay (LWOP) status for an extended period beginning on January 4, 2011. [TAB P-3, Chief, Preventive Medicine Clinic Memo dated June 8, 2011)]. After a period of LWOP under the Family Medical Leave Act (FMLA) expired, the Whistleblower failed to return to work to perform her duties on 7 October 2011. On 17 October 2011 she was issued a letter of termination as a probationary employee for being Absent Without Authority (AWOL) effective 21 October 2011. [TAB P-4, Chief, Preventive Medicine Clinic Memo dated October 11, 2011, p. 3].

7. Despite the Whistleblower's failure to perform her assigned duties, there is no evidence of patient injury or a substantial and specific danger to public health.

During the course of the investigation no evidence was discovered that indicated that any patients were injured or had negative outcomes due to the Whistleblower performing or not performing any of the duties stated in the complaint. Deputy Commander for Nursing, Supervising Preventive Medicine Physician's and Chief, Preventive Medicine Clinic's sworn statements address issues of patients receiving delayed follow-up care while another employee was tasked with this duty as result of the Whistleblower's perception that these duties were outside the scope of her practice. These lapses in follow-up care did not result in injury or negative outcomes to the patients involved. It should be noted that the verbiage "perform liver enzyme tuberculosis test" is used by the the Whistleblower several times throughout this report. The Whistleblower never performed any invasive tests on any patient. Her part in the process was to order liver enzyme tests and order the test for tuberculosis in the computer for completion at the LAHC labortory.

The duties that the Whistleblower was asked to perform at LAHC are consistent with those duties that a Community Health Nurse with the Whistleblower's education, training and experience is qualified for and capable of performing. [TAB Q, Statement of Chief, Policy and Programs Branch, p. 4, paragraph 6b]. Further according to the testimony provided by Chief, U.S. Army MEDCOM Quality Management Division and Chief, Policy and Programs Branch, these duties do not require a certification or qualification as an "advance practice" nurse. [TAB Q, Statement of Chief, Policy and Programs Branch, p. 1, paragraph 4]. Thus, the performance of these duties by the Whistleblower would not constitute a substantial danger to public health or safety. To this end, LAHC had the proper protocols and SOPs in place at the time of the Whistleblower's tenure related to performing the duties stated in the complaint. [TABs N-11, N-12, and N-13]. The existence of these protocols and SOPs is to ensure that the Community Health Nurse has the proper guidance and authority to perform the duties required of this position. CPGs, SOPs, and protocols are designed to reduce unwarranted variation in practice and provide patients with benchmark quality care rooted in science, so following clinical guidelines mitigates any danger to public health or patient safety.

Agency Discussion

OSC-Referred Allegation 1:

The Whistleblower was hired in August 2010 after responding to a vacancy announcement for a Community Health Nurse (CHN) posted by LAHC. The OSC letter noted that "[w]hile the Whistleblower, who does not have any higher level graduate education or advanced public health training, was not authorized to perform the advanced functions of a Community Health Nurse, she did meet the requirements of the published vacancy announcement."

Army Findings as to Allegation 1:

A reading of the published federal and State guidelines clearly establish that the requirements for being a Community Health Nurse (CHN) is the same as for a Registered Nurse (RN), either a Bachelors or Associates degree from a program accredited by the National League for Nursing or the Commission on Collegiate Nursing Education, or accepted by the U.S. Secretary of Education. Additionally, a CHN must be a licensed RN. The Whistleblower had an Associate's degree from Purdue University, a program accredited by the National League for Nursing. Additionally, she was licensed as an RN through the State of California.

CHNs are *not* Advanced Practice Registered Nurses (APRNs) and do *not* require a higher level graduate education or advanced public health training, according to the Chief, Quality Management Division, U.S. Army MEDCOM, the proponent of AR 40-68. Although the current version of AR 40-68 places CHNs under the category of APRNs, paragraph 7-4a(2), it provides that "CHNs function in an expanded role using clinical practice guidelines (CPGs) approved by the [Executive Committee of the Medical Staff] and the [Deputy Commander for Nursing]. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature, but he/she does not independently initiate, alter, or discontinue any medical treatment." Further, the California Board of Registered Nurses where the Whistleblower is licensed provides that "[t]he means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the organized health care system in which it will be used." Regarding the placement of CHNs under paragraph 7-4 that deals with advanced practice registered nurses, Chief, U.S. Army MEDCOM Quality Management Division as the proponent of AR 40-68 stated, "The placement of CHNs under the description of APRNs in AR 40-68, para. 7-4a(2) is inaccurate and confusing. CHNs are not APRNs and should not be placed under para. 7-4."

Therefore, the prevailing policy across all organizations, federal and State, is that as long as written protocols, i.e. CPGs or SOPs, are in place, RNs can perform medical functions, to include ordering and interpreting lab tests and ordering medication refills. There were four specific CPGs related to the duties of CHNs at LAHC to include: (1) Community Health Nursing Isoniazid (INH) Chemoprophylaxis Program; (2) Refill (INH) Chemoprophylaxis Therapy by Community Health Nurses (CHNs); (3) Sexually Transmitted Diseases (STD) Patient Management Procedures; and (4) Tuberculosis Program. These CPGs outline the nursing and physician responsibilities and detailed instructions on ordering and interpreting lab tests, ordering medication refills of INH, duration of treatment and what to do in the case of abnormal findings.

OSC-Referred Allegation 2:

As a Registered Nurse (RN) with an Associate's Degree in nursing, she was immediately assigned advanced nursing duties beyond the scope of her training and experience. Specifically, she was responsible for ordering and interpreting sexually transmitted infection (STI), tuberculosis, and hepatic liver enzyme tests, and refilling prescriptions for Isoniazid (INH), an antibiotic used to treat tuberculosis.

Army Findings as to Allegation 2:

As a licensed RN with an Associate's Degree in nursing, the Whistleblower met the requirements for the CHN position. [TABs M-2 and N-2, Position Description for Nurse (Clinical/COMM-OCC HLTH); See also TAB Q, Statement of Chief, Policy and Programs Branch]. The duties she was assigned to perform as a CHN, specifically ordering and interpreting STI, tuberculosis and hepatic enzyme tests, and refilling prescriptions for INH were within the scope of her duties as there were established CPG's which detailed the policies and procedures on performing these duties.

Although the Whistleblower claimed that these duties were beyond the scope of her training and experience, the Whistleblower was a licensed RN with 37 years of experience in nursing. LAHC had established CPGs that provided detailed policies and procedures for ordering and interpreting lab tests and ordering medication refills. The Whistleblower was provided proper training and orientation upon coming to LAHC on how to perform the specific duties of her position as a CHN. The fact that the Whistleblower refused to perform these duties did not make them beyond the scope of the duties of an RN in the role of CHN under the established protocols. Under the guidelines set forth by the California Board of Registered Nurses, RNs are authorized to perform medical tasks in accordance with established written protocols. Additionally, under AR 40-68, CHNs are authorized to refill prescriptions and perform other clinical functions in accordance with established CPGs.

The testimony of all of the Whistleblower's supervisors clearly establish that the standard scope of practice for CHNs at LAHC Preventive Medicine Clinic included ordering and interpreting STI, tuberculosis and hepatic enzyme tests, and refilling prescriptions for INH. Supervising Preventive Medicine Physician and Chief, Preventive Medicine Clinic testified that these duties were directed by the CPGs at LAHC as being within the scope of practice by CHNs. In addition, Supervising Preventive Medicine Physician and Occupational Health Nurse testified that they expected that a licensed nurse would have the ability to understand the policies and procedures and apply them in the performance of her duties. In her statement, Occupational Health Nurse, who had previously held the CHN position, stressed, "The Whistleblower only wanted to perform certain duties . . . and if it was a duty she DID NOT desire to do, then she claimed she was not provided training or it was out of the scope of her license."

OSC-Referred Allegation 3:

The Whistleblower informed her supervisors, Supervising Preventive Medicine Physician and Chief of Preventive Medicine that as an RN, she was not qualified to perform these advanced tasks, but was told that the tasks were part of the required job duties of a CHN. When the Whistleblower continued to object to refilling the Isoniazid prescriptions and performing the hepatic liver enzyme and tuberculosis tests, and fully

refused to perform STI tests, on the grounds that she lacked the requisite training, she was threatened with disciplinary action.

Army Findings as to Allegation 3:

The tasks that the Whistleblower refused to perform were detailed in established CPGs and were not outside of the scope of her duties. Under both federal and State practicing guidelines, RNs are authorized to perform in an expanded role which includes ordering medication refills and ordering and interpreting lab tests when working under established protocols.

The Whistleblower received two written counseling statements from Chief, Preventive Medicine Clinic, dated October 5, 2010 and January 4, 2011, specifically citing failure to perform duties related to her position as a CHN. On October 5, 2010, the Whistleblower was specifically counseled on the expectation that she complete training on the assigned programs of CHNs, to include the management of latent tuberculosis, HIV and STI using the "Initial Competency Assessment" worksheet which contained all of the above tasks. When the Whistleblower refused perform her duties related to STI management, she was counseled for her failure to observe the SOP.

In the January 4, 2011 counseling, Chief, Preventive Medicine Clinic addressed the Whistleblower's concerns regarding the scope of practice for ordering labs and medication refills by advising her that per guidelines established by military officials and California Board of Registered Nursing, "Army [CHNs] do not practice under a Privilege-based but a Protocol-based practice." As such, the duties that she was required to perform were within the scope of practice under the SOPs and her continued failure to comply with the SOPs "may result in the initiation of formal disciplinary action."

OSC-Referred Allegation 4:

At the insistence of Chief, Preventive Medicine Clinic and Supervising Preventive Medicine Physician and despite her misgivings, the Whistleblower ordered liver enzyme tests, interpreted the test results, and refilled prescriptions for Isoniazid for approximately 10 to 12 patients per month between August 2010 and January 2011. She contended that given her lack of training and experience in providing advanced medical services, this posed a significant danger to the health and safety of patients because should she misinterpret liver enzyme test results and fail to detect abnormal liver activity, the continued prescription of Isoniazid could result in severe liver damage.

Army Findings as to Allegation 4:

All witnesses interviewed, to include the Whistleblower, testified that no patients were injured by the Whistleblower's actions. Further, although the Whistleblower claimed that her lack of training and experience posed a danger to the health and safety of patients, Supervising Preventive Medicine Physician testified that after he expressed his initial concerns to Chief, Preventive Medicine Clinic that the Whistleblower consulted with him periodically on latent tuberculosis patients having their 30-day follow-ups and to the best of his knowledge, the Whistleblower followed the protocols. Further, none of the patients cared for by the Whistleblower for latent tuberculosis developed active tuberculosis which could have been a threat to public safety and none were in danger for their health or safety as the authorized protocol was followed. Supervising Preventive Medicine Physician also testified that the Whistleblower vehemently rejected completing any of the duties related to patients with STI's, so she never performed these evaluations.

The only negative patient impact due to the Whistleblower's actions was a delay in patient management due to the Whistleblower's absence from work pending coverage by another department employee. However, the duties assigned CHNs under the established CPGs at LAHC appropriately detailed the standard scope of practice for CHNs and in no way posed a substantial or specific danger to public health. Although the Whistleblower claimed that performance of these duties posed a substantial or specific danger to patients, there is no evidence that the Whistleblower ever committed any errors when she chose to perform her assigned duties. The only negative impact was through the Whistleblower's refusal to perform her assigned duties and although a burden on other department employees, there is no evidence that her refusal to manage patients ever posed a substantial or specific danger to patients.

Discussion:

The purpose of Quality Assurance process in medicine is to *improve* the delivery of healthcare. If there are procedures or practices that are found to endanger patients, they are identified and stopped. The Army's healthcare system is not a 'for profit venture' so there is no incentive to cut corners to improve the bottom line. The Whistleblower was being asked to do the job at Lyster AHC for which she was hired and she refused to do it, despite her superior qualifications. Her objections that she was being asked to perform outside the scope of her practice were misplaced. These objections were properly addressed by her supervisors and were confirmed by her state licensing agency, the California Board of Registered Nursing. The Whistleblower refused to accept their response and refused to work pursuant to the CPGs for whatever her personal reasons. Contrary to her assertions, the actions of her supervisors in the Preventive Medicine Clinic at Lyster AHC did not constitute a substantial and specific danger to public health and safety.

VIOLATIONS OR APPARENT VIOLATIONS OF LAW, RULE, OR REGULATION

The Army investigation revealed no violations or apparent violations of law, rule, or regulation in this matter.

CORRECTIVE ACTIONS UNDERTAKEN

The placement of CHNs under the description of APRNs in AR 40-68, paragraph 7-4a(2) is incorrect. The proponent of AR 40-68 has stated that in the next iteration of the regulation Chapter 7 will be revised and CHNs will be removed from the APRN section.

CONCLUSION

The Department of the Army takes very seriously its responsibility to address, in a timely and thorough fashion, the concerns of the OSC. In this case, the Army conducted a thorough and comprehensive investigation in response to the OSC's referral. This investigation revealed that with respect to each of the whistleblower's allegations concerning, none of them were substantiated. Additionally, there was no evidence that the health or safety of any patient or the public was harmed or threatened.

Clearly, the LAHC leadership took great patience to work with the whistleblower to ensure that she could perform her job based on not only her paper credentials and resume but her oral assurances that she was qualified to perform all of the duties that would be required for her to perform. Further, as did occur, the whistleblower received the appropriate guidance, mentoring and training that were provided to each and every new hire and practicing nurse at LAHC. When problems arose in that the whistleblower alleged that she was not qualified to perform her assigned tasks, the LAHC leadership endeavored to explain to her that her concerns were not founded and she could perform her assigned duties in the manner that they expected without any adverse consequences or jeopardizing her state licensure with the California State Board of Nursing. In spite of their repeated assurances that she could perform her assigned duties and even after conveying to her the California State Board of Nursing's concurrence with the LAHC's CPGs, SOPS and other guidance procedures and requirements without any fear of discipline by the state licensing agency, the whistleblower refused to accept their assurances and instead, continued to challenge their directions and not perform her assigned duties.

I am satisfied that this is the correct outcome in this matter. Accordingly, the Army has made no referral of the alleged criminal violation to the Attorney General pursuant to Title 5, U.S.C. § 1213(d)(5)(d).

This letter, with enclosures, is submitted in satisfaction of my responsibilities under Title 5, U.S.C. § 1213(c) and (d). Please direct any further questions you may have concerning this matter to Ms. Cassandra Tsintolas Johnson, at 703-614-3500.

Sincerely,

Thomas R. Lamont
Assistant Secretary of the Army
(Manpower and Reserve Affairs)

Army Report Documents

Lyster Army Health Clinic

Fort Rucker, Alabama

OSC File Number DI-11-1358

Tab/Exhibit	Description
TAB A	Secretary of the Army (SA) delegation to the Assistant Secretary of the Army (Manpower & Reserve Affairs) his authority, as agency head, to review, sign, and submit to Office of Special Counsel the report required by Title 5, USC, Sections 1213(b), (c), and (d), dated March 18, 2011
TAB B	Army Regulation 40-1, *Composition, Mission, and Functions of the Army Medical Department,* dated July 1, 1983
TAB C	Army Regulation (AR) 15-6, *Procedures for Investigating Officers and Boards of Officers,* dated October 2, 2006
TAB D	Appointment Memoranda for the Investigating Officer **D-1** Appointment Memorandum for the Investigating Officer dated May 6, 2011, Appointing Authority BG Joseph Caravalho, Jr. **D-2** Appointment Memorandum for the Investigating Officer, dated June 13, 2011, Appointing Authority MG M. Ted Wong
TAB E	AR 10-87, *Army Commands, Army Service Component Commands, and Direct Reporting Units,* dated September 4, 2007 (Note: this is an extract)
TAB F	MEDCOM Regulation 10-1, *Organization and Functions Policy*, dated May 6, 2009 (Note, this is an extract)
TAB G	Lyster Army Health Clinic Organizational Charts
TAB H	Army Regulation (AR) 40-68: *Clinical Quality Management, dated* February 26, 2004 (Note: this is an extract)
TAB I	DoD 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation*, dated June 11, 2004 (Note: this is an extract)

TAB J DA Pamphlet 40-11, *Preventive Medicine*, dated July 22, 2005 (Note: this is an extract)

TAB K Army Regulation (AR) 40-5: *Preventive Medicine,* dated May 25, 2007

TAB L Excerpts from the California State Board of Nursing (Whistleblower's State of RN Licensure)

1. Board of Registered Nursing, "An Explanation of the Scope of RN Practice Including Standardized Procedures"
2. Board of Registered Nursing, Standardized Guidelines
3. Board of Registered Nursing, Standards of Competent Performance
4. Board of Registered Nursing, Advanced Practice Certification
5. Board of Registered Nursing, Business and Professional Code, Chapter 6, Nursing

TAB M Sworn Statement: the Whistleblower, dated May 17, 2011

1. Vacancy Announcement dated June 11, 2009
2. Position Description
3. The Whistleblower's Resume
4. The Whistleblower's Civilian Evaluation Report Support Form dated September 1, 2010
5. Memorandum of Warning to the Whistleblower from Chief, Preventive Medicine Clinic, dated January 4, 2011
6. G-mail message, "Error in AHLTA Regarding Provider Status" dated December 28, 2010
7. Excerpts from AR 40-68 and AR 40-3 with handwritten notes
8. Instructions for Applying for a Nurse Practitioner Furnishing Number

TAB N Sworn Statement: Chief, Preventive Medicine Clinic, dated May 17, 2011

1. E-mail to Deputy Commander for Clinical Services from the Whistleblower dated December 28, 2010
2. Memorandum of Warning to the Whistleblower from Chief, Preventive Medicine Clinic dated January 4, 2011
3. Memo to Record from Supervising Preventive Medicine Physician dated January 4, 2011
4. The Whistleblower Initial Evaluation dated September 17, 2010
5. September and October 2010 Calendar Pages entitled "Orientation and Competency"
6. Initial Competency Assessment September 7, 2010 through 13 Oct 2010
7. Memo of Counseling to the Whistleblower from Chief, Preventive Medicine Clinic dated October 5, 2010
8. Memo to Chief Preventive Medicine Clinic from the Whistleblower dated October 11, 2010

9. E-mail to Chief, Preventive Medicine Clinic from the Whistleblower dated January 4, 2011
10. INH Clinic Flow Sheets, various dates
11. SOP: Prescribing Isoniazid (INH) Chemoprophylactic Therapy by CHNs
12. LAHC Regulation No. 40-554: Sexually Transmitted Disease (STD) Patient Management Procedures
13. SOP: Tuberculosis Program
14. E-mail to Deputy Commander for Nursing from California Nursing Education Consultant dated January 7, 2011
15. Typewritten excerpts from AR 40-5, AR 600-110, AR 608-10, AR 40-68
16. APHN/CHN Newsletter dated June 2008
17. California Board of Registered Nursing Article, "An Explanation of the Scope of RN Practice"
18. The Whistleblower's resume
19. USA Jobs announcement "Nurse (Community Health)"
20. Position Description for Nurse (Clinical/Comm-Occ-Hlth)
21. Email, FW: Scope of Practice Discrepancy, Chief, Preventive Medicine Clinic forwarded email she received from California Nursing Education Consultant (dated January 7, 2011) to the Whistleblower on January 13, 2011

TAB O Documents Regarding Request Approval for Advanced In-Hire Rate, the Whistleblower

1. Memorandum, Request Approval for Advanced In-Hire Rate the Whistleblower, Deputy Commander for Nursing, dated July 29, 2010
2. Memorandum, Request for Appointment Above Minimum rate-the Whistleblower, dated July 29, 2010
3. Recruitment/Relocation Service Agreement, the Whistleblower, dated August 30, 2010

TAB P Personnel Documents Regarding the Whistleblower

1. Statement of Prior Federal Service dated August 30, 2011
2. Statement Regarding Education Level
3. Letter to the Whistleblower from Chief, Preventive Medicine Clinic Regarding LWOP Status dated June 8, 2011
4. Memorandum to the Whistleblower from Chief, Preventive Medicine Clinic Regarding Separation During Probationary Period dated October 17, 2011
5. Notification of Personnel Action Regarding the Whistleblower Termination, effective date October 21, 2011

TAB Q Statement of Chief, Policy and Programs Branch, Civilian Human Resources Division, HQ, MEDCOM, dated November 30, 2011

TAB R Witness Listing for Army Report – DI-11-1358 ***(copy only in unredacted Army Report version)***

A

SECRETARY OF THE ARMY
WASHINGTON

MAR 18 2011

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY
(MANPOWER AND RESERVE AFFAIRS)

SUBJECT: Delegation of Certain Authority Under Title 5, United States Code, Section 1213

In accordance with Title 10, United States Code, Section 3013(f), I hereby delegate to you certain authority conferred upon me as the head of the Department of the Army by Title 5, United States Code, Section 1213. Specifically, you are authorized to review, sign and submit written reports setting forth the findings of investigations into information and any related matters transmitted to me by The Special Counsel in accordance with Title 5, United States Code, Sections 1213. This authority may not be further delegated.

Although not a limitation on your authority to act in my behalf, in those cases in which your proposed decisions or actions represent a change in precedent or policy; are of significant White House, Congressional, Department or public interest; or have been, or should be, of interest or concern to me, for any reason, you will brief me prior to decision or action, unless precluded by the exigencies of the situation.

This delegation shall remain in effect for three years from the date of its execution, unless earlier rescinded in writing by me.

John M. McHugh

CF:
Office of the Army General Counsel

TAB A

B

Army Regulation 40–1

MEDICAL SERVICES

COMPOSITION, MISSION, AND FUNCTIONS OF THE ARMY MEDICAL DEPARTMENT

Headquarters
Department of the Army
Washington, DC
1 July 1983

Unclassified

TAB B

SUMMARY of CHANGE

AR 40-1
COMPOSITION, MISSION, AND FUNCTIONS OF THE ARMY MEDICAL DEPARTMENT

Headquarters
Department of the Army
Washington, DC
1 July 1983

*Army Regulation 40–1

Effective 1 August 1983

MEDICAL SERVICES

COMPOSITION, MISSION, AND FUNCTIONS OF THE ARMY MEDICAL DEPARTMENT

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Major General, United States Army
The Adjutant General

History. This revision provides for the designation of The Assistant Surgeon General for Veterinary Services as Executive Agent for all DOD Veterinary Services; sets the policy pertaining to contract surgeons, to include justification for employment, duties, qualifications, full–time or part–time status, compensation and leave, contract negotiations, and contracts; sets the policy pertaining to off–duty employment of Army Medical Department (AMEDD) officers; makes changes in processing procedures for applications for employment as social workers and psychologists; updates the composition of, and duties of, officers in all AMEDD Corps; makes changes in AMEDD warrant officer descriptions, to reflect Food Inspection Technicians (military occupational specialty 051A); and adds an appendix of required reference publications.

Summary. Not applicable.

Applicability. This regulation applies to—

a. The Active Army and Army National Guard (ARNG).

b. The US Army Reserve (USAR) when called to active duty.

Proponent and exception authority. Not applicable

Impact on New Manning System. This regulation does not contain information that affects the New Manning System.

Army management control process. Not applicable.

Supplementation. Supplementation of the is regulation is prohibited unless prior approval is obtained from HQDA (DASG–HCD), WASH DC 20310.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG–HCD), WASH DC 20310.

Distribution. Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12–9A requirements for AR Medical Services–A. (Applicable to All Army Elements)

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*This regulation supersedes AR 40–1, 5 May 1976.

Unclassified

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Glossary

Chapter 1
INTRODUCTION

1–1. Purpose
This regulation—

a. Prescribes the composition, mission, and functions of the Army Medical Department (AMEDD).

b. Provides general information regarding the AMEDD, each AMEDD Corp, and civilian personnel employed by the department.

1–2. Applicability.
This regulation applies to—

a. The Active Army and Army National Guard (ARNG).

b. The US Army Reserve (USAR) when called to active duty.

1–3. References.
Required publications are listed in appendix A.

1–4. Explanation of abbreviations.
Abbreviations used in this regulation are explained in the glossary.

1–5. Concept.
a. The AMEDD encompasses those Army special branches that are under the supervision and management of The Surgeon General. Specifically, these special branches are the Medical Corps (MC), Dental Corps (DC), Veterinary Corps (VC), Medical Service Corps (MSC), Army Nurse Corps (ANC), and Army Medical Specialist Corps (AMSC).

b. The mission of the AMEDD is to—

(1) Maintain the health of members of the Army.

(2) Conserve the Army's fighting strength.

(3) Prepare for health support to members of the Army in time of war, international conflict, or natural disaster.

(4) Provide health care for eligible personnel in peacetime, concurrently with (3) above.

c. Accomplishment of this mission requires the following:

(1) Development and execution of coordinated plans and programs to provide the best possible health service in war and peace to eligible personnel, within available resources.

(2) Establishment of health standards.

(3) Selection of medically fit personnel; disposition of the medically unfit.

(4) Application of effective means of preventative and curative health services.

(5) Execution of the approved medical research, development, test, and evaluation (RDTE) program.

(6) Application of effective means of health education and management.

d. The AMEDD will provide health services for members of the Army and other agencies and organizations under AR 10–5. Each AMEDD component contributes to accomplishing the mission and functions of the AMEDD in its particular sphere of responsibility.

1–6. Responsibilities.
Responsibilities within the AMEDD are outlined below.

a. The Surgeon General (TSG). TSG is a general officer of the MC who has—

(1) Overall responsibilities for development, policy direction, organization, and management of an integrated Army–wide health services system.

(2) Direct access to the Secretary of the Army and the Chief of Staff, US Army (CSA) on all health and medical matters; these matters include the utilization of AMEDD professional personnel. (See AR 10–5.)

b. Deputy Surgeon General. The Deputy Surgeon General is a general officer of the MC who will—

(1) Perform duties prescribed by TSG.

(2) Serve as acting TSG in TSG's absence.

c. Assistant Surgeon General for Dental Services. The Assistant Surgeon General for Dental Services, a general officer of the DC, will make recommendations to TSG and through TSG to CSA on all matters concerning dentistry and the dental health of members of the Army. All dental functions of the Army are under the direction of the Assistant Surgeon General for Dental Services.

d. Assistant Surgeon General for Veterinary Services. The Assistant Surgeon General for veterinary services, a general officer of the VC, will—

(1) Serve as the Executive Agent for all veterinary services within the Department of Defense (DOD).

(2) Advise, represent, and act for, as directed, TSG on all aspects of DOD veterinary functions.

e. Officers commissioned in the MC, DC, VC, MSC, ANC, and AMSC. Officers commissioned in these special branches of the AMEDD will carry out the duties outlined in chapter 2.

f. Warrant officers of the AMEDD. Warrant officers assigned to AMEDD specialties will carry out the duties outlined in chapter 3.

g. Enlisted personnel assigned to the AMEDD. Enlisted personnel assigned to AMEDD specialties will perform medically related technical and administrative functions prescribed in AR 611–201.

h. Civilian personnel. Civilian personnel assigned to the AMEDD will perform the duties shown in chapter 4. These civilian personnel include the following: Physicians, dentists, veterinarians, nurses, specialists in science allied to the practice of medicine, medical support and service personnel, contract surgeons, and professional consultants.

i. Fee–basis physicians. Fee–base physicians will perform duties set forth in AR 601–270.

1–7. Policy.
a. An AMEDD member may not be assigned to perform professional duties unless qualified to perform those duties. Assignments that involve professional expertise as recognized in the civilian sector must be filled by members of the AMEDD with equal, or similar, qualifications; however, emergency situations could cause exceptions. Qualifications may be met by education, training, or experience in a particular profession.

b. AMEDD members (including contract surgeons and other civilian employees) while on duty will not recommend to anyone authorized to receive health service in a Uniformed Services medical treatment facility (MTF) or at Army expense that this person receive health services from the member when off duty; this prohibition will include civilians associated in practice with the member. An exception would be that such health service would be provided without cost to the patient, the Government, or any other person or firm.

(1) Active members of the Army will not accept payment or other compensation for providing health services at any time or place to anyone authorized to receive health services in a Uniformed Services MTF, under AR 40–121 and AR 40–3 or at Army expense. Payment or other compensation will exclude military pay and allowances, and whether received directly or indirectly. Health services will include examination or consultation.

(2) AMEDD personnel who are active duty members or civilian employees are prohibited by Federal law from receiving additional US Government compensation of any nature, whether received directly or indirectly, for health services rendered to any person. Active duty members or civilian employees are defined in section 2105, title 5 United States Code; the Federal law cited above is section 5536, title 5, United States Code. Compensation of any nature also cited above will be other than ordinary pay and allowances.

c. The furnishing of testimony or production of records in civil courts by members of the AMEDD will be governed by AR 27–40 and guidance published in related technical bulletins.

(1) Testimony before civilian tribunals can involve State, Federal, or foreign courts, and many different situations. A member of the AMEDD in a nonduty status can appear in court on personal business not connected with the member's profession or official duties; usually, no official clearance will be required for this situation and appearance normally will be in civilian clothing. In cases where litigation is of interest to the United States, appearances and other

matters related to the litigation will be reported to The Judge Advocate General of the Army. A member of the AMEDD receiving an informal request or formal subpoena to give evidence or produce documents immediately will consult with the judge advocate or legal adviser of the member's command or agency.

(2) A member of the AMEDD whose official duties lead to appearance in court as a witness, or to furnishing testimony by deposition in litigation to which the Government is not a party, will not accept payment or compensation other than pay and allowance. Travel and subsistence expenses may be collected if the testimony is limited to matters observed in the performance of official duties. If the member's appearance in court is unrelated to his/her performance of official duties, and if he/she testifies as an expert on behalf of a State or the District of Columbia, or for a private individual, corporation, or agency (for example, other than the US Government) on matters outside the scope of his duties, he/she may accept pay as an expert witness. Further guidance may be obtained from the local Judge Advocate. However, all appearances by military personnel and civilian employees as expert witnesses require prior approval of TJAG under AR 27–40.

(3) No member of the AMEDD is authorized to give testimony against the Government except in the performance of official duty or under AR 27–40.

(4) If a member needs to take time off during normal duty hours because of something connected with his/her off– duty employment, duty or leave status is covered by AR 27–40.

d. No active duty member or civilian employee of the AMEDD, including contract surgeons, will accept appointments as, or act in the capacity of, a State or local official if contrary to Federal law or if included within the restrictions of AR 600–20. Before accepting appointment as, or acting in the capacity of, a State or local official, the advice of the local Judge Advocate will be sought. (See AR 600–50 for restrictions on other outside employment.)

1–8. Remunerative professional civilian employment.

a. A commissioned or warrant officer of the AMEDD on active duty will not engage in civilian employment without command approval. This will include the furnishing of testimony for remuneration. Active duty officers are in a 24–hour, 7–day duty status; their military duties at all times will take precedence on their time, talents, and attention. Subject to the limitations set forth in this regulations, members will not be restrained from employment during their normal off–duty hours. Permission for remunerative civilian professional employment will be withdrawn at any time by the commander when such employment is inconsistent with this regulation. In a case where such permission is withdrawn, the affected officer may submit to the commander a written statement containing views or information pertinent to the situation.

b. Before authorizing engagement in remunerative civilian professional employment, commanders will consider the following conditions of each case regarding the civilian community and the officer involved:

(1) The officer's primary military duty will not be impaired by civilian employment. Requests for civilian employment that exceed 16 hours a week usually will be denied. Commanders can grant exceptions if circumstances clearly show that the additional hours will not adversely affect military duties. Because of potential conflict with military obligations, AMEDD officers will not assume primary responsibility for the care of critically ill or injured persons on a continuing basis nor engage in private (solo) practice. Officer trainees (in graduate training programs) are prohibited from remunerative professional employment.

(2) The officer will not request, or be granted administrative absence for the primary purpose of engaging in civilian employment. However, ordinary leave may be granted to provide testimony in connection with authorized off–duty employment (para 1–7*c*), providing such absence does not adversely affect military duties.

(3) Civilian employment will not involve expense to the Federal Government nor involve use of military medical equipment or supplies.

(4) Individuals will advise employers that they will be subject to respond to alerts or emergencies that—

(a) May arise during non–duty hours.

(b) Could possibly delay the individual in reporting for civilian employment.

(c) Could require the individual to leave his or her civilian employment without warning.

(5) Civilian employment will be conducted entirely during non–duty hours and outside the Army MTF. Military personnel may not be employed by AMEDD officers in civilian employment.

(6) Except as indicated in (7) below, a demonstrated need must exist because of the relative lack of civilian physicians, veterinarians, nurses, or other professional personnel to serve the local community. A letter from the local professional society (or other responsible community agency) expressing no objection to such employment will be a required attachment to the request. This letter also must certify to the need and to the fact that such service is not available from any reasonable civilian source.

(7) AMEDD officers may engage in charitable civilian employment when voluntarily performed for, or for the benefit of, institutionalized persons and recognized nonprofit, charitable organizations; examples are the Boy Scouts and community clinics. (A letter to the benefiting institution or nonprofit organization should clearly state that the officer is performing charitable work as a private citizen and that the Government assumes no responsibility for the officer's actions.)

(8) Medical, nursing, dental, or veterinary officers prescribing drugs in civilian employment are subject to all the requirements of the Federal narcotic law. This will include Drug Enforcement Agency (DEA) registration and payment of taxes that are imposed upon other physicians, nurses, dentists, or veterinarians conducting private practice.

c. The responsibility for meeting local licensing requirements is a personal matter for officers who wish to engage in civilian employment. Similarly, malpractice insurance is a personal responsibility of the individual requesting permission to engage in civilian employment. The Army will not be responsible for officers' acts while they are engaged in off–duty employment.

d. Officers will submit written requests when they wish to engage in off–duty employment. The request will describe the position to be filled and the terms of employment; it will state that requester fully understands the provisions of this paragraph concerning off–duty employment; see appendix F. Commanders will approve or disapprove the request in writing and return a copy to the requester within 10 days. Approved requests will be reviewed at least annually by the commanders concerned.

e. Provided the provisions cited in b through d above are met (and authorized absence during normal duty hours does not adversely affect military duties) AMEDD officers—

(1) May, in isolated cases, provide remunerative advice or services to civilian practitioners in the diagnosis or treatment of patients not entitled to medical, dental, or veterinary care under AR 40–3. Employment must be authorized by their commanders; officers must be certified by an American Specialty Board or recognized by TSG as having achieved an equivalent level of professional ability.

(2) Will perform procedures necessary to save life or prevent undue suffering at any time in an emergency.

(3) May engage in teaching, lecturing, and writing as provided in AR 600–50.

1–9. Command positions.

a. The provisions of AR 600–20 apply in the designation or assumption of command; exceptions are shown in the modifications outlined below.

(1) *Health clinics.* Administrative directions of small outpatient health clinics may be vested in any qualified health care professional officer; this will be done without regard to the officer's basic health care profession. These clinics will be integral parts of the US Army Medical Center (MEDCEN) or medical department activity (MEDDAC) organization. In implementing this policy, due consideration will be given to the availability of qualified officers and the

size and mission of these outpatient facilities. In certain Army health clinics, the senior position is designated as commander. These commanders will provide for disciplinary control over personnel assigned to these clinics. The clinic will remain as an organizational element of the MEDCEN or MEDDAC to which assigned; the parent organization will be responsible for administrative control over personnel and financial resources. Professional direction of health clinics will come from the MEDCEN or MEDDAC commander, or an MC officer designated for this purpose.

(2) *Dental clinic.* Professional direction of dental clinics will come from the Director of Dental Services (DDS) or dental activity (DENTAC) commander.

b. MEDCENs, MEDDACs, community hospitals, and specific Army health clinics designated by HQDA(DASG–ZA) will be commanded by an MC officer qualified to assume command under AR 600–20. The MC officer will command, even though an officer of another branch may be the senior regularly assigned officer present.

c. DENTACs and dental units and detachments will be commanded by a DC officer qualified to assume command under AR 600–20. The DC officer will command, even though an officer of another branch may be the senior regularly assigned officer present.

d. When tables of organization and equipment (TOE) units normally commanded by MC, DC, or VC officers are in a training status, they will be commanded by the senior AMEDD officer qualified to assume command under AR 600–200, unless otherwise directed by HQDA.

1–10. Utilization of AMEDD officers.

a. AMEDD officers' duty time will be devoted, to the maximum extent possible, to actions and procedures for which they are specifically trained. They normally will be utilized in their primary occupational specialties.

b. Commanders of AMEDD units will establish local utilization policies for assigned members of their commands. These policies will include performance of additional duties. Policies will be based on—

(1) Workload.

(2) Assigned level of personnel.

(3) General situation of the command.

(4) Utilization guidance provided in subsequent chapters in this regulation for each AMEDD Corps and for AMEDD warrant officers.

Chapter 2
CORPS OF THE ARMY MEDICAL DEPARTMENT

Section I
MEDICAL CORPS

2–1. Composition.

The Medical Corps (MC) consists exclusively of commissioned officers who are qualified doctors of medicine or doctors of osteopathy.

2–2. Duties of MC officers.

a. Professional. Professional duties are those directly related to—

(1) Evaluation of medical fitness for duty of members and potential members of the Armed Forces.

(2) Analysis of the medical and physical condition of patients.

(3) Practice of preventive and therapeutic medicine.

(4) Development and adoption of medical principles required for the—

(a) Prevention of disease and disability.

(b) Treatment of patients.

(5) Solution, through research and development (R&D), of medical professional problems in the—

(a) Prevention of disease and injury.

(b) Treatment and reconditioning of patients.

b. Staff.

(1) The senior MC officer present for duty with a headquarters (other than medical) will be officially titled—

(a) The "surgeon" of the field command.

(b) The "chief surgeon" of the oversea major Army command (MACOM).

(c) The "director of health services (DHS)" at the installation level.

These titles indicate the medical officer's staff position rather than qualifications.

(2) Duties of this individuals are advisory or technical: advisory as staff officers; technical in the supervision of all medical units of the command. These individuals—

(a) Advise the commander and members of the staff on all medical matters pertaining to the command.

(b) Take part in all planning activities dealing with military operations.

(c) Exercise complete technical control within a command over medical units in the maintenance of health, and in the care of the sick and wounded. This care will include those means of evacuation that are organic to the AMEDD.

(3) Except for direct coordination of professional and technical matters, coordination with staff counterparts at higher and subordinate headquarters is through command channels.

(4) When medical and nonmedical TOE units are stationed at installations where a DHS is authorized and assigned, the designated DHS, if other than the MEDDAC or MEDCEN commander, may retain the position, on approval of the installation commander (see AR 10–43), even though a senior MC officer is on duty with the TOE units.

(5) By mutual agreement between commanders, the appropriate medical staff officer may, as an additional duty, serve as the staff surgeon to other commands which do not have medical staff officers assigned.

(6) Specific duties of a medical staff officer are explained in AR 10–6 and AR 611–101.

2–3. Utilization of MC officers.

a. MC officers' duty time will be devoted, to the maximum extent possible, to actions and procedures for which they are specially trained. A minimum of time will be given to those duties that can be adequately performed under their direction by other AMEDD personnel

b. Except when regulations provide otherwise, such officers will not be—

(1) Detailed as members of—

(a) Courts–martial.

(b) Nonprofessional boards or committees.

(2) Assigned to other duties in which medical training is not essential.

To preclude requiring the personal appearance of MC officers as witnesses to present testimony, every effort consistent with due process of law will be made to use reports, depositions, or affidavits submitted by MC officers in connection with courts–martial and boards or committees.

2–4. Applicability of Federal and State licensing laws.

When duties are performed by MC officers under valid orders issues by lawful Federal authority, such officers are—

a. "Exempt officials," as explained by the DEA.

b. Not required to register and pay the Federal narcotics tax.

Section II
DENTAL CORPS

2–5. Composition.

The Dental Corps (DC) consists exclusively of commissioned officers who are qualified doctors of dental surgery or dental medicine.

2–6. Duties of DC officers.

a. Professional. Professional duties will be those directly related to the science of dentistry as practiced by the dental profession.

These will include dental examinations, preservation and promotion of dental health, and execution of approved dental RDTE programs.

b. Staff.

(1) The primary duty of the senior DC officer present for duty with a non–DENTAC headquarters will be that of dental staff officer, except where designated as deputy commander. The title of a dental staff officer will be "dental surgeon."

(2) Individuals exercise complete technical control within the command over dental activities in the—

(a) Prevention of oral disease.

(b) Care of dental patients.

(3) Coordination with staff counterparts at high and subordinate headquarters is through command channels; an exception will be for direct coordination of professional and technical matters.

(4) By mutual agreement between commanders, the appropriate dental staff officers may, as an additional duty, serve as the staff dental surgeon to other commands that do not have a dental staff officer assigned.

(5) Specific duties of a dental staff officer are explained in AR 10–6 and AR 611–101.

2–7. Utilization of DC officers.

This applicable portions of paragraph 2–3 govern in the utilization of dental officers.

2–8. Dental organizations.

a. Dental personnel required by commands will be organized into DENTACs, as well as US Army Area Dental Laboratories (ADLs), and TOE units, as required. The DENTAC is part of the MEDCEN or MEDDAC table of distribution and allowance (TDA); however, the DENTAC is supported by, not commanded by, the MEDCEN or MEDDAC. The DENTAC receives complete administrative and logistical support from the MEDCEN or MEDDAC.

b. The dental care program is managed separately by the appropriate AMEDD command headquarters (for example, Headquarters US Army Health Services Command (HQ, HSC); Medial Command (TOE 8–111H2)) as a discrete, functionally managed program. On matters pertaining to the dental health of the command, the installation commander will communicate directly with the DDS, under AR 5–3.

2–9. Application of narcotic and licensing laws to DC officers.

Paragraph 2–4 applies.

Section III
VETERINARY CORPS

2–10. Composition.

The Veterinary Corps (VC) consists exclusively of commissioned officers who are qualified doctors of veterinary medicine.

2–11. Duties of VC officers.

a. The Assistant Surgeon General for Veterinary Services—

(1) Serves as executive agent for veterinary services for the DOD; see DODD 6015.5.

(2) Provides veterinary support to the DA, Department of the Navy and the US Marine Corps, the Air Force, all DOD agencies, and the US Coast Guard.

b. Professional duties of VC officers are discussed below.

(1) Provide consultative services to personnel performing food hygiene, safety, and quality assurance inspections. This will include advising the appropriate authority on the acceptability of food as follows:

(a) Food processing inspections incident to and following the procurement of foods of animal origin or other foods, when requested by proper authority.

(b) Sanitation inspection of establishments in which foods are produced, processed, prepared, manufactured, stored, or otherwise handled; excluded are food service facilities, such as dining facilities and snack bars.

(c) Inspections on receipt at destination for identity and condition of all foods of animal and non–animal origin.

(d) Perform professional functions in medical laboratories, such as chemical, bacteriological, and radiological analyses of foods.

(e) Inspections to determine fitness for human consumption of all foods which may have been contaminated by chemical, bacteriological, or radioactive materials.

(2) Assist the senior medical staff officer or the MEDCEN or MEDDAC commander at all levels of command in discharging responsibilities for conducting a comprehensive preventive medicine program. This will include the prevention and control of diseases common to man and animals in areas of responsibility specified by the—

(a) Senor medical staff officer.

(b) MEDCEN or MEDDAC commander.

(3) Provide a comprehensive program for prevention and control if diseases or conditions that may—

(a) Be transmissible to humans or animals.

(b) Constitute a military community health problem.

(4) Provide veterinary service support—

(a) In AMEDD training programs.

(b) To medical and subsistence R&D programs and activities.

(5) Provide complete veterinary services for US Government public–owned animals. Morale support activities–owned animals will be provided veterinary services as time and resources permit.

(6) Collect and maintain data on—

(a) Food supplies and animal diseases that may affect the health of members to the Army.

(b) Animal diseases that may affect the health of public animals. In this respect, they will advise and make recommendations to the appropriate authority of existing or anticipated conditions that may be of military or civilian significance. Under applicable circumstances, these would include local, State, Federal, and comparable agencies.

(7) Provide technical consultation to the senior medical staff officer or the MEDCEN or MEDDAC commander. In this capacity the VC officer will—

(a) Identify unsanitary conditions associated with subsistence and animals.

(b) Make recommendations for correction of these unsanitary conditions.

(8) Assist, on request and when authorized, civilian authorities or other Federal departments in emergency animal disease control programs.

c. Specific duties of a veterinary staff officer are defined in AR 10–6 and AR 611–101.

2–12. Utilization of VC officers.

a. Applicable portions of paragraph 2–3 govern the utilization of VC officers.

b. At installations and activities where no VC officer is assigned, required military veterinary service may be provided on an attending basis; this must be authorized by the Commanding General, US Army Health Services Command (CG, HSC) and the oversea MACOM commander for their areas of responsibility.

2–13. Title of VC officers.

a. The general officer in the VC may, when so designated by TSG, be called—

(1) The Assistant Surgeon General for Veterinary Services.

(2) Chief, Veterinary Services.

(3) Chief, VC.

b. The title of the senior VC officer assigned to a command, agency, or activity is "Veterinarian."

Section IV
MEDICAL SERVICE CORPS

2–14. Composition.

The Medical Service Corps (MSC) is authorized one officer in the grade of Brigadier General who serves as Chief of the MSC. The

MSC by law (section 3068, title 10, United States Code) is organized into four sections: Pharmacy, Supply, and Administration Section; Medical Allied Sciences Section; Sanitary Engineering Section; and Optometry Section. An officer is selected and certified by TSG and the Chief of the MSC to be Chief of each Section; each officer concurrently is designated an Assistant Chief of the MSC. These MSC sections are subdivided as follows:

a. Pharmacy, Supply and Administration Section.

(1) Health care administration.
(2) Field medical assistant.
(3) Health services comptroller.
(4) Biomedical information systems.
(5) Patient administration.
(6) Health services personnel management.
(7) Health services manpower control.
(8) Health services plans, operations, intelligence, and training.
(9) Aeromedical evaluation.
(10) Health services materiel.
(11) Health facilities planning.
(12) Pharmacy.

b. Medical Allied Sciences Section.

(1) Microbiology.
(2) Biochemistry.
(3) Parasitology.
(4) Immunology.
(5) Clinical laboratory.
(6) Physiology.
(7) Podiatry.
(8) Audiology.
(9) Social work.
(10) Clinical psychology.
(11) Research psychology.

c. Sanitary Engineering Section.

(1) Nuclear medical science.
(2) Entomology.
(3) Environmental science.
(4) Sanitary engineering.

d. Optometry Section.

2–15. Duties of MSC officers.

a. Officers of the branch perform a wide variety of administrative, technical, scientific, and clinical duties within the AMEDD. These duties will be consistent with the officer's education, training, and experience. MSC officers will perform duty in branch immaterial assignments only when authorized by HQDA (DASG–PTZ).

b. See AR 10–6 and AR 611–101 for a more definitive explanation of duties of MSC officers.

2–16. Utilization of MSC officers.

a. MSC officers normally will be utilized in their primary professional specialty.

b. Applicable portions of paragraph 2–3 govern the utilization of those MSC officers who, in the performance of their assigned duties, provide patient care through either of the following:

(1) Direct professional services on an appointment basis.
(2) Preventative medicine functions.

c. Exceptions to b above are duties involving courts, boards, administrative officer of the day (AOD), or staff duty officer (SDO).

d. Provisions of paragraph 1–9*d* and the annually published HQDA Letter (MEDO Letter) govern MSC officers exercising command.

Section V
ARMY NURSE CORPS

2–17. Composition.

The Army Nurse Corps (ANC) consists exclusively of the Chief, Assistant Chief, and other commissioned officers who are qualified, registered, professional nurses.

2–18. Duties of ANC officers.

a. Professional. Duties of ANC officers are those related to the theory and practice of nursing.

(1) The focus of the practice of nursing is on the assessment of individual, family, or group health care needs to—

(a) Promote health.
(b) Prevent illness.
(c) Provide assistance in coping with physical and psychological aspects of illness. This goal is accomplished by a variety of modalities, such as teaching, counseling, case–finding, and skilled supportive care.

(2) Nursing is based on recognized professional standards of practice. It has certain functions for which its practitioners accept responsibility. These include both independent nursing functions and delegated medical functions that may be either—

(a) Performed autonomously in coordination with other health team members.
(b) Delegated by the professional nurse to other persons.

(3) In US Army MEDCENs and MEDDACs the Department of Nursing is the administrative unit that provides the organization framework for nursing activities to accomplish the following:

(a) Define, design, and implement nursing care systems.
(b) Establish specific nursing care technologies, processes, and standards; develop mechanisms to insure that these standards are maintained.
(c) Collect and evaluate data concerning categories of patients and nursing resources.
(d) Assess and evaluate results of nursing actions on a continuous basis.
(e) Forecast and plan for requirements in money, materials, and personnel resources.
(f) Coordinate nursing actions with other health care providers.
(g) Establish a climate for and promote nursing research.
(h) Provide opportunities for continuing education for nursing personnel.
(i) Provide flexibility and modification of practice in response to technological advances and social changes.

b. Staff and other duties. Detailed duties, responsibilities, and titles of ANC officers are outlined in AR 40–6, AR 10–6, and AR 611–101.

2–19. Utilization of ANC officers.

a. ANC officers will be assigned to nurse–related professional, administrative, and staff duties that directly contribute to the accomplishment of the AMEDD mission. ANC officers will be considered appropriately assigned when performing duties related to their specialty skills identifier.

b. The applicable portions of paragraph 2–3 govern the utilization of ANC officers may be detailed as members of courts–martial boards of nonprofessional boards or committees when ANC officers or other nursing service personnel are involved in the proceedings.

c. ANC officers will not perform AOD, SDO, or other additional duties in which nursing professional education, training, and experience are not essential. Exceptions include serving—

(1) In an administrative headquarters (for example, HQ, HSC; HQDA; or Medical Group (TOE 8–122H)).
(2) As an administrative resident.
(3) As chief nurse in a TOE unit.

Section VI
ARMY MEDICAL SPECIALIST CORPS

2–20. Composition.

a. The Army Medical Specialist Corps (AMSC) is composed of a Dietitian Section, Occupational Therapist Section, and Physical Therapist Section.

b. The AMSC consists exclusively of officers who are—

(1) Registered dietitians, certified occupational therapists, or licensed physical therapists.
(2) Eligible for membership in the American Physical Therapy Association.

(3) Taking part in AMSC professional education programs for the purpose of becoming qualified in one of the specialties cited in (1) or (2) above.

2–21. Duties of AMSC officers.

a. Duties of AMSC officers will be directly related to the specialties of dietetics, physical therapy, or occupational therapy, as practiced by the respective civilian professions. These will include development and adoption of principles and standards to meet the total needs of patients in these specialized fields.

b. See AR 10–6 and AR 611–101 for specific duties of AMSC officers.

2–22. Utilization of AMSC officers.

a. When AMSC officers are assigned to Army MTFs—

(1) The senior dietitian will be Chief of the Food Service Division.

(2) The senior physical therapist and senior occupational therapist will be chiefs of their respective sections.

b. The applicable portions of paragraph 2–3 govern the utilization of AMSC officers. An exception is that AMSC officers may be detailed as members of courts–martial boards or nonprofessional boards or committee when the following are involved in the proceedings:

(1) AMSC officers.

(2) Other food service, physical therapy, or occupational therapy personnel.

c. AMSC officers working regularly established clinic hours may perform AOD and SDO functions. Fair and equitable scheduling of those officers who work shifts or who are on weekend and holiday duty rosters within their sections must be evident.

d. AMSC officers will not be assigned to AOD or SDO or assistant AOD or SDO function when they are taking part in the following:

(1) The Army Dietetic Internship Program.

(2) The Army Occupational Fieldwork Program.

e. AMSC officers will not be assigned special administrative duties. These include, but are not limited to, additional duties; for example, line inventory, drug inventory, hospital inspection, and cash verification. The only exception would be those officers serving—

(1) In an administrative HQ.

(2) As administrative residents.

Chapter 3
ARMY MEDICAL DEPARTMENT WARRANT OFFICERS

3–1. Physician assistant, military.

a. Composition. Military physician assistants (PAs) are school–trained warrant officers who are qualified for and who have been awarded military occupational specialty (MOS) 011A.

b. Duties. Military PAs have the following duties:

(1) Provide general medical care for the sick and wounded under the supervision of designated physicians. Perform technical and administrative duties as—

(a) Indicated in AR 611–112.

(b) Assigned by supervisors in MTFs.

(2) Provide for preparation and maintenance of necessary records and reports.

(3) Supervise or assist in supervising enlisted specialists and comparable civilian employees in utilization, care, and maintenance of medical supplies and equipment.

(4) Assist in the training of enlisted specialists and comparable civilian employees in technical aspects of patient care and treatment.

c. Utilization. The provisions of paragraph 1–10 and AR 40–48 govern the utilization of military PAs.

(1) PAs will be utilized only within their MOS in troop medical clinics, aviation medicine clinics, emergency rooms, physical examination sections, general outpatient clinics, family practice clinics, other primary care clinics, field medical units, and other medical facilities.

(2) Career management of military PAs is monitored by the MC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, Office of The Surgeon General (OTSG), HQDA.

3–2. Biomedical equipment repair technician.

a. Composition. Biomedical equipment repair technicians are warrant officers who are qualified for and have been awarded MOS 202A.

b. Duties. Biomedical equipment repair technicians perform specialized, equipment–oriented management functions; these include skills, knowledge, and abilities to manage programs for the maintenance of medical equipment. AR 611–112 prescribes the full range of duties performed by biomedical equipment repair technicians. Specific areas of responsibility are shown below.

(1) Planning and scheduling workload.

(2) Supervising and instructing subordinates.

(3) Administering a repair parts program.

(4) Recording maintenance performance and historical equipment data; coordinating with user and support activities.

(5) Developing and operating ancillary support programs.

(6) Advising on the layout of health care facilities as related to equipment and applicable installation requirements.

(7) Advising the commander and staff on maintenance–related matters.

c. Utilization. Provisions of paragraph 1–10 and AR 40–48 govern utilization of biomedical equipment repair technicians.

(1) Personnel with this specialty will be utilized only in their MOS; they normally will be assigned to TDA hospitals, MEDCENs, MEDDACs, or equivalent modifications TOE units. Some personnel also will be assigned for the following functions:

(a) Managing depot or combined maintenance operations.

(b) Performing as equipment specialists in varying assignments.

(c) Serving as instructors in service schools.

(d) Commanding TOE medical equipment maintenance detachments.

(2) Other personnel with this specialty also serve in successively higher levels of management with MACOMs and the National Maintenance Point.

(3) Career management of biomedical equipment repair technicians is monitored by the MSC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, OTSG, HQDA.

3–3. Food inspection technician.

a. Composition. Food inspection technicians are school–trained warrant officers who are qualified for and have been awarded MOS 051A.

b. Duties. Food inspection technicians—

(1) Manage and direct personnel, facilities, and equipment required for military hygiene, safety, and quality assurance.

(2) Provide assistance in programs to—

(a) Prevent animal diseases.

(b) Control zoonotic and foodborne illnesses.

(3) Assist in animal control programs.

(4) Prepare reports relative to veterinary activities.

(5) Maintain liaison with Federal, State, and local health agencies.

(6) Assistant in the conduct of training of enlisted personnel and civilian employees.

(7) Other technical and administrative duties are performed as—

(a) Indicated in AR 611–112.

(b) Assigned by the technician's supervisor.

c. Utilization. The provisions of paragraph 1–10 govern the utilization of food inspection technicians. They will be utilized only

within their MOS in TOE units, TDA activities, MEDCENs or MEDDACs, and other DOD agencies and activities. Career management of food inspection technicians is monitored by the VC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, OTSG, HQDA.

Chapter 4
ARMY MEDICAL DEPARTMENT CIVILIAN PERSONNEL

4–1. Civilian employees.

a. Composition. The civilian complement of the AMEDD consists of US citizens and direct– and indirect–hire local nationals employed under appropriate regulations issued by the US Office of Personnel Management, HQDA, and the AMEDD.

b. Duties. Civilian are employed in a wide range of occupational categories; these include physicians, nurses, those in other medical and allied specialties, and support and service personnel.

c. Utilization. General utilization policy of AMEDD civilian employees is outlined in AR 570–4.

d. Social workers and psychologists. Policy for employment of social workers and psychologists is contained in appendix E.

4–2. Contract surgeons.

a. Authorization. In an emergency, TSG may employ as many contract surgeons as may be necessary within applicable personnel limitations (section 4022, title 10, United States Code). An emergency may exist when utilization of the services of an MC officer or a graded Civil Service physician is not practicable or feasible for providing essential health services. Contract surgeons will not be employed as a means for circumventing general schedule pay scales (Civil Service) established for physicians employed by the US Government.

b. Justification for employment. Justification for employment of private physicians as contract surgeons in peacetime will be forwarded for approval through command channels to HQDA (DASG–PSC), WASH DC 20310, to arrive 60 days before the desired date of employment. When intermediate MACOM commanders do not concur with any part of the justifications, it will be returned to the originator with reasons for nonoccurrence. As a minimum, each justification submitted to HQDA will contain appropriate data with the following information:

(1) Workload data for the most recent 6–month period. This will include, for example, the number of visits (inpatient and outpatient, as appropriate) and the number of medical examinations, as pertains to areas in which a private physician will be employed.

(2) Projected workload data for period of contract. (See (1) above.)

(3) Number, by type of personnel (military, civil service, contract surgeon, or fee–for–service), presently authorized, required, and assigned in the work area where the contract surgeon is required.

(4) Other procurement actions taken to provide necessary services; an example is through the US Office of Personnel Management.

(5) Number of active duty medical officers programmed to fill existing or projected vacancies.

(6) Effective dates of contract.

(7) Activity or installation to be serviced by contractor.

(8) Compensation; hourly, daily, weekly, monthly, or yearly, as applicable.

(9) Hours, days, place of duty, and full–time or part–time; examples of place of duty are clinic or emergency room.

(10) Types of services to be provided; examples are sick call or emergency room.

(11) Types of personnel to be provided medical care; see AR 40–3 for eligibility for medical care. Specify as active duty Army, other active duty, dependents of US Uniformed Services personnel (active duty and retired), retired US Uniformed Services personnel, or other personnel.

(12) Restrictions imposed or contemplated to be imposed upon the contractor.

(13) Proposed source and address.

(14) Monitoring headquarters; name and telephone (automatic voice network (AUTOVON)) of the individual conducting preliminary negotiations with the private physician.

(15) Statements that—

(a) Employment will be within all applicable personnel limitations and funding availability.

(b) The contractor will possess the applicable qualifications outlined in d below.

c. Duties. Professional and administrative duties of contract surgeons will be comparable to those which MC officers with similar training and experience normally would be called upon to perform. Contract surgeons are not eligible for detail on courts–martial boards, but may be detailed to serve on—

(1) Medical boards convened under AR 40–3.

(2) Administrative boards to which civilian employees may be appointed.

d. Qualifications.

(1) To be eligible as a contract surgeon within the United States, the contractor must be one of the following:

(a) A graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association.

(b) A graduate of a school of osteopathy approved by the Bureau of Professional Education Committee in Colleges of the American Osteopathic Association.

(c) A holder of a permanent certification by the Educational Council for Foreign Medical Graduates.

(2) The candidate must—

(a) Have a full or unrestricted license to practice medicine in a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

(b) Be legally authorized to prescribe and administer all drugs and perform all surgical procedures in the area concerned.

(3) Oversea MACOM commanders will prescribe the qualifications for contract surgeons for their respective area of employment.

e. Full–time and part–time status.

(1) A full–time contract surgeon is one who is required to devote full time to the performance of duties under the contract; full time here means not less than 40 hours each calendar week.

(2) A part–time contract surgeon is one who is required each week to devote less than 40 hours to the performance of duties under the contract.

f. Compensation and leave.

(1) Pay and allowances for full–time and part–time contract surgeons will be as prescribed in Misc Publ 13–1.

(2) Pay of part–time contract surgeons may not exceed the monthly base pay of an officer, O3, with over 4, but less than 6, years of service.

(3) Part–time contract surgeons are entitled only to the travel and transportation allowances in the same amount and under the same conditions as allowed for commissioned officers.

(4) Special and incentive pays may not be included in the contract for either part–time or full–time contract surgeons.

(5) Contract surgeons are not entitled to officers' uniform allowances.

(6) Within the limitations prescribed above, oversea MACOM commanders are authorized to determine applicable compensation of part–time contract surgeons within the geographical limits of their commands. These rates will take in account—

(a) Comparable rates paid for similar services in the locality.

(b) Background, experience, and other qualifications of the contractor.

(c) Extent of service required under to contract.

g. Contract negotiation. Section 2304a(4) and 2304a(6), title 10, United States Code and Misc Pub 28–25, paragraph 22–102.1 contain authority for negotiation of contracts with private physicians.

On approval of justification by HQDA (DASC–PSC) (para 4–2*b*), commanders of installations and activities may enter into contracts for services of contract surgeons.

h. Contracts.

(1) *General.* The following provisions apply to both full–time and part–time contract surgeons:

(a) Contracts will be executed by the local contracting officer under applicable provisions of Misc Pub 28–24 and Misc Pub 28–25 (32 CFR 591 et seq.).

(b) The term of the contract will be for a specific period of time; it will not extend beyond the end of a fiscal year during which the available appropriated funds are authorized to be obligated.

(c) A contract will not be renewed automatically upon expiration. Justifications for re–employment of private physicians as contract surgeons for the ensuring fiscal year will be forwarded under paragraph 4–2*b*.

(d) One copy of each executed contract will be forwarded to HQDA (DASG–PSC), WASH DC 20310 within 10 working days after the effective date of the contract; the executed contract will be for initial employment or re–employment.

(2) *Contract format.*

(a) Contracts will conform to the format prescribed by Misc Pub 28–24 (para 16–102.2) and by Misc Pub 28–25 (app F 100–26).

(b) Each contract will contain a statement of work substantially as shown in appendixes B, C, or D. Modifications to these statements to meet local requirements are not prohibited; however, changes should be kept to a minimum.

4–3. Professional consultants.

a. General. This paragraph contains information and instructions regarding professional consultants (hereafter referred to as consultants). Those portions of this paragraph that deal with civilian consultants supplement CPR A–9 and FPM chapter 304. Unless otherwise specifically indicated, provisions of this paragraph are applicable to both military and civilian consultants.

b. Duties.

(1) Consultants will—

(a) Assist in the maintenance of high standards of professional practice and research.

(b) Further the educational program for the advancement of AMEDD officers in the medical , dental, nursing, and allied specialties.

(c) Provide close liaison with leaders in related professions.

(2) These consultants will assist TSG, the Commanding Genera, US Army Medical Research and Development Command (CG, USAMRDC), the CG, HSC, chief surgeons of oversea MACOMs, and commanders of AMEDD activities, particularly treatment and R&D facilities—

(a) On matters pertaining to professional practice by providing advice on professional subjects.

(b) On new developments in prophylaxis, diagnosis, treatment, and technical procedures.

(c) By stimulating interest in professional problems and aiding in their investigation.

(d) By giving advice on RDTE programs.

(e) By encouraging participation in programs such as clinical and pathological conferences, ward rounds, and journal clubs.

(3) Proper performance of these duties involves an appraisal of all factors concerned with the prevention of disease and the professional care of patients. These include—

(a) Organization and program of professional services in medical installations.

(b) Quality, numbers, distribution, and assignment of specialty qualified professional personnel.

(c) Diagnostic facilities and availability and suitability of equipment and supplies for professional needs.

(d) Dental care, nursing care, and dietary provisions.

(e) Physical therapy and occupational therapy.

(f) Reconditioning and recreational facilities.

(g) Other ancillary services which are essential to the welfare and morale of patients.

(4) Execution of these duties involves periodic visits to MTFs and other types of AMEDD units concerned with health service or medical R&D activities.

c. Utilization categories. Utilization of consultants falls into the following categories:

(1) *OTSG.* In addition to AMEDD officers assigned or designated as consultants, other specialty qualified individuals may be utilized to—

(a) Provide TSG with professional advice or assistance, as required.

(b) Perform duties set forth in b above.

(2) *OTSG field operating agencies (FOAs).* OTSG FOAs are activities under the command jurisdiction of TSG.

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance. (For further information regarding the educational program of the AMEDD in the medical, dental, nursing, and allied specialties, see AR 351–3.)

(b) In activities where intern or residency training programs are conducted, a representative consultant may be appointed to the Hospital Education Committee. This consultant may advise and recommend on all matters pertaining to graduate education. (For further information regarding AMEDD residency or intern training programs see AR 351–3.)

(3) *HSC.*

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance.

(b) In hospitals conducting residency or intern training, a representative consultant may be appointed to the Hospital Education Committee. This consultant may advise and recommend on all matters pertaining to graduate education.

(4) *Oversea MACOMs.*

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance.

(b) In hospitals conducting residency or intern training, a representative consultant in surgery, internal medicine, psychiatry and neurology, pathology, and dentistry may be appointed to the Hospital Education Committee. These consultants may advise and recommend on matters pertaining to graduate education.

4–4. Administrative procedures for professional consultants.

Before the initial appointment of consultants in the medical, dental, nursing, and allied specialties, the appropriate command or agency will evaluate the prospective consultant's professional qualifications.

a. Appointment.

(1) *Military consultants.* In addition to AMEDD officers assigned as consultants, other specialty qualified individuals may be utilized to advise TSG, the CG, USAMRDC, the CG, HSC, and oversea MACOM commanders on major subjects and board problems connected with the following:

(a) Policy and practice in the prevention of disease.

(b) Care of patients.

(c) Health and environment activities.

(d) Evaluation and maximum utilization of specialized personnel.

(e) R&D program.

(f) Postgraduate education.

(g) Continuing education programs for AMEDD officers.

(h) Other important professional matters. TSG and MACOM commanders will appoint these designated individuals on appropriate military orders.

(2) *Civilian consultants.* TSG, the CG, HSC, the CG, USAMRDC, and oversea MACOM commanders may approve appointment of civilian consultants within their respective commands or agencies. Normally, civilian consultants will not be utilized for a period or periods exceeding 90 calendar days in 1 fiscal year. Prior approval by the appropriate approval authority must be obtained in

additional days of service are required during any fiscal year. In order to maintain a single pay account and to insure that consultants do not exceed the authorized maximum number of days in any fiscal year, civilian consultants will be carried in an appointive status on the rolls of only one command or agency. Short–term consultant appointments, not to exceed 6 months in total tenure, will be requested when individuals are required for brief periods of time to carry out special assignments; examples would be a trip overseas or giving a series of lectures.

(a) Security requirements. The security requirements established in the FPM, chapter 732 and CPR A–9, chapter 732 for assignment OT civilian positions in the competitive service will apply to civilian consultants. Nonsensitive positions require completion of National Agency Check and written inquiries with satisfactory results. These may be conducted as post–appointive actions.

(b) Reappointment. Civilian consultants will be reappointed by the employing command or agency at the end of each fiscal year instead of at the end of the service year, as specified in CPR A–9.

(c) Roster. To maintain a current roster of all AMEDD civilian consultants to the Army in an appointive status, each appointing command or agency will publish an annual roster no later than 15 July of each year. Addendum's will be published as required. Appointment data on consultants is provided through the DA Civilian Personnel Information System (CIVPERSINS). If needed, rosters may be obtained through CIVPERSINS channels.

b. Joint utilization. Consultants appointed by one command or agency may be used by another command or agency through agreements made between the commands or agencies concerned. Payment for services rendered by civilian consultants, plus travel and per diem for military consultants, will be made by the parent command from funds available for this purpose and cited by the using command. Transfer of funds between commands is not authorized.

c. Civilian spaces incident to employment. Approving authorities will determine the number of civilian spaces required for the employment of consultants in activities under their respective jurisdiction. Such spaces will be included in their overall manpower programs.

d. Payment. The rate of pay for each civilian consultant will be determined by the approving authority. However, consultants will not be paid more than the maximum rate per day stated in AT 40–330, paragraph 6.

(1) Consultants will be paid by the parent command or agency. For joint utilization (see b above), prior coordination will be made. Information concerning the consultant's visit must be forwarded to the appropriate command or agency on completion of the visit; such information will include the purpose, additional costs, funding cite, and services rendered.

(2) Funds available locally will be used for employment of professional consultants.

e. Special services. Purchase requests for consultant services will clearly state the specific services to be performed.

(1) When the services of a civilian consultant are desired on a one–time basis, a consultant appointment is not required. Services of these individuals may be obtained by contract under Misc Pub 28–24 and Misc Pub 28–25.

(2) A contract can be negotiated locally by the contracting officer when—

(a) The services required are non–personal.

(b) An end product is involved.

(3) Contracts for consultant services that are purely personal in nature will be submitted through contracting channels for advance approval under Misc Pub 28–25, paragraph 22–205. Determinations and findings will be prepared under Misc Pub 28–24, paragraph 22–205.

Appendix A
References

Section I
Required Publications

DODI 6015.5
Joint Use of Military Health and Medical Facilities and Services. Cited in paragraph 2–11*a*. This publication may be obtained from Commander, US Naval Publications and Forms Center (ATTN: Code 301), 581 Tabor Ave., Philadelphia, PA 19120.)

AR 5–3
Installation Management and Organization. Cited in paragraph 2–8*b*.

AR 10–5
Department of the Army. Cited in paragraphs 1–5*d* and 1–6*a*(2).

AR 10–6
Branches of the Army. Cited in paragraphs 2–2*b*(6), 2–6*b*(5), 2–11*c*, 2–15*b*, 2–18*b*, and 2–21*b*.

AR 10–43
US Army Health Services Command. Cited in paragraph 2–2*b*(4).

AR 27–40
Litigation. Cited in paragraphs 1–7*c* and *c*(2), (3), and (4).

AR 40–3
Medical, Dental, and Veterinary Care. Cited in paragraphs 1–7*b*(1), 1–8*e*(1), 4–2*b*(11), and 4–2*c*(11).

AR 40–6
Army Nurse Corps. Cited in paragraph 2–18*b*.

AR 40–48
Health Care Extenders. Cited in paragraph 3–1*c* and 3–2*c*.

AR 40–121
Uniformed Services Health Benefits Program. Cited in paragraphs 1–7*b*(1) and B–5*a*.

AR 40–330
Rate Codes and General Policies for Army Medical Department Activities. Cited in paragraph 4–4*d*.

AR 351–3
Professional Training of Army Medical Department Personnel. Cited in paragraphs 4–3*c*(2)(*a*) and (*b*).

AR 570–4
Manpower Management. Cited in paragraph 4–1*c*.

AR 600–20
Army Command Policy and Procedures. Cited in paragraphs 1–7*d* and 1–9*a*, *b*, *c*, and *d*.

AR 600–50
Standards of Conduct for Department of the Army Personnel. Cited in paragraphs 1–7*d* and 1–8*e*(3).

AR 601–270
Armed Forces Examining and Entrance Stations. Cited in paragraph 1–6*i*.

AR 611–101
Commissioned Officer Specialty Classification System. Cited in paragraphs 2–2*b*(6), 2–6*b*(5), 2–11*c*, 2–15*b*, 2–18*b*, and 2–21*b*.

AR 611–112
Manual of Warrant Officer Military Occupational Specialties. Cited in paragraphs 3–1*b*(1)(*a*), 3–2*b*, and 3–3*b*(7).

AR 611–201
Enlisted Career Management Fields and Military Occupational Specialties. Cited in paragraph 1–6*g*.

AR 630–5
Leave, Passes, Permissive Temporary Duty, and Public Holidays. Cited in paragraph B–4*b*.

Misc Pub 13–1
DOD Military Pay and Allowances Entitlements Manual. Cited in paragraphs 4–2*f*(1) and B–4*b*.

Misc Pub 28–24
Defense Acquisition Regulation. Cited in paragraphs 4–2*h*(1)(*a*) and (2)(*a*) and 4–4*e*(1) and (3).

Misc Pub 28–25
Army Defense Acquisition Regulation Supplement (ADARS). Cited in paragraph 4–2*g* and *h*(1)(*a*) and (2)(*a*) and 4–4*e*(1) and (3).

FPM, chapter 304
Federal Personnel Manual, US Civil Service Commission. Cited in paragraph 4–3*a*.

FPM, chapter 732
Federal Personnel Manual, US Civil Service Commission. Cited in paragraph 4–4*a*(2)(*a*).

CPR A–9
Employment of Experts and Consultants. Cited in paragraphs 4–3*a* and 4–4*a*(2)(*a*) and (*b*).

OPM HDBK X–118
Qualification of Standards for Position Under the General Schedule. Cited in paragraph E–2.

HQDA Ltr (Sngl Address to MACOMs) (Current FY)
Staffing Authorization and Utilization of Army Medical Department Personnel in Active Component MTOE Unite of US Army Forces Command (FORSCOM) (Short Title: MEDO Letter). Cited in paragraphs 2–16*d*.

Section II
Related Publications
This section contains no entries.

Section III
Prescribed Forms
This section contains no entries.

Section IV
Referenced Forms
This section contains no entries.

Appendix B
SUGGESTED STATEMENT OF WORK FOR FULL–TIME CONTRACT SURGEON CONTRACT (DUTIES TO BE PERFORMED AT A GOVERNMENT FACILITY

B–1. Scope of contract.

a. The contractor agrees, during the term of this contract, to perform for and on behalf of the Government the duties of a contract surgeons, US Army, under—

(1) The laws and regulations in effect on the execution of this contract, and as they may be amended from time to time.

(2) Duty assignments specified by the contracting officer or his or her duly authorized representative. Services rendered to eligible personnel will be at no expense to the individual.

b. b. The contractor will not, while on duty, advise, recommend, or suggest to persons authorized to receive medical care at Army expense that such persons should receive medical care from—

(1) The contractor when he or she is not on duty.

(2) A civilian associated in practice with the contractor. An exception will be unless such medical care will be furnished without cost to the patient, the Government, or any other person or firm.

c. The contractor is not prohibited, by reason of employment under this contract, from conducting a private medical practice, if the following prevail:

(1) No conflict with the performance of duties under the contract exists.

(2) Practice is not conducted during the regular hours established under this contract, during which the contractor is required to render services to the Government.

(3) The contractor makes no use of any Government facilities or other Government property in connection with this contract.

B–2. Duty hours.

The contractor will be on duty
at _____
(name and location of medical facility)
on a full–time basis, 40 hours per week, for performance under this contract, in accordance with duties prescribed by this contract and a schedule mutually agreed upon between the contractor and the contracting officer. This schedule may be changed from time to time by mutual agreement.

B–3. Duties.

a. The contractor agrees to perform the service which a Medical Corps officer with similar training and experience normally would be called on to perform while in a similar duty assignment. The contractor's professional and administrative duties will consist of providing health services as specified in this contract, under the control and general supervision of the contracting officer or designated representative.

b. The contractor further agrees to be on call for emergencies at any time. Duty performed as a result of an emergency situation will be credited against the number of hours specified in the contract, when feasible; however, duty performed as a result of emergency situation, in excess of the number of hours specified in contract will not be the subject of additional compensation.

c. The contractor will maintain proper medical records on all military and dependent personnel to whom treatment is provided. The contractor will prepare such additional records and reports, when requested, as would be required of officers of the Army Medical Department charged with the same professional or administrative responsibilities.

d. Specific duties to be performed will include those shown below.

Note. Duties shown below are suggested for guidance. They may be modified, deleted, or supplemented as appropriate to the specific position.)

(1) Sick call service to military personnel on active duty at
_____
(name and location of installation concerned)

(2) Sick call service to eligible dependents of such military personnel. (Only applicable when care is also furnished to military.)

(3) Pre–school and pre–athletic examinations, as required.

(4) Administration of vaccines and immunizing agents furnished by the US Government.

(5) Planning and administration of the Army Occupational or Industrial Health Program.

(6) Direction of special preventive medicine programs such as vision or hearing programs and chest X–ray surveys.

(7) Conducting sanitary inspections; submission of appropriate recommendations to concerned commanders.

(8) Other duties appropriate for performance by a contract surgeon as directed or assigned by the contracting officer or duly authorized representative.

B–4. Compensation.

a. For the satisfactory performance of the services required under this contract, the contractor will be paid the basic pay, basic allowances, and other allowances of a commissioned officer in pay grade O3 with over 4, but not more than 6, years of service, as authorized under section 421(a), title 37, United States Code. The contractor's entitlement to pay continues during periods of authorized leave. Special and incentive pays may not be included in the contracts for part–time or full–time contract surgeons.

b. The laws and regulations as to leave of absence for commissioned officers, as they will exist from time to time, will govern leaves and absences of the contractor. The contractor is not entitled to sick leave as such under AR 630–5. (This paragraph may be omitted if leave is not authorized. See Misc Pub 13–1, part four, chap 6.)

c. Subject to a above, the contracting officer will assure that payments are made monthly during the period at the rate of $_____ per month on SF Form 1034 (Public Voucher for Purchases and Services Other Than Personal), directed to the finance and accounting officer. This contract must be presented at the time of payment for appropriate notation as to the payment made, together with a statement signed by the contracting officer that services have been satisfactorily rendered under terms of this contract.

B–5. Exclusions.

This contract does not include—

a. Medical and surgical care of dependents of military personnel who are hospitalized, or receiving treatment, under conditions that provide a basis for separate reimbursement in accordance with the dependents' medical care under AR 40–121.

b. Routine medical and surgical care of dependents or military personnel involving house calls, furnishing medication, or other care which is considered to be other than office or sick call service.

c. Provision of medicines or medical supplies other than those—

(1) Normally furnished as part of office or sick call treatment.

(2) For which no additional charge is made, unless otherwise provided for by contract.

Appendix C
SUGGESTED STATEMENT OF WORK FOR PART–TIME CONTRACT SURGEON CONTRACT DUTIES TO BE PERFORMED AT A GOVERNMENT FACILITY

C–1. Scope of contract.

See paragraph B–1.

C–2. Duty hours.

The contractor will be on duty for the medical treatment of eligible military personnel and their dependents at
_____from _____
(name and location of medical facility)
hours to_____ hours on _____
(days of week)

C–3. Duties.

a. See paragraph B–3*a*

b. The contractor further agrees to be on call for emergencies in situations when no other physician employee is available. Duty performed as a result of an emergency situation will be credited against the number of hours specified in the contract, when feasible; however, duty performed as a result of an emergency situation, in excess of the number of hours specified in the contract, will not be the subject of additional compensation.

c. See paragraph B–3*c*.
d. See paragraph B–3*d*.

C–4. Compensation.
a. The Government will pay the contractor the sum of $_____ for the satisfactory performance of services described in and required by this contract. (Compensation is limited under AR 40–1, para 4–2f.) Special and incentive pays may not be included in the contracts for part–time and full–time contract surgeons.
b. Same as paragraph B–4*c*.

C–5. Exclusions.
See paragraph B–5.

Appendix D
SUGGESTED STATEMENT OF WORK FOR PART–TIME CONTRACT SURGEON CONTRACT DUTIES TO BE PERFORMED OUTSIDE GOVERNMENT FURNISHED FACILITY

Note. The statement of work will follow the suggested format in app C for a part–time contract surgeon who performs at a Government facility. Exceptions and additions are shown below.
</paratext>

D–1. Duty hours.
Add to the end of paragraph C–2, duty hours, the address at which at which the contractor will be on duty for the purpose of this contract.

D–2. Duties.
Under paragraph C–3*d*, Duties, those duties to be performed by the contractor will be specified in detail, since supervision by the Government will not be feasible.

D–3. Additional provisions.
The following additional provisions will be included as a separate subparagraph to paragraph C–3, Duties:
a. A requirement for furnishing drugs and medications or medical supplies from Government sources. Restrictions as to types and quantities of such items will be clearly set forth and procedures for resupply specified.
b. Methods established to determine eligibility for care.
c. Instructions for referral of patients to service medical treatment facilities for further evaluation or hospitalization.

Appendix E
PROCESSING PROCEDURES FOR APPLICATIONS FOR EMPLOYMENT AS SOCIAL WORKERS AND PSYCHOLOGISTS

E–1. General.
a. To insure uniformity of professional standards and a high degree of professional competency, this appendix provides procedures for the processing of applications of civilian personnel for employment or placement in the position of Social Workers, GS–185, or Psychologists, GS–180. These will include those whose duties will be concerned, all or in part, with research activities.
b. Civil Service personnel employed as social workers and psychologists will be under the direction and responsibility of the commander of the installation or MTF on whose TDA the position is authorized. They will be guided in their utilization by overall policies established by TSG.

E–2. Qualifications.
The qualification standards for the position of Social Worker and Psychologist as set forth in OPM HDBK X–118, will be observed. These are minimum standards; fullest efforts will be made to locate candidates who, for the position of social worker, hold a master's degree in social work. For the position of psychologist, individuals must hold an acceptable doctoral degree in clinical or counseling psychology with an American Psychological Association (APA)–approved internship in clinical psychology if they are to do clinical work. If they do research work they must hold a doctoral degree in psychology in an appropriate specialty. The degree in clinical, counseling, or other sub–specialties of psychology must be from a school accredited by the APA or otherwise acceptable to TSG or the regional psychology consultant (when specifically designated for that purpose.

E–3. Procedure.
Applications for Civil Service positions in social work and psychology will be screened by the commander of the installation or MTF on whose TDA to position is authorized. After determination of the best qualified applicants, and before employment and placement in positions as social workers and psychologists, an appraisal of professional qualifications and an approval of the appointments will be obtained from HQDA(DASG–PSC), WASH DC 20310. For positions that are on medical TDA within the continental United States (CONUS), Alaska, Hawaii, Panama, 7th Medical Command, and 8th Medical Command (Provisional), approval will be obtained from the medical command social worker or psychology consultant, when specifically authorized by OTSG, together with HQDA(DASG–PSC), WASH DC 20310. Forwarded recommendations will be accompanied by—
a. Complete SF 171 (Application for Federal Employment).
b. Official transcript of all graduate work completed by the applicant toward professional training.
c. Written appraisal of the applicant's professional performance by at least three former supervisors or employers familiar with the applicant's work. Letters should contain relevant and specific information regarding individual's qualifications for the position to be filled.

Appendix F
SUGGESTED REQUEST FOR OFF–DUTY REMUNERATIVE PROFESSIONAL CIVILIAN EMPLOYMENT

FROM:_____ GRADE: _____
name (last, first, middle)
BRANCH:_____ SERVICE: _____
TO: COMMANDER
_____
(activity)
SUBJECT: Request for Off–Duty Remunerative Professional Civilian Employment
F–1. In accordance with AR 40–1, paragraph 1–8, I request permission to engage in remunerative professional civilian employment apart from my assigned military duties. I have attached a statement from the local medical, dental, or other applicable association indicating no objection to my professional employment in the community.
a. Type of employment and nature of work:
b. Beginning date:_____
c. Hours per day: _____ Number of days per week:_____
TOTAL hours per week: _____
d. Location of work:
_____
(name and address of employer)
Telephone number at place of employment: _____
F–2. I understand the provisions of AR 40–1, paragraph 1–8 concerning off–duty employment and I agree to conduct any off–duty employment activities in accordance with those provisions. Further, I understand that—

a. It is my obligation to inform my commanding officer in writing of any deviation in my off–duty employment from my proposal, as set forth in this letter, before the inception of such change.

b. No outside responsibilities will be assumed that will in any manner compromise the effective discharge of my duties as an officer in the US Army Medical Department, both as to number of hours devoted to outside work and my individual limit and capacity.

c. A copy of this proposal may be forwarded to the Office of The Surgeon General of the US Army, HQDA(DASG–PSZ), WASH DC 20310.

F–3. I recognize that I am prohibited from, and cannot in good conscience assume, the primary responsibility as an individual practicing health care, provide for the care and critically ill or injured patients on a continuing basis as this will inevitably result in the compromise of my responsibility to the patient on the one hand, or the primacy of my military obligation on the other hand.

_____ _____

requester (signature) date

1st Ind

FROM: Commander

TO: Requester

Subject request is_____ approved

_____not approved Reasons:_____

_____

_____ _____

signature (commander) (date)

Glossary

Section I
Abbreviations

ADL
Area Dental Laboratory

AMEDD
Army Medical Department

AMSC
Army Medical Specialist Corps

ANC
Army Nurse Corps

AOD
administrative officer of the day

ARNG
Army National Guard

AUTOVON
automatic voice network

CG
Commanding General

CIVPERSINS
Civilian Personnel Information System

CPR
Civilian Personnel Regulation

DC
Dental Corps

DDS
Director of Dental Services

DEA
Drug Enforcement Agency

DENTAC
dental activity

DHS
Director of Health Services

DOD
Department of Defense

FPM
Federal Personnel Manual

HSC
US Army Health Services Command

HQ
Headquarters

HQDA
Headquarters, Department of the Army

MACOM
major Army command

MC
Medical Corps

MEDCEN
US Army medical center

MEDDAC
medical department activity

MOS
military occupational specialty

MSC
Medical Service Corps

MTF
medical treatment facility

NAC
National Agency Check

OTSG
Officer of The Surgeon General

PA
physician assistant

R&D
research and development

RDTE
research, development, test, and evaluation

SDO
staff duty officer

SSI
specialty skills identifier

TDA
table of distribution and allowances

TJAG
The Judge Advocate General

TOE
table of organization and equipment

TSG
The Surgeon General

USAR
US Army Reserve

VC
Veterinary Corps

Section II
Terms
This section contains no entries.

Section III
Special Abbreviations and Terms
This section contains no entries.

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C

Army Regulation 15–6

Boards, Commissions, and Committees

Procedures for Investigating Officers and Boards of Officers

Headquarters
Department of the Army
Washington, DC
2 October 2006

UNCLASSIFIED

TABC

SUMMARY of CHANGE

AR 15-6
Procedures for Investigating Officers and Boards of Officers

This rapid action revision, dated 2 October 2006--

- Clarifies the distinction between levels of appointing authorities for hostile fire death investigations and friendly fire death investigations (para 2-1a(3)).

- Permits the general court-martial convening authority to delegate appointing authority to the special court-martial convening authority in hostile fire death investigations (para 2-1a(3)).

This regulation, dated 30 September 1996--

- Is a complete revision of the earlier regulation dated 24 August 1977.

- Updates policies and procedures concerning the procedures for investigating officers and boards of officers.

Headquarters
Department of the Army
Washington, DC
2 October 2006

*Army Regulation 15–6

Effective 2 November 2006

Boards, Commissions, and Committees

Procedures for Investigating Officers and Boards of Officers

By Order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official:

JOYCE E. MORROW
Administrative Assistant to the Secretary of the Army

History. This publication is a rapid action revision. The portions affected by this rapid action revision are listed in the summary of change.

Summary. This regulation establishes procedures for investigations and boards of officers not specifically authorized by any other directive.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. During mobilization, chapters and policies contained in this regulation may be modified by the proponent.

Proponent and exception authority. The proponent of this regulation is The Judge Advocate General. The Judge Advocate General has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The Judge Advocate General may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

Army management control process. This regulation does not contain management control provisions.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from HQDA (DAJA–AL), Washington, DC 20310–2212.

Suggested improvements. The proponent agency of this regulation is the Office of The Judge Advocate General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DAJA–AL), Washington, DC 20310–2212.

Distribution. This publication is available in electronic media only and is intended for command level A for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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*This regulation supersedes AR 15–6 dated 30 September 1996.

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Chapter 1
Introduction

1–1. Purpose

This regulation establishes procedures for investigations and boards of officers not specifically authorized by any other directive. This regulation or any part of it may be made applicable to investigations or boards that are authorized by another directive, but only by specific provision in that directive or in the memorandum of appointment. In case of a conflict between the provisions of this regulation, when made applicable, and the provisions of the specific directive authorizing the investigation or board, the latter will govern. Even when not specifically made applicable, this regulation may be used as a general guide for investigations or boards authorized by another directive, but in that case its provisions are not mandatory.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

Responsibilities are listed in chapter 2.

1–5. Types of investigations and boards

a. General. An administrative fact-finding procedure under this regulation may be designated an investigation or a board of officers. The proceedings may be informal (chap 4) or formal (chap 5). Proceedings that involve a single investigating officer using informal procedures are designated investigations. Proceedings that involve more than one investigating officer using formal or informal procedures or a single investigating officer using formal procedures are designated a board of officers.

b. Selection of procedure.

(1) In determining whether to use informal or formal procedures, the appointing authority will consider these among other factors:

(a) Purpose of the inquiry.

(b) Seriousness of the subject matter.

(c) Complexity of issues involved.

(d) Need for documentation.

(e) Desirability of providing a comprehensive hearing for persons whose conduct or performance of duty is being investigated. (See paras 1–8, 4–3, and 5–4*a*.)

(2) Regardless of the purpose of the investigation, even if it is to inquire into the conduct or performance of a particular individual, formal procedures are not mandatory unless required by other applicable regulations or directed by higher authority.

(3) Unless formal procedures are expressly required, either by the directive authorizing the board or by the memorandum of appointment, all cases to which this regulation applies will use informal procedures.

(4) In determining which procedures to use, the appointing authority will seek the advice of the servicing judge advocate (JA).

(5) Before opening an investigation involving allegations against general officers or senior executive service civilians, the requirements of Army Regulation (AR) 20–1, subparagraph 8–3*i*(3) must be met.

c. Preliminary investigations. Even when formal procedures are contemplated, a preliminary informal investigation may be advisable to ascertain the magnitude of the problem, to identify and interview witnesses, and to summarize or record their statements. The formal board may then draw upon the results of the preliminary investigation.

d. Concurrent investigations. An administrative fact finding procedure under this regulation, whether designated as an investigation or a board of officers, may be conducted before, concurrently with, or after an investigation into the same or related matters by another command or agency, consistent with subparagraph *b*(5) above. Appointing authorities, investigating officers, and boards of officers will ensure that procedures under this regulation do not hinder or interfere with a concurrent investigation directed by higher headquarters, a counterintelligence investigation or an investigation being conducted by a criminal investigative. In cases of concurrent or subsequent investigations, coordinatins, coordination with the other command or agency will be made to avoid duplication of investigative effort, where possible.

1–6. Function of investigations and boards

The primary function of any investigation or board of officers is to ascertain facts and to report them to the appointing authority. It is the duty of the investigating officer or board to ascertain and consider the evidence on all sides of each

issue, thoroughly and impartially, and to make findings and recommendations that are warranted by the facts and that comply with the instructions of the appointing authority.

1–7. Interested persons

Appointing authorities have a right to use investigations and boards to obtain information necessary or useful in carrying out their official responsibilities. The fact that an individual may have an interest in the matter under investigation or that the information may reflect adversely on that individual does not require that the proceedings constitute a hearing for that individual.

1–8. Respondents

In formal investigations the appointing authority may designate one or more persons as respondents in the investigation. Such a designation has significant procedural implications. (See chap 5, sec II, in general, and para 5–4*a*, in particular.) Respondents may not be designated in informal investigations.

1–9. Use of results of investigations in adverse administrative actions

a. This regulation does not require that an investigation be conducted before adverse administrative action, such as relief for cause, can be taken against an individual. However, if an investigation is conducted using the procedures of this regulation, the information obtained, including findings and recommendations, may be used in any administrative action against an individual, whether or not that individual was designated a respondent, and whether formal or informal procedures were used, subject to the limitations of *b* and *c* below.

b. The Office of Personnel Management and Army Regulations establish rules for adverse actions against Army civilian personnel and establish the procedural safeguards. In every case involving contemplated formal disciplinary action against civilian employees, the servicing civilian personnel office and labor counselor will be consulted before the employee is notified of the contemplated adverse action.

c. Except as provided in *d* below, when adverse administrative action is contemplated against an individual (other than a civilian employee, see *b* above), including an individual designated as a respondent, based upon information obtained as a result of an investigation or board conducted pursuant to this regulation, the appropriate military authority must observe the following minimum safeguards before taking final action against the individual:

(1) Notify the person in writing of the proposed adverse action and provide a copy, if not previously provided, of that part of the findings and recommendations of the investigation or board and the supporting evidence on which the proposed adverse action is based.

(2) Give the person a reasonable opportunity to reply in writing and to submit relevant rebuttal material.

(3) Review and evaluate the person's response.

d. There is no requirement to refer the investigation to the individual if the adverse action contemplated is prescribed in regulations or other directives that provide procedural safeguards, such as notice to the individual and opportunity to respond. For example, there is no requirement to refer an investigation conducted under this regulation to a soldier prior to giving the soldier an adverse evaluation report based upon the investigation because the regulations governing evaluation reports provide the necessary procedural safeguards.

e. When the investigation or board is conducted pursuant to this regulation but the contemplated administrative action is prescribed by a different regulation or directive with more stringent procedural safeguards than those in *c* above, the more stringent safeguards must be observed.

Chapter 2
Responsibilities of the Appointing Authority

2–1. Appointment

a. Authority to appoint. The following people may appoint investigations or boards to inquire into matters within their areas of responsibility.

(1) Except as noted in subparagraph 2–1*a*(3) below, the following individuals may appoint a formal investigation or board (chap 5) after consultation with the servicing judge advocate (JA) or legal advisor (LA):

(a) Any general court–martial (GCM) or special court–martial convening authority, including those who exercise that authority for administrative purposes only.

(b) Any general officer.

(c) Any commander or principal staff officer in the grade of colonel or above at the installation, activity, or unit level.

(d) Any State adjutant general.

(e) A Department of the Army civilian supervisor permanently assigned to a position graded as a general schedule

(GS)/general management, grade 14 or above and who is assigned as the head of an Army agency or activity or as a division or department chief.

(2) Except as noted in subparagraph 2–1*a*(3), the following individuals may appoint an informal investigation or board (chap 4):

(a) Any officer authorized to appoint a formal board.

(b) A commander at any level.

(c) A principal staff officer or supervisor in the grade of major or above.

(3) Only a general court–martial convening authority may appoint a formal investigation or board (chap 5) or an informal investigation or board (chap 4) for incidents resulting in property damage of $1,000,000 or more, the loss or destruction of an Army aircraft or missile, an injury and/or illness resulting in, or likely to result in, permanent total disability, the death of one or more persons, and the death of one or more persons by fratricide/friendly fire.

(a) For investigations of a death or deaths involving a deployed force(s), from what is believed to be hostile fire, the general court-martial convening authority may delegate, in writing, appointing/approval authority to a subordinate commander exercising special court-martial convening authority. This authority may not be further delegated.

(b) If evidence is discovered during a hostile fire investigation that indicates that the death(s) may have been the result of fratricide/friendly fire, the investigating officer will immediately suspend the investigation and inform the appointing authority and legal advisor. At this time the general court-martial convening authority will appoint a new investigation into the fratricide/friendly fire incident. Any evidence from the hostile fire investigation may be provided to the investigating officer or board conducting the fratricide/friendly fire investigation.

(4) Appointing authorities who are general officers may delegate the selection of board members to members of their staffs.

(5) When more than one appointing authority has an interest in the matter requiring investigation, a single investigation or board will be conducted whenever practicable. In case of doubt or disagreement as to who will appoint the investigation or board, the first common superior of all organizations concerned will resolve the issue.

(6) Appointing authorities may request, through channels, that persons from outside their organizations serve on boards or conduct investigations under their jurisdictions.

b. Method of appointment. Informal investigations and boards may be appointed orally or in writing. Formal boards will be appointed in writing but, when necessary, may be appointed orally and later confirmed in writing. Any written appointment will be in the form of a memorandum of appointment. (See figs 2–1 through 2–5.) Whether oral or written, the appointment will specify clearly the purpose and scope of the investigation or board and the nature of the findings and recommendations required. If the appointment is made under a specific directive, that directive will be cited. If the procedures of this regulation are intended to apply, the appointment will cite this regulation and, in the case of a board, specify whether it is to be informal or formal. (Refer to chaps 4 and 5.) Any special instructions (for example, requirement for verbatim record or designation of respondents in formal investigations) will be included.

c. Who may be appointed. Investigating officers and board members shall be those persons who, in the opinion of the appointing authority, are best qualified for the duty by reason of their education, training, experience, length of service and temperament.

(1) Except as provided in paragraph 5–1*e*, only commissioned officers, warrant officers, or Department of the Army civilian employees permanently assigned to a position graded as a GS–13 or above will be appointed as investigating officers or voting members of boards.

(2) Recorders, legal advisors, and persons with special technical knowledge may be appointed to formal boards in a nonvoting capacity. (See para 5–1.)

(3) An investigating officer or voting member of a board will be senior to any person whose conduct or performance of duty may be investigated, or against whom adverse findings or recommendations that may be made, except when the appointing authority determines that it is impracticable because of military exigencies. Inconvenience in obtaining an investigating officer or the unavailability of senior persons within the appointing authority's organization would not normally be considered military exigencies.

(a) The investigating officer or board president will, subject to the approval of the appointing authority, determine the relative senority of military and civilian personnel. Actual superior/subordinate relationships, relative duty requirements, and other sources may be used as guidance. Except where a material adverse effect on an individual's substantial rights results, the appointing authority's determination of senority shall be final (see para 2–3*c*).

(b) An investigating officer or voting member of a board who, during the proceedings, discovers that the completion thereof requires examining the conduct or performance of duty of, or may result in findings or recommendations adverse, to, a person senior to him or her will report this fact to the board president or the appointing authority. The appointing authority will then appoint another person, senior to the person affected, who will either replace the investigating officer or member, or conduct a separate inquiry into the matters pertaining to that person. Where necessary, the new investigating officer or board may be furnished any evidence properly considered by the previous investigating officer or board.

(c) If the appointing authority determines that military exigencies make these alternatives impracticable, the appointing authority may direct the investigating officer or member to continue. In formal proceedings, this direction will be

written and will be an enclosure to the report of proceedings. If the appointing authority does not become aware of the problem until the results of the investigation are presented for review and action, the case will be returned for new or supplemental investigation only where specific prejudice is found to exist.

(4) Specific regulations may require that investigating officers or board members be military officers, be professionally certified, or possess an appropriate security clearance.

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: *(President)*

SUBJECT: Appointment of Board of Officers

1. A board of officers is hereby appointed pursuant to AR 735–5 and AR 15–6 to investigate the circumstances connected with the loss, damage, or destruction of the property listed on reports of survey referred to the board and to determine responsibility for the loss, damage, or destruction of such property.

2. The following members are appointed to the board:

MAJ Robert A. Jones, HHC, 3d Bn, 1st Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Member (President)

CPT Paul R. Wisniewski, Co A, 2d Bn, 3d Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Member

CPT David B. Braun, Co C, 1st Bn, 3d Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Member

CPT John C. Solomon, HHC, 2d S & T Bn, DISCOM 20th Inf Div, Ft Blank, WD 88888 Alternate member (see AR 15–6, para 5–2c)

1LT Steven T. Jefferson, Co B, 2d Bn, 2d Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Recorder (without vote)

3. The board will meet at the call of the President. It will use the procedures set forth in AR 735–5 and AR 15–6 applicable to formal boards with respondents. Respondents will be referred to the board by separate correspondence.

4. Reports of proceedings will be summarized (the findings and recommendations will be verbatim) and submitted to this headquarters, ATTN: ABCD–AG–PA. Reports will be submitted within 3 working days of the conclusion of each case. The Adjutant General's office will furnish necessary administrative support for the board. Legal advice will be obtained, as needed, from the Staff Judge Advocate's office.

5. The board will serve until further notice.

(Authority Line)

(Signature block)

CF: *(Provide copy to board personnel)*

Figure 2–1. Sample memorandum for appointment of a standing board of officers using formal procedures

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(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: *(President of standing board)*

SUBJECT: Referral of Respondent

1. Reference memorandum, this headquarters, dated *(day–month–year)*, subject: Appointment of Board of Officers.

2. *(Enter rank, name, SSN, and unit)* is hereby designated a respondent before the board appointed by the referenced memorandum. The board will consider whether *(enter name of respondent)* should be held pecuniarily liable for the loss, damage, or destruction of the property listed on the attached report of survey. The correspondence and supporting documentation recommending referral to a board of officers are enclosed.

3. *(Enter rank, name, branch, and unit)* is designated counsel for *(enter name of respondent)*.

4. For the consideration of this case only, *(enter rank, name, and unit)* is designated a voting member of the board, vice *(enter rank, name, and unit)*.

(Authority line)
Encl

(Signature block)

CF: *(Provide copy to board personnel, counsel, and respondent)*

Figure 2–2. Sample memorandum for referral of a respondent to a standing board

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: *(Officer concerned)*

SUBJECT: Appointment as a Board of Officers to Investigate Alleged Corruption and Mismanagement

1. You are hereby appointed a board of officers, pursuant to AR 15–6, to investigate allegations of *(enter subject matter to be investigated, such as corruption and mismanagement in the office of the Fort Blank Provost Marshal)*. The scope of your investigation will include *(mention specific matters to be investigated, such as whether military police personnel are properly processing traffic tickets, whether supervisory personnel are receiving money or other personal favors from subordinate personnel in return for tolerating the improper processing of traffic tickets, and so forth)*. Enclosed herewith is a report of proceedings of an earlier informal investigation into alleged improper processing of traffic tickets that was discontinued when it appeared that supervisory personnel may have been involved.

2. As the board, you will use formal procedures under AR 15–6.*(Enter duty positions, ranks, and names)* are designated respondents. Additional respondents may be designated based on your recommendations during the course of the investigation. Counsel for each respondent, if requested, will be designated by subsequent correspondence.

3. *(Enter rank, name, branch, and unit)* will serve as legal advisor to you, the board. *(Enter rank, name, duty position, and unit)*, with the concurrence of *(his)(her)* commander, will serve as an advisory member of the board. The office of the adjutant general, this headquarters, will provide necessary administrative support. The Fort Blank Resident Office, Criminal Investigation Division Command (CIDC), will provide technical support, including preserving physical evidence, if needed.

4. Prepare the report of proceedings on DA Form 1574 and submit it to me within 60 days.

(Signature of appointing authority)

CF: *(Provide copy to all parties concerned)*

Figure 2–3. Sample memorandum for appointment of a single officer as a board of officers, with legal advisor and advisory member, using formal procedures

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: *(Officer concerned)*

SUBJECT: Appointment of Investigating Officer

1. You are hereby appointed an investigating officer pursuant to AR 15–6 and AR 210–7, paragraph 4–3, to conduct an informal investigation into complaints that sales representatives of the *Fly–By–Night* Sales Company have been conducting door–to–door solicitation in the River Bend family housing area in violation of AR 210–7. Details pertaining to the reported violations are in the enclosed file prepared by the Commercial Solicitation Branch, Office of the Adjutant General, this headquarters (Encl).

2. In your investigation, all witness statements will be sworn. From the evidence, you will make findings whether the Fly–By–Night Sales Company has violated AR 210–7 and recommend whether to initiate a show cause hearing pursuant to AR 210–7, paragraph 4–5, and whether to temporarily suspend the company's or individual agents' solicitation privileges pending completion of the show cause hearing.

3. Submit your findings and recommendations in four copies on DA Form 1574 to this headquarters, ATTN: ABCD–AG, within 7 days.

(Authority line)

Encl

(Signature block)

Figure 2–4. Sample memorandum for appointment of an investigating officer under AR 15–6 and other directives

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: *(Officer concerned)*

SUBJECT: Appointment as Investigating Officer

1. You are hereby appointed an investigating officer pursuant to AR 15–6 and AR 380–5, paragraph 10–8, to investigate the circumstances surrounding the discovery of a CONFIDENTIAL document in a trash can in the office of the 3d Battalion S–3 on 31 August 1987. A preliminary inquiry into the incident proved inconclusive (see enclosed report).

2. In your investigation, use informal procedures under AR 15–6. You will make findings as to whether security compromise has occurred, who was responsible for any security violation, and whether existing security procedures are adequate.

3. This incident has no known suspects at this time. If in the course of your investigation you come to suspect that certain people may be responsible for the security violation, you must advise them of their rights under the UCMJ, Article 31, or the Fifth Amendment, as appropriate. In addition, you must provide them a Privacy Act statement before you solicit any (further) personal information. You may obtain assistance with these legal matters from the office of the Staff Judge Advocate.

4. Submit your findings and recommendations on DA Form 1574 to the Brigade S–2 within 10 days.

(Authority line)

(Signature block)

Figure 2–5. Sample memorandum for appointment of an investigating officer in a case with potential Privacy Act implications

2–2. Administrative support

The appointing authority will arrange necessary facilities, clerical assistance, and other administrative support for investigating officers and boards of officers. If not required by another directive, a verbatim transcript of the proceedings may be authorized only by The Judge Advocate General (TJAG) or the GCM convening authority in his or her sole discretion. However, before authorization, the GCM convening authority will consult the staff judge advocate (SJA). A contract reporter may be employed only for a formal board and only if authorized by the specific directive under which the board is appointed. A contract reporter will not be employed if a military or Department of the Army

(DA) civilian employee reporter is reasonably available. The servicing JA will determine the availability of a military or DA civilian employee reporter.

2–3. Action of the appointing authority

a. Basis of decision. Unless otherwise provided by another directive, the appointing authority is neither bound nor limited by the findings or recommendations of an investigation or board. Therefore, the appointing authority may take action less favorable than that recommended with regard to a respondent or other individual, unless the specific directive under which the investigation or board is appointed provides otherwise. The appointing authority may consider any relevant information in making a decision to take adverse action against an individual, even information that was not considered at the investigation or board (see para 1–9*c* and *d*). In all investigations involoving fratricide/friendly fire incidents (see AR 385–40), the appointing authority, after taking action on the investigation, will forward a copy of the completed investgation to the next higher Army headquarters for review.

b. Legal review. Other directives that authorize investigations or boards may require the appointing authority to refer the report of proceedings to the servicing JA for legal review. The appointing authority will also seek legal review of all cases involving serious or complex matters, such as where the incident being investigated has resulted in death or serious bodily injury, or where the findings and recommendations may result in adverse administrative action (see para 1–9), or will be relied upon in actions by higher headquarters. The JA's review will determine—

(1) Whether the proceedings comply with legal requirements.

(2) What effects any errors would have.

(3) Whether sufficient evidence supports the findings of the investigation or board or those substituted or added by the appointing authority (see para 3–10*b*).

(4) Whether the recommendations are consistent with the findings.

c. Effect of errors. Generally, procedural errors or irregularities in an investigation or board do not invalidate the proceeding or any action based on it.

(1) *Harmless errors.* Harmless errors are defects in the procedures or proceedings that do not have a material adverse effect on an individual's substantial rights. If the appointing authority notes a harmless error, he or she may still take final action on the investigation.

(2) *Appointing errors.* Where an investigation is convened or directed by an official without the authority to do so (see para 2–1*a*), the proceedings are a nullity, unless an official with the authority to appoint such an investigation or board subsequently ratifies the appointment. Where a formal board is convened by an official authorized to convene an informal investigation or board but not authorized to convene formal investigations, any action not requiring a formal investigation may be taken, consistent with paragraph 1–9 and this paragraph.

(3) *Substantial errors.*

(a) Substantial errors are those that have a material adverse effect on an individual's substantial rights. Examples are the failure to meet requirements as to composition of the board or denial of a respondent's right to counsel.

(b) When such errors can be corrected without substantial prejudice to the individual concerned, the appointing authority may return the case to the same investigating officer or board for corrective action. Individuals or respondents who are affected by such a return will be notified of the error, of the proposed correction, and of their rights to comment on both.

(c) If the error cannot be corrected, or cannot be corrected without substantial prejudice to the individual concerned, the appointing authority may not use the affected part of that investigation or board as the basis for adverse action against that person. However, evidence considered by the investigation or board may be used in connection with any action under the Uniform Code of Military Justice (UCMJ), civilian personnel regulations, AR 600–37, or any other directive that contains its own procedural safeguards.

(d) In case of an error that cannot be corrected otherwise, the appointing authority may set aside all findings and recommendations and refer the entire case to a new investigating officer or board composed entirely of new voting members. Alternatively, the appointing authority may take action on findings and recommendations not affected by the error, set aside the affected findings and recommendations, and refer the affected portion of the case to a new investigating officer or board. In either case, the new investigating officer or board may be furnished any evidence properly considered by the previous one. The new investigating officer or board may also consider additional evidence. If the directive under which a board is appointed provides that the appointing authority may not take less favorable action than the board recommends, the appointing authority's action is limited by the original recommendations even though the case subsequently is referred to a new board which recommends less favorable action.

(4) *Failure to object.* No error is substantial within the meaning of this paragraph if there is a failure to object or otherwise bring the error to the attention of the legal advisor or the president of the board at the appropriate point in the proceedings. Accordingly, errors described in (3) above may be treated as harmless if the respondent fails to point them out.

Chapter 3
General Guidance for Investigating Officers and Boards

Section I
Conduct of the Investigation

3–1. Preliminary responsibilities
Before beginning an informal investigation, an investigating officer shall review all written materials provided by the appointing authority and consult with the servicing staff or command judge advocate to obtain appropriate legal guidance.

3–2. Oaths
a. Requirement. Unless required by the specific directive under which appointed, investigating officers or board members need not be sworn. Reporters, interpreters, and witnesses appearing before a formal board will be sworn. Witnesses in an informal investigation or board may be sworn at the discretion of the investigating officer or president. The memorandum of appointment may require the swearing of witnesses or board members.

b. Administering oaths. An investigating officer, recorder (or assistant recorder), or board member is authorized to administer oaths in the performance of such duties, under UCMJ, Art. 136 (for military personnel administering oaths) and Section 303, Title 5, United States Code (5 USC 303) (for civilian personnel administering oaths) (see fig 3–1 for the format for oaths).

3–3. Challenges
Neither an investigating officer nor any member of a board is subject to challenge, except in a formal board as provided in paragraph 5–7. However, any person who is aware of facts indicating a lack of impartiality or other qualification on the part of an investigating officer or board member will present the facts to the appointing authority.

3–4. Counsel
Only a respondent is entitled to be represented by counsel (see para 5–6). Other interested parties may obtain counsel, at no expense to the Government, who may attend but not participate in proceedings of the investigation or board which are open to the public. The proceedings will not be unduly interrupted to allow the person to consult with counsel. When a civilian employee is a member of an appropriate bargaining unit, the exclusive representative of the unit has the right to be present whenever the employee is a respondent or witness during the proceedings if requested by the employee and if the employee reasonably believes that the inquiry could lead to disciplinary action against him or her (see para 3–8).

3–5. Decisions
A board composed of more than one member arrives at findings and recommendations as provided in section II of this chapter. A formal board decides challenges by a respondent as provided in paragraph 5–7. The investigating officer or president decides administrative matters, such as time of sessions, uniform, and recess. The legal advisor or, if none, the investigating officer or president decides evidentiary and procedural matters, such as motions, acceptance of evidence, and continuances. The legal advisor's decisions are final. Unless a voting member objects to the president's decision on an evidentiary or procedural matter at the time of the decision, it too is final. If there is such an objection, a vote will be taken in closed session, and the president's decision may be reversed by a majority vote of the voting members present.

3–6. Presence of the public and recording of proceedings
a. The public. Proceedings of an investigation or board are normally open to the public only if there is a respondent. However, if a question arises, the determination will be made based on the circumstances of the case. It may be appropriate to open proceedings to the public, even when there is no respondent, if the subject matter is of substantial public interest. It may be appropriate to exclude the public from at least some of the proceedings even though there is a respondent, if the subject matter is classified, inflammatory, or otherwise exceptionally sensitive. In any case, the appointing authority may specify whether the proceedings will be open or closed. If the appointing authority does not specify, the investigating officer or the president of the board decides. If there is a respondent, the servicing JA or the legal advisor, if any, will be consulted before deciding to exclude the public from any portion of the proceedings. Any proceedings that are open to the public will also be open to representatives of the news media.

b. Recording. Neither the public nor the news media will record, photograph, broadcast, or televise the board proceedings. A respondent may record proceedings only with the prior approval of the appointing authority.

Preliminary Matters

PRES: This hearing will come to order. This board of officers has been called to determine_____

*When RESP is without counsel:*_____

PRES:_____, you may, if you desire, obtain civilian counsel at no expense to the Government for this hearing. If you do not obtain civilian counsel, you are entitled to be represented by a military counsel designated by the appointing authority. Do you have counsel?

RESP: No (Yes).

If RESP has counsel, the RCDR should identify that counsel at this point for the record. If RESP does not have counsel, the PRES should ask this question:

PRES: Do you desire to have military counsel?

RESP: Yes (No).

If RESP answers "yes," the PRES should adjourn the hearing and ask the appointing authority to appoint counsel for RESP (see para 5–6b). If counsel is supplied, the RCDR should identify that counsel for the record when the board reconvenes.

A reporter and an interpreter, if used, should be sworn.

RCDR: The reporter will be sworn.

RCDR: Do you swear (or affirm) that you will faithfully perform the duties of reporter to this board, (so help you God)?

REPORTER: I do.

RCDR: The interpreter will be sworn.

RCDR: Do you swear (or affirm) that you will faithfully perform the duties of interpreter in the case now in hearing, (so help you God)?

INTERPRETER: I do.

RCDR: The board is appointed by Memorandum of Appointment, Headquarters,_____, dated_____ Have all members of the board read the memorandum of appointment? (If not, the memorandum of appointment is read aloud by RCDR or silently by any member who has not read it.)

When RESP has been designated by a separate memorandum of appointment, the same procedure applies to that memorandum of appointment.

RCDR: May the memorandum of appointment be attached to these proceedings as Enclosure 1?

PRES: The memorandum of appointment will be attached as requested.

RCDR: The following members of the board are present:

The following members are absent:

RCDR should account for all personnel of the board, including RESP and COUNSEL, if any, as present or absent at each session. RCDR should state the reason for any absence, if known, and whether the absence was authorized by the appointing authority.

PRES:_____, you may challenge any member of the board (or the legal advisor) for lack of impartiality. Do you desire to make a challenge?

Figure 3–1. Suggested procedure for board of officers with respondents

RESP (COUNSEL): No. (The respondent challenges_____)

If RESP challenges for lack of impartiality, the LA, PRES, or next senior member, as appropriate, determines the challenge. See paragraph 5–7. If sustaining a challenge results in less than a quorum, the board should recess until additional members are added. See paragraph 5–2b.

RCDR swears board members, if required. PRES then swears RCDR, if required.

RCDR: The board will be sworn.

All persons in the room stand while RCDR administers the oath. Each voting member raises his or her right hand as RCDR calls his or her name in administering the following oath:

RCDR: Do you, Colonel_____, Lieutenant Colonel_____, Major_____, swear (affirm) that you will faithfully perform your duties as a member of this board; that you will impartially examine and inquire into the matter now before you according to the evidence, your conscience, and the laws and regulations provided; that you will make such findings of fact as are supported by the evidence of record; that, in determining those facts, you will use your professional knowledge, best judgment, and common sense; and that you will make such recommendations as are appropriate and warranted by your findings, according to the best of your understanding of the rules, regulations, policies, and customs of the service, guided by your concept of justice, both to the Government and to individuals concerned, (so help you God)?

MEMBERS: I do.

The board members lower their hands but remain standing while the oath is administered to LA and to RCDR, if required.

PRES: Do you_____, swear (or affirm) that you will faithfully perform the duties of (legal advisor) (recorder) of this board, (so help you God)?

LA/RCDR: I do.

All personnel now resume their seats.

PRES may now give general advice concerning applicable rules for the hearing.

RCDR: The respondent was notified of this hearing on_____ 19_____.

RCDR presents a copy of the memorandum of notification with a certification that the original was delivered (or dispatched) to RESP (para 5–5) and requests that it be attached to the proceedings as Enclosure_____.

PRES: The copy of the memorandum of notification will be attached as requested.

Presentation of Evidence by the Recorder

RCDR may make an opening statement at this point to clarify the expected presentation of evidence.

RCDR then calls witnesses and presents other evidence relevant to the subject of the proceedings. RCDR should logically present the facts to help the board understand what happened. Except as otherwise directed by PRES, RCDR may determine the order of presentation of facts. The following examples are intended to serve as a guide to the manner of presentation, but not to the sequence.

RCDR: I request that this statement of (witness) be marked Exhibit_____ and received in evidence. This witness will not appear in person because_____.

LA (PRES): The statement will (not) be accepted.

RCDR may read the statement to the board if it is accepted.

RCDR: I request that this (documentary or real evidence) be marked as Exhibit_____ and received in evidence.

A foundation for the introduction of such evidence normally is established by a certificate or by testimony of a witness indicating its authenticity. LA (PRES) determines the adequacy of this foundation. If LA (PRES) has a reasonable basis to believe the evidence is what it purports to be, he or she may waive formal proof of authenticity.

Figure 3–1. Suggested procedure for board of officers with respondents—Continued

RCDR: The recorder and respondent have agreed to stipulate_____.

Before LA (PRES) accepts the stipulation, he or she should verify that RESP joins in the stipulation.

LA (PRES): The stipulation is accepted.

If the stipulation is in writing, it will be marked as an exhibit.

RCDR conducts direct examination of each witness called by RCDR or at the request of PRES or members. RESP or COUNSEL may then cross–examine the witness. PRES and members of the board may then question the witness, but PRES may control or limit questions by board members.

RCDR: The board calls_____ as a witness.

A military witness approaches and salutes PRES, then raises his or her right hand while RCDR administers the oath. A civilian witness does the same but without saluting. See MCM, Rules for Court–Martial 807, for further guidance with regard to oaths.

RCDR: Do you swear (or affirm) that the evidence you shall give in the case now in hearing shall be the truth, the whole truth, and nothing but the truth, (so help you God)?

If the witness desires to affirm rather than swear, the words "so help you God" will be omitted.

WITNESS: I do.

The witness then takes the witness chair. RCDR asks every witness the following question no matter who called the witness.

RCDR: What is your full name (grade, branch of service, organization, and station) (and address)?

Whenever it appears appropriate and advisable to do so, the board should explain the rights of a witness under Article 31 of the UCMJ or the Fifth Amendment to the Constitution. See paragraph 3–6e(5).

If the report of proceedings will be filed in a system of records under the witness's name, the board must advise that witness in accordance with the Privacy Act. See paragraph 3–7e. Normally, this requirement applies only to RESP.

RCDR then asks questions to develop the matter under consideration.

RCDR: The recorder has no further questions.

RESP (COUNSEL) may cross–examine the witness. RCDR may then conduct a redirect examination.

RCDR: Does the board have any questions?

Any board member wishing to question the witness should first secure the permission of PRES.

If RCDR and RESP (COUNSEL) wish to ask further questions after the board has examined the witness, they should seek permission from the PRES. PRES should normally grant such requests unless the questions are repetitive or go beyond the scope of questions asked by the board.

When all questioning has ended, PRES announces:

PRES: The witness is excused.

PRES may advise the witness as follows:

PRES: Do not discuss your testimony in this case with anyone other than the recorder, the respondent, or his or her counsel. If anyone else attempts to talk with you about your testimony, you should tell the person who originally called you as a witness.

Verbatim proceedings should indicate that the witness (except RESP) withdrew from the room.

Unless expressly excused from further attendance during the hearing, all witnesses remain subject to recall until the proceedings have ended. When a witness is recalled, the RCDR reminds such witness, after he or she has taken the witness stand:

RCDR: You are still under oath.

The procedure in the case of a witness called by the board is the same as outlined above for a witness called by RCDR.

Figure 3–1. Suggested procedure for board of officers with respondents—Continued

RCDR: I have nothing further to offer relating to the matter under consideration.

Presentation of Respondent's Evidence

RESP (COUNSEL): The respondent has (an) (no) opening statement.

RESP presents his or her stipulations, witnesses, and other evidence in the same manner as did RCDR. RCDR administers oath to all witnesses and asks the first question to identify the witness.

Should the RESP be called to the stand as a witness, the RCDR will administer the oath and ask the following preliminary questions, after which the procedure is the same as for other witnesses:

RCDR: What is your name, (grade, branch of service, organization, and station) (address, position, and place of employment)?

RESP:_____.

RCDR: Are you the respondent in this case?

RESP: Yes.

The board may advise RESP of his or her rights under Article 31 of the UCMJ, or the Fifth Amendment of the Constitution. See paragraph 3–6c(5).

If the report of proceedings will be filed in a system of records under RESP's name, the board must advise RESP in accordance with the Privacy Act. See paragraph 3–7e.

When RESP has concluded his or her case, RESP announces:

RESP (COUNSEL): The respondent rests.

RCDR: The recorder has no further evidence to offer in this hearing. Does the board wish to have any witnesses called or recalled?

PRES: It does (not).

Closing Arguments and Deliberations

PRES: You may proceed with closing arguments. RCDR: The recorder (has no) (will make an) opening argument.

RCDR may make the opening argument and, if any argument is made on behalf of RESP, the rebuttal argument. Arguments are not required (see para 5–9). If no argument is made, RESP or RCDR may say:

RESP (COUNSEL)/RCDR: The (respondent) (recorder) submits the case without argument.

PRES: The hearing is adjourned.

Adjourning the hearing does not end the duties of the board. It must arrive at findings based on the evidence and make recommendations supported by those findings. See chapter 3, section II. Findings and recommendations need not be announced to RESP, but in certain proceedings, such as elimination actions, they customarily are. RCDR is responsible for compiling the report of proceedings and submitting properly authenticated copies thereof to the appointing authority. See chapter 3, section III.

Legend
PRES: President of the board of officers.
LA: Legal Advisor
LA(PRES): Legal Advisor, if one has been appointed; otherwise the board President.
RCDR: Recorder (junior member of the board if no recorder has been appointed). (If the board consists of only one member, that member has the responsibilities of both PRES and RCDR.)
RESP: Respondent.
RESP (COUNSEL): Respondent or respondent's counsel, if any.

Figure 3–1. Suggested procedure for board of officers with respondents—Continued

3–7. Rules of evidence and proof of facts

a. General. Proceedings under this regulation are administrative, not judicial. Therefore, an investigating officer or board of officers is not bound by the rules of evidence for trials by courts–martial or for court proceedings generally. Accordingly, subject only to the provisions of *c* below, anything that in the minds of reasonable persons is relevant and material to an issue may be accepted as evidence. For example, medical records, counseling statements, police reports, and other records may be considered regardless of whether the preparer of the record is available to give a statement or testify in person. All evidence will be given such weight as circumstances warrant. (See para 3–5 as to who decides whether to accept evidence.)

b. Official notice. Some facts are of such common knowledge that they need no specific evidence to prove them (for example, general facts and laws of nature, general facts of history, location of major elements of the Army, and organization of the Department of Defense (DOD) and its components), including matters of which judicial notice may be taken. (See Military Rules of Evidence (MRE) 201, sec II, part III, Manual for Courts-Martial, United States (MCM).)

c. Limitations. Administrative proceedings governed by this regulation generally are not subject to exclusionary or other evidentiary rules precluding the use of evidence. The following limitations, however, do apply:

(1) *Privileged communications.* MRE, section V, part III, MCM, concerning privileged communications between lawyer and client (MRE 502), privileged communications with clergy (MRE 503), and husband-wife privilege (MRE 504) apply. Present or former inspector general personnel will not be required to testify or provide evidence regarding information that they obtained while acting as inspectors general. They will not be required to disclose the contents of inspector general reports of investigations, inspections, inspector general action requests, or other memoranda, except as disclosure has been approved by the appropriate directing authority (an official authorized to direct that an inspector general investigation or inspection be conducted) or higher authority. (See AR 20–1, para 3–6.)

(2) *Polygraph tests.* No evidence of the results, taking, or refusal of a polygraph (lie detector) test will be considered without the consent of the person involved in such tests. In a formal board proceeding with a respondent, the agreement of the recorder and of any respondent affected is required before such evidence can be accepted.

(3) *"Off the record" statements.* Findings and recommendations of the investigating officer or board must be supported by evidence contained in the report. Accordingly, witnesses will not make statements "off the record" to board members in formal proceedings. Even in informal proceedings, such statements will not be considered for their substance, but only as help in finding additional evidence.

(4) *Statements regarding disease or injury.* A member of the Armed Forces will not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury that he or she has suffered. Any such statement against his or her interest is invalid (10 USC 1219) and may not be considered on the issue of the origin, incurrence, or aggravation of a disease or injury that the member concerned has suffered. A statement made and signed voluntarily by a soldier is not a statement that the soldier was "required to sign" within the meaning of this paragraph.

(5) *Ordering witnesses to testify.*

(a) No military witnesses or military respondents will be compelled to incriminate themselves, to answer any question the answer to which could incriminate them, or to make a statement or produce evidence that is not material to the issue and that might tend to degrade them (see UCMJ, Art. 31).

(b) No witnesses or respondents not subject to the UCMJ will be required to make a statement or produce evidence that would deprive them of rights against self-incrimination under the Fifth Amendment of the U.S. Constitution.

(c) A person refusing to provide information under (a) or (b) above must state specifically that the refusal is based on the protection afforded by UCMJ, Art. 31, or the Fifth Amendment. The investigating officer or board will, after consultation with the legal advisor or, if none has been appointed, the servicing JA, unless impractical to do so, decide whether the reason for refusal is well taken. If it is not, the witness may be ordered to answer.

(d) Whenever it appears appropriate and advisable, an investigating officer or board will explain their rights to witnesses or respondents. A soldier, for example, who is suspected of an offense under the UCMJ, such as dereliction of duty, will be advised of his or her rights under UCMJ, Art. 31, before being asked any questions concerning the suspected offense. The soldier will be given a reasonable amount of time to consult an attorney, if requested, before answering any such questions. No adverse inference will be drawn against soldiers who invoke that right under UCMJ, Art. 31. It is recommended that the procedure for explaining rights set forth on DA Form 3881 (Rights Warning Procedure/Waiver Certificate) be used.

(e) The right to invoke UCMJ, Art. 31, or the Fifth Amendment is personal. No one may assert the right for another person, and no one may assert it to protect anyone other than himself or herself. An answer tends to incriminate a person if it would make it appear that person is guilty of a crime.

(f) In certain cases the appropriate authority may provide a witness or respondent a grant of testimonial immunity

and require testimony notwithstanding UCMJ, Art. 31, or the Fifth Amendment. Grants of immunity will be made under the provisions of AR 27–10, chapter 2.

(6) *Involuntary admissions.* A confession or admission obtained by unlawful coercion or inducement likely to affect its truthfulness will not be accepted as evidence. The fact that a respondent was not advised of his or her rights under UCMJ, Art. 31, or the Fifth Amendment, or of his or her right to a lawyer does not, of itself, prevent acceptance of a confession or admission as evidence.

(7) *Bad faith unlawful searches.* If members of the Armed Forces acting in their official capacity (such as military police acting in furtherance of their official duties) conduct or direct a search that they know is unlawful under the Fourth Amendment of the U.S. Constitution, as applied to the military community, evidence obtained as a result of that search may not be accepted or considered against any respondent whose personal rights were violated by the search. Such evidence is acceptable only if it can reasonably be determined by the legal advisor or, if none, by the investigating officer or president that the evidence would inevitably have been discovered. In all other cases, evidence obtained as a result of any search or inspection may be accepted, even if it has been or would be ruled inadmissible in a criminal proceeding.

3–8. Witnesses

a. General.

(1) Investigating officers and boards generally do not have authority to subpoena witnesses to appear and testify. An appropriate commander or supervisor may, however, order military personnel and Federal civilian employees to appear and testify. Other civilians who agree to appear may be issued invitational travel orders in certain cases (see Joint Travel Regulations (JTR), vol 2, para C6000.11). The investigating officer or board president normally will inform witnesses of the nature of the investigation or board before taking their statements or testimony. The investigating officer or board president, assisted by the recorder and the legal advisor, if any, will protect every witness from improper questions, unnecessarily harsh or insulting treatment, and unnecessary inquiry into his or her private affairs. (See para 3–2 as to placing witnesses under oath.)

(2) During an investigation under this regulation, the exclusive representative of an appropriate bargaining unit has the right to be present whenever a civilian employee of the unit is a respondent or witness during the proceedings if requested by the employee and if the employee reasonably believes that the inquiry could lead to disciplinary action against him or her. Unless required by the collective bargaining agreement, there is no requirement to advise the employee of this right. If the employee requests the presence of the exclusive representative, a reasonable amount of time will be allowed to obtain him or her. The servicing civilian personnel office and labor counselor will be consulted before denying such a request.

b. Attendance as spectators. Witnesses other than respondents normally will not be present at the investigation or board proceedings except when they are testifying. In some cases, however, it is necessary to allow expert witnesses to hear evidence presented by other witnesses in order that they may be sufficiently advised of the facts to give informed testimony as to the technical aspects of the case. In such instances, the report of proceedings will indicate that the expert witnesses were present during the testimony of the other witnesses.

c. Taking testimony or statements.

(1) If a board is formal, or if the appointing authority has directed a verbatim record (see para 2–2), witnesses' statements will be elicited by questions and answers. However, narrative testimony may be used.

(2) In informal proceedings, statements of witnesses may be obtained at informal sessions in which they first relate their knowledge and then summarize those statements in writing. A tape recorder may be used to facilitate later preparation of written statements, but the witness will be informed if one is used. The investigating officer or board will assist the witness in preparing a written statement to avoid inclusion of irrelevant material or the omission of important facts and circumstances. However, care must be taken to ensure that the statement is phrased in the words of the witness. The interviewer must scrupulously avoid coaching the witness or suggesting the existence or nonexistence of material facts. The witness may be asked to read, correct, and sign the final statement.

(3) Whether the witness swears to the statement is within the discretion of the investigating officer or president. If the statement is to be sworn, use of DA Form 2823 (Sworn Statement) is recommended. If the witness is unavailable or refuses to sign, the person who took the statement will note, over his or her own signature, the reasons the witness has not signed and will certify that the statement is an accurate summary of what the witness said.

(4) Whether the proceeding is formal or informal, to save time and resources, witnesses may be asked to confirm written sworn or unsworn statements that have first been made exhibits. The witnesses remain subject to questioning on the substance of such statements.

(5) Although the direct testimony of witnesses is preferable, the investigating officer or board may use any previous statements of a witness as evidence on factual issues, whether or not the following conditions exist:

(a) Proceedings are formal or informal.

(b) Witness is determined to be unavailable.

(c) Witness testifies.

(d) Prior statements were sworn or unsworn.

(e) Prior statements were oral or written.

(f) Prior statements were taken during the course of the investigation.

d. Discussion of evidence. An investigating officer or board may direct witnesses who are subject to Army authority, and request other witnesses, not to discuss their statements or testimony with other witnesses or with persons who have no official interest in the proceedings until the investigation is complete. This precaution is appropriate to eliminate possible influence on the testimony of witnesses still to be heard. Witnesses may not be precluded from discussing any relevant matter with the recorder, a respondent, or counsel for a respondent.

e. Privacy Act statements.

(1) *When required.* A Privacy Act statement (AR 340–21) will be provided to a witness if the report of proceedings will be filed in a system of records from which it can be retrieved by reference to the name or other personal identifier of that witness. Unless otherwise informed by the appointing authority, an investigating officer or board may presume that the report of proceedings will be retrievable by the name of each person designated as a respondent, but that the report will not be retrievable by the name of any other witness. If any question arises as to the need for a Privacy Act statement, the investigating officer or board will consult the legal advisor, if any, or the servicing JA.

(2) *Method of providing statement.* Appendix B provides guidance for preparing Privacy Act statements. The statement may be written or oral, but it must be provided before taking the witness's testimony or statement. A written statement will be attached to the report of proceedings as an enclosure. An oral statement will be noted in the report either as part of a verbatim transcript or as an enclosure, in the form of a certificate by the officer who provided the Privacy Act statement.

(3) *Copy of the statement.* Anyone to whom this requirement applies is entitled to a copy of the Privacy Act statement in a form suitable for retention. Providing a respondent a copy of the part of the report of proceedings (see para 5–10) that includes the statement satisfies this requirement. Any other witness who is provided a Privacy Act statement will, on request, be furnished a copy of the statement in a form suitable for retention.

3–9. Communications with the appointing authority

If in the course of the investigation or board something happens that could cause the appointing authority to consider enlarging, restricting, or terminating the proceedings, altering the composition of the fact–finding body or otherwise modifying any instruction in the original appointment, the investigating officer or president of the board will report this situation to the appointing authority with recommendations.

Section II
Findings and Recommendations

3–10. Findings

a. General. A finding is a clear and concise statement of a fact that can be readily deduced from evidence in the record. It is directly established by evidence in the record or is a conclusion of fact by the investigating officer or board. Negative findings (for example, that the evidence does not establish a fact) are often appropriate. The number and nature of the findings required depend on the purpose of the investigation or board and on the instructions of the appointing authority. The investigating officer or board will normally not exceed the scope of findings indicated by the appointing authority. (See para 3–9.) The findings will be necessary and sufficient to support each recommendation.

b. Standard of proof. Unless another directive or an instruction of the appointing authority establishes a different standard, the findings of investigations and boards governed by this regulation must be supported by a greater weight of evidence than supports a contrary conclusion, that is, evidence which, after considering all evidence presented, points to a particular conclusion as being more credible and probable than any other conclusion. The weight of the evidence is not determined by the number of witnesses or volume of exhibits, but by considering all the evidence and evaluating such factors as the witness's demeanor, opportunity for knowledge, information possessed, ability to recall and relate events, and other indications of veracity.

c. Form. Findings will be stated to reflect clearly the relevant facts established by the evidence and the conclusions thereon of the investigating officer or board. If findings are required on only one subject, normally they will be stated in chronological order. If findings are required on several distinct subjects, they normally will be stated separately for each subject and chronologically within each one. If the investigation or board is authorized by a directive that establishes specific requirements for findings, those requirements must be satisfied.

3–11. Recommendations

The nature and extent of recommendations required also depend on the purpose of the investigation or board and on the instructions of the appointing authority. Each recommendation, even a negative one (for example, that no further action be taken) must be consistent with the findings. Investigating officers and boards will make their recommendations according to their understanding of the rules, regulations, policies, and customs of the service, guided by their concept of fairness both to the Government and to individuals.

3–12. Deliberation

After all the evidence has been received (and arguments heard, if there is a respondent), the investigating officer or board members will consider it carefully in light of any instructions contained in the original appointment and any supplemental instructions. These deliberations will (and if there is a respondent, must) be in closed session, that is, with only voting members present. Nonvoting members of the board do not participate in the board's deliberations but may be consulted. The respondent and the respondent's counsel, if any, will be afforded the opportunity to be present at such consultation. The board may request the legal advisor, if any, to assist in putting findings and recommendations in proper form after their substance has been adopted by the board. A respondent and counsel are not entitled to be present during such assistance.

3–13. Voting

A board composed of more than one voting member arrives at its findings and recommendations by voting. All voting members present must vote. After thoroughly considering and discussing all the evidence, the board will propose and vote on findings of fact. The board will next propose and vote on recommendations. If additional findings are necessary to support a proposed recommendation, the board will vote on such findings before voting on the related recommendation. Unless another directive or an instruction by the appointing authority establishes a different requirement, a majority vote of the voting members present determines questions before the board. In case of a tie vote, the president's vote is the determination of the board. Any member who does not agree with the findings or recommendations of the board may include a minority report in the report of proceedings, stating explicitly what part of the report he or she disagrees with and why. The minority report may include its own findings and/or recommendations.

Section III
Report of Proceedings

3–14. Format

a. Formal. If a verbatim record of the proceedings was directed, the transcript of those proceedings, with a completed DA Form 1574 (Report of Proceedings by Investigating Officer/Board of Officers) as an enclosure, and other enclosures and exhibits will constitute the report. In other formal boards, a completed DA Form 1574, with enclosures and exhibits, will constitute the report.

b. Informal. In an informal investigation or board, the report will be written unless the appointing authority has authorized an oral report. Written reports of informal investigations will use DA Form 1574; however, its use is not required unless specifically directed by the appointing authority. Every report—oral or written, on DA Form 1574 or not—will include findings and, unless the instructions of the appointing authority indicate otherwise, recommendations.

3–15. Enclosures

In written reports, all significant letters and other papers that relate to administrative aspects of the investigation or board and that are not evidence will be numbered consecutively with roman numerals and made enclosures, including such items as these:

a. The memorandum of appointment or, if the appointment was oral, a summary by the investigating officer or board including date of appointment, identification of the appointing authority and of all persons appointed, purpose of the investigation or board, and any special instructions.

b. Copies of the notice to any respondent (see para 5–5).

c. Copies of other correspondence with any respondent or counsel.

d. Written communications to or from the appointing authority (see para 3–8).

e. Privacy Act statements (see para 3–8*e*).

f. Explanation by the investigating officer or board of any unusual delays, difficulties, irregularities, or other problems encountered.

3–16. Exhibits

a. General. In written reports, every item of evidence offered to or received by the investigation or board will be marked as a separate exhibit. Unless a verbatim record was directed, statements or transcripts of testimony by witnesses will also be exhibits. Exhibits will be numbered consecutively as offered in evidence (even if not accepted), except that those submitted by each respondent will be lettered consecutively (and further identified by the name of the respondent, if more than one). Exhibits submitted but not admitted in evidence will be marked "Not admitted."

b. Real evidence. Because attaching real evidence (physical objects) to the report is usually impractical, clear and accurate descriptions (such as written statements) or depictions (such as photographs) authenticated by the investigating officer, recorder, or president may be substituted in the report. In any case, the real evidence itself will be preserved, including chain of custody, where appropriate, for use if further proceedings are necessary. The exhibit in the report will tell where the real evidence can be found. After final action has been taken in the case, the evidence will be disposed of as provided in AR 190–22, where applicable.

c. Documentary evidence. When the original of an official record or other document that must be returned is an exhibit, an accurate copy, authenticated by the investigating officer, recorder, or president, may be used in the written report. The exhibit in the report will tell where the original can be found.

d. Official notice. Matters of which the investigating officer or board took official notice (para 3–6*b*) normally need not be recorded in an exhibit. If, however, official notice is taken of a matter over the objection of a respondent or respondent's counsel, that fact will be noted in the written report of proceedings, and the investigating officer or board will include as an exhibit a statement of the matter of which official notice was taken.

e. Objections. In a formal board, if the respondent or counsel makes an objection during the proceedings, the objection and supporting reasons will be noted in the report of proceedings.

3–17. Authentication

Unless otherwise directed, a written report of proceedings will be authenticated by the signature of the investigating officer or of all voting members of the board and the recorder. Board members submitting a minority report (see para 3–13) may authenticate that report instead. If any voting member of the board or the recorder refuses or is unable to authenticate the report (for example, because of death, disability, or absence), the reason will be stated in the report where that authentication would otherwise appear.

3–18. Safeguarding a written report

a. When the report contains material that requires protection but does not have a security classification, the report will be marked "For Official Use Only" as provided by AR 25–55.

b. No one will disclose, release, or cause to be published any part of the report, except as required in the normal course of forwarding and staffing the report or as otherwise authorized by law or regulation, without the approval of the appointing authority.

3–19. Submission

A written report of proceedings will be submitted, in two complete copies, directly to the appointing authority or designee, unless the appointing authority or another directive provides otherwise. If there are respondents, an additional copy for each respondent will be submitted to the appointing authority.

3–20. Action of the appointing authority

The appointing authority will notify the investigating officer or president of the board if further action, such as taking further evidence or making additional findings or recommendations, is required. Such additional proceedings will be conducted under the provisions of the original appointing memorandum, including any modifications, and will be separately authenticated per paragraph 3–16. If applicable, the appointing authority will ensure that the provisions of paragraph 1–8 have been satisfied. (See para 2–3 for further guidance.)

Chapter 4
Informal Investigations and Boards of Officers

4–1. Composition

Informal procedures may be used by a single investigating officer or by a board of two or more members. (One officer is not designated a board unless procedures are formal.) All members are voting members. Appointment of advisory members or a legal advisor is unnecessary because persons with special expertise may be consulted informally whenever desired. The senior member present acts as president. There is no recorder. The president prescribes the duties of each member. A quorum is required only when voting on findings and recommendations. (See para 3–13.)

4–2. Procedure

An informal investigation or board may use whatever method it finds most efficient and effective for acquiring information. (See chap 3 for general guidance.) A board may divide witnesses, issues, or evidentiary aspects of the inquiry among its members for individual investigation and development, holding no collective meeting until ready to review all the information collected. Although witnesses may be called to present formal testimony, information also may be obtained by personal interview, correspondence, telephone inquiry, or other informal means.

4–3. Interested persons

Informal procedures are not intended to provide a hearing for persons who may have an interest in the subject of the investigation or board. No respondents will be designated and no one is entitled to the rights of a respondent. The

investigating officer or board may still make any relevant findings or recommendations, including those adverse to an individual or individuals.

Chapter 5
Formal Boards of Officers

Section I
General

5–1. Members

a. Voting members. All members of a formal board of officers are voting members except as provided elsewhere in this paragraph, in other applicable directives, or in the memorandum of appointment.

b. President. The senior voting member present acts as president. The senior voting member appointed will be at least a major, except where the appointing authority determines that such appointment is impracticable because of military exigencies. The president has the following responsibilities:

(1) *Administrative.* The president will—

(a) Preserve order.

(b) Determine time and uniform for sessions of the board.

(c) Recess or adjourn the board as necessary.

(d) Decide routine administrative matters necessary for efficient conduct of the business of the board.

(e) Supervise the recorder to ensure that all business of the board is properly conducted and that the report of proceedings is submitted promptly. If the board consists of only one member, that member has the responsibilities of both the president and the recorder.

(2) *Procedural.*

(a) When a legal advisor has been appointed, the legal advisor rules finally on matters set forth in paragraph *d* below.

(b) When a legal advisor has not been appointed, the president will rule on evidentiary and procedural matters. The ruling on any such matter (other than a challenge) may be reversed by majority vote of the voting members present. (See para 3–5.) If the president determines that he or she needs legal advice when ruling on evidentiary and procedural matters, he or she will contact the legal office that ordinarily provides legal advice to the appointing authority and ask that a JA or a civilian attorney who is a member of the Judge Advocate Legal Service be made available for legal consultation. When a respondent has been designated, the respondent and counsel will be afforded the opportunity to be present when the legal advice is provided.

c. Recorder. The memorandum of appointment may designate a commissioned or warrant officer as recorder. It may also designate assistant recorders, who may perform any duty the recorder may perform. A recorder or assistant recorder so designated is a nonvoting member of the board. If the memorandum of appointment does not designate a recorder, the junior member of the board acts as recorder and is a voting member.

d. Legal advisor.

(1) A legal advisor is a nonvoting member. He or she rules finally on challenges for cause made during the proceedings (except a challenge against the legal advisor (see para 5–7*c*)) and on all evidentiary and procedural matters (see para 3–5), but may not dismiss any question or issue before the board. In appropriate cases, the legal advisor may advise the board on legal and procedural matters. If a respondent has been designated, the respondent and counsel will be afforded the opportunity to be present when legal advice is provided to the board. If legal advice is not provided in person (for example, by telephone or in writing), the right to be "present" is satisfied by providing the opportunity to listen to or read the advice. The right to be present does not extend to general procedural advice given before the board initially convened, to legal advice provided before the respondent was designated, or to advice provided under paragraph 3–12.

(2) A JA or a civilian attorney who is a member of the Judge Advocate Legal Service may be appointed as legal advisor for a formal board of officers under the following circumstances:

(a) TJAG authorizes the appointment.

(b) Another directive applicable to the board requires the appointment.

(c) The appointing authority is a GCM convening authority.

(d) The appointing authority is other than a GCM convening authority, and a JA is assigned to his or her organization or a subordinate element thereof under an applicable table of organization and equipment or tables of distribution and allowances; or the appropriate GCM convening authority authorizes appointment of a legal adviser.

(3) Appointment of a legal advisor under this paragraph will occur only after consultation with the SJA of the GCM jurisdiction concerned. The SJA will then be responsible for providing or arranging for the legal advisor.

e. Members with special technical knowledge. Persons with special technical knowledge may be appointed as voting

members or, unless there is a respondent, as advisory members without vote. Such persons need not be commissioned or warrant officers. If appointed as advisory members, they need not participate in the board proceedings except as directed by the president. (See para 3–12 with regard to participation in the board's deliberations.) The report of proceedings will indicate the limited participation of an advisory member.

5–2. Attendance of members

a. General. Attendance at the proceedings of the board is the primary duty of each voting member and takes precedence over all other duties. A voting member must attend scheduled sessions of the board, if physically able, unless excused in advance by the appointing authority. If the appointing authority is a GCM convening authority or a commanding general with a legal advisor on his or her staff, the authority to excuse individual members before the first session of the board may be delegated to the SJA or legal advisor. The board may proceed even though a member is absent, provided the necessary quorum is present (see *d* below). If the recorder is absent, the assistant recorder, if any, or the junior member of the board will assume the duties of recorder. The board may then proceed at the discretion of the president.

b. Quorum. Unless another directive requires a larger number, a majority of the appointed voting members (other than nonparticipating alternate members) of a board constitutes a quorum and must be present at all sessions. If another directive prescribes specific qualifications for any voting member (for example, component, branch, or technical or professional qualifications), that member is essential to the quorum and must be present at all board sessions.

c. Alternate members. An unnecessarily large number of officers will not be appointed to a board of officers with the intention of using only those available at the time of the board's meeting. The memorandum of appointment may, however, designate alternate members to serve on the board, in the sequence listed, if necessary to constitute a quorum in the absence of a regular member. These alternate members may then be added to the board at the direction of the president without further consultation with the appointing authority. A member added thereby becomes a regular member with the same obligation to be present at all further proceedings of the board. (See subpara *a* above.)

d. Member not present at prior sessions. A member who has not been present at a prior session of the board, such as an absent member, an alternate member newly authorized to serve as a member, or a newly appointed member, may participate fully in all subsequent proceedings. The member must, however, become thoroughly familiar with the prior proceedings and the evidence. The report of proceedings will reflect how the member became familiar with the proceedings. Except as directed by the appointing authority, however, a member who was not available (because of having been excused or otherwise) for a substantial portion of the proceedings, as determined by the president, will no longer be considered a member of the board in that particular case, even if that member later becomes available to serve.

5–3. Duties of recorder

a. Before a session. The recorder is responsible for administrative preparation and support for the board and will perform the following duties before a session:

(1) Give timely notice of the time, place, and prescribed uniform for the session to all participants, including board members, witnesses, and, if any, legal advisor, respondent, counsel, reporter, and interpreter. Only the notice to a respondent required by paragraph 5–5 need be in writing. It is usually appropriate also to notify the commander or supervisor of each witness and respondent.

(2) Arrange for the presence of witnesses who are to testify in person, including attendance at Government expense of military personnel and civilian government employees ordered to appear and of other civilians voluntarily appearing pursuant to invitational travel orders. (See para 3–8*a*.)

(3) Ensure that the site for the session is adequate and in good order.

(4) Arrange for necessary personnel support (clerk, reporter, and interpreter), recording equipment, stationery, and other supplies.

(5) Arrange to have available all necessary Privacy Act statements and, with appropriate authentication, all required records, documents, and real evidence.

(6) Ensure, subject to security requirements, that all appropriate records and documents referred with the case are furnished to any respondent or counsel.

(7) Take whatever other action is necessary to ensure a prompt, full, and orderly presentation of the case.

b. During the session. The recorder will perform the following duties during the session:

(1) Read the memorandum of appointment at the initial session or determine that the participants have read it.

(2) Note for the record at the beginning of each session the presence or absence of the members of the board and, if any, the respondent and counsel.

(3) Administer oaths as necessary.

(4) Execute all orders of the board.

(5) Conduct the presentation of evidence and examination of witnesses to bring out all the facts.

c. After the proceedings. The recorder is responsible for the prompt and accurate preparation of the report of

proceedings, for the authentication of the completed report, and, whenever practicable, the hand–carried delivery of the report, including delivery to the appointing authority or designee.

Section II
Respondents

5–4. Designation

a. General. A respondent may be designated when the appointing authority desires to provide a hearing for a person with a direct interest in the proceedings. The mere fact that an adverse finding may be made or adverse action recommended against a person, however, does not mean that he or she will be designated a respondent. The appointing authority decides whether to designate a person as a respondent except where designation of a respondent is—

(1) Directed by authorities senior to the appointing authority; or

(2) Required by other regulations or directives or where procedural protections available only to a respondent under this regulation are mandated by other regulations or directives.

b. Before proceedings. When it is decided at the time a formal board is appointed that a person will be designated a respondent, the designation will be made in the memorandum of appointment.

c. During the proceedings.

(1) If, during formal board proceedings, the legal advisor or the president decides that it would be advisable to designate a respondent, a recommendation with supporting information will be presented to the appointing authority.

(2) The appointing authority may designate a respondent at any point in the proceedings. A respondent so designated will be allowed a reasonable time to obtain counsel (see para 5–6) and to prepare for subsequent sessions.

(3) If a respondent is designated during the investigation, the record of proceedings and all evidence received by the board to that point will be made available to the newly designated respondent and counsel. The respondent may request that witnesses who have previously testified be recalled for cross–examination. If circumstances do not permit recalling a witness, a written statement may be obtained. In the absence of compelling justification, the proceedings will not be delayed pending the obtaining of such statement. Any testimony given by a person as a witness may be considered even if that witness is subsequently designated a respondent.

5–5. Notice

The recorder will, at a reasonable time in advance of the first session of the board concerning a respondent (including a respondent designated during the proceedings), provide that respondent a copy of all unclassified documents in the case file and a letter of notification. In the absence of special circumstances or a different period established by the directive authorizing the board, a "reasonable time" is 5 working days. The letter of notification will include the following information:

a. The date, hour, and place of the session and the appropriate military uniform, if applicable.

b. The matter to be investigated, including specific allegations, in sufficient detail to enable the respondent to prepare.

c. The respondent's rights with regard to counsel. (See para 5–6.)

d. The name and address of each witness expected to be called.

e. The respondent's rights to be present, present evidence, and call witnesses. (See para 5–8*a*.)

f. (Only if the board involves classified matters.) The respondent and counsel may examine relevant classified materials on request and, if necessary, the recorder will assist in arranging clearance or access. (See AR 380–67.)

5–6. Counsel

a. Entitlement. A respondent is entitled to have counsel and, to the extent permitted by security classification, to be present with counsel at all open sessions of the board. Counsel may also be provided for the limited purpose of taking a witness's statement or testimony, if respondent has not yet obtained counsel. An appointed counsel will be furnished only to civilian employees or members of the military.

b. Who may act.

(1) *Civilian counsel.* Any respondent may be represented by civilian counsel not employed by and at no expense to the Government. A Government civilian employee may not act as counsel for compensation or if it would be inconsistent with faithful performance of regular duties. (See 18 USC 205.) In addition, a DA civilian employee may act as counsel only while on leave or outside normal hours of employment, except when acting as the exclusive representative of the bargaining unit pursuant to 5 USC 7114(a)(2)(B). (See para 3–4.)

(2) *Military counsel for military respondents.* A military respondent who does not retain a civilian counsel is entitled to be represented by a military counsel designated by the appointing authority. A respondent who declines the services of a qualified designated counsel is not entitled to have a different counsel designated.

(3) *Military counsel for civilian respondents.* In boards appointed under the authority of this regulation, Federal civilian employees, including those of nonappropriated fund instrumentalities, will be provided a military counsel under

the same conditions and procedures as if they were military respondents, unless they are entitled to be assisted by an exclusive representative of an appropriate bargaining unit.

c. Delay. Whenever practicable, the board proceedings will be held in abeyance pending respondent's reasonable and diligent efforts to obtain civilian counsel. However, the proceedings will not be delayed unduly to permit a respondent to obtain a particular counsel or to accommodate the schedule of such counsel.

d. Qualifications. Counsel will be sufficiently mature and experienced to be of genuine assistance to the respondent. Unless specified by the directive under which the board is appointed, counsel is not required to be a lawyer.

e. Independence. No counsel for a respondent will be censured, reprimanded, admonished, coerced, or rated less favorably as a result of the lawful and ethical performance of duties or the zeal with which he or she represents the respondent. Any question concerning the propriety of a counsel's conduct in the performance of his or her duty will be referred to the servicing JA.

5–7. Challenges for cause

a. Right of respondent. A respondent is entitled to have the matter at issue decided by a board composed of impartial members. A respondent may challenge for cause the legal advisor and any voting member of the board who does not meet that standard. Lack of impartiality is the only basis on which a challenge for cause may be made at the board proceedings. Any other matter affecting the qualification of a board member may be brought to the attention of the appointing authority. (See para 3–3.)

b. Making a challenge. A challenge will be made as soon as the respondent or counsel is aware that grounds exist; failure to do so normally will constitute a waiver. If possible, all challenges and grounds will be communicated to the appointing authority before the board convenes. When the board convenes, the respondent or counsel may question members of the board to determine whether to make a challenge. Such questions must relate directly to the issue of impartiality. Discretion will be used, however, to avoid revealing prejudicial matters to other members of the board; if a challenge is made after the board convenes, only the name of the challenged member will be indicated in open session, not the reason for believing the member is not impartial.

c. Deciding challenges. The appointing authority decides any challenge to a board of officers composed of a single member and may decide other challenges made before the board convenes. Otherwise, a challenge is decided by the legal advisor or, if none or if the legal advisor is challenged, by the president. If there is no legal advisor and the president is challenged, that challenge is decided by the next senior voting member.

d. Procedure. Challenges for lack of impartiality not decided by the appointing authority will be heard and decided at a session of the board attended by the legal advisor, the president or the next senior member who will decide the challenge, the member challenged, the respondent and his or her counsel, and the recorder. The respondent or counsel making the challenge may question the challenged member and present any other evidence to support the challenge. The recorder also may present evidence on the issue. The member who is to decide the challenge may question the challenged member and any other witness and may direct the recorder to present additional evidence. If more than one member is challenged at a time, each challenge will be decided independently, in descending order of the challenged members' ranks.

e. Sustained challenge. If the person deciding a challenge sustains it, he or she will excuse the challenged member from the board at once, and that person will no longer be a member of the board. If this excusal prevents a quorum (see para 5–2*b*), the board will adjourn to allow the addition of another member; otherwise, proceedings will continue.

5–8. Presentation of evidence

a. Rights of respondent. Except for good cause shown in the report of proceedings, a respondent is entitled to be present, with counsel, at all open sessions of the board that deal with any matter concerning the respondent. The respondent may—

(1) Examine and object to the introduction of real and documentary evidence, including written statements.

(2) Object to the testimony of witnesses and cross–examine witnesses other than the respondent's own.

(3) Call witnesses and otherwise introduce evidence.

(4) Testify as a witness; however, no adverse inference may be drawn from the exercise of the privilege against self–incrimination. (See para 3–7*c*(5).)

b. Assistance.

(1) Upon receipt of a timely written request, and except as provided in (4) below, the recorder will assist the respondent in obtaining documentary and real evidence in possession of the Government and in arranging for the presence of witnesses for the respondent.

(2) Except as provided in subparagraph (4) below, the respondent is entitled to compulsory attendance at Government expense of witnesses who are soldiers or Federal civilian employees, to authorized reimbursement of expenses of other civilian witnesses who voluntarily appear in response to invitational travel orders, and to official cooperation in obtaining access to evidence in possession of the Government, to the same extent as is the recorder on behalf of the Government. If the recorder, however, believes any witness's testimony or other evidence requested by the respondent is irrelevant or unnecessarily cumulative or that its significance is disproportionate to the delay, expense, or difficulty

in obtaining it, the recorder will submit the respondent's request to the legal advisor or president (see para 3–5), who will decide whether the recorder will comply with the request. Denial of the request does not preclude the respondent from obtaining the evidence or witness without the recorder's assistance and at no expense to the Government.

(3) Nothing in this paragraph relieves a respondent or counsel from the obligation to exercise due diligence in preparing and presenting his or her own case. The fact that any evidence or witness desired by the respondent is not reasonably available normally is not a basis for terminating or invalidating the proceedings.

(4) Evidence that is privileged within the meaning of paragraph 3–7*c*(1) will not be provided to a respondent or counsel unless the recorder intends to introduce such evidence to the board and has obtained approval to do so.

5–9. Argument

After all evidence has been received, the recorder and the respondent or counsel may make a final statement or argument. The recorder may make the opening argument and, if argument is made on behalf of a respondent, the closing argument in rebuttal.

5–10. After the hearing

Upon approval or other action on the report of proceedings by the appointing authority, the respondent or counsel will be provided a copy of the report, including all exhibits and enclosures that pertain to the respondent. Portions of the report, exhibits, and enclosures may be withheld from a respondent only as required by security classification or for other good cause determined by the appointing authority and explained to the respondent in writing.

Appendix A
References

Section I
Required Publications

Military Rules of Evidence are found in the Manual for Courts–Martial, United States.

AR 20–1
Inspector General Activities and Procedures. (Cited in paras 1–5 and 3–7.)

AR 25–55
The Department of the Army Freedom of Information Act Program. (Cited in para 3–18.)

AR 27–10
Military Justice. (Cited in para 3–7 and app B.)

AR 195–5
Evidence Procedures. (Cited in para 3–16.)

AR 340–21
The Army Privacy Program. (Cited in para 3–8 and app B.)

AR 380–67
The Department of the Army Personnel Security Program. (Cited in para 5–5.)

JTR, vol. 2
(Cited in para 3–7.) (Available at https://secureapp2.hqda.pentagon.mil/perdiem.)

MCM 2005
See Military Rules of Evidence contained therein. (Cited in para 3–7.)

MRE 201
Judicial notice of adjudicative facts.

MRE 502
Lawyer-client privilege.

MRE 503
Communications to clergy.

MRE 504
Husband-wife privilege.

UCMJ, Art. 31
Compulsory self-incrimination prohibited

UCMJ, Art. 136
Authority to administer oaths and act as notary. (Cited in paras 1–3, 2–3, 3–2, and 3–7.) (Available from www.army.mil/references/UCMJ.)

UCMJ, Art. 138
Complaints of wrongs

Section II
Related Publications

A related publication is a source of additional information. The user does not have to read it to understand this regulation. United States Code is found at www.gpoaccess.gov/uscode.

AR 210–7
Commercial Solicitation on Army Installations

AR 380–5
Department of the Army Information Security Program

AR 385–40
Accident Reporting and Records

AR 600–8–14
Identification Cards for M

AR 600–37
Unfavorable Information

AR 735–5
Policies and Procedures for Property Accountability

5 USC 303
Oaths to witnesses

5 USC 7114
Representation rights and duties

10 USC 933
Conduct unbecoming an officer and a gentleman

10 USC 1219
Statement of origin of disease or injury: limitations

10 USC 3012
Department of the Army: seal

18 USC 205
Activities of offices and employees in claims against and other matters affecting the Government

U.S. Constitution, amend. 5
No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury. . . .

Section III
Prescribed Forms

The following forms are available on the APD Web site (www.apd.army.mil) unless otherwise stated.

DA Form 1574
Report of Proceedings by Investigating Officer/Board of Officers. (Cited in para 3–14.)

Section IV
Referenced Forms

DA Form 2823
Sworn Statement

DA Form 3881
Rights Warning Procedure/Waiver Certificate

Appendix B
Guidance for Preparing Privacy Act Statements

B–1. General

a. The Privacy Act requires that, whenever personal information is solicited from an individual and the information

will be filed so as to be retrievable by reference to the name or other personal identifier of the individual, he or she must be advised of the following information:

(1) The authority for soliciting the information.

(2) The principal purposes for which the information is intended to be used.

(3) The routine uses that may be made of the information.

(4) Whether disclosure is mandatory or voluntary.

(5) The effect on the individual of not providing all or part of the information.

b. Each Privacy Act statement must be tailored to the matter being investigated and to the person being asked to provide information. The servicing JA will be consulted for assistance in preparing Privacy Act statements, as necessary.

B–2. Content

a. Authority. If a specific statute or executive order authorizes collection of the information, or authorizes performance of a function that necessitates collection of the information, the Privacy Act statement will cite it as the authority for solicitation. For example, if a commander appoints an investigating officer to inquire into a UCMJ, Art. 138, complaint under the provisions of AR 27–10, the statutory authority for solicitation of the information would be 10 USC 938. Regulations will not be cited as the authority. If no specific statute or executive order can be found, the authority to cite is 10 USC 3012.

b. Principal purposes. The statement of principal purposes will consist of a short statement of the reason the investigation is being conducted. The following examples apply to particular types of investigations:

(1) Administrative elimination proceeding under AR 635–200: "The purpose for soliciting this information is to provide the commander a basis for a determination regarding your retention on active duty and, if a determination is made not to retain you on active duty, the type of discharge to award."

(2) Investigation of a UCMJ, Art. 138, complaint: "The purpose for soliciting this information is to obtain facts and make recommendations to assist the commander in determining what action to take with regard to (your) (complainant's) UCMJ, Art 138, complaint."

(3) Investigation of a security violation: "The purpose for soliciting this information is to determine whether the security violation under investigation resulted in a compromise of national defense information, to fix responsibility for the violation, and to determine whether to change existing security procedures."

(4) Flying evaluation board pursuant to AR 600–107: "The purpose for soliciting this information is to provide the commander a basis for a determination regarding your flying status."

c. Routine uses. In order to advise an individual of what routine uses may be made of solicited information, it is necessary to identify the system of records in which the report of proceedings will be filed. The routine uses will be summarized from the system notice and from the routine uses of general applicability in AR 340–21. The routine use statement may be introduced as follows: "Any information you provide is disclosable to members of the Department of Defense who have a need for the information in the performance of their duties. In addition, the information may be disclosed to Government agencies outside of the Department of Defense as follows: (list of routine uses external to the Department of Defense)."

d. Routine uses. Disclosure mandatory or voluntary; the effect of not providing information. Providing information is voluntary unless the individual may be ordered to testify. The following statement can be used in most situations:

(1) Respondent or other individual warned of his or her rights under the UCMJ, Art. 31, or the Fifth Amendment: "Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain information might not otherwise be available to the commander for his or her decision in this matter."

(2) Individual who may be ordered to testify: "Providing the information is mandatory. Failure to provide information could result in disciplinary or other adverse action against you under (the UCMJ or Army regulations) (civilian personnel regulations)."

2. UCMJ, Art. 31 rights advisement. If during the proceeding it is determined to advise an individual of his or her rights under the UCMJ, Art. 31, or the Fifth Amendment, after he or she has been told it is mandatory to provide information, the advising official must be certain that the individual understands that such rights warning supersedes this portion of the Privacy Act statement.

Glossary

Section I
Abbreviations

AR
Army regulation

DA
Department of the Army

DOD
Department of Defense

GCM
general court-martial

GS
general schedule

JA
judge advocate

LA
legal advisor

MCM
Manual for Courts-Martial, United States, 2005

MRE
Military Rules of Evidence

SJA
staff judge advocate

TJAG
The Judge Advocate General

UCMJ
Uniform Code of Military Justice

USC
United States Code

Section II
Terms

Adverse administrative action
Adverse adction taken by appropriate military authority against an individual other than actions taken pursuant to the UCMJ or MCM.

Military exigency
An emergency situation requiring prompt or immediate action to obtain and record facts.

Section III
Special Abbreviations and Terms
This section contains no entries.

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D

TAB D-1

DEPARTMENT OF THE ARMY
SOUTHERN REGIONAL MEDICAL COMMAND
4070 STANLEY ROAD
FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF:

MCSR-JA

6 May 2011

MEMORANDUM FOR Investigating Officer , Regional Nurse Executive, Southern Regional Medical Command, Fort Sam Houston, Texas 78234-6200

SUBJECT: Appointment of Investigating Officer

1. You are hereby appointed an investigating officer (IO) pursuant to Army Regulation (AR) 15-6. You will conduct an informal investigation under AR 15-6, Chapter 4. You are directed to investigate allegations that the Department of Preventive Medicine at the Lyster Army Health Clinic (LAHC), Fort Rucker, Alabama, required the Community Health Nurse to perform advanced medical tasks that she was not trained or certified to complete.

2. Specifically you are directed, at a minimum, to investigate and determine:

a. What are the educational, licensing, training and experience requirements for a Community Health Nurse?

b. Are there published federal guidelines or Army regulations regarding the educational, licensing, training and experience requirements for Community Health Nurse? If so, what are they?

c. Are there published federal guidelines or Army regulations for duties of a Community Health Nurse at a military treatment facility? If so, what are they?

d. Did LAHC Department of Preventive Medicine know of federal guidelines or Army regulations pertaining to the educational, licensing, training and experience requirements and duties of a Community Health Nurse at a military treatment facility?

e. Did LAHC's vacancy announcement for the Community Health Nurse include the proper educational, licensing, training and experience requirements and duties of a Community Health Nurse?

f. Did the Whistleblower , who was selected to fill the Community Health Nurse position at LAHC possess the requisite educational, licensing, training and experience to be a Community Health Nurse?

g. Did the Whistleblower have knowledge of the requisite educational, licensing, training, and experience requirements to be a Community Health Nurse when she accepted the job?

h. If so, did she inform LAHC selecting officials prior to accepting the position that she did not have the requisite educational, licensing, training and experience to fulfill the position?

TAB D-1

i. Did the Whistleblower knowingly misrepresent her qualifications or training during the selection process for the position of Community Health Nurse or any time thereafter?

j. Are the duties the Whistleblower was directed to perform as the LAHC Community Health Nurse, to wit: the responsibility to order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to re-fill prescriptions for Isonizaid, fall within duties only a Community Health Nurse with the requisite educational, licensing, training and experience can perform?

k. Were the above listed responsibilities/duties (order and interpret STI, tuberculosis and hepatic enzyme tests and re-fill Isonizaid prescriptions) specifically defined in the position description or the vacancy announcement?

l. What duties listed in the position description does the Whistleblower have the requisite educational, licensing, training and experience requirements to perform?

m. When did the Whistleblower inform her supervisors, Occupational Health Physician Sup. Prev. Med. Phys. and/or Chief of Preventative Medicine, Chief, Prev. Med. Clinic, or anyone else irthe Whistleblower supervisory chain of command that she did not possess the requisite educational, licensing, training and experience requirements to perform the duties that they required of her?

n. Once informed of her lack of requisite educational, licensing, training or experience, did Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command knowingly direct her to continue to perform duties for which she was not properly trained or qualified to perform?

o. Did Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command threatened her with adverse or disciplinary action if she did not continue to perform any duties, to include ordering and interpreting STI, tuberculosis and hepatic enzyme tests and re-filling Isonizaid prescriptions, that she should not perform due to the lack of requisite educational, licensing, training and experience requirements?

p. Has the Whistleblower been disciplined or received any adverse actions as a result of informing her supervisors that she should not be performing duties of a Community Health Nurse?

q. Was any patient injured as the result of the Whistleblower actions performing the duties required by Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command?

r. Do the acts of Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command requiring her to perform these duties constitute a substantial and specific danger to public health or safety?

3. In your investigation, you are not limited to the questions listed above. You will investigate any relevant related matters. If you are in doubt about the relevance of a matter, you will consult with your legal advisor and consult with me regarding additional issues.

4. You will interview all witnesses in person, if practical. Caution all individuals that they must not discuss the subject matter of the investigation with anyone other than a properly

detailed investigator. If, during the investigation, you suspect that certain people may have committed criminal conduct, you must advise them of their rights under Article 31, UCMJ or the Fifth Amendment, U.S. Constitution, as appropriate. In such a case, waivers should be documented on DA Form 3881 (Rights Warning Procedure/Waiver Certificate). Consult your legal advisor if you have any questions regarding these procedures.

5. During the course of your investigation, you will find it necessary to interview civilian employees. Generally speaking, civilian employees are required to cooperate with official investigations. There are some exceptions:

a. Civilian employees who are members of a bargaining unit have a right to union representation at any interview with management if they reasonably believe that the interview could result in a disciplinary action against them. Should a bargaining unit employee seek to invoke this right, simply reschedule the interview for at least 24 hours later in order to allow the employee to arrange for union representation. You have no obligation to arrange representation for the employee, only an obligation to permit the employee the opportunity to secure representation. The Civilian Personnel Advisory Center can tell you whether any particular employee you wish to interview is a member of the bargaining unit.

b. Civilian employees who reasonably believe that information they provide during an official investigation may be used against them in a criminal prosecution cannot be required to cooperate without a grant of immunity. Should any civilian employee you attempt to interview decline to cooperate for any reason, suspend the interview and seek guidance from your legal advisor on how to precede.

c. If your investigation involves a grievance, a personnel practice or policy or other conditions of employment, you may be required to notify the union of any interviews you have scheduled with bargaining unit employees and afford the union the opportunity to be present. Check with your legal advisor to determine if this rule applies in your case and how to proceed if it does.

d. You have no authority to compel the cooperation of contractor employees. If you find it necessary to interview contractor employees, you must contact the contracting officer's representative for the applicable contract to request cooperation.

6. If, in the course of your investigation, you suspect wrongdoing or neglect on the part of a person senior to you, inform me so that a new IO may be appointed. An IO may not, absent military exigency, investigate someone senior to himself or herself.

7. Make specific findings and recommendations. If certain evidence conflicts with other evidence, state what you believe and why. In addition:

a. Reference your analysis and findings to the specific evidence upon which you rely;

b. Make two copies of your report of investigation (ROI);

c. Provide an index and clearly tab the original ROI, to include your findings and recommendations on DA Form 1574, with appropriate enclosures;

d. Please identify any exhibits as Quality Assurance documents protected under 10 U.S. Code Section 1102, as appropriate; and

e. Submit your completed investigation through Redacted , Command Judge Advocate, Southern Regional Medical Command not later than 21 days from the date of this memorandum.

8. This investigation takes precedence over all other normal duties, TDY or leave. Prior to commencing your investigation, consult with Redacted , Office of the Staff Judge Advocate at US Army Medical Command (210) 221-8400, who will be your legal advisor. If, in the event it is not possible to complete the investigation in the time limit provided, submit requests for any extension in writing through your legal advisor to me. Any request for extension will include the basis for the extension and contain a brief summary of the status of your investigation.

JOSEPH CARAVALHO, JR.
Brigadier General, MC
Commanding

TAB D-2

DEPARTMENT OF THE ARMY
SOUTHERN REGIONAL MEDICAL COMMAND
4070 STANLEY ROAD, SUITE 121
FORT SAM HOUSTON, TEXAS 78234-2715

REPLY TO ATTENTION OF

MCSR-JA

13 June 2011

MEMORANDUM FOR Investigating Officer , Regional Nurse Executive, Southern Regional Medical Command, Fort Sam Houston, Texas 78234

SUBJECT: Appointment of Investigating Officer

1. You are hereby appointed an investigating officer (IO) pursuant to Army Regulation (AR) 15-6. You will conduct an informal investigation under AR 15-6, Chapter 4. You are directed to investigate allegations that the Department of Preventive Medicine at the Lyster Army Health Clinic (LAHC), Fort Rucker, Alabama, required the Community Health Nurse to perform advanced medical tasks that she was not trained or certified to complete.

2. Specifically you are directed, at a minimum, to investigate and determine:

a. What are the educational, licensing, training and experience requirements for a Community Health Nurse?

b. Are there published federal guidelines or Army regulations regarding the educational, licensing, training and experience requirements for Community Health Nurse? If so, what are they?

c. Are there published federal guidelines or Army regulations for duties of a Community Health Nurse at a military treatment facility? If so, what are they?

d. Did LAHC Department of Preventive Medicine know of federal guidelines or Army regulations pertaining to the educational, licensing, training and experience requirements and duties of a Community Health Nurse at a military treatment facility?

e. Did LAHC's vacancy announcement for the Community Health Nurse include the proper educational, licensing, training and experience requirements and duties of a Community Health Nurse?

f. Describe the differences in layman's terms between various types of nurses, such as a Registered Nurse, a Licensed Practical Nurse, and a Community Health Nurse.

g. Did the Whistleblower , who was selected to fill the Community Health Nurse position at LAHC possess the requisite educational, licensing, training and experience to be a Community Health Nurse?

h. Did the Whistleblower have knowledge of the requisite educational, licensing, training, and experience requirements to be a Community Health Nurse when she accepted the job?

TAB D-2

i. If so, did she inform LAHC selecting officials prior to accepting the position that she did not have the requisite educational, licensing, training and experience to fulfill the position?

j. Determine if the Whistleblower knowingly misrepresented her qualifications or training during the selection process for the position of Community Health Nurse or any time thereafter?

k. Are the duties the Whistleblower was directed to perform as the LAHC Community Health Nurse, to wit: the responsibility to order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to re-fill prescriptions for Isonizaid, fall within duties only a Community Health Nurse with the requisite educational, licensing, training and experience can perform?

l. Were the above listed responsibilities/duties (order and interpret STI, tuberculosis and hepatic enzyme tests and re-fill Isonizaid prescriptions) specifically defined in the position description or the vacancy announcement?

m. What duties listed in the position description does the Whistleblower have the requisite educational, licensing, training and experience requirements to perform?

n. When did the Whistleblower inform her supervisors, Occupational Health Physician Sup. Prev. Med. Phys. and/or Chief of Preventative Medicine, Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command that she did not possess the requisite educational, licensing, training and experience requirements to perform the duties that they required of her?

o. Once informed of her lack of requisite educational, licensing, training or experience, did Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command knowingly direct her to continue to perform duties for which she was not properly trained or qualified to perform?

p. Did Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command threatened her with adverse or disciplinary action if she did not continue to perform any duties, to include ordering and interpreting STI, tuberculosis and hepatic enzyme tests and re-filling Isonizaid prescriptions, that she should not perform due to the lack of requisite educational, licensing, training and experience requirements?

q. Has the Whistleblower been disciplined or received any adverse actions as a result of informing her supervisors that she should not be performing duties of a Community Health Nurse?

r. Was any patient injured as the result of the Whistleblower actions performing the duties required by Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command?

s. Do the acts of Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in the Whistleblower supervisory chain of command requiring her to perform these duties constitute a substantial and specific danger to public health or safety?

3. In your investigation, you are not limited to the questions listed above. You will investigate any relevant related matters. If you are in doubt about the relevance of a matter, you will consult with your legal advisor and consult with me regarding additional issues.

4. In conducting your investigation, you will use the informal procedures specified in AR 15-6, Chapter 4. Upon completing your investigation, make appropriate specific findings and recommendations. Reference your analysis and findings to the specific evidence upon which you rely. Recommend remedial measures, to include any corrective and personnel or disciplinary actions you deem appropriate, if any. You may also recommend any necessary management actions to preclude a recurrence of any founded misconduct or identified systemic problems. If certain evidence conflicts with other evidence, state what you believe and why. If any question asked solicits an answer that requires a follow-up question and answer, ensure that you have pursued those questions in order to further develop the recorded evidence.

5. You should contact those witnesses you consider relevant during the course of your investigation. You are to thoroughly document all witness interviews in writing, preferably on DA Form 2823 (Sworn Statement), and have witnesses certify their statements when final. In addition, you must provide all persons interviewed with a Privacy Act statement before you solicit any information.

6. All witness statements will be written (typed or block printed) and sworn. You will interview all witnesses in person, if practical. Caution all individuals that they must not discuss the subject matter of the investigation with anyone other than a properly detailed investigator. If, in the course of your investigation, you come to suspect that certain people may have committed criminal conduct, you must advise them of their rights under Article 31, UCMJ, or the Fifth Amendment, US constitution, as appropriate. In such a case, waivers should be documented on DA Form 3881 (Rights Warning Procedure/Waiver Certificate).

7. During the course of your investigation, you will find it necessary to interview civilian employees. Generally speaking, civilian employees are required to cooperate with official investigations. There are some exceptions:

a. Civilian employees who are members of a bargaining unit have a right to union representation at any interview with management if they reasonably believe that the interview could result in a disciplinary action against them. Should a bargaining unit

employee seek to invoke this right, simply reschedule the interview for at least 24 hours later in order to allow the employee to arrange for union representation. You have no obligation to arrange representation for the employee, only an obligation to permit the employee the opportunity to secure representation. The Civilian Personnel Advisory Center can tell you whether any particular employee you wish to interview is a member of the bargaining unit.

b. Civilian employees who reasonably believe that information they provide during an official investigation may be used against them in a criminal prosecution cannot be required to cooperate without a grant of immunity. Should any civilian employee you attempt to interview decline to cooperate for any reason, suspend the interview and seek guidance from your legal advisor on how to precede.

c. If your investigation involves a grievance, a personnel practice or policy or other conditions of employment, you may be required to notify the union of any interviews you have scheduled with bargaining unit employees and afford the union the opportunity to be present. Check with your legal advisor to determine if this rule applies in your case and how to proceed if it does.

d. You have no authority to compel the cooperation of contractor employees. If you find it necessary to interview contractor employees, you must contact the contracting officer's representative for the applicable contract to request cooperation.

8. This investigation has been directed by the OSC pursuant to a whistleblower complaint. Pursuant to OSC policy, you must interview the whistleblower, the Whistleblower , as part of your investigation.

9. If, in the course of your investigation, you suspect wrongdoing or neglect on the part of a person senior to you, inform me so that a new IO may be appointed. An IO may not, absent military exigency, investigate someone senior to himself or herself.

10. In your investigation, you will make such findings as are relevant and supported by the facts. You will also make such recommendations as are appropriate and are supported by the facts. In compiling your report of investigation, consider carefully that information contained therein will be subject to public disclosure and release. Please identify any exhibits as Quality Assurance documents protected under 10 U.S. Code Section 1102, as appropriate

11. You will submit your completed investigation on a DA Form 1574 with a table of contents and enclosures. The enclosures will include all documentary materials considered by you. Make two copies of your report of investigation (ROI). Provide an index and clearly tab the original ROI, to include your findings and recommendations on

DA Form 1574, with appropriate enclosures and forward the entire package, to me, through Redacted , Command Judge Advocate, Southern Regional Medical Command. Before beginning your investigation, you will receive a legal briefing from Redacted , Office of the Staff Judge Advocate at US Army Medical Command Redacted , who will be your legal advisor. You may consult the legal advisor at any time during the investigation and you will consult the legal advisor before warning any witness as a suspect and before putting your report in final form. Additionally, along with your report of investigation, you will submit a draft final agency response describing any actions taken to address the allegations.

12. This investigation takes precedence over all other normal duties, TDY or leave. If, in the event it is not possible to complete the investigation in the time limit provided, submit requests for any extension in writing through your legal advisor to me. Any request for extension will include the basis for the extension and contain a brief summary of the status of your investigation.

13 . You are directed to complete your investigation as soon as practicable.

M. TED WONG
Major General, DC
Commanding

E

Army Regulation 10–87

Organization and Functions

Army Commands, Army Service Component Commands, and Direct Reporting Units

Headquarters
Department of the Army
Washington, DC
4 September 2007

UNCLASSIFIED

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g. NETCOM/9th SC(A) provides signal related requirements to combat developers, HQDA staff elements, and the acquisition community.

h. NETCOM/9th SC(A) integrates Army theater networks into Global Information Grid enterprise constructs.

i. NETCOM/9th SC(A) exercises, develops, and enforces, reporting, and policy requirements for the enterprise level for all organizations that operate, connect to, or maintain portions of the Army Enterprise Infostructure, and integrates the implementation and fielding of all enterprise NetOps capabilities.

j. NETCOM/9th SC(A) performs technical oversight of installation directors of information management (DOIMs) and provides oversight of command, control, communications, computers, and information technology (C4/IT) infrastructure programs, projects, and funding requirements.

k. NETCOM/9th SC(A) exercises operational review and coordination authority for standard system architecture, design, or devices that impact the Army Enterprise Infostructure and operates, certifies, accredits, and maintains enterprise common user information technology (IT) services and capabilities throughout the Army.

l. NETCOM/9th SC(A) plans, installs, operates, maintains, and defends information services supporting the National Military Communications Center–R, combatant commands, DOD, and other Federal agencies.

m. NETCOM/9th SC(A) supports the communication teams of combatant commanders, North Atlantic Treaty Organization commander, ASCC commanders and their deputy commanders with secure FM radio, ultrahigh frequency tactical satellite, record telecommunications message support, and communications security equipment maintenance.

n. NETCOM/9th SC(A) provides communications support to chemical, biological, radiological, nuclear, and high impact explosive, consequence management, and civil support missions.

o. NETCOM/9th SC(A) serves as the Telecommunications Coordination Office and National Security Invocation Authority for telecommunications for the Army and interfaces with the Defense Information Technology Contracting Organization.

p. NETCOM/9th SC(A) operates and maintains a logistics support system for information systems and equipment unique to NETCOM/9th SC(A) including area maintenance supply facilities.

q. NETCOM/9th SC(A) designs, implements, and delivers enterprise C4/IT common user services and manages the Army's IT service management program and contracts.

r. NETCOM/9th SC(A) enforces Computer Network Defense (CND) and information assurance (IA) policy, standards, processes and operational procedures, and coordinates Army IA programs and funding. NETCOM/9th SC(A) operates, certifies, maintains, and manages enterprise CND attack sensing and warning capability.

s. NETCOM/9th SC(A) manages the network enterprise portion of the Army materiel release program.

t. NETCOM/9th SC(A) provides facility engineering support by planning and programming for communication and supporting facility construction. This includes the procurement and sustainment of redundant utility support systems IAW DOD reliability standards.

u. NETCOM/9th SC(A) develops and enforces NetOps with Joint and Army enterprise directions and synchronizes and integrates the implementation and fielding of enterprise NetOps capabilities.

14–3. Command and staff relationships

a. The Commander, NETCOM/9th SC(A) is supervised by the CIO/G–6.

b. The Commander, NETCOM/9th SC(A) is responsible to the SA for execution of assigned responsibilities contained in 10 USC 3013(b). The Commander, NETCOM/9th SC(A) exercises ADCON authority and responsibility on behalf of the SA and in this regard is primarily responsible for the administration and support of Army forces worldwide for certain ADCON functions.

c. The Commander, NETCOM/9th SC(A) is authorized to communicate and coordinate directly with ACOM, ASCC, and other DRU commanders; HQDA; other DOD headquarters and agencies; and other Government departments, as required, on matters of mutual interest subject to procedures established by the CIO/G–6.

d. The Commander, NETCOM/9th SC(A) assumes delegated authority from Commander, USASMDC/ARSTRAT as the USASMDC/ARSTRAT deputy for NetOps to represent USASMDC/ARSTRAT in communicating and coordinating directly with DOD and USSTRATCOM regarding NetOps.

e. For command relationships—

(1) Command relationships for operational Service forces are established by the SECDEF and applicable CCDRs.

(2) Pursuant to the direction of the SA, certain authorities and responsibilities for ADCON of Army forces assigned to a combatant command are shared by the Commander, NETCOM/9th SC(A); ACOMs; the ASCC of the combatant command; and other DRUs. Subject to applicable law, regulation, and policy, the allocation of authorities and responsibilities pertinent to the exercise of shared ADCON will be documented in appropriate agreements/understandings between the commanders of NETCOM/9th SC(A), ACOMs, ASCCs, and other DRUs as appropriate.

f. NETCOM/9th SC(A), in coordination with USASMDC/ARSTRAT, develops Army NetOps capabilities and requirements for Army forces supporting USSTRATCOM.

g. NETCOM/9th SC(A) coordinates with USASMDC/ARSTRAT to synchronize NetOps with other Army organizations in support of USSTRATCOM.

h. NETCOM/9th SC(A) is dependent on other Army organizations and agencies for appropriate support and services per prescribed regulations and policies and maintains the following relationships:

(1) NETCOM/9th SC(A) coordinates requirements, doctrine, design changes, capabilities, modernization, and proposed missions and functions for theater–level signal forces.

(2) NETCOM/9th SC(A) coordinates the management of enterprise–level collaborative intelligence support and predictive analysis to NetOps and its IA component with primary focus on emerging threats.

(3) NETCOM/9th SC(A) collaborates with pertinent commands, the USARC, the materiel developer and responsible program manager for doctrine, fielding, integration, installation, new equipment training team, and sustainment of signal specific systems.

(4) NETCOM/9th SC(A), in conjunction with the USARC and ARNG, develops theater–level signal unit force design updates for TRADOC, influences modernization with HQDA, and coordinates military occupational specialty restructure initiatives with Human Resources Command and TRADOC. Relationships concerning Service responsibilities for RC units are regulated by MOUs.

(5) NETCOM/9th SC(A) advises and assists the USARC and ARNG in developing IDT and AT programs for RC signal units and personnel.

(6) NETCOM/9th SC(A) collaborates with the U.S. Army Corps of Engineers (USACE) on requirements for information and telecommunications in all facilities serviced by outside the CONUS DOIMs.

(7) NETCOM/9th SC(A) coordinates with INSCOM as required for the defense of the LWN.

(8) NETCOM/9th SC(A) for multicomponent SC(T) exercises a shared ADCON relationship with the ASCC and USARC. NETCOM/9th SC(A) exercises ADCON over forward stationed Active Army theater–level signal forces to include the Active Army element of the SC(T) and technical authority over all aspects of the LWN. NETCOM/9th SC(A) exercises C4/IT and NetOps enterprise control over all Army theater signal forces.

Chapter 15
U.S. Army Medical Command

15–1. Mission

MEDCOM provides medical, dental, and veterinary capabilities to the Army and designated DOD activities; operates fixed facilities; conducts medical research, materiel development, testing and evaluation; executes medical materiel acquisition programs as assigned by the Army Acquisition Executive; manages Army medical materiel; educates and trains personnel; and develops medical concepts, doctrine, and systems to support Army health care delivery.

15–2. Functions

a. MEDCOM is designated as a DRU by the SA and reports directly to The Surgeon General (TSG) of the Army.

b. MEDCOM is responsible for the planning and execution of DRU responsibilities by exercising specified ADCON of organic, assigned and attached Army forces.

c. MEDCOM advises supported commanders without adequate organic medical, dental, and veterinary capability for health services and health issues.

d. MEDCOM provides medical and dental care worldwide; coordinates Army health services for Army, civilian, and Federal health care resources in a given health service area; and conducts health care education, training and studies.

e. MEDCOM provides veterinary services for the Army and DOD.

f. MEDCOM manages and conducts activities concerning biomedical research and technology; regulatory compliance and quality; and medical advanced technology. Provides regulatory oversight of all Army research involving human subjects.

g. MEDCOM provides Armywide expertise and services in disease prevention and control; clinical and field preventive medicine, environmental and occupational health, health promotion and wellness, hearing conservation, epidemiology and disease surveillance, toxicology, and related laboratory sciences.

h. MEDCOM provides medical logistics, acquisition services, and materiel research, development, test, and evaluation to Army units and DOD components. Develops logistics policy for management, distribution, and storage of medical materiel and for medical equipment maintenance. Delivers Class VIII support for military health care operations.

i. MEDCOM is the proponent for, and implements, the Medical Professional Filler System.

j. MEDCOM trains the medical force, develops medical doctrine and future concepts; conducts combat developments; develops training devices, simulations, and publications; and manages medical force structure.

k. MEDCOM conducts life cycle management for Army medical information systems.

l. MEDCOM, in coordination with IMCOM, provides base operations support and installation management for MEDCOM and tenant activities at MEDCOM installations. MEDCOM, in coordination with TRICARE Management

Activity and USACE, manages acquisition of Army medical facilities funded by military construction (MILCON), Defense.

15–3. Command and staff relationships

a. TSG is dual hatted as the Commander, MEDCOM and is supervised by the CSA.

b. The Commander, MEDCOM is responsible to the SA for execution of assigned responsibilities contained in 10 USC 3013(b). The Commander, MEDCOM exercises ADCON authority and responsibility on behalf of the SA and in this regard is primarily responsible for the administration and support of Army forces worldwide for certain ADCON functions.

c. The Commander, MEDCOM is authorized to communicate and coordinate directly with ACOM, ASCC, or other DRU commanders; HQDA; other DOD headquarters and agencies; and other Government departments, as required, on matters of mutual interest subject to procedures established by CSA.

d. Commander, MEDCOM directs all Active Army health services activities involved in providing direct health care support within the prescribed geographical limits of responsibility; designates missions and levels of care to be provided by subordinate military treatment facilities; and determines manpower staffing standards and levels of staffing.

e. MEDCOM is dependent on other Army organizations and agencies for appropriate support and services per prescribed regulations and policies and maintains the following relationships:

(1) Coordinates with TRADOC on medical combat development functions and doctrinal concepts and systems for health services support to the Army in the field.

(2) Supervises and evaluates the performance of Army Medical Department RC units when training with MEDCOM activities.

(3) Administers the individual medical training programs for RC personnel performing Advanced Individual Training at MEDCOM activities.

(4) Provides doctrinal support for training and evaluation of both Active Army and RC medical units and individuals throughout the Army.

(5) Coordinates with TRICARE Management Activity to ensure integrated, standardized health care delivery.

(6) Coordinates with Defense Logistics Agency to develop and execute policies and procedures for medical logistics organizations pertaining to Theater Lead Agents for medical materiel.

f. For command relationships—

(1) Command relationships for operational Service forces are established by the SECDEF and applicable CCDRs.

(2) Pursuant to the direction of the SA, certain authorities and responsibilities for ADCON of Army forces assigned to a combatant command are shared by the Commander, MEDCOM; ACOMs; the ASCC of the combatant command; and other DRUs. Subject to applicable law, regulation, and policy, the allocation of authorities and responsibilities pertinent to the exercise of shared ADCON will be documented in appropriate agreements/understandings between the commanders of MEDCOM, ACOMs, the ASCC, and other DRUs as appropriate.

Chapter 16
U.S. Army Intelligence and Security Command

16–1. Mission

a. INSCOM synchronizes the operations of all INSCOM units to produce intelligence in support of the Army, combatant commands, and the National intelligence community. INSCOM responds to taskings from national and departmental authorities for Signal intelligence (SIGINT), human intelligence (HUMINT), counterintelligence (CI), imagery intelligence, measurement and signature intelligence (MASINT), technical intelligence (TI), electronic warfare (EW), and information operations (IO).

b. INSCOM provides Title 50 USC National Intelligence Program support to combatant commands and Army organizations.

16–2. Functions

a. INSCOM is designated by the SA as a DRU and reports directly to the Deputy Chief of Staff, G–2 (DCS, G–2).

b. INSCOM is responsible for the planning and execution of DRU responsibilities by exercising command and control of organic, assigned and attached Army forces.

c. INSCOM serves as the principal Army advisor to the Director, National Security Agency/Chief, Central Security Service for the United States Signals Intelligence Directive System and maintains liaison with national agencies for SIGINT operations. INSCOM supports the National SIGINT Special Activities Office program and DOD and DA SIGINT programs; performs worldwide SIGINT operations; advises and assists other Army organizations on SIGINT

matters; and monitors intelligence and EW systems development by the National Security Agency and other service/military departments.

d. INSCOM intelligence operations are conducted in coordination with and under the staff supervision of the DCS, G–2. In addition, the DCS, G–3/5/7 exercises OPCON over selected INSCOM activities.

e. INSCOM commands organizations tailored to provide intelligence to CCDRs and other supported commands and agencies.

f. INSCOM performs counterterrorism operations in support of the Army Anti–Terrorism Strategic Plan.

g. INSCOM provides intelligence capabilities for JCS and HQDA collection projects.

h. INSCOM is the Army authority for project TROJAN and operates the Army Technical Control and Analysis Element.

i. INSCOM is the proponent for the Army HUMINT program and is the Army program administrator for Army target exploitation assets.

j. INSCOM plans, conducts, and coordinates theater and strategic CI, cyber–CI, and offensive CI operations and activities; administers the Army Intelligence Polygraph Program; is responsible for the Army Central Control Office and subcontrol offices; conducts counterespionage investigations; manages the Army technical CI program; oversees the Army TEMPEST countermeasures program; and provides CI support to selected DA and DOD acquisition and special access programs.

k. INSCOM is the Army proponent for CI/HUMINT collection management, for the Army Cover Support Program and for the Army Intelligence Badge and Credentials Program. INSCOM administers and maintains the DA CI/HUMINT source registries and databases.

l. INSCOM performs imagery intelligence operations, provides technical and operational support to the Army tactical exploitation of National Space Capabilities effort, and supports the Special Activities Office Intelligence Program.

m. INSCOM performs Advanced Geospatial Intelligence (AGI), MASINT and technical collection for the Army, other services, the combatant commands and the intelligence community; when directed by HQDA, INSCOM coordinates AGI, MASINT and technical collection operations with National Geospatial–Intelligence Agency, Defense Intelligence Agency (DIA), other services, and other agencies; maintains and deploys MASINT and technical collection systems to meet Army and national intelligence collection requirements; assists in the preparation of the AGI/MASINT and technical collection doctrine and training; and establishes, maintains, and disseminates classification and security guidance for AGI/MASINT and technical collection within the Army.

n. INSCOM is the Army proponent for TI and document/media exploitation; performs threat foreign materiel acquisition and exploitation operations in support of the Army and other Services; conducts TI collection operations and battlefield–level TI exploitation of foreign ground forces materiel; provides interface with strategic scientific and TI agencies in support of foreign materiel exploitation; and supports the DA Foreign Materiel Exploitation and Foreign Materiel Acquisition Program.

o. INSCOM provides EW capabilities to Army and CCDRs, technical guidance to the Army on EW threat and maintains the operational level database for meaconing, intrusion, jamming, and interference information.

p. INSCOM provides an IO reach back capability and deploys IO support teams for Army and other forces as directed by the DCS, G–3/5/7; manages facets of Army CND in coordination with computer network service providers; executes the Army Reprogramming Analysis Team Threat Analysis Program; conducts computer network attack (CNA) and computer network exploitation; is the functional proponent for battlefield deception; and oversees the Army Operations Security Support Element.

q. INSCOM is the Army proponent for open source intelligence under the Defense Intelligence Information Support Program.

r. INSCOM exercises centralized oversight of sensitive compartmented information contracting; serves as an obligation authority for designated intelligence funding programs; and assists HQDA in developing the Army intelligence portions of the Five Year Defense Plan.

s. INSCOM is the Army proponent for design and development of operational level and expeditionary intelligence systems; develops the overall functional description of intelligence systems for which INSCOM is the sole user; is the Army representative for all phases of SIGINT systems development applicable to Army participation in the national SIGINT system; coordinates with pertinent commands and acquisition agencies for INSCOM sole user systems; is the Army combat developer for MASINT and CNA/special purpose electronic attack weapons; conducts test and evaluation (T&E) for assigned classified or secure source systems; and manages and directs the operations of specialized nonstandard intelligence equipment and the National Inventory Control Point.

t. INSCOM is the Army proponent for the Expeditionary Signals Intelligence Training Program; is the Army coordinator for Project Foundry and the Tactical Intelligence Readiness Training Program; and conducts the O–5 series aircraft Aviator Qualification Course.

u. INSCOM administers the Army Contract Linguistics Program.

v. INSCOM directs the Military Intelligence Civilian Excepted Career and Great Skills Programs.

w. INSCOM establishes and manages the Technical Surveillance Counter Measure Certification Program.

x. INSCOM, in compliance with DIA and DCS, G–2, develops attaché personnel requirements and provides personnel, financial, and administrative support for Army personnel assigned to the Defense Attaché System and the Foreign Area Officer Program.

y. INSCOM operates the Army Central Security Facility and the Cryptologic Records Center.

z. INSCOM oversees the Army personnel security clearance adjudication program.

16–3. Command and staff relationships

a. The Commander, INSCOM is supervised by the DCS, G–2.

b. The Commander, INSCOM is responsible to the SA for execution of assigned responsibilities contained in 10 USC 3013(b). The Commander, INSCOM exercises ADCON authority and responsibility on behalf of the SA and in this regard is primarily responsible for the administration and support of Army forces worldwide for certain ADCON functions.

c. INSCOM is authorized to communicate and coordinate directly with ACOM, ASCC, or other DRU commanders; HQDA; other DOD headquarters and agencies; and other foreign and domestic Government departments, as required, on matters of mutual interest subject to procedures established by the DCS, G–2.

d. INSCOM is subordinate to the Chief, Central Security Service IAW U.S. Signals Intelligence Directives for the conduct of SIGINT operations.

e. Relationships concerning Service responsibilities for RC units and personnel are regulated by MOUs.

f. INSCOM is dependent on other Army organizations and agencies for appropriate support and services per prescribed regulations and policies.

g. For command relationships—

(1) Command relationships for operational Service forces are established by the SECDEF and applicable CCDRs.

(2) Pursuant to the direction of the SA, certain authorities and responsibilities for ADCON of Army forces assigned to a combatant command are shared by the Commander, INSCOM; ACOMs; the ASCC of the COCOM; and other DRUs. Subject to applicable law, regulation, and policy, the allocation of authorities and responsibilities pertinent to the exercise of shared ADCON will be documented in appropriate agreements/understandings between the commanders of INSCOM, ACOMs, the ASCC, and other DRUs as appropriate.

Chapter 17
U.S. Army Criminal Investigation Command

17–1. Mission

USACIDC conducts sensitive or special interest investigations as directed by the SA or the CSA; plans for and provides personal security (protective services) for DOD and DA officials as designated by the SA or CSA; provides criminal investigative support, including forensic support, to all Army elements; maintains overall responsibility for Army investigations of controlled substances; conducts and controls all Army investigations of serious crimes, less serious crimes, upon request, or as necessary for effective Army law enforcement, and fraud; and, other crimes arising in Army procurement activities.

17–2. Functions

a. USACIDC is designated as a DRU by the SA and reports directly to The Provost Marshal General (PMG), Army.

b. USACIDC is responsible for the planning and execution of DRU responsibilities by exercising specified ADCON of organic, assigned and attached Army forces.

c. USACIDC conducts sensitive, classified and other significant criminal investigations and keeps the SA informed of such investigations.

d. USACIDC prepares reports of criminal investigations and distributes these reports to affected commander's organizations and activities.

e. USACIDC reports incidents or situations to the SA, CSA, field commanders, and agency heads to keep them aware of matters within their areas of interest.

f. USACIDC conducts crime prevention surveys and criminal activity threat assessments of facilities, activities, events, and areas that are under Army control or that directly affect the Army community. The USACIDC also conducts crime prevention surveys of other DOD facilities and activities as requested if criminal investigative resources are available.

g. USACIDC establishes liaison, coordination requirements, and procedures for USACIDC personnel to ensure effective exchange of information on matters of mutual interest with Federal, State, local, and indigenous law enforcement agencies and Army commanders and their staffs.

h. USACIDC develops criminal intelligence through the collection of raw criminal information and the centralized

analysis of crime cases and other related data. The USACIDC analyzes and identifies modus operandi, trends, and vulnerabilities, and disseminates this information to DOD and Army law enforcement and investigative agencies.

i. USACIDC plans, coordinates, develops, and establishes criminal investigative standards, procedures, and policies.

j. USACIDC selects and accredits individuals as USACIDC special agents on behalf of the SA, granting them continuing authority to investigate violations of the Uniform Code of Military Justice and other criminal statutes in which the U.S. Army has or may have an interest.

k. USACIDC operates the Army Criminal Investigation Laboratory to provide forensic support for all of DOD.

l. USACIDC operates and maintains the Army Crime Records Center.

m. USACIDC approves controlled purchases of illegal drugs by CID special agents outside military installations from persons not subject to the Uniform Code of Military Justice, pursuant to the provisions of DOD Inspector General Criminal Investigative Policy Memorandum 5.

n. USACIDC obtains approval for and directs all wiretap, eavesdrop, and investigative monitoring operations conducted by USACIDC special agents.

o. USACIDC executes search warrants, warrants of attachment, subpoenas, complaints, orders, and other legal processes issued by Federal courts. In addition, USACIDC executes apprehensions and arrests, with and without warrants, and executes searches without warrants, as authorized by law.

p. USACIDC establishes Army polygraph policies and procedures for criminal investigations.

q. USACIDC plans for and provides personal security (protective services) for DOD and DA officials as designated by the SA or CSA. Performs Personal Security Vulnerability Assessments on senior DOD and Army personnel.

r. USACIDC is the responsible agent of the DOD Criminal Investigative Task Force, with oversight by the Army General Counsel, to initiate investigations of alleged or suspected war crimes and other related offenses that may be, or have been, committed by foreign governments or its agents against U.S. personnel or interests; and, secure and preserve evidence of atrocities that may come under U.S. control, including those committed against all foreign nationals.

s. USACIDC conducts all aspects of special agent accreditation and investigations into agent misconduct.

t. USACIDC manages the Army Limitation .0015 Fund.

u. USACIDC conducts investigations of computer crimes and information network intrusions in which the Army has an interest.

v. USACIDC conducts investigations of fraud and other offenses arising in Army procurement activities.

17–3. Command and staff relationships

a. The PMG is dual hatted as the CG, USACIDC and is supervised by the CSA.

b. The Commander, USACIDC is responsible to the SA for execution of assigned responsibilities contained in 10 USC 3013(b). The Commander, USACIDC exercises ADCON authority and responsibility on behalf of the SA and in this regard is primarily responsible for the administration and support of Army forces worldwide for certain ADCON functions.

c. The Commander, USACIDC is authorized to communicate and coordinate directly with ACOM, ASCC, or other DRU commanders; HQDA; other DOD headquarters and agencies; and other foreign and domestic Government departments and agencies, as required, on matters of mutual interest subject to procedures established by the CSA.

d. The Commander, USACIDC exercises command authority, direction, and control of USACIDC units and its criminal investigative activities worldwide.

e. The Commander, USACIDC assumes command and control of RC CID units upon mobilization.

f. In time of war or under emergency conditions, USACIDC subordinate units may be attached temporarily to other Army or Joint commanders when agreed to by the commander receiving the attachment and the Commander, USACIDC, and approved by HQDA.

g. USACIDC coordinates with the Federal Bureau of Investigation and participates in the National Joint Terrorism Task Force and Joint Terrorism Task Forces.

h. USACIDC is dependent on other Army organizations and agencies for appropriate support and services per prescribed regulations and policies and maintains the following relationships:

(1) USACIDC coordinates for sustaining base information management support.

(2) USACIDC coordinates with installation commanders for base operations support activities located on their installations.

(3) USACIDC coordinates with INSCOM for CI and operational security support.

(4) USACIDC coordinates with IMCOM and USACE for facility support, including programming and execution of MILCON projects.

(5) USACIDC coordinates polygraph matters within and between DA, DOD, and external agencies.

(6) USACIDC advises and assists TRADOC in developing criminal investigative training programs.

(7) USACIDC advises and assists RCs in developing IDT and AT programs for RC CID units and personnel.

(8) USACIDC supervises and evaluates the performance of RC CID units when training with USACIDC activities.

F

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Regulation
No. 10-1

6 May 2009

Organization and Functions

ORGANIZATION AND FUNCTIONS POLICY

Supplementation of this regulation and establishment of forms other than MEDCOM/OTSG forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCRM-M.

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* This regulation supersedes MEDCOM Regulation 10-1, 26 June 1997.

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Chapter 1
General

1-1. History. This issue publishes a major revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

1-2. Purpose. This regulation provides policy and guidance for the organization and functions of the Army Medical Department (AMEDD) tables of distribution and allowances (TDA) units, activities, and installations assigned to Headquarters (HQ), United States Army (USA) Medical Command (MEDCOM). This regulation prescribes the organization and functions of AMEDD units and activities under the HQ MEDCOM, as required to accomplish the missions prescribed in Army Regulation (AR) 10-87. In areas where functions and/or policies are contained duplication has been omitted from this regulation. HQ MEDCOM staff functions are covered in MEDCOM Memo 10-2/ OTSG Reg 10-32.

1-3. References. References are listed in appendix A.

1-4. Explanation of abbreviations and terms. Abbreviations used in this regulation are explained in the glossary.

1-5. Applicability. This regulation applies to all MEDCOM units, installations, and activities. If the provisions of this policy/regulation conflict with existing negotiated union agreements, the terms of those agreements will be controlling. In any MEDCOM activity where a union has been granted exclusive recognition, no new conditions of employment should be implemented without prior discussion with the servicing civilian personnel officer regarding the obligation to negotiate with recognized unions.

1-6. Supplementation. Publication of supplements to this regulation is prohibited unless specifically approved by the Commander, HQ MEDCOM, ATTN: MCRM-M. Any *Organization and Functions* publication issued by MEDCOM major subordinate commands (MSCs) must have prior approval as above and shall conform to guidance issued in this regulation.

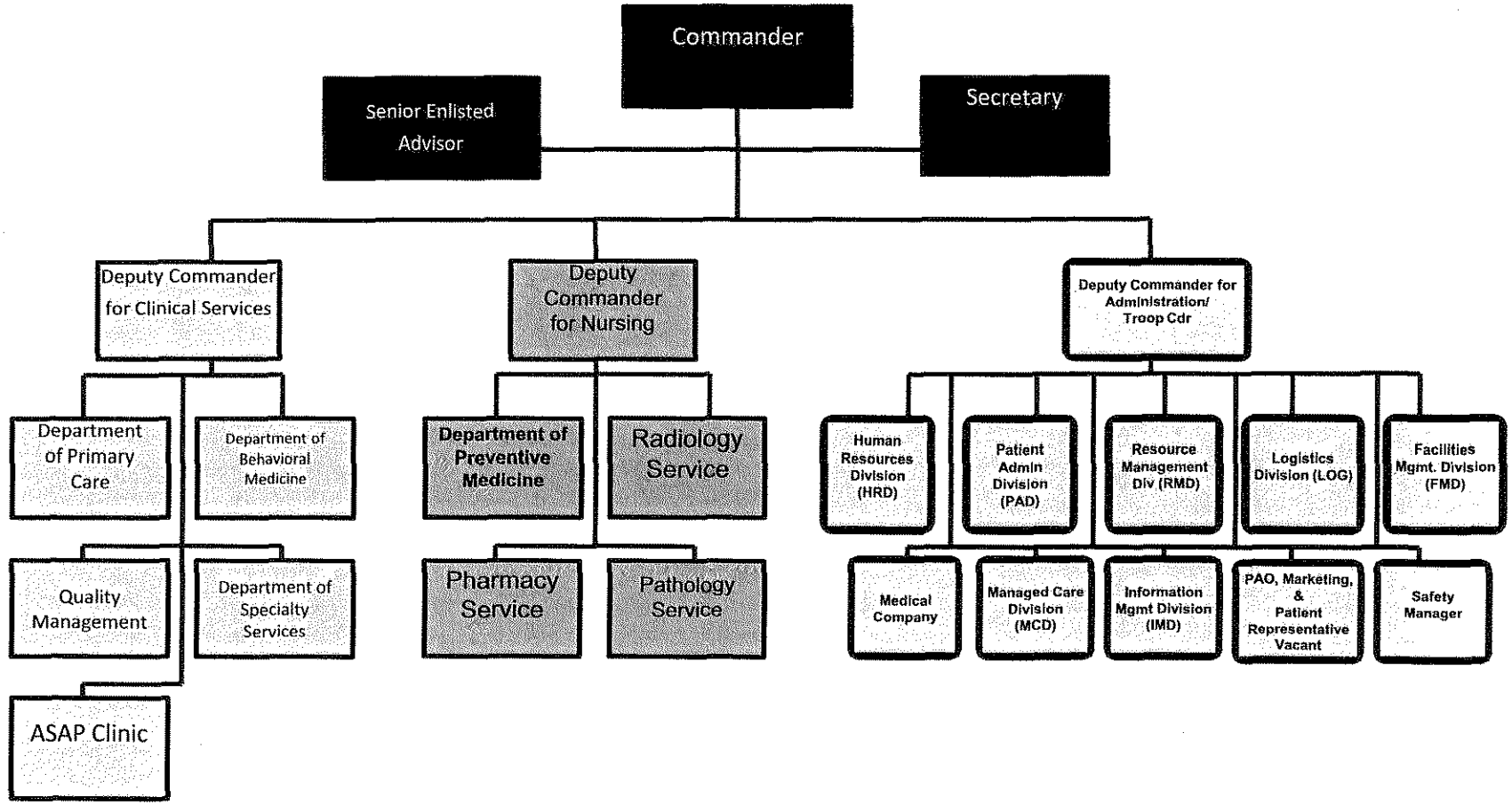
1-7. General organizational guidance

a. General.

(1) Each MEDCOM organization will structure units and activities to facilitate effective and efficient mission accomplishment; assign specific functional responsibilities to each organizational element oriented to accomplishing missions; group similar functions; eliminate functions and structures that become non-essential;

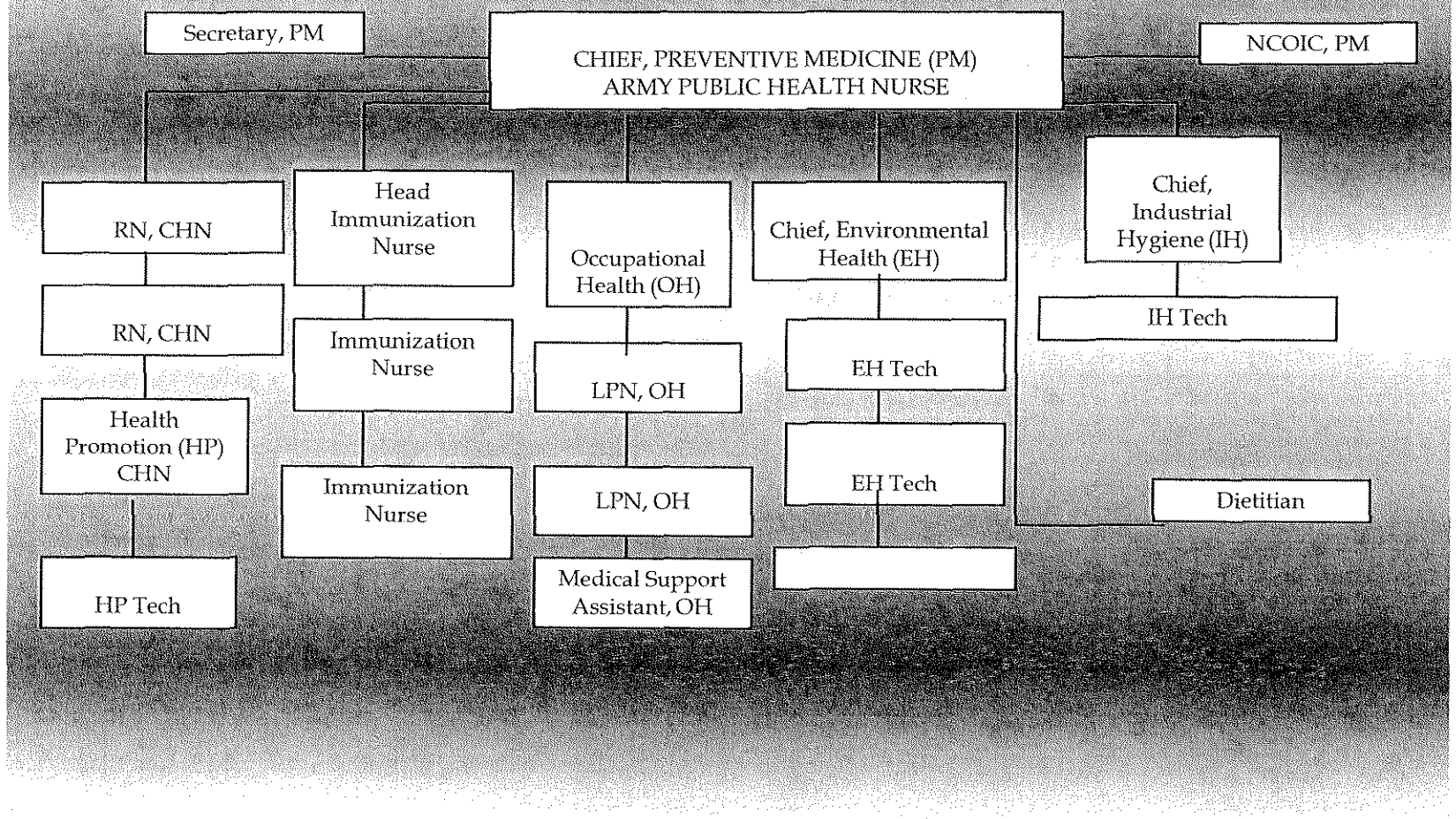
G

Lyster Army Health Clinic Organization Chart



Lyster Army Health Clinic Organization Chart

PREVENTIVE MEDICINE



H

Army Regulation 40–68

Medical Services

Clinical Quality Management

Rapid Action Revision (RAR) Issue Date: 22 May 2009

Headquarters
Department of the Army
Washington, DC
26 February 2004

TAB H

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-68
Clinical Quality Management

This rapid action revision, dated 22 May 2009--

- Establishes specific responsibilities for credentialing functions by Army Reserve Clinical Credentialing Affairs, Human Resources Command-St.Louis, and Active Army units (para 1-4*h*).

- Replaces all content in chapter 2 with new guidance regarding the Executive Committee of the Medical Staff; medical staff bylaws; military treatment facility committees and functions; and departmental/service organization, structure, and leadership (chap 2).

- Eliminates the requirement to submit the annual military treatment facility Quality Management Program Summary Report to the U.S. Army Medical Command (previously covered in chap 2).

- Identifies the American Nurses Association Standards of Nursing Practice or other national professional organizations' standards as the source of practice expectations (para 3-3*b*(7)).

- Relocates information regarding confidentiality of quality assurance documents from paragraph 2-5 to chapter 3 (para 3-7).

- Requires veterinarians to maintain a current, active, valid, and unrestricted license to practice independently within their defined scope of practice (para 4-4*a*(1)).

- Specifies the educational preparation by an accredited institution for military and civilian registered nurses and licensed practical nurses and requires the National Council Licensure Examination- Registered Nurses/ Practical Nurses for the military Army Nurse Corps and 68WM6/M3 (para 4-6*c*).

- Restates the requirement for an unrestricted license (all Corps) and explains the process for limited waiver/exception (paras 4-6*g* and 4-7).

- Clarifies the licensure requirement for personal services versus non-personal services contract healthcare personnel (para 4-8*a*).

- Specifies the use of DA Forms 7653 and 7654 for competency verification of Army Nurses Corps personnel with skill identifier 8A (Critical Care) and M5 (Emergency Nursing) (para 5-1*a*(1)(b)).

- Requires currency of emergency life support training at all times (para 5-1*e*).

- Deletes the requirement for the advanced practice registered nurse, other than the non-personal services advanced practice registered nurse, to possess and maintain advanced practice licensure (para 7-4*b*(2)).

- Restates the collaborative interaction required between the certified registered nurse anesthetist and anesthesiologist or operating surgeon (para 7-4*e*(4)(a)-(c)).

- Authorizes selected prescription writing by occupational therapists (para 7-13*c*(2)(a)(6)).

- Updates professional credentials requirements for physician assistants (para 7-16*b*).

- Clarifies Category I and II privileges for physical therapists (para 7-17*c*).

- Provides 10 USC 1102 protection to all documents in the provider credential file and the provider activity file (paras 8-3*b*(2)(c) and 8-9*a*).

- Stipulates that the chairperson of the credentials committee will be a physician and that he/she will vote only in event of a tie (paras 8-5*b* and 8-5*c*(5).

- Indicates that the responsibility for credentials verification for contracted personnel will be specified in the contract (para 8-6*d*).

- Allows use of the American Board of Medical Specialties Web site to verify board certification (para 8-7*d*).

- Exempts providers outside the continental United States from the requirement of a current Drug Enforcement Agency certificate (para 8-7*k*).

- Directs that qualified healthcare providers obtain a National Provider Identifier (para 8-7*r*).

- Provides detailed information related to telemedicine procedures (para 9-2*c*(7)(a)).

- Directs the military treatment facility credentials office to maintain the provider credential file for any assigned provider not currently involved in clinical practice (para 9-6*b*).

- Provides new instruction for U.S. Army Reserve/Army National Guard deployment privileging (para 9-8*c*(4)(d)).

- Clarifies that peer review for an adverse privileging/practice action be performed by a panel (para 10-6*e*(2)(c)).

- Requires that a physician chair the adverse actions hearing board (para 10-8*a*) and that he/she will vote only in the event of a tie (para 10-8*g*).

- Eliminates the requirement for verbatim transcript of the adverse actions hearing board (para 10-8*e*(3)).

- States that the voluntary modification of privileges/practice as a result of a medical or behavioral condition is not an adverse privileging/practice action (para 11-4*c*).

- Revises the risk management content entirety and omits reference to the now disbanded Consultation Case Review Branch (paras 13-1 through 13-5).

- Specifies that any death/disability of a military member as a result of medical care will be treated as a potentially compensable event (para 13-5*b*).

- Revises the layout and contents of the competency assessment file (app C).

- Make additional rapid action revision changes (chaps 6, 7, 8, 9, 10, 11, 13,14, and apps E, F, G, H, I, J).

Headquarters
Department of the Army
Washington, DC
26 February 2004

*Army Regulation 40–68

Effective 26 March 2004

Medical Services

Clinical Quality Management

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:

JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision (RAR). This RAR is effective 29 June 2009. The portions affected by this RAR are listed in the summary of change.

Summary. This consolidated regulation prescribes policies, procedures, and responsibilities for the administration of the Clinical Quality Management Program. It includes DOD and statutory policies addressing medical services quality management requirements. In addition, it implements DOD 6025.13–R, DODD 6000.14, and other DOD guidance.

Applicability. This regulation applies to the Active Army, the Army National Guard of the United States, including periods when operating in an Army National Guard capacity, and U.S. Army Reserve. This document applies in both the table of distribution and allowances and table of organization and equipment environments. It applies to all personnel (Active Army, Army National Guard of the United States, the U.S. Army Reserve, civilian employees, contract personnel, and foreign national local hires) who work within medical department activities, medical centers, dental activities, and organizations for which the Army Medical Department is the responsible official. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or a direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated. (See appendix J.)

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from The Surgeon General (DASG–HSZ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Office of The Surgeon General (DASG–HSZ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. This publication is available in electronic media only and is intended for command levels B, C, D, and E for the Active Army; C, D, and E for the Army National Guard of the United States; and B, C, D, and E for the U. S. Army Reserve.

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Purpose • 1–1, *page 1*
References • 1–2, *page 1*
Explanation of abbreviations and terms • 1–3, *page 1*

*This regulation supersedes AR 40–68, dated 26 February 2004. This regulation supersedes Army Regulation 40–68, dated 20 December 1989, and Army Regulation 40–48, dated 7 November 2000. It rescinds DA Forms 5440–17–R, 5440–27–R, and 5441–27–R, dated June 1991; and DA Forms 5440–26–1–R, 5440–26–2–R 5441–17–R, 5441–26–1–R, 5441–26–2–R, and 5753–R, dated July 1989. (DA Forms 5440–26–3–R and 5441–26–3–R were rescinded in June 1995.) This edition publishes a rapid action revision.

UNCLASSIFIED

Army Regulation 40–68

Medical Services

Clinical Quality Management

Rapid Action Revision (RAR) Issue Date: 22 May 2009

Headquarters
Department of the Army
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Headquarters
Department of the Army
Washington, DC
26 February 2004

*Army Regulation 40–68

Effective 26 March 2004

Medical Services

Clinical Quality Management

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Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated. (See appendix J.)

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*This regulation supersedes AR 40–68, dated 26 February 2004. This regulation supersedes Army Regulation 40–68, dated 20 December 1989, and Army Regulation 40–48, dated 7 November 2000. It rescinds DA Forms 5440–17–R, 5440–27–R, and 5441–27–R, dated June 1991; and DA Forms 5440–26–1–R, 5440–26–2–R 5441–17–R, 5441–26–1–R, 5441–26–2–R, and 5753–R, dated July 1989. (DA Forms 5440–26–3–R and 5441–26–3–R were rescinded in June 1995.) This edition publishes a rapid action revision.

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Glossary

Chapter 1
Introduction

1–1. Purpose
This regulation establishes policies, procedures, and responsibilities for the administration of the Army Medical Department (AMEDD) Clinical Quality Management Program (CQMP).

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities
a. The Surgeon General. The Surgeon General (TSG), as the senior medical officer in the Department of Army (DA), is/will—

(1) Responsible for the quality of health care delivered to all categories of beneficiaries.

(2) Establish CQMP policy to implement Department of Defense (DOD) 6025.13–R, other applicable DODD/ Department of Defense Instructions (DODIs), and current accrediting/regulatory guidance.

(3) Responsible for the quality of care provided in all military treatment facilities (MTFs) within the AMEDD. Serves as the governing body (GB) for health care facilities worldwide.

(4) The sole authority for reporting adverse privileging/practice actions and malpractice claims against providers to State and other regulatory agencies and to the National Practitioner Data Bank (NPDB).

(5) Delegate GB authority to MTF commanders, thus, making them responsible and accountable for the quality of health care provided in their treatment facilities.

b. Commander, United States Army Recruiting Command. The Commander, United States Army Recruiting Command (USAREC) is/will—

(1) Ensure adherence to requirements for selection, commissioning, and accession of health care professionals.

(2) Responsible for primary source verification (PSV) of licensure, or other authorizing documents for the AMEDD new accession, as well as collecting and forwarding these documents to the appropriate unit of assignment.

c. U.S. Army Medical Command (USAMEDCOM) Staff Judge Advocate. The U.S. Army Medical Command (USAMEDCOM) Staff Judge Advocate (SJA) will provide legal interpretation of and guidance related to the contents and application of this regulation.

d. USAMEDCOM Inspector General. The USAMEDCOM Inspector General (IG) will conduct independent assessments of the issues related to the quality of health care in the AMEDD.

e. USAMEDCOM Quality Management Division staff. The USAMEDCOM Quality Management Division (QMD) staff will—

(1) Exercise broad oversight responsibility for implementation of the AMEDD CQMP as delegated by TSG.

(2) Represent TSG as a member of various committees and working groups sponsored by the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA), Department of Defense (DOD), and other health care quality agencies.

(3) Provide corporate-level clinical quality management (CQM) guidance within the AMEDD to include policy on credentialing, performance-based privileging, outcomes management (OM), medical staff appointment, and accreditation processes.

(4) Provide corporate guidance, administrative and/or clinical advice, consultation, and education to define and/or clarify standards of care, practice, and policy.

(5) Administer the corporate AMEDD Patient Safety (PS) and Risk Management (RM) Programs that include but are not be limited to: risk assessment, risk avoidance, safety practices, incident monitoring/management, adverse privileging/practice actions, sentinel events (SEs), and malpractice claims.

(6) Provide policy guidance, consultation, monitoring, and review of SEs that occur within the AMEDD.

(7) Monitor trends in processes and outcomes of care and report the results to both internal and external sources, as appropriate.

(8) Collect aggregate AMEDD CQM data, as required by TSG, OASD/HA, or other agencies.

(9) Serve as the corporate repository for select CQMP data.

(10) Implement the administrative procedures related to reporting adverse privileging/practice actions to appropriate national, professional, and State licensure, certification, and registration agencies according to DOD guidance.

(11) Implement the administrative procedures related to reporting providers to the NPDB according to established DOD guidance.

(12) Maintain the AMEDD corporate contract with The Joint Commission (TJC), or other accrediting agency as approved by the OASD(HA), and provide guidance on the accreditation processes.

(13) Responsible for PSV of selected documents as well as collecting and forwarding to their gaining MTF (see chap 8) initial credentials documents for deferred medical officers entering active duty (AD).

f. Commanders of major subordinate commands. Commanders of major subordinate commands (except Veterinary Command), 18th Medical Command, and Command Surgeons of the Training and Doctrine Command, Forces Command, U.S. Army Reserve Command (USARC), and National Guard Bureau are/will—

(1) Responsible for administration of this regulation; the effectiveness of the CQM, Performance Improvement (PI), and RM Programs in their subordinate units; and for tables of distribution and allowances (TDA), table of organization and equipment (TOE), and modified TOE units under their command.

(2) Control the extent of patient care services in those TDA and TOE treatment facilities in their areas of responsibility.

(3) Employ qualified IG assets or subject matter experts as necessary to conduct local quality-of-care investigations.

(4) Ensure integration of the U.S. Army Reserve and Army National Guard of the United States (USAR/ARNG) provider/professional issues/actions into all aspects of the organization's CQMP.

(5) Regional Medical Command (RMC) commanders will provide input to and recommend modifications or corrections to the support plan as submitted by the TOE commander for field patient care exercises within the RMC command area (see para *i*(3) below), as required. The RMC commander may delegate approval authority to the director of health services (DHS).

g. MTF commanders. MTF commanders will—

(1) Meet the appropriate requirements related to health care quality management and quality assurance as delineated in current published regulations, statutes, accreditation standards, and DODDs/DODIs.

(2) Approve the award of medical and dental staff appointments for qualified providers (any discipline), clinical privileges, alterations in privileges, adverse privileging actions, and written notification of same, to all military, civilian, contract, and volunteer health care providers.

(3) Ensure that a comprehensive, integrated CQMP is established in compliance with this regulation.

(4) Appoint one or more personnel qualified by education, training, and experience to manage the CQMP components as addressed in this regulation.

(5) Ensure coordination of actions under appropriate regulations and the Uniform Code of Military Justice (UCMJ) when necessitated by findings under this regulation.

(6) Employ or request from the RMC/regional dental command (RDC) qualified subject matter experts as necessary to conduct local quality-of-care investigations.

(7) Designate a chairperson for the credentials committee/function.

(8) Designate membership of the committee/function tasked to provide support and oversight of impaired health care personnel (IHCP) (previously the Impaired Healthcare Provider Program).

(9) Ensure systematic credentials authentication and competency assessment for all health care personnel. This includes PSV of all licensure, certification, registration, and/or other authorizing documents required for practice prior to employment.

(10) Ensure that interactive collaboration is maintained with civilian agencies involved in external resource sharing agreements to communicate credentialing and privileging information.

(11) Ensure the organization is in continuous compliance with current TJC standards and other regulatory/accreditation requirements, as appropriate. For TJC purposes, the medical commander is the delegated authority to represent the GB at the local level.

(12) Ensure implementation of an integrated Patient Safety Program (PSP) throughout the organization.

(13) Provide opportunities for integration of USAR/ARNG TDA caretaker hospital health care personnel into all aspects of the facility-specific CQM processes/functions.

(14) Award appropriate practice privileges to USAR/ARNG providers upon the review of inter-facility credentials transfer briefs (ICTBs) and required privileging documentation from civilian health care organizations. Current competency in the duty area of concentration (AOC) and/or specialty skill must be ensured before granting or renewing privileges for USAR/ARNG providers who do not currently hold comparable privileges within their Reserve unit.

(15) As DHS, coordinate with the TOE commander for the provision of health care and services during training exercises.

(16) Ensure that an optimal professional relationship exists among all healthcare providers in the facility.

h. USAR and ARNG State Surgeons. For the USAR, Army Reserve Clinical Credentialing Affairs (ARCCA) performs the CQMP procedures noted below for providers in TPUs; HRC-St. Louis is responsible for these activities for IRR Soldiers; and, for IMA providers assigned to AA units, the AA medical/dental unit performs these functions. For the ARNG, State Surgeons are responsible for the administration of the policies contained in this regulation. The above named authorities are required to establish PI programs within their respective commands and will—

(1) Designate a CQMP manager.

(2) Establish a credentials committee/function and ensure systematic credentials verification and competency assessment for all health care professionals. This includes authentication of all licensure, certification, registration, and/or other authorizing documents required for practice.

(3) Establish and maintain provider credentials files (PCFs).

(4) Provide complete and current ICTBs for review by the serviced MTF.

(5) Award privileges (USAR medical unit commanders/ARNG State Surgeons) to assigned healthcare providers involved in delivering health care to eligible beneficiaries during unit-controlled inactive duty training (IDT) and annual training (AT) activities. Examples of these activities include physical examinations, immunizations, dental examinations, Soldier readiness processing, field exercises, and medical support missions. Clinical privileging for medical treatment provided during IDT is limited to acute and emergent care only. NOTE: USAR providers who perform IDT or AT at an AA MTF will be privileged by that MTF.

i. Commanders of TOE and modified TOE units. Commanders of TOE and modified TOE units will—

(1) During training exercises, establish an open dialogue for coordination of health care and services with the DHS for the area of operations.

(2) Propose a scope of service/practice for the unit to the DHS, specifying, as a minimum, the following elements:

(a) Types and ages of patients served.

(b) The appropriateness, clinical necessity, and timeliness of support services to be provided directly by the hospital or through referral contracts.

(c) The availability of necessary staff to provide care.

(d) The extent to which the level of care or service provided meets patients' needs.

(e) Practice based on recognized standards of medical care or clinical practice guidelines, where these are in use.

(f) The extent to which the facility will be operational and proposed staffing while operational.

(3) In coordination with the DHS, establish a plan that includes both the TOE unit's scope of services and the professional support and backup to be provided by the co-located TDA unit.

(4) Forward the plan in (3) above for approval to the RMC commander.

j. Other MTF personnel.

(1) *Deputy commander for clinical services (DCCS).* The DCCS is/will—

(a) A privileged physician holding an active appointment to the medical staff and designated as Chief of the Medical Staff.

(b) The principal executive staff advisor to the commander concerning matters of quality and scope of medical care and utilization of professional resources, medical policy, and planning.

(c) Responsible for and has oversight of the credentialing and privileging process.

(d) Act as liaison between assigned members of the medical staff and the commander and, as such, advocate on behalf of the medical staff and executive leadership.

(e) Chairperson of the executive committee of the medical staff (ECMS). (In the absence of the DCCS, this responsibility may be delegated by the MTF commander to another appropriately qualified individual.)

(f) Chairperson of the credentials committee/function or, with approval of the commander, this responsibility may be delegated.

(g) With the approval of the commander, delegate selected DCCS responsibilities to a physician with appropriate qualifications.

(h) Intervene on behalf of the commander to immediately hold in abeyance or suspend privileges when a provider's conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this regulation. (See chap 9.)

(i) Orient all medical staff applicants concerning MTF bylaws governing patient care, medical staff responsibilities, professional ethics, continuing education requirements, privileging, adverse privileging actions, and due process proceedings.

(j) Responsible for ensuring organizational PI activities are in place and actively participates in these processes.

(k) Ensure that an ongoing, proactive program for identifying risks to PS and for reducing medical/health care errors is implemented according to DODI 6025.17 and USAMEDCOM guidance.

(l) Participate in the development and implementation of policies and procedures that guide and support the provision of services ensuring that such policies and procedures are integrated into the overall plan for patient care.

(m) Ensure an effective peer review program (see glossary) is in place for the organization's health care professionals.

(2) *Deputy commander for nursing (DCN) (or comparable title).* The DCN is/will—

(a) A licensed professional registered nurse.

(b) The principal executive staff advisor to the commander on matters concerning the scope of patient care services and clinical policy (specifically related to the provision of nursing care and services and nurse staffing standards), nursing policy, and the availability and utilization of nursing resources.

(c) Act as liaison between members of the nursing staff and the commander and, as such, advocate for the provision of quality nursing care, treatment, and services.

(d) Participate in the development, implementation, and integration into the organization's overall plan for patient care, policies and procedures that guide and support the provision of quality patient care services.

(e) A voting member of the ECMS (or comparably named committee).

(f) Ensure PI activities are in place in all arenas in which nursing care, treatment, or services are rendered and actively participate in these processes.

(g) A voting member of the MTF credentials committee with responsibility for review and concurrence with scope of practice and privileges for nursing personnel.

(h) Reduce or appropriately limit the scope of practice of any nursing staff member whose competence, quality of care, behavior/conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this regulation. (See chap 9.)

(i) Support and actively engage in an ongoing, proactive program for identifying PS risks and for reducing nursing/healthcare errors according to DOD 6025.13–R and USAMEDCOM guidance.

(j) An active participant in the organization's RM program.

(k) Ensure the presence of an effective nursing peer review program (see glossary).

(l) Executive staff advisor to the commander for other non-nursing hospital personnel and services under his/her supervision and authority, with the associated quality management responsibilities as noted above.

(3) *Chief, department, service, or clinic and TOE command surgeons.* (References to departments and services include alternate organizational structures such as product line teams or multidisciplinary care teams in facilities with these alternative structures.) For clinical department/services/clinics with chiefs who are not physicians, also see paragraph 2–3. In his/her area of responsibility, or technical oversight, the chief/command surgeon is/will—

(a) Responsible for all clinically related activities.

(b) Perform ongoing surveillance of the clinical performance of individuals who are required to hold a license, certification, or registration for clinical practice.

(c) Responsible for ongoing functional CQM activities and their integration, as appropriate, into the organizational PI Program.

(d) Provide oversight of and participate in the peer review process.

(e) Recommend to the medical staff the clinical privileging criteria that are relevant to the care provided in the department/service/unit.

(f) Recommend privileges for each provider in the department/service/unit, as authorized.

(g) Make recommendation to the relevant hospital authority for needed patient care services not provided by the department/service/unit or the MTF.

(h) Integrate the services of the department/service/unit with the primary functions of the MTF.

(i) Coordinate and integrate inter/intradepartmental services.

(j) Participate in the development and implementation of policies and procedures that guide and support the provision of services. Ensure that such policies and procedures are integrated into the overall plan for patient care.

(k) Determine the qualifications and competencies of department/service/unit health care personnel.

(l) Establish objective, quantifiable methods to continually assess and improve the quality of care and service provided. Utilize ORYX™ data, or like data, as applicable.

(m) Maintain quality control programs, as appropriate, and ensure that PS issues are given high priority and addressed when department/service/unit-level processes, functions, or services are designed or redesigned.

(n) Provide and support orientation, in-service training, and continuing education of all personnel in the department/service/unit.

(o) Make recommendations for space and other resources required by the department/service/unit.

(p) Recommend a sufficient number of qualified and competent persons to provide care.

(q) Participate in outside source selection for needed services.

(4) *Privileged staff.* The privileged provider will—

(a) Acknowledge, in writing, at the time clinical privileges and medical staff appointment (if applicable) are awarded, the intent to abide by applicable bylaws.

(b) When appointed a member of the credentials committee/function, make recommendations on renewals, reevaluations, denials, or modifications of privileges of assigned providers.

(c) Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the privileges requested and/or according to the AOCs and additional skill identifiers (ASIs) awarded, accomplish required training, and ensure the currency of all documents and other information contained in his/her provider files.

(d) Participate in PI, quality control, and peer review processes.

(5) *All other organizational assigned personnel.* Personnel, other than privileged providers, will—

(a) Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the scope of practice of the assigned position, accomplish required training, and ensure the currency of all documents and other information contained in his/her competency assessment file (CAF).

(b) Participate in PI, quality control, and peer review processes, as applicable.

(c) Ensure knowledge of and responsibility for implementing all applicable organizational policies and procedures relevant to his/her job description and/or scope of practice.

(6) *CQM coordinator.* The CQM coordinator, or similarly titled individual (for example, PI coordinator), is tasked with overall responsibility for the organization's CQMP. The individual in this role may be expected to exercise broad oversight and to collaborate with various key staff to ensure the integration of the quality functions performed by the organization. This requires the incumbent to be an active member of the executive leadership team. He/she will—

(a) Ensure that organization-wide PI is a dynamic process based on ongoing identification of opportunities for change.

(b) Provide leadership and consultative services to departments and sections within the organization with regard to credentialing and privileging issues, accreditation requirements, CQM and QA regulatory compliance issues, PI, and RM/PS.

(c) Participate in the development of policies for the organization, giving special consideration to the integration of and collaboration between internal administrative and clinical policies.

(d) Participate in the identification of opportunities for PI, recommendation of solutions for facility issues and concerns, and implementation of plans and followup activities related to organizational PI.

(e) Serve as subject-matter expert in conjunction with patient administration and the servicing Staff Judge Advocate/ legal advisor in areas such as accreditation standards for health care documentation and the medical-legal aspects of health care practice.

(f) Direct the collection, analyses, and dissemination of PI data within the organization ensuring that basic statistical analyses and comparative processes are included.

(g) Facilitate organizational efforts to provide prevention, wellness, and specific medical condition-based management programs as well as other health management programs, as required, based on timely MTF data and identified beneficiary need.

(h) Ensure that facility-specific CQM and PI Program changes are identified and implemented as data analyses dictate.

(i) Keep organizational leadership informed of public policies, DOD and DA regulations and guidance, and legislative and health care trends that affect various CQM and other related health care initiatives.

(j) Facilitate the development and implementation of PI education and training sessions for the MTF staff at all levels.

(k) Oversee the preparation of intra- and inter-organizational PI reports that demonstrate evidence of collaborative, multi-service/departmental input.

(7) *Credentials manager.* The individual in this role will—

(a) Provide technical advice and direction to the MTF commander on issues related to health care provider credentialing and/or privileging processes.

(b) Serve as a subject matter expert to the MTF staff for appropriate credentialing and privileging procedures, guidelines, and mandates according to Army regulations (ARs), DODDs and/or DODIs, TJC standards, and other regulatory agency requirements. Maintain a resource library of such reference materials.

(c) Provide technical oversight and management of the process for verification of all licensure, certification, registration, and/or other authorizing documents required for practice.

Note. At the discretion of the MTF commander, responsibility for nonprivileged providers may be assigned to another individual(s).

(d) Provide technical oversight and management of all health care provider credentialing and privileging functions.

(e) Manage all privileging and medical staff appointment processes. Serve as a point of contact (POC) to privileged staff during initial application for medical staff appointment and for biennial re-appointments.

(f) Offer comprehensive guidance and support to providers during the initial and renewal privileging processes.

(g) Ensure peer and supervisory clinical performance review of health care providers who hold initial medical staff appointment and clinical privileges.

(h) Manage and update documents of evidence contained in the PCF relevant to education, experience, licensure/ certification/registration, and training to ensure accuracy and currency of information.

(i) Conduct NPDB and other relevant inquiries and PSV to authenticate credentials of staff members for initial award/biennial renewal of clinical privileges and for initial appointment/biennial re-appointment to the medical staff.

Note. Requirements also apply for biennial update of the PCF for USAR/ARNG practitioners who are not currently privileged.

(j) When licensure, certification, or registration is required as a condition of employment, ensure that the credentials of all general schedule (GS) civilian and contract health care providers have been primary source verified prior to initial employment.

(k) Establish and maintain the organization's Centralized Credentials and Quality Assurance System (CCQAS).

(l) Ensure the CCQAS database is current and complete.

(m) Research and respond as appropriate to inquiries regarding the status of medical staff membership.

(n) Maintain all PCFs according to this regulation.

(o) Prepare and forward PCFs and/or ICTBs for privileged providers to the gaining MTF within the specified time requirements. (See chap 8.)

(p) In collaboration with the ARCCA and ARNG unit credentials manager, maintain the PCFs and CCQAS input for privileged providers in those TDA caretaker hospitals for which the MTF is responsible.

(q) Ensure that ICTBs and mandatory attachments (see paras 8–10*c* (AA) and 8–11*b* (USAR/ARNG)) are integrated into the credentials committee/function review process for timely privileging of providers.

(r) Facilitate the review of all AA/USAR/ARNG and other Federal Service PCFs or ICTBs in compliance with this regulation.

(s) Forward all requests for adverse credentialing and privileging information on individuals previously assigned or employed as privileged Federal Service providers to the USAMEDCOM QMD for action.

(t) Ensure a process for communicating credentialing and privileging information to civilian agencies involved in external resource sharing agreements.

(8) *Chief, RM and/or PS.*

Note. This may be a single position with combined responsibilities or two separate positions with individually defined responsibilities. See chap 12 and 13 for additional information.

The person performing these duties will—

(a) Integrate and coordinate all RM/PS administrative and management activities within the medical/dental facility.

(b) Collaborate with executive leadership to develop compliance programs for all regulatory and accrediting requirements associated with RM and PS.

(c) Ensure that organizational RM/PS Programs are supported at all levels.

(d) Establish/maintain a dedicated program for avoiding adverse events or medical misadventures and improving PS.

(e) Collaborate with executive leadership and the MTF safety and occupational health manager (comparable title) (DODI 6055.1) to ensure a comprehensive safety program for all patients, employees, visitors, volunteers, and others.

(f) Recommend, develop, monitor, and evaluate plans and programs to decrease facility and Government liability and/or financial loss associated with medical misadventures, accidents, and other untoward events.

(g) Initiate actions and processes that will secure, preserve, and protect evidence related to an SE.

(h) Oversee the investigation of all SEs to ensure coordination of all data collection activities, completion of a thorough and credible root cause analysis (RCA), and reporting through appropriate channels. (See para 12–5 for more detailed information regarding SEs.)

(i) Inform and coordinate all activities associated with adverse events and SEs with the Center/Claims/Command Judge Advocate (CJA).

(j) Participate in structured organizational processes to identify potential risk, analyze trends, and implement PI initiatives to reduce risks.

(k) Collaborate with the patient representative/advocate and the MTF safety and occupational health manager to identify trends related to customer concerns, complaints, or incidents and to manage problems/risks appropriately.

(l) Present opportunities for improvement related to organizational risks (including recommended solutions, implementation plans, and followup activities) to the MTF executive committee for action in support of quality patient care.

(m) Provide consultative information and risk assessment/PS reports to the executive leadership, various committees or individuals, and all levels of staff on general and specific medical RM issues and events.

k. AMEDD Center and School course directors. AMEDD Center and School course directors for all academic programs under the auspices of the AMEDD Center and School will ensure that their program of instruction contains content relevant to current AMEDD CQM policy and processes, health care facility accreditation standards, and professional practice standards. Curriculum instruction will highlight each AMEDD member's responsibility to participate in organizational CQM activities.

Chapter 2
Medical Staff and Military Treatment Facility Committee Structure and Functions

2–1. General

The Joint Commission requires an organized, self-governing medical staff to provide direction and oversight of the quality of care, treatment, and services delivered by privileged providers. The organized medical staff--referred to in this publication as the ECMS, or equivalent title--is also responsible for evaluating the competency of privileged providers on an ongoing basis, delineating the scope of privileges that will be granted, ensuring a uniform standard of

care, and providing leadership in PI activities within the organization. The medical staff is accountable to the governing body (TSG) as represented by the MTF commander.

2–2. Medical staff bylaws

a. The bylaws will be developed, adopted, and amended by the medical staff and approved by the commander as representative of the governing body. The medical staff will enforce and comply with the bylaws.

b. Many of TJC requirements for the medical staff bylaws are contained in this regulation and need not be repeated in MTF medical staff bylaws.

c. The MTF medical staff bylaws must meet current requirements of TJC. Those developed by the MTF should expand the partial listing provided in this chapter. TJC requires that bylaws include–

(1) The qualifications, roles, and responsibilities of department chiefs. (See para 1-4 j(3).)

(2) The structure, function, size, and composition of the ECMS (or equivalent committee) and of the methods for selecting and removing its members and the organized medical staff officers.

(3) The empowerment of the ECMS to act on behalf of the medical staff.

(4) The processes for credentialing, privileging, and medical staff appointment. (See chaps 8 and 9.)

(5) The indications for automatic suspension or summary suspension of medical staff membership or clinical privileges and when these procedures are implemented. (See chap 10.)

(6) The mechanism for a fair hearing and the appeal process for an adverse privileging action. (See chap 10.)

2–3. Military treatment facility departmental structure and leadership

The bylaws will describe the qualifications, roles, and responsibilities of department chiefs.

a. Physicians or other privileged providers will be appointed as chiefs of medical departments/services by the commander. Selection will be based on qualifications including clinical and leadership experience and ability. In instances where a non-physician serves as the chief of a department/service, a physician will be selected as the medical director. The medical director will advise the chief and be responsible for practice issues outside the clinical scope of the non-physician chief. The medical director will be responsible for peer review and the credentialing and privileging of physicians and other privileged providers. The chief will represent the department/service at the ECMS and other required meetings.

b. Rating schemes will reflect the administrative command and control regardless of the Corps (discipline) of the department/service chief.

2–4. Executive committee of the medical staff

The ECMS is authorized to carry out medical staff responsibilities and performs its work within the context of the functions of governance, leadership, and PI. The ECMS has the primary authority for activities related to self governance of the medical staff and for PI of the professional services provided by privileged healthcare providers. This committee reports to the executive committee. Note: There is currently no requirement for an executive committee of the dental staff (ECDS). Where this regulation requires information/action to route through the ECMS to the commander, it may go directly to the dental commander.

a. The majority (at least 51 percent) of voting ECMS members will be licensed physicians with current privileges and medical staff appointments.

b. Voting membership will include the DCCS (chairperson), the DCN, and chiefs of clinical departments. Other members, qualifications for membership, and the voting status of members (who are not members of the medical staff) will be as delineated in the medical staff bylaws. Other members may include senior privileged providers from garrison-level units and chiefs of administrative divisions/services related to patient care (for example, patient administration division (PAD) and CQM).

c. The ECMS functions may be conducted by the entire medical staff (committee of the whole) concurrently with those of another MTF committee (for example, the credentials committee) or by a separate committee.

d. The ECMS acts upon reports of MTF committees/functions, clinical departments, and subcommittees or workgroups designated by the ECMS. In addition, this committee provides recommendations to the commander at a minimum on the following:

(1) The medical staff structure.

(2) The process for credentials review and delineation of individual clinical privileges.

(3) Medical staff membership and termination of membership.

(4) The delineation of privileges for each eligible provider. (If the ECMS and the credentials committee are not the same body, the privileging recommendations of the credentials committee for each provider will be reviewed by the ECMS and forwarded to the commander.)

(5) The mechanism for terminating medical/dental staff membership.

(6) The mechanism for adverse actions fair hearing and appeal procedures.

(7) The participation of the medical staff in organizational PI activities.

2–5. Medical staff participation in performance improvement activities

a. Required functions. The Joint Commission requires the medical staff to provide leadership in measuring, assessing, and improving processes that primarily depend on the activities of privileged providers, as well as participating in organization-wide PI activities. All committee minutes/reports regarding these activities will be routed through the ECMS to the commander. As a minimum, the following functions will be evaluated, documented, tracked, and reported—

(1) Medical assessment and treatment of patients.

(2) Use of medications.

(3) Use of blood and blood components.

(4) Operative and other procedures.

(5) Appropriateness of clinical practice patterns.

(6) Significant departures from established patterns of clinical practice.

(7) Use of information about adverse privileging decisions.

(8) Use of developed criteria for autopsies.

(9) Sentinel event data.

(10) Patient safety data.

b. Suggested functions. Other PI functions that may be significant to the organization include: medical records review, tumor board/cancer conference, pain management processes, outcomes related to cardiopulmonary resuscitation, and services provided to high-risk populations.

2–6. Other military treatment facility organizational functions and committees

The Joint Commission requires an ECMS (or committee with a similar function). In addition, TJC directs the performance of other select functions; however, a committee need not be dedicated to that purpose. These functions must be accomplished by the organization, on a recurring basis, with documentation forwarded to the ECMS. The use of minutes or summary reports to document the function is a facility-level decision. Certain other committees (such as risk management) are required by agencies other than TJC, as noted below. The following committees/functions are required by this regulation:

a. Executive committee. Membership will include the commander (chairperson), DCCS, deputy commander for administration (DCA), deputy commander for nursing (DCN), or equivalents, the Command Sergeant Major, and those CQM staff/other staff designated by the commander. This committee is the conduit for channeling MTF CQM information to the commander who executes oversight authority.

b. Patient safety committee/function. PS activities are designed to maintain and improve healthcare processes and practices, reduce the potential for harm to patients, and ensure the general safety and security of patients in all settings. Membership of this multidisciplinary committee will be according to guidance from USAMEDCOM (MCHO–CL–Q). The PS committee reports through the ECMS to the executive committee

c. Risk management committee/function. DOD 6025.13–R requires an RM committee. If these risk management duties are not performed by a dedicated committee, the medical staff bylaws will specify how this function will be accomplished. See chapter 13 for RM and the committee/function.

d. Credentials committee/function. See chapters 8-10.

e. Impaired healthcare personnel committee. See chapter 11.

f. Healthcare consortium. This forum offers an opportunity for beneficiaries to provide input into healthcare delivery policy and to promote communication between the MTF and its beneficiaries. Participants will include the commander or designee (as chairperson); MTF leadership; and representation from officer, enlisted, Family member, and retiree beneficiaries. Local policy will define additional parameters of this committee (frequency of meetings, etc.). In settings like Europe where DoD beneficiaries are dispersed over a wide geographical area, commanders may delegate authority for holding local meetings. To satisfy this requirement, MTF commanders may attend installation town hall meetings.

g. Other formal committees. Various committees, boards, and councils may be established with the approval of the executive committee to perform the monitoring and evaluation required in paragraph 2-5 of this regulation and other relevant guidance (DOD 6025.13–R) as well as the PI functions as described in the MTF CQM plan.

h. Committee/function records and reports. A written record of all CQM committees/functions will be maintained by the MTF. The quality management (QM) office, or equivalent, is the recommended site. The MTF CQM plan will define the process for communicating the results of CQM activities and associated recommendations/actions within the organization and to other outside organizations.

Chapter 3
The Clinical Quality Management Program and Organizational Performance Improvement

3–1. The Clinical Quality Management Program

a. The purpose of the AMEDD medical and dental CQMP is to continuously and objectively assess key aspects of individual and institutional performance with the intent to improve the health care and services provided to eligible DOD beneficiaries and others.

b. Military treatment facility/dental activity (DENTAC) commanders will establish and resource a CQMP that coincides with any RMC/regional dental command (RDC) and/or DOD programs, as appropriate, and meets the unique needs of the organization. When developing the facility-level CQMP, consideration must be given to all accreditation and regulatory requirements. A comprehensive program requires integration of these criteria that offer evidence of the quality, cost, availability, and appropriateness of care and services being provided to DOD beneficiaries of all ages. Critical to the success of the CQMP is the active involvement and participation of all staff members.

c. Clinical quality management will be integrated into the organization's vision and mission statements and guiding principles. Such integration affords MTF/DENTAC leadership an opportunity to develop an effective strategic plan of action for the delivery and continuous improvement of quality care.

d. Each MTF/DENTAC will maintain a single written plan that includes all departments/services/functions and will define how each of its established CQM processes and PI activities will be implemented. When devising such a plan, various CQM models are available including the Find-Plan-Do-Study-Act/Plan-Do-Check-Act (that is, FOCUS/PDCA) framework (see glossary and app A).

e. Improving individual and organizational performance necessitates the use of various techniques, tools, and methodologies within a structured framework to measure and ultimately enhance the quality and cost efficiency of healthcare delivery. While all healthcare personnel are stakeholders in the PI process, an executive leadership committed to quality is crucial to linking organizational strategic priorities with QI efforts, thereby optimizing the impact of improvement activities on organizational performance as a whole.

3–2. Processes and functions requiring measurement

Effective PI requires the measurement, evaluation, and comparison over time of a variety of patient-focused functions, organizational functions, and other activities. Standards addressing these activities are found in various TJC comprehensive accreditation manuals including those for hospitals, ambulatory care, behavioral health, home care, long-term care, laboratory services, and others. The facility's review mechanisms designed to systematically measure and continuously evaluate these activities must be collaborative and multidisciplinary.

3–3. Performance improvement data sources and analyses

a. Successful PI will be based on effective use of both clinical and administrative data from a variety of sources. The MTF/DENTAC, in coordination with the RMC/RDC and USAMEDCOM, will determine which data are appropriate to consider for the purpose of organizational improvement.

b. Various activities, programs, and processes such as those in (1) through (7), below, merit consideration as sources of information that may influence the PI Program within the organization.

(1) Beneficiary and health care professional education and feedback sessions;

(2) CPG-based condition management programs;

(3) Putting Prevention into Practice, Healthy People 2010, and other illness prevention and health promotion activities;

(4) UM activities such as demand and referral management, case management, and discharge planning;

(5) Provider, clinic, and clinic team profiling related to morbidity, mortality, length of stay, access, disease and prevention program and/or outcomes-related metrics, patient satisfaction, and cost;

(6) Discipline-specific standards of care for privileged providers; and

(7) American Nurses Association (ANA) Standards of Nursing Practice or other nursing specialty organization's standards of practice (for example, the Association of periOperative Registered Nurses or the American Association of Critical Care Nursing, as appropriate) for the delivery of nursing care and recognized practice standards for other healthcare specialties.

c. An expected consequence of effective data analyses related to OM/UM activities is the identification of those clinical practices with significant positive outcomes that are successfully contributing to the organization's PI objectives. At the same time, practices that are ineffective in promoting PI objectives (that is, result in negative outcomes) may be noted. Careful analysis of the risk-adjusted outcomes data will facilitate determination of both best and least effective practices for the organization. Organizational personnel, working in small focus groups, may be tasked to address processes that result in statistically significant positive or negative outcomes. These personnel should carefully evaluate the circumstances resulting in negative patient/organizational outcomes with specific emphasis on recommendations for PI. Those circumstances with notably positive outcomes may warrant promulgation throughout the organization, the AMEDD, or the DOD.

d. The commander is responsible for analyzing the results of MTF studies conducted by external accrediting agencies as well as DOD or AMEDD-level organizations. In addition, the results from TJC and the National Committee on Quality Assurance metrics monitoring, CMS and Health Plan Employer and Data Information Set standards/metrics provide useful data. The National Quality Management Program contract reports, as applicable, and the contractor CQM monitoring of the civilian health care provider network as stipulated in the TRICARE regional contract should be carefully considered. Actions to improve performance outcomes based on the various data available should be taken.

3–4. Performance improvement activities in the facility's written plan

a. The MTF-specific approach to process improvement will be articulated in a plan (see para 2–2*b*) that clearly defines how all levels of the organization will address improvement issues. Emphasis on quantifiable improvements relative to the processes and outcomes of care is essential. The PI plan will provide a systematic approach to PI and will contain—

(1) An identified scope and focus for measurement (that is, what data elements will be assessed).

(2) Structured processes to assess performance (that is, how the data will be assessed).

(3) Clearly established priorities for improvement.

(4) Application of OM/UM/UR information to prioritize management and use of limited organizational resources.

(5) Implementation of PI activities based on assessment conclusions.

(6) Identified processes to maintain achieved improvements.

b. The PI plan will describe all processes, procedures, and criteria used to evaluate care as well as the functions of the staff responsible for implementation and evaluation of the various UM/OM activities. A systematic process for considering and acting on recommendations for organizational improvement will be clearly identified in the plan.

3–5. Facility accreditation

Accreditation of AMEDD MTFs and designated health care programs/functions by recognized national organizations, as required by law and DOD guidance, is an integral part of the AMEDD CQMP, specifically in support of organizational PI.

a. Facilities requiring accreditation. It is DOD policy that all fixed hospitals, troop medical clinics, hospital-sponsored substance abuse rehabilitation programs, and free standing ambulatory care clinics (medical only) will maintain accreditation by the TJC or other accreditation source approved by the OASD(HA).

b. Accreditation requirements. All facilities will maintain accreditation under the TJC standards or other nationally recognized accreditation organization standards, as approved by OASD(HA), that apply to the services and delivery systems that describe their care. (See para 3–2.)

c. Accreditation guidance. Information related to accreditation standards is contained in various references listed in appendix A and will not be duplicated in this regulation. On occasion, TSG may direct policies and procedures that exceed the standards of recognized accrediting agencies; in these cases, appropriate implementing instructions will be issued. If a conflict exists between accrediting agency standards and U.S. Army policy, current Army policy will prevail. The USAMEDCOM QMD will pursue resolution of any recognized inconsistency in guidance with the accrediting agency.

d. Accreditation funding. The TJC Accreditation Program for the AMEDD is centrally funded and administered by the USAMEDCOM QMD. Facilities will complete applications for survey in accordance with current requirements of TJC. The USAMEDCOM QMD will review the application in consultation with the facility and RMC personnel and provide authorization for the MTF to electronically forward the application to the TJC. The USAMEDCOM QMD is responsible for reimbursement of the triennial TJC surveys. A copy of each MTF's application for survey will be maintained on file in conjunction with survey-related expenditures. To ensure correct Government payment to TJC, requests for survey date changes or changes in the scope of a scheduled TJC survey will be made only by the USAMEDCOM QMD.

e. AMEDD equivalencies for TJC survey. The TJC recognizes the following equivalencies when applying TJC standards to AMEDD MTFs.

(1) TSG serves as the GB for all MTFs worldwide.

(2) Federal law, DODDs, ARs, TSG policies, and USAMEDCOM directives/policies serve as the hospital bylaws. These need not be rewritten to be included in facility-level documents. In addition, MTF commanders may require local policy for issues/activities not prescribed by guidance from other sources. Such local policies complement higher headquarters' requirements and are also part of the MTF formal bylaws.

(3) The MTF's mission statement describes its purpose and community responsibilities.

(4) The MTF commander serves as the chief executive officer and represents the GB.

(5) The deputy commander for administration (DCA) or equivalent serves as the chief operating officer.

(6) The DCCS or equivalent serves as the chief or president of the medical staff.

(7) The deputy commander for nursing (DCN) or equivalent serves as the nurse executive.

(8) The MTF executive committee formally links the functions of the GB representative, the chief operating officer, and the medical and other professional staff, with other important aspects of the organization's operation.

f. TJC survey report submission. The MTF commander (medical units only) will submit to the USAMEDCOM QMD a copy of the preliminary report provided by TJC surveyors at the completion of the survey regardless of the survey results or disagreement on the part of MTF staff with the survey results. This requirement applies to all surveys by TJC.

g. MTF after-action reports. Within 30 days of completion of any TJC survey (triennial, unannounced, surveys for cause, or focused), the MTF commander will submit, through the next higher headquarters, to the Commander, USAMEDCOM, ATTN: MCHO–CL–Q, 2050 Worth Road, Fort Sam Houston, TX 78234–6010, an after-action report detailing the survey preparation process (planned surveys) and any lessons learned as a result of the survey process. The USAMEDCOM QMD will disseminate lessons learned, as appropriate.

3–6. Patient rights and responsibilities

a. The health care beneficiary is the central focus of all CQM activities. This focus recognizes the patient as a partner, optimizes patient rights within the health care system, and capitalizes on the value of consumer feedback to effectively improve the processes of care.

b. Implementation of patient rights as defined in DODD 6000.14, current TJC standards, and the Health Insurance Portability and Accountability Act of 1996 is an important component of the CQMP. These rights include but are not limited to—

(1) Information disclosure and access and amendment rights.

(2) Choice of providers and health plans.

(3) Access to emergency services (military or civilian).

(4) Participation in treatment decisions.

(5) Respect and nondiscrimination.

(6) Confidentiality of patient-specific health information.

(7) Complaints and appeals.

c. All health care personnel share in the professional responsibility of ensuring that beneficiaries understand not only their rights but also their responsibility to participate in their own health care decisions. Patients will be provided information as to their rights as beneficiaries of the DOD military health system (MHS), according to local policy.

d. Written and verbal beneficiary perceptions of care and services, both positive and negative, will be incorporated into MTF CQMP processes as appropriate.

3–7. Confidentiality of quality assurance documents and records

The National Defense Authorization Act for fiscal year 1987 (Public Law (PL) No. 99-661), section 1102, Title 10, (10 USC 1102) mandates that records created by or for the DOD in a medical or dental QA program are confidential and privileged. PL 99-661 and subsequent guidance predicated on this law (10 USC 1102) preclude disclosure of, or testimony about, any records or findings, recommendations, evaluations, opinions, or actions taken as part of a QA program except in limited situations. Under the provisions of 10 USC 1102, this information is exempt from release in accordance with Exemption 3 of the FOIA. Additional detailed information regarding the confidentiality of QA documents and records is contained in appendix B.

Chapter 4
Licensure, Certification, and/or Registration of Health Care Professionals

4–1. Policy

To promote the highest quality health care for its beneficiaries, it is the policy of the U.S. Army that its employed and contracted health care professionals meet established standards relative to educational preparation, professional standing, and technical ability. These standards are met, in part, by the application for and maintenance in good standing of a license, certificate, and/or registration (as mandated by State law, Federal statute, Office of Personnel Management (OPM), Army, or DOD (HA) policy) to practice within the individual's health care specialty. The requirements of this chapter also apply to those who are not classified as employees of the U.S. Army but are providing patient care services (for example, volunteers, members of other Services) under the auspices of the military or based on U.S./foreign country memorandum of understanding (MOU)/memorandum of agreement (MOA)) guidelines (for example, non-U.S. health care personnel in a deployed theater of operations).

4–2. Scope of licensure requirement

a. Military, civil service, contract personnel, who require a license, certification, and/or registration to perform their

duties must maintain a current, active, valid, and unrestricted license or other authorizing document such as certification or registration from any U.S. jurisdiction (DOD 6025.13–R).

b. Licensure, certification, and/or registration requirements apply to professionals performing both clinical and/or administrative duties. Individuals not assigned to or privileged by an MTF or Armed Forces Institute of Pathology (AFIP) (for example, Medical Research and Materiel Command (MRMC)) will provide evidence of a current, active, valid, and unrestricted license, certification, and/or registration to the appropriate next higher command that has professional or technical control.

4–3. Basic licensure, certification, registration criteria

a. A license is a grant of permission to a health care professional by a recognized licensing agency of a State; the District of Columbia; the Commonwealth of Puerto Rico, Guam, or the United States (U.S.) Virgin Islands; or other territory or possession of the U.S. to provide health care within the scope of practice for a specific health care discipline.

(1) In lieu of a license when such is not available/offered for certain occupations, another mechanism such as State certification or registration serves as evidence to support practice within a specified discipline.

(2) In specialties that are not licensed by the State, and the requirements of the granting authority for State registration or certification are highly variable, there must be validation by a national organization that the individual is professionally qualified to provide health care in a specified discipline. Examples of this are the National Commission on the Certification of Physicians Assistants (NCCPA) for physician assistants (PAs) and the National Registry of Emergency Medical Technicians (NREMT) for emergency medical technicians.

(a) Soldiers (AA/USAR/ARNG) possessing the 68W military occupational specialty (MOS) are required to obtain and maintain certification by the NREMT. Certification will be, at a minimum, at the basic level (emergency medical technician-basic). AA 68Ws will be NREMT certified and meet all other requirements for the MOS by 30 September 2007 (USAR/ARNG Soldiers by 30 September 2009). Periodic recertification as established by the NREMT is mandatory. Soldiers who fail to recertify according to NREMT guidance will immediately be suspended from all duties requiring NREMT-basic certification.

(b) Soldiers who fail to recertify according to NREMT guidance will be granted an additional 90 calendar days (for AA) and 180 calendar days (for USAR/ARNG) to obtain NREMT-basic certification; Soldiers will be deemed MOS qualified during this period. A Soldier's failure to obtain NREMT certification immediately following the respective 90- or 180-day period will result in his/her classification as non-MOS qualified and the initiation of an appropriate personnel action (that is, mandatory reclassification, separation) according to governing regulations.

(3) In the case of health care provided in a foreign country by a provider/professional who is not a U.S. citizen or national, a grant of permission from an official agency of that foreign country will suffice. This authorizes the individual to provide health care within the specified discipline to DOD beneficiaries in nondeployed settings and in deployed theaters of operation, in accordance with established U.S./foreign country MOU/MOA guidelines.

b. The license, certification, and/or registration will be current (not revoked, suspended, or lapsed); active (characterized by present activity, participation, practice, or use); valid (the issuing authority accepts and considers professional performance and conduct in determining continued licensure); and unrestricted (not subject to restriction pertaining to the scope, location, or type of practice ordinarily granted to all other applicants for similar licensure in the granting jurisdiction).

c. If a State elects to eliminate the licensure requirement for a particular discipline, those health care professionals employed by the U.S. Army (and who are licensed only in that State) must obtain licensure in another State.

d. Health care professionals who are attending licensure- qualifying educational programs must apply for licensure at the earliest available opportunity after having successfully met the qualifying prerequisites.

e. Licensed, certified, and/or registered health care personnel (privileged/nonprivileged) must immediately notify their supervisor, and the appropriate MTF office responsible for authentication of practice credentials, that their license no longer meets the requirements noted in paragraph *b*, above. Notification will likewise be provided when an authorizing agency has imposed a restriction on their license, certification, and/or registration. Failure of an individual to obtain or maintain the appropriate current, active, valid, and unrestricted credentials (license, certification, registration) required by this regulation is the basis for immediate suspension of privileges/practice and/or other adverse personnel action as referenced in paragraph 4–10. Such personnel will be reported to the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010.

4–4. Professional disciplines requiring license, certification, and/or registration

a. License. Licensure in one's respective discipline is required for all providers/professionals.

Note. Advanced practice registered nurses (APRNs) are given until 1 July 2009 to meet the requirement for State licensure. If a license is not provided by the individual's State or U.S. jurisdiction, the official authorizing document issued in lieu of a license will be maintained.

(1) The following health care providers/professionals must possess and maintain a current, active, valid, and unrestricted license from a U.S. jurisdiction before practicing independently within the defined scope of practice for

their specialty (list not all inclusive): APRNs, audiologists, behavioral health practitioners, chiropractors, clinical pharmacists, clinical psychologists, clinical social workers, counseling psychologists, dental hygienists, dentists, dietitians, occupational therapists (OTs), optometrists, physical therapists (PTs), non-personal services PAs, physicians, podiatrists, practical/vocational nurses (LPN/LVN), psychological associates, registered nurses (RNs), substance abuse counselors, speech pathologists, and veterinarians. The basic qualifications for award of a medically related military enlisted MOS/ASI are contained in DA Pam 611–21. The OPM has established the minimum qualification requirements for comparable civilian positions by employee classification series and grade level in its Qualification Standards Handbook for General Schedule Positions.

Note. The information presented in this chapter regarding licensure (or other authorizing document) of personnel providing direct/indirect health services or patient care may change over time as regulatory requirements at the State level evolve. Requirements related to licensure/certification/registration of AMEDD health care personnel (military/civilian) will, at all times, comply with current OASD(HA) guidance.

(2) Health care personnel (military/civilian) employed by the Federal Government will abide by the practice requirements imposed by their State of licensure/certification/registration to the fullest extent possible.

Note. Compliance with State requirements shall not interfere with the individual's performance of assigned duties/responsibilities in the specified discipline within the Federal sector.

Individuals who provide ancillary health services and who hold licensure/certification/registration (national/State) in their individual specialty must reveal this authorizing documentation and are subject to the adverse practice action reporting requirements outlined in chapter 14. Professional conduct, behavior, or performance that, based on peer review, warrants an adverse practice action will be reported to the appropriate authorizing agency, according to current DOD guidance.

b. Certification and/or registration for select disciplines.

(1) All PAs must possess NCCPA (or its successor) certification as a condition of employment (GS/contract employees) and before being granted clinical privileges (military, GS, personal services contact, and volunteer).

(2) Dietitians must possess and maintain current registration by the Commission on Dietetic Registration of the American Dietetic Association (ADA) in addition to a current, active, valid, and unrestricted State license.

(3) Substance abuse counselors are required to possess and maintain a current, active, valid, and unrestricted license as a social worker or psychologist, or if the counselor is prepared at the master's degree level and is in the GS 180–series, the license may be as a licensed professional counselor, with State or national certification in substance abuse rehabilitation. The deadline for substance abuse counselors to obtain this license was 31 May 2003.

(4) See chapter 7 for additional guidance related to scope of practice and other specific professional requirements for privileged providers.

(5) Although national certification of health care personnel (enlisted, civilian) who provide ancillary health services is not mandated, except mammography technicians (Federal Drug Administration, "Quality Mammography Standards") and emergency medical technicians (AR 40–3), it is highly encouraged in any specialty for which it may be available. Certification and/or registration requirements for AMEDD health care personnel (military/civilian) will, at all times, comply with DOD guidance.

Note. State licensure as a qualified radiology technician and continuing education in mammography may substitute for the certification specified (21 CFR Part 900 - Mammography).

4–5. Professional responsibility regarding licensure

It is the professional and individual responsibility of military and civilian health care professionals, and other health care personnel as may be required, to obtain and maintain the license, certification, and/or registration required to practice in a particular health care discipline. Deployment or other extended training does not exempt the military member from this requirement. This responsibility includes payment of requisite fees and knowledge of and compliance with all requirements for continuing education and other mandates of the licensing, certification, and/or registration authority.

a. Use of appropriated funds for payment of fees. Appropriated funds may be used to pay professional licensure expenses for military health care personnel who are required to be licensed in their State of practice in order to participate in a resource sharing agreement with a civilian institution. This entails performance of officially assigned professional duties at an authorized location outside the MTF and any military installation. Federal statute, 10 USC 1096, allows the Secretary of Defense to reimburse the military member for up to $500.00 of the amount of the license fee. This applies only to situations in which the host State or civilian facility refuses to recognize the individual's professional license/authorizing document despite the licensure portability statute as described in 10 USC 1094 and DODI 6025.16.

b. Civilian employee time off. When in the best interest of the Government and the employee, civilian employees may be given brief excused absences from duty and official time off for required licensing and certification purposes. Permissive TDY is authorized for military health care personnel taking licensure examinations.

4–6. Guidance on licensure requirements

a. Professionals directly accessed from a training program who require a license, certification, and/or registration to practice must obtain such authorizing documents within 1 year of the date when all required didactic and clinical requirements are met; within 1 year of completion of postgraduate year 1 (PGY–1) for physicians; and within 2 years after award of the doctoral degree for clinical psychologists. The GS civilian RN who is appointed to a position pending State licensure may not be extended beyond 6 months, or promoted, if licensure has not been attained.

(1) *AA/USAR/ARNG physicians.* To be eligible for licensure, physicians must successfully complete Step III of the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMPLEX), as appropriate, and complete 1 year of postgraduate training. Physicians who choose to be licensed in a State that requires more than 1 year of postgraduate training must first obtain a license from a State that requires only 1 year of postgraduate training.

(2) *Other military physicians.* Military in deferred status or USAR/ARNG physicians in civilian graduate medical education (GME) training programs—including those receiving financial benefits (Special Training Assistance Program or Financial Assistance Program (FAP))—must meet the applicable licensure standards of their civilian training programs. These physicians must possess a current, active, valid, and unrestricted license in a State or other U.S. jurisdiction upon successful completion of the training program or upon entering the FAP at the PGY3 level.

b. Health care providers who are eligible for privileges but have not acquired the appropriate license, certification, and/or registration will be awarded supervised privileges and may practice only under a written plan of supervision. The supervision will be more comprehensive than that afforded a licensed privileged provider of that same discipline. The supervision provided must be from a licensed, fully qualified, independently practicing, and, if appropriate, privileged provider of the same or similar specialty.

c. For RNs and LPNs/LVNs, both military and civilian, the following stipulations apply in addition to the requirement for a current, active, valid, and unrestricted license from a State, U.S. Commonwealth, or territory:

(1) *AN officer.* The AN officer who graduated after 31 December 1997 must be a graduate of a nursing program accredited by the American Association of Colleges of Nursing or the National League for Nursing. Effective 1 October 2012, all AN personnel must have taken and passed the National Council Licensure Examination - Registered Nurses (NCLEX–RN), an examination developed and administered by the National Council of State Boards of Nursing (NCSBN) (in accordance with USAREC guidance). Those individuals who passed an RN licensing examination other than the NCLEX–RN prior to 12 December 1986 are granted an exception to this requirement. Before working without supervision within his/her designated scope of practice, the AN officer must pass the NCLEX–RN.

(2) *Enlisted practical nurse.* The 68WM6 or 68WM3 who graduated after 31 December 1997 must be a graduate of a nationally accredited or State approved practical nursing program. Effective 1 October 2012, the 68WM6/M3 must have taken and passed the NCSBN's National Council Licensure Examination-Practical Nurses (NCLEX–PN) according to USAREC guidance). Those individuals who have passed an LPN/LVN licensing examination other than the NCLEX–PN prior to 12 December 1986 are granted an exception to this requirement. Before working without supervision within his/her designated scope of practice, the 68WM6/M3 must pass the NCLEX–PN.

(3) *Civilian RN.* The civilian RN must be a graduate of an approved professional nursing program, as noted above in paragraph (1). Current OPM Qualification Standards (civilian RN employment standards) do not include the requirement for the NCLEX-RN. Thus, the civilian RN is exempt from this requirement. The foreign national local hire (FNLH) RN practicing outside the continental U.S. (OCONUS) must maintain the appropriate written authorization from the country in which he/she is employed (see para 4–9*d*).

(4) *Civilian LPN.* The civilian LPN must be a graduate of an approved practical nursing program, as noted in paragraph (2), above. To qualify for the grade GS–4 and above, the civilian LPN/LVN is required to possess a minimum of 6 months of practical nursing experience or have successfully completed a program in practical nursing of at least 9 months duration. Current OPM Qualification Standards (civilian LPN employment standards) do not include the requirement for the NCLEX-PN. Thus, the civilian LPN/LVN is exempt from this requirement.

(5) *Individuals with both RN and LPN/LVN licenses.* In instances where an individual maintains both an RN and an LPN/LVN license, he/she will be held accountable to the scope of practice of the position for which he/she was hired. LPNs/LVNs employed by the U.S. Army who, through advanced education, qualify for and obtain an RN license must maintain an LPN/LVN license when employed in an LPN/LVN position. Likewise, the RN who has accepted a position as an LPN/LVN must maintain a current, active, valid and unrestricted license as an LPN/LVN. The RN license is not a substitute for a license as an LPN/LVN.

d. USAR/ARNG enlisted practical nurses (68WM6/M3) must be in compliance with the above stated licensure requirement. Individuals accessed into the USAR/ARNG for whom an RN license was considered an acceptable substitute for the LPN/LVN license, or others who, through advanced education, now hold the RN license, must obtain an LPN/LVN license from their State of licensure (or other State). Those individuals who have been unsuccessful in documented attempts to obtain dual State licensure will forward a request for assistance through Headquarters, USARC (AFRC–MD), 1401 Deshler Street SW, Fort McPherson, GA 30330–2000, to the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010.

e. Clinical psychologists who have not been awarded their doctoral degree are required to make continual progress

toward completing the doctoral dissertation and meeting State licensure requirements throughout the period of their initial contract with the U.S. Army. Due to differences in dissertation requirements, no specific guidelines can be established for all clinical psychologists. The majority of States require 1 year of postdoctoral supervision before a clinical psychologist is eligible for testing and provisional licensure. Direct accession clinical psychologists must possess a current, active, valid, and unrestricted license upon commissioning (military) or when hired (civilian).

f. Dentists, new dental accessions, health professions scholarship program graduates, and advanced general dentistry (AGD 12-month) residents must hold a current, active, valid, and unrestricted license to practice dentistry in a State or U.S. jurisdiction except as noted below.

(1) Recent dental graduates (up to 90 days after graduation) and AGD 12-month selectees must show proof of having passed both Part 1 and Part 2 of the National Board Dental Examination and of having taken a licensure examination in a State or U.S. jurisdiction prior to reporting for AD. Recent graduates must obtain a license within 1 year of graduation from dental school.

(2) Dental officers with unusual or extenuating circumstances may request a waiver of the 1-year timeline to meet licensure requirements. Requests should be submitted through the chain of command to TSG.

g. Unrestricted license specifications for the military are defined below.

(1) An individual with an unrestricted license has met all clinical, financial, professional, and administrative requirements of the issuing State; such license does not differ from the active license of the civilian counterpart. The requirement to possess a current, unrestricted license was established by law (10 USC 1094, as amended by section 734 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, Public Law 105–261).

(2) For members of the Medical Corps (MC), Dental Corps (DC), Army Nurse Corps (AN), Medical Service Corps (MS), Army Medical Specialist Corps (SP), and Veterinary Corps (VC), an unrestricted license (or authorizing document) is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

(a) The unrestricted license must allow the professional unabridged permission to practice in any civilian community in the jurisdiction of licensure without having to take any additional action on his/her license.

(b) The requirement to hold an unrestricted license also applies to physicians in residency programs who are eligible for licensure as described above.

4–7. Exceptions to the requirement for unrestricted license

a. Legislation does permit waiver of the requirement for providers to possess an unrestricted license in "unusual circumstances." Note: The payment of a State's license renewal fee is not considered an "unusual circumstance" and is not subject to waiver.

(1) TSG has delegated licensure waiver authority through the USAMEDCOM to the MTF commander. The commander may not exercise independent judgment or decision making in this activity. In order to qualify for approval, the OASD(HA) must first have identified that the specific requirement is eligible for waiver.

(2) Waiver of licensure requirements is not automatic. The provider must submit an application for waiver (obtained from the credentials manager). The waiver is valid only for the licensure period for which it was requested. A new application for waiver must be submitted for each licensure renewal period. Submission of subsequent application for license waiver is the responsibility of the provider.

(3) If a State presents an unusual and substantial licensure requirement that has yet to be identified, this requirement and any supporting documentation will be submitted with the waiver application. The waiver request packet is forwarded through the RMC to the Commander, USAMEDCOM, who will submit the request to the OASD(HA) for consideration. The approval/disapproval from the OASD(HA) will be forwarded by USAMEDCOM through the RMC to the MTF of origination.

(4) Approved licensure waivers will be placed in Section VI of the PCF next to the copy of the provider's license.

b. For military, GS, and personal services contract PAs, the requirement to possess and maintain a current, active, valid, and unrestricted license is waived. Current NCCPA certification is the recognized authorizing document in lieu of license.

c. The complexity of licensure, certification, and/or registration requirements and the changing environment of State licensure policies renders this a dynamic process. Up-to-date guidance will be provided as necessary via conventional and electronic mail and will be posted to the USAMEDCOM QMD homepage, http://www.qmo.amedd.army.mil/home.htm.

4–8. Contract privileged providers

All contract employees must maintain a current, active, valid, and unrestricted license or authorizing document in accordance with paragraphs 4–3, 4–4, 4–7, and *a* and *b*, below.

a. Personal services contractors, and non-personal services contracted providers with duty in non-U.S. locations, may practice under a current, active, valid, and unrestricted license from any State or U.S. jurisdiction. U.S.-based non-personal services contracted providers, in all disciplines, will be licensed by the State or jurisdiction in which they are providing services.

b. In OCONUS locations, the host country must grant a waiver to permit an American citizen (civilian) to be hired under a non-personal services contract. This waiver must stipulate that the individual will provide services only on the U.S. Federal enclave and will be licensed in any U.S. jurisdiction, not the host nation. The contracted employee may also obtain a license, or other authorizing document, from the host nation via endorsement or reciprocity. Personal service contract personnel must be determined to be acting within the scope of employment to be covered.

4–9. International health care graduates

Health care professionals trained in foreign countries are eligible to practice in the AMEDD in their respective disciplines if the appropriate requirements are met. (The term, "international" replaces the previously used term, "foreign.")

a. International medical graduates. Graduates of foreign medical schools practicing in the U.S. are required to possess both a medical license and certification by the Educational Commission for Foreign Medical Graduates (ECFMG) or Fifth Pathway. International medical graduates participating in U.S. Army-sponsored GME who have more restrictive requirements for GME or who encounter administrative obstacles related to meeting licensure requirements will not be flagged nor subject to other adverse privileging/personnel action. Their status will be equal to that mandated by the State's requirement for individuals of that category. (See the glossary for additional details regarding Fifth Pathway.) International medical school graduates (including U.S. citizens) who desire FAP entry must additionally be enrolled full time in, or accepted to attend, an accredited program in the U.S. or Puerto Rico for the designated specialized training. They must have completed an accredited PGY–1 program for FAP entry at the PGY–2 level. The specialized training program must be accredited by the Accreditation Council for Graduate Medical Education (ACGME) for residents. The GME programs must meet the requirements of the GME Directory published by the American Medical Association or Yearbook and Directory of Osteopathic Physicians published by the American Osteopathic Association, as applicable.

b. International nurse graduates. Nurses who are graduates from jurisdictions other than the U.S. must possess a current, active, valid, and unrestricted license and certification, the Full Education Course-by-Course Report, by the Commission on Graduates of Foreign Nursing Schools. This certification validates the educational credentials of graduates of international nursing schools and verifies that these individuals are qualified to practice in the U.S.

c. International dental graduates. Dentists who are graduates from jurisdictions other than the U.S. and Canada are expected to meet the criteria of paragraph *d* below and will be managed by the DC on a case-by-case basis.

d. International Health Care Graduates and DOD OCONUS. To fulfill the requirements for licensure, FNLH health care professionals from jurisdictions other than the U.S. who are providing care to DOD beneficiaries OCONUS require written authorization (grant of permission of an official agency) from the country in which they are practicing or where they were trained. Newly employed FNLH health care personnel shall practice with supervision for 1 year. M&E of the FNLH's practice provides evidence of current competence and serves as the basis for continuation of practice. The commander (or designee) will delegate responsibility for conducting and documenting the necessary locally established M&E activities. (See glossary for the definition of M&E.) For purposes of hiring the FNLH, and during the period of M&E data collection, initial authorization for the FNLH to provide care to DOD beneficiaries, and to subsequently continue practice, must be determined based on the following:

(1) Comprehension of and proficiency in oral and written use of the English language as demonstrated by external agency evaluation, if available, or a personal interview by the selecting official.

(2) Documented clinical competency assessed by objective performance measures.

(3) Possession of a current, active, valid, and unrestricted license; certification; registration; or other authorizing document to practice in the country of employment (host nation) or a license, certification, and/or registration accepted by the U.S. as a basis for employment and practice in that country.

4–10. Failure to obtain or maintain a license, certification, and/or registration

All health care personnel must be in full compliance with the stipulations of this chapter. An individual who is required to possess a current, active, valid, and unrestricted license, or other authorizing document, and fails to obtain the license or other authorizing document within the time frame specified is prohibited from practicing. In the event the license or other authorizing document is not obtained by the privileged (privileges-eligible) individual within the time frame specified, he/she must request a formal extension from the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010. Said request will include an explanation of why the license or authorizing document was not obtained in accordance with this guidance, and will address the individual's specific plan for obtaining the license or authorizing document. Only the Commander, USAMEDCOM, is authorized to grant the privileged (privileges-eligible) provider an extension to obtain the license or other authorizing document. Failure on the part of the individual to request an extension may result in the actions outlined in paragraph *a* or *b*, below. If an individual fails to maintain the license or other authorizing document in good standing, or allows it to lapse for any reason, he/she will be prohibited from practicing. Health care personnel not subject to UCMJ who provide care in violation of this regulation are subject to a civil monetary penalty of not more than $5000.00 (10 USC 1094).

a. The following applies to military personnel, both officer and enlisted, who fail to maintain the proper credentials to practice in their clinical AOC/MOS/ASI.

(1) Individuals who are not in compliance with this chapter may have all favorable actions suspended under AR 600–8–2. Unfavorable personnel action (a nontransferable flag) is initiated pending involuntary separation/elimination due to lack of Soldier qualification.

(2) The Soldier's obligated status does not exempt him/her from adverse administrative actions, to include early separation from service for loss of professional qualifications, should this be in the best interest of the U.S. Army.

(3) Individuals separated prior to completion of obligated service may be subject to recoupment of educational subsidies.

(4) Soldiers (AA/USAR/ARNG) with MOS 68WM6/M3 who fail to maintain a current, active, valid, and unrestricted LPN/LVN license do not meet the established requirements for the M6/M3 ASI (Military Personnel Message Number 01–212). At the discretion of the unit commander, AA Soldiers may be authorized 90 calendar days (180 calendar days for the USAR/ARNG) to renew their State licensure. However, during this period of nonlicensure, the Soldier will not be permitted to function as an LPN/LVN. While the Soldier is considered nonqualified in the ASI M6/M3, he/she will remain qualified in the primary MOS 68W. A Soldier's failure to renew State licensure immediately following the 90- or 180-day interval will result in the unit commander initiating action for removal of M6/M3 ASI according to governing regulations.

(5) Subject to the needs of the U.S. Army, the Soldier may be cross-trained into another military career field or may revert to a previously held AOC/MOS.

(6) Regular Army/USAR officers and enlisted Soldiers who are not in compliance with this regulation may be involuntarily separated from the Service under the provisions of AR 600–8–24, AR 635–200, AR 135–175, or AR 135–178. The local military personnel office (MILPO) will be consulted for assistance in processing the individual for separation/discharge from service.

(7) Service obligations resulting from receipt of special incentive pays, military education (advanced course, long-term civilian schooling), acceptance of promotion, or resulting from the 3-year initial AD obligation incurred upon accession without Service-sponsored education will be handled as noted above in paragraphs (2) and (4). The appropriate finance office will determine recoupment of any incentive pays or other remuneration.

b. If OPM, Army, or DOD requires a specific license, certification, and/or registration to qualify for certain occupations, maintenance of that license, certification, and/or registration is considered a condition of employment. Failure to meet this condition of employment may result in administrative action to reassign, suspend, or remove the employee from their civil service position. GS civilian personnel may be subject to adverse personnel action according to Title 5, USC, and Title 5, Part 752, Code of Federal Regulations (CFRs), as implemented by appropriate DOD policies, ARs, and applicable labor agreements. The servicing civilian personnel advisory center (CPAC) and SJA should be consulted for guidance throughout all phases of deprivileging, disciplinary, or adverse personnel actions against the civilian employee.

c. The status of individual professional licensure, certification, and/or registration for all health care personnel will be tracked at the facility level on a regular basis. This information will be kept up to date in the CCQAS or the AMEDD-identified database equivalent.

Chapter 5
Competency Assessment, Delegation, and Supervision of Practice

5–1. Competency assessment

a. General. Competence is the ability of a staff member to apply decision-making, psychomotor, and interpersonal skills at the level of knowledge expected for his/her current duty position. Highly competent performance by members of the organization is predicated on a variety of factors to include: a carefully structured new employee orientation, ongoing education and training opportunities, and formalized evaluation processes. In this regulation, the word, "staff" refers to all MTF employees, those with patient care, administrative, or other support services responsibilities within the organization (for example, housekeeping, maintenance, supply, and so forth) including both military (AA/USAR/ARNG) and civilian, contracted, and volunteer personnel. The term, "health care personnel" includes all categories of individuals involved in the provision of health care and services (for example, laboratory technicians, nurses, physicians, respiratory therapists).

(1) Competency assessment is required of all members of the staff and is demonstrated by one's performance in a designated setting. Performance must meet established standards that are determined, in part, by the work setting and the employee's designated role in that setting. Thus, the leaders of an organization must have clearly defined the qualifications and competencies that staff must possess to accomplish the organization's mission.

(a) To standardize criteria for competency skills verification throughout the Army, forms implemented at the DA level must be used.

(b) Two forms currently required for this purpose are DA Form 7653, Verification of Clinical Competencies for

Critical Care Skill Identifier (SI 8A) and DA Form 7654, Verification of Clinical Competencies for Emergency Nursing Skill Identifier (SI M5).

(2) Each MTF will have in place a mechanism to collect and analyze individual and group aggregate data, from a variety of sources, to assess the competence of staff and to identify training needs.

(a) An annual report to the MTF executive committee, as required by the TJC, will elaborate levels of competence, patterns and trends, and competency maintenance activities for all staff. The responsibility for data collection from all departments/services and the preparation of the consolidated MTF report to the executive committee will be according to local policy. This report should include such data as—

1. Total number of personnel (entire organization).

2. Percentage of new employees who received new employee orientation.

3. Percentage of total staff who have met AT requirements.

4. Percentage of total staff who are competent, based on organizational criteria, to perform the specific requirements of their positions.

5. Of those staff for whom licensure, certification, and/or registration is appropriate, the percentage of total for whom these credentials are current.

6. Specific education or training needs as identified for all levels of staff.

(b) While all staff must be considered in the preparation of this report, those who have clinical contact with patients should receive special focus related to identification of training needs and staff development opportunities. Local policy will direct who in the organization is responsible for data collection and preparation of this report.

b. Responsibilities.

(1) *Organizational.* Immediate supervisors (officer, enlisted, civilian) are responsible for assessing, maintaining, and improving staff competency through an ongoing series of activities. The organization will—

(a) Ensure all newly assigned/employed staff receive an orientation to organization and job-specific policies, procedures, and responsibilities. This orientation is accomplished within 45 days of arrival (military)/employment start date (civilian). If military deployment or other select mission requirements necessitate extension of this time frame, an annotation to this effect will be made in the individual's CAF.

(b) Identify the competencies, to include age-specific knowledge or skills (for health care personnel), that staff must demonstrate to perform in their assigned duty positions. The ANA Standards of Nursing Practice and recognized national nursing specialty organization practice standards provide the professional framework upon which nursing competency assessment is based. Likewise, for other healthcare disciplines, professional specialty-endorsed practice standards will apply.

(c) Conduct initial and periodic competency assessment of staff and document these results. Aggregate data from these assessments should be used to identify competency needs, patterns, and trends for a given unit or the organization. Specific training plans and activities at the unit, department, or organizational level will address the staff's identified learning needs.

(d) Inform staff of the expectations and objective criteria used to evaluate individual performance and any specific actions required to improve or enhance job performance. This includes reviewing job descriptions and performance standards.

(e) Design and implement various educational and training programs and an improvement plan, as needed, to enable staff to successfully meet the competency and performance standards established by the organization.

(f) Monitor and evaluate, at least annually, the formal educational and training programs in place and the response of staff members to these programs. The evaluation performed will assess the overall value of the organization's programs and the degree to which staff competence has been achieved and maintained relative to these programs.

(2) *Individual health care personnel.* Health care personnel, both privileged and nonprivileged, must maintain the requisite competencies associated with the job position to which they are assigned within the organization. For licensed, certified, or registered health care personnel, failure to maintain current competency may result in formal evaluation of one's performance through the peer review process. This may include a standard of care (SOC) determination and, if applicable, recommendation to the commander for adverse action against one's privileges/scope of practice or for appropriate disciplinary action. Health care personnel will—

(a) Complete department and unit competency-based assessment and orientation, as appropriate, prior to independently performing duties required of the position.

(b) Perform those duties based on individual licensure/certification/registration for which they are competent and those for which competency has been validated or privileges have been awarded, as determined by organizational/unit policy or requirements.

(c) Request and participate in various training and educational programs as needed to enhance performance skills.

(d) Notify the appropriate supervisor of assigned duties they are not competent to perform.

c. Orientation. All staff are required to orient to and be proficient in the performance of the duties, responsibilities, expectations, and components of their job position. Throughout their employment with the organization, staff members will receive information and training on confidentiality, new equipment, new procedures or processes, new or revised

policies, and new performance expectations (that is, age-specific, population-related skills, as appropriate). This training is in addition to that for which an annual update is currently required, for example, fire and safety, infection control, basic life support (BLS), and so forth

d. Education and training activities. In-service education, as well as formal continuing health professional education and training activities, will be made available to assist all staff in acquiring, maintaining, and improving job-related competence.

e. Emergency life support training.

(1) All health care personnel (civilian or military) assigned, or subject to reassignment, to duties involving the provision of patient care will possess and maintain BLS certificate of training. Deployment or other extended absence does not exempt the military member from this requirement. Others, such as part-time civilian consultants, faculty members, and so forth, may be excluded from this requirement on a case-by-case basis at the discretion of the MTF commander. Said exceptions will be documented.

(2) As a minimum, the anesthesiologists and certified registered nurse anesthetists (CRNAs) assigned to the anesthesia department/service will possess and maintain advanced cardiac life support (ACLS) certification. The physicians, PAs, nurse practitioners (NPs), and RNs assigned to the emergency department/service will possess and maintain advanced emergency life support training (for example, ACLS, advanced trauma life support (ATLS), and so forth) according to AR 40–3. Other health care personnel (medical/dental) requiring ACLS, ATLS, or other advanced life support training, are at the discretion of the MTF commander. ACLS or other advanced life support training is not a substitute for BLS training. The demonstrated mastery of life support skills is essential. Online BLS, ACLS, pediatric advanced life support (PALS), or ATLS courses do not satisfy the requirement for this training. Emergency life support training sponsored or endorsed by the American Heart Association is the only training recognized as acceptable.

(3) In support of a deployed force that will include Soldiers with a broad spectrum of health care needs, DA or DOD civilians, and Government contractors, PAs assigned to all TOE units are encouraged to obtain and maintain ACLS certification. Coordination of ACLS training for divisional assets is a joint responsibility between the Division Surgeon and the DHS.

f. Performance evaluation. Each staff member's performance is evaluated according to Army and OPM (GS civilians) regulatory guidance, both periodically (for example, quarterly counseling or as needed) and at regularly scheduled intervals (for example, midpoint or annual performance appraisal counseling, as required by the Army Performance Appraisal System). Performance evaluation is usually conducted by the person who directly supervises the individual's day-to-day work performance. These evaluations are analyzed by the supervisor for patterns or trends related to specific performance issues for which additional training, education, or more formal corrective action may be required. Both individual and aggregate employee data should be considered when determining how best to improve and sustain the skills of assigned personnel. In selected circumstances, written tests may be appropriate to determine the employee's competency and ability to fulfill specific job-related responsibilities (for example, dosage calculations related to potentially high-risk medications).

g. Competency factors. The skills and abilities that are essential to every staff member's successful job performance fall into three distinct categories: cognitive, psychomotor, and interpersonal. These factors directly correlate to performance standards and are the basis for employee competency assessment and evaluation.

(1) *Cognitive or critical thinking skills.* Identifying subjective and objective data that are relevant to one's clinical practice and assessing their significance to determine what action, if any, is warranted.

(2) *Psychomotor or knowledge-based physical task skills.* Performing selected patient care or support functions that require manual dexterity/ability and an understanding of what series of steps are required and in what specific order.

(3) *Interpersonal skills.* Various interactions that take place when meeting, establishing rapport, interviewing, and providing care or service to patients, Family members, and visitors, as well as working with other staff. Such interactions occur in any and all settings both within the organization and outside the organization (that is, the RMC, USAMEDCOM, TRICARE lead agent) and reflect the individual's ability to function effectively within an assigned team or work group.

h. Competency documentation.

(1) *Nonprivileged health care personnel.* A CAF will be maintained by the first line supervisor for all nonprivileged health care personnel working within the AMEDD. The CAF will be readily available to the employee for updates but protected from general view or public access. For non-privileged USAR/ARNG personnel, the credentials file maintained by ARCCA contains the documents typically included in the CAF. In the context of this chapter, the terms, "CAF" and "credentials file" are interchangeable.

(a) The CAF is the repository for a variety of relevant professionally oriented data and information that are accumulated throughout the individual's tenure with the organization. The CAF should contain information that relates to or may influence clinical performance; it is not a personnel or counseling folder. Counseling/disciplinary records, performance appraisals, and similar documents will not be retained in the CAF.

(b) The CAF is a chronological record that is utilized throughout the individual's employment, contract, assignment, or agreement with the AMEDD during deployment, any TDY in support of health care/service mission, and permanent change of station (PCS)/transfer. It will be hand carried by the nonprivileged professional (military/civilian) from one

place of duty to the next. For RC, the CAF should accompany members during all assigned periods of duty with AA MTFs. Upon separation from Federal employment, the contents of the CAF will be turned over to the individual in question or destroyed.

(c) Xerographic copying of the nursing license, certification, or registration is permissible. These copies will be protected and secured as specified for PCF/PAF contents (see para 8–3*b*(2)(c)). Neither the original nor a copy of the individual's license (other authorizing document) will be maintained in the CAF. Instead, an annotation to indicate that the document was verified with the primary source will be made in the CAF or other location as specified in local policy. This annotation will include: date, method of verification, the POC contacted, and the name of the individual doing the verification. To prevent identity theft, social security numbers (SSNs), home addresses or other personal identifying information--other than the employee's name--will not be recorded in the CAF.

(d) The nonprivileged professional has a right to review, make comment on, and receive copies of all materials in his/her CAF. He/she is responsible for ensuring that all information in the CAF is current.

(e) Adverse information will be maintained according to local policy (that is, in a unit-level personnel file maintained by the first-line supervisor) and not in the CAF. The individual in question will be provided a copy of any material of an adverse nature (that which reflects negatively on the professional's conduct, condition, clinical competence, or clinical performance) and offered the opportunity to comment or reclama before it is placed in his/her personnel file (not CAF). Statements by the individual in response to this adverse information will also be included. Unprofessional conduct or performance that may be grounds to suspend, revoke, or restrict a staff member's license, certification, and/or registration will require a formal peer review as defined in chapter 6.

(f) Removal of any adverse information contained in the unit-level personnel file will be accomplished only if authorized by the commander (or designee).

(g) Documents that reflect the individual's employment history, education, and assessment of competence will be maintained in the CAF for a minimum of 3 years and may be purged according to local policy. For USAR/ARNG members, the contents of the CAF that reflect past practice/competency assessment will be maintained for 5 years. The specific forms to be included in the CAF, in keeping with the general guidance in appendix C, will be at the discretion of the local command.

(h) Local policy will address security of the CAF and identify responsibilities for updating its contents. For USAR/ARNG members, the CAF will be available during all IDT, active duty for training (ADT), and AT periods. Additions and modifications to the USAR/ARNG CAF contents are a joint responsibility of both the Reserve unit and the AA facility staff.

(i) See appendix C for additional information regarding the recommended structure and contents of the employee CAF.

(2) *Privileged health care providers.* Initial competency assessment is based on documented academic education, letters of reference and/or supervised practice, and standardized credentials data contained either in the PCF or the provider activity file (PAF). This same information serves as the basis for initial medical staff appointment and clinical practice privileges. The biennial renewal process, as described in chapter 9, integrates findings from a variety of performance-based determinants and substantiates privileged provider competency.

(3) *Special forces medical sergeants.* The special forces medical sergeant, MOS 18D, is a combat arms Soldier with extensive medical education and training in life sustaining skills. This individual performs the military-unique function of providing primary care medical support to operational units in remote or isolated environments in the absence of a medical officer.

(a) The 18D's responsibility for health care of special forces unit members in operational situations worldwide demands that compassion, comfort, and care be provided to the utmost of a person's ability even though the situation may well require skills far beyond those of an unlicensed health care giver. In order to maintain and improve the operational readiness of this Army medical resource, the 18D is authorized to perform specific clinical tasks, procedures, and interventions, as approved by the MTF commander, under the direct supervision of a privileged provider.

(b) The 18D assigned to an MTF for sustainment training will participate in a structured training program with integrated components of direct, hands-on patient care sufficient to ensure competency in the advanced scope of practice as addressed in appendix D. It is expected that the 18D, in consultation with the supervising privileged provider, will participate in the delivery of routine health care, perform patient assessments, provide initial stabilization of acute illnesses and injuries, and manage a variety of health care needs to include complex, chronic conditions, according to the individual's academic preparation and prior clinical experience.

(c) The specific guidelines and parameters related to 18D medical proficiency training will be based on the MTF's scope of services and the availability of appropriate supervisory support. At the conclusion of the sustainment training, a performance evaluation will be conducted to evaluate the 18D's competence and to determine if the identified training objectives were achieved.

(d) Because the 18D is a nonmedical MOS, this brief discussion has been provided to acquaint the reader with the

nontypical medical proficiency training requirements these individuals place on a TDA MTF. For additional information on career management field 68-series clinical competencies (scope of practice), contact the Commander, USAMEDCOM, ATTN: MCHO–CL–C, 2050 Worth Road, Fort Sam Houston, TX 78234–6010.

5–2. Delegation

a. Delegation transfers to a competent individual the authority to perform a selected patient care task in a given situation. Typically, delegation involves the licensed or privileged professional allowing a specified patient care activity, that is within his/her own scope of practice, to be performed by unlicensed assistive personnel (UAPs), an RN/LPN, or other nonnursing personnel. The authority to perform the task is passed to another but the professional responsibility and accountability for the overall care provided, and for associated patient outcomes, remains with the delegating individual.

Note. In structured training situations, a provider may delegate a privileged task, function, or process to a competent nonprivileged professional (for example, a medical student, or 18D. The privileged provider is responsible and accountable for the task, function, or process that has been delegated, and for the patient outcomes. A specific, written plan for supervision of the nonprivileged individual, as determined by the assessed level of his/her competence, is required. (See para 5–3 for additional detail regarding types of supervision.)

b. Various health care personnel—to include 68-series career management field Soldiers, nursing assistants, and others—may be considered and utilized to perform delegated tasks in the delivery of patient care if the individual is competent to perform those tasks. The 18D is authorized to perform an extensive variety of clinical tasks in order to sustain and improve wartime readiness. Appendix D provides an overview (not all inclusive) of the 18D's advanced scope of practice and outlines the types of clinical experiences that are critical to his medical skills proficiency. The specific guidelines and parameters related to 18D medical skills sustainment training will be based on the MTF's scope of services and the availability of appropriate supervisory support.

c. Professional judgment on the part of the privileged provider or the licensed, certified, and/or registered individual is required to determine which patient care activities are appropriate to delegate. The determination must take into consideration the safety/protection of the patient, any patient-unique needs, the level of care required by the patient, the education and training of the individual to whom the task is delegated, and the extent of supervision required. Any intervention that requires independent, specialized professional knowledge or skill and/or requires assessment, evaluation, and clinical judgment will not be delegated. Activities appropriate for delegation are those which meet all of the following criteria:

(1) Frequently or routinely reoccur in the daily care of a patient or group of patients (that is, vital signs, intake and output, select exercises/activity routines, preparation for or conducting certain diagnostic procedures or tests, and so forth).

(2) Do not require the individual to exercise independent judgment.

(3) Do not require complex and/or multi-dimensional application of the clinical or nursing process.

(4) Have predictable results and minimal potential risk to the patient.

(5) Use an established and unchanging procedure (that is, protocol, CPG, or standing operating procedure).

d. Selected invasive and high-risk tasks/procedures may be performed by UAPs and others who have received documented, formal training; such training may include a certification process. Local policy will direct which high-risk tasks/procedures may be delegated and to whom and what level of supervision is required. The privileged provider/professional who is responsible for direct/indirect supervision of the UAP, the 18D, or other individual performing a given task/procedure is also responsible for the immediate post-procedure evaluation and disposition of the patient.

e. It is the responsibility of local leadership to ensure, for all health care personnel to whom patient care tasks/procedures have been delegated, that individual competency is assessed; competency-based orientation is provided; and utilization of personnel is based upon demonstrated knowledge, skills, and technical proficiency.

5–3. Supervision of practice

To ensure the competence and skill of those providing health care and services to every category of AMEDD beneficiaries, all health care personnel are provided supervision of their clinical performance, as appropriate. This requirement, based on a concern for public protection and PS, is predicated on PL and reinforced by various State authorizing agencies. In addition, the supervision of clinical practice is fundamental to both the MTF's provider privileging and individual performance evaluation processes, and it is scrutinized by the external bodies/organizations that accredit or certify institutional performance.

a. Activities. Supervisory activities are performed in the context of the relationship that exists between supervisor (senior staff member) and employee (subordinate staff member). The assessment and ongoing validation of the employee's ability to perform various privileged tasks or patient care activities, as applicable, substantiates the competency of both privileged and nonprivileged health care personnel.

b. Types of supervision.

(1) The performance of all health care personnel is supervised, indirectly or directly, and evaluated according to

established AR and OPM guidance. Specific requirements related to individuals requiring direct supervision will be locally determined based on the unique circumstances necessitating this level of supervision.

(a) Indirect. The supervisor performs retrospective review of selected records and/or observes the results of the care provided. Criteria used for this review relate to quality of care, quality of documentation, and the staff member's authorized scope of practice.

(b) Direct. During the delivery of health care and services, the supervisor is involved in the decision-making process. This may be further subdivided—

1. Verbal. The supervisor is contacted by telephone or by informal consultation before the supervised individual implements or changes a regimen or plan of care.

2. Physically present. The supervisor is physically present through all or a portion of care.

Note. "Physically present" will be locally defined and determined on a case-by-case basis given the unique needs of the individual being supervised. This will be addressed in his/her personalized plan of supervision.

(2) In select circumstances (that is, for professionals not yet licensed, for novices or those returning to patient care responsibilities who must develop/refine skill and competence, or for those staff whose performance is less than acceptable) supervision is a formal requirement. The type of supervision that is warranted will be clearly identified and the plan for supervision articulated in writing.

(a) MTFs with graduate professional health education (GPHE) programs will have a mechanism(s) in place and approved by the medical staff for supervision of program participants in the performance of their patient care responsibilities. Supervision will be rendered by an appropriately privileged provider, ideally in the same discipline, who is familiar with the role, responsibilities, and patient care activities of the GPHE program participant. This requirement applies to members of all disciplines who are not yet licensed/privileged but are involved in the provision of patient care.

Note. In the context of this regulation, GPHE applies to graduate level clinical training for all health-related disciplines (all corps).

(b) Individuals without clinical privileges must function within the written guidance of a job description specific to the level of care being provided. Job descriptions may be based on the role and need not be trainee-specific. (See glossary for detailed definitions of supervised privileges for providers and enhanced supervision.)

c. The plan of supervision. The intent of providing appropriate oversight of practice, in the context of this regulation, is to evaluate and enhance performance of health care personnel in delivering patient care services. Given that objective, a planned and organized approach to supervision is appropriate. The written plan of supervision, maintained in the PAF (privilege-eligible provider) or CAF (nonprivileged professional), as appropriate, will include—

(1) *The type of supervision to be provided.* (See para *b* above.) The type of supervision will be based upon the assessed needs of individually privileged providers/nonprivileged personnel.

(2) *The name of the supervisor.* The commander will appoint—in writing—a primary and alternate supervisor. This individual (same or similar discipline) will possess the professional experience and competence to provide appropriate oversight of the supervised provider's/professional's practice. The supervisor will ensure that care and/or services provided are consistent with the authorized scope of practice or privileges and all approved policies, procedures, and practice guidelines, as applicable.

(3) *Performance evaluations.* The specific intervals at which performance evaluations will be conducted during the period of supervision will be noted.

(a) Privileged providers. Supervisors of privileged providers will complete periodic clinical performance evaluations based on the individual's experience and competency utilizing DA Form 5441 (Evaluation of Clinical Privileges – Anesthesia) and DA Form 5374 (Performance Assessment). These are filed initially in the PAF and transferred to the PCF at the time of clinical privileges renewal, PCS, or release from service/employment. A variety of parameters allow for review of the appropriateness of care and the privileged provider's current competence. Organizations must consider, and integrate into the plan for supervision and the evaluation of privileged provider performance, current TRICARE and other managed care performance assessment variables/outcomes. These address such factors as—

1. Diagnostic techniques and procedures and associated costs.

2. Therapeutic practice patterns and outcomes of care.

3. Consultation and referral patterns.

4. Availability and productivity.

5. Documentation of patient care and services.

(b) Nonprivileged personnel. Supervisors of nonprivileged health care personnel will complete periodic clinical performance evaluations, as specified in the plan of supervision, (narrative format or other locally devised format) that address the individual's demonstrated abilities and competency to perform the duties, responsibilities, expectations, and components of his/her job position. The individual's improvement or lack of improvement related to his/her documented performance limitations/inadequacies will be assessed and addressed in each written evaluation.

d. Unlicensed health care personnel.

(1) Both privileged providers and nonprivileged professionals who require an authorizing document for practice and who are not licensed, certified, and/or registered (for example, students in health professions' training, graduates

awaiting licensure examination results, and so forth) will practice only under the supervision of a properly licensed, certified, and/or registered (and privileged, if required) professional of the same or similar discipline.

Note. Foreign military health care personnel or others involved in official exchange student capacity are included in this category.

(2) The level of supervision will be more comprehensive than that provided a licensed individual of the same discipline. At pre-determined intervals, as stipulated in local policy, the professional's performance, competence, and capabilities in his/her assigned military or civilian position will be assessed and documented.

e. Privileged providers.

(1) Privileged providers are responsible to their discipline-specific department chief or supervisor for the ongoing assessment of the quality of care they provide within their discipline-specific scope of practice and defined privileges. The discipline-specific chief/supervisor will—

(a) Review and recommend approval of the application for privileges and the PCF prior to submission to the credentials committee/function.

(b) Monitor and evaluate the discipline-specific scope of practice.

(c) Conduct routine peer review of individual practice according to local policy.

(2) In instances of a sole privileged provider in a given setting, or the provider is the senior member of his/her discipline (that is, the chief of the department), the provider is responsible to an assigned clinical authority, as appropriate to the organization. This individual (from within the MTF or the RMC) will perform appropriate supervisory functions and provide oversight of the care and services delivered to authorized beneficiaries.

(a) The individual tasked with oversight authority may be of the same discipline, a similar discipline, or a physician.

(b) The individual selected must be qualified by education and experience to provide the appropriate level of supervision and oversight of practice that is required.

(3) Physician supervision of members of another discipline (for example, OTs, PTs, nurses, pharmacists) is not required for functions performed that are within the scope of practice authorized by the individual's license, registration, certification, or privileges.

f. Other considerations related to supervision and evaluation of health care personnel.

(1) Army policy and/or State licensing laws require physician supervision of PAs privileged to provide patient care and services. Said physician supervisor (and an alternate) will be named in writing by the MTF commander.

(2) Significant variation exists among States relative to physician supervision of nonphysician providers. Likewise, variation among States may exist regarding supervision and/or the scope of practice of the RN, LPN, or other licensed/certified/registered professional. The individual nonphysician privileged provider/professional is responsible for informing his/her immediate supervisor of any specific State-directed requirements for supervision of clinical practice. Ideally, this information should be elicited from the employee during orientation and will be documented in his/her CAF. The immediate supervisor will ensure appropriate coordination to facilitate organizational compliance, wherever feasible.

(3) Regardless of the oversight and/or supervisory relationship that exists, provider collaboration and collegial interchange in support of high quality patient care is the standard in all settings and circumstances.

(4) Individuals responsible for clinical oversight of privileged or nonprivileged health care personnel need not be responsible for the overall performance evaluation (OER/Enlisted Evaluation Report/civilian performance appraisal). Decisions regarding nonclinical rating schemes must be based on the structure of the organization and other variables that are individual provider and facility specific.

(5) A copy of the privileged provider's clinical performance evaluation (not the OER or its civilian evaluation equivalent) will be forwarded to the MTF credentials committee/function. These documents will be maintained in Section II of the PCF and are the basis for biennial renewal or revision, as needed, of clinical privileges.

g. Supervision of screening personnel. Screening personnel (enlisted or civilian) assigned for duty in various clinic settings are permitted to utilize the algorithm-directed troop medical care (ADTMC) system (or comparable system) to screen AD Soldiers during daily sick call activities. (Contact USAMEDCOM ATTN: MCHO–CL–C for use of this system.) Use of an algorithm-based system is mandatory when screening personnel provide evaluation, treatment, and/or disposition of AD sick call patients. MTF commanders will—

(1) Establish a local training program in the appropriate use of ADTMC. Screeners must complete the formal training program prior to being assigned to evaluate, treat, and/or make disposition of AD Soldiers who present for care. This training will be documented in the individual's CAF.

(2) Ensure that screeners are provided adequate supervision and performance evaluation by a physician, PA, or other qualified provider specifically assigned this responsibility. Documentation of the care provided by ADTMC screeners, DA Form 5181 (Screening Note of Acute Medical Care), or like form, will be reviewed on a daily basis. Screener evaluation will be documented according to instructions from the USAMEDCOM ATTN: MCHO–CL–C.

(3) Ensure that the screener's scope of practice with regard to evaluating, treating, and/or determining the disposition of AD sick call patients is delineated in writing and that it is reviewed and revised at least annually.

(4) Approve the list of self-care medications, as recommended by the pharmacy and therapeutics (P&T) committee (see AR 40–3), to be dispensed by screeners. Screeners may be approved to dispense the over-the-counter medications

addressed in the screening manual. Additions requested for use at the local level are authorized only if formal, documented training related to the safe and appropriate use of these medications has occurred.

(5) Require monthly visits by the appropriate department/service chief to all clinics utilizing ADTMC to ensure compliance with the above requirements. This oversight responsibility may not be delegated.

Chapter 6
The Peer Review Process

6–1. General

Peer review of day-to-day performance, is integral to the PI and competency assessment processes for all licensed, certified, and/or registered health care personnel both privileged and nonprivileged. This routine review typically focuses on medical records' contents and direct observation of performance. However, in the context of a possible adverse privileging/practice action, the process takes on a greater degree of formality and involves fact finding, study, and analysis of a single incident that resulted in significant harm to a patient or a series of events involving a professional's performance, conduct, or condition. It is conducted in a collegial climate and is focused on obtaining all relevant information about the situation. Prior to any adverse action related to privileges/scope of practice, peer review is required for individuals who are licensed, certified, and/or registered. Likewise, in the event that an action against an individual's license (other authorizing document) may be contemplated, a formal peer review will be conducted. This chapter presents the basic framework for a formal peer review. Additional specifics associated with peer review and adverse privileging/practice actions are contained in chapter 10. Peer review in relation to an SOC determination for a medical malpractice claim is discussed in chapter 13.

6–2. The peer review function

a. A peer is one who is from the same professional discipline/specialty as the individual undergoing review. During a peer review, selected health care personnel (that is, peers) evaluate the quality of the patient care rendered by another professional. These selected health care personnel, who are qualified by education and experience, will identify opportunities for clinical PI and, as appropriate, determine whether or not, given an adverse event or malpractice claim, recognized standards of practice were followed or the SOC was met by the individual in question. Professional qualifications; adherence to established professional standards for the discipline; the merits of any allegations of substandard skill, abilities, or performance; and recommendations for adverse privileging/practice or administrative action to be taken concerning these complaints are also considered.

Note. In circumstances where nursing practice is subject to scrutiny, in order to determine quality, efficacy, or appropriateness, the specialty-specific ANA Standards of Clinical Nursing Practice will apply.

b. Each MTF will establish peer review processes that are nonadversarial. Ideally, the peer review should be conducted as soon as possible (within 30 calendar days) after identification of the incident, circumstance, or behavior for which a peer review is warranted. The results of the peer review shall be made known to the individual in question as soon as possible following the conclusion of the peer review activities. See chapter 10 for specific time frames related to notification. The department/service chief is responsible for initiating and coordinating the peer review activities for nonprivileged personnel. For a privileged provider, the peer review is typically coordinated by the credentials or the RM committee. Peer review subjects are entitled to due process which includes, but is not limited to, the right to a hearing and the right to appeal the decision of the MTF commander to the next higher level of command. (See para 10–6*f* for additional detail.)

6–3. Composition of peer review board

Peer review activities may be accomplished either by an established committee/subcommittee (that is, credentials/RM) or by an ad hoc peer review panel/committee constituted on an as-needed basis. The formal committee/subcommittee structure may perform the peer review function for all categories of personnel, or for only privileged staff; the ad hoc committee may be responsible for the nonprivileged personnel. The peer review mechanism that is most appropriate for the organization will be addressed in local policy. The size of the MTF and the number and variety of health care personnel for whom peer review is appropriate will determine whether one, or more than one, peer review mechanism is established. One option is a single peer review panel with selective membership of an odd number of participants, the majority of whom are peers of the staff member whose practice is being reviewed. This is a more flexible alternative than each department/service assuming responsibility for its own ad hoc peer review panel. In circumstances, such as outlying health clinics, where sufficient staff are not available to conduct peer review, the process will be performed at the next level in the chain of command.

6–4. The intent of peer review

Structured feedback from an individual's peers (that is, a performance assessment (chaps 5 and 9)) may be used at any time an unbiased, external review of a staff member's day-to-day performance is appropriate. This is considered an

informal peer review. However, peer review as presented in this chapter is in the context of an adverse privileging/practice action and is a formal process. A formal peer review is required whenever an SOC determination must be made, or when the staff member's performance is such that an adverse practice action (for example, limitation of duty or removal from the clinical setting) is considered. The purpose of this review is to examine information obtained from the structured, unbiased investigation/inquiry and any other relevant materials. Following the review, recommendations are presented to the commander regarding the clinical performance, competence, and liability (medical malpractice case) of the individual. The peer review mechanism is intended to—

a. Protect the rights of the individual (afford due process).

b. Identify systemic issues and refer to appropriate CQM channels for resolution.

c. Separate professional actions and considerations from administrative or legal considerations.

d. Provide timely reporting to the USAMEDCOM QMD, utilizing Department of Defense Form (DD) 2499 (Health Care Provider Action Report) (see chap 10) or DD Form 2526 (Case Abstract for Malpractice Claims) (see chap 13), when the need is identified to report a health care privileged provider or nonprivileged professional to a regulatory body.

6–5. Conducting the peer review

a. When a privileged or nonprivileged staff member is removed from all or a portion of his/her patient care duties, the peer review function must be initiated to determine the extent of the problem and to make recommendations for further action on the professional issues in the case (for example, retraining, supervised practice, a licensing action). The focus of the peer review is on how the action under review impacts the individual's ability to practice clinically.

b. All procedures related to peer review (notification, withdrawal of permission for off-duty employment, hearing rights, the appeal process) are the same for both privileged and nonprivileged personnel. See chapter 10 for additional guidance associated with peer review.

6–6. Recommendations and followup reporting

a. In all cases, the recommendations resulting from peer review and subsequent action by the commander will be forwarded to the supervisor of the staff member whose practice/conduct was the subject of the peer review proceedings. It is the responsibility of the supervisor to ensure that the recommendations from the peer review function, and actions taken by the commander, are implemented.

b. The peer review function may recommend reporting the staff member to a licensing/regulatory agency. Local policy will establish who is responsible for preparation of the DD Form 2499. The MTF commander will forward this document to Commander, USAMEDCOM, MCHO–CL–Q, 2050 Worth Road, Fort Sam Houston, Texas 78234–6010, with copy furnished to the RMC or other higher headquarters, as appropriate. The recommendations of the peer review panel, and all other information related to the case, will accompany the DD 2499 when reporting of a privileged provider or nonprivileged professional to a licensing or other regulatory body is required. TSG is the sole reporting authority (para 14–3).

Chapter 7
Privileged Health Care Providers

7–1. General

a. This chapter includes general information and specific professional requirements related to each category of privileged provider (military or civilian) listed below. The information presented is intended to be a broad overview, rather than all-inclusive, and will change over time as health care requirements evolve. The privileged providers addressed include, but are not limited to—

(1) APRN.

(a) Certified nurse midwife (CNM).

(b) CRNA.

(c) Clinical nurse specialist (CNS).

(d) NP to include Family, adult, pediatric, women's health care, acute care, geriatric, emergency, and so forth.

(2) Audiologist.

(3) Behavioral health practitioner.

(4) Chiropractor.

(5) Clinical pharmacist.

(6) Clinical psychologist.

(7) Clinical social worker.

(8) Dentist.

(9) Dietitian.

(10) OT.
(11) Optometrist.
(12) Physician.
(13) PA and specialty physician assistant.
(14) PT.
(15) Podiatrist.
(16) Psychological associate.
(17) Speech pathologist.
(18) Substance abuse counselor.

b. Clinical privileges, which define the individual's scope of practice in a specific institution, are granted to health care providers based on their credentials, clinical competence, and the mission and requirements of the organization.

(1) The privileged provider is authorized to make independent decisions related to beneficiary health care management based on his/her recognized scope of practice. He/she may supervise, coordinate, and direct, as appropriate, the care provided by other members of the health care team. A representative scope of practice, by discipline, is provided in the pages that follow. Changes to the scope of practice for any of the privileged providers presented in this chapter are at the discretion of the MTF commander, who is the privilege-granting authority.

Note. While the specialist in blood banking (SBB) may be awarded clinical privileges in the specialty, he/she does not function independently to diagnose, initiate, alter or terminate health care treatment regimens. The term "provider," as defined in this regulation, does not apply to the SBB. (See paras 9–1 and 9–2 for additional information regarding the granting of clinical privileges.)

(2) The specific and individual privileges of each provider are delineated on the appropriate DA Form 5440, Delineation of Clinical Privileges, contained in his/her PCF.

Note. See app A for a complete listing of the DA Forms 5440 series.

Providers with admitting privileges and all physicians will be appointed to the medical staff. For health care providers who are not authorized to admit patients, medical staff appointment is optional. The individual's category of privileges, appointment status, and authority to admit patients are reflected on DA Form 5440A, Approval of Clinical Privileges/ Staff Appointment.

7–2. Clinical practice

a. Decision making. Clinical care decisions and specific therapeutic interventions on the part of the provider are based, in part, on CPGs; nationally recognized standards of care/practice; current professional clinical references; and other relevant regimens, guidelines, or policies, as appropriate. These serve as a framework for practice and are the basis for the specific clinical privileges requested by the individual provider and for periodic performance review and evaluation activities.

b. Collaboration. For privileged providers other than physicians and dentists, a designated physician will always be available for consultation and collaboration in person, telephonically, or by any other means that allows person-to-person exchange of information. Collaboration reflects both independent and cooperative decision making based on the professional preparation and ability of each provider. Collaborative practice implies an open exchange of patient data and information and includes such activities as consultation, referral, coordination, and co-management of patient care.

c. Pharmaceuticals. Privileged providers are authorized to prescribe pharmaceuticals contained in the MTF formulary according to the guidance established by the local P&T committee. For providers other than physicians and dentists, the drugs approved for prescription writing will be based on the provider's scope of practice and the beneficiary group(s) served. An open formulary is authorized. Facility-specific exceptions, either by category of drug or itemized by name of drug, will be noted in writing. Prescription writing authorization—as recommended by the P&T committee, reviewed by the credentials committee, and approved by the MTF commander—will be annotated in the PCF as an addendum to the provider's delineation of clinical privileges.

d. Procedures and diagnostic testing. Privileged providers are authorized to perform those procedures for which they have been appropriately trained, are properly qualified, and are privileged. Nonphysician privileged providers may be authorized to perform, and document in the medical record, minimally complex or selected moderately complex diagnostic procedures classified as provider-performed microscopy by the DOD Clinical Laboratory Improvement Program. (See AFIP Pam 40–24.) Other radiological studies, diagnostic testing, and procedures authorized according to local guidance will be addressed on the discipline-specific DA Form 5440.

e. Continuing education requirements. Professional competency is maintained, in part, by the ongoing accumulation of advanced knowledge in one's practice discipline. For all privileged providers, the annual requirement for continuing professional education and development is according to AR 351–3, or as determined by the provider's State of licensure, whichever is more stringent.

f. Readiness training. This is of paramount importance to prepare U.S. Army privileged providers for mobilization in support of the Army's global mission. Local command decisions will govern the training of assigned personnel. Suggested training includes—

(1) *ACLS and ATLS or an equivalent.* This training ensures that military providers are qualified in advanced cardiac and trauma management to care for the wounded/injured on the battlefield or other mission-related settings.

(2) *Medical management of chemical, biological, nuclear, radiological illness/injury.* The increased risk that weapons of mass destruction will be employed on the battlefield or in terrorist activity worldwide requires that privileged providers, as appropriate, be prepared to diagnose and appropriately manage the injuries or diseases that will result from the use of these unconventional agents.

7–3. Clinical performance review

a. Ongoing professional competency assessment and periodic formal evaluation of performance, to include both quantitative and qualitative data, are required for all privileged providers. This is accomplished at least biennially as part of the privilege reappraisal/privilege renewal processes and is documented on DA Forms 5374 and 5441. (See app A for a complete listing of DA Forms 5441 series.) An example of professional competency assessment is the periodic peer review, in the context of PI, of a representative sample of medical records. Competency assessment also includes analyses by one's peers and supervisor of specific outcomes-related data, RM data, and patient letters of appreciation or complaints, as well as direct observation of performance and verbal/written assessment of clinical knowledge/skills. Other performance review criteria, as recommended by the TJC or other accrediting agencies, as approved by the Office of the Secretary of Defense (Health Affairs) (OSD(HA)), may also apply. Performance-based peer review will be according to local policy.

Note. Performance review in this context applies to providers with current clinical privileges, and other professionals, who are actively engaged in the provision of patient care and services.

b. Additional requirements for enhanced supervision of the licensed novice or entry-level provider (or the experienced provider who has returned to clinical practice after a lapse (see glossary) in patient care duties) must be individually determined. This supervision will be provided by a designated individual of the same discipline or by a medical officer with more recent clinical experience.

7–4. Advanced practice registered nurse

a. Description.

(1) The APRN, as a result of master's or doctoral level education and in-depth clinical experience, possesses the advanced knowledge and clinical competency to provide health care in a defined area of specialization. The APRN demonstrates expertise in the assessment, diagnosis, and treatment of actual or potential health problems; the prevention of illness and injury; maintenance of wellness; and the provision of comfort to individuals, Families, or communities. The APRN group includes—

(a) CNMs.

(b) CRNAs.

(c) CNSs.

(d) NPs. This includes Family, adult, pediatric, women's health care, and others.

(2) Community health nurses (CHNs) function in an expanded role using CPGs approved by the ECMS and the DCN. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature, but he/she does not independently initiate, alter, or discontinue any medical treatment. Likewise, the scope of practice of occupational health nurses (OHNs) typically includes CPG or protocol-based patient interventions. In selected circumstances, either the CHN or OHN may be assigned duties or functions for which clinical privileges are deemed appropriate. CHNs and OHNs who meet the criteria as an APRN may be granted clinical privileges as approved by the MTF commander.

b. Professional credentials.

(1) *Education.* APRNs who complete their respective specialty programs after 31 December 2001 must be graduates of an accredited master's level or doctoral program acceptable to DA that prepares RNs with additional knowledge and skills to practice in their clinical specialty.

(2) *Licensure.* APRNs will maintain a current, active, valid, unrestricted RN license in at least one U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction (para 4–4).

(3) *Certification.* Within 12 months of graduation, the APRN will achieve certification by a nationally recognized certifying body appropriate to the specialty area of practice. Certification will be maintained for the duration of the individual's advanced clinical practice.

(4) *Residency.* New graduate APRNs, and those returning to clinical practice after a lapse, may be in an intern status with enhanced supervision (see para 9–4*e*) for a period of 12-24 weeks. The supervision associated with the period of residency is not considered an adverse status. For specific guidance related to APRN residency requirements, contact MCHO-CL.

c. Scope of practice.

(1) The APRN is a licensed and privileged practitioner and, as such, co-signature by a physician or other privileged provider of APRN entries in the patient's medical record, prescriptions, and so forth, is not required.

(2) As designated by his/her delineated privileges or scope of practice, demonstrated competence, and experience, the APRN (independently and collaboratively with other health care professionals) performs a wide variety of tasks or duties based on organizational requirements and according to local policy. The APRN may, among other tasks, perform medical examinations and document findings; screen health records (HRECs) for individuals participating in overseas deployments or other military duties; assist in weekly inspections of confinement facilities; examine and treat prisoners in confinement; recommend temporary limited-duty profiles on DA Form 3349 (Physical Profile) for AD Soldiers to include those on flight status (AR 40–501); place patients under his/her care on quarters status (AR 40–66); and perform other duties, as authorized by the commander.

(3) The APRN may authenticate temporary limited-duty profiles for pregnancy and other conditions according to the guidance outlined in AR 40–501.

d. Certified nurse midwife.

(1) *Description.* CNMs are RNs with advanced, specialized training in midwifery. Nurse-midwifery practice is the independent management of women's health care, focusing particularly on pregnancy, childbirth, postpartum, and newborn care, as well as the Family planning, well woman care, and the gynecological needs of women. The CNM practices within a health care system that provides consultation, collaborative management, or referral as indicated by the health status of the beneficiary.

(2) *Additional professional credentials.* CNMs will demonstrate continued competency through active participation in the Continuing Competency Assessment Program of the American College of Nurse-Midwives. All CNMs will achieve and maintain current Continuing Competency Assessment Program certification.

(3) *Scope of practice.* The CNM—

(a) Provides routine prenatal care, labor and delivery management, immediate newborn care, and postpartum care. (See para (*c*) below.) In addition, they provide well-woman gynecological services including yearly physical exams, breast exams, pap smears, Family planning services, preventive health screening, and health education. With the appropriate training and experience, the CNM may also be privileged to perform such procedures as colposcopy, ultrasound, and birth control implant insertions/removals and to provide primary care services to adult female beneficiaries.

(b) Practices according to the Standards for the Practice of Nurse-Midwifery, as defined by the American College of Nurse-Midwives, the ANA Standards of Clinical Nursing Practice for Nurse Midwifery, and local nurse midwifery service guidelines. The MTF-specific guidelines define conditions for which referral or collaborative care (co-management) is appropriate.

(c) May provide obstetrical care within his/her scope of practice and expertise using physician consultation and/or co-management to provide comprehensive care for other than low-risk patients according to MTF guidelines. The CNM may perform outpatient care and be privileged to admit and discharge patients when an obstetrician is on call and is available by telephone to provide medical consultation, collaborative management, and/or referral when indicated.

e. Certified registered nurse anesthetist.

(1) *Description.* CRNAs are RNs with advanced, specialized training in the administration of anesthesia. Nurse anesthesia practice includes the independent administration and management of patient anesthesia to include preoperative evaluation and preparation, perioperative management, and postoperative followup and evaluation. The CRNA may provide consultation, collaborative management, or referral to other health care providers as indicated by the health status of the patient.

(2) *Additional professional credentials.* CRNAs will maintain current certification by the Council on Certification of Nurse Anesthetists.

(3) *Scope of practice.* The CRNAs will be responsible and privileged for the entire anesthetic process. The CRNA will—

(a) Perform and document a preanesthetic assessment and evaluation of the patient to include requesting consultations and diagnostic studies.

(b) Establish an anesthesia plan and, based on the preanesthetic assessment, determine that the patient is an appropriate candidate to undergo the planned anesthetic.

(c) Obtain informed consent for anesthetic services.

(d) Select, prescribe, or administer medications and treatment modalities related to the perianesthetic care of patients.

(e) Conduct the pre-induction assessment to determine the patient's readiness to enter the surgical environment immediately prior to administering the selected anesthetic.

(f) Select, obtain, and administer anesthetics, adjunct drugs, accessory drugs, and fluids necessary to manage the patient in the perianesthetic period, to maintain the patient's physiologic homeostasis, and to correct responses to the anesthesia or surgery consistent with the spectrum of anesthesia privileges.

(g) Ensure that the patient's postoperative status is assessed on admission to and discharge from (or bypass of) the post-anesthesia recovery area.

(h) Release or discharge patients from the post-anesthesia recovery area.

(i) Order and initiate perioperative pain relief therapy.

(4) *Collaboration and anesthesia-related decisions.*

(a) CRNAs routinely provide independent anesthesia care for American Society of Anesthesiologists (ASA) physical status classification 1 and 2 patients. They are responsible and accountable for determining when a physician (anesthesiologist, if available) will be consulted for the delivery of anesthesia care to ASA 1 and 2 patients. Consultation will be requested, as necessary, regardless of the patient's ASA classification.

(b) Collaboration, and subsequent implementation of the specific recommendations provided by the physician, does not relieve the CRNA of his/her overall responsibility to ensure the utmost safety of the patient. At all times, the CRNA remains accountable for his/her decisions and all professional actions associated with the anesthesia care rendered. The consulted physician is accountable for his/her anesthesia-related decisions.

(c) For patients in ASA physical status classification 3, 4, 5, or 6, CRNAs will collaborate with a physician (anesthesiologist, if available) or oral surgeon before induction of anesthesia. This collaboration may be face-to-face or by telephone. In an MTF without an assigned or available anesthesiologist, this collaboration will be with the operating surgeon. The CRNA will document the results of this interaction in the medical record prior to the start of the case. There is no requirement for the collaborating physician or oral surgeon to be privileged in the administration or management of anesthetics.

(5) *Graduate nurse anesthetists.* Graduate nurse anesthetists (GNAs) are individuals who have successfully completed a nurse anesthesia program but have not achieved CRNA certification.

(a) Prior to CRNA certification, the GNA will be granted supervised clinical privileges. A CRNA or anesthesiologist will supervise the GNA.

(b) The GNA will not be assigned to unsupervised on-call duties or emergency procedures nor will he/she teach/supervise anesthesia nursing students or other anesthesia providers in training.

f. Clinical nurse specialist.

(1) *Description.* CNSs are RNs who have obtained advanced, specialized education and certification to practice collaboratively as APRNs for the purpose of providing specialty care (for example, oncology, psychiatric, cardiovascular, pulmonary). CNSs participate in the care of both inpatients and outpatients and have primary responsibility for providing clinical expertise; consultation; case management; disease management; patient/Family education; and research application in primary, secondary, or tertiary health care settings.

(2) *Additional professional credentials.*

(a) Certification. CNSs must be certified in their specialty by the American Nurses Credentialing Center or the recognized national nursing certification organization for the specialty (for example, Oncology Nursing Society, American Association for Critical Care Nursing, Emergency Nurses Association, and so forth).

(b) Other. CNSs desiring prescriptive authority must meet the criteria specified by the ANA as well as the privileging requirements as described in chapter 9 of this regulation. A CNS requesting prescriptive authority, or authorization to function beyond the routine CNS scope of practice, may be privileged to provide expanded services to designated beneficiaries (for example, patients requiring comprehensive pain management).

(3) *Scope of practice.* CNSs practice independently and collaboratively with other members of the health care team to ensure a comprehensive plan of care for the patient. They function in a variety of practice environments ranging from primary care (as disease manager) to the intensive care setting (as acute care CNSs). Health care activities of the CNS may include taking initial and interval histories; performing developmental assessments and screenings; conducting diagnostic and screening tests; teaching and counseling patients/Family members regarding identified problems, health maintenance, and disease prevention; and initiating and evaluating treatment regimens that may include prescribing and dispensing medication appropriate to the privileged scope of care.

g. Nurse practitioner.

(1) *Description.* NPs are RNs with advanced, specialized education and clinical competency to provide medical/health care for diverse populations in a variety of primary, acute, and long-term care settings according to their practice specialty. NPs provide nursing and medical services to individuals, Families, and groups. NP specialties include, but are not limited to, acute care, adult, emergency, Family, geriatric, pediatric, psychiatric, and women's health.

(2) *Additional professional credentials.* NPs will maintain current certification by a national certifying body (for example, American Nurses Credentialing Center; American Academy of Nurse Practitioners; National Certification Board of Pediatric Nurse Practitioners and Nurses; ANA; National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties), as appropriate, for their specialty area of practice.

(3) *Scope of practice.*

(a) The NP practices independently and collaboratively with other health care professionals to provide primary care and to diagnose, treat, and manage the patient's preventive, acute, and chronic health problems. Services include but are not limited to ordering, conducting, and interpreting diagnostic and laboratory tests; prescribing pharmacologic agents and nonpharmacologic therapies; and teaching and counseling individuals, Families, and groups.

(b) The NP practices according to his/her specialty, the ANA Standards of Clinical Nursing Practice for Nurse Practitioners, and his/her individual DA Form 5440 as determined by the organizational mission and scope of care and

services. MTF-specific guidelines and the individual's privileges define conditions for which referral or collaborative care is appropriate.

7–5. Audiologist

a. Description.

(1) Audiologists contribute to the operational readiness and quality of life of the fighting force and other eligible beneficiaries by providing cost-effective hearing health care through audiological services including prevention, medical surveillance, treatment, education, and research.

(2) Audiologists support the missions of DOD personnel by implementing the Army Hearing Conservation Program and preventing noise-induced hearing loss to enhance auditory performance in operational environments. Audiologists prevent hearing loss through the provision and fitting of hearing protective devices, consultation on the effects of noise on hearing, management of hearing conservation programs, and presentation of educational programs. Audiologists diagnose and treat hearing deficits of authorized beneficiaries by selecting, fitting, and dispensing amplification/hearing aids and other devices; providing aural rehabilitation; and, when necessary, referring patients for medical intervention.

b. Professional credentials.

(1) *Education.* Audiologists must have a master's or doctoral degree in audiology from an accredited institution acceptable to DA.

(2) *Licensure.* Audiologists will maintain a current, active, valid, and unrestricted audiology license, registration, or certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of practice. Audiologists follow the guidelines published by the American Speech-Language-Hearing Association, American Academy of Audiology, and the National Hearing Conservation Association. Audiologists are privileged to provide comprehensive diagnostic and rehabilitative services for all areas of auditory, vestibular, and related disorders. Those with advanced training and current competence may be privileged to perform special procedures such as intraoperative monitoring of the cranial nerves, cerumen removal, cochlear implant assessments and management, posturography, and other advanced balance mechanism evaluations. Audiologists will manage hearing conservation programs. Once certified as a course director by the Council for Accreditation in Occupational Hearing Conservation, audiologists will provide certification training for personnel conducting audiometry for hearing conservation programs.

7–6. Behavioral health practitioner

a. Description. Behavioral health practitioners are trained in behavioral science, counseling theories, and practical applications of behavior change principles. They may manage numerous behavioral and emotional problems, in both general and particular specialty practice levels, providing a variety of behavioral health services, including screening, treatment, and consultation. The behavioral health practitioner may develop additional expertise in psychometrics, industrial psychology, substance abuse rehabilitation, geriatric care, school or health psychology, neuropsychology, pediatric or adolescent psychology, aeromedical psychology, and combat stress reactions.

Note. The provisions of this section are applicable to GS 180-series counseling psychologists that do not meet State licensure requirements as a doctoral-level psychologist. These individuals shall be privileged to engage in clinical practice only as defined in this regulation, using the title of behavioral health practitioner or psychological associate. (See para 7–19.)

b. Professional credentials. Behavioral health practitioners must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. The minimum educational and licensure requirements for category I–III level of privileges include—

(1) *Category I.* The individual has earned a master's degree in counseling psychology, fulfilling the requirements of a 2-year academic program, including a minimum of 12 supervised practicum hours in the major specialty. The graduate program must be offered by a college/university fully accredited by a U.S. regional accrediting body. The practitioner performs specialty counseling services and works under the supervision of a psychologist, psychiatrist, or clinical social worker licensed in his/her discipline. The individual must possess either the Licensed Professional Counselor (LPC) license or a master's level psychology license, such as psychological associate license, from a State licensing board.

Note. Not all States offer licenses to master's level psychologists, but all offer the LPC, though some States use a different title for their LPC-equivalent license. The education and experience requirements for licensure are the basis for determining equivalency.

(2) *Category II.* The individual has completed a 2-year master's degree program in counseling psychology, at a fully accredited college/university, including a minimum of 12 semester hours of supervised practicum. The individual possesses the LPC/LPC-equivalent licensure, or a psychological associate (or other master's level psychology license) available in some states. He/she has a minimum of 2 years' full-time experience in the specialty in which services are performed under the supervision of a higher level privileged provider with a license in social work, psychology, or psychiatry.

(3) *Category III.* The individual has completed a post-master's specialty degree from an accredited university and passed a comprehensive examination in that specialty. The individual has a LPC/LPC-equivalent license, or a license as a master's level psychologist, from a State licensing body. He/she provides a wide range of services in the designated

specialty and may supervise category II or I counselors in their provision of services in the specialty. The individual will be supervised by a psychologist, psychiatrist, or a social worker who is licensed in their respective disciplines and privileged at a higher level (category).

Note. Incumbent Army Substance Abuse Program (ASAP) counselors who are already clinically licensed but do not possess the educational qualifications as noted above are permitted to continue in their present positions (current grade and GS-series). However, they are not eligible for lateral transfer to another position or promotion to a higher grade.

c. Scope of practice. Individuals will practice within the guidelines of their respective State licensing boards as LPCs (or equivalent) or, if offered by their State, a license for master's-level psychology graduates such as psychological associate or licensed mental health provider. Behavioral health practitioners adhere to the State LPC or psychology licensing board's code of ethics and conduct. Specific clinical privileges are granted based upon training, experience, and competency. In general, behavioral health practitioners will—

(1) Conduct screening evaluations, utilizing information from clinical interviews, nonpsychometric tests, and collateral sources, as appropriate.

(2) Determine a provisional diagnosis according to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(3) Provide individual and group behavioral health treatment within the scope of practice/privileges granted.

(4) Manage the behavioral health care of patients and refer those having needs beyond their scope of practice.

(5) Serve as collaborator in human behavioral issues with, and consultant to, community agencies, health care providers, and organizational leaders.

d. Supervision.

(1) Master's level graduates who have recently (within the past year) obtained a master's level license such as an LPC or psychological associate license, will be fully supervised during their first year of employment as a behavioral health practitioner.

(2) LPCs or psychological associates with 2 or more years' experience (after attaining licensure), will receive general supervision, according to the individual's level of competence, as assessed by his/her supervisor.

(3) LPCs or psychological associates with more than 2 years' experience and with post-master's work leading to a specialty degree, will require supervision in their specialty with difficult, high-risk cases, or for cases in which one or more of the patient's problems fall outside the scope of the counselor's specialty.

7–7. Chiropractor

a. Description. Chiropractors provide treatment and care of spine-related neuromusculoskeletal conditions to eligible beneficiaries. The chiropractor utilizes chiropractic manipulation—also called chiropractic adjustment—to restore joint and related soft tissue function. This treatment may be used with other supporting forms of treatment (physical modalities) depending on the patient's specific needs. The chiropractic approach to health care is holistic, stressing the patient's overall well-being. The natural, drugless, nonsurgical methods of chiropractic treatment rely on the body's inherent recuperative abilities to promote healing.

b. Professional credentials.

(1) *Education.* The individual must be a graduate of a chiropractic college accredited by the Council on Chiropractic Education or its successor.

(2) *Licensure.* A current, active, valid, and unrestricted license to practice chiropractic in a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction is required.

(3) *Experience.* To qualify for clinical privileges, the chiropractor must have 2 years' minimum full-time active post-graduate chiropractic experience involving the delivery of both diagnostic and treatment services.

(4) *Optional credentials.* Optional credentials include postgraduate credits approved or accredited by an appropriate State licensing board, recognized diplomat status, formal hospital staff privileges (or evidence of actively seeking hospital privileges) at a nationally accredited health care facility.

c. Scope of practice. At the discretion of the MTF commander, clinical privileges may be granted based on the individual's documented education, competence, and experience. The minimum practice privileges for which the chiropractor is authorized include—

(1) Performing patient history and chiropractic physical examination, excluding vaginal examination.

(2) Ordering radiologic examinations such as spine/four views (anterior-posterior, lateral, oblique, spot) and pelvic series.

(3) Ordering standard diagnostic laboratory tests (for example, electrolytes, glucose, urinalysis, urine culture and sensitivity, complete blood count, occult blood, and erythrocyte sedimentation rate).

(4) Performing standard osseous and soft tissue procedures consistent with chiropractic care as commonly contained in the core curriculum of Council on Chiropractic Education-accredited chiropractic colleges.

(5) Utilizing heat and cold modalities, electrical stimulation, hydrotherapy, and ultrasound therapy in patient treatment.

(6) Providing patient instruction and recommendations pertaining to hygiene, nutrition, exercise, sanitary measures, lifestyle changes, stress reduction, and modifications of ergonomic factors.

(7) Placing AD Soldiers on limited duty profiles not to exceed 30 days according to local policy and on quarters for a maximum of 72 hours.

d. Supervision. The chiropractor functions under the indirect medical supervision of a physician assigned by the MTF. Both clinical supervision and professional evaluation of the individual are integrated into the organization's current evaluation structure.

7–8. Clinical pharmacist

a. Description. Clinical pharmacists are licensed pharmacists with complex clinical skills and capabilities acquired through advanced education and practical experience. Clinical pharmacists practice collaboratively in the area of pharmacoeconomics and with patients requiring therapy (for example, anticoagulant, asthma, hypertension, diabetes, hyperlipidemia, immunization, and oncology nuclear). Clinical pharmacists practice in primary care, medicine, pediatrics, geriatrics, infectious disease, nutrition, and pharmacotherapy settings. They provide medication refills. In many cases, the clinical pharmacist works directly for a physician or group of physicians in a particular specialty or primary care clinic. The pharmacist functions under clinical treatment protocols or CPGs developed in coordination with the medical staff, recommended by the P&T committee, and approved by the ECMS, or DOD/USAMEDCOM-developed and approved CPGs. Clinical pharmacists provide pharmacokinetic consultation, enteral and parenteral nutrition consultation, and perform drug therapy management activities on inpatient units and in outpatient clinics. In all cases, communication between pharmacists and physicians is essential for quality patient care.

b. Professional credentials. Pharmacists must demonstrate appropriate skills, training, and/or experience to be considered for clinical privileges. Minimum requirements include—

(1) *Education/certification.* Pharmacists must have—

(a) A post-baccalaureate or entry level doctor of pharmacy (PharmD) degree, or

(b) A master of science degree in pharmacy from a clinically oriented program, or

(c) Board certification in one or more of the pharmacy specialties recognized by the Board of Pharmaceutical Specialties, or

(d) Completed a clinical pharmacy residency or fellowship accredited by the American Society of Health System Pharmacists or American College of Clinical Pharmacy, or

(e) A bachelor of science degree in pharmacy with documentation of appropriate education, training, and/or continuing education in the practice of clinical pharmacy.

Note. The didactic content of current bachelor of science programs is nearly identical to entry-level PharmD programs. The difference is that PharmD programs have 1 additional year of clinical experience.

(f) Appropriate formal education and clinical training to perform limited physical assessment (that is, assessment focused on the specific system under examination). This is included in PharmD programs but may not be for bachelor's and master's programs. Other sources of this training may include the Physical Assessment Education Program and/or a formal certification process.

(2) *Licensure.* Clinical pharmacists will maintain a current, active, valid, unrestricted pharmacy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of practice. Pharmacists may be granted clinical privileges to provide clinical treatment protocol/CPG-based direct patient care. (See para *a* above.) Communication with the patient's physician, through documentation of clinical activities in the patient's medical record and other verbal/written means, is essential to ensure continuity of care. Pharmacist privileges may include, but are not limited to—

(1) Assessing patient's response to drug therapy and planning drug therapy based on physician-established diagnoses.

(2) Ordering and assessing laboratory tests necessary to evaluate drug therapy effects and therapeutic outcomes.

(3) Initiating, modifying, or discontinuing medications for ongoing therapy of chronic disease states (for example, hypertension, hyperlipidemia, diabetes, asthma, and so forth) in cooperation with the medical staff.

(4) Monitoring and managing pharmacotherapy requiring periodic adjustment due to specific or changing pharmacokinetic characteristics (for example, aminoglycosides, phenytoin, antithrombotics).

(5) Initiating or modifying drug therapy for minor acute conditions such as colds, rashes, and allergies.

(6) Administering prescription or nonprescription drugs according to established treatment protocols or practice guidelines.

(7) Assessing metabolic needs and ordering therapeutic enteral or parenteral nutrition products in inpatient and outpatient settings.

(8) Evaluating medical and medication histories for drug-related problems and adjusting drug therapy accordingly.

(9) Consulting with other health care providers (for example, physicians, dietitians, nurses, PTs, and so forth) regarding patient pharmacologic treatment needs or options.

(10) Consulting to therapeutically evaluate, recommend, or modify medication therapy for patients with complex medical conditions or difficult-to-manage-disease states.

(11) Conducting and coordinating clinical investigation and research (consistent with other health care professionals) approved by a local or regional investigational review board and participating in outcome studies generated by the department of pharmacy and approved by the P&T committee.

(12) Providing patient education/counseling services to enhance compliance and reduce the occurrence of medication-related problems and adverse drug events.

(13) Applying advanced knowledge of drug therapy to provider and patient education, MTF drug formulary analysis and recommendations, and serving as preceptor for pharmacy students.

d. Supervision.

(1) Clinical pharmacists granted MTF privileges must have a physician available for consultation, either in person or by phone, when they are performing direct patient care activities.

(2) All clinical pharmacists must work via protocols recommended for approval by the ECMS and practice with the supervision of a physician preceptor, identified in writing. The physician preceptor must provide consultation, clinical feedback, and general oversight of the clinical pharmacist's practice.

7–9. Clinical psychologist

a. Description. Clinical psychologists are specialists in the areas of behavioral science, psychological processes, and behavioral health. Clinical psychologists provide comprehensive behavioral health services as independently privileged health care providers. Behavioral health services include a variety of evaluation, treatment, and consultation activities that address behavioral and emotional problems at both the general practice and specialty practice levels. Clinical psychologists may develop additional expertise in neuropsychology, health psychology, child/pediatric psychology, personnel assessment and selection, aeromedical psychology, survival, evasion, resistance, and escape (SERE) psychology, and combat stress control.

Note. The provisions of this section are applicable to GS 180-series counseling psychologists prepared at the doctoral degree level.

b. Professional credentials. Clinical psychologists must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. Minimum requirements for category I–IV level of privileges are—

(1) *Category I.* The practitioner has completed predoctoral internship but has not yet completed degree requirements for a Doctor of Philosophy (Ph.D.) or Psy.D. in clinical or counseling psychology. The graduate program and internship must meet requirements of DA Pam 611–21. The practitioner assists in performance of psychological and other services and works under the supervision of a licensed psychologist.

(2) *Category II.* The practitioner has a Ph.D. or Psy.D. in clinical or counseling psychology but is not yet licensed. The graduate program and internship must meet requirements of DA Pam 611–21. The practitioner provides a full range of psychological services as qualified to deliver by virtue of training. He/she participates in team delivery of services, research, and teaching and receives qualified supervision (per licensing criteria) from a licensed psychologist.

(3) *Category III.* The practitioner has Ph.D. or Psy.D. in clinical or counseling psychology and is licensed. Graduate programs and internships must meet requirements of DA Pam 611–21. The practitioner is recognized as possessing a high level of skill in psychological assessment, intervention, and administration of services. He/she delivers psychological services to individuals and treatment teams and may be appointed as supervising psychologist for category I and II practitioners.

(4) *Category IV.* The practitioner has a Ph.D. or Psy.D. in clinical or counseling psychology and is licensed and board certified by the American Board of Professional Psychology. Graduate programs and internships must meet requirements of DA Pam 611–21. The practitioner is recognized as possessing the highest level of skill in psychological assessment, intervention, and administration. He/she may be appointed as a supervising psychologist for category I and II practitioners.

c. Scope of practice. Clinical psychologists practice within the guidelines of their respective State licensing boards and within the guidelines for providers of psychological services published by the American Psychological Association (APA). Psychologists adhere to the APA's Ethical Principles of Psychologists and Code of Conduct. Specific clinical privileges are granted based on training, experience, and competency.

(1) In general, clinical psychologists—

(a) Conduct psychological evaluations utilizing information from clinical interviews, psychological testing, and collateral sources, as appropriate.

(b) Establish psychiatric diagnoses according to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(c) Provide individual and group behavioral health treatments for which the provider holds privileges.

(d) Independently and collaboratively manage the behavioral health care of patients and refer patients to appropriate providers for health care which falls outside their scope of practice.

(e) Serve as expert consultants in human behavior to community agencies, health care providers, and organizational leaders.

(f) Provide operational psychological services to include combat stress control, aeromedical psychology, and SERE psychology.

(g) Conduct behavioral research in diverse settings to address the full range of psychological issues that impact individuals, groups, and military organizations.

(h) Conduct personnel assessment and selection for specialized military occupations.

(2) Clinical psychologists are authorized to admit, independently and collaboratively treat, and collaborate on the discharge of patients from inpatient care to include psychiatric units staffed by psychiatrists.

(a) Clinical psychologists may admit patients to the MTF only if a physician member of the medical staff, to include a psychiatrist in cases requiring admission to a psychiatric unit, assumes responsibility for performing the admission history and physical (H&P) examination. The physician must also be responsible for the patient's medical problems that exist at the time of admission, or may arise during hospitalization, and are outside the psychologist's scope of practice.

(b) Coordination will occur between the admitting clinical psychologist and physician for patient discharge. The clinical psychologist's discharge recommendation will be documented in the medical record.

(c) The appropriate DA Form 5440 will clearly specify the wards/units to which the clinical psychologist may admit and discharge patients.

d. Supervision.

(1) Psychology officers who are recent graduates of military psychology residencies and are awaiting award of their Ph.D. or Psy.D. will receive supervision of their clinical activities, based on individual needs, from a licensed psychologist.

(2) Unlicensed military clinical psychologists who hold a Ph.D. or Psy.D. in clinical or counseling psychology but have not yet obtained a State license to practice psychology will be supervised by a licensed psychologist until licensed, as specified in the written plan for supervision.

(3) Licensed clinical psychologists who are privileged in the independent practice of psychology do not require supervision except when engaging in new areas of practice. Psychologists who have not engaged in clinical practice for a period of 12 months or more will require assignment to a 12-month period of general supervision. Psychologists will adhere to guidelines of the APA which require psychologists to receive appropriate training and supervision before engaging in new practice areas.

(4) If another psychologist is not available to provide the required supervision, the MTF will coordinate with the RMC senior psychologist before establishing the plan of supervision.

7–10. Clinical social worker

a. Description. The primary mission of Army social work is to provide comprehensive professional services through a broad range of individual, Family, command level and community interventions, programs, and services to sustain, restore, or enhance the social well-being and functioning of individuals, Families, units, and the Army community. Social workers are members of the health care team, most frequently working in social work service, outpatient mental health clinics, Family Advocacy Programs (AR 608–18), substance abuse treatment services, division mental health services, combat stress control detachments, and correctional facilities.

b. Professional credentials.

(1) *Education and experience.* Clinical social workers must have a master of social work (MSW) degree from a school of social work accredited by the Council on Social Work Education. Social workers practicing in the AMEDD must be qualified in clinical social work through the master's level educational program and post-MSW experience.

(a) In order to engage in independent practice, clinical social workers must have completed an MSW, have a minimum of 2 years' post-MSW clinical social work experience, and possess the appropriate State license/certification. (If the State offers a license for independent clinical practice, this will be the level of license required. Otherwise, the license must be at the level appropriate for an MSW social worker with 2 years' experience.) These individuals may be awarded regular clinical privileges.

Note. Incumbent ASAP counselors who are already clinically licensed but do not possess the educational qualifications as noted above are permitted to continue in their present positions (current grade and GS-series). However, they are not eligible for lateral transfer to another position or promotion to a higher grade.

(b) Entry-level clinical social workers may be granted regular privileges with enhanced supervision as described in paragraph 9–4*e*. A written plan of supervision will be documented. This applies to the licensed entry-level clinical social workers possessing an MSW and less than 2 years' post-MSW experience and to clinical social workers with greater than 2 years' post-MSW experience that hold a license which does not authorize independent practice in their State of licensure.

(c) Social workers who are practicing clinical social work but have only an entry-level license from a State that offers a higher level of license, as described above, will be awarded regular privileges with enhanced supervision until they obtain the necessary level of license. Individuals will be given until 1 October 2004 to meet this independent practice licensure requirement. (This allows 2 years to meet State clinical experience/supervision requirements plus an

additional year to obtain the appropriate license. Individuals who have already completed the experience and supervision requirements will be given up to 1 year to complete the examination and licensure/certification process.)

(2) *Licensure.* A current, active, valid, and unrestricted MSW license at any level from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction is required and must be maintained.

c. Scope of practice. Clinical social worker privileges may include but are not limited to—

(1) Interviewing and evaluating patients.

(2) Diagnosing mental disorders and formulating appropriate treatment plans.

(3) Recommending administrative and medical dispositions.

(4) Providing individual, couple, Family, and group psychotherapy.

d. Supervision. Clinical social workers with regular privileges will supervise entry level social workers. A psychologist or psychiatrist may supervise a social worker qualifying for an advanced clinical license if a privileged, independent clinical practice social worker is unavailable, and if the supervisor meets the individual's State licensing authority requirements for supervision.

7–11. Dentist

a. Description. Dentists ensure the optimal oral health of the Soldier through preservation, restoration, and replacement dental services and they provide dental health care to eligible DOD beneficiaries (AR 40–400). Dentists examine, diagnose, and treat or prescribe courses of treatment for beneficiaries suffering from defects, diseases, injuries, or disorders of the teeth, jaws, oral cavity, and supporting maxillofacial structures. In addition, dentists support casualty identification through dental forensic identification operations. Dental services are classified as general dentistry or specialty dentistry to include comprehensive dentistry, pediatric dentistry, periodontics, endodontics, prosthodontics, orthodontics, oral and maxillofacial surgery, oral pathology, and public health dentistry.

b. Professional credentials.

(1) *Education.*

(a) General dentist. To qualify as a general dentist, an individual must be a graduate of a dental school that is accredited by the American Dental Association, or an accepted equivalent program, and have passed all parts of the National Board Dental Examination.

(b) Specialty dentist. To qualify as a specialty dentist, an individual must meet all qualifications as a general dentist and be a graduate of a dental specialty training program that is accredited by the American Dental Association or an accepted equivalent program.

(2) *Licensure.* All dentists will maintain a current, active, valid, and unrestricted license to practice dentistry from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of practice. The general dentist is required and privileged to perform procedures appropriate to AOC 63A. The specialty dentist is privileged to perform the same procedures as the general dentist in addition to those appropriate to his/her specialty AOC. Dentists in residency training programs will perform specialty procedures as assigned and supervised by their program mentors.

7–12. Dietitian

a. Description. Dietitians provide nutrition services to include providing medical nutrition therapy (MNT); procuring, managing, and safeguarding all nutrition care division resources; supervising food production and service operations; educating patients, health care providers, and staff; managing the nutrition component of health promotion programs; and serving as nutrition consultants to the military community.

Note. Dietitians who provide MNT must be privileged to perform this therapy.

b. Professional credentials. The minimum criteria for determining an applicant's ability to provide MNT within his/her defined scope of clinical privileges are—

(1) *Education.* A baccalaureate degree from a U.S. regionally accredited college or university (or foreign equivalent) and completion of specific course work approved by the Commission on Accreditation for Dietetics Education is required. This course work must be validated by a verification statement from the Commission on Accreditation for Dietetics Education.

(2) *Registration.* Successful completion of the Commission on Accreditation for Dietetics Education-accredited supervised practice requirements for registration by the Commission on Dietetic Registration of the ADA is required. (If the applicant entered the Army as a "fully qualified" dietitian, current registration by the Commission on Dietetic Registration of the ADA is required. If the applicant is a graduate of the Military Dietetic Internship Consortium, registration must be obtained no later than October of the graduating year.) Registration eligibility must be achieved through one of the following pathways:

(a) Dietetic internship.

(b) Approval of Preprofessional Practice Program.

(c) A coordinated undergraduate program in dietetics.

(3) *Licensure.* Dietitians will maintain a current, active, valid, and unrestricted dietetics license or certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(4) *Scope of practice.* Dietitians may be granted clinical privileges to provide MNT that include nutrition assessment/evaluation, counseling, ordering laboratory tests and other assessment procedures, as well as implementing MNTs such as enteral/parenteral feedings for inpatients and outpatients and writing prescriptions for nutrition-related pharmaceuticals as described in paragraph 7–2*c*.

(a) Nutrition assessment/evaluation includes analyses of nutrient intake; activity level; appetite; intake of vitamins, minerals, nutritional supplements, and other complimentary alternative medicine usage; weight history; taste changes; feeding problems; food intolerance; food-drug interactions; unhealthy diet behaviors; socioeconomic and ethnic background; documented medical history; current diagnoses and medical treatment modalities; current drug therapy; and clinical signs and symptoms of nutritional deficiencies. Physiological symptoms that may accompany nutrient intake problems may be part of the analyses (for example, nausea, vomiting, diarrhea, and constipation). Nutrition assessment/evaluation may also include anthropometric measures (height; weight; skinfold measurements; mid-arm and mid-arm muscle circumferences; elbow breadth; wrist, waist, hip, and neck circumferences).

(b) Nutrition counseling includes identifying nutritional inadequacies; planning and implementing dietary modifications and interventions; evaluating and documenting clients' progress toward desired outcomes and goals; initiating health maintenance nutrition education; M&E and documenting individualized MNT plans; and initiating nutrition counseling follow up at defined intervals to ensure nutrition goals are met or redefined as appropriate.

(c) Advanced specialists with additional certifications may be privileged to order tube feedings, parenteral formulas, transitional feedings, and additional laboratory tests to support nutrition therapy decisions.

(d) To support MNT, dietitians may refer to other health care providers as needed such as to the diabetes educator; Women, Infants, and Children Program; hospice; home health care; and other community support programs.

(5) *Supervision.* If a dietitian is assigned where no other dietitian is available to provide supervision or assessment of the individual's performance, this responsibility is delegated to the senior RMC dietitian or the MTF DCCS. The competency assessment may include periodic review of a representative sample of medical records, direct observation of performance, or verbal/written assessment of clinical knowledge/skills according to the ADA Manual of Clinical Dietetics. Competency assessment will be documented and maintained in the dietitian's CAF.

7–13. Occupational therapist

a. Description. OTs contribute to operational readiness and quality of life by providing cost-effective occupational therapy care to the fighting force and eligible beneficiaries. Occupational therapy is the use of purposeful activity or interventions designed to achieve functional outcomes which promote health; prevent injury or disability; and which develop, improve, sustain or restore the highest possible level of independence of any individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, or other disorder or condition. It includes assessment by means of skilled observation or evaluation through the administration and interpretation of standardized or nonstandardized tests and measurements. OTs evaluate, treat, and consult with individuals whose abilities to cope with the tasks of everyday living are threatened or impaired by physical illness or injury, psychosocial disability, or developmental deficits. The OT uses goal-directed activities—appropriate to each person's age and social role—to restore, develop, or maintain the ability for independent, productive, and satisfying lives.

b. Professional credentials.

(1) *Education and internship.* The OT registered must be a graduate of an occupational therapy program that is accredited by The Accreditation Council for Occupational Therapy Education leading to a degree in occupational therapy. Completion of a clinical internship of not less than 6-months' duration is required. (This is an occupational therapy certification examination prerequisite that is usually accomplished prior to graduation from an accredited program.)

(2) *Certification.* Current certification from the National Board for Certification in Occupational Therapy (NBCOT) is required.

(3) *Licensure.* OT registered will maintain a current, active, valid, unrestricted occupational therapy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(4) *Other.* The advanced OT registered clinical specialist in the treatment of upper extremity neuromusculoskeletal conditions must—

(a) Attend the U.S. Army Occupational Therapy Evaluation and Treatment of Upper Extremity Conditions course.

(b) Complete a 6-month preceptorship under the supervision of an orthopedic physician and be awarded the 7H designator.

c. Scope of practice.

(1) *Category I.* Category I clinical privileges are appropriate for the OT whose activities are limited to the standard scope of practice as defined by his/her license or certification. The OT with category I level of practice will—

(a) Use guidelines published by the American Occupational Therapy Association and the NBCOT.

(b) Provide occupational therapy evaluation and diagnostic and treatment services for patients seen by providers in the MHS as well as those referred by civilian providers.

(c) Evaluate and treat deficits in occupational performance components that include motor, neuromusculoskeletal, cognitive, social, and psychological dysfunction. Treatment includes individual and group-based purposeful activity, exercise, physical agent modalities (used as adjuncts to purposeful activity), fabrication and training in the use of temporary functional orthotics, splints and adaptive devices, counseling, and education.

(d) Conduct ergonomic evaluations and training, work capacity evaluations, and work site analyses.

(e) Provide assessment, education, and training to Soldiers/beneficiaries in the areas of health promotion and disease/injury prevention, to include prevention of psychosocial dysfunction and stress management.

(f) Perform combat neuropsychiatric triage.

(g) Provide command consultation on the prevention and management of combat stress casualties.

(h) Conduct unit stress and morale surveys and provide consultation and recommendations to command staff.

(i) Provide interventions that enhance communication, team building, motivation, and prevent suicide and misconduct stress behaviors.

(j) Serve as occupational therapy consultant to both MTF and troop commanders.

(2) *Category II.* Category II clinical privileges are appropriate for the OT who demonstrates advanced education, training, and/or board certification, as appropriate.

(a) The OT skilled in the management of upper extremity neuromusculoskeletal conditions may be privileged to—

1. Provide direct access (that is, no referral required) upper extremity neuromusculoskeletal evaluation (NMSE) for acute musculoskeletal and neuromuscular conditions.

2. Request appropriate radiographs and laboratory tests for patients with neuromusculoskeletal conditions for whom they are performing primary evaluation and treatment.

3. Assign patients to quarters not to exceed 72 hours.

4. Refer patients to appropriate specialty clinics.

5. Authenticate temporary limited-duty profiles according to the guidance outlined in AR 40–501.

6. Write prescriptions for selected medications as described in paragraph 7–2*c*.

(b) The OT skilled in the management of patients with occupational performance deficits resulting from psychosocial conditions may be privileged to—

1. Conduct critical incident stress debriefings and other crisis intervention or critical incident stress management activities.

2. Assist doctoral-level mental health care providers in the assessment of patients referred for mental health evaluations by performing psychiatric diagnostic screening interviews and mental status examinations.

(c) The OT with advanced training in pediatrics may be privileged to—

1. Conduct infant and pediatric developmental evaluations and treatment.

2. Assist the radiologist and pediatrician in evaluation of pediatric modified barium swallow studies.

d. Supervision. The OT with either category I or II privileges will be provided supervision/oversight of his/her clinical practice by a more experienced OT. In the absence of a more experienced OT, a physician may provide supervision/oversight.

7–14. Optometrist

a. Description. Doctors of Optometry (ODs) are primary health care providers who examine, diagnose, and treat (or prescribe courses of treatment) for beneficiaries suffering from diseases, injuries, or disorders of the visual system, the eye, and associated structures as well as diagnosis-related systemic conditions. As primary eye care providers, optometrists are part of the health care team and provide an entry point into the health care system. They are skilled in the co-management of conditions that affect their patients' eye health and vision and are sources of referral and consultation for other health care professionals.

b. Professional credentials.

(1) *Education.* ODs must have a 4-year OD degree from an accredited 4-year college of optometry acceptable to DA.

(2) *Licensure.* Optometrists will maintain a current, active, valid, and unrestricted optometry license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of practice. Optometrists may have privileges that include, but are not limited to—

(1) Examining, diagnosing, and treating or prescribing courses of treatment for eligible beneficiaries suffering from diseases, injuries, or disorders of the visual system, the eye, and associated structures as well as diagnosing related systemic conditions.

(2) Co-managing post-surgical eye cases and ocular complications of systemic illness in the inpatient and outpatient setting.

(3) Serving as consultant in optometry (primary eye care) for other health care professionals in the MHS.

(4) Promoting prevention and wellness, vision conservation, education and training activities, vision screenings, and positive eye and vision health behaviors.

(5) Prescribing drugs appropriate for ocular therapy. Prescriptive authority is based on the optometrist's education and experience. Graduates from U.S. schools of optometry (1985 and following) are deemed to possess the appropriate education.

d. Supervision. Optometrists are licensed independent practitioners and have no requirement for physician supervision.

7–15. Physician

a. Description. Physicians are primary or specialty health care providers who examine, diagnose, and treat or prescribe courses of treatment for beneficiaries suffering from diseases, injuries, or disorders of any or all of the body's systems. As either primary or specialty care providers, physicians are an integral member of the health care team and participate in most clinical pathways in the health care system. They are skilled in the management of acute and chronic conditions that affect their patients and are primary sources of consultation for other health care professionals.

b. Professional credentials.

(1) *Education.* Physicians must have completed an accredited medical degree program acceptable to DA.

(2) *Licensure.* Physicians will maintain a current, active, valid, and unrestricted (OSD(HA) authorized waiver) medical or osteopathic medical license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction acceptable to DA.

(3) *Board certification.* Physicians who have completed requirements for training and experience meeting the standards of various member boards of the American Board of Medical Specialties (ABMS) are encouraged to attain board certification in their respective specialties. However, board certification is not required to practice independently.

c. Scope of practice. Physician privileges may include, but are not limited to—

(1) Examining, diagnosing, and treating or prescribing courses of treatment within the scope of their training and experience for eligible beneficiaries suffering from diseases, injuries, or disorders.

(2) Serving as consultants for other health care professionals in the MHS.

(3) Promoting prevention and wellness, health and safety education and training activities, disease screenings, and positive health behaviors.

d. Supervision. Physicians are licensed independent practitioners and have no requirement for direct supervision. They will act independently in areas of medical and surgical care when they have demonstrated competency within their delineated privileges. Physicians in post-graduate clinical training (interns, residents, and fellows) are required to function under the supervision of experienced physicians participating in the GME system. A physician returning to practice after a lapse in providing patient care may be required to function for a specified period under the supervision of another more experienced physician (that is, enhanced supervision, as described in para 9–4*e*) if recommended by the credentials committee and approved by the MTF commander.

7–16. Physician assistant and specialty physician assistant

a. Description. PAs are health care providers who deliver primary or specialty medical care with physician supervision. Within that physician-PA relationship, PAs exercise significant professional autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services to all DOD beneficiaries. The clinical role of the PA includes but is not limited to primary care, Family practice, and specialty areas such as aviation medicine, cardiovascular perfusion, emergency medicine, occupational medicine, and orthopedics. PAs deploy to provide medical support during mobilization, humanitarian assistance, and peacekeeping missions. PA practice is centered on the management of illness and injury, disease prevention, and health promotion and may include—in addition to patient care responsibilities—didactic instruction in a formal setting, patient education, research, and administrative activities.

Note. The majority of Army PAs are assigned to TOE combat and combat service support units. More detailed explanation (for example, regarding training requirements, continuing education, and so forth) is offered about PAs so that non-AMEDD personnel will better understand the duties and responsibilities of these providers both in garrison and in the field.

b. Professional credentials.

(1) *Education.* Military PAs must meet the educational criteria for commissioning as a 65D according to AR 135–101 which stipulates a baccalaureate or master's degree. All PAs must be graduates of a PA training program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or previously recognized accrediting body) and acceptable to the DA.

(2) *Certification.* All PAs (AA/USAR/ARNG and civilian) are required to possess current certification by the NCCPA before regular clinical privileges are granted/renewed.

(a) Initial certification. PAs who received their training from the Interservice Physician Assistant Training Program (IPAP) (see AR 601–20) must take the NCCPA Physician Assistant National Certifying Examination (PANCE) at the first available testing period following Phase II of training. The IPAP graduate must pass the PANCE within 12 months following completion of the IPAP Phase 2. Individuals who, due to circumstances beyond their control, are unable to take the PANCE within the 12-month interval noted above must request deferment, in writing, from the Chief, Army

Medical Specialist Corps, prior to the scheduled examination date. Any approved deferment will delay the 12-month mandatory period to pass the PANCE. The Soldier will retain any unused portion of his/her 12 months for use upon termination of the deferment. IPAP graduates who are unsuccessful in passing the PANCE within the allotted 12 months will have their privileges revoked. This is considered an administrative action, not an adverse privileging action. PAs with an existing AD service obligation for training, who fail to complete the PANCE within 12 months, will be processed for involuntary branch transfer according to AR 614-100.

(b) Certification renewal. All PAs will continuously maintain NCCPA certification while employed by the Federal Government. Biennial renewal is mandatory.

(c) Recertification. The PA National Recertification Examination/Pathway II is required every 6 years. PAs who are unsuccessful in passing this examination after two attempts will have their privileges revoked and are prohibited from practicing in their AOC/ASI. The PA with an existing AD service obligation for training will be processed for involuntary branch transfer according to AR 614–100. Individuals with no AD service obligation may be eliminated from service according to AR 600–8–24. See MEDCOM guidance for additional NCCPA certification requirements.

(3) *Licensure.* Non-personal services contract PAs employed by the Federal Government must be licensed in the particular State in which they are working (see para 4-8*a*). All other PAs (AD, GS, and personal services contract) are granted a waiver to the licensure requirement by DOD.

c. Scope of practice. The PAs provide medical care for Soldiers and eligible beneficiaries in all age groups, including children under the age of 2, according to the clinical privileges awarded by the MTF commander.

(1) *Outpatient duties.* The PA outpatient duties include, but are not limited to—

(a) General medical care. Within the limits of their training and privileges, PAs provide primary and specialty medical care for the sick and injured.

(b) Diagnosis, treatment, and prescription. PAs may diagnose, prescribe for, and treat diseases, disorders, and injuries.

(c) Minor surgery and wound management. PAs may perform minor surgery and wound management that require completion of a Optional Form (OF) 522 (Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures). (See AR 40–66 for instructions on the use of this form.)

(d) Patients returning with the same complaint. PAs must consult with a physician when a patient presents with the same unresolved complaint twice in a single episode of care. Physician consultation will be documented on either a standard form (SF) 600 (Health Record-Chronological Record of Medical Care) or an SF 513 (Medical Record-Consultation Sheet). (See AR 40–66 for instructions on the use of these forms.) This does not apply to patients who are returning for routine follow up as directed or for treatment of chronic illnesses previously documented in their medical record.

(e) Referral and evacuation. Situations requiring higher levels of medical diagnosis and treatment will be referred or evacuated. In the absence of a physician, the PA will be the primary source of advice to determine the medical necessity, priority, and requirements for patient evacuation.

(f) Authentication of medical record entries. PAs will sign all entries made in the patient's inpatient treatment record (ITR) or outpatient treatment record (OTR). Documentation in the ITR of the patient's medical history, physical examination, and narrative summary, as well as entries on DA Form 4256 (Doctor's Orders) (see AR 40–66) require physician countersignature. Countersignature will be within 24 hours. Entries made by a PA in the HREC or the OTR do not require a physician's countersignature.

(2) *Inpatient duties.* The attending physician is responsible for the health care delivered by the PA. A PA may assist the physician in performing a variety of inpatient-related duties that may include, but is not limited to the following:

(a) Admit patients to an inpatient service, in consultation with the on-call/attending physician. All patients admitted to an inpatient service will have an attending physician.

(b) Write orders for inpatient care using DA Form 4256.

(c) Complete the medical histories and perform physical examinations.

(d) Prepare and dictate narrative summaries.

(e) Discharge patients but only at the direction of the attending physician.

(f) Specific pre-operative counseling is the responsibility of the attending surgeon. PAs may not perform a pre-surgical anesthesia evaluation that requires completion of a DA Form 7389 (Medical Record-Anesthesia). (See AR 40–66.)

(g) PAs may not sign the DA Form 3647 (Inpatient Treatment Record Cover Sheet). (See AR 40–400.)

(3) *Pharmaceutical usage.* PAs may be privileged to write prescriptions for a wide variety of pharmaceuticals as described in paragraph 7–2*c*.

(a) PAs are authorized to prescribe controlled substances (Schedule II–V).

(b) When the PA is providing primary field medical support during a field training exercise or deployment, he/she may administer or prescribe any pharmaceutical stocked in the U.S Army field medical set, kit, or assemblage authorized at that level of assignment. This is in addition to the pharmaceuticals authorized by addendum to the PA's delineation of clinical privileges.

(4) *Medical examinations.* PAs may—

(a) Conduct medical examinations, following the guidance in AR 40–501, and as deemed appropriate by the supervising physician.

(b) Perform medical screening for overseas movement and sign the DA Form 4036 (Medical and Dental Preparation for Overseas Movement). (See AR 600–8–11.)

(5) *Profiles.* PAs may authenticate temporary limited-duty profiles according to the guidance outlined in AR 40–501.

(6) *Personnel on flight status.* All PAs may assign duty limitations and recommend to an aviation unit commander that an aircrew member be medically restricted from flight duty. Only a flight surgeon (FS) may remove duty limitations on flight personnel.

(7) *Additional duties.* PAs will not be used in lieu of the professional officer-of-the-day or for administrative duties for which they have not been trained. Duties such as staff duty officer, report of survey officer, or AR 15–6 investigation officer are not appropriate for the PA whose primary responsibility involves day-to-day delivery of health care and services.

(8) *Expanded roles.* PAs with advanced education, training, experience, and the appropriate privileges may be used in specialty practice settings such as aviation medicine, cardiovascular perfusion, emergency medicine, occupational health, and orthopedics. Additions and deletions of PA specialties will be approved by the Commander, USAMEDCOM (MCHO–CL–C), 2050 Worth Road, Fort Sam Houston, TX 78234–6010. A specialty-trained PA may perform the initial patient work-up or consultation. The consultation prepared by the PA will be reviewed and countersigned by a physician according to established CQM procedures and/or locally developed scopes of practice. Guidance for each PA specialty is as follows—

(a) Aviation medicine. A PA who successfully completes the U.S. Army Flight Surgeon Primary Course will be designated as aeromedical PA, ASI M3, and may be assigned to assist the FS in the practice of aviation medicine. Aeromedical PAs—

1. Perform his/her aviation medicine duties under the supervision of a designated aviation-medicine-trained physician (61N) or resident in aerospace medicine.

2. Contribute to aviation medicine in the areas of medical examination for flight duty and primary health care for aviation personnel and their Family members.

3. Participate in the Aviation Safety Program and may supervise the fitting and use of crew member personal safety equipment. The aeromedical PA will not be a substitute for an FS in these activities.

4. Assist in aircraft accident investigations. The aeromedical PA will neither substitute for the FS in aircraft accident investigations or flight evaluation boards nor will the aeromedical PA sign reports for these investigations or boards.

5. Sign the DA Form 4186 (Medical Recommendation for Flying Duty) (see AR 40–501) recommending an air crew member's return to flight duty only after consultation with an FS. The name of the consulted FS will be annotated on the DA Form 4186 according to AR 600–106 and on SF 600 filed in the patient's HREC.

6. Be placed on noncrewmember flight status by Headquarters, DA, under the provisions of AR 600–106.

(b) Cardiovascular perfusion. A PA who successfully completes an accredited cardiovascular perfusion training program may be designated as a cardiothoracic perfusion PA. Cardiothoracic perfusion PAs—

1. Function under the supervision of a board-eligible or board-certified cardiothoracic surgeon when assigned duties as a cardiothoracic perfusion PA.

2. Obtain certification (highly encouraged but not required) as a certified cardiovascular perfusionist through the American Board of Cardiovascular Perfusion.

3. Operate extracorporeal circulation and autologous blood recovery equipment during any situation where it is necessary to support or replace a patient's circulatory or respiratory function.

4. Administer blood products, anesthetic agents, and other medication through the extracorporeal circuit according to training guidelines and established protocols.

5. Use ancillary techniques such as hypothermia, hemoconcentration, intra-aortic balloon counterpulsation, ventricular assist devices, and hemodilution.

6. Assist with a variety of surgical or invasive procedures to include saphaneous vein harvesting, sternotomy and thoracostomy, chest tube insertion/removal, and cannulation of major vessels.

(c) Emergency medicine. A PA who successfully completes a TSG-approved graduate PA emergency medicine training program may be designated as an emergency medicine PA (EMPA), (ASI M2). EMPAs—

1. Function under the supervision of a board certified/eligible emergency medicine physician when working in an emergency department/service.

2. Identify, evaluate, and initiate appropriate treatment to stabilize patients presenting to an emergency department/service with life threatening or medically urgent injuries, illnesses, or conditions.

3. Perform all diagnostic and therapeutic emergency medicine procedures for which he/she has been properly trained and privileged.

4. Maintain/sustain those skills and certifications (that is, ACLS, ATLS, pediatric advanced life support (PALS))

which are required as part of the EMPA scope of practice and are necessary in the performance of duties within an emergency department/service.

(d) Occupational health. A PA who receives a graduate level degree in occupational health/public health may be designated as an occupational health PA (OHPA). The OHPA assists the occupational medicine physician (60C) or preventive medicine physician (60D) in occupational and preventive medicine duties for the medical center (MEDCEN), medical department activity (MEDDAC), or TOE unit areas of responsibility. OHPAs—

1. Conduct job-related, fitness-for-duty, and health-maintenance examinations for military and civilian personnel.

2. Conduct occupational and non-occupational disease and injury prevention and treatment of military and civilian personnel.

3. Conduct illness and injury monitoring and investigations.

4. Supervise chronic disease surveillance to include tuberculosis and sexually transmitted diseases.

5. Provide occupational and environmental health education to Soldiers and DOD civilian employees.

(e) Orthopedics. A PA who successfully completes a TSG-approved graduate PA orthopedic training program may be designated an orthopedic PA (ASI M1). Orthopedic PAs—

1. Diagnose, treat, and appropriately manage musculoskeletal trauma and/or disease.

2. Perform minor orthopedic-related surgical procedures.

3. Perform orthopedic procedures to include traction pin placement and removal and adjustment of external fixation devices.

4. Function as first assistant in the operating room and emergency center/service/department for patients with orthopedic injuries or problems.

5. Directly assist the physician with reductions of all complex fractures and dislocations.

6. Perform all diagnostic and therapeutic orthopedic procedures for which he/she has been properly trained and privileged.

Note. Outpatient procedures by an orthopedic PA should not include any manipulation, minor surgery, or wound management requiring other than local or peripheral nerve block anesthesia.

d. Privileges.

(1) PAs will be awarded privileges commensurate with their education, experience, competence, and the operational needs of the unit to which they are assigned.

(2) New graduates of the Interservice Physician Assistant Training Program may be granted and maintained in a supervised privilege status until they have successfully passed the PANCE and are licensed (effective 1 July 2009).

(3) The appropriate TOE surgeon will participate in the privileging process for PAs assigned to TOE units.

e. Supervision. MTF commanders must exercise the utmost care when selecting physicians to be designated as supervisors for military and civilian PAs. These physicians (appointed by name and in writing) must demonstrate the ability to provide the required professional supervision, guidance, and support that is of vital importance in all patient treatment settings. The supervising physician must, when needed, prescribe standards of good medical practice. The supervisor must be available for consultation in person, telephonically, by radio, or by any other means that allows person-to-person exchange of information. An alternate physician supervisor must be available during temporary absences of the primary physician supervisor.

(1) *Qualifications and duties.* The physician supervisor will—

(a) Be qualified by education, training, and privileges to perform any treatment or procedure that he/she directs a PA to perform.

(b) Be responsible for the PA's medical practice and the quality of care rendered.

(c) Ensure that the PA's practice remains within the scope of his/her clinical privileges.

(d) Monitor the PA's performance using established outcome criteria for treatment, referral, and followup care.

(e) Ensure that performance evaluations are conducted according to established CQM policies. These evaluations may be delayed for PAs working at geographically remote or inaccessible locations, with operationally deployed forces, or in units on field training exercises. Delayed evaluations will be conducted at the first opportunity and should not be delayed for a period greater than 6 months. (The 6-month maximum delay period may be waived for deployed forces only if compliance would jeopardize the operational mission of the unit. In this case, the review will be completed at the earliest available opportunity.)

(f) Review medical treatment records for patients managed by PAs according to current unit CQM policies.

(g) Participate in the rating of the PA for whom supervision is provided. In all cases, the physician supervisor will be included as either the PA's rater or senior rater according to AR 623–3.

(2) *Nonpersonal services contract PA supervision.* A PA in this status may have supervision requirements imposed by his/her State of licensure that exceed U.S. Army requirements. (Given the variation among States regarding supervision of PAs under non-personal services contract to the Government, MTFs are encouraged to hire contracted PAs via personal services contract.) For PAs who require additional supervision, the following two options, listed in order of preference, may apply—

(a) The contractor is responsible for providing the additional supervision. In this case, the MTF will cooperate by providing copies of medical records for external review. The number of medical records will be locally determined.

(b) The MTF must petition the State board of licensure to honor physician license portability (10 USC 1094) in order for the MTF-appointed physician to provide the necessary supervision. In this case, the MTF is obliged to meet the other established supervision requirements of the State of licensure.

f. CME and training. CME is critical for sustainment of clinical skills necessary for the PA to perform his/her duties.

(1) PAs are required to obtain 100 hours of CME every 2 years in order to maintain current NCCPA certification. Commanders are encouraged to provide the time and the necessary funding, as appropriate, to ensure that all assigned PAs remain current in their clinical skills.

(2) Readiness training is of paramount importance to prepare U.S. Army PAs for their wartime mission. Recommended training for AA/USAR/ARNG PAs includes—

(a) ATLS or an equivalent. This training helps ensure that military PAs are qualified in advanced trauma management to meet the doctrinal mission to care for the wounded/injured on the battlefield. Advanced trauma management sustainment training is required for military PAs once every 4 years.

(b) Medical Management of Chemical and Biological Casualties Course. The increased risk that weapons of mass destruction will be employed in a battlefield scenario requires that military PAs be able to recognize and treat the injuries or diseases that will result from the use of chemical or biological agents. PAs should attend this training as soon as possible following graduation.

(c) Tropical/global medicine. The increasing likelihood of deployments and missions in the tropical and subtropical regions of the world requires familiarity with diseases and conditions that are endemic to those areas and which pose a threat to the health and well-being of Soldiers.

7–17. Physical therapist

a. Description. PTs ensure operational readiness and quality of life to the fighting force and other eligible beneficiaries by providing appropriate physical therapy care. This is achieved through physical therapy services that include examination, evaluation, diagnosis, prognosis, intervention, prevention, health promotion, education, and research.

b. Professional credentials.

(1) *Education.* PTs must be graduates of a physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent.

(2) *Licensure.* PTs will maintain a current, active, valid, and unrestricted physical therapy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of practice.

(1) *Category I.* Category I clinical privileges are appropriate for the PT whose activities are limited to the standard scope of practice as defined by his/her State license.

(a) Perform functions in support of physical therapy evaluation and treatment.

(b) Provide physical therapy examination, evaluation, diagnosis, prognosis, and intervention services for patients seen by providers within the MHS as well as those referred by civilian providers.

(c) Serve as PT clinical consultant for other health care professionals in the MHS, the DOD, and/or Department of Veteran's Affairs (VA) facilities concerning patient-specific treatment approaches.

(d) Perform prevention and wellness activities, education, screening, and promote positive health behaviors.

(2) *Category II.* Category II clinical privileges are awarded to PTs who demonstrate appropriate education, training, and/or board certification. These authorize the PT to—

(a) Perform functions in support of physical therapy evaluation and treatment as follows:

1. Request appropriate imaging studies for patients with neuromuscular disorders for whom they are performing primary evaluation and treatment.

2. Assign patients to quarters for intervals not to exceed 72 hours.

3. Refer patients to specialty clinics.

4. Authenticate temporary limited-duty profiles according to the guidance outlined in AR 40–501.

5. Write prescriptions for selected medications as described in paragraph 7–2*c*, for musculoskeletal conditions.

(b) Perform and interpret electrophysiologic tests to include nerve conduction studies, needle electromyography, and somatosensory-evoked potentials. These privileges should only be granted if the PT has met the American Board of Physical Therapy Specialties guidelines for the practice of clinical electrophysiologic physical therapy published in Clinical Electrophysiologic Physical Therapy: Description of Advanced Clinical Practice (1995).

1. Documentation in support of the PT's request for such privileges includes a summary of post-graduate professional education, qualifying clinical experience, and a formal statement by the clinical preceptor and the medical officer attesting the proficiency of the candidate.

2. A qualified electrophysiologic supervisor, as defined below, will be designated by the MTF commander to be a direct liaison with the PT performing electrophysiologic tests and will serve as the PT's clinical preceptor for problem

cases, review of cases, ascertaining the quality of practice, and to answer questions concerning new equipment or special techniques.

3. An ongoing peer review process between the electrophysiologic supervisor and the practicing PT will be established. This should include a quarterly review of at least a 10 percent sample of patient medical records and reports and a yearly on-site review of the clinical electrophysiologic testing procedures. A qualified military or civilian electrophysiologic supervisor shall be a physician certified by the American Board of Electrodiagnostic Medicine, a physician holding a Certificate of Added Qualification in Clinical Neurophysiology of the American Board of Psychiatry and Neurology, or a PT certified by the American Board of Physical Therapy Specialties as an electrophysiologic certified specialist.

(c) Provide early intervention (that is, physical therapy care for high-risk infants) in the neonatal intensive care unit.

d. Supervision. The PT with category I privileges will be provided supervision/oversight of his/her clinical practice, as required, by a PT with category II privileges, or in the absence of a category II privileged PT, by a physician.

7–18. Podiatrist

a. Description. Doctors of podiatric medicine (DPM) provide comprehensive medical and surgical management of disorders of the foot and ankle. This includes examination, diagnosis, medical and surgical treatment, prevention, and care of conditions/functions of the foot and related structures. Podiatrists are members of the orthopedic/surgery service.

b. Professional credentials.

(1) *Education.* Podiatrists will have a DPM degree (4-year DPM degree) from an accredited college or university of podiatric medicine acceptable to DA. While completion of a 24-month podiatric surgical residency is preferred, completion of a 12-month podiatric surgical residency plus a 12-month podiatric orthopedic/primary podiatric medical residency is accepted.

(2) *Licensure.* Podiatrists will maintain a current, active, valid, and unrestricted podiatry license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) *Certification.* Board certification (not required but encouraged) is via one of two certifying boards recognized by the American Podiatric Medical Association's Council on Podiatric Medical Education—

(a) American Board of Podiatric Surgery.

(b) American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

c. Scope of practice. A DPM may be privileged as any other member of the medical staff in the surgical service. The national standard for DPMs with the appropriate post-graduate education, as stated in *b* above, is the management of all disorders of the anatomic region of the foot and ankle and related structures affecting the foot and ankle. Podiatrists for whom residency training included medical history taking and physical examination may be privileged to perform the complete H&P for ASA patient classification status 1 and 2 patients in both the inpatient and outpatient settings. The DPM will perform and record the H&P on the appropriate medical form(s), for example, SF 504 (Clinical Record - History Part I), SF 505 (Clinical Record - History Part II, III), and SF 506 (Medical Record - Physical Examination) for the inpatient, or SF 600 (outpatient). Patients classified as ASA patient classification status 3 and greater will require an H&P, either all or part of which is performed by a qualified physician. The podiatric portion of the H&P may be performed, recorded, and signed by the DPM; the remaining medical portion of the H&P is the responsibility of the consulting physician. Findings, conclusions, and assessment of risk will be confirmed or endorsed by a qualified physician prior to initiation of any major high-risk diagnostic or therapeutic intervention. The DPM may be privileged to admit patients only if he/she is educationally prepared to perform the H&P. Otherwise, a privileged physician must admit the patient, perform the H&P, and assume responsibility for the patient's inpatient medical care during hospitalization.

d. Supervision. Podiatrists are licensed independent practitioners and have no requirement for physician supervision.

7–19. Psychological associate

a. Description. Psychological associates are trained in general psychology, psychometric theory, psychological testing, behavioral science, counseling theories, and practical applications of psychological principles. The psychological associate may develop additional expertise in industrial psychology, school or health psychology, neuropsychology, and pediatric or adolescent psychology.

Note. The provisions of this section are applicable to GS 180-series counseling psychologists that do not meet State requirements as a doctoral level psychologist. These individuals shall be privileged to engage in clinical practice only as defined in this regulation, using the title psychological associate or behavioral health practitioner. (See para 7–6.)

b. Professional credentials. Psychology associates must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. The minimum educational and licensure requirements for category I–III level of privileges include—

(1) *Category I.* The individual has earned a master's degree in psychology, fulfilling the requirements of an academic program, including a minimum of 6 semester hours of supervised practicum in the major specialty. The graduate program must be offered by a college/university fully accredited by a U.S. regional accrediting body.

(2) *Category II.* The individual has completed a master's degree program in psychology, at a fully accredited college/university, including a minimum of 6 semester hours of supervised practicum. The individual possesses licensure as a psychological associate, or the LPC/LPC-equivalent licensure (or other master's level psychology license) available in some states. The individual has a minimum of 2 years' full-time experience in the specialty in which services are performed under the supervision of a higher level privileged provider with a license in psychology.

Note. Not all States offer licenses to master's level psychologists, but all offer the LPC, though some States use a different title for the LPC-equivalent license. The education and experience requirements for licensure are the basis for determining equivalency.

(3) *Category III.* The individual has completed a post-master's specialty degree from an accredited college/university and passed a comprehensive examination in that specialty. The individual is a master's level psychologist, or has an LPC/LPC-equivalent license from a State licensing body. The individual provides a wide range of services in the designated specialty and may supervise category II or I counselors in the provision of services in the specialty.

c. Scope of practice. Individuals will practice within the guidelines of their respective State licensing boards as a licensed psychological associate (if offered by their State), or LPC (or equivalent), or "licensed mental health provider." Psychological associates adhere to the State licensing board's Code of Ethics and Conduct for psychologists or LPCs. Specific clinical privileges are granted based upon training, experience, and competency. In general, psychological associates will—

(1) Conduct an intake interview of assigned patients to include the history of the presenting problem, a psychosocial history, as well as a mental status evaluation, and any relevant behavioral observations.

(2) Conduct screening evaluations, utilizing information from clinical interviews, nonpsychometric tests, and collateral sources, as appropriate.

(3) Recommend an assessment strategy sufficient to answer the diagnostic question presented.

(4) Administer and score all psychological tests used in the assessment and present the data in a format to facilitate evaluation of the data.

(5) Determine a provisional diagnosis according to the Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(6) Prepare, under the general supervision of a licensed psychologist, a report or evaluation that includes the presenting problem, all pertinent historical data, information from collateral sources, and psychological testing. Integrate all data to facilitate conclusions and recommendations.

(7) Provide feedback to patients on the results of the psychological evaluation.

d. Supervision.

(1) Master's level graduates will be fully supervised during their first year of employment and will work under the direct supervision of a licensed psychologist. Thereafter, the work product will be fully reviewed and general supervision provided by a licensed psychologist according to the individual's level of competence, as assessed by his/her supervisor.

(2) Licensed psychology associates (or LPCs) with 2 or more years' experience (after attaining licensure) will receive general supervision by a licensed psychologist according to the individual's level of competence, as assessed by his/her supervisor.

(3) Licensed psychology associates (or LPCs) with more than 2 years' experience and with a post-master's specialty degree—such as the Ed.S.—require supervision in their specialty only with difficult, high-risk cases, or for cases in which one or more of the patient's problems fall outside the scope of the associate's training.

7–20. Speech pathologist

a. Description. Speech pathologists help ensure operational readiness and quality-of-life to the fighting force and other eligible beneficiaries by providing cost-effective speech communication health care. Speech, language, voice, and swallowing services are offered to include prevention, medical surveillance, education, and research. The goal of speech pathology is to support the DOD mission and DOD personnel through implementation of communication enhancement and voice conservation. Speech pathologists diagnose and treat speech, voice, and communication deficits of Soldiers and other beneficiaries by prescribing appropriate treatment and, when necessary, providing referral for medical intervention.

b. Professional credentials.

(1) *Education.* Speech pathologists are required to have a master's or doctoral degree in speech pathology from an accredited institution acceptable to DA.

(2) *Licensure.* Speech pathologists will maintain a current, active, valid, and unrestricted license, registration, or certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) *Certification.* A Certificate of Clinical Competence from the American Speech-Language-Hearing Association is required.

c. Scope of practice. Speech pathologists follow the guidelines published by the American Speech-Language-Hearing Association. They are privileged to provide comprehensive diagnostic and therapeutic procedures of the speech and voice mechanism. Those with advanced training and current competence may be privileged to perform advanced

procedures such as electrophysiological measures of speech functions, acoustic analyses of voice production, fiberoptic endoscopic evaluation of swallowing, modified barium swallow study, dysphagia therapy, stuttering treatments, and voice therapy.

d. Supervision. The speech pathologist will be supervised/provided oversight of his/her clinical practice by a more senior or experienced speech pathologist, as determined by the MTF commander. In the absence of a senior speech pathologist, a physician or other qualified privileged provider, as designated by the DCCS, may provide supervision/oversight.

Chapter 8
Credentials Review

8–1. General

Credentials are those documents presented by the health care professional, regardless of the nature of his/her practice or duty position, that constitute evidence of current licensure, certification, registration, or other authorizing document, as appropriate. In addition, professional credentials substantiate relevant education, training, and experience; current competence and judgment; and the ability to carry out the duties and responsibilities of the assigned position or, for the privileged provider, to perform the privileges requested.

8–2. Credentials authentication for military accessions

a. Prior to selection for military service, the appropriate personnel from the respective AMEDD Recruiting Detachments will complete PSV of selected military provider/professional credentials and these are forwarded to the appropriate branch at USAREC, (Health Services Directorate (HSD)), Fort Knox, KY.

(1) The PSV performed by USAREC need not be repeated by the MTF credentials manager if appropriately authenticated provider credentials are available. The methods used to primary source verify credentials are those outlined in paragraph *8–6f.*

(2) The documents and forms required by USAREC to apply for military service vary by AMEDD program type. For privileged provider applicants (direct accessions) the documents that may subsequently become part of the PCF include but are not limited to—

(a) Personnel Data Sheet.

(b) Professional license and PSV (copy).

(c) Curriculum vitae (CV) or resume (copy).

(d) Diploma (copy).

(e) Qualifying degree official transcripts (copy).

(f) Continuing medical or health education (copy).

(g) Malpractice insurance coverage and PSV (copy).

(h) Additional documents: board certification(s); NPDB query results; ECFMG/Fifth Pathway certificate (if applicable); and internship, residency, fellowship certification or verification, as appropriate.

b. In addition to the various documents noted above, USAREC requires an Electronic Personnel Security Questionnaire from all individuals who do not currently hold a secret clearance.

Note. An NPDB query is placed for all privileged providers, unless a verified copy of the response from a recent query (less than 1 year old) is available from a civilian organization.

c. Once military appointment is accepted, all primary source verified documents and other credentials, as noted in paragraph *a* above, submitted as part of the application for military appointment will be forwarded by USAREC (HSD) as follows—

(1) *AA providers/practitioners.* USAREC (HSD) will forward credentials to the first MTF of assignment, as applicable, upon receipt of written request (see fig 8–1) from the MTF credentials office. These documents will be forwarded by Federal Express (FedEx), or comparable mail service, to the MTF credentials manager.

(a) USAREC (HSD) will process credentials requests for the following categories of AA accessions:

1. Fully qualified direct accession applicants in all AMEDD corps. Credentials will be forwarded upon request as noted above.

2. Army Medical Specialists Corps. Credentials for student accessions into the U.S. Army/Baylor Program in Physical Therapy, the AMEDD Dietetic Internship, and Occupational Therapy Fieldwork Programs will be forwarded to the appropriate program directors (no formal request required).

3. Medical Service Corps. Credentials for participants of the Clinical Psychology and Podiatry Residency Programs will be forwarded to the appropriate program directors (no formal request required).

4. Dental AGD 12-month applicants. Documents will be forwarded to the individual program directors at each training site following the AGD selection board (no formal request required).

(b) USAREC (HSD) is not responsible for forwarding credentials on the following categories of AA accessions:

1. Retiree recalls. The retiree's PCF must be requested from the U.S. Army Human Resources Command (HRC), AHRC–RSA–Q, 1 Reserve Way, St. Louis, MO 63132–5200. Credentials acquired since retirement will be appropriately verified (PSV) by the credentials office at the unit of assignment.

2. Reserve Officer Training Corps (ROTC) cadets. The Army ROTC Program is an accessions source for generic (nonspecialized) officers, primarily AN and MS. A baccalaureate degree, verified by ROTC Cadet Command, from a DA-approved college or university is the single credential required of all ROTC officers. Prior to being assigned to an Officer Basic Course class, the ROTC-commissioned AN officer must have successfully passed the National Council for Licensure Examinations Registered Nurse and hold a valid, unrestricted RN license as confirmed by ROTC Cadet Command with the respective State board of nursing.

3. ROTC educational delay participants. These individuals are involved in an advanced degree program (most often self-funded) in a health care specialty (for example, OT, PT, and so forth). If the individual is accessed into the military in a health care AOC, credentials from the appropriate source must be requested and PSV conducted by the credentials manager at the first unit of assignment.

4. Health Professions Scholarship Program participants. Upon graduation from medical school or other professional education program, certified true copies of official academic credentials (that is, diploma, final transcripts, and so forth) will be hand carried by the individual to his/her first year unit of assignment.

Note. Official sealed copies of academic credentials are the only credentials that may be hand carried by the individual in question.

5. Financial Assistance Program participants (same as para 6 below).

6. Military/civilian residency, fellowships, or training program participants. Credentials for military trainees in any of these programs will be forwarded in accordance with paragraph 9–4*d*(1). For students participating in GPHE in civilian deferred status (includes FAP), credentials must be requested from the training site. PSV will be conducted by the credentials office at the individual's first MTF of assignment.

(2) *USAR providers/practitioners.* Forwarding instructions will be determined by assignment/attachment as follows:

(a) For providers assigned to troop program units (TPUs), forward to the designated unit of assignment.

(b) For providers assigned to a unit but attached to the National AMEDD Augmentation Detachment (NAAD), forward to Commander, NAAD (AFRC–NAD–QA), 1401 Deshler Street SW, Fort McPherson, GA 30330–2000.

(c) For providers assigned to the Individual Ready Reserve (IRR) (excludes GME participants in civilian-deferred status) or the Individual Mobilization Augmentation Program, documents will be forwarded to Commander, HRC, (AHRC–RSA–Q), 1 Reserve Way, St. Louis, MO 63132–5200.

(3) *National Guard providers.* Forward documents to Strength Maintenance Division (NGB–ASM–S) (AMEDD), Suite 3400, 1411 Jefferson Davis Highway, Arlington, VA 22202–3231. Strength Maintenance Division will forward documents to the appropriate State Surgeon/Deputy State Surgeon who will forward the documents to the designated credentials manager.

8–3. Military treatment facility authentication of professional credentials

a. Review and PSV of the authenticity of credentials for all professional health care personnel is mandatory. In no instance will an individual be assigned or privileged to perform professional duties unless appropriately qualified by education, training, and experience.

b. Verification of credentials, as stipulated in this chapter, will be accomplished for all categories of privileged and nonprivileged Federal employees: AA/USAR/ARNG military, civil service, consultant status, FNLH, contract, or volunteer health care practitioners (includes new medical school graduates and trainees completing GME in civilian deferred status). For all privileged providers, inquiry will also be made to the NPDB (see para 8–7*l*) prior to the initial granting of clinical privileges when expanding or adding new clinical privileges, and at each biennial renewal.

(1) *Nonprivileged staff.* Verification of nonprivileged professional credentials is managed by the MTF readiness, education, and training department/service (or other service) according to local policy. The professional credentials that will be primary source verified and annotated in the individual's CAF (see chap 5 and app C) or other locally prescribed training file include but are not limited to—

(a) Academic. Pre-existing academic achievement is verified prior to military accession. Pre-employment verification of academic credentials for civilians (GS, personal services contract, and volunteer) is the responsibility of the MTF. Health-care-related professional degrees attained while employed by the Federal Government will be verified by the MTF.

(b) Licensure/certification/registration or other authorizing documentation. For new military accessions, PSV of an existing license(s) prior to entry into Federal service will be accomplished by USAREC. Local policy will direct who at the MTF is responsible for PSV of license for recently assigned nonprivileged military accessions and for pre-employment licensure verification for civilians (GS, personal services contract, and volunteer). The contracting agency will verify licensure with the primary source for non-personal services contract personnel prior to the employee being assigned to the MTF for duty. For military and civilian employees, periodic license renewal, as determined by the issuing State/national agency, will likewise be authenticated with the primary source by the responsible MTF authority.

The contracting agency is responsible for PSV of licensure/certification/registration renewal for non-personal services contracted employees. This requirement applies to all nonprivileged personnel who possess a license, certification, or registration as a professional credential. (See paras 8–6*e* and f for more information on PSV.)

(c) State or national specialty skills certification. This includes those offered by the ANA or other professional organization, mammography skills certification for radiology technicians, and so forth

(d) Authentication of other discipline-specific skill or technical training to include DOD-sponsored training. This excludes in-service education and other locally established training requirements.

(2) *Privileged staff.* Privileged provider credentials are verified, updated, and maintained during the individual's tenure with the U.S. Army by the MTF credentials manager, or other responsible authority, as designated by the commander. Professional information about the privileged provider is contained in both the PCF and the PAF.

(a) The PCF is the primary repository of permanent information related to provider credentials and performance. The contents must remain intact and the security of the information ensured at all times. Any request by the subject provider for amendment of information contained in the PCF (for example, correction of erroneous or inaccurate information, or the removal of improperly filed documents) must be considered under the provisions of the Privacy Act and AR 340–21. The PCF will be released only to the MTF commander, the credentials committee, department/service chiefs, recognized reviewing authorities, or officially appointed inspectors. The provider may authorize, in writing, release of his/her PCF to others, but the PCF should be retained in the credentials office with authorized access in that secure location. See appendix E for additional information regarding the PCF.

(b) The PAF is considered a working file that contains a variety of clinical data that are used to profile the provider's practice, to periodically reevaluate performance, and to reappraise privileges. Selected contents of this file (See app E for specific information regarding the contents and organization of the PCF.) are transferred to the PCF, according to local procedures, for permanent inclusion in the PCF. Other contents should be maintained for a minimum of 2 years to allow tracking and trending of provider clinical performance data and other information considered significant to the organization from a business or clinical perspective. (See additional PAF information in para 8–9 and app F.)

(c) Both the PCF and the PAF contain sensitive, confidential information. The documents contained in these files qualify for protection under 10 USC 1102. (See app E for specific information regarding the contents and organization of the PCF.) To protect these files and to maintain the integrity of the contents, the PCF and the PAF must be stored in a secure location (for example, in a file cabinet, desk drawer, and so forth that can be locked). Access to either file is limited to authorized individuals only. The PAF should be retained in the credentials office with authorized access only in that secure location. If either the PCF or the PAF is required outside this area, personal delivery by the credentials coordinator (or designated individual) is recommended. The integrity of these files and security of the contents must be maintained at all times.

(d) A provider may, on request and in the presence of the credentials manager or other command representative, be allowed to review the contents of his/her PAF and PCF.

8–4. Privileged provider credentialing

a. The credentialing process includes a series of activities designed to collect relevant data that serve as the basis for decisions regarding appointment and reappointment to the medical/dental staff, as well as delineation of individual clinical privileges. This information may also be the basis for subsequent action to expand or limit a provider's privileges.

b. Recommendations for the award of clinical privileges and medical staff appointment (if applicable) will be made by the department/service chief, acted upon by the credentials committee/function, and forwarded through the ECMS (AA facilities and USAR/ARNG units wherever feasible) to the commander for approval or disapproval. Recommendations from peers, who have firsthand knowledge of the applicant's competence, skill, and ability in the professional discipline are essential to the medical/dental staff appointment/reappointment process, as well as to the granting, renewing, or revising of clinical privileges. Peer recommendations may include written feedback from—

(1) The PI committee/function, the majority of whose members are the provider's peers.

(2) A department or clinical service chief who is a peer.

(3) The ECMS, the majority of whose members are the provider's peers.

(4) A reference letter or documented telephone conversation about the provider from a peer who is a member of the MTF's medical staff or who is from outside the organization. Peer recommendations will be maintained in the PCF and are filed with the recommendations by the provider's department or service chief.

8–5. Military treatment facility credentials committee/function

Central to the responsibility of assuring quality care and improving the performance of services rendered by privileged providers are the requirements for credentials review, delineation of individual clinical privileges for professional staff members, appointment/reappointment to the medical staff, and adverse privileging action hearing/appeals processes, as appropriate. These functions may be executed by the ECMS/ECDS (see glossary) or other group properly constituted to perform this series of activities, for example, the credentials committee. If the credentials committee is charged with

these responsibilities, the ECMC must review and concur with all recommendations for actions associated with provider privileging and medical staff appointment/reappointment prior to their consideration by the commander.

a. Purpose.

(1) The credentials committee/function reviews the credentials and the performance of each provider requesting clinical privileges and appointment to the medical/dental staff. Subsequent to this review, recommendations for provider privileging/appointment actions, to include those for USAR/ARNG providers for whom the committee has privileging responsibility, are made through the ECMS/ECDS to the commander. The committee's recommendations relevant to a provider's request for privileges are based upon his/her credentials, performance data, departmental peer recommendations, and the needs and capabilities of the institution.

(2) The credentials committee/function will also consider and recommend to the commander whether providers in a less-than-fully privileged status should be allowed to function under clearly defined supervision, involuntarily separated, or released from AD or civilian employment.

(3) No action recommended by the credentials committee/function is final until it has been reviewed by the ECMS/ECDS and approved/signed by the commander.

b. Membership and duties. The MTF commander will designate the DCCS (or other senior physician) as chairperson and will name the permanent members and a designated alternate for each member of the committee. Alternates will exercise all the duties and responsibilities of the permanent voting member whom they represent.

(1) The chairperson will ensure that all assigned members receive appropriate orientation to assume the duties and responsibilities of this committee.

(2) Membership will reflect the diversity of privileged providers practicing within the facility, in outlying patient care settings under the command and control of the MTF, and in garrison-level TOE units, where present. The majority (51 percent or greater) will be fully appointed members of the medical/dental staff.

(3) No action on a provider will be taken without the presence of a majority (51 percent or greater) of the voting membership.

(4) The chairperson may request the presence of a legal advisor (nonvoting).

(5) The senior nurse executive (that is, the Chief Nurse/DCN) is a voting member.

(6) At least one voting member of the same discipline, if available, will be present when clinical privileges for a nonphysician provider are considered.

(7) Members in the same discipline as the provider being evaluated should be present when the committee acts on the credentials of such providers.

Note. This is not mandatory for actions on temporary or supervised privileges.

(8) When the credentials of any member of the group are being considered, that member will be excused from that portion of the meeting. This will be reflected in the minutes/reports.

(9) The review of credentials and privileges for the MTF commander and deputy commander will be performed according to paragraph 9–2*c*.

c. Meetings and reports. The credentials committee will meet, or the function initiated, as often as necessary to ensure the timely appraisal of credentials and to prevent the expiration of privileges. The chairperson will ensure there are written records of all actions recommended/taken by this group.

(1) Reports and recommendations of the committee are provided through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the commander.

(2) Announcements of meetings, with the exception of on-call meetings, will be made no later than 5 days (no later than 30 days for USAR/ARNG committee meetings) prior to the planned meeting date.

(3) Those providers to be considered will receive 30-days' notice (60 days for USAR/ARNG providers) to review and update their credentials, as appropriate, and to submit a current request for privileges.

(4) The chairperson may schedule an on-call meeting, as directed by the commander, or as needed to—

(a) Evaluate provider requests for modification (augmentation or reduction) of individual clinical privileges.

(b) Evaluate the credentials of providers newly assigned (initial DOD assignment, following PCS/transfer, or TDY).

(c) Reevaluate providers who are in initial or restricted categories of professional activities.

(d) Consider or make recommendations to the commander that a provider's privileges be suspended, restricted, revoked, reduced, or denied.

(5) Voting is by a show of hands, or by written or electronic ballot, with either a "yes" or "no" vote; no abstentions are allowed. The chairperson will vote only in the event of a tie.

Note. Voting related to routine reprivileging actions may be accomplished by electronic means rather than paper ballot. Local policy will prescribe the application of, and any restrictions associated with, this method of credentials committee information dissemination and balloting.

In the case of an adverse privileging action against a provider, or a controversial issue involving a particular provider, the voting may be by secret ballot. If a member believes he/she should be disqualified from voting for (or against) a

given individual, a request with justification is submitted to the chairperson. If the request is granted, the minutes will reflect, by name, the member who has recused him/herself from the vote.

(6) The minutes will reflect the total "yes" and "no" votes cast for each action. Voting by nonpermanent members of the committee is restricted to actions or privileges for members of their respective discipline. Disqualified members will not vote.

d. USAR/ARNG credentials management and credentials committee/function. ARCCA manages credentials for the USAR—except for those managed by HRC-St. Louis (IRR providers) and those managed by the AA MTF (IMA providers). For the ARNG, a credentials manager will be appointed on orders. He/she will maintain a complete credentials file, and CCQAS data file, for all ARNG privileged providers within the State.

(1) State Surgeons will establish a credentials committee (or ensure the function is performed by one of the mechanisms described below) to perform the various credentialing and privileging activities as outlined in this regulation. The State Surgeon will not serve as chairman of the credentials committee. He/she will serve as the approval authority for all privileging actions and will sign in block 9a, DA Form 5440A for both initial privileges/staff appointment and for renewal of privileges/staff appointment.

(2) A variety of ARNG unit-specific circumstances exist that influence credentials committee structure and function.

(a) The State Surgeon's credentials committee serves as the centralized credentialing authority for all ARNG healthcare providers in the State. The State Surgeon may delegate this function to another activity, if performance is comparable to that of the State Surgeon's credentials committee.

(b) ARNG medical units with a minimum of three privileged providers may form a credentials committee.

(c) Units unable to form a credentials committee, due to insufficient providers or other reasons, may coordinate to convene a regional credentials committee. An MOU between the participating States serves as the charter for this committee.

(3) The credentials committee will—

(a) Make recommendations to the ARNG State Surgeon/MTF commander on privileging a unit provider for IDT/AD activities such as those identified in paragraph 1–4*h*(5).

(b) Review each provider's education, training, and current competencies against regular duty/mobilization AOC requirements. All ARNG providers will be credentialed in both their duty AOC and their civilian-equivalent AOC. However, privileges will be granted in accordance with the ARNG provider's duty AOC.

(c) Consider, and make recommendations to the State Surgeon, as appropriate, that an ARNG provider's privileges be denied, suspended, restricted, reduced, or revoked.

8–6. Provider credentials verification

Prior to being privileged and awarded appointment to the medical/dental staff, PSV of those provider's credentials that require such verification will be accomplished. Other credentials, as noted below, will be verified as true and authentic.

a. Credentials for which renewal is not appropriate (diploma, certificate of internship, and so forth) need only be primary source verified once if the individual maintains continual employment within the DOD. Credentials that require periodic renewal will be verified upon renewal. The privileged health care provider's license is the only exception, as described in paragraph 8–7*b*(2).

b. For military (AA/USAR/ARNG), credentials verification occurs during pre-selection processing prior to military commissioning. (See para 8–2 for more information.)

c. For civil service, consultant status, FNLH, personal services contract, or volunteer health care privileged providers, credentials verification by the MTF is required. Verification of the applicant's education, training, experience; licensure; certification and/or registration; current competence; and ability to perform the requested privileges or scope of practice is required. The MTF credentials manager (or other, as designated by the commander) will ensure that PSV of all credentials has been accomplished prior to position appointment/placement of the nonmilitary employee/volunteer. See appendix F for Civilian Personnel Operations Center (CPOC)/CPAC duties/responsibilities associated with prospective employee credentials.

d. For the non-personal services contract privileged provider, the contract will specify who is responsible for PSV of the provider credentials as noted in paragraph *c*, above.

e. The primary source for verification of a credential is the original source of the specific document. The primary source attests to the accuracy of a qualification. A reasonable effort must be made to verify, with the primary issuing authority, all documents that require PSV. These documents become part of the PCF. Unsuccessful attempts made to obtain verification of a credential from the primary source will be documented.

f. Documents may be primary source verified by one of the following methods (listed in order of preference):

(1) *Written confirmation directly from the issuing authority.*

(2) *Verbal telephone confirmation from the issuing authority.* A detailed record of the telephone interaction will be made in the PCF to include the name of the individual contacted, the date/time, and the signature of the person responsible for verification.

(3) *American Medical Association masterfile verification of U.S. medical school graduation and U.S. residency*

program completion. The American Osteopathic Association (AOA) provides a similar service for osteopathic physicians. Profile entries in either the AMA or AOA master files are only valid if they have been annotated as "Verified."

(4) *World Wide Web PSV.* Such verification is acceptable if the information is obtained directly from the professional organization's Web site. The identification of the individual making the Web site contact and the date will be annotated on the Web page printout and this will be entered in the PCF. Any discrepancy between information provided by the applicant and that on the Web site should be pursued by personal contact with the professional organization.

(5) *Touch-tone telephone PSV.* Electronic access by telephone of a database is acceptable only if the other methods listed above are not available. The individual responsible for telephone verification will annotate in the PCF the date, time, his/her signature, and why this was the only verification method available.

g. When certificates (for example, BLS, ACLS, specialty board) are renewed, the credentials manager (or other individual as designated by the commander) must view the original renewal certificate and annotate on a photocopy of the document, "I certify this is a true and valid copy of the original." The photocopy will be signed, dated, and entered in the PCF. If verification documentation from the primary source is available for inclusion in the PCF, or other appropriate file (nonprivileged professional), the requirement to photocopy the official document(s) does not apply.

8–7. Provider credentials file

The credentials information that originates during the pre-employment/accession application period serves as the basis of a comprehensive record (the PCF) that originates at the first unit of assignment/employment and is maintained and routinely updated throughout the provider's entire period of employment with the Federal Government. The contents of this record are permanent; however, data determined to be either erroneous or inaccurate will be removed in accordance with AR 340–21 and local policy. See appendix E for additional information regarding the PCF. The credentials contained in the PCF include the following:

Note. Those credentials specified in paragraphs a through *d* and paragraph *j* ,below, will be primary source verified.

a. Qualifying degrees, diplomas, ECFMG, Fifth Pathway, or other discipline-specific certificate, as appropriate.

(1) If the ECFMG certificate is dated prior to 1986, medical school graduation must be verified. (Prior to this date, the ECFMG did not verify graduation from medical school before issue of the certificate.)

(2) The MTF will notify the RMC/RDC who will telephonically contact the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010 or the Commander, U.S. Army Dental Command (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234–6004 for guidance and assistance when—

(a) The medical/dental diploma was issued by a school in a foreign country that has no diplomatic relations with the U.S. and direct communication to primary source verify the diploma or other credentials is not possible.

(b) There are other concerns regarding the diploma or the foreign medical/dental school.

(c) PSV of credentials by a source outside the U. S. in a reasonable period of time is not forthcoming.

b. State licenses, registrations, certifications, other authorizing documents, and current renewal certificates.

(1) A list of all licenses ever held will be provided (on DA Form 4691 (Initial Application for Clinical Privileges and Staff Appointment)) along with an explanation of any that are not current or that have ever been subjected to disciplinary action. The provider's signature on this form indicates that the list and any related explanation are complete and accurate.

(2) Licensure of providers will be verified with the primary source, by one of the methods described in paragraph 8–6*f*, at the time of—

(a) Staff appointment and initial granting of clinical privileges,

(b) Reappointment or renewal/revision of clinical privileges, and

(c) Renewal of an expired license.

c. Postgraduate training certificates (for example, residency, fellowship, nurse midwifery, nurse anesthesia school).

d. Specialty board and fellowship certificates. Specialty board certificates and certificates of renewal will be subject to PSV with the issuing board, or by referencing the AMA or AOA master files. The publication, "Official American Board of Medical Specialties (ABMS) Directory of Board Certified Medical Specialties" (at Web site http://www.abms.org), is now a recognized site for PVS and may also be used. The ABMS directory only includes those specialty boards that are members of this organization.

Note. It is not necessary to delay the award of regular privileges pending verification of board certification if all other credentials are in order.

e. A dated curriculum vitae to account for all periods of time subsequent to obtaining the initial qualifying degree.

f. Proof of current (within 1 year or most recent clinical practice if in an administrative role) competence. This may include letters of reference/peer recommendations from a program or department director, or peer, describing the scope of practice and/or clinical privileges in the department/service/setting in which the applicant is currently practicing. (See para *j*, below, for additional detail.) A copy of the most recent list of privileges with evaluation of the provider's

performance related to assigned privileges from the current or previous place of employment/assignment may be included, if available. The extent and description of recent clinical privileges will be verified.

g. Malpractice insurance history as requested on DA Form 5754 (Malpractice History and Clinical Privileges Questionnaire) with narrative comments, as appropriate.

(1) Explanation of any malpractice claims, settlements, or judicial or administrative adjudication with a brief description of the facts of each claim settled on the behalf of the provider.

(2) Dates of malpractice coverage and history of suits and claims verified for the 10 years prior to initial application.

(3) Verification with the insurance carrier of all self-reported suits and claims.

h. Detailed explanation of adverse clinical privileging and/or disciplinary action by institutions, State licensure boards, or other governing or regulatory agencies and those by any civilian medical or dental facility where the privileged provider is employed or practicing. This will include voluntary or involuntary termination of professional and/or medical staff membership or voluntary or involuntary suspension, restriction, reduction, or revocation of clinical privileges at a hospital or other healthcare delivery setting and any resolved or open charges of misconduct, unethical practice, or substandard care. The "yes" and "no" questions on DA Form 5754 with appropriate explanation capture this provider-specific information.

Note. A lapse between periods of clinical privileges, that is less than 180 days, due to PCS, hospitalization, mobilization, and so forth, is not considered an adverse circumstance or voluntary termination and does not require explanation as described here.

i. A statement by the applicant of his/her health status (physical, mental, and emotional health) relative to his/her ability to provide healthcare and to perform the privileges requested. Such a statement is required on page 2 (block 9) of DA Form 5754. Validation by another privileged provider familiar with the individual and his/her health status will be noted in separate memorandum to the credentials committee or as a comment in Section II, DA Form 5440-series, by the provider's supervisor.

j. Letters of reference/peer recommendations. The letters submitted with the application for Federal service are referred to in this document as letters of reference. These same letters of reference may be used for initial application for privileges/staff appointment; thereafter, for renewal of privileges/staff appointment written input in the form of peer recommendations is required. The individuals providing the letters of reference or peer recommendations should be personally familiar with the subject provider's clinical, professional, and ethical performance. This written input will address the provider's medical knowledge, clinical judgment, and technical skills as well as his/her interpersonal skills, communication skills, and professionalism.

(1) *Letters of reference.* A minimum of two current letters of reference from appropriate sources in (paras *a*) through (*c*) below are required for verification of experience and current competence. To best represent the applicant being considered for initial privileges and staff appointment, these letters of reference should be dated within 12 months of submission.

(a) A letter from either the chief of the hospital medical staff, the clinic administrator, the professional supervisor, or the department head, where the appointee has current clinical privileges or is professionally associated.

(b) A letter from the director or a faculty member of the appointee's training program, if the appointee was in a training program within the last year.

(c) A letter from a provider (in the appointee's discipline, if possible) who is in a position to evaluate the appointee's professional standing, character, and ability (for example, a peer or a president or secretary of the local professional society). A letter of reference from both a peer and a professional association or society are mandatory if the appointee is self-employed.

(d) The non-board certified physician who alleges to be a specialist requires two letters of reference attesting to his/her clinical competence by physicians certified in the specialty in which the non-board certified physician is practicing. For the physician who has not completed his/her initial period of qualification for board certification, two letters attesting to the applicant's clinical competence are required from board certified specialists who have current knowledge of his/her clinical practice.

(2) *Peer recommendations.* For providers (AA, USAR/ARNG, civilian, volunteer, and contracted personnel) with current privileges, peer recommendations will be submitted every 2 years as part of the clinical privileges/staff appointment renewal process.

k. A copy of the provider's Federal narcotics license with current and prior Drug Enforcement Agency (DEA) or Controlled Drug Substance (CDS) numbers, as appropriate.

The requirement of a current DEA certificate does not apply to providers credentialed by OCONUS MTFs located in Germany, Korea, and other non-territories of the U.S.

l. A current NPDB report on each provider. Conducting an NPDB query within 24 months of the previous query is permissible. However, under no circumstances will a provider's query interval exceed 24 months. Query of the NPDB will occur—

(1) By the appropriate recruiting agency at the time of application for employment or appointment (military accessions). This report may be used at the initial duty station if dated within 1 year.

(2) By the MTF at the time a provider initially applies for clinical privileges (initial duty station or place of

employment unless para (1) above applies), when expanding or adding new clinical privileges, and every 24 months thereafter as part of the clinical privileges reappraisal (renewal) process.

(3) If initial privileging by the provider's first MTF occurs more than 1 year after the NPDB query for entry on AD. In this case, querying the NPDB will be required as part of the initial privileging process.

(4) By the facility providing training or serving as the site of assignment, if necessary, for USAR/ARNG providers. If a valid NPDB query is present in the provider's PCF, re-query is not necessary.

m. Evidence of current BLS certification. ACLS or ATLS, PALS, or advanced pediatric life support (APLS), and/or the Neonatal Resuscitation Program may be additional performance requirements, but these are not a substitute for the BLS requirement. (See para 5–1*e* for more specific guidance regarding emergency life support training requirements.)

n. Evidence of approved continuing medical/health education. Such evidence will be accumulated by the provider for intervals of not less than 2 years and made available to the credentials manager for initial privileges/appointment and for biennial renewal. The annual requirement for CME credits according to AR 351–3 or as determined by the provider's State of licensure, whichever is more stringent.

o. Criminal history background checks (CHBCs) for all contract and volunteer providers who care for patients under the age of 18. Other providers (AA, USAR/ARNG, and civil service) do not require a CHBC as this security check is routinely performed as part of the new accession/employment process. Contracting agencies are responsible for performing the CHBC on their employees for whom this investigation is required.

(1) For non-personal service contract personnel, the contractor is responsible for completion of CHBCs and must forward results to the gaining MTF. As addressed in local policy, the MTF must ensure the CHBC has been completed prior to allowing the contracted provider to care for patients under the age of 18. For personal services contract personnel, the MTF is responsible for CHBC completion.

(2) Pending completion of the CHBC, the provider's practice will be supervised. The commander will determine the level of supervision that is required. The plan for supervision, with designated supervisor noted, will be in writing.

(3) See DODI 1402.5 or Assistant Secretary of Defense (Force Management (ASD(FM)) policy, subject: Criminal History Background Checks on Healthcare Personnel, dated 20 April 1992, for additional information.

p. Special requirements for radiologists providing mammography service. The Mammography Quality Standards Act imposes specific requirements on radiologists who are involved in providing mammography service. These providers will abide by Mammography Quality Standards Act requirements and submit the appropriate documentation for inclusion in the PCF. (Refer to Department of Health and Human Services, Food and Drug Administration, 21 CFR, Part 900, Quality Mammography Standards, Final Rule, published in the Federal Register, Vol. 62, No. 208, Tuesday, 28 October 1997, effective 28 April 1999.) The Mammography Quality Standards Act can be found on the internet at http://www.fda.gov/cdrh/mammography/frmamcom2.html.

q. Special requirements for physicians providing nuclear medicine services. The radiopharmaceuticals used in nuclear medicine may only be prescribed by providers who are "authorized users" under the facility's nuclear regulatory commission license. For regular privileges in diagnostic nuclear medicine, the provider must submit documentation that he/she is an authorized user at the facility. For privileges in therapeutic nuclear medicine, there must be specific approval as an "authorized user" in this capacity as well. Approval by the commander may be for all or selected therapies.

r. National provider identifier. The national provider identifier (NPI)-Type 1 is a 10-digit provider-unique number assigned by CMS to healthcare personnel, both privileged and non-privileged, who meet established eligibility criteria (HA Policy: 05-002). It is used to identify providers on claims, prescriptions, referrals, and other healthcare related documents. MHS providers were required to obtain and begin using their NPI-Type 1 by 23 May 2007. The credentials manager will ensure that the NPI is entered into CCQAS and that a copy is maintained in the PCF.

8–8. Previous experience and reference checks

Every effort should be made to authenticate all provider credentials, stated experience, references, and other information contained in the PCF in a timely manner. Granting of clinical privileges and medical/dental staff appointment, as appropriate, will be withheld until sufficient verified data to document training, experience, and current clinical competence are available.

a. In general, reference checks should not be limited to only those references noted by the provider on the application form. Providers will be notified that other individuals may be contacted, as necessary.

b. Annotated records of each contact made with all personal and professional references will be maintained, to include names of all parties to the call, the date, and a summary of the conversation. Contacts will be advised that the providers may request and be provided this information.

8–9. Provider activity file

The PAF is the repository for supporting information and data to validate privileging of the provider by the MTF. See appendix G for suggested content of the PAF. Various PAF criteria definitions are contained in the glossary.

a. A PAF will be established and maintained for each privileged provider. The cover of the PAF must bear the

disclosure statement as noted in paragraph B–9 of this regulation. It is a working file with contents considered confidential quality assurance (QA) documents protected by 10 USC 1102.

b. Metric performance data, both qualitative and quantitative, and aggregate data from a representative peer group sample, are examples of the data contained in the PAF. The information and data contained are summarized and available for review and evaluation by designated staff (peer level performance assessment) and by the department or service chief for biennial provider reprivileging/reappointment to the medical/dental staff.

c. Any data included in the PAF that is not required for transfer to the PCF and is greater than 2 years old may be removed and destroyed according to local policy. (The provider will be given the opportunity to keep any productivity and computer-generated data prior to its destruction.) Data determined to be either erroneous or inaccurate will be removed from the PAF and in accordance with AR 340–21 and local policy.

d. The contents of the PAF may be used by supervisors for administrative purposes (for example, counseling, evaluation reports, preparation of GPHE documentation, and letters of reference or peer recommendations).

8–10. The inter-facility credentials transfer brief

a. The ICTB is a computer-generated summary of information contained in the PCF. It is a standardized format (see app H) for transmittal of privileged provider credentials information across the MHS (Health Affairs Policy 94–004 and Health Affairs memorandum, subject: Expanded Use of Inter-Facility Credentials Transfer Brief (ICTB), 11 December 1995). The ICTB may be used for all categories of privileged providers to include uniformed military (AA/USAR/ARNG); civilian (GS, contractors (personal services only), resource sharing); VA; and nonmilitary uniformed providers (for example, Public Health Service). This document may be maintained in a temporary PCF created by the gaining facility.

b. When a DOD provider is temporarily assigned to another MTF for clinical practice, the sending MTF must convey all relevant credentials and privileging information to the gaining MTF. The receiving commander uses this information as the basis for assessing current clinical competence and making appropriate privileging and staff appointment decisions in a timely manner.

(1) Non-personal services contract personnel (that is, individuals working for the Government, yet employed by a non-Federal agency) are not authorized temporary assignment to another MTF. Assignment for duty is only as stipulated in their contract. Use of an ICTB is not authorized.

(2) Providers (AA/USAR/ARNG) mobilized/activated in support of covert operations (that is, a command structure with privilege granting authority may not be known or available) do not require an ICTB. While the provider is TDY in this capacity, his/her PCF may be placed in an inactive status at the sending facility. The PCF will be closed out and archived. Credentials committee minutes will reflect those providers whose PCF is in an inactive status. Upon return from deployment, the PCF will be reactivated and updated, as necessary, prior to the provider resuming assigned patient care duties.

c. Required attachments to the ICTB for AA providers include—

(1) Discipline-specific DA Form 5440-series for privileges being requested.

(2) DA Form 5440A, with top portion completed.

(3) A copy of the current DA Form 5440-series for clinical privileges held at the sending facility.

(4) DA Form 5754.

(5) Two peer recommendations, dated within 24 months of submission, for providers who do not hold current military clinical privileges. (See para H–3*a*(10) for additional detail.)

(6) Authorization for release of information signed by the provider (may be specific to the gaining MTF, if provided).

d. The ICTB and required attachments accompany the formal application for privileges by the privileged provider. Information that appears in the ICTB need not be duplicated on any DA or local privileging forms that contain essentially like information. An annotation will be made on these forms, as appropriate, to "See ICTB."

e. Additional information regarding the ICTB is contained in paragraph 9–6*c* and in appendix H.

8–11. The inter-facility credentials transfer brief and USAR/ARNG training

a. The ICTB with appropriate supporting documents will be made available to the facility (training site) by the USAR/ARNG credentials manager at least 45 days before the scheduled arrival of the USAR/ARNG provider. The USAR/ARNG privileged provider's ICTB will be forwarded electronically or by mail; it will not be hand carried by the privileged provider. If the 45-day time frame cannot be met, direct coordination between the AA and USAR/ARNG units is required.

b. Required attachments to the ICTB for USAR/ARNG providers include—

(1) Discipline-specific DA Form 5440-series for privileges being requested.

(2) DA Form 5440A, with top portion completed.

(3) A copy of the clinical privileges currently held (civilian facility and military).

(4) DA Form 5754 signed within 60 days of ICTB submission.

(5) Two peer recommendations, dated within 24 months of submission, for providers who do not hold current military clinical privileges. (See para H–3*b*(10) for additional detail.)

(6) Authorization for release of information signed by the provider (may be specific to the gaining MTF, if provided).

c. USAR/ARNG providers will not be accepted for IDT, ADT, AD for special work, or AT as privileged providers until the AA MTF notifies the provider's parent unit that privileges have been awarded.

d. AA MTF commanders will ensure that USAR/ARNG privileged provider ICTBs are reviewed expeditiously and that prompt notice of this review is provided to the USAR/ARNG credentials manager. This will allow timely processing of personnel actions related to provider training by the unit. Delays in reviewing the ICTB and notifying the USAR/ARNG credentials manager that the documentation is in order could delay the provider's availability for duty.

e. Upon completion of the required training by USAR/ARNG providers, the AA MTF will forward a DA Form 5374, and any other specific privileged provider activity data to ARCCA, the appropriate unit commander, the administrative headquarters, or the credentials manager responsible for custody of the PCF. This information will be forwarded electronically or by mail; it will not be hand carried by the USAR/ARNG provider.

8–12. USAR/ARNG credentials and privileging for activation/mobilization

a. Privileged providers who are activated on individual orders for a period that is less than 30 days will have an ICTB generated and forwarded with attachments to the gaining facility. The gaining facility is responsible for granting privileges, as appropriate, based on the ICTB.

b. For USAR/ARNG Soldiers mobilized for 30 days or more, the PCF manager will ensure that the PCF is current and complete and will initiate privileging actions by transmitting an ICTB with attachments to the gaining facility or by preparing the PCF for review by the local credentials committee.

c. Commanders of units that are mobilized either as a derivative unit or as a total medical asset, and designated (typically in a field environment) to function independently of a fixed-facility MTF, are authorized to grant clinical privileges for their assigned providers. The privileging process as described in paragraph 9–6*a* will be followed.

d. Mobilized providers that are assigned to, or within the area of operations of, a fixed-facility MTF (AA) will be granted privileges by the commander of that MTF.

e. USAR/ARNG providers participating in clinical training (prior to arrival in theater) for which privileges are required will be granted privileges for these activities by the facility conducting the training. An ICTB with appropriate attachments will be prepared and transmitted to the gaining/training MTF. The commander of the gaining/training MTF will grant privileges, as appropriate, based on the ICTB.

f. Medical personnel assigned to nonmedical units will request guidance from their higher headquarters as to the privilege granting authority in their given situation. If patient care activities are included in the provider's description of duties, the prescribed credentialing and privileging processes will be followed regardless of the unit of assignment or the mobilization assignment. Privileges should be granted prior to the provider's arrival in theater.

g. For mobilized USAR privileged providers in TPUs, ARCCA will retain control of the PCF during the period of mobilization; HRC-St. Louis will do this for IRR members; and, the AA unit credentials manager will perform this function for IMA providers. The ARNG unit PCF managers are responsible for the PCF during periods of ARNG provider mobilization. Transfer of the PCF to the Soldier's unit of assignment within the theatre of operations is not authorized.

h. During the period of mobilization, credentialing actions that can reasonably be completed by the PCF manager should continue. This includes, but is not limited to, PSV of license and certification renewals.

OFFICE SYMBOL Date

MEMORANDUM FOR Commander, United States Army Recruiting Command, ATTN: RCHS-OPS (Credentials), 1307 Third Avenue, Ft Knox, KY 40121-2726

SUBJECT: Request for Credential Documents

1. Request credential documents according to AR 40-68 for the following individual:

a. Name: (provide first and last name and middle initial)

b. Social security number (SSN): (provide full SSN)

c. Corps: AOC:

d. Date assigned to your organization:

2. Request documents be forwarded to: (provide complete mailing address to include room number and name of person receiving credentials).

3. POC is (provide POC name) at telephone (DSN and commercial), or e-mail (provide e-mail address).

SIGNATURE BLOCK

Figure 8–1. Sample format for request of new accessions credentials from USAREC (HSD)

Chapter 9
The Privileging Process and Medical Staff Appointment

9–1. General

Privileging is the process whereby a specific scope and content of patient care services (delineated clinical privileges) are authorized for a healthcare provider by the privileging authority (MTF/USAR/ARNG unit commander/State Surgeon). Such authority is based on an evaluation of the individual's credentials, performance, and the specific needs of the organization.

a. The privileging process is directed solely and specifically to the provision of quality patient care and is not a disciplinary or personnel management mechanism. Privileging actions may, however, accompany actions of an administrative or judicial nature or may engender such actions.

b. A number of privileging actions, both routine and adverse, are available to the commander at the recommendation of the credentials committee. The routine privileging actions that are addressed in this chapter include privilege approval (with or without restrictions), privilege reappraisal, and privilege renewal. Adverse privileging actions include

privilege restriction, reduction, suspension, revocation, and denial. These, and the non-adverse privileging action of placing a provider's privileges in abeyance and summary suspension, are discussed in chapter 10.

c. Privileges are facility-specific. As such, the facility's characteristics, supportive resources, and staff are considered in the privileging decisions.

d. Each department or service chief will develop criteria relevant to the award of clinical privileges for the department or service and will identify what privileges are appropriate for the scope of work in the given setting. DA Form 5440-series provides basic privileging criteria and other information that are applicable to the practice discipline. The form provides space for comments and privileges to be added, as needed, based on the MTF's scope of services, the provider's experience, and the DOD beneficiary healthcare requirements.

Note. While the criteria for award of privileges and the specific privileges pertinent to each department are the responsibility of the department/service chief, the MTF commander is the clinical privileges approval authority within the MHS.

e. Providers will be granted clinical privileges appropriate to the settings in which they practice. This includes various departments, services, clinics, and the emergency center/service/department, both within the MTF and in MTF controlled outlying locations.

f. Where full performance in a given GS civilian position requires the incumbent to be privileged, obtaining and maintaining clinical privileges in good standing is deemed a condition of employment.

(1) In this regulation, "good standing" requires that the employee is—

(a) Not in a remedial training program.

(b) Able to practice independently.

(c) Functioning with privileges that have not been reduced, restricted, suspended, revoked, or denied.

(2) For civilian employees whose privileges are not in good standing, the MTF commander may elect to—

(a) Terminate the employee.

(b) Change the employee to a position at a lower grade (may be voluntary or involuntary).

(c) Reassign the employee to a position for which privileges are not required (may be voluntary or involuntary).

Note. Any financial incentives associated with the previously held position shall be terminated.

g. Reappraisal of defined clinical privileges will take place at least every 24 months (prior to the renewal of privileges) and when a provider is reassigned to a new duty station. (See paras 9–4*d*(2) and 9–4*e*.) For USAR/ARNG providers, see para 9–8*d*(1).) Renewal of clinical privileges is based on the provider's professional qualifications and demonstrated competence to perform the privileges requested. Providers who are assigned to nonclinical duty positions (for example, commander, USAREC or Office of TSG staff officer, or AMEDD Center and School instructor) who desire medical staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges. These individuals will only be privileged if they are expressly engaged in patient care activities appropriate to the discipline in which they are requesting privileges. The medical staff bylaws will address how the current competence of providers in administrative positions will be assessed for reappointment and clinical reprivileging. Examples of criteria that may be considered include, but are not limited to, department/service chief interview; documented continuing education/training; the acceptable interval between performance of procedures that are identified as complex, high risk, or problem prone; available patient outcomes assessment data; and clinical practice hours per month/year.

9–2. Practitioners who may be privileged

a. Healthcare practitioners who function independently to initiate, alter, or terminate a regimen of medical care must be privileged. In this regulation, practitioners who are granted privileges are referred to as providers. Providers include audiologists, behavioral health practitioners, chiropractors, clinical pharmacists, clinical psychologists, clinical social workers, dentists, dietitians, nurse anesthetists, nurse midwives, NPs, OTs, optometrists, PTs, physicians, PAs, podiatrists, psychological associates, speech therapists, and substance abuse rehabilitation counselors. Also included are CNSs, CHNs, and OHNs who, in selected circumstances and at the discretion of the commander, may be granted clinical privileges (see chap 7) and SBBs.

b. Members of the healthcare staff who function under a standard job description in the performance of their duties—utilizing practice guidelines or standing policies and/or procedures—do not require clinical privileges. Department/service chiefs are responsible for the ongoing assessment of the competence of personnel to safely perform assigned duties. For those who are not privileged, an internal certification process may be used to designate selected personnel who have achieved the competence needed to perform specific complex, high-risk, or problem-prone clinical functions.

c. Special privileging considerations are as follows.

(1) *Commander and deputy commander privileges.* Approval of privileges (to include periodic privilege renewal) and appointment to the medical staff for the DCCS and the commander (and comparable dental positions) will be as follows.

(a) The commander/DCCS will submit his/her application for privileges and request for medical/dental staff appointment (DA Form 4691–1 (Application for Renewal of Clinical Privileges and Staff Appointment)) through the appropriate department chief.

(b) The DCCS is excused from the credentials committee meeting (if he/she is being reviewed), and the remaining senior member of the credentials committee will act as chairperson.

(c) The credentials committee recommendations regarding clinical privileges and medical/dental staff appointment for the DCCS (or like DC position) will be submitted through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the local MTF commander for approval/disapproval.

(d) For commanders, the credentials committee recommendations regarding clinical privileges and medical/dental staff appointment and all supporting provider documentation will be forwarded by certified return receipt requested mail as noted below (by healthcare facility type)—

1. Freestanding ambulatory/health clinic, MEDDAC, and DENTAC. Documents will be forwarded to the responsible RMC/RDC commander.

2. 121 General Hospital. Documents will be forwarded to Commander, 18th Medical Command, Unit 15281, APO AP 96205–0054.

3. MEDCEN, RMC/RDC, and major subordinate command. Documents will be forwarded to the Commander, USAMEDCOM, ATTN: MCHO–CL–Q, 2050 Worth Road, Fort Sam Houston, TX 78234–6010 or the Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234–6004.

4. 18th Medical Command. Documents will be forwarded to TSG, 5109 Leesburg Pike, Skyline 6, Room 684, Falls Church, VA, 22041–3258.

(2) *Emergency or disaster situations.* Scope of practice limitations as defined by the clinical privileges granted by the MTF may be ignored only in bona fide emergency circumstances (see glossary) or disaster situations. In such cases, providers are expected to intervene and to do everything possible to save the patient's life or to prevent injury, or to effectively respond to a significant increase in demand for medical treatment. This includes requesting consultation with available medical resources and coordinating care and services as appropriate.

(3) *The Armed Forces Medical Examiner System.* This system, as addressed in DODD 5154.24, authorizes medicolegal death investigations for all DOD MTFs. The range of support includes onsite autopsies by deputy or regional medical examiners, telephonic consultations, and written reports. Deputy and regional medical examiners hold privileges granted by the AFIP. Deputy and regional medical examiners are authorized to perform autopsies upon presentation of their Armed Forces Medical Examiner credentials to the commanding officer. An application for medical staff appointment with clinical privileges is not required for this service.

(4) *The Organ and Tissue Procurement Program and the Armed Services Medical Regulating System.* Organ donation and transplant conducted by organ and tissue procurement teams, and the related treatment provided within MTFs by personnel assigned to the Armed Forces Medical Regulating System, is addressed in DODD 6465.3. These personnel are authorized to perform their duties in Federal facilities without formal credentials review and privileging. However, the individuals assigned to support these programs will present sufficient documentation (for example, official orders, assignment letter, or identification card) to the MTF commander to establish their authorization to perform these services.

(5) *Musculoskeletal manipulations.* Musculoskeletal manipulations involve palpation and other manual techniques used to evaluate and correct somatic dysfunction that impairs or alters function of the somatic systems. These include the skeletal, arthrodial, myofascial, vascular, lymphatic, and neural systems. This does not refer to the spinal or peripheral joint manipulations commonly used by PTs that are included in their accepted standard scope of practice as defined by the American Physical Therapy Association. The following policy guidance applies to the performance of musculoskeletal manipulation procedures.

(a) Privileged providers—other than doctors of osteopathy, PTs, and chiropractors for whom manipulation is considered part of their routine scope of practice—with evidence of appropriate education, training, and experience acceptable to the credentials committee may be granted specific privileges to perform musculoskeletal manual manipulations.

(b) Only specifically privileged physicians (Doctor of Medicine or Osteopathy) may perform manipulation procedures using general anesthesia or intravenous medications. An appropriately privileged anesthesiologist or nurse anesthetist will administer the required anesthesia or sedation for these procedures.

(6) *Privileging for new medical procedures and technology.* The privileging process remains the same. Particular attention will be focused on provider training, experience, and competence and MTF capabilities in granting privileges for use of recently developed or approved technologies and equipment.

(a) New procedure. Prior to the introduction of a substantially new and innovative procedure into an MTF, the commander will ensure that privileging criteria are developed at the departmental level and endorsed by the credentials committee. The criteria will include the specific preparatory training that providers must complete prior to being granted the privilege to perform the new procedure. The privileging process for providers will be accomplished prior to the procedure being performed on eligible beneficiaries.

(b) New technology. MTF commanders will ensure that new technology (for example, excimer lasers) does not

surpass the staff's abilities. MTF commanders will establish safety protocols for an instrument's use and provide for proper privileging procedures prior to the application or use of the new technology. The plan for implementation of new technology must include training of nonprivileged support staff. Adverse patient outcomes involving equipment malfunction will be reported according to MTF policy and will include notification of the PS manager/risk manager. (See para 12–10.)

(7) *Miscellaneous privileging issues.*

(a) Telemedicine. Telemedicine involves electronic communication or other communication technologies to provide or support clinical care at a distance.

1. The medical/dental staff will determine which clinical services are appropriately delivered via telemedicine link. Telemedicine encounters require written informed patient consent before the use of said technology. All medical information generated in the delivery of telemedicine will be properly documented and archived in the medical record. Any patient information associated with telemedicine, in either electronic or paper format, is subject to current Health Insurance Portability and Accountability Act (HIPAA) standards.

2. Providers who write orders or direct care/treatment/services via telemedicine must be privileged by the facility receiving this service. The ICTB and a copy of the delineation of privileges will be submitted to the privileging MTF; privileges will be granted for only the services to be rendered via telemedicine. Types of services that require privileges include, but are not limited to, those which involve video-teleconference or other direct interactions between patient and provider.

3. Providers who render official readings of images, tracings, or specimens or who provide only consultative advice do not require privileges at the receiving MTF. In such cases, the MTF must obtain and maintain a copy of the ICTB and delineation of privileges from the provider's MTF of assignment, but need not privilege the provider. Examples of these types of services include, but are not limited to, teleradiology (except mammography for which there are additional requirements), teleechocardiography, telepathology, and store-forward teledermatology.

4. The above paragraphs apply to telemedicine services between MTFs and/or other military organizations, for example, AFIP. When the telemedicine service is provided via contracted services, regardless of the type of service in question, the providers must be privileged by the receiving MTF. In instances where the contract for services described in paragraph 3 is with a civilian hospital accredited by TJC, the receiving MTF need not privilege the providers if provider information equivalent to that on an ICTB and his/her delineation of current privileges from the hospital are obtained and maintained on file at the MTF.

(b) Management of impaired providers. A physical or psychological condition that adversely affects (or has the potential to adversely affect) or limits an individual's ability to safely execute his/her responsibilities in providing healthcare can be considered an impairment. This includes alcohol or other drug dependency/abuse or mental health disorders. Typically, acute or chronic medical conditions will require a limited-duty profile or medical evaluation board (MEB) to decide fitness for duty of the military member. Comparable processes exist for the civilian employee with duty restrictions related to health problems. Such circumstances are managed as medical problems (short or long term) and are not considered impairments. The credentials committee/function will review the performance of privileged providers who are impaired to determine to what extent their impairment hampers their ability to safely practice the privileges they have been granted. The provider's condition or impairment may require modification of his/her clinical privileges, as appropriate. For further information, see chapters 10 and 11.

(c) Providers assigned to a geographically separated unit. The host unit with privileging authority is responsible for maintaining the provider's PCF and for awarding clinical privileges and a medical staff appointment if requested by the provider.

(d) Oral surgeons. The organization (AA/USAR/ARNG) to which a dental officer is assigned has primary responsibility for managing the oral surgeon's PCF, verifying credentials, and awarding clinical privileges and dental staff appointment, as appropriate. For the oral surgeon with duty at a facility other than the dental unit of assignment (that is, a MEDDAC or MEDCEN), an ICTB and all appropriate attachments (see para 8–10*b* (AA) or 8–11*b* (USAR/ARNG)) will be provided for use by that organization in awarding clinical privileges/staff appointment.

(e) Dentists administering conscious sedation. As with all procedures, the award of specific privileges to a dentist to perform conscious sedation is based upon appropriate education, training, and experience. Because this skill is not part of basic dental education, specific training in this procedure must be obtained and documented before dentists can be authorized to administer conscious sedation.

(f) Complementary and alternative medicine. Application and/or use of these techniques and therapies (acupuncture, homeopathy, massage therapy, and so forth) are gaining acceptance within the MHS. With the approval of the commander, these may be integrated into the broad array of healthcare and services offered to DOD beneficiaries by qualified providers. Privileges may be granted following the guidance relative to new procedures detailed in paragraph (6)(*a*) above.

9–3. Categories of clinical privileges

Clinical privileges define the scope and limits of independent patient care services that a provider may render within

the granting healthcare organization. Privileges may be granted with or without an accompanying appointment to the medical/dental staff. The three categories of clinical privileges that may be awarded are—

a. Regular privileges.

(1) Regular privileges grant the provider permission to independently provide medical, dental, and other patient care services in the facility within defined limits. Regular privileges are granted to providers only after full verification and review of credentials. Regular privileges will not exceed a 24-month period without renewal.

(2) In granting regular privileges, the commander will define the limits of those privileges to include whether or not enhanced supervision is required. The nature and extent of enhanced supervision will be delineated in writing. The commander will also specify limits on regular privileges based upon the MTF mission requirements and the ability to support the requested privileges.

(3) A provider granted regular privileges may be considered for any type of medical staff appointment as discussed in paragraph 9–5*d*.

b. Temporary privileges.

(1) Temporary privileges authorize a provider to independently provide medical, dental, and other patient care services on a time-limited basis to meet pressing patient care needs when time constraints will not allow full credentials review. The use of temporary privileges should be rare. This category of privileges is appropriate in bona fide patient emergency situations or a declared disaster and is not intended for the administrative convenience of the department/service. Temporary privileges will not exceed a period of 30 days and are not subject to renewal. Any subsequent request for consecutive privileges should be assessed to determine if regular privileges are more appropriate.

(2) Because the MTF has not conducted a thorough credentials review prior to granting temporary privileges, there is an added degree of risk relevant to the competency of the provider. In order to minimize the risk associated with granting temporary privileges, the following actions, as a minimum, will occur.

(a) A copy of the provider's license will be obtained and verified with the issuing agency.

(b) Telephonic contact will be made with the facility where the provider has regular privileges to verify that the individual is clinically competent, fully qualified, and that the requested privileges are within the individual's current scope of practice and privileges. The chief of the medical staff, department chair, or other appropriate authority may provide this information. Or, if available, the ICTB may be used for the purpose of granting temporary privileges.

(3) A complete, thorough credentials review will occur during the period of the temporary privileges.

(4) Temporary privileges may be granted with or without a temporary appointment to the medical staff.

(5) The use of temporary privileges is authorized for all categories of providers.

c. Supervised privileges.

(1) Supervised privileges are granted to providers who do not meet the requirements for independent practice because they lack the necessary license, certification, or other authorizing document. These providers are not eligible for a medical staff appointment and are unable to practice independently. Providers working under supervised privileges can practice only under a written plan of supervision with a licensed person of the same or a similar discipline. See paragraph 5–3 for additional information regarding supervision of practice.

(2) This category of privileges will not be granted to licensed providers, or providers holding other authorizing documents, even though the defined limits of their privileges include supervision.

(3) Supervised privileges should not be confused with enhanced supervision of practice offered to those privileged providers who, for a defined period of time, require oversight of their clinical practice. (See para 9–4*e* for additional information regarding enhanced supervision.)

(4) Supervised privileges will be granted for periods not to exceed 24 months. Providers who are required to have a license will obtain that license within the time frame specified in chapter 4. These providers may request regular privileges and a medical/dental staff appointment once a license is obtained.

9–4. The clinical privileging process

a. Forms required for award of privileges. Performance data and other information (appropriate DA forms) to be considered in the privileging process are maintained in the PAF. These documents are transferred to the PCF, as appropriate, upon biennial renewal of the provider's clinical privileges (see para 9–4*c*(6)), PCS, or separation from service/employment. The original will be placed in the PCF with a copy furnished to the provider.

Note. Providers will transition to use of the revised privileging documents addressed below at their next reappraisal/reprivileging opportunity.

(1) *DA Form 4691.* DA Form 4691 provides a synopsis of the provider's education and experience at the time of initial application for clinical privileges and medical staff appointment (if applicable). It includes professional education, postgraduate training, previous clinical assignments, specialty board certification, professional society membership, and credentials action history. For the provider with continuous Federal service, DA Form 4691 is completed only once, at the provider's first military duty station or place of DOD employment. For all categories of providers with noncontinuous Federal service (that is, there is a lapse in clinical privileges/staff appointment within the DOD), this form must be completed if the interval between periods of service is greater than 180 days. Initial clinical privileges

and medical staff membership are valid for a period of 1 year. During this 12-month period, regularly scheduled evaluation of the provider's performance is required.

(2) *DA Form 4691–1 (new).* DA Form 4691–1 is used by providers with continuous Federal service, or a lapse in periods of service of less than 180 days, to request renewal of clinical privileges and medical staff reappointment. Information entered on this form relates to the provider's professional activities (for example, education, experience, professional recognition, and so forth) since the previous application for clinical privileges and medical staff appointment.

(3) *DA Form 5374.* This form contains provider-specific performance data, both qualitative and quantitative. It is used to evaluate the provider's demonstrated clinical performance according to established standards and compared to that of his/her peers. In conjunction with DA Form 5441-series, this two-page assessment contains evidence of the individual's competence, skills, and abilities, and provides objective and subjective data upon which to base award/renewal of clinical privileges and appointment/reappointment to the medical staff.

(4) *DA Form 5440.* The appropriate discipline-specific DA Form 5440 (as delineated in app A) will be used to document the request by the provider for clinical privileges and the recommendation for approval by the department/service chief and the credentials committee. Any variance between the privileges requested by the provider and the privileges recommended for approval by the supervisor should be discussed prior to submission of the DA Form 5440. Any unresolved discrepancies must be explained in Section II, Comments, for consideration by the credentials committee. These forms may contain categorical (patient risk and provider training requirements) and itemized disease and procedure-based privileging information by discipline. The disease-related and procedural content of this form will be individualized to address the current competency of the provider requesting privileges as well as the needs and capabilities of the MTF. The requirements for residency training and board certification as stated on the DA Form 5440 cannot be changed at the local level. The entire DA Form 5440-series is available in the AMEDD Electronic Forms Support System and at http://www.apd.army.mil/USAPA_formsPUBformrange_f.asp for printing and/or local reproduction on 8½- by 11-inch paper.

(5) *DA Form 5440–22 (Delineation of Clinical Privileges).* This blank form is used as a continuation sheet for those providers completing their discipline-specific DA Form 5440 and for expanded role functions or practice specialties not otherwise included in the DA Form 5440 series (for example, endocrinology, adolescent psychiatry). This form is available for customized use, as needed.

(6) *DA Form 5440A.* DA Form 5440A is used to record executive-level medical staff recommendations and decisions by the commander concerning the clinical privileges and medical/dental staff appointment (if applicable) of all privileged providers.

(7) *DA Form 5441.* The discipline-specific DA Form 5441 will be used to evaluate the provider's competence and skill in the performance of his/her clinical privileges. Appendix A contains a listing of forms in the 5441-series. The content of this document corresponds to the privileges of the specialty as outlined on the DA Form 5440.

(8) *DA Form 5753 (USAR or ARNG Application for Clinical Privileges to Perform Active or Inactive Duty Training).* This form is obsolete and is replaced by revised DA Form 4691 (for initial privileges) or DA Form 4691–1 (for privilege renewal) which are used for clinical privileging by both AA/USAR/ARNG.

(9) *DA Form 5754.* All privileged providers will complete a DA Form 5754. DA Form 5754 provides information on licensure, malpractice, clinical privileges, and conditions that may impact the individual's ability to deliver care. The form is completed as part of the initial application for clinical privileges and at each subsequent renewal of privileges.

b. Initial application for privileges.

(1) Upon arrival at the first duty station or place of DOD employment, the provider must submit a request for initial clinical privileges. The request will include the following:

(a) DA Form 4691.

(b) The appropriate DA Form 5440 with the provider completing the column on the left side of the form by properly coding the specific category of privileges requested, if applicable, and each individually listed privilege.

(c) For the newly graduated provider requesting privileges for the first time, DA Forms 5440, 5441, and 5374, if available, (prepared by the clinical director/faculty) document his/her competence, skill, and ability in the training setting. (See para *h*(3) below.) For providers currently involved in civilian practice or those with a lapse in privileges/staff appointment in the DOD of greater than 180 days, the most current evaluation of clinical performance (DA Forms 5441 and 5374) and peer recommendations contained in the PCF will substitute.

(d) DA Form 5754 completed and signed by the provider.

(e) All verified/validated credentials and other documents, as required in paragraph 8–7.

(f) Evidence that a CHBC has been initiated as per the Crime Control Act of 1990 (42 USC 13041) and AR 608–10 for individuals (contract/volunteer) who provide healthcare or other services for children under the age of 18 years. (Also see para 8–7*o*.)

(2) The request will be reviewed by the department or service chief who will properly code each category, if applicable, and privilege in the appropriate column of the DA Form 5440. The recommendation by the department or service chief for the award or the limitation of privileges requested will include specific rationale or justification of

same in the "Comments" area (Section II). The request will then be forwarded to the MTF credentials committee/function for review.

(3) The provider's validated credentials (para 8–7) and the completed DA Forms 4691 and 5440-series serve as the basis for the granting of clinical privileges. The credentials committee/function will forward its recommendation for clinical privileges and medical/dental staff appointment (if applicable) through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the facility commander.

(4) The commander is the approving authority for the award of clinical privileges and medical/dental staff appointment. The commander's signature on DA Form 5440A authorizes clinical privileges and staff appointment, if appropriate, based on the individual provider's licensure, education and training, experience, and his/her demonstrated professional competence.

(a) DA Form 5440A will be used to record the executive level medical staff recommendations and the commander's decision concerning the clinical privileges and medical/dental staff appointment of providers. Credentials committee/function minutes/reports will reflect deliberations made by this committee regarding both privileging and appointment status for each provider.

(b) The type of medical/dental staff appointment, if applicable, will be recorded in Block 6b, DA Form 5440A.

(c) Block 6c of DA Form 5440A will reflect the current recognized privileging category. Block 6d notes admitting privileges.

(d) Signature by the department/service chief and the chairperson of the credentials committee affirms that a review was made of the provider's primary-source-verified licensure, education and training, experience, capability to perform the requested privileges, and documented current competence. Age groups for whom the provider will render healthcare services are indicated in block 6g. Any age or patient population-specific comments will be included in block 7.

(e) For providers who are assigned to one department/service/clinic and request privileges in another, the discipline-specific DA Form 5440s will be submitted; the appropriate chiefs in both departments/services/clinics will be named and will sign the DA Form 5440A. Block 7 may be used for the additional signatures.

(f) When privileges are modified from those requested, the reason will be stated in block 7. (Examples of such reasons include lack of technological resources, lack of support staff, privileges unauthorized by the AMEDD, lack of provider credentials, lack of demonstrated competency, or lack of professional performance.)

(5) The authenticated copies of DA Forms 5440 and 5440A serve as notification to the provider of the award/renewal of his/her clinical privileges and medical staff appointment. A cover memorandum to the provider may also be prepared. (See fig 9–1.) The provider must acknowledge receipt of these documents by signed memorandum returned to the PCF manager. (See fig 9–2.) The original DA Forms 5440, 5440A, 4691, and 5754 will be maintained in the provider's PCF with copies returned to the provider.

c. Periodic reappraisal and renewal of privileges.

(1) Provider performance will be continuously monitored through facility-specific ongoing performance assessment activities to ensure that quality patient care is rendered. Providers are responsible for submitting CME, continuing dental education, or documentation of other discipline-specific professional education, licensure renewals, BLS certification renewals, and other certification renewals or credential updates to the PCF manager in a timely manner.

(2) Clinical privileges are in effect for a period not to exceed 24 months from the date granted. It is the responsibility of each provider to request the renewal of his/her clinical privileges and medical/dental staff appointment (if applicable) every 2 years. The request for renewal will be submitted far enough in advance to permit an evaluation of current clinical privileges and performance. Failure to request renewal in a timely fashion may result in the expiration of the provider's privileges.

(3) For clinical privileges renewal, DA 4691–1 will be submitted. Appropriate attachments include a new DA Form 5440 and 5754 completed and signed by the provider and DA Forms 5441 and 5374 prepared by the individual's department/service chief.

(4) DA Form 5441 documents the assessment of the provider's performance of currently assigned privileges and his/her professional performance according to established standards. Reappraisal and renewal of clinical privileges are based on provider performance, facility capabilities, and the needs of the beneficiaries. (See app A for a complete listing of the DA Forms 5440 and 5441 series.)

(a) The "privileges performed" and evaluated on DA Form 5441 must be identical to the "privileges delineated" as requested on DA Form 5440.

(b) When privileges are to be modified because of the performance reappraisal, the reason will be stated under "Comments" on DA Form 5441.

(c) DA Form 5374 will be used to evaluate professional clinical and interpersonal skills. It will be completed by the department/service/clinic chief and will include both qualitative and quantitative performance data. The assessment will address the individual's clinical and technical skills based on locally determined performance criteria, as well as a comparative analysis of the provider's performance in relation to aggregate data from a representative peer group sample. The comparative analysis that is performed should contain both intra- and inter-facility data.

(5) A review of provider credentials will be conducted. Privilege reappraisal and subsequent renewal will be based

on education, training, experience, clinical performance evaluations, provider activity profile data, professional conduct, PI activities, and the provider's capability to perform the requested privileges (formerly called health status).

(6) If the provider's performance is deemed to be substandard, or not current, enhanced supervision may be required for a period of time as specified by the commander (see para *e*, below), or remedial training may be warranted (para *f*, below).

(7) At the time of privilege reappraisal/renewal, other than current data may be removed from the PAF and destroyed (or given to the provider). This will take place only after it has been determined, based on credentials committee criteria, that this information is reflected accurately and completely in the current performance appraisal and other privilege delineation information contained in the PCF.

(8) The authenticated DA Forms 5440 and 5440A serve as notification to the provider of the renewal of his/her clinical privileges and medical staff appointment. A cover memorandum to the provider may also be prepared. (See fig 9–1.) The provider must acknowledge receipt of these documents by signed memorandum returned to the PCF manager. (See fig 9–2.) The original DA Forms 5440, 5440A, 5441, 4691–1, and 5754 will be maintained in the provider's PCF with copies returned to the provider.

d. Application for renewal of privileges following PCS or permanent transfer.

(1) Upon notification of the provider's impending PCS/transfer to another MTF, the losing unit will complete new DA Forms 5441 and 5374. The biennial appraisal will be considered current if it was completed within 6 months of departure. The credentials manager of the losing MTF will forward these forms together with the PCF and the provider's CCQAS file, by certified return receipt requested mail, to the receiving unit. The files will be forwarded far enough in advance to ensure arrival at the receiving facility at least 15 days prior to the provider's reporting date. Any documents that have not been included in the PCF, prior to its release, will be forwarded at the earliest possible opportunity. If the gaining facility has not received these documents upon the provider's arrival, immediate action should be taken to locate these sensitive files.

(2) The gaining MTF will use this documentation as the basis for initiating clinical privileging and medical/dental staff appointment actions. The PCF will include the most recent clinical performance appraisals (DA Forms 5441 and 5374), even if the provider transfers to a leadership or administrative position involving no clinical practice or to student status (see para 9–5).

(3) With the release of CCQAS version 2.6, the data contained in this restricted-access data base—in conjunction with DA Forms 5374 and 5441—will facilitate the privileging of newly assigned providers. Preliminary review of credentials for privileging and medical staff appointment can begin in advance of the provider's actual arrival or the facility's receipt of his/her PCF.

(4) Electronic/telephonic communication between facility credentials managers regarding providers in transit is likewise encouraged. The information documented as a result of these interactions may serve in place of the actual forms in the privileging process. Any credentialing/privileging action taken by the credentials committee based on other than actual documents in the PCF will be annotated in meeting minutes/reports. Verification of receipt of the document(s) in question, and that it is in order, will be noted in subsequent meeting minutes/reports.

(5) Upon arrival at the new duty station or place of employment, the provider will submit a request for renewal of clinical privileges and, if applicable, medical/dental staff appointment. The request will include the documents noted above. Transfer between AMEDD facilities is considered continuous DOD service under the same GB (TSG) and, provided the stipulations of paragraph *a*(1), above, are met, renewal of provider privileges and professional staff reappointment are appropriate.

(6) The provider (AA/USAR/ARNG) will apply for privileges immediately but in no case later than 5 duty days (10 duty days for OCONUS providers) following arrival. The USAR/ARNG privileged provider will meet with the unit credentials manager as soon as possible to submit his/her credentials for review and to apply for unit-level privileges, if appropriate. All providers must be privileged prior to being involved in or assigned to patient care activities.

e. Enhanced supervision for providers.

(1) Enhanced supervision is not an adverse privileging action against a provider. It does not alter the individual's medical/dental staff appointment status nor does it reduce the provider's category of privileges as awarded by the institution.

(2) Enhanced supervision for up to 6 months (with extension granted on an individual basis) may be required when, in the best interest of quality patient care, the privileged provider's performance warrants closer attention or scrutiny. Some examples include—

(a) Following a PCS move or during a TDY to ensure full clinical competence.

(b) When privileges for a new procedure or technology are considered.

(c) For providers returning to clinical practice following an extended absence from patient care responsibilities.

(d) For the novice provider who is developing his/her clinical practice skills.

(3) Although only the initial category of medical/dental privileges/staff appointment specifically requires review of the medical/dental staff member's performance, this does not preclude enhanced supervision or performance review of providers in an active, affiliate, or temporary appointment status or providers who do not have a medical/dental staff appointment.

(4) Routine, ongoing performance assessment is the basis for all PI activities and is essential for providers with all types of medical/dental staff appointments and all categories of privileges. The credentials committee/function will recommend, for the commander's approval, the specific enhanced supervision requirements based upon the provider's needs.

(a) The requirement for enhanced supervision will be indicated in block 6e of DA Form 5440A. The provider's performance will be reviewed by the credentials committee upon completion of the specified time period for the supervision. If it is determined that the supervision is no longer required, a new annotation will be made in block 7. The appropriate credential committee/function minutes/report will reflect this decision. The provider's privileging period will not change.

(b) The requirement for supervision to determine or monitor the clinical competence of newly assigned providers, those who practice infrequently, or those requesting new privileges is not considered adverse and does not require reporting.

(c) If the period required for enhanced supervision is greater than 12 months, remedial training for the privileged provider should be considered.

(d) In contrast to the above, requirements for supervision resulting from an adverse privileging action (for example, restriction of privileges) will be reported as adverse according to the procedures outlined in paragraph 10–6*f*(5).

f. Formal remedial training program.

(1) When a provider with clinical privileges fails to maintain required proficiency levels to practice in his/her specialty, at the discretion of the commander, a remedial training plan designed to enhance proficiency levels may be implemented. The decision to implement a formal remedial training program must be based on the individual circumstances of the provider and any additional unit-related considerations.

(2) The formal remedial training program, as addressed here, is appropriate for AD service-obligated providers who have had their privileges either suspended or restricted by the facility commander. (See para 10–6*f*(5).) Providers who have had their privileges reduced or revoked are not eligible for remedial training.

(3) The unique nature of each situation necessitates an individualized approach to determining the length of the formal training, the location, and other specifics.

(4) In the interest of the privileged provider, this training is best accomplished after PCS to a new assignment or during a period of TDY.

(5) Requests for remedial training will be initiated by the provider's current MTF commander and forwarded through the next higher headquarters to Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010. Requests concerning dentists will be forwarded to the Commander, USADENCOM (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234–6004. Specific criteria defining the expected trainee outcomes will be included as part of the request.

(6) The goals, duration, and location of remedial training will be addressed in recommendations to TSG by the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010 or the Commander, USADENCOM (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234–6004 in consultation with the appropriate specialty consultant to TSG.

(a) The decision will be coordinated with the MTF commander or designee, the MTF commander or designee at the training site, and, if necessary, the Health Services Division, HRC (TAPC–MSR), 200 Stovall Street, Alexandria, VA 22332–0002.

(b) The respective corps chief or designee has final approval of the remedial training plan.

(c) The Chief, QMD, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010 will be kept informed of the privileged provider's progress in the remedial program and the ultimate outcome.

(7) Generally, an individual identified as needing remedial training will be assigned to an MTF that is at 85 percent or higher fill against the authorizations in his/her specific AOC or as determined by the TSG consultant in the AOC/ASI. At the time the provider in remedial training returns to full practice, he/she may be slotted against a valid authorization. The provider may be retained at the facility that provided the training, returned to his/her original unit, or reassigned to a new duty station. Coordination for reassignment will be accomplished by HRC in conjunction with the appropriate TSG specialty consultant.

(8) Providers who do not successfully complete remedial training may be processed for separation under the provisions of AR 600–8–24 or AR 135–175, as appropriate.

(9) In contrast to formal remedial training, informal training may be utilized for any category/discipline of provider/professional at any time. This is coordinated at the local level by the individual's chain of command. The USAR/ARNG provider who wishes to re-establish clinical competency may request, through his/her chain of command, an AT opportunity for skills enhancement purposes.

g. Modification of privileges at the request of the provider.

(1) If a provider requests modification of his/her clinical privileges for the upcoming period, a new DA Form 5440 will be prepared with the specific privileges to be modified appropriately coded. The requested modification may be for augmentation or reduction of privileges. If the request is for an augmentation of privileges, documentation of appropriate education, training, and experience to support the additional privileges is required. Providers who request

privileges substantially less than those of members of their specialty AOC or skill identifier (SI) will require careful evaluation and subsequent action by the credentials committee.

(2) If the modification reduces the provider's privileges, written justification will be submitted with the DA Form 5440. The credentials committee will determine if—

(a) The request is warranted and what accommodations are appropriate considering the individual's special needs associated with a medical condition or other documented situation related to performance deficit(s).

(b) The privileged provider will undergo a period of structured training. If the training is approved (does not include the formal remedial training described above), the temporary modification of privileges, if 30 days or less, will not result in an adverse privileging action.

(c) A recommendation should be made to change the provider's AOC or SI and terminate any special pay.

(d) Separation in a less-than-fully-privileged status should be recommended.

(3) A privileged provider cannot voluntarily request a modification of privileges in order to avoid an adverse privileging action. A voluntary surrender or restriction of privileges while under investigation for possible professional incompetence or unprofessional conduct, or as part of an agreement with the organization for not conducting an investigation or professional review action, will be reported to the Commander, USAMEDCOM, ATTN: MCHO–CL–Q, 2050 Worth Road, Fort Sam Houston, TX 78234–6010. Such actions may require subsequent reporting to the NPDB according to paragraph 10–12*a*(1).

h. GPHE participants.

(1) *Supervision.*

(a) Physician and dental providers with regular privileges in the same AOC or SI and an active appointment on the medical/dental staff will supervise MC/DC graduate level clinical residency and fellowship program participants. Nonphysician privileged providers in graduate clinical training programs will be supervised by a provider with the same or similar AOC/SI and regular privileges or by a physician.

(b) The degree of supervision (direct or indirect) afforded the provider in student status will be appropriate to the individual's level of progress, the risk of the procedure, and the seriousness of the patient's illness. (See para 5–3*b*(2)(*a*) for additional information regarding supervision of GPHE trainees.) Concurrent consultation will be obtained for any patient for whom a substantial risk is implied or the diagnosis is obscure. This consultation will be documented on SF 509 (Medical Record-Progress Notes), on SF 513, or on SF 600. (See AR 40–66 for instructions on the use of these forms.) Situations that require mandatory direct supervision will be identified by the program director—in writing—and documentation of such will be provided to all those involved.

(2) *Privileges/staff appointment for eligible trainees.* Fellows and other privileged providers involved in a second residency may apply for regular privileges in their primary specialty (for example, fellows in plastic surgery who are eligible for regular privileges in otolaryngology may apply for otolaryngology privileges; eligible pediatricians in endocrinology fellowships may apply for pediatric privileges). These providers may be granted either an active or affiliate appointment according to their expected participation in medical staff activities or an initial appointment if they have not held a medical staff appointment in a DOD facility during the past 180 days.

(3) *Training credentials files (TCFs).* A TCF and a PAF will be developed and maintained during GPHE for interns, residents, and other trainees (all disciplines), in military training programs, for whom a PCF has not yet been established. The TCF will be initiated during the first year of training and will contain verified copies of diplomas, licenses, clearing house reports, training certificates, practice experience documents, curriculum vitae, and other documents, as appropriate. TCFs and PAFs will be maintained by the GME director or as indicated by the commander. Performance assessments will be conducted at least every 6 months; on an annual basis the department chief will provide a written recommendation to approve/disapprove matriculation to the next year's training level. All such assessments will be filed in the PAF. Other documentation such as letters of appreciation, patient complaints, and other reports that may lend themselves to trending or profiling the trainee's performance will also be filed in his/her PAF.

(4) *Clinical performance evaluation.* Prior to completion of the clinical training program, trainees will submit the appropriate discipline-specific DA Form 5440 through their service and department chiefs to the GPHE committee (military setting) or to their faculty advisor/preceptor (civilian setting). The trainee, based on a self-appraisal, is attesting to his/her current level of competence related to privileges appropriate to his/her specialty.

(a) One month prior to completion of the training, the trainee's clinical supervisor will complete, and the GPHE committee (or committee with comparable professional oversight authority) will authenticate, DA Forms 5441 and 5374. These documents address the trainee's professional skills, abilities, and competence and reflect recommendations for clinical privileges at the provider's subsequent duty assignment based on his/her performance during training. DA Forms 5440, 5441, and 5374 will become a permanent part of the TCF. The information contained in the TCF becomes the basis for the PCF.

(b) The GPHE committee will decide which, if any, of the interval performance assessments and other data accumulated during the training period will remain in the TCF. In instances where an MTF GPHE committee does not exist, a comparable line of academic authority must be locally established based on the availability of professional resources. The MTF commander will delegate responsibility for the duties performed by the GPHE office/committee, for academic/clinical oversight, and for documentation of the trainee's clinical competence, as appropriate. The TCF

will be forwarded by certified return receipt requested mail, to the credentials coordinator at the gaining facility to arrive 15 days prior to PCS. In the absence of GPHE committee, as a minimum DA Forms 5440, 5441, and 5374 will be forwarded by the supervisor through the credentials committee/function to the trainee's next unit of assignment.

(c) DA Forms 5440, 5441, and 5374 are available at Web site http://www.apd.army.mil/. Each corps will ensure that instructions for proper completion, authentication, and transmittal to the first unit of assignment are provided to military and GS civilian trainees enrolled in civilian GPHE/long-term health education and training clinical programs. The trainee will ensure that the completed documents are mailed by the authorized supervisor (program director/faculty member/preceptor) to the trainee's first unit of assignment (ATTN: MTF Credentials Office). These documents will not be relinquished to the trainee. The performance data contained on the DA Forms 5441 and 5374 serve as the basis for award of initial clinical privileges and professional staff appointment. Clinical performance evaluation is in addition to, and does not substitute for, the academic evaluation report that is required in accordance with AR 623–3.

(5) *Failure to complete.* In the case of a provider's failure to complete his/her training program or he/she is removed from a program for lack of competence or for disciplinary reasons, the details will be documented in the individual's TCF.

(6) *Reporting.* The administrative management and reporting of providers who fail to complete or are removed from a training program for substandard performance or unprofessional conduct will be made according to paragraphs 9–7, 10–13, and 10–15.

i. Formal on-the-job training (OJT). OJT programs involve formal, structured training designed to provide knowledge and technical expertise to providers who are expected to receive privileges in a given AOC or SI or for augmentation of clinical privileges associated with new technology or a new procedure(s). The commander will require a written program of instruction, specific learning objectives, and clearly identified training outcomes for the OJT program.

(1) Providers with defined privileges in the same AOC or SI will supervise OJT trainees. The degree of supervision will be appropriate to each trainee's level of progress, the risk of the procedure, and the seriousness of the patient's illness. The trainee will obtain concurrent consultation for any patient for whom a substantial risk is implied or the diagnosis is obscure. Situations requiring mandatory direct supervision will be identified in writing by the OJT program director/coordinator, and documentation of this requirement will be provided to all those involved.

(2) Individuals progressing unsatisfactorily in a formal OJT program will be managed according to established training program procedures.

(3) One month prior to completion of training, the preceptor will complete DA Forms 5441 and 5374 which will reflect those clinical privileges warranted at the individual's MTF of assignment based on performance during training. These forms will be forwarded through the GPHE committee, if one exists, otherwise through the credentials committee, to the gaining facility. They will be forwarded by certified return receipt requested mail, to the credentials coordinator at the gaining facility to arrive 15 days prior to PCS. The gaining facility will use this information as the basis for granting clinical privileges. These forms become a permanent part of the individual's PCF.

9–5. Medical/dental staff appointment

a. Appointment to the medical/dental staff is a process distinct from that of granting clinical privileges. While similar data are considered for these concurrent procedures, they are separate recommendations to the commander by the credentials committee and must be reflected as such in the credentials committee minutes. DA Form 4691 or DA Form 4691–1, signed by the privileged provider and submitted to the credentials committee, is utilized to request clinical privileges and medical/dental staff appointment, if desired.

b. A medical/dental staff appointment reflects the provider's relationship with the medical/dental staff and the degree to which the provider participates in medical/dental staff surveillance and review as well as quality improvement activities related to the governance of the medical/dental staff.

(1) An appointment to the medical/dental staff can be granted only to licensed, certified, or registered providers and it must be accompanied by the granting of clinical privileges.

(2) A medical staff appointment is required for privileged providers to admit patients to inpatient services.

(3) Medical staff membership is not required of individually privileged nonphysician providers who do not admit patients, but they may request membership, if desired.

(4) No provider with regular or temporary privileges is precluded from membership on the medical staff solely because of his/her professional discipline or specialty.

c. The applicant for medical staff appointment with accompanying privileges will be oriented to pertinent U.S. Army and MTF procedures, policies, and regulations governing patient care and medical/dental staff responsibilities and expectations. The applicant will acknowledge in writing his/her intention (an attestation) to abide by these standards. The MTF is responsible for providing each privileged provider, who is a member of the medical/dental staff, copies of any significant revisions to the rules and regulations governing their practice.

d. The type of appointment will vary depending upon the clinical privileges granted, the availability of the provider to the facility, and the defined role of the provider in the delivery of healthcare by the MTF. There are five categories of medical staff appointment.

(1) *Initial appointment.*

(a) An initial medical/dental staff appointment is granted to a provider when he/she is first assigned or employed in a DOD MTF. Or, if the provider (AA/USAR/ARNG) has not held a medical staff appointment in a DOD MTF during the previous 180 days, an initial appointment is the only appointment that will be granted. This is in the best interest of quality patient care and is not intended to reflect negatively on the individually privileged provider. The initial appointment will not exceed a 12-month period.

(b) During the initial appointment period, the privileged staff member's performance will be under review by the responsible department/service/clinic chief(s) to determine clinical competence and to evaluate the provider's knowledge and conduct with respect to the medical/dental staff bylaws, policies, procedures, regulations, and code of professional conduct. The commander will determine specific supervisory requirements for the provider when an initial appointment is granted.

(c) A provider may subsequently be granted either an active or an affiliate medical staff membership depending upon his/her type of employment or relationship with the medical/dental staff. Advancement from initial to active or affiliate appointment status is discretionary and is not a right of the appointee. Advancement will depend upon the appointee's qualifications, performance, and the needs of the facility. When an appointee is not advanced because of changing needs of the facility, the medical/dental staff appointment will expire; this is not considered an adverse occurrence.

(2) *Active appointment.*

(a) An active appointment is granted to a provider exercising regular privileges and meeting all qualifications for membership on the medical/dental staff, according to the needs of the Government, after successfully completing the initial appointment period. A provider who has completed an initial appointment period at another MTF, and has not had a lapse of greater than 180 days, may be granted an active appointment upon arrival at the new duty station. Active appointments will not exceed a 24-month period without renewal.

(b) Medical/dental staff members with active appointments will participate fully in appropriate activities of the medical/dental staff. Active members will agree to abide by all bylaws, rules, regulations, policies, and procedures of the medical staff and are responsible for being knowledgeable of the same.

(3) *Affiliate appointment.*

(a) An affiliate appointment is granted to a provider exercising regular privileges and meeting all qualifications for membership on the medical/dental staff, according to the needs of the Government, after successfully completing the initial appointment period. A provider with an affiliate appointment, due to conditions of employment, is neither assigned organizational responsibilities of the medical/dental staff nor expected to be a full participant in activities of the medical/dental staff. Affiliate appointments will not exceed a 24-month period without renewal.

(b) The category of affiliate member was created to relieve certain medical/dental staff members of the requirement to serve on medical/dental staff committees, including the ECMS/ECDS. Affiliate members may, therefore, be precluded from membership on the ECMS/ECDS and may be relieved of the requirement to participate in other medical/dental staff committees and activities. Affiliate members, however, will be encouraged to participate in department/service/clinic and medical/dental staff meetings and PI activities. Affiliate members will agree to abide by all bylaws, rules, regulations, policies, and procedures of the medical/dental staff and are responsible for being knowledgeable of the same. The MTF will keep affiliate members informed of changes to the bylaws, rules, regulations, policies, and procedures of the medical/dental staff.

(c) Affiliate status may be considered for contracted staff, consultants, experts, staff in a TDY status, resource sharing personnel, part-time staff, USAR/ARNG providers performing individual duty for training (for example, monthly drills) at the MTF, and individual mobilization augmentees (IMAs). Also included are providers who are not nationals of the U.S. but are rendering care to DOD beneficiaries under an established U.S./foreign country MOU/MOA.

(4) *Temporary appointment.* A temporary appointment is granted in emergency or disaster situations when time constraints will not allow full credentials review but when there are pressing patient care needs and a temporarily privileged provider will be admitting patients. The use of temporary appointments should be rare. The temporary appointment will be time limited and will not exceed 30 days. A complete, thorough credentials review will occur during the period of the temporary appointment.

(5) *No appointment.* Providers without a license or other authorizing document, or who have not been granted clinical privileges, will not be appointed to the medical/dental staff. These providers do not share medical/dental staff responsibility to the GB for medical/dental staff surveillance, review, and quality improvement activities within the MTF; they are not authorized admitting privileges.

e. When a provider is privileged and appointed to the medical/dental staff, if applicable, the commander will advise the provider—in writing—of their defined privileges and the medical staff appointment that has been granted. DA Form 5440A will be utilized for this purpose, with or without a cover memorandum (see fig 9–1). The provider will acknowledge receipt of the privileges and professional staff appointment, if applicable, by signed memorandum.

9–6. Provider privileging for temporary duty and other actions involving the provider credentials file

a. Provider temporary duty.

(1) For providers on TDY for clinical practice to another MTF/unit, the information conveyed in the ICTB is the basis for making appropriate medical staff appointment and privileging decisions in an expeditious manner. The sending MTF commander, or designee, will ensure that all information communicated in the ICTB is accurate and will sign the document. The commander's signature imparts their recommendation for subsequent privileges. However, the gaining institution retains full responsibility and authority for making privileging decisions.

(2) The ICTB, which serves in place of documents contained in the PCF, is joined with the formal application for privileges (DA 4691 or DA Form 4691–1) and supplants sections of these forms containing essentially like information. Every effort must be made to avoid unnecessary duplication of information in the privileging of temporarily assigned providers. (See app H for guidance on the preparation of the ICTB.)

(3) When privileges are requested other than those granted at the sending facility, additional documentation will be provided supporting these new privileges (for example, training documentation or privileging and evaluation documentation from another hospital). The gaining facility will review this documentation, in addition to the ICTB, to evaluate the provider's competencies and to determine what privileges will be granted.

(4) After customary departmental/service/clinic and credentials committee review and recommendation, and consideration of the facility's capability, the gaining MTF commander may grant privileges, with or without modifications, based on the approved privilege list from the sending MTF/unit. The gaining facility will use DA Form 5440A for notifying providers of their clinical appointments and for documenting the same. Privileges applied for but not granted, due to facility-based limitations, are not adverse privileging actions.

(5) The ICTB becomes invalid upon expiration of the clinical privileges and professional staff appointment (sending facility) on which it is based. If the provider is assigned temporarily for several brief periods to the same location, the ICTB remains valid over the duration of the combined periods, provided the clinical privileges and medical/dental staff appointment (if applicable) at the sending MTF remain active. If other credentials have expired in the interim, telephonic or message confirmation of the renewal of the credential(s) with the facility holding the PCF will suffice. A new ICTB is not required. A record of the telephone call or the message confirmation will be maintained in the PCF at the gaining facility. The sending facility will keep an accurate record of each MTF to which an ICTB is sent to ensure updates on provider status are forwarded as required. The sending MTF will provide a new ICTB whenever the provider's privileges change (for example, renewal of privileges, adverse privileging actions, and so forth).

(6) Performance appraisals received by the provider while practicing under the authority of an ICTB will be maintained in the PAF and incorporated into his/her clinical privileges reappraisal process. The MTF (sending facility) credentials committee/function will accept provider performance appraisals/evaluations submitted on the other Services' forms.

b. Administrative assignment. If the privileged provider is assigned to a position outside an MTF involving no clinical practice (for example, USAMEDCOM, MRMC, AMEDD Center and School) or attends a civilian or military school (other than GPHE or other graduate level training for which clinical privileges are required), the PCF and CCQAS provider file will be forwarded to the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010 for other than DC providers. Dental officer files will be sent to Commander, USADENCOM (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234–6004. These files will be held until requested. If the provider applies for privileges at a local MTF while in an academic or administrative position, the facility credentials manager will request the PCF for clinical privileging and medical staff appointment, if appropriate. The PCF for the individual assigned to an MTF who is currently not involved in clinical practice will be retained in the local credentials office, and the CCQAS file will be maintained in active status at the MTF.

c. Academic assignment. For those attending military graduate medical/dental education, or other graduate level professional health education, the PCF and CCQAS provider file will be forwarded to the military facility conducting the internship, residency, or fellowship training. For those attending civilian graduate medical or dental education, the losing facility will send a copy of the PCF, by certified return receipt requested mail, to the civilian institution and the original, along with the provider's CCQAS file, to the appropriate command as identified in paragraph *a*, above.

9–7. Separation of privileged providers

a. Military. AA officers who experience a loss of professional qualifications will be processed for elimination in accordance with the provisions of AR 600–8–24.

b. Civilian. A civilian provider's failure to attain or to maintain the required proficiency may be the basis for separation from Federal service. Commanders will consider separation under one of the following three options, each of which requires close coordination and consultation with the servicing CPOC/CPAC, as appropriate:

(1) *Separation during probation.* If the GS provider is serving as a new DOD employee under a probationary appointment (initial competitive appointment, typically a 365-day period), he/she may be separated under the provisions of Section 315.804, Title 5, CFR. Such an action should be completed before the end of the last duty day prior to the provider's 365th day following appointment. For providers who are in a probationary status, this is the preferred

course of action. Close scrutiny of employees during their first year of employment is encouraged to identify potential clinical practice problems.

(2) *Separation based on performance.* This option is based on poor performance of one or more critical elements in a provider's performance plan and need not include a loss of privileges. This action is taken under the provisions of Title 5, Part 752, CFR. Organizational leadership must be aware of significant employee rights to include rights to notice, opportunity to improve, and opportunity to seek external review.

(3) *Separation based on loss of qualifications.* This alternative is based on the fact that the provider is no longer qualified to perform the duties of the position to which he/she was appointed or when misconduct or malfeasance is the issue. This option may also be exercised if provider misconduct or malfeasance is the issue. (The misconduct must be related to the individual's ability to perform the duties of the position, that is, the "nexus" requirement.) In this instance, there are significant employee rights to notice, hearing, representation, and appeal beyond the agency.

9–8. USAR/ARNG privileging procedures

a. Privileging at the unit-level. The clinical privileging process for USAR/ARNG privileged providers will meet all the requirements addressed in this chapter. Privileging of USAR/ARNG commanders will be coordinated with the next higher medical headquarters or the State Surgeon's office, as appropriate.

(1) USAR/ARNG providers will complete DA Form 4691 at the time of initial application for unit-level privileges and submit it to their unit's credentials committee or other appropriate credentials committee. (See para 8–5*d*(1).) Members of the IRR will submit DA Form 4691 at the time of initial application to Commander, HRC, ATTN: AHRC–RSA–Q, 1 Reserve Way, St. Louis, MO 63132–5200.

(2) Other appropriate privileging documents as outlined in paragraphs 9–4*a* through *c*, will be used to request privileges at the unit level. Unit-level privileges will be based on mission and/or medical taskings from higher headquarters. The extent to which privileges are granted may differ based upon type and length of duty performed. For privileged providers assigned to the IRR who request duty at an AA MTF, HRC Quality Management Directorate will coordinate completion of the appropriate privileging documents with the AA MTF. (See para *b*, below.)

(3) The originals of each privileging forms (DA Form 4691, 4691–1, 5440, 5440A, and 5754) are maintained in the PCF with a copy furnished to the USAR/ARNG provider.

b. Privileging for USAR/ARNG training or duty at AA MTFs.

(1) The provider documentation that will be forwarded to the AA MTF includes an ICTB generated by the unit and the attachments as specified in paragraph 8–11*b*. The USAR/ARNG unit commander/State Surgeon will recommend privileges to be granted by the AA MTF based on recommendations by the unit's credentials committee. The AA credentials committee/function will integrate the ICTB with attachments provided by the USAR/ARNG unit into its routine privileging process.

(2) Given the organizational structure and mission of HRC and the NAAD, traditional credentials committee function is not practical. Thus the Director, Quality Management Directorate, HRC Health Services and the Commander, NAAD may recommend that privileges be granted based upon direct review of the PCF without the preliminary action (review and recommendations) by a credentials committee.

(3) USAR/ARNG providers who cannot supply documentation to support current clinical competence may be subject to an evaluative AT period of duty. This is not considered an adverse privileging action. There will be coordination between the unit of assignment/attachment and higher headquarters to identify the facility that will accommodate the healthcare provider for the evaluative period. At no time will this period of evaluation be less than 14 days.

(4) A current ICTB and other supporting documentation are required for each period of AT, ADT, or IDT except in situations where USAR/ARNG provider training occurs at the same AA facility, and his/her clinical scope of practice remains the same. In these situations, the period of clinical privileges may be up to 12 months if no professional staff appointment has been granted and up to 24 months if the provider holds a professional staff appointment.

(5) If the USAR/ARNG provider's scope of privileges is limited due to the inability of the AA MTF to support specific practices, the limitations will be annotated in the "Comments" section of DA Form 5440A. This is not considered an adverse privileging action and does not require reporting.

(6) If an USAR/ARNG provider's privileges are denied, or if in the performance of duty his/her privileges are restricted due to professional incompetence or misconduct, the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010 will be notified according to paragraph 10–16*b*. The USAMEDCOM will then notify the following as appropriate:

(a) IRR and IMA members. Commander, HRC (AHRC–RSA–Q), 1 Reserve Way, St. Louis, MO 63132–5200.

(b) USAR TPU members. Through Commander, USARC (AFRC–MD), 1401 Deshler Street SW, Fort McPherson, GA 30330–2000 to the commander, unit of assignment/attachment.

(c) ARNG. Through the ARNG Readiness Center (NGB–ARS), 111 South George Mason Drive, Arlington, VA 22204–1382, to The Adjutant General, ATTN: State Surgeon and MILPO of the applicable State.

(7) USAR/ARNG providers with recurrent duty at the same AA MTF are eligible and may request an appointment to the professional staff as described in paragraph 9–5.

c. Remote site training, medical site support, and tactical exercise support.

(1) Remote sites are defined as USAR/ARNG training sites with troop medical clinics, physical examination sites, Army Materiel Command depots, semi-active Federal sites, medical readiness and training exercises, and field sites when conducting unit training.

(2) For remote sites that are under the command and control of an AA MTF, the MTF commander, as the DHS, is the privileging authority for all assigned providers. At sites located away from an AA MTF, USAR/ARNG providers may be granted privileges by the USAR/ARNG unit commander or State Surgeon to perform unit integrity requirements as identified in paragraph 1–4*h*(5). These USAR/ARNG providers are subject to credentials review and privileging according to chapters 8 and 9.

(3) The standard scope of practice for providers at these sites will be based on the appropriate DA Form 5440.

(4) Privileges may be granted by the appropriate GB (or designee) based upon the recommendation of the credentials committee. For RC, this responsibility is delegated to the unit medical or dental commander. There are four possible scenarios—

(a) The State Surgeon's credentials committee provides centralized credentialing for all healthcare providers in the State and recommends approval of privileges to the State Surgeon. The State Surgeon is the privileging authority.

(b) The participating USAR/ARNG medical unit has sufficient MC staff to form its own credentials committee. The committee reviews the provider's PCF and makes recommendations to the unit commander who is the granting authority for clinical privileges.

(c) The credentials committee of the medical unit at the next level in the USAR/ARNG chain of command (if the unit does not have its own committee) reviews the provider's PCF and makes recommendations for privileges to the unit commander who is the granting authority for clinical privileges.

(d) For deployment to a theatre of operation, USAR/ARNG providers will be privileged by the AA MTF privileging authority at, or responsible for, the deployment site. This will be accomplished using the ICTB with required attachments provided by the ARCCA or the individual State Surgeon's office. A copy of the ICTB and delineation of privileges granted by the MTF will be presented to the commander of the medical unit to which the individual is assigned.

(e) If the USAR/ARNG provider will be delivering healthcare at, or under the supervision of, an AA MTF, the MTF credentials committee will review the individual's ICTB and make recommendations to the MTF commander who is the privilege granting authority.

(5) For informational purposes, copies of the USAR/ARNG provider's privileges granted by the USAR/ARNG commander, any other relevant clinical privileging documentation, and the ICTB will be forwarded to the DHS within whose area the site is located or the exercise takes place.

d. Evaluation of USAR/ARNG providers/activities.

(1) Reappraisal and renewal or modification (augmentation or restriction) of clinical privileges will follow the guidance in this chapter. Evaluations will normally be performed during AT or following each AD period of 5 or more days.

(2) The appropriate DA Form 5441 will be used to evaluate each AD training period. For USAR/ARNG providers who participate in an inactive duty status, evaluation will be conducted following the completion of a minimum of 24 nonconsecutive inactive duty days. DA Form 5374 will be used to evaluate periods of IDT. This process allows the evaluation of performance to be completed, giving consideration to current policies regarding fragmented training or excused absences from training. The original copy of DA Forms 5441 or 5374 will be included in the PCF. If the PCF is maintained by the USAR/ARNG unit, these forms will be forwarded by the AA MTF credentials manager as soon after completion as possible. A copy may be attached to the ICTB maintained by the AA MTF. A copy will also be furnished to the USAR/ARNG privileged provider.

(3) Except for evaluations following each AD period of five or more consecutive days, evaluation of providers is required only once annually.

(4) For evaluation of medical or dental care providers at remote sites, the DHS may defer to the USAR/ARNG "on-site" medical unit commander. The medical unit commander may be required to certify by letter, at the completion of AT, that healthcare (as assessed by current, established, objective criteria) met the required standards. In other training units where the medical unit commander is unable to personally verify the quality of care being provided, the DHS has the following options:

(a) Conduct site visits using various staff representatives from the MTF.

(b) Accept certification by the on-site clinical officer in charge that the quality of care provided by his/her USAR/ARNG unit or privileged providers meets established performance requirements mandated by provider credentials, scope of practice, and current professional standards of care. This certification requires a medical or dental staff of three or more officers to conduct a quality-of-care review at the USAR/ARNG treatment facility.

(c) Require a retrospective medical record review by the DHS representative. A representative sample of medical records will be reviewed for quality, medical necessity, and appropriateness of care.

(5) DA Form 5374 and the appropriate DA Form 5441 will be used to record individual clinical performance evaluations based on type of duty as discussed above.

(6) State-owned and State-operated ARNG facilities will undergo periodic site evaluation visits from the area DHS (or representative) to enable the RMC commander to fulfill his/her technical oversight responsibility (AR 10–87).

OFFICE SYMBOL (640-10e) (Date)

MEMORANDUM FOR (Applicant's Name, Department/Service)

SUBJECT: Clinical Privileges and Medical Staff Appointment Status

1. Your application for clinical privileges and medical staff appointment at (MTF name) was reviewed by the credentials committee at the (date) meeting. Based on review and recommendations of that committee and the executive committee of the medical/dental staff, and approval by the commander, (MTF name), clinical privileges are granted as specified at enclosure (DA Form 5440-XX, Delineation of Clinical Privileges).

2. You are granted (specify category) privileges for the period (date) through (date) as specified on DA Form 5440-XX.

3. You are granted a/an (specify status) appointment to the medical staff for the period (date) through (date), as indicated on DA Form 5440A.

4. Two copies of this memorandum and attachments are provided. Please acknowledge receipt on the attached memorandum and return the original to the Credentials Office. The second copy of the memorandum, a copy of your delineated privileges (DA Form 5440-XX), a copy of the approval of clinical privileges/medical staff appointment (DA Form 5440A), and a copy of the plan of supervision, if applicable, are provided for your files.

Encls
1. DA Form 5440-XX
2. DA Form 5440A
3. Plan of supervision (if applicable)

Signature Block
Credentials Manager

Figure 9–1. Sample format for memorandum notifying provider of clinical privileges and medical staff appointment status

S: (Suspense date)

PROVIDER'S OFFICE SYMBOL (640-10e) date

MEMORANDUM FOR Commander, MEDCEN, MEDDAC, or DENTAC and Address

SUBJECT: Receipt of Notification of Clinical Privileges and Medical Staff Status

I hereby acknowledge receipt of a copy of DA Form 5440A granting me clinical privileges (to include/but not to include admitting privileges) and (appointment to the medical staff). A listing of my approved clinical privileges (DA Form 5440-XX) (and plan of supervision) as addressed in the memorandum from the commander has also been provided. I understand that I am granted 10 duty days from receipt of this memorandum to appeal the commander's decision, should I disagree.

(Signature of Provider)

(Typed Name)
(Grade, Corps)

Figure 9–2. Sample format for provider memorandum acknowledging clinical privileges and staff appointment status

Chapter 10
Adverse Clinical Privileging/Practice Actions

10–1. General

This chapter describes the management of adverse privileging/practice actions for privileged providers and other professionals. The process has four steps: investigation, professional peer review, hearing, and appeal. The term, "provider" is used for individuals granted clinical privileges. In select instances, information contained in this chapter may also apply to the nonprivileged professional. In those instances, the term, "professional" will be used. (See chap 6 for adverse practice action and peer review information regarding nonprivileged personnel.)

10–2. Command responsibility

a. Action taken on the part of the commander against a provider's privileges (professional's scope of practice) may be warranted based on performance suspected or deemed not to be in the best interest of quality patient care. These actions include holding in abeyance, denying, suspending, restricting, reducing, or revoking clinical privileges/practice. The action taken may be immediate (summary) in the event of a critical incident or as a result of the credential committee's deliberation (routine) on information made available through CQM reporting channels.

b. The commander's prerogative to hold in abeyance, to deny, or to summarily suspend clinical privileges/practice is exercised when there is reasonable cause to doubt the individual's competence to practice or for any other cause affecting the safety of patients or others. Reasonable cause includes—

(1) A single incident of gross negligence.
(2) A pattern of inappropriate prescribing.
(3) A pattern of substandard care.

DoD 6025.13-R

MILITARY HEALTH SYSTEM (MHS) CLINICAL QUALITY ASSURANCE (CQA) PROGRAM REGULATION

JUNE 11, 2004

ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

TAB I

FOREWORD

11 JUN 2004

This Regulation is issued under the authority of Department of Defense Directive 6025.13, "Clinical Quality Assurance in the Military Health System," (reference (a)). It identifies the various components comprising the Department of Defense's efforts to ensure that beneficiaries receive quality care.

This Regulation applies to the Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the Department of Defense Field Activities, and all other organizational entities in the Department of Defense (hereafter referred to collectively as "the DoD Components"). The term "Military Services," as used herein, refers to the Army, the Navy, the Air Force, and the Marine Corps.

The Regulation is effective immediately and is mandatory for use by all the Department of Defense Components.

Send recommended changes to this regulation to the following address:

Office of the Assistant Secretary of Defense (Health Affairs)
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REFERENCES

(a) DoD Directive 6025.13, "Quality Assurance in the Military Health System," May 4, 2004
(b) DoD Directive 5154.24, "Armed Forces Institute of Pathology," October 3, 2001
(c) Sections 1346(b) and 2671-80(h) of title 28, United States Code
(d) Sections 801-940 (chapter 47), 1094, 1094a, 1096, 1102, 2731-2739 (chapter 163) of title 10, United States Code
(e) Sections 552 and 552a of title 5, United States Code
(f) Sections 11131 through 11152 of title 42, United States Code
(g) Joint Commission on Accreditation of Healthcare Organizations, "Accreditation Manual for Hospitals," Volumes 1 and II, current editions
(h) Joint Commission on Accreditation of Healthcare Organizations, "Ambulatory Healthcare Standards Manual," Volumes I and II, current editions
(i) Joint Commission on Accreditation of Healthcare Organizations, "Accreditation Manual for Health Care Networks," current edition
(j) Joint Commission on Accreditation of Healthcare Organizations, "Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services," current edition
(k) Commission on Accreditation of Rehabilitation Facilities (CARF), "Standards Manual for Organizations Serving People With Disabilities," current edition
(l) National Committee for Quality Assurance, "NCQA Standards for Accreditation and Review Guidelines," current edition
(m) DoD Instruction 6025.5, "Personal" Services Contracts for Health Care Providers," January 6, 1995
(n) DoD Instruction 1402.5, "Criminal History Background Checks On Individuals in Child Care Services," January 19, 1993
(o) DoD 5500.7-R, "Joint Ethics Regulation (JER), "August 1993
(p) Section 5536 of title 5, United States Code
(q) Sections 742 and 754 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Pub. L. 106-398
(r) DoD 8910.1-M, "DoD Procedures for Management of Information Requirements," June 30, 1998
(s) Title 45 of the Code of Federal Regulations, Part 60, "National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners" (Department of Health and Human Services (DHHS) regulations)
(t) DoD Instruction 1332.38, "Physical Disability Evaluation" November 14, 1996

(u) Title 45 of the Code of Federal Regulations, Part 61, "Health Care Fraud and Abuse Data Collection Program: Reporting of Final Adverse Actions"
(v) Section 7501-7543 (Chapter 75) of title 5, United States Code
(w) Part 209 of the Defense Federal Acquisition Regulation Supplement, 48 CFR

DL1. DEFINITIONS

DL1.1.1. Abeyance. The temporary assignment of a provider from clinical duties to non-clinical duties while an internal or external peer review or quality assurance investigation is conducted. It cannot exceed 30 days and is not considered an adverse privileging action.

DL1.1.2. Adverse Events. Occurrences or conditions associated with care or services when they cause unexpected harm to a patient during such care or services. These may be because of acts of commission or omission.

DL1.1.3. Adverse Privileging Action. Denying, suspending, restricting, reducing, or revocation of clinical privileges based upon misconduct, professional impairment, or lack of professional competence. The termination of professional staff appointment based upon conduct incompatible with continued professional staff membership may also result in an adverse privileging action.

DL1.1.4. Aggregate Statistical Information. An assembled collection of numerical facts and other information or data derived from various DoD health program activities. Names, social security numbers, or other specific information that would identify or reasonably lead to identification of individual healthcare providers, patients, or organizational entities below the Military Department level may not be included in aggregate statistical data, except that the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) may authorize the release of aggregate statistical data at the Military Treatment Facility (MTF) (medical or dental) level as part of participation in national QA program activities

DL1.1.5. Approved Postgraduate Training. Postgraduate training program accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association (AOA), or other similar entities regulating healthcare professional training programs

DL1.1.6. Clinical Privileging. The granting of permission and responsibility of a healthcare provider to provide specified or delineated healthcare within the scope of his or her license, certification, or registration. Clinical privileges define the scope and limits of practice for individual providers and are based on the capability of the healthcare facility, licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.

DL1.1.7. Credentials. The documents that constitute evidence of appropriate education, training, licensure, experience, and expertise of a healthcare practitioner.

DL1.1.8. Credentials Review. The credentials inspection and verification process conducted for healthcare practitioners before selection for military service, employment, and procurement. The credentials review process is also conducted for healthcare providers before medical staff appointment and granting of clinical privileges, and is repeated at the time of reappointment and renewal of privileges.

DL1.1.9. Credentials, Verified. Documents confirming authenticity has been obtained from the primary (issuing) source by the Military Service or a representative of the Military Service. Confirmation, independent of the practitioner, is a key criterion. With respect to credentials that will never change, once verified, confirmation of authenticity with the primary source need not be repeated during subsequent credentials review. However, State licenses/certifications/registrations, NPDB/HIPDB/DPDB queries and current competency shall be verified at every granting and renewal of privileges.

DL1.1.10. Current Competence. The state of having adequate ability to perform the functions of a practitioner in a particular discipline as measured by meeting the following:

DL1.1.10.1. Authorized to practice a specified scope of care under a written plan of supervision at any time within the past 2 years; or, completed formal graduate professional education in a specified clinical specialty at any time within the past 2 years; or, privileged to practice a specified scope of care at any time within the past 2 years.

DL1.1.10.2. Actively pursued the practice of his or her discipline within the past 2 years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested; and,

DL1.1.10.3. Satisfactorily practiced the discipline as determined by the results of professional staff monitoring and evaluation of the quality and appropriateness of patient care.

DL1.1.11. Defense Practitioner Data Bank (DPDB). The automated information system maintained as part of the Risk Management and Adverse Actions Modules of the Centralized Credentials Quality Assurance System (CCQAS) and electronically monitored by the Department of Legal Medicine of the Armed Forces Institute of Pathology. It consists of data on the professional competence and conduct of licensed healthcare providers and malpractice cases involving the Department of Defense, including all filed and paid claims. It also includes cases in which disability system or

other payments are made because of personal injury or death of a member of a Uniformed Service caused by the failure of a practitioner(s) to meet the professional standard of care.

DL1.1.12. Denial of Privileges. Refusal to grant provider-requested privileges. This could occur at initial application for privileges or when renewal of privileges is requested. Denial of privileges because of professional incompetence or misconduct is reportable to the National Practitioner Data Bank (NPDB).

DL1.1.13. Department of Legal Medicine. The Department of Legal Medicine of the Armed Forces Institute of Pathology (AFIP) (reference (b)).

DL1.1.14. Feres-bared Cases. Cases of actual or alleged medical malpractice torts for which Federal court jurisdiction is not available under the Federal Tort Claims Act (reference (c)) based on the Supreme Court decision in Feres v. United States, 340 U.S. 135 (1950), (and/or similar cases) that the military disability system and other compensation programs, rather than tort litigation, provided the exclusive remedies for military members killed or injured incident to Military Service. Although payments under such military compensation programs that are a result of medical care are not malpractice payments under NPDB rules, this Regulation requires that they be reviewed for reporting to the DPDB. (NOTE: Although the "Feres doctrine" applies to all tort cases, not just medical malpractice cases, the term "Feres barred cases" in this Regulation refers only to actual or alleged torts involving medical malpractice.)

DL1.1.15. Healthcare Entity. A hospital, ambulatory health clinic, or dental clinic with an independent healthcare practitioner staff that provides healthcare to medical or dental patients and carries out professional staff review. The term also includes applicable professional staff components of each Military Department, as designated by the respective Surgeon General, that also perform peer reviews as part of the quality assurance and/or quality improvement program.

DL1.1.16. Healthcare Practitioner. Synonymous with "healthcare professional." Any physician, dentist, or healthcare practitioner of one of the professions whose members are required to possess a professional license or other similar authorization. These include DoD healthcare personnel who are physicians, dentists, registered nurses, practical nurses, physical therapists, podiatrists, optometrists, clinical dieticians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD(HA).

DL1.1.17. Healthcare Provider. Military (Active or Reserve component) and civilian personnel (Civil Service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens within the scope of his or her license, certification, or registration. This category includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD(HA). This term is equivalent to Licensed Independent Practitioner (LIP). (See DL1.1.24.)

DL1.1.18. Healthcare Quality Assurance (QA) Program. Any activity performed before, on, or after the enactment of 10 U.S.C. 1102 (reference (d)) by or for the Department of Defense to assess the quality of medical care. This includes activities conducted by individuals, MTF committees, contractors, military medical departments, or DoD Agencies responsible for QA, credentials review and clinical privileging, infection control, patient care assessment (including review of treatment procedures, therapeutics, blood use, medication use), review of healthcare records, health resources management review, and risk management (RM) review.

DL1.1.19. Healthcare Trainee. Any resident, intern, or other healthcare practitioner in a formal healthcare training status.

DL1.1.20. Host State. The State in which off-base duties are or shall be performed.

DL1.1.21. Individual QA Action. A provider sanction, privileging action, or other activity on an individual healthcare provider intended to address a quality of healthcare matter. Such an action is based on processes structured by the QA program.

DL1.1.22. Intentional Unsafe Act. Any alleged or suspected act or omission of a provider, staff member, contractor, trainee, or volunteer pertaining to a patient involving a criminal act; a purposefully unsafe act; patient abuse; or an event caused or affected by drug or alcohol abuse. Intentional unsafe acts are matters for law enforcement, disciplinary system, or administrative investigation.

DL1.1.23. License. A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide healthcare within the scope of practice for a discipline. The stages of license are as follows:

DL1.1.23.1. Current. Active, not revoked, suspended, or lapsed in registration.

DL1.1.23.2. Valid. The issuing authority accepts, investigates, and acts upon quality assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.

DL1.1.23.3. Unrestricted. Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. An unrestricted license must allow the provider unabridged permission to practice in any civilian community in the jurisdiction of licensure without having to take any additional action on her/his license.

DL1.1.24. Licensed Independent Practitioner. Any individual permitted by law and by the organization to provide care, treatment and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. This term is equivalent to Healthcare Provider. (See DL1.1.17.)

DL1.1.25. Malpractice Payment. A monetary award under the authority of the Federal Tort Claims Act (reference (c)), the Military Claims Act (10 U.S.C. Chapter 163) (reference (d)), or the Foreign Claims Act (reference (d)) relating to the provision of healthcare services under the organizational responsibility of the Department of Defense.

DL1.1.26. Medical Readiness Training Certification. A process used to verify the preparation of healthcare providers for operational requirements. The commander's review and verification of individual, collective, and unit medical readiness training, education, and experiences is a critical element of the process.

DL1.1.27. Military Health System (MHS). The combination of military and civilian medical systems used to provide healthcare to DoD medical beneficiaries.

DL1.1.28. MHS Official Responsible. The Surgeon General, the TRICARE Lead Agent, the MTF Commander, or other official authorized by the ASD(HA) making the off-base duty assignment of the healthcare professional involved.

DL1.1.29. National Practitioner Data Bank (NPDB). The agency designed by the DHHS receiving and providing data on substandard clinical performance and conduct of physicians, dentists, and other licensed healthcare practitioners, including data on malpractice claims payment made on behalf of those practitioners.

DL1.1.30. Near Miss. Any process variation or error or other circumstance that could have resulted in harm to a patient but through chance or timely intervention did not reach the patient or did not harm the patient. Such events or circumstances have also been referred to as "close calls."

DL1.1.31. Network. The combination of the MTF and other civilian preferred providers (e.g., individuals, groups, hospitals, and clinics) who have agreed to accept the DoD and Uniformed Services beneficiaries enrolled in the regional managed care program authorized by the ASD(HA). Civilian networks' providers deliver healthcare at negotiated rates, adhere to provider agreements, and follow other requirements of the managed care program. Civilian network healthcare providers are independent contractors of the Government (or other independent entities having business arrangements with the Government).

DL1.1.32. Off-base Duties. Officially assigned professional duties performed at an authorized location outside a MTF and any military installation. Off-base duties include, but are not limited to, training or skill maintenance duties in non-DoD healthcare facilities, professional activities performed under the authority of the military-civilian health services partnership program under 10 U.S.C. 1096 (reference (d)), and telemedicine services involving a patient outside an MTF and any military installation. Off-base duties do not include participation in approved postgraduate training of physicians, or assigned professional duties performed in a Department of Veterans Affairs (DVA) or other Federal Government healthcare facility.

DL1.1.33. Other Authorizing Document

DL1.1.33.1. A mechanism, such as registration and certification, by which a State; the District of Columbia; or a Commonwealth, territory, or possession of the United States grants authority to provide healthcare in a specified discipline; or,

DL1.1.33.2. In specialties not licensed and where the requirements of the granting authority for registration or certification are highly variable, the validation by a national organization that a practitioner is professionally qualified to provide healthcare in a specified discipline; or

DL1.1.33.3. In the case where healthcare is provided in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide healthcare in a specified discipline.

DL1.1.34. Privileges (Clinical). Permission to provide medical and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, competence, ability, health, and judgment.

DL1.1.35. Potentially Compensable Event. An adverse event that occurs in the delivery of healthcare and services with resulting beneficiary injury. It includes any adverse event or outcome, with or without legal fault, in which the patient experiences any unintended or unexpected negative result.

DL1.1.36. Professional Impairment. A healthcare practitioner characteristic that may adversely affect the ability to render quality care. Professional impairment may include deficits in medical knowledge, expertise or judgment; unprofessional, unethical, or criminal conduct; and any medical condition that reduces or prevents the practitioner's ability to safely execute his or her responsibilities in providing healthcare.

DL1.1.37. Professional Review. A process that monitors, reviews, and evaluates the standard of care or quality of care given by a healthcare provider within a healthcare entity.

DL1.1.38. Professional Staff Appointment. Formal, written authorization to perform patient care accompanied by a delineation of authorized clinical privileges and a pledge to abide by the rules and regulations of the medical or dental staff.

DL1.1.38.1. Active Staff Appointment. Staff appointments granted to providers, according to the needs of the Government, who successfully complete the initial staff appointment period.

DL1.1.38.2. Initial Staff Appointment. The initial professional staff appointment granted to a provider when first assigned or employed by a DoD facility. The initial appointment for a period, not to exceed 12 months, is to allow the provider to demonstrate current clinical competence and compliance with the facility's policies, procedures, and bylaws.

DL1.1.39. QA Record. The proceedings, records, minutes, and reports that derive from healthcare QA program activities and are produced or compiled by the Department of Defense as part of a healthcare QA program. The term "medical QA Record" includes medical, mental health, and dental QA records, programs, activities, and information.

DL1.1.40. Reduction in Privileges. A portion of a provider's clinical privileges permanently removed. It may be based on misconduct, physical impairment, or other factors limiting a provider's capability. Reduction in privileges is reportable to the NPDB.

DL1.1.41. Reinstatement of Privileges. The revision of an adverse privileging action that restores all or a portion of the provider's clinical privileges. Reinstatement of privileges is reportable to the NPDB.

DL1.1.42. Restriction of Privileges. A temporary or permanent limit placed on all or a portion of the provider's clinical privileges so the provider is required to obtain concurrence before providing all or some specified healthcare procedures within the scope of his or her certification, license, or registration. The restriction may require some type of supervision. Restriction of privileges is reportable to the NPDB.

DL1.1.43. Revocation of Privileges. All clinical privileges of a healthcare provider permanently removed. In most cases, such action may be followed by action to terminate the provider's DoD service. Revocation of privileges is reportable to the NPDB.

DL1.1.44. Root Cause Analysis (RCA). A process for identifying the basic or contributing causal factors associated with actual adverse events and near misses. An RCA includes the following characteristics:

DL1.1.44.1. The review is interdisciplinary in nature with involvement of those closest to the process.

DL1.1.44.2. The analysis focuses primarily on systems and processes rather than individual performance.

DL1.1.44.3. The analysis digs deeper by asking "what" and "why" until all aspects of the process are reviewed and all contributing factors are identified.

DL1.1.44.4. The analysis identifies changes that may be made in systems and processes through either redesign or development of new processes or systems that may improve performance and may reduce the risk of actual adverse events or recurrence of near misses.

DL1.1.45. Sentinel Events. Unexpected occurrences involving death or serious physical or psychological injury or risk thereof.

DL1.1.46. Serious Adverse Events. Unexpected occurrences involving death or serious physical or psychological injury.

DL1.1.47. Significantly Involved Practitioners. Practitioners who (based on medical record entries) actively delivered care in primary or consultative roles during the episode(s) of care that gave rise to the allegation, regardless of the standard of care determination.

DL1.1.48. Standard of Care. Healthcare diagnostic or treatment judgments and actions of a provider generally accepted in the healthcare discipline or specialty involved as reasonable and appropriate.

DL1.1.49. State. Any of the 50 States, the District of Columbia, or a commonwealth, territory, or possession of the United States.

DL1.1.50. State Licensing Board. The entity or entities authorized under the applicable State law to issue licenses or other authorizing document such as certificate or registration to healthcare professionals.

DL1.1.51. Summary Suspension (or Summary of Action of Suspension of Privileges). The temporary removal of all or part of a provider's privileges, taken prior to the completion of due process procedures, based on peer assessment or command that the action is needed to protect patients or the integrity of the command resulting from cases involving the temporary removal from cases, professional or behavioral impairment or negligence. A summary suspension could continue until due process procedures are completed. Summary suspension of privileges within the Department of Defense is not reportable to the NPDB, unless the final action is reportable.

DL1.1.52. Supervision. The process of reviewing, observing, and accepting responsibility for assigned personnel. The types of supervision are as follows:

DL1.1.52.1. Indirect. The supervisor performs retrospective record review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of practice.

DL1.1.52.2. Direct. The supervisor is involved in the decision-making process. This may be further subdivided as follows:

DL1.1.52.2.1. Verbal. The supervisor is contacted by phone or informal consultation before implementing or changing a regimen of care.

DL1.1.52.2.2. Physically Present. The supervisor is present physically through all or a portion of care.

DL1.1.53. Suspension of Privileges. The temporary removal of all or part of a provider's privileges resulting from incompetence, negligence, or unprofessional conduct after due process procedures are completed. Suspension of privileges is reportable to the NPDB. This term includes a summary suspension.

DL1.1.54. Temporary Assignment. For clinical practice this term refers to all clinical assignments other than permanent change of station.

DL1.1.55. Verification. Confirmation of authenticity obtained from the primary source by the MTF, a previous MTF, or a representative of the Military Service.

C1. CHAPTER 1

QUALITY ASSURANCE PROGRAM OVERVIEW

C1.1. PURPOSE

This Regulation implements the policy guidance concerning quality assurance in the MHS established in reference (a).

C1.2. APPLICABILITY

This Regulation applies to:

C1.2.1. The Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereafter referred to collectively as the "DoD Components"). The term "Military Services," as used herein, refers to the Army, the Navy, the Air Force, and the Marine Corps.

C1.2.1.1. DoD healthcare practitioners who are involved in the delivery of healthcare services to eligible beneficiaries.

C1.2.1.2. DoD MTFs.

C1.2.1.3. Groups of civilian-preferred providers under managed care support contracts to the Department of Defense, in health services regions throughout the MHS.

C1.2.1.4. DoD personnel who prepare and evaluate contract specifications and who select, procure, and administer networks of civilian preferred providers to deliver healthcare to eligible beneficiaries.

C1.3. RESPONSIBILITIES

C1.3.1. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall:

C1.3.1.1. Monitor the implementation of this Regulation to ensure consistent application across the MHS.

C1.3.1.2. Ensure all preferred provider healthcare contracts reflect the guidance set forth in this Regulation.

C1.3.1.3. Exercise authority to grant waivers to this Regulation in exceptional circumstances.

C1.3.2. The Secretaries of the Military Departments shall ensure compliance with this Regulation.

C1.4. MHS DEFINITION OF QUALITY IN HEALTHCARE

C1.4.1. Definition. Quality in Health Care is defined as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." More specifically the services provided will be safe, effective, patient-centered, timely, efficient, and equitable.

C1.4.2. Principles. The MHS emphasizes the following principles:

C1.4.2.1. Accountability. Is accountable to healthcare providers, military leadership and beneficiaries, and places an inherent value on the scientific measurement of individual and system performance characteristics, providing timely relevant feedback in a continuous fashion.

C1.4.2.2. Continuity of Care. Healthcare is provided by professionals whose commitment extends beyond the individual patient encounter or incident of healthcare delivery and encompasses a continuum of concern and care extending indefinitely.

C1.4.2.3. Quality Improvement. Employs strategies to continuously study and improve the processes and outcomes of providing healthcare services to meet the needs of individuals.

C1.4.2.4. Medical Readiness. Able to field a uniquely trained, equipped, and qualified team to meet the health needs of the fighting forces anytime, anywhere, and is capable of projecting military healthcare forces worldwide to advance our national security interests.

C1.5. QUALITY MANAGEMENT REVIEWS

To evaluate outcomes as a principal measure of quality and the relationship of outcomes to cost, the MHS utilizes Quality Management Reviews to do the following:

C1.5.1. Perform external comparisons of MHS outcomes with civilian benchmarks through participation in external organization quality measurement processes, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) ORYX Initiative.

C1.5.2. Perform internal comparisons between Regional and Service MTFs.

C1.5.3. Identify best clinical practice by finding those facilities with best cost and quality outcomes.

C1.5.4. Facilitate MHS-wide, Service, Regional, and MTF continuous quality improvement efforts.

C1.6. COMMUNICATION WITH PATIENTS

The Quality Assurance Program shall include procedures and standards to provide guidance to staff to ensure that in cases of unanticipated outcomes of care, including serious medical errors that cause harm to a patient, a qualified healthcare provider shall inform the patient or applicable family members. Information provided may not include medical QA records and information prohibited from disclosure by reference (d) and Chapter 2 of this Regulation. That information is provided as a matter of clinical policy and does not affect any rights or obligations in legal or administrative proceedings.

C2. CHAPTER 2

QUALITY ASSURANCE RECORDS CONFIDENTIALITY

C2.1. REQUIREMENT OF CONFIDENTIALITY

C2.1.1. Medical QA records created by or for the Department of Defense, as part of a medical QA program, are confidential and privileged. They may not be made available to any person under the "Freedom of Information Act" (5 U.S.C. 552, reference (e)). As a system of records, they are within the purview of the "Privacy Act" (Section 552a of reference (e)) and, therefore, the individual healthcare provider who is the subject of an individual QA action may be entitled to access to the records. With the exception of such a provider, the identities of third parties in the record; i.e., any person receiving healthcare services (patients) from the Department of Defense or any other person associated with the DoD QA program, shall be deleted from the record before any disclosure of the record is made outside the Department of Defense. This identity deletion requirement does not apply to disclosures under 5 U.S.C. 552a (reference (e)), but other deletion requirements under 5 U.S.C. 552a may apply in certain circumstances.

C2.1.2. No part of any medical QA record may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except in accordance with 10 U.S.C 1102 (reference (d)).

C2.1.3. A person who reviews or creates medical QA records for the Department of Defense or who participates in any proceeding that reviews or creates such records may not testify in any judicial or administrative proceeding on such records or on any finding, recommendation, evaluation, opinion, or action taken by such person or body for such records, except in accordance with 10 U.S.C. 1102 (reference (d)).

C2.1.4. A person or entity having possession of or access to medical QA records or testimony may not disclose the contents of such record or testimony in any manner or for any purpose, except in accordance with 10 U.S.C. 1102 (reference (d)).

C2.1.5. Any person who willfully discloses a medical QA record, other than as provided in 10 U.S.C. 1102 (reference (d)), knowing that such record is a medical QA record, shall be subject to adverse personnel action (to include, in appropriate cases, dismissal or separation), and may be liable for a fine of not more than $3,000 in the case of a first offense and not more than $20,000 in the case of a subsequent offense.

C2.1.6. Information on healthcare providers who are found to be incompetent, negligent, medically or psychiatrically impaired, or guilty of misconduct as defined in this Regulation shall be provided to Agencies specified in Chapter 5 of this Regulation.

C2.1.7. Information shall be submitted to the NPDB, as instituted by 42 U.S.C. 11131-11152 (reference (f)), in accordance with applicable law and this Regulation.

C2.1.8. Aggregate statistical information on results of DoD medical QA programs may be provided in response to written requests or as directed by the ASD(HA).

C2.1.9. As provided in 10 U.S.C. 1102 (reference (d)), a person who participates in or provides information to a person or body that reviews or creates medical QA records shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith, based on prevailing professional standards at the time the medical QA program activity took place.

C2.1.10. Nothing in this Chapter shall be construed as limiting access to the information in a record created and maintained outside a medical QA program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a healthcare QA program.

C2.2. STANDARDS FOR DISCLOSURE OF MEDICAL QA RECORDS

C2.2.1. QA records are protected from disclosure, except as described in paragraph C2.2.2., below. Those records include, but are not limited to, the data, testimony, and working documents of any MTF, DoD contractor, Military Department, or DoD Agency involved in monitoring, assessing, or documenting quality of healthcare.

C2.2.2. DoD QA Records may be authorized for disclosure or testimony to the following:

C2.2.2.1. A Federal Executive Agency, or private organization, if such medical QA record or testimony is needed by such Agency or organization to perform licensing or accreditation functions related to DoD healthcare facilities or to perform monitoring, required by law, of DoD healthcare facilities.

C2.2.2.2. An administrative or judicial proceeding commenced by a present or former DoD healthcare provider concerning the termination, suspension, reduction, restriction, or revocation of clinical privileges of such healthcare provider.

C2.2.2.3. A governmental board or Agency or a professional healthcare society or organization, if such medical QA record or testimony is needed by such board, Agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards of any healthcare provider who is, or was, a member or an employee of the Department of Defense.

C2.2.2.4. A hospital, medical center, or other institution that provides healthcare services, if such medical QA record or testimony is needed by such institution to assess the professional qualifications of any healthcare provider who is, or was, a member or employee of the Department of Defense and who has applied for, or has been granted, authority or employment to provide healthcare services in or on behalf of such institution.

C2.2.2.5. An officer, employee, or contractor of the Department of Defense who has need for such record or testimony to perform official duties.

C2.2.2.6. A criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

C2.2.2.7. An administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality discussed in subparagraph C2.2.2.6., above, but only for the subject of such proceeding.

C2.2.3. Aggregate Statistical Information. Nothing in this Chapter shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information on the results of DoD medical QA programs.

C2.2.4. Congressional Requests. Nothing in this Chapter shall be construed as authority to withhold any medical QA record from a committee of either House of Congress, any joint committee of Congress, or the General Accounting Office if such record pertains to any matter within their respective jurisdictions.

C3. CHAPTER 3

FACILITY STANDARDS

C3.1. ACCREDITATION

C3.1.1. All fixed hospitals and free-standing ambulatory clinics, including those providing care to DoD beneficiaries under various managed care support contracts, shall maintain accreditation by the JCAHO, under the "Accreditation Manual for Hospitals" (reference (g)) or the "Ambulatory Health Care Standards Manual" (reference (h)), or as a component of a network system approved by the Service under the "Accreditation Manual for Health Care Networks" (reference (i)), or through an accreditation source approved by the ASD(HA).

C3.1.2. Operational ambulatory clinics (those treating active duty personnel only) are exempt from the accreditation requirement. Each Military Service shall establish and implement comparable quality of care oversight mechanisms for those operational clinics under its cognizance.

C3.1.3. Hospital-sponsored alcoholism and drug dependence programs shall maintain accreditation under the standards contained in reference (g). All other Service-sponsored, free-standing alcoholism and drug dependence programs shall maintain accreditation through the "Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services" (reference (j)) or the Commission on Accreditation of Rehabilitation Facilities (CARF) in the Standards Manual for Organizations Serving People With Disabilities" (reference (k)).

C3.1.4. All preferred provider networks shall maintain accreditation either through the JCAHO in reference (i) or through the National Committee on Quality Assurance (NCQA) in the "NCQA Standards for Accreditation and Review Guidelines" (reference (l)).

C3.1.5. All MTFs and networks listed in paragraphs C3.1.1., C3.1.3., and C3.1.4., above, shall attain and maintain accreditation. The ASD(HA) shall consider accreditation waivers on a case-by-case basis. Waiver requests shall specify patient volume statistics, provider specialty mix, ongoing performance, and alternate oversight mechanisms.

C3.1.6. Accreditation guidance is found in references (g) through (k) and shall not be duplicated in this Regulation. When appropriate, the ASD(HA) shall implement policy, direct procedures that exceed the standards of accrediting bodies, and issue implementing instructions.

C4. CHAPTER 4

CREDENTIALS AND CLINICAL PRIVILEGES

C4.1. LICENSING REQUIREMENT

C4.1.1. Statutory Requirement

C4.1.1.1. 10 USC 1094 (reference (d)) provides: "A person under the jurisdiction of the Secretary of a Military Department may not provide healthcare independently as a healthcare professional . . . unless the person has a current license to provide such care. In the case of a physician, the physician may not provide healthcare as a physician under this chapter unless the current license is an unrestricted license that is not subject to limitation on the scope of practice ordinarily granted to other physicians for a similar specialty by a jurisdiction that granted the license."

C4.1.1.2. The statute allows the Secretary of Defense to waive this requirement regarding any person in unusual circumstances, and directs the Secretary to prescribe by regulation the circumstances under which such a waiver may be granted. This authority and responsibility was delegated to the ASD(HA) by reference (a).

C4.1.1.3. Healthcare practitioners who do not possess a license or other authorizing document may practice only under a written plan of supervision with a licensed person of the same or a similar discipline.

C4.1.1.4. The statutory requirement is applicable to all healthcare practitioners practicing independently in military facilities or operational environments. This includes healthcare practitioners who are member of the Uniformed Services (Active and Reserve), Federal employees, volunteers (who are considered to be employees for certain purposes), and personal services contractors (under DoD Instruction 6025.5, reference (m)). The statutory requirement has no impact on non-personal services contractors in MTFs. Non-personal services contractor healthcare practitioners are required to maintain an unrestricted license in the State in which the MTF is located.

C4.1.2. Implementation of Licensure Requirement and Waiver Provision

C4.1.2.1. Any physician's license in a licensure category that restricts the physician to practice in a Federal facility or within some other confined limits does not comply with the requirement for an "unrestricted license." Unless waived, all physicians must have at least one current, valid, unrestricted license. Physicians may hold

additional licenses from States in licensure categories that have practice restrictions associated with military exemptions from certain fees or requirements as long as the physician also holds at least one license for which there are no limitations on the scope of practice. A physician without a full-scope license may not provide healthcare as a physician unless a waiver is granted under this Chapter.

C4.1.2.2. A licensure category that includes limitations on scope of practice shall not be considered for a waiver of the unrestricted license requirement unless it includes all the same requirements pertaining to clinical competency (e.g., education, training, national tests, continuing medical education, investigation, and sanction authority of the license board) as the full scope category and has no restrictions pertaining to clinical competency (e.g., practice under supervision). A waiver shall be considered only if the differences between the full scope license and limited scope license are solely of an administrative or financial nature.

C4.1.2.3. The statute permits a waiver of the unrestricted scope requirement only in "unusual circumstances." A waiver may be considered in cases in which the administrative or financial requirements applicable to the full scope license that are not applicable to the limited scope license are substantial and seek to achieve a State purpose clearly inapplicable to military physicians based on Federal policy, and thus are inharmonious with Federal policy. Examples of this would be a requirement that the physician reside in the State (Federal policy calling for worldwide service), pay a substantial amount into a medical injury compensation fund (Federal policy provides for medical injury compensation under Federal statutes), or maintain private malpractice liability insurance (Federal policy provides for malpractice liability through the U.S. Treasury). Among the situations not deemed to constitute an unusual circumstance are the following:

C4.1.2.3.1. A requirement to pay the standard license fee associated with an unrestricted license is not deemed an unusual circumstance and does not provide a basis to justify use of the waiver.

C4.1.2.3.2. In any case in which a physician holds a restricted license in more than one State and a waiver is not authorized for at least one of the restricted licenses (even if the waiver is authorized for at least one of the licenses), the physician is not eligible for a waiver. For example, if a physician has two State licenses, one with restrictions that would be removed through the payment of the standard license fee (see subparagraph C4.1.2.3.1., above) and one in a State listed in subparagraph C4.1.2.5. for which a waiver is authorized, the physician must obtain an unrestricted license in the first State by paying the standard license renewal fee. There are no unusual circumstances justifying use of the waiver authority in this example. The question has

arisen as to whether a waiver may be granted in this circumstance if the physician surrenders all licenses, except for the limited scope license in a State for which a waiver is granted. Physicians should not terminate a license just to avoid paying the fee for an unrestricted license. Some physicians may have legitimate reasons for surrendering multiple State licenses, which coincidentally make them eligible for a waiver.

C4.1.2.3.3. A physician's duties in a particular position being entirely administrative in nature and not involving the provision of patient care is not considered an unusual circumstance and thus does not provide a basis to justify use of the waiver.

C4.1.2.4. Waiver consideration is a two-step process.

C4.1.2.4.1. Step 1. The ASD(HA) shall determine, based on a review of a State's licensure requirements, that the standards outlined in subparagraphs C4.1.2.2. and C4.1.2.3., above, are met and identify the particular State administrative or financial requirements that may be considered for waiver. Requests for this determination may be made by a Surgeon General.

C4.1.2.4.2. Step 2. Individual healthcare practitioners who do not hold a full scope license in any State, but who hold a limited scope license in a State for which a waiver may be considered based on the step one determination may request a waiver from the Surgeon General of the Service involved. The request must include a justification for the waiver in the case of the individual physician. A waiver shall not be granted for longer than the applicable time period of licensure; a subsequent licensure renewal would require a new waiver. The Surgeons General shall submit to the ASD(HA) an annual account of the waivers granted and the applicable justifications.

C4.1.2.5. Waivers for Physicians. The following paragraphs indicate the status of respective State laws at the time of publication of this Regulation. Current State statutes should be consulted to ensure that there have been no intervening changes. The requirement for an "unrestricted license that is not subject to limitation on the scope of practice ordinarily granted" by the State may be waived for individual physicians who do not hold a full scope license, but who hold one of the following licenses:

C4.1.2.5.1. Colorado. Colorado requires every physician who holds or desires to obtain a Colorado medical license must maintain a certain level of professional liability coverage. A Federal civilian or military physician whose practice is limited solely to that required by his/her Federal/Military Agency is exempted from this requirement. Although the exclusive practice provision is a limitation on the scope

of practice, the requirement for an unrestricted license may be waived for a physician who obtains a Colorado license in a licensure category that exempts the physician from professional liability coverage. This requirement is unrelated to clinical competency and is inharmonious with Federal policy, under which professional liability is managed under the Federal Tort Claims Act (reference (c)).

C4.1.2.5.2. Florida. Florida requires that most physicians as a condition of licensure maintain a certain level of professional liability coverage and that all physicians contribute to the birth-related Neurological Injury Compensation Association (NICA), but exempt from this requirement physicians who practice "exclusively" as an officer or employee of the Federal Government. Although the exclusive practice provision is a limitation on the scope of practice, the requirement for an unrestricted license may be waived for a physician who obtains a Florida license in a licensure category that exempts the physician from the professional liability coverage and payment into the NICA risk pool requirement. The requirement is unrelated to clinical competency and is inharmonious with Federal policy, under which professional liability is managed under reference (c).

C4.1.2.5.3. Kansas. Kansas maintains a physician licensure category called a "federally active license," which requires compliance with all generally applicable State licensing requirements, except requirements for professional liability insurance and contributions to the State healthcare stabilization fund, and which limits licensees to practice in connection with official duties. Although this licensure category includes limits on the scope of practice, the requirement for an unrestricted license may be waived for a physician who obtains a Kansas "federally active license." This licensure category deviates from no standards pertaining to clinical competency and merely recognizes that the liability requirements are inharmonious with Federal policy, under which professional liability is managed under reference (c).

C4.1.2.5.4. Massachusetts. Massachusetts requires Massachusetts licensees who render any direct or indirect patient care in Massachusetts to maintain a certain level of professional malpractice liability insurance coverage, but exempts categories of licensees who do not provide direct or indirect patient care in Massachusetts or who do so only on behalf of Federal healthcare facilities. Although these licensure categories include limits on the scope of practice, the requirement for an unrestricted license may be waived for a physician who obtains a Massachusetts license in such licensure categories. These licensure categories deviate from no standards pertaining to clinical competency. The Massachusetts policy of exempting military physicians from the malpractice insurance requirement recognizes that the requirement is inharmonious with Federal policy, under which professional liability is managed under reference (c).

C4.1.2.5.5. Oregon. Oregon includes a licensure category called an "active military license," which is comparable to the generally issued "active" license, except that a military physician is exempt from the requirement to maintain an actual physician presence and medical practice in Oregon. The "active military license," however, limits the licensee to practice in connection with military duties. Although these licensure categories include limits on the scope of practice, the requirement for an unrestricted license may be waived for a physician who obtains an Oregon "active military license." This licensure category deviates from no standards pertaining to clinical competency and merely recognizes that Oregon's generally applicable physical presence requirement is inharmonious with Federal policy, which requires of military physicians worldwide requirements.

C4.1.2.5.6. Pennsylvania. Pennsylvania requires that in order to practice medicine "in the Commonwealth" of Pennsylvania, a physician must maintain, at the risk of revocation of license, particular levels of professional liability coverage and participate in a State liability contingency fund, Medical Professional Liability Catastrophe Loss Fund. These requirements are inapplicable to Federal medical personnel discharging official duties. When these requirements must be met before a physician may practice medicine other than in connection with official duties without risking license revocation, they reflect a limitation on the scope of practice. This limitation may be waived. The requirements for professional liability coverage and participation in the State liability contingency fund are unrelated to clinical competency and inharmonious with Federal policy, under which professional liability is managed under reference (c).

C4.1.2.6. Waivers for Physician Assistants (PAs). Given the unusual circumstances that require a PA and his or her supervising physician to be licensed in the same State, the ASD(HA) has exercised his authority to waive the license requirement for PAs who meet the criteria in subparagraphs C4.1.2.6.1. through C4.1.2.6.4. Since these are the identical criteria reviewed to determine if privileges are initially granted or renewed, any PA who has been granted privileges within the MHS by an authorized privileging authority shall be automatically granted a waiver. The waiver shall be documented in the CCQAS, with the date of the waiver reflecting the date that privileges were granted. At the time of privilege renewal, the criteria shall be reviewed again. If the criteria are not met, the waiver lapses, the request for renewal of privileges is withdrawn, and the individual must practice under a plan of supervision until such time as the criteria can be met. If the criteria are met, the waiver should automatically renew. If privileges are then renewed by the privileging authority, the waiver in the CCQAS shall be updated to reflect the date of the approved privileges. If for any reason the privileges are not approved by the privileging authority, the waiver

shall lapse, and the appropriate procedures for an adverse privileging action shall be initiated. A PA shall provide care under a formal plan of supervision unless he or she possesses both a waiver and clinical privileges. Monitoring for compliance with this process shall be via the standard unlicensed provider report in the CCQAS. This waiver is applicable to any MHS PA who is a member of a Uniformed Service (Active or Reserve), a civilian employee, a personal services contractor, or an authorized volunteer. It is not applicable to non-personal services contract personnel. The waiver criteria for qualified MHS PAs (including Reserve component PAs) are as follows:

C4.1.2.6.1. Has successfully completed an educational program for physician assistants accredited by the Accreditation Review Commission on Education for the Physician Assistant or, prior to 2001, by either the Committee on Allied Health Education and Accreditation, the Commission on Accreditation of Allied Health Education Programs;

C4.1.2.6.2. Has passed the PA National Certifying Examination administered by the National Commission on Certification of PAs;

C4.1.2.6.3. Has accumulated 100 approved hours of Continuing Medical Education every 2 years (after initial certification); and

C4.1.2.6.4. Achieves recertification with the National Commission on Certification of PAs every 6 years (after initial certification).

C4.1.2.7. Waivers For Other Categories of Healthcare Practitioners. The ASD(HA) shall establish waiver procedures for other categories of healthcare practitioners, as appropriate.

C4.2. PORTABILITY OF STATE LICENSURE FOR HEALTHCARE PROFESSIONALS

C4.2.1. General Provisions

C4.2.1.1. As directed by 10 U.S.C. 1094(d) (reference (d)), notwithstanding any State law regarding the licensure of healthcare professionals, a licensed healthcare professional who is a member of the Armed Forces may practice the member's profession in any State, regardless of whether the practice occurs in a healthcare facility of the Department of Defense, healthcare facility of the Veterans Administration, a civilian facility affiliated with the Department of Defense, or any other authorized location as long as the individual is practicing within the scope of Federal duties.

C4.2.1.2. The Military Departments and MHS officials responsible shall, prior to assigning licensed providers to off-base duties, follow the procedures established in this section to promote cooperation and good will with State licensing boards.

C4.2.2. Qualifications. To be eligible for assignment of off-base duties, the active duty healthcare professional shall have the following qualifications:

C4.2.2.1. The healthcare professional shall have a current, valid, and unrestricted license or other authorizing document such as certificate or registration, consistent with the requirements of this Chapter, which encompasses the professional activities involved in the off-base duty assignment.

C4.2.2.2. A healthcare professional shall not be assigned to off-base duties if there is an unresolved allegation which, if substantiated, would result in an adverse licensing or privileging action.

C4.2.2.3. The healthcare professional shall have current clinical competence to perform the professional duties assigned.

C4.2.2.4. In the case of physicians and other privileged providers, the healthcare professional shall have current clinical privileges granted and maintained in accordance with this Chapter, which encompass the professional duties assigned. Alternatively, if such duties are outside the scope of clinical privileges granted by the applicable privileging authority, the provider shall have clinical competence sufficient for such privileges.

C4.2.2.5. In the case of physicians, the following additional qualification requirements apply:

C4.2.2.5.1. The physician shall have completed at least 3 years of approved postgraduate training (including completion of PGY-3) or have achieved American Board of Medical Specialties (ABMS) or AOA specialty board certification.

C4.2.2.5.2. The physician shall have maintained current competence, in that if 10 years or more have passed since completion of the licensing examination, the physician must have ABMS/AOA specialty board certification.

C4.2.2.5.3. The physician shall be current with applicable continuing medical education requirements under the system established pursuant to 10 U.S.C. 1094a (reference (d)).

Department of the Army
Pamphlet 40–11

Medical Services

Preventive Medicine

Rapid Action Revision (RAR) Issue Date: 19 October 2009

Headquarters
Department of the Army
Washington, DC
22 July 2005

TAB J

UNCLASSIFIED

SUMMARY of CHANGE

DA PAM 40-11
Preventive Medicine

This rapid action revision, dated 19 October 2009--

- Identifies the Army public health nurse role in the behavioral health aspect of suicide prevention (para 7-2*f*(4)).
- Incorporates common Army terms and definitions for suicide prevention (paras 7-23*c*(1) through (4)).
- Identifies the installation Community Health Promotion Council as the lead coordinating agency for suicide prevention training on an installation (para 7-23*f*(1)).
- Makes additional rapid action revision changes (throughout).

Headquarters
Department of the Army
Washington, DC
22 July 2005

*Department of the Army Pamphlet 40–11

Medical Services

Preventive Medicine

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:

JOYCE E. MORROW
Administrative Assistant to the Secretary of the Army

History. This publication is a rapid action revision (RAR). This RAR is effective 19 October 2009. The portions affected by this RAR are listed in the summary of change.

Summary. This pamphlet defines and establishes programs, services, functions, and procedures for implementing the essential elements of Army preventive medicine; it is to be used with AR 40–5.

Applicability. This pamphlet applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated.

Proponent and exception authority. The proponent of this pamphlet is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this pamphlet that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this pamphlet by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA, The Surgeon General (DASG–PPM–NCR), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. This publication is available in electronic media only and is intended for command level C for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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Glossary

Chapter 1
Introduction

1–1. Purpose

The purposes of this pamphlet are to—

a. Define the programs and services within the medical functional area of preventive medicine.

b. Identify Army publications that delineate functions and contain the detailed instructions, guidance, and procedures necessary for implementing the policies and responsibilities outlined in Army Regulation (AR) 40–5.

c. Provide detailed preventive medicine functions, instructions, guidance, and procedures not published in other Army documents.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this pamphlet are explained in the glossary.

1–4. Background

a. Army preventive medicine includes a broad set of capabilities, ranging from basic field sanitation techniques to comprehensive medical, behavioral health, and occupational and environmental health (OEH) exposure surveillance systems and procedures. These capabilities are focused on the medical readiness of the force to combat health threats across the full spectrum of military operations in the continental U.S. (CONUS) and outside the continental U.S. (OCONUS). They are also designed to promote and maintain the health and well-being of all personnel for whom the Army is responsible.

b. Army preventive medicine directly supports two of the three pillars of the Joint strategy for Force Health Protection (FHP), as described in the Joint capstone document, Force Health Protection - Healthy and Fit Force, Casualty Prevention, Casualty Care and Management (http://www.dtic.mil/jcs/j4/organization/hssd/hssd.htm).

(1) The first pillar of the Joint strategy, a healthy and fit force, is the necessary pre-condition for all other elements of FHP. Healthy and fit personnel are more resistant to disease, less prone to injury and the influence of stress, and better able to quickly recover should illness or injury occur. The process of creating a healthy and fit force begins at entry to service and continues through an individual's time in service.

(2) The second pillar of the Joint strategy for FHP, casualty prevention, protects the healthy and fit Service member from occupational, environmental, and operational threats of disease and non-battle injury (DNBI). The sustainment of health and performance is essential throughout a Service member's entire time in service, especially during pre-deployment, deployment, and post-deployment phases.

(3) The concept that a healthy and fit force and casualty prevention are the responsibility of both commanders and individual Service members is an essential element of the Joint FHP strategy.

(4) Part of the mission statement of the U.S. Army Medical Department (AMEDD) is to project and sustain a healthy and medically protected force.

c. The goals of Army preventive medicine are—

(1) To ensure that deployable military forces in CONUS and OCONUS are in a state of optimal health and fitness, trained and equipped to protect themselves from DNBI.

(2) To sustain the health and fitness of forces deployed in CONUS and OCONUS and prevent casualties from DNBI.

(3) To ensure that Army units and personnel are trained, equipped, and capable of supporting the preventive medicine requirements of our forces across the full spectrum of military operations, CONUS, and OCONUS.

(4) To prevent and mitigate injuries and illnesses, improving and maintaining the health of all Army personnel, as defined in AR 40–5.

(5) To reduce the Army's medically related costs, in part by reducing demand for the more costly and less effective tertiary treatment services.

(6) To minimize the risks of long-term adverse health effects of military service.

d. The term "Army personnel" used throughout this pamphlet has a broad definition and includes uniform and civilian personnel in all components. See the glossary for the complete definition of "Army personnel" as the term is used in this pamphlet.

e. For National Guard personnel—

(1) Each state/territory and the District of Columbia are considered separate installations. The National Guard State Adjutant General is the installation commander.

(2) The term "occupational health clinic" used in this pamphlet translates to "occupational health program," since

each National Guard state/territory does not operate occupational health clinics but rather administers and manages a statewide occupational health program.

1–5. Programs and services

a. Army preventive medicine consists of a broad scope of clinical, installation, and field public health programs and services applied in a wide range of military settings. These specific programs and services include—

(1) Disease prevention and control.

(2) Field preventive medicine.

(3) Environmental health.

(4) Occupational health.

(5) Health surveillance and epidemiology.

(6) Soldier, Family, community health, and health promotion.

(7) Preventive medicine toxicology.

(8) Preventive medicine laboratory services.

(9) Health risk assessment.

(10) Health risk communication.

b. A brief discussion of each of the Army preventive medicine programs and services is provided in AR 40–5, paragraph 1–7, and at the beginning of each chapter in this pamphlet.

1–6. Planning, programming, budgeting, and executing preventive medicine resources

a. The Army mission, goals, and objectives drive resource requirements for dollars and personnel. The Army identifies and articulates its resource requirements to the Department of Defense (DOD) through the DOD's Planning, Programming, and Budgeting System and the Army's Planning, Programming, Budgeting, and Execution System (AR 1–1).

b. Knowledge and application of the principles of obtaining and executing resources through the Army's Planning, Programming, Budgeting, and Execution System are essential skills for Army public health personnel. Without such skills, Army public health personnel responsible and accountable for obtaining and executing resources will not be able to perform those functions.

c. The Army Management Structure is the official Army framework for interrelating programming, budgeting, accounting, and manpower control through a standard classification of all Army activities and functions. The Defense Finance and Accounting Service (DFAS)-Indianapolis Center (IN) Manual 37–100–FY, published annually, is the fiscal code manual that provides the coding structure for a wide variety of Army and DFAS users.

d. The first level of detail in the coding structure defined by DFAS–IN Manual 37–100–FY consists of 11 major programs for which the DOD programs resources by fiscal year (FY). A subset of the many program elements in Program 8 (Training, Medical, and other General Personnel Activities) reflects the various medical support missions of DOD and the resources related to those missions. The Army preventive medicine programs and services receive resources through the Congressional appropriations for the Operations and Maintenance, Army account; the Army Working Capital Fund; and the Defense Health Program (DHP).

(1) Military Public/Occupational Health is the medical program element in the DHP through which Army preventive medicine programs and services are provided resources. The program element code (also known as an Army Management Structure Code or AMSCO) for Military Public/Occupational Health is 847705. The definition of the Military Public/Occupational Health program element 847705 is provided in the DHP section of the DFAS–IN Manual 37–100–FY chapter on Office of the Secretary of Defense (OSD), DOD, and Other Agency Accounts.

(2) The DHP section of the DFAS–IN Manual 37–100–FY chapter on OSD, DOD, and Other Agency Accounts also breaks down the 847705 program element into an extensive list of subactivities or functions that are identified in the program element code by two-digit decimal numbers added to 847705. For example, Hearing Conservation is identified as 847705.24 and Environmental Health Engineering as 847705.30.

e. The AMEDD articulates medical funding requirements through the DHP Program Objective Memorandum process, managed by the Office of the Assistant Secretary of Defense for Health Affairs or OASD(HA). Funding for the DHP is provided from DOD through OASD(HA) directly to the services' medical departments.

f. A preventive medicine resource model exists to assist in determining local resource requirements. The model is a predictive, population-based and geographically based model of local mission requirements. The model relies on regulations, laws, and strategic and command guidance to identify the preventive medicine functions and tasks that must be performed. A series of formulas, relating to the functions and tasks, is used to estimate the dollars and personnel required to complete the preventive medicine mission.

g. Preventive medicine resource requirements and allocated funds are to be described and documented locally using the DHP activity structure and codes in DFAS–IN Manual 37–100–FY. The activity structure and codes provide a

consistent structure for preventive medicine budget execution tracking and program analysis and review across the AMEDD.

Chapter 2
Disease Prevention and Control

Section I
Communicable Disease Prevention and Control

2–1. Introduction

Communicable diseases can rapidly degrade the medical readiness of military units and their ability to carry out their mission. Communicable diseases can also cause significant suffering and excess utilization of military health care services among the beneficiary population. The prevention and control of communicable diseases are conducted according to policies, directives, and instructions from The Surgeon General (TSG); AR 40–5; AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E; or Technical Manual (TM) 4–02.33.

2–2. Functions

The following functions and those outlined in paragraphs 2–3 through 2–11 are necessary for the prevention and control of communicable disease as required by AR 40–5. The organization and function to support programs and services under each general topic will vary by installation based on the population served, the mission of the installation or organization, and the supporting preventive and non-preventive medicine assets.

a. TSG, through the Functional Proponent for Preventive Medicine, develops and publishes policies, procedures, and guidance for the prevention and control of communicable diseases.

b. Commanders—

(1) Provide manpower, training, resources, personal protective equipment, supplies, and facilities necessary to implement required disease preventive and control measures.

(2) Validate that all eligible personnel comply with prescribed individual protective measures.

(3) Comply with immunization requirements in AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E and command policy specified in AR 600–20.

(4) Maintain copies of current policy and guidance on disease prevention and control.

c. Medical commanders—

(1) Identify potential disease and environmental threats based on epidemiological information, intelligence, and knowledge of military activities.

(2) Recommend individual protective measures and environmental control measures to the commands they support based on the health threat assessment.

(3) Conduct medical surveillance of individuals and units operating in environments where the threat of serious disease or occupational and environmental injury or illness is present.

(4) Conduct epidemiological investigations of suspected disease outbreaks or disease occurrences capable of reducing military effectiveness or readiness.

(5) Report unusual occurrences of diseases or environmental health problems to appropriate commanders so corrective action can be taken immediately.

d. Preventive medicine organizations and personnel—

(1) Maintain knowledge of current disease prevention and control policies, procedures, and techniques.

(2) Advise commanders, units, and individuals on the prevention and control of communicable diseases.

(3) Advise units on disease and environmental threats, specific preventive measures, and medical surveillance before, during, and following deployments.

(4) Conduct outbreak investigations and contact tracing as appropriate for communicable diseases.

e. Individuals—

(1) Implement all preventive measures directed by command authorities.

(2) Avoid unnecessary exposure to infectious agents, hosts, or vectors of disease.

(3) Practice good personal hygiene.

2–3. Immunization and chemoprophylaxis

a. Immunization and chemoprophylaxis are provided according to the policies and procedures in AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E or as directed by TSG.

b. Immunization requirements for Active and Reserve Component personnel contained in AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E, or as directed by TSG, take precedence over guidance provided

by the U.S. Public Health Service (USPHS) or the Centers for Disease Control and Prevention (CDC), Atlanta, Georgia.

c. Immunization requirements for civilian beneficiaries will be consistent with Department of the Army (DA) policies and with the immunization requirements for the general population according to the USPHS or the CDC. USPHS or CDC recommendations may be supplemented by guidance from TSG.

2–4. Acute respiratory disease

Acute respiratory disease (ARD) can result in considerable resources lost due to morbidity from various infectious agents and their high transmission potential. Agents of greatest military significance are: influenza, parainfluenza, adenoviruses, streptococcal infections, and mycoplasma infections. Other viral and bacterial agents are capable of causing ARD. Appendix B provides detailed background information, definitions, outbreak investigation procedures, and additional ARD surveillance guidance.

a. ARD surveillance for all trainees at basic training installation.

(1) TSG determines the need for penicillin (benzathine penicillin G) prophylaxis to protect against the occurrence of virulent streptococcal disease. Following each respiratory disease season (no later than 30 June of each year), the Office of The Surgeon General (OTSG) will review and validate on an installation-by-installation basis whether penicillin prophylaxis continues to be required. This review will be conducted in coordination with the U.S. Army Training and Doctrine Command (TRADOC) Surgeon and appropriate representatives from the supporting military treatment facilities (MTFs).

(2) Medical commanders—

(a) Monitor and provide ARD rates among all trainees to appropriate higher headquarters. See appendix B for guidance.

(b) Monitor Group A streptococcal infections among all trainees, directing particular attention to changes in throat culture recovery rates and the presence of rheumatogenic strains of Group A streptococcal organisms.

(c) Administer influenza and adenovirus immunizations to recruits according to AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E.

(3) The installation/division commander implements non-vaccine-related procedures as recommended by TSG to control ARD outbreaks. These may include increasing space requirements, implementing hand-washing policies, or altering heating, ventilation, and air-conditioning air exchanges.

(4) An OTSG memorandum published on the Armed Forces Health Surveillance Center (AFHSC) Web site at http://afhsc.army.mil/documents.asp#army) provides detailed guidance on ARD surveillance. Guidance includes reporting procedures at basic combat training installations and frequency, data elements, format, instructions, and examples for weekly reporting from basic trainee installations using the AFHSC software.

b. ARD surveillance at non-basic training installations.

(1) The medical commander supporting the installation implements, in coordination with the installation and mission commanders, surveillance procedures to detect unusual outbreaks of ARDs, to include coordination with preventive medicine, clinics and emergency rooms and monitoring of overall rates of school or work absenteeism.

(2) Medical commanders—

(a) Administer influenza vaccine to active-duty Soldiers, civilian employees, Family members, and retirees per AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E and TSG guidance.

(b) Implement any new surveillance or immunization program directed by TSG.

2–5. Meningococcal infection

a. Meningococcal vaccine is routinely administered year-round to basic trainees, individuals with theater-specific disease risk and to selective beneficiary populations based on CDC recommendations.

b. TSG defines settings, other than the recruit-training environment, where meningococcal vaccine should be routinely administered.

c. Unit and command surgeons and medical commanders—

(1) Maintain knowledge of the current requirements for immunization and chemoprophylaxis specified in AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E, paragraphs 35 and 44.

(2) Report promptly meningococcal infections using the Reportable Medical Events System (RMES) at the AFHSC Web site: http://afhsc.army.mil/documents.asp#army. See paragraph 6–12.

(3) Submit all Neisseria meningitidis specimens to the Walter Reed Army Institute of Research, Division of Communicable Diseases and Immunology, Department of Bacterial Diseases, Building 503, Room 3A24, Forest Glen, Maryland, with patient status information included. Notify the Department of Bacterial Diseases prior to sample shipment.

(4) Coordinate with civilian public health authorities on contact investigations, chemoprophylaxis recommendations and risk communication during an outbreak affecting both DOD and non-beneficiary populations.

d. Appendix B contains a decision support matrix to assist in determining appropriate courses of action in the event of one or more cases of meningoccocal infection.

2–6. Malaria

a. Malaria chemoprophylaxis is instituted when personnel are at risk of contracting malaria. Chemoprophylactic measures are implemented to protect Soldiers against all types of malaria known to be in the area of operations.

b. TSG develops and publishes guidance on the most appropriate malarial chemoprophylactic medication. Specific drugs to be used are based on current drug resistance patterns and the prevalence of specific types of malaria in the theater of operations or in the area of anticipated travel. Additional directive guidance is provided in AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E, paragraph 45. Combatant command surgeons establish policy and vaccination requirements for personnel deploying into the command's area of responsibility.

c. Commanders—

(1) Train all their personnel in malaria prevention, including personal protective measures and the need to seek medical attention should they experience any febrile illnesses during or following assignment in malarious areas.

(2) Enforce appropriate chemoprophylaxis before, during, and following periods of travel to malarious areas.

(3) Enforce the use of personal protective measures to include military-approved skin and clothing repellents, the use of bed netting, and the proper wear of uniforms.

(4) Ensure an adequate supply and serviceability of personal protective equipment such as bed nets, skin repellents, and clothing repellents.

d. Unit and command surgeons and medical commanders report any suspected or confirmed cases of malaria using the RMES.

e. Unit field sanitation teams (FSTs) recommend vector control measures to unit leadership and implement countermeasures at the company level and below.

f. Preventive medicine assets provide disease and vector surveillance, recommend personal and collective protective measures, and establish additional mosquito control measures during deployment if necessary.

2–7. Viral hepatitis

A hepatitis prevention and control program is designed and implemented to prevent infection and spread of viral hepatitis by—

a. Immunizing with hepatitis A and hepatitis B vaccine as required. Command monitoring and enforcement of immunization of military personnel against hepatitis A and B are essential to the prevention and control of hepatitis.

(1) Immunize with hepatitis A vaccine according to AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E and TSG guidance. If the hepatitis A vaccine is contraindicated or unavailable, administer immune globulin to personnel considered to be at risk of contracting hepatitis A.

(2) Immunize all new accessions with hepatitis B vaccine (AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E).

(3) Immunize all active-duty AMEDD personnel and other people considered to be at risk of contracting hepatitis B (AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E). Those at risk include health care workers and all individuals with occupational exposure to blood and body fluids in their regular duties, spouses or sexual contacts of hepatitis B carriers, newborns of hepatitis B carrier mothers, and close contacts of persons known to be infected with the hepatitis B virus and other individuals or populations as listed by the CDC.

(4) Immunize Army personnel against hepatitis B prior to permanent change of station (PCS) moves to the Republic of Korea. Completion of the series or, at a minimum, the first two doses will be achieved prior to the PCS.

(5) Immunize other military personnel considered to be at risk of contracting hepatitis B infection, such as selected Special Forces personnel.

b. Using command emphasis to ensure that unit personnel receive appropriate training and information on the prevention and control of hepatitis, especially on the principles of good personal hygiene and sanitation (hepatitis A); proper preparation and storage of foods (hepatitis A); importance of safe and clean drinking water (hepatitis A); safer sex practices (hepatitis B and C); and, for those occupationally exposed to blood or body fluids, appropriate personal protective equipment (hepatitis B and C) (Title 29, Code of Federal Regulations (CFR), part 1910.1030).

c. Performing prenatal screening for the presence of hepatitis B surface antigen.

d. Screening donated blood for the presence of hepatitis B virus and hepatitis C, and performing other screening procedures recommended by the American Association of Blood Banks. Suspected contaminated blood units must be removed from the inventory. (See appendix B.)

e. Performing medical evaluation and counseling of all suspected and confirmed cases of hepatitis, to include acutely ill individuals and chronically infected persons.

f. Conducting an epidemiological investigation on all cases of viral hepatitis.

g. Reporting all cases of acute hepatitis using the RMES.

h. Implementing a program to manage individuals with a bloodborne pathogen exposure consistent with current CDC guidelines.

i. Screening for hepatitis C virus according to CDC guidelines and TSG guidance (AR 40–501).

2–8. Sexually transmitted diseases

a. Successful prevention and control of sexually transmitted diseases (STDs/sexually transmitted infections (STIs)) requires the following:

(1) Accurate diagnosis and appropriate treatment of infected persons and their sexual partners.

(2) Personal interviews and epidemiological contact investigation.

(3) Active surveillance at the installation level.

(4) Health education directed at all sectors of the military community.

(5) Reporting of STD/STIs through the RMES as soon as possible after diagnosis.

b. The success of STD/STI prevention and control in the military is also contingent on a satisfactory working relationship with civilian public health authorities. A cooperative atmosphere with local, county, and state health offices involved in STD/STI prevention and control is encouraged.

c. At the installation level, STD/STI prevention and control efforts include appropriate therapy and follow-up, disease intervention, identification of locations where a high level of STD/STI transmission may occur, and community and unit health education. Centralization of diagnostic efforts, interviewing, counseling, and treatment procedures are ideal and lend themselves to better quality control and maintenance of patient confidentiality. The STD/STI case interviews, contact investigations, and education should be conducted by a designated disease intervention specialist or public health nurse (PHN). A disease intervention specialist is an individual who has attended the Sexually Transmitted Disease Intervention Course (6H–F9/322–F9) at the AMEDD Center and School (AMEDDC&S) or other comparable civilian training.

d. Unit health education classes are strongly encouraged and should be incorporated with human immunodeficiency virus (HIV) education efforts and classes on personal hygiene whenever possible.

e. Army STD/STI control programs will adhere to guidance published by the CDC on screening procedures, treatment, follow-up and prevention strategies. The current preferred treatment regimens are outlined in the latest edition of the CDC Sexually Transmitted Diseases Treatment Guidelines. Guidance provided by TSG on the recommended treatment for uncomplicated gonorrhea and other STD/STIs takes precedence over CDC guidelines.

f. Sexually transmitted disease information and statistics should not be used to compile indices of unit morale or integrity or commander efficiency.

g. The release of medical information concerning persons who have been diagnosed with an STD/STI will be based on applicable laws and regulations. This applies to the reporting of STD/STIs to state and/or local public health authorities in CONUS locations. Civilian contacts of DOD beneficiaries infected with an STD/STI will be determined and reported through medical channels to local public health departments.

h. A screening program implemented in accordance with CDC guidelines to detect chlamydia and gonococcal infections in military personnel is a cost-effective approach in protecting the health of Soldiers.

(1) Medical commanders should have a plan in place to conduct chlamydia screening of all female military Service members up until the age of 25 years during their annual routine Papanicolaou smear screening pelvic examinations.

(2) Male and female Service members of any age should be tested for chlamydia infection during appropriate medical encounters as clinically indicated by symptoms or risk factors for STD/STI.

i. The Army conducts an HIV surveillance program as prescribed in AR 600–110. Medical commanders establish programs to offer post-exposure chemoprophylaxis and appropriate laboratory testing for all individuals exposed to blood or body fluids potentially infected with HIV. Programs should be consistent with current CDC recommendations. Other requirements for potential occupational exposure to HIV are found in 29 CFR 1910.1030.

2–9. Rabies

a. Rabies prevention and control includes pre- and post-exposure prophylaxis, stray animal control efforts, surveillance of animal rabies in domestic and wild animal populations, and community health education.

b. Medical commanders—

(1) Designate a Rabies Advisory Team/Board consisting of at least two qualified physicians (usually one physician is the preventive medicine medical officer) and one veterinarian. Although the incidence is low, rabies is almost 100 percent fatal; therefore, medical authorities involved in rabies prevention and control efforts should carefully evaluate each bite incident.

(2) Ensure rabies pre-exposure and post-exposure vaccination series are based on guidance in AR 40–562/AFJI 48–110/BUMEDINST 6230.15/CG COMDTINST M6230.4E, TSG guidance, and current U.S. Preventive Services Task Force (USPSTF) Advisory Committee on Immunization Practices (ACIP) recommendations (http://www.cdc.gov/vaccines/pubs/ACIP-list.htm).

(3) Report any cases of human rabies using RMES.

c. Attending physicians—

(1) Prepare animal bite incident reports on every domestic and wild animal bite or suspected rabies exposure using DD Form 2341 (Report of Animal Bite – Potential Rabies Exposure) as prescribed in AR 40–905/SECNAVINST 6401.1A/ARI 48–131.

(2) Consult with a physician member of the Rabies Advisory Board whenever contemplating the use of rabies post-exposure prophylaxis in accordance with current ACIP guidelines.

d. The responsible veterinarian—

(1) Reviews all new animal bite incident reports each duty day and coordinates with the animal owner and local authorities to have the animal examined/quarantined or euthanized and examined according to AR 40–905/SECNAVINST 6401.1A/ARI 48–131.

(2) Provides recommendation to Rabies Advisory Board physician(s) and the treating physician on the risk of rabies from an animal bite incident.

(3) Completes veterinary section of DD Form 2341 and forwards it to the chief, preventive medicine service.

e. Chief, preventive medicine service—

(1) Provides DD Forms 2341 to the attending physicians and tracks the status of each form.

(2) Reviews all new animal bite incident reports each duty day and coordinates with the veterinary service to identify the status of the biting animal.

(3) Identifies and coordinates rabies post-exposure prophylaxis under ACIP guidelines for all individuals exposed to an animal which has a high risk of being rabid.

(4) Ensures that the Rabies Advisory Board has reviewed and provided guidance for all bite incidents in which the biting animal is not caught, quarantined, and tested to be free of rabies.

(5) Monitors patients started on rabies post-exposure prophylaxis to ensure that they complete the series.

(6) Ensures that the chairman, Rabies Advisory Board, and the chief, preventive medicine service sections of DD Form 2341 are completed.

(7) Maintains a copy of the completed DD Form 2341 and ensures the form is filed according to AR 40–66.

(8) Coordinates rabies pre-exposure prophylaxis for personnel who have potential for exposure to rabies as part of their DOD occupation.

f. The preventive medicine staff and the veterinarian coordinate evaluation and approval of animals in child development centers and Family child care center homes identifying permitted species and breeds and required animal immunizations.

2–10. Tuberculosis

a. Introduction. The purpose of tuberculosis surveillance and control is to prevent active tuberculosis cases through the identification and treatment of persons with latent tuberculosis infection (LTBI).

b. Functions. Following are the functions related to tuberculosis surveillance and control.

(1) Tuberculosis surveillance and control is conducted by the preventive medicine service; overseen by the chief, preventive medicine; and managed by the chief, Army public health nursing.

(2) The chief, preventive medicine, or a designated physician, initially evaluates individual patients with LTBI and prescribes appropriate chemoprophylaxis. Public health nurses meeting the requirement to be individually credentialed as advanced nurse clinicians may also be granted privileges to initiate LTBI chemoprophylaxis.

(3) Staff PHNs are authorized to refill isoniazid and pyridoxine via specific medical protocols approved by the chief, preventive medicine, or other designated physician. Management of pediatric LTBI patients is determined by the individual MTF based on coordination among the chief, preventive medicine; the chief, Army public health nursing; and the chief, pediatrics/Family practice and/or the child's primary care manager.

c. Additional guidance. Appendix C provides additional guidance on testing, evaluation, treatment of LTBI, documentation, and coding.

2–11. Biowarfare threat

a. Preparation to respond to single or multiple cases of illness that may represent the use of biowarfare agents is a key element of FHP. The CDC publishes a list of the major threats of concern; other activities within DOD update the threat list as needed. Preparation for and response to a potential use of biowarfare agents is and must remain a high priority for commanders at all levels.

b. Preventive medicine capabilities that are likely to be critical in any response to a potential or actual use of biowarfare agents include—

(1) *Case detection.* Potential detectors of sentinel events include astute clinicians, information systems that analyze morbidity occurrence, and environmental detectors of threat agents. Various systems are under development to lower the threshold of detecting the use of biowarfare agents. Educational efforts must target health care providers to ensure they are knowledgeable of the signs and symptoms of the illnesses caused by the use of biowarfare agents. MTFs must maintain a high state of alertness to detect and immediately report any cases of potential use of biowarfare agents.

(2) *Case confirmation.* Case confirmation will likely rely on laboratory capabilities at appropriate Laboratory Response Network facilities. MTFs will assure that laboratory diagnostic support is defined and available for biowarfare agents high on the applicable threat list.

(3) *Case surveillance.* Surveillance to ascertain all cases will be critical to define the immediate and evolving scope of any attack.

(4) *Investigation to determine the source of the outbreak.* An investigation to determine the "who, what, where, and when" of early cases will help decision makers in identifying the source of a perceived attack and identify strategies for response.

(5) *Implementation of appropriate disease control actions to limit the spread of potentially communicable diseases.* MTFs must remain knowledgeable and prepared to implement appropriate treatment and disease control actions in response to the use of biowarfare agents.

(6) *Use of effective risk communication.* In the event of the use of biowarfare agents, all members of the community will become stakeholders in a perceived crisis. The development and dissemination of appropriate, accurate, and timely health information messages directed toward specific populations (for example, Soldiers, other employees, commanders, health care workers, other beneficiaries) will be a necessary element of an effective response plan.

c. Guidance from within DOD and from TSG concerning the use of biowarfare agents and bioterrorism attack and response continues to evolve at a rapid pace. Containment of a large-scale outbreak of disease caused by the use of biowarfare agents would require a rapid, prolonged, and substantial augmentation of the public health and medical infrastructure. Local contingency plans must be established in advance, to include coordination with emergency management services, the local medical community, and state and local public health agencies.

Section II
Travel Medicine

2–12. Introduction

Travel medicine services are provided at MTFs or by referral to appropriate facilities for Army Soldiers, beneficiaries and personnel who have health concerns or requirements for travel OCONUS, PCS, or deployment. Travel medicine recommendations are based on current guidelines from CDC, the World Health Organization, TSG, Armed Forces Medical Intelligence Center (AFMIC), or other pertinent references for travel medicine.

2–13. Services

Travel medicine services include—

a. Review of medical history, travel itinerary, and other travel-related factors to determine health risks. This determination may be based on self-completed questionnaires and/or personal interview.

b. Review of the immunization and health record for overall compliance with routine immunization recommendations with a focus on travel-related immunizations.

c. Recommendations for additional screening tests (for example, serologic titers), immunizations, chemoprophylaxis, personal protective measures, and other medical advice based on the geographic location of travel.

d. Ordering of immunizations, medications, and other screening tests, as required.

e. Advice on measures to reduce travel-related health risks.

f. Medical threat briefings to Soldiers or other groups.

Section III
Population Health Management

2–14. Background

a. This section provides guidance and direction for improving the interface of preventive medicine with curative medicine, primarily in the MTF environment.

b. Population health management comprises all the objectives of preventive medicine as described in AR 40–5 and involves personnel from the entire preventive medicine community. Any health care delivery system that incorporates a population health management approach will include components of public health, health promotion, disease prevention, and primary care. In a very broad sense, a population health approach will include an examination of different determinants of health of a given population, such as the socioeconomic environment, genetic endowment, and physical environment based on a community assessment.

c. The DOD Population Health Improvement Plan and Guide describes the key process improvement elements required to effectively engage in population health management. These process elements encompass programs and services in medical surveillance, epidemiology, preventive medicine, occupational and environmental medicine, and health promotion and wellness. The major functional elements of population health management that can involve the preventive medicine community are described below.

K

Army Regulation 40–5

Medical Services

Preventive Medicine

Headquarters
Department of the Army
Washington, DC
25 May 2007

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TAB K

SUMMARY of CHANGE

AR 40-5
Preventive Medicine

This rapid action revision, dated 25 May 2007--

- Includes the definition of "deployment" from Joint Publication 1-02 and Department of Defense Instruction 6490.03 (para 1-5d).
- Introduces the 10 essential national public health services established by the American Public Health Association (para 1-6d).
- Establishes acquired immunodeficiency syndrome as a specific disease of military concern, separate from a sexually transmitted disease (para 1-7a(2)).
- Clarifies responsibilities of The Surgeon General with respect to developing medical criteria for exposure to chemical/biological/radiological/nuclear warfare agents (para 2-8b).
- Emphasizes the role of military audiologists as the managers of installation hearing clinical and conservation services (para 2-18j).
- Incorporates the change in name of the U.S. Army Safety Center to the U.S. Army Combat Readiness Center (para 2-19b(2)).
- Updates the mission parameters of the Department of Defense Serum Repository (para 2-19m).
- Adds new responsibility paragraph for the Commander, U.S. Army Medical Research and Materiel Command (para 2-24).
- Adds the following new related publications: Department of Defense Directive 5400.11 (para 2-19m), Department of Defense Regulation 4500.9-R (para 2-19x), Department of Defense Directive 5134.8 (app A, sec II), and an Institute of Medicine Report entitled Noise and Military Service: Implications for Hearing Loss and Tinnitus (app A, sec II).
- Adds definitions to the glossary for the following terms: direct reporting unit; garrison; and hearing readiness, clinical, operational, and conservation services (glossary, sec II).
- Changes "operational risk management" to "composite risk management" (throughout).
- Incorporates the name changes for Army commands, Army service component commands, and direct reporting units (throughout).

- Incorporates changes in acronyms and capitalization of words based on guidance from the U.S. Army Records Management and Declassification Agency (throughout).

This regulation is a comprehensive and substantive revision of the 1990 policy and responsibilities relating to preventive medicine. Specifically, this major revision, dated 22 July 2005--

- Redefines preventive medicine and preventive medicine services (chap 1, section II).

- Requires the incorporation of health threats into the Army's operational risk management process (chap 1, para 1-5e).

- Revises the list of the preventive medicine components of the Army Occupational Health Program (chap 1, para 1-7d).

- Incorporates the concepts of the Joint Staff's Force Health Protection strategy (chaps 1 and 2).

- Adds medical surveillance and occupational and environmental health and exposure surveillance policies and responsibilities (chaps 1 and 2).

- Incorporates measures to decrease the risk and improve the management of communicable disease outbreak on an installation (chaps 1 and 2).

- Implements Department of Defense Directive 6490.2 and Department of Defense Instruction 6490.3 policy and procedures for medical surveillance (chaps 1 and 2).

- Implements Department of Defense Instruction 6055.1 policy and procedures for ergonomics (chaps 1 and 2).

- Requires the addition of programs and services for vision conservation and readiness, deployment occupational and environmental health threat management, health risk assessment, medical and occupational and environmental health surveillance, surety programs, ergonomics, population health management, and health risk communication (chaps 1 and 2).

- Redefines responsibilities for preventive medicine programs and services (chap 2).

- Adds additional Army Secretariat and Army Staff responsibilities (chap 2).

- Incorporates the U.S. Army Medical Department Functional Proponent for Preventive Medicine and the Proponency Office for Preventive Medicine (chap 2, para 2-8b).

- Requires the use of the Reportable Medical Events System (chap 2).

- Identifies responsibilities for commanders of regional medical commands (chap 2).

- Provides guidance and responsibilities for using the Defense Health Program activity structure and codes for preventive medicine budget execution tracking and program analysis and review (chap 2).

- Establishes an installation-level ergonomics subcommittee and a vision conservation and readiness team (chap 2).

- Rescinds Requirement Control Symbol, Medical-3 (RCS MED-3) command health report requirement, DA Form 3075 (Occupational Health Daily Log), and DA Form 3076 (Army Occupational Health Report (RCS MED-20)).

- No longer prescribes DD Form 2215 (Reference Audiogram) and DD Form 2216 (Hearing Conservation Data), which are now prescribed by Department of the Army Pamphlet 40-501.

- No longer prescribes DD Form 2493-1 (Asbestos Exposure, Part I-Initial Medical Questionnaire) and DD Form 2493-2 (Asbestos Exposure, Part II-Periodic Medical Questionnaire), which are now prescribed by Department of the Army Pamphlet 40-11.

- No longer prescribes DA Form 3897-R (Tuberculosis Registry), which is now prescribed by Department of the Army Pamphlet 40-11.

- No longer prescribes DA Form 5402-R (Barber/Beauty Shop Inspection), which is now prescribed by Department of the Army Pamphlet 40-11.

- Eliminates the term "installation medical authority" and replaces it with "medical commander" throughout this regulation.

- Removes detailed roles, functions, procedural guidance, and technical standards and criteria throughout this regulation for inclusion in other appropriate Army publications.

Headquarters
Department of the Army
Washington, DC
25 May 2007

*Army Regulation 40–5

Effective 25 June 2007

Medical Services

Preventive Medicine

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:

JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision. The portions affected by this rapid action revision are highlighted in the Summary of Change.

Summary. This regulation establishes practical measures for the preservation and promotion of health and the prevention of disease and injury. This regulation implements Executive Order 12196; Department of Defense 1400.25–M; Department of Defense 6055.5–M; Department of Defense Directives 1000.3, 1010.10, 4715.1, 6000.12, 6050.16, and 6490.2; Department of Defense Instructions 1322.24, 4150.7, 6050.5, 6055.1, 6055.5, 6055.7, 6055.8, 6055.11, 6055.12, 6060.2, 6060.3, 6205.2, 6205.4, and 6490.3, and Presidential Review Directive 5.

Applicability. This regulation applies to all elements of the Army across the full spectrum of military operations from peacetime through major theater warfare. This regulation applies to all Army personnel to include the Active Army; the Army National Guard/Army National Guard of the United States and United States Army Reserve personnel on active duty or in drill status; United States Military Academy cadets; United States Army Reserve Officer Training Corps cadets, when engaged in directed training activities; foreign national military personnel assigned to Army components; and civilian personnel and nonappropriated fund personnel employed by the Army worldwide. Except for those preventive medicine services defined in Department of Defense Instruction 6055.1 for supporting Department of Defense contractor personnel during outside continental United States force deployments or specifically provided for in contracts between the Government and a contractor, this regulation does not generally apply to Army contractor personnel and contractor operations. This regulation is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulations. The proponent may delegate the approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from HQDA (DASG–PPM–NC), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG–HS), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Committee Continuance Approval. The Department of the Army Committee Management Officer concurs in the establishment of an installation-level ergonomics subcommittee.

Distribution. This publication is available in electronic media only, and is intended for command level C for the Active Army, the Army National Guard/Army National Guard of the United States, and the United States Army Reserve.

*This regulation supersedes AR 40–5, dated 22 July 2005.

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Glossary

Chapter 1
Introduction

Section I
General

1–1. Purpose

This regulation—

a. Establishes policies for preventive medicine.

b. Defines preventive medicine and directs the establishment of preventive medicine programs and services.

c. Assigns responsibilities for—

(1) Improving and sustaining health throughout the Army and across the spectrum of military operations, including joint and combined operations.

(2) Developing and implementing preventive medicine programs and services.

(3) Providing preventive medicine resources, services, and technical support.

(4) Providing preventive medicine guidance, strategy, doctrine, and oversight.

(5) Conducting comprehensive, coordinated military health surveillance activities to include medical surveillance and occupational and environmental health (OEH) surveillance for Army personnel throughout their time in service.

(6) Identifying or developing military-unique OEH standards, criteria, and guidelines.

(7) Identifying, developing, and providing military-specific force health preparedness, protection, sustainment and recovery interventions and measures.

(8) Implementing Department of Defense Directives (DODDs) and Department of Defense Instructions (DODIs), including those listed in appendix A.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

Responsibilities are listed in chapter 2.

1–5. Preventive medicine policies

The Army will—

a. Enhance and sustain optimal levels of health and fitness of all Army personnel by applying the principles of population medicine to promote health and prevent and minimize the impacts of diseases and injuries as defined in paragraph 1–7, below.

b. Protect Army personnel from potential and actual harmful exposures to chemical/biological/radiological/nuclear (CBRN) warfare agents; endemic communicable diseases; food-, water-, and vector-borne diseases; ionizing and nonionizing radiation; combat and operational stressors; heat, cold, and altitude extremes; environmental and occupational hazards; toxic industrial materials (TIMs); and other physical agents.

c. Adhere to Federal, state, and host nation laws, regulations, and guidance governing OEH during peacetime in nondeployed situations and during training exercises, except for uniquely military equipment, systems, and operations as authorized in Executive Order 12196. These statutes and regulations also apply during military operational deployments and war unless specifically exempted by appropriate authority based on the tactical situation. Contractors whose personnel are using Government-furnished facilities will similarly adhere to Federal, state, and host nation laws, regulations, and guidance governing OEH.

d. Strive to adhere to peacetime United States (U.S.) or host nation health standards, whichever are more stringent, during military operational deployments.

(1) Deployment is defined as the relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intracontinental United States, intertheater, and intratheater movement legs, staging, and holding areas (Joint Publication 1-02, definition no. 4; DODI 6490.03).

(2) When the mission or the overall health of deployed personnel warrant risk decisions that may require overriding the peacetime health standards, such decisions should be made by the first general officer (or colonel frocked to the grade of brigadier general) in the chain of command or as specified in the operational plans and orders.

(3) These decisions must be based on a complete consideration of operational as well as health risks and available

contingency guidance and criteria so that the total risk to our Soldiers and civilians is minimized. This decisionmaking will be deliberate, documented, and archived.

e. Use the composite risk management process to minimize the total health threat and risk to personnel in garrison, training, contingency operations, and war. Army health policies are intended to allow commanders to execute the full spectrum of military operations while minimizing the total health risk to Soldiers and civilian employees, according to applicable Department of Defense (DOD)/Army policies, implementing instructions, and regulations.

f. Have Army leaders make informed risk decisions about OEH risks and consider, in all risk decisions, health risks to personnel arising from short-term and long-term exposures across the full spectrum of operations.

g. Operate a system of medical, behavioral, and OEH surveillance to—

(1) Provide preventive medicine assessments supporting composite risk management decisionmaking.

(2) Identify health threats to Army personnel and other Military Health System beneficiaries.

(3) Assist in establishing military public health and health promotion goals and targets.

(4) Monitor and assess the health status of all Army personnel throughout their service.

(5) Report the health status of Army units and the impact on readiness.

(6) Archive data for future analyses.

h. Incorporate Army preventive medicine information management and information technology requirements into military health information systems.

i. Inform Army personnel and co-located contractor personnel of health threats, risks, and appropriate unit and individual preventive countermeasures using health risk communication techniques.

j. Provide pre-placement, job transfer, periodic, and termination medical examinations for military personnel and civilian employees potentially exposed to health hazards in the work environment.

k. Ensure all preventive medicine laboratories are accredited or abide by accepted quality assurance procedures to guarantee the accuracy and quality of the data.

l. Ensure all new equipment and materials acquired by the Army are subjected to a health hazard assessment (HHA).

m. Ensure that all new chemicals and materials being added to the Army Supply System have a toxicity clearance.

n. Procure and use in any military operation within the continental U.S. (CONUS) and outside the continental U.S. (OCONUS) only those pesticide active ingredients that are not cancelled by the U.S. Environmental Protection Agency for use within the U.S.

o. Acquire, archive, and store health-related data using only approved military health information systems and procedures that will comply, when applicable, with the provisions of the Health Insurance Portability and Accountability Act, codified in Part 201 et seq., Title 42, United States Code (42 USC 201 et seq.); and the Act's regulations, Parts 160, 162, and 164, Title 45, Code of Federal Regulations (45 CFR Parts 160, 162, and 164).

Section II
The Preventive Medicine Functional Area

1–6. Background

a. Preventive medicine is one of the functional areas of Army health care delivery for which The Surgeon General (TSG) is the Army functional proponent. It is the application of many of the principles of public health and preventive medicine practice to military situations and populations. A component of force health protection, preventive medicine is the anticipation, prediction, identification, surveillance, evaluation, prevention, and control of disease and injuries. These include—

(1) Communicable diseases.

(2) Vector-, food-, air-, and water-borne diseases.

(3) OEH-related diseases and injuries.

(4) Disease and non-battle injuries (DNBIs).

(5) Training injuries.

b. Core public health functions as applied to military preventive medicine include assessment, policy development, and assurance. Assessment includes the key capabilities of general health evaluation of the beneficiary populations, medical surveillance, occupational and environmental health surveillance, investigation of outbreaks, and determination of risk factors and causes of major disease and injury syndromes. Policy development includes advocacy, prioritization of needs, development of plans and policies, and provision of resources to implement programs, plans, and policies. The assurance function includes the direct provision and assurance of delivery of services; it entails implementing programs, plans and policies; management of resources; and monitoring outcomes. A key aspect of all public health practice is effective communication and education with all affected populations.

c. Preventive medicine supports the concept of population health management within the Military Health System. Population health management is the intentional and proactive use of a variety of individual, organizational, and population interventions to help improve patterns of disease and injury burdens, health status, and the health care demand of defined populations. Preventive medicine support includes individual and community health risk and needs

assessments, surveillance, program planning, defined responses, and health outcome evaluation for the entire beneficiary community.

d. Army preventive medicine will include relevant and appropriate capabilities and functions of the following 10 essential national public health services established by the American Public Health Association:

(1) Monitoring health status to identify community health problems.

(2) Diagnosing and investigating health problems and health hazards in the community.

(3) Informing, educating, and empowering people about health issues.

(4) Mobilizing community partnerships to identify and solve health problems.

(5) Developing policies and plans to support individual and community health efforts.

(6) Ensuring compliance with laws and regulations that protect health and ensure safety.

(7) Linking people to needed health services.

(8) Assuring a competent public health and personal health care work force.

(9) Evaluating effectiveness, accessibility, and quality of personal and population-based health services.

(10) Researching new insights and innovative solutions to health problems.

e. Effective preventive medicine will meet the following objectives:

(1) Improvement in beneficiary health.

(2) Reduction in short- and long-term health risks.

(3) Reduction of health care costs due to chronic disease and conditions caused by injury.

(4) Improved performance through reduced morbidity.

(5) Improvement in Soldier and other beneficiary self-care capabilities and activities.

(6) Mitigation of the impact of large-scale public health emergencies.

f. The process for providing effective preventive medicine services consists of the following actions:

(1) Identification of requirements and objectives.

(2) Allocation of resources to accomplish objectives.

(3) Development of policies, plans, and implementing guidance.

(4) Accomplishment of objectives.

(5) Demonstration of accomplishments using process and outcome measurements.

g. Knowledge and application of the principles of obtaining and executing resources through the Military Planning, Programming, Budgeting, and Execution System are essential skills for Army preventive medicine personnel. Without such skills, preventive medicine personnel responsible and accountable for obtaining and executing resources will not be able to perform those functions.

1–7. Preventive medicine programs and services

This paragraph broadly describes the components and scope of the Army preventive medicine functional areas. It directs the development and implementation of a wide range of specific preventive medicine/military public health programs and services. Health surveillance and epidemiology; toxicology and laboratory services; health risk assessment; and health risk communication are foundation components of Army preventive medicine that directly support and must be integrated into the other components of preventive medicine. The detailed implementing guidance and instructions for each of the required programs and services in this regulation are provided in Department of the Army Pamphlet (DA Pam) 40–11. The publication of new Army documents with guidance and instructions specific to any of the required individual programs and services is authorized. The following describe the Army preventive medicine functional areas:

a. Disease prevention and control.

(1) Primary care, preventive medicine, and other health care providers in both tables of distribution and allowances (TDA) and tables of organization and equipment (TOE) medical organizations deliver disease prevention and control services. These services, delivered in clinical and nonclinical settings, are initiated to prevent the occurrence and reduce the severity and consequences of diseases in individuals and populations. Examples include screening and monitoring procedures for early detection of disease (using a variety of clinical examinations and laboratory tests), immunizations to prevent disease, chemoprophylaxis for individuals exposed to infectious diseases, infection control, and preventive medicine counseling.

(2) Disease prevention and control programs and services will be provided according to the detailed implementing instructions and guidance published in DA Pam 40–11, chapter 2. Specific programs, services, and capabilities will be established and provided for the following areas:

(a) Communicable disease prevention and control to include—

1. Immunization and chemoprophylaxis.

2. Acute respiratory disease.

3. Meningococcal infection.

4. Malaria.

5. Viral hepatitis.

6. Sexually transmitted diseases.

7. Acquired immunodeficiency syndrome.

8. Rabies.

9. Tuberculosis.

10. Biowarfare threat.

(b) Travel medicine.

(c) Population health management.

(d) Hospital-acquired infection control.

b. Field preventive medicine.

(1) The principles and practices of Army preventive medicine will apply to all Army individuals and units in all field-training environments and across the full spectrum of military operations. Field preventive medicine services will focus on the health and fitness components of force medical readiness and on the operational management and effective communication of health risks.

(2) The overall objectives of field preventive medicine are to provide commanders with healthy and fit deployable forces; to sustain the health and fitness in any military operation; and to prevent casualties from DNBI and stress reactions.

(3) Field preventive medicine services will include capabilities from the following U.S. Army Medical Department (USAMEDD) functional areas, as described in Field Manual (FM) 4–02, chapter 5:

(a) Preventive medicine services.

(b) Veterinary services.

(c) Combat and operational stress control.

(d) Dental services (preventive dentistry).

(e) Laboratory services (those supporting the above four USAMEDD functional areas).

(4) Field preventive medicine services will be provided according to Army doctrine published in FM 4–02, FM 4–02.17, FM 4–02.18, FM 4–02.19, FM 4–25.12, FM 8–51, FM 8–55, and their supporting references, as well as in DA Pam 40–11, chapter 3.

(a) Soldiers will apply the basic individual preventive medicine measures prescribed in FM 8–55, paragraph 11–5, and FM 21–10/MCRP 4–11.1D, chapter 2. Unit leaders will motivate, train, and equip subordinates prior to and during field training exercises and all deployments to defeat the medical threat through the use of individual and unit preventive measures as described in FM 4–25.12, chapters 1–2 and appendices A–D, and FM 21–10/MCRP 4–11.1D, chapters 2 through 4 and appendix A.

(b) Company-sized units will establish and employ manned, trained, and equipped unit field sanitation teams (FSTs), according to the Army doctrine published in FM 4–02.17, chapter 2 and appendix A, and FM 4–25.12, chapters 1–2 and appendixes A–D.

(c) Medical and OEH surveillance will be provided for each Soldier from accession through the entire length of each Soldier's service commitment. Such surveillance will be provided according to the doctrinal principles defined in FM 4–02.17, chapters 3, 4, 6 through 9, and appendixes A, C, E, and F. Additional guidance can be found in DA Pam 40–11, chapter 6.

(d) Field preventive medicine information management needs will be met using standard military medical and nonmedical information and communication systems, and tactics, techniques and procedures prescribed by doctrine (for example, FM 4–02.16, chapters 1 through 5 and appendixes A–H).

(e) Health risk communication will be provided in the field through planning and implementation using proven processes and tools.

c. Environmental health.

(1) In Army preventive medicine, environmental health consists of those capabilities and activities necessary to anticipate, identify, assess, and control risks of immediate and delayed-onset DNBI to personnel from exposures encountered in the environment. These exposures include risks from chemical, biological, radiological, and physical hazards. These risks will be evaluated using standardized risk assessment principles and procedures.

(2) Environmental health programs and services will be provided according to the detailed implementing instructions and guidance published in DA Pam 40–11, chapters 3 and 4. Environmental health programs, services, and capabilities will be established and provided for the following specific areas:

(a) Drinking water.

(b) Recreational waters.

(c) Ice manufacture.

(d) Wastewater.

(e) Pest and disease vector prevention and control.

(f) Solid waste.

(g) Hazardous waste.
(h) Groundwater and subsurface release of hazardous constituents.
(i) Regulated medical waste.
(j) Waste disposal guidance.
(k) Spill control.
(l) Air quality.
(m) Environmental noise.
(n) Climatic injury prevention and control.
(o) Sanitation and hygiene, including the following topics:
1. Troop housing sanitation.
2. Barber and beauty shops.
3. Dry cleaning operations.
4. Mobile home parks.
5. Child development services facilities.
6. Recreational areas.
7. Laundry operations.
8. Confinement facilities.
9. Food service sanitation.
10. Sports facilities, gymnasiums, and fitness centers.
11. Tattooing and piercing businesses.
d. Occupational health.
(1) In Army preventive medicine, occupational health consists of those capabilities and activities necessary to anticipate, identify, assess, communicate, mitigate, and control occupational disease and injury threats. This includes management of the risks to personnel from exposures encountered at their worksite in garrison and field settings. Occupational health hazards include risks from chemical, biological, radiological, physical, and psychological threats. These risks will be evaluated using standardized risk assessment methodologies.
(2) The Army Occupational Health Program's medical components will be developed and provided consistent with the Defense Safety and Occupational Health Program and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 5. Occupational health programs, services, and capabilities will be established and provided for the following specific areas:
(a) Medical surveillance examinations and screening.
(b) Health hazard education.
(c) Surety programs.
(d) Reproductive hazards.
(e) Bloodborne pathogens.
(f) Hearing readiness, clinical, operational, and conservation services.
(g) Vision conservation and readiness.
(h) Workplace epidemiological investigations.
(i) Ergonomics.
(j) Radiation exposure and medical surveillance.
(k) Industrial hygiene.
(l) Personal protective equipment.
(m) Respiratory protection.
(n) Asbestos exposure control and surveillance.
(o) Injury prevention and control.
(p) Occupational illness and injury prevention and mitigation.
(q) Work-related immunizations.
(r) Recordkeeping and reporting.
(s) Worksite evaluations.
(t) Other Federal programs (for example, Department of Labor (DOL), Office of Workers' Compensation).
(u) Evaluation of occupational health programs and services.
(3) Other occupational health-related programs and services that are not listed above will also be provided according to the detailed instructions and guidance published in DA Pam 40–11, chapter 5. These programs and services will include—
(a) Army aviation medicine.
(b) HHA of Army equipment and materiel.
(c) Medical facility and systems safety, health, and fire prevention.

(d) Nonoccupational illness and injury.

(4) Where local commanders establish and resource a command Prevention of Violence in the Workplace Program, preventive medicine will assist upon request.

e. Health surveillance and epidemiology.

(1) Health surveillance is defined to be those capabilities and activities necessary to effectively collect, analyze, report, and archive information pertaining to the—

(a) Health status of Army personnel throughout their time in service.

(b) Health hazards, risks, and exposures to Army personnel.

(c) Preventive medicine and health risk communication measures necessary to counter those hazards and reduce risks.

(d) Diseases, injuries, and behavioral problems that result from those hazards.

(2) Epidemiology will consist of those capabilities and activities necessary to effectively identify Army populations at risk of disease, injury, or behavioral difficulties and the associated risk factors to—

(a) Identify and characterize morbidity and mortality in Army populations.

(b) Identify the causes of occupational, environmental, and infectious diseases.

(3) Health surveillance and epidemiology programs and services are critical to the success of preventive medicine activities in disease prevention and control; field preventive medicine; occupational health; environmental health; and Soldier, family, and community health and health promotion. Programs and services will be developed and implemented according to the detailed implementing instructions and guidance published in DA Pam 40–11, chapter 6. Health surveillance and epidemiology programs, services, and capabilities will be established and provided for the following specific areas:

(a) OEH surveillance in deployment, training, and in garrison.

(b) Defense Occupational and Environmental Health Readiness System (DOEHRS).

(c) Occupational Health Management Information System.

(d) Medical surveillance.

(e) Epidemiology.

f. Soldier, family, community health, and health promotion.

(1) Soldier, family and community health programs and services consist of activities necessary to anticipate, identify, assess, and communicate health needs across a continuum of home, school, and work environments as well as specific communicable and chronic disease prevention and control activities. Soldier readiness is a priority in the development and execution of these programs. They are intended to address and improve the level of population health. The cornerstone of these programs and services is a comprehensive community health needs assessment. This assessment is the basis for a program document that plans, implements, evaluates, and prioritizes local health needs, resource agencies, and program implementation.

(2) Soldier, family, and community health programs and services will be developed and implemented according to the detailed implementing instructions and guidance published in DA Pam 40–11, chapter 7. Community health programs, services, and capabilities will be provided to support the following areas:

(a) Soldier medical readiness.

(b) Soldier dental readiness.

(c) Community health support of Army operations.

(d) Communicable disease prevention and control.

(e) Community health needs assessment.

(f) Community health referrals.

(g) Chronic disease prevention and control.

(h) Case management.

(i) Child and youth services.

(j) Health of school-age children.

(k) Childhood lead poisoning prevention.

(l) Spousal and child abuse.

(m) Family safety.

(n) Women's health.

(o) Health assessment.

(p) Tobacco use cessation.

(q) Nutrition.

(r) Stress management.

(s) Alcohol and substance abuse prevention and control.

(t) Suicide prevention.

(u) Spiritual health and fitness.

(v) Oral health.

(3) Health promotion is concerned with the promotion of wellness through health education and related activities designed to facilitate behavioral and environmental changes that will improve and maintain health as prescribed in AR 600–63, chapters 1–5.

(4) USAMEDD health promotion services to support the Army Health Promotion Program will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 7.

g. Preventive medicine toxicology and laboratory services.

(1) Preventive medicine toxicology and laboratory services provide for the analytical needs of all elements of preventive medicine.

(2) Toxicology programs and services will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 8. Toxicology programs, services, and capabilities will be established and provided for the following specific areas:

(a) Toxicological assessments of potentially hazardous materials.

(b) Toxicity clearances for Army chemicals and materiel.

(c) Toxicologically based assessments of health risks.

(3) Laboratory programs and services will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 9. In addition to the necessary analytical capabilities, laboratory programs and services will be established and provided for the following specific areas:

(a) Certification and accreditation.

(b) Quality control and quality management.

(c) DOD Cholinesterase Monitoring Program.

h. Health risk assessment.

(1) Health risk assessment is those capabilities and activities necessary to identify and evaluate a health hazard to determine the associated health risk (probability of occurrence and resulting outcome and severity) of potential exposure to the hazard.

(2) Health risk assessment programs and services will be developed and implemented according to the detailed implementing instructions and guidance in DA Pam 40–11, chapter 10. Health risk assessment programs, services, and capabilities will be established and provided for all preventive medicine programs and service areas.

i. Health risk communication.

(1) Health risk communication is defined to be those capabilities and activities necessary to identify who is affected by potential or actual health and safety threats, to determine the interests and concerns those people have about the threats, and to develop strategies for effectively communicating the complexities and uncertainties associated with the scientific processes of determining risk. Effective risk communication can only be accomplished through building and maintaining relationships that provide a framework of credibility for the message and the messenger.

(2) Health risk communication programs and services will be developed and implemented according to the detailed implementing instructions and guidance in DA Pam 40–11, chapter 11. Health risk communication programs, services, and capabilities will be established and provided for all preventive medicine program and service areas.

1–8. Technical and consultative assistance

Technical assistance will be available through preventive medicine units, U.S. Army medical centers (USAMEDCENs), U.S. Army medical department activities (USAMEDDACs), regional medical commands (RMCs), and U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM). All technical assistance will be coordinated with the appropriate commands. Consultative assistance may be obtained from command surgeons, the U.S. Army Medical Department Center and School (USAMEDDC&S), U.S. Army Medical Research and Materiel Command (USAMRMC), veterinary commanders, and U.S. Army Dental Command (USADENCOM).

Chapter 2
Responsibilities

2–1. The Assistant Secretary of the Army (Installations and Environment)

The Assistant Secretary of the Army (Installations and Environment) (ASA(I&E)) will—

a. Provide executive leadership at the Army Secretariat level to ensure timely—

(1) Integration of DOD directives and policies concerning Army OEH with Army policies, doctrine, and guidance.

(2) Compliance with the Army OEH requirements.

b. Establish goals, policies, priorities, and oversight for Army OEH.

c. Provide Army OEH input to the defense planning guidance and the defense medical planning guidance in coordination with the Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)).

d. Provide policy, goals, guidance, and management oversight of the Army Occupational Health Program, as the Army component of the DOD Safety and Occupational Health Program.

2–2. The Assistant Secretary of the Army (Manpower and Reserve Affairs)

The ASA(M&RA) will—

a. Provide executive leadership at the Army Secretariat level—

(1) To ensure timely integration of DOD directives and policies concerning health and fitness with Army policies, doctrine, and guidance.

(2) For the development and implementation of Army health and fitness policies.

b. Oversee the integration of Army health and fitness policy with Army activities, operations, policies, and doctrine.

c. Provide preventive medicine input to the defense planning guidance and the defense medical planning guidance in coordination with the ASA(I&E).

2–3. The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/The Army Acquisition Executive

The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/Army Acquisition Executive (AAE) will plan, program, and budget for the integration of preventive medicine factors with the Army's acquisition programs. This includes but is not limited to—

a. The HHA of Army materiel and systems throughout the full life cycle of these items (see AR 40–10, para 2–1; AR 70–1, para 2–1o; AR 200–1, para 1–8; and AR 385–16, para 4a(2)).

b. The development of nonmedical material (such as instruments, equipment) in conjunction with the USAMEDD to rapidly identify and assess the short- and long-term health risks to Army personnel presented by deployment OEH threats.

c. The establishment of procedures to assure that program managers and other individuals authorized to add chemicals and chemical-based materiel to the Army Supply System request toxicity clearances for those products.

2–4. The Deputy Chief of Staff, G–1

The Deputy Chief of Staff, G–1 will—

a. Provide executive leadership at the Army staff level for the integration of health and fitness policies and doctrine with Army personnel policies and doctrine.

b. Ensure that Army personnel data in support of designated major joint deployments are provided to the Defense Manpower Data Center. Data will include daily strength by unit and total deployed, grid location of each unit (company size and higher), and inclusive dates of individual Army personnel deployment. These personnel data provide denominators for deployment medical surveillance analyses as well as location information for identifying potential exposures for OEH surveillance.

c. Ensure that the Deputy Chief of Staff, G–1 information systems, which include medical data, are compatible with Army medical information systems.

2–5. The Deputy Chief of Staff, G–2

The Deputy Chief of Staff, G–2 will—

a. Advise the ASA(I&E) and TSG on medical intelligence.

b. Provide functional policy and guidance on collection and dissemination of medical intelligence.

c. Serve as Army liaison with DOD intelligence agencies on all matters regarding medical intelligence.

2–6. The Deputy Chief of Staff, G–3/5/7

The Deputy Chief of Staff, G–3/5/7 will exercise Army general staff responsibility for the integration of preventive medicine into Army planning and training.

2–7. The Deputy Chief of Staff, G–4

The Deputy Chief of Staff, G–4 will ensure the—

a. Integration of preventive medicine factors into—

(1) The transportation, storage, handling, and disposal of hazardous material or hazardous waste.

(2) Deployable housing, food preparation, water purification, mortuary affairs, laundry, and shower operations.

b. Coordination of field sanitation activities.

2–8. The Surgeon General

a. The Surgeon General will execute and provide oversight of preventive medicine activities as outlined in this regulation and will—

(1) Provide leadership, proponency, policy, prioritization, oversight, and coordination for Army-wide preventive medicine programs and services.

(2) Plan, program, budget, and oversee the execution of resourcing in support of preventive medicine and health promotion activities consistent with—

(a) DOD and Department of the Army (DA) policies and guidance.

(b) The resourcing provided in the Defense Health Program by the Office of the Assistant Secretary of Defense for Health Affairs.

(c) The resourcing provided in the operations and maintenance, Army (OMA) account.

(3) Determine and direct the use of appropriate preventive measures, pharmaceuticals, and biologics for disease and injury control.

(4) Ensure that prevention is integrated with the practice of Army medicine at all levels and in all settings.

(5) Determine if Army medical and nonmedical materiel presents a health hazard to personnel, according to AR 40–10, paragraph 2–6, and AR 70–1, paragraph 2–18, and provide medical policies, health standards and guidance, and recommendations to protect personnel from the health hazard presented by that materiel.

(6) Develop functional policy and guidance for the medical components of Army deployment OEH threat policies.

(7) Develop guidance that allows commanders to quantify and mitigate the health risks resulting from exposures to occupational and environmental hazards.

(8) Develop policy for medical care to prevent disability from occupational injuries and illnesses.

(9) Execute the medical aspects of the Army Occupational Health Program.

b. The USAMEDD Functional Proponent for Preventive Medicine will serve as TSG's principal advisor on preventive medicine issues. The Proponency Office for Preventive Medicine will provide staff support to the USAMEDD Functional Proponent for Preventive Medicine. The USAMEDD Functional Proponent for Preventive Medicine will—

(1) Have TSG authority for preventive medicine policies, standards, regulations, and directives to protect and promote health, improve effectiveness, communicate health risks, and enhance the environment of Army personnel.

(2) Provide strategic direction, guidance, and prioritization for preventive medicine activities that take into account USAMEDD strategies and validated medical threat assessments.

(3) Provide staff support and consultative services for preventive medicine to the Army staff and to U.S. Army Medical Command (USAMEDCOM) and Office of The Surgeon General (OTSG) staffs.

(4) Execute TSG's responsibilities, as specified in AR 200–1, paragraph 1–18, functioning as the Army executive point of contact for all OEH aspects of the Army's Environmental Program and as TSG's reviewing authority for all environmental documents submitted by DA activities.

(5) Execute TSG's responsibilities in implementing the preventive medicine components of Army deployment OEH threat policies by—

(a) Developing policy and guidance for the medical surveillance and the OEH surveillance aspects of those Army policies, as well as policies developed by the Assistant Secretary of Defense for Health Affairs or the Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs. Specifically, the Functional Proponent for Preventive Medicine will be responsible for the development of chemical, biological, and radiological health criteria and guidelines to support Army deployment OEH threat policies. This includes criteria and guidance on long-term acceptable levels of exposures and risks resulting from exposures to low levels of OEH threat agents for various exposure scenarios, consistent with the policies and guidance provided by the Assistant Secretary of Defense for Health Affairs or the Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs.

(b) Developing consistent guidance that allows commanders to quantify and mitigate, through their medical or other appropriately qualified assets, the health risks resulting from exposures to OEH threats during deployments. This guidance may include other aspects of identifying, quantifying, and communicating risks, such as direct and indirect bioassay measurements in addition to the monitoring of ambient exposure levels.

(c) Supporting and advocating the preventive medicine requirements for adequate Defense Health Program and other appropriate funding to ensure timely and effective implementation of Army deployment OEH threat policies and procedures.

(6) Execute TSG's responsibilities for The Army Chemical Agent Safety Program and Biological Defense Safety Program according to AR 385–61, paragraph 1–4i, and AR 385–69, paragraph 1–4e, respectively.

(7) Execute TSG's responsibilities for the Army Ergonomics Program.

(8) Coordinate with the Director of Army Safety to ensure Army compliance with Occupational Safety and Health Act (Public Law 91–596, as amended) health standards.

(9) Provide preventive medicine representation and liaison as appropriate.

(10) Coordinate with the USAMEDDC&S and USAMRMC concerning doctrine, organizations, training, materiel, leadership and education, personnel, and facilities (DOTMLPF) solutions to Army preventive medicine issues.

(11) Coordinate with U.S. Army Training and Doctrine Command (USATRADOC) concerning the prevention and control of injuries and communicable diseases in recruit and other training populations.

(12) Coordinate with the Assistant Surgeon General for Force Projection on clinical preventive medicine policies.

(13) Coordinate the inclusion of preventive medicine in medical information management and information technology initiatives.

(14) Provide staff oversight including process and outcome metrics for execution of preventive medicine activities.

(15) Coordinate with the U.S. Army Materiel Command (USAMC) Logistic Civil Augmentation Program concerning combat service support contracts written in support of contingency operations.

c. The USAMEDD professional consultants will advise and assist the USAMEDD Functional Proponent for Preventive Medicine.

2–9. The Director of Army Safety

The Director of Army Safety will—

a. Coordinate with TSG and the USAMEDD Functional Proponent for Preventive Medicine on occupational safety and health issues including medical aspects of safety policy regarding hazard communication and hazardous materials program requirements.

b. Exchange accidental injury data with TSG for an accurate assessment of the Army health status.

c. Provide support to commanders in developing and implementing installation ergonomics programs.

d. Advance partnership initiatives that prevent workplace injuries and illnesses.

2–10. The Commander, U.S. Army Corps of Engineers/Chief of Engineers

The U.S. Army Corps of Engineers (USACE) and the Chief of Engineers, in addition to the responsibilities in paragraph 2–11, below, will—

a. Coordinate with TSG and the USAMEDD Functional Proponent for Army Preventive Medicine on the health aspects of environmental issues including environmental compliance, environmental baseline surveys, environmental health site assessments, pollution prevention, hazardous waste minimization, risk assessment, and risk communication program requirements.

b. Ensure coordination of environmental program data with TSG for an accurate assessment of the impact of environmental conditions on the Army health status.

c. Ensure that health risk assessments are submitted to TSG for review and approval.

2–11. Commanders, Army commands, Army service component commands, and direct reporting units

Commanders, Army commands (ACOMs), Army service component commands, and direct reporting units will provide command emphasis, resources, policy implementation, guidance, and oversight to subordinate commands and activities to execute preventive medicine activities within their commands.

2–12. The Director, Army National Guard/Army National Guard of the United States

The Director, Army National Guard/Army National Guard of the United States, will—

a. Provide emphasis, resources, policy, and implementation guidance to each state and territory adjutant general.

b. Appoint the Army National Guard/Army National Guard of the United States Surgeon to coordinate with TSG and the USAMEDD Functional Proponent for Preventive Medicine on preventive medicine issues.

2–13. The Commanding General, U.S. Army Forces Command

The Commanding General, U.S. Army Forces Command, in addition to the responsibilities in paragraph 2–11, above, will—

a. Coordinate with the USAMEDDC&S to identify the required force structure and capabilities to implement the preventive medicine aspects of combat health support according to military doctrine.

b. Coordinate with OTSG in planning, programming, and budgeting for required capabilities to implement the preventive medicine aspects of combat health support according to Army and Joint doctrine.

c. Coordinate with USAMEDCOM, USATRADOC, and the Army Deputy Chief of Staff, G–3/5/7 to provide in-theater medical analytical capability (using organic or augmented medical assets) for theater-level, rapid nuclear (and radiological), biological, chemical, environmental and infectious disease risk identification and assessment to support operational health risk management.

2–14. The Commanding General, U.S. Army Training and Doctrine Command

The Commanding General, USATRADOC, in addition to the responsibilities in paragraph 2–11, above, will—

a. Develop, in coordination with USAMEDCOM, doctrine, tactics, techniques, and procedures; implementation plans; operational requirements; and appropriate training and education for leaders and others to use in assessing, managing, and countering deployment OEH threats.

b. Incorporate training in deployment OEH into USATRADOC leadership schools as appropriate.

c. Develop and implement, through the U.S. Army Chemical School and in close cooperation with the USAMEDCOM, the doctrinal, training, organizational, and materiel solutions to the risks presented by chemical and biological agents, toxic industrial hazards, and radiation.

d. Coordinate with USAMEDCOM and OTSG regarding health issues in the training base.

e. Incorporate deployment and garrison risk mitigation of communicable diseases and injuries into cadre training.

2–15. The Commanding General, U.S. Army Materiel Command

The Commanding General, USAMC, in addition to the responsibilities in paragraph 2–11, above, will—

a. Support the AAE in developing the nonmedical materiel (such as instruments, equipment) in conjunction with the USAMEDD to rapidly identify and assess the short- and long-term health risks presented by deployment OEH threats.

b. Support the AAE, program executive officers, and program managers in analyzing all emerging Army systems for environmental effects, including noise and toxic and hazardous wastes associated with normal system testing, operation, use, maintenance, and disposal.

2–16. The Commander, U.S. Army Medical Command

The Commander, USAMEDCOM, in addition to the responsibilities defined in paragraph 2–11 above, will—

a. Provide heath care services and resources of the Army within CONUS, Europe, Pacific, Alaska, Puerto Rico, Hawaii, and Guam and other territories.

b. Develop and execute installation, regional, and worldwide preventive medicine programs to support the entire spectrum of military operations.

c. Plan and program for OMA, Army and Defense Health Program funding requirements. Prioritize, budget, and resource all USAMEDCOM subordinate command assets necessary to support preventive medicine. Use the Defense Health Program activity structure and codes for effective Defense Health Program budget execution tracking and program analysis and review (see Defense Finance and Accounting Service—Indianapolis Center (DFAS–IN) Manual 37–100–FY). Track execution of OMA resources provided for preventive medicine programs and services.

d. Coordinate with the DA staff and appropriate medical organizations OCONUS to provide preventive medicine augmentation support when directed or requested.

e. Provide command guidance and oversight including program evaluation of the priorities, services, and direction for preventive medicine with the assistance of the USAMEDD Functional Proponent for Preventive Medicine.

f. Monitor the obligation of funds for USAMEDCOM preventive medicine assets against the Defense Health Program activity structure to ensure that expenditures coincide with priorities.

g. Provide command guidance to the USAMEDDC&S and to the USAMRMC for preventive medicine issues and needs for DOTMLPF solutions.

h. Ensure the development of doctrine, implementation plans, procedures, capabilities, and training relative to medical and OEH surveillance to address exposures to Soldiers and civilian employees throughout their time in service.

i. Ensure that deployment OEH training is incorporated into the USAMEDDC&S curriculum.

j. Include preventive medicine in Army medicine strategic and mid-term planning activities.

k. Establish chemical, biological, radiological, and nuclear advisory medical teams at appropriate locations.

l. Establish a performance improvement program for preventive medicine.

m. Develop appropriate strategies and processes to ensure the availability of adequate information management and information technology support to implement the prevention-related objectives and requirements of Army deployment OEH threat policies.

n. Develop the procedures and guidance for USAMEDCOM subordinate commands to obtain intelligence products regarding medical, industrial, and other environmental threats.

o. Prepare the production requirements for valid intelligence product requests to the USAMEDCOM supporting intelligence office as defined in the Department of Defense Intelligence Production Program.

p. Ensure that any requests for reimbursable preventive medicine services (from either Active Army or Reserve Component organizations) are assessed by preventive medicine staff in coordination with RMC or USAMEDCOM resource management staff and program analysis and evaluation staff prior to accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army principles encoded in the Economy Act (31 USC 1535 and 1536).

q. Provide periodic evaluation of installation occupational health programs along with a plan to ensure appropriate followup and resolution of corrective actions. A copy of the evaluation along with the plan for resolution should be provided to the installation commander.

2–17. Commanders, regional medical commands

Commanders of regional medical commands (RMCs) will—

a. Provide command and operational guidance, oversight, mentorship, coordination, and consultative support for effective preventive medicine programs and services within the region based on this regulation and the guidance provided in DA Pam 40–11.

b. Plan, program, prioritize, budget, and resource all RMC assets necessary to support preventive medicine based on priorities, policy, and guidance from TSG. Use the Defense Health Program activity structure and codes for effective Defense Health Program budget execution tracking and program analysis and review (see DFAS–IN Manual

37–100–FY). Track execution of Defense Health Program and OMA resources provided for preventive medicine programs and services.

c. Develop, train, staff, equip, and operate augmentation response teams to support the full spectrum of military operations, including the stability and support operations defined and described throughout FM 8–42.

d. Coordinate support for Army Reserve and Army National Guard/Army National Guard of the United States units requiring preventive medicine services according to established memorandum of agreement/understanding, this regulation, and the guidance provided in DA Pam 40–11.

e. Ensure that any requests for reimbursable preventive medicine services (from Active Army or Reserve Component organizations) are assessed by preventive medicine staff in coordination with RMC resource management staff before accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army reimbursable policy (see 31 USC 1535 and 1536).

f. Review and consolidate environmental program requirements submitted from military treatment facilities (MTFs) within the region for transmission to USAMEDCOM.

g. Conduct a formal evaluation of each installation Occupational Health Program within the region at least once every 3 years. Evaluation officials may come from occupational health assets within the region or from other USAMEDCOM assets. Results of these evaluations will be forwarded to USAMEDCOM along with formal plans for corrective actions. Correction of identified deficiencies also will be forwarded to USAMEDCOM when completed.

2–18. Commanders, U.S. Army medical centers and U.S. Army medical department activities

Commanders of USAMEDCENs and USAMEDDACs, as the local medical authorities, will—

a. Establish and provide effective installation and clinical preventive medicine programs and services, designating a chief of preventive medicine to execute the commander's installation and clinical preventive medicine responsibilities. The primary purpose of preventive medicine services is to support installation commanders in preventing disease and injury throughout the health services support area, not to function solely as an in-house clinical service.

(1) Preventive medicine services will be resourced accordingly for the installation support mission—

(a) Personnel.

(b) Funding.

(c) Office and laboratory space.

(d) Equipment and supplies.

(e) Transportation and communication.

(2) The chief of preventive medicine, on behalf of the medical commander, is responsible for establishing, implementing, and directing the preventive medicine programs and services described in this regulation. The chief of preventive medicine, or his or her designee, will—

(a) Serve as consultant and provide preventive medicine liaison to the installation commander and staff and tenant activities.

(b) Establish and maintain liaison with appropriate Federal, state, and local public health authorities.

(c) Serve as the medical representative on installation boards, councils, and committees.

b. Plan, program, prioritize, budget, and resource all assets necessary to support installation and clinical preventive medicine programs and services based on the priorities, policy, and guidance from TSG. Use the Defense Health Program activity structure and codes for effective budget execution tracking and program analysis and review (see DFAS–IN Manual 37–100–FY). Track execution of Defense Health Program and OMA resources provided for preventive medicine programs and services (see DA Pam 40–11, para 1–6).

c. Provide local implementing guidance for installation and clinical preventive medicine programs and services described in this regulation.

d. Ensure that medical events on the current tri-Service list are reported through the Reportable Medical Events System (RMES) as soon as possible after the diagnosis has been made or within 48 hours. This includes case reports from subordinate clinics and clinics at satellite locations.

(1) The U.S. Army Medical Surveillance Activity (USAMSA) maintains the current tri-Service list of reportable medical events on the USAMSA Web site (http://amsa.army.mil). The staff at USAMSA can provide current versions of the RMES software for use at each preventive medicine service. Technical assistance may be obtained from USAMSA, USACHPPM, ATTN: MCHB–TS–EDM, Bldg. T20, 6900 Georgia Avenue, Washington, D.C. 20307–5001; or through the USAMSA Web site (http://amsa.army.mil/AMSA/amsa_home.htm).

(2) Commanders must also comply with all Federal, state and local medical reporting requirements including applicable Occupational Safety and Health Administration (OSHA) requirements for work-related injuries and illnesses.

e. Participate on Armed Forces disciplinary control boards and coordinate with representatives of civil agencies concerned with health and welfare as prescribed in AR 190–24/OPNAVINST 1620.2A/AFI 31–213/MCO 1620.2C/COMDTINST 1620.1D, chapter 2.

f. Coordinate with medical departments of other military services; appropriate representatives of international,

Federal, state, and local public health organizations; and those organizations responsible for developing consensus standards.

g. Ensure complete documentation of workload for all installation and clinical preventive medicine programs and services.

h. Provide a health consultant to the local installation child development services according to AR 608–10, paragraph 2–3c.

i. Provide preventive medicine representation to installation boards, councils, and committees, as directed by published instructions establishing such boards, councils, and committees.

j. Ensure that assigned military audiologists have the primary duty title of Installation Hearing Program Manager; that their primary responsibility is to manage the installation hearing clinical and conservation services; and that they are afforded at least 50 percent of their available time to accomplish the installation hearing conservation mission, for example, health education, unit visits, command inspections, and range inspections.

k. Ensure that the job series codes for all supported civilian employees are entered into medical surveillance databases.

l. Establish a Hospital Infection Control Program and a hospital infection control committee to oversee and guide efforts to prevent and control hospital-acquired infections according to the implementing guidance provided in DA Pam 40–11, chapter 2.

m. Ensure that any requests for reimbursable preventive medicine services (from either Active Army or Reserve Component organizations) are assessed by preventive medicine staff in coordination with USAMEDCEN or USAMEDDAC resource management staff prior to accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army reimbursable policy (see 31 USC 1535 and 1536).

n. Serve as or appoint a director of health services as principal medical advisor to the installation commander and staff on health care delivery matters, including installation and clinical preventive medicine programs and services for the installation commander's area of responsibility. The director of health services, in coordination with the chief of preventive medicine services, will—

(1) Notify unit and installation commanders of special or potentially serious health problems. The initial telephonic or electronic notification will be followed by a written report within 72 hours. The purpose is to inform commanders of serious sanitary deficiencies, OEH hazards, potential epidemic conditions, or other serious situations that may affect the health of the command.

(2) Provide preventive medicine information along with other health-related input to the Installation Status Report according to AR 210–14, paragraphs 9 and 11, and implementing instructions as published by the DA Assistant Chief of Staff for Installation Management.

(3) Work with the installation safety manager to provide the installation commander with a comprehensive Safety and Occupational Health Program that includes, but is not limited to, ergonomics, injury prevention and control, respiratory protection, industrial hygiene, hearing conservation, vision conservation and readiness, hazard communication, laboratory safety, and occupational health surveillance.

(4) Provide technical and quality assurance oversight of the OEH Program, and provide qualifications and competency oversight for preventive medicine and occupational health service providers.

(5) Advise the installation commander on the health aspects of the installation Environmental Program, and arrange for medical consultation and support services.

(6) Work with the installation pest management coordinator on prevention and control of medically important pests and OEH exposures from pest management operations.

o. Coordinate with field units within the area of responsibility to provide any required or requested supplemental preventive medicine support.

p. Maintain a deployable medical augmentation team to reinforce the medical response team on installations having a chemical surety mission.

q. Designate physicians to provide required physician support to each Occupational Health Program supported by the command, including supported installations where no physician is assigned.

2–19. The Commander, U.S. Army Center for Health Promotion and Preventive Medicine

The Commander, USACHPPM, will—

a. Provide worldwide support of Army preventive medicine activities through consultations, program evaluations, supportive services, program development, development of best practices, investigations, and training in the areas of disease and injury prevention and control; field preventive medicine; environmental health; occupational health; health surveillance and epidemiology; Soldier, family, and community health, and health promotion; preventive medicine toxicology and laboratory services; health risk assessment; and health risk communication.

b. Provide support for comprehensive health surveillance for the Army and DOD, and develop and maintain data analysis and archiving for worldwide military health surveillance activities such as the Defense Medical Surveillance System and DOEHRS. This will include, at a minimum—

(1) Summarizing reportable medical events, injuries, and conditions across installations and commands, and notifying all reporting sites at least monthly.

(2) Assuring injury data are synchronized with Army accidental injury data and with AR 385-40 reporting requirements by direct coordination with the U.S. Army Combat Readiness Center.

(3) Updating and distributing, as needed through official preventive medicine channels, the tri-Service list of reportable medical events, and maintaining the current reportable medical events list on the USAMSA Web site.

(4) Providing timely and useful feedback to assist garrison and field commanders in reducing OEH risks.

c. Provide reference laboratory support for OEH surveillance. These programs include but are not limited to the laboratory quality assurance for the DOD Cholinesterase Monitoring Program; radiological bioassay for the Army; and toxicity clearances and toxicological profiles for chemicals, radiological materials, and unregulated substances commonly found in the military.

d. Develop, train, staff, equip, and operate preventive medicine augmentation response teams to support the full spectrum of military operations as defined and described throughout FM 4–02 and FM 8–42.

e. Provide additional preventive medicine material and personnel augmentation and Preventive Medicine Level V support to deployed forces, including theater medical laboratory support when requested.

f. Serve as the lead agent and the Army liaison for the DOD in executing the Memorandum of Understanding between the Agency for Toxic Substances and Disease Registry and the DOD.

g. Augment local preventive medicine assets by providing installation-level preventive medicine services as directed or as approved by Commander, USAMEDCOM. Such installation-level support may require regionally established memoranda of understanding and close coordination with the medical commander for the region in which support services are provided.

h. Plan, program, budget, and resource USACHPPM preventive medicine capabilities according to priorities set by the USAMEDCOM using the Defense Health Program activity structure and codes for tracking and accountability of Defense Health Program resources. Track execution of any Defense Health Program and OMA resources provided to USACHPPM for preventive medicine programs and services.

i. Provide support to commanders in developing and implementing installation ergonomics and occupational health programs.

j. Conduct periodic evaluations of regional and local preventive medicine programs and services in support of USAMEDCOM oversight responsibilities.

k. Ensure that any requests for reimbursable preventive medicine services (from either Active or Reserve Component military organizations) are assessed by USACHPPM technical staff in coordination with USACHPPM resource management staff prior to accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army reimbursable policy (see 31 USC 1535 and 1536).

l. Provide the following pest management programs and services:

(1) Provide consultative, field, and laboratory services to monitor, evaluate, and support the USAMEDD's role in the Army Pest Management Program. These include—

(a) The Pesticide Regulatory Action System to include the operation of the DOD Pesticide Hotline.

(b) The DOD Lyme Disease Program and other tick-borne disease prevention programs.

(2) Field a Pesticide-Use Reporting System to Army preventive medicine units.

(3) Serve as the DA repository for the archiving of pesticide use reports generated by deployed forces.

(4) Maintain laboratories for the surveillance, identification, and analyses of vector-borne diseases.

m. Operate and maintain the DOD Serum Repository for medical surveillance for clinical diagnosis and epidemiology studies. According to DODD 6490.2, paragraphs 4.12 and 4.13, the serum repository will be used for the identification, prevention, and control of diseases associated with military service. The serum repository and other systems of records containing health surveillance information will comply with the DOD Privacy Program, as defined in DODD 5400.11.

n. Provide OEH guidance to assist commanders in applying the Army risk management process to OEH hazards.

o. Establish and maintain a capability to provide a comprehensive support for the conduct of OEH operational health risk assessments for garrison activities and deployments.

p. Provide the capability to support the TSG responsibility to review and approve human health risk assessments.

q. Provide the capability to support the TSG responsibility to review ecological risk assessments.

r. Provide technical sustainment training to installation preventive medicine organizations and field (TOE) preventive medicine units upon request or as directed.

s. Coordinate with USATRADOC to develop training aids for cadre training on mitigating deployment and garrison risks for communicable diseases and injuries.

t. Provide epidemiologic consultation services to RMCs, ACOMs, Army service component commands, and direct reporting units upon request. These services may include informal or formal analysis, reports, and recommendations.

As needed to support this service, the Commander, USACHPPM, will deploy teams to on-site locations to conduct or assist in field investigations of disease or injury outbreaks or clusters.

u. Review, interpret, and respond to assessment and surveillance data, as needed, to identify, prevent, and control newly identified or evolving health problems. Response capabilities will include regular communication with preventive medicine staffs at the RMCs, ACOMs, Army service component commands, and direct reporting units.

v. Provide technical consultation on Federal Employees' Compensation Act (Sections 8101–8193, Title 5, United States Code (5 USC 8101–8193)), perform review and analysis of available civilian lost-day data, and provide recommendations for targeted interventions to prevent and mitigate work-related injuries and illnesses.

w. Partner with the Director of Army Safety to support the Army Safety and Occupational Health Program.

x. Provide DOD certification training to personnel who sign shipping papers for the transport of medical specimens to include infectious substances, select agents, and regulated medical waste. (See DOD 4500.9-R, chapter 204, part II.)

2–20. The Director, DOD Veterinary Service Activity

The Director, DOD Veterinary Service Activity will—

a. Coordinate with the USAMEDD Functional Proponent for Preventive Medicine on veterinary preventive medicine issues.

b. Develop standards, criteria, and methods to determine the safety of—

(1) Foodstuffs contaminated with chemical or biological material.

(2) Subsistence and equipment damaged by man-made or natural disasters.

2–21. Veterinary commanders

Veterinary commanders will, when requested, provide veterinary assets, as resources permit—

a. To support preventive medicine installation and field food sanitation programs, the screening and approval of pets in child development centers and family child care homes, and public health education activities.

b. To support and coordinate zoonotic disease surveillance and control efforts with preventive medicine epidemiology assets.

c. To support theater preventive medicine surveillance by providing any analytical results obtained during a foodborne illness investigation and from the sampling and analysis of all locally procured (within the theater of operations) bottled water, food, and ice to the USACHPPM Deployment Environmental Surveillance Program at USACHPPM, ATTN: MCHB–TS–RDE, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010–5403, for database archiving.

2–22. The Commander, U.S. Army Dental Command

The Commander, USADENCOM will coordinate with the USAMEDD Functional Proponent for Preventive Medicine concerning the health promotion and disease prevention aspects of dental services.

a. Initiatives that support oral health include, but are not limited to, nutrition counseling, tobacco use cessation, delivery of dental sealants and mouth guards, and other preventive medicine program components supporting oral health such as fluoridation of drinking water supplies.

b. The semiannual Community Oral Health Protection Report (formerly the Preventive Dentistry Report) data are submitted through the USADENCOM's Web-based reporting system termed the Corporate Data Application located at https://conus.dencom.army.mil/. The data and accompanying narrative provide documentation of activities and outcomes of the Clinical Oral Health and Health Promotion Program as well as the Community Health Promotion and Disease Prevention Program.

2–23. The Commander, U.S. Army Medical Department Center and School

The Commander, USAMEDDC&S, will—

a. Identify, develop, and validate Active Army and Reserve Component preventive medicine requirements. Develop and provide doctrine, training, leader development, organization, and Soldier system solutions to those requirements. Coordinate, through USAMEDCOM, with USAMRMC in the development of materiel solutions to preventive medicine requirements.

b. Coordinate, through the appropriate chain of command, with USAMEDCOM subordinate commands and Reserve Component organizations for participation in and technical support of the preventive medicine components of the training mission and functions of the Academy of Health Sciences.

c. Coordinate, through the appropriate chain of command, with USAMEDCOM subordinate commands and Reserve Component organizations for preventive medicine participation in, and support of, force integration activities, such as—

(1) Combat and doctrine development.

(2) Force structure and analysis.

(3) Theater medical information management.

(4) Technology insertion.

(5) War fighting experimentation.

(6) USAMEDD systems integration.

(7) Operational test and evaluation.

(8) Strategic planning and force management.

d. Coordinate, through the appropriate chain of command, with USAMEDCOM subordinate commands and Reserve Component organizations for planning and providing preventive medicine sustainment training for individuals and units.

e. Coordinate, through USAMEDCOM, with the USAMEDD Functional Proponent for Preventive Medicine concerning USAMEDD preventive medicine personnel proponency issues.

f. Coordinate, through the appropriate chain of command, with USATRADOC to incorporate preventive medicine principles into officer and enlisted training manuals and Soldier common task training manuals.

g. Represent and advocate through USATRADOC, and in coordination with USAMRMC, preventive medicine-related Army science and technology objectives.

h. Provide preventive medicine doctrine and training on reportable medical events, the use of the RMES software, pesticide use reporting and recordkeeping, and the North Atlantic Treaty Organization disease and injury reporting procedures.

i. Incorporate appropriate preventive medicine training in command surgeon preparation courses such as brigade/division surgeons' courses, USAMEDD Officer Basic Course, U.S. Army School of Aviation Medicine's Army Flight Surgeons' Primary Course to include deployment surveillance requirements and procedures, OEH-related diseases and injuries, travel medicine, and field preventive medicine.

j. Train health care providers on the principles of preventive medicine and the basics of OEH threats, their potential for health effects, and requirements for treatment and/or medical surveillance.

k. Establish, maintain, and disseminate lessons learned from deployment OEH-related issues from previous and ongoing deployments.

l. Update training support packages for mitigating risk of communicable diseases, injuries, combat and operational stress reactions, and suicide.

2–24. The Commander, U.S. Army Medical Research and Materiel Command

The Commander, USAMRMC, will—

a. Provide biomedical materiel and information solutions for military public health capabilities to enhance, sustain, and protect health, fitness, and performance.

b. Provide capabilities to support DOD and joint surveillance and laboratory diagnosis of emerging and reemerging infectious diseases of military significance.

c. Provide capabilities to support the surveillance for early notification of disease outbreaks of military importance..

d. Support the graduate medical education residency training programs in preventive medicine and occupational medicine through the Walter Reed Army Institute of Research, in collaboration with USACHPPM.

2–25. Health care providers

Health care providers will—

a. Promote the health and fitness of their patients by integrating appropriate and current prevention strategies in their delivery of primary care services.

b. Support and participate in the advocacy of approved Army health promotion and preventive medicine and population health improvement activities.

c. Inform the supporting preventive medicine service of—

(1) All incidences of disease and injury on the Tri-Service Reportable Events list as well as any other incidences that must be reported to local civilian public health authorities, using the guidance provided in DA Pam 40–11 (http://amsa.army.mil).

(2) Disease or injury hazards that may require preventive medicine assessment and intervention.

2–26. Commanders at all levels

Commanders at all levels are responsible and accountable for the health of their command. They will—

a. Ensure that the health of all personnel in their command is sustained and protected in all military activities through aggressive implementation of preventive medicine activities. Command Preventive Medicine Program responsibilities should include—

(1) Training.

(2) Hazard control.

(3) Proper use of personal protective measures and protective clothing and equipment.

(4) Immunization and chemoprophylaxis.

(5) Health risk and hazard communication.

(6) Worksite, occupational health, and environmental health surveillance.

(7) Workplace violence prevention.

b. Program and budget for resources, and provide training to comply with individual and unit responsibilities for improving and maintaining health and fitness.

c. Implement health surveillance requirements ensuring that Soldiers and civilian employees under their command who are enrolled in an Occupational Medicine Surveillance Program comply with the occupational medicine surveillance requirements including pre-placement, periodic, and outprocessing or termination medical evaluation (see DA Pam 40–11, chap 5, and FM 4–02.17, chap 9).

d. Provide leadership and personal example in improving and sustaining individual and unit health and fitness.

e. Ensure that contingency and operational plans include the appropriate elements of preventive medicine.

f. Minimize health risks using Army composite risk management principles (see FM 5–19).

g. Adhere to Federal, state, and host nation statutory and regulatory laws, directives, licenses, and guidance governing OEH in garrison and during training exercises. These statutes and regulations will also apply during military operational deployments and war unless specifically exempted by appropriate authority based on the tactical situation.

h. Ensure that contracts provide for adherence to occupational health laws and regulations.

2–27. Installation commanders and state and territory adjutants general

a. Installation commanders and state and territory adjutants general are responsible and accountable for providing a safe and healthy environment for all assigned and supported military personnel. They will also ensure that required preventive medicine programs and services are provided to all personnel under their command and all other military personnel they support, such as tenant organizations. Such preventive medicine support will be provided in coordination with the supporting medical commander and that commander's preventive medicine assets. Preventive medicine support of tenant organizations and other supported military personnel will be established through local installation or other type of support agreement. (See DA Pam 40–11, chaps 1–11 and apps B–G, for implementing guidance.)

b. Installation commanders are responsible for resourcing and implementing the preventive medicine components of installation infrastructure and services in coordination with the director of health services and the chief of preventive medicine services. Installation commanders provide the safe and healthy living and work environments and services such as drinking water, food, safe worksites, and recreational activities. Preventive medicine personnel provide the medical oversight and monitoring of installation infrastructure and services that may pose health threats. They provide the technical advice and assistance to installation commanders to minimize risks from such threats.

c. Installation occupational health programs and services that will include, but are not limited to the following:

(1) Safety and Occupational Health Program according to AR 385–10, chapter 4, and 29 CFR Part 1960.

(2) Ergonomics Program with an ergonomics subcommittee and an installation ergonomics officer according to DA Pam 40–21, chapters 1–7 and appendix B.

(3) Respiratory Protection Program according to AR 11–34, chapters 1–3.

(4) Hearing Conservation Program according to DA Pam 40–501, chapters 1–10.

(5) Vision Conservation and Readiness Program according to DA Pam 40–506, chapters 1–6 and appendixes B–H.

(6) Health Promotion Program according to AR 600–63, paragraph 1–19 and chapters 2–3.

(7) The Army Industrial Hygiene Program according to DA Pam 40–503, chapters 1–7 and appendixes B–D.

(8) The Army Radiation Safety Program according to AR 11–9, paragraph 1–4j, chapters 2–6 and appendixes A–C.

2–28. Unit and command surgeons

Unit and command surgeons, as the senior USAMEDD officers present for duty within a headquarters (other than medical), will—

a. Advise the command on all preventive medicine matters pertaining to the command.

b. Provide staff and technical oversight of all preventive medicine assets of the command.

c. Provide implementing guidance for field preventive medicine programs and services.

d. Ensure that medical events on the current Tri-Service Reportable Events list are reported through the RMES as soon as possible after the diagnosis has been made or within 48 hours.

e. Coordinate preventive medicine support provided to the command by installation medical assets with the medical asset commander or installation director of health services and the chief of preventive medicine services of the supporting USAMEDCEN or USAMEDDAC.

2–29. Unit commanders and leaders

Unit commanders and leaders will—

a. Inform, motivate, train, and equip subordinates and work closely with Army preventive medicine personnel to defeat the threat of DNBI. Broad categories of DNBIs include—

(1) Heat injuries caused by heat stress and insufficient water consumption.

(2) Cold injuries caused by combinations of low temperatures, wind, and wetness.

(3) Diseases and injuries caused by arthropods, other animals, and hazardous plants.

(4) Diarrheal diseases caused by drinking contaminated water, eating contaminated foods, and not practicing good personal and unit sanitation and hygiene measures.

(5) Diseases, trauma, or injuries caused by poor health or fitness or injuries caused by training or sports.

(6) Occupational and environmental diseases and injuries caused by physical, chemical, biological, and radiological hazards.

(7) Disease threats resulting from exposure at high altitudes.

(8) Communicable diseases and sexually transmitted diseases.

(9) Noise-induced hearing injury.

b. Ensure compliance with preventive medicine guidance and the use of countermeasures.

c. Promote combat and operational stress control programs and procedures.

d. Ensure the establishment, manning, training, and equipping of unit FSTs at the company level, or obtain FST support from another unit, according to Army doctrine published in FM 4–02.17, chapters 1–2; FM 4–25.12, chapters 1–2 and appendixes A–D; and FM 8–55, paragraphs 11–1 through 11–6.

e. Execute the unit leader responsibilities defined in FM 4–02.17. U.S. Army Reserve Component unit commanders and leaders may request guidance and support from the local Active Army RMC, using the RMC point of contact for Reserve Component support.

f. Provide after-action reports after deployments and training exercises that include preventive medicine issues to the USAMEDDC&S as part of the Center for Army Lessons Learned Program (see AR 11–33).

g. Record and report all pesticide applications, except arthropod skin and clothing repellent applications, according to the guidance in DA Pam 40–11, chapter 4.

h. Ensure compliance with pre- and post-deployment surveillance procedures.

2–30. Managers and supervisors at all levels

a. Army managers and supervisors at all levels will—

(1) Ensure that the health of all personnel under their supervision is sustained and protected in all Army activities through aggressive implementation of preventive medicine activities, to include—

(a) Training.

(b) Hazard control.

(c) Immunizations and chemoprophylaxis.

(d) Health risk and hazard communication.

(e) Worksite, OEH surveillance.

(2) Program and budget resources to—

(a) Correct workplace deficiencies and control hazards.

(b) Provide training to comply with individual and unit responsibilities according to FM 8–55, paragraphs 11–5 and 11–6, and FM 21–10/MCRP 4–11.1D, chapters 1–2 and appendix A.

(3) Implement health surveillance requirements, ensuring that personnel enrolled in an Occupational Medicine Surveillance Program comply with the occupational medicine surveillance requirements including pre-placement, periodic, and outprocessing or termination medical evaluations (see DA Pam 40–11, chap 5, and FM 4–02.17, chap 9).

(4) Provide leadership and personal example in improving and sustaining individual and unit health and fitness.

(5) Ensure that contingency and operational plans include the appropriate elements of preventive medicine.

(6) Minimize health risks using Army composite risk management principles (see FM 5–19).

(7) Adhere to Federal, state, and host nation statutory and regulatory laws, directives, licenses, and guidance governing OEH in garrison and during training exercises. These statutes and regulations will also apply during military operational deployments and war unless specifically exempted by appropriate authority based on the tactical situation.

(8) With respect to civilian employees—

(a) Ensure that essential elements of the job and potential health hazards are identified in the job description.

(b) Ensure that any requirements to undergo a medical examination; receive laboratory testing and immunization; and use protective clothing and equipment, including respiratory equipment, safety eye and foot wear, and hearing protection, are written in job descriptions and job announcements as conditions of employment.

(c) Ensure that employees comply with the pre-placement, periodic, and outprocessing medical surveillance requirements of their employment.

(d) Request an occupational health evaluation of personnel with an occupational illness or injury at the time of illness or injury and whenever new job restrictions are imposed or accommodations are required. Supervisors should refer employees who have a work-related injury or illness to the supporting occupational health services, or have the employees see their treating physicians, for periodic reevaluation of their ability to work until the employees return to full duty (see DOD 1400.25–M, subchap 810).

(e) Ensure that personnel enrolled in a Medical Surveillance Program complete a baseline, periodic, and outprocessing or termination medical evaluation.

(f) Provide to occupational health services a copy of the releasable portions of DOL Forms CA–1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation), CA–2 (Federal Employee's Notice of Occupational Disease and Claim for Compensation), and CA–20 (Attending Physician's Report), if applicable.

(g) Refer all employees to occupational health services before they return to duty from any absence due to any illness or injury that could impair their job performance according to Equal Employment Opportunity Commission (EEOC) guidelines (see EEOC Notice Number 915.002).

(h) Refer food handlers and patient care personnel to occupational health services before they return to duty from any absence due to illness according to EEOC guidelines noted in paragraph (g), above.

(9) Be held personally accountable, by appropriate means, for preventive medicine compliance of their subordinates.

b. U.S. Army Reserve Component managers and supervisors may request guidance and support from the local Active Army RMC, using the appropriate chain of command and the RMC point of contact for Reserve Component support.

2–31. Civilian personnel or human resources managers

Local servicing civilian personnel support offices or human resources managers will take the following actions, subject to EEOC guidelines and U.S. Office of Personnel Management regulations, to assist medical personnel in implementing the Army Occupational Health and Safety Program:

a. Provide consultative assistance to managers and supervisors for their responsibilities described in paragraph 2–30.

b. Refer applicants for jobs with medical standards or physical requirements or that are part of a Medical Evaluation Program for preplacement physical examinations.

(1) Coordinate the scheduling of the exam with the employee, the supervisor, and the health clinic.

(2) Provide the examining medical officer the physical and psychological job requirements.

c. Ensure that all new personnel whose jobs have medical standards or physical requirements inprocess through the supporting occupational health services. New personnel whose jobs do not have medical standards or physical requirements may voluntarily inprocess through the supporting occupational health services.

d. During outprocessing or termination of employment—

(1) Assist management in ensuring that departing personnel enrolled in a Medical Surveillance Program complete an outprocessing or termination medical evaluation.

(2) Include occupational health services on all personnel outprocessing checklists for those personnel whose jobs have medical standards or physical requirements or are part of a Medical Evaluation Program.

(3) Offer voluntary outprocessing to those personnel whose jobs do not have medical standards or physical requirements or are not part of a Medical Evaluation Program.

e. Provide the supporting occupational health services a list of all local civilian personnel whose jobs have medical standards or physical requirements or are part of a Medical Evaluation Program and their job series codes within the supporting occupational health services' local areas of responsibility for use in medical surveillance planning and implementation.

2–32. Installation Federal Employee Compensation Act or Injury Compensation Program administrator

The installation Injury Compensation Program administrator, assisted by local or organizational personnel who are assigned injury compensation duties, will—

a. Provide consultative assistance to managers and supervisors for their responsibilities related to employee injury and illness compensation described in paragraph 2–30.

b. Advise and support the installation safety and occupational health advisory council, as established by AR 385–10, paragraph 2–1k, on injury compensation matters.

c. Make available to health care providers who treat employees with occupational injuries and illnesses the necessary forms for completion as well as job requirements and environmental conditions. Such forms will include DOL Forms CA–1, CA–2, CA–17 (Duty Status Report), and CA–20 or equivalent medical documentation.

d. Provide occupational health services a copy of the position description, the physical and environmental requirements of the position, and personnel-related questions for any fitness-for-duty medical examination recommended by management, in conjunction with the supporting civilian personnel or human resources office.

e. Refer personnel at the time of injury or illness, or when reasonably required, to occupational health services, or to their treating physicians, for a duty status determination when such personnel will be absent from work or have work limitations due to their work-related injuries or illnesses.

2–33. Military personnel officers

a. Military personnel officers for both TDA and TOE units will—

(1) Ensure all Soldier inprocessing and outprocessing checklists include occupational health services where such services are provided.

(2) Assist commanders in ensuring that Soldiers enrolled in an Occupational Medicine Surveillance Program comply with the occupational medicine surveillance requirements including a pre-placement and an outprocessing or termination medical evaluation.

(3) Provide a list of all Soldiers including their military occupational specialty codes to occupational health services, where such services are provided, for use in medical surveillance databases.

(4) Support the application of medical information management tools to document unit and individual Soldier medical readiness.

b. Military personnel officers at initial entry training installations will provide installation troop strength data weekly to the supporting medical commander.

c. U.S. Army Reserve unit personnel officers will contact the supporting Active Army RMC's Reserve Component support point of contact, through the appropriate chain of command, for guidance and assistance.

2–34. Army personnel

All Army personnel will—

a. Apply personal protective measures and use protective clothing and equipment when required.

b. Share the responsibility for ensuring a safe and healthy work environment by following administrative and engineering hazard controls.

c. Report unsafe conditions, hazardous exposures, and occupational injury or illness to their supervisors.

d. Report to the supporting occupational health services for medical examination or treatment for occupational injuries and illnesses as prescribed by established procedures.

Appendix A
References

Section I
Required Publications

Except as noted below, Army regulations and DA pamphlets are available online from the U.S. Army Publishing Directorate Web site: http://www.apd.army.mil/. Field manuals are available online from the General Dennis J. Reimer Training and Doctrine Digital Library Web site: http://www.train.army.mil/. Technical bulletins, medical and USACHPPM technical guides are available online from the USACHPPM Web site: http://chppm-www.apgea.army.mil. DOD manuals, directives, and instructions are available online from the Washington Headquarters Services Web site: http://www.dtic.mil/whs/directives.

AR 11–9
The Army Radiation Safety Program. (Cited in para 2–27c(8).)

AR 11–34
The Army Respiratory Protection Program. (Cited in para 2–27c(3).)

AR 40–10
Health Hazard Assessment Program in Support of the Army Materiel Acquisition Decision Process. (Cited in para 2–8a(5).)

AR 70–1
Army Acquisition Policy. (Cited in paras 2–3a and 2–8a(5).)

AR 190–24/OPNAVINST 1620.2A/AFI 31–213/MCO 1620.2C/COMDTINST 1620.1D
Armed Forces Disciplinary Control Boards and Off-Installation Liaison and Operations. (Cited in para 2–18e.)

AR 200–1
Environmental Protection and Enhancement. (Cited in paras 2–3a and 2–8b(4).)

AR 210–14
The Army Installation Status Report Program. (Cited in para 2–18n(2).)

AR 385–10
The Army Safety Program. (Cited in paras 2–27c(1) and 2–32b.)

AR 385–16
System Safety Engineering and Management. (Cited in para 2–3a.)

AR 385–40
Accident Reporting and Records. (Cited in para 2–19b(2).)

AR 385–61
The Army Chemical Agent Safety Program. (Cited in para 2–8b(6).)

AR 385–69
Biological Defense Safety Program. (Cited in para 2–8b(6).)

AR 600–63
Army Health Promotion. (Cited in paras 1–7f(3) and 2–27c(6).)

AR 608–10
Child Development Services. (Cited in para 2–18h.)

DA Pam 40–11
Preventive Medicine. (Cited in paras 1–7, 1–7a(2), 1–7b(4), 1–7b(4)(c), 1–7c(2), 1–7d(2), 1–7d(3), 1–7e(3), 1–7f(2), 1–7f(4), 1–7g(2), 1–7g(3), 1–7h(2), 1–7i(2), 2–17a, 2–17d, 2–18b, 2–18l, 2–25c(1), 2–26c, 2–27a, 2–29g, and 2–30a(3).)

DA Pam 40–21
Ergonomics Program. (Cited in para 2–27c(2).)

DA Pam 40–501
Hearing Conservation Program. (Cited in para 2–27c(4).)

DA Pam 40–503
Industrial Hygiene Program. (Cited in para 2–27c(7).)

DA Pam 40–506
The Army Vision Conservation and Readiness Program. (Cited in para 2–27c(5).)

Executive Order 12196
Occupational and Safety Health Programs for Federal Employees. (Cited in para 1–5c.) (Available at http://www.nara.gov/federal.register/index.html.)

FM 4–02
Force Health Protection in A Global Environment. (Cited in paras 1–7b(3), 1–7b(4), and 2–19d.)

FM 4–02.16
Army Medical Information Management Tactics, Techniques, and Procedures. (Cited in para 1–7b(4)(d).)

FM 4–02.17
Preventive Medicine Services. (Cited in paras 1–7b(4), 1–7b(4)(b), 1–7b(4)(c), 2–26c, 2–29d, 2–29e, and 2–30a(3).)

FM 4–02.18
Veterinary Services Tactics, Techniques, and Procedures. (Cited in para 1–7b(4).)

FM 4–02.19
Dental Service Support In a Theater of Operations. (Cited in para 1–7b(4).)

FM 4–25.12
Unit Field Sanitation Team. (Cited in paras 1–7b(4), 1–7b(4)(a), 1–7b(4)(b), and 2–29d.)

FM 8–42
Combat Health Support in Stability Operations and Support Operations. (Cited in paras 2–17c and 2–19d.)

FM 8–51
Combat Stress Control in a Theater of Operations Tactics, Techniques, and Procedures. (Cited in para 1–7b(4).)

FM 8–55
Planning for Health Service Support. (Cited in paras 1–7b(4), 1–7b(4)(a), 2–29d, and 2–30a(2)(b).)

FM 21–10/MCRP 4–11.1D
Field Hygiene and Sanitation. (Cited in paras 1–7b(4)(a) and 2–30a(2)(b).)

FM 5–19
Composite Risk Management. (Cited in paras 2–26f and 2–30a(6).)

Public Law 91–596
Occupational Safety and Health Act of 1970, 84 Stat. 1590, as amended. (Cited in para 2–8b(8).) (Available at http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=OSHACT&p_id=2743.)

5 USC 8101–8193
Federal Employees' Compensation Act. (Cited in para 2–19v.) (Available at http://uscode.house.gov/search/criteria.php or http://www.dol.gov/esa/regs/compliance/owcp/INDEXofResources.htm#bookmark2.)

42 USC 201
Public Welfare, Department of Health and Human Services, Administrative and Miscellaneous Provisions. (Cited in paras 1–5o.) (Available at http://uscode.house.gov/search/criteria.php.)

29 CFR Part 1960
Basic Program Elements for Federal Employee Occupational Safety and Health Programs and Related Matters. (Cited in para 2–27c(1).) (Available at http://www.gpoaccess.gov/cfr/index.html.)

45 CFR Parts 160, 162, and 164
Health Insurance Reform: Modifications to Electronic Data Transactions Standards and Code Sets. (Cited in para 1–5o.) (Available at http://www.gpoaccess.gov/cfr/index.html.)

Section II
Related Publications

A related publication is a source of additional information. The user does not have to read it to understand this publication.

AR 5–22
The Army Proponent System

AR 10–5
Headquarters, Department of the Army

AR 10–88
Field Operating Agencies, Office of Chief of Staff, Army

AR 11–2
Management Control

AR 11–33
Army Lessons Learned Program: System Development and Application

AR 40–1
Composition, Mission, and Functions of the Army Medical Department

AR 40–3
Medical, Dental, and Veterinary Care

AR 40–35
Dental Readiness and Community Oral Health Protection

AR 40–216
Neuropsychiatry and Mental Health

AR 40–656/NAVSUPINST 4355.10/MCO 10110.45
Veterinary Surveillance Inspection of Subsistence

AR 40–657/NAVSUP 4355.4H/MCO P10110.31H
Veterinary/Medical Food Safety, Quality Assurance, and Laboratory Service

AR 40–905/SECNAVINST 6401.1A/ARI 48–131
Veterinary Health Services

AR 70–45
Scientific and Technical Information Program

AR 200–2
Environmental Effects of Army Actions

AR 200–5
Pest Management

AR 350–10
Management of Army Individual Training Requirements and Resources

AR 381–11
Productions Requirements and Threat Intelligence Support to the U.S. Army

AR 600–9
The Army Weight Control Program

AR 600–60
Physical Performance Evaluation System

AR 600–85
Army Substance Abuse Program (ASAP)

AR 600–110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV)

AR 602–2
Manpower and Personnel Integration (MANPRINT) in the System Acquisition Process

AR 608–18
The Army Family Advocacy Program

AR 623–105
Officer Evaluation Reporting System

AR 690–300
Employment (Civilian Personnel)

AR 700–48
Management of Equipment Contaminated with Depleted Uranium or Radioactive Commodities.

AR 700–135
Soldier Support in the Field

AR 700–136
Tactical Land Based Water Resources Management in Contingency Operations

DA Pam 40–578
Health Risk Assessment Guidance for the Installation Restoration Program and Formerly Used Defense Sites

DA Pam 385–40
Army Accident Investigation and Reporting

DFAS–IN Manual 37–100–FY
The Army Management Structure. (Available at http://www.asafm.army.mil/secretariat/document/dfas37–100/dfas37–100.asp)

DOD 1400.25–M
Department of Defense Civilian Personnel Manual

DOD 4500.9–R
Defense Transportation Regulation

DOD 6055.5–M
Occupational Medical Surveillance Manual

DODD 1000.3
Safety and Occupational Health Policy for the Department of Defense

DODD 1010.10
Health Promotion and Disease/Injury Prevention

DODD 4715.1
Environmental Security

DODD 5134.8
Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs (ATSD(NCB))

DODD 5400.11
DOD Privacy Program

DODD 6000.12
Health Services Operations and Readiness

DODD 6050.16
DOD Policy for Establishing and Implementing Environmental Standards at Overseas Installations

DODD 6200.4
Force Health Protection (FHP)

DODD 6490.2
Comprehensive Health Surveillance

DODI 1322.24
Medical Readiness Training

DODI 1336.5
Automated Extracts of Active Duty Military Personnel Records

DODI 4150.7
DOD Pest Management Program

DODI 4715.7
Environmental Restoration Program

DODI 6050.5
DOD Hazard Communication Program

DODI 6055.1
DOD Safety and Occupational Health (SOH) Program

DODI 6055.5
Industrial Hygiene and Occupational Health

DODI 6055.7
Accident Investigation, Reporting, and Record Keeping

DODI 6055.8
Occupational Radiation Protection Program

DODI 6055.11
Protection of DOD Personnel from Exposure to Radiofrequency Radiation and Military Exempt Lasers

DODI 6055.12
DOD Hearing Conservation Program (HCP)

DODI 6060.2
Child Development Programs (CDPs)

DODI 6060.3
School-Age Care (SAC) Program

DODI 6205.2
Immunization Requirements

DODI 6205.4
Immunization of Other Than U.S. Forces (OTUSF) for Biological Warfare Defense

DODI 6490.03
Deployment Health

DOD Information Memorandum
Military and Veterans Health Coordinating Board (MVHCB) and Presidential Review Directive-5 (PRD–5). December 1999. (For information regarding this publication, contact the Assistant Secretary of the Army for Installations and Environment (ASA(I&E)), 110 Army Pentagon, Washington, DC 20310–0110.)

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Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans With Disabilities Act (ADA). July 27, 2000. Equal Employment Opportunity Commission (EEOC). (Available at http://www.eeoc.gov/policy/docs/guidance-inquiries.html.)

Engineer Manual 385–1–1
Safety and Health Requirements Manual, USACE, latest edition. (Available at http://www.usace.army.mil/inet/usace-docs/eng-manuals/em385–1–1/entire.pdf.)

FM 3–11.34/MCWP 3–37.5/NTTP 3–11.23/AFTTP(I) 3–2.33
Multi-Service Procedures for Nuclear, Biological, and Chemical (NBC) Defense of Theater Fixed Sites, Ports, and Airfields

FM 3–100.4/MCRP 4–11B
Environmental Considerations in Military Operations

FM 4–02.33
Control of Communicable Diseases Manual

Force Health Protection Capstone Document
Available at http://www.deploymentlink.osd.mil/pdfs/fhp2004.pdf.

Joint Publication 1–0
Joint Doctrine for Personnel Support to Joint Operations. (Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp1_0.pdf.)

Joint Publication 1–02
Department of Defense Dictionary of Military and Associated Terms. (Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp1_02.pdf.)

Joint Publication 4–02
Doctrine for Health Service Support in Joint Operations. (Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp4_02.pdf.)

Memorandum
Office of DASA (ESOH), 20 March 1998, subject: Agency for Toxic Substances and Disease Registry (ATSDR) Program Management Plan. (Available at http://chppm-www.apgea.army.mil/atsdr/docs.aspx.)

Memorandum of Understanding
The Agency for Toxic Substances and Disease Registry, U.S. Public Health Service, and the U.S. Department of Defense, The Development of Toxicological Profiles for Hazardous Substances and Public Health Assessments and Related Activities at DOD Facilities, 22 November 2004. (Available at http://chppm-www.apgea.army.mil/atsdr/Documents/MOUfinal21Nov04ATSDR.pdf and http://chppm-www.apgea.army.mil/atsdr/Documents/ATSDRMOU2004signaturepage.pdf.)

Institute of Medicine Report
Noise and Military Service: Implications for Hearing Loss and Tinnitus. (2006). National Academy of Sciences. (Available at http://www.nap.edu.)

Institute of Medicine Report
Potential Radiation Exposure in Military Operations: Protecting the Soldier Before, During and After. (1999). National Academy of Sciences. (Available at http://www.nap.edu.)

Institute of Medicine Report
Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces. (2000). National Academy of Sciences. (Available at http://www.nap.edu.)

Presidential Review Directive 5
Planning for Health Preparedness For and Readjustment of the Military, Veterans, and Their Families After Future Deployments. (Available at http://www.fas.org/irp/offdocs/prd-5-report.htm.)

TB MED 530
Occupational and Environmental Health Food Sanitation

Unified Facilities Guide Specifications
Available at http://www.hnd.usace.army.mil/techinfo/gspec.htm.

USACHPPM Technical Guide 230
Chemical Exposure Guidelines for Deployed Military Personnel. (Available from the U.S. Army Center for Health Promotion and Preventive Medicine, ATTN: MCHB–TS–EES, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010–5403 or http://chppm-www.apgea.army.mil.)

USACHPPM Reference Document 230
A Companion Document to USACHPPM Technical Guide 230, Chemical Exposure Guidelines for Deployed Military Personnel. (Available from the U.S. Army Center for Health Promotion and Preventive Medicine, ATTN: MCHB–TS–EES, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010–5403 or http://chppm-www.apgea.army.mil.)

USACHPPM Technical Guide 248
Guide for Deployed Preventive Medicine Personnel on Health Hazard Risk Management. (Available from the U.S. Army Center for Health Promotion and Preventive Medicine, ATTN: MCHB–TS–EES, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010–5403 or http://chppm-www.apgea.army.mil.)

31 USC 1535 and 1536
Economy Act

50 USC 1522
Conduct of chemical and biological defense program. (Available at http://uscode.house.gov/download/pls/50C32.txt

Section III
Prescribed Forms
This section contains no entries.

Section IV
Referenced Forms

DA Form 11–2–R
Management Control Evaluation Certification Statement. (Available at http://www.apd.army.mil/)

DOL Form CA–1
Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. (Available at http://www.dol.gov/esa/regs/compliance/owcp/ca-1.pdf.)

DOL Form CA–2
Notice of Occupational Disease and Claim for Compensation. (Available at http://www.dol.gov/esa/regs/compliance/owcp/ca-2.pdf.)

DOL Form CA–17
Duty Status Report. (Available at http://www.dol.gov/esa/regs/compliance/owcp/ca-17.pdf.)

DOL Form CA–20
Attending Physician's Report. (Available at http://www.dol.gov/esa/regs/compliance/owcp/ca-20.pdf.)

Appendix B
Management Control Evaluation

B–1. Function
The function covered by this evaluation is preventive medicine.

B–2. Purpose
The purpose of this evaluation is to assist commanders in evaluating the key management controls as outlined below (with medical personnel evaluating these key controls or resulting evaluation certified by some medical officer/official). This evaluation should be used at the following levels: Headquarters, Department of the Army, field operating agency, ACOMs, Army service component commands, direct reporting units, major subordinate commands, installations, and TOE units. It is not intended to cover all controls, but you must evaluate all controls applicable to your activity.

B–3. Instruction
Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that indicate deficiencies *must* be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2–R (Management Control Evaluation Certification Statement).

B–4. Test Questions
a. Are practices and procedures in place and operating to determine adherence to health standards established in pertinent Federal, state, local and host Government statutes and regulations and in Army regulations?

b. Were sufficient resources requested to accomplish all responsibilities designated in this regulation? Where actual resources received were insufficient, were those resources applied to the highest priority areas? Was the adverse impact of the unfunded requirements communicated to higher headquarters?

c. Is medical and OEH surveillance performed as required?

d. Are Army personnel informed of all health threats and risks and appropriate countermeasures?

e. Is accreditation and quality assurance for preventive medicine laboratory services monitored?

f. Are health hazards of new equipment and materiel assessed?

g. Are the same preventive medicine support services provided to all personnel (for example, military, civilian, contractor) deployed for military operations?

h. Are there standard process outcome metrics applied to evaluate preventive medicine activities?

i. Are commanders, supervisors, and preventive medicine staff provided basic, specialized, and sustainment training that will enable them to properly execute their preventive medicine leadership and staff responsibilities?

j. Are Defense Health Program structure codes used for preventive medicine budget execution tracking and program analysis review?

k. Are preventive medicine issues addressed through the DOTMLPF process?

l. Are preventive medicine workloads documented?

m. Are preventive medicine principles incorporated into Army officer and enlisted training manuals and Soldier common task training manuals?

n. Are medical events reported through a military Medical Event Reporting System in compliance with state and local medical reporting requirements?

B–5. Supersession

This evaluation replaces the checklists (DA Circular 11–88–7) previously published for this regulation.

B–6. Comments

Help make this a better tool for evaluating management controls. Submit comments to the Deputy Functional Proponent for Preventive Medicine, ATTN: DASG–PPM–NC, 5109 Leesburg Pike, Suite 684, Falls Church, VA 22041–3258.

Glossary

Section I
Abbreviations

AAE
Army Acquisition Executive

ACOM
Army Command

ASA(I&E)
Assistant Secretary of the Army (Installations and Environment)

ASA(M&RA)
Assistant Secretary of the Army (Manpower and Reserve Affairs)

ATSDR
Agency for Toxic Substances and Disease Registry

ATTN
attention

CBRN
chemical/biological/radiological/nuclear

CBRNE
chemical/biological/radiological/nuclear/explosives

CFR
Code of Federal Regulations

CONUS
continental U.S.

DA Pam
Department of the Army pamphlet

DFAS–IN
Defense Finance and Accounting Service—Indianapolis Center

DNBI
disease and non-battle injury

DODD
Department of Defense directive

DODI
Department of Defense instruction

DOEHRS
Defense Occupational and Environmental Health Readiness System

DOL
Department of Labor

DOTMLPF
doctrine, organizations, training, materiel, leadership and education, personnel, and facilities

EEOC
Equal Employment Opportunity Commission

eV
electron volt

FM
field manual

FST
field sanitation team

FY
fiscal year

HHA
health hazard assessment

MTF
military treatment facility

OCONUS
outside the continental U.S.

OEH
occupational and environmental health

OMA
operations and maintenance, Army

OSHA
Occupational Safety and Health Administration

OTSG
Office of The Surgeon General

RMC
regional medical command

RMES
Reportable Medical Events System

TDA
tables of distribution and allowances

TIM
toxic industrial material

TOE
tables of organization and equipment

TSG
The Surgeon General

USACHPPM
U.S. Army Center for Health Promotion and Preventive Medicine

USADENCOM
U.S. Army Dental Command

USAMC
U.S. Army Materiel Command

USAMEDCEN
U.S. Army medical center

USAMEDCOM
U.S. Army Medical Command

USAMEDD
U.S. Army Medical Department

USAMEDDAC
U.S. Army medical department activity

USAMEDDC&S
U.S. Army Medical Department Center and School

USAMRMC
U.S. Army Medical Research and Materiel Command

USAMSA
U.S. Army Medical Surveillance Activity

USATRADOC
U.S. Army Training and Doctrine Command

USC
United States Code

Section II
Terms

Army installation
A grouping of facilities located in the same vicinity supporting particular DA functions. Installations may include locations such as posts, camps, stations, or communities and land and improvements permanently affixed thereto that are under the DA control and used by Army organizations. Where installations are located contiguously, the combined property is designated as one installation and the separate functions are activities of that installation. In addition to those used primarily by troops, the term applies to installation real properties such as depots, arsenals, ammunition plants (both contractor and Government-operated), hospitals, terminals, and other special mission installations. An installation is a physical site uniquely identified by an Army Location Code. The Army National Guard/Army National Guard of the United States by state is equivalent to an installation and has a designated unique Army location code.

Army personnel
As used in this publication, includes Active Army; Army National Guard/Army National Guard of the United States and U.S. Army Reserve personnel on active duty or inactive duty for training status; U.S. Military Academy cadets; U. S. Army Reserve Officer Training Corps cadets, when engaged in directed training activities; other DOD and foreign national military personnel assigned to Army components; and civilian personnel and nonappropriated fund personnel employed by the Army worldwide. Except for those preventive medicine services defined in DODI 6055.1 for supporting DOD contractor personnel during OCONUS force deployments or specifically provided for in contracts between the Government and a contractor, Army contractor personnel are not included in this definition.

Augmentation response teams
Teams consisting of subject matter experts who are sufficiently trained and prepared to provide the appropriate level of response on order of Headquarters, Department of The Army Surgeon General/U.S. Army Medical Command, at the request of legitimate civil, Federal, or defense authorities. These teams provide short-duration medical augmentation to regional domestic, Federal and DOD agencies responding to disaster, civil-military, humanitarian, and emergency incidents.

Biologics
Medicinal preparations made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

Biological agent
A microorganism that causes disease in personnel, plants, or animals or causes the deterioration of materiel.

Biopsychosocial
A term combining biological, psychological, and social factors or aspects into one term for convenience, and to maintain the sense of complex interaction among these various aspects of human behavior.

Chemical warfare agent or chemical agent
A chemical substance intended for use in military operations to kill, seriously injure, or incapacitate people through its physiological effects. Deny or hinder the use of areas, facilities, or materials or defense against such use. Included are blood, nerve, choking, blister, and incapacitating agents. Excluded are riot control agents, chemical herbicides, and smoke and flame materials.

Combat and operational stress reactions
Acute, debilitating mental, behavioral or somatic symptoms thought to be caused by operational or combat stressors that are not adequately explained by physical disease, injury, or preexisting mental disorder and that can be managed with reassurance, rest, physical replenishment (such as, hydration, food, hygiene, sleep), and activities that restore confidence.

Communicable disease
Illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly, through an intermediate plant or animal host, vector, or the inanimate environment. Synonymous with infectious disease.

Deployment
The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intracontinental United States, intertheater, and intratheater movement legs, staging, and holding areas.

Direct reporting unit
An Army organization comprised of one or more units with institutional or operational functions; designated by the Secretary of the Army; providing broad general support to the Army in a normally single, unique discipline not otherwise available elsewhere in the Army. Direct reporting units report directly to a Headquarters Department of the Army principal and/or Army command and operate under authorities established by the Secretary of the Army. Direct reporting units include the following 11 commands:

a. U. S. Army Network Enterprise Technology Command/9th Signal Command.
b. U.S. Army Medical Command.
c. U.S. Army Intelligence and Security Command.
d. U.S. Army Criminal Investigation Command.
e. U.S. Army Corps of Engineers.
f. U.S. Army Military District of Washington.
g. U.S. Army Test and Evaluation Command.
h. U.S. Military Academy.
i. U.S. Army Reserve Command.
j. U.S. Army Acquisition Support Center.
k. U.S. Army Installation Management Command.

Director of health services
The principal medical advisor to the installation commander and staff on health care delivery matters, including installation and clinical preventive medicine programs and services for the installation commander's areas of responsibility. Commanders of USAMEDCENs and USAMEDDACs, as the local medical authority, either serve as the director of health services on the installation staff, or more commonly, appoint a representative.

Disease and non-battle injury
Preventable diseases and injuries that are not a result of hostile action by or against an organized enemy, but of non-battle conditions that render a Soldier combat-ineffective. These diseases and injuries include infectious diseases, arthropod-borne diseases, food- and water-borne diseases, environmental injury/illness (such as, heat, cold, altitude,

toxic materials), and occupational injury/illness (such as noise-induced hearing loss). Non-battle injuries include self-inflicted wounds and all injuries that occur during peacetime.

Ergonomics
The field of study that seeks to fit the job to the person, rather than the person to the job. This is achieved by the evaluation and design of workplaces, environments, jobs, tasks, equipment, and processes in relationship to human capabilities and interactions in the workplace.

Force Health Protection
The medical portion of Force Protection; all measures taken by commanders, leaders, individual Service members, and the Military Health System to promote, improve, conserve, or restore the mental and physical well-being of Service members across the range of military activities and operations. These measures enable the fielding of a healthy and fit force, prevention of injuries and illness, protection of the force from health hazards, and provision of excellent medical and rehabilitative care to those who become sick or injured anywhere in the world.

Garrison
The basic organizational structure for providing programs, services and management to an installation and its resident community. An Army garrison is a TDA organization that commands, controls, and manages Army installations. Garrison command is the execution arm of the Installation Management Agency. It delivers the majority of installation management services to both resident and nonresident organizations. The garrison's mission is linked to the installation's purpose. As the execution arm of the Installation Management Agency, the garrison's mission is to provide installation management programs and services for mission activity commanders, Soldiers, civilians, family members, and retirees.

Health hazard assessment
The application of biomedical knowledge and principles to document and quantitatively determine the health hazards of Army systems. This assessment identifies, evaluates, and recommends controls to reduce risks to the health and effectiveness of personnel who test, use, or service Army systems. This assessment includes—

a. The evaluation of hazard severity, hazard probability, risk assessment, consequences, and operational constraints.
b. The identification of required precautions and protective devices.
c. Training requirements.

Health risk assessment
The identification and evaluation of a health hazard to determine the associated health risk (probability of occurrence and resulting outcome and severity) of potential exposure to hazard.

Health risk communication
The process of building and maintaining strategic partnerships that is the foundation for information exchange, dialogue, and collaborative problem solving among interested stakeholders about health and safety issues.

Hearing readiness, clinical, operational, and conservation services
The four elements that embody the leadership policies, strategies, and processes to prevent noise-induced hearing loss among military and civilian personnel. Together these elements constitute The Army Hearing Program. The hearing readiness element provides for audiometric monitoring and the tracking of individual and unit hearing readiness status for deployability. The clinical services element provides for treatment of hearing injury in garrison and deployed settings, as well as audiological diagnostic capabilities in fixed facilities. The operational services element focuses on preventing or mitigating noise-induced hearing loss during military operations while maintaining or enhancing the ability to communicate. This element includes risk communication, training, communication enhancement and hearing protection devices, sound-level monitoring, noise abatement control measures, and evaluation of effectiveness of countermeasures. The hearing conservation element focuses on protecting military and civilian personnel from hearing loss due to occupational/industrial noise exposures in fixed facilities.

Industrial hygiene
The science and art devoted to anticipation, recognition, evaluation, and control of those environmental factors or stresses, arising in or from the workplace, that may cause sickness, impaired health and well-being, or significant discomfort and inefficiency among workers.

Initial entry training
Training presented to new enlistees with no prior military service. It is designed to produce disciplined, motivated,

physically fit Soldiers ready to take their place for the Army in the field. This training includes basic combat training, one station unit training, and advanced individual training.

Ionizing radiation
Charged subatomic particles and ionized atoms with kinetic energies greater than 12.4 electron volt (eV), electromagnetic radiation with photon energies greater than 12.4 eV, and all free neutrons and other uncharged subatomic particles (except neutrinos and antineutrinos).

Medical surveillance
The ongoing systematic collection, analysis, and interpretation of medical data essential to evaluating, planning, and implementing public health practice and prevention that is closely integrated with the timely dissemination of this data to those who need to know. In particular, it means the medical data related to individual patient encounters and the summary of portions of the data in the calculation of DNBI rates for a defined population for the primary purposes of prevention and control of health and safety hazards.

Medical Surveillance System
An integrated set of information management capabilities, information technologies, databases, and procedures for the collection, analysis, archiving, and dissemination of information in support of preventive medicine activities.

Military treatment facility
A civilian or uniformed services medical center, hospital, clinic, or other facility that is authorized to provide medical, dental, or veterinary care.

Nonionizing radiation
Electromagnetic radiation with photon energies less than 12.4 eV.

Occupational and environmental health surveillance
The continuous process of assessing potential exposures and health effects, recommending health risk reduction options, and evaluating the effectiveness of health risk reduction methods for chemicals of concern, weapons of mass destruction, pathogens, disease vectors (such as, arthropods and rodents), and radioactive materials in air, soil, water, and food. It also includes surveillance of health effects from heat, cold, nonionizing radiation (such as, radio frequency, microwave and laser), ionizing radiation sources, noise, and psychological stressors. It includes coordination and information transfer with agencies responsible for surveillance of safety hazards (such as, ground, vehicle, and aviation) and environmental management actions to comply with U.S. or host nation environmental compliance, cleanup, and pollution prevention laws and regulations.

Occupational and environmental health threat
Any condition that could result in exposures of any Army personnel to chemical, biological, radiation, and physical hazards in any aspect of military operations in garrison and during deployments. In deployments, occupational and environmental health threats include but are not limited to—

a. Accidental or deliberate release of non-weaponized TIMs, hazardous physical agents, ionizing and nonionizing radiological hazards, as well as direct hazard effects from weaponized chemical/biological/radiological/nuclear/explosive (CBRNE) devices, and the residue from the use of CBRNE devices.

b. Environmental hazards to include physical hazards and vector- and arthropod-borne threats, residues, or agents naturally occurring or resulting from previous activities of U.S. forces or other concerns, such as non-U.S. military forces, enemy forces, local national governments, or local national agricultural, industrial, or commercial activities.

c. The TIMs or hazardous physical agents, such as noise or ionizing and nonionizing radiation hazards, currently being generated as a by-product of the activities of U.S. forces or other concerns, such as non-U.S. military forces, enemy forces, local national governments, or local national agricultural, industrial, or commercial activities.

d. Combat and operational stress.

Pharmaceuticals
Pertaining to pharmacy or to medicinal drugs.

Preventive medicine level V support
One of the five levels of support for preventive medicine. In the theater of operation, preventive medicine support is tailored and phased to enhance mission requirements, counter the medical threat, and provide preventive medicine support as far forward as the tactical situation will permit. Level V support is provided by preventive medicine units in CONUS. Home station operations centers, such as USAMEDDACs and USAMEDCENs, in the CONUS-sustaining base will provide technical support for preventive medicine issues and support to the force during pre- and post-deployment surveillance. The USACHPPM and its subordinate activities provide definitive laboratory analysis, serve as

the technical center of expertise, and are the ultimate repository of all medical surveillance data collected within the theater.

Principles of population medicine
A systematic approach to healthcare delivery for a beneficiary population. Such an approach includes self-care; community-based public health health care activities; and medical interventions to render primary, secondary, and tertiary comprehensive care, taking into consideration the determinants of health.

Reimbursable preventive medicine services
Those services that fall beyond the normal mission area of the servicing organization but within that organization's technical competency; these services are provided to a requesting agency under a fund cite from that requesting agency.

Risk management
The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk cost with mission benefits.

Toxic industrial materials (TIMs)
Materials such as chemicals and radioactive material that pose hazards to individuals. TIMs are generally in one of the following categories:

a. Agriculture—includes insecticides, herbicides, fertilizers.

b. Industrial—chemical and radiological materials used in manufacturing processes or for cleaning.

c. Production and research—chemicals and biologicals produced or stored in a facility.

d. Radiological—nuclear power plants, medical facilities/laboratories, uranium mining and refining operations, nuclear fuel fabrication, transportation, and radiological waste storage operations (see FM 3–11.34/MCWP 3–37.5/NTTP 3–11.23/AFTTP(I) 3–2.33).

Weapons of mass destruction
In arms control usage, weapons that are capable of a high order of destruction and/or of being used in such a manner as to destroy large numbers of people. Can be nuclear, chemical, biological, or radiological weapons but excludes the means of transporting or propelling the weapon where such means is a separable and divisible part of the weapon.

Section III
Special Abbreviations and Terms
This section contains no entries.

USAPD

ELECTRONIC PUBLISHING SYSTEM
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Louise R. Bailey, MEd, RN, Executive Officer

AN EXPLANATION OF THE SCOPE OF RN PRACTICE INCLUDING STANDARDIZED PROCEDURES

The Legislature, in its 1973-74 session, amended Section 2725 of the Nursing Practice Act (NPA), amplifying the role of the registered nurse and outlining activities which comprise the practice of nursing.

LEGISLATIVE INTENT

The Legislature recognized that nursing is a dynamic field, continually evolving to include more sophisticated patient care activities. It declared its intent to recognize the existence of **overlapping functions** between physicians and registered nurses and to permit **additional such sharing** and to provide **clear legal authority** for those functions and procedures which have common acceptance and usage. Prior to this, nurses had been educated to assume advanced roles, and demonstration projects had proven their ability to do this safely and effectively. Thus, legal amplification of the role paralleled the readiness of nurses to assume the role and recognized that many were already functioning in an expanded role.

SCOPES OF PRACTICE

A knowledge of the respective scopes of practice of registered nurses and physicians is important in determining **which activities overlap** medical practice and therefore require standardized procedures. Failure to distinguish nursing practice from medical practice may result in the limitation of the registered nurse's practice and the development of unnecessary standardized procedures. Registered nurses are cautioned not to confuse nursing policies and procedures with standardized procedures.

1. Scope of Registered Nursing Practice

The activities comprising the practice of nursing are outlined in the Nursing Practice Act, Business and Professions Code Section 2725. A broad, all inclusive definition states that the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill.

In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which **does not** require a standardized procedure. Nursing practice is divided into three types of functions, which are described below.

A. Independent Functions

Subsection (b)(1) of Section 2725, authorizes direct and indirect patient care services that insure the safety, comfort, personal hygiene and protection of patients, and the performance of disease prevention and restorative measures. Indirect services include delegation and supervision of patient care activities performed by subordinates.

Subsection (b)(3) of Section 2725, specifies that the performance of skin tests, immunization techniques and withdrawal of human blood from veins and arteries is included in the practice of nursing.

TAB L-1

Subsection (b)(4) of Section 2725, authorizes observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition and determination of whether these exhibit abnormal characteristics; and based on this determination, the implementation of appropriate reporting or referral, or the initiation of emergency procedures. These independent nursing functions have long been an important focus of nursing education, and an implied responsibility of the registered nurse.

B. Dependent Functions

Subsection (b)(2) of Section 2725, authorizes direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist or clinical psychologist.

C. Interdependent Functions

Subsection (b)(4) of Section 2725, authorizes the nurse to implement appropriate standardized procedures or changes in treatment regimen in accordance with standardized procedures after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. These activities overlap the practice of medicine and may require adherence to a standardized procedure when it is the nurse who determines that they are to be undertaken.

2. Scope of Medical Practice

The Medical Practice Act authorizes physicians **to diagnose** mental and physical conditions, **to use drugs in or** upon human beings, **to sever or penetrate the tissues** of human beings and **to use other methods** in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these by a registered nurse requires a standardized procedure; however, activities within each of these categories have already become common nursing practice and therefore do not require standardized procedures; for example, the administration of medication by injection requires penetration of human tissue, and registered nurses have performed this function through the years.

In Section 2725(a), the Legislature referred to the dynamic quality of the nursing profession. This means, among other things, that some functions which today are considered medical practice will become common nursing practice and no longer require standardized procedures. Examples of medical functions which have evolved into common nursing functions are the measurement of cardiac output pressures, and the insertion of PICC lines.

STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS

The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the **organized health care system** in which it is to be used. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse. Section 2725(a) defines "organized health care systems" to include, but are not limited to, licensed health facilities, clinics, home health agencies, physicians' offices, and public or community health services.

GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES

Standardized procedures are **not subject to prior approval** by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.

(2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.

(3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

(4) Specify any **experience, training and/or education** requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.

(7) Specify the scope of **supervision** required for performance of standardized procedure functions, for example, telephone contact with the physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.

(9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.

(10) Specify patient **record-keeping** requirements.

(11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.

SUMMARY OF RN FUNCTIONS UNDER STANDARDIZED PROCEDURES
Registered nursing functions under standardized procedures may be summarized as follows:

WHO: the registered nurse

WHAT: may perform a medical function beyond the usual scope of RN practice

HOW: in accord with a written standardized procedure developed by nursing, medicine and administration

WHERE: in an organized health care system

WHEN: after the RN has been evaluated and approved as having met the education and experience requirements specified in the procedure

WHY: because the standardized procedure authorizes the RN to exceed the usual scope of RN practice

TO DETERMINE IF A STANDARDIZED PROCEDURE IS REQUIRED

sk each question below in the order presented. Continue only until your answer points to "S.P. required," or to "S.P. not required."

1. Is the function commonly recognized as nursing practice?

   NO ⇓ **YES ⇒ S.P. not required**

2. Is it the standard of practice in the community that RNs perform this function in the clinical area for which it is being considered?

   NO ⇓ **YES ⇒ S.P. not required**

3. Does the function require the nurse to:
   Diagnose disease,
   Prescribe medicine or treatment, or
   Penetrate or sever tissue?

   NO ⇓ **YES ⇒ S.P. required**

4. Does safe performance of the function require judgment based on medical knowledge beyond that usually possessed by the competent RN in the area for which it is being considered?

   NO ⇓ **YES ⇒ S.P. required**

   S.P. not required

WHO DEVELOPS STANDARDIZED PROCEDURES?

1. Organized Health Care Systems → Health Facilities licensed by Dept. of Public Health
   → Health Facilities not licensed (CCR 1470): Clinics, Home Health Agencies, Physicians Offices, Public or Community Health Services

2. Collaborating:

   Administrators, and Health Care Professionals, including → REGISTERED NURSI
   → PHYSICIAI

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STANDARDIZED PROCEDURE GUIDELINES

Website: http://www.rn.ca.gov/regulations/title16.shtml#1470

ARTICLE 7. STANDARDIZED PROCEDURE GUIDELINES

1470. Purpose

The Board of Registered Nursing in conjunction with the Division of Allied Health Professions of the board of Medical Quality Assurance (see the regulations of the Board of Medical Quality Assurance, Article 9.5, Chapter 13, Title 16 of the California Code of Regulations) intends, by adopting the regulations contained in the article, to jointly promulgate guidelines for the development of standardized procedures to be used in organized health care systems which are subject to this rule. The purpose of these guidelines is:

(a) To protect consumers by providing evidence that the nurse meets all requirements to practice safely.

(b) To provide uniformity in development of standardized procedures.

1471. Definitions

For purposes of this article:

(a) "Standardized procedure functions" means those functions specified in Business and Professions Code Section 2725(c) and (d) which are to be performed according to "standardized procedures";

(b) "Organized health care system" means a health facility which is not licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the Health and Safety Code and includes, but is not limited to, clinics, home health agencies, physicians' offices and public or community health services;

(c) "Standardized procedures" means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions.

1472. Standardized Procedure Functions

An organized health care system must develop standardized procedures before permitting registered nurses to perform standardized procedure functions. A registered nurse may perform standardized procedure functions only under the conditions specified in a health care system's standardized procedures; and must provide the system with satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform such functions.

1473. Standardized Procedures

NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725, Business and Professions Code. HISTORY: Repealed 12-4-85.

1474. Standardized Procedure Guidelines

Following are the standardized procedure guidelines jointly promulgated by the Division of Allied Health Professions of the Board of Medical Quality Assurance and by the Board of Registered Nursing:

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.

(2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

(3) State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

(4) Specify any experience, training, and/or education requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

(7) Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.

(10) Specify patient record keeping requirements.

(11) Provide for a method of periodic review of the standardized procedures.

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STANDARDS OF COMPETENT PERFORMANCE

Website: http://www.rn.ca.gov/regulations/title16.shtml#1443.5

1443.5. STANDARDS OF COMPETENT PERFORMANCE

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and the health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

CALIFORNIA BOARD ' 'GISTERED NURSING
Understanding the Role of the Re ed Nurse and Interim Permittee
According to the Nursing Practice Act, the California Code of Regulations, and Selected Sections of Title XXII

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of Competent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulations Title 22 Section 70215.
(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.	Section 1443.5 (1) A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows: ➢ formulates a nursing diagnosis through observation of the client's physical condition and behavior and ➢ through interpretation of information obtained from the client and others, including the health team	70215. (a) (1) A registered nurse shall directly provide: Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift and upon receipt of the patient when he/she is transferred to another patient care area.
	Comments/Notes: → RN must assess every patient every shift to direct patient care (Title 22). → RN performs nursing process functions independently, dependently, and interdependently and knows when each type of function should be used. → RN independently initiates and performs complex thinking strategies in all phases of the nursing process. This includes the ability to formulate a patient specific set of diagnoses when there is uncertain, inconsistent, unique and conflicting patient information.	**Comments/Notes:** See 2725 (b) (2) comments related to the assessment component of this section.

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of Competent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulations Title 22 Section 70215.
(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:	Section 1443.5 (2) A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows: ➢ formulates a care plan in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for the disease prevention and restorative measures.	70215. (a) (2) A registered nurse shall directly provide: The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed staff, or may be assigned to unlicensed staff, subject to any limitation of their licensure.
Comments/Notes: RN is accountable for an ongoing comprehensive assessment that includes data collection, analysis, and drawing conclusions/making judgments in order to: → formulate diagnoses and update diagnoses → formulate or change the plan of care → decide on specific activities to implement the plan of care (immediate and long-term) → prioritize and coordinate delivery of care → delegate to nursing care competent staff to deliver required care → anticipate discharge planning/teaching needs → advocate for the patient as needed RN uses scientific knowledge and experience to make clinical judgments about observed abnormalities and changes based on a series of complex, independent and collaborative decision making activities.	**Comments/Notes:** RN role necessitates rapid information processing and application of scientific knowledge to coordinate, delegate and supervise the delivery of safe, timely care. This includes knowledge, skill, and ability to: → Check accuracy/reliability of information; → Identify patterns by case type, standards of treatment, familiar circumstances, and relevance of data; → Recognize inconsistencies and missing information; → Search for additional information; → Cluster clues; → Generate a hypothesis about disease conditions, health problems, patient needs; → Make predictions about findings, needs, use of → interventions, outcomes; → Set priorities for implementation of nursing care, priorities regarding urgency of patient concerns; → Evaluate and revise based on review of new information; LVN is not prepared by formal education to make RN level nursing judgments that include independent analysis, synthesis, and decision-making. RN is responsible for collecting, analyzing, and collaborating with all information sources to ensure a comprehensive written plan of care that is based on current standards of safe practice.	**Comments/Notes:** Refer to BPC 2725 and CCR 1443.5(4)

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of Competent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulations Title 22 Section 70215.
(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.	Section 1443.5 (3) A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows: ➢ performs skills essential to the kind of nursing action to be taken ➢ explains the health treatment to the client and family ➢ teaches the client and family how to care for the client's health needs	70215. (a) (3) A registered nurse shall directly provide: The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of a patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.
Comments/Notes: This section of the NPA authorizes many of the independent nursing functions the RN performs based on pre-licensure educational preparation and RN licensure in California.	**Comments/Notes:** Also, see pg. 2, 1443.5(2), comments for detailed strategies used by the RN. RN develops, implements and evaluates teaching plan in collaboration with patient and health care team through: → Delegation of teaching activities based on education, skills, experience, and competence of the staff → Coordination and review of complete patient/family teaching activities including documentation → Validation of patient/family understanding of teaching provided → Identification of additional teaching needs	**Comments/Notes:** Refer to BPC Section 2725(6) and CCR 1443.5(3)

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of Competent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulations Title 22 Section 70215.
(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.	Section 1443.5 (4) A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows: ➢ delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the task to be delegated ➢ effectively supervises nursing care given by subordinates	70215. (b) The planning and delivery of patient care shall reflect all elements of nursing process: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. Note: Assessment Nursing Diagnosis Planning Intervention Evaluation Advocacy
Comments/Notes: In many situations, RNs administer meds and implement treatment regimens based on patient specific physicians' orders. When the RN performs these services based on patient specific orders, this is a dependent nursing function. RNs performing medication administration using approved standardized procedures are performing an interdependent function authorized by BPC 2725(6)(4). These functions are interdependent because the RN collaborates with the supervising MD to develop the approved standardized procedures and implements these functions based on the RN's knowledge, skill, and competence to perform the service.	**Comments/Notes:** Delegation to the LVN: RN can't delegate scope of practice and direction for care to the LVN. RN can't delegate functions in BPC 2725 or CCR 1443.5 except as allowed by LVN scope of practice. Delegation must occur within LVN scope of practice. RN ensures delegatee has appropriate education, skills, and experience to perform the delegated task or assignment. RN ensures there is documented evidence of current competence before assigning tasks. RN delegates tasks using the "Five Rights of Delegation" → Right task → Right circumstances → Right person → Right direction/communication → Right supervision provided RN intervenes as necessary if task is being performed improperly. Ensures appropriate documentation of delegated tasks. Supervision of the LVN: Provides direction and clear expectations of how a task is to be performed. Monitors performance to assure compliance with established practice standards, policies, and procedures.	**Comments/Notes:** Refer to BPC 2725 and CCR 1443.5

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of C. .petent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulat. . Title 22 Section 70215.
(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.	Section 1443.5 (5) A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows: ➢ evaluate the effectiveness of the care plan through observation of the clients physical condition and behavior ➢ signs and symptoms of illness ➢ reaction to treatment through communication with the client and the health team members ➢ modify the plan as needed	70215. (c) The nursing plan for the patient's care shall be discussed with and developed as a result of the coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.
Comments/Notes: It is within the RN scope of practice to perform these functions without a physician's order provided the RN is knowledgeable and competent. In some practice settings, facility-specific requirements dictate a physician's order for the RN to perform these functions.	**Comments/Notes:** RN is continually making collaborative and independent judgments related to the appropriateness/effectiveness of the plan of care and makes modifications based on changes in patient condition, responses to treatment, and changes in treatment orders/plans. If revisions are needed in any phase of the nursing process, the RN is expected to ensure interventions are timely, appropriate/effective for the patient. RN plays the predominate role in the timely communication of the patient's response or lack of response to treatment to others, i.e. collaborating, → informing the physician. → RN is accountable to oversee the appropriate timely movement through all phases of the nursing process in the delivery of care for assigned group(s) of patients.	

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of Competent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulations Title 22 Section 70215.
(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.	Section 1443.5 (6) A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows: ➢ Acts as a client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client, the opportunity to make informed decisions about health care before it is provided.	70215. (d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.
Comments/Notes: RN is responsible for independently: interpreting/making judgments about the appropriateness/effectiveness of care. initiating needed changes in treatment. Using a series of complex information processing critical thinking/decision making skills to plan, coordinate, implement, and evaluate each aspect of care and patient response to treatment as listed on pg. 2.	**Comments/Notes:** By virtue of education, skill, and experience, the RN is the designee accountable to oversee each phase of care delivery in collaboration with the physician. RN is responsible/accountable to see actual and potential patient needs/health problems are addressed and get recorded on the plan of care. The exhaustive monitoring and evaluation functions routinely performed by the RN for every aspect of care delivery enable her/him to act as an advocate. The RN is expected to demonstrate "big picture" knowledge of the care delivered and the patient's needs and wishes. Evidence that the RN has advocated for the patient includes: → Clarification of physician orders and comprehensive plan of care → Ensure informed consent for treatment/care → Appropriate/timely discharge planning → Ensure safe, timely delivery of all aspects of care → Recognize/record quality variance reporting of actual or "near misses" → Monitor and follow-up on patient response to treatment regimen → Ensure patient care assignments for self and others are appropriate and supervised properly	**Comments/Notes:** Refer to BPC 2725 and CCR 1443.5

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of Competent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulations Title 22 Section 70215.
(c) "Standardized procedures," as used in this section, means either of the following: (1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.	CCR Section 1474 Standardized Procedure Guidelines (a) Written description of the method used in developing and approving them. (b) Each standardized procedure shall: (1) Written, dated, and signed by the organized health care system personnel authorized to sign it. (2) Specify SP functions RNs may perform and under what circumstances. (3) State specific requirements which are to be followed by RNs performing particular SP functions. (4) Specify experience, training, and/or education requirements for performance of SP functions. (5) Establish a method for initial and continuing evaluation of the competence of the RNs competence to perform the SP functions. (6) Provide a method of maintaining written record of those authorized RN functions. (7) Specify the scope of supervision required for performance of the authorized function. (8) Set forth special circumstances which the RN is to immediately communicate with the patient's physician. (9) State the limitations on settings, if any, in where SP functions can be performed. (10) Specify patient record keeping. (11) Provide a method of periodic review of the SP(s).	
(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.		
Comments/Notes: Only RNs may perform medical functions using the standardized procedure (SP) mechanism. Approved SPs may only be used in an organized health care system. Refer to BRN website advisory section for a detailed explanation of SPs: www.rn.ca.gov.		

Nursing Practice Act Business & Professions Code Chapter 6 Nursing Section 2725	Standards Of Competent Performance California Code Of Regulations Title 16 Section 1443.5	California Code of Regulations Title 22 Section 70215.
Article 2 Section 2732.1 Interim Permittee's Approval of the RN application, the board issues interim permits authorizing the applicant to practice nursing pending the results of the first licensing examination following completion of his or her nursing courses or for a maximum period of six months, whatever occurs first.	Section 1414: Interim Permittee (c) A permittee shall practice under the direct supervision of a registered nurse who shall be present and available on the patient care unit during all the time the permittee is rendering professional services. The supervising registered nurse may delegate to the permittee any function taught in the permittee's basic nursing program which, in the judgment of the supervising registered nurse, the permittee is capable of performing.	
	Comments/Notes: → The supervising RN must be on the patient care unit with the IP, not simply in the building. → Responsibility for meeting these conditions belongs to the director of nursing, supervising RN, and the permittee. Interim permits are not renewable and are in effect from 6 months of the date issued or until the results of the NCLEX-RN exam are mailed, at which time the interim permit is null and void (CCR 1414(b)).	

DEPARTMENT OF CONSUMER AFFAIRS
BOARD of REGISTERED NURSING

Advanced Practice Certification

The Board of Registered Nursing (BRN) certifies public health nurses and advanced practice nurses. Advanced practice nurses include nurse practitioners, nurse-midwives, clinical nurse specialists, and nurse anesthetists. The BRN also maintains a listing of psychiatric/mental health nurses. In each of these categories, the individual must first have a California registered nurse license before obtaining the certificate.

- Clinical Nurse Specialist (CNS)
- Nurse Anesthetist (NA)
- Nurse-Midwife (NMW)
- Nurse-Midwife Furnishing Number (NMF)
- Nurse Practitioner (NP)
- Nurse Practitioner Furnishing Number (NPF)
- Psychiatric/Mental Health Nurse (PMH)
- Public Health Nurse (PHN)

Clinical Nurse Specialist

The clinical nurse specialist is a BRN certified RN who is an advanced practice nurse providing expert clinical practice, research, education, consultation and clinical leadership with an identified patient population. The scope of clinical nurse specialist practice includes patients, nursing personnel and organization systems. Clinical nurse specialists work in direct patient care and indirect patient care activities that affect a broad range of patients.

There are three (3) methods to qualify for certification as a clinical nurse specialist with the BRN. General reporting of prior conviction or disciplines are required for all methods.

- Clinical Nurse Specialist Application

Nurse Anesthetist

The nurse anesthetist is a registered nurse who provides anesthesia services ordered by a physician, dentist, or podiatrist, and is certified by the BRN in this specialty.

- Nurse Anesthetist Application

Nurse-Midwife

The nurse-midwife is a registered nurse who, having received a certificate from the BRN, under the supervision of a licensed physician and surgeon, attends cases of normal childbirth and provides prenatal, intrapartum, and postpartum care, including family planning care for mothers and immediate care for the newborn.

There are three methods to qualify for certification as a nurse-midwife with the BRN. General reporting of prior conviction/disciplines are required for all methods.

- Nurse-Midwife Application

Nurse-Midwife Furnishing Number

A furnishing number is issued by the BRN to a nurse-midwife which allows him or her to "order" or furnish drugs and devices to patients using approved standardized procedures. The nurse-midwife with a furnishing number may obtain a Drug Enforcement Administration (DEA) registration number if he or she wants to order controlled substances as needed for patient care.

TAB L-4

- Nurse-Midwife Furnishing Number Application

Nurse Practitioner

The nurse practitioner is a registered nurse who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health and illness needs in primary health care.

There are three methods to qualify for certification as a nurse practitioner with the BRN. General reporting of prior convictions or disciplines are required for all methods.

- Nurse Practitioner Application

Nurse Practitioner Furnishing Number

The BRN issues a furnishing number to a nurse practitioner that allows him or her to "order" or furnish drugs and devices to patients using approved standardized procedures. A nurse practitioner with a furnishing number may obtain a Drug Enforcement Administration (DEA) registration number if they want to order controlled substances as needed for patient care.

- Nurse Practitioner Furnishing Number Application

Psychiatric/Mental Health Nurse

Pursuant to Insurance Code Section 10176, the BRN maintains a listing of registered nurses who possess a master's degree in psychiatric/mental health nursing plus two years of supervised experience providing services as a psychiatric/mental health nurse and who have applied to the BRN to be listed. This voluntary listing enables the certificate holder to receive direct reimbursement from insurance carriers for counseling services.

There are two methods to qualify for listing as a psychiatric/mental health nurse with the BRN. General reporting of prior conviction/disciplines are required for both methods.

- Psychiatric/Mental Health Nurse Application

Public Health Nurse

The public health nurse is a registered nurse who has received a certificate from the BRN. He or she is an integral part of the public health community and provides direct patient care as well as services related to maintaining public health.

- Public Health Nurse Application

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DEPARTMENT OF CONSUMER AFFAIRS
BOARD of REGISTERED NURSING

Business and Professions Code

Extracted from the Business and Professions Code of California.

For addtional information, please refer to the Business and Professions Code of California at www.leginfo.ca.gov. To order a copy of the latest edition of the Nursing Practice Act, please refer to bookstore.lexis.com.

Chapter 6. Nursing
Article 1. Administration

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2700. Citation
This chapter of the Business and Professions Code constitutes the chapter on professional nursing and shall be construed as revisory and amendatory of the laws heretofore enacted. It may be cited as the Nursing Practice Act.

(Added Stats 1939 ch 807 § 2.)

2701. Board of Registered Nursing (Repealed January 1, 2012)
(a) There is in the Department of Consumer Affairs the Board of Registered Nursing consisting of nine members.

(b) Within the meaning of this chapter, board, or the board, refers to the Board of Registered Nursing. Any reference in state law to the Board of Nurse Examiners of the State of California or California Board of Nursing Education and Nurse Registration shall be construed to refer to the Board of Registered Nursing.

(c) This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

Added Stats 1939 ch 807 § 2. Amended Stats 1949 ch 392 § 1; Stats 1961 ch 1821 § 17, ch 1823 § 2; Stats 1971 ch 716 § 38, ch 1593 § 28, operative July 1, 1973; Stats 1972 ch 847 § 1, operative July 1, 1973; Stats 1973 ch 122 § 3, effective June 29, 1973; Stats 1974 ch 632 § 1; Stats 1977 ch 141 § 6, effective June 29, 1977; Stats 1994 ch 908 § 15 (SB 2036), ch 1275 § 10 (SB 2101); Stats 1995 ch 599 § 2 (AB 778); Stats 1997 ch 759 § 15 (SB 827); Stats 2003 ch 640 § 1 (SB 358); Stats 2006 ch 658 § 48 (SB 1476), effective January 1, 2007; Stats 2009 ch 270 § 4 (AB 1071), effective January 1, 2010; Stats 2010 ch 695 § 8 (SB 294), effective January 1, 2011, repealed January 1, 2012.

2702. Membership qualifications
Each member of the board shall be a citizen of the United States and a resident of the State of California. Four members shall represent the public at large, and shall not be licensed under any board under this division or any board referred to in Section 1000 or 3600 and shall have no pecuniary interests in the provision of health care services. Two members shall be licensed registered nurses under the provisions of this chapter, each of whom shall be active in the practice of his or her profession engaged primarily in direct patient care with at least five continuous years of experience, and who shall not be engaged as an educator or administrator of a nursing education program under the provisions of this chapter. One member shall be a licensed registered nurse who shall be active as an advanced practice registered nurse as defined in Section 2725.5. One member shall be a licensed registered nurse under the provisions of this chapter who shall be active as an educator or administrator in an approved program to train registered nurses. One member shall be a licensed registered nurse who is an administrator of a nursing service with at least five continuous years of experience.

(Added Stats 1939 ch 807 § 2. Amended Stats 1961 ch 1821 § 18; Stats 1972 ch 847 § 3; Stats 1974 ch 632 § 3; Stats 1976 ch 1188 § 12. Amended Stats 2003 ch 640 § 2 (SB 358).)

2703. Appointments, terms, vacancies
All appointments shall be for a term of four years and vacancies shall be filled for the unexpired term. No person shall serve more than two consecutive terms.

The Governor shall appoint two of the public members and the licensed members of the board qualified as provided in Section 2702. The Senate Rules Committee and the Speaker of the Assembly shall each appoint a public member.

(Added Stats 1939 ch 807 § 2. Amended Stats 1961 ch 1821 § 19; Stats 1972 ch 847 § 4; Stats 1974 ch 632 § 4; Stats 1976 ch 1188 § 13; Stats 1982 ch 676 § 10. Amended Stats 2003 ch 640 § 3 (SB 358).)

2706. Removal from office
The Governor has the power to remove any member of the board from office for neglect of any duty required by law, or for incompetency, or unprofessional or dishonorable conduct.

(Added Stats 1939 ch 807 § 2.)

2707. Elections of officers
The board shall annually elect from its members a president, vice president, and any other officers as it may deem necessary. The officers of the board shall hold their respective positions during its pleasure.

(Added Stats 1939 ch 807 § 2. Amended Stats 1994 ch 1275 § 11 (SB 2101).)

2708. Executive officer (Repealed January 1, 2012)
(a) The board shall appoint an executive officer who shall perform the duties delegated by the board and who shall be responsible to it for the accomplishment of those duties.

(b) The executive officer shall be a nurse currently licensed under this chapter and shall possess other qualifications as determined by the board.

(c) The executive officer shall not be a member of the board.

(d) This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date.

Added Stats 1939 ch 807 § 2. Amended Stats 1953 ch 1174 § 2; Stats 1983 ch 742 § 1; Stats 1994 ch 908 § 16 (SB 2036); Stats 1997 ch 759 § 16 (SB 827); Stats 2003 ch 640 § 4 (SB 358); Stats 2006 ch 658 § 49 (SB 1476), effective January 1, 2007; Stats 2009 ch 270 § 5 (AB 1071), effective January 1, 2010; Stats 2010 ch 695 § 9 (SB 294), effective January 1, 2011, repealed January 1, 2012.

2708.1. Priority of board; Protection of the public
Protection of the public shall be the highest priority for the Board of Registered Nursing in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

(Added Stats 2002 ch 107 § 10 (AB 269).)

2709. Regular meetings
The board for the purpose of transacting its business shall meet at least once every three months, at times and places it designates by

resolution.

(Added Stats 1939 ch 807 § 2.)

2709.5. Mediums of exchange
The board shall accept in payment of any fee required by this chapter cash or any customary or generally accepted medium of exchange, including check, cashier's check, certified check or money order. For the purposes of this section, customary or generally accepted medium of exchange does not include postage stamps.

(Added Stats 1957 ch 1468 § 1. Amended Stats 2002 ch 810 § 23 (SB 2022).)

2710. Special meetings
Special meetings may be held at such times as the board may elect, or on the call of the president of the board, or of not less than three members thereof.

A written notice of the time, place and object of any special meeting shall be mailed by the executive officer to all members of the board who are not parties to the call, at least fifteen days before the day of the meeting.

(Added Stats 1939 ch 807 § 2. Amended Stats 1983 ch 742 § 2.)

2710.5. Advisory committees
The board, with permission of the Director of the Department of Consumer Affairs, may form advisory committees to advise the board on the implementation of this chapter. Members of such advisory committees shall be entitled to a per diem and expenses as provided in Section 103.

(Added Stats 1974 ch 632 § 5.)

2712. Quorum
Five members of the board constitute a quorum for the transaction of business at any meeting.

(Added Stats 1939 ch 807 § 2. Amended Stats 1961 ch 1821 § 20; Stats 1985 ch 220 § 1, ch 1055 § 1.)

2713. Records
The board shall keep a record of all its proceedings, including a register of all applicants for licenses under this chapter and the action of the board upon each application.

(Added Stats 1939 ch 807 § 2. Amended Stats 1951 ch 1659 § 2; Stats 1983 ch 742 § 4.)

2714. Offices; Venue
The office of the board shall be in the city of Sacramento. Suboffices may be established in Los Angeles and San Francisco and such records as may be necessary may be transferred temporarily to them. Legal proceedings against the board may be instituted in any county in which any of the three cities above mentioned is located.

(Added Stats 1939 ch 807 § 2.)

2715. Prosecutions; Employment matters; Seal; Rule-making authority
The board shall prosecute all persons guilty of violating the provisions of this chapter.

Except as provided by Section 159.5, the board, in accordance with the provisions of the Civil Service Law, may employ such personnel as it deems necessary to carry into effect the provisions of this chapter.

The board shall have and use a seal bearing the name "Board of Registered Nursing." The board may adopt, amend, or repeal, in accordance with the provisions of Chapter 4.5 (commencing with Section 11371), Part 1, Division 3, Title 2 of the Government Code, such rules and regulations as may be reasonably necessary to enable it to carry into effect the provisions of this chapter.

(Added Stats 1939 ch 807 § 2. Amended Stats 1951 ch 1659 § 1; Stats 1957 ch 2084 § 5; Stats 1961 ch 1823 § 3; Stats 1971 ch 716 § 39; Stats 1974 ch 632 § 6.)

2716. Compensation and expenses
Each member of the board shall receive a per diem and expenses as provided in Section 103.

(Added Stats 1959 ch 1645 § 10.)

2717. Collection, analysis, and publication of workforce data
(a) The board shall collect and analyze workforce data from its licensees for future workforce planning. The board may collect the data at the time of license renewal or from a scientifically selected random sample of its licensees. The board shall produce reports on the workforce data it collects, at a minimum, on a biennial basis. The board shall maintain the confidentiality of the information it receives from licensees under this section and shall only release information in an aggregate form that cannot be used to identify an individual. The workforce data collected by the board shall include, at a minimum, employment information such as hours of work, number of positions held, time spent in direct patient care, clinical practice area, type of employer, and work location. The data shall also include future work intentions, reasons for leaving or reentering nursing, job satisfaction ratings, and demographic data.

(b) Aggregate information collected pursuant to this section shall be placed on the board's Internet Web site.

(c) The board is authorized to expend the sum of one hundred forty-five thousand dollars ($145,000) from the Board of Registered Nursing Fund in the Professions and Vocations Fund for the purpose of implementing this section.

(d) This section shall be implemented by the board on or before July 1, 2003.

(Added Stats 2002 ch 1089 § 1 (AB 1140). Amended Stats 2007 ch 588 § 36 (SB 1048), effective January 1, 2008.)

2725. Legislative intent; Practice of nursing defined
(a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

(c) "Standardized procedures," as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

(d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing.

(e) No state agency other than the board may define or interpret the practice of nursing for those licensed pursuant to the provisions of this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless so authorized by this chapter, or specifically required under state or federal statute. "State agency" includes every state office, officer, department, division, bureau, board, authority, and commission.

(Added Stats 1939 ch 807 § 2. Amended Stats 1968 ch 348 § 1; Stats 1974 ch 355 § 1, ch 913 § 1; Stats 1978 ch 1161 § 172; Stats 1980 ch 406 § 1; Stats 1989 ch 886 § 52; Stats 1995 ch 279 § 15 (AB 1471); Stats 1996 ch 124 § 2 (AB 3470). Amended Stats 2003 ch 640 § 5 (SB 358).)

2725.1. Dispensation of drugs or devices by registered nurse
Notwithstanding any other provision of law, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon if the nurse is functioning within a licensed clinic as defined in paragraphs (1) and (2) of subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b) or (c) of Section 1206, of the Health and Safety Code.

No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

(Added Stats 1986 ch 493 § 1. Amended Stats 1999 ch 83 § 3 (SB 966) (ch 914 prevails), ch 914 § 1 (AB 1545); Stats 2001 ch 289 § 2 (SB 298).)

2725.3. Functions performed by unlicensed personnel
(a) A health facility licensed pursuant to subdivision (a), (b), or (f), of Section 1250 of the Health and Safety Code shall not assign unlicensed personnel to perform nursing functions in lieu of a registered nurse and may not allow unlicensed personnel to perform

functions under the direct clinical supervision of a registered nurse that require a substantial amount of scientific knowledge and technical skills, including, but not limited to, any of the following:

(1) Administration of medication.

(2) Venipuncture or intravenous therapy.

(3) Parenteral or tube feedings.

(4) Invasive procedures including inserting nasogastric tubes, inserting catheters, or tracheal suctioning.

(5) Assessment of patient condition.

(6) Educating patients and their families concerning the patient's health care problems, including postdischarge care.

(7) Moderate complexity laboratory tests.

(b) This section shall not preclude any person from performing any act or function that he or she is authorized to perform pursuant to Division 2 (commencing with Section 500) or pursuant to existing statute or regulation as of July 1, 1999.

(Added Stats 1999 ch 945 § 2 (AB 394).)

2725.5. "Advanced practice registered nurse" defined
"Advanced practice registered nurse" means those licensed registered nurses who have met the requirements of Article 2.5 (commencing with Section 2746), Article 7 (commencing with Section 2825), Article 8 (commencing with Section 2834), or Article 9 (commencing with Section 2838).

(Added Stats 2003 ch 640 § 6 (SB 358).)

2726. Unauthorized practices
Except as otherwise provided herein, this chapter confers no authority to practice medicine or surgery.

(Added Stats 1939 ch 807 § 2. Amended Stats 1974 ch 355 § 2.)

2727. Practices not prohibited
This chapter does not prohibit:

(a) Gratuitous nursing of the sick by friends or members of the family.

(b) Incidental care of the sick by domestic servants or by persons primarily employed as housekeepers as long as they do not practice nursing within the meaning of this chapter.

(c) Domestic administration of family remedies by any person.

(d) Nursing services in case of an emergency. "Emergency," as used in this subdivision includes an epidemic or public disaster.

(e) The performance by any person of such duties as required in the physical care of a patient and/or carrying out medical orders prescribed by a licensed physician; provided, such person shall not in any way assume to practice as a professional, registered, graduate or trained nurse.

(Added Stats 1939 ch 807 § 2. Amended Stats 1943 ch 573 § 1.)

2727.5. Liability for emergency care
A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care.

This section shall not grant immunity from civil damages when the person is grossly negligent.

(Added Stats 1963 ch 698 § 1. Amended Stats 1984 ch 1391 § 2.)

2728. Services by attendants and psychiatric technicians; Supervised services of unlicensed graduates of accredited psychiatric technician training programs
If adequate medical and nursing supervision by a professional nurse or nurses is provided, nursing service may be given by attendants, psychiatric technicians, or psychiatric technician interim permittees in institutions under the jurisdiction of the State Department of Mental Health or the State Department of Developmental Services or subject to visitation by the State Department of Health Services or the Department of Corrections. Services so given by a psychiatric technician shall be limited to services which he or she is authorized to perform by his or her license as a psychiatric technician. Services so given by a psychiatric technician interim permittee shall be limited to skills included in his or her basic course of study and performed under the supervision of a licensed psychiatric technician or registered nurse.

The Directors of Mental Health, Developmental Services, and Health Services shall determine what shall constitute adequate medical and nursing supervision in any institution under the jurisdiction of the State Department of Mental Health or the State Department of Developmental Services or subject to visitation by the State Department of Health Services.

Notwithstanding any other provision of law, institutions under the jurisdiction of the State Department of Mental Health or the State Department of Developmental Services may utilize graduates of accredited psychiatric technician training programs who are not licensed psychiatric technicians or psychiatric technician interim permittees to perform skills included in their basic course of study when

supervised by a licensed psychiatric technician or registered nurse, for a period not to exceed nine months.

(Added Stats 1939 ch 807 § 2. Amended Stats 1957 ch 558 § 1; Stats 1971 ch 1593 § 30 (ch 1007 prevails), ch 1007 § 1, operative July 1, 1973; Stats 1973 ch 142 § 7, effective June 30, 1973, operative July 1, 1973; Stats 1977 ch 1252 § 32, operative July 1, 1978; Stats 1987 ch 464 § 1, effective September 9, 1987.)

2728.5. Utilization of licensed psychiatric technicians and psychiatric technician interim permittees
Except for those provisions of law relating to directors of nursing services, nothing in this chapter or any other provision of law shall prevent the utilization of a licensed psychiatric technician or psychiatric technician interim permittee in performing services used in the care, treatment, and rehabilitation of mentally ill, emotionally disturbed, or developmentally disabled persons within the scope of practice for which he or she is licensed or authorized in facilities under the jurisdiction of the State Department of Mental Health or the State Department of Developmental Services or licensed by the State Department of Health Services, that he or she is licensed to perform as a psychiatric technician, or authorized to perform as a psychiatric technician interim permittee including any nursing services under Section 2728, in facilities under the jurisdiction of the State Department of Mental Health or the State Department of Developmental Services or subject to visitation by the State Department of Health Services.

(Added Stats 1971 ch 1007 § 2. Amended Stats 1973 ch 142 § 8, effective June 30, 1973, operative July 1, 1973; Stats 1977 ch 1252 § 33, operative July 1, 1978; Stats 1978 ch 429 § 15, effective July 17, 1978, operative July 1, 1978; Stats 1987 ch 464 § 2, effective September 9, 1987.)

2729. Services by student nurses
Nursing services may be rendered by a student when these services are incidental to the course of study of one of the following:

(a) A student enrolled in a board-approved prelicensure program or school of nursing.

(b) A nurse licensed in another state or country taking a board-approved continuing education course or a postlicensure course.

(Added Stats 1939 ch 807 § 2. Amended Stats 1953 ch 1174 § 4; Stats 1978 ch 212 § 1, effective June 6, 1978.)

2730. Nurses qualified outside state and engaged to care for patient temporarily in California
If he does not represent or hold himself out as a professional nurse licensed to practice in this State and if he has an engagement, made in another State or country, requiring him to accompany and care for a patient temporarily residing in this State during the period of such engagement, a nurse legally qualified by another State or country may give nursing care to such patient in this State.

(Added Stats 1939 ch 807 § 2.)

2731. Nonprofit religious care
This chapter does not prohibit nursing or the care of the sick, with or without compensation or personal profit, when done by the adherents of and in connection with the practice of the religious tenets of any well recognized church or denomination, so long as they do not otherwise engage in the practice of nursing.

(Added Stats 1939 ch 807 § 2.)

2732. Licensure requirement; Use of "R.N."
No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter except as otherwise provided in this act.

Every licensee may be known as a registered nurse and may place the letters "R.N." after his name.

(Added Stats 1939 ch 807 § 2. Amended Stats 1976 ch 1053 § 1, effective September 28, 1976.)

2732.05. Verification of current R.N. status
(a) Every employer of a registered nurse, every employer of a registered nurse required to hold any board-issued certification, and every person acting as an agent for such a nurse in obtaining employment, shall ascertain that the nurse is currently authorized to practice as a registered nurse or as a registered nurse pursuant to a board-issued certification within the provisions of this chapter. As used in this section, "board-issued certification" includes, but is not limited to, certification as a nurse practitioner, nurse practitioner with a furnishing number, nurse anesthetist, nurse midwife, nurse midwife with a furnishing number, public health nurse, clinical nurse specialist, or board listed psychiatric mental health nurse.

(b) Every employer of a temporary licensee or interim permittee and every person acting as an agent for a temporary licensee or interim permittee in obtaining employment shall ascertain that the person is currently authorized to practice as a temporary licensee or interim permittee.

(c) As used in this section, the term "agent" includes, but is not limited to, a nurses registry and a traveling nurse agency.

Examination by an employer or agent of evidence satisfactory to the board showing the nurse's, licensee's, or permittee's current authority to practice under this chapter, prior to employment, shall constitute a determination of authority to so practice.

Nothing in this section shall apply to a patient, or other person acting for a specific patient, who engages the services of a registered nurse or temporary licensee to provide nursing care to a single patient.

(Added Stats 1961 ch 1110 § 1. Amended Stats 1965 ch 680 § 1, ch 727 § 1; Stats 1970 ch 524 § 1; Stats 2007 ch 588 § 37 (SB 1048), effective January 1, 2008.)

2732.1. Applications; Interim permits; Waiver of examination; Fees
(a) An applicant for license by examination shall submit a written application in the form prescribed by the board.

Upon approval of the application, the board may issue an interim permit authorizing the applicant to practice nursing pending the results of the first licensing examination following completion of his or her nursing course or for a maximum period of six months, whichever occurs first.

If the applicant passes the examination, the interim permit shall remain in effect until a regular renewable license is issued by the board. If the applicant fails the examination, the interim permit shall terminate upon notice thereof by first-class mail.

(b) The board upon written application may issue a license without examination to any applicant who is licensed or registered as a nurse in a state, district or territory of the United States or Canada having, in the opinion of the board, requirements for licensing or registration equal to or higher than those in California at the time the application is filed with the Board of Registered Nursing, if he or she has passed an examination for the license or registration that is, in the board's opinion, comparable to the board's examination, and if he or she meets all the other requirements set forth in Section 2736.

(c) Each application shall be accompanied by the fee prescribed by this chapter for the filing of an application for a regular renewable license.

The interim permit shall terminate upon notice thereof by first-class mail, if it is issued by mistake or if the application for permanent licensure is denied.

(Added Stats 1953 ch 1174 § 5. Amended Stats 1959 ch 190 § 1; Stats 1965 ch 727 § 2; Stats 1972 ch 668 § 1; Stats 1987 ch 850 § 10; Stats 1992 ch 1289 § 20 (AB 2743); Stats 1994 ch 26 § 57.5 (AB 1807), effective March 30, 1994.)

2733. Issuance of temporary license where examination waived
(a) Upon approval of an application filed pursuant to subdivision (b) of Section 2732.1, and upon the payment of the fee prescribed by subdivision (k) of Section 2815, the board may issue a temporary license to practice professional nursing, and a temporary certificate to practice as a certified nurse midwife, certified nurse practitioner, certified public health nurse, certified clinical nurse specialist, or certified nurse anesthetist for a period of six months from the date of issuance.

A temporary license or temporary certificate shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(b) Upon written application, the board may reissue a temporary license or temporary certificate to any person who has applied for a regular renewable license pursuant to subdivision (b) of Section 2732.1 and who, in the judgment of the board has been excusably delayed in completing his or her application for or the minimum requirements for a regular renewable license, but the board may not reissue a temporary license or temporary certificate more than twice to any one person.

(Added Stats 1953 ch 1174 § 7, as B & P C § 2733.1. Amended Stats 1963 ch 1400 § 1. Amended and renumbered by Stats 1965 ch 727 § 4. Amended Stats 1978 ch 1161 § 172.5; Stats 1987 ch 850 § 11; Stats 1992 ch 1135 § 2.3 (SB 2044); Stats 1994 ch 26 § 58 (AB 1807), effective March 30, 1994. Amended Stats 2000 ch 568 § 7 (AB 2888).)

2734. Inactive licenses
Upon application in writing to the board and payment of the biennial renewal fee, a licensee may have his license placed in an inactive status for an indefinite period of time. A licensee whose license is in an inactive status may not practice nursing. However, such a licensee does not have to comply with the continuing education standards of Section 2811.5.

(Added Stats 1976 ch 1053 § 2, effective September 28, 1976.)

2736. Qualifications generally
(a) An applicant for licensure as a registered nurse shall comply with each of the following:

(1) Have completed such general preliminary education requirements as shall be determined by the board.

(2) Have successfully completed the courses of instruction prescribed by the board for licensure, in a program in this state accredited by the board for training registered nurses, or have successfully completed courses of instruction in a school of nursing outside of this state which, in the opinion of the board at the time the application is filed with the Board of Registered Nursing, are equivalent to the minimum requirements of the board for licensure established for an accredited program in this state.

(3) Not be subject to denial of licensure under Section 480.

(b) An applicant who has received his or her training from a school of nursing in a country outside the United States and who has complied with the provisions of subdivision (a), or has completed training equivalent to that required by subdivision (a), shall qualify for licensure by successfully passing the examination prescribed by the board.

(Added Stats 1939 ch 807 § 2. Amended Stats 1945 ch 1249 § 1; Stats 1953 ch 1174 § 8; Stats 1957 ch 2084 § 6; Stats 1963 ch 1537 § 1.5; Stats 1965 ch 727 § 5; Stats 1969 ch 1541 § 1; Stats 1972 ch 463 § 1; Stats 1974 ch 516 § 1; Stats 1977 ch 1130 § 2; Stats 1978 ch 1161 § 173; Stats 1992 ch 1289 § 21 (AB 2743).)

2736.1. Training in detection and treatment of client abuse, and alcohol and chemical substance dependency
(a) The course of instruction for an applicant who matriculates on or after September 1, 1985, shall include training in the detection and treatment of alcohol and chemical substance dependency.

(b) The course of instruction for an applicant who matriculates on or after January 1, 1995, shall include training in the detection and treatment of client abuse, including, but not limited to, spousal or partner abuse. The requirement for coursework in spousal or partner abuse detection and treatment shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation.

(Added Stats 1984 ch 1149 § 4. Amended Stats 1993 ch 1234 § 5 (AB 890).)

2736.5. Qualifications of persons serving in medical corps of armed forces; Records and reports
(a) Any person who has served on active duty in the medical corps of any of the armed forces of the United States and who has successfully completed the course of instruction required to qualify him for rating as a medical service technician-independent duty, or other equivalent rating in his particular branch of the armed forces, and whose service in the armed forces has been under honorable conditions, may submit the record of such training to the board for evaluation.

(b) If such person meets the qualifications of paragraphs (1) and (3) of subdivision (a) of Section 2736, and if the board determines that his education and experience would give reasonable assurance of competence to practice as a registered nurse in this state, he shall be granted a license upon passing the standard examination for such licensure.

(c) The board shall, by regulation, establish criteria for evaluating the education and experience of applicants under this section.

(d) The board shall maintain records of the following categories of applicants under this section:

(1) Applicants who are rejected for examination, and the areas of such applicants' preparation which are the causes of rejection.

(2) Applicants who are qualified by their military education and experience alone to take the examination, and the results of their examinations.

(3) Applicants who are qualified to take the examination by their military education and experience plus supplementary education, and the results of their examinations.

(e) The board shall attempt to contact by mail or other means individuals meeting the requirements of subdivision (a) who have been or will be discharged or separated from the armed forces of the United States, in order to inform them of the application procedure provided by this section. The board may enter into an agreement with the federal government in order to secure the names and addresses of such individuals.

(Added Stats 1969 ch 1592 § 2. Amended Stats 1971 ch 1397 § 1; Stats 1978 ch 1161 § 173.5; Stats 1979 ch 373 § 12.)

2736.6. Eligibility of vocational nurse to take examination for licensure as registered nurse
The board shall determine by regulation the additional preparation in nursing, in a school approved by the board, which is required for a vocational nurse, licensed under Chapter 6.5 (commencing with Section 2840) of this division, to be eligible to take the examination for licensure under this chapter as a registered nurse. The board shall not require more than 30 units in nursing and related science subjects to satisfy such preparation.

(Added Stats 1969 ch 1541 § 2.)

2737. Application fee
An applicant for a license authorizing him to practice nursing in this State under this chapter, upon the filing of his application shall pay the fee required by this chapter.

(Added Stats 1939 ch 807 § 2.)

2738. Holding of examinations
The board shall hold not less than two examinations each year at such times and places as the board may determine.

(Added Stats 1939 ch 807 § 2. Amended Stats 1953 ch 1174 § 10.)

2740. Conduct of examinations; Finality of decisions
Examinations shall be written, but in the discretion of the board may be supplemented by an oral or practical examination in such subjects as the board determines. All examinations shall be conducted by such persons and in such manner and under such rules and regulations as the board may prescribe.

The board shall finally pass or reject all applicants. Its actions shall be final and conclusive and not subject to review by any court or other authority.

(Added Stats 1939 ch 807 § 2.)

2741. Reexamination
An application for reexamination shall be accompanied by the fees prescribed by this chapter.

(Added Stats 1939 ch 807 § 2. Amended Stats 1953 ch 1174 § 11; Stats 1965 ch 727 § 7; Stats 1972 ch 901 § 1; Stats 1979 ch 933 § 1; Stats 1981 ch 437 § 1; Stats 1987 ch 850 § 12; Stats 1994 ch 26 § 60 (AB 1807), effective March 30, 1994. Amended Stats 2005 ch 621 § 38 (SB 1111).)

2742. Issuance of license
The board shall issue a license to each applicant who passes the examination and meets all other licensing requirements. The form of the license shall be determined in accordance with Section 164.

(Added Stats 1939 ch 807 § 2. Amended Stats 1971 ch 716 § 40; Stats 1987 ch 850 § 13.)

2746. Issuance of certificates
The board shall issue a certificate to practice nurse-midwifery to any person who qualifies under this article and is licensed pursuant to the provisions of this chapter.

(Added Stats 1974 ch 1407 § 1.)

2746.1. Compliance with article required
Every applicant for a certificate to practice nurse-midwifery shall comply with all the provisions of this article in addition to the provisions of this chapter.

(Added Stats 1974 ch 1407 § 1.)

2746.2. Educational prerequisites; Nurse-midwifery committee
Each applicant shall show by evidence satisfactory to the board that he has met the educational standards established by the board or has at least the equivalent thereof. The board is authorized to appoint a committee of qualified physicians and nurses, including, but not limited to, obstetricians and nurse-midwives, to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters.

(Added Stats 1974 ch 1407 § 1.)

2746.3. Renewal of midwife's certificates
Midwife's certificates issued by the Medical Board of California prior to the effective date of this article shall be renewable only by such board.

(Added Stats 1974 ch 1407 § 1. Amended Stats 1978 ch 1161 § 174; Stats 1989 ch 886 § 53.)

2746.4. Practice of midwifery by midwife's certificates
Nothing in this article shall be construed to prevent the practice of midwifery by a person possessing a midwife's certificate issued by the Medical Board of California on the effective date of this article.

(Added Stats 1974 ch 1407 § 1. Amended Stats 1978 ch 1161 § 175; Stats 1989 ch 886 § 54.)

2746.5. Authority conferred by certificate; Required supervision
(a) The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

(b) As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician immediately. The practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

(c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician.

(d) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

(e) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board.

(Added Stats 1974 ch 1407 § 1. Amended Stats 2002 ch 764 § 1 (SB 993).)

2746.51. When nurse-midwife may furnish drugs or devices
(a) Neither this chapter nor any other provision of law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when all of the following apply:

(1) The drugs or devices are furnished or ordered incidentally to the provision of any of the following:

(A) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(B) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(C) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(2) The drugs or devices are furnished or ordered by a certified nurse-midwife in accordance with standardized procedures or protocols. For purposes of this section, standardized procedure means a document, including protocols, developed and approved by the supervising physician and surgeon, the certified nurse-midwife, and the facility administrator or his or her designee. The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:

(A) Which certified nurse-midwife may furnish or order drugs or devices.

(B) Which drugs or devices may be furnished or ordered and under what circumstances.

(C) The extent of physician and surgeon supervision.

(D) The method of periodic review of the certified nurse-midwife's competence, including peer review, and review of the provisions of the standardized procedure.

(3) If Schedule II or III controlled substances, as defined in Sections 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(4) The furnishing or ordering of drugs or devices by a certified nurse-midwife occurs under physician and surgeon supervision. For purposes of this section, no physician and surgeon shall supervise more than four certified nurse-midwives at one time. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(A) Collaboration on the development of the standardized procedure or protocol.

(B) Approval of the standardized procedure or protocol.

(C) Availability by telephonic contact at the time of patient examination by the certified nurse-midwife.

(b)(1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed at least six months of physician and surgeon supervised experience in the furnishing or ordering of drugs or devices and a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.

(4) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Agency shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) under the following conditions:

(1) The drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (2) to (4), inclusive, of subdivision (a) and in paragraphs (1) to (3), inclusive, of subdivision (b).

(2) When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure or protocol. Use of the term "furnishing" in this section shall include the following:

(1) The ordering of a drug or device in accordance with the standardized procedure or protocol.

(2) Transmitting an order of a supervising physician and surgeon.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(Added Stats 1991 ch 870 § 2 (AB 1350). Amended Stats 2001 ch 289 § 3 (SB 298); Stats 2002 ch 764 § 2 (SB 993). Amended Stats 2005 ch 266 § 1 (SB 614).)

2746.52. Authority to perform episiotomies and repair lacerations of perineum

Notwithstanding Section 2746.5, the certificate to practice nursemidwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum, in a licensed acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, and a licensed alternate birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, but only if all of the following conditions are met:

(a) The supervising physician and surgeon and any backup physician and surgeon is credentialed to perform obstetrical care in the facility.

(b) The episiotomies are performed pursuant to protocols developed and approved by all of the following:

(1) The supervising physician and surgeon.

(2) The certified nurse-midwife.

(3) The director of the obstetrics department or the director of the family practice department, or both, if a physician and surgeon in the obstetrics department or the family practice department is a supervising physician and surgeon, or an equivalent person if there is no specifically identified obstetrics department or family practice department.

(4) The interdisciplinary practices committee, if applicable.

(5) The facility administrator or his or her designee.

(c) The protocols, and the procedures which shall be developed pursuant to the protocols, shall relate to the performance and repair of episiotomies and the repair of first-degree and second-degree lacerations of the perineum, and shall do all of the following:

(1) Ensure that all complications are referred to a physician and surgeon immediately.

(2) Ensure immediate care of patients who are in need of care beyond the scope of practice of the certified nurse midwife, or emergency care for times when the supervising physician and surgeon is not on the premises.

(3) Establish the number of certified nurse-midwives that a supervising physician and surgeon may supervise.

(Added Stats 1996 ch 158 § 1 (SB 1738), effective July 12, 1996.)

2746.7. Applications and fees
An applicant for certification pursuant to this article shall submit a written application in the form prescribed by the board, accompanied by the fee prescribed by Section 2815.5.

(Added Stats 1974 ch 1407 § 1.)

2746.8. Renewal of nurse-midwifery certificates
Each certificate issued pursuant to this article shall be renewable biennially, and each person holding a certificate under this article shall apply for a renewal of his certificate and pay the biennial renewal fee required by Section 2815.5 every two years on or before the last day of the month following the month in which his birthday occurs, beginning with the second birthday following the date on which the certificate was issued, whereupon the board shall renew the certificate.

Each such certificate not renewed in accordance with this section shall expire but may within a period of eight years thereafter be reinstated upon payment of the biennial renewal fee and penalty fee required by Section 2815.5 and upon submission of such proof of the applicant's qualifications as may be required by the board, except that during such eight-year period no examination shall be required as a condition for the reinstatement of any such expired certificate which has lapsed solely by reason of nonpayment of the renewal fee. After the expiration of such eight-year period the board may require as a condition of reinstatement that the applicant pass such examination as it deems necessary to determine his present fitness to resume the practice of nurse-midwifery.

(Added Stats 1974 ch 1407 § 1.)

2750. Persons subject to discipline; Conduct of proceedings
Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article. As used in this article, "license" includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

(Added Stats 1939 ch 807 § 2. Amended Stats 1945 ch 895 § 1; Stats 1965 ch 727 § 8; Stats 1976 ch 1053 § 3, effective September 28, 1976; Stats 1983 ch 696 § 1; Stats 1984 ch 144 § 10; Stats 1994 ch 1275 § 13 (SB 2101).)

2751. Acceptance of surrender of license through stipulated agreement
(a) Notwithstanding any other law, the board may, in its discretion, accept the surrender of a license through a stipulated agreement in the absence of a pleading when the ability of a registered nurse to practice nursing safely is impaired due to mental or physical illness.

(b) This alternative proceeding shall apply only to cases that would otherwise have been processed pursuant to Section 820.

(c) Until the time that the licensee signs the stipulated agreement for license surrender, he or she may elect to have the disciplinary process conducted pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) The stipulated agreement in this alternative proceeding shall specify that:

(1) The license surrender shall be public information and shall be considered a disciplinary action.

(2) The licensee may petition the board for reinstatement after a period of not less than one year after the effective date of the decision.

(3) Any reinstatement proceeding shall be conducted pursuant to Section 2760.1.

(4) Upon seeking reinstatement, it is the responsibility of the former licensee to submit competent evidence of the ability to safely and competently practice as a registered nurse.

(Added Stats 2002 ch 1011 § 6 (SB 2021).)

2759. Scope of discipline
The board shall discipline the holder of any license, whose default has been entered or who has been heard by the board and found guilty, by any of the following methods:

(a) Suspending judgment.

(b) Placing him upon probation.

(c) Suspending his right to practice nursing for a period not exceeding one year.

(d) Revoking his license.

(e) Taking such other action in relation to disciplining him as the board in its discretion may deem proper.

(Added Stats 1939 ch 807 § 2.)

2760. Effect of suspension; Conditions of reinstatement
If the holder of a license is suspended, he or she shall not be entitled to practice nursing during the term of suspension.

Upon the expiration of the term of suspension, he or she shall be reinstated by the board and shall be entitled to resume his or her practice of nursing unless it is established to the satisfaction of the board that he or she has practiced nursing in this state during the term of suspension. In this event, the board shall revoke his or her license.

(Added Stats 1939 ch 807 § 2. Amended Stats 1972 ch 300 § 1; Stats 1994 ch 1275 § 14 (SB 2101).)

2760.1. Petition for reinstatement or modification of penalty; Notice to Attorney General; Hearing
(a) A registered nurse whose license has been revoked or suspended or who has been placed on probation may petition the board for reinstatement or modification of penalty, including reduction or termination of probation, after a period not less than the following minimum periods has elapsed from the effective date of the decision ordering that disciplinary action, or if the order of the board or any portion of it is stayed by the board itself or by the superior court, from the date the disciplinary action is actually implemented in its entirety, or for a registered nurse whose initial license application is subject to a disciplinary decision, from the date the initial license was issued:

(1) Except as otherwise provided in this section, at least three years for reinstatement of a license that was revoked, except that the board may, in its sole discretion, specify in its order a lesser period of time provided that the period shall be not less than one year.

(2) At least two years for early termination of a probation period of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination of probation of less than three years.

(b) The board shall give notice to the Attorney General of the filing of the petition. The petitioner and the Attorney General shall be given timely notice by letter of the time and place of the hearing on the petition, and an opportunity to present both oral and documentary evidence and argument to the board. The petitioner shall at all times have the burden of proof to establish by clear and convincing evidence that he or she is entitled to the relief sought in the petition.

(c) The hearing may be continued from time to time as the board deems appropriate.

(d) The board itself shall hear the petition and the administrative law judge shall prepare a written decision setting forth the reasons supporting the decision.

(e) The board may grant or deny the petition, or may impose any terms and conditions that it reasonably deems appropriate as a condition of reinstatement or reduction of penalty.

(f) The petitioner shall provide a current set of fingerprints accompanied by the necessary fingerprinting fee.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole, or subject to an order of registration pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

(h) Except in those cases where the petitioner has been disciplined pursuant to Section 822, the board may in its discretion deny without hearing or argument any petition that is filed pursuant to this section within a period of two years from the effective date of a prior decision following a hearing under this section.

(Added Stats 1994 ch 1275 § 15 (SB 2101). Amended Stats 1997 ch 758 § 33 (SB 1346); Stats 1998 ch 970 § 11 (AB 2802); Stats 2009 ch 308 § 33 (SB 819), effective January 1, 2010.)

2761. Grounds for action
The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

(2) A conviction of practicing medicine without a license in violation of Chapter 5 (commencing with Section 2000), in which event the

record of conviction shall be conclusive evidence thereof.

(3) The use of advertising relating to nursing which violates Section 17500.

(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

(b) Procuring his or her certificate or license by fraud, misrepresentation, or mistake.

(c) Procuring, or aiding, or abetting, or attempting, or agreeing, or offering to procure or assist at a criminal abortion.

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or regulations adopted pursuant to it.

(e) Making or giving any false statement or information in connection with the application for issuance of a certificate or license.

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a certificate or license.

(h) Impersonating another certified or licensed practitioner, or permitting or allowing another person to use his or her certificate or license for the purpose of nursing the sick or afflicted.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of, or arranging for, a violation of any of the provisions of Article 12 (commencing with Section 2220) of Chapter 5.

(j) Holding oneself out to the public or to any practitioner of the healing arts as a "nurse practitioner" or as meeting the standards established by the board for a nurse practitioner unless meeting the standards established by the board pursuant to Article 8 (commencing with Section 2834) or holding oneself out to the public as being certified by the board as a nurse anesthetist, nurse midwife, clinical nurse specialist, or public health nurse unless the person is at the time so certified by the board.

(k) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensed or certified nurse to patient, from patient to patient, and from patient to licensed or certified nurse. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health Services developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300), Division 5, Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the Board of Podiatric Medicine, the Dental Board of California, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that licentiates and others regulated by the board are informed of the responsibility of licentiates to minimize the risk of transmission of blood-borne infectious diseases from health care provider to patient, from patient to patient, and from patient to health care provider, and of the most recent scientifically recognized safeguards for minimizing the risks of transmission.

(Added Stats 1939 ch 807 § 2. Amended Stats 1953 ch 1053 § 1; Stats 1977 ch 439 § 1; Stats 1978 ch 212 § 2, effective June 6, 1978; Stats 1979 ch 933 § 2; Stats 1983 ch 696 § 2; Stats 1984 ch 144 § 11; Stats 1987 ch 850 § 15; Stats 1991 ch 1180 § 4 (SB 1070); Stats 1992 ch 1350 § 4 (SB 1813); Stats 1994 ch 26 § 61 (AB 1807), effective March 30, 1994, ch 1275 § 16 (SB 2101); Stats 1997 ch 759 § 17 (SB 827). Amended Stats 2000 ch 568 § 8 (AB 2888).)

2762. Drug-related transgressions

In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

(d) Be committed or confined by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in subdivisions (a) and (b) of this section, in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

(Added Stats 1953 ch 1053 § 2. Amended Stats 1957 ch 923 § 1; Stats 1961 ch 378 § 1; Stats 1978 ch 1161 § 178; Stats 1984 ch 1635 § 4. Amended Stats 1998 ch 970 § 12 (AB 2802).)

2764. Jurisdiction in event license suspended or surrendered
The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

(Added Stats 1953 ch 1053 § 4.)

2765. What deemed conviction
A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions and duties of a registered nurse is deemed to be a conviction within the meaning of this article. The board may order the license or certificate suspended or revoked, or may decline to issue a license or certificate, when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information or indictment.

(Added Stats 1955 ch 336 § 1. Amended Stats 1978 ch 1161 § 179; Stats 1983 ch 696 § 3.)

2770. Legislative intent
It is the intent of the Legislature that the Board of Registered Nursing seek ways and means to identify and rehabilitate registered nurses whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness so that registered nurses so afflicted may be rehabilitated and returned to the practice of nursing in a manner which will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Registered Nursing shall implement this legislation by establishing a diversion program as a voluntary alternative to traditional disciplinary actions.

(Added Stats 1984 ch 865 § 1.)

2770.1. Definitions
As used in this article:

(a) "Board" means the Board of Registered Nursing.

(b) "Committee" means a diversion evaluation committee created by this article.

(c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

(Added Stats 1984 ch 865 § 1. Amended Stats 2008 ch 548 § 17 (SB 1441), effective January 1, 2009.)

2770.2. Diversion evaluation committees; Composition of committees; Appointments
One or more diversion evaluation committees is hereby created in the state to be established by the board. Each committee shall be composed of five persons appointed by the board. No board member shall serve on any committee. Each committee shall have the following composition:

(a) Three registered nurses, holding active California licenses, who have demonstrated expertise in the field of chemical dependency or psychiatric nursing.

(b) One physician, holding an active California license, who specializes in the diagnosis and treatment of addictive diseases or mental illness.

(c) One public member who is knowledgeable in the field of chemical dependency or mental illness.

It shall require a majority vote of the board to appoint a person to a committee. Each appointment shall be at the pleasure of the board for a term not to exceed four years. In its discretion the board may stagger the terms of the initial members appointed.

(Added Stats 1984 ch 865 § 1. Amended Stats 1999 ch 655 § 36 (SB 1308).)

2770.3. Per diem and expenses of committee members
Each member of a committee shall receive per diem and expenses as provided in Section 103.

(Added Stats 1984 ch 865 § 1.)

2770.4. Quorum; Majority vote requirement
Three members of a committee shall constitute a quorum for the transaction of business at any meeting. Any action requires a majority vote of the committee.

(Added Stats 1984 ch 865 § 1.)

2770.5. Election of chairperson and vice chairperson
Each committee shall elect from its membership a chairperson and a vice chairperson.

(Added Stats 1984 ch 865 § 1.)

2770.6. Administration of article
The board shall administer the provisions of this article.

(Added Stats 1984 ch 865 § 1.)

2770.7. Establishment of criteria for acceptance, denial, or termination of registered nurses in program
(a) The board shall establish criteria for the acceptance, denial, or termination of registered nurses in the diversion program. Only those registered nurses who have voluntarily requested to participate in the diversion program shall participate in the program.

(b) A registered nurse under current investigation by the board may request entry into the diversion program by contacting the board. Prior to authorizing a registered nurse to enter into the diversion program, the board may require the registered nurse under current investigation for any violations of this chapter or any other provision of this code to execute a statement of understanding that states that the registered nurse understands that his or her violations that would otherwise be the basis for discipline may still be investigated and may be the subject of disciplinary action.

(c) If the reasons for a current investigation of a registered nurse are based primarily on the self-administration of any controlled substance or dangerous drug or alcohol under Section 2762, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drug for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the registered nurse is accepted into the board's diversion program and successfully completes the requirements of the program. If the registered nurse withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(d) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any registered nurse for any unprofessional conduct committed before, during, or after participation in the diversion program.

(e) All registered nurses shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when the program manager or diversion evaluation committee determines the licentiate presents a threat to the public's health and safety shall result in the utilization by the board of diversion treatment records in disciplinary or criminal proceedings.

(f) Any registered nurse terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the diversion program. A registered nurse who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

(Added Stats 1984 ch 865 § 1. Amended Stats 2008 ch 548 § 18 (SB 1441), effective January 1, 2009.)

2770.8. Duties and responsibilities of committees
A committee created under this article operates under the direction of the diversion program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those registered nurses who request participation in the program according to the guidelines prescribed by the board, and to make recommendations.

(b) To review and designate those treatment services to which registered nurses in a diversion program may be referred.

(c) To receive and review information concerning a registered nurse participating in the program.

(d) To consider in the case of each registered nurse participating in a program whether he or she may with safety continue or resume the practice of nursing.

(e) To call meetings as necessary to consider the requests of registered nurses to participate in a diversion program, and to consider reports regarding registered nurses participating in a program.

(f) To make recommendations to the program manager regarding the terms and conditions of the diversion agreement for each registered nurse participating in the program, including treatment, supervision, and monitoring requirements.

(Added Stats 1984 ch 865 § 1. Amended Stats 1999 ch 655 § 37 (SB 1308); Stats 2008 ch 548 § 19 (SB 1441), effective January 1, 2009.)

2770.9. Informing participants of procedures, rights, and responsibilities
The committee shall inform each registered nurse who requests participation in a program of the procedures followed in the program, of the rights and responsibilities of the registered nurse in the program, and of the possible results of noncompliance with the program.

(Added Stats 1984 ch 865 § 1.)

2770.10. Authority of committee to convene in closed session
Notwithstanding the provisions of Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a committee may convene in closed session to consider reports pertaining to any registered nurse requesting or participating in a diversion program. A committee shall only convene in closed session to the extent that it is necessary to protect the privacy of such a licentiate.

(Added Stats 1984 ch 865 § 1. Amended Stats 1993 ch 589 § 6 (AB 2211).)

2770.11. Termination of participation for noncompliance with provisions of program
(a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by the committee and approved by the program manager. Any failure to comply with the provisions of a rehabilitation program

may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If the program manager determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the program manager shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

(Added Stats 1984 ch 865 § 1. Amended Stats 1999 ch 655 § 38 (SB 1308); Stats 2002 ch 1011 § 7 (SB 2021); Stats 2008 ch 548 § 20 (SB 1441), effective January 1, 2009.)

2770.12. Purging of records following diversion program
(a) After the committee and the program manager in their discretion have determined that a registered nurse has successfully completed the diversion program, all records pertaining to the registered nurse's participation in the diversion program shall be purged.

(b) All board and committee records and records of a proceeding pertaining to the participation of a registered nurse in the diversion program shall be kept confidential and are not subject to discovery or subpoena, except as specified in subdivision (b) of Section 2770.11 and subdivision (c).

(c) A registered nurse shall be deemed to have waived any rights granted by any laws and regulations relating to confidentiality of the diversion program, if he or she does any of the following:

(1) Presents information relating to any aspect of the diversion program during any stage of the disciplinary process subsequent to the filing of an accusation, statement of issues, or petition to compel an examination pursuant to Article 12.5 (commencing with Section 820) of Chapter 1. The waiver shall be limited to information necessary to verify or refute any information disclosed by the registered nurse.

(2) Files a lawsuit against the board relating to any aspect of the diversion program.

(3) Claims in defense to a disciplinary action, based on a complaint that led to the registered nurse's participation in the diversion program, that he or she was prejudiced by the length of time that passed between the alleged violation and the filing of the accusation. The waiver shall be limited to information necessary to document the length of time the registered nurse participated in the diversion program.

(Added Stats 1999 ch 655 § 39.1 (SB 1308). Amended Stats 2008 ch 548 § 21 (SB 1441), effective January 1, 2009.)

2770.13. Provision of representation in defamation action resulting from reports or information given to committee
The board shall provide for the legal representation of any person making reports under this article to a committee or the board in any action for defamation directly resulting from those reports regarding a registered nurse's participation in a diversion program.

(Added Stats 1984 ch 865 § 1. Amended Stats 1999 ch 655 § 40 (SB 1308).)

2770.14. Board reports
(a) The board shall produce reports which include, but are not limited to, information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance.

(b) The board shall conduct a periodic cost analysis of the program.

(Added Stats 1984 ch 865 § 1. Amended Stats 1999 ch 655 § 41 (SB 1308).)

2775. Definition
A nursing corporation is a corporation which is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are registered nurses are in compliance with the Moscone-Knox Professional Corporation Act, the provisions of this article and all other statutes and regulations now or hereafter enacted or adopted pertaining to such corporation and the conduct of its affairs.

With respect to a nursing corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Board of Registered Nursing.

(Added Stats 1981 ch 621 § 1.)

2776. Individual unprofessional conduct
It shall constitute unprofessional conduct and a violation of this chapter for any person licensed under this chapter to violate, attempt to violate, directly or indirectly, or assist in or abet the violation of, or conspire to violate any provision or term of this article, the Moscone-Knox Professional Corporation Act, or any regulations duly adopted under those laws.

(Added Stats 1981 ch 621 § 1.)

2777. Corporate unprofessional conduct
A nursing corporation shall not do or fail to do any act the doing of which or the failure to do which would constitute unprofessional conduct under any statute or regulation, now or hereafter in effect. In the conduct of its practice, it shall observe and be bound by such statutes and regulations to the same extent as a person holding a license under this chapter.

(Added Stats 1981 ch 621 § 2.)

2778. Name
The name of a nursing corporation and any name or names under which it may render professional services shall contain the words "nursing" or "registered nursing," and wording or abbreviations denoting corporate existence.

(Added Stats 1981 ch 621 § 1.)

2779. Shareholders, directors and officers
Except as provided in Sections 13401.5 and 13403 of the Corporations Code, each shareholder, director and officer of a nursing corporation, except an assistant secretary and an assistant treasurer, shall be a licensed person as defined in Section 13401 of the Corporations Code.

(Added Stats 1981 ch 621 § 1.)

2780. Income while shareholder is disqualified
The income of a nursing corporation attributable to professional services rendered while a shareholder is a disqualified person, as defined in Section 13401 of the Corporations Code, shall not in any manner accrue to the benefit of such shareholder or his or her shares in the nursing corporation.

(Added Stats 1981 ch 621 § 1.)

2781. Regulations
The board may adopt and enforce regulations to carry out the purposes and objectives of this article, including regulations requiring (a) that the bylaws of a nursing corporation shall include a provision whereby the capital stock of such corporation owned by a disqualified person (as defined in Section 13401 of the Corporations Code), or a deceased person, shall be sold to the corporation or to the remaining shareholders of such corporation within such time as such regulations may provide, and (b)that a nursing corporation shall provide adequate security by insurance or otherwise for claims against it by its patients arising out of the rendering of professional services.

(Added Stats 1981 ch 621 § 1.)

2785. List of approved schools
The board shall prepare and maintain a list of approved schools of nursing in this state whose graduates, if they have the other necessary qualifications provided in this chapter, shall be eligible to apply for a license to practice nursing in this state.

(Added Stats 1939 ch 807 § 2. Amended Stats 1983 ch 742 § 5.)

2785.5. Board to facilitate efficient transfer agreements between associate degree nursing programs and baccalaureate degree nursing programs
The board shall establish a workgroup, or use an existing committee, to encourage and facilitate efficient transfer agreements or other enrollment models between associate degree nursing programs and baccalaureate degree nursing programs so students are able to complete the baccalaureate program without unnecessary repetition of coursework.

(Added Stats 2004 ch 271 § 1 (AB 2839).)

2786. Approval of schools
(a) An approved school of nursing is one that has been approved by the board, gives the course of instruction approved by the board, covering not less than two academic years, is affiliated or conducted in connection with one or more hospitals, and is an institution of higher education or is affiliated with an institution of higher education. For purposes of this section, "institution of higher education" includes , but is not limited to, community colleges offering an associate of arts or associate of science degree and private postsecondary institutions offering an associate of arts or associate of science degree. An approved school of nursing that is not an institution of higher education shall make an agreement with an institution of higher education in the same general location to grant an associate of arts or associate of science degree to individuals who graduate from the school of nursing or to grant a baccalaureate degree in nursing with successful completion of an additional course of study as approved by the board and the institution involved.

(b) The board shall determine by regulation the required subjects of instruction to be completed in an approved school of nursing for licensure as a registered nurse and shall include the minimum units of theory and clinical experience necessary to achieve essential clinical competency at the entry level of the registered nurse. The board's standards shall be designed to encourage all schools to provide clinical instruction in all phases of the educational process.

(c) The board shall perform or cause to be performed an analysis of the practice of the registered nurse no less than every five years. Results of the analysis shall be utilized to assist in the determination of the required subjects of instruction, validation of the licensing examination, and assessment of the current practice of nursing.

Added Stats 1939 ch 807 § 2. Amended Stats 1951 ch 1748 § 1; Stats 1953 ch 1032 § 1; Stats 1974 ch 516 § 2; Stats 1975 ch 87 § 1, effective May 17, 1975; Stats 1983 ch 742 § 6; Stats 1985 ch 1055 § 2; Stats 2001 ch 435 § 6 (SB 349); Stats 2010 ch 208 § 1 (AB 2344), effective January 1, 2011.

2786.6. Grounds for denial of approval
The board shall deny the application for approval made by, and shall revoke the approval given to, any school of nursing which:

(a) Does not give to student applicants credit, in the field of nursing, for previous education and the opportunity to obtain credit for other acquired knowledge by the use of challenge examinations or other methods of evaluation; or,

(b) Is operated by a community college and discriminates against an applicant for admission to a school solely on the grounds that the applicant is seeking to fulfill the units of nursing required by Section 2736.6.

The board shall prescribe, by regulation, the education for which credit is to be given and the amount of credit which is to be given for each type of education. The word "credit," as used in the preceding sentence, is limited to credit for licensure only. The board is not authorized to prescribe the credit which an approved school of nursing shall give toward an academic certificate or degree.

(Added Stats 1969 ch 1541 § 3. Amended Stats 1976 ch 1405 § 1; Stats 1983 ch 742 § 8.)

2788. Inspections; Approval of schools meeting requirements; Notice of defects
It shall be the duty of the board, through its executive officer, to inspect all schools of nursing in this state at such times as the board shall deem necessary. Written reports of the executive officer's visits shall be made to the board, which shall thereupon approve those schools of nursing that meet the requirements provided by the board.

Upon receiving the report of the executive officer, if the board determines that any approved school of nursing is not maintaining the standard required by the board, notice thereof in writing specifying the defect or defects shall be immediately given to the school. If the defects are not corrected within a reasonable time, the school of nursing may be removed from the approved list and notice thereof in writing given to it.

(Added Stats 1939 ch 807 § 2. Amended Stats 1983 ch 742 § 10.)

2789. Exempt schools
None of the provisions of this chapter shall be applicable to any school or schools conducted by any well recognized church or denomination for the purpose of training the adherents of such church or denomination in the care of the sick in accordance with its religious tenets.

(Added Stats 1939 ch 807 § 2.)

2795. Unlawful practice; Misrepresentation of licensee status
Except as provided in this chapter, it is unlawful for any person to do any of the following:

(a) To practice or to offer to practice nursing in this state unless the person holds a license in an active status.

(b) To use any title, sign, card, or device to indicate that he or she is qualified to practice or is practicing nursing, unless the person has been duly licensed or certified under this chapter.

(Added Stats 1939 ch 807 § 2. Amended Stats 1976 ch 1053 § 5, effective September 28, 1976; Stats 1983 ch 696 § 4; Stats 1990 ch 350 § 2 (SB 2084).)

2796. Use of "R. N.", etc.
It is unlawful for any person or persons not licensed or certified as provided in this chapter to use the title "registered nurse," the letters "R.N.," or the words "graduate nurse," "trained nurse," or "nurse anesthetist."

It is unlawful for any person or persons not licensed or certified as provided in this chapter to impersonate a professional nurse or pretend to be licensed to practice professional nursing as provided in this chapter.

(Added Stats 1939 ch 807 § 2. Amended Stats 1965 ch 727 § 9; Stats 1983 ch 696 § 5.)

2797. Impersonation of applicants or examinees
It is unlawful for a person to wilfully make any false representation or to impersonate any other person or permit or aid any person in any manner to impersonate him in connection with any examination or application for a license, or request to be examined or licensed.

(Added Stats 1939 ch 807 § 2.)

2798. Conduct of unaccredited schools
It is unlawful for anyone to conduct a school of nursing unless the school has been approved as an accredited school by the board.

This section is not applicable to schools conducted under Section 2789 of this chapter.

(Added Stats 1939 ch 807 § 2. Amended Stats 1947 ch 504 § 1; Stats 1961 ch 1823 § 6.)

2799. Penalty for violations
Any person who violates any of the provisions of this chapter is guilty of a misdemeanor and upon a conviction thereof shall be punished by imprisonment in the county jail for not less than 10 days nor more than one year, or by a fine of not less than twenty dollars ($20) nor more than one thousand dollars ($1,000), or by both such fine and imprisonment.

(Added Stats 1939 ch 807 § 2. Amended Stats 1983 ch 1092 § 10, effective September 27, 1983, operative January 1, 1984.)

2800. Applicability of article
None of the sections in this article, except Sections 2796 and 2797, shall be applicable to any person or persons specifically exempted from the general provisions of this act by Section 2731 hereof, or to schools conducted by any well recognized church or denomination for the purpose of training the adherents of such church or denomination in the care of the sick in accordance with its religious tenets; and any adherent of any well recognized church or denomination who engages in nursing or the care of the sick in connection with the practice of the religious tenets of such well recognized church or denomination may use the word "nurse" in connection with or following his or her name, provided he or she shall not use the title "registered nurse," the letters "R.N.," the words "graduate nurse," "trained nurse," "nurse anesthetist," or any other name, word or symbol in connection with or following his or her name so as to lead another or others to believe that he or she is a professional nurse licensed under the provisions of this chapter.

(Added Stats 1939 ch 807 § 2. Amended Stats 1983 ch 696 § 6.)

2810. Board of Registered Nursing Fund
There is established in the State Treasury a Board of Registered Nursing Fund. The California Board of Nursing Education and Nurse Registration Fund of the State of California is abolished. The Controller, on, January 1, 1975, shall transfer any balance in that fund to the Board of Registered Nursing Fund. Any reference in state law to the Board of Nurse Examiners Fund or the Board of Nurse Examiners Fund of the State of California shall be construed to refer to the Board of Registered Nursing Fund.

(Added Stats 1939 ch 807 § 2. Amended Stats 1961 ch 1823 § 7; Stats 1974 ch 632 § 8.)

2811. Renewal of licenses; Expiration and reinstatement; Restoration of license in inactive status to active status
(a) Each person holding a regular renewable license under this chapter, whether in an active or inactive status, shall apply for a renewal of his license and pay the biennial renewal fee required by this chapter each two years on or before the last day of the month following the month in which his birthday occurs, beginning with the second birthday following the date on which the license was issued, whereupon the board shall renew the license.

(b) Each such license not renewed in accordance with this section shall expire but may within a period of eight years thereafter be reinstated upon payment of the biennial renewal fee and penalty fee required by this chapter and upon submission of such proof of the applicant's qualifications as may be required by the board, except that during such eight-year period no examination shall be required as a condition for the reinstatement of any such expired license which has lapsed solely by reason of nonpayment of the renewal fee. After the expiration of such eight-year period the board may require as a condition of reinstatement that the applicant pass such examination as it deems necessary to determine his present fitness to resume the practice of professional nursing.

(c) A license in an inactive status may be restored to an active status if the licensee meets the continuing education standards of Section 2811.5.

(Added Stats 1939 ch 807 § 2. Amended Stats 1945 ch 1249 § 2; Stats 1953 ch 1174 § 12; Stats 1957 ch 1626 § 1; Stats 1963 ch 599 § 1; Stats 1965 ch 727 § 10; Stats 1971 ch 1516 § 2; Stats 1972 ch 919 § 3; Stats 1974 ch 923 § 2; Stats 1976 ch 1053 § 6, effective September 28, 1976.)

2811.5. Continuing education as prerequisite for renewal
(a) Each person renewing his or her license under Section 2811 shall submit proof satisfactory to the board that, during the preceding two-year period, he or she has been informed of the developments in the registered nurse field or in any special area of practice engaged in by the licensee, occurring since the last renewal thereof, either by pursuing a course or courses of continuing education in the registered nurse field or relevant to the practice of the licensee, and approved by the board, or by other means deemed equivalent by the board.

(b) For purposes of this section, the board shall, by regulation, establish standards for continuing education. The standards shall be established in a manner to assure that a variety of alternative forms of continuing education are available to licensees, including, but not limited to, academic studies, in-service education, institutes, seminars, lectures, conferences, workshops, extension studies, and home study programs. The standards shall take cognizance of specialized areas of practice. The continuing education standards established by the board shall not exceed 30 hours of direct participation in a course or courses approved by the board, or its equivalent in the units of measure adopted by the board.

(c) The board shall encourage continuing education in spousal or partner abuse detection and treatment. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(d) In establishing standards for continuing education, the board shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(e) In establishing standards for continuing education, the board may include a course on pain management.

(f) This section shall not apply to licensees during the first two years immediately following their initial licensure in California or any other governmental jurisdiction.

(g) The board may, in accordance with the intent of this section, make exceptions from continuing education requirements for licensees residing in another state or country, or for reasons of health, military service, or other good cause.

(Added Stats 1974 ch 923 § 4. Amended Stats 1976 ch 1053 § 7, effective September 28, 1976, operative July 1, 1978; Stats 1978 ch 212 § 3, effective June 6, 1978; Stats 1990 ch 1207 § 2 (AB 3242); Stats 1993 ch 1234 § 6 (AB 890). Amended Stats 1998 ch 791 § 3 (SB 1140).)

2811.6. Availability of continuing education course records for board inspection
Providers of continuing education programs approved by the board pursuant to Section 2811.5 shall make available for board inspection records of continuing education courses given to registered nurses.

(Added Stats 1978 ch 167 § 1.)

2812. Reports; Deposit of funds
Within 10 days after the beginning of each month, the board shall report to the State Controller the amount and source of all collections made under this chapter. At the same time, all amounts shall be paid into the State Treasury, where they shall be placed to the credit of the Board of Registered Nursing Fund and to the Registered Nurse Education Fund, as specified in Section 128400 of the Health and Safety Code.

(Added Stats 1939 ch 807 § 2. Amended Stats 1961 ch 1823 § 8; Stats 1974 ch 632 § 9; Stats 1988 ch 252 § 1; Stats 1996 ch 1023 § 11

(SB 1497), effective September 29, 1996.)

2814. Use of funds
All money in the Board of Registered Nursing Fund is hereby appropriated to carry out the provisions of this chapter, and the promotion of nursing education in this state.

(Added Stats 1939 ch 807 § 2. Amended Stats 1941 ch 1081 § 1; Stats 1961 ch 1823 § 9; Stats 1974 ch 632 § 10.)

2815. Fee schedule for registered nurses
Subject to the provisions of Section 128.5, the amount of the fees prescribed by this chapter in connection with the issuance of licenses for registered nurses under its provisions is that fixed by the following schedule:

(a) The fee to be paid upon the filing of an application for a licensure by examination shall be fixed by the board at not less than seventy-five dollars ($75) nor more than one hundred fifty dollars ($150).

(b) The fee to be paid for taking each examination shall be the actual cost to purchase an examination from a vendor approved by the board.

(c) The fee to be paid for application for licensure by endorsement shall be fixed by the board at not less than fifty dollars ($50) nor more than one hundred dollars ($100).

(d) The biennial fee to be paid upon the filing of an application for renewal of the license shall be not less than seventy-five dollars ($75) nor more than one hundred fifty dollars ($150). In addition, an assessment of ten dollars ($10) shall be collected and credited to the Registered Nurse Education Fund, pursuant to Section 2815.1.

(e) The penalty fee for failure to renew a license within the prescribed time shall be fixed by the board at not more than 50 percent of the regular renewal fee, but not less than thirty-seven dollars ($37) nor more than seventy-five dollars ($75).

(f) The fee to be paid for approval of a continuing education provider shall be fixed by the board at not less than two hundred dollars ($200) nor more than three hundred dollars ($300).

(g) The biennial fee to be paid upon the filing of an application for renewal of provider approval shall be fixed by the board at not less than two hundred dollars ($200) nor more than three hundred dollars ($300).

(h) The penalty fee for failure to renew provider approval within the prescribed time shall be fixed at not more than 50 percent of the regular renewal fee, but not less than one hundred dollars ($100) nor more than one hundred fifty dollars ($150).

(i) The penalty for submitting insufficient funds or fictitious check, draft or order on any bank or depository for payment of any fee to the board shall be fixed at not less than fifteen dollars ($15) nor more than thirty dollars ($30).

(j) The fee to be paid for an interim permit shall be fixed by the board at not less than thirty dollars ($30) nor more than fifty dollars ($50).

(k) The fee to be paid for a temporary license shall be fixed by the board at not less than thirty dollars ($30) nor more than fifty dollars ($50).

(l) The fee to be paid for processing endorsement papers to other states shall be fixed by the board at not less than sixty dollars ($60) nor more than one hundred dollars ($100).

(m) The fee to be paid for a certified copy of a school transcript shall be fixed by the board at not less than thirty dollars ($30) nor more than fifty dollars ($50).

(n) The fee to be paid for a duplicate license shall be fixed by the board at not less than thirty dollars ($30) nor more than fifty dollars ($50).

(o) The fee to be paid by a registered nurse for an evaluation of his or her qualifications to use the title "nurse practitioner" shall be fixed by the board at not less than seventy-five dollars ($75) nor more than one hundred fifty dollars ($150).

No further fee shall be required for a license or a renewal thereof other than as prescribed by this chapter.

(Added Stats 1939 ch 807 § 2. Amended Stats 1953 ch 1174 § 13; Stats 1955 ch 1769 § 1; Stats 1959 ch 1578 § 1; Stats 1963 ch 1400 § 2; Stats 1965 ch 1191 § 13; Stats 1974 ch 1407 § 2; Stats 1975 ch 999 § 1; Stats 1978 ch 1161 § 180; Stats 1979 ch 933 § 3; Stats 1981 ch 437 § 2; Stats 1984 ch 525 § 1; Stats 1988 ch 252 § 2; Stats 1991 ch 352 § 1 (AB 485). Amended Stats 2003 ch 640 § 7 (SB 358).)

2815.1. Increase in license renewal fee
As provided in subdivision (d) of Section 2815, the Board of Registered Nursing shall collect an additional ten dollar ($10) assessment at the time of the biennial licensure renewal. This amount shall be credited to the Registered Nurse Education Fund. This assessment is separate from those fees prescribed in Section 2815.

(Added Stats 1988 ch 252 § 3. Amended Stats 1991 ch 352 § 2 (AB 485). Amended Stats 1999 ch 146 § 1 (AB 1107), effective July 22, 1999, ch 149 § 1 (SB 308), effective July 22, 1999. Amended Stats 2003 ch 640 § 8 (SB 358).)

2815.5. Fee schedule for nurse-midwives
The amount of the fees prescribed by this chapter in connection with the issuance of certificates as nurse-midwives is that fixed by the following schedule:

(a) The fee to be paid upon the filing of an application for a certificate shall be fixed by the board at not less than seventy-five dollars ($75) nor more than one hundred fifty dollars ($150).

(b) The biennial fee to be paid upon the application for a renewal of a certificate shall be fixed by the board at not less than fifty dollars ($50) nor more than one hundred dollars ($100).

(c) The penalty fee for failure to renew a certificate within the prescribed time shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars ($25) nor more than fifty dollars ($50).

(d) The fee to be paid upon the filing of an application for the nursemidwife equivalency examination shall be fixed by the board at not less than one hundred dollars ($100) nor more than two hundred dollars ($200).

(Added Stats 1974 ch 1407 § 3. Amended Stats 1978 ch 1161 § 181; Stats 1981 ch 437 § 3. Amended Stats 1991 ch 352 § 3 (AB 485).)

2815.7. Report to the legislature upon proposal or adoption of fee increase
The board shall report to the appropriate policy and fiscal committees of each house of the Legislature whenever the board proposes or adopts an increase in any fee imposed pursuant to this chapter. The board shall specify the reasons for each fee increase and shall identify the percentage of the funds derived from an increase in any fee that will be used for investigational or enforcement related activities by the board.

(Added Stats 1991 ch 352 § 4 (AB 485).)

2816. Fee
The nonrefundable fee to be paid by a registered nurse for an evaluation of his or her qualifications to use the title "public health nurse" shall be equal to the fees set out in subdivision (o) of Section 2815. All fees payable under this section shall be collected by and paid to the Registered Nursing Fund. It is the intention of the Legislature that the costs of carrying out the purposes of this article shall be covered by the revenue collected pursuant to this section.

(Added Stats 1992 ch 1135 § 2.8 (SB 2044).)

2817. Child abuse and neglect detection training requirement
The qualifications prescribed by the board under this article shall include a requirement that an applicant for employment as a public health nurse and all public health nurses employed on or after January 1, 1981, acquire training in child abuse and neglect detection.

(Added Stats 1992 ch 1135 § 2.8 (SB 2044).)

2818. Legislative findings; Use of title "public health nurse"
(a) The Legislature recognizes that public health nursing is a service of crucial importance for the health, safety, and sanitation of the population in all of California's communities. These services currently include, but are not limited to:

(1) Control and prevention of communicable disease.

(2) Promotion of maternal, child, and adolescent health.

(3) Prevention of abuse and neglect of children, elders, and spouses.

(4) Outreach screening, case management, resource coordination and assessment, and delivery and evaluation of care for individuals, families, and communities.

(b) The Legislature also finds that conflicting definitions of "public health nurse" have been created by various state and local agencies within California. The Legislature also finds that the public is harmed by the conflicting usage of the title "public health nurse" and lack of consistency between the use of the term and the qualifications required in state law and in administrative regulations. Therefore, the Legislature finds that the public interest would be served by determining the conditions for the legitimate use by registered nurses of a title which includes the term "public health nurse."

(c) No individual shall hold himself or herself out as a public health nurse or use a title which includes the term "public health nurse" unless that individual is in possession of a valid California public health nurse certificate issued pursuant to this article.

(d) No employer subject to regulation by Section 602 of the Health and Safety Code shall hold out any employee to be a public health nurse or grant a title to any employee including the term "public health nurse" unless that employee holds a valid California public health nurse certificate pursuant to this article.

(Added Stats 1992 ch 1135 § 2.8 (SB 2044).)

2819. Repeal and adoption of regulations
In order to effect a speedy and efficient transfer of public health nurse certification from the State Department of Health Services to the board, existing Sections 4500 to 4504, inclusive, of Title 17 of the California Code of Regulations shall be repealed by the State Department of Health Services and adopted by the board to place them in Chapter 14 of Title 16 of the California Code of Regulations, and any reference to the State Department of Health Services in those regulations shall be changed to refer to the board. The repeal of the regulations and adoption of the revised regulations pursuant to this section shall be exempt from the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, except that the repealed and adopted regulations shall be filed with the Office of Administrative Law for publication in the California Code of Regulations.

(Added Stats 1992 ch 1135 § 2.8 (SB 2044).)

2820. Scope of practice
Nothing in this article shall be construed as expanding the scope of practice of a registered nurse beyond that which is authorized under Section 2725.

(Added Stats 1992 ch 1135 § 2.8 (SB 2044).)

2825. Citation of article
This article may be cited as the Nurse Anesthetists Act.

(Added Stats 1983 ch 696 § 7.)

2826. Definitions
As used in this article:

(a) "Nurse anesthetist" means a person who is a registered nurse, licensed by the board and who has met standards for certification from the board. In the certification and recertification process the board shall consider the standards of the Council on Certification of Nurse Anesthetists and the Council on Recertification of Nurse Anesthetists and may develop new standards if there is a public safety need for standards more stringent than the councils' standards. In determining the adequacy for public safety of the councils' standards or in developing board standards, the board shall comply with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) "Accredited Program" means a program for the education of nurse anesthetists which has received approval from the board. In the approval process the board shall consider the standards of the Council on Accreditation of Nurse Anesthesia Education Programs and Schools and may develop new standards if the councils' standards are determined to be inadequate for public safety. In determining the adequacy for public safety of the councils' standards or in developing board standards, the board shall comply with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) "Appropriate committee" means the committee responsible for anesthesia practice which is responsible to the executive committee of the medical staff.

(d) "Trainee" means a registered nurse enrolled in an accredited program of nurse anesthesia.

(e) "Graduate" means a nurse anesthetist who is a graduate of an accredited program of nurse anesthesia awaiting initial certification results for not more than one year from the date of graduation.

(Added Stats 1983 ch 696 § 7.)

2827. Anesthesia services; Approval; Permit
The utilization of a nurse anesthetist to provide anesthesia services in an acute care facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist or podiatrist. If a general anesthetic agent is administered in a dental office, the dentist shall hold a permit authorized by Section 1646.

(Added Stats 1983 ch 696 § 7.)

2828. Nonemployee nurse anesthetists working in acute care facilities
In an acute care facility, a nurse anesthetist who is not an employee of the facility shall, nonetheless, be subject to the bylaws of the facility and may be required by the facility to provide proof of current professional liability insurance coverage. Notwithstanding any other provision of law, a nurse anesthetist shall be responsible for his or her own professional conduct and may be held liable for those professional acts.

(Added Stats 1983 ch 696 § 7.)

2829. Unlawful use of title "nurse anesthetist"
It is unlawful for any person or persons to advertise, use any title, sign, card, or device, or to otherwise hold himself or herself out as a "nurse anesthetist" unless the person meets the requirements of subdivision (a) of Section 2826 and has been so certified under the provisions of this article.

(Added Stats 1983 ch 696 § 7.)

2830. Certificate to practice
The board shall issue a certificate to practice nurse anesthesia to any person who qualifies under this article and is licensed pursuant to the provisions of this chapter.

(Added Stats 1983 ch 696 § 7.)

2830.5. Evidence that applicant has met requirements
Every applicant shall show by evidence satisfactory to the board that he or she has met the requirements of this article.

(Added Stats 1983 ch 696 § 7.)

2830.6. Certification
Notwithstanding Section 2830, the board shall certify all applicants who can show certification by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists as of the effective date of this chapter. This certification shall be documented to the board in a manner to be determined by the board. Proof of certification shall be filed with the board within six months from the effective date of this article and the board shall, within one year from the effective date of this article, issue a certificate to applicants who have filed proof of certification within that six-month period.

(Added Stats 1983 ch 696 § 7.)

2830.7. Fee schedule for nurse anesthetists
The amount of the fees prescribed by this chapter in connection with the issuance of certificates as nurse anesthetists is that fixed by the following schedule:

(a) The fee to be paid upon the filing of an application for a certificate shall be fixed by the board at not less than seventy-five dollars ($75) nor more than one hundred fifty dollars ($150).

(b) The biennial fee to be paid upon the application for a renewal of a certificate shall be fixed by the board at not less than fifty dollars ($50) nor more than one hundred dollars ($100).

(c) The penalty fee for failure to renew a certificate within the prescribed time shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars ($25) nor more than fifty dollars ($50).

(Added Stats 1991 ch 352 § 4.5 (AB 485).)

2831. Written application; Fee
An applicant for certification pursuant to this article shall submit a written application in the form prescribed by the board, accompanied by the fee prescribed by Section 2830.7 which shall also apply to the issuance of a certificate under the provisions of this article.

(Added Stats 1983 ch 696 § 7. Amended Stats 1991 ch 352 § 5 (AB 485).)

2832. Applicant to comply with all provisions of article
Every applicant for a certificate to practice nurse anesthesia shall comply with all the provisions of this article in addition to the provisions of this chapter.

(Added Stats 1983 ch 696 § 7.)

2833. Renewal of certificate; Reinstatement of expired certificate
Each certificate issued pursuant to this article shall be renewable biennially, and each person holding a certificate under this article shall apply for a renewal of his or her certificate and pay the biennial renewal fee required by Section2830.7 every two years on or before the last day of the month following the month in which his or her birthday occurs, beginning with the second birthday following the date on which the certificate was issued, whereupon the board shall renew the certificate. Each certificate not renewed in accordance with this section shall expire but may within a period of eight years thereafter be reinstated upon payment of the biennial renewal fee and penalty fee required by Section 2830.7 and upon submission of such proof of the applicant's qualifications as may be required by the board, except that during that eight-year period no examination shall be required as a condition for the reinstatement of any expired certificate which has lapsed solely by reason of nonpayment of the renewable fee. After the expiration of the eight-year period the board may require as a condition of reinstatement that the applicant pass an examination as it deems necessary to determine his or her present fitness to resume the practice of nurse anesthesia.

(Added Stats 1983 ch 696 § 7. Amended Stats 1991 ch 352 § 6 (AB 485).)

2833.3. Article not limitation on ability to practice nursing
Nothing in this article shall be construed to limit a certified nurse anesthetist's ability to practice nursing.

(Added Stats 1983 ch 696 § 7.)

2833.5. Practice not authority to practice medicine or surgery
Except as provided in Section 2725 and in this section, the practice of nurse anesthetist does not confer authority to practice medicine or surgery.

(Added Stats 1983 ch 696 § 7.)

2833.6. Effect of provisions on existing scope of practice
This chapter is not intended to address the scope of practice of, and nothing in this chapter shall be construed to restrict, expand, alter, or modify the existing scope of practice of, a nurse anesthetist.

(Added Stats 1983 ch 696 § 7.)

2834. Legislative finding of conflicting definitions and usage
The Legislature finds that various and conflicting definitions of the nurse practitioner are being created by state agencies and private organizations within California. The Legislature also finds that the public is harmed by conflicting usage of the title of nurse practitioner and lack of correspondence between use of the title and qualifications of the registered nurse using the title. Therefore, the Legislature finds the public interest served by determination of the legitimate use of the title "nurse practitioner" by registered nurses.

(Added Stats 1977 ch 439 § 2.)

2835. License requirement
No person shall advertise or hold himself out as a "nurse practitioner" who is not a nurse licensed under this chapter and does not, in addition, meet the standards for a nurse practitioner established by the board.

(Added Stats 1977 ch 439 § 2.)

2835.5. Submission of credentials; Issuance of certificate; Persons already found qualified
(a) A registered nurse who is holding himself or herself out as a nurse practitioner or who desires to hold himself or herself out as a nurse practitioner shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified

person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to the effective date of this section, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(1) Hold a valid and active registered nursing license issued under this chapter.

(2) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.

(3) Satisfactorily complete a nurse practitioner program approved by the board.

(Added Stats 1984 ch 525 § 2. Amended Stats 2004 ch 344 § 1 (AB 2226).)

2835.7. Authorized standardized procedures
(a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in statute or regulation for inclusion in standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses, pursuant to Section 2725, standardized procedures may be implemented that authorize a nurse practitioner to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in the standardized procedures. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner and collaboration with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(b) Nothing in this section shall be construed to affect the validity of any standardized procedures in effect prior to the enactment of this section or those adopted subsequent to enactment.

(Added Stats 2009 ch 308 § 34 (SB 819), effective January 1, 2010.)

2836. Establishment of categories and standards
(a) The board shall establish categories of nurse practitioners and standards for nurses to hold themselves out as nurse practitioners in each category. Such standards shall take into account the types of advanced levels of nursing practice which are or may be performed and the clinical and didactic education, experience, or both needed to practice safely at those levels. In setting such standards, the board shall consult with nurse practitioners, physicians and surgeons with expertise in the nurse practitioner field, and health care organizations utilizing nurse practitioners. Established standards shall apply to persons without regard to the date of meeting such standards. If the board sets standards for use of nurse practitioner titles which include completion of an academically affiliated program, it shall provide equivalent standards for registered nurses who have not completed such a program.

(b) Any regulations promulgated by a state department that affect the scope of practice of a nurse practitioner shall be developed in consultation with the board.

(Added Stats 1977 ch 39 § 2. Amended Stats 2002 ch 764 § 3 (SB 993).)

2836.1. Furnishing or ordering of drugs or devices by nurse practitioners
Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c)(1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

(f)(1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

(g)(1) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed (1) at least six month's physician and surgeon-supervised experience in the furnishing or ordering of drugs or devices and (2) a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

(2) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

(i) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(Added Stats 1986 ch 493 § 2. Amended Stats 1991 ch 870 § 3 (AB 1350); Stats 1996 ch 455 § 1 (AB 1077). Amended Stats 1999 ch 749 § 1 (SB 816); Stats 2002 ch 764 § 4 (SB 993); Stats 2003 ch 748 § 1 (AB 1196). Amended Stats 2004 ch 205 § 1 (AB 2560).)

2836.2. What constitutes furnishing or ordering of drugs or devices
Furnishing or ordering of drugs or devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. All nurse practitioners who are authorized pursuant to Section 2831.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

(Added Stats 1986 ch 493 § 3. Amended Stats 1999 ch 749 § 2 (SB 816).)

2836.3. Issuance of number to nurse practitioners dispensing drugs or devices
(a) The furnishing of drugs or devices by nurse practitioners is conditional on issuance by the board of a number to the nurse applicant who has successfully completed the requirements of subdivision (g) of Section 2836.1. The number shall be included on all transmittals of orders for drugs or devices by the nurse practitioner. The board shall make the list of numbers issued available to the Board of Pharmacy. The board may charge the applicant a fee to cover all necessary costs to implement this section.

(b) The number shall be renewable at the time of the applicant's registered nurse license renewal.

(c) The board may revoke, suspend, or deny issuance of the numbers for incompetence or gross negligence in the performance of functions specified in Sections 2836.1 and 2836.2.

(Added Stats 1986 ch 493 § 4.)

2837. Registered nursing practice not limited
Nothing in this article shall be construed to limit the current scope of practice of a registered nurse authorized pursuant to this chapter.

(Added Stats 1977 ch 439 § 2.)

2838. License required
No person shall advertise or hold himself or herself out as a "clinical nurse specialist" unless he or she is a nurse licensed under this chapter, and meets the standards for a clinical nurse specialist established by the board.

(Added Stats 1997 ch 159 § 3 (AB 90), operative July 1, 1998.)

2838.1. Qualifications and credentials
(a) On and after July 1, 1998, any registered nurse who holds himself or herself out as a clinical nurse specialist or who desires to hold himself or herself out as a clinical nurse specialist shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit his or her education, experience, and other credentials, and any other information as required by the board to determine that the person qualifies to use the title "clinical nurse specialist."

(b) Upon finding that a person is qualified to hold himself or herself out as a clinical nurse specialist, the board shall appropriately indicate on the license issued or renewed that the person is qualified to use the title "clinical nurse specialist." The board shall also issue to each qualified person a certificate indicating that the person is qualified to use the title "clinical nurse specialist."

(Added Stats 1997 ch 159 § 3 (AB 90), operative July 1, 1998.)

2838.2. Standards and fees
(a) A clinical nurse specialist is a registered nurse with advanced education, who participates in expert clinical practice, education, research, consultation, and clinical leadership as the major components of his or her role.

(b) The board may establish categories of clinical nurse specialists and the standards required to be met for nurses to hold themselves out as clinical nurse specialists in each category. The standards shall take into account the types of advanced levels of nursing practice that are or may be performed and the clinical and didactic education, experience, or both needed to practice safety at those levels. In setting the standards, the board shall consult with clinical nurse specialists, physicians and surgeons appointed by the Medical Board with expertise with clinical nurse specialists, and health care organizations that utilize clinical nurse specialists.

(c) A registered nurse who meets one of the following requirements may apply to become a clinical nurse specialist:

(1) Possession of a master's degree in a clinical field of nursing.

(2) Possession of a master's degree in a clinical field related to nursing with course work in the components referred to in subdivision (a).

(3) On or before July 1, 1998, meets the following requirements:

(A) Current licensure as a registered nurse.

(B) Performs the role of a clinical nurse specialist as described in subdivision (a).

(C) Meets any other criteria established by the board.

(d) A nonrefundable fee of not less than seventy-five dollars ($75), but not to exceed one hundred fifty dollars ($150), shall be paid by a registered nurse applying to be a clinical nurse specialist for the evaluation of his or her qualifications to use the title "clinical nurse specialist." A biennial renewal fee shall be paid upon submission of an application to renew the clinical nurse specialist certificate and shall be established by the board at no less than fifty dollars ($50) and no more than one hundred dollars ($100). The penalty fee for failure to renew a certificate within the prescribed time shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars ($25), nor more than fifty dollars ($50). The fees authorized by this subdivision shall not exceed the amount necessary to cover the costs to the board to administer this section.

(Added Stats 1997 ch 159 § 3 (AB 90), operative July 1, 1998.)

2838.3. Operative date of article
This article shall become operative on July 1, 1998.

(Added Stats 1997 ch 159 § 3 (AB 90), operative July 1, 1998.)

2838.4 Effect of article
Nothing in this article shall be construed to limit, revise, or expand the current scope of practice of a registered nurse.

(Added Stats 1997 ch 159 § 3 (AB 90), operative July 1, 1998.)

Resolution of Chapter 156
Assembly Concurrent Resolution No. 103 - Relative to nursing.

[Filed with Secretary of State November 27, 1972.]

WHEREAS, The licensing laws for physicians, registered nurses, and licensed vocational nurses are ambiguous concerning the performance of certain roles by registered nurses and vocational nurses, and of the congruent roles of nurses and physicians; and

WHEREAS, commencing in 1957, the California Nurses' Association, the California Medical Association, and the California Hospital Association have developed and distributed a series of joint statements on the role of the registered nurse in meeting new and changing needs of patient care and on the congruent roles of the nurse and the physician; and

WHEREAS, the joint statements have primarily functioned to validate developments in practice after the changes have become common practice, and have not been used to anticipate new needs or to encourage responsible innovative demonstrations of methods and practice for registered nurses and licensed vocational nurses; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring,

That it will best serve the public interest if such joint statements are utilized in cases of conflicting or absent statutory definition to validate generally accepted practices or patterns of care, and in addition, to assist the Legislature, licensing boards, other appropriate agencies, and responsible professional associations in anticipating new needs, making responsible innovations in practice patterns, and developing demonstration projects, all in the interest of patient care; and be it further

Resolved, That it is in the public interest that such joint statements are made a matter of public record for information and guidance to educators, practitioners, the public and the Legislature, and it is therefore directed that permanent files of such joint statements be maintained by the State Department of Public Health, the Board of Medical Examiners of the State of California, the California Board of Nursing Education and Nurse Registration and the Board of Vocational Nurse and Psychiatric Technician Examiners of the State of California, for public inspection; and it is further directed that the State Department of Public Health report annually to the Legislature as to new joint statements or modifications of existing joint statements; and be it further

Resolved, That the appropriate professional organizations representing physicians, registered nurses, vocational nurses, and hospitals

are encouraged to form a joint practice commission which shall have as one of its purposes the encouragement, development, modification and publication of joint statements and interdisciplinary accords relating to needs and methodology of better and more effective nursing care.

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M

TAB M

SUBJECT: Privacy Act Statement

DATE: 17 May 2011 NAME: the Whistleblower

1. AUTHORITY: The authority for the collection of personal information during the conduct of this investigation is Title 10, United States Code, Section 3012 (10 USC 3012).

2. PRINCIPAL PURPOSE: The purpose for soliciting this information is to obtain facts and make recommendations to assist the Office of Special Counsel in to determine the validity of allegations that in the Department of Preventive Medicine at Lyster Army Health Clinic the lack of appropriate qualifications, certifications and training of the Community Health Nurse poses a danger to public health and safety.

3. ROUTINE USES: Any information you provide may be disclosed to members of the Department of Defense (DoD) who have a need for the information in the performance of their official duties. In addition, the information may be disclosed to government agencies outside of the DoD as follows:

a. To members of the U.S. Department of Justice when necessary in the defense of litigation brought against the DoD, or against the members of that department as a result of actions taken in their official capacity.

b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.

4. DISCLOSURE MANDATORY; EFFECT OF NOT PROVIDING INFORMATION:

a. For individual warned of his or her rights under Article 31, UCMJ, or the Fifth Amendment to the U.S. Constitution, providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than essential information may not be provided which might not otherwise be available to the Commander for his/her decision(s) in this matter.

b. For individual who may be ordered to testify, providing this information is mandatory. Failure to provide information could result in disciplinary action or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations.

c. For individual who may not be ordered to testify, providing this information is voluntary. There will be no adverse effect on you for not furnishing the information other than essential information may not be provided which might not otherwise be available to the Commander for his/her decision(s) in this matter.

the Whistleblower

Signature of Witness

TAB M

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is PMG.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC Section 301; Title 5, USC Section 2951; E.O. 9397 Social Security Number (SSN).

PRINCIPAL PURPOSE: To document potential criminal activity involving the U.S. Army, and to allow Army officials to maintain discipline, law and order through investigation of complaints and incidents.

ROUTINE USES: Information provided may be further disclosed to federal, state, local, and foreign government law enforcement agencies, prosecutors, courts, child protective services, victims, witnesses, the Department of Veterans Affairs, and the Office of Personnel Management. Information provided may be used for determinations regarding judicial or non-judicial punishment, other administrative disciplinary actions, security clearances, recruitment, retention, placement, and other personnel actions.

DISCLOSURE: Disclosure of your SSN and other information is voluntary.

1. LOCATION	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUMBER
Redacted , Dothan Alabama	2011/05/17	1000	

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
the Whistleblower	Redacted	GS-11

8. ORGANIZATION OR ADDRESS

Lyster Army Health Clinic, Ft. Rucker Alabama

9. I, the Whistleblower the Whistleblower WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

See attached sworn statement

the Whistleblower

the Whistleblower

the Whistleblower

the Whistleblower

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 8 PAGES
	the Whistleblower	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF _____ TAKEN AT _____ DATED _____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED.

Q1. Do you remember if the LAHC's vacancy announcement for the Community Health Nurse position included the proper educational, licensing, training and experience requirements and duties of a Community Health Nurse?

A.1 Yes, however it did not address the specific duties that I was asked to perform at LAHC regarding ordering medication refills and lab test under my name as provider or diagnosing and treating STI/STDs: I have attached to this statement the Vacancy Announcement exhibit D1-3

Q2. Did you feel that you had the requisite educational, licensing, training and experience to be a Community Health Nurse when you accepted the job at LACH?

A2. From the wording in the job announcement, it read as if it was a job with providing patient education, counseling and coordination of health programs for child youth services. There was **nothing(** in the Vacancy announcement: Exhibit D1- to D-3) that mentioned I would be prescribing medication under my name as provider, ordering lab tests and x-rays under my name as provider or diagnosing and treating sexually transmitted diseases as a provider. I had basic knowledge of Public Health, experience in patient education, crisis counseling and coordinating programs.

Q3. If no, did you inform LAHC selecting officials prior to accepting the position that you did not have the requisite educational, licensing, training and experience to fulfill the position?

A3. I was very honest and forthright about my credentials, education and experience with the selection officials. As the marking on my resume by a selection or interviewing person shows on my resume: Exhibit D4 to D-8; the selecting officials were aware of my not having CHN or OH experience or certification and only possessing an Associate's Degree in Nursing.

Q4. Do you feel that you knowingly misrepresented your qualifications or training during the selection process for the position of Community Health Nurse or any time thereafter?

A4. No I did not; I was honest about my qualifications and training. They knew I did not have a Public Health Certificate, was not an advanced practice nurse and did not have work experience or training as a public health nurse/community health nurse.

the Whistleblower

A4. (cont.)

Exhibit D4- D8 which is my resume, Someone involved in selection or interviewing process at LAHC had written: **0 CHN exp,? OH** ADN and placed my resume on the Preventive Medicine hard drive.

Q5. Were the duties you were directed to perform as the LAHC Community Health Nurse, to wit: the responsibility to order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to re-fill prescriptions for Isoniazid, fall within duties only a Community Health Nurse with the requisite educational, licensing, training and experience could perform?

A5. Prescriptions for Isoniazid (INH) as a practitioner (which is how I was listed in AHLTA) are duties only a licensed practitioner such as a MD, DO, Physician Assistant or an Advanced Nurse Practitioner should perform according to Exhibit F1 to F-9 Army regulations: AR 40-68 Chp 7, 7-1 (a), AR 40-68 chp 7, 7-2, a, b,c,d, AR 40-3 14-9. a. (1) and b. (2), AR 40-3, 11-11. a. (1),(2) b. (1), AR 40-3 11-12 a. ,AR 40-68 4-4 (2)and AR 40-68 Chp 5, 5-3 f. (2). Also in section F1-f.9 is the application process for a nurse practitioner to obtain a furnishing number to prescribe medication (not a nurse) and the DEA application for controlled substances.

Q6. To the best of your recollection, were the above listed responsibilities/duties (order and interpret STI, tuberculosis and hepatic enzyme tests and re-fill Isoniazid prescriptions) specifically defined in the position description or the vacancy announcement?

A6. The duties to order and interpret STI, tuberculosis and hepatic enzyme test and refill Isoniazid (INH) prescriptions were not listed in the vacancy announcement Exhibit D1-D3, position description Exhibit D9-D14 or in the civilian evaluation report form: Exhibit D15-16.

Q7. **To the best of your recollection, what duties listed in the position description did you have the requisite educational, licensing, training and experience requirements to perform?**

A7. Exhibit D10-D14 (position description) I had education and experience to train (see resume exhibit D4-D8). I completed a CA Level 1 teaching credential class and at one time had a preliminary vocational teaching credential for health course design, implementation and evaluation. I was able to plan and coordinate health services to assist families. I had the education and experience for conducting health education activities revolving around group interaction. I had experience working with patients with active tuberculosis, HIV/AIDS, epidemiological diseases and STI/STDs in the *emergency room and operating room* setting only. I was able to deliver training at all levels and evaluate training. I had experience and training to give crisis counseling and gain cooperation of patients who were afraid, resistant, suspicious or non-compliant with public health directives.

Q8. When did you inform your supervisors, Occupational Health Physician

Sup. Prev. Med. Phys. **and/or Chief of Preventative Medicine,** Chief. Prev. Med. Clinic

, or anyone else in your supervisory chain of command that you

did not possess the requisite educational, licensing, training and

experience requirements to perform the duties that you were directed to

perform?

A8. I told Chief, Prev. Med. Clinic that I needed training as soon as I found out that was my job. On September 24, I asked Sup. Prev. Med. Phys. to show me how to interview my first Latent tuberculosis (LTBI)patient as I had not been properly trained and did not feel comfortable-he interviewed the patient and ordered the labs and told me he would give me some information from CDC. I told him that I should not be ordering medications or ordering labs without a physician's order; that if that was the job, they needed a nurse practitioner. I told him that according to the SOP I found on the hard drive, it said I should order the first medication and that was not in my scope of practice. I also spoke to Chief. Prev. Med. Clinic about this being out of my scope of practice and if the refills and labs were ordered under Sup. Prev. Med. Phys. name then the SOP needed to be re-written saying such. On many occasions throughout my employment I asked Sup. Prev. Med. Phys. to interpret the hepatic enzyme results as I could not. I also asked Dep. Cdr of Clin. Serv., medical director of hospital, to do so in November when Sup. Prev. Med. Phys. was not present and told her it was not in my scope of practice to interpret abnormal results and then decide if I should order refills of INH. She told me "Its good you stay in your scope of practice". I often asked Sup. Prev. Med. Phys. for advice on the patients and documented that he told me to refill the INH after the patient labs were not normal range. I also expressed this lack of education to Chief, Prev. Med. Clinic many times.

the Whistleblower

Q9. Once you informed your supervisory chain of command of your lack of requisite educational, licensing, training or experience, did Sup. Prev. Med. Phys. Prev. Med. Phys. , Chief, Prev. Med. Clinic **, or anyone else in your supervisory chain of command knowingly direct you to continue to perform duties for which you were not properly trained or qualified to perform?**

A9. Yes they did. On December 23, when they added that I was to diagnose and treat STD/STIs, I again said I was not a nurse practitioner and that was not in my scope of practice, did not feel comfortable doing it: as I did not with the LTBI patients and it was not safe practice for the soldiers –they deserved the right to a medical exam by a practitioner.

December 23, I spoke with a nurse practitioner, physician assistant and a registered nurse who all said that it was not in their LACH clinic's practice for nurses to order medication and labs under their name as practitioner as that was illegal. The registered nurses selected the physician, physician assistant or nurse practitioner's name under the ordering provider's name and they showed me how to do so. I was unable because I was in the electronic AHLTA as a provider. I was off work for Christmas holidays and returned to work Jan 3. I asked one of my LTBI patient's that came in whose name was on the bottle and found out it was my name and not Sup. Prev. Med. Phys. . I immediately went to the pharmacy and talked with the Director, Chief, Dept. of Pharm. . I told Chief, Dept. of Pharm. I thought I was refilling the INH under Sup. Prev. Med. Phys. name as he had ordered the first prescription. He told me that yes, my name was on several of the bottles, when he checked his computer and he offered to make a list and give it to me (which he never did). I told him it was not in my scope of practice to prescribe medication and he told me that it was fine in the Army and I told him it was not safe practice and I did not want my name on the prescriptions. He told me that it was alright and he was not going to change it. I told Chief, Prev. Med. Clinic about the conversation and she told me we should talk since I was concerned.

Q10. Did Sup. Prev. Med. Phys. , Chief, Prev. Med. Clinic **, or anyone else in your supervisory chain of command threatened you with adverse or disciplinary action if you did not continue to perform any duties, to include ordering and interpreting STI, tuberculosis and hepatic enzyme tests and re-filling Isoniazid prescriptions, that you should not perform due to the lack of requisite educational, licensing, training and experience requirements?**

the Whistleblower

A10. See Exhibit A3 to A 5. On December 28, 2010, I wrote an email to the Deputy Commander for Nursing, Dep. Cdr for Nursing and Dep. Cdr of Clin. Serv., Deputy Commander for Clinical Services, Chief, Prev. Med. Clinic and Sup. Prev. Med. Phys. regarding my concerns and telling them it was not in my scope of practice. I received an email from Dep. Cdr for Nursing Exhibit A-4.

Q11. Were you disciplined or did you receive any adverse actions as a result of informing your supervisors that you should not be performing duties of a Community Health Nurse?

A11. Yes, On January 4, 2011 I was given a letter of warning stating I would be fired if I did not comply.

The letter also had reference to possibly insubordination for talking with the pharmacist.–See exhibit A1-A2

Q12. Was any patient injured as the result of you performing the duties required by Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in your supervisory chain of command?

A12. To the best of my knowledge, no.

Q13. In your opinion, what acts of Sup. Prev. Med. Phys., Chief, Prev. Med. Clinic, or anyone else in your supervisory chain of command requiring you to perform these duties constitute a substantial and specific danger to public health or safety?

A13. In my experience and my knowledge as a registered nurse of 37 years, it is standard of practice that registered nurses are not qualified to perform the duties of prescribing medication and ordering specific labs without a doctor's direct order. The orders for medication and labs must have the doctor's name as prescribing or ordering doctor on the ordering slips. In many states nurse practitioners and physician assistants are not allowed to prescribe medication or order labs without a physician's supervision or a physician checking their charts and signing their names as approving the order. Registered nurses are not trained to diagnose and treat patients and it is not in their scope of practice. Further training is needed as a nurse practitioner.

I did not have the requisite training as a nurse practitioner and was not qualified to perform the duties of prescribing refills of medication, ordering hepatic enzymes and interpreting the results nor diagnosing and treating patients. Exhibit F-8 application for nurse practitioner furnishing number and DEA for prescribing medications clearly shows that one must be trained as a nurse practitioner with a Board approved pharmacology course and a minimum of 520 supervised hours of prescribing by a physician.

I was a substantial and specific danger to the public health and safety of the patients for whom I was told to diagnose, treat and prescribe medications, as I was unqualified, unskilled and untrained. I did not possess the requisite educational, licensing, training and experience requirements required for diagnosing and treating patients, ordering labs and interpreting them and ordering refills of a liver toxic medication such as INH as an independent practitioner

I could easily unknowingly overlook a possible contraindication or a symptom which would cause damage to a patient's health while on the INH. Simply reading material from the CDC website does not make me an expert and I was never tested for my competency or knowledge. Patients with STD/ STIs need to be examined by a provider because they may not verbalize all of their symptoms and could have something else going on health wise. I also have no idea about what medications to prescribe for STD/STIs.

Q14. Please provide a chronological account of your professional nursing experience beginning with your graduation from Nursing School (just need dates and positions).

Q14 See resume.: D4 to D8.

STATEMENT OF the Whistleblower TAKEN AT Dothan, AL DATED 2011/05/17

9. STATEMENT *(Continued)* See attached sworn statement

the Whistleblower

the Whistleblower

the Whistleblower

the Whistleblower

AFFIDAVIT

I, the Whistleblower, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 8. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

the Whistleblower
(Signature of Person Making Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 17 day of May, 2011 at Dothan, Alabama

Investigating Officer
(Signature of Person Administering Oath)

Investigating Officer
(Typed Name of Person Administering Oath)

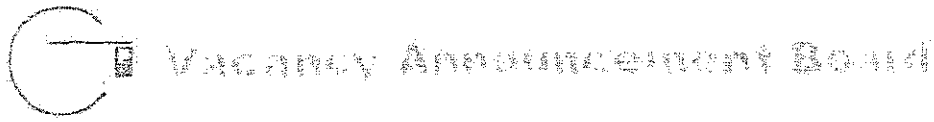
Article 136, UCMJ
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

TAB M-1

the Whistleblower

Section D-1 to D-16



DEPARTMENT OF THE ARMY
Vacancy Announcement Number: SCEG09508786

Opening Date: June 11, 2009 **Closing Date:** June 24, 2009

Position:	COMMUNITY HEALTH NURSE , GS-0610-11
Salary:	$56,411 - $73,329 Annual
Place of Work:	US ARMY MEDICAL COMMAND, LYSTER ARMY MEDICAL CLINIC, DEPUTY COMMANDER FOR NURSING, DEPT OF PREVENTIVE MEDICINE, COMMUNITY HEALTH, FT. RUCKER AL.
Position Status:	This is a Permanent position. – Full Time
Number of Vacancy:	1

Duties: Coordinates with civilian school nurses regarding the health of children and is a consultant for the Child and Youth Services (CYS) . Plans, implements, evaluates health education classes for active duty soldiers, their commanders, military and civilian supervisors and their staff, health care workers, and other eligible populations with the goal of maximizing assimilation information and encouraging behavioral change to prevent HIV infection. Assists with the epidemiological investigation of HIV positive persons. Counsels families and individuals, to include those who are HIV positive and their contacts, regarding disease transmission. Uses adult principles of learning, designs class for each target audience. Assists in the coordination and implementation of a comprehensive Community Health Nursing Program. Participates in operation of Tuberculosis Control Program. Conducts health education activities, which revolve around group interaction. Assess individual health status.

About the Position: Exposure to contagious disease. Prolonged periods of walking, standing, and driving a motor vehicle. *This position is located at Fort Rucker, Alabama, home of the United States Army Aviation "Warfighting Center". Fort Rucker is located in the "Wiregrass" area in Southeast Alabama, surrounded by Enterprise, Ozark and Daleville. The geography and climate are ideal for year round military training. Recreation activities are abundant in the immediate and surrounding areas for family and fun.

Who May Apply: (Click on Who May Apply)

- All Federal employees serving on a career or career-conditional appointment.
- Reinstatement eligibles.
- Applicants eligible under Veterans Employment Opportunities Act of 1998 (VEOA)
- Interagency Career Transition Assistance Plan (ICTAP) eligibles.
- Family member employees eligible under Executive Order 12721.

Qualifications: Click on link below to view qualification standard.

General Schedule

- BASIC REQUIREMENTS:*Degree or diploma from a professional nursing program approved by the legally designated State accrediting agency AND Registration: Applicants must have active, current registration as a professional nurse in a State, District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States. Must be able to obtain and maintan Basic Life Support (BLS) Training and certification. Current Advanced Life Support of other advanced certification does not supersede BLS completion. In addition to meeting the Basic requirements above, applicants must meet specialized experience. : Applicants must possess one (1) year of specialized experience equivalent to the GS-09 grade level. Specialized experience is experience that provided a full range of the following knowledge, skills, and abilities: (1) Knowledge of an extensive range of public health nursing theories, principles and procedures to provide specialized services to persons with infectious disease or chronic disease of public health importance; (2) Skills to performs crisis intervention with patient and family in a stressful environment in order to provide support and consolation concerning the disease process. To recognize when a

TAB M-1

the Whistleblower
Section D-2

physical or psychological stress factors will require direct intervention by a physician. (3) Ability to gain the cooperation of individuals and families some of whom is suspicious, afraid, resistant or noncompliant with public health directives. *SUBSTITUTION OF EDUCATION FOR EXPERIENCE: Completion of all requirements for a doctoral degree or 3 full years of progressively higher level graduate education. Graduate-level education must have been in nursing with a concentration in a field of nursing (e.g., teaching, a clinical specialty, research, administration, etc.) or closely related non-nursing field directly applicable to the requirements of the position to be filled.

- The experience described in your resume will be evaluated and screened for the Office of Personnel Management's basic qualifications requirements, and the skills needed to perform the duties of this position as described in this vacancy announcement.
- Applicants who have held a General Schedule (GS) position within the last 52 weeks must meet the Time in Grade Restriction.
- Education can be substituted for experience. Review the qualification requirements for specific information.
- One year of experience in the same or similar work equivalent to at least the next lower grade or level requiring application of the knowledge, skills, and abilities of the position being filled.
- Must have 52 weeks of Federal service at the next lower grade (or equivalent).
- Only degrees from an accredited college or university recognized by the Department of Education are acceptable to meet positive education requirements or to substitute education for experience. For additional information, please go to the Office of Personnel Management (OPM) and U.S. Department of Education websites at -

Redacted

- Demonstrated work experience that equipped the applicant with the particular knowledge, skills, and abilities to successfully perform the duties of the position, and that is typically in or related to the work of the position to be filled.
- On your resume, please include college/university, dates attended, degree achieved, semester hours earned, GPA, major field of study, 24 semester hours of specific courses and course hours in your major. Failure to provide this education information on your resume may result in an ineligible rating.

Other Information:(Click on Other Information)
- To successfully claim veteran's preference, your resume/supplemental data must clearly show your entitlement. Please review the information listed under the Other Requirements link on this announcement or review our on-line Job Application Kit.
- May require shift work and/or work on rotating shifts to provide coverage on evenings, weekends, holidays and in other situations.
- The Department of Defense (DoD) policy on employment of annuitants will be used in determining eligibility of annuitants. The DoD policy is available on

- Salary includes applicable locality pay or Local Market Supplement.
- In accordance with section 9902(h) of title 5, United States Code, annuitants reemployed in the Department of Defense shall receive full annuity and salary upon appointment. They shall not be eligible for retirement contributions, participation in the Thrift Savings Plan, or a supplemental or redetermined annuity for the reemployment period. Discontinued service retirement annuitants (i.e., retired under section 8336(d)(1) or 8414(b)(1)(A) of title 5, United States Code) appointed to the Department of Defense may elect to be subject to retirement provisions of the new appointment as appropriate. (See DoD Instruction 1400.25, Volume 300, at)
- Payment of Permanent Change of Station (PCS) costs is not authorized, based on a determination that a PCS move is not in the Government interest.
- Temporary Duty (TDY) travel is 05 percent.
- Defense National Relocation Program will not be authorized.

Other Advantages: BENEFITS: The Department of Army offers excellent benefits programs some of which may include:*Comprehensive health and life insurance*Competitive salaries*Generous retirement programs*Paid holidays, sick leave, and vacation time*Flexible work environment and alternate work schedules*Paid employment related training and education*Possible student loan repayment*Payment of licenses, certification, and academic degrees as applicable*Bonuses, incentives, and awards as appropriate for the job.

Other Requirements:(Click on Other Requirements)
- Personnel security investigation required.
- Must comply with Drug Abuse Testing Program requirements.
- A medical examination is required in accordance with Army Regulation 190-56, Appendix B and C, prior to employment. Reimbursement of examination is authorized if obtained at other than a military treatment facility. Must obtain medical clearance to perform essential job functions and to take a physical agility test.
- This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.
- You will be required to provide proof of U.S. Citizenship.
- If selected, official college or university transcript must be submitted.
- For Registered Nurse positions, applicants must have active, current registration as a professional nurse in a State,

the Whistleblower Doc
Section D3

District of Columbia, the Commonwealth of Puerto Rico, or territory of the United States.

- License/Certification: Obtain and maintain a valid driver's license
- All Health Care Providers must be able to obtain and maintain current Basic Life Support (BLS) Training and certification Current Advanced Life Support of other advanced certification does not supersede BLS completion.
- Male applicants born after December 31, 1959 must complete a Pre-Employment Certification Statement for Selective Service Registration.
- Direct Deposit of Pay is Required.
- Position requires employee to wear a uniform and/or protective clothing.
- Failure to provide all of the required information as stated in the vacancy announcement may result in an ineligible rating or may affect the overall rating.

How to Apply: (Click on How to Apply)

- Resumes must be received by the closing date of this announcement.
- Self-nomination must be submitted by the closing date.
- Resume must be on file in our centralized database.
- Announcements close at 12:00am (midnight) Eastern Time.

TAB M-2

the Whistleblower DOC
Section D-9.

Top of Form

EG	109795	172042	998396

Bottom of Form

Position Description

PD#: EG109795 **Replaces PD#:**

Sequence#: 998396

NURSE (CLINICAL/COMM-OCC HLTH)

GS-0610-11

Servicing CPAC: FORT RUCKER, AL

Agency: ARMY

Installation: EGMCW2MQAA3D4
US ARMY MEDICAL COMMAND
LYSTER ARMY HEALTH CLINIC
DEPUTY COMMANDER FOR NURSING
DEPARTMENT OF PREVENTIVE MEDICINE
EPID AND DISEASE
FORT RUCKER, ALABAMA 36362 3D4

MACOM: MC

Command Code: MC
US ARMY MEDICAL COMMAND

Region: SOUTH CENTRAL

Citation 1: OPM PCS NURSE SERIES, GS-610, JUN 77

PD Library PD: NO

COREDOC PD: NO

Classified By: Redacted

Classified Date: 01/11/2002

FLSA: E	**Drug Test Required:**	**DCIPS PD:** NO
Career Program: 00	**Financial Disclosure Required:** NO	**Acquisition Position:** NO
Functional Code: 81	**Requires Access to Firearms:** NO	**Interdisciplinary:** NO
Competitive	**Position Sensitivity:** 1	**Target Grade/FPL:**

TAB H-2

Area: MM 11

Competitive Level: 0189

Emergency Essential: No [N: Position Not Designated Emergency-Essential Or Key]

Career Ladder PD: NO

Bus Code: 1914

Personnel Reliability Position:

Information Assurance:

PD Status: VERIFIED

Influenza Vaccination: YES

Duties:

13. STATEMENT OF DUTEIS AND RESPONSIBILITIES:
MAJOR DUTIES

Assists in the coordination and implementation of a comprehensive Community Health Nursing Program for Fort Rucker. Community health nursing is a synthesis of nursing practice and community health principles applied to promoting, preserving, and/or restoring the health of military personnel, their families, and the retired military community through community assessment, adult and child health care, chronic and communicable disease control, health education, referrals, follow-up and liaison activities.

HIV/AIDS = 20%

Plans, implements, evaluates health education classes for active duty soldiers, their commanders, military and civilian supervisors and their staff, health care workers, and other eligible populations with the goal of maximizing assimilation of information and encouraging behavioral change to prevent HIV infection.

Uses adult principles of learning, designs class for each target audience, chooses format for class, e.g., lecture, discussion, small group participation and content, relevant medical and psycho-social information with appropriate language and audiovisual aids to meet the learning needs of each group.

Evaluates classes using a variety of procedures to include pre/post testing and class critiques. Revises classes as necessary to meet teaching/learning objectives.

Provides counseling and education to families affected by or associated with HIV. Counsels families and individuals, to include those who are HIV antibody positive and their contacts, regarding disease transmission and concerns of daily living. Assists with the epidemiological investigation of HIV positive persons and contacts using interview techniques and data collection methods as required. Documents information obtained using approved format and within the parameters of confidentiality. Plans and coordinates health services to assist individuals and families with complex problems involving family disruption and compliance with a medical regime associated with HIV disease. Makes referrals to other Military Treatment Facilities (MTF), civilian health agencies, and special agencies in support of disease control and contact assistance.

Health Promotion = 20%

Assesses individual?s health status based on responses to health risk questionnaire, and clinical determination of height, weight, blood pressure, and glucose / cholesterol readings.

Provides nursing intervention to include individual and group counseling about identified life style health risks and their control (e.g., smoking cessation, stress reduction).

Refers those individuals with high-risk clinical findings for follow-up medical evaluation, treatments and further health education.

Child and Youth Services = 25%

Serves as Child and Youth Services (CYS) consultant. Cooperates with and assists CYS with health concerns (available for specific concerns on children; conducts monthly inspections; conducts classes on health, medication, and communicable disease for staff). Coordinates with civilian school nurses regarding the health of children who are military beneficiaries. Participates on the Special Needs Resource Team.

Communicable Disease/Epidemiological Investigation and Follow-up = 30%

Participates in operation of Tuberculosis Control Program (cases, contacts, follow-up, preventive therapy).

Participates in the epidemiological investigation of communicable diseases.

Conducts health education activities, which revolve around group interaction (e.g., sexually transmitted disease prevention classes for soldiers).

Performs other duties as assigned.
Factor 1. Knowledge Required by the Position - Level 1-7 -- 1250 Points

- Knowledge of an extensive range of public health nursing theories, principles and procedures to provide specialized services to persons with infectious disease or chronic disease of public health importance.

- Knowledge of human growth and development and the interrelatedness of host, agent, and environmental factors when maintaining individual and community health.

- Skills to perform crisis intervention with patient and family in a stressful environment in order to provide support and consolation concerning the disease process. Skills to recognize when a physical or psychological stress factors will require direct intervention by a physician.

- Skill to interact with military commanders, civilian and military groups, school officials, and civilian public health agencies in coordinating patient care, disease control and troop education efforts.

- Knowledge of the epidemiological method and skill in applying the techniques used in gathering data.

- Ability to independently assess need, design program goals and objectives, develop quality assurance monitors in support of program goals and to set program priorities based on community need.

- Knowledge of infectious diseases, sexually transmitted diseases and diseases interfering with the body?s normal immune system, especially as related to AIDS and the HIV viruses.

- Knowledge of and ability to develop and present a variety of forma and informal training

classes to individuals and various groups in community health issues.

- Ability to drive a motor vehicle.

- Ability to gain the cooperation of individuals and families some of whom is suspicious, afraid, resistant or noncompliant with public health directives.

Factor 2. Supervisory Controls - Level 2-4 -450 Points

Works under the general supervision of Chief, Community Health Nursing. Coordinates with the supervisor when writing program goals, planning workload and assisting with epidemiological investigations. Performs assignment independently without specific instructions. Adjusts schedules in accordance with community needs. Work is reviewed for effectiveness and contribution to mission accomplishment.
Factor 3. Guidelines - Level 3-3 - 275 Points

Guidelines include physician?s instructions, applicable governing regulations, and standard operating procedures for Preventive Medicine and Community Health Nursing. Guidelines do not provide specific instructions for every possibility. Judgment is required in assessing the psychological and emotional status for patients and in establishing plans of action, which foster patient compliance. Independent decisions beyond the scope of guidelines are required in practicing crisis intervention.

Factor 4. Complexity - Level 4-4 - 225 Points

Provides comprehensive public health nursing services which require skills in planning programs based on community-wide assessment, setting priorities, teaching, psycho-social skills in relating with all segments of the military and civilian community, crisis intervention, knowledge of epidemiology disease control and public health, and knowledge of nursing science. Must be extremely adaptable to work with a wide variety of family health problems and to stay flexible in a generalized multifaceted program.

Factor 5. Complexity - Level 5-3 - 150 Points

Plans, develbps, and provides nursing services in accordance with program objectives and priorities and sound professional principles. Work impacts the physical and emotional well being to9 the patient, the patient?s family, and the target population of the community.

Factor 6. Personal Contacts - Level 6-3 - 60 Points

Personal contacts are with patients, families, hospital personnel, community leaders, classes and groups, military commanders, and public health department officials.

Factor 7. Purpose of Contacts - Level 7=3 - 120 Points

Contact with patients and families are to provide nursing care and disease surveillance, allay fears, and encourage treatment compliance. Contacts with individuals and groups are to provide information and allay fears. Contacts with health workers are to coordinate patient care. Contacts with officials are to coordinate programs and relay information.

Factor 8. Physical Demands - Level 8-2 - 20 Points

The work requires prolonged periods of walking, standing, and driving a motor vehicle.

Factor 9. Work Environment - Level 9-2k - 20 Points

Exposure to contagious disease. Danger from driving a motor vehicle. Possible danger from mentally disturbed persons.

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Section D-13

EVALUATION STATEMENT

1. Background. This is a revision of Position Description #S0129, which was rewritten to accurately reflect the current duty assignments.

2. Title and Series Determination:

a. Series GS-610: This position involves a variety of non-clinical and specialized services to clients with infectious disease or chronic disease of public health importance. Plans, develops and provides comprehensive programs and services designed to meet the needs of special individuals and groups. Assists and collaborates with military treatment facilities and local health authorities in support of disease control, contact efforts, and epidemiological investigations. Designs and implements public health nursing services in accordance with program objectives, priorities, and community-wide assessment. Develops criteria for ongoing monitoring of program. Supports Preventive Medicine mission.

b. Title: The authorized title for positions in this series that perform the above duties is Community Health Nurse.

3. Grade Determination: The appropriate grade is GS-11 as listed the FES factor points below:

Factor 1 Knowledge Required by the Position Level 1-7 1250 Points
Factor 2 Supervisory Control Level 2-4 450 Points
Factor 3 Guidelines Level 3-3 275 Points
Factor 4 Complexity Level 4-4 225 Points
Factor 5 Scope and Effect Level 5-3 150 Points
Factor 6 Personal Contacts Level 6-3 60 Points
Factor 7 Purpose of Contacts Level 7-3 120 Points
Factor 8 Physical Demand Level 8-2 20 Points
Factor 9 Work Environment Level 9-2 20 Points

Total Points 2570 Points

4. Classification: Community Health Nurse, GS-610-11

Redacted

This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.

Evaluation:

FLSA EVALUATION OUTLINE

____Foreign Exemption

____Executive Exemption

____Exercises appropriate supervisory responsibility (primary duty)

____Customarily and regularly exercises independent judgment

____80% test, if applicable (GS 5/6; Sit I & 2 WS supervisors; law enforcement & firefighter supervisors thru GS 9)

____Professional Exemption

____Professional work (primary duty)

____Intellectual and varied work (more than dealing with procedures/precedents)

____Discretion & independent judgment

____80% test, if applicable (This virtually never applies since GS 5/6 positions are trainees and other eligible employees are not professional)

_x__Administrative Exemption

____Primary duty
____Policy or
_x__Management or general business or supporting services or
____Participation in the executive/administrative FUNCTIONS of a management official

_x__Nonmanual work test
_x__intellectual and significant (more than dealing with procedures/precedents), or
____specialized & technical in nature requiring considerable training/experience

_x__Discretion & independent judgment

____80% test, if applicable

CONCLUSION: EXEMPT

TAB M-3

the Whistleblower

Section D-4

Ø CHN exp. ? or AON

the Whistleblower
Redacted

Redacted

This was done by someone at Ft. Rucker & my resume along with 13 other nurses was on the public drive. I asked it be taken off as violation of privacy - no one else in clinic had their resume on there, it was removed

Work Experience
the Whistleblower
Redacted

Country of citizenship;
United States of America

Raytheon Technical Services 7/2007 - 8/2007
Reston, VA US Salary; 15,000 USD Per Month
Hours per week; 84

Occupational Health Nurse/Monitor (Russia)
Nurse/Monitor DOD START Treaty in Votkinsk Russia,term contract. Occupational health clinic; work related injuries and illnesses. Inventoried clinic, set up database to analyze results and wrote new policies and procedures to improve clinic. Gave power point presentation on Medevac procedures. Collected water sampling once a week for testing and monitored food prep for sanitation. Monitored unsafe working environment and practices according to OSHA, NIOSH and DOD. Maintained records HIPPA legal and ethical compliance.
Supervisor's Name; Scott Marble, Supervisor's Phone; 703-295-2000

Department Health Human Services, HRSA 7/2006 - 7/2007
ockville, Maryland US Grade Level; GS 9
alary; 46,000 USD Per Year
hours per week; 40

Public Health Analyst 685
Analyzed semi annual report for grants and wrote recommendations for revision of report guidelines
Analyzed Bio-terrorism applications for sentinel indicators,developed a database and used data to produce a report on compliance of grantees
Conducted qualitative and quantitative analysis evaluation data for specific benchmarks of Bio-terrorism applications to assess program efficiency
Developed measurements for sentinel indicators with team member; Policy, Evaluation and Planning
Analyzed, reviewed and developed contingency plan for software failure
Analyzed and developed a revision of web page for Utilized GIS, Archview to map shortage areas and census tracts- Researched and analyzed regulations, legislation and policy issues wrote report regarding information
Edited and revised report to the Federal General Accountability Office
Assisted Senior Adviser to Associate Administrator Office of Performance Review on various Performance Reviéw projects
WORK EXPERIENCE National Disaster Medical System, Disaster Medical Assistance Team 4/1997 - 2007
Los Angeles and Washington, CA DC US Grade Level; GS 09
Salary; 25 USD Per Hour
Hours per week; intermittent

Supervisory Nurse , 0610
Nurse Supervisor on NDMS DMAT team
Trainer for Trauma Assessment and Treatment Station of Field Training 06-19-04
Provided medical assistance and care at San Bernardino, CA Fires October 2003
Deployed for Orange Alert 2003; Presented training session on Emergency Medical Treatments for First Responders and Crisis Mental Health Intervention to fellow PHS DMAT members. Deployed for President's State of the Union Address 2001, stand by medical

erican Red Cross 2/1988 - Present
Washington Santa Ana, CA DC CA US Salary; 0 USD Per Year
Hours per week; intermitt

National Disaster Mental Health Tech

TAB H-3

7/2007 Roosevelt, Utah Mental Health Supervisor
Assessed mental health needs of popultion affected and debriefed departing Red Cross workers. Counseled 2 families who lost family members in wild firesand ,made referrals further counseling
../2005 Louisiana Post Katrina
Assessed and surveyed American Red Cross Shelters for Public Health related issues to improve performance of care to evacuees in a safe environment
Simplified publication on mold safety for public distribution
Compiled and published a list of no cost medical care for evacuees living in shelters .Received information by collaborating with Louisiana State Public Health Officials and Federal Public Health Officials.
9/2005 Case management assisting disaster victims in receiving emergency funds and accessing the Los Angeles Social Service system.
Liaison with LA Co Department of Health Services Officials and UCLA Medical CEO to effect policy of treating Katrina evacuees for no or low cost medical care
10/2001 Provided mental health crisis intervention for rescue workers and law enforcement in disaster field of Pentagon Disaster following disaster. Team leader of 20 ARC mental health workers first day
11/2001 Provided mental health counseling for families of survivors following memorial services and distribution of ashes to families
11/1996 Provided crisis intervention for families affected by Hurricane Opal and debriefed fellow ARC workers
1988 Joined Disaster Mental Health Team and provided crisis intervention and debriefing for various local disasters. Provided mental health crisis following major fires and also a minor flood.

Surgical Staff 6/2003 - 7/2005, 1988-2000
Culver City, CA US Salary; 40 USD Per Hour
Hours per week; 24
Temporary direct patient care nurse for various medical facilities and hospitals; operating rooms,emergency room,radiology, and cardiac cath lab. OSHA standards.

International Rescue Committee 2/2004 - 4/2004
NY, NY US Salary; 3000 USD Per Month
Hours per week; 40

NSULTANT GENDER BASED VIOLENCE SEXUAL ASSAULT EXAMINER TRAINER Liberia Post Conflict
Conducting qualitative surveys on the type of training needed, developed and implemented training and training materials for physicians and midwives.
Performed assessment of program needs pre,intra and post training;short term and long term
Liased with Ministry of Public Health, Ministry of Social Work and Ministry of Justice Officers to develop program that would be sustainable in Liberia
Liason with UN delegated officer for Gender and various NGO Gender Directors when conducting training
Wrote final report analyzing Program accomplishments, problem areas and future needs

Progressive Nursing Staffers 11/2001 - 4/2003
Springfield, VA US Salary; 40 USD Per Hour
Hours per week; 24

Registry Nurse Emergency Room, Operating Room and Radiology
Worked as a temporary direct patient care nurse in various operating rooms and emergency medical areas. I always interfaced with new people,new policies and procedures which required a great deal of flexibility and adaptability. OSHA standards

Walter Reed Army Medical Command 8/2000 - 10/2000
Washington, DC US Salary; 58,000 USD Per Year
Hours per week; 40

Critical Care Nurse Emergency Room
Emergency room nurse, direct patient care.
Assessed and treated medical /surgical patients. Attended Disaster Preparedness Planning meetings.

International Medical Corp 7/1999 - 10/1999
Santa Monica, CA US Salary; 2100 USD Per Month
Hours per week; 40

Medic) Nurse Coordinator Emergency Medical System, Kosvo Post Conflict
3 month paid volunteer contract
Coordinated Emergency Medical System(EMS) development for IMC's catchment area
Edited and revised World Health Organization Policy Draft for EMS Kosovo after consulting with Physician from World Health Organization

Conducted qualitative surveys of Kosovo province Health Care Facilities and UN Military Health Care Systems to assess and compare pre conflict EMS with post conflict EMS
sisted in analyzing data to prepare plan to develop a viable EMS system for IMC Kosovo
tchment area
Liaison with North Atlantic Treaty Organization (NATO) Headquarter Medical Officer to glean information for survey and to obtain permission to survey various NATO bases
Edited and revised the policy draft for WHO on Emergency Medical Service in Kosovo.

Los Angeles County, King Drew Medical Center 2/1991 - 4/1997
Los Angeles, CA US Salary; 27 USD Per Hour
Hours per week; 36-40

Emergency Room Nurse, Sexual Assault Nurse Coordinator

Conducted qualitative and quantitative survey of FBI, LAPD, LA Sheriff and Compton PD data of sexual assaults in the Medical Center catchment area and compared data to the data of King Drew Medical Center treatment of sexual assaults patients. Analyzed data and wrote proposal to start a Sexual Assault Response Team at the Medical Center.
Developed a training program for sexual assault examiner to train emergency room, ob-gyn and pediatric physicians, midwives and nurses.

Trained several physicians, midwives and nurses in the medical, forensic and psycho-social aspects of sexual assault in mini trainings.
Developed policies and procedures for the treatment of victims of sexual assault within the Medical Center and policies and procedures to ensure the program was being continually evaluated for quality deliverance of care. During the development of this program held many meetings with high level officials of the Medical Center and with many high level officials outside of the Medical Center.
Presentations to Law Enforcement, District Attorneys, Crime Labs and Rape Crisis Centers.

Developed the training materials from the Department of Justice Training Manual for Sexual Assault.

EMERGENCY ROOM NURSING
1991-1995 Emergency Room nurse for multi systems and single trauma patients.
983-85,1980,1978-79 Operating Room nurse for multi-trauma, emergency and other surgical
pecialty patients
91-95Functioned as a direct emergency patient care giver; assessed, monitored and treated critical adult and pediatric patients in the trauma resuscitation unit and the medical critical care area of emergency room.
As an MICN, gave treatment orders to pre- hospital paramedics
Mentored nurses & paramedic students on delivery of critical care emergency procedures and standards . OSHA compliant

EDUCATION
Purdue University
W. Lafayette, IN US
Associate Degree - 12/1974

CA nursing license current to 4-2010

Department of Homeland Security
Anniston, AL 7/2005
Certified Instructor WMD (adult model education)
Technical Emergency Responder WMD Certification
Incident Command WMD Certification

Ft. Detrick , MD 2003
Medical Management of Chemical and Biological Casualty Training Certification

Johns Hopkins University
Baltimore, MD US
Certification - 7/2002
Completed the International Committee Red Cross course for Health Emergencies in Large Populations. This included Human Rights, security, and health emergencies in disaster situations for adults and pediatric patients in refugee situations

009 IT Project Management II Santa Monica College
2009 Disaster Public Affairs American Red Cross
2008 E-commerce Mira Costa College
2008 American College of Surgeons National Surgery Quality Improvement Data Collection Training

2008 ACLS, BLS
2008 Disaster Frontline Supervisor American Red Cross
2008 Work Stress Training
08 Preliminary Vocational Teaching Credential ;Level I CA vocational teaching
edential course
2008 Monitoring and Evaluation USAID
2007 Monitoring Training DTRA/Raytheon
2007 Legislative Training DHHS
2006 Project Officer DHHS
2006 Federal Budget DHHS
2006 Grants and Cooperative Agreements DHHS
2006 Appropriations Training DHHS
2006 Microsoft Applications Certification Course
2006 Mental Health in Disasters American Red Cross
2006 Victim Advocacy Colorado State University
2005 Emergency Response Technician Weapons Mass Destruction (WMD) DHS
2005 Instructor adult education model WMD DHS
2005 Incident Command WMD DHS
2005 National Response DHS FEMA
2005 Professional Development Certification DHS FEMA
2003 Medical Chemical Biological Casualty Training Ft Detrick
2003 Completed several FEMA Emergency Management online courses and NDMS courses
2002 Health Emergencies in Large Populations Johns Hopkins School Public Health
1997 Hazmat and Decontamination Los Angeles
1996 Death Investigations Forensic Coroner s Course Orange County Sheriff
1995 Sexual Assault Investigation Los Angeles County Sheriff
1994 Sexual Assault Nurse Examiner Training Santa Cruz, CA
1989 Crisis Intervention and Debriefing ARC

AFFILIATIONS American Red Cross Mental Health Team
NDMS DMAT CA 9 Supervisory Nurse

PROFESSIONAL PUBLICATIONS Wrote article on Pentagon 9-11 disaster published in NURSEWEEK

Education
Purdue University Lafayette, Indiana Associate's Degree Nursing 1974 GPA C

ditional Information
SBBI clearance with DOD 2007, Secret clearance, DOD and DOS
CA nursing license current to 4-2010

Department of Homeland Security
Anniston, AL 7/2005
Certified Instructor WMD (adult model education)
Technical Emergency Responder WMD Certification
Incident Command WMD Certification

Ft. Detrick , MD 2003
Medical Chemical Casualty Training Certification

Johns Hopkins University
Baltimore, MD US
Certification - 7/2002
Completed the International Committee Red Cross course for Health Emergencies in Large Populations. This included Human Rights, security, and health emergencies in disaster situations for adults and pediatric patients in refugee situations

2009 IT Project Management II Santa Monica College
2009 Disaster Public Affairs American Red Cross
2008 E-commerce Mira Costa College
2008 American College of Surgeons National Surgery Quality Improvement Data Collection Training
2008 ACLS, BLS
2008 Disaster Frontline Supervisor American Red Cross
2008 Work Stress Training
2008 Preliminary Vocational Teaching Credential ;Level I CA vocational teaching credential course
2008 Monitoring and Evaluation USAID
7 Monitoring Training DTRA/Raytheon
..07 Legislative Training DHHS
2006 Project Officer DHHS
2006 Federal Budget DHHS
2006 Grants and Cooperative Agreements DHHS

2006 Appropriations Training DHHS
2006 Microsoft Applications Certification Course
2006 Mental Health in Disasters American Red Cross
`6 Victim Advocacy Colorado State University
,5 Emergency Response Technician Weapons Mass Destruction (WMD) DHS
2005 Instructor adult education model WMD DHS
2005 Incident Command WMD DHS
2005 National Response DHS FEMA
2005 Professional Development Certification DHS FEMA
2003 Medical Chemical Biological Casualty Training Ft Detrick
2003 Completed several FEMA Emergency Management online courses and NDMS courses
2002 Health Emergencies in Large Populations Johns Hopkins School Public Health
1997 Hazmat and Decontamination Los Angeles
1996 Death Investigations Forensic Coroner s Course Orange County Sheriff
1995 Sexual Assault Investigation Los Angeles County Sheriff
1994 Sexual Assault Nurse Examiner Training Santa Cruz, CA
1989 Crisis Intervention and Debriefing ARC

AFFILIATIONS American Red Cross Mental Health Team
NDMS DMAT CA 9 Supervisory Nurse

PROFESSIONAL PUBLICATIONS Wrote article on Pentagon 9-11 disaster published in NURSEWEEK

TAB M-4

SENIOR SYSTEM CIVILIAN EVALUATION REPORT SUPPORT FORM

For use of this form, see AR 690-400; the proponent agency is ASA(M&RA)

PART I - RATEE IDENTIFICATION

a. NAME OF RATEE (Last, First, Middle Initial)	b. PAY PLAN, SERIES/GRADE	c. ORGANIZATION/INSTALLATION
the Whistleblower	GS-0610-11	LYSTER ARMY HEALTH CLINIC

PART II - RATING CHAIN - YOUR RATING CHAIN FOR THE EVALUATION PERIOD IS:

	NAME	POSITION
RATER	Chief, Prev. Med. Clinic	CHIEF, PREVENTIVE MEDICINE
INTERMEDIATE RATER (Optional)		
SENIOR RATER	Dep. Cdr for Nursing	DEPUTY COMMANDER FOR NURSING

PART III - VERIFICATION OF FACE-TO-FACE DISCUSSION

The following face-to-face discussions of duties, responsibilities, performance objectives, standards, and accomplishments for the rating period 20100830 to 20110829 took place:

	DATES	RATEE INITIALS	RATER INITIALS	INTERMEDIATE RATER INITIALS	SENIOR RATER INITIALS (If used)	DATE
INITIAL	20100917	the Whistleblower	Chief, Prev. Med. Clinic		Dep. Cdr for Nursing	17 Sep 10
MIDPOINT						

PART IV - RATEE (Complete a, b, c below for this rating period)

a. STATE YOUR SIGNIFICANT DUTIES AND RESPONSIBILITIES. DUTY TITLE IS:

Serves as Community Health Nurse for the Fort Rucker community. Plans, implements and evaluates health education classes for beneficiaries and civilian employees. Responsible for the coordination and implementation of the installation Sexually Transmitted Diseases, HIV Awareness Program and Latent Tuberculosis Surveillance. Creates health promotion and wellness training for all units installation wide. Provides counseling and education to families and Soldiers affected by communicable diseases. Conducts epidemiological investigations of patients with communicable diseases, bloodborne pathogens, and all other reportable infections. Assists with the Child and Youth Services as a medical consultant and conducts monthly inspections and monthly mandatory classes on medication administration, bloodborne pathogens, and communicable diseases. Conducts Tobacco Use Cessation classes and provided 1.1 counseling for individuals as needed. Assumes additional duties as requested.

b. INDICATE YOUR MAJOR PERFORMANCE OBJECTIVES/INDIVIDUAL PERFORMANCE STANDARDS

ACCESS:
1. Complete orientation at the Immunization Clinic front reception desk area with in/out processing clients and completing Alabama Blue Cards, and assists with documentation during the Flu Season Campaign.
2. Will conduct at least 10% of the Tobacco Use Cessation Classes (once certified) and be available for conducting 1.1 counseling.
3. Will conduct a minimum of 4 classes on the topic of communicable disease prevention and or Health Promotion and Wellness to various units on the installation.

SATISFACTION:
1. Will receive at least a 95% rating of "completely satisfied" by STD/TB patients of from classes taught.

OUTCOMES:
1. Will contact all referrals and consults received by AHLTA/CHCS within 72 hours received.
2. Will complete all documentation entries in AHLTA within 72 hours per organization policy.
3. Will conduct a minimum of 3 CYS, CDC, and FCC inspections and 2 Classes to the CDC staff

COMMUNICATION:
1. Prepare monthly reports and submit to the Investigation Prevention Team, the Army for Cases Overall and quarterly report to the Chief, Preventive Medicine within the allocated timeline.
2. Will maintain 100% tracking of all TB, STD, and HIV cases evaluated by the Clinic.

ESOURCES:
1. Establish a relationship with local and State of Alabama Public Health Department.

c. LIST YOUR SIGNIFICANT CONTRIBUTIONS

SIGNATURE AND DATE

PART V - PERFORMANCE STANDARDS - SENIOR SYSTEM CIVILIAN POSITIONS

To derive Objectives ratings, apply the applicable performance standards below; the standards are written at the SUCCESS level, e.g., Ratee, in most cases:

TECHNICAL COMPETENCE. Exhibits technical knowledge, skills, and abilities to get desired results within established time frames and with the appropriate level of supervision. Sets and meets realistic milestones. Establishes priorities that reflect mission and organizational needs. Plans so that adequate resources are available. Makes prompt and sound decisions.

INNOVATION/INITIATIVE. Develops and implements or suggests better ways of doing business--methods, equipment, processes, resources. Seeks/accepts developmental opportunities. Serves on professional/technical committees, writes technical papers, joins professional societies to enhance personal knowledge and advance state-of-the-art of profession.

RESPONSIBILITY/ACCOUNTABILITY. Uses resources prudently and for intended purposes. Complies with DA emphasis programs, e.g., EEO/AA, safety/security, internal control, inventory management, quality assurance, personnel management, contract awards to small business concerns. Supports and encourages Total Army Quality *(TAQ)* approaches, e.g., team effort, continuous process/product improvement and customer satisfaction. Takes responsibility for personal errors, takes or proposes timely/adequate corrective measures. Establishes personal performance objectives that are challenging and reflect mission needs.

WORKING RELATIONSHIPS. Is an effective team player. Works well with group and others to get the job done. Exhibits a customer care attitude; e.g., shows respect to others; is courteous and seeks acceptable compromise in areas of difference.

COMMUNICATION. Provides or exchanges accurate/complete oral and written ideas and information in a timely manner. Listens effectively so that resultant actions show understanding of what was said. Coordinates so that all relevant individuals and functions are included in/informed of decisions and actions.

FOR SUPERVISORY POSITIONS ONLY:

ORGANIZATIONAL MANAGEMENT AND LEADERSHIP. Provides vision and communicates mission and organizational goals to all subordinates. Sets standard/leads by example. Implements/complies with appropriate DA emphasis programs. Secures/allocates/manages resources for effectiveness and efficiency. Takes timely and appropriate personnel actions. Develops subordinates through mentoring, counseling, providing challenging training and work assignments and timely performance evaluations. Recruits and retains high quality people by creating a positive environment that offers challenge and growth.

EQUAL EMPLOYMENT OPPORTUNITY/AFFIRMATIVE ACTION *(EEO/AA)*. Applies EEO principles to all aspects of personnel management *(e.g., hiring, training, work assignments/schedules, discipline, counseling and awards)*. As appropriate, takes immediate corrective action if sexual harassment or other discriminatory/unfair treatment is observed, reported or suspected. Provides leadership and emphasis to the execution of the Affirmative Employment Plan. Participates in EEO/AA activities and encourages subordinates to do so.

TAB M-5

the Whistleblower

Section A-1 of A-8

DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES ARMY AEROMEDICAL CENTER
BUILDING 301 ANDREWS AVENUE
FORT RUCKER ALABAMA 36362-5333

MCXY-PM

4 January 2011

MEMORANDUM FOR the Whistleblower, U. S. Army Aeromedical Center, Lyster Army Health Clinic, 301 Andrews Avenue, Fort Rucker, Alabama 36362

SUBJECT: Memorandum of Warning

1. You are hereby warned of stating to fail to observe written standard order of procedures for Sexually Transmitted Diseases Patient Management Procedures, LAHC Regulation No. 40-554. The following incident led to this warning.

a. On 23 December, 2010, the preventive medicine staff reviewed and discussed the Sexually Transmitted Disease Patient Management Procedures, LAHC Regulation No. 40-554. You expressed concern about your understanding of scope of practice for ordering labs or medications without a prior examination from a physician, physician assistant, nurse practitioner or equivalent. Your verbal expressions were absolute and adamant that under no circumstances would you comply with this Standard Operating Procedure. (Provide brief but specific details. Include specific incidents, names, dates, times, words stated, rules, regulations, instructions violated, etc.)

b. On your behalf, based on your concern, I immediately took the document to the Deputy Commander for Nursing and patient care services for guidance. It was made clear, the LAHC Regulation had been approved by deputy officials and had no discretionary guidelines or was written outside of the federal guidelines for safe medical practice according to military, Department of Defense, civilian or private rule. (Use as many subparagraphs as necessary.)

c. On 28 December, 2010 you addressed me, your immediate supervisor, the Deputy Commander for Clinical Services, Dep. Cdr for Clin. Serv., the Deputy Commander for Nursing, Dep. Cdr for Nursing, and the Preventive Medicine Physician, Sup Prev. Med. Physician in writing that you refuse to comply with the LAHC regulations for ordering lab tests for patients who have not been prior examined by a physician or equivalent. In addition, you wrote you would not order INH refill medications as directed according to the LAHC policy.

d. Again, I proceeded in your favor to investigate the guidelines according to Army policies for Army Public Health/ Community Health Nursing Practices. I also researched the guidelines for Board of Registered Nurses in California. As result, Army Public Health Nurses do not practice under a Privilege-base but a Protocol-based Practice (Reference APHN/CHN Newsletter, June 2008, "Privileging & RVUs".) In addition, I contacted the regional APHN Consultant to verify other STD SOP's.

e. According to the California Board for Registered Nurses, Example A (Process Protocol) page 7-21 clearly states,

" ***nurses may perform the following functions within their training specialty area and consistent with their experience and credentialing: assessment, and treatment of episodic illnesses, chronic illness, contraception, and the common nursing function of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies, recommending diets, and referring to specialty clinics when indicated. Standardized***

THM-5

procedure functions such as managing medication regimens, are to be performed in (list area, i.e., short appointment clinic)."

f. You informed me on 3 January, 2011 you had spoken with the Chief of Pharmacy, Chief, Dept of Pharm with regards to removing your name from any future INH medications. I received an e-mail message from him requesting to speak with me about your request for this change. At this point in time, I have not had the opportunity to speak with him, but this action is another attempt to not comply with the current standard operating procedures, in addition it can be an example of insubordination.

2. The purpose of this warning is to assist you in correcting your behavior and to inform you that this type of conduct is not to occur again.

3. I will continue to work with you in allowing the freedom for reviewing standard Operating Procedures in so that they may be rewritten clearer to suit your personal understanding. It must be noted the current Standard Operating Procedures for all Army Public Health nursing functions were and currently are in compliance with MEDCOM policies and procedures.

4. If I may be of further assistance to you, please contact me. This is extremely important, because continued conduct of this nature may result in the initiation of formal disciplinary action against you which may include your removal from Federal Service. This document will **not** be forwarded for inclusion in your Official Personnel Folder, but it will be maintained in your organizational employee record folder. It will be used to support future actions prompted by any recurrence of behavior referenced herein.

5. If you believe that a personal problem may be affecting your conduct and/or performance, with your concurrence, I will arrange for an appointment for you with the Employee Assistance Program Coordinator at this installation.

Chief, Prev. Med. Clinic

MAJ, AN
Chief, Preventive Medicine

MCXY-PM

ACKNOWLEDGEMENT OF RECEIPT:

This is to certify that I have received a copy of this memorandum:

_____ Date: _____
(Employee Signature)

TAB M-6

the Whistleblower

Section A-3

the Whistleblower

Error in AHLTA Regarding Provider Status

Redacted

Tue, Dec 28, 2010 at 9:32 AM
Redacted

Dep. Cdr for Clin. Serv., Dep. Cdr for Nursing, Chief, Prev. Med. Clinic and Sup Prev. Med. Physician

On December 23, 2010 Chief, Prev. Med. Clinic and I had a discussion regarding ordering STD labs without a physician, nurse practitioner or physician assistant examining the patient. I told Chief, Prev. Med. Clinic that it was not in my scope of practice to order labs or medications under my name as that constitutes practicing medicine without a license,which is criminally prosecutable.

Under my registered nurse scope of practice, labs and refills for medications must have a physician, nurse practitioner or physician assistants" name on them with a written order from them. I told Chief, Prev. Med. Clinic that I felt that patients, requesting an STD test should be examined/evaluated by a physician, nurse practitioner or physician assistant, as there could be other medical problems.

My 36 years as a registered nurse has allowed me to order labs with a current dated written doctor's order and with the physician, nurse practitioner, or physician assistant as the provider on the lab slip. I have practiced in several states and the registered nurse scope practice is consistently uniform.

After the discussion with Chief, Prev. Med. Clinic, I spoke with a nurse practitioner and registered nurse in the LAHC Adult Medicial Clinic. They concurred with me that I should be ordering in AHLTA under a physician, nurse practitioner or physician assistants' name as provider and not under my name as provider. The registered nurse then showed me how to order under that system; which I had not been shown, when I was briefly orientated to the Preventive Medicine CHN LTBI function.

It was at this time that I discovered I was in the list of providers erroneously and all that I had ordered was under my name as provider, not Sup Prev. Med. Physician name. This needs to be corrected immediately as my name should not be on bottles of INH. I should not be able to order anything with my name as provider, as I am not a provider. I am a nurse and this is not within my scope of practice.

I do not have a problem placing lab orders in AHLTA under Sup Prev. Med. Physician name as provider, under a current SOP and electronically transferring the chart to him after I have completed my nursing charting, so that he may continue or discontinue medication refills as he deems from the written assessment of the LTBI patient.

I have asked for current signed and dated specific SOPs for LTBI, HIV, STD and notifiable diseases several times since September 2010. As of December 23, 2010, only the HIV has been sent forward to command for review and possible implementation. There is not an SOP for notifiable diseases. I have emailed all Army CHN and APHN for their SOPs . When I received an SOP from WRAMC for HIV, Chief, Prev. Med. Clinic, Sup Prev. Med. Physician and I met to revise it to meet Lyster's needs. I have also received SOPs for STD, LTBI and notifiable diseases from other Army facilities and shared them with Chief, Prev. Med. Clinic so that LAHC PM SOPs could be updated, reviewed and signed into official implementation.

I am awaiting correspondence from the California Board of Registered Nurses, CMS and Joint Commission regarding these matters as I consider my nursing license in jeopardy. I have also consulted with an attorney regarding any variances of employment position description.

Thank you for your time and prompt attention to this matter.

Respectfully Yours,

AM-6

the Whistleblower
Section A-4

the Whistleblower

Re: Error in AHLTA Regarding Provider Status (UNCLASSIFIED)

Redacted

Tue, Dec 28, 2010 at 6:04 PM
Redacted

Classification: UNCLASSIFIED
In the military system (and probably in the civilian system as well), if you have a written policy/procedure signed by a physician or other LIP in place, that covers you for having a written order. This is how immunizations are given without the requirement to see a provider first. There is, essentially, a standing order for a particular process. For STDs, there is a standing policy (recently updated and approved by Dep. Cdr for Clin. Serv.) for when certain labs can be ordered without the patient seeing their PCM first. For HIV, there is a standing policy to guide the care of those patients. For TB management, there is a standing policy for management. Standing orders/policies do allow a RN to order tests, and even give medicines (i.e. immunizations, INH) and remain within their scope of practice. If you have further questions, please contact Redacted to get on my calendar to meet and discuss this further.

On 12/28/10, > wrote:

> Dep. Cdr for Clin. Serv., Dep. Cdr for Nursing, Chief, Prev. Med. Clinic and Sup Prev. Med. Physician
>
>
>
>
>
> On December 23, 2010 Chief, Prev. Med. Clinic and I had a discussion regarding ordering STD labs without a physician, nurse practitioner or physician assistant examining the patient. I told Chief, Prev. Med. Clinic that it was not in my scope of practice to order labs or medications under my name as that constitutes practicing medicine without a license,which is criminally prosecutable.
>
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> Under my registered nurse scope of practice, labs and refills for medications must have a physician, nurse practitioner or physician assistants'' name on them with a written order from them. I told Chief, Prev. Med. Clinic Chief, Prev. Med. Clinic that I felt that patients, requesting an STD test should be examined/evaluated by a physician, nurse practitioner or physician assistant, as there could be other medical problems.
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>
> My 36 years as a registered nurse has allowed me to order labs with a current dated written doctor's order and with the physician, nurse practitioner, or physician assistant as the provider on the lab slip. I have practiced in several states and the registered nurse scope practice is consistently uniform.
>

the Whistleblower
Section A-5

the Whistleblower

Re: Error in AHLTA Regarding Provider Status (UNCLASSIFIED)

Redacted

Tue, Dec 28, 2010 at 6:46 PM
Redacted

Written current standing orders do cover certain processes. However, I am still must have a physician name on the lab and the medication bottles. It is not within my scope of practice to order anything with only my name-it must have a physician's name, nurse practitioner's name or a physician assistant's name.

I understand that standing orders have their limits and my name should not be on the medication bottles of the patients as a provider nor should my name be on the lab orders. I will not order any labs or medications as long as I am not able to choose Sup Prev. Med. Physician name under provider in the ordering system. To do so would be practicing medicine without a license.

Again, I will not order any labs or medication refills under my name as provider. I have been instructed to make this very clear in writing. I am not adverse to ordering them under Sup Prev. Med. Physician name with a current standing order.

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informal peer review. However, peer review as presented in this chapter is in the context of an adverse privileging practice action and is a formal process. A formal peer review is required whenever an SOC determination must be made, or when the staff member's performance is such that an adverse practice action (for example, limitation of duty or removal from the clinical setting) is considered. The purpose of this review is to examine information obtained from the structured, unbiased investigation/inquiry and any other relevant materials. Following the review, recommendations are presented to the commander regarding the clinical performance, competence, and liability (medical malpractice case) of the individual. The peer review mechanism is intended to—

a. Protect the rights of the individual (afford due process).

b. Identify systemic issues and refer to appropriate CQM channels for resolution.

c. Separate professional actions and considerations from administrative or legal considerations.

d. Provide timely reporting to the USAMEDCOM QMD, utilizing Department of Defense Form (DD) 2499 (Health Care Provider Action Report) (see chap 10) or DD Form 2526 (Case Abstract for Malpractice Claims) (see chap 13), when the need is identified to report a health care privileged provider or nonprivileged professional to a regulatory body.

6–5. Conducting the peer review

a. When a privileged or nonprivileged staff member is removed from all or a portion of his/her patient care duties, the peer review function must be initiated to determine the extent of the problem and to make recommendations for further action on the professional issues in the case (for example, retraining, supervised practice, a licensing action). The focus of the peer review is on how the action under review impacts the individual's ability to practice clinically.

b. All procedures related to peer review (notification, withdrawal of permission for off-duty employment, hearing rights, the appeal process) are the same for both privileged and nonprivileged personnel. See chapter 10 for additional guidance associated with peer review.

6–6. Recommendations and followup reporting

a. In all cases, the recommendations resulting from peer review and subsequent action by the commander will be forwarded to the supervisor of the staff member whose practice/conduct was the subject of the peer review proceedings. It is the responsibility of the supervisor to ensure that the recommendations from the peer review function, and actions taken by the commander, are implemented.

b. The peer review function may recommend reporting the staff member to a licensing/regulatory agency. Local policy will establish who is responsible for preparation of the DD Form 2499. The MTF commander will forward this document to Commander, USAMEDCOM, MCHO–CL–Q, 2050 Worth Road, Fort Sam Houston, Texas 78234–6010, with copy furnished to the RMC or other higher headquarters, as appropriate. The recommendations of the peer review panel, and all other information related to the case, will accompany the DD 2499 when reporting of a privileged provider or nonprivileged professional to a licensing or other regulatory body is required. TSG is the sole reporting authority (para 14–3).

Chapter 7
Privileged Health Care Providers

7–1. General

a. This chapter includes general information and specific professional requirements related to each category of privileged provider (military or civilian) listed below. The information presented is intended to be a broad overview, rather than all-inclusive, and will change over time as health care requirements evolve. The privileged providers addressed include, but are not limited to—

(1) APRN.

(a) Certified nurse midwife (CNM).

(b) CRNA.

(c) Clinical nurse specialist (CNS).

(d) NP to include Family, adult, pediatric, women's health care, acute care, geriatric, emergency, and so forth.

(2) Audiologist.

(3) Behavioral health practitioner.

(4) Chiropractor.

(5) Clinical pharmacist.

(6) Clinical psychologist.

(7) Clinical social worker.

(8) Dentist.

(9) Dietitian.

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(10) OT.
(11) Optometrist.
(12) Physician.
(13) PA and specialty physician assistant.
(14) PT.
(15) Podiatrist.
(16) Psychological associate.
(17) Speech pathologist.
(18) Substance abuse counselor.

b. Clinical privileges, which define the individual's scope of practice in a specific institution, are granted to health care providers based on their credentials, clinical competence, and the mission and requirements of the organization.

(1) The privileged provider is authorized to make independent decisions related to beneficiary health care management based on his/her recognized scope of practice. He/she may supervise, coordinate, and direct, as appropriate, the care provided by other members of the health care team. A representative scope of practice, by discipline, is provided in the pages that follow. Changes to the scope of practice for any of the privileged providers presented in this chapter are at the discretion of the MTF commander, who is the privilege-granting authority.

Note. While the specialist in blood banking (SBB) may be awarded clinical privileges in the specialty, he/she does not function independently to diagnose, initiate, alter or terminate health care treatment regimens. The term "provider," as defined in this regulation, does not apply to the SBB. (See paras 9–1 and 9–2 for additional information regarding the granting of clinical privileges.)

(2) The specific and individual privileges of each provider are delineated on the appropriate DA Form 5440, Delineation of Clinical Privileges, contained in his/her PCF.

Note. See app A for a complete listing of the DA Forms 5440 series.

Providers with admitting privileges and all physicians will be appointed to the medical staff. For health care providers who are not authorized to admit patients, medical staff appointment is optional. The individual's category of privileges, appointment status, and authority to admit patients are reflected on DA Form 5440A, Approval of Clinical Privileges/Staff Appointment.

7–2. Clinical practice

a. Decision making. Clinical care decisions and specific therapeutic interventions on the part of the provider are based, in part, on CPGs; nationally recognized standards of care/practice; current professional clinical references; and other relevant regimens, guidelines, or policies, as appropriate. These serve as a framework for practice and are the basis for the specific clinical privileges requested by the individual provider and for periodic performance review and evaluation activities.

b. Collaboration. For privileged providers other than physicians and dentists, a designated physician will always be available for consultation and collaboration in person, telephonically, or by any other means that allows person-to-person exchange of information. Collaboration reflects both independent and cooperative decision making based on the professional preparation and ability of each provider. Collaborative practice implies an open exchange of patient data and information and includes such activities as consultation, referral, coordination, and co-management of patient care.

c. Pharmaceuticals. Privileged providers are authorized to prescribe pharmaceuticals contained in the MTF formulary according to the guidance established by the local P&T committee. For providers other than physicians and dentists, the drugs approved for prescription writing will be based on the provider's scope of practice and the beneficiary group(s) served. An open formulary is authorized. Facility-specific exceptions, either by category of drug or itemized by name of drug, will be noted in writing. Prescription writing authorization—as recommended by the P&T committee, reviewed by the credentials committee, and approved by the MTF commander—will be annotated in the PCF as an addendum to the provider's delineation of clinical privileges.

d. Procedures and diagnostic testing. Privileged providers are authorized to perform those procedures for which they have been appropriately trained, are properly qualified, and are privileged. Nonphysician privileged providers may be authorized to perform, and document in the medical record, minimally complex or selected moderately complex diagnostic procedures classified as provider-performed microscopy by the DOD Clinical Laboratory Improvement Program. (See AFIP Pam 40–24.) Other radiological studies, diagnostic testing, and procedures authorized according to local guidance will be addressed on the discipline-specific DA Form 5440.

e. Continuing education requirements. Professional competency is maintained, in part, by the ongoing accumulation of advanced knowledge in one's practice discipline. For all privileged providers, the annual requirement for continuing professional education and development is according to AR 351–3, or as determined by the provider's State of licensure, whichever is more stringent.

f. Readiness training. This is of paramount importance to prepare U.S. Army privileged providers for mobilization in support of the Army's global mission. Local command decisions will govern the training of assigned personnel. Suggested training includes—

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when authorized by the MTF commander and competency assessed. In such cases, the PPM lab must be registered with CLIP and approved procedures for PPM tests must be instituted.

d. At MTFs that do not have an assigned pathologist, a qualified licensed physician according to AFIP Pamphlet 40-24 , will be assigned as the director of the laboratory and competency assessed. At inpatient facilities without an assigned pathologist, the commander will ensure that appropriate and timely professional pathology services are available to the staff and patients of the facility.

e. At all MTFs without an assigned civilian or military pathologist or without an equivalent contracted pathologist, the commander of the facility will appoint an appropriate regional military pathologist to the medical staff of the MTF as a consultant.

14–6. Quality control

a. Sound quality control systems in all MTF clinical laboratories, including decentralized laboratories, are essential to providing excellent services. Quality control systems must be designed to ensure medical reliability and timeliness of laboratory data. The goal of quality control is to achieve the most accurate test results and outcomes.

b. Each laboratory must have a written, defined, and approved quality control program that meets the standards of the CLIP and any applicable accrediting body. The quality control system must address pre-analytical, analytical, and postanalytical phases of laboratory testing and results reporting.

c. For the subspecialty of cytopathology, a written quality control program must be in place to measure, assess, and improve quality in cytology addressing the accuracy of both positive and negative findings. Each cytopathology service will be directed by a pathologist or other physician qualified in cytology who will maintain the quality of the service through direct supervision and adequate oversight. Cytology service personnel will be assessed in accordance with cytopathology competency requirements in AFIP Pamphlet 40-24.

14–7. Monetary collections for laboratory services

The laboratory will not serve as a monetary collection agency for medical laboratory test services. However, laboratory personnel will assist the command's third party collection office in billing third party insurers for laboratory tests authorized under the TPCP.

14–8. Improving organizational performance

a. A laboratory's performance of important health care functions significantly affects the outcomes of the patients it serves, the costs to achieve these outcomes, and the patient's/customer's perceptions or satisfaction. The goal of organizational PI is to continuously improve the laboratory services that affect patient health outcomes.

b. The Chief, Laboratory Services will implement a collaborative and interdisciplinary performance improvement process that will demonstrate improvement in laboratory services. This process will be integrated with the MTF organizational PI structure and documentation will provide evidence of ongoing improvement processes.

c. Data will be collected on important laboratory processes and outcomes, including as a minimum patient preparation; handling of specimens; communication processes; appropriateness of laboratory tests offered (utilization management); and the needs, expectations, and satisfaction of patients and other customers. Data on important processes and outcomes are also collected from risk management and quality control activities.

d. Data for the defined RMC metrics will be collected and reported electronically using the MEDCOM Laboratory Program Office automated tool for assessment.

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14–9. Individuals authorized to order laboratory tests

a. The following categories of personnel are authorized to order laboratory tests:

(1) Uniformed and civilian physicians, dentists, veterinarians, optometrists, and podiatrists engaged in professional practice at uniformed services MTFs.

(2) Other uniformed and civilian providers with privileges at the MTF which allow them to do so. Providers include, but are not limited to certified nurse midwives, NPs, PAs, chiropractors, dietitians, clinical pharmacists, and psychologists.

(3) Civilian physicians, dentists, optometrists, and podiatrists not assigned to a uniformed services MTF, but licensed in the jurisdiction of their practice and treating personnel eligible for care within the MHS.

(4) Civilian nonphysician health care providers not assigned to a uniformed services MTF, but licensed within the jurisdiction of their practice and treating personnel eligible for care in the MHS, to the extent authorized by State law and by policies for equivalent staff nonphysician health care providers.

b. Requests for medical laboratory tests written by licensed civilian practitioners not assigned to a uniform services MTF for personnel eligible for care in the MHS will be honored at Army MTFs according to AR 40–400 subject to the availability of space, facilities, the capabilities of the professional staff, and the following considerations.

(1) A policy relative to performing and reporting laboratory tests ordered by civilian practitioners will be established and announced by the local commander. This policy will coincide with policies regulating staff ordering of laboratory

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(1) The completed DA Form 4106 will be forwarded through appropriate supervisory channels to the designated authority as soon as possible but not later than 48 hours after the occurrence.

(2) Reports of adverse events/close calls or other incidents occurring on the weekend or holidays will be submitted on the first duty day following the incident.

(3) The attending prescriber will be notified, and the error will be evaluated using the pharmacy PI structure. The pharmacy will refer these and the necessary supporting records as appropriate within the MTF-specific PI structure.

(4) A root cause analysis, in accordance with the Patient Safety Program, USAMEDCOM, and current accrediting body's (for example, TJC or other) standards, will be conducted on any error in categories G through I and as deemed appropriate by the specific MTF.

(5) Copies of the form may be provided to individuals, services, or departments deemed appropriate to clarify and rectify the problem according to AR 40–68.

11–10. Controlled substances

a. General.

(1) Controlled substances are drugs so designated by the Drug Enforcement Administration (DEA). The DEA assigns controlled substances to one of five schedules according to the abuse potential and degree of control required. A list of controlled substances in each schedule and changes are published in the Federal Register and in the SB 8–75S1 series.

(2) Medical treatment facility commanders may designate items as locally controlled if they deem them subject to potential abuse or diversion. The method of accountability for such items will be as either Schedule II or Schedule III–V as determined by the commander.

(3) The use of methadone for drug dependency withdrawal or maintenance of narcotic addiction is not authorized in Army MTFs. Methadone may be utilized for extreme uncontrolled discomfort of rapid withdrawal or for the temporary maintenance of patients hospitalized for the treatment of conditions other than narcotic addiction in accordance with the USC and the CFR. There is no restriction on the use of methadone when it is used for analgesia.

(4) Amphetamines and methamphetamines will not be prescribed as anorexic agents. Also, any medication used solely for its anorexic activity is prohibited from use in Army MTFs. This does not preclude the use of FDA-approved alternative medications with weight loss effects when medically indicated and used in a structured medical staff approved, multidisciplinary program to treat obesity.

(5) Prescription writing for controlled substances will be according to paragraph 11–13. Paragraphs 11–7, 11–11, 11–12, 11–14, 11–19, 11–20, 11–21, 11–24, and 11–30 of this regulation also contain discussion of controlled substances.

b. Accounting for controlled substances used in the manufacture of pharmaceutical preparations. DD Form 1289 (DOD Prescription) or an equivalent automated record will be used to account for all controlled substances used in the manufacture of pharmaceutical preparations. Such orders will be authenticated and signed by a pharmacist and will be filed in the appropriate prescription file (also see app B).

c. Procedures regarding controlled drugs.

(1) The AMEDD currently has in effect regulatory guidance that exceeds requirements of Federal law and standards of accrediting bodies (for example, TJC or other). Specific guidance for inventory, control, and accountability of controlled substances is included in appendix B. It is essential that commanders place emphasis on the audit and inventory procedures outlined in this appendix.

(2) Periodic reviews to detect overuse and/or abuse of controlled substances will be conducted and findings reported to the MTF commander via the P&T committee.

(3) Controlled substance histories recorded in patient medication profiles for prescriptions from civilian practitioners will be made available to MTF prescribers upon their request.

(4) The Controlled Substances Act (21 USC 801 et seq) requires facilities that maintain controlled substances to conduct an inventory of all controlled substances every 2 years. The inventory can be accomplished without performing an additional inventory if the MTF designates the first monthly inventory every other FY as the biennial inventory.

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11–11. Individuals authorized to write prescriptions

a. The following categories of personnel are authorized to write prescriptions:

(1) Uniformed and civilian physicians, dentists, veterinarians, and podiatrists engaged in professional practice at uniformed services MTFs.

(2) Civilian physicians, dentists, and podiatrists not assigned to a uniformed services MTF but licensed in the jurisdiction of their practice and treating personnel eligible for care in the Military Health System (MHS).

b. The following personnel are authorized to write prescriptions only for selected medications as established under the provisions of AR 40–68:

(1) Uniformed and civilian optometrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners (NPs), physician assistants (PAs), physical therapists, occupational therapists, and clinical pharmacists engaged in professional practice at uniformed services MTFs and privileged to prescribe medications.

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(2) Civilian personnel not assigned to a uniformed service MTF but licensed in the jurisdiction of their practice and treating personnel eligible for care in the MHS will prescribe to the extent authorized by State law and by policies for equivalent staff nonphysician health care providers.

(3) Other nonphysician health care providers not listed above but assigned to a uniformed service MTF and granted limited prescribing privileges.

(4) Retired uniformed practitioners not in a professional practice but with a valid State license may prescribe only noncontrolled substances for themselves or their Family. Retired medical personnel not in a professional practice and not having a valid State license will not prescribe medications.

c. Prescriptions written by licensed civilian practitioners not assigned to a uniformed service MTF for personnel eligible for care in the MHS will be honored at Army MTFs if the prescribed medication is on the MTF's formulary and meets local dispensing policies.

(1) A policy relative to filling civilian prescriptions will be established and announced by the commander. The policy will coincide with those regulating staff prescribers except in those MTFs located in a State where the law limits product substitution by the pharmacist. In such areas, the generic equivalent will not be substituted for a brand name drug on a civilian prescription without prior approval of the prescriber.

(2) Filling a prescription written by a civilian practitioner does not imply knowledge of or responsibility for a patient's medical condition. Under no circumstances will civilian prescriptions be countersigned or rewritten by military practitioners. Special or nonformulary drug requests will not be submitted by military providers on behalf of prescriptions from civilian providers that are written for nonformulary medications.

d. A distance factor or geographic boundary limitation will not be a basis for denying prescription services. MTF pharmacists will adhere to all applicable Federal and State laws when filling prescriptions originating from outside the State.

e. Individuals with prescribing privileges are not authorized to prescribe controlled substances for themselves or members of their families.

f. Nonphysician health care providers may, when authorized by the commander, dispense the drugs they are privileged to prescribe after the drugs are properly prepackaged and labeled. In those instances where a non-pharmacist dispenses, the same standards of care and practice as required and expected of a pharmacist will be followed. To the greatest extent possible, the MTF pharmacy will serve as the primary point of distribution and dispensing for all medications.

g. Personnel assigned to a uniformed service MTF will utilize the Composite Health Care System (CHCS), AHLTA, or other officially designated computer systems Physician Order Entry (POE) menus for prescribing inpatient (IPOE) and outpatient medications on the MTF formulary. IPOE may vary depending on location and scope of practice.

h. The approval of prescriptive authority and the access to and utilization of CHCS POE menus will coincide with the completion, approval, and annual reassessment of the credentialing/privileging process.

11–12. Signatures

a. With the exception of physician order entry via the CHCS, no prescription or order will be filled in the pharmacy unless it bears the signature of an individual authorized to write prescriptions. Signature stamps are not authorized for prescriptions. The pharmacy service will maintain a system that allows their staff to validate the signature of individuals privileged to write prescriptions within their MTF.

b. Subject to such restrictions as may be imposed by the local commander, the pharmacy will honor bulk orders for drugs other than controlled substances when signed by a designated representative of the officer in charge of the patient care area. The name and signature of each designee must be provided to the pharmacy in advance.

c. Orders for controlled substances will be signed by individuals authorized to write prescriptions or by a registered nurse.

d. Medical treatment facilities with electronic ordering capability may use electronic signatures if security measures are provided.

11–13. Prescription writing

a. Prescriptions will be stamped, typed, or written in ink and signed in ink by an authorized prescriber. As an exception to this rule—

(1) Electronic prescriptions generated through the CHCS, to include prescriptions for Schedules II through V controlled substances, may be filled by the pharmacy contingent upon guidelines established in ASD(HA) Memorandum dated 31 May 1990 and letter dated 26 Mar 1990. Otherwise, prescriptions for Schedule II substances require an original prescription.

(2) Medical treatment facilities may accept prescriptions electronically from civilian prescribers outside the facility according to appropriate State laws.

(3) A carbon, facsimile, or electronic copy of prescription orders noted for a patient at the time of discharge in the nursing notes, to include prescriptions for Schedules II through V controlled substances, may be filled by the pharmacy.

http://www.scribd.com/doc/1748243/US-Army-M4053 2/16/2011

Health care personnel will abide by their legal scope of practice

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their specialty (list not all inclusive): APRNs, audiologists, behavioral health practitioners, chiropractors, clinical pharmacists, clinical psychologists, clinical social workers, counseling psychologists, dental hygienists, dentists, dietitians, occupational therapists (OTs), optometrists, physical therapists (PTs), non-personal services PAs, physicians, podiatrists, practical/vocational nurses (LPN/LVN), psychological associates, registered nurses (RNs), substance abuse counselors, speech pathologists, and veterinarians. The basic qualifications for award of a medically related military enlisted MOS/ASI are contained in DA Pam 611–21. The OPM has established the minimum qualification requirements for comparable civilian positions by employee classification series and grade level in its Qualification Standards Handbook for General Schedule Positions.

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Note. The information presented in this chapter regarding licensure (or other authorizing document) of personnel providing direct/indirect health services or patient care may change over time as regulatory requirements at the State level evolve. Requirements related to licensure/certification/registration of AMEDD health care personnel (military/civilian) will, at all times, comply with current OASD(HA) guidance.

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(2) Health care personnel (military/civilian) employed by the Federal Government will abide by the practice requirements imposed by their State of licensure/certification/registration to the fullest extent possible.

Note. Compliance with State requirements shall not interfere with the individual's performance of assigned duties/responsibilities in the specified discipline within the Federal sector.

Individuals who provide ancillary health services and who hold licensure/certification/registration (national/State) in their individual specialty must reveal this authorizing documentation and are subject to the adverse practice action reporting requirements outlined in chapter 14. Professional conduct, behavior, or performance that, based on peer review, warrants an adverse practice action will be reported to the appropriate authorizing agency, according to current DOD guidance.

b. Certification and/or registration for select disciplines.

(1) All PAs must possess NCCPA (or its successor) certification as a condition of employment (GS/contract employees) and before being granted clinical privileges (military, GS, personal services contact, and volunteer).

(2) Dietitians must possess and maintain current registration by the Commission on Dietetic Registration of the American Dietetic Association (ADA) in addition to a current, active, valid, and unrestricted State license.

(3) Substance abuse counselors are required to possess and maintain a current, active, valid, and unrestricted license as a social worker or psychologist, or if the counselor is prepared at the master's degree level and is in the GS 180–series, the license may be as a licensed professional counselor, with State or national certification in substance abuse rehabilitation. The deadline for substance abuse counselors to obtain this license was 31 May 2003.

(4) See chapter 7 for additional guidance related to scope of practice and other specific professional requirements for privileged providers.

(5) Although national certification of health care personnel (enlisted, civilian) who provide ancillary health services is not mandated, except mammography technicians (Federal Drug Administration, "Quality Mammography Standards") and emergency medical technicians (AR 40–3), it is highly encouraged in any specialty for which it may be available. Certification and/or registration requirements for AMEDD health care personnel (military/civilian) will, at all times, comply with DOD guidance.

Note. State licensure as a qualified radiology technician and continuing education in mammography may substitute for the certification specified (21 CFR Part 900 - Mammography).

4–5. Professional responsibility regarding licensure

It is the professional and individual responsibility of military and civilian health care professionals, and other health care personnel as may be required, to obtain and maintain the license, certification, and/or registration required to practice in a particular health care discipline. Deployment or other extended training does not exempt the military member from this requirement. This responsibility includes payment of requisite fees and knowledge of and compliance with all requirements for continuing education and other mandates of the licensing, certification, and/or registration authority.

a. Use of appropriated funds for payment of fees. Appropriated funds may be used to pay professional licensure expenses for military health care personnel who are required to be licensed in their State of practice in order to participate in a resource sharing agreement with a civilian institution. This entails performance of officially assigned professional duties at an authorized location outside the MTF and any military installation. Federal statute, 10 USC 1096, allows the Secretary of Defense to reimburse the military member for up to $500.00 of the amount of the license fee. This applies only to situations in which the host State or civilian facility refuses to recognize the individual's professional license/authorizing document despite the licensure portability statute as described in 10 USC 1094 and DODI 6025.16.

b. Civilian employee time off. When in the best interest of the Government and the employee, civilian employees may be given brief excused absences from duty and official time off for required licensing and certification purposes. Permissive TDY is authorized for military health care personnel taking licensure examinations.

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awaiting licensure examination results, and so forth) will practice only under the supervision of a properly licensed, certified, and/or registered (and privileged, if required) professional of the same or similar discipline.

Note. Foreign military health care personnel or others involved in official exchange student capacity are included in this category.

(2) The level of supervision will be more comprehensive than that provided a licensed individual of the same discipline. At pre-determined intervals, as stipulated in local policy, the professional's performance, competence, and capabilities in his/her assigned military or civilian position will be assessed and documented.

e. Privileged providers.

(1) Privileged providers are responsible to their discipline-specific department chief or supervisor for the ongoing assessment of the quality of care they provide within their discipline-specific scope of practice and defined privileges. The discipline-specific chief/supervisor will—

(a) Review and recommend approval of the application for privileges and the PCF prior to submission to the credentials committee/function.

(b) Monitor and evaluate the discipline-specific scope of practice.

(c) Conduct routine peer review of individual practice according to local policy.

(2) In instances of a sole privileged provider in a given setting, or the provider is the senior member of his/her discipline (that is, the chief of the department), the provider is responsible to an assigned clinical authority, as appropriate to the organization. This individual (from within the MTF or the RMC) will perform appropriate supervisory functions and provide oversight of the care and services delivered to authorized beneficiaries.

(a) The individual tasked with oversight authority may be of the same discipline, a similar discipline, or a physician.

(b) The individual selected must be qualified by education and experience to provide the appropriate level of supervision and oversight of practice that is required.

(3) Physician supervision of members of another discipline (for example, OTs, PTs, nurses, pharmacists) is not required for functions performed that are within the scope of practice authorized by the individual's license, registration, certification, or privileges.

f. Other considerations related to supervision and evaluation of health care personnel.

(1) Army policy and/or State licensing laws require physician supervision of PAs privileged to provide patient care and services. Said physician supervisor (and an alternate) will be named in writing by the MTF commander.

(2) Significant variation exists among States relative to physician supervision of nonphysician providers. Likewise, variation among States may exist regarding supervision and/or the scope of practice of the RN, LPN, or other licensed/certified/registered professional. The individual nonphysician privileged provider/professional is responsible for informing his/her immediate supervisor of any specific State-directed requirements for supervision of clinical practice. Ideally, this information should be elicited from the employee during orientation and will be documented in his/her CAF. The immediate supervisor will ensure appropriate coordination to facilitate organizational compliance, wherever feasible.

(3) Regardless of the oversight and/or supervisory relationship that exists, provider collaboration and collegial interchange in support of high quality patient care is the standard in all settings and circumstances.

(4) Individuals responsible for clinical oversight of privileged or nonprivileged health care personnel need not be responsible for the overall performance evaluation (OER/Enlisted Evaluation Report/civilian performance appraisal). Decisions regarding nonclinical rating schemes must be based on the structure of the organization and other variables that are individual provider and facility specific.

(5) A copy of the privileged provider's clinical performance evaluation (not the OER or its civilian evaluation equivalent) will be forwarded to the MTF credentials committee/function. These documents will be maintained in Section II of the PCF and are the basis for biennial renewal or revision, as needed, of clinical privileges.

g. Supervision of screening personnel. Screening personnel (enlisted or civilian) assigned for duty in various clinic settings are permitted to utilize the algorithm-directed troop medical care (ADTMC) system (or comparable system) to screen AD Soldiers during daily sick call activities. (Contact USAMEDCOM ATTN: MCHO–CL–C for use of this system.) Use of an algorithm-based system is mandatory when screening personnel provide evaluation, treatment, and/or disposition of AD sick call patients. MTF commanders will—

(1) Establish a local training program in the appropriate use of ADTMC. Screeners must complete the formal training program prior to being assigned to evaluate, treat, and/or make disposition of AD Soldiers who present for care. This training will be documented in the individual's CAF.

(2) Ensure that screeners are provided adequate supervision and performance evaluation by a physician, PA, or other qualified provider specifically assigned this responsibility. Documentation of the care provided by ADTMC screeners, DA Form 5181 (Screening Note of Acute Medical Care), or like form, will be reviewed on a daily basis. Screener evaluation will be documented according to instructions from the USAMEDCOM ATTN: MCHO–CL–C.

(3) Ensure that the screener's scope of practice with regard to evaluating, treating, and/or determining the disposition of AD sick call patients is delineated in writing and that it is reviewed and revised at least annually.

(4) Approve the list of self-care medications, as recommended by the pharmacy and therapeutics (P&T) committee (see AR 40–3), to be dispensed by screeners. Screeners may be approved to dispense the over-the-counter medications

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BOARD OF REGISTERED NURSING
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nurse practitioner not nurse

INSTRUCTIONS FOR APPLYING FOR A NURSE PRACTITIONER FURNISHING NUMBER

Section 2836.3 of the Business and Professions Code requires that the nurse practitioners who wish to furnish drugs and/or devices pursuant to Section 2836.1 have a Board issued furnishing number. The number is renewable at the time of the applicant's registered nursing (RN) license renewal. To be eligible for the furnishing number, the board certified nurse practitioner must have completed a Board approved pharmacology course and a minimum of 520 hours of physician supervised experience in furnishing drug and/or devices. These hours may be accumulated during a period of time that is not less than six (6) months (minimum of twenty-four (24) weeks).

APPLICATION PROCESS

For applicants who completed supervised furnishing experience in California, please provide the following:

- Nurse Practitioner Furnishing Number Application form completed by the applicant and $50.00 application fee. **Physician supervised furnishing experience completed prior to certification as a nurse practitioner will not be accepted.**
- Verification of Physician Supervised Furnishing Experience form completed by the supervising physician.
- Advanced Pharmacology Course Verification form completed by the academic program or continuing education (CE) provider

For applicants who completed supervised experience outside of California, in addition to the items noted above, you must also provide the following:

- A copy of the procedures/protocols AND collaborative agreement set in place by the supervising physician that allowed the nurse practitioner to use their prescriptive/furnishing authority in the state where the supervised prescriptive/furnishing experience was completed.
- A copy of that State's rules/regulations regarding prescriptive/furnishing authority for nurse practitioners.

Falsification of information on the application is a violation of the Nursing Practice Act and may result in not only denial of the issuance of the furnishing number, but also in Board disciplinary action against the applicant's registered nursing license.

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Form-224

APPLICATION FOR REGISTRATION
Under the Controlled Substances Act

APPROVED OMB NO 1117-0014
FORM DEA-224 (9-05)
Previous editions are obsolete

INSTRUCTIONS

1. To apply by mail complete this application. Keep a copy for your records.
2. Print clearly, using black or blue ink, or use a typewriter.
3. Mail this form to the address provided in Section 7 or use enclosed envelope.
4. Include the correct payment amount. FEE IS NON-REFUNDABLE.
5. If you have any questions call 800-882-9539 prior to submitting your application.
6. Save time - apply online at www.deadiversion.usdoj.gov.

IMPORTANT: DO NOT SEND THIS APPLICATION AND APPLY ONLINE.

REGISTRATION INFORMATION :

$390.00

FEE IS NON-REFUNDABLE

SECTION 1 APPLICANT IDENTIFICATION

Last Name (if registration is for individual) -OR- Business or Facility Name (if registration is for business entity)

First Name (if registration is for individual) Middle Initial

Business or Facility Name 2 ("doing business as", continuation of business name, or name of fee exempt institution)

Address Line 1 (street address)

Address Line 2

City State Zip Code

Business Phone Number Business Fax Number

see that RN not included in applying

DEBT COLLECTION INFORMATION

Mandatory pursuant to Debt Collection Improvements Act

Tax Identification Number (if registration is for business)

Social Security Number (if registration is for individual)

NOT RN

Provide SSN or TIN. See note #3 on bottom of page 2

SECTION 2

BUSINESS ACTIVITY

Check one box only

See page 3 for additional instructions

Hospital/Clinic | Ambulance Service | Practitioner (DDS, DMD, DO, DPM, DVM, MD or PHD)

Nursing Home | Animal Shelter | Practitioner Military (DDS, DMD, DO, DPM, DVM,MD or PHD)

Central Fill Pharmacy | Teaching Institution | Mid-level Practitioner (MLP) (DOM, HMD, MP, ND, NP, OD, PA, or RPH)

Retail Pharmacy | Automated Dispensing System | Euthanasia Technician

PROFESSIONAL DEGREE

Practitioners and MLPs : Enter your professional degree from list

FOR Automated Dispensing System (ADS) ONLY:

DEA Registration # of Retail Pharmacy for this ADS

An ADS is automatically fee-exempt. Skip Section 6 and Section 7 on page 2. You must attach a notorized affidavit.

SECTION 3

DRUG SCHEDULES

Check all that apply

Schedule II Narcotic | Schedule III Narcotic | Schedule IV

Schedule II Non-Narcotic | Schedule III Non-Narcotic | Schedule V

Check this box if you require official order forms for purchase of schedule II narcotic/schedule II non-narcotic controlled substances

N

TAB N

SUBJECT: Privacy Act Statement

DATE: 17 May 2011 NAME: Chief, Prev. Med. Clinic

1. AUTHORITY: The authority for the collection of personal information during the conduct of this investigation is Title 10, United States Code, Section 3012 (10 USC 3012).

2. PRINCIPAL PURPOSE: The purpose for soliciting this information is to obtain facts and make recommendations to assist the Office of Special Counsel in to determine the validity of allegations that in the Department of Preventive Medicine at Lyster Army Health Clinic the lack of appropriate qualifications, certifications and training of the Community Health Nurse poses a danger to public health and safety.

3. ROUTINE USES: Any information you provide may be disclosed to members of the Department of Defense (DoD) who have a need for the information in the performance of their official duties. In addition, the information may be disclosed to government agencies outside of the DoD as follows:

a. To members of the U.S. Department of Justice when necessary in the defense of litigation brought against the DoD, or against the members of that department as a result of actions taken in their official capacity.

b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.

4. DISCLOSURE MANDATORY; EFFECT OF NOT PROVIDING INFORMATION:

a. For individual warned of his or her rights under Article 31, UCMJ, or the Fifth Amendment to the U.S. Constitution, providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than essential information may not be provided which might not otherwise be available to the Commander for his/her decision(s) in this matter.

b. For individual who may be ordered to testify, providing this information is mandatory. Failure to provide information could result in disciplinary action or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations.

c. For individual who may not be ordered to testify, providing this information is voluntary. There will be no adverse effect on you for not furnishing the information other than essential information may not be provided which might not otherwise be available to the Commander for his/her decision(s) in this matter.

Chief, Prev. Med. Clinic

Signature of Witness

TAB N

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is PMG.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC Section 301; Title 5, USC Section 2951; E.O. 9397 Social Security Number (SSN).

PRINCIPAL PURPOSE: To document potential criminal activity involving the U.S. Army, and to allow Army officials to maintain discipline, law and order through investigation of complaints and incidents.

ROUTINE USES: Information provided may be further disclosed to federal, state, local, and foreign government law enforcement agencies, prosecutors, courts, child protective services, victims, witnesses, the Department of Veterans Affairs, and the Office of Personnel Management. Information provided may be used for determinations regarding judicial or non-judicial punishment, other administrative disciplinary actions, security clearances, recruitment, retention, placement, and other personnel actions.

DISCLOSURE: Disclosure of your SSN and other information is voluntary.

1. LOCATION	2. DATE (YYYYMMDD)	3. TIME	4. FILE NUMBER
Lyster Army Health Clinic	2011/05/17	1400	

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
Chief, Prev. Med. Clinic	Redacted	MAJ

8. ORGANIZATION OR ADDRESS

Lyster Army Health Clinic, Ft. Rucker, Alabama

9.

I Chief, Prev. Med. Clinic, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

SEE ATTACHED SWORN STATEMENT

Chief, Prev. Med. Clinic

Chief, Prev. Med. Clinic Chief, Prev. Med. Clinic

Chief, Prev. Med. Clinic

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT Chief, Prev. Med. Clinic	PAGE 1 OF 6 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF _____ TAKEN AT _____ DATED _____

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED.

17 May 2011

SWORN STATEMENT by Chief, Prev. Med. Clinic reference the Whistleblower

Q1. What are the educational, licensing, training and experience requirements for a Community Health Nurse (CHN)?

A1. There are no specific or specialized educational or training requirements for a CHN. The only requirement for licensing is to be a Registered Nurse. Experience or exposure in any one or more related Community or Public Health programs or situations such as Home Health, Emergency Preparedness, Health Promotion, Occupational Health and Safety, Communicable diseases, bioterrorism, teen pregnancy, environmental hazards, chronic diseases, marketing research, awareness through media, and working in any capacity of health outside of the hospital environment dealing with individuals, families, groups, or entire communities and populations.

Q2. Are there published federal guidelines or Army regulations regarding the educational, licensing, training and experience requirements for a CHN? If so, what are they?

A2. Yes. Army Regulation 40-68 (Chapter 7, 9) addresses professional requirements for CHN's. In addition, the following Army Regulations provide guidelines for Community Health Programs set by MEDCOM in which individual MTF 's establish local Standard Operations Procedures (SOP's) and Protocols which describe a Community Health Nurse's role and responsibility to carry out the functions of those programs and mission. They are: AR 40-5 (Chapters 5, 6), AR 600-110 (Chpt 1, Section II, 2, 6, 8), AR 608-10 (Chpt 2, 4,) , AR 600-63. See supporting documents

Q3. Are there published federal guidelines or Army regulations for duties of a CHN at a military treatment facility? If so, what are they?

A3. Yes. All military treatment facilities, being federal establishments have published Standard Operation Procedures (SOP's) and Protocols based on Army Regulations which address the functions, roles and responsibilities, and duty performance expectations for the CHN. See example enclosed SOP's used at LAHC.

Q4. Did LAHC Department of Preventive Medicine know of federal guidelines or Army regulations pertaining to the educational, licensing, training, experience requirements and duties of a CHN at a military treatment facility?

A4. Yes. LAHC Dept of Preventive Medicine uses the federal guidelines including Army regulations to develop the position description for CHN's, for establishing Standard Operating Procedures and Protocols pertaining to the mission requirements in Preventive Medicine Programs such as STD's, HIV, Latent Tuberculosis Surveillance, Child Development Centers, Tobacco Cessation, etc.

Q5. Did LAHC vacancy announcement for the CHN include the proper educational, licensing, and training, experience requirements and duties of a CHN?

A5. Yes. The LAHC vacancy announcement for the CHN specifically stated applicants must have a current registration as a professional Nurse in any of the United States, Commonwealth or territory and possess 1 year specialized experience in public health theories, principles and procedures to provide services to persons with infectious diseases, or diseases of public health importance. See attached Vacancy Announcement.

Q6. Did the Whistleblower *, who was selected to fill the CHN position at LAHC possess the requisite educational, licensing, and training and experience requirements to be a CHN?*

A6. Yes. the Whistleblower holds a registered Nurses license from the State of California and has had several years experience with related Public Health Programs such as Disaster Preparedness, American Red Cross, Population Health, Evacuations, etc. See copy of Resume enclosed.

Q7. Did the Whistleblower *have knowledge of the requisite educational, licensing, training and experience requirements to be a CHN when she accepted the job?*

A7. Yes. During her telephone interview, she restated on several different occasions when answering our questions that she had a clear understanding of the experience requirement s for the CHN position as she read the vacancy announcement verbatim.

Q8. If so, did she inform LAHC selecting officials prior to accepting the position that she did not have the requisite educational, licensing, and training and experience to fulfill the position?

A8. Prior to accepting the CHN Position, the Whistleblower never stated she did not have the required educational, licensing, training or experience to fulfill the CHN position. Neither had the selecting officials at anytime determine she did not have the requirement s to fulfill the position. On the contrary, she impressed the interview panel with having researched our organization (LAHC) prior to the interview which indicated she was a higher caliber candidate because most interviewees would not go to such lengths, also, she spoke extensively of what she had to offer the for the position and the programs.

Q9. Did the Whistleblower *knowingly misrepresent her qualifications or training during the selection process for the position of CHN or anytime thereafter?*

A9. No,.

Q10. Are the duties the Whistleblower *was directed to perform as the LAHC CHN, to wit, the responsibility to order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to refill prescriptions for Isonzid (INH), fall within the duties only a CHN with requisite educational, licensing, training and experience can perform?*

A10. Yes. The Standard Operating Procedures and Protocols pertaining to STI's and Latent Tuberculosis Surveillance (INH Refills) which dictate the responsibilities of the CHN fall within the Standard Scope of practice for Registered Nurses under MEDCOM policies, Army Regulations and the United States Board of Nursing practice.

Q11. Were the responsibilities listed above in Q10 (order and interpret sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to refill prescriptions for Isonzid (INH)) specifically defined in the position description or the vacancy announcement?

A11. No. The specific details in refill prescriptions pertaining to the Operation of Tuberculosis Control Program was covered under "preventive therapy". The ordering of labs for STI's are covered under "knowledge of infectious diseases, and sexually transmitted diseases".

Q12. When did the Whistleblower *inform you or anyone else in her supervisory chain of command that she did not possess the requisite educational, licensing, and training and experience requirements to perform the duties that she was being asked to do?*

A12. the Whistleblower informed me of her concerns regarding her license around the 21- 22 December2010. When the Whistleblower verbalized concern that by performing such duties would jeopardize her license, I immediately checked with my supervisor, Dep. Cdr for Nursing, I had the SOP's and protocols (all enclosed) reviewed by the Public Health Command to ensure they were aligned with other standard MTF practices, and I received direct confirmation by a Consultant of the Board of Nursing in the State California that the duties fell within the scope of practice for any RN. At that time, as department group, I , Sup Prev Med. Phys. and Occ. Health Nurse (CHN), individually, and together discussed with the Whistleblower that these were the protocols set by the MTF and she had no need to worry about her License. The following day I received and e-mail message (see enclosed) where she addressed her concern to me and my supervisors. At this time, and never before did I learn of her concern regarding the label on the INH refill medication which had her name on them as the provider. She had without my knowledge gone to the Chief of Pharmacy about that same time to have him remove her name. Had she come to me first with this particular concern, we could have resolved it immediately with Sup. Prev. Med. Phys. name being the default as he is the Preventive medicine physician.

Q13. Once informed of her lack of requisite educational, licensing, training or experience, did you, or anyone else in the Whistleblower *supervisory chain of command knowingly direct her to continue to perform duties for which she was not properly trained or qualified to perform?*

A13. the Whistleblower was never told she lacked the educational, licensing, training or experience to perform her duties. She had initialed all the documentation provided earlier for her training and orientation in the programs pertaining to Community Health Nursing. She was directed to perform her duties according to which she was hired to perform.

Q14. Did you or anyone else in the Whistleblower *supervisory chain of command threaten her with adverse or disciplinary action if she did not continue to perform any duties, to include ordering and interpreting sexually transmitted infection (STI), tuberculosis and hepatic enzyme tests and to refilling*

INH prescriptions, that she should not perform due to the lack of educational, licensing, training and experience requirements?

A14. the Whistleblower was counseled first informally with a joint and participative discussion to perform the duties according to the SOP for STI's and Tuberculosis Surveillance. Once she verbalized she refused to perform those duties, I checked with the Human Resources for guidance on follow up courses of action of which in the Table of Punishments stated written counseling are titled Memorandum of Warning. She was then given a written counseling statement to perform her duties (See attached counseling (Memorandum of Warning), I had Sup. Prev. Med. Phys., Preventive Medicine physician present for counseling.

Q15. Has the Whistleblower *been disciplined or received any adverse actions as a result of her informing you that she should not be performing duties of a CHN?*

A15. the Whistleblower has received 2 written counseling statements regarding the expectations for her to perform her duties as a CHN. (See Enclosures)

Q16. Was any patient injured as a result of the Whistleblower *actions performing the duties required by you, or anyone else in* the Whistleblower *supervisory chain of command.*

A16. No patient was injured as a result of the Whistleblower actions. However, there is evidence the Whistleblower neglected to document on follow up cases. (see attached)

Q17. Do the acts of yourself or anyone else in the Whistleblower *supervisory chain of command requiring her to perform these duties constitute a substantial and specific danger to public health or safety?*

A17. No, they do not.

Chief, Prev. Med. Div

STATEMENT OF Chief, Prev. Med. Clinic TAKEN AT Lyster AHC DATED 2011/05/17

9. STATEMENT *(Continued)* SEE ATTACHED SWORN STATEMENT

Chief, Prev. Med. Clinic

Chief, Prev. Med. Clinic

Chief, Prev. Med. Clinic

Chief, Prev. Med. Clinic

AFFIDAVIT

I, Chief, Prev. Med. Clinic, HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1, AND ENDS ON PAGE 6. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

Chief, Prev. Med. Clinic
(Signature of Person Making Statement)

WITNESSES:

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 18 day of MAY 2011 at Lyster Army Health Clinic

Investigating Officer
(Signature of Person Administering Oath)

Investigating Officer, IO
(Typed Name of Person Administering Oath)

Article 136, UCMJ
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

TAB N-1

MCXY - Pal

Chief, Prev. Med. Clinic

From: Redacted
nt: Tuesday, December 28, 2010 9:32 AM
o: Redacted

Subject: Error in AHLTA Regarding Provider Status

Dep. Cdr for Clin. Serv., Dep. Cdr for Nursing, Chief, Prev. Med. Clinic and Sup. Prev. Med. Phys.,

On December 23, 2010 Chief, Prev. Med. Clinic and I had a discussion regarding ordering STD labs without a physician, nurse practitioner or physician assistant examining the patient. I told Chief, Prev. Med. Clinic Chief, Prev. Med. Clinic that it was not in my scope of practice to order labs or medications under my name as that constitutes practicing medicine without a license,which is criminally prosecutable.

Under my registered nurse scope of practice, labs and refills for medications must have a physician, nurse practitioner or physician assistants'' name on them with a written order from them. I told Chief, Prev. Med. Clinic that I felt that patients, requesting an STD test should be examined/evaluated by a physician, nurse practitioner or physician assistant, as there could be other medical problems.

My 36 years as a registered nurse has allowed me to order labs with a current dated written doctor's order and with the physician, nurse practitioner, or physician assistant as the provider on the lab slip. I have practiced in several states and the registered nurse scope practice is consistently uniform.

After the discussion with Chief, Prev. Med. Clinic, I spoke with a nurse practitioner and registered rse in the LAHC Adult Medicial Clinic. They concurred with me that I should be ordering n AHLTA under a physician, nurse practitioner or physician assistants' name as provider and not under my name as provider. The registered nurse then showed me how to order under that system; which I had not been shown, when I was briefly orientated to the Preventive Medicine CHN LTBI function.

It was at this time that I discovered I was in the list of providers erroneously and all that I had ordered was under my name as provider, not Sup. Prev. Med. Phys. name. This needs to be corrected immediately as my name should not be on bottles of INH. I should not be able to order anything with my name as provider, as I am not a provider. I am a nurse and this is not within my scope of practice.

I do not have a problem placing lab orders in AHLTA under Sup. Prev. Med. Phys. name as provider, under a current SOP and electronically transferring the chart to him after I have completed my nursing charting, so that he may continue or discontinue medication refills as he deems from the written assessment of the LTBI patient.

I have asked for current signed and dated specific SOPs for LTBI, HIV, STD and notifiable diseases several times since September 2010. As of December 23, 2010, only the HIV has been sent forward to command for review and possible implementation. There is not an SOP for notifiable diseases. I have emailed all Army CHN and APHN for their SOPs . When I received an SOP from WRAMC for HIV, Chief, Prev. Med. Clinic, Sup. Prev. Med. Phys. and I met to revise it to meet Lyster's needs. I have also received SOPs for STD, LTBI and notifiable diseases from other Army facilities and shared them with Chief, Prev. Med. Clinic so that LAHC PM SOPs could be updated, reviewed and signed into official implementation.

I am awaiting correspondence from the California Board of Registered Nurses, CMS and Joint Commission regarding these matters as I consider my nursing license in jeopardy. I have also consulted with an attorney regarding any variances of employment position description.

TABN-1

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I am awaiting correspondence from the California Board of Registered Nurses, CMS and Joint Commission regarding these matters as I consider my nursing license in jeopardy. I have also consulted with an attorney regarding any variances of employment position description.

Thank you for your time and prompt attention to this matter.

Respectfully Yours,

Whistleblower

Classification: UNCLASSIFIED
Caveats: NONE

Classification: UNCLASSIFIED
Caveats: NONE

TAB N-2

DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES ARMY AEROMEDICAL CENTER
BUILDING 301 ANDREWS AVENUE
FORT RUCKER ALABAMA 36362-5333

MCXY-PM 4 January 2011

MEMORANDUM FOR Whistleblower , U. S. Army Aeromedical Center, Lyster Army Health Clinic, 301 Andrews Avenue, Fort Rucker, Alabama 36362

SUBJECT: Memorandum of Warning

1. You are hereby warned of stating to fail to observe written standard order of procedures for Sexually Transmitted Diseases Patient Management Procedures, LAHC Regulation No. 40-554. The following incident led to this warning.

a. On 23 December, 2010, the preventive medicine staff reviewed and discussed the Sexually Transmitted Disease Patient Management Procedures, LAHC Regulation No. 40-554. You expressed concern about your understanding of scope of practice for ordering labs or medications without a prior examination from a physician, physician assistant, nurse practitioner or equivalent. Your verbal expressions were absolute and adamant that under no circumstances would you comply with this Standard Operating Procedure. (Provide brief but specific details. Include specific incidents, names, dates, times, words stated, rules, regulations, instructions violated, etc.)

b. On your behalf, based on your concern, I immediately took the document to the Deputy Commander for Nursing and patient care services for guidance. It was made clear, the LAHC Regulation had been approved by deputy officials and had no discretionary guidelines or was written outside of the federal guidelines for safe medical practice according to military, Department of Defense, civilian or private rule. (Use as many subparagraphs as necessary.)

c. On 28 December, 2010 you addressed me, your immediate supervisor, the Deputy Commander for Clinical Services, Dep. Cdr for Clin. Serv., the Deputy Commander for Nursing, Dep. Cdr for Nursing , and the Preventive Medicine Physician, Sup. Prev. Med. Phys. in writing that you refuse to comply with the LAHC regulations for ordering lab tests for patients who have not been prior examined by a physician or equivalent. In addition, you wrote you would not order INH refill medications as directed according to the LAHC policy.

d. Again, I proceeded in your favor to investigate the guidelines according to Army policies for Army Public Health/ Community Health Nursing Practices. I also researched the guidelines for Board of Registered Nurses in California. As result, Army Public Health Nurses do not practice under a Privilege-base but a Protocol-based Practice (Reference APHN/CHN Newsletter, June 2008, "Privileging & RVUs".) In addition, I contacted the regional APHN Consultant to verify other STD SOP's.

e. According to the California Board for Registered Nurses, Example A (Process Protocol) page 7-21 clearly states,

" nurses may perform the following functions within their training specialty area and consistent with their experience and credentialing: assessment, and treatment of episodic illnesses, chronic illness, contraception, and the common nursing function of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies, recommending diets, and referring to specialty clinics when indicated. Standardized

TAB N-2

procedure functions such as managing medication regimens, are to be performed in (list area, i.e., short appointment clinic)."

f. You informed me on 3 January, 2011 you had spoken with the Chief of Pharmacy, Chief, Dept. of Pharm. with regards to removing your name from any future INH medications. I received an e-mail message from him requesting to speak with me about your request for this change. At this point in time, I have not had the opportunity to speak with him, but this action is another attempt to not comply with the current standard operating procedures, in addition it can be an example of insubordination.

2. The purpose of this warning is to assist you in correcting your behavior and to inform you that this type of conduct is not to occur again.

3. I will continue to work with you in allowing the freedom for reviewing standard Operating Procedures in so that they may be rewritten clearer to suit your personal understanding. It must be noted the current Standard Operating Procedures for all Army Public Health nursing functions were and currently are in compliance with MEDCOM policies and procedures.

4. If I may be of further assistance to you, please contact me. This is extremely important, because continued conduct of this nature may result in the initiation of formal disciplinary action against you which may include your removal from Federal Service. This document will **not** be forwarded for inclusion in your Official Personnel Folder, but it will be maintained in your organizational employee record folder. It will be used to support future actions prompted by any recurrence of behavior referenced herein.

5. If you believe that a personal problem may be affecting your conduct and/or performance, with your concurrence, I will arrange for an appointment for you with the Employee Assistance Program Coordinator at this installation.

Chief, Prev. Med. Clinic

Chief, Prev. Med. Clinic
MAJ, AN
Chief, Preventive Medicine

Employee Refused to sign would Above from her lawyer. Abruptly left office stating I

MCXY-PM

ACKNOWLEDGEMENT OF RECEIPT:

This is to certify that I have received a copy of this memorandum:

_____ Date: _____
(Employee Signature)

TAB N-3

04JAN2011

Memorandum for the Record

SUBJ: LETTER OF WARNING ICO Whistleblower

1. I was present during the meeting between Chief, Prev. Med. Clinic and Whistleblower during which Chief, Prev. Med. Clinic presented a letter of warning for Whistleblower to read.
2. Whistleblower began reading the letter and stopped before completing to comment that she does not refuse to renew Latent TBI medications, but they cannot be under her name as the prescribing official. Chief, Prev. Med. Clinic asked her to read the complete letter and that Whistleblower would be given the opportunity to write her comments related to the content of the letter.
3. Whistleblower appeared to disregard this comment and expounded on supporting her argument that she is not authorized to have her name on prescriptions.
4. Chief, Prev. Med. Clinic again asked her to read the entire letter. Whistleblower continued to defend her argument that she cannot sign prescriptions and as far the STD procedures are concerned that the protocols need to be more precise.
5. Chief, Prev. Med. Clinic began to provide the documents and guidance that do authorize Whistleblower Whistleblower to perform the functions discussed in the Letter of Warning, I assume because Whistleblower did not appear to want to read the letter in its entirety but discuss each item as she read them.
6. When Chief, Prev. Med. Clinic began this process, Whistleblower appeared to dismiss Chief, Prev. Med. Clinic Chief, Prev. Med. Clinic explanation just as it began, stating something like, "and if I don't do this you will fire me, I guess you just want me to leave, so I am going to leave". Whistleblower took her copy of the letter of warning and left Chief, Prev. Med. Clinic office.
7. Whistleblower did not sign the letter for Chief, Prev. Med. Clinic, but I do not remember clearly that Chief, Prev. Med. Clinic told her to sign the letter after Whistleblower completed reading it. However, it did not appear to me that Whistleblower actually completed reading the letter.

Sup. Prev. Med. Phys.

Sup. Prev. Med. Phys.

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TAB N-4

SENIOR SYSTEM CIVILIAN EVALUATION REPORT SUPPORT FORM

For use of this form, see AR 690-400; the proponent agency is ASA(M&RA)

PART I - RATEE IDENTIFICATION

a. NAME OF RATEE *(Last, First, Middle Initial)*	b. PAY PLAN, SERIES/GRADE	c. ORGANIZATION/INSTALLATION
Whistleblower	GS-0610-11	LYSTER ARMY HEALTH CLINIC

PART II - RATING CHAIN - YOUR RATING CHAIN FOR THE EVALUATION PERIOD IS:

	NAME	POSITION
RATER	Chief, Prev. Med. Clinic	CHIEF, PREVENTIVE MEDICINE
INTERMEDIATE RATER *(Optional)*		
SENIOR RATER	Dep. Cdr for Nursing	DEPUTY COMMANDER FOR NURSING

PART III - VERIFICATION OF FACE-TO-FACE DISCUSSION

The following face-to-face discussions of duties, responsibilities, performance objectives, standards, and accomplishments for the rating period 20100830 to 20110829 took place:

	DATES	RATEE INITIALS	RATER INITIALS	INTERMEDIATE RATER INITIALS	SENIOR RATER INITIALS *(If used)*	DATE
INITIAL	20100917	Whistleblower	Chief, Prev. Med. Clinic		Dep. Cdr for Nursing	17 Sep 10
MIDPOINT						

PART IV - RATEE *(Complete a, b, c below for this rating period)*

a. STATE YOUR SIGNIFICANT DUTIES AND RESPONSIBILITIES. DUTY TITLE IS:

Serves as Community Health Nurse for the Fort Rucker community. Plans, implements and evaluates health education classes for beneficiaries and civilian employees. Responsible for the coordination and implementation of the installation Sexually Transmitted Diseases, HIV Awareness Program and Latent Tuberculosis Surveillance. Creates health promotion and wellness training for all units installation wide. Provides counseling and education to families and Soldiers affected by communicable diseases. Conducts epidemiological investigations of patients with communicable diseases, bloodborne pathogens, and all other eportable infections. Assists with the Child and Youth Services as a medical consultant and conducts monthly inspections and monthly mandatory classes on medication administration, bloodborne pathogens, and communicable diseases. Conducts Tobacco Use Cessation classes and provided 1.1 counseling for individuals as needed. Assumes additional duties as requested.

b. INDICATE YOUR MAJOR PERFORMANCE OBJECTIVES/INDIVIDUAL PERFORMANCE STANDARDS

ACCESS:
1. Complete orientation at the Immunization Clinic front reception desk area with in/out processing clients and completing Alabama Blue Cards, and assists with documentation during the Flu Season Campaign.
2. Will conduct at least 10% of the Tobacco Use Cessation Classes (once certified) and be available for conducting 1.1 counseling.
3. Will conduct a minimum of 4 classes on the topic of communicable disease prevention and or Health Promotion and Wellness to various units on the installation.

SATISFACTION:
1. Will receive at least a 95% rating of "completely satisfied" by STD/TB patients of from classes taught.

OUTCOMES:
1. Will contact all referrals and consults received by AHLTA/CHCS within 72 hours received.
2. Will complete all documentation entries in AHLTA within 72 hours per organization policy.
3. Will conduct a minimum of 3 CYS, CDC, and FCC inspections and 2 Classes to the CDC staff

COMMUNICATION:
1. Prepare monthly reports and submit to the Investigation Prevention Team, the Army for Cases Overall and quarterly report to the Chief, Preventive Medicine within the allocated timeline.
2. Will maintain 100% tracking of all TB, STD, and HIV cases evaluated by the Clinic.

RESOURCES:
1. Establish a relationship with local and State of Alabama Public Health Department.

TAB N-4

TAB N-5

ORIENTATION & COMPETENCY

TRAIN-S

September 2010

Whistleblower

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	APEX / IMD TRNG	AKO address	1 RECEIVED CAC	2 TRAINING	3 TRAINING	4
5	6	7 CYS - BRIEF ORIENTATION NPI # Reg. STD REPORT APEX	8 APEQ DIMHRSI train SNAPS LTB orient	9 MCE Warrant OH training personnel discuss training needs. APEQ STD orient	10 Mtg health fair LTB pt. call from Redacted APEQ	11
12	13 Notif Disease report - Diarrhea QMES W.O. Training SOP search archive APDES	14 SOPs - Read Public Health Conf. Epi charts Warrant OHTR Fed Home Sleep Smoking Cess	15 NPI CASHI - DT APEQ Review lost injury SOP - Sensitive data Review FMH safety AR-40-5 SOP smoking cess assist	16 Safety Stand Down	17 NPI # STD contact tracing in AIMES Workshop getting NPI CORNET and Kidder Workshop prevention hygiene & otitis info	18
19	20 New Comp'n Orient	21	22 Orient HS 2hr AHLTA given paperwork for STD pt x 2 and 1 notifiable to comp myself	23 Computer training STD Presentation for WOCC	24 Retirement mtg STD training called & coordinated on LTBI pt & STD counseling referred to Sup. Prev. Med. Phys. Occ. Health Nurse	25
26	27 Sent STD CODING TRAINING	28 Std sent to HD training on Epi: completed STD pt, self hiring people, Cato & [illegible] AHLTA. 2 employees [illegible] health dept. [illegible] Sup. Prev. Med. Phys. Ft. Worth Office Redacted AHLTA	29 1 HB 1 std training on new Epic software AHLTA doc	30 1 std 1 epi AHLTA doc		

October 2010

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4 ØCHCSi appt com Presentation faxed [illegible]	5 ØCHCSi appt com	6 LTB, [illegible], EPI, CYS, [illegible]	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

TAB N-6

INITIAL COMPETENCY ASSESSMENT

Lyster Army Health Clinic, Fort Rucker, AL: Army Public Health Nursing

Patient Population Served: ☐ Infants ☐ Toddlers ☐ Preschool ☐ School Age ☐ Adolescents ☐ Adults ☐ Older Adults

Employee Name: Whistleblower Assessment Start Date: 7 September 2016 Completion Date: 13 October 2016

Required Competency or Skill	* Self Assess	Orientation (Preceptor initials & date)	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources
Organization (all staff)	CRITICAL THINKING: *Communicates this information to the staff and seeks every opportunity to make the vision a reality.*				
A. Knowledge of the Mission and Vision of:	1				
(1) Lyster Army Health Clinic	1				
(2) Department of Preventive Medicine Service	1				
(3) Army Public Health Nursing and Health Promotion	1				
B. Verbalizes understanding of roles & responsibilities of	1				
(1) Commanders and Deputies	1				
(2) Department Chief	1				
(3) Section Supervisor	1				
(4) NCOIC	1				
Team Work (all staff)	CRITICAL THINKING: *Communicates appropriate information to members of the team in a courteous, professional, and approachable manner. Maintains professional composure at all times, ensures thoroughness in patient care, and manages conflicts appropriately and in a timely manner.*				
A. Demonstrates ability to communicate and use effective interpersonal skills with colleagues and other members of the health center	1				
B. Fosters a positive work environment and encourages team work	1				
C. Verbalizes knowledge of patient and staff rights and responsibilities	1				
D. Ensures customer satisfaction with familiarization of installation community services	1				
E. Demonstrates appropriate time management skills	1				
F. Ensures a safe environment for patients/families/ staff, identifying health & safety risks & takes appropriate and immediate steps to alleviate the risk	1				
G. Demonstrates knowledge of current status of CHN Performance Improvement (PI Projects)	1				
Managing and Supervising for the Chief, CHN section	CRITICAL THINKING: *Appropriately delegates authority, accountability, and duties for Community Health Nursing functions and responsibilities. Assists with developing policies and procedures and standards of care for all staff, patients, visitors, and contractors. Fosters multidisciplinary collaborative relationships among other services to ensure provision of quality care. Prioritizes tasks and manages time schedules, personnel, and resources to meet department goals and health and safety standards.*				
A. Knowledge of time and attendance policies for staff	1				
B. Knowledge of proper procedures for reporting patient/ staff injuries/ illnesses.	1				
C. Knowledge of annual appraisal and periodic counseling procedures	1				

* Self Assessment:
1 = Experience
2 = Needs Practice/Assistance
3 = Never Done

NA = Not A able

+ Evaluation/Validation Methodologies:
T = Tests
D = Demonstration/Observation
V = Verbal

I = Interactive Class

Clinical Skills Reference:
Professional Licensure and Scope of Practice
AR 40-5 Preventive Medicine

Required Competency or Skill	* Self Assess	Orientation (Preceptor initials & date)	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources
D. Knowledge of setting performance standards for staff	1				
E. Knowledge of managing and projecting CHN budget	2	N/A			
F. Ensures appropriate qualified and competent staff	1				
Infection Control Procedures (all staff)	**CRITICAL THINKING:** ***Demonstrates ability to identify and reduce the risks of acquiring and transmitting infections between patients, employees, and visitors.***				
Refers to and implements the LAHCInfection Control Policies	2	Occ. Health Nurse			
Recognizing Abuse and Neglect (all staff)	**CRITICAL THINKING:** ***Treats patient and family with dignity and respect with emphasis placed on their psychological needs. Refer to AR 608-18 for additional information.***				
Knowledgeable of identifying high risk families or an abusive home environment of patients and reporting procedures	1	Newborn's			
Staff Education for Chief, CHN	**CRITICAL THINKING:** ***Involves all staff members and encourages their participation at all levels of the organization.***				
Provides opportunity for staff education and professional development	1	N/A			
Community Health Nursing: Overview (all staff)					
A. Demonstrate a working knowledge of the fundamentals of CHN	1	Occ. Health Nurse			
B. Conduct patient and program assessments and guidance to CHN staff	1	Occ. Health Nurse			
C. Ability to make appropriate referrals to other safety and health professionals.	1	Occ. Health Nurse			
D. Knowledgeable of immunizations	1				
a. demonstrates proper administration of b. Verbalizes indications and contraindications for basic vaccines c. Provides proper patient education d. Adheres to infection control procedures	NA	Occ. Health Nurse			
E. Ability to conduct individual counseling on various subjects.	1				
F. Develop, plan and implement mass screening such as immunizations, blood pressure, cholesterol and PPD testing.	NA				
G. Ability to demonstrate knowledge and skill to provide care for appropriate age of patients served such as infants, children, adolescents and adults.	1	Occ. Health Nurse			
H. Provides various health education topics to individuals and groups	1				
I. Communicable Disease monitoring and reporting. a. Familiarization with CDC and county guidelines b. Ability to conduct case contact interview c. Verbalizes common STD's and management of disease to include signs and symptoms d. Correctly completes required reports and documentation e. Orders appropriate labs f. Provides proper patient education g. Follows proper referral procedures to HCP	2	Occ. Health Nurse Occ. Health Nurse Occ. Health Nurse Occ. Health Nurse Occ. Health Nurse Occ. Health Nurse Occ. Health Nurse			

* Self Assessment:
1 = Experienced
2 = Needs Practice/ Assistance
3 = Never Done
NA = Not Applicable

+ Evaluation/Validation Methodologies:
T = Tests
D = Demonstration/Observation
V = Verbal
I = Interactive Class

Required Competency or Skill	* Self Assess	Orientation (Preceptor initials & date)	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources
h. Inputs visit into CHCS and AHLTA					
i. Monitors other reportable medical events		Nu Occ. Health Nurse			
j. RMES competency	2				
J. Interfaces with community, local, state and federal agencies.	2	Occ. Health Nurse			
K. Identifies and utilizes civilian and military health care resources.	2				
L. Knowledge of unit SOP's, infection control, EMP	2	Occ. Health Nurse			
M. Knowledge of Tobacco Cessation Program					
a. DOD CPGs					
b. Conducts pre-screening					
c. Conducts classes					
d. Provides accurate patient education	2				
N. Adheres to TJC accreditation standards, federal and local standards, DA regulations, LAHC specific policies and procedures, departmental/unit specific SOPs.	2				
Tuberculosis Surveillance Program Overview					
A. TB SCREENING:					
a. Correct administration of TB skin test (TBST)	NA				
b. Correct Interpretation of TBST	NA				
c. TB Screen for those with past positive test	NA				
d. Initial screening for signs and symptoms	2				
B. INITIAL EVALUATION OF LTBI PT:	2				
a. Referral Management	2	Occ. Health Nurse			
b. Complete assessment interview	2	Occ. Health Nurse			
c. TB Education	2	Occ. Health Nurse			
d. Refer for appropriate F/U	2				
e. Order appropriate Labs and Chest X-Rays	2	Occ. Health Nurse			
f. Complete documentation	2				
g. Schedule appointments with designated provider	2	Occ. Health Nurse			
C. MONTHLY VISIT WITH CHN:	2				
a. Assess for medication side effects	2				
b. INH Clinic Flow Sheet	2				
c. Conduct F/U Education	2				
d. Refill medication if indicated	2				
e. Order F/U Labs if indicated	2				
f. Schedule F/U appointment	2				
g. Track/Reschedule No-shows	2				
h. Document in CHCS and AHLTA	2				
i. Refer abnormal findings to designated provider	2				
D. ACTIVE TB MANAGEMENT:	2				

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2 = Needs Practice/ Assistance
3 = Never Done
NA = Not Applicable

+ Evaluation/Validation Methodologies:
T = Tests
D = Demonstration/Observation
V = Verbal
I = Interactive Class

Required Competency or Skill	* Self Assess	Orientation (Preceptor Initials & date)	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources
a. Correct referral of suspected Active TB	1	Occ. Health Nurse			
b. Identification of contacts needing testing	2	Occ. Health Nurse			
c. Follow-up contact testing procedures	2	Occ. Health Nurse			
d. Facilitates follow-up appointments for Active TB PT's	2	Occ. Health Nurse			
Child and Youth Services – Health Consultant (all staff)					
A. Verbalizes knowledge of AR 609-10 and CYS SOP	2	Occ. Health Nurse			
B. Completes all inspection forms correctly	2	Occ. Health Nurse			
C. Knowledge of SNAP process	2	Occ. Health Nurse			
D. Demonstrates ability to thoroughly complete inspections of SAS, YS, FCC and CDC	2	Occ. Health Nurse			
E. Verbalizes knowledge of current childhood immunization requirements	2	Occ. Health Nurse			
F. Familiar with installation and regional inspections	2	Occ. Health Nurse			
G. Demonstrates ability to conduct CYS staff training	2				
HIV Program					
A. Verbalizes knowledge of AR 600-110 and CHN SOP	2				
B. Verbalizes knowledge of notification procedure for positive HIV	2				
C. Provides complete and accurate PM counseling	2				
D. Completes all required forms	2				
E. Knowledge of reporting procedures	2				
F. Knows referral procedures to chaplain, HCP, Behavioral Health	2				
G. Maintains strict confidentiality and management of records	1				
H. Thorough knowledge of HIV, transmission and treatment	2				
I. Conducts thorough contact investigation and interviews	1				
Equipment and Systems (all staff)	CRITICAL THINKING: *Describes the capabilities, limitations and special applications of each item of equipment. Demonstrates basic operating and safety procedures for equipment items. Reports routine problems with equipment. Identifies emergency procedures in the event of equipment failure. Describes the process for reporting user errors and/or patient incidents. Performs actions IAW unit SOP and RWBAHC Regulations*				
A. Computers	1				
B. Printers	1				
C. Vital sign monitoring equipment	1				
D. Audio/Visual equipment	1				
E. Digital camera	NA				
F. Fax/Copier	1				
G. Identifies unserviceable equipment and makes arrangements for repair	1				
H. Maintains all equipment within specific calibration criteria.	1				
I. MEDPROS	3				
J. DTS	3				

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3 = Never Done
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+ Evaluation/Validation Methodologies:
T = Tests
D = Demonstration/Observation
V = Verbal
I = Interactive Class

Lyster Army Health Clinic **Army Public Health Nurse**

Required Competency or Skill	* Self Assess	Orientation (Preceptor initials & date)	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources
9-23-10 9/22/10					
K. CHCS and AHLTA	3				
L. DMLSS	3				
M. RMES DMRS	2				
Supplies (all staff)	**CRITICAL THINKING:** ***Ensures appropriate supplies are on hand and non-standard items are ordered in sufficient amount of time. Maintains a safe environment appropriate for the age specific population. Ensures that all supplies are secured to maintain a safe environment.***				
A. Maintains an appropriate level of supplies	1				
A. Knowledge of how to obtain supplies	1				
C. Conserves supplies	1				

Preceptor's Initials: _____ Printed Name: _____ Signature: _____

Preceptor's Initials: _____ Printed Name: _____ Signature: _____

I understand that of all the topics listed, I will be allowed to perform only those for my skill level/scope of practice and only after I have successfully demonstrated competency.

Employee Signature: _____ **Date:** _____

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1 = Experienced
2 = Needs Practice/ Assistance
3 = Never Done
NA = Not Applicable

+ Evaluation/Validation Methodologies:
T = Tests
D = Demonstration/Observation
V = Verbal
I = Interactive Class

TAB N-7

DEPARTMEN T OF THE ARMY
HEADQUARTERS UNITED STATES ARMY AEROMEDICAL CENTER
BUILDING 301 ANDREWS AVENUE
FORT RUCKER ALABAMA 36362-5333

MCXY-PM

5 October 2010

MEMORANDUM FOR: Whistleblower

SUBJECT: Counseling

1. **PURPOSE:** This counseling statement is designed to outline my expectations of you as a member of the Preventive Medicine Department (PM), Lyster Army Health Clinic (LAHC) with regards to the directive training of new Community Health Nurse personnel.

2. **ADMINISTRATIVE:** As a member of the PM, LAHC team, I expect you to adhere to all departmental, clinic and USAAMC policies and regulations, your job description and this counseling statement and to support the mission and vision of the Lyster Army Health Clinic.

3. **RESPONSIBILITIES:**

a. You are expected to complete training with Occ. Health Nurse , on the assigned programs of Community Health Nursing consideration to flexibility, respect and friendliness within but not limited to the specific time period appropriated. Good communication skills are essential to your position and important not only in dealing with patients, but equally important when dealing with co-workers or other staff members.

b. The time period allotted to complete training for you , Whistleblower , as the newly hired Community Health Nurse will be 13 October 2010. The competency sheet provided by the department will be signed by you and Occ. Health Nurse after each function has been agreed by both as received understanding of the task.

c. As the management of LTBI, HIV, STI and Epidemiological cases fall into a situational training opportunity, both you and Occ. Health Nurse will make sure only sudden or emergent appointments will interrupt your available office and training time.

d. I expect you to keep me apprised of situations of activities that may impact on the Department either in a positive of negative manner. Please report immediately any form of activity which can be interpreted as a "hostile Environment".

Chief, Prev. Med. Clinic

Signature Whistleblower
Date 07-OCT-2010

Chief, Prev. Med. Clinic
MAJ, AN
Chief, Preventive Medicine

TAB N-7

TAB N-8

October 11, 2010

MEMORANDUM FOR: Chief, Prev. Med. Clinic Chief, Preventive Medicine

SUBJECT: Counseling Training Memo Breach and Hostile Working Environment

The counseling memo I signed and received on October 5, 2010 has been breached and hostile environment has not improved.

The training check list was marked off by Occ. Health Nurse in accordance with the calendar which you had asked me to keep. She noted that she was to give me a list of child immunizations and did so. Occ. Health Nurse asked if I had any other questions. I then inquired about the 3 STI reports and who were they to be addressed and received an answer of Redacted , Redacted and Chief, Prev. Med. Clinic-no copies of the reports other than the one emailed on October 4th were provided from her. I also asked that I observe an initial evaluation of an LTBI patient. On October 7th, I told Occ. Health Nurse that I had an LTBI patient (that she had told me to telephone and have come into the clinic) coming in and asked her to go through the total initial evaluation. She told me she was going to go to the CDC and that I could ask Sup. Prev. Med. Phys. if I had questions as he was helpful.

In the memo it stated unless there was an urgent or emergent need, she would be available to train me. This CDC visit was one she had made with you. When she told me to call the patient in for evaluation she did not mention that she would not be available during that time or to have the patient come in at another time.

When I had asked where to contact an HIV patient's unit (for an email task she had received; told me it was my patient and I should contact him), I was told that he was in the band and his unit number was in the phone book. It happened to be a phone book I had not been given.

I had also been given information (on October 5th) for the monthly STI report to be mailed to a person who I could not locate in the global phone book. I asked another employee if there was another place to look and she called Occ. Health Nurse Occ. Health Nurse and found that the person had a different last name. This same type of incident later took place on Friday October 8th when Occ. Health Nurse told me to look in the HIV SOP to contact a Redacted . The SOP did not have Redacted Redacted name as a contact. I told her I did not see it-she came , looked at the SOP and pointed out that I was to call this person and then said "oh her name had changed".

I have had to take two initial evaluation patients by myself as she was gone from the department to the child care centers. I asked Sup. Prev. Med. Phys. for help with both patients. I do not understand how I am expected to be completely trained by October 13, 2010 and Occ. Health Nurse has not been available ,is not giving me the correct information I need to perform my job and the SOPs are not definitive in detailed instructions. I understand that you are going to update the SOP for LTBI and HIV. I also would like to state that there is no SOP for epidemiological cases.

I have been flexible, respectful and available to learn my position. I do not have any communication problems with any other employees at Lyster Clinic. In fact, the other employees in the Preventative Medicine Clinic have been extremely helpful. When Occ. Health Nurse asked if I would like to go to the CYS for an inspection, I eagerly agreed and we took separate cars (as she said we would be all afternoon and would go home from there).

When I ask Occ. Health Nurse a question, it is given a brief curt answer and twice I have been given the wrong information. I do feel that the hostile working environment has not improved. It has been and continues to be extremely stressful for me to work/train with Occ. Health Nurse and is not only impacting my work performance but also my health.

Whistleblower

TAB N-8

TAB N-9

Chief, Prev. Med. Clinic

From: Whistleblower Redacted
Sent: Tuesday, January 04, 2011 2:28 PM
To: Chief, Prev. Med. Clinic
Subject: Whistleblower Redacted

Chief, Prev. Med. Clinic

After the meeting this morning I became ill and I gave you report on the two Patients who needed medication refills and the two patients who had appointments tomorrow afternoon. I left the clinic because I became ill.

I still am not feeling well but feel that I should give the presentation to the warrant officers and will do so shortly.

Whistleblower

TAB N-9

TAB N-10

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: ISONIAZID (INH) CLINIC FLOW SHEET

OTSG APPROVED (Date): 27 August 1984

DATE STARTED INH: 11-01-10

CODES: NO YES CS (Comment Section

Today's Date	11-01-10	12-06-10 1	2	3								
Time												
# Months of INH	0											
SUBJECTIVE												
FATIGUE	Ø	Redacted	Ø									
NAUSEA	Ø	Ø	Ø									
LOSS OF APPETITE	Ø	Ø	Ø									
DARK URINE	Ø	Ø	Ø									
LIGHT STOOLS	Ø	Ø	Ø									
JOINT PAIN	Ø	Ø	Ø									
LOSS OF WEIGHT	Ø	Ø	Ø									
VISUAL CHANGES	Ø	Ø	Ø									
ELEVATED TEMPERATURE	Ø	Ø	Ø									
TINGLING HANDS/FEET	Ø	Ø	Ø									
OBJECTIVE												
RASH	Ø	Ø	Ø									
ICTERUS	Ø	Ø	Ø									
OTHER	Ø	Ø	Ø									
ASSESSMENT												
PATIENT TAKING MEDICATION	Yes	Yes	Yes									
SIDE EFFECTS NOTED	No	No	No									
PLAN/ACTION												
REFILL INH # 30	—	Yes	—									
REFILL B6 # 30	X											
PATIENT GUIDANCE PROVIDED	X											
REPEAT LIVER FUNCTION TESTS	DONE	(illegible)										
DISCONTINUE INH												
REFER TO MD	Y											
REFERRAL TO NEXT DUTY STA												
NEXT APPOINTMENT (Date)	12-06-10	1-06-10										
INTERVIEWER'S NAME	Whistleblower	Whistleblower										

Redacted

Redacted

you saw on 1-4-2011 but no documentation in AHLTA pt was seen - no meds ordered

Wendy ordered the meds for you over a telephone consult.

www.humana-military.com

COMMENT SECTION

Occ. Health Nurse

1-4-2011 - appt. w Whistleblower. will call for a February appt.

(Continue on reverse)

PREPARED BY (Signature & Title): Whistleblower

DEPARTMENT/SERVICE/CLINIC: Preventive Medicine Service

DATE: 11-01-10

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

TABN-10

NAME												
			1	2	3	4	5	6	7	8	9	10	11	12

DATE		BRANCH
-01-85	☒ AD ☐ RET ☐ DEP	☒ ARMY ☐ NAVY ☐ MARINE ☐ AF ☐ OTHER (Specify)

SPONSOR	RANK	SSN	UNIT ADDRESS	DUTY PHONE
20 AD	2001 ~~SGT~~			

HOME ADDRESS		HOME PHONE
1,3 6	1 36322	808-341-4351

ADMITTED	ATS CODE	CONTACTS CHECKED
☐ YES ☐ NO		☐ YES ☐ NO

☐ CLOSE ☐ CAS	DATE CONTACT TERMINATED

SI	CTOR	
	EGATIVE SKIN TEST	CONTACTS CHECKED
	TYPE	☐ YES ☐ NO

DATE	
July 2003	

DATE STARTED	LENGTH OF THERAPY

Next Appt 1/27/2011 @ 10^00

Redacted

Save this encounter on Tues 5th. w/in refill

Redacted

Redacted

*American Thoracic Society standard di

DA FORM 3887-R, AUG 90 Previous

REGISTRY

proponent agency is the OTSG

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: ISONIAZID (INH) CLINIC FLOW SHEET

OTSG APPROVED (Date): 27 August 1984

DATE STARTED INH: 1/5/2011

CODES: NO YES CS (Comment Section)

Today's Date	1/5/2011											
Time												
# Months of INH												

SUBJECTIVE

FATIGUE												
NAUSEA												
LOSS OF APPETITE												
DARK URINE												
LIGHT STOOLS												
JOINT PAIN												
LOSS OF WEIGHT												
VISUAL CHANGES												
ELEVATED TEMPERATURE												
TINGLING HANDS/FEET												

JECTIVE

RASH												
ICTERUS												
OTHER												

SSESSMENT

PATIENT TA												
SIDE EFFEC												

N/ACTION

REFILL INH												
T/REFI												
PATIENT GU												
REPEAT LIVE												
DISCONTINU												
REFER TO M												
REFERRAL T												

1/7/2011
PPD - results
PE - Test requested
Coming 11 JAN 2011 in afternoon to see Lawrence
You contacted but not seen?

Sup. Prev. Med. Phys.

www.humana-military.com

Redacted

NEXT APPOIN												
INTERVIEWER'S NAME												

COMMENT SECTION

12-17-10 - Called & pt. who stated he [illegible] to PM [illegible] 15 - pt unable to come to a pt CB 12-19 - A. phone busy signal. 1-4 - Called pt - pt to come in on 1-4 1-5-2011 - Pt. requested.

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
	Preventive Medicine Service	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first,

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 78 4700 USAAMC (PM) OP 92, 1 May 85

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: ISONIAZID (INH) CLINIC FLOW SHEET

OTSG APPROVED (Date): 27 August 1984

DATE STARTED INH: 8-16-10

CODES: NO YES CS (Comment Sectio

Today's Date	8/16/10	9/10/10	10/9/10	11/8/10	12-7-10	01-7-11						
Time	10:00											
# Months of INH	0	1	2	3	4	5						
SUBJECTIVE												
FATIGUE	Ø	Yes	Yes	Ø	Ø	Ø						
NAUSEA	Ø	Ø	Ø	Ø	Ø	Ø						
LOSS OF APPETITE	Ø	Ø	Ø	Ø	Ø	Ø						
DARK URINE	Ø	Ø	Ø	Ø	Ø	Ø						
LIGHT STOOLS	Ø	Bothersome	Ø	Ø	Ø	Ø						
JOINT PAIN	Ø	Ø new	Ø new	Ø	Ø	Ø new						
LOSS OF WEIGHT	Ø	Ø	Ø	Ø	Ø	Ø						
VISUAL CHANGES	Ø	Ø	Ø	Ø	Ø	Ø						
ELEVATED TEMPERATURE	Ø	Ø	Ø	Ø	Ø	Ø						
TINGLING HANDS/FEET	Ø	Ø	Ø	Ø	Ø	Ø						
OBJECTIVE												
RASH	Ø	Ø	Ø	Ø	Ø	Ø						
ICTERUS												
OTHER												
PATIENT TAKING MEDICATION												
SIDE EFFECTS NOTED												
REFILL INH # 30												
/REFILL B6 # 30												
NT GUIDANCE PROVIDED												
REPEAT LIVER FUNCTION TESTS												
DISCONTINUE INH												
REFER TO MD												
REFERRAL TO NEXT DUTY STA												
NEXT APPOINTMENT (Date)												
INTERVIEWER'S NAME												

Redacted

Saw Pt on Monday 10 Jan 2011 Prescribed Meds + Labs

You saw the pt on Tues 4 Jan in am but did not put in meds, Labs or documentation that you saw him in AHLTA.

Redacted

www.humana-military.com

COMMENT SECTION

9/10/10 Pt. diagram for 1 week" com — Sup. Prev. Med. Phys.

10/09/10 Pt. states he is not taking diagram currently. [illegible] fish back pain & states he is extremely tired. [illegible] medicine. 11/12 Pt. noted weight [illegible] — Sup. Prev. Med. Phys.

Pt. [illegible] 01-10-11 Patient in office stating "needing meds and back

(continue on reverse)

PREPARED BY (Signature & Title): Whistleblower

DEPARTMENT/SERVICE/CLINIC: Preventive Medicine Service

DATE: 10-15-10

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA 1 MAY 78 4/UU USAAMC (PM) OP 92, 1 May 85

Occ. Health Nurse

1-10-11 requesting hepatic profile. RN CHN
Refill of medications ordered and Hepatic
panel ordered. Occ. Health Nurse RN CHN

NAME (Last, First, MI)	1	2	3	4	5	6	7	8	9	10	11	12

DATE OF BIRTH	STATUS ☐ AD ☐ RET ☐ DEP	BRANCH ☐ ARMY ☐ NAVY ☐ MARINE ☐ AF ☐ OTHER (Specify)

SPONSOR	RANK	SSN	UNIT ADDRESS	DUTY PHONE

HOME ADDRESS (Include Zip Code)	HOME PHONE

ACTIVE CASE

ADMITTED ☐ YES ☐ NO	ADMITTED DATE	DISCHARGE DATE	*ATS CODE	CONTACTS CHECKED ☐ YES ☐ NO

CONTACT

☐ CLOSE ☐ CASUAL	CONTACT OF	DATE CONTACT TERMINATED

CONVERTER REACTOR

SKIN TEST RESULTS			LAST NEGATIVE SKIN TEST		CONTACTS CHECKED
DATE	TYPE	SIZE	DATE	TYPE	☐ YES ☐ NO

DRUG REGIMEN

DATE STARTED	TYPE	DOSE	FREQUENCY	LENGTH OF THERAPY

*American Thoracic Society standard diagnostic and therapeutic code.

DA FORM 3897-R, AUG 90 Previous editions obsolete.

TUBERCULOSIS REGISTRY

For use of this form, see AR 40-5; the proponent agency is the OTSG

REPORTED TO STATE/LOCAL HEALTH DEPARTMENT *(If yes, list name of State or Local Health Department and date reported.)*

☐ YES ☐ NO

X-RAY FINDINGS

DATE	TEST RESULTS	DATE	NOTES

RETURN VISIT ACTIONS *(Use pencil)*

Tab N-11

DEPARTMENT OF THE ARMY
UNITED STATES ARMY AEROMEDICAL CENTER
FORT RUCKER, ALABAMA 36362-5333

STANDARD OPERATING PROCEDURE 2 September 2008

Preventive Medicine Service
PRESCRIBING ISONIAZID (INH) CHEMOPROPHYLACTIC THERAPY
BY COMMUNITY HEALTH NURSES (CHNs)

1. PURPOSE: To provide a standard procedure for prescribing Isoniazid (INH) Chemoprophylactic Therapy.

2. SCOPE: This SOP is applicable to all personnel who prescribe INH therapy.

3. REFERENCES:

a. AR 40-5, Medical Services, Preventive Medicine, 22 July 2005

b. CDC TB Core Curriculum on Tuberculosis, What the Clinician Should Know, 4th Edition, CDC, 2000.

c. Control of Communicable Diseases, 2000.

4. GENERAL. All military and military dependents, retirees and their dependents, and Department of the Army Civilians working in a health care setting are eligible for INH Chemoprophylaxis regardless of age, if they are:

a. Recent Tuberculin Skin Test (TST) converters reactors whose TST has changed from negative or doubtful to positive (greater than 5mm in high risk individuals; greater than 10mm for individuals with other risks; and greater than15mm in individuals with no risk factors) within the past 2 years.

b. Induration of 5 millimeters (mm) or > is considered positive for the high risk groups listed below:

(1) Human immunodeficiency virus (HIV) positive persons.

(2) Recent contacts of a TB case.

(3) Person with fibrotic changes on chest radiograph consistent with old TB.

(4) Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of > or = 15mg/day of Prednisone for > or = one month).

THIS SOP SUPERCEDES SUBJECT SOP DATED 11 January 2007

c. Indurations of 10 millimeters (mm) or > is considered positive for the high risk groups listed below:

(1) Recent arrivals (<5 years) from high prevalence countries.

(2) Injection drug users.

(3) Residents and employees of high-risk congregate settings (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities).

(4) Mycobacteriology laboratory personnel.

(5) Persons with clinical conditions that make them high-risk (substance abuse, diabetes mellitus, silicosis, prolonged corticosteriod therapy, other immunosuppressive therapy, cancer of the head and neck, end stage renal disease, intestinal bypass, gastrectomy, chronic malabsorption syndromes, low body weight (10 percent or more below the ideal body weight), and hematologic and reticuloendothelial diseases).

(6) Children <4 years of age or children and adolescents exposed to adults in high-risk categories.

d. Induration of 15mm in persons with a positive TST who are younger than 35 years with no known risk factors.

e. Persons over 35 years of age should be carefully evaluated and INH chemoprophylaxis should be made on a case-by-case basis based on risk and time of likely exposure.

f. TST reactors with risk factors for the development of active TB should be placed on INH 9 months as indicated. Risk factors include those mentioned in 4b(5) above.

5. All clients prior to starting INH prophylaxis will be monitored for:

a. Possibility of TB disease with a medical history and chest x-ray.

b. History of treatment for TB infection or disease.

c. Contraindications for treatment, including previous INH associated hepatic injury, history of severe adverse reactions to INH, such as a drug fever, rash, or arthritis, and acute or unstable liver disease of any cause, liver function tests (LFTs) will be ordered.

d. Determine whether patient is at high risk for adverse reactions.

6. Clients who have any of the above contraindications will be cleared by a physician prior to being placed on INH chemoprophylaxis.

7. Appropriate drug treatment can be given to infected persons identified through screening, and chemoprophylaxis against the development of active disease can be administered to those at risk. INH administered orally is normally used for preventive therapy (300 mg) po daily for adults and 10-14 mg/kg body weight not to exceed 300 mg daily for children. Recommended length of INH chemoprophylaxis for adults and children is 9 months.

8. Education on the significance of a positive TST, the difference in TB infection and TB disease, the recommendation for treatment, and the possible adverse effects of INH will be given to all clients prior to beginning INH chemoprophylaxis. Clients will be given an opportunity to ask questions concerning their health status and recommended treatment.

9. All clients on INH chemoprophylaxis return monthly to Preventive Medicine to be assessed for adverse reactions, such as fatigue, nausea, dark urine, loss of appetite, light stools, loss of weight, visual changes, elevated temperature, tingling of hand/feet, rash, and icterus. LFTs will be ordered after 1 and 3 months of INH therapy and as clinically indicated. If transaminase levels exceed 3 to 5 times the upper limit of the normal range of the laboratory, the decision to discontinue INH prophylaxis should be strongly considered.

10. A local tuberculosis registry of all persons under medical surveillance will be maintained. This registry will serve as a current listing of all active and inactive cases and contacts requiring medical follow-up.

11. Pediatric clients up to 14 years of age with a positive TST will be assessed, treated and followed in Pediatric Clinic. A local tuberculosis registry will be maintained in Preventive Medicine on pediatric clients.

12. Clients with TB disease will be assessed and followed in Internal Medicine. A local tuberculosis registry will be maintained in Preventive Medicine on these clients.

LTC, AN
CHIEF, Preventive Medicine Service

PROTOCOL
COMMUNITY HEALTH NURSING INH CHEMOPROPHYLAXIS PROGRAM

1. OBJECTIVE. To describe the responsibilities and procedures used by Community Health Nurses (CHN) in the management of the INH Chemoprophylaxis Program.

2. SCOPE/RESPONSIBILITIES.

a. This protocol describes the conditions under which CHN's may renew prescriptions for Isoniazid (INH) and Pyridoxine (B6) and specifics the associated evaluation, referral, treatment, and surveillance processes.

b. The Primary Care Manager (PCM), Internal Medicine Physician, or Occupational Health Physician is responsible for the diagnosis of TB infection and the initiation and alteration of INH and Pyridoxine prescriptions. The CHN's are responsible for monitoring the patients, renewing prescriptions, and the termination of Isoniazid and Pyridoxine IAW procedures described below.

3. PROCEDURES.

a. Initial Evaluation:

(1) CHN will interview patient using DA Form 4700 (LAHC OP 62), Tuberculosis Surveillance Form (Enclosure 1).

(2) CHN will order chest x-ray (PA view), Liver Function Tests (LFT), and UA, CBC and HIV, as needed.

(3) DA Form 4700, LAHC OP Form 92, Clinic Flow Sheet will be filed in the patient's medical record (Enclosure 2).

(4) CHN will provide laboratory tests and radiology results for physician review. CHN will document laboratory results on DA 3897-R, Tuberculosis Registry Card (Enclosure 3).

b. Physician Evaluation.

(1) Physician will:

(a) Determine treatment regimen and document specific medication dosage, length of treatment, and referral to CHN for monthly surveillance on DA Form 4700 (LAHC OP 62).

(b) Approve the initial prescription for INH and if indicated, Pyridoxine based on CDC guidelines and prevention therapy. Determine the need for liver function tests in excess of baseline IAW AR 40-5, Preventive Medicine.

(c) Evaluate patients referred by CHN with possible/actual signs/symptoms of INH toxicity, questionable need for Pyridoxine, or other problems of concern to CHN.

(d) Peer review 10 percent of records monthly to ensure CHN compliance with protocol and document and report any significant findings to Chief, CHN or (C, PM).

(2) CHN will interview each patient after physician's evaluation and prescription for medication addressing the following:

(a) Review side effects of medication, procedure to follow if symptoms appear, and the need for monthly appointment for CHN surveillance and renewal of prescriptions. Give patient the INH Instruction Sheet for Preventive Therapy (enclosure 4).

(b) Note treatment regiment on TB Registry Card; make follow-up appointment.

(c) Ensure Master Problem List is documented with statement "TB infection, no disease, no further PPD".

(3) If physician determines that no INH prophylaxis or follow-up by CHN is needed, CHN will:

(a) Provide client education regarding no further need for TB skin testing or follow-up chest x-rays as medically indicated. The CHN will also inform the client of symptoms of active disease.

(b) Note decision on TB Registry Card.

c. CHN Follow-up

(1) CHN will interview patient monthly to determine compliance with medication regimen and to ascertain signs/symptoms of INH toxicity or side effects using DA Form 4700, LAHC OP Form 92.

(a) Patients with symptoms of possible INH toxicity and side effects (see flow sheet) will be told to discontinue medication and LFTs will be ordered. If LFTs are elevated three times above "normal" limits using reference range provided by LAHC laboratory, patient will be given a physician appointment. If elevated, but less than three times the normal limit, they will be monitored on a monthly basis until they return to baseline or go beyond the three times limit, at which point CHN will refer the patient to a provider immediately for evaluation.

(b) Patients with symptoms of possible peripheral neuropathy, complaints indicative of possible adverse effects, or other problems which CHN determines need physician evaluation will be given appointment for physician evaluation (telephone consultation may precede appointment to determine course of action).

(2) Patients without significant symptoms as described above will be given renewal prescriptions for one month supply of prescribed medications, e.g., Isoniazid and Pyridoxine.

(3) Patients who leave Fort Rucker prior to completion of therapy for PCS will be referred to the gaining installation and on ETS to the gaining civilian public health department on DA Form 3763, Community Health Nursing Case Referral (Enclosure 5) and will be provided a 90-day supply of medication.

(4) Patients who miss periods of prophylaxis (one week to one month) will have the equivalent time added on the length of the prophylaxis. Patients who miss more than one month at a time will resume medication until 9 months are completed in a 12 month time frame. Patients who continue non-compliance will be referred to the PCM.

(5) CHN will counsel patients at the end of the prescribed period of treatment regarding:

(a) No need for further CHN follow-up, TB skin tests, or periodic chest x-ray (CXR) as medically indicated.

(b) Symptoms of active disease.

(c) When to seek medical evaluation for symptoms.

(6) CHN will ensure that medication start and end dates are documented on the Master Problem List.

d. Non-compliance.

(1) Active duty who fails to keep scheduled appointments will receive telephonic notification of a re-scheduled appointment. Failure to keep two appointments will result in a telephone call to the Soldier's First Sergeant with patient information disclosure IAW HIPPA guidelines. If the Soldier is still not compliant, the Company Commander will be notified.

(2) Family members and retirees who do not keep appointments will be re-scheduled by telephone or mail. If they do not keep re-scheduled appointments they will be notified by mail that CHN follow-up has been terminated. Attempts to contact and termination of follow-up will be documented on SF Form 600 and forwarded to the outpatient record, with one copy remaining in CHN files.

(3) All clients are counseled at the initial interview and when they are started on INH regarding the importance of compliance with the prescribed regimen. Every effort will be made to coordinate the client's work, school, or personal schedule with the INH follow-up appointment to increase compliance.

4. REFERENCES.

a. AR 40-5, Preventive Medicine.

b. Core Curriculum on Tuberculosis: Division of Tuberculosis Elimination, Center for Prevention Services, Centers for Disease Control, Atlanta, Georgia, and the American Thoracic Society, New York, New York, Third Edition, 1994.

Occupational Health Physician
Preventive Medicine Service

MAJ, AN
CHIEF, Preventive Medicine Service

5 Enclosures:
1. DA Form 4700, LAHC OP 62, Tuberculosis Surveillance Form
2. DA Form 4700, LAHC OP 92, IHN Clinic Flow Sheet
3. DA Form 3879-R, Tuberculosis Registry
4. IHH Instruction Sheet
5. DA Form 3763, Community Health Nursing Case Referral

TAB N-12

DEPARTMENT OF THE ARMY
HEADQUARTERS LYSTER ARMY HEALTH CLINIC
Building 301 Andrews Avenue
Fort Rucker Alabama 36362-5333

LAHC Regulation
No. 40-554

17 June 2010

Medical Services

SEXUALLY TRANSMITTED DISEASES (STD) PATIENT MANAGEMENT PROCEDURES

Supplementation of this regulation and establishment of forms other than LAHC forms are prohibited without prior approval from HQ, LAHC, ATTN: MCXY-PM.

1. **HISTORY.** This issue publishes a revision of this publication.

2. **PURPOSE.** This document has been prepared to provide guidance to health care providers of the Lyster Army Health Clinic (LAHC) who, through their duties, participate in the medical and administrative management of clients suspected or confirmed to have a Sexually Transmitted Disease (STD). The Human Immunodeficiency Virus (HIV) is recognized as an STD; however, the ramifications of the disease are not covered in this document as they are specifically governed by AR 600-110.

3. **REFERENCES.**

a. AR 40-5, Preventive Medicine.

b. CDC MMWR Volume 55, Number RR-11, August 2006.

c. FM 4-02.33, Control of Communicable Diseases Manual, 18th Edition, 2004.

d. DA Pam 25-51, The Army Privacy Program-System of Records Notices and Exemption Rules, 30 April 1999.

4. **SCOPE.** This regulation is applicable to all personnel assigned and /or attached for duty at USAAMC, Fort Rucker, Alabama.

5. **GENERAL.**

a. The accurate identification, management, and timely reporting of STDs is an integral part of a successful disease control effort. Critical for prevention and control is the education and follow-up of patients and the investigation of known contacts. Cases of STD diagnosed within LAHC, and thus the health center's area of responsibility, will be reported to Preventive Medicine Services for entry into the Reportable Medical Events System (RMES) and reporting

*This Regulation supersedes USAAMC Reg 40-554, 1 June 2004

to the Alabama Department of Public Health (Confidential Disease Report ADPH-STD-15/Rev.7-01[BS]).

b. Guidelines for the prevention, treatment, and management of STDs are updated periodically by the Centers for Disease Control (CDC) and serve as the basis for patient care and case management at U.S. Army medical facilities (ref. b).

6. **PROCEDURES.**

a. All STD information is to be handled in a confidential manner IAW the Privacy Act of 1974, AR 340-21, and HIPPA requirements.

b. The CDC Sexually Transmitted Disease Treatment Guidelines should be followed for the management and treatment of STDs (Reference 3.b, this publication).

c. Clinical Departments:

(1) Diagnostic Protocol. Persons with signs or symptoms of an STD should have the following standard laboratory tests ordered as a minimum:

(a) Rapid Plasma Reagin (RPR) blood test.

(b) Chlamydia DNA.

(c) Neisseria Gonorrhea DNA.

(d) HIV blood antibody test (with consent statement except for active duty).

(e) Urinalysis.

(2) Additional tests will be ordered IAW the patient's history and exam. If the screening RPR is positive, a quantitative VDRL and FTA must be done for confirmation of Syphilis infection. Hepatitis B screening should be conducted on patients with risk factors who do not have documented evidence of Hepatitis B immunization. Specific risk factors are – a confirmed diagnosis of Gonorrhea/Syphilis/Chlamydia, sexually active homosexual or bisexual males, IV drug use, prostitution, multiple sexual partners (>1 in previous 6 months), irregular safe sex/condom use practice (<50% use). A Hepatitis B panel should be obtained consisting of HBsAg, HBcAb, and HBsAb. If screening tests are negative, refer to Immunization Clinic for Hepatitis B immunization. If screening tests are reactive, consult Preventive Medicine for further evaluation/guidance.

(3) Medical record entry will include the following:

(a) Diagnosis.

(b) Documentation of laboratory work ordered and results received.

(c) Contact interview with Community Health Nurse (CHN).

(d) Treatment.

(e) Test of Cure (TOC) appointment date if appropriate (not necessary for positive STDs, if treatment has been completed).

(4) All clients will be referred to Preventive Medicine Service (PMS) for contact interview, epidemiological interview, health education, counseling and follow-up management.

(a) During duty hours: Consults can be made by telephone to better attempt to coordinate the CHN process with the treatment. If a CHN is available, a walk-in visit will be promptly coordinated to assure continuity between the provider and the counseling. A consult for all STD patients is to be placed in AHLTA by the provider (the CHN is listed in AHLTA under A/P; Order Consults tab; Refer To - STD; Specialty-Community Health; Community Health Nursing). A patient should not be asked to make their own appointment with CHN.

(b) After duty hours: Treat patient appropriately and refer to Community Health Nursing the next day. Place the consult in AHLTA (see steps above).

(5) Follow-up Procedures:

(a) Centers for Disease Control and Prevention (CDC) recommends that patients who have uncomplicated Gonorrhea and Chlamydia who are treated with any of the recommended regimens need not return for a test of cure (TOC) - except in pregnant women.

(b) Clients diagnosed with Syphilis will be followed by PMS for VDRL titer testing at six and twelve months post treatment (also 24 months for Syphilis greater than one year).

d. Treatment Protocol: The Treatment Schedule (CDC, MMWR, Volume 55, Number RR-11, 4 August 2006) is provided in Appendix A.

e. Departmental Responsibilities:

(1) Deputy Commander of Clinical Services will:

(a) Ensure that all health care providers follow this STD protocol and are aware of the CDC recommended treatment standards.

(b) Ensure patients with presumptive or confirmed diagnosis of STD are referred to Preventive Medicine Service (PM) for epidemiologic investigation, education, and contact interview. The Public Health Nursing (PHN) section of PM will be the main proponent of the STD Control Program.

(c) Ensure the reporting of notifiable STD cases to Preventive Medicine.

(2) Chief, Preventive Medicine Service will:

(a) Provide guidelines for the management of the STD Control Program within the LAHC service area.

(b) Ensure appropriate epidemiological interviewing and case reporting is conducted as part of the STD Control Program.

(c) Monitor the standards of care for STD management within the LAHC health service area.

(d) Ensure the STD intervention specialist has completed the Sexually Transmitted Disease Intervention Course (6H-F9/322-F9) through the AMEDD Center and School (AMEDDC&S) or other comparable civilian training (ex. CDC Sexually Transmitted Diseases course).

(3) Chief, Laboratory Services will:

(a) Develop a reporting protocol to ensure that PMS is notified directly of all positive tests for Gonorrhea, Syphilis, Chlamydia, Chancroid, Granuloma Inguinale, and Lymphogranloma Venereum infections (as a back-up for the required physician/provider notification).

(b) Ensure the laboratory department will complete laboratory report form ADPH-F-STD-30 weekly and forward to Alabama Department of Public Health, STD Division (Alabama Department of Public Health does CDC mandatory notification). A copy of the weekly ADPH-F-STD-30 will be provided to the CHN.

(4) Attending Physician/Health Care Provider will:

(a) Obtain/order appropriate diagnostic laboratory tests on patients presenting with signs or symptoms suggestive of a STD.

(b) Refer all patients with presumptive or confirmed diagnosis of STD to PM for epidemiologic/contact investigation and disease reporting.

(c) During duty hours, treatment of STD should be administered after the STD interview is completed (if readily available).

(d) Follow the procedures outlined in this regulation and refer to Reference 3.b for the CDC treatment guidelines.

(5) Community Health Nurse will:

(a) Complete (with the reassurance of confidentiality of any information given) an Interview Record on all referred STD cases. Interview records will be maintained for one year, and then destroyed. Provide appropriate health education with special emphasis on preventive measures; conduct a contact investigation; and make arrangements for needed follow-up services. Contact investigations will include all sexual contact during the following timeframes:

-**Chlamydia**: 60 days before symptom onset or diagnosis.
-**Gonorrhea**: 60 days before symptom onset or diagnosis.
-**Syphilis**:
Primary - 3 months plus duration of symptoms.
Secondary - 6 months plus duration of symptoms.
Latent - 1 year.

(b) Complete the administrative requirements and data verification for reporting STDs through the Reportable Medical Events System (RMES) and to the Alabama Department of Public Health-Confidential Disease Report STD -15/Rev.7-01 (Appendix C). The RMES database is located on one computer in Preventive Medicine (Office L-107). The ADPH form is sent in a pre-addressed envelope (Alabama Department of Public Health, Sexually Transmitted Disease Program, The RSA Tower/Suite 1440, P.O. Box 303017 Montgomery, AL 36177-9981)

(c) Maintain clinic tracking and statistics for internal use only (electronic log of cases - authorized as long as privacy is maintained per IMD/IT protections and IAW HIPAA requirements). Each diagnosed STD will be assigned a case number by month, year and patient sequence and recorded in an STD electronic logbook.

(d) Attempt to contact each referred case at least three (3) times. If unsuccessful with the third attempt, document on internal log and submit information to RMES and ADPH.

(e) Annotate in the patient's health record (AHLTA) the contact interview and health education were completed. Any patient referrals will also be documented in the health record.

(f) Order the minimum laboratory tests listed under Diagnostic Protocol 6.c.(1) for all walk in suspect STD clients and investigative contacts at the Preventive Medicine Clinic. When labs are ordered, a clinic appointment for the individual must be made with their primary health care provider.

(g) Civilian contacts of DoD beneficiaries will be channeled to local public health departments. For civilian contacts telephone the Houston County Health Department at (334) 678-2800, extension 360 or (334) 793-1917 to set up an appointment with the Disease Intervention Officer for this area.

(h) Conduct STD preventive education for all sectors of the military community.

The proponent of this publication is Department of Preventive Medicine. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, Lyster Army Health Clinic, ATTN: MCXY-PM, Fort Rucker, AL 36362-5333.

FOR THE COMMANDER:

Redacted
Redacted
LTC, MS
Deputy Commander
for Administration

Redacted
Redacted
Chief, Administrative Services

DISTRIBUTION:
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TAB N-13

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY AEROMEDICAL CENTER
FORT RUCKER, ALABAMA 36362-5333

STANDARD OPERATING PROCEDURE 2 September 2008

Preventive Medicine Service
TUBERCULOSIS PROGRAM

1. PURPOSE. The purpose of this SOP is to establish Preventive Medicine Service (PMS) procedures for evaluation and follow-up of individuals with positive reactions to Tuberculin Skin Tests (TST) and individuals who are a close or other than close contact to an index case of tuberculosis.

2. SCOPE. This SOP applies to all Community Health Nurses (CHN) in PMS.

3. REFERENCES:

a. AR 40-5, Preventive Medicine, 22 July 2005.

~~b. Core Curriculum on Tuberculosis, What the Clinician Should Know, 4th Edition, CDC,~~ 2000.

c. CDC-MMWR, Guidelines for Preventing Transmission of Mycobacterium Tuberculosis in Health Care Facilities, Oct 64.

d. Red Book, Report of the Committee on Infectious Diseases, 2000.

4. DEFINITIONS:

a. Positive Reaction.

(1) Induration of 5 millimeters (mm) or > is considered positive for the high risk groups listed below:

(a) Human Immunodeficiency Virus (HIV) persons.

(b) Recent contacts of a TB case.

THIS SOP SUPERSEDES SUBJECT SOP DATED 11 January 2007

(c) Person with fibrotic changes on chest radiograph consistent with old TB.

(d) Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of > or = 15mg/day of Prednisone for > or = one month.

(2) Indurations of 10 (mm) or > is considered positive for other high risk groups, such as:

(a) Recent arrivals (<5 years) from high prevalence countries.

(b) Injection drug users.

(c) Residents and employees of high-risk congregate settings (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)>

(d) Mycobacteriology laboratory personnel.

(e) Persons with clinical conditions that make them high-risk (substance abuse, diabetes mellitus, silicosis, prolonged corticosteriod therapy, other immunosuppressive therapy, cancer of the head and neck, end stage renal disease, intestinal bypass, gastrectomy, chronic malabsorption syndromes, low body weight (10 percent or more below the ideal body weight), and hematologic and reticuloendothelial diseases).

(f) Children <4 years of age or children and adolescents exposed to adults in high-risk categories.

(3) Induration of 15mm in persons with a positive TST who are younger than 35 years with no known risk factors. Persons over 35 years of age should be carefully evaluated and INH chemoprophylaxis should be made on a case-by-case basis based on risk and time of likely exposure.

b. Negative Reaction: A tuberculin skin test is negative when induration does not exceed the above parameters. A small reaction below the cutting point is considered negative for each of the above categories.

c. Index Case. A tuberculosis patient.

d. Close Contact: Any individual living in the same household, or who associates with the index case many hours per day at work or in school. Occasionally, other individuals will have to be considered "close" contacts, such as persons who share a carpool or attend choir practice with the index case.

e. Other than Close Contacts: Previously referred to as "casual contacts" these are individuals who have had only a brief encounter with an index case.

5. PROCEDURE FOR EVALUATION AND FOLLOW-UP:

a. Patients referred for evaluation will be scheduled by the Occupational Health Medical support assistant or CHN.

b. All reactors/converters will be interviewed by a CHN using DA Form 4700 USAAMC (OP) 62, 1 June 1995 (Enclosure 1).

(1) At the time of the initial evaluation patients will be given information about the implications of a positive tuberculin skin test and the reason why some are selected for preventive INH therapy and others are not.

(2) Those who are selected for preventive therapy will be briefed regarding the possibility of hepatotoxicity. Specifically, they must be warned about unexplained anorexia, nausea, fatigue, weakness, rash, fever, dark urine and jaundice. They must understand that if these symptoms appear, they should stop taking INH and notify the CHN immediately.

c. A TB registry card, DA Form 3897R will be filled out on all reactors/converters (Enclosure 2), except those patients over 35 years old with a normal chest X-ray (CXR) who are not in a high risk category. Generally, these patients will not be considered as candidates for INH chemoprophylaxis. Initiation of INH chemoprophylaxis will be made on a case-by-case basis, based on risk and time of likely conversion.

d. The following procedures will be ordered:

(1) PA/LAT CXR.

(2) Liver function test - ALK Phos, LDH, Total Bili, Direct Bili, AST, and ALT.

(3) CBC, Urinalysis, and HIV testing.

e. When the results are returned to PMS, they will be recorded on the TB registry card and reviewed by the CHN.

f. If significant symptoms or signs specified in 5b(2) appear, the CHN must:

(1) Stop the medication.

(2) Obtain LFT's.

(3) Repeat AST or ALT which is greater then three times the upper limits of normal and refer the patient to a physician for clinical evaluation.

(4) Repeat AST, ALT in one week provided the initial AST, ALT is elevated but less than three times the upper limits of normal. If the patient is stabilized, cautiously restart medication.

g. If for any reason the CHN is doubtful as to whether the patient should continue taking INH, contact must be made with the responsible physician.

6. PROCEDURE FOR FOLLOW-UP FOR ALL CLIENTS ON INH:

a. All clients on INH will be seen monthly by the CHN. Appointments will be scheduled during regular duty hours.

b. Liver function studies will be ordered on all clients after one month and three months of taking INH or when clinically indicated by symptoms of hepatoxiciy.

c. Upon completion of chemoprophylaxis the TB registry card is marked "Nine months of INH completed", and filed appropriately. Cards are kept for one year.

e. Individuals on flight status are automatically grounded upon starting INH, and must report to Aviation Medicine for evaluation prior to being returned to flight duties.

7. PROCEDURE FOR CLIENTS WHO ARE PCS'ING TO FORT RUCKER:

a. Clients will furnish PMS with a copy of their orders.

b. Clients PCS'ing to Fort Rucker will be located (either through their orders if attached to the referral or through the post locator) and an appointment will be set up on the next clinic day.

c. After the client has been seen, the CHN will document the visit on the referral and return a copy to the sender, and file the original in the patient's chart. One copy should be filed in PMS.

8. PROCEDURE FOR FOLLOW-UP OF CONTACT TO AN ACTIVE TB CASE:

a. All active cases will be extensively interviewed for contacts (casual and close).

b. Contacts will be notified by the PMS and an appointment for evaluation scheduled.

c. If a previous negative skin test is documented apply a PPD 5TU. If a previous positive test is documented, a CXR will be ordered.

d. Results of all follow-up TST will be recorded on a SF 600 (Chronological Record of Medical Care), and SF 601 (Immunization Record).

e. Positive reactors will be followed per routine.

f. Negative reactors will have the skin test repeated in three months and one year.

9. DOCUMENTATION: All contacts of clients, which have been interviewed, counseled, or treated, will be documented on a SF 600 in SOAP format and logged as a patient contact. All skin tests will be recorded on SF 601.

10. PERFORMANCE IMPROVEMENT PROGRAM:

a. The Preventive Medicine (PM) physician will review all TB chemoprophylaxis initiation for appropriate therapy.

b. The CHN will consult with the PM consultant and/or Internal Medicine Clinic when medically indicated.

2 Encl
as

Occupational Health Physician

LTC, AN
CHIEF, Preventive Medicine
Service

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

VACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information ...ay be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY/ID NUMBER	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NUMBER

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 11/2010)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letter

VACCINATION AGAINST SMALLPOX *(Number of previous vaccination scars)*

	DATE	ORGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print):*

Patients's Name--last, first, middle initial; Sex, Age or Year of Birth; Relationship to Sponsor; Component/ Status; Department/ Service.

Sponsor's Name--last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

601-105

IMMUNIZATION RECORD
Standard Form 601--October 1975 (Rev.)
General Services Administration & Interagency Committee on Medical Records
FIRMR (4) CFR) 201-45.505

ORAL POLIOVIRUS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

OTHER IMMUNIZATIONS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				5			
2				6			
3				7			
4				8			

SENSITIVITY TEST (*Tuberculin, etc.*)

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						

REMARKS:

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO.2

* U.S.GPO:1997-427-590/69093

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: TUBERCULOSIS SURVEILLANCE FORM

OTSG APPROVED (Date): 28 Oct 80

DATE:_____ TIME:_____ TYPE VISIT:_____

REFERRED FROM:_____

S: AGE:_____ M/F MILITARY STATUS:_____ MARITAL STATUS:_____

BIRTHPLACE:_____ OCCUPATION:_____ WORK PLACE:_____

IF PREGNANT, EDC:_____ PREVIOUS HX BCG Y/N (EXPLAIN):_____

OVERSEAS TRAVEL PAST YEAR Y/N (WHERE)_____

PREVIOUS HX OF TB/TST AND TREATMENT? Y/N (EXPLAIN)_____

HX POSITIVE TST? Y/N (EXPLAIN)_____

FAMILY HX OF TB AND TREATMENT? Y/N (EXPLAIN)_____

NUMBER IN IMMEDIATE HOUSEHOLD:_____ AGE AND TST STATUS:_____

KNOWN CONTACT WITH ACTIVE TB: _____HOME _____WORK _____OTHER _____UNKNOWN

HISTORY	YES	NO		YES	NO		YES	NO		YES	NO
COUGH			ANOREXIA			GASTRECTOMY			PULMONARY DISEASE		
HEMOPTYSIS			WEIGHT LOSS			SARCOIDOSIS			DIABETES		
CHILLS (UNEXPLAINED)			NIGHT SWEATS			RENAL DISEASE			RETROVIRUS		
SHORTNESS OF BREATH			SILICOSIS			HEPATIC DISEASE			STEROID THERAPY		
FEVER (UNEXPLAINED)			CANCER			OTHER			OTHER		

EXPLAIN ANY "YES" REPLIES OR "OTHER(S)":_____

PAST/CURRENT MEDICAL ILLNESS (i.e., Opportunistic Disease, Immunocompromised):_____

PAST/CURRENT MEDICATIONS (DILANTIN, STEROIDS):_____

KNOWN DRUG ALLERGIES:_____ALCOHOL/TOBACCO USE: Y/N___

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: COMMUNITY HEALTH NURSING

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

O: CONTACTS SKIN TESTED OTHER THAN IMMEDIATE FAMILY? Y/N

HIV TEST OFFERED/ORDERED? Y/N DATE ORDERED/RESULTS_____/_____

DATE/RESULTS OF POSITIVE PPD:_____/_____

DATE/RESULTS OF LAST NEGATIVE TEST:_____/_____

DATE/RESULTS OF LAST NEGATIVE HIV:_____/_____

DATE/RESULTS OF CXR:_____/_____

DATE/RESULTS OF LFT'S:_____SGOT_____SGPT_____OTHER_____

A: _____

_____

_____

_____

P:

- [ ] NO FURTHER TST
- [ ] RECOMMEND INH 300MG AND PYRIDOXINE 50MG PO QD FOR 6-12 MONTHS.
- [ ] REFER TO PREVENTIVE MEDICINE CONSULTANT FOR FURTHER EVALUATION.
- [ ] ADDITIONAL LABS/CXR
- [ ] RETURN APPOINTMENT:_____

	YES	NO
E: EXPLAINED TB INFECTION AND IMPLICATIONS OF POSITIVE TST:		
EXPLAINED RELATIONSHIP BETWEEN TB AND HIV:		
EXPLAINED CHEMOPROPHYLAXIS WITH INH:		
EXPLAINED CONTRAINDICATIONS FOR FUTURE TST:		
GIVEN EDUCATION MATERIAL ON TB:		
CLIENT VERBALIZED UNDERSTANDING OF INSTRUCTIONS GIVEN AND PLAN OF CARE:		

_____

CHN SIGNATURE

PREVENTIVE MEDICINE CONSULTANT CLEARANCE

P: CONCUR. INH 300MG PO QD FOR 6-12 MONTHS.
PYRIDOXINE 50MG QD FOR 6-12 MONTHS.

PREVENTIVE MEDICINE CONSULTANT SIGNATURE

(Reverse of AAMC OP 62, Jun 95)

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED (Date)
ISONIAZID (INH) CLINIC FLOW SHEET	27 August 1984

DATE STARTED INH: _____

CODES: NO YES CS (Comment Section)

Today's Date												
Time												
# Months of INH												
SUBJECTIVE												
FATIGUE												
NAUSEA												
LOSS OF APPETITE												
DARK URINE												
LIGHT STOOLS												
JOINT PAIN												
LOSS OF WEIGHT												
VISUAL CHANGES												
ELEVATED TEMPERATURE												
TINGLING HANDS/FEET												
OBJECTIVE												
RASH												
ICTERUS												
OTHER												
ASSESSMENT												
PATIENT TAKING MEDICATION												
SIDE EFFECTS NOTED												
PLAN/ACTION												
REFILL INH # 30												
START/REFILL B6#30												
ENT GUIDANCE PROVIDED												
AT LIVER FUNCTION TESTS												
DISCONTINUE INH												
REFER TO MD												
REFERRAL TO NEXT DUTY STA												

NEXT APPOINTMENT (Date)												
INTERVIEWER'S NAME												

COMMENT SECTION

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
	Preventive Medicine Service	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700 USAAMC (PN) OP 92, 1 May 85

(SEE PRIVACY ACT STATEMENT ON REVERSE)

COMMUNITY HEALTH NURSING – CASE REFERRAL

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

TO: *(Name and location)*	FROM: *(Name and location)*

1. NAME OF PATIENT *(Last, First, Middle Initial)*	2. ADDRESS OF PATIENT *(Give specific directions)*
3. DATE OF BIRTH / 4. HOME PHONE	
5. NAME OF SPONSOR *(Last, First, Middle Initial)*	
6. GRADE AND SSN / 7. OFFICE PHONE	
8. ORGANIZATION	

9. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of the medical information relevant to this referral to the _____

_____

_____ _____

Signature of Patient (or person authorized to consent for patient) *Date*

10. REASON FOR REFERRAL, OTHER SIGNIFICANT DATA

S- The above-named individual is a _____y/o_____found to have a positive ___ measuring _____mm with/without vesticulation on _____. Denies hx of active TB or signs/symptoms of active TB. Contact of known case 19___.

O- Previous PPD/Monovac on _____ was _____ CXR on _____ is _____.

A- Asymptomatic.
Contact/Reactor/Converter.

P- 1) Advised to have no further TB skin testing.
2) Education re. significance of positive test provided and questions answered.
3) Instructed to report for FU upon arrival at new station.
4) Please locate and follow. Response to this referral requested.

Thank you,

11. SIGNATURE OF INITIATOR	12. DATE

13. LOCATION OF RECORDS *(Check applicable box(es))*

MEDICAL RECORDS ☐ ARE ☐ ARE NOT IN FILES OF THIS INSTALLATION.

FAMILY RECORDS ☐ ARE ☐ ARE NOT IN FILES OF THIS INSTALLATION.

This form in and of itself DOES NOT constitute a contract with the Army for payment of services to be rendered.

DA FORM 1 SEP 79 3763

REPLACES DA FORM 3763, 1 SEP 75 and DA FORM 3763-R, 26 SEP 75, WHICH ARE OBSOLETE.

USAAMC (PM) OP 015, 1 Feb 96

14. REPORT OF FINDINGS AND RECOMMENDATIONS

15. SIGNATURE OF INDIVIDUAL COMPLETING ITEM 14.	16. DATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: 5 US Code 301; 10 US Code 1071; 42 US Code; 44 US Code 3101.

2. PRINCIPAL PURPOSE(S): Provides a means for medical and allied medical personnel to refer individuals and families for Army community health nursing services.

3. ROUTINE USES: a. To refer patients or family units to other military and civilian health and welfare agencies or to Army community health nurses at other military installations.

b. A case referral which contains medical information requires written consent of the patient or legal representative prior to release to a civilian agency.

c. A doctor's signature is required when medication and/or treatments are ordered.

d. To provide continuity of care, minimize duplication of effort and furnish accurate information to other health care providers.

e. When case is completed or inactive, one copy of record is returned to the initiator (item 2, above) and duplicate copies of record are destroyed when no longer needed.

4. MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary however failure to provide information may prevent continuity of care, cause duplication of effort and prevent accuracy of information to other health care providers.

☆ USGPO 1986-491-003/43272

NAME (Last, First, MI)	1	2	3	4	5	6	7	8	9	10	11	12

DATE OF BIRTH	STATUS ☐ AD ☐ RET ☐ DEP	BRANCH ☐ ARMY ☐ NAVY ☐ MARINE ☐ AF ☐ OTHER (Specify)

SPONSOR	RANK	SSN	UNIT ADDRESS	DUTY PHONE

HOME ADDRESS (Include Zip Code)	HOME PHONE

ACTIVE CASE				
ADMITTED ☐ YES ☐ NO	ADMITTED DATE	DISCHARGE DATE	*ATS CODE	CONTACTS CHECKED ☐ YES ☐ NO

CONTACT		
☐ CLOSE ☐ CASUAL	CONTACT OF	DATE CONTACT TERMINATED

CONVERTER/REACTOR					
SKIN TEST RESULTS			LAST NEGATIVE SKIN TEST		CONTACTS CHECKED ☐ YES ☐ NO
DATE	TYPE	SIZE	DATE	TYPE	

DRUG REGIMEN				
DATE STARTED	TYPE	DOSE	FREQUENCY	LENGTH OF THERAPY

*American Thoracic Society standard diagnostic and therapeutic code.

DA FORM 3897-R, AUG 90 Previous editions obsolete.

TUBERCULOSIS REGISTRY

For use of this form, see AR 40-5; the proponent agency is the OTSG

REPORTED TO STATE/LOCAL HEALTH DEPARTMENT *(If yes, list name of State or Local Health Department and date reported.)*

☐ YES ☐ NO

X-RAY FINDINGS

DATE	TEST RESULTS	DATE	NOTES

RETURN VISIT ACTIONS *(Use pencil).*

TAB N-14

Chief, Prev. Med. Clinic **MIL USA**

m: CA Nursing Ed. Redacted
ent: Friday, January 07, 2011 6:44 PM
To: Dep. Cdr for Nursing USA; Chief, Prev. Med. Clinic
Cc: Redacted
Subject: FW: Scope of Practice Discrepancy (UNCLASSIFIED)

Hello Dep. Cdr for Nursing and Chief, Prev. Med. Clinic,
I have responded below to Chief, Prev. Med. Clinic Additionally, there is BPC Article 10 Federal Personnel sections that address the questions you are asking.

In Sections Sec. 715 Licenses to practice in state, Sec 716 Denial of License; Disciplinary action against holder of state license, and Sec 717 makes a reference as to federal statues and regulations that federal employees, including the military staff. As federal employees, military staff needs to abide by the federal rules, and if federal rules are in conflict or require the staff (RN) to do beyond the scope allowed in the CA NPA, as long as the federal employee functions within the policies of the federal agency, the staff may do so and would not be disciplined by the BRN.

I think this is the response you were seeking.

Sincerely,

CA Nursing Ed.
Nursing Education Consultant
CA Board of Registered Nursing
Tel: Redacted
Email: CA Nursing Ed.

-----Original Message-----
From: CA Nursing Ed.
Sent: Friday, January 07, 2011 2:00 PM
To: Chief, Prev. Med. Clinic
Cc: Redacted
Subject: RE: Scope of Practice Discrepancy (UNCLASSIFIED)

Hello Chief, Prev. Med. Clinic
When a CA licensed RN is doing the functions specified in the military protocol as a military staff, he/she can perform the functions in the assigned setting. However, the same RN, outside of the assigned setting and the military role, must be bound by the CA NPA as specified in the BPC section 2725.

Sincerely,

CA Nursing Ed.
Nursing Education Consultant
CA Board of Registered Nursing
Tel: Redacted
Email: CA Nursing Ed.
-----Original Message-----
From: NEC BRN
Sent: Friday, January 07, 2011 11:54 AM

TABN-14

To: CA Nursing Ed.
Subject: FW: Scope of Practice Discrepancy (UNCLASSIFIED)

For your followup, CA Nursing Ed.

Thanks.

Redacted

From: Chief, Prev. Med. Clinic Redacted
Sent: Thursday, January 06, 2011 7:42 PM
To: NEC BRN
Cc: Redacted
Subject: Re: Scope of Practice Discrepancy (UNCLASSIFIED)

Thank you for your prompt response, and I understand your point. It would be helpful if you could clarify concurrence in the case where an RN registered under the CA Board of nursing, is hired and working for the military is legally protected and bound to practice nursing under their protocols.

Respectfully,

Chief, Prev. Med. Clinic

----- Original Message -----
From: NEC BRN <NEC.BRN@dca.ca.gov>
To: Chief, Prev. Med. Clinic
Cc: Redacted
ent: Thu Jan 06 19:03:57 2011
Subject: RE: Scope of Practice Discrepancy (UNCLASSIFIED)

Hello Chief, Prev. Med. Clinic,
We are unable to review the attached documents to do comparison of discrepancies as you have requested.
The rules under which army staff work are different than that of RNs in CA who practices within the NPA.
Since the NPs obtained the furnishing authority, the Board has moved away from RNs managing medications using standardized procedures.

Sincerely,
CA Nursing Ed.
CA Nursing Ed.

From: Chief, Prev. Med. Clinic Redacted
Sent: Thursday, January 06, 2011 1:30 PM
To: NEC BRN
Cc: Renewals BRN; Dep. Cdr for Nursing MIL USA; Redacted USA MEDCOM USAAMC
Subject: Scope of Practice Discrepancy (UNCLASSIFIED)

Classification: UNCLASSIFIED
Caveats: NONE

Dear Sir/Ma'am,

I need your assistance to confirm if our Standard of Operating Procedures (SOP's) and protocols in the Army are in line with your regulations for the California Board of Nursing. I would appreciate if you could review the attached SOP's and let me know if you have any questions or if it is clearly within the scope of skill level 3 nursing Practice.

Respectfully,

Chief, Prev. Med. Clinic
Redacted Army Nurse
Chief, Preventive Medicine and Radiology
Lyster Army Health Clinic
Bldg 301 Andrews Avenue
Fort Rucker, AL 36362
Office: Redacted
BB: Redacted
Cell: Redacted
FAX: Redacted

Classification: UNCLASSIFIED
Caveats: NONE

TAB N-15

AR 40-5 Preventive Medicine

Chapter 5 Occupational Health Program

5–4 Program Functions

The OH nurse and the CHN, as deemed necessary by the chief of the PVNTMED service, will coordinate Occupational Health Program activities in the areas of epidemiology, educational programs, communicable disease programs, and use of community resources.

Chapter 6 Community and Family Health

Ch 6-2

The goals of the community and family health programs are to—Coordinate with and use community resources for individual families to conserve and achieve maximum use of Army CHN resources.

6–3. Functions

a. MEDDAC and/or MEDCEN commanders. MEDDAC and/or MEDCEN commanders have overall responsibility for the health care of persons or families in the military community.

b. Chief, PVNTMED. The chief, PVNTMED, through the CHN, assists in the overall responsibility as the principal health adviser with extensive access in the residential community and as the interface agent between the MTF and the community.

c. CHN. The specific functions of the CHN include but are not limited to—

(1) Assessing the total health needs, morbidity trends, and resources in the community.

(2) Planning, developing, organizing, implementing, and evaluating programs to meet the identified needs in the community.

(3) Providing health promotion, health education, and disease prevention programs for service members and other members of the military community.

(4) Conducting a home visiting program.

(5) Supporting patient advocacy in the community.

(6) Evaluating, training, and supervising other healthcare personnel in community health nursing.

(7) Writing prescriptions for medicines when authorized by the MEDDAC and/or MEDCEN credentials committee per AR 40–2 and AR 40–400.

(8) Providing consultation to the OH nurse as outlined in paragraph5–4h.

TAB N-15

(9) Acting as health adviser to the CDS staff as directed by the MEDCEN or MEDDAC commander.

6–4. Program elements

a. Maternal health.

(1) Maternal health is concerned with the physical and emotional health of pregnant and post partum women and the parenting role of women in general. The CHN will assure that programs are provided for the military community that will enhance the understanding of all phases of the birth process and will foster awareness of the stress associated with the role of parenting in the military community.

(2) The effects of the work environment on the pregnant employee and her fetus, and the effect of the pregnant employee on the work situation (para 5–20) are primarily the responsibility of the OH nurse per guidelines developed by the OH physician. For military women, the program should be coordinated with the CHN or obstetrics and gynecology nursing staff.

b. Child health.

(1) Program availability. The CHN will assure that programs are available to provide parent education, well-child supervision, and support services for high-risk families. Programs will be fully coordinated with those of other military health and welfare organizations and civilian organizations.

(2) CDS support. PVNTMED personnel will provide health and environmental support to CDS staff and facilities per AR 608–10.

Specifically—

(a) The CHN will provide health consultation to CDS staff regarding communicable disease control and disease prevention, assist CDS staff with "special needs" infants and children, and provide education and training in health related areas.

(b) Environmental health section staff will provide environmental consultation and inspection to center-based programs; specific services include, for example, consultation, inspection, and training to center-based programs, depending on local policy.

(3) Army family advocacy program (AFAP) support. The CHN will support AFAP per AR 608–18. specifically, the CHN will—

(a) Provide services directed toward prevention of spouse and child abuse; for example, health education to individuals, families, and groups on subjects such as prenatal, parenting, and child development concerns.

(b) Assist with identifying high-risk families and provide direct services to selected families.

(c) Act as nursing consultant to the MTF staff to identify suspected abuse and neglect cases.

(d) Refer cases to a family advocacy case management team (FACMT) when the CHN suspects that spouse abuse or child abuse and neglect may exist.

(e) Provide nursing input into the assessment, intervention, and evaluation process of individual cases discussed during FACMT meetings.

(f) Receive referrals from FACMT for family health counseling and provide this service in the clinic, CHN office, or family home.

(g) Conduct a nursing assessment of the family in the home when indicated.

(4) School health. The Army CHN will provide health program supervision at on-post dependent schools that are not otherwise provided with public health nursing services. Close liaison should be maintained with nursing service at all schools attended by military dependents.

c. Community health. Programs will be established to identify persons or groups having special health needs and to provide and/or coordinate required health services.

d. Chronic disease control. The objectives are to—

(1) Identify risk factors that are associated with specific chronic diseases.

(2) Evaluate and control environmental factors that are associated with the development of chronic disease (such as occupational hazards and safety hazards).

(3) Promote knowledge regarding risk factors associated with the development of chronic disease.

(4) Facilitate, through education, the change of client behavior to reduce risk factors associated with the development of chronic disease.

(5) Identify persons at risk of developing chronic disease and initiate preventive and early treatment programs.

(6) Participate in a coordinated plan of rehabilitation for personnel with chronic disease.

e. Family safety. Family safety will be addressed by the CHN.

(1) As a routine part of home evaluation, the CHN will be alert to the common hazards in the home and instruct the family on safety.

(2) All home accidents resulting in medical care should be reported to the CHN.

6–5. Referrals

a. Referrals will be prepared under AR 40–407.

b. Telephonic referrals are acceptable for emergency situations or to alert the CHN of the written referral.

c. Referrals to the health nurse should be made regarding, but not necessarily limited to—

(1) All infants with a diagnosis of failure to thrive.

(2) Cases in which multifaceted health and social problems require home evaluation in planning and providing effective treatment.

(3) Cases requiring continuity of care from hospital to home.

(4) Persons or groups requiring health counseling regarding control of communicable or chronic diseases.

(5) Patients that require other health nursing services.

AR 600-110 Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV)

1–12. Installation and community commanders

These commanders will—

a. Coordinate with the servicing medical department activity (MEDDAC) or medical center (MEDCEN) to accomplish scheduling, education, and testing of personnel assigned to their installation/community.

b. Assist servicing MEDDAC or MEDCEN in developing and implementing well-defined health education programs for soldiers, family members, civilian employees, and other HCBs in the community.

c. Establish a support network of professional personnel (chaplain, psychologist, psychiatrist, social worker, community health nurse) trained to provide assistance to HIV-infected HCBs and their uninfected family members in such areas as family support and suicide prevention.

Section II

Functions of Medical Personnel

2–3. Medical personnel

Clinical Manager or attending physician—

(1) Schedules or performs initial medical evaluation physical examinations for all newly identified HIV-infected HCBs.

(2) Refers all newly identified HIV-infected HCBs to the PMP or community health nurse (CHN) for administrative and public health followup.

6–13. Child Development Services

b. The placement decision will be made by a team consisting of the child's physician, his or her parents, the CDS coordinator, the preventive medicine physician, and the community health nurse.

8–3. HIV/AIDS Education Program Coordinator

The Community Health Nurse consultant to TSG is designated as the HIV/AIDS Education Program Coordinator to serve as the focal point for all HIV/AIDS education program issues and, in conjunction with HQDA(DAPE–HR), to integrate the educational activities of the Army.

AR 608-10 Child Development Services

Chapter 2
Program Oversight
2–3. Installation commanders
The health consultant(s) as designated by Medical Department Activity (MEDDAC) or Medical Center (MEDCEN) (usually the health nurse for nutrition and health, and the environmental science officer for environmental and food sanitation) will—

(1) Consult on standing operating procedures (SOPs) developed by the CDS coordinator to meet program health requirements.

(2) Monitor the health, nutritional, environmental, and food sanitation aspects of child development programs in coordination with the appropriate Medical Treatment Facility (MTF) staff on a monthly basis in centers; and conduct FCC home inspections as specified in paragraph 6–40.

(3) Act as POCs for all issues and actions regarding the overall health program within CDS.

(4) Verify compliance with CDS health standards on DA Form 4841–R annually.

(5) Coordinate meal planning and nutrition education aspects of CDS programs in collaboration with the MTF dietitian.

(6) Provide and/or approve education and instructional content for training of CDS personnel in health related matters.

(7) Serve on the CDS ICCET.

(8) Coordinate veterinary services as required for pets involved with CDS.

(9) Ensure all foods are procured from approved sources as prescribed by AR 40–657. (Coordination with the installation veterinarian is required.)

(10) Confirm outbreaks of disease of public health significance occurring in CDS programs and assist CDS coordinator in reporting such cases (para 2–20).

(11) Identify individuals (on or off–post) responsible for providing training and instruction on the administration of medications and caregiving health practices for children with special needs.

2–11. Exceptions to policy

a. Exceptions to existing criteria may be requested only when alternative methods of compliance do not endanger the safety or well–being of the children in care. Exceptions will only be granted when the intent of the standard can be met by means other than that specified or stated as an equivalency in the single source criteria. Exceptions to policy are required for the following:

(1) Deviation from regulatory requirements for CDC, FCC, or SPS systems.

(2) New facility construction which deviates from the Department of the Army approved standard/definitive designs for CDCs.

(3) Deviation from design criteria in paragraph 5–27.

(4) Facility deficiencies in existing or renovated CDCs.

b. Requests for exceptions must be made in writing and include the following information:

(1) CDS system and program type (e.g., center hourly care, FCC infant/toddler home).

(2) Identification of the unmet single source standard including document source and paragraph.

(3) Description of condition(s) needing alternative equivalency.

(4) Installation proponents involved in request (e.g., DEH, community health nurse, safety officer).

4–27. Care of children infected with HIV

The placement decision will be made by a team consisting of the child's physician, his or her parents, the CDS coordinator, the preventive medicine physician, and the community health nurse.

AR 40-68 Clinical Quality Management

7–4. Advanced practice registered nurse

(2) Community health nurses (CHNs) function in an expanded role using CPGs approved by the ECMS and the DCN. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature, but he/she does not independently initiate, alter, or discontinue any medical treatment. Likewise, the scope of practice of occupational health nurses (OHNs) typically includes CPG or protocol-based patient interventions. In selected circumstances, either the CHN or OHN may be assigned duties or functions for which clinical privileges are deemed appropriate. CHNs and OHNs who meet the criteria as an APRN may be granted clinical privileges as approved by the MTF commander.

9–2. Practitioners who may be privileged

Healthcare practitioners who function independently to initiate, alter, or terminate a regimen of medical care must be privileged. In this regulation, practitioners who are granted privileges are referred to as providers. Providers include audiologists, behavioral health practitioners, chiropractors, clinical pharmacists, clinical psychologists, clinical social workers, dentists, dietitians, nurse anesthetists, nurse midwives, NPs, OTs, optometrists, PTs, physicians, PAs, podiatrists, psychological associates, speech therapists, and substance abuse rehabilitation counselors. Also included are CNSs, CHNs, and OHNs who, in selected circumstances and at the discretion of the commander, may be granted clinical privileges (see chap 7) and SBBs.

TAB N-16

June 2008

APHN/CHN NEWSLETTER

Web site address Redacted

Greeting from the Consultant:

Fmr. Pub. Health Consult.

Greetings APHNS and Community Health Nurses. A special thanks to all of you who are deployed: Redacted Redacted, Redacted , Redacted , Redacted , Redacted , **and** Redacted . Please know that we appreciate your sacrifice, and want to do whatever we can to lighten your load. Please keep us informed on your activities and any concerns that may arise.

INSIDE THIS ISSUE

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Hot Topics:

Inappropriate Medication Refills

It has come to my attention that some APHN's are being asked to (or maybe are asking to) refill tobacco medications.

Please remember that we only operate under protocols approved by the medical staff. This is for limited clinical practice, which should be restricted to ordering necessary laboratory tests, x-rays (chest only), and selected medication refills (NOT initial prescriptions).

While the refill portion has never been fully defined, I've not been anywhere where we did more than anti-tuberculin meds (INH and Rifampin, not even the complete regimen for active TB, although I'd be comfortable with that, as it mirrors what civilian public health nurses do), and in some places NRT refills (even with NRT, the issue would be one of a "slippery slope" - "if this, then why not that

I am aware that some places have expanded to Zyban, which as a psychoactive medication, is NOT within the scope of practice for a skill-type 3 provider (which is what the majority of APHNs are)

Now I hear that some APHN's are also refilling Chantix, the new tobacco-cessation medication. And in some cases, even providing initial Rx's. This is NOT in our scope of practice. Chantix is relatively new and has recently been associated with some serious complications

Redacted

Redacted I DO think we should use it, but it should only be prescribed AND refilled by a NP, PA, or Physician (skill-type 1 or 2, a Licensed Independent Practitioner). APHN's should not be refilling these medications. Monitoring for side effects, counseling, etc. is where we should be providing support. For more information, see

Redacted

TAB N-16

Privileging & RVUs

I have also had quite a few questions about privileging and relative value units (RVU's). Indeed, in the past, we were all privileged as advanced practice nurses. While we are still considered advanced practice nurses, the guidance has changed regarding privileging. You should not be privileged.

You should be operating under protocols approved by the medical staff. It is in these protocols where the aforementioned clinical aspects of your practice are to be defined.

I will be meeting with the Army Public Health Nursing leadership in the near future to develop standardized protocols for use in the field.

These will be staffed through our preventive medicine medical staff (the OTSG consultant), and will guide what we should be doing. Rest assured, there will be a "local annex" at the end of any document produced to address any unusual circumstances, but in my opinion, this will be fairly straightforward guidance that should not need to change dramatically from installation to installation.

I wanted to give you a heads up on this, as I will be providing this information to the MTFs through the AMEDD leadership.

I am aware that some places are attempting to continue privileging APHNs in order to keep you as skill-type 2 providers and "game" the RVU system (to clarify: ST 1 = physician; ST 2 = nurse practitioner/physician assistant; ST 3 = nurse).

Some have commented that because of the low-RVU's assigned to nursing, that "we get no credit for our work", and our work has "low-value."

This is definitely not the case. It is simply the wrong model for measuring the effectiveness of public health services.

Relative value units are linked to direct care, under the prospective payment system.

The RVU system measures revenue for insurance purposes.

As many of you know, public health is not a revenue-generating service.

Actually it is a COST center for your resource managers.

However, the MTFs <u>ARE</u> receiving funding for your programs, but from a different "bag" of money (the "readiness" bag).

It's a little bit complicated, and I do not want to belabor this point. Suffice it to say, you do not need to be privileged, and they're not supposed to be measuring your relative value units.

The obvious follow-on question is, "how ARE they supposed to measure our performance/productivity?" Answer: The Program Status Report. That's where the money is.

So stick to the 10 essential services and you won't go wrong. Detailed explanations are hyperlinked on the site

Redacted

.

Please feel free to check with your regional consultants for further clarification. (You can also contact me, but as stated in my "getting to know you" message to the group, I do recommend a good working relationship with your regional consultant, who in most cases will be much better capable/prepared to assist you with getting some answers)

Operational Public Health Nursing

I wanted to share my thoughts on operational public health nursing. We have only a few public health nurses deployed right now in Iraq and one in Afghanistan. The reports I've received back from the group indicate that it is not enough. Currently in Iraq, we only have APHN's serving in the CSH's. All are in agreement that there is yet a greater need out in the various sectors of the country. In short, we need to get more nurses over there. Today we have no civil affairs activity occurring in Iraq, although from a risk management standpoint, it is possible that the area is still too dangerous for this to happen. Similarly, in Afghanistan, we have men and women with unmet public health needs. While there is the opportunity/possibility of civil affairs activity, we obviously need to make sure that we have met the needs of our own forces first. That said, I think the civil affairs piece is important, and will strive to get us involved. Obviously, I'm talking about the possibility of more deployments. The good news is that they are now 12 months in length, and we can "share", (two 180-day deployments... if everyone does a little, no one has to do a lot). The intent is that those who have not had the opportunity to deploy will do so before others are called to serve a second tour. If you have not yet had an opportunity to serve, please communicate with your regional consultants (through your chief Army public health nurses) about your personal situation and preferences. Obviously, we will do our best to accommodate them, but we will not be able to give everyone all they ask for. Would just ask for your understanding and flexibility -- work with us please. I would like to pull together a list of all our deployed nurses, so I can keep people up to speed on who is going where and when they are due to rotate. If we have already done so, identify who is scheduled to replace them (and if we do not have someone yet, let them know that we are looking for volunteers). The sooner we identify who is to deploy, the sooner they can start preparing.

Miscellaneous:

1. **Congratulations:** Redacted was selected as the Outstanding Community Health Care employee of the year by the Veterans of Foreign Wars. Quite an honor, so please congratulate her when you see her.
   Redacted
   Redacted

2. **USUHS:** for long-term health education training, it is likely that we'll be depending primarily on their excellent master of public health program. Us doing this will enable the Army nurse Corps to send many more people for graduate degrees, since this is available to us tuition-free. A few folks have asked me about how this would affect the certification possibilities.

3. **Certification:** The American Nurses Credentialing Center (the credentialing body of the ANA) is considering reestablishing the basic public health certification for those prepared at the undergraduate level. So far, no promises, and their Public/Community Health Clinical Nurse Specialist certification seems more focused on the CLINICAL aspects (versus the community focus that we are now working towards). Additionally, it is only available for people with graduate level academic preparation. The alternative is the American Public Health Association's Certification in Public Health Redacted , which I wrote to you about a few months ago.

4. **AMEDD C&S –** Redacted and Redacted are currently enrolled in 6A-F5. Four nurses are projected to attend the September class, but assignments have not yet been made.

5. **Workgroups –** We have a number of workgroups, and I would like to have periodic synopses of what progress is being made and how soon we might expect to have a product for people's review... I know the CDYS SNAP group is tracking... we'll definitely have something relatively soon... new forms, (trimmed 8 pages to two), health SOP's, etc... hoping to pilot at locations where the group participant are, for at least a few months, before sending out to the field (part of the problem with the ORIGINAL new-and-improved SNAP process was that it wasn't piloted). There is also a work-group for TB/LTBI.

6. **BRAC news:** I would be interested in hearing from you all how BRAC (base realignment and closure) is affecting your particular location. As our population shifts, we need to take that under consideration in our community needs assessments, and be talking with each other about movement of large groups of people, such as entire units. This is especially important because it may require changes in the allocations of Army public health nurses to meet the needs of our communities. Please get this information to your regional consultants, so we can take a look at it.

Thank for all you do!

Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.
Fmr. Pub. Health Consult.

TAB N-17

BOARD OF REGISTERED NURSING
P.O Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov

AN EXPLANATION OF THE SCOPE OF RN PRACTICE including standardized procedures

The Legislature, in its 1973-74 session, amended Section 2725 of the Nursing Practice Act (NPA), amplifying the role of the registered nurse and outlining activities which comprise the practice of nursing.

LEGISLATIVE INTENT

The Legislature recognized that nursing is a dynamic field, continually evolving to include more sophisticated patient care activities. It declared its intent to recognize the existence of **overlapping functions** between physicians and registered nurses and to permit **additional such sharing** and to provide **clear legal authority** for those functions and procedures which have common acceptance and usage. Prior to this, nurses had been educated to assume advanced roles, and demonstration projects had proven their ability to do this safely and effectively. Thus, legal amplification of the role paralleled the readiness of nurses to assume the role and recognized that many were already functioning in an expanded role.

SCOPES OF PRACTICE

A knowledge of the respective scopes of practice of registered nurses and physicians is important in determining **which activities overlap** medical practice and therefore require standardized procedures. Failure to distinguish nursing practice from medical practice may result in the limitation of the registered nurse's practice and the development of unnecessary standardized procedures. Registered nurses are cautioned not to confuse nursing policies and procedures with standardized procedures.

1. Scope of Registered Nursing Practice

The activities comprising the practice of nursing are outlined in the Nursing Practice Act, Business and Professions Code Section 2725. A broad, all inclusive definition states that the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill.

In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which **does not** require a standardized procedure. Nursing practice is divided into three types of functions, which are described below.

AB N-17

A. Independent Functions
Subsection (b)(1) of Section 2725, authorizes direct and indirect patient care services that insure the safety, comfort, personal hygiene and protection of patients, and the performance of disease prevention and restorative measures. Indirect services include delegation and supervision of patient care activities performed by subordinates.

Subsection (b)(3) of Section 2725, specifies that the performance of skin tests, immunization techniques and withdrawal of human blood from veins and arteries is included in the practice of nursing.

Whistleblower refuses to give immunizations skin test.

Subsection (b)(4) of Section 2725, authorizes observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition and determination of whether these exhibit abnormal characteristics; and based on this determination, the implementation of appropriate reporting or referral, or the initiation of emergency procedures. These independent nursing functions have long been an important focus of nursing education, and an implied responsibility of the registered nurse.

B. Dependent Functions
Subsection (b)(2) of Section 2725, authorizes direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist or clinical psychologist.

C. Interdependent Functions
Subsection (b)(4) of Section 2725, authorizes the nurse to implement appropriate standardized procedures or changes in treatment regimen in accordance with standardized procedures after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. These activities overlap the practice of medicine and may require adherence to a standardized procedure when it is the nurse who determines that they are to be undertaken.

2. Scope of Medical Practice
The Medical Practice Act authorizes physicians **to diagnose** mental and physical conditions, **to use drugs in or** upon human beings, **to sever or penetrate the tissues** of human beings and **to use other methods** in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these by a registered nurse requires a standardized procedure; however, activities within each of these categories have already become common nursing practice and therefore do not require standardized procedures; for example, the administration of medication by injection requires penetration of human tissue, and registered nurses have performed this function through the years.

In Section 2725(a), the Legislature referred to the dynamic quality of the nursing profession. This means, among other things, that some functions which today are considered medical practice will become common nursing practice and no longer require standardized procedures. Examples of medical functions which have evolved into common nursing functions are the measurement of cardiac output pressures, and the insertion of PICC lines.

STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS
The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the **organized health care system** in which it is to be used. Because of this

TAB N-18

Redacted

Call

Submitted August 2009

Whistleblower
Redacted

— cardiac
— wrote

Redacted

ACLS current
DISASTER Courses w/ ~~Red~~ Red Cross

Work Experience
Whistleblower
Redacted

Redacted

In 3 wks
DISASTER prepared

RN Lic

Country of citizenship;
United States of America

Raytheon Technical Services 7/2007 - 8/2007
Reston, VA US Salary; 15,000 USD Per Month
Hours per week; 84

Occupational Health Nurse/Monitor (Russia)
Nurse/Monitor DOD START Treaty in Votkinsk Russia,term contract. Occupational health clinic; work related injuries and illnesses. Inventoried clinic, set up database to analyze results and wrote new policies and procedures to improve clinic. Gave power point presentation on Medevac procedures. Collected water sampling once a week for testing and monitored food prep for sanitation. Monitored unsafe working environment and practices according to OSHA, NIOSH and DOD. Maintained records HIPPA legal and ethical compliance.
Supervisor's Name; Scott Marble, Supervisor's Phone; 703-295-2000

Department Health Human Services, HRSA 7/2006 - 7/2007
Rockville, Maryland US Grade Level; GS 9
Salary; 46,000 USD Per Year
Hours per week; 40

Public Health Analyst 685
Analyzed semi annual report for grants and wrote recommendations for revision of report guidelines
Analyzed Bio-terrorism applications for sentinel indicators,developed a database and used data to produce a report on compliance of grantees
Conducted qualitative and quantitative analysis evaluation data for specific benchmarks of Bio-terrorism applications to assess program efficiency
Developed measurements for sentinel indicators with team member; Policy, Evaluation and Planning
Analyzed, reviewed and developed contingency plan for software failure
Analyzed and developed a revision of web page for Utilized GIS, Archview to map shortage areas and census tracts- Researched and analyzed regulations, legislation and policy issues wrote report regarding information
Edited and revised report to the Federal General Accountability Office
Assisted Senior Adviser to Associate Administrator Office of Performance Review on various Performance Review projects
WORK EXPERIENCE National Disaster Medical System, Disaster Medical Assistance Team 4/1997 - 2007
Los Angeles and Washington, CA DC US Grade Level; GS 09
Salary; 25 USD Per Hour
Hours per week; intermittent

Supervisory Nurse , 0610
Nurse Supervisor on NDMS DMAT team
Trainer for Trauma Assessment and Treatment Station of Field Training 06-19-04
Provided medical assistance and care at San Bernardino, CA Fires October 2003
Deployed for Orange Alert 2003; Presented training session on Emergency Medical Treatments for First Responders and Crisis Mental Health Intervention to fellow PHS DMAT members. Deployed for President's State of the Union Address 2001, stand by medical

American Red Cross 2/1988 - Present
LA Washington Santa Ana, CA DC CA US Salary; 0 USD Per Year
Hours per week; intermitt

National Disaster Mental Health Tech

TAB N-18

7/2007 Roosevelt, Utah Mental Health Supervisor
Assessed mental health needs of popultion affected and debriefed departing Red Cross workers. Counseled 2 families who lost family members in wild firesand ,made referrals r further counseling
/2005 Louisiana Post Katrina
Assessed and surveyed American Red Cross Shelters for Public Health related issues to improve performance of care to evacuees in a safe environment
Simplified publication on mold safety for public distribution
Compiled and published a list of no cost medical care for evacuees living in shelters .Received information by collaborating with Louisiana State Public Health Officials and Pederal Public Health Officials.
9/2005 Case management assisting disaster victims in receiving emergency funds and accessing the Los Angeles Social Service system.
Liaison with LA Co Department of Health Services Officials and UCLA Medical CEO to effect policy of treating Katrina evacuees for no or low cost medical care
10/2001 Provided mental health crisis intervention for rescue workers and law enforcement in disaster field of Pentagon Disaster following disaster. Team leader of 20 ARC mental health workers first day
11/2001 Provided mental health counseling for families of survivors following memorial services and distribution of ashes to families
11/1996 Provided crisis intervention for families affected by Hurricane Opal and debriefed fellow ARC workers
1988 Joined Disaster Mental Health Team and provided crisis intervention and debriefing for various local disasters. Provided mental health crisis following major fires and also a minor flood.

Surgical Staff 6/2003 - 7/2005, 1988-2000
Culver City, CA US Salary; 40 USD Per Hour
Hours per week; 24
Temporary direct patient care nurse for various medical facilities and hospitals; operating rooms,emergency room,radiology, and cardiac cath lab. OSHA standards.

International Rescue Committee 2/2004 - 4/2004
NY, NY US Salary; 3000 USD Per Month
Hours per week; 40

ISULTANT GENDER BASED VIOLENCE SEXUAL ASSAULT EXAMINER TRAINER Liberia Post Conflict
conducting qualitative surveys on the type of training needed, developed and implemented training and training materials for physicians and midwives.
Performed assessment of program needs pre,intra and post training;short term and long term
Liased with Ministry of Public Health, Ministry of Social Work and Ministry of Justice Officers to develop program that would be sustainable in Liberia
Liason with UN delegated officer for Gender and various NGO Gender Directors when conducting training
Wrote final report analyzing Program accomplishments, problem areas and future needs

Progressive Nursing Staffers 11/2001 - 4/2003
Springfield, VA US Salary; 40 USD Per Hour
Hours per week; 24

Registry Nurse Emergency Room, Operating Room and Radiology
Worked as a temporary direct patient care nurse in various operating rooms and emergency medical areas. I always interfaced with new people,new policies and procedures which required a great deal of flexibility and adaptability. OSHA standards

Walter Reed Army Medical Command 8/2000 - 10/2000
Washington, DC US Salary; 58,000 USD Per Year
Hours per week; 40

Critical Care Nurse Emergency Room
Emergency room nurse, direct patient care.
Assessed and treated medical /surgical patients. Attended Disaster Preparedness Planning meetings.

International Medical Corp 7/1999 - 10/1999
Santa Monica, CA US Salary; 2100 USD Per Month
Hours per week; 40

.dic) Nurse Coordinator Emergency Medical System, Kosvo Post Conflict
3 month paid volunteer contract
Coordinated Emergency Medical System(EMS) development for IMC's catchment area
Edited and revised World Health Organization Policy Draft for EMS Kosovo after consulting with Physician from World Health Organization

Conducted qualitative surveys of Kosovo province Health Care Facilities and UN Military Health Care Systems to assess and compare pre conflict EMS with post conflict EMS
Assisted in analyzing data to prepare plan to develop a viable EMS system for IMC Kosovo tchment area
.aison with North Atlantic Treaty Organization (NATO) Headquarter Medical Officer to glean information for survey and to obtain permission to survey various NATO bases
Edited and revised the policy draft for WHO on Emergency Medical Service in Kosovo.

Los Angeles County, King Drew Medical Center 2/1991 - 4/1997
Los Angeles, CA US Salary; 27 USD Per Hour
Hours per week; 36-40

Emergency Room Nurse, Sexual Assault Nurse Coordinator

Conducted qualitative and quantitative survey of FBI, LAPD, LA Sheriff and Compton PD data of sexual assaults in the Medical Center catchment area and compared data to the data of King Drew Medical Center treatment of sexual assaults patients. Analyzed data and wrote proposal to start a Sexual Assault Response Team at the Medical Center.
Developed a training program for sexual assault examiner to train emergency room, ob-gyn and pediatric physicians, midwives and nurses.

Trained several physicians, midwives and nurses in the medical, forensic and psycho-social aspects of sexual assault in mini trainings.
Developed policies and procedures for the treatment of victims of sexual assault within the Medical Center and policies and procedures to ensure the program was being continually evaluated for quality deliverance of care. During the development of this program held many meetings with high level officials of the Medical Center and with many high level officials outside of the Medical Center.
Presentations to Law Enforcement, District Attorneys, Crime Labs and Rape Crisis Centers.

Developed the training materials from the Department of Justice Training Manual for Sexual Assault.

EMERGENCY ROOM NURSING
1991-1995 Emergency Room nurse for multi systems and single trauma patients.
^983-85,1980,1978-79 Operating Room nurse for multi-trauma, emergency and other surgical ecialty patients
91-95Functioned as a direct emergency patient care giver; assessed, monitored and treated critical adult and pediatric patients in the trauma resuscitation unit and the medical critical care area of emergency room.
As an MICN, gave treatment orders to pre- hospital paramedics
Mentored nurses & paramedic students on delivery of critical care emergency procedures and standards . OSHA compliant

EDUCATION
Purdue University
W. Lafayette, IN US
Associate Degree - 12/1974

CA nursing license current to 4-2010

Department of Homeland Security
Anniston, AL 7/2005
Certified Instructor WMD (adult model education)
Technical Emergency Responder WMD Certification
Incident Command WMD Certification

Ft. Detrick , MD 2003
Medical Management of Chemical and Biological Casualty Training Certification

Johns Hopkins University
Baltimore, MD US
Certification - 7/2002
Completed the International Committee Red Cross course for Health Emergencies in Large Populations. This included Human Rights, security, and health emergencies in disaster situations for adults and pediatric patients in refugee situations

. 09 IT Project Management II Santa Monica College
2009 Disaster Public Affairs American Red Cross
2008 E-commerce Mira Costa College
2008 American College of Surgeons National Surgery Quality Improvement Data Collection Training

2008 ACLS, BLS
2008 Disaster Frontline Supervisor American Red Cross
2008 Work Stress Training
98 Preliminary Vocational Teaching Credential ;Level I CA vocational teaching
edential course
2008 Monitoring and Evaluation USAID
2007 Monitoring Training DTRA/Raytheon
2007 Legislative Training DHHS
2006 Project Officer DHHS
2006 Federal Budget DHHS
2006 Grants and Cooperative Agreements DHHS
2006 Appropriations Training DHHS
2006 Microsoft Applications Certification Course
2006 Mental Health in Disasters American Red Cross
2006 Victim Advocacy Colorado State University
2005 Emergency Response Technician Weapons Mass Destruction (WMD) DHS
2005 Instructor adult education model WMD DHS
2005 Incident Command WMD DHS
2005 National Response DHS FEMA
2005 Professional Development Certification DHS FEMA
2003 Medical Chemical Biological Casualty Training Ft Detrick
2003 Completed several FEMA Emergency Management online courses and NDMS courses
2002 Health Emergencies in Large Populations Johns Hopkins School Public Health
1997 Hazmat and Decontamination Los Angeles
1996 Death Investigations Forensic Coroner s Course Orange County Sheriff
1995 Sexual Assault Investigation Los Angeles County Sheriff
1994 Sexual Assault Nurse Examiner Training Santa Cruz, CA
1989 Crisis Intervention and Debriefing ARC

AFFILIATIONS American Red Cross Mental Health Team
NDMS DMAT CA 9 Supervisory Nurse

PROFESSIONAL PUBLICATIONS Wrote article on Pentagon 9-11 disaster published in NURSEWEEK

Education
Purdue University Lafayette, Indiana Associate's Degree Nursing 1974 GPA C

Additional Information
SBBI clearance with DOD 2007, Secret clearance, DOD and DOS
CA nursing license current to 4-2010

Department of Homeland Security
Anniston, AL 7/2005
Certified Instructor WMD (adult model education)
Technical Emergency Responder WMD Certification
Incident Command WMD Certification

Ft. Detrick , MD 2003
Medical Chemical Casualty Training Certification

Johns Hopkins University
Baltimore, MD US
Certification - 7/2002
Completed the International Committee Red Cross course for Health Emergencies in Large Populations. This included Human Rights, security, and health emergencies in disaster situations for adults and pediatric patients in refugee situations

2009 IT Project Management II Santa Monica College
2009 Disaster Public Affairs American Red Cross
2008 E-commerce Mira Costa College
2008 American College of Surgeons National Surgery Quality Improvement Data Collection Training
2008 ACLS, BLS
2008 Disaster Frontline Supervisor American Red Cross
2008 Work Stress Training
2008 Preliminary Vocational Teaching Credential ;Level I CA vocational teaching credential course
8 Monitoring and Evaluation USAID
07 Monitoring Training DTRA/Raytheon
2007 Legislative Training DHHS
2006 Project Officer DHHS
2006 Federal Budget DHHS
2006 Grants and Cooperative Agreements DHHS

2006 Appropriations Training DHHS
2006 Microsoft Applications Certification Course
2006 Mental Health in Disasters American Red Cross
06 Victim Advocacy Colorado State University
05 Emergency Response Technician Weapons Mass Destruction (WMD) DHS
2005 Instructor adult education model WMD DHS
2005 Incident Command WMD DHS
2005 National Response DHS FEMA
2005 Professional Development Certification DHS FEMA
2003 Medical Chemical Biological Casualty Training Ft Detrick
2003 Completed several FEMA Emergency Management online courses and NDMS courses
2002 Health Emergencies in Large Populations Johns Hopkins School Public Health
1997 Hazmat and Decontamination Los Angeles
1996 Death Investigations Forensic Coroner s Course Orange County Sheriff
1995 Sexual Assault Investigation Los Angeles County Sheriff
1994 Sexual Assault Nurse Examiner Training Santa Cruz, CA
1989 Crisis Intervention and Debriefing ARC

AFFILIATIONS American Red Cross Mental Health Team
NDMS DMAT CA 9 Supervisory Nurse

PROFESSIONAL PUBLICATIONS Wrote article on Pentagon 9-11 disaster published in NURSEWEEK

TAB N-19

USAJOBS is the official job site of the US Federal Government.
It's your one-stop source for Federal jobs and employment information.

My USAJOBS | Info Center | Veterans | Forms | Employer Services

U.S. Army Medical Command

Department: Department Of The Army
Agency: Army Medical Command
Job Announcement Number:
MD-DHL-09-1468

Overview

NURSE (COMMUNITY HEALTH)

SALARY RANGE: 56,411.00 - 73,329.00 USD /year

SERIES & GRADE: GS-0610-11/11

OPEN PERIOD: Friday, August 07, 2009 to Monday, September 07, 2009

POSITION INFORMATION: - This is a Permanent position. -- Full Time

DUTY LOCATIONS: vacancy(s) in one of the following locations: 1 vacancy - AL - Ft. Rucker

WHO MAY BE CONSIDERED: US Citizens

JOB SUMMARY:
Challenge Yourself - Be an Army Civilian - Go Army!
Civilian employees serve a vital role in supporting the Army mission. They provide the skills that are not readily available in the military, but crucial to support military operations. The Army integrates the talents and skills of its military and civilian members to form a Total Army.

First Cut off Date:08/21/2009

Organization(s):
LYSTER ARMY MEDICAL CLINIC, DEPARTMENT OF PREVENTATIVE MEDECINE, FORT RUCKER, AL

About the Position: Applicants must have active, current registration as a professional nurse in a state, District of Columbia, the Commonwealth of Puerto Rico, or territory of the United States.

Must be able to obtain and maintain Basic Life Support (BLS) Training and certification current Advanced Life Support of other advanced certification does not supersede BLS completion.

Exposure to contagious disease.

Prolonged periods of walking,standing, and driving a motor vehicle.

Ability to obtain and maintain a valid driver's license.

The position is located in the Preventive Medicine Department, Community Health, Lyster Army Health Clinic, Building 301, Andrews Avenue, Fort Rucker, AL. Fort Rucker is the home of the United States Army Aviation Center of Excellence.

Who May Apply: Click here for more information.
- This is a Direct Hire Authority Solicitation.
- All U. S. citizens and Nationals with allegiance to the United States.
- Interagency Career Transition Assistance Plan (ICTAP) eligibles.

KEY REQUIREMENTS:

Redacted

PRINT PREVIEW | EMAIL A FRIEND | SAVE THIS JOB

THBN-19

Redacted

Send Mail

Send Mail to:
Redacted
USACHRA, NC CPOC, 1 Rock Island Arsenal
Rock Island, IL 61299
Redacted

Questions!

For questions about this job:
Redacted
Phone: Redacted
Fax: Redacted
Email: Redacted

USAJOBS Control Number: 1641850

EEO Policy Statement | Reasonable Accommodation Policy Statement | Veterans Information
Legal and Regulatory Guidance

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Contact Us| Privacy Act and Public Burden Information

This is a United States Office of Personnel Management website. USAJOBS is the Federal Government's official one-stop source for Federal jobs and employment information.

Department:
Department Of The Army

Agency:
Army Medical Command

Job Announcement Number:
MD-DHL-09-1466

Job Title:
NURSE (COMMUNITY HEALTH)

Salary Range:
56,411.00 - 73,329.00 USD /year

Series & Grade:
GS-0610-11/11

Open Period:
Friday, August 07, 2009
to Monday, September 07, 2009

Position Information:
- This is a Permanent position. -- Full Time

Duty Locations:
1 vacancy - AL - Ft. Rucker

Who May Be Considered:
US Citizens

Job Summary:
Challenge Yourself - Be an Army Civilian - Go Army!

Civilian employees serve a vital role in supporting the Army mission. They provide the skills that are not readily available in the military, but crucial to support military operations. The Army integrates the talents and skills of its military and civilian members to form a Total Army.

First Cut off Date:08/21/2009

Organization(s):
LYSTER ARMY MEDICAL CLINIC, DEPARTMENT OF PREVENTATIVE MEDECINE, FORT RUCKER, AL

About the Position: Applicants must have active, current registration as a professional nurse in a state, District of Columbia, the Commonwealth of Puerto Rico, or territory of the United States.

Must be able to obtain and maintain Gasic Life Support (BLS) Training and certification current Advanced Life Support of other advanced certification does not supersede BLS completion.

Exposure to contagious disease.

Prolonged periods of walking;standing, and driving a motor vehicle.

Ability to abtain and maintain a valid driver's license.

The position is located in the Preventive Medicine Department, Community Health, Lyster Army Health Clinic, Building 301, Andrews Avenue, Fort Rucker, AL. Fort Rucker is the home of the United States Army Aviation Center of Excellence.

Who May Apply: Click here for more information.
- **This is a Direct Hire Authority Solicitation.**
- **All U. S. citizens and Nationals with allegiance to the United States.**
- **Interagency Career Transition Assistance Plan (ICTAP) eligibles.**

Key Requirements:

com.monster.schemas.Monster.OPM.XmlJobBodyTypeOverviewKeyRequirement@1

Major Duties:
Assists in the coordination and implementation of a comprehensive Community Health Nursing Program for Fort Rucker. Community health nursing is a synthesis of nursing practice and community health principles applied to promoting, preserving, and/or restoring the health of military personnel, their families, and the retired military community through community assessment, adult and child health care, chronic and communicable disease control, health education, referrals, follow-up and liaison activities. Provides counseling and education to families affected by or associated with HIV. Assesses individual's health status based on responses to health risk questionnaire, and clinical determination of height, weight, blood pressure, and glucose / cholesterol readings. Serves as Child and Youth Services (CYS) consultant. Participates in operation of Tuberculosis Control Program (cases, contacts, follow-up, preventive therapy).

here.

Qualifications:
Click on link below to view qualification standard.
General Schedule
- BASIC QUALIFICATION REQUIREMENTS:

A. Education: Degree or diploma from a professional nursing program approved by the legally designated State accrediting agency at the time the program was completed by the applicant. Applicants for Community Health Nurse positions at GS-5 and above must have graduated from a baccalaureate or higher degree nursing program.

B. Registration: Must have active, current registration as a professional nurse in a State, DC, Puerto Rico, or US territory.

SPECIALIZED EXPERIENCE:In addition to meeting the basic requirements above, applicant must possess *1 year specialized experience* equivalent to the next lower grade level GS-09, which equipped the applicant with comprehensive knowledge of an extensive range of public health nursing theories, principles and procedures to provide specialized services to persons with infectious disease or chronic disease of public health importance. Knowledge of human growth and development and the interrelatedness of host, agent, and environmental factors when maintaining individual and community health. Skills to perform crisis intervention with patient and family in a stressful environment in order to provide support and consolation concerning the disease process. Ability to independently assess need, design program goals and objectives, develop quality assurance monitors in support of program goals and to set program priorities based on community need. Knowledge of infectious diseases, sexually transmitted diseases and diseases interfering with the body's normal immune system, especially as related to AIDS and the HIV viruses.

OR

EDUCATION SUBSTITUTION: Completion of all requirements for a doctoral degree (Ph.D. or equivalent) or 3 years of progressively higher level graduate education. Graduate-level education must have been in nursing with a concentration in a field of nursing (e.g., teaching, a clinical specialty, research, administration, etc.) or in a closely related non-nursing field directly applicable to the requirements of the position to be filled.

Regardless of the method that is used to apply, applicants must remember to provide the following :
1. Job announcement # MD-DHL-09-1466.

2. Social security number.

3. Full name, mailing address and day and evening phone numbers.

4. Citizenship.

5. Complete dates (month, day, year, hours per week) of any current or previous employment with a complete description of the duties you performed.

6. If ever employed by the Federal Government, please state the highest grade held, job series, and dates of employment in grade.

7. Nursing degree received and the school received from.

8. Reference the state in which currently and actively licensed as a Registered Nurse.

Failure to provide the required information as stated above, may result in an ineligible rating or may affect the overall rating.

The experience described in your resume will be evaluated and screened for the Office of Personnel Management's basic qualifications requirements, and the skills needed to perform the duties of this position as described in this vacancy announcement.
Applicants who have held a General Schedule (GS) position within the last 52 weeks must meet the Time in Grade Restriction.
Education can be substituted for experience. Review the qualification requirements for specific information.
Only degrees from an accredited college or university recognized by the Department of Education are acceptable to meet positive education requirements or to substitute education for experience. For additional information, please go to the Office of Personnel Management (OPM) and U.S. Department of Education websites at - http://www.opm.gov/qualifications and http://www.ed.gov/admins/finaid/accred/index.html
Foreign education must be evaluated for U.S. equivalency in order to be considered for this position. Please include this information in your resume.
Other Requirements:
Click here for more information.
Personnel security investigation required.
A medical examination is required.
Immunization screening is required.
Child Care Criminal History background checks may be required prior to movement to position.
Must comply with Drug Abuse Testing Program requirements.
Must possess and maintain a valid stateside driver's license.
This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.
Male applicants born after December 31, 1959 must complete a Pre-Employment Certification Statement for Selective Service Registration.
Direct Deposit of Pay is Required.
Position requires employee to wear a uniform and/or protective clothing.
You must include the announcement number on your application.
Applicants claiming veteran's preference must clearly show an entitlement to such preference on the resume/supplemental data submitted.
Failure to provide all of the required information as stated in the vacancy announcement may result in an ineligible rating or may affect the overall rating.
One year trial/probationary period may be required.

How You Will Be Evaluated:
Resumes will be evaluated for basic qualifications requirements and for the skills needed to perform the duties of the position, as described in this vacancy announcement and identified by the Selecting Official for the position.

Benefits:
The Department of Defense offers excellent benefits programs some of which may include:
Comprehensive health and life insurance
Competitive salaries
Generous retirement programs
Paid holidays, sick leave, and vacation time
Flexible work environment and alternate work schedules
Paid employment related training and education
Possible student loan repayment
Payment of licenses, certification, and academic degrees as applicable
Bonuses, incentives, and awards as appropriate for the job.

Other Information:
Click here for more information.
To successfully claim veteran's preference, your resume/supplemental data must clearly show your entitlement. Please review the information listed under the Other Requirements link on this announcement or review our on-line Job Application Kit.
Selection is subject to restrictions resulting from Department of Defense referral system for displaced employees.
The Department of Defense (DoD) policy on employment of annuitants will be used in determining eligibility of annuitants. The DoD policy is available on http://www.coms.osd.mil/ASSETS/E8AB932EA1E44617BAC7222922E42A62/DoDI140025-V300.pdf
Salary includes applicable locality pay or Local Market Supplement.
More information on Army Civilian Nurse Titles is available on https://cpolwapp.belvoir.army.mil/public/forward/VAB?id=nurse
For more information on Army Civilian Nurse Titles click on the link.
In accordance with section 9902(h) of title 5, United States Code, annuitants reemployed in the Department of Defense shall receive full annuity and salary upon appointment. They shall not be eligible for retirement contributions, participation in the Thrift Savings Plan, or a supplemental or redetermined annuity for the reemployment period. Discontinued service retirement annuitants (i.e., retired under section 8336(d)(1) or 8414(b)(1)(A) of title 5, United States Code) appointed to the Department of Defense may elect to be subject to retirement provisions of the new appointment as appropriate. (See DoD Instruction 1400.25, Volume 300, at http://www.dtic.mil/whs/directives.)
Payment of Permanent Change of Station (PCS) costs is not authorized, based on a determination that a PCS move is not in the Government interest.
Temporary Duty (TDY) travel is 5 percent.

Other Advantages: Fort Rucker is located in the "Wiregrass" area in southeast Alabama. Surrounding towns are Enterprise, Ozark, and Daleville, Fort Rucker is approximately 100 miles from the Gulf Coast beaches, and there are numerous fresh water lakes with a short driving distance. The geography and climate are ideal for year round military training. Recreational activities are abundant in the immediate areas for family and fun.

How To Apply:
Click here for more information.
Resumes must be received by the closing date of this announcement.
Announcements close at 12:00am (midnight) Eastern Time.
You may send your resume via surface mail to: North Central, Kathy Young (MEDCELL), USACHRA, NC CPOC, 1 Rock Island Arsenal, Rock Island, IL 61299
You may fax your resume to: 1-866-879-4468
You may email your resume to: ROCK-NCCPOC.medical@conus.army.mil. You must include Job Announcement Number on the subject line.

Required Documents:
You will be required to provide proof of U.S. Citizenship.
If selected, official college or university transcript must be submitted.
Must provide documents for credentialing for health care positions.
For Registered Nurse positions, applicants must have active, current registration as a professional nurse in a State, District of Columbia, the Commonwealth of Puerto Rico, or territory of the United States.
License/Certification: CURRENT, VALID UNRESTRICTED REGISTERED NURSE
All Health Care Providers must be able to obtain and maintain current Basic Life Support (BLS) Training and certification Current Advanced Life Support of other advanced certification does not supersede BLS completion.

Contact Information:
Redacted
Phone: Redacted
Fax: Redacted
Email: Redacted

Or write:
Redacted
USACHRA, NC CPOC, 1 Rock Island Arsenal
Rock Island, IL 61299
Fax: Redacted

What To Expect Next:
Once this announcement closes, candidates will be evaluated using an automated system, (Resumix) which compares your skills and experience as described in your resume with the requirements of the position. If you are found to be a highly qualified candidate, you will be referred to the selecting official for further consideration. (In some cases, individuals with priority for special consideration must be considered and selected before other candidates.) Whether or not you are contacted for an interview depends upon the location of the position and the judgment of the selecting official. You can view the status of announcements that you applied for through our automated response system, ANSWER, accessed through our Civilian Personnel On-Line web page.

TAB N-20

Position Description

PD#: EG109795
Sequence#: 998396

Replaces PD#:

NURSE (CLINICAL/COMM-OCC HLTH)

GS-0610-11

Servicing CPAC: FORT RUCKER, AL
Installation: EGMCW2MQAA3D4
US ARMY MEDICAL COMMAND
LYSTER ARMY HEALTH CLINIC
DEPUTY COMMANDER FOR NURSING
DEPARTMENT OF PREVENTIVE MEDICINE
EPID AND DISEASE
FORT RUCKER, ALABAMA 36362 3D4

Agency: ARMY
Army Command: MC
Command Code: MC
US ARMY MEDICAL COMMAND

Region: SOUTH CENTRAL

Citation 1: OPM PCS NURSE SERIES, GS-610, JUN 77
PD Library PD: NO
FOREDOC PD: NO

Classified By: Redacted
Classified Date: 01/11/2002

FLSA: EXEMPT
Career Program: 00
Functional Code: 81
Competitive Area: MM
Competitive Level: 0189
Emergency Essential: No
[N: Position Not Designated Emergency-Essential Or Key]
Information Assurance: N
PD Status: VERIFIED

Drug Test Required: YES *
Financial Disclosure Required: NO
Requires Access to Firearms: NO
Position Sensitivity: 1
Target Grade/FPL: 11
Bus Code: 1914
Influenza Vaccination: YES

DCIPS PD: NO
Acquisition Position: NO
Interdisciplinary: NO
Security Access: 0
Career Ladder PD: NO
Personnel Reliability Position:

Position Duties:

Assists in the coordination and implementation of a comprehensive Community Health Nursing Program for Fort Rucker. Community health nursing is a synthesis of nursing practice and community health principles applied to promoting, preserving, and/or restoring the health of military personnel, their families, and the military community through community assessment, adult and child health care, chronic and communicable disease control, health education, referrals, follow-up and liaison activities.

TAB N-20

Redacted

8/30/2010

HIV/AIDS = 20%

Plans, implements, evaluates health education classes for active duty soldiers, their commanders, military and civilian supervisors and their staff, health care workers, and other eligible populations with the goal of maximizing assimilation of information and encouraging behavioral change to prevent HIV infection.

Uses adult principles of learning, designs class for each target audience, chooses format for class, e.g., lecture, discussion, small group participation and content, relevant medical and psycho-social information with appropriate language and audiovisual aids to meet the learning needs of each group.

Evaluates classes using a variety of procedures to include pre/post testing and class critiques. Revises classes as necessary to meet teaching/learning objectives.

Provides counseling and education to families affected by or associated with HIV. Counsels families and individuals, to include those who are HIV antibody positive and their contacts, regarding disease transmission and concerns of daily living. Assists with the epidemiological investigation of HIV positive persons and contacts using interview techniques and data collection methods as required. Documents information obtained using approved format and within the parameters of confidentiality. Plans and coordinates health services to assist individuals and families with complex problems involving family disruption and compliance with a medical regime associated with HIV disease. Makes referrals to other Military Treatment Facilities (MTF), civilian health agencies, and special agencies in support of disease control and contact assistance.

Health Promotion = 20%

Assesses individual?s health status based on responses to health risk questionnaire, and clinical determination of height, weight, blood pressure, and glucose / cholesterol readings.

Provides nursing intervention to include individual and group counseling about identified life style health risks and their control (e.g., smoking cessation, stress reduction).

Refers those individuals with high-risk clinical findings for follow-up medical evaluation, treatments and further health education.

Child and Youth Services = 25%

Serves as Child and Youth Services (CYS) consultant. Cooperates with and assists CYS with health concerns (available for specific concerns on children; conducts monthly inspections; conducts classes on health, medication, and communicable disease for staff). Coordinates with civilian school nurses regarding the health of children who are military beneficiaries. Participates on the Special Needs Resource Team.

Communicable Disease/Epidemiological Investigation and Follow-up = 35%

Participates in operation of Tuberculosis Control Program (cases, contacts, follow-up, preventive therapy).

Participates in the epidemiological investigation of communicable diseases.

Conducts health education activities, which revolve around group interaction (e.g., sexually transmitted disease prevention classes for soldiers).

Performs other duties as assigned.

Factor 1. Knowledge Required by the Position - Level 1-7 -- 1250 Points

- Knowledge of an extensive range of public health nursing theories, principles and procedures to provide specialized services to persons with infectious disease or chronic disease of public health importance.

- Knowledge of human growth and development and the interrelatedness of host, agent, and environmental factors when maintaining individual and community health.

- Skills to perform crisis intervention with patient and family in a stressful environment in order to provide support and consolation concerning the disease process. Skills to recognize when a physical or psychological stress factors will require direct intervention by a physician.

- Skill to interact with military commanders, civilian and military groups, school officials, and civilian public health agencies in coordinating patient care, disease control and troop education efforts.

- Knowledge of the epidemiological method and skill in applying the techniques used in gathering data.

- Ability to independently assess need, design program goals and objectives, develop quality assurance monitors in support of program goals and to set program priorities based on community need.

- Knowledge of infectious diseases, sexually transmitted diseases and diseases interfering with the body?s normal immune system, especially as related to AIDS and the HIV viruses.

- Knowledge of and ability to develop and present a variety of forma and informal training classes to individuals and various groups in community health issues.

- Ability to drive a motor vehicle.

- Ability to gain the cooperation of individuals and families some of whom is suspicious, afraid, resistant or noncompliant with public health directives.

Factor 2. Supervisory Controls - Level 2-4 -450 Points

Works under the general supervision of Chief, Community Health Nursing. Coordinates with the supervisor when writing program goals, planning workload and assisting with epidemiological investigations. Performs assignment independently without specific instructions. Adjusts schedules in accordance with community needs. Work is reviewed for effectiveness and contribution to mission accomplishment.

Factor 3. Guidelines - Level 3-3 - 275 Points

Guidelines include physician?s instructions, applicable governing regulations, and standard operating procedures for Preventive Medicine and Community Health Nursing. Guidelines do not provide specific instructions for every possibility. Judgment is required in assessing the psychological and emotional status for patients and in establishing plans of action, which foster patient compliance. Independent decisions beyond the scope of guidelines are required in practicing crisis intervention.

Factor 4. Complexity - Level 4-4 - 225 Points

Provides comprehensive public health nursing services which require skills in planning programs based on community-wide assessment, setting priorities, teaching, psycho-social skills in relating with all segments of the military and civilian community, crisis intervention, knowledge of epidemiology disease control and public health, and knowledge of nursing science. Must be extremely adaptable to work with a wide variety of family health problems and to stay flexible in a generalized multifaceted program.

Factor 5. Complexity - Level 5-3 - 150 Points

Plans, develops, and provides nursing services in accordance with program objectives and priorities and sound professional principles. Work impacts the physical and emotional well being to9 the patient, the ent?s family, and the target population of the community.

Factor 6. Personal Contacts - Level 6-3 - 60 Points

Personal contacts are with patients, families, hospital personnel, community leaders, classes and groups, military commanders, and public health department officials.

Factor 7. Purpose of Contacts - Level 7=3 - 120 Points

Contact with patients and families are to provide nursing care and disease surveillance, allay fears, and encourage treatment compliance. Contacts with individuals and groups are to provide information and allay fears. Contacts with health workers are to coordinate patient care. Contacts with officials are to coordinate programs and relay information.

Factor 8. Physical Demands - Level 8-2 - 20 Points

The work requires prolonged periods of walking, standing, and driving a motor vehicle.

Factor 9. Work Environment - Level 9-2k - 20 Points

Exposure to contagious disease. Danger from driving a motor vehicle. Possible danger from mentally disturbed persons.
EVALUATION STATEMENT

ckground. This is a revision of Position Description #S0129, which was rewritten to accurately reflect the current duty assignments.

2. Title and Series Determination:

a. Series GS-610: This position involves a variety of non-clinical and specialized services to clients with infectious disease or chronic disease of public health importance. Plans, develops and provides comprehensive programs and services designed to meet the needs of special individuals and groups. Assists and collaborates with military treatment facilities and local health authorities in support of disease control, contact efforts, and epidemiological investigations. Designs and implements public health nursing services in accordance with program objectives, priorities, and community-wide assessment. Develops criteria for ongoing monitoring of program. Supports Preventive Medicine mission.

b. Title: The authorized title for positions in this series that perform the above duties is Community Health Nurse.

3. Grade Determination: The appropriate grade is GS-11 as listed the FES factor points below:

Factor 1 Knowledge Required by the Position Level 1-7 1250 Points
Factor 2 Supervisory Control Level 2-4 450 Points
Factor 3 Guidelines Level 3-3 275 Points
Factor 4 Complexity Level 4-4 225 Points
Factor 5 Scope and Effect Level 5-3 150 Points
Factor 6 Personal Contacts Level 6-3 60 Points
Factor 7 Purpose of Contacts Level 7-3 120 Points
Fa 8 Physical Demand Level 8-2 20 Points
Factor 9 Work Environment Level 9-2 20 Points

Total Points 2570 Points

Classification: Community Health Nurse, GS-610-11

DCA Date

* This position is subject to drug testing if the incumbent:

1. Has direct patient contact or performs diagnostic or therapeutic functions

2. Extracts or works with patients' body fluids or tissues; prepares patient specimens for examination, performs specialized or non-routine tests on body fluids or tissue samples, or confirms patients' test results

3. Maintains, stores, safeguards, inputs, fills or distributes drugs and medicines

This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.

Position Evaluation:

FLSA EVALUATION OUTLINE

___Foreign Exemption

___Executive Exemption

___Exercises appropriate supervisory responsibility (primary duty)

___Customarily and regularly exercises independent judgment

___80% test, if applicable (GS 5/6; Sit I & 2 WS supervisors; law enforcement & firefighter supervisors thru GS 9)

___Professional Exemption

___Professional work (primary duty)

___Intellectual and varied work (more than dealing with procedures/precedents)

___Discretion & independent judgment

___80% test, if applicable (This virtually never applies since GS 5/6 positions are trainees and other eligible employees are not professional)

___Administrative Exemption

Redacted

___Primary duty
___Policy or
_Management or general business or supporting services or
___Participation in the executive/administrative FUNCTIONS of a management official

_x__Nonmanual work test
_x__intellectual and significant (more than dealing with procedures/precedents), or
___specialized & technical in nature requiring considerable training/experience

_x__Discretion & independent judgment

___80% test, if applicable

CONCLUSION: EXEMPT

Redacted

TAB N-21

From: Chief, Prev. Med. Clinic @us.army.mil]
Sent: Thursday, August 18, 2011 5:51 PM
To:
Subject: FW: Scope of Practice Discrepancy (UNCLASSIFIED)

Classification: UNCLASSIFIED
Caveats: NONE

Chief, Prev. Med. Clinic
Chief, Preventive Medicine & Radiology
Lyster Army Health Clinic
Bldg 301 Andrews Avenue
Fort Rucker, AL 36362
Office: Redacted
BB: Redacted
Cell: Redacted
FAX: Redacted

-----Original Message-----
From: Chief, Prev. Med. Clinic
Sent: Thursday, January 13, 2011 4:53 PM
To: Whistleblower
Cc: Dep. Cdr for Nursing USA
Subject: FW: Scope of Practice Discrepancy (UNCLASSIFIED)

Classification: UNCLASSIFIED
Caveats: NONE

Whistleblower

As you requested, please see the message below. Let me know if you have any questions.

Chief, Prev. Med. Clinic

-----Original Message-----
From: CA Nursing Ed.
Sent: Friday, January 07, 2011 6:44 PM
To: Dep. Cdr for Nursing MIL USA; Chief, Prev. Med. Clinic
Cc: Redacted
Subject: FW: Scope of Practice Discrepancy (UNCLASSIFIED)

Hello Dep. Cdr for Nursing and Chief, Prev. Med. Clinic,
I have responded below to Chief, Prev. Med. Clinic. Additionally, there is BPC Article 10 Federal Personnel sections that address the questions you are asking.

In Sections Sec. 715 Licenses to practice in state, Sec 716 Denial of License; Disciplinary action against holder of state license, and Sec 717 makes a reference as to federal statues and regulations that federal employees, including the military staff. As federal employees, military staff needs to abide by the federal rules, and if federal rules are in conflict or require the staff (RN) to do beyond the scope allowed in the

TRN-21

CA NPA, as long as the federal employee functions within the policies of the federal agency, the staff may do so and would not be disciplined by the BRN.

I think this is the response you were seeking.

Sincerely,

CA Nursing Ed.
Nursing Education Consultant
CA Board of Registered Nursing
Tel: Redacted
CA Nursing Ed.

-----Original Message-----
From: CA Nursing Ed.
Sent: Friday, January 07, 2011 2:00 PM
To: Chief, Prev. Med. Clinic
Cc: Redacted
Subject: RE: Scope of Practice Discrepancy (UNCLASSIFIED)

Hello Chief, Prev. Med. Clinic
When a CA licensed RN is doing the functions specified in the military protocol as a military staff, he/she can perform the functions in the assigned setting. However, the same RN, outside of the assigned setting and the military role, must be bound by the CA NPA as specified in the BPC section 2725.

Sincerely,

CA Nursing Ed.
Nursing Education Consultant
CA Board of Registered Nursing
Tel: Redacted
CA Nursing Ed.
-----Original Message-----
From: NEC BRN
Sent: Friday, January 07, 2011 11:54 AM
To: CA Nursing Ed.
Subject: FW: Scope of Practice Discrepancy (UNCLASSIFIED)

For your followup, CA Nursing Ed.

Thanks.

Redacted

From: Chief, Prev. Med. Clinic [Chief, Prev. Med. Clinic@us.army.mil]
Sent: Thursday, January 06, 2011 7:42 PM
To: NEC BRN
Cc: Redacted
Subject: Re: Scope of Practice Discrepancy (UNCLASSIFIED)

Thank you for your prompt response, and I understand your point. It would be helpful if you could clarify concurrence in the case where an RN registered under the CA Board of nursing, is hired and working for the military is legally protected and bound to practice nursing under their protocols.

Respectfully,

Chief, Prev. Med. Clinic

----- Original Message -----
From: NEC BRN <NEC.BRN@dca.ca.gov>
To: Chief, Prev. Med. Clinic
Cc: Redacted
Sent: Thu Jan 06 19:03:57 2011
Subject: RE: Scope of Practice Discrepancy (UNCLASSIFIED)

Chief, Prev. Med. Clinic,

We are unable to review the attached documents to do comparison of discrepancies as you have requested.
The rules under which army staff work are different than that of RNs in CA who practices within the NPA.
Since the NPs obtained the furnishing authority, the Board has moved away from RNs managing medications using standardized procedures.

Sincerely,
CA Nursing Ed.
CA Nursing Ed.

From: Chief, Prev. Med. Clinic [Chief, Prev. Med. Clinic]
Sent: Thursday, January 06, 2011 1:30 PM
To: NEC BRN
Cc: Renewals BRN; Dep. Cdr for Nursing MIL USA; Redacted USA MEDCOM USAAMC
Subject: Scope of Practice Discrepancy (UNCLASSIFIED)

Classification: UNCLASSIFIED
Caveats: NONE

Dear Sir/Ma'am,

I need your assistance to confirm if our Standard of Operating Procedures (SOP's) and protocols in the Army are in line with your regulations for the California Board of Nursing. I would appreciate if you could review the attached SOP's and let me know if you have any questions or if it is clearly within the scope of skill level 3 nursing Practice.

Respectfully,

Chief, Prev. Med. Clinic
Redacted Army Nurse
Chief, Preventive Medicine and Radiology Lyster Army Health Clinic Bldg 301 Andrews Avenue Fort Rucker, AL 36362
Office: Redacted
BB: Redacted
Cell: Redacted
FAX: Redacted

Classification: UNCLASSIFIED
Caveats: NONE

Classification: UNCLASSIFIED

TAB O-1

MCXY-DCN 29 July 2010

MEMORANDUM FOR Commander, Lyster Army Health Clinic

SUBJECT: Request Approval for Advanced In-Hire Rate the Whistleblower

1. Purpose. The purpose of this memorandum is to obtain the Commander's approval to set the rate of pay of the Whistleblower at a rate above the minimum rate of the General Schedule (GS) grade because of the candidate's superior qualifications for the position of Community Health Nurse, GS-0610-11 in the, Preventive Medicine Department, Lyster Army Health Clinic, Fort Rucker, Alabama.

2. Discussion.

a. the Whistleblower brings to the civilian workforce extensive experience as well as training and education in the career field. Her experience and education make her very well qualified for this position.

b. Respectfully request the candidate's pay be set at the GS-11 step 10 level. The current salary for GS-11 step 10 is $74, 628. This requested rate is based upon the compensatory equivalent for a Community Public Health Nurse's salary in the private sector. the Whistleblower previously held a GS-11 step 10. It is accurately in proportion to the demands for the position description used at this facility.

3. Recommendation. Because of the mission criticality of this position, our continuing desire to maintain the highest ethical, professional, and performance standards, we strongly recommend the Commander approve the advanced in-hire rate of pay for the Whistleblower.

5. In addition, request approval for a 22 % relocation incentive in the amount of $16,418.00.

4. Point of contact. For additional information, please contact Dep. Cdr for Nursing Redacted

TAB B-1

MCXY-DCN
SUBJECT: Request Approval for Advanced In-Hire Rate the Whistleblower

Dep. Cdr for Nursing

Dep. Cdr for Nursing
LTC, AN
Deputy Commander for Nursing

Redacted

APPROVE _____ Date: 30 Jan 10

~~DISAPPROVE~~: _____ Date: _____

Redacted

Redacted
COL, MS
Commanding

CF:
CPAC

TAB O-2

MCXY-C 29 July 2010

MEMORANDUM FOR Director, Civilian Personnel Advisory Center, Building 5700, Fort Rucker, AL 36362

SUBJECT: Request for Appointment Above Minimum Rate – the Whistleblower

1. Reference MCXY-DCA memo dated 29 July 2010, subject as above.

2. The request for the Whistleblower to be hired immediately at the GS-11, Step 10 level is approved.

3. Point of contact is Redacted Redacted, Human Resources Division, Lyster Army Health Clinic.

Redacted

Redacted
COL, MS
COMMANDING

CONCUR NON-CONCUR

Redacted
Director, Civilian Personnel
Advisory Center

TAB O-2

TAB O-3

RECRUITMENT / RELOCATION BONUS
SERVICE AGREEMENT

A. LOCATION:	B. TITLE, PAY PLAN, SERIES AND GRADE:
Lyster Army Health Clinic, Fort Rucker, AL	Community Health nurse GS-0610-11

C. ANNUAL RATE OF BASIC PAY:	D. BONUS AMOUNT:	PD NUMBER:
$74,628	$16,418	109795

F. BEGINNING DATE:	G. ENDING DATE:
30 Aug 2010	29 Aug 2011

EMPLOYEE'S STATEMENT

I understand that:

a. As a condition of accepting payment, I hereby agree to remain as an employee of the Lyster Army Health Clinic (LAHC) in the above position from the beginning date at least through the ending date of this agreement , following the effective date of my appointment / relocation, unless the agreement is terminated sooner as indicated a below.

b. If my employment in the position shown above is terminated during the period of the agreement at the convenience of the government, I will be entitled to retain the entire bonus.

c. If my employment in the position shown above is terminated during the period of the agreement at my request, or as a result of misconduct or delinquency, I will be required to repay the bonus on a prorate basis to LAHC. The amount to be repaid shall be determined by providing credit for each full month of employment completed under this agreement. I understand that under such circumstances these monies are recoverable from me as a debt due to the United States Government. The approving official may waive repayment if it is determined that a waiver is advantageous to the Federal Government.

d. The bonus is not considered basic pay for computing overtime, retirement, insurance entitlement, or other benefits based on basic pay.

e. This agreement does not in any way commit the Government to continue my employment until the expiration date.

TYPED NAME:	GRADE:	SSN:
the Whistleblower	GS-11	Redacted

SIGNATURE:	DATE:
the Whistleblower	Aug 30, 2010

APPROVING OFFICIAL: (typed name, grade, position title)

Dep. Cdr for Nursing , AN, Deputy Commander for Nursing

SIGNATURE:	DATE:
Dep. Cdr for Nursing DCN	AUG 30 2010

P

TAB P-1

Standard Form 144 (Rev. 10/95) Page 2
Office of Personnel Management
The Guide to Processing Personnel Actions

STATEMENT OF PRIOR FEDERAL SERVICE

To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)
the Whistleblower	Redacted	Redacted

4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?
[X] Yes — If "Yes", check this block and skip to item 8. [ ] No — If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	
HHS, HRSA Rockville, MD	06	07	07	07	07	05	excepted full time
WRAMC - DC	00	08	15	00	09	15	full time Perm
HHS, DMAT, NDMS	99	07	30	07	05	05	intermittent

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?
[ ] Yes — If "Yes", list the following information. [X] No — If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	

8. Do you claim any type of veterans' preference which has not been verified?
[X] No [ ] Yes — Check one of the statements, if it applies to you. I claim preference as the:
[ ] Spouse of a disabled veteran [ ] Mother of a deceased or disabled veteran [ ] Unmarried widow/widower of a veteran

9. **CERTIFICATION:** The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature	Date
the Whistleblower	8-30-2010

NSN 7540-00-634-4101 Previous Edition Usable 144-114

*U.S. Government Printing Office: 1996 - 404-761/32401

TAB P1

TAB P-2

EDUCATION LEVEL

NAME the Whistleblower SSN Redacted

EDUCATION LEVEL: (Circle One)

YY = Not Applicable
01 = No formal education or some elementary school – did not complete
02 = Elementary school completed – no high school
03 = Some high school – did not graduate
04 = High school graduate or certificate of equivalency
05 = Terminal occupation program – did not complete
06 = Terminal OCC program – certificate of completion or diploma or equivalency
07 = Some college – less than one year
08 = 1 year college
09 = 2 years college
10 = Associate degree
11 = 3 years college
12 = 4 years college
13 = Bachelor's Degree
14 = Post Bachelor's
15 = First Professional Degree
16 = Post First Professional
17 = Master's Degree
18 = Post Master's
19 = Sixth year degree
20 = Post sixth year degree
21 = Doctorate Degree
22 = Post Doctorate Degree

ACADEMIC DISCIPLINE: 10

NUMBER OF CREDIT HOURS EARNED: 60

TYPE OF CREDIT HOURS: (Circle One)

1 = Semester 2 = Quarter 3 = Other ____ None

TYPE OF SCHOOL ATTENDED: (Circle One)

B = Junior College
C = College/University
H = High School
S = Secretarial/Business/Commercial School
V = Vocational, Trade, Technical School (At High School Level)
W = Vocational, Trade, Technical School (Above High School Level)
___ Not Applicable

MAJOR OR MINOR ACHIEVED: (Circle One)

0 = None
1 = Major Field of Study Achieved (20 semester/30 quarter hours in major)
2 = Minor Field of Study Achieved (12 semester/18 quarter hours in major)
__ Not Applicable

YEAR HIGHEST LEVEL OF EDUCATION ACHIEVED: AD

SCHOOL WHERE HIGHEST LEVEL OF EDUCATION ATTAINED: Purdue 1974

PERSONNEL USE

EEB ____ ____

ECA ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

AB-P2

TAB P-3

DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES ARMY AEROMEDICAL CENTER
BUILDING 301 ANDREWS AVENUE
FORT RUCKER ALABAMA 36362-5333

REPLY TO
ATTENTION OF

June 8, 2011

the Whistleblower Whistleblower
Redacted

Dear the Whistleblower,

Since 4 January 2011 you have been carried in a Leave Without Pay (LWOP) duty status. In an attempt to substantiate your absence you have provided only minimum medical documentation to support your claim of a medical condition that makes you unable to return to work and perform your assigned duties. On 20 May 2011 you provided me a copy of a medical certificate in which Redacted states that you will never be able to return to work at Fort Rucker. This and previous medical documentation is insufficient to continue you in an authorized absence status as it does not address a diagnosis, prognosis, and an expected duration of your illness.

You are directed to return to work at Fort Rucker, Alabama no later than 29 June 2011. In addition, within 15 days of receipt of this letter, you are directed to provide sufficient medical documentation that addresses what reasonable accommodations, if any, we can make in order for you to perform the essential elements of your job. I have included a copy of your current job description for you to provide to your medical provider. The medical documents from your medical care provider must be a signed original and be on your medical provider's standard office letterhead.

the Whistleblower, it is extremely important that you return to work as directed and that you provide the medical documentation requested. Should you not return to work on 29 June 2011 as directed your duty status will be changed to Absent Without Leave (AWOL) and could lead to disciplinary action against you.

Sincerely,
Chief, Prev. Med. Clinic
Chief, Prev. Med. Clinic

MAJ, AN
Chief, Preventive Medicine

TAB P-3

TAB P-4

MCXY- PM 17 October 2011

MEMORANDUM FOR the Whistleblower, GS-0610-11, Community Health Nurse

SUBJECT: Separation During Probationary Period

1. This memorandum is to notify you of your removal from your position as a Community Health Nurse, GS-610-11, effective close of business 21 October 2011. The basis for your removal is an attendance related offense in violation of AR 690-700, AWOL. You have been AWOL since 7 October 2011.

2. You were hired into the position of Community Health Nursing on 30 August 2010. As a Community Health Nurse, you are required to report to work at 0730 until 1615, Monday through Friday. Your job requirements of caring for patients under the Communicable Disease Surveillance Program including Latent Tuberculosis, Sexually Transmitted Diseases, the HIV program, and potential Outbreaks have not been met. You have failed to successfully complete any of these requirements and you have not indicated a desire or ability to perform your duties under any circumstances.

3. You are being separated during your probationary period which began on the date of your appointment and has been extended pursuant to 5 CFR 315.802(c). The purpose of the probationary period is to allow you the opportunity to prove whether or not you possess the abilities and characteristics essential for your position. You have not demonstrated the appropriate abilities essential for your position. Therefore, I find it is in the best interest of the government and this agency that you be removed from the position of a Community Health Nurse.

4. You may appeal this action to the Merit Systems Protection Board (MSPB) if you feel this action was based on one of the reasons stated in 5 CFR, Section 315.806(b). The address for the Merit Systems Protection Board (MSPC) is Atlanta Region Office, 401 West Peachtree Street, N.W., Tenth Floor, Suite 1050, Atlanta, Georgia 30308. The telephone number is Redacted 1 and FAX number is Redacted Redacted. As an alternative, as of 20 October 2003, an appeal may be filed electronically by using the internet filing option available at the MSPB's website Redacted ml. Your appeal must be filed no earlier than 1 calendar day after the effective date of this action and no later than 30 calendar days after the effective date. The MSPB appeal regulation and forms are on the board's website. However, as an alternative to filing an appeal with the MSPB, you may submit a discrimination complaint by contacting your local Equal Employment Office (EEO) within 45 calendar days of the effective date of this separation. You may not file both a complaint of discrimination utilizing local installation procedures and an appeal with the MSPB which raises discrimination as an issue.

Chief, Prev. Med. Clinic
Chief, Prev. Med. Clinic
MAJ, AN
C, PREVENTIVE MEDICINE

ACKNOWLDGEMENT OF RECEIPT:

Employee's Signature Date

TAB P-4

TAB P-5

Standard Form 50-B
Rev. 7/91
U.S. Office of Personnel Management

NOTIFICATION OF PERSONNEL ACTION

1. Name (Last, First, Middle)	2. Social Security Number	3. Date of Birth	4. Effective Date
the Whistleblower	Redacted	Redacted	10-21-2011

FIRST ACTION		SECOND ACTION	
5-A. Code: 385	5-B. Nature of Action: Termination During Prob/Trial Period	6-A. Code	6-B. Nature of Action
5-C. Code: L2M	5-D. Legal Authority: Reg 315.804	6-C. Code	6-D. Legal Authority
5-E. Code	5-F. Legal Authority	6-E. Code	6-F. Legal Authority

7. FROM: Position Title and Number
NURSE (CLINICAL/COMM-OCC HLTH)
109795 - 2057144

15. TO: Position Title and Number

8. Pay Plan	9. Occ. Code	10. Grade/Level	11. Step/Rate	12. Total Salary	13. Pay Basis	16. Pay Plan	17. Occ. Code	18. Grade/Level	19. Step/Rate	20. Total Salary/Award	21. Pay Basis
GS	0610	11	10	$74,628.00	PA						

12A. Basic Pay	12B. Locality Adj.	12C. Adj. Basic Pay	12D. Other Pay	20A. Basic Pay	20B. Locality Adj.	20C. Adj. Basic Pay	20D. Other Pay
$65,371.00	$9,257.00	$74,628.00					

14. Name and Location of Position's Organization
US ARMY MEDICAL COMMAND
LYSTER ARMY HEALTH CLINIC
DEPUTY COMMANDER FOR NURSING
DEPARTMENT OF PREVENTIVE MEDICINE
EPID AND DISEASE
FORT RUCKER, ALABAMA 36362 3D4

22. Name and Location of Position's Organization

EMPLOYEE DATA

23. Veterans Preference: 1 (1 - None; 2 - 5-Point; 3 - 10-Point/Disability; 4 - 10-Point/Compensable; 5 - 10-Point/Other; 6 - 10-Point/Compensable/30%)

24. Tenure: 2 (0 - None; 1 - Permanent; 2 - Conditional; 3 - Indefinite)

25. Agency Use:

26. Veterans Preference for RIF: YES [ ] NO [X]

27. FEGLI: C0 Basic only

28. Annuitant Indicator: 9 Not Applicable

29. Pay Rate Determinant: 0

Retirement Plan: K FERS and FICA

31. Service Comp. Date (Leave): 11-27-2010

32. Work Schedule: F Full-Time

33. Part-Time Hours Per Biweekly Pay Period:

POSITION DATA

34. Position Occupied: 1 (1 - Competitive Service; 2 - Excepted Service; 3 - SES General; 4 - SES Career Reserved)

35. FLSA Category: E (E - Exempt; N - Nonexempt)

36. Appropriation Code: 84770571BHF

37. Bargaining Unit Status: AR1914

38. Duty Station Code: 011235045

39. Duty Station (City - County - State or Overseas Location): FORT RUCKER / DALE / ALABAMA

40. Agency Data	41.	42.	43.	44.
	PON# OA			TDA DATA MC/W2MQAA/0741/099

45. Remarks

Forwarding address: Redacted

Lump-sum payment to be made for any unused annual leave.

SF 2819 was provided. Life insurance coverage is extended for 31 days during which you are eligible to convert to an individual policy (nongroup contract).

Not entitled to severance pay.

SF8, SF293 and SF2821 issued.

Thrift Savings Plan withdrawal information provided.

46. Employing Department or Agency
S. Army Medical Command (ARMC)

47. Agency Code: ARMC

48. Personnel Office ID: 1991

49. Approval Date: 10-27-2011

50. Signature/Authentication and Title of Approving Official
Redacted
Approving Official

5-Part 50-316

TURN OVER FOR IMPORTANT INFORMATION

Editions Prior to 7/91 Are Not Usable After 6/30/93
NSN 7540-01-333-6238

TAB P-5

NOTICE TO EMPLOYEE

This is your copy of the official notice of a personnel action. Keep it with your records because it could be used to make employment, pay, and qualifications decisions about you in the future.

The Action

- Blocks 5-B and 6-B describe the personnel action(s) that occurred.
- Blocks 15-22 show the position and organization to which you are assigned.

Pay

- When the personnel action is an award or bonus, block 20 shows the amount of that one-time cash payment. When the action is not an award or bonus, block 12 shows your former total annual salary, and block 20 shows your new total annual salary (block 20C plus 20D). The amount in blocks 12 and 20 do NOT include any one-time cash payments (such as performance awards and recruitment or relocation bonuses) or payments that may vary from one pay period to the next (such as overtime pay), or other forms of premium pay.
- Block 20A is the scheduled amount for your grade and step, including any special salary rate you receive. It does NOT include any locality-based pay. This rate of pay serves as the basis for determining your rate of pay upon promotion, change to a lower grade, or reassignment, and is used for pay retention purposes.
- Block 20B is the annual dollar amount of your Interim Geographic Adjustment or, beginning in 1994, your locality-based comparability payment.
- Block 20C is your Adjusted Basic Pay, the total of blocks 20A and 20B. It serves as the basis for computing your retirement benefits, life insurance, premium pay, and severance pay.
- Block 20D is the total dollar amount of any Retention Allowances, Supervisory Differentials, and Staffing Differentials that are listed in the remarks block. These payments are made in the same manner as basic pay, but are not a part of basic pay for any purpose.

Block 24 - Tenure

- Identifies the nature of your appointment and is used to determine your rights during a reduction in force (RIF). Tenure groups are explained in more detail in subchapter 26 of FPM Supplement 296-33 and RIF is explained in FPM Supplement 351-1; both should be available for review in your personnel office.

Block 26 - Veterans Preference for RIF

- Indicates whether you have preference for reduction-in-force purposes.

Block 30 - Retirement Plan

- FICA - Social Security System
- CS - Civil Service Retirement System
- CS-Spec - Civil Service Retirement System for law enforcement and firefighter personnel
- FS - Foreign Service Retirement and Disability System
- FERS - Federal Employees' Retirement System
- FERS-Reserve Tech -Federal Employees' Retirement System for National Guard Reserve Technicians
- FERS-ATC - Federal Employees' Retirement System for Air Traffic Controllers
- FERS-Spec - Federal Employees' Retirement System for law enforcement and firefighter personnel
- FSPS - Foreign Service Pension System

Block 31 - Service Computation Date (Leave)

- Shows when your Federal service began unless you have prior creditable service. If so, this date is constructed to include your total years, months and days of prior creditable civilian and military service.
- Full-time employees with fewer than 3 years of service earn 4 hours of annual leave each pay period; those with 3 or more years but less than 15 years earn 6 hours each pay period; and those with 15 or more years earn 8 hours each pay period.
- Your earnings and leave statement or your time and attendance card will show the rate at which you earn leave and your current unused leave balance.

Block 32 - Work Schedule

- Your work schedule is established by your supervisor.
- A full-time employee works on a prearranged scheduled tour of duty that is usually 40 hours per week. A part-time employee has a prearranged scheduled tour of duty that is usually between 16 and 32 hours per week. An intermittent employee has no prearranged scheduled tour of duty and works when needed.
- Full-time and part-time employees whose appointments are for 90 days or more are usually elegible to earn annual leave; intermittent employees are not.
- Seasonal employees work on an annually recurring basis for periods of less than 12 months each year; they may have a full-time, a part-time, or an intermittent schedule during their work season.
- On-call employees work during periods of heavy workload and are in pay status for at least 6 months of each year; they may have either a full-time or a part-time schedule when they are in pay status.

Block 33 - Part-time Hours Per Biweekly Pay Period

- Indicates the number of hours a part-time employee is scheduled to work during a two-week pay period.

Block 34 - Position Occupied

- Identifies the employment system under which you are serving -- the Competitive Service, the Excepted Service, or the Senior Executive Service (SES).
- The employment system determines your eligibility to move to other jobs in the Federal service, your rights in disciplinary and adverse actions, and your eligibility for reemployment if you leave Federal service.

Block 35 - FLSA Category

- Exempt employees are not covered by the minimum wage and overtime Law (the Fair Labor Standards Act); nonexempt employees are covered.

Block 37 - Bargaining Unit Status

- Identifies a bargaining unit to which you belong, whether or not you are actually a member of a labor organization. Code "7777" indicates you are eligible but not in a bargaining unit; code "8888" indicates you are ineligible for inclusion in a bargaining unit.

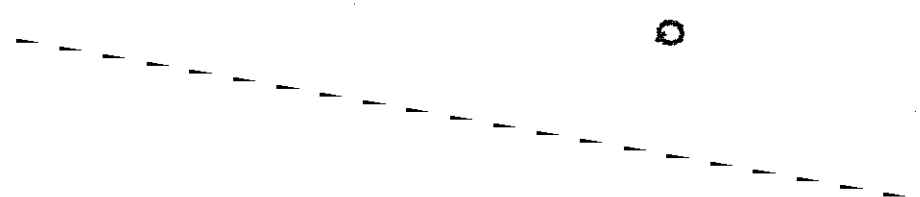
Block 38 and 39 - Duty Station

- Identifies the city, county, and state or the overseas location, where you actually work.

OTHER INFORMATION

- If your appointment entitles you to elect health benefits or life insurance, and you have not been provided materials explaining the programs available and the enrollment forms, contact your personnel specialist.
- Your personnel specialist will also tell you if your position is covered by an agreement between an employee organization (union) and your agency. If you are eligible to and elect to join an employee organization, you can elect to have your dues withheld from your salary.
- If you have questions or need more information about your rights and benefits, ask your supervisor or your personnel office.
- Definitions for any coded data in Blocks 1-24, 27-39 and 45-50 may be found in Federal Personnel Manual Supplement 292-1.

It is your responsibility to read all the information on the front of this notice and tell your personnel office immediately if there is an error in it.



Declaration

I am Chief, Policy & Prog. Br., Chief, Policy and Programs Branch, Civilian Human Resources Division, Headquarters, U.S. Army Medical Command (MEDCOM). I make the following declaration pursuant to 28 U.S.C. § 1746:

1. The Assistant Chief of Staff for Human Resources, Office of the Surgeon General, has responsibility to prescribe personnel administration services for military and civilian personnel of the command. The Civilian Human Resources Division (CHRD), located in San Antonio, Texas, is responsible for the development and execution of all programs, initiatives and regulatory requirements pertaining to the employment and management of 42000 civilian employees command-wide. The Policy and Programs Branch, one of three branches in CHRD, is responsible for the analysis of new legislation, higher echelon policies, directives, and decisions affecting MEDCOM's employment programs. As Chief of a branch with seven specialists, I am responsible for addressing potential issues affecting our healthcare occupations and employees; exploring policy issues and developing recommendations for the command. I am responsible for developing and executing plans for new civilian human resource (CHR) initiatives, such as changes in compensation plans and/or qualification standards; I am responsible for coordinating programs and actions as appropriated with HQDA, OSD, and the other two Services; provide assistance and guidance on CHR matters to lower echelon levels within MEDCOM; implement, maintain, and administer changes in compensation, qualification, and other in other federal wide programs for the MEDCOM civilian workforce.

2. Based on a review of the Whistleblower job application on file, the Whistleblower is a U.S. citizen who possesses an Associate Degree from Purdue University and a current license for Registered Nurse from California Board of Registered Nursing. Based on a description of her training, to include a 2002 Certification from John Hopkins University in Health Emergencies in Large Populations and her work experience from 1978 to August 2002, she is highly qualified for this Community Health Nurse (CHN) position at Lyster Army Health Clinic (LAHC), Fort Rucker, Alabama.

3. On or about early March 2011, I was contacted by the Office of Special Counsel and asked several generic questions related to distinguishing the various types of nursing occupations, to include nursing assistants, licensed vocational nurses / licensed practical nurses (LVN/LPN), registered nurses (RN), and advanced practice registered nurses (APRN). To the best of my recollection, during our discussion, I reviewed AR 40-68, para. 7-4a(2) which listed CHNs as APRNs. I also advised that APRNs are required to possess a Master's Degree or higher, and in many cases required certification as to a specific specialty.

4. Since that time, I have reviewed the Office of Personnel Management (OPM) Position Classification Standard for Nurse Series, GS-0610, dated 8 Jun 1977 which describes the requirements for RN positions throughout the federal government. It is used to establish the occupational series, title, and grade level of each RN position. When I reviewed the specific specializations and titles of RNs, I found

TAB Q

that the CHN specialty can be classified at an entry level beginning above the grade of GS-07. Therefore, CHNs do not necessarily fall under the classification of APRNs.

a. Employees at a grade of GS-07 work under specific instructions when there are variations from established routines and routine duties are performed independently without specific instruction. APRNs are classified at a grade of GS-12 and above and work under administrative direction with broadly defined missions or functions established by the supervisor. At this grade level, APRNs have responsibility for planning, designing and carrying out programs, projects, studies, and other work independently with minimal supervision. In general, the higher the grade, the higher the level of work independence granted to the incumbent and less direct supervisory oversight is necessary.

b. Based on this and a review of the Whistleblower PD, the CHN position at LAHC was advertised and the Whistleblower was hired at the grade of GS-11. Therefore, this position was neither designed nor advertised to be an advanced nursing position.

5. Additionally, I was asked to review the vacancy announcement to determine whether the duties and responsibilities to order and interpret Sexually Transmitted Infection (STI), Tuberculosis and Hepatic Enzyme tests and re-fill Isonizid prescriptions were specifically defined.

a. I reviewed Vacancy Announcement #SCEG09508786, with closing date of 24 Jun 2009. Although the Whistleblower may have learned about the CHN position through this announcement, she was appointed to her position as a CHN at LAHC using the OPM direct hire appointment authority. This government-wide appointment authority for registered nurses allows Fort Rucker officials to appoint qualified individuals without a competitive specific job announcement as long as Army has met its public notice requirement to post a direct hire vacancy announcement for registered nurses on USAJOBS. It is not unusual for hiring officials to consider candidates for employment using applications received from HQ MEDCOM, the MEDCELL MEDIC database, nurse employees, or applications from applicants who visit the military treatment facility or from prior referrals.

b. The duties described in the vacancy announcement are a general overview of the duties of a Community Health Nurse (CHN), GS-0610-11. Additionally, since the Whistleblower was hired using a direct hire appointment, the description of the duties in the position description (PD) are more pertinent than the vacancy announcement.

6. In addition to the vacancy announcement, I also reviewed the PD for the Whistleblower position as a CHN at LAHC to determine whether the duties and responsibilities to order and interpret Sexually Transmitted Infection (STI), Tuberculosis and Hepatic Enzyme tests and re-fill Isonizid prescriptions were specifically defined in the position description or vacancy announcement. The position description (PD) for the CHN position at LAHC[1] described the duties as follows: "Assists in the coordination and implementation of a comprehensive Community Health Nursing Program for Fort Rucker..."

[1] Position Description # EG109795, Sequence #2057144, classified on 11 January 2002 (Nurse – Clinical / Community – Occupational Health)

a. In addition to the description of the assigned duties, the standard PD required by OPM includes a description of the factors used to determine the appropriate occupational series, title, and grade for a particular position. The following is an explanation of the process used to determine the proper occupational series, title, and grade for the Whistleblower position.

1) As discussed above, Classification Series GS 0610 was the classification series used by LAHC to classify the Whistleblower position as a CHN. Under the General Schedule (GS) federal compensation system, the OPM Position Classification Standard is used to assign the proper occupational series, title and value of the officially assigned duties in order to determine the proper grade (salary range) for a position. The GS 0610 occupational series covers all positions which require a professional knowledge of nursing and registration to practice as a professional nurse (i.e. RNs). Based on a review of the CHN PD developed by LAHC, the Whistleblower position is properly classified in the GS 0610 occupational series.

2) The GS 0610 Classification Standard also establishes the grade level of positions based on the evaluation of factors or using comparable benchmarks, or both. the Whistleblower position was evaluated on a factor basis. The nine factors utilized to determine the grade level listed on the last page of her officially assigned job description are: Factor 1 is the Knowledge Required by the Position; Factor 2 is the Supervisory Controls; Factor 3 is the Guidelines for the Position; Factors 4 is Complexity of the position; Factor 5 is Scope and Effect, Factors 6 and 7 are for Personal Contacts and Purpose of Contacts; Factor 8 is Physical Demands of the position; and Factor 9 is the Work Environment. The most pertinent factors as documented on her job description are:

a) Factor 1 (Knowledge Required by the Position) which included the following: Knowledge of an extensive range of public health nursing theories, principles and procedures to provide specialized services to persons with infectious or chronic disease of public health importance; Skills to perform crisis intervention with patient and family; Skill to interact with military commanders, civilian and military groups, school officials, and civilian public health agencies in coordinating patient care, disease control and troop education efforts; Knowledge of the epidemiological method and skill in applying the techniques used in gathering data; Ability to independently assess need, design program goals and objectives, develop quality assurance monitors and to set program priorities; Knowledge of infectious diseases, sexually transmitted diseases, and diseases interfering with the body's immune system; Knowledge of and ability to develop and present a variety of formal and informal training classes on community health issues.

b) Factor 2 (Supervisory Controls) states that the position works under the general supervision of Chief, Community Health Nursing and performs assignment independently without specific instructions. The supervisor sets overall objectives and reviews work for effectiveness in meeting requirements. This factor clearly establishes the position as non-supervisory in nature, although established the position as highly independent, requiring the application of judgment, self motivation, and ability to collaborate and work with others as a team to achieve a common goal.

c) Factor 3 (Guidelines) include physician's instructions, applicable governing regulations, and Standard Operating Procedures for Preventative Medicine and Community Health Nursing. Factor 3 notes, "Guidelines do not provide specific instructions for every possibility" and "Independent decisions beyond the scope of guidelines are required in practicing crisis intervention."

b. Although the specific duties stated above were not explicitly delineated in the PD, such specific tasks are not required to be explicitly stated in a PD or vacancy announcement under the OPM Position Classification Standard. PDs established under OPM guidance are not intended to capture or delineate all tasks or all duties expected to be performed by an incumbent; instead, they are intended to capture paramount grade-controlling major duties and to identify the knowledge, skills, and abilities essential to satisfactorily perform the duties of the position. Beyond the general requirements for the PD, supervisory officials have the authority to assign duties to for each position within the scope of the overall job description as mission requirements dictate. Based on a review of her application in conjunction with the PD for the CHN position at LAHC, the Whistleblower met all the qualification requirements to perform the full scope of the assigned duties.

7. Other than the Position Description and Vacancy Announcement, management officials have other opportunities to define the required duties of a position being filled through the interview process, while assigning performance objectives to the new hire, and through the initial orientation of the new employee. In this case, LAHC established an Initial Competency Assessment form to be used during orientation. It is appropriate and expected that during the interview and selection process, while developing performance objectives, and completing the Initial Competency Assessment that discussions would focus on required duties of the position and defining the expectations to the new hire.

8. During the hiring process in this case, the Commander of LAHC authorized an advanced in-hire rate for the Whistleblower to have her entry pay set at GS-11, Step 10. Based on a review of job description and vacancy announcement, this position was advertised as a GS-11, RN. Without the advanced in-hire rate, the Whistleblower would have started at GS-11, Step 1. The difference in annual pay between GS-11, Step 1 and GS-11, Step 10 would have been $17,220. In addition to the advanced in-hire rate, also received a relocation incentive of $16,418.00 at the time of hire.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 30 November 2011.

Chief, Policy & Prog. Br.

Chief, Policy & Prog. Br.

Chief, Policy and Programs Branch
Civilian Human Resources Division
HQ, U. S. Army MEDCOM