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Headquarters, U S Army Medical Command
Operation Directorate, Plans Division
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MEDCOM REDEPLOYMENT/DEMobilIZATION PLAN (U) (FULL PLAN)

1. (U) PURPOSE AND BACKGROUND: This plan provides Health Support Operations guidance for processing Active Component (AC) redeployment and Reserve Component (RC) demobilization. The Deployment Cycle Support (DCS) Contingency Plan (CONPLAN), dated 3 May 03, divides the overall operation into three phases; redeployment, post-deployment, and reconstitution. Redeployment and demobilization processing will be conducted in a manner that demonstrates priority to the health and welfare of the returning soldiers.

2. (U) CONDITIONS FOR IMPLEMENTATION: This plan will be implemented under conditions of either large or small-scale redeployment/demobilization of soldiers, and pertains to soldiers activated in support of all active operations regardless of deployment within the Continental United States (CONUS) or Outside the Continental United States (OCONUS), unless otherwise indicated. US Army Medical Centers (MEDCEN)/US Army Medical Activities (MEDDAC) Commanders having Power Projection Platforms (PPP)/Power Support Platforms (PSP) (demobilization sites) within their Health Service Area (HSA) must be prepared to conduct large or small-scale processing, on order, from Regional Medical Commands (RMC) and Health Care Operations, US Army Medical Command (MEDCOM). The dynamic and probable changing nature of the redeployment/demobilization operations dictates the requirement for frequent and rapid communication up and down the medical command structure to ensure shifting of resources within a region or nationally can be accomplished in time to meet the requirements.

3. (U) OPERATIONS TO BE CONDUCTED:
 - a. (U) Elements Assigned: Office of the Surgeon General (OTSG)/MEDCOM elements tasked by this plan are:
 - (1) (U) The OTSG/MEDCOM Staff (within their functional areas).
 - (2) (U) Major Subordinate Commands (MSC), other than RMCs (within their functional areas).
 - (3) (U) Regional Medical Commands (overall management of demobilization operations within their health service region (HSR)).

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(4) (U) MEDCENS/MEDDACs/US Army Dental Activities (DENTAC) (those having direct responsibility for medical and dental care at demobilization stations (PPP/PSP) within their HSA).

b. (U) Supporting Plans: Supporting plans are required from elements having direct responsibility/involvement.

4. (U) SUMMARY OF CHANGES: NA.

5. (U) CONFLICTING GUIDANCE: If guidance in this plan conflicts with Army Regulations or Headquarters Department of the Army (HQDA) guidance, notify HQ MEDCOM, ATTN: MCOP-P, then follow the guidance in the regulation or HQDA guidance until resolution of the conflict.

6. (U) COMMAND RELATIONSHIPS:

a. (U) The OTSG/MEDCOM will retain overall control of the Medical/Dental demobilization processing within CONUS.

b. (U) Operational control will be exercised by the MEDCOM through the RMCs.

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MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U) (FULL PLAN)

UNITED STATES ARMY MEDICAL COMMAND OPERATION PLAN FOR THE REDEPLOYMENT DEMOBILIZATION OF MEMBERS OF THE UNITED STATES ARMY (U) (FULL PLAN)

(U) REFERENCES:

- a. Memorandum Chu USD (P&R), 22 Apr 03 , Subject: Enhanced Post-Deployment Health Assessment with Attachment
- b. AR 40-501, Standards for Medical Fitness, 30 Sep 02, paragraph 8-23c. Separation and Retirement Examinations
- c. AR 40-66, Medical records Administration and Health Care Documentation, 10 Mar 03, paragraphs 5-13, 5-14, 5-19, 5-28, 5-29, 5-30, and 5-36
- d. MSG HQDA, Subject: Personnel Planning Guidance (PPG), Annex E (Medical and Dental), updated Feb 03
- e. OTSG Memorandum, DASG-ZA, 20 Dec 2002, Subject: Demobilization Guidance for all Reserve Component (RC) Soldiers activated in Support of Contingencies.
- f. CONPLAN (U) DA, Deployment Cycle Support (DCS), 2 May 03.
- g. Memorandum Embrey USD (P&R), 1 May 03, Subject: Tracking Post-Deployment Health Assessments.

1. (U) SITUATION:

a. (U) General:

(1) (U) DA CONPLAN Deployment Cycle Support integration. Our Soldiers have responded to the call to duty in an exemplary manner. We have demanded levels of excellence from them to which they have risen and surpassed. We have also placed a tremendous physical and mental stress on them and their families. We are moving into a new dimension by addressing reconstitution of Soldiers within the context of reconstituting units and The Army. The intent is to provide "the right tools and training",

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and follow-on support to facilitate Soldier and family readiness beyond current operations. The Army will communicate the DCS plan to leaders at all levels and establish the means by which to account for and track all personnel throughout the DCS process.

(a) (U) A key element of DCS is the reestablishment of soldier readiness to include personnel readiness, deployment readiness, and family readiness. In order to effectively reconstitute Soldiers, The Army will conduct DCS operations in depth beginning in-Theater / Area of Responsibility (AOR), continuing at home and/or Demobilization Stations, and with sustainment at Home Stations. DCS operations will include ALL Soldiers, to include those departing theater/AOR on emergency leave, medical evacuation, and other individual redeployment scenarios. The chain of command must be involved at all levels to ensure that DCS requirements are accomplished for all effected Soldiers including Army personnel deployed with other services. While the most visible effort is oriented at Soldiers redeploying from Iraq, DCS requirements apply equally for those Soldiers deployed OCONUS and within CONUS, but away from Home Station. This is especially true for RC soldiers who have been away from their home and place of employment for an extended period of time.

(b) (U) Post-employment DCS consists of the following major components – education, assessment, and processing, conducted during three phases – Redeployment, Post-deployment, and Reconstitution – which will extend into the post-conflict normal Train-up/Sustainment phase. Soldiers will receive assessments to determine required support to be performed either in-Theater/AOR, during Redeployment, Post-deployment, Reconstitution and normal Train-up/Sustainment operations. Actions take place concurrently at deployed location, Demobilization Stations, and Home Stations where possible. In general, soldiers are not held in-Theater to conduct all tasks if required transportation is available. Task completion must be tracked for every Soldier. Those tasks not completed in phase become the responsibility of all commanders at the next phase or location. Tasks from subsequent phases may be completed earlier, given appropriate resources and time to accomplish these tasks. For more specific guidance, a discussion of each phase of DCS, and specific tasking tables for OTSG/MEDCOM see Annex G (DCS CONPLAN).

(2) (U) This plan provides guidance for the medical/dental processing through all phases of the DCS process, with the focus on the post-deployment phase, specifically the demobilization of RC soldiers at the demobilization site.

(3) (U) This plan and supporting plans must demonstrate sufficient flexibility to encompass the wide spectrum of variables created by the phasing, while accomplishing the following:

(a) (U) Integration of redeployment (phase 1) medical processing, as time and resources permit with post-deployment (phase 2) demobilization processing at demobilization sites, and continuing actions during reconstitution (phase 3).

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- (b) (U) Expeditious processing
- (c) (U) Providing to the medical / dental care needs of each soldier.
- (d) (U) Integration with Reserve Component Home Station medical activities.

b. (U) Enemy Forces: Not applicable.

c. (U) Friendly Forces:

(1) (U) The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) serves as the principal staff assistant and civilian advisor to the Secretary of Defense. The ASD (HA) will:

(a) (U) Provide policy oversight for all medical/dental activities in the Department of Defense (DoD).

(b) (U) Establish and maintain liaison with the DoD Components, Military Services, and other Government Agencies

(c) (U) Provide policy direction to the DoD Components and Military Services.

(2) (U) The OTSG/MEDCOM provides policy guidance and direction to all MEDCOM subordinate elements regarding the medical/dental aspects of demobilization.

d. (U) Assumptions:

(1) (U) Units will be returned to the same installation from which they deployed. Individual Mobilization Augmentees (IMA) may demobilize from their current duty station.

(2) (U) Soldiers Medical/Dental records will be available at their initial deployment platform for review during demobilization. Those records taken back to the RC unit's home station after soldier readiness processing (SRP) will be returned to the deployment platform through coordination with the unit.

(3) (U) Soldiers will return with their DD Form 2766 Adult Preventive and Chronic Care Flow sheet containing any of the following completed forms as may be appropriate: DD Form 2795 and 2796, Pre and Post Deployment Health Assessment, Documentation showing all treatment received in theater and a corresponding Line of Duty (LOD) (DA Form 2173), completed by the unit.

(4) (U) The new Enhanced DD Form 2796 Post-Deployment Health Assessment (four pages) will be used in paper or electronic form.

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(5) (U) The populations at installations will not exceed the installation's capacity.

2. (U) MISSION To establish a CONUS wide capability for the effective and rapid medical/dental AC redeployment and RC demobilization. The goal of this plan is twofold.

a. (U) To ensure each soldier is provided, as needed, all medical and dental care resulting from illness or injury incurred while deployed or on active duty status. This includes a complete briefing to ensure a full understanding of the continuing benefits that are available.

b. (U) To minimize the necessary "time on station" that will permit a rapid return to home station or civilian status without sacrificing the thoroughness of post-deployment evaluation.

3. (U) EXECUTION:

a. (U) Concept of Operation:

(1) (U) Soldiers will redeploy and demobilize in three phases in accordance with (IAW) the DCS plan. Soldiers will redeploy to the deployment platform from which they deployed and mobilized. Individual Mobilization Augmentee may demobilize at their current duty deployment platform. The installation commander has overall responsibility of the redeployment/ demobilization process, but the MEDCEN/MEDDAC/DENTAC Commander or designated representative has responsibility for the medical and dental aspects of redeployment/demobilization processing.

(2) (U) The medical/dental requirements identified in paragraph 2 of Reference D to this plan, as modified by Reference A, are the minimal requirements for redeployment/demobilization. The requirements are specifically defined and expanded in Annex A (medical) and Annex B (dental) of this plan.

(3) (U) Returning soldiers will be treated with the utmost courtesy and respect. The soldiers will be anxious to return to family and friends and the redeployment/ demobilization process must support that goal without overlooking necessary documentation that may be required to ensure eligibility for possible long term health care needs.

b. (U) Responsibilities:

(1) (U) The Office of the Surgeon General/MEDCOM:

(a) (U) Acts as the overall coordinator for the US Army Medical Department on all matters pertaining to medical/dental demobilization.

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(b) (U) Provides overall guidance and instructions concerning medical examinations and evaluation and subsequent rehabilitation procedures for returning soldiers.

(c) (U) Monitors all aspects of this plan to ensure effective and successful accomplishment of all assigned tasks.

(d) (U) Establish and maintain liaison with other Government agencies and military departments.

(e) (U) Monitor arrangements in OCONUS processing locations to ensure that the Post Mobilization Health Assessment and other medical/dental demobilization actions are completed or initiated to facilitate rapid transition to civilian status.

(2) (U) MEDCOM, Assistant Chief of Staff, Personnel (ACSPER):

(a) (U) Monitors the planned return of AC Professional Filler System (PROFIS) personnel. When possible provide advance notice to RC backfill personnel to prepare for demobilization.

(b) (U) Provide quick response to taskings for medical personnel requirements in support of demobilization efforts.

(3) (U) MEDCOM, Assistant Chief of Staff, Operations (ACSOPS):

(a) (U) Primary staff element for plan and execution coordination.

(b) (U) Overall control of plan execution.

(4) (U) MEDCOM, Assistant Chief of Staff, Logistics (ACSLOG): Responsible for logistical support of this plan (See Annex D).

(5) (U) Regional Medical Commands : Commanders of CONUS RMCs will monitor medical/dental demobilization operations at all sites in their region. RMC Commanders will ensure adequate resources are available for subordinate commanders via the management of regional personnel and logistical assets as required.

(6) (U) MEDCEN/MEDDAC/DENTAC Commanders: Maintain close coordination with the host installation staff regarding the arrival of demobilizing soldiers. Develop detailed demobilization actions plans in concert with installation parameters and the guidance/direction provided in this plan. Shortfalls/concerns that impair medical/dental redeployment/demobilization processing must be communicated to the next higher headquarters in the medical/dental command channels at the earliest date and time.

4. (U) ADMINISTRATION AND LOGISTICS:

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a. (U) Administration: Administrative guidance is contained in the Annexes of this plan.

b. (U) Logistics: See ANNEX D.

5. (U) COMMAND AND SIGNAL:

a. (U) Command:

(1) (U) MEDCOM Health Care Operations is responsible for the overall direction and coordination of the medical/dental demobilization processing.

(2) (U) The OTSG/MEDCOM staff directors will continue to provide detailed guidance and direction to subordinate elements with respect to demobilization in their specific functional area.

(3) (U) The MEDCOM Emergency Operations Center (EOC) will function as the communications center for all demobilization processing matters.

b. (U) Signal:

(1) (U) All communications concerning this plan and its execution will reference the short title MEDCOM Demobilization Plan.

(2) (U) Maximum use will be made of voice and electronic communications networks when appropriate.

(3) (U) All MEDCOM elements assess secure communications capabilities within their organization. Report any shortfalls through the chain of command to the MEDCOM EOC.

(4) (U) All unclassified communications will be conducted with commercial phones, e-mail and fax.

(5) (U) All classified communications will be conducted using secure phones and FAX VIA STU III or STE. All secure electronic mail communications will be handled VIA SIPRNET and Global Command and Control System (GCCS) in priority.

(6) (U) Annex F to MEDCOM Operation Order (OPORD) 01-99 (Force Protection) will be used as the guideline for establishing Information Operations standards and essential operating guidance in support of the Force Protection Program.

6. (U) SUPPORTING DOCUMENTS:

ANNEXES:

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A - MEDICAL PROCESSING
B - DENTAL PROCESSING
C - PERSONNEL POLICIES/SERVICES
D - SERVICE SUPPORT
E - MEDICAL/DENTAL DEMOBILIZATION FORMS
F – PUBLIC AFFAIRS/HEALTH INFORMATION OPERATIONS
G – DEPLOYMENT CYCLE SUPPORT PLAN [EXTRACT]
H - REPORTS
I - GLOSSARY
J - THRU Y. NOT USED
Z - DISTRIBUTION

BY ORDER OF THE SURGEON GENERAL OF THE ARMY:

JAMES B. PEAKE
Lieutenant General
The Surgeon General

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ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLAN (U)

1. (U) Situation. (see paragraph 1 of basic plan)
2. (U) Mission. To rapidly and thoroughly complete the medical demobilization requirements indicated in the appendices of this annex.
3. (U) Execution.
 - a. (U) Commanders Intent. All redeploying AC and demobilizing members of the RC be provided the same standardized medical demobilization processing throughout all CONUS demobilization stations. Medical processing must be completed as expeditiously as possible without sacrificing any benefit/entitlement due a soldier injured in the line of duty while in an active or federal status. This includes the proper documenting of medical/records and entries into the Medical Protection System (MEDPROS).
 - b. (U) Concept of Operations. Complete the following listing of actions at each demobilization station. The sequence may vary depending on the confines of the physical facility. Details will be provided in the Appendices of this Annex. At a minimum, the following requirements must be met:

(1) (U) Provide all soldiers with a benefits and entitlements briefing. The briefing should include at least, but are not limited to, the following topics (see Appendix 1 of this Annex):

- (a) (U) The right to request a Release from Active Duty (REFRAD) physical.
- (b) (U) TRICARE benefits following REFRAD.
- (c) (U) Points of Contact (POCs) for TRICARE claim issues (hard copy).
- (d) (U) Department of Veterans Affairs (DVA) access.
- (e) (U) Active Duty Medical Extension (ADME)
- (f) (U) Summary of the major deployment-specific health threats.

(2) (U) A “face to face” interview will be accomplished by a health care provider (physician, physician assistant or nurse practitioner) and the soldier to review, discuss, and document all entries on the enhanced DD Form 2796, Post-Deployment Health Assessment (4 pages) now available at <http://www.dior.whs.mil/icdhome/forminfo/FormInfoPage2347.htm>. Positive responses may trigger the use of supplemental assessment tools (available at <http://www.pdhealth.mil/> and in other Appendices of this Annex, and/or referrals for

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medical consultation based on all items noted in the Health Assessment section, on page 4, of the DD Form 2796. In addition the DD Form 2697 Report of Medical Assessment will be completed for soldiers pending REFRAD with the needed input from the soldier (see Appendix 2 to this Annex).

(3) (U) A health care provider will conduct a complete the record review including DD Forms 2795, Pre-Deployment Health Assessment, 2796 Post-Deployment Health Assessment and 2697, Record of Medical Assessment and review all available medical records to determine if a consultation, physical examination, depleted uranium bioassay, or further medical care is required. In addition, the health care provider will ensure that a DA Form 2173 Statement of Medical Examination and Duty Status was initiated at the time of treatment for each injury and/or disease including those relating to dental care. If a DA Form 2173 is required and none present, the health care provider will initiate one at the time of medical/dental out-processing. If applicable, a completed DD Form 261, Report of Investigation-Line of Duty and Misconduct Status, must be completed by the unit and also be included.

(4) (U) A copy of the completed and signed DD Form 2796 will be forwarded (VIA FedEx or other express mail carrier) to the Army Medical Surveillance Activity (AMSA), Building T-20, Room 213, (ATTN: MCHB-TS-EDM), 6900 Georgia Avenue, N.W., Washington, D.C. 20307-5001; phone (202) 782-0471 (DSN: 662).

(5) (U) All soldiers will receive a Post-Deployment tuberculin skin test (TST) to screen for latent tuberculosis infection. The test will be performed twice, first during medical demobilization then again between 3 and 6 months after demobilization. Except for the second TST results, TST and demobilization related data will be entered into MEDPROS Individual Medical Record (IMR) for all personnel by the demobilization processing station. The Army Reserve Regional Readiness Command (RRC) Surgeons and Army National Guard (ARNG) State Surgeons are responsible for ensuring that TST and demobilization related data has been entered into MEDPROS IMR for all personnel (see Appendix 3 to this Annex).

(6) (U) A redeployment blood sample for HIV antibodies will be obtained from all soldiers no later than 30 days following demobilization/home station. Samples will be obtained from all RC soldiers before REFRAD during medical demobilization processing (see Appendix 4 to this Annex).

(7) (U) All soldiers that do not meet the medical retention standards indicated in Chapter 3, AR 40-501 Standards of Medical Fitness, must be referred to a medical evaluation board/physical evaluation board (MED/PEB) (see Appendix 5 of this Annex for more details).

(a) (U) DA Form 2173 Statement of Medical Examination and Duty Status. The health care provider should have initiated part 1 of this form at the time of treatment for each injury and/or disease to include dental care. It should be located in the DD Form 2766 folder. If the initiated/completed DA Form 2173 is not found that supports

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treatment while on active duty, it will be initiated during medical redeployment/demobilization. If applicable, a DD Form 261, Report of Investigation-Line of Duty and Misconduct Status will be completed by the unit and , must also be included.

(b) (U) The Active Duty for Medical Extension Option.

(8) (U) Disposition of Forms and Records (see Appendix 6).

4. (U) Administration/Logistics. (see paragraph 4 of basic plan) Specific administrative and/or logistical requirement may be indicated.

5. (U) Command and Signal: No Change.

Appendix 1 - Medical Benefits and Entitlements Briefing.

Appendix 2 - Health Care Provider Interview.

Appendix 3 - Tuberculin Skin Test (TST).

Appendix 4 - Blood Draw.

Appendix 5 - Soldiers not meeting Retention standards.

Appendix 6 - Disposition of Records and Forms.

Appendix 7 - Preventive Medicine Issues.

Appendix 8 - Medical Protection System (MEDPROS).

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APPENDIX 1 (MEDICAL BENEFITS AND ENTITLEMENTS BRIEF) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING) (U)

1. (U) Purpose: To provide direction and guidance for the medical benefits and entitlement briefings to be provided to each soldier. This information is designed to ensure uniformity, standardization and completeness of the briefing content worldwide.
2. (U) General Guidance.
 - a. (U) Briefing information should include, but is not limited to, the following topics:
 - (1) (U) The right to request a REFRAD physical
 - (2)(U) Active Duty Medical Extension.
 - (3)(U) TRICARE benefits following REFRAD.
 - (4)(U) Points of contact for TRICARE claim issues.
 - (5)(U) Department of Veterans Affairs access.
 - (6)(U) Summary of the major deployment-specific health threats.

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APPENDIX 2 (HEALTH CARE PROVIDER: INTERVIEW) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING) (U)

1. (U) Purpose: To provide direction and guidance for the health assessment interview to be conducted with each soldier. This information is designed to ensure uniformity, standardization and completeness of the interview content worldwide.
2. (U) General Guidance.
 - a. (U) During the redeployment process, the Military Departments shall ensure that each returning individual has a face-to-face health assessment with a trained health care provider.
 - b. (U) Health care providers must be a physician, physician assistant, or a nurse practitioner.
 - c. (U) This assessment will include discussion of:
 - (1) (U) The individual's responses to the health assessment questions on the revised DD Form 2796.
 - (2) (U) Mental health or psychosocial issues commonly associated with deployments.
 - (3) (U) Special medications taken during the deployment.
 - (4) (U) Concerns about possible environmental or occupational exposures.
 - (5) (U) Retained shrapnel fragments/Depleted Uranium (DU) exposure.
 - d. (U) Positive responses require use of supplemental assessment tools (available at <http://www.pdhealth.mil/>) and/or referrals for medical consultation. The provider will document concerns and referral needs and discuss resources available to help resolve any post-deployment health issues, both near-term and in the future, based upon DoD guidance such as that reflected in the Post-Deployment Health Clinical Practice Guideline (PDH CPG).
 - e. (U) The original completed DD Form 2796 will be maintained in the individual's permanent medical record. Copies (paper or electronic) will be sent to the Army Medical Surveillance Activity.
 - f. (U) Forms:
 - (1) (U) DD Form 2796, Post Deployment Health Assessment, April 2003 .

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(2) (U) DD Form 2697, Record of Health Assessment.

g. (U) Forms required for review include:

- (1) (U) DD Form 261 - Report of Investigation-Line of Duty and Misconduct Status
- (2) (U) DD Form 2697 - Report of Medical Assessment
- (2) (U) DD Form 2766 - Adult Preventive and Chronic Care Flow Sheet
- (3) (U) DD Form 2795 - Pre-Deployment Health Assessment
- (4) (U) DD Form 2796 - Post-Deployment Health Assessment
- (5) (U) DD Form 2807-1 - Report of Medical History
- (6) (U) DD Form 2808 - Report of Medical Examination
- (7) (U) DA Form 2173 - Statement of Medical Examination and Duty Status
- (8) (U) SF 603 - Health Record - Dental
- (9) (U) SF 603A - Health Record – Dental Continuation
- (10)(U) MEDPROS IMR - MEDPROS Individual Medical Record

TAB A – Health Care Providers' Guidelines for Use of the Post Deployment Health Assessment, DD Form 2796

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TAB A (HEALTH CARE PROVIDERS' GUIDELINES FOR USE OF THE POST DEPLOYMENT HEALTH ASSESSMENT, DD FORM 2796) TO APPENDIX 1 (MEDICAL BENEFITS AND ENTITLEMENTS BRIEF) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMobilIZATION PLAN (U)

1. (U) References:

a. DOD Instruction 6490.3 "Implementation and Application of Joint Medical Surveillance for Deployments," 7 August 1997.

b. 10 USC 1074f, "Medical tracking system for members deployed overseas," 18 November 1997.

c. ASD(HA) Memorandum, "Policy for Pre- and Post-Deployment Health Assessments and Blood Samples," 6 October 1998 (HA Policy 99-002).

d. ASD(HA) Memorandum, "Updated Policy for Pre- and Post-Deployment Health Assessments and Blood Samples," 25 October 2001 (HA Policy 10-017).

e. JCS Memorandum, "Updated Procedures for Deployment Health Surveillance and Readiness," 1 February 2002 (MCM-0006-02).

f. USD(P&R) Memorandum, "Enhanced Post-Deployment Health Assessments," 22 April 2003.

2. (U) Background:

a. (U) In accordance with public law, military regulation, and policy, all soldiers returning from deployment will complete a DD Form 2796 and receive a face-to-face health assessment by a trained health care provider (HCP). The purpose of this screening is to review each soldier's current health, possible exposures, and to field any deployment-related health concerns the individual may have.

b. (U) The Post-Deployment Health Assessment (DD Form 2796) is primarily used to document post-deployment health and any deployment-related occupational/ environmental (O/E) exposures. The form provides a preliminary clinical template for the assessment of O/E exposures potentially associated with both physical and psychological ailments. It is not necessarily a sensitive screening tool for detecting or predicting such post-deployment medical conditions as latent malaria, tuberculosis, or even post-traumatic stress disorder; but it will serve as a useful adjunct to future clinical encounters related to the deployment, and permits early-as-possible referral to appropriate care for high-risk individuals.

3. (U) General Guidance:

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a. (U) Key to the success of this screening program is provider sensitivity. Given battlefield conditions and the fog of war, isolating the reality of exposure to trauma or to O/E significant elements (toxins, vectors, etc.) is very difficult. Providers need to listen to and be empathetic to the soldier's clinical complaints. Based on the screening HCP's clinical judgment, soldiers who may need further assessment or definitive specialty care should be given an opportunity to obtain it. Experience from the last Gulf War and the "Gulf War Syndrome" that followed indicates the importance of communicating honestly, openly, and forthrightly with soldiers and their exposure concerns.

b. (U) When dealing with exposure or trauma-linked symptoms, a quick diagnosis may be obtained, but in some cases multiple clinic visits and evaluations are needed to arrive at a final diagnosis. Specialty assessment or consultation with the Deployment Health Clinical Center (DHCC) may be needed. Further, some symptoms may not present for months, so it is imperative that all soldiers be provided a fact sheet listing available resources and points of contact should they have symptoms or concerns that arise in the future.

c. (U) A systematic approach in evaluating patients with symptoms associated with deployment has been developed by the DHCC in conjunction with the Veteran's Administration, link to the following Web page for additional information (<http://www.pdhealth.mil/clinicians/PDHEM/Guideline/content/algorithms/algo1.htm>). The DHCC website (<http://www.pdhealth.mil/main.asp>) also provides several behavioral health screening tools to aid providers in better evaluation of soldiers.

4. (U) Screening Algorithm (see Enclosure 1)

a. (U) The screening algorithm depicts the normal flow of screening, and may be modified as circumstances warrant. Further, this algorithm is not meant to restrict a HCP's clinical judgment, only to aid in the screening and decision-making processes.

b. (U) Soldiers should be thoroughly screened by the screening HCP prior to referral to specialty care. Sometimes soldiers endorse items by mistake. Based on the HCP's clinical interview and judgment, many of these mistaken endorsements can be resolved prior to a specialty care referral.

c. (U) In sum, there are three likely types of situations screeners will face:

(1) (U) The soldier without symptom or complaint. This individual will have selected few if any positive exposure answers, will deny any complaints, and will not have any concerns. During the interview, probe a little to ensure the person is not merely "pencil-whipping" the form or is "in denial" while actually being at risk. Once cleared, this individual should be given a standard fact sheet discussing available resources and points of contact should concerns or symptoms arise in the future.

(2) (U) The soldier with some exposure and some symptoms that cannot be explained and resolved during the screening visit or the soldier that concerns you

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because of the amount of exposure, trauma, or other health issues. This individual should be given specific fact sheets regarding those exposures or symptoms involved, and referred to his/her primary care provider (PCP) and/or specialty care as appropriate. In the case of demobilizing reservists, these PCP and/or specialty visits should be scheduled prior to their release from active duty if possible. This individual should also be given a standard fact sheet discussing available resources and points of contact should other concerns or symptoms arise in the future.

(3) (U) The soldier who has little exposure and no significant symptoms, but who is concerned – the “worried well.” This individual should be given specific fact sheets targeted towards their concerns and a standard fact sheet discussing available resources and points of contact should other concerns or symptoms arise in the future. If the individual remains concerned or requests a more thorough examination, refer the individual to his/her PCP for follow-up. In the case of demobilizing reservists, these PCP visits should be scheduled prior to their release from active duty if possible.

d. (U) The primary purpose of the DD Form 2796 is to provide HCPs a brief screening form to evaluate the post-deployment health of returning soldiers. Questions on the 2796 generally fall into four categories: demographic questions (primarily found on the first page), general health questions (items 1-3, 6 and interview questions 1-3, 6), O/E / exposure questions (items 4, 5, 7-9, 14-18 and interview question 5), and mental health questions (items 10-13, and interview question 4).

5. (U) General Health Questions

a. (U) General health questions (items 1-3, 6 and interview questions 1-3, 6) should provide the screening HCP the basis for determining the current state of a soldier's health. The questions listed on the 2796 should not be seen as all inclusive, but rather as a point of departure for any health issues, symptoms, or concerns the soldier may have.

b. (U) The screening HCP should develop a general sense of each soldier's health by reviewing the soldier's answers on the 2796, having a face-to-face interview with the soldier, and by reviewing, if available, the soldier's deployment medical records, to include the soldier's DD Form 2795, Pre-Deployment Health Assessment if available. General health questions, health care utilization during deployment, vaccinations given, medications (current and taken during the deployment), and clinical symptoms should be components of the health assessment. A limited physical exam to evaluate positive symptoms may be indicated if time, privacy conditions, and circumstances allow.

c. (U) General health issues or complaints that need additional assessment (beyond what time and circumstance will allow during the brief face-to-face screening) should be referred to the soldier's PCP or to specialty care as appropriate. In the case of demobilizing reservists, these PCP visits should be scheduled prior to their release from active duty if possible.

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6. (U) Occupational and Environmental Exposure Questions

a. (U) Redeploying soldiers may have concerns related to biological, chemical, and physical substance/agent exposures that they experienced, or believe they experienced, during this deployment. Their questions will likely center on potential health effects from these exposures. They will wonder if their exposures caused health effects they had during the deployment, or that they may currently have. Some may be concerned that they will suffer long-term health effects as a result of an exposure (such as cancer). They will also worry if any exposure may affect their spouses or children (born or unborn).

b. (U) These exposures can come from the ambient environment (such as surrounding air, food, water, dirt/dust/sand, or insects), specifically from an occupational exposure (directly related to their MOS or job functions), or related to the wartime activities/military agent usage they were involved in. These are referred to collectively as O/E exposures.

c. (U) The screening HCP has a limited amount of time at the screening, and may or may not be the soldier's primary care provider (PCP). His/her primary purpose regarding disposition of the soldier with O/E exposures or possible exposures is to: a. determine if the soldier has concerns, b. if the concerns can be answered with information or risk communication tools at hand, by the screening HCP, or c. if the concerns are realistic and potentially significant, health-wise (see below) and the soldier should be referred for more in-depth evaluation with either his/her PCP and/or specialist such as in Occupational and Environmental Medicine (OEM). [Note: any soldier who has concerns on the questionnaire that are not addressed at screening should have a follow-up visit, at least with their PCP, and/or provided information on resources available].

d. (U) Steps to follow (if resources and/or knowledge are readily available to the screening HCP, otherwise follow-up may be needed with a follow-on appointment or the soldier's PCP) to determine a potentially significant, realistic event or concern include:

(1) (U) Determine if there was a realistic/plausible exposure.

(2) (U) Determine if there is/was a health effect.

(3) (U) Determine if the exposure could have caused the health effect.

(4) (U) Determine if the amount of exposure was enough to have caused the health effect, or if latent effects may be possible (which may require medical surveillance).

(5) (U) Determine if there were objective measurements taken to corroborate the concerns. (If the screening HCP discovers that there were measurements taken,

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and the soldier was unaware that they existed, determine if the exposure was sufficient to further evaluate the soldier based on this).

(6) (U) Determine if the soldier's comrades were also affected.

e. (U) A realistic/plausible exposure is one in which the soldier can give an account of what s/he was exposed to, from a trustworthy source, and even better if s/he can characterize the amount of exposure somehow (how often exposed, level of exposure). There may be objective evidence (e.g. measurements) or knowledge of such exposures from in-theater and these should be documented, if available. Other Army databases (e.g. Deployment Environmental Surveillance Program (US Army) [DESP] <http://chppm-www.apgea.army.mil/desp>) may contain such information. In addition, use of protective clothing and equipment – availability and compliance - are important variables to consider.

f. (U) Health effects related to deployment may have many possible causes. However, soldiers may perceive symptoms or health issues (as raised in the questionnaire) to be related to O/E exposures. These concerns should be addressed, either by the screening HCP, or in a follow-on visit with the soldier's PCP or specialist. A review of (deployment) medical records may provide more objective insight into health issues. If there are or have been symptoms/health effects during or after the deployment, and a realistic/plausible exposure, follow-up with a specialist may be indicated to determine if there is an association, and what follow-up may be indicated (e.g. medical surveillance).

g. (U) A lot of information is available regarding the association between realistic/plausible O/E exposures and their potential health effects. Some websites include: <http://www.pdhealth.mil/> and the CHPPM website (<http://chppm-www.apgea.army.mil/>). In addition, consultation is available with OEM physicians/HCPs. The screening HCP may not have the time to look into these associations during the screening (so it may be up to the follow-on PCP or specialist to explore), however, the screening HCP could make a judgment regarding health effects and route and timing of exposure (e.g. an inhalation hazard and lung symptoms, a skin contact and rash subsequently).

h. (U) Regarding the exposures listed in question 14 and other common exposures and/or concerns among redeploying soldiers, fact sheets for both the HCP and the soldier are available on the above websites and may provide answers that address these concerns at the time of the screening.

i. (U) The screening HCP may have limited time to address many of the issues that arise from positive answers to O/E exposure questions on DD Form 2796 and possible related health effects during the interview. This section has provided a framework to understand and approach O/E issues as much as is possible, address what can be addressed in the interview, and make appropriate judgments as to when a soldier should be referred to a follow-on appointment with their PCP or a specialist, e.g.

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in OEM. Here are some suggested minimum questions to ask about the exposures/agents that the soldier lists as his/her top concerns:

- (1) (U) Agent/exposure.
- (2) (U) Date and location (Nearest city/troop camp) of exposure.
- (3) (U) How did you determine you were exposed?
 - (a) (U) () Env testing () NBC Alarm/Monitor () Inhaled it?
 - (b) (U) () Got on Skin () Read report/Heard fm others?
 - (c) (U) () Penetrating wound/imbedded fragment.
- (4) (U) How much exposure did you have?
 - (a) (U) () High/frequent?
 - (b) (U) () Med/Occasional?
 - (c) (U) () Low/Rare () Not sure?
- (5) (U) Has the exposure caused any health problems for you and/or did you see sick call for it/them? () yes () No?
- (6) (U) Did you use protective equipment? () No () Yes?

7. (U) Mental Health Questions

a. (U) The DA Form 2796 is a screening tool and is intended to be a starting point towards a discussion of potential psychosocial issues with a HCP. It is not intended to be a definitive, diagnostic tool.

b. (U) The DA Form 2796 provides brief screening for “interest in care” (item 10 and interview item 4), depression (item 11), suicidal ideation (item 11c), post-traumatic stress (item 12), and aggressive ideation (item 13).

c. (U) Many mental health symptoms following traumatic events are normal reactions to the very unusual circumstances. In order to avoid potential stigma sometimes associated with seeking mental health services, soldiers should be thoroughly screened by the HCP and options such as treatment by the primary care provider or counseling by a chaplain should be explored prior to being referred to mental health providers for further assessment or treatment.

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d. (U) Particular attention must be paid to items 10-13. If a soldier screens positive for one or more of the following items, gather additional information through the clinical interview and a medical records review:

(1) (U) A desire for assistance (item 10),

(2) (U) Any concerns about self-harm (item 11c),

(3) (U) "A Lot" to any of the other depression screening items (item 11),

(4) (U) Three or more of the acute stress disorder/post-traumatic stress disorder screening items (item 12).

(5) (U) Any concerns over loss of control (item 13b).

e. (U) In order to avoid potential stigma sometimes associated with seeking mental health services, soldiers should be thoroughly screened by the HCP prior to being referred to mental health providers for further assessment or treatment.

f. (U) Items 7-9 address combat exposure. Most soldiers cope very well with traumatic exposure and do not need any further medical support. If a soldier endorses one of these items, the HCP may wish to inquire if the individual is interested in discussing the issue further. However, unless there is significant associated symptoms, a referral for follow-up is contraindicated if the soldier declines the invitation.

g. (U) At each screening location, behavioral health personnel should be available or on-call to handle any concerns screening HCPs may have and to follow-up on soldiers needed more in-depth specialty assessment. In addition, chaplain support should also be available or on-call.

8. (U) Health Risk Communication and Handling Soldier Concerns

a. (U) General Guidelines.

(1) (U) Soldiers returning from a hostile environment may be highly concerned about environmental exposures they may have encountered during their deployment. Do not take their mistrust and apprehension personally, and do not discount their concerns. Other underlying factors are probably contributing to feelings of mistrust, confusion and frustration. HCPs must remain professional, actively listen to service member concerns, answer questions when possible, and document all concerns raised, taking extra care not to pass judgment on validity or non-validity of the concern.

(2) (U) Screening HCPs should provide feedback on exceptionally difficult or exceptionally well-handled communication issues to U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) Health Risk Communication

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Program (Ms. Marilyn Null (Marilyn.Null@apg.amedd.army.mil)) in order to improve deployment risk communication efforts.

b. (U) Specific Guidelines.

(1) (U) HCPs should have as much information as possible about actual and potential environmental exposures at specific deployment locations. This allows HCPs to anticipate likely questions and prepare to answer them. Having information on specific exposure concerns ahead of time can help the HCP better answer service member questions directly and immediately, not relying solely on written products, or sending the service member to someone else for answers. By providing as much information as possible about known deployment location conditions pre-, during, and post-deployment, HCPs can reduce the effects of rumors, mistrust, and allegations of cover-up.

(2) (U) HCPs should actively listen to returning service member concerns, answer questions immediately when possible, and let them know where to get additional information (DHCC, CHPPM website, etc.).

(3) (U) Do not confront, contradict, or minimize individuals or their concerns; all concerns deserve an HCP's complete professionalism. HCPs should avoid taking personally expressions of mistrust or anger at reassurances they might offer. Document concerns raised during the screening interview for further evaluation and analysis of underlying issues.

(4) (U) HCPs need to show respect and appreciation for the service member's recent service, and demonstrate care and respect for the service member at all times. When indicated, spend a few extra minutes to gain their perspective regarding possible exposures at their deployment locations.

9. (U) Documentation.

a. (U) The HCP will document soldier concerns and any referral needs on the DD Form 2796. The original completed DA Form 2796 will be filed in the soldier's permanent medical records.

b. (U) If the soldier is screened in-theater, the original DA Form 2796 will be temporarily filed in the soldier's deployment medical packet, pending final posting to his/her permanent medical records once the permanent record becomes available.

c. (U) A copy of each individual's DA Form 2796 will be forwarded to the Army Medical Surveillance Activity, Building T-20, Room 213, (Attn: MCHB-TS-EDM), 6900 Georgia Avenue, N.W., Washington, D.C. 20307-5001; phone (202) 782-0471 (DSN: 662).

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d. (U) Referrals to the PCP or to specialty care will be documented on both the DD Form 2796 and on an SF 513 (Consultation Request) form.

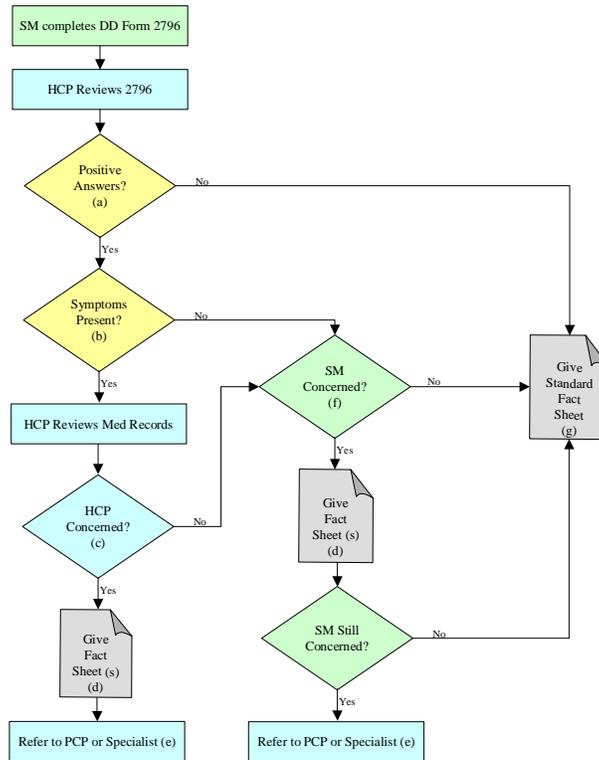
e. (U) Local procedures will be developed for tracking requested and completed consultations in order to streamline the screening process and to ensure that soldiers receive the requested care.

Enclosure 1 – DD Form 2796 Screening Pathway

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ENCLOSURE 1 (DD FORM 2796 SCREENING PATHWAY) TO TAB A (HEALTH CARE PROVIDERS' GUIDELINES FOR USE OF THE POST-MOBILIZATION HEALTH ASSESSMENT, DD FORM 2796) TO APPENDIX 1 (MEDICAL BENEFITS AND ENTITLEMENTS BRIEF) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMobilIZATION PLAN (U)

DD Form 2796 Screening Pathway



Footnotes To DD Form 2796 Screening Pathway

a. (U) Review 2796 for positive answers to general health questions, occupational/environmental (O/E) and mental health exposures and concerns. O/E exposures come from the ambient environment (such as surrounding air, food, water, dirt/dust/sand, or insects), specifically from an occupational exposure (directly related to their MOS or job functions), or from a soldier's wartime activities/military agent usage he or she was involved in. For mental health, pay particular attention to the following items and gather additional information as needed:

- (1) (U) A desire for assistance (item 10),
- (2) (U) Any concerns about self-harm (item 11c),

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(3) (U) "A Lot" to any of the other depression screening items (item 11),

(4) (U) Three or more of the acute stress disorder/post-traumatic stress disorder screening items (item 12).

(5) (U) Any concerns over loss of control (item 13b).

b. (U) Review physical and mental health symptoms on 2796 and through interview and/or possibly a limited physical exam. The medical record or the history by the soldier may provide information on a likely cause for some symptoms listed (e.g. orthopedic injuries). Some symptoms may be associated with exposures, or may be perceived by the soldier to be associated. It will be difficult in some cases to rule in or out an exposure cause, especially during the screening.

c. (U) Use clinical judgment to determine if further care is needed in one or more areas. You may have concerns about the individual's mental health based on his/her responses on the DA Form 2796 and/or your interview. You may also be concerned about O/E exposures if you suspect a possible linkage between exposures and symptoms. If a linkage is suspected, or the soldier feels this is a top exposure concern, possible follow-on questions may include:

(1) (U) Agent/exposure.

(2) (U) Date and location (Nearest city/troop camp) of exposure.

(3) (U) How did you determine you were exposed?

(a) (U) () Env testing.

(b) (U) () NBC Alarm/Monitor.

(c) (U) () Inhaled it.

(d) (U) () Got on Skin.

(e) (U) () Read report/Heard fm others.

(f) (U) () Penetrating wound/imbedded fragment.

(4) (U) How much exposure did you have?

(a) (U) () High/frequent.

(b) (U) () Med/Occasional.

(c) (U) () Low/Rare.

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(d) (U) () Not sure.

(5) (U) Has the exposure caused health problems for you and/or did you go to sick call for them? () No () Yes.

(6) (U) Did you use protective equipment? () No () Yes.

d. (U) Provide the soldier a fact sheet for each specific mental health and/or exposure concern. These are available on the CHPPM or PDHealth websites for general mental health issues and for each of the exposures listed in item 14. There are those aimed at the HCP and those aimed at the soldier. These fact sheets provide information about what health effects these exposures and/or issues may cause, and what levels of exposure may cause harm.

e. (U) If soldier needs more thorough evaluation, refer for a follow-up appointment with primary care provider or, if warranted, with a specialist. Mental health referrals – particularly for possible harm to self (item 11c) or to others (item 13b) – should be seen ASAP.

f. (U) Even in the absence of existing symptoms, some redeploying soldiers may have concerns related to biological, chemical, physical substance/agent exposures, or psychosocial trauma which they experienced, or believe they experienced, during this deployment. These concerns usually center on current health effects, long-term health effects (such as cancer), and/or threat of harm to their spouses or children (born or unborn). These concerns are real and must be taken seriously. Provide information sensitively and honestly.

g. (U) Provide each soldier a standard fact sheet listing information and resources should concerns and/or symptoms appear at a later date.

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APPENDIX 3, TUBERCULIN SKIN TEST (TST) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING) (U)

1. (U) Purpose: To provide direction and guidance in completing the Tuberculin Skin Test.

2. (U) General Guidance.

a. (U) Redeploying Soldiers are required to receive screening for latent tuberculosis infection during post deployment. This is to ensure that personnel who have been deployed to high-risk areas are screened.

b. (U) All soldiers will have a TST applied and read at the time of redeployment and again between 3 and 6 months later.

c. (U) All reserve component soldiers will have the initial TST performed at the demobilization station. The TST should be administered within 24 hours of arrival and read 48-72 hours later.

d. (U) The Army Reserve Regional Readiness Command Surgeons and Army National Guard State Surgeons are responsible for ensuring that follow on TST results are conducted and entered into the MEDPROS IMR for all personnel.

e. (U) Ensure that the reading of the TST is marked on the Demobilization Checklist, the medical record and in MEDPROS. Health record documentation must include the amount of site induration 48-72 hours after application in terms of "mm of induration".

f. (U) Reserve Component Commands requiring assistance to coordinate soldier's follow-on medical care should contact the Regional Medical Command RC Noncommissioned Officer for their area. These POCs are:

(1) (U) North Atlantic RMC (202) 782-3441.

(2) (U) Southeast RMC (706) 787-2485.

(3) (U) Great Plains RMC (210) 295-2365.

(4) (U) Western RMC (253) 968-4590.

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APPENDIX 4 (BLOOD DRAW) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING) (U)

1. (U) Purpose: To provide direction and guidance to obtain an HIV blood sample during redeployment, from each soldier. This information is designed to ensure uniformity and standardization of the blood sample drawn.
2. (U) General Guidance.
 - a. (U) As a part of the redeployment process, a blood sample for HIV antibody will be obtained from each individual no later than 30 days after arrival at a redeployment/demobilization site.
 - b. (U) The HIV blood samples for individuals separating from active duty (including Reserve Component members who are demobilizing) should be obtained before REFRAD during demobilization.
 - c. (U) The blood sample will be forwarded to the DoD Serum Repository using the trans-shipment process used for routine HIV testing..

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APPENDIX 5 (SOLDIERS NOT MEETING RETENTION STANDARDS) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING) (U)

1. (U) References:

a. OTSG Memorandum, DASG-ZH, 26 Feb 03, Subject: MEDCOM Field Operating Guide (FOG) for Reserve Component Soldiers on Active Duty Medical Extension (ADME). The memorandum can be located on the web at <http://pad.amedd.army.mil/MEDCOM/patient/ADME%20FOG%203-03%20.pdf>.

b. Active Duty Medical Extension Template Forms can be located on the web at <http://pad.amedd.army.mil/MEDCOM/patient/ADME%20form%20templates%20Mar%2003.doc>.

2. (U) Purpose/objective of this Appendix: To provide requirements and guidance on the disposition of soldiers who are identified with medical conditions that do not meet the medical retention standards of Chapter 3, AR 40-501. This information is designed to ensure uniformity of benefit and entitlement administration, standardization, correctness, and the tracking of soldiers entitled to continuing care beyond active duty.

3. (U) Guidance.

a. (U) Reserve Component soldiers (army Reserve or National Guard) on orders for more than 30 days who are identified as not meeting medical retention standards of Chapter 3, AR 40-501 are required to undergo Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processing prior to release from active duty.

b. (U) Referral to an MEB will be made as soon as the medical condition(s) is identified as not meeting medical retention standards. The MTF Commander is responsible for ensuring timely completion of the MEB and referral to a PEB.

c. (U) Reserve Component soldiers on orders for more than 30 days who do not meet medical retention standards will be referred to the MEB/PEB regardless of whether the condition is determined to have existed prior to service.

d. (U) The MEBs will be conducted IAW the provisions of Chapter 7, AR 40-400.

e. (U) If the soldier's mobilization orders expire prior to completion of the MEB/PEB, the soldier can request to remain on active duty in an ADME status for completion of the MEB/PEB. The reference in Para 1 above, OTSG Memorandum, DASG-ZH, 26 Feb 03, Subject: MEDCOM Field Operating Guide (FOG) for Reserve Component (RC) Soldiers on Active Duty Medical Extension (ADME), contains the ADME guidance.

f. (U) Soldiers will be tracked in the Medical Evaluation Board Internal Tracking Tool (MEBITTS).

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APPENDIX 6 (DISPOSITION OF RECORDS AND FORMS) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING) (U)

1. (U) Purpose: To provide direction and guidance on the disposition of records and forms. This information is designed to ensure uniformity, standardization and disposition of medical records and forms worldwide.

2 (U) General Guidance.

a. (U) Demobilization Medical Record/Document Disposition:

(1) (U) The original DD form 2795, DD Form 2796, DD Form 2697 and any completed DA Form 2173 will be placed in the soldiers' health record. All documentation related to medical treatment received during the period of Active Duty (AD) will also be included in the health record. When complete the health record will be forwarded back to the appropriate record custodian at the service member's unit.

(2) (U) A copy of the completed DD Form 2796 will be sent to the Army Medical Surveillance Activity, ATTN: MCHB-TS-EDM, Bldg T-20, Room 213, 6900 Georgia Ave., NW, Washington D.C. 20307-5001

(3) (U) A copy of all DA Form 2173s and DD Form 261s will be given to the unit and to soldier for his/her personal records.

(4) (U) A copy of the DD Form 2697, Record of Medical Assessment will be sent to the Department of Veterans Affairs, DVA Records Management Center, P.O. Box 50200, St. Louis, MO 63115-8959.

b. (U) Medical personnel at the demobilization site will enter the completion dates for the DD Form 2795 and DA Form 2796 into the Medical Protection System (MEDPROS) Individual Readiness Module (IMR).

c. (U) Dental personnel at the demobilization site will ensure that the need for authorized extended dental care is documented on the SF 603/603A, which will be transposed onto the soldiers DD Form 214 by Adjutant General (AG) personnel, where appropriate.

d. (U) Forms may be obtained at the following Websites:

(1) (U) DA Forms <http://www.usapa.army.mil>

(2) (U) DD Forms . <http://www.dior.whs.mil/ICDHOME/DDEFORMS.HTM>

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APPENDIX 7 (RETAINED FRAGMENTS, INCLUDING DEPLETED URANIUM [DU] GUIDANCE) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING) (U)

1. (U) References.

- a. Army Regulation (AR) 40-5, 15 October 1990, Preventive Medicine.
- b. Memorandum, U.S. Army Medical Command, 9 Apr 1999, subject: Policy for the Treatment of Personnel Wounded by Depleted Uranium Munitions
- c. Army Regulation (AR) 11-9, 28 May 1999, The Army Radiation Safety Program
- d. Army Regulation (AR) 700-48, 16 September 2002, Logistics: Management of Equipment Contaminated with Depleted Uranium or Radioactive Commodities
- e. Department of the Army Pamphlet (DA Pam) 700-48, Logistics: Handling Procedures for Equipment Contaminated with Depleted Uranium or Radioactive Commodities
- f. Technical Guide 211, "Radiobioassay, Collection Labeling and Shipping Requirements," U.S. Army Center for Health Promotion and Preventive Medicine, July 1998. <http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG211.pdf>
- g. Clinical Practice Guideline for Post-Deployment Health Evaluation and Management, December 2001. <http://www.pdhealth.mil/main.asp>
- h. American National Standards Institute (ANSI), HPS N13.22-1995, Bioassay Programs for Uranium, 1996.
- i. Agency for Toxic Substances and Disease Registry (ATSDR), Uranium Toxicological Profile and Public Health Statement, September 1999. <http://www.atsdr.cdc.gov/toxprofiles/tp150.html>

2. (U) Mission. USAMEDCOM assets will provide treatment and occupational health follow-up for personnel with retained fragments of any kind and for personnel who internalized significant amounts of depleted uranium (DU) that is consistent with current policies and the policies outlined in this Appendix.

3. (U) Execution.

- a. (U) Commander's Intent.

(1) (U) The Army will care for specifically identified Soldiers with either embedded metal fragments or aerosolized exposures to same IAW references in this Appendix. Procedures will be in place to identify Soldiers with embedded fragments,

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ensure required procedures are followed and allow the centralized tracking of these patients. There will be sufficient redundancies in the tracking system to allow the identification and rapid resolution of anomalies as they arise. This will require the centralized accumulation of data and patient information at the MEDCOM.

(2) (U) The joint nature of current medical operations requires that close coordination be effected with the other Services and DoD to ensure the transparent exchange of data between Services. Close coordination will be maintained with the Department of Veterans Affairs to ensure continuity of care and procedures. The occupational follow-up of soldiers exposed to DU will be IAW the policies outlined in this Appendix. Risk communication is a vital aspect of the execution of this policy and will require providers to familiarize themselves with the program and its implications. Our actions will be consistent with DoD policies and with the DVA/DoD Post Deployment Clinical Practice Guideline: <http://www.pdhealth.mil/main.asp> This web site will serve as the focal point for the provision of risk communication information.

(3) (U) The desired end-state will be that::

(a) (U) All personnel with embedded metal fragments will be identified, monitored, and tracked. See TAB A, for definition of categories of exposure to DU).

(b) (U) Removed fragments will be sent to USACHPPM for analysis IAW the policies outlined in this Appendix.

(c) (U) All Category I and II DU personnel will be identified, monitored, and tracked with their status readily retrievable and verifiable with the numerator and denominator data fully characterized.

(d) (U) All Category III DU personnel with bioassays performed will be known

(e) (U) All personnel with retained DU will be offered the opportunity to participate with the VA Health Care System in the DU follow-up study.

(f) (U) All DU bioassay results with dose estimates will be reported to and maintained at the U.S. Army Radiation Standards and Dosimetry Laboratory, Ionizing Radiation Dosimetry Branch.

(g) (U) The Office of Primary Responsibility (USAMEDCOM Health Policy and Services) will perform verifications at multiple levels to ensure consistency between systems (e.g., does the total number of bioassays performed by the laboratory equal the number of results on file in the Ionizing Radiation Dosimetry Branch?)

b. (U) Concept of Operations. The AMEDD will utilize Medical Treatment Facilities (MTF), Medical stations at Demobilization sites (installations), US Army Center for Health Promotion and Preventive Medicine (USACHPPM), and other appropriate resources (e.g., contracted laboratory support) to ensure the highest level of care and necessary follow-up of patients with embedded metal fragments. The Army Medical

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Department (AMEDD) will coordinate with DVA to ensure Soldiers are referred, appropriately, to the DVA DU follow-up program. Close coordination with other Services, DoD, and DVA will be maintained using appropriate venues.

c. (U) Tasks to Units:

(1) (U) MTF will:

(a) (U) Identify personnel with retained metal fragments and, using existing automated patient records, provide the necessary support for bioassay, patient encounter tracking, and close patient-to-provider interaction. Providers must clearly document these cases and coders will input as accurately as possible to the ICD-9-CM diagnosis that best fits the patient's condition.

(b) (U) Treat removed fragments as if they are laboratory specimens and send to the USACHPPM for analysis of the composition of the fragment. Notify USACHPPM if it is believed that the patient still retains fragments of the type submitted for analysis. When multiple similar fragments are removed from a patient the attending physicians may permit the patient to keep selected non-radioactive fragments as souvenirs provided USACHPPM has been sent a representative sampling. Results of this analysis will be retained in automated and paper medical records and reported to the patient.

(c) (U) Use the 1999 OTSG DU fragment removal policy (Reference b.) in treating and communicating bioassay results regarding personnel suspected of being wounded by DU munitions or being wounded by the penetration of DU armor by any munition.

(d) (U) Use the guidance delineated in TAB A to determine if bioassay is required for occupational monitoring.

(2) (U) Medical Demobilization stations will include questions on retained fragments, possible exposures, and other data (see TAB B for supplemental questions and response matrix) in follow-up to the completion of the DD Form 2796, Post-Deployment Health Assessment. Results will be reported through Command Channels.

(3) (U) The RMCs will provide oversight and guidance to their Health Service Region (e.g., radiation safety support).

(4) (U) The USACHPPM will be responsible for the Army bioassay and metal fragment identification processes. USACHPPM will serve as the Army lead for coordination of the laboratory procedures between the Services and the DVA. USACHPPM will provide USAMEDCOM Patient Administration Division (PAD) with lists of names of personnel and status of laboratory actions. Dose assessment reports and status reports will be sent to the U.S. Army Radiation Standards and Dosimetry Laboratory, Ionizing Radiation Dosimetry Branch for Army personnel and to other Services as required. USACHPPM will report results of fragment analysis to the MTF

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that submitted the sample. This MTF is responsible for ensuring the results are entered into the individual's medical records.

(5) (U) USAMEDCOM PAD will be responsible for identifying the coding requirements to ensure that patients with retained fragments post-conflict have their medical records coded appropriately. If a Soldier, either inpatient or outpatient, has any retained fragments, the medical record, DD Form 2766, (Adult Preventive and Chronic Care Flowsheet) item 20, will be annotated with an appropriate entry. Entries may include; suspected DU, embedded fragment, retained tungsten fragment, suspected retained shrapnel, retained metal fragments, embedded metal fragments.

(a) (U) Patients medically evacuated (both in and outpatient) require a TRAC2ES entry in the Patient Movement Request (PMR) type injury code.

(b) (U) Patients followed up or evaluated per treatment guidelines at all MTF must have appropriate Standard Ambulatory Data Record (SADR) entry.

(c) (U) Receive, summarize, and cross check all reports received to ensure completeness and identify anomalies in the procedure.

(d) (U) Coordinate with Army G-1 for lists of personnel awarded the Purple Heart. These will be used as a method for ensuring that our list of patients is complete.

(6) (U) OTSG Health Care Operations will develop a training program to ensure key installations are properly trained on these procedures. Key installations include Fort Bragg, Fort Stewart, Fort Hood, Fort Campbell, and other installations from where significant troop units have been deployed.

d. (U) Coordinating Instructions:

(1) (U) Military personnel from the other Services will be treated within the military or DVA healthcare system. Tests or care obtained from outside of the military or DVA healthcare system will be in accordance with the current TRICARE Management guidelines. Veterans as identified by military or DVA healthcare providers may participate in the DVA's long-term study on embedded metal fragments.

(2) (U) The Assistant Chief of Staff, Health Policy and Services (HP&S) through USAMEDCOM PAD, will be the OTSG-level oversight on the planning, execution and follow up process of this order. HP&S will conduct staffing and review of policies and procedures, identify and seek solutions for issues raised and serve as an advocate for funding for the program.

(3) (U) The Proponency Office for Preventive Medicine (POPM) will coordinate with Army Materiel Command to verify and cross-reference bioassay results with the U.S. Army Radiation Standards and Dosimetry Laboratory, Ionizing Radiation Dosimetry Branch.

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(4) (U) POC's Clinical issues: COL Terry Walters, DSN 761-0104; Tracking Issues: COL James Halvorson DSN 471-6113; Depleted Uranium Issues: LTC Mark Melanson, DSN 584-3548; Training Issues: COL Kenneth Crook (DSN 471-7867.

TAB A - DU Bioassay Requirements at Post-Deployment Processing

TAB B - Supplemental Questions and Response Matrix

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TAB A (DU BIOASSAY REQUIREMENTS AT POST-MOBILIZATION PROCESSING) TO APPENDIX 7 (RETAINED FRAGMENTS, INCLUDING DEPLETED URANIUM [DU], GUIDANCE) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMobilIZATION PLAN (U)

1. (U) Guidance regarding depleted uranium (DU) bioassay requirements during post-deployment processing.

a. (U) Personnel potentially exposed to DU should be categorized as a casualty, Category I, Category II or Category III as described below:

(1) (U) Category I: Personnel Who Were In, On, or Near (less Than 50 Meters) An Armored Vehicle at the Time the Vehicle Was Struck. These personnel may exceed peacetime occupational exposure standards. Based upon field environmental measurements, research results and dose assessments during combat or deployment operations, depleted uranium may be internalized in sufficient amounts to exceed current peacetime depleted uranium occupational standards in three exposure scenarios:

(a) (U) Personnel who are in, on, or near (within 50 meters) an armored vehicle at the time the vehicle is struck by depleted uranium munitions. These personnel can internalize depleted uranium through inhalation, ingestion, wound contamination and embedded depleted uranium fragments.

(b) (U) Personnel who are in, on, or near (within 50 meters) a vehicle with depleted uranium armor at the time the armor was breached by DU or non-DU munitions. These personnel can internalize depleted uranium through inhalation, ingestion, wound contamination and embedded depleted uranium fragments.

(c) (U) First responders who entered struck vehicles to perform evacuation, first-aid/buddy-aid for the personnel in the struck vehicle. These personnel may internalize depleted uranium through inhalation and ingestion.

(d) (U) DU bioassays will be administered to all personnel in this category. Bioassays are to be administered on a priority basis as soon as their medical condition permits a urine specimen collection. Non-hospitalized Category I personnel will have bioassays performed as soon as possible but no later than 180 days post-incident.

(2) (U) Category II: Personnel Who May Exceed Peacetime Exposure "Action" Levels that Require Biomonitoring. During deployment and combat operations, depleted uranium may be internalized in amounts that are below occupational exposure standards, but at levels that the Nuclear Regulatory Commission (NRC), the Occupational Safety and Health Administration (OSHA), or Army policy requires a bioassay for peacetime operations in the following scenarios:

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(a) (U) Personnel who are in, on, or near (within 50 meters) a fire involving depleted uranium munitions. These personnel can be exposed through inhalation and ingestion.

(b) (U) Personnel who routinely enter vehicles with DU dust to perform maintenance, recovery operations, battle damage assessment and intelligence gathering operations. These are personnel who, as a result of their military occupation, are required to routinely enter vehicles with DU dust and spend more than 800 hours inside a vehicle.

(3) (U) Category III: Personnel in the vicinity of an event involving DU munitions or armor and receive "incidental exposure" (e.g., downwind from a tank fire involving DU, but greater than 50 meters distance). Personnel in this category should only have the DU bioassay performed if, in the physician's opinion, the patient or patient's family would benefit from the process. The DVA/DOD Post-Deployment Clinical Practice Guidelines will be used for this assessment (under development, see <http://www.pdhealth.mil/main.asp> for more information).

b. (U) Whenever practical, bioassays using the 24-hour urine collection protocol should be used for casualties and Category I individuals. The 24-hour urine collection protocol provides the maximum sensitivity and accuracy. Remember the 24-hour urine is the gold standard. If a 24-hour urine collection is not practical, a 120-milliliter (mL) spot urine collection is acceptable with a creatinine measurement. You have the flexibility within your command to do either one depending upon your resources and the needs of your patients.

c. (U) The 120 mL spot collection protocol is acceptable for Category II and Category III personnel, although the attending physician may prefer the sensitivity and accuracy achieved by the 24-hour urine collection protocol. The 120 mL spot collection protocol can only be used if the originating MTF determines creatinine levels in accordance with the 1999 OTSG policy and provides these results with the sample. Should a 120 mL spot sample indicate a significant DU exposure, further sampling using the 24-hour urine collection protocol will probably then be required.

d. (U) MTFs must follow the guidance in USACHPPM TG-211, Radiobioassay Collection, Labeling, and Shipping Requirements (<http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG211.pdf>). Contact information is listed in section 1-7 of TG-211. MTFs must coordinate with the USACHPPM Laboratory by telephoning DSN 584-3983 or commercial (410) 436-3983 before shipping any specimens or samples for analysis.

e. (U) Follow the guidance on urine collection containers provided in TG-211. Collection of urine for uranium bioassays can be done using standard laboratory collection containers, such as round polyethylene bottles (1.0 liter size) or environmental sample bottles (32 oz high density polyethylene with assemble closure materials). Do not use clinical 24-hour collection containers or collapsible water

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collection containers for urine collection (They will leak during shipment of the specimens to USACHPPM). More specific information on bottle types and procurement sources is given in TG-211, page 2-3, and elsewhere. The USACHPPM laboratory methods include laboratory spikes, blanks, and duplicates that correct for any uranium present in the collection containers' material.

f. (U) For any Category I patient, who provides urine for uranium bioassay, any embedded DU fragments or other metal shrapnel extracted from the patient should also be sent to USACHPPM for validation by laboratory identification.

3. (U) References:

a. Memorandum, MEDCOM, MCHO-CL-W, 9 April 1999, subject: Policy for the Treatment of Personnel Wounded by Depleted Uranium Munitions.

b. Memorandum, MEDCOM/OTSG, MCPO-SA, TBD 2003, subject: Draft Policy for Depleted Uranium Bioassay.

c. USACHPPM HEALTH PHYSICS PROGRAM/MCHB-TS-OHP/(410) 436-3502

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TAB B (SUPPLEMENTAL QUESTIONS AND RESPONSE MATRIX) TO APPENDIX 7 (RETAINED FRAGMENTS, INCLUDING DEPLETED URANIUM [DU], GUIDANCE) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLAN (U)

1. Purpose (U). To provide a supplemental questions and response matrix for determination of DU exposure or retained fragments.

2. (U) The supplemental questionnaire for determination of DU exposure or retained fragments is provided below.

- a. Were you in, on, or near (within 50 meters) an armored vehicle at the time the vehicle was struck by depleted uranium munitions? YES / NO
- b. Were you in a vehicle struck by kinetic energy munitions or Friendly fire? YES / NO
- c. If you were in a vehicle struck by kinetic energy munitions, were DU or did you observe burning fragments (like a Fourth of July Sparkler) when the vehicle was hit? YES / NO
- d. Were you in, on, or near (within 50 meters) of a vehicle with Depleted uranium armor (Abrams tank) at the time the armor Was breached by DU or non-DU munitions? YES / NO
- e. Were you in, on, or near (within 50 meters) a fire involving depleted uranium munitions (i.e. burning Abrams or Bradley)? YES / NO
- f. Did you routinely enter vehicles with DU to perform maintenance, recovery operations, battle damage assessment and intelligence gathering operations? YES / NO
- g. Did you have any other reason to believe you were exposed to DU? YES / NO
- h. Do you currently retain fragments in your body from enemy or friendly fire? YES / NO

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APPENDIX 8 (MEDPROS) TO ANNEX A (MEDICAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING (U)

1. (U) In April 2003, Dr. Winkenwerder approved a memorandum entitled "Policy for Individual Medical Readiness," which directs the services to track six key Individual Medical Readiness (IMR) elements. Individual Medical Readiness metrics will be reported to the Assistant Secretary of Defense for Health Affairs quarterly starting 1 April 21, 2003, these IMR metrics include:

- a. (U) Periodic Health Assessment.
- b. (U) Deployment Limiting Conditions.
- c. (U) Dental Readiness.
- d. (U) Immunization status
- e. (U) Readiness Laboratory studies.
- f. (U) Individual Medical Equipment

2. (U) Periodic health assessment.

a. (U) The periodic health assessment is defined as compliance with the periodic physical exam. Periodic physical exam intervals are defined in AR 40-501, Chapter 8 paragraph 8-14 for active duty component Soldiers and Chapters 9 and 10 for US Army Reserve and Army National Guard Soldiers respectively.

b. (U) As of January 2003 each Soldier's individual's physical exam status is available online at the Soldier's home Army Knowledge Online (AKO) web site. Through MEDPROS unit commanders can determine which soldier is due a physical exam.

c. (U) Unit commanders and individual soldiers are responsible for ensuring compliance with PE requirements.

d. (U) Until the physical exam data entry process is changed the current procedure will be used to document compliance with physical exams. The results of the physical exam, which consist of, date of physical examination and PULHES serial, will be sent to the soldier's servicing Personnel Services Branch (Standard Installation/Division Personnel System (SIDPERS) data entry personnel through memorandum, email or other communication means. Entry of physical exam data by Personnel Service Branch personnel into the SIDPERS, results in a data feed MEDPROS.

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e. (U) As the Army Personnel System transforms, the Electronic Military Personnel Office (eMILPO) and the Defense Integrated Management Human Resources System (DIMHRS) system will allow physical exam data entry.

3. (U) Deployment Limiting Conditions.

a. (U) According to table 7-1 AR 30-501 Standards of Medical Fitness a 3 or 4 PULHES serial are “defects or impairments that require significant of use” or are so severe that Soldiers are “unable to perform full effort except for brief or moderate periods”

b. (U) Soldiers with deployment limiting conditions are defined as:

(1) (U) Those Soldiers with a permanent profile with a 3 or 4 PULHES serial which has not been reviewed by either an MOS Medical Review Board or a Medical Evaluation Board.

(2) (U) Those active duty Soldiers presently admitted to hospitals. Data for hospitalized reserve component Soldiers not on active duty is unavailable and will not be counted in the IMR metric.

(3) (U) Those active duty Soldiers with a 3 or 4 PULHES serial temporary profile of six months or longer duration. This includes pregnant Soldiers and those Soldiers convalescing from a serious illness or injury. Temporary profile data on reserve component Soldiers not on active duty is generally unavailable and will not be counted in the IMR metric.

c. (U) Soldiers are assumed to have a 1/1/1/1/1/1 PULHES unless changed by a permanent profile or physical exam. When a soldier receives a permanent profile a copy of the profile is forwarded to the soldier’s servicing Personnel Services Branch. Personnel Service Branch personnel enter profile PULHES data by into SIDPERS, which then results in a data feed MEDPROS.

d. (U) Soldiers on active duty who are inpatients will be recorded into MEDPROS by a data feed from the daily Standard Inpatient Data Report from Patient Administration Systems and Biostatistics Activity (PASBA).

e. (U) Unit commanders will be responsible for manual entry of extended temporary profiles into MEDPROS. These are profiles of 6 months or more duration and restricting activity to a PULHES 3 or 4 level. The data entered will include the PULHES serial and date of profile expiration.

f. (U) MEDPROS will require a data field that indicates a profile expiration date. All permanent profiles will be revalidated with every periodic physical (at least every 5 years).

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g. (U) As the Army Personnel System transforms, the Electronic Military Personnel Office (eMILPO) and DIMHRS will allow PULHES data entry.

4. (U) Dental Readiness.

a. (U) Soldiers are required to have annual dental screening. Classification into dental class 1 through 4.

b. (U) Soldiers in dental class 1 and 2 are defined as dental deployable (green).

c. (U) Soldiers in dental class 3 are classified as not dental ready (red).

5. (U) Immunization status.

a. (U) Mandatory immunizations for all Army personnel include the following:

(1) (U) Hepatitis A: 2 doses 0 and 6-12 months.

(2) (U) Hepatitis B: 3 doses at 0, 1-2, 4-6 months.

(3) (U) Influenza immunization – one annual dose.

(4) (U) Measles-Mumps-Rubella (MMR) - one dose.

(5) (U) Oral Polio Vaccine /Inactivated Polio Vaccine – total of 3 doses.

(6) (U) Tetanus/Diphtheria (Td) one dose with booster every 10 years.

b. (U) Soldiers are fully medically ready if they are current on all mandatory immunizations and the data is entered into MEDPROS.

c. (U) Soldiers missing one or more mandatory immunizations will be categorized as partially medically ready or amber for IMR reporting purposes.

d. (U) The medical facility or medical personnel that vaccinated the Soldier is responsible for ensuring entry of immunization data into MEDPROS. Unit commanders are responsible for ensuring that Soldiers report to immunization clinics to obtain needed immunizations.

6. (U) Readiness Laboratory studies.

a. (U) Readiness laboratory studies include MEDPROS documentation of the following:

(1) (U) Human Immune Deficiency Virus (HIV) antibody test as required by AR 600-110.

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(2) (U) DNA specimen on file at the Armed Forces DNA Repository – obtained once.

(3) (U) Blood type – obtained once.

b. (U) Soldiers with a DNA sample, blood type, and current HIV recorded in MEDPROS are fully medically ready with respect to readiness laboratory studies.

c. (U) Soldiers with one or more readiness laboratory studies undocumented in MEDPROS are considered partially medically ready or amber for IMR reporting purposes.

d. (U) DNA and HIV results are automatically entered into MEDPROS.

e. (U) Blood type requires manual entry into MEDPROS and will be the responsibility of those medical facilities that perform blood typing during initial entry training.

(1) (U) If a Soldier does not have a blood type entered in MEDPROS it is the responsibility of the unit commander to ensure that the Soldier reports to a medical facility for a blood type test.

(2) (U) It is the responsibility of the medical treatment facility that performs the blood type test to enter the results into MEDPROS.

7. (U) Individual Medical Equipment.

a. (U) Required medical equipment includes the following:

(1) (U) 2 pairs of glasses if vision correction is required.

(a) (U) No glasses needed - document Not Applicable (NA) in MEDPROS.

(b) (U) Glasses needed - document Yes if Soldier has 2 pairs of glasses.

(c) (U) Glasses needed - document No if Soldier does not have 2 pairs of glasses.

(2) (U) Hearing aid with batteries for 6 months if required by the Soldier.

(a) (U) No hearing aid needed - document NA in MEDPROS.

(b) (U) Hearing aid needed - document Yes if Soldier has hearing aid and batteries for 6 months.

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(c) (U) Hearing aid needed - document No if Soldier does not have hearing aid and batteries for 6 months.

(3) (U) Medical Warning Tags if required.

(a) (U) No tags needed - document Not Applicable (NA) in MEDPROS.

(b) (U) Warning tags needed - document Yes if Soldier has tags.

(c) (U) Warning tags needed - document No if Soldier does not have tags.

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ANNEX B (DENTAL PROCESSING) TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLANNING (U)

1. (U) Situation. (see paragraph 1 of basic plan)
2. (U) Mission. To rapidly and thoroughly complete the dental demobilization requirements indicated in the appendices of this annex.
3. (U) Execution.
 - a. (U) Commanders Intent. All redeploying Active Component (AC) and demobilizing members of the Reserve Component (RC) be provided the same standardized dental demobilization processing throughout all CONUS demobilization stations. Dental processing must be completed as expeditiously as possible without sacrificing benefits/entitlements due a soldier from an oral condition incurred in the line of duty while in an active or federal status. This includes proper documentation of dental records.
 - b. (U) Concept of Operations. Complete the following actions at each demobilization station. The sequence may vary depending on the confines of the physical facility. DD Form 2796, Health Care Provider Only section, question 2, which asks if the soldier has any dental problems that developed during this deployment, does not need to be completed by a medical provider prior to completion by a dental provider. If the soldier reports to the dental station before the medical station, the dentist will complete question 2 of this section of the DD Form 2796 as detailed in the General Requirements of Operation, section (c.) below. Additional details will be provided in the Appendices of this ANNEX.
 - c. (U) General Requirements of Operations:
 - (1) (U) The dental demobilization station ensures that the following forms have been documented and reviewed:
 - (a) (U) DD Form 2796 (Post Deployment Health Assessment) is completed by the soldier and reviewed by a health care provider. If the soldier reports to the dental station before the medical station and the soldier states they have a dental problem that developed during this deployment, the dentist will complete question two (2) of the Health Care Provider Only section. The dentist will circle the word "dental" in question 2, check "yes" next to question 2 and then color the circle next to "Dental" in the "Health Assessment-Referral Indicated For:" section of the DD Form 2796. If the soldier reports to the medical processing station before the dental station, DD Form 2796, question 2 will be reviewed/documentated by a medical provider. The soldier will then process through the dental station where a dentist will review question 2 for entries concerning dental problems that developed during this deployment.

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(b) (U) DD Form 2697 is completed by the RC [US Army Reserve (USAR) and Army National Guard (ARNG)] soldier separating from active duty. This form is reviewed by a dentist.

(c) (U) SF 603/603A (Dental Record) - The RC soldier's dental record will be returned from the RC unit home station or other custodial record site to the demobilization site for the demobilization process. If the dental record is not present at the demobilization site, a SF 603 is created and documented.

(d) (U) DA Form 2173 (Statement Of Medical Examination And Duty Status). This form may have been completed in theatre or may be created and documented at the dental processing station. The dental officer completes Section I. The dentist does not determine whether the dental injury was incurred in the line of duty. The dentist gives an opinion, documented in Section 1, question 11d, which will help a commander to determine if the dental injury occurred in the line of duty. The unit commander or unit adviser in Section II of DD Form 2173 documents final approval of the LOD.

(2) (U) The dental demobilization station reviews the DD Form 2796, the DD Form 2697, the SF 603/603 and the DA Form 2173 forms to determine if further dental evaluation is required. Post deployment procedures for AC soldiers are outlined in (3) below. Dental demobilization procedures for RC soldiers are outlined in (4) below.

(3) (U) AC Soldier Dental Post Deployment Procedures

(a) (U) DD Form 2796, interview section, is reviewed to determine if further dental treatment is required. If DD Form 2796 states that a dental problem exists, the AC soldier will be referred to the appropriate dental treatment facility (DTF) for post deployment evaluation and treatment.

(b) (U) If the AC soldier presents with a SF 603/603A dental record, the record will be collected and forwarded to the appropriate DTF records custodian.

(4) (U) RC Soldier Dental Demobilization Procedures.

d. (U) Specific dental demobilization procedures for RC soldiers depend upon the length of active duty (AD) performed during mobilization. A flowchart of these procedures is outlined in Appendix 1. Review of the individual soldier's record by AG personnel will determine the length of AD service. Procedures are as follows:

(1) (U) Ninety (90) or more days of Active Duty.

(a) (U) The DD Form 2796, DD Form 2697, DA Form 2173 and SF 603/603A forms are reviewed. LOD dental concerns/injuries are noted by reviewing entries in the DD Form 2796, DD Form 2697, DA Form 2173 and SF 603/603A.

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(b) (U) If the soldier states that he/she has a line of duty (LOD) dental concern or if the record review shows a possible LOD dental injury, the dentist will examine and document the potential LOD dental injury in the soldier's SF 603/603A dental record. A DA Form 2173 is not required on an RC soldier with 90 or more days of active duty in order to receive treatment for LOD dental injuries. However, if the RC soldier presents with a documented DA Form 2173, the dentist will examine and document the potential LOD dental injury in the soldier's SF 603/603A dental record and complete Section 1 of the DA Form 2173 if necessary. LOD injuries are treated as a part of the VA benefits for dental care as outlined in Appendix 2 of this Annex.

(c) (U) All RC SF 603/603A dental records will contain the following statement: "Member was provided a complete Dental Exam and all appropriate Dental services and treatment within 90 days prior to separation. YES NO". The appropriate response will be indicated. This statement will assist AG personnel at the demobilization station in checking the correct response block in item 17 on the DD Form 214. An example of a stamp with the required dental demobilization process checklist and this statement appears in Appendix 4.

(d) (U) The RC soldier will be given an information paper that describes VA dental benefits/eligibility. The information paper also describes Transitional Health Benefits and the TRICARE Dental Program (TDP) for post deployment dental care. See Appendix 2 of this Annex.

(2) (U) Less Than 90 days of Active Duty.

(a) (U) The DD Form 2796, DD Form 2697 and SF 603/603A are reviewed. LOD dental concerns/injuries are determined by previous entries in the DD Form 2796, DD Form 2697 and SF 603/603A. The soldier may also present a documented DA Form 2173.

(b) (U) If the soldier states that he/she has a LOD dental concern or if the record review shows a possible LOD dental injury or if the soldier presents a documented DA Form 2173, the dentist will examine and document the potential LOD dental injury in the soldier's SF 603/603A dental record and complete Section I if necessary. If the soldier presents without a documented DA Form 2173 and has a potential LOD dental injury, a new DA Form 2173 must be completed. All RC soldiers with less than 90 day of active duty and a potential LOD dental injury must have a DA Form 2173 completed for post deployment treatment of the LOD dental injury.

(c) (U) DA Form 2173, Section 1, is completed by the dentist for LOD dental injuries on RC soldiers with less than 90 days of AD. The unit commander determines the approval of a LOD dental injury and completes the DA Form 2173, Section II, indicating this approval. The unit commander may ask the dentist for guidance on the LOD dental injury approval.

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(d) (U) All RC SF 603/603A dental records will contain the following statement: “ Member was provided a complete Dental Exam and all appropriate Dental services and treatment within 90 days prior to separation. YES NO”. The appropriate response will be indicated. This statement will assist AG personnel at the demobilization station in checking the correct response block in item 17 on the DD Form 214. An example of a stamp with the required dental demobilization process checklist and this statement appears in Appendix 4 this Annex.

(e) (U) The soldier is given an information paper that describes the Military Medical Support Office (MMSO) process for treatment of LOD dental injuries. The information paper also describes Transitional Health Benefits and the TDP for post deployment dental care. See Appendix 3 this Annex.

Appendix 1 - Dental Demobilization Flowsheet

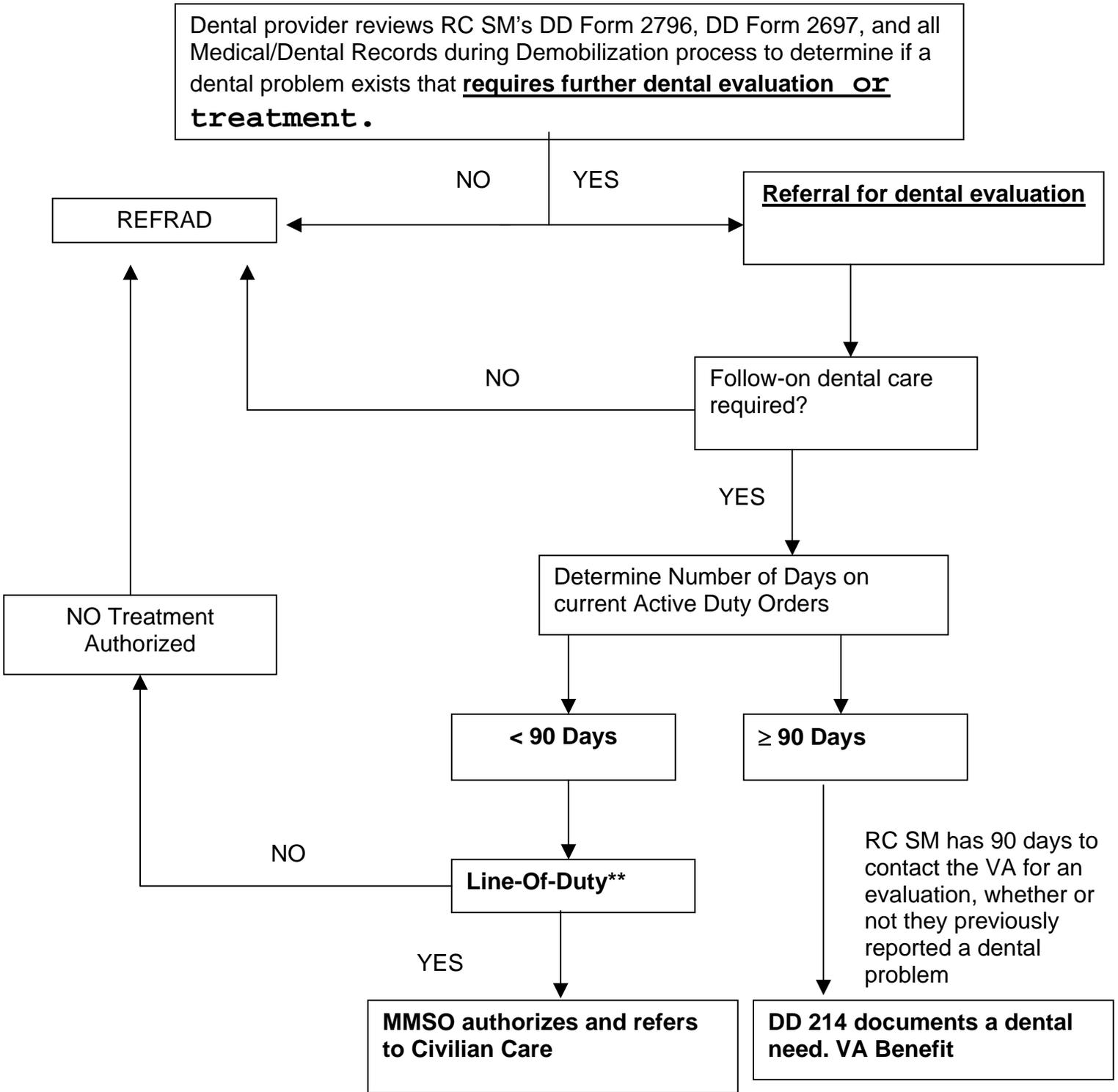
Appendix 2 - Post Deployment Dental Benefits- 90 days and more of active duty.

Appendix 3 - Post Deployment Dental Benefits-less than 90 days of active duty.

Appendix 4 - Example of Record Stamp for SF Form 603

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APPENDIX 1 DENTAL DEMOBILIZATION FLOW DIAGRAM) TO ANNEX B (DENTAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)



** Documentation in the Health/Dental Record (SF 603, 603A) and completed LODs (DA Form 2173 and/or DD Form 261) are required for RC SM to receive authorization for follow-on dental

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APPENDIX 2 (POST DEPLOYMENT DENTAL BENEFITS FOR THOSE WHO SERVED 90 OR MORE DAYS ON ACTIVE DUTY) TO ANNEX B (DENTAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose. To provide information on dental benefits for those who served 90 or more days on active duty.
2. (U) All reserve component (RC) soldiers on AD greater than 90 consecutive days are eligible for dental care through the Department of Veterans Affairs (DVA) system subject to the requirements/limitations defined in Title 38 USC. The soldier has 90 days from their REFRAD to contact the DVA to coordinate dental treatment. The need for follow-on dental care must be documented at demobilization on the soldier's SF 603/603A. The personnel section will use these forms when completing the DD Form 214, Certificate of Release or Discharge from Active Duty, which the VA uses for verification of veteran benefits.
3. (U) Transitional Health Benefits (THB), outlined in Title 10 USC, Section 1145, allow for the provision of dental services on a space available basis in military dental clinics. If soldiers have less than 6 years creditable service, they are eligible for 60 days of space-available dental care; if greater than 6 years service, they have 120 days. Unfortunately, space-available dental care in CONUS dental facilities is severely restricted. Staffing of military dental clinics is based on the supported active duty population; as a result, current staffing and policies governing dental readiness do not allow for any significant space-available treatment time. A DD214 form documenting the entry date, separation date and length of service is required in order for the dental treatment facility to determine if the soldier is eligible for space-available THB dental care.
4. (U) The final option is voluntary enrollment in the TRICARE Dental Program. Selected Reserve and IRR members are eligible for TDP, a government cost share dental insurance program, which provides reasonably priced access to comprehensive dental care from the civilian dentist of their choosing. To minimize costs, the enrollee is encouraged to utilize the TDP's participating network of dentists for their care. Enrollment in TDP requires a 12-month commitment and includes an optional family member benefit for an additional premium. RC soldiers, who were participating in the TDP prior to deployment and were dropped from the program when activated, will automatically be re-enrolled following DEMOB when their military status is updated in DEERS. Reserve Component soldiers should be made aware that a small gap in coverage may occur between their deactivation date and the date TDP re-enrollment coverage begins. All TDP enrollees should contact the TDP contractor to verify coverage prior to seeking dental services after REFRAD.
(<http://www.tricare.osd.mil/dental/>)

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APPENDIX 3 (POST DEPLOYMENT DENTAL BENEFITS FOR THOSE WHO SERVED LESS THAN 90 DAYS ON ACTIVE DUTY) TO ANNEX B (DENTAL PROCESSING) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose. To provide policy and guidance for post deployment dental benefits for those who served less than 90 days on active duty.
2. (U) Only a LOD dental condition that occurred while the RC soldier was activated for greater than 30 days, but less than 90 days, will be addressed at no charge upon demobilization. It is important to distinguish that this is care for conditions that resulted from injury or disease occurring during Active Duty (AD), and not care for pre-existing dental conditions present prior to mobilization. All soldiers must have required follow-on dental treatment needs documented on the Standard Form (SF) 603 Health Record-Dental, or SF 603A, Health Record-Dental Continuation. Soldiers will require a completed DA Form 2173, documenting the dental disease/injury occurred while the soldier was activated. The soldier's unit will then coordinate with the Military Medical Support Office to facilitate the soldier's reimbursement for required civilian provided dental care. (<http://mmsso.med.navy.mil>)
3. (U) Transitional Health Benefits, outlined in Title 10 USC, Section 1145, allow for the provision of dental services on a space available basis in military dental clinics. If soldiers have less than 6 years creditable service, they are eligible for 60 days of space-available dental care; if greater than 6 years service, they have 120 days. Unfortunately, space-available dental care in CONUS dental facilities is severely restricted. Staffing of military dental clinics is based on the supported active duty population; as a result, current staffing and policies governing dental readiness do not allow for any significant space-available treatment time. A DD Form 214 documenting the entry date, separation date and length of service is required in order for the dental treatment facility to determine if the soldier is eligible for space-available THB dental care.
4. (U) Voluntary enrollment in the TDP. Selected Reserve and Individual Ready Reserve (IRR) members are eligible for TDP, a government cost share dental insurance program, which provides reasonably priced access to comprehensive dental care from the civilian dentist of their choosing. To minimize costs, the enrollee is encouraged to utilize the TDP's participating network of dentists for their care. Enrollment in TDP requires a 12-month commitment and includes an optional family member benefit for an additional premium. RC soldiers, who were participating in the TDP prior to deployment and were dropped from the program when activated, will automatically be re-enrolled following DEMOB when their military status is updated in Defense Enrollment Eligibility Reporting System (DEERS). Reserve Component soldiers should be made aware a small gap in coverage may occur between their deactivation date and the date TDP re-enrollment coverage begins. All TDP enrollees should contact the TDP contractor to verify coverage prior to seeking dental services after REFRAD. (<http://www.tricare.osd.mil/dental/>)

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APPENDIX 4 (EXAMPLE OF DENTAL RECORD SF 603 DEMOBILIZATION STAMP)
TO ANNEX B (DENTAL PROCESSING) TO MEDCOM REDEPLOYMENT/
DEMOBILIZATION PLAN (U)

EXAMPLE OF DENTAL RECORD SF 603 DEMOBILIZATION STAMP

All documents have been reviewed
as required in Annex B, MEDCOM
demobilization plan. YES ___

Member was provided a complete
Dental Exam and all appropriate YES ___
Dental services and treatment
within 90 days prior to separation. NO ___

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ANNEX C (PERSONNEL POLICIES/SERVICES) TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLANNING (U)

1. (U) Purpose: This annex contains specific direction and guidance regarding the return of PROFIS staff and the subsequent release of RC PROFIS backfill.

2. (U) Pay:

a. (U) Family Separation Allowance (FSA). Soldiers in a temporary change of station (TCS) status may be authorized FSA type II (T) at the rate of \$100 per month, IAW chapter 27, DoD FMR 7000.14-R volume 7A, when a soldier is away from the permanent duty station (PDS) (for mobilized RC personnel this is their home of residence) continuously for a period of 30 days, and the soldier's dependents are not residing at or near the TCS station. Army/service married couples who were living together prior to and immediately before the deployment and single soldiers with authorized primary dependents may be paid FSA-T.

b. (U) Imminent Danger Pay (IDP). The locations authorized IPD are listed in chapter 10 of the DoD FMR Volume 7A. The Planning and Programming Guidance (PPG) will provide an interim list of approved locations as they are approved until the DoD FMR is updated.

c. (U) Combat Zone Tax Relief (CZTR). Authorized for the areas in direct support of the combat area; these locations are listed in Para 3b(2), above.

d. (U) Tax Filing Extension. Personnel in direct support of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) are authorized a tax filing extension up to 180 days after leaving the area of operation.

e. (U) Personnelists must ensure that returning PROFIS soldiers terminate any FSA, IDP, and CZTR entitlements effective the day they arrive at the first CONUS Airport of debarkation (APOD).

f. (U) Pay Procedures. Pay and allowances, to include travel, for demobilized soldiers will be processed IAW appropriate DoD pay manuals and HQDFAS-IN messages.

3. (U) Leave.

a. (U) Annual Leave. Soldiers will accrue 2.5 days of leave per month. Soldiers are directed to develop a leave plan, at their TCS location, to take leave as available, per Para 2-2, AR 600-8-10, leaves and passes. Currently when processing leave requests, the last leave earned is the first leave used. Online leave and earning statements with leave balance are available at the mypay web site at <http://www.dfas.mil/mypay/>. All RC soldiers, except Active Guard/reserve (AGR), are

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encouraged to take leave during the period of active duty or as part of the REFRAD process. However, if military requirements limit taking leave the RC soldier does have the authority to cash in leave prior to REFRAD. This will not impact on their career maximum (60 days) for cashing in their leave. Request for extension of active duty by RC personnel for the purpose of taking leave will not be approved. All soldiers that submit accrual travel vouchers should annotate these vouchers with the appropriate leave periods taken during the period of the accrual, if applicable. This action is to prevent overpayment and to provide the defense network operations (DNO) section with accurate information on leave taken, the following procedures will be implemented:

(1) (U) All mobilization and demobilization sites must brief soldiers on the requirement to annotate leave taken on the travel voucher and to attach a copy of the DA form 31 to the final settlement voucher when it is filed.

(2) (U) Units will create a soldier management individual file (SMIF) file, IAW AR 25-50, on all soldiers that are TCS'd to their location. A copy of the leave form should be placed in this file for return to the unit and to validate leave days taken. When the soldier departs the TCS location the SMIF file will accompany the soldier to the next location or to the demobilization location. Soldiers will attach a copy of the leave document (DA Form 31) to their final settlement voucher when they complete their mobilization tour.

b. (U) Special Leave Accrual (SLA):

(1) (U) For actions on 11-30 September 2001; active army, RC, and AGR personnel who on 30 September 2001 had leave accumulated in excess of 60 days are granted SLA and may retain the SLA for a period not to exceed 1 October 2004.

(2) (U) Soldiers located in selected areas designated as in direct support of the Afghanistan operation, see b (2) below, are authorized SLA, as approve by Office of the Secretary of Defense -Manpower & Reserve Affairs (OSD (M&R)). SLA is also authorized for those locations in the Central Command (CENTCOM) Area of Operation (AO) as designated in chapter 10 of the DoD Financial Management Regulation Chapter Volume 7A. Procedures for requesting SLA are in Chapter 3 of AR 600-8-10, leaves and passes.

(3) (U) Soldiers assigned or not assigned to a contingency operation who do not meet the requirements for standard SLA authorization, due to an assignment in a imminent danger or hostile fire area IAW 37USC310, and as a consequence of duty in support of a contingency operation are denied leave may be authorized leave in excess of 60 days until the end of the succeeding year. The SLA approving authority must have denied leave of the soldier for the entire year or for a specific period of time that would not allow the soldier to schedule the leave period. For example a soldier at CENTCOM headquarters Florida was denied leave per a memorandum from the commander during FY 02, the soldier would be entitled to retain up to 90 days of leave until 30 September 2003.

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(4) (U) SLA does not apply to service members working at normal home stations even though all were supporting current contingency operations in one form or other.

c. (U) Accrued Leave. Soldiers with accrued leave will, within statutory limitations, be given the option of receiving payment for the leave, taking pre-separation/transition leave, or a combination thereof. Commanders should allow soldiers the opportunity to use accrued leave within the 365-day mobilization period, within operational constraints. RC personnel desiring to take accrued leave prior to release from active duty may be voluntarily retained on active duty, upon approval by Assistant Secretary of the Army - Manpower & Reserve Affairs (ASA (M&RA)) based on unit mission, past their normal release date for up to the number of days of leave, that they have accrued. If the total number of days an individual is retained on active duty in order to use accrued leave will exceed 24 months, the orders must be amended to reference 10 USC 12301 (d) as the authority for retention beyond 24 months.

4. (U) Awards and Decorations:

a. (U) General. All awards must be processed through the PROFIS soldier's MTOE unit chain of command. RMC/MTF Personnelists will not use the TDA chain of command to approve awards for PROFIS fillers. As an exception, RMC/MTF Personnelists will utilize the TDA chain of command to recommend/approve awards for IMA backfill personnel.

(1) (U) Any RC soldier who is mobilized in support of operations noble eagle, enduring freedom, and Iraqi Freedom is eligible to receive the armed forces reserve medal with "M" device. The individual mobilization order will serve as documentation for wear of the award.

(2) (U) The shoulder sleeve insignia for former wartime service and overseas service bars are approved for wear by soldiers who have been assigned to units that have participated in ground operations during operation enduring freedom.

(3) (U) The National Defense Service Medal (NDSM).

(a) (U) OEF/OIF PPG authorized the reinstatement of the NDSM for members of the U.S. Armed Forces serving on active duty on or after 11 Sep 01. The termination date will be determined in the future.

(b) (U) The NDSM is awarded for honorable active service and includes the following inclusive periods: 27 Jun 50 to 27 Jul 54; 1 Jan 61 to 14 Aug 74; 2 Aug 90 to 30 Nov 95; and 11 Sep 01 to a date to be determined.

(c) (U) For award of the NDSM for the period 11 Sep 01 to a date to be determined, the following persons will not be considered as performing active service:

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1. (U) Army National Guard and U.S. Army Reserve personnel on short tours of duty to fulfill training obligations under an inactive duty training program.

2. (U) Any service member on temporary duty or temporary active duty to serve on boards, courts, commissions, and like organizations.

3. (U) Any service member on active duty for the sole purpose of undergoing a physical examination.

4. (U) A one time only exception, for members of the Army National Guard of the United States and U.S. Army Reserve, who were part of the selected reserve in good standing, was authorized, per executive orders 12778, dated 18 Oct 91, for the period 2 Aug 90 to 30 Nov 95.

(d) (U) To signify receipt of a second or subsequent award of the NDSM, a bronze service star will be worn on the service ribbon by U.S. army personnel so qualified. Second or third award of the NDSM is authorized for soldiers who served in one or more of the four qualifying time periods. It is not authorized for soldiers who met the criteria in one time period, left active duty and returned during the same period of eligibility. (service stars are described in Chap 6, ref n).

(e) (U) Effective immediately, commanders are authorized to issue the NDSM to qualified personnel. Permanent orders are not, repeat, are not required. SIDPERS transactions to update the Officer Record Brief (ORB) and Enlisted Record Brief (ERB) are not required; HQDA will top load the system to add/change the NDSM

(f) (U) Unit commanders are responsible for the original issue of medals. For requisition purposes, the national stock number for the NDSM is 8455-00-281-3214.

5. (U) PERSONNEL STEMPO (PERSTEMPO). Each demobilization site/designated transition center needs to update the PERSTEMPO database to reflect soldiers current status. (currently, army G1/G3 estimate a 10 July 2003 reactivation of the PERSTEMPO database.)

6. (U) Stabilization. The period of stabilization will commence on the date the soldier arrives at his/her new permanent duty station (PDS). All other provisions of the previously implemented deployment stabilization policy remain firm. This paragraph establishes the policy to provide a period of stabilization from operational deployments for the following soldiers:

a. (U) Soldiers (either as individuals or in unit sets) returning from temporary duty (TDY) or TCS away from their PDS as part of an operational deployment.

b. (U) Soldiers returning from a completed dependent-restricted Overseas tour.

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c. (U) The purpose is to ensure a level of fairness in the treatment of soldiers completing lengthy periods of time on TDY, TCS, unit deployment, or Permanent Change of Station (PCS) assignment to dependent-restricted overseas areas; allow soldiers time to reacquaint themselves with families, provide time to readjust to home station living and working environment, and reward soldiers for arduous periods of duty separated from family members.

d. (U) Effective 19 Feb 02, soldiers placed on TDY/TCS as individuals or in unit sets (both active army and RC), for a period of at least 30 consecutive days, participating in the type of "operations other than war (OOTW) deployments" or small scale operations, described below will, to the maximum extent feasible, be provided a period of stabilization equal to one month of stabilization for each month of TDY/TCS. Soldiers returning from a PCS assignment in a dependent- restricted overseas tour area will be stabilized from deployment for not more than six months (this feature of the policy is not retroactive).

(1) (U) Operational (e.g., OIF, OJE, OJG, Southern Watch, Enduring Freedom, Noble Eagle).

(2) (U) Domestic civil (riots, forest fires, natural disaster relief).

(3) (U) Humanitarian international (OCONUS humanitarian assistance).

(4) (U) United Nations (UN) staff/SF operational team (UN/NATO staff and all operational U.S> Army Special Operations Command (USASOC) team deployments).

(5) (U) Counter-drug (CONUS/OCONUS in support of counter-drug Operations).

e. (U) During the period of stabilization, soldiers are generally ineligible to be involuntarily placed on TDY/TCS away from their PDS to participate in operational type deployments. The first general officer in the soldier's chain of command may terminate the period of stabilization based on immediate and critical operational needs.

f. (U) Deployment stabilization is not applicable for soldiers who are selected to perform the following type duty:

(1) (U) TDY for personnel management or professional development reasons (e.g., AOC, CAS3, BNOC, ANCOC, MOS, ASI, SQI training).

(2) (U) Local training exercises.

(3) (U) Major training exercises to combined training centers and off-post/installation training exercises.

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g. (U) Calculating the periods of stabilization. The period of deployment stabilization will be calculated using the methodology for recording overseas service contained in AR 600-8-104.

h. (U) Deployment stabilization authorized for soldiers serving overseas in a PCS status will not retain them beyond their established DEROS (example: soldiers assigned to U.S. Army Europe (USAREUR) spends six months in Kosovo. Their period of earned deployment stabilization of six months will not be completed until two months after date Eligible for Return From Overseas (DEROS)). In this case, the unused period of stabilization will be carried over to the gaining command in CONUS and the soldier will return on his/her DEROS.

i. (U) RMC/MTF commanders will issue instructions as necessary to implement and monitor the deployment stabilization policy

7. (U) POC. Contact either MAJ R.G. Dickinson, Chief, Personnel Operations Branch, HQUSAMEDCOM, DSN 471-7060, or COL Keith B. Parker, Chief, Military Personnel Division, HQUSAMEDCOM, DSN 471-7802, for information in this annex.

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ANNEX D (SERVICE SUPPORT) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLANNING (U)

SERVICE SUPPORT.

a. (U) Concept of Support.

(1) (U) Requirements to support MEDCOM Demobilization operations are dependent upon the specific situation and/or logistic arrangements made by the ACSLOG.

(2) (U) Funding Requirements and Tracking. MEDCOM components are responsible for capturing and reporting incremental costs to HQ MEDCOM. Costs will be captured through use of appropriate Functional Cost Account codes (FCA) codes as stated in MEDCOM RM Global War on Terrorism (GWOT) guidance dated 7 & 12 March 2003.

b. (U) Concept of Logistic Support for Unit Redeployment/Demobilization.

(1) (U) MEDCOM, through the appropriate Agency and/or Subordinate Commanders will provide logistical support for all units redeploying/demobilizing within their Health Service Areas. Necessary Inter-Service/Interagency Support Agreements will be executed in accordance with current MEDCOM directives, and as directed from this headquarters.

(2) (U) MTFs / Installation Medical Support Agencies (IMSA) will be prepared to process and receive any Class VIII material, which is presented for turn-in by redeploying/demobilizing units. Credit will not be given for turned in items. Under no circumstances will DHP/DWWCF activities grant credit for turn-in material.

(3) (U) MTFs/IMSAs will procure and turn-in items according to Standard Operating Procedures (SOP). Specified IMSAs, those having Power Projection Platforms (PPP)/Power Support Platforms (PSP) (demobilization sites) within their Health Service Area must establish adequate stock levels of Tuberculin and Purified Protein Derivative vaccine and serum draw supplies to accommodate troop redeployment and demobilization.

(4) (U) MTFs/IMSAs at specified locations will evaluate and quantify storage capacity (above normal usage) to accommodate increased quantities of retrograde Class VIII material. Evaluations should include storage capacity of vault, reefer, freezer, hazardous materials, as well as the normal environmentally controlled areas. Any funding requirements for additional storage areas must be identified and captured for reimbursement by ONE/OEF/OPN Iraqi Freedom.

(5) (U) The MTFs/IMSAs in support of redeployment and demobilization operations will use existing systems and procedures to record all transactions

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associated with the retrograde. All procurement and retrograde materiel and services will be processed through established logistics automated information systems (Defense Medical Logistics Standard Support (DMLSS) or Theater Army Medical Management Information System (TAMMIS)).

(6) (U) The MTF, to ensure vision readiness, will validate that each redeploying soldier requiring corrected eyewear will have two pair of glasses (one pair of civilian eyewear does count as one) and one optical insert before they depart the demobilization station for the Reserve Components or return to their unit of assignment for Active Component.

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ANNEX E (MEDICAL/DENTAL DEMOBILIZATION FORMS TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U))

1. (U) Purpose/objective of this Annex: This Annex will contain a listing of all medical and dental forms used during the demobilization process.
2. (U) Websites where forms may be downloaded will be included
3. (U) MEDCOM demobilization checklist and administrative instructions for completion of the checklist are attached as Appendices 1 and 2 to this Annex.
4. (U) The following Forms must be considered:
 - a. DA Form 2173 Statement of Medical Examination and Duty Status
 - b. DD Form 214 Certificate of Release or Discharge from Active Duty
 - c. DD Form 261 Investigation, Report of Line of Duty and Misconduct Status
 - d. DD Form 2795 Pre-Deployment Health Assessment
 - e. DD Form 2796 Post-Deployment Health Assessment
 - f. DD Form 2697 Report of Medical Assessment
 - g. DD Form 2807-1 Report of Medical History
 - h. DD Form 2808 Report of Medical Examination
 - i. DD Form 2813 DoD Active/Reserve Forces Dental Examination
 - j. SF 600 Chronological Record of Medical Care (To use as continuation sheet as necessary).
 - k. Website for forms:
 - (1) DA Forms <http://www.usapa.army.mil>
 - (2) DD Forms . <http://www.dior.whs.mil/ICDHOME/DDEFORMS.HTM>

Appendix 1 – MEDICAL/DENTAL CHECKLIST

Appendix 2 – INSTRUCTIONS FOR THE COMPLETION OF THE MEDICAL/DENTAL CHECKLIST

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APPENDIX 2 (INSTRUCTION FOR COMPLETION OF THE MEDICAL/DENTAL CHECKLIST) to ANNEX E (MEDICAL/DENTAL DEMOBILIZATION FORMS TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLAN (U))

Instructions for the completion of the Medical/Dental Checklist:

MEDICAL Section IX

1. Soldier has received required medical briefings and any handouts provided?

This confirms that this soldier has been presented the mandatory medical/dental briefings. To be done in groups of 20 to 30. This includes any handouts (TRICARE or RMC/MEDCEN/MEDDAC POC regarding health questions/or concerns following demobilization)

2. Soldier has requested a separation Physical Exam (IAW AR 40-501, para 8-23)?

This entry records the soldiers' intent with respect to requesting a physical exam. **Note:** The soldier will initial the remark block following his/her response.

3. A blood sample has been obtained from soldier.

This confirms a blood sample has been obtained from this soldier.

4. A Tuberculin skin test has been given. (also required between 3 and 6 months)

This records that the soldier has received the initial TST during demobilization. **Note:** The note reminds the soldier that a second TST is required between 3 and 6 months from the date of this test. RC Command Surgeons are responsible for ensuring the 3-6 month TST is given and recorded in medical records and IMR (MEDPROS).

5. "Face to Face" with Health Care Provider & completed DD Forms 2796 & 2697?

This confirms the "face to face" with HCP and soldier is complete and the two required forms are complete. Referrals, consultations or other follow-up work is scheduled, as needed. Originals of DD Forms 2795, 2796, and 2897 and any other treatment records are added to the soldiers' medical record. Medical personnel at the demobilization site will enter the completion dates for the DD Form 2795 and 2796 (Apr 2003) into the Medical Protection System (MEDPROS) Individual Readiness Module (IMR).

6. Based on all medical information available, soldier is cleared for REFRAD?

This block confirms that the soldiers meets the retention standards in Chapter 3, of AR 40-501 and is cleared for REFRAD. (Blocks 8 and 9 below will be marked "NA")

7. All forms and Records are complete and ready for disposition.

- ◆ The original DD form 2795, 2796 (Apr 2003), and 2797 and any completed DA 2173 will be placed in the soldiers' health record. All documentation related to medical treatment received during the period of AD will also be included in the health record. When complete the health record will be forwarded back to the appropriate record custodian at the service member's unit.

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- ◆ A copy of the completed DD Form 2796 will be sent to the Army Medical Surveillance Activity, ATTN: MCHB-TS-EDM, Bldg T-20, Room 213, 6900 Georgia Ave., NW, Washington D.C. 20307-5001. An electronic copy is preferred if available.
- ◆ A copy of all DA Form 2173s and DD Form 261s will be given to the soldier for his/her personal records.
- ◆ A copy of the DD Form 2697, Record of Medical Assessment will be sent to the Department of Veterans Affairs, DVA Records Management Center, P.O. Box 50200, St. Louis, MO 62115-8959.

8. If 6 is no, MEB/PED required & scheduled?

If the response in item 6 is no, then an MEB/PEB is required.

9. If 6 is no, is ADME an option, did the soldier elect this option.

Those soldiers that cannot perform their normal military duties and whose care will require more than 30 days after his/her orders expire, may request Active Duty for Medical Extension (ADME) status. If the soldier should choose to apply for this benefit the procedures found at

See <http://www.armyg1.army.mil/default.asp?pageid=83f> for *Procedural guidance for RC Soldiers on Active Duty Medical Extension (ADME)* should be followed.

DENTAL Section X.

1. Dental record/care reviewed (while on active duty) ?

Verifies that dental record for this period of AD was reviewed.

2. Dental care needed and authorized beyond AD

Needs documented on SF 603 & 603A in dental records.
For authorization for care see Title 38, Pensions, Bonuses and Veterans' Relief Code of Federal Regulations, Part 17.161, Authorization of Outpatient Dental Treatment, <http://www.access.gpo.gov/ecfr>.

3. If 2 is yes, soldier given handout of entitlements

Soldier is provided a simple statement of benefits and time limitations of benefits as applicable.

4. If 2 is yes, dental care authorization notation made on soldiers' DD 214

Dental personnel at the demobilization site will ensure that the need for dental care is documented on the soldiers' DD 214 (item 17) where appropriate.

5. Based on all dental information available, soldier is cleared for REFRAD

Verifies that all dental actions have been completed for REFRAD.

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**ANNEX F (PUBLIC AFFAIRS AND HEALTH INFORMATION OPERATIONS) TO
MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)**

**Communication Plan
Post-OIF Deployment Health**

Goals and Objectives	Strategies	Audiences	Messages	Tools
<p>To inform OIF veterans and their families about re-deployment healthcare issues and options</p> <p>To ensure all SV receive the appropriate care when needed.</p> <p>To maintain AMEDD credibility with beneficiaries, DOD leadership, and other government entities.</p> <p>To make civilian providers aware of Needs of former SM.</p> <p>Ensure all AMEDD providers have knowledge of reqments</p>	<p>Inform & educate soldiers about need to take care of health & available options'</p> <p>I&E FM to insist soldiers get needed health care</p> <p>Ensure AMEDD complies with law & other guidance.</p> <p>I&E line commanders to ensure troops' medical needs are met before REFRAD/Rtn</p> <p>Maintain relationships w/ other Fed agencies</p> <p>Make accurate info available</p>	<p>AC and RC soldiers, especially OIF veterans</p> <p>Family members of OIF veterans</p> <p>DOD/DA Leaders, including OASD(HA)</p> <p>Congress and Exec. Branch</p> <p>Dept Vet Affairs</p> <p>AMEDD providers and administrators, including Div and Bde surgeons</p> <p>Soldiers/veterans advocacy groups</p>	<p>Health of soldiers is our top concern</p> <p>Soldiers have right to medical exam when re-deploying, but there are options on when and where</p> <p>If a soldier has a med. problem, he/she should have exam soon as possible.</p> <p>It's more important to take care of medical problems than to get home earlier.</p> <p>Commanders have duty to ensure their troops take necessary steps to avoid future medical problems.</p>	<p>News Releases for CI and public media throughout MEDCOM</p> <p>ALARACT message</p> <p>SRTV spot</p> <p>"TSG Sends" message to AMEDD providers</p> <p>Web-based CHPPM HIO products, e.g. fact sheets, FAQ, etc.</p> <p>Congrsnl Testimony</p> <p>AMEDD homepage</p> <p>CSA Weekly Summ.</p> <p>GSC/MSC3/AUSA Symposium topic</p>

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ANNEX G (DEPLOYMENT CYCLE SUPPORT CONPLAN (DCS) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose. This Annex is derived from paragraphs 5 and 6 of the DCS CONPLAN, dated 2 May 03, and modified (reduced in length) to consider those areas of direct interest to the AMEDD. These paragraphs and the supporting Appendices provide needed understanding of the overall redeployment, post-deployment, and reconstitution phasing and the medical activities associated with each.

2. (U) The Appendices, 1, 2, and 3, identify taskings to OTSG/MEDCOM in support of redeployment, post-deployment and reconstitution phases respectively. Appendices 4 and 5 are critical enabling tasks and DSC tracking. Note that only OTSG/ MEDCOM taskings are shown.

3. (U) Concept of Operation.

a. (U) Specific Guidance. Post-employment DCS is conducted in depth. The three phases of DCS associated with post-employment – Redeployment, Post-deployment and Reconstitution – will take place concurrently; they are specified as follows with planning considerations and friction points:

b. (U) Redeployment. Redeployment is the period of time during which units re-posture themselves in the in-Theater/AOR; transfer forces and material to support other operational requirements; or return personnel, equipment, and material to the Home Station (AC) or demobilization Station (RC). Redeployment begins with the warning order from the combatant commander in-Theater or AOR, proceeds through arrival at the redeployment assembly area (RAA) and completion of preparations for strategic lift from in-Theater/AOR, continues through individual/unit's arrival at Port of Embarkation (POE), and ends with the unit/individual's arrival at new employment site, Home Station (AC) or demobilization (RC) station. Units redeploying to support other operations transition directly to Employment phase of DCS. All others will transition to Post-deployment. During the Redeployment phase, units and individuals may begin to conduct recovery in-Theater/AOR. During recovery the activity level of units will be ramped down, providing members of the unit and leaders the opportunity for well-deserved rest. Selection of locations for recovery in concert with the RAA will be the purview of the combatant commander. During this phase, unit leaders will balance in-Theater/AOR recovery / reconstitution requirements with rest, and unit directed activities. As a part of this phase, select DCS actions will begin. These actions are found in ANNEX A. Conduct of DCS during this phase will undoubtedly compete for other requirements in-Theater/AOR, and will encounter friction points for which leaders must prepare. Although units begin Redeployment activities in-Theater/AOR, other actions will take place concurrently at Home Station. A key element of the successful reintegration of families will center on proper preparation, to include spouse and family education. ANNEX A identifies a number of tasks to be accomplished at Home Station prior to return of Soldiers. Reception activities in some form, such as parades, picnics,

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etc., should occur for every Soldier and DA civilian from first to last regardless of where assigned in support of OEF/OIF. Rear Detachment Commanders (RDC), DA civilians, volunteers, Family Support Groups (FSG), community agencies and employers, should all participate. Mobilization Station reception plans for arrival ceremonies, reception, and installation ceremonies will be short and simple with minimal requirements imposed on returning Soldiers and civilians.

(1) (U) Redeployment Time Line. Anticipate the redeployment time line to become the first friction point. There will be significant pressure to begin redeployment as quickly as possible. The Executive Branch and Members of Congress will wish to return the RC as quickly as possible to mitigate the disruption of civilian lives, reintegrate RC soldiers back into their communities, and reduce the manpower bill associated with OEF/OIF. The SECDEF directs that members of the Ready Reserve ordered to active duty without their consent shall be retained on active duty no longer than absolutely necessary. They shall receive priority by combatant commanders for redeployment over AC units, and be released from active duty as expeditiously as possible.

(2) (U) Redeployments. The second friction point will center on the requirement for the combatant commander to develop a Time-Phased Force Deployment List that will govern the redeployment of units within, and from, in-Theater/AOR. Expect that unit integrity will be maintained during Redeployment wherever possible. However, strategic airlift availability, combined with operational requirements, will cause many units to be divided into serials, with individual fillers assigned to fill empty spaces on airframes. This will cause accountability challenges for unit commanders and for PERSCOM. Reducing the friction associated with this will require close coordination with U.S. Army, Central Command (ARCENT).

(a) (U) AC units will undergo a phased process of reintegration and recovery upon completion of Redeployment, providing a balance of recovery requirements with family / personal time. It is essential that unit leaders also conduct personal reconstitution. Unit commanders will develop a plan for so doing.

(b) (U) ARCENT and USASOC will establish procedures to identify and notify Soldiers to report to their original units during a stand down period. Return of AC soldier's cross-leveled in-Theater/AOR will begin in-Theater/AOR. AC soldiers who do not return to parent unit in-Theater/AOR will return to the CONUS demobilization station with the RC unit to which assigned or AC Home Station if assigned to an AC unit. Continued movement of these AC soldiers to their parent unit will occur from the demobilization stations. ARCENT Personnel Command (PERSCOM) will manage the assembly, pre-transition processing, and movement of individual RC soldiers.

(c) (U) Continuing operations in-Theater/AOR, and the length of time to return and dispose of equipment will require some RC units to remain in-Theater/AOR and/or additional units to be activated and deployed in support of in-Theater/AOR operations or within CONUS.

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(d) (U) RC units begin pre-transition processing in-Theater/AOR, with an advance party departing with critical data elements for all assigned/attached soldiers. This data will be used to expedite the processing at demobilization stations. DCS requirements will be incorporated into RC unit pre-transition processing.

(3) (U) Individual Soldier Redeployment. The third friction point centers on the fact that there will be a variety of circumstances whereby an a very limited number of individuals will re-deploy separately and apart from a unit. Every effort must be taken in the process to ensure redeploying individuals, to include individual augmentees and IRRs, redeploying complete all DCS actions. Complete all investigations to include line of duty investigations (LOD), and AR 15-6, Report of Survey (ROS), and, etc. to ensure quality and completeness, investigating officers and /or boards must ensure investigations are as complete as possible before leaving theater. Award initiation must be completed prior to actual redeployment. The following scenarios provide a baseline for planning purposes:

(a) (U) Individual Soldiers may re-deploy with their unit main body, as a part of an advance or trail party, or individually based upon airframe availability. In addition, individual Soldiers may re-deploy based upon emergency leave, medical evacuation, escort, or other possible scenarios. Prior to redeployment, individual returnees must complete DCS actions prior to release from their assigned units. Personnel Support organizations will assist commanders to ensure actions are complete. Soldiers will be provided instructions for actions to be conducted upon return to the Port Of Debarkation (POD). Responsibility for tracking DCS actions for individual returnees will be borne by PERSCOM for personnel actions, and OTSG for medical action, using a redeployment checklist.

(b) (U) RC soldiers serving as fillers/replacements in AC units may re-deploy with their assigned unit and demobilize at the unit's Home Station or be released to re-deploy as an individual. RC soldiers serving as fillers/replacements in RC units may re-deploy with their assigned RC unit and demobilize with the unit at the unit's designated demobilization station or be released to re-deploy as an individual. IRR/IMA soldiers in CONUS will out-process at the installation to which they are currently assigned. Those in the training base and/or CONUS Replacement Centers (CRC) will out-process from that installation. RC members in the training base will complete the training to which they were ordered, and then be demobilized. DCS actions will be completed on IRR/IMA soldiers prior to their REFRAD.

(c) (U) IRR soldiers who return from overseas or OEF/OIF as individuals will move to CRC. Redeployment will be as individuals once Redeployment tasks are complete. Personnel records for IRR soldiers will be moved to the transition separation points upon notification by 3rd PERSCOM of the location to which the Soldier will be moved. IRR soldiers will out-process at that installation and be provided transportation to home of record. Records will be forwarded to those installations via overnight mail. PERSCOM and 3rd PERSCOM must establish visibility over IRR soldiers and their unit

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of assignment. Movement of records will be kept to a minimum, reducing the potential loss of records and/or delay of IRR out-processing. Turn-in of equipment, to include small arms, should take place at the CRC. Remaining DCS actions will be accomplished at the CRC prior to REFRAD. To complete DD Form 214, only current information to include awards will be entered on the form. On completion, documents will be scanned and emailed to Personnel Electronic Records Management System (PERMS) for inclusion in Military Personnel File (MPF).

(4) (U) Civilian Redeployment. Redeployment of deployed civilians assigned TDY to CONUS, or overseas will be triggered by the decision of the appropriate commander to terminate the assignment and arrange return transportation to the permanent duty station. All civilians will re-deploy through the CRC or other processing center from which they deployed. They will enter tracking data in the Army Civilian Tracking System (CIVTRACKS) upon departure from theater, upon arrival at the CRC, and finally upon return to Home Station. DA Pam 690-47 provides additional guidance on civilian redeployment procedures, to include medical screening during return processing.

c. (U) Post-deployment. Begins with arrival at Home Station (AC) or demobilization station (RC), includes actions to recover equipment, personnel and demobilization activities. This phase ends with release from recovery mission (AC) or arrival at Home Station (RC). Individual redeployment and demobilization processing (reverse SRP, medical screening, DCS process) will be completed during this phase. DCS actions to be completed in this phase are found in ANNEX B. Demobilization begins with personnel recovery at the POD and ends with recovery at Home Station, to include individual redeployment and demobilization processing. Units conduct equipment recovery at POD ending with rearm/refuel/refit at Home Station.

(1) (U) AC units will balance recovery operations with DCS requirements to ensure that unit, equipment, and soldier reconstitution is accomplished. Unit commanders will employ a Soldier Reconstitution Checklist to assist them in managing Soldier reconstitution. As with equipment recovery, Soldiers will be in various forms of recovery and will require chain of command actions to ensure they transition from a "clean and complete" level of readiness to "10/20" standards of readiness. During the initial week of recovery, units will implement a "half-day" Program of Instruction (POI) per FORSCOM guidance. This POI will provide for basic elements of unit recovery and soldier personal time. Soldier personal time applies equally to single and married soldiers, as well as unit leaders. Unit leaders are responsible for ensuring the unit "ramps up" progressively based upon readiness guidance provided through Army G3 and FORSCOM.

(2) (U) For RC units, demobilization will begin concurrently with redeployment to facilitate actions at the demobilization station. RC units will be reorganized in-Theater/AOR, to include USAREUR and U.S. Army Pacific (USARPAC), reassigning, to the maximum extent possible, original deployed unit members back into the unit. Actions will be taken in-Theater to complete pre-transition processing and other

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administrative actions (OER/NCOER, awards, draft TDY travel vouchers LOD investigations, and medical evaluations, tasks by phase, etc) prior to redeployment. The demobilization process will occur in the following order: in-Theater/AOR preparation for demobilization, demobilization at Mobilization Stations, return to Home Station, and return to Home of Record. This process will be characterized by specific, standard requirements developed by FORSCOM to ensure that all RC units maintain maximum readiness and that RC Soldiers and their families reconstitution and reintegration needs are properly addressed. RC soldiers will be briefed at the demobilization station on their benefits derived from active duty. Approved legislative initiatives will be briefed to all Soldiers supporting OEF/OIF, as well as normal transition briefings. RC units deployed will return to Home Station in Desert Battle Dress Uniforms (DBDU) or Battle Dress Uniforms (BDU) (if DBDUs were not issued). DBDU's deemed unserviceable may be retained by the service member.

(3) (U) The demobilization process for RC soldiers who must demobilize as individuals will follow the same basic pattern as that for units. Every process, task, benefit provided to units will be provided to individuals. RC soldiers who were assigned to USAREUR or USARPAC based units will out-process from their unit in USAREUR or USARPAC, and then proceed to a separation point for final out-processing. USAREUR soldiers will be out-processed at Fort Dix or Fort Jackson. USARPAC soldiers will be out-processed at Fort Shafter. AC filler replacement personnel in RC units re-deploy with the RC unit to the RC unit demobilization station. These AC soldiers will be reported to PERSCOM for reassignment or released from TDY and returned to their parent unit. Individual RC soldiers will travel to their Home of Record in civilian clothes or DBDUs.

(4) (U) Units will coordinate plans with their installations to receive and assist families meeting returning Soldiers and DA civilians. Units will ensure that families are integrated into the plan for reception of units and individuals, and will remain proactive in ensuring that appropriate family receptions are made.

(5) (U) All RC soldier records will be brought up-to-date prior to completion of demobilization. Major Commands (MACOM) will take action to ensure that all personnel actions and DCS actions are updated and reviewed prior to departure from demobilization stations. Individual USAR soldiers not assigned to a unit will have their records shipped to Army Reserve – Personnel Command (AR-PERSCOM) once they are complete. Records of USAR and ARNG unit members will be completed prior to departure of the unit for Home Station. Units will be responsible for update and maintenance of the records of permanently assigned personnel during the entire demobilization process. The MPF should reflect all awards and OER/NCOER actions must be completed and married up with the MPF prior to completion of demobilization. RC soldiers should retain copies of all personnel documents needed to keep personal affairs in order. All pay entitlements to include those associated with promotions will be resolved prior to REFRAD.

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(6) (U) Under the provisions of 10 U.S.C. 12686, any RC soldier whose combined period of active duty will exceed 18 years prior to demobilization or who is within 2 years of qualifying for a non-regular retirement will not be involuntarily released from active duty without approval by the Secretary of the Army.

d. (u) Reconstitution. Begins at Home Station with the recovery of equipment, completion of administrative requirements, continuation of Soldier reconstitution, reintegration with family, and civilian jobs (RC). Preparations begin for future deployment missions. DCS activities include family readiness, reintegration of Soldiers into families and communities, equipment maintenance, and Soldier readiness. DCS actions to be completed in this phase are found in ANNEX C. These continue as the unit/individuals prepare to begin collective / unit training. This phase ends when units have achieved sufficient reconstituted state as to allow for the beginning of collective/unit training.

(1) (U) Family readiness activities will remain active during the entire reconstitution phase, with emphasis on reunion assistance, and follow-up transition issues. Reception activities in some form, such as parades, picnics, etc., should occur for every Soldier and DA civilian from first to last regardless of where assigned in support of OEF/OIF. RDCs, DA civilians, volunteers, FRGs, community agencies and employers, should be encouraged to participate.

(2) (U) Follow-on ceremonies will occur as a part of normal holiday celebrations. During this phase, soldiers will have opportunities to participate in community celebrations and ceremonies. The expectation of participation in ceremonies should be balanced with unit and Soldier/family needs to ensure that these do not place an undue burden on returning Soldiers and family members. This could be acute as units return in the time frame leading up to Independence Day.

(3) Maintenance of Personnel Readiness. Maintenance of personnel readiness relates to deployment and distribution of AC soldiers, and RC soldiers as applicable. During the reconstitution phase, Army G1 will promulgate updated policies related to the following areas:

- (a) (U) Reversal of STOP-MOVE and Foreign Service Tour Extension (FSTE).
- (b) (U) Reversal of STOP-LOSS.
- (c) (U) Distribution Priorities.
- (d) (U) Retention Policies.
- (e) (U) Professional Development.
- (f) (U) Separations.

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4. (U) Specific Instructions. All agencies must work together in a united, coordinated effort to achieve the objectives set out in this plan. All MACOMS and HQDA Staff will examine existing policies and ensure that all policies support Soldier Reconstitution and that these policies and processes are coherent and coordinated by a clearly designated lead agent. All MACOMs and HQDA Staff will review the DCS requirements in this plan, develop plans to implement DCS, and conduct a capability assessment associated with executing DCS requirements. Specific attention will be paid to the resourcing requirements, by type, to effectively execute DCS. MACOMs will cross-level internally to maximize efficiencies. Once this is accomplished, MACOMs will coordinate with specific support provider commands (IMA, MEDCOM, CFSC) to determine what assets can be re-missioned to support a near term surge requirement for DCS. Once all resources have been identified and re-missioned, MACOMs will provide HQDA with any resource shortfall information.

a. (U) FORSCOM.

(1) (U) Assist OCCH and OTSG with additional available chaplain and medical resources in support of the DCS Installation Team for use at remote and austere locations and troop surges.

(2) (U) Assist OTSG to ensure Soldier and family members are provided information on TRICARE benefits, eligibility, and insurance options post-deployment.

b. (U) Army G1.

(1) (U) ICW OTSG, develop and promulgate personnel policy regarding medical and dental evaluation and treatment requirements for demobilization of RC soldiers, to include conditions for which RC soldiers are required to remain on active duty for medical evaluation (ADME) to complete additional assessment and/or treatment.

(2) (U) Assist OCCH and OTSG with additional available chaplain and medical resources in support of the DCS Installation Team for use at remote and austere locations and troop surges.

(3) (U) Assist OTSG to ensure Soldier and family members are provided information on TRICARE benefits, eligibility, and insurance options post-deployment.

(4) (U) Coordinate with OTSG in tracking ARNG soldiers required to remain on ADME ensuring that these Soldiers complete all required DCS processing prior to release to State control.

c. (U) Office, Chief Army Reserve (OCAR). Coordinate with OTSG in tracking USAR soldiers required to remain on ADME ensuring that these soldiers complete all required DCS processing prior to release to RSC control.

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d. (U) U.S. Army Reserve Command (USARC). Coordinate with OTSG in tracking USAR soldiers required to remain on ADME ensuring that these soldiers complete all required DCS processing prior to release to RSC control.

e. (U) Office, Chief Chaplain (OCCH). Assist OTSG in identifying and resolving installation issues associated with DCS Installation Team.

f. (U) Officer of The Surgeon general (OTSG).

(1) (U) Assist G1 in development of Unit Risk Reduction Leader Tip Card.

(2) (U) Implement DCS process for Soldiers and DA civilians redeployed and/or redeploying through medical channels. Direct execution of DCS within MHS at treatment facilities for individuals who are in-patient.

(3) (U) Track DCS for Soldiers evacuated through medical system through fields on U.S. Army Transportation Command (TRANSCOM) regulating and Command and Control Evacuation System (TRACE2S) and Patient Accounting and Reporting Real-Time Tracking System (PARRTS). Provide the G1 with a clearly defined work-around to ensure that individual soldiers redeploying are properly tracked through the DCS process.

(4) (U) Coordinate with TRICARE Management Activity for development of information materials for educating RC soldiers on TRICARE benefits, eligibility, and insurance options post deployment.

(5) (U) Distribute TRICARE information to installation DEMOB Stations.

(6) (U) Develop TRICARE counselor information sheet for use by benefits advisors to explain RC benefits.

(7) (U) Lead for identifying and resolving installation issues associated with DCS IT (OCCH and IMA assist).

(8) (U) Develop medical component of DCS IT in support of remote or austere locations and troop redeployment surges. Be prepared to deploy medical component as part of DCS-IT.

(9) (U) Validate MEDCOM's requests for augmentation necessary to properly conduct DCS operations.

(10) (U) Develop and deploy briefings and training materials for augmentation to theater and demobilization / home stations to assist in training care providers and leaders.

(11) (U) Ensure that behavioral health assets are in place at POD.

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(12) (U) Provide technical support to G1 for development of personnel policy regarding medical and dental evaluation and treatment requirements for demobilization of RC soldiers, to include conditions for which RC soldiers are required to remain on ADME for completion of additional assessment and/or treatment.

(13) (U) Assist CFSC in monitoring Fort Bragg Employee Assistance Program (EAP) (telephonic and email 24/7 for AC only) and FORSCOM's EAP (pilot program) at Forts Devens, Dix, and McCoy (RC only). Coordinate with CFSC to expand EAP at Fort Stewart (AC only) and assist CFSC in acquiring supplemental funds from the OSD to fund EAP for FY 03.

(14) (U) Expand current Employee Assistance Program (EAP) support to include telephonic support contract for IRR and IMA soldiers and DA civilians returning from deployment, and their families to include 6 face-to-face counseling sessions per year, per Soldier and family.

g. Assistant Chief of Staff, Installation management, Installation Management Agency (IMA). Assist OTSG in identifying and resolving installation issues associated with DCS Installation Team in support of remote or austere locations and troop redeployment surges.

- Appendix 1 - Redeployment Phase Actions
- Appendix 2 - Post-Deployment Phase Tasks
- Appendix 3 - Reconstitution Phase Tasks
- Appendix 4 - Critical Enabling Tasks
- Appendix 5 - DCS Tracking
- Appendix 6 - DCS Installation Teams
- Appendix 7 - Deferred Deployment Cycle Tasks

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APPENDIX 1 (REDEPLOYMENT PHASE ACTIONS) TO ANNEX G (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLAN

1. (U) Purpose. To provide guidance for the DCS tasks to be accomplished during redeployment of Army forces currently serving in support of OEF/OIF.
2. (U) General Guidance.
 - a. (U) Ensure units that experienced significant losses do not skip DCS tasks, and are not “fast tracked” home without proper post conflict/mobilization processing. (Army Component Commander)
 - b. (U) As individuals re-deploy as early returns, emergency leaves, or medical evacuations, units will ensure that Rear Detachment Commanders (RDCs), to include State Area Reserve Commanders and Regional Support Commanders, are provided contact information and completed DCS tasks. (Unit Commanders)
 - c. (U) During preparation for redeployment, provide email and telephone support for Soldiers in RAA and civilians. (CFSC MWR lead, AAFES and NETCOM assist)
 - d. (U) Commanders will certify that their unit has completed DCS tasks to the first Colonel in the chain of command prior to arrival at DEMOB or Home Station (Unit Commanders)
 - e. (U) During this phase, DCS tasks will occur both in-Theater and at Home Station concurrently. In addition to Soldier DCS tasks, there are a number of actions that will be occurring at Home Station to prepare spouses and families for Soldiers’ return. Paragraph 3 addresses Soldier tasks to be accomplished either in-Theater or at Home Station. Paragraph 4 addresses Spouse/Family tasks to be accomplished concurrently.
3. (U) DCS Tasks. (U) The following tasks will be performed for deployed Soldiers, and for select care providers with whom Soldiers will interact. Most of these tasks will occur while the Soldier is still deployed. Once Soldiers return, units, Soldiers, and their families enter the Post-Deployment phase, where all tasks are performed at Home Station.

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a. (U) Individual Actions (Must be accomplished in the RAA prior to departure from Theater)

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
1.1.3	Receive Suicide Awareness and Prevention Training	Unit / Unit Ministry Teams	DA G1 (OTSG & OCCH assist)	
1.1.4	Receive Medical Threat Brief	Unit Leadership (Medical staff)	OTSG	
1.1.6	Document exposures in Theater (DD 2796)	Unit Leadership (Medical staff)	OTSG	

b. (U) Medical Support Actions.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
1.3.1	Identify any recently acquired negative health related problems	Unit Leadership, Medical Health System	OTSG	1.1.6
1.3.2	Refer Soldiers with deployment related problems to appropriate local agency for assistance.	Unit Leadership	OTSG	
1.3.3	Treat, and document any adverse or potentially adverse exposures or negative health-related behaviors that occurred during deployment/mobilization	OTSG	OTSG	
1.3.4	Ensure the availability of behavioral health assets in the RAA	OTSG	OTSG	

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c. (U) In-Theater Support Actions.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
1.4.2	Ensure Personnel Reporting System is updated, provides visibility of all returning Soldiers to Home Station commands & organizations, and Redeployment Rosters are transmitted	Unit Ldrship, Army Component Cdr, MHS, PERSCOM	DA G1 (OTSG assist)	
1.4.3	Ensure all returning civilians are entered/updated in CIVTRACKS	In-Theater supervisor; CRC staff; Supervisor at Home Station	DA G1 (OTSG assist)	

d. (U) Demobilization Station (RC), Home Station (AC), and RDC Actions. These tasks will be performed at Home Station for Spouses and Families of Soldiers and DA civilians, and for select care providers with whom Army families will interact. Most of these tasks will occur while the Soldier is still deployed. Once Soldiers return, units, Soldiers, and their families enter the Post-Deployment phase, where all tasks are performed at Home Station.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
1.5.8	Assess DCS Installation capability; identify shortfalls and request additional assets.	Mobilization Station, FORSCOM, USAREUR	DA G3 (OTSG assist)	
1.5.14	Provide health threat brief to educate spouses on health symptoms and myths	Installation MHS	OTSG	
1.5.15	Provide briefing and information to spouses on potential Signs and Symptoms of Distress	Installation MHS	OTSG	
1.5.20	Provide health threat brief to educate installation childcare providers (facility based and "in home care providers) on health symptoms and myths.	Installation MHS	OTSG	

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APPENDIX 2 (POST DEPLOYMENT PHASE ACTIONS) TO ANNEX G
(DEPLOYMENT CYCLE SUPPORT (DCS)) TO MEDCOM REDEPLOYMENT/
DEMOBILIZATION PLAN (U)

1. (U) General Guidance.

- a. (U) RDCs provide updated manifests to key local agencies.
- b. (U) RDCs identify potential family issues awaiting returning Soldiers and advise unit commander.
- c. (U) Gaining command is responsible for completion of any tasks left incomplete by the previous phase.
- d. (U) Completion of tasks in Post-deployment is event driven not time driven.
- e. (U) Leave should be taken after completion of DCS tasks (in particular individual, chain of command actions and institutional support actions for RC soldiers.)

2. DSC Action Items.

a. (U) Soldier Actions

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
2.1.2	Receive Suicide Awareness & Prevention Training in all units	Unit Ministry Teams	DA G1 (OTSG & OCCH assist)	1.1.3
2.1.3	Receive health threat brief	Unit Ldrship (Medical staff)	OTSG	1.1.4
2.1.4	Receive briefing on how to identify signs and symptoms of distress	Unit Ldrship (Medical staff)	OTSG	
2.1.5	Receive briefing and information on Post-Deployment Stress	Unit Ldrship (Medical staff)	OTSG	
2.1.6	Normalization of Experiences	Unit Ldrship (Medical staff)	OTSG	1.1.5
2.1.13	Receive safety briefings covering at a minimum: POV, Alcohol, Water Sports, STD	Unit Leadership	Army Safety Center (ACSAP assist)	
2.1.14	Individual Soldiers revalidate driver / safety training	Unit Leadership	Army Safety Center	

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b. (U) Chain of Command Actions.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
2.2.6	Ensure Personnel Reporting System is updated, provides visibility of all returning soldiers to Home Station commands & organizations, and is shared with authorized, interested parties	Unit Leadership, Army Component Cdr, Medical Health System, PERSCOM	DA G1 (OTSG assist)	1.4.2
2.2.12	Conduct MMRB, MEB, PEB	Unit Leadership, Medical Health System, PERSCOM	DA G1 (OTSG & OTJAG assist)	2.3.10

c. (U) Medical Support Actions.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
2.3.1	Perform initial TB test and 90-day TB test	MEDCOM	OTSG	
2.3.4	Complete all appropriate healthcare related assessments & treatments to include completion, review, submission, and placement of permanent medical record the DD 2796 and 2795, documentation of exposures in theater, special medications such as PB as anti-malarial, interviews on environmental and occupational exposures, medical record reviews, and appropriate medical tests to include the TB tine test IAW current HA direction. Visits related to deployment shall be coded within the patient tracking system as V70.5_6.	MEDCOM	OTSG	1.1.6, 1.5.2, 2.3.2
2.3.5	Draw serum specimens within 30 days of return to DEMOB Station (RC) or Home Station (AC)	Medical Health System	OTSG	

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2.3.6	Continue to assess, treat, and document any adverse or potentially adverse exposures or negative health-related behaviors that occurred during deployment/mobilization	OTSG	OTSG	1.3.3
2.3.7	Conduct medical record review	MEDCOM	OTSG	
2.3.8	Screen behavioral health records (where existing)	MEDCOM	OTSG	
2.3.9	Update individual's permanent health record with deployment health records	Medical Health System, RC Unit Leadership	OTSG	
2.3.10	Ensure that DD 3349 (Medical Profile) is completed prior to release from mobilization station/CRC	DEMOB Station, Unit Leadership	OTSG	2.3.7, 2.3.9
2.3.11	Convert identified soldiers to ADME status	MEDCOM, DEMOB Station, Unit Leadership, Installation AG	DA G1 (OTSG and ACSIM assist)	2.3.10
2.3.12	Extend health care for deployment-connected conditions to DA civilians	OTSG	OTSG	
2.3.14	Intervene against abusive behavior (non-criminal)	CFSC / Medical Health System	CFSC (DA G1)	1.5.6

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APPENDIX 3 (RECONSTITUTION PHASE ACTIONS) TO ANNEX G (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLAN (U)

1. (U) General Guidance.

- a. (U) All actions for both AC and RC are accomplished at Home Station
- b. (U) Gaining command is responsible for completion of any tasks left incomplete by previous phases.

2. (U) DSCActions.

a. (U) Chain of Command Actions.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
3.2.2	Conduct leader counseling after block leave periods, and integrate DCS considerations	Unit Leadership	DA G1 (OTSG assist)	2.2.10
3.2.4	Complete any outstanding MMRB, MEB, PEB	Unit Leadership, Medical Health System, PERSCOM	DA G1 (OTSG & OTJAG assist)	2.2.12

b. (U) Medical Support Actions

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
3.3.1	Complete 90-day TB Testing requirements	MEDCOM	OTSG	2.3.1
3.3.2	Complete any serum specimen requirements	Medical Health System	OTSG	2.3.5
3.3.3	Complete update individual's permanent health record with deployment health records	Medical Health System, RC Unit Leadership	OTSG	2.3.9

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c. (U) Institutional Support Actions.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
3.4.8	Continue to provide TRICARE benefits briefing	Unit Leadership (Medical staff)	OTSG	2.4.10

d. Army Enabling Actions.

#	Task	Responsibility to Provide	Proponent	Preceding Tasks
3.6.1	Conduct Applied Suicide Intervention Skills Training (ASIST) in all units	Unit Ministry Teams	DA G1 (OTSG & OCCH assist)	
3.6.3	Create capability at Power-Projection Platform to manage surge medical hold requirements.	MEDCOM, DEMOB Station, Unit Leadership, Installation AG	OTSG (DA G1 assist)	

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APPENDIX 4 (CRITICAL ENABLING TASKS) TO ANNEX G (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose to provide DCS critical enabling tasks.
2. (U) General Guidance.
 - a. (U) G1.
 - (1) (U) Assist CFSC, OTSG, Army Safety Center. Develop Unit Risk Reduction Leader Tip Card for unit level leaders. Tip Card must integrate risk reduction, domestic violence, behavioral health, post-deployment stress, and safety topics for leaders to use as resource guide and standardized briefing scenario. Produce and distribute Unit Risk Reduction Leader Tip Card to AOR by 15 May 2003.
 - (2) (U) Assist CFSC, OTSG. Develop Redeployment Checklist that incorporates DCS and deployment readiness factors.
 - (3) (U) Assist CFSC, OTSG. Evaluate current Army 1-800 support mechanisms to determine the most effective and efficient use of resources for providing assistance to AC and RC Soldiers and families. Provide Army guidance on recommended solution.
 - (4) (U) ICW OTSG, develop and promulgate personnel policy regarding medical and dental evaluation and treatment requirements for demobilization of RC soldiers, to include conditions for which RC soldiers are required to remain on ADME for additional assessment and/or treatment.
 - b. (U) G3. (Assist G1, OTSG. Develop and implement a NCO leader/mentor policy and program to identify and train select NCOs within deployed units to assist in identification of post-conflict issues and referral options for Soldiers. Intent is to ensure select NCOs are provided with sufficient training and tools (through ongoing BH professional support and training at the Home Station unit level) to serve as a unit facilitator for individual and small group discussions of post-deployment issues and concerns, and provide a means for Soldiers to seek information and assistance without fear of career concerns.
 - c. (U) OTSG:
 - (1) (U) Implement DCS process for Soldiers redeployed and/or redeploying through medical channels. Direct execution of DCS within Military Health System (MHS) at treatment facilities for Soldiers who are in-patient.

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(2) (U) Implement tracking and additional support/Care Management components of DCS for soldiers evacuated through medical system through fields on TRACE2S and PARRTS. Provide the G1 with a clearly defined workaround to ensure that individual soldiers redeploying through medical means are properly tracked through the DCS process.

(3) (U) Coordinate with TRICARE Management Activity for development of information materials for educating RC soldiers on TRICARE benefits, eligibility, and insurance options post deployment. Coordinate with TRICARE Management Activity to develop TRICARE counselor information sheet for use by benefits advisors to explain RC benefits. Ensure that TRICARE information is distributed to installation demobilization stations.

(4) (U) Serve as Army lead for developing and deploying DCS Installation Team (IT) in support of remote or austere locations and troop redeployment surges. Work closely with FORSCOM to identify potential surges and critical remote/austere locations. Coordinate DCS IT support with Office of Chief of Chaplains, IMA, and CFSC.

(5) (U) Ensure that behavioral health assets are in place at POD.

(6) (U) Train health care providers and select NCOs on unit leader/mentor program in theater. Provide unit mentors with training / ongoing Behavioral Health professional support at the unit level at Home Station.

(7) (U) OTSG - Provide technical support to G1 for development of personnel policy regarding medical and dental evaluation and treatment requirements for demobilization of RC soldiers, to include conditions for which RC soldiers are required to remain on ADME for additional assessment and/or treatment.

d. (U) Director, Army National Guard (DARNG):

(1) (U) Assist OTSG to ensure Soldier and family members are provided information on TRICARE benefits, eligibility, and insurance options post-deployment.

(2) (U) Coordinate with OTSG in tracking ARNG soldiers required to remain on ADME ensuring that these soldiers complete all required DCS processing prior to release to State control.

e. (U) OCAR Coordinate with OTSG in tracking USAR soldiers required to remain on ADME ensuring that these soldiers complete all required DCS processing prior to release to RSC control.

f. (U) FORSCOM. Assist OTSG to ensure Soldier and family members are provided information on TRICARE benefits, eligibility, and insurance options post-deployment.

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APPENDIX 5 (DCS PERSONNEL TRACKING) TO ANNEX G (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

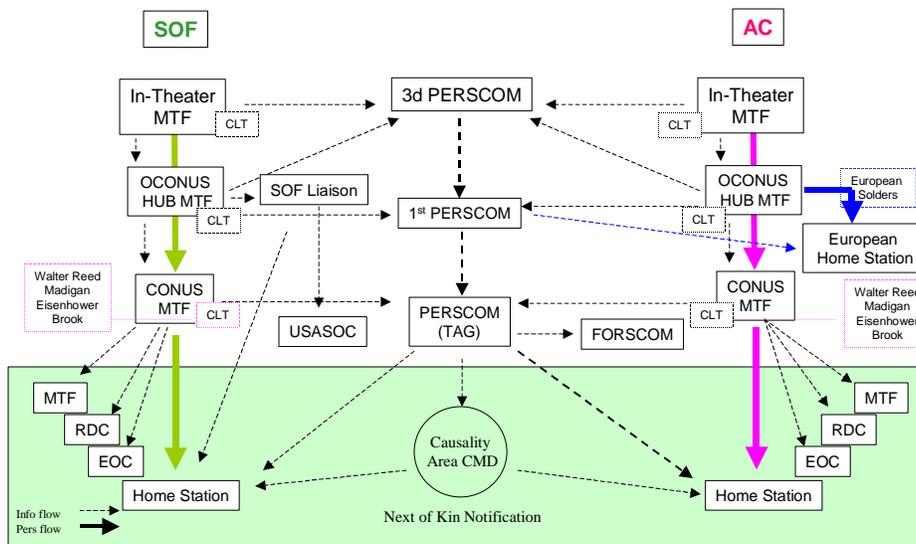
1. (U) Purpose. To provide guidance on DCS personnel tracking.
2. (U) General Guidance.
 - a. (U) Every effort will be made to redeploy Soldiers as part of their assigned unit they are serving with in-Theater. This effort allows them to participate in welcome home ceremonies, preliminary DCS activities and medical screening with those leaders and Soldiers with whom they have faced the stress of combat.
 - b. (U) For RC soldiers, commanders will, whether the Soldier redeploys with the unit or as an individual, accomplish DCS tasks prior to the Soldiers' departure from the unit. The unit commander will provide that information to the individuals Demobilization Station Installation Commander.
 - c. (U) It is the responsibility of the gaining commander (Demobilization Station Installation Commander) to ensure completion of those portions of DCS processing not completed or documented by the losing command. If no documentation is provided, the gaining commander will complete all redeployment and post deployment tasks of the DCS process.
 - d. (U) Commanders at all levels will ensure that Soldiers and civilians processing for redeployment as individuals, traveling on emergency leave or being Medically Evacuated will be tracked for DCS requirements.
3. (U) Specific Guidance. For Soldiers and civilians medically evacuated from theatre (not returned to duty), MTF commanders are responsible for completing DCS tasks. Once the Soldier/DA civilian is released from the CONUS MTF, RDC is responsible for completion of the redeployment and reconstitution phase tasks. (OCONUS MTF for OCONUS based personnel). See Tabs A and B to this Appendix

TAB A – MEDICAL EVACUATION OF SOF AND AC
TAB B – MEDICAL EVACUATION OF RC AND DAC

TAB A (MEDICAL EVACUATION FOR SOF AND AC) TO APPENDIX 5 (DCS PERSONNEL TRACKING) TO ANNEX G (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose. To provide information on the medical evacuation of SOF and AC personnel.
2. (U) General Guidance. See the flow chart depicted below.

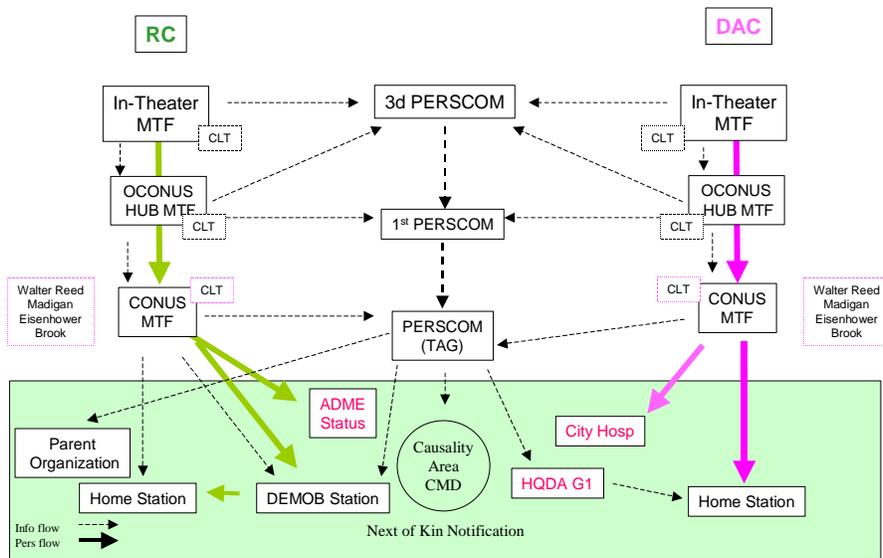
Medical Evacuation for SOF & AC



TAB B (MEDICAL EVACUATION FOR RC AND DAC) TO APPENDIX 5 (DCS PERSONNEL TRACKING) TO ANNEX G (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose. To provide information on the medical evacuation of RC and DAC personnel.
2. (U) General Guidance. See the flow chart depicted below.

Medical Evacuation for RC & DAC



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APPENDIX 6 (DCS INSTALLATION TEAMS) TO ANNEX G (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose. Provide guidance and identify resources required for DCS tasks to be accomplished by DCS-IT.

2. (U) Concept. Deployment Cycle Support (DCS) Installation Team (IT) is a holistic life-cycle concept in support of real-world operations. Subject Matter Experts, primary from OTSG, Office, The Judge Advocate General (OTJAG), OCCH and CFSC, have identified those tasks that must be done to take care of our Soldiers, civilians and their families following the employment of AC and RC units and Soldiers. The DCS Plan lays out those tasks and identifies the Army Staff proponent for each task. DCS IT takes that work and focuses it on the return of Soldiers and DA Civilians. That focus includes identification of critical tasks in the Redeployment and Post-Redeployment phases, and quantifying added resources to accomplish those tasks. DCS IT is formed at demobilization and home station based the size of anticipated flow through that installation. When installation requirements fall short of anticipated requirements, request for augmentation are submitted and processed through normal channels.

3. (U) General Guidance.

a. (U) The DCS IT focuses on the immediate requirements of the Redeployment and Post-Deployment phases of the DCS and is intended to provide immediate feedback to the Army staff in order to modify the DCS Plan for subsequent units.

b. (U) Incorporated in the DCS IT are:

(1) (U) The DCS IT represents redeployment and Post-Deployment phase tasks that are executed at an installation.

(2) The personnel and skills of the proposed DCS IT.

(3) Tailored augmentation requirements for the major installations (Fort Stewart, Fort Bragg, Fort Benning, and Fort Bliss)

4. (U) Assumptions.

a. (U) No more that 2 battalions (+) arriving per day = 2,000 soldiers

b. (U) Arrival processing estimated to take 5 days

c. (U) Space is available on the installation. RC units awaiting operational deployment will deploy, or be demobilized as no longer needed and off the installation prior to arrival processing of main bodies.

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- d. (U) All units/soldiers will return to the station from which they departed, or as directed by Continental U.S. Army (CONUSA).
 - e. (U) No severe bottlenecks will occur in the arrival processing.
 - f. (U) Only one divisional-sized unit will redeploy at a time.
 - g. (U) New mobilization at installations to support other operational requirements will continue concurrent with redeployments.
 - e. (U) DCS Installation Teams will consist of uniformed, DA civilians, or contractors.
 - f. (U) Post-deployment surge will occur from arrival at POD through beginning of block leave. Post surge will occur from end of block leave through POD arrival plus 90 days.
5. (U) Tasks.
- a. (U) OTSG is designated as lead in executing this DCS IT; other agencies identified as Task Proponents in this Annex are in support of CG FORSCOM.
 - b. (U) NLT _____, be prepared to execute taskings and provide support as specified in this Annex.
 - c. (U) OTSG will form and identify required DSC ITs as specified in this CONPLAN to CG, FORSCOM NLT _____, and be prepared to deploy that team when directed. (OTSJA, OCCH and ACSIM will support OTSG in this.)
 - d. (U) CG FORSCOM may adjust tasks, timings, and resources IOT meet mission requirements, but will report those changes to the Army G1 IOT facilitate improvements to subsequent DCS activities in support of (ISO) other redeploying Soldiers.
6. (U) DCS Installation Team: (per 1,000 redeploying soldiers):
- a. (U) Primary Team Leader – from installation.
 - b. (U) Community Health Nurse – 1 per team.
 - c. (U) Medical Augmentation (12-hour day) MD / PA / CNP – (Estimate)
- (1) (U) 20 Health Care Providers (MD / PA / CNP) for a 15 minute interview (without physical) per thousand soldiers;

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(2) (U) (U) 80 Health Care Providers (MD / PA / CNP) for a 1-hour exam (with physical) per thousand soldiers.

d. (U) Behavioral Health Team – 2 providers and 1 NCO per thousand soldiers.

c. (U) Chaplains.

(1) (U) Two teams (consisting of 1 each Chaplain and Chaplain Assistant) per thousand soldiers (surge).

(2) One teams (consisting of 1 each Chaplain and Chaplain Assistant) per thousand (post surge).

d. (U) Judge Advocate General (JAG) – 2 Attorneys and / 4 Legal Specialists (27D) per thousand soldiers.

e. (U) Health Benefit Advisor 4 per thousand.

f. (U) ACS Staff – 4 senior service managers per thousand.

7. (U) (U) DCS Installation-specific requirements for DCS IT Installations (per 1,000 soldiers):

Installation	Team Leader	Com m Health Nurse	Behavior al Health Team	Med. <u>Augment</u>	Chap-lain	JAG	Health Benefit Advisor	ACS Staff
Ft. Stewart	M	M	M	M	.5M	M	M	.5M
Ft. Benning	M	M	M	M	.25M	M	M	M
Ft. Bragg	M	M	M	M	.25M	M	M	M

(NOTE: M = DCS Installation Team (Defined above))

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APPENDIX 7 (DEFERRED DEPLOYMENT CYCLE TASKS) TO ANNEX G
 (DEPLOYMENT CYCLE SUPPORT (DCS) CONPLAN) TO MEDCOM
 REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. (U) Purpose. To provide guidance on deferred DCS tasks.
2. (U) General.
 - a. (U) A number of DCS tasks remain unresourced. These tasks are moved from Annexes A through C and are no longer mandatory.
 - b. (U) Units and commands may execute any of the tasks from this list at their discretion and within the constraints of their resources.
 - c. (U) Upon availability of additional resourcing, these tasks will be reconsidered as a part of execution of this or future DCS Task support.

Redeployment				
Home Station Actions				
#	Task	Responsibility to Provide	Proponent	Preceding Tasks
1.1.7	Establish squad level assessment of Soldier distress level	Unit Leadership	OTSG	
1.5.2	Begin screening of active soldiers and family members for deployment related health concerns via post-deployment clinical practice guideline / Care Managers during routine health care visits	Medical Health System	OTSG	
1.5.3	Begin assistance with remote AC & RC FM deployment related health concerns via centralized telephone CPG/Care Management through DHCC	OTSG	OTSG	

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Post-Deployment				
Soldier Actions				
#	Task	Responsibility to Provide	Proponent	Preceding Tasks
2.1.7	Establish squad level assessment of Soldier distress level	Unit Leadership	OTSG	1.1.7
2.1.8	Peer Mentor with Behavioral Health professional support conducts ongoing AC unit level risk assessments/referrals to care	Unit Leadership, Medical Health System	DA G-1 (OTSG assist)	
Medical Support Actions				
2.3.2	Identify any recently acquired negative health related problems	Unit Ldrship, MHS System	OTSG	1.1.6, 1.3.1
2.3.3	Provide mandatory medical assessments and treatments (to include laboratory work-ups)	MEDCOM	OTSG	1.3.2
2.3.13	Use Clinical Practice Guidelines to provide TRICARE beneficiaries with positive responses to post deployment health concerns	Medical Health System	OTSG	1.5.2
2.3.15	Continue to provide assistance to remote AC / RC soldiers and family members for deployment related health concerns via centralized telephone CPG / Care Management through DHCC	OTSG	OTSG	1.5.3

Post-Deployment				
Institutional Support Actions				
#	Task	Responsibility to Provide	Proponent	Preceding Tasks
Army Enabling Actions				
2.6.1	Embed deployment related health care ombudsmen/managers into primary healthcare	MEDCOM	OTSG	

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Medical Support Actions				
3.3.4	Peer Mentor with behavioral health professional support conducts ongoing unit level risk assessments/referrals to care	Unit Leadership, Medical Health System	DA G-1 (OTSG assist)	2.1.8
3.3.5	Continue to use Clinical Practice Guidelines to provide TRICARE beneficiaries with positive responses to post deployment health concerns	Medical Health System	OTSG	2.3.13, 2.4.10
3.3.6	Continue to provide assistance to remote AC / RC soldiers and family members for deployment related health concerns via centralized telephone CPG / Care management through DHCC	OTSG	OTSG	1.5.3, 2.4.10, 2.4.11
3.3.7	Continued deployment-related health care management (beyond post-deployment and Demobilization) -support in negotiating the medical system via telephone for active or RC soldiers identified with medical or exposure concerns	MEDCOM	OTSG	2.3.16, 2.4.12
Institutional Support Actions				
3.4.1	Continue to screen active Soldiers and family members for deployment related health concerns via post-deployment clinical practice guideline / Care managers during routine health care visits	Medical Health System	OTSG	2.3.13
Army Enabling Actions				
3.6.5	Embed deployment related health care ombudsmen/advocates into primary healthcare	MEDCOM	OTSG	

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ANNEX H (REPORTS REQUIREMENTS) TO MEDCOM REDEPLOYMENT/ DEMOBILIZATION PLAN (U)

1. Purpose. To provide a list of required reports generated by the redeployment/demobilization process.
2. Reports. The following data will be gathered by each redeployment/demobilization site, and reported through Regional Medical Commands and or other appropriate Major Subordinate Commands to MEDCOM/OTSG command channels. All required information will be entered into the MEDPROS reporting system. RMCs/MSCs will be expected to provide the information directly via the Daily Situation reports, paragraph 8, if difficulties or delays are incurred during input to the MEDPROS system.
 - a. Each DD Form 2796, Post-Deployment Health Assessment will be entered into MEDPROS.
 - b. Submit a copy of DD Form 2796 , Post-Deployment Health Assessment (VIA FedEx or other express mail carrier) to the Army Medical Surveillance Activity (AMSA), Building T-20, Room 213, (ATTN: MCHB-TS-EDM), 6900 Georgia Avenue, N.W., Washington, D.C. 20307-5001; phone (202) 782-0471 (DSN: 662).
 - c. Submission daily of the number of Soldiers, by compo, that have been processed for redeployment and / or demobilization.
 - d. Daily submission of the number of completed and submitted DD Form 2796, Post-Deployment Health Assessment, divided into numbers of the old 2 page form and the new 4 page form.
 - e. Daily submission of the number of blood samples taken and sent to the DoD Serum Repository.
 - f. Track and report number of consults/ referral by type on a daily basis.
 - g. Track and report number of soldiers requesting physical exams.
 - h. Track and report number of Reserve Component soldiers requiring MEB, PEB process.
 - i. Track and report number of Reserve Component soldiers entering ADME.

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ANNEX I (GLOSSARY) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION PLAN (U)

1. Purpose. To provide a list of ACRONYM and their definitions used within this plan.

<u>ACRONYM</u>	<u>DEFINITION</u>
AAFES	Army Air Force Exchange Service
AC	Active Component
ACS.....	Assistant Chief of Staff
ACSLOG	Assistant Chief of Staff, Logistics
ACSOPS	Assistant Chief of Staff, Operations
ACSPER	Assistant Chief of Staff, Personnel
AD	Active Duty
ADME.....	Active Duty Medical Extension
AG	Adjutant General
AMEDD	Army Medical department
AMSA	Army Medical Surveillance Activity
AO.....	Area of Operations
AOR	Area of Responsibility
ARCENT	U.S. Army, Central Command
ARNG.....	Army National Guard
AR-PERSCOM.....	Army Reserve Personnel Command
ADS-HA.....	Assistant Secretary of Defense – Health Affairs
ATTN.....	Attention
BDU.....	Battle Dress Uniform
CFSC	Community and Family Support Center
CHPPM	Center for Health promotion and Preventive Medicine
CIVTRACK	Army Civilian Tracking System
CNR	Certified Nurse Practitioner
CONPLAN.....	Concept Plan
CONUS	Continental United States
CONUSA.....	Continental U.S. Army
CRC	CONUS Replacement Center
DARNG	Director, Army National Guard
DBDU	Desert Battle Dress Uniform
DCS.....	Deployment Cycle Support
DCS-IT	Deployment Cycle Support-Installation Teams
DEERS.....	Defense Enrollment Eligibility Reporting System
DENTAC	Dental Activity
DEROS	Date Eligible for Return From Overseas
DHCC.....	Deployment Health Clinical Center
DIMHRS	Defense Integrated Management Human Resource System
DMLSS.....	Defense Medical Logistics Standard Support
DNA.....	Deoxyribonucleic Acid

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DOD	Department of Defense
DTF	Dental Treatment Facility
DU	Depleted Uranium
DVA	Department of Veterans Affairs
EAP	Employee Assistance Program
EOC	Emergency Operations Center
FOG	Field Officers Guide
FORSCOM	U.S. Army Forces Command
FRG	Family Readiness Group
FSG	Family Support Group
FSTE	Foreign Service Tour Extension
GCCS	Global Command and Control System
HCP	Health care Provider
HIV	Human Immune deficiency Virus
HP&S	Health Policy and Services
HQ	Headquarters
HQDA	Headquarters Department of the Army
HSA	Health Service Area
HSR	Health Service Region
IAW	In Accordance With
ICW	In Accordance With
IMA	Individual Mobilization Augmentee / Installation Management Activity
IMR	Individual Medical record
IMSA	Installation Medical Support Activity
ISO	In Support Of
MACOM	Major Command
MD	Medical Doctor
MEB	Medical Evaluation Board
MEBITTS	Medical Evaluation Board Internal Tracking System
MEDCEN	Medical Center
MEDCOM	U.S. Army Medical Command
MEDDAC	Medical Department Activity
MEDPROS	Medical protection System
MHS	Military Health System
MMSO	Military Medical Support Office
MOS	Military Occupational Specialty
MPF	Military Personnel File
MSC	Major Subordinate Command
MTF	Medical Treatment Facility
MWR	Moral, Welfare, and Recreation
NCO	Non-Commissioned Officer
NCOER	Non-Commissioned Officer Evaluation Report
NLT	Not Later Than
NRC	Nuclear Regulatory Commission
OCAR	Office, Chief Army Reserve

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OCONUS	Outside Continental United States
OE	Occupational and Environmental
OEM	Occupational and Environmental Medicine
OER	Officer Evaluation Report
OCCH.....	Office of Chief Chaplain
OPORD	Operations Order
OSHA	Occupational Safety and Health Administration
OTJAG	Office of The Judge Advocate General
OTSG	Officer of the Surgeon General
PA	Physician Assistant
PAD.....	Patient Administration Division
PARRTS.....	Patient Accounting and Reporting Real-Time Tracking System
PASBA	Patient Administration Systems and Biostatistics Activity
PEB	Physical Evaluation Board
PERMS	Personnel Electronic Records Management System
PERSCOM	Personnel Command
PDH CPG.....	Post-Deployment Health Clinical Practice Guidance
PMR	Patient Movement Request
POC	Point of Contact
POD	Port of Debarkation
POE.....	Port of Embarkation
POI.....	Program of Instruction
POPM.....	Proponency for Preventive Medicine
PPP	Power Projection Platform
PROFIS.....	Professional Filler System
PSP	Power Support Platform
RAA.....	Redeployment Assembly Area
RC	Reserve Component
RDC	Read Detachment Commander
REFRAD	Release From Active Duty
RMC	Regional Medical Command
ROS	Report of Survey
RRC	Regional Readiness Command
SADR	Standard Ambulatory data request
SECDEF.....	Secretary of Defense
SIDPERS	Standard Installation/Division Personnel System
SRP.....	Soldier Readiness Processing
STU.....	Secure Telephone Unit
TAMMIS	Theater Army Medical Management Information System
TDP	TRICARE Dental Program
THB.....	Transition Health Benefits
TRACE2S.....	TRANSCOM Regulating and Command and Control Evacuation System
TRANSCOM.....	U.S. Transportation Command
TST	Tuberculin Skin Test

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USARC..... U.S. Army Reserve Command
USAREUR..... U.S. Army Europe
USARPAC..... U.S. Army Pacific

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ANNEX Z (DISTRIBUTION) TO MEDCOM REDEPLOYMENT/DEMOBILIZATION
PLAN (U)

1. Purpose. To provide a distribution list for this plan.