USCENTCOM 201214Z AUG 25 MOD EIGHTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL-UNIT DEPLOYMENT POLICY

1. **MOD 18 SUPERSEDES ALL PREVIOUS VERSIONS**.

2. **DEFINITIONS:**

    a. **DEPLOYMENT.** For medical purposes, the definition of deployment is travel to or through the USCENTCOM Area of Responsibility (AOR), with expected or actual time in country (Physically present, excluding in-transit or travel time) for a period of greater than 30 days, excluding shipboard operations, as defined in REF C.

    b. **TEMPORARY DUTY (TDY).** TDY missions are those missions with time in country of 30 days or less.

    c. **PERMANENT CHANGE OF STATION (PCS).** PCS personnel, including embassy personnel, will coordinate with their respective service component medical personnel for medical guidance and requirements for PCS to specific countries in the USCENTCOM AOR. All personnel must be current with advisory committee on immunization practices (ACIP) immunization guidelines and DoD travel guidelines. Host nation immunization and medical screening requirements apply. Portions of MOD 18 will apply as delineated in Tab B.

        i. Authorized dependents must process through the overseas screening process and Exceptional Family Member Program (EFMP), if required per component regulations and policies. MOD 18 does not apply to dependents.

    d. **SHIPBOARD PERSONNEL.** All shipboard personnel who deploy into the AOR must have current sea duty screening and remain fully medically ready following annual Periodic Health Assessment (PHA). Deployment health assessment applies if deployed to OCONUS for greater than 30 days with non-fixed U.S. Medical treatment facilities (MTF).

3. **APPLICABILITY.** This MOD applies to U. S. Military Personnel, to include activated reserve and national guard personnel, DoD civilians, DoD contractors, DoD sub-contractors, volunteers, and third country nationals (TCN) deploying to the CENTCOM AOR and working under the auspices of the DoD. Local nationals (LN) will meet the minimal medical standards addressed in PARA 5.F.

    a. **MILITARY WORKING DOGS (MWD) AND CONTRACT WORKING DOGS (CWD).** Will meet minimal standards addressed in PARA 5.G.

4. **MEDICAL DEPLOYABILITY.** The final authority for entry into the CENTCOM AOR rests with the CENTCOM Surgeon and may be delegated to CENTCOM Service Component Surgeons. The deployer's medical evaluating entity or deploying platform or commander (loosing or gaining) are not authorized to waive medical deployment standards. Deployed health service support infrastructure is designed and prioritized to provide acute and emergency support to the expeditionary mission. All personnel (uniformed service

members, government civilian employees, volunteers, DoD contractor employees), Contract Working Dogs (CWD) and Military Working Dogs (MWD) traveling to the CENTCOM AOR must meet medical, dental, and behavioral health fitness standards, and be reasonably expected to remain so for the duration of their deployment. Individuals deemed unable to comply with CENTCOM deployment requirements are disqualified for deployment IAW service policy and MOD 18. Personnel found to be medically non-deployable while outside of the CENTCOM AOR for any length of time will not enter or re-enter the theater until the non-deployable condition is completely resolved or an approved waiver from a CENTCOM waiver authority is obtained. Personnel found to have a disqualifying condition, or a degradation of a previously controlled condition while in the CENTCOM AOR must have an approved waiver to remain in theater. Adjudication of a waiver for personnel already in theater should consider the duration in which the member will not be fully mission capable and if the risks of keeping the member in theater until their disqualifying condition stabilized outweighs the benefits. REF D, E. F, G, H. DoD civilian employees are covered by the Rehabilitation Act of 1973. As such, an apparently disqualifying medical condition nevertheless requires that an individualized assessment be made to determine whether the employee can perform the essential functions of their position in the deployed environment, with or without reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a substantial risk of significant harm to the employee or others when considering the conditions of the relevant deployed environment. See REF I.

5. MEDICAL FITNESS, INITIAL AND ANNUAL SCREENING

a. MEDICAL READINESS PROCESSING. The medical section of the deployment screening site may publish guidance, IAW MOD 18 and service standards, to assist in determining medical deployment fitness. Deploying personnel must have an evaluation by a medical provider to determine if they can safely deploy and obtain an approved waiver for any disqualifying medical condition(s) from the Component Surgeon or CENTCOM Surgeon prior to deploying.

b. FITNESS. Includes, but is not limited to, the ability to accomplish all required tasks and duties, by service requirements or duty position, considering the environmental and operational conditions of the deployed location. At a minimum, personnel must be able to wear ballistic, respiratory, safety, chemical, and biological personal protective equipment; use required prophylactic medications; and ingress/egress in emergency situations with minimal risk to themselves or others.

c. EXAMINATION INTERVALS. An examination with all medical issues and requirements addressed will remain valid for a maximum of 15 months from the date of the physical, or 12 months following deployment, whichever is first. See Tab A and REF D, J, K, L for further guidance. Government civilian employees, volunteers, and DoD contractor personnel deployed for multiple or extended tours of more than 12 months must be re-evaluated for fitness to stay deployed. Annual in-theater rescreening may be focused on health

changes, vaccination currency, and monitoring of existing conditions rather than being comprehensive, but should continue to meet all medical guidance as prescribed in MOD 18. Unless specifically obligated by contractual arrangement, expeditionary military medical assets are not to be used for re-evaluation of contractors to stay deployed. If individuals are unable to adequately complete their medical screening evaluation in the AOR, they should be redeployed to accomplish this yearly requirement. Periodic health surveillance requirements and prescription needs assessments should remain current through the deployment period.

d. SPECIALIZED GOVERNMENT CIVILIAN EMPLOYEES. Employees who must meet specific physical standards (e.g., firefighters, security guards, police, aviators, aviation crew members, air traffic controllers, divers, marine craft operators, commercial drivers, etc.) must meet those standards without exception, in addition to being found fit for the specific deployment by a medical and dental evaluation prior to deployment IAW MOD 18. Certifications must be valid and renewed as required throughout the entirety of the deployment. It is up to the individual to plan for and recertify their respective requirements.

e. DOD CONTRACTOR EMPLOYEES. Must meet standards of fitness for deployment and must be documented to be fit for the performance of their duties, without limitations, by medical and dental evaluation prior to deployment IAW MOD 18. Contractors must comply with REF J and specifically Section 3.13 for medical requirements. Evaluations should be completed prior to arrival at the deployment platform.

i. Pre-deployment and/or Travel Medicine Services for Contractor Employees, including compliance with immunization, DNA, and panograph requirements, evaluation of fitness, and annual screening are the responsibility of the contracting agency per the contractual requirements. Questions should be submitted to the supported command's contracting and medical authority. See Tab B and REF J for further guidance.

ii. All contracting agencies are responsible for providing the appropriate level of medical screening for their employees. Screening must be completed by a medical provider licensed in a country with oversight and accountability of the medical profession, and a copy of the completed medical screening documentation, in English, must be maintained by the contractor. Documentation may be requested by base operations center personnel prior to issuance of access badges as well as by medical personnel for compliance reviews. Installation commanders, in concert with their local medical assets and contracting representatives, may conduct quality assurance audits to verify the validity of medical screenings.

iii. Contractor expense. IAW REF J, contractors will provide pre-deployment medical and dental evaluations. Annual in theater rescreening, if

required, will be at contractor expense. Required immunizations outlined in the Foreign Clearance Guide (https://www.fcg.pentagon.mil) for the countries to be visited, as well as those outlined in paragraph 9 of this document, will be done at contractor expense. The sole exception to this policy is anthrax vaccine, which will be provided at military expense. See REF C, J, O. A disqualifying medical condition, as determined by an in-theater qualified medical provider, will be immediately reported to the contractor employee's contracting officer with a recommendation that the contractor be immediately redeployed and replaced at contractor expense unless an approved waiver is obtained. All the above expenses will be covered by the contractor unless otherwise specified in the contract.

f. LN AND TCN EMPLOYEES. MINIMUM SCREENING REQUIREMENTS ARE:

i. Pre-employment and annual medical screening of LN and TCN employees is not to be performed in military MTFs. Local contracting agencies must keep documentation from all requirements listed in PARA. 5.E.III

ii. All LN and TCN employees whose job requires close or frequent contact with non-LN/TCN personnel (e.g., dining facility workers, security personnel, interpreters, etc.) must be screened for tuberculosis (TB) using an annual symptom screen. A tuberculin skin test (TST) is unreliable as a stand- alone screening test for TB disease in LN/TCN personnel and should not be used. Specific questions regarding appropriate screening of detainees, prison guards and other higher risk populations should be referred to the theater preventive medicine consultant through unit medical personnel.

iii. LN and TCN employees involved in food service, water, and ice production must be screened annually for signs and symptoms of infectious disease. Contractors must ensure employees receive Typhoid and Hepatitis A and B vaccinations and this information must be documented in the employees' medical record / screening documentation.

iv. Further guidance regarding medical suitability or force health protection may be provided by the local task force commander or equivalent in consultation with their military medical assets.

g. WORKING DOGS. Only those animals formally classified as a Military Working Dog (MWD) or Contract Working Dog (CWD), and deployed with appropriate handlers for a specific purpose, are authorized. Ensure appropriate kenneling, veterinary support, and food prior to deployment. MWD and CWD deploying to the CENTCOM AOR must meet the following requirements.

i. MWDs/CWDs are subject to the import requirements of the countries to

which they travel. Requirements are subject to change without official notice to DoD. Veterinary Corps Officers (VCOs) responsible to prepare dogs for deployment will review host nation import requirements for any countries the MWDs/CWDs may travel to, or transit through, to ensure associated requirements are met.

ii. Only MWDs/CWDs assigned deployment category 1 will deploy into the CENTCOM AOR. MWDs/CWDs assigned categories 2-4 are only authorized to deploy into the CENTCOM AOR after receiving a medical waiver from the USCENTCOM/USARCENT Command Veterinarian. MWD/CWD deployment categories are defined in PARA 2.15 of REF LL.

iii. Be implanted with a European Union (EU) approved 15 digit ISO 11784/11785307 compliant microchip.

iv. Current on rabies and distemper/adeno/parvovirus (DAP) and leptospirosis vaccines, given within 2 months of deployment.

v. The red semi-annual physical examination (RSAPE) with all necessary laboratory tests is completed performed prior to travel, as well as 4dx snap tests for dirofilarial and tick-borne diseases, and detailed anesthetized oral 313 exam to include all teeth. RSAPE is only required for MWD.

vi. Fluorescent antibody virus neutralization (FAVN) titers are required for any working dog that is traveling from a gulf state (excluding Bahrain) through Europe. VCOs will ensure the most recent FAVN is sufficient (> 0.5 iu/ml), linked to their 15-digit iso microchip, and their rabies vaccine coverage has never lapsed since the FAVN was performed.

vii. Any working dog deploying to the CENTCOM AOR will arrive with, at minimum, their tour's worth of all necessary prescription medications, in addition to heartworm preventative (ensure if injectable heartworm prevention being used that it will last the entire length of deployment) and flea and tick control (including Advantix and Scalibor/Seresto collars). Dogs that may go to Egypt require praziquantel for the country's tapeworm treatment requirement.

viii. Working dogs with a history of heat injury are ineligible to deploy to the CENTCOM AOR.

h. UNFIT PERSONNEL. Cases of in-theater/deployed personnel identified as unfit, IAW this MOD 18, due to conditions that existed prior to deployment will be forwarded to the appropriate Component Surgeon for determination regarding potential medical waiver or redeployment. Findings/actions will be forwarded to the CENTCOM Surgeon at CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL.

6. MEDICAL WAIVERS

a. MEDICAL WAIVER APPROVAL AUTHORITY. Medical waiver approval authority lies at the Combatant Command Surgeon level IAW REF I, K, M and is delegated to the USCENTCOM Component Surgeons for all deploying personnel within their respective component for all health conditions. MWD/CWD waivers will be evaluated by the USCENTCOM/USARCENT Veterinary Corps Officer (VCO). Sending unit commander or designee endorsement of uniformed service member waivers is required prior to submission to ensure command awareness.

b. Contractors' and sub-contractors' respective service affiliation is determined by the "contractor issuing agency" block on their "letter of authorization", and waivers should be sent to the appropriate service component waiver authority. See section 6.E. The CENTCOM Surgeon is the waiver authority for DoD civilians, contractors, and organizations, such as Defense Intelligence Agency, American Red Cross, etc., who are not directly associated with a particular CENTCOM component.

c. An individual may be medically disqualified by the local medical authority or chain of command. An individualized assessment is still required for all DoD personnel. See REF I. Authority to approve deployment of any person (uniformed or civilian) with disqualifying medical conditions lies solely with the CENTCOM Surgeon and the CENTCOM Service Component Surgeons who have been delegated this authority by the CENTCOM Surgeon.

d. WAIVER PROCESS. If a medical waiver is desired, local medical personnel will inform the non-deployable individual and the unit command/supervisor about the waiver process as follows.

i. Authorized agents (local medical provider, commander/supervisor, representative) will forward a completed medical waiver request form (utilize the most current version of Tab C which can be found here https://www.centcom.mil/CONTACT/THEATER-MEDICAL-CLEARANCE/), to be adjudicated by the appropriate surgeon IAW paragraph 6.E. Adjudication will account for specific medical support capabilities in the local region of the AOR, including possible medication unavailability. Waiver submission by or through a medical authority is strongly encouraged to avoid unnecessary adjudication delays due to incomplete information. The case summary portion of the waiver should include a synopsis of the concerning condition(s) and all supporting documentation to include the provider's assessment of ability to deploy.

ii. The signed waiver will be returned to the request originator for inclusion in the patient's deployment medical record and the electronic medical record (EMR). Disapprovals must be documented and should not be given telephonically.

iii. A CENTCOM waiver does not preclude the need for service-specific medical waivers (e.g., small arms waivers) or occupational medical waivers (e.g., aviators, commercial truck drivers, etc.) if required.

iv. Requests for religious exemptions to medical requirements must have an approved religious accommodation from the member's command prior to waiver submission to CENTCOM. Waivers submitted without the approved religious accommodation will be denied.

v. Appeal process. If the sending unit disagrees with the component surgeon's decision, an appeal may be submitted to the CENTCOM Surgeon. If the disagreement is with the CENTCOM Surgeon's decision, an appeal may be coordinated with the individual's chain of command, through the CENTCOM Surgeon, to the CENTCOM Chief of Staff for exemption to policy consideration.

vi. Waivers are approved for a maximum of 15 months or for the timeframe specified on the waiver. Waiver coverage begins on the date of the initial deployment.

vii. Waivers may be approved, at the waiver authority's sole discretion, for periods of time (e.g. 90 days) shorter than the scheduled deployment duration in order to require reassessment of a medical condition. Such waivers will include resubmission instructions. All labs, assessments, etc. Required for resubmission are the responsibility of the employee to obtain and submit.

viii. All adjudicating Surgeons will maintain a waiver database and record all waiver requests.

ix. Recommend all initial waiver requests be submitted at least 60 days prior to planned departure.

e. **CONTACTS FOR WAIVERS** (send waiver to appropriate component first with the exception of DoD personnel and contractors identified in PARA 6.B)

i. **CENTCOM SURGEON**.CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL ; CML: 813.529.0361; DSN: 312.529.0361
ii. **AFCENT SURGEON**. SG.CLINOPS@US.AF.MIL; CML: 803.717.7101; DSN: 313.717.7101
iii. **ARCENT SURGEON**. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@ARMY.MIL; CML: 803.885.7946; DSN: 312.889.7946
iv. **MARCENT SURGEON**. MARCENT.WAIVERS@USMC.MIL; CML: 813.827.4410/4415; DSN: 312.651.7175
v. **NAVCENT SURGEON**. C5FMEDWAIVERS@US.NAVY.MIL; CML: 011.973.1785.4558; DSN: 318.439.4558
vi. **SOCCENT SURGEON**. SOCCENT.SG@SOCOM.MIL; CML: 813.828.7351; DSN: 312.968.7351

7. PHARMACY

a. SUPPLY. All personnel deploying or traveling to the CENTCOM Area of Responsibility are required to bring medications and other prescription products, other than Force Health Protection Prescription Products (FHPPP), for the duration of the deployment (minimum 90-day supply for deployments > 30 days outside the United States) REF CC. Exceptions to this policy will be granted for prescription medications that have quantity limitations, reduced product availability (e.g. national shortages), product expiration dates less than the days' supply of the prescription or are scheduled controlled substances. Personnel should coordinate with their medical provider and deployment processing unit at a minimum of 30 days in advance of deployment to ensure compliance and medication availability. Procurement lead times vary based on geographical area and pharmacy scope. Medical providers, deployment processing units and service members should coordinate with MTF pharmacy to allow sufficient time to procure TRICARE covered products.

b. Theater pharmacies are not stocked to support chronic medication refills.

i. Personnel requiring malaria chemoprophylactic medications (doxycycline, atovaquone/proguanil, etc.) will deploy with either enough medication for their entire deployment or with enough to cover approximately half of the deployment with plans to receive the remainder of their medication in theater (excluding primaquine for terminal prophylaxis) based on unit preference. Units will distribute terminal prophylaxis upon redeployment. The deployment period will include an additional 28 days after leaving the malaria risk area (for doxycycline) or 7 days (for atovaquone/proguanil) to account for required primary prophylaxis. Terminal prophylaxis with primaquine for 14 days should begin once the individual member has left the area of malaria risk.

ii. All Drug Enforcement Agency (DEA) controlled substances (schedule II-V)) are limited to a 90-day supply and schedule II medications will have no refills. Theater pharmacies cannot be used to fill renewals/refills of medications, with the exception of locations that are unable to obtain prescriptions via the DPP. Renewals/refills must be completed via Tricare mail order pharmacy (TMOP) deployed prescription program (DPP) or express scripts. Information on this program may be found at https://militaryrx.express-scripts.com/deployment-prescription-program. Those eligible for TMOP will complete on-line enrollment and registration prior to deployment. It is the patient's responsibility to provide a follow-on prescription (day 180+ or day 90+ for controlled substances) to TMOP prior to deployment. All schedule II medications require a hardcopy prescription mailed to TMOP if not utilizing MHS Genesis. Schedule III-V can be submitted via MHS genesis or faxed to

TMOP. Submission of a DEA controlled substance to TMOP requires a provider DEA number.

DEPLOYMENT MEDICATION ANALYSIS AND REPORTING TOOL (DMART). Soldier Readiness Processing (SRP) and other deployment platforms and unit medical officer personnel will maximize the use of the Deployment Medication Analysis and Reporting Tool (DMART) to screen deploying personnel for high-risk medications, as well as to identify medications which are temperature-sensitive, over the counter (for situational awareness regarding medication interaction), or not available and/or through the TMOP/DPP. Contact the DHA pharmacy analytics support section at 1.866.275.4732 or dha.jbsa.pharmacy-ops.mbx.pass-dmt@mail.mil for information on how to obtain a DMART report. Information regarding DMART can be found at the website: https://health.mil/military-health-topics/access-cost-quality-and-safety/pharmacy-operations/pod-analytics-support/d-mart. The current CENTCOM formulary can be requested from the USCENTCOM pharmacist at usammc-swa-auab-pharmacist@army.mil

8. MEDICAL EQUIPMENT.

a. PERMITTED EQUIPMENT. Personnel who require medical equipment (e.g. corrective eyewear, hearing aids) must deploy with all required items in their possession TO INCLUDE TWO PAIRS OF EYEGLASSES, PROTECTIVE MASK EYEGLASS INSERTS, BALLISTIC EYEWEAR INSERTS, AND HEARING AID BATTERIES. SEE REF D.

b. NON-PERMITTED EQUIPMENT. Personal durable medical equipment (nebulizers, scooters, wheelchairs, catheters, dialysis machines, insulin, implanted defibrillators, spinal cord stimulators, cerebral implants, etc.) are not permitted. Medical maintenance, logistical support, and infection control protocols for personal medical equipment are not available and electricity is often unreliable.

c. WAIVERS. A waiver for a medical condition requiring personal durable medical equipment is applicable to the equipment, and vice versa. Durable medical equipment used for relief or maintenance of a medical condition requires a waiver. Waiver requests must describe deployer's ability to meet mission requirements in the event of failure of the equipment. Maintenance and resupply of equipment is the responsibility of the individual.

d. CONTACT LENSES. Personnel will not deploy with contact lenses except IAW service policy. Authorized personnel deploying with contact lenses must receive pre-deployment education in the safe wear and maintenance of contact lenses in the deployed environment and deploy with two pairs of eyeglasses and a supply of contact lens maintenance items (e.g., cleansing solution) adequate for the duration of the deployment.

e. **MEDICAL WARNING TAGS.** Deploying personnel requiring medical warning tags (medication allergies, G6PD deficiency, diabetes, sickle cell disease, etc.) Will deploy with red medical warning tags worn in conjunction with their personal identification tags.

i. Medical personnel will identify need for medical warning tags and prepare documentation.

ii. Installation or organization commanders will direct embossing activities to provide tags IAW service procedures.

9. IMMUNIZATIONS

a. **ADMINISTRATION.** All immunizations will be administered IAW REF N. Refer to the DHA immunization healthcare branch website Vaccine Recommendations by AOR | Health.mil or contact the DHA immunization healthcare branch dha.dodvaccines@health.mil for questions and clarifications.

b. **REQUIREMENTS.** All personnel (to include PCS and shipboard personnel) traveling for any period of time to the theater will be current with Advisory Committee on Immunization Practices (ACIP) immunization guidelines and Service Individual Medical Readiness (IMR) requirements IAW REF C. Otherwise IAW REF C shipboard operations that are not anticipated to involve operations ashore are exempt from other requirements of this issuance. Personnel with medical exemptions will require separate waivers for routine assignments, but may not be eligible for positions where the exempted vaccine is required to address a specific occupational or public health threat. Current DoD immunizations requirements and recommendations can be found at the defense health agency website, on the CENTCOM tab, at HTTPS://WWW.HEALTH.MIL/MILITARY- HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR. In addition, all TDY personnel must comply with foreign clearance guidelines for the countries to or through which they are traveling. Mandatory vaccines for DoD personnel (military, civilian & contractors) traveling for any period of time in theater are:

i. Tetanus/diphtheria. Receive a one-time dose of TDAP if no previous dose(s) recorded. Receive tetanus (Td) if ≥ 10 years since last TDAP or Td booster.

ii. Varicella. Required documentation of one of the following: born before 1980 (health care workers may not use this exemption), documented previous infection (confirmed by either epidemiologic link or laboratory result), sufficient varicella titer, or documented administration of vaccine (2 doses).

iii. Measles / mumps / rubella. Required documentation of one of the following: born before 1957, documentation of effective immunity by titer for all three vaccine components, or documented administration of 2

lifetime doses of MMR.

iv. Polio. Documentation of past immunization is required. For travel to/through Afghanistan or Pakistan for ≥4 weeks a one-time booster dose administered prior to departure is required.

1. Immunization should be documented on the CDC 731 certificate of vaccination or prophylaxis (yellow shot record) in addition to the DD2766c to meet international standards.

2. Medical assumed (MA) and medical immune (MI) exemptions are not accepted for this requirement.

3. IAW World Health Organization (WHO) or ACIP disease outbreak guidance, more stringent vaccination requirements may be recommended.

v. Seasonal influenza (including event-specific influenza, e.g., H1N1).

vi. Hepatitis A. At least one dose prior to deployment with subsequent completion of series in theater.

vii. Hepatitis B. At least one dose prior to deployment with subsequent completion of series in theater.

viii. Typhoid. Booster dose of typhoid vaccine if greater than two years since last vaccination with inactivated / injectable vaccine or greater than five years since receipt of live / oral vaccine. Oral vaccine is an acceptable option only if time allows for receipt and completion of all four doses prior to deployment.

ix. Anthrax**.** Anthrax is required for Department of Defense personnel and Department of Defense contractor personnel assigned to or deploying to the U.S Central Command Area of Responsibility for 15 consecutive days or longer. See REF O, P, Q. Note this is a DoD requirement and cannot be waived by CENTCOM.

1. Military personnel. Required for personnel assigned to or deploying to the U.S Central Command Area of Responsibility for 15 consecutive days or longer.

2. DoD civilians. Required at government expense, for emergency- essential and non-combat essential, or equivalent, personnel IAW REF O.

3. DoD contractors. Required at government expense as directed in the contract and IAW REF J and O.

4. Volunteers. Voluntary at government expense.

x. Smallpox**.** As of 16 MAY 2014, smallpox vaccination is no longer required for the CENTCOM AOR. See REF O.

xi. Rabies. Pre-exposure vaccination will be accomplished as below or otherwise considered for personnel who are not reasonably expected to receive prompt medical evaluation and risk-based rabies post-exposure prophylaxis within 72 hours of exposure to a potentially rabid animal. For already-vaccinated personnel, serum samples should be tested every two years for virus neutralizing antibodies, with booster doses required when titers fall below the minimum standard levels. Exceptions may be identified by Unit Surgeons.

1. High risk personnel: pre-exposure vaccination is required for veterinary personnel, military working dog handlers, animal control personnel, certain security personnel, civil engineers at risk of exposure to rabid animals, and laboratory personnel who work with rabies suspect samples.

2. Special operations forces (SOF)/SOF enablers: all personnel deploying in support of SOF will be administered the pre-exposure rabies vaccine series as indicated below.

3. Pakistan. All personnel.

4. Other areas. Per USSOCOM service-specific policies. Contact USSOCOM preventive medicine officer at DSN (312) 299-5051 for more information.

xii. Cholera**.** Oral cholera vaccine is of limited operational use and not recommended or required for most personnel. Those specifically designated by their unit or mission requirements to receive the vaccine should take the following into account when planning:

1. Oral cholera vaccine recipients should not be on oral antibiotics for fourteen days prior to, and ten days after, vaccination, to include malaria chemoprophylaxis. Risk from malaria due to this course of action must be considered during planning. See PARA 14.A. And REF N and R.

2. Allow for ten days for oral cholera vaccine to be effective.

3. Efficacy of oral cholera vaccine is unknown past 90 days, and revaccination may need to occur to ensure effectiveness.

4. Follow storage and reconstitution requirements described in

labeling included with product packaging for oral cholera vaccine.

xiii. COVID-19. Must meet a host nation definition of vaccinated when deploying to countries with a COVID-19 vaccination requirement. For country specific COVID-19 requirements, reference the foreign clearance guide and/or U.S. Embassy website.

xiv. MWD vaccinations are covered in PARA 5.G.

xv. Exceptions. Required immunizations will be administered prior to deployment, with the following possible exceptions:

1. The first vaccine in a required series must be administered prior to deployment with arrangements made for subsequent immunizations to be given in theater.

2. IAW REF Q, Anthrax may be administered up to 120 days prior to deployment. It is highly advisable to get the first two anthrax immunizations or subsequent dose/booster prior to deployment in order to avoid unnecessary strain on the deployed healthcare system.

xvi. Adverse medical events related to immunizations should be reported through reportable medical events (RME) if case definitions are met. All immunization related unexpected adverse events will be reported through the Vaccine Adverse Events Reporting System (VAERS) at https://www.vaers.hhs.gov. Questions or concerns may be directed to the dha-immunization healthcare branch at (1-877-438-8222).

xvii. USCENTCOM and components will monitor immunization compliance via their service specific readiness portal.

10. MEDICAL / LABORATORY TESTING.

a. HIV TESTING. HIV lab testing, with documented negative result, will be within 120 days prior to deployment or departure for any required deployment training if training is enroute to deployment location. IAW Ref I, S and MM the CENTCOM Command Surgeon shall be directly consulted in all instances of HIV seropositivity before medical clearance for deployment. Individuals may be denied entry to the AOR secondary to host nation prohibitions regarding HIV.

i. SERUM SAMPLE: If the individual's health status has recently changed or has had an alteration in occupational exposures that increases health risks, a health care provider may choose to have a specimen drawn closer to the actual date of deployment. See REF T**.**

b. G6PD TESTING. Documentation of one-time glucose-6-phosphate dehydrogenase (G6PD) deficiency testing is IAW REF U. Ensure result is in

medical record or draw prior to departure. Pre-deployment medical screeners will record the result of this test in the service member's permanent medical record, deployment medical record (DD form 2766) and service specific electronic medical record. If an individual is found to be G6PD-deficient, they should be issued medical warning tags (see 8.E) that states “G6PD deficient: no primaquine”. If primaquine is going to be issued to a DoD civilian or DoD contractor, complete the testing at government expense.

c. HCG. Required within 30 days of deployment for all members with retained female anatomy.

d. Whole blood screening. Pre-deployment whole blood donor screening will be required for all deployments greater than 30 days outside the United States.

i. In accordance with standardized procedures established by the Director, DHA: (1) Whole blood donor screening will be conducted within 120 days of deployment. For Service members who deploy more than once during a 4-month period, screening results collected within the previous 120 days will be considered current for their upcoming deployment. (2) Whole blood donor screening will include a health history questionnaire and screen for transfusion transmitted diseases, blood type and, for Service members with group O blood, current anti-A and anti-B titer levels, REF OO.

e. DNA sample. Required for all DoD personnel, including civilians and contractors. Obtain sample or confirm sample is on file or identify local collection sites by contacting the DoD DNA specimen repository (comm: 302-346-8600, fax 302-346-8819). Https://hothcoopcd3.dha.mil/about%20dha/organizational%20structure/health%20care%20administration/afmes/DoD%20dna%20operations

f. Tuberculosis (TB) testing. See REF V.

i. Tuberculosis testing for service members will be performed and documented IAW service policy. Current policy is to avoid universal testing, and instead use targeted testing based upon risk assessment, usually performed with a simple questionnaire. TB testing for DoD civilians, contractors, volunteers, and other personnel should be similarly targeted IAW centers for disease control and prevention (CDC) guidelines, with testing for TB to be accomplished within 90 days of deployment if indicated. If testing is performed tuberculin skin test (TST) or an interferon-gamma release assay may be used unless otherwise indicated.

ii. Positive TB tests will be handled IAW service policy and CDC guidelines.

iii. Unit-based / large group or individual LTBI testing should not be performed in the AOR except among close contacts of cases of known tb

disease.

iv. U.S. Forces and DoD civilians with tb disease will be evacuated from theater for definitive treatment. Evaluation and treatment of tb among U.S. Contractors, local nationals (LN) and third country national (TCN) employees will be at contractor expense. Employees with suspected or confirmed pulmonary TB disease will be excluded from work and otherwise restricted as directed by the theater preventive medicine consultant until cleared by the theater preventive medicine consultant for return to work.

v. Other laboratory testing. Other testing may be performed at the clinician's discretion commensurate with ruling out or monitoring non-deployable conditions and ensuring personnel meet standards of fitness IAW PARA 5 of this document.

11. HEALTH ASSESSMENTS.

a. **HEALTH ASSESSMENTS AND EXAMS**. Periodic Health Assessments must be current IAW service policy at time of deployment and special duty exams must be current for the duration of travel or deployment period. See REF D, J. For MWD, see PARA 5.G

b. **PRE-DEPLOYMENT HEALTH ASSESSMENT** (DD2795).

i. All DoD personnel (military, civilian, contractor) traveling to the theater for more than 30 days will complete or confirm as current a Pre-Deployment Health Assessment within 120 days of the expected deployment date. This assessment will be completed on form DD2795 IAW REF C, W. This does not apply to PCS personnel, shipboard personnel, or personnel located with a DHP funded fixed medical treatment facility (e.g. Bahrain) IAW REF C.

ii. Personnel traveling to the theater for 15 to 30 days may consider completing a Pre-Deployment Health Assessment in order to document their health status and address any health concerns prior to travel to theater. This is especially relevant to those whose position requires frequent travel to the AOR. These individuals are encouraged to complete at least one Pre-Deployment Health Assessment each year, along with a corresponding Post-Deployment Health Assessment for the same year.

iii. Following completion of the deployer portion of the form DD2795, the deployer will have a person-to-person dialogue with a trained and certified health care provider (physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, special forces medical sergeant, independent duty medical technician, or independent health services technician) to complete the assessment.

iv. The completed original form DD2795 will be placed in the deployer's permanent medical record. The form DD2795 must be completed electronically in the medical readiness system designated by DoD component or agency. If a deployer does not have access to the medical readiness system designated by the DoD component, the DD2795 can be transcribed into the readiness system by a medical personnel with access. Contact DHA for paper use of the form DD2795, email: dha.ncr.bus-ops.mbx.dha-formsmanagement@health.mil.

c. **AUTOMATED NEUROPSYCHOLOGICAL ASSESSMENT METRIC (ANAM).** All service members as designated in REF X will undergo ANAM testing within 12 months prior to deployment. ANAM testing will be recorded in appropriate service database and electronic medical record. Contractors, pcs and shipboard personnel are not required to undergo ANAM testing.

d. **POST-DEPLOYMENT HEALTH ASSESSMENT** (DD2796). All personnel who were required to complete a Pre-Deployment Health Assessment will complete a Post-Deployment Health Assessment on form DD2796. The Post-Deployment Health Assessment must be completed no earlier than 30 days before expected redeployment date and no later than 30 days after redeployment.

i. Individuals who were not required to complete a Pre-Deployment Health Assessment, but who completed one to cover multiple trips to theater each of 30 days or less duration, should complete a Post-Deployment Health Assessment at least once a year to document any potential exposures of concern resulting from any such travel and the potential need for medical follow-up.

ii. Individuals who were not required to complete a Pre-Deployment Health Assessment may be required (by the combatant commander, service component commander, or commander exercising operational control) to complete a Post-Deployment Health Assessment if any health threats evolved or occupational and/or CBRN exposures occurred during the deployment that warrant medical assessment or follow-up. REF C.

iii. All redeploying personnel will undergo a person-to-person health assessment with an independent practitioner. The original completed copy of the DD Form 2796 must be placed in the individual's medical record. The DD Form 2796 must be completed electronically in the medical readiness system designated by DoD component or agency. If a deployer does not have access to the medical readiness system designated by the DoD component, the 2796 can be transcribed into the readiness system by a medical personnel with access. Contact dha for paper use of the dd form 2796, email: dha.ncr.bus-ops.mbx.dha-formsmanagement@health.mil.

e. **MENTAL HEALTH ASSESSMENTS**. Will be completed by a licensed mental

health professional or trained and certified health care personnel, specifically a physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, special forces medical sergeant, independent duty medical technician, independent health services technician, mental health nurses, or mental health technicians.

i. Mental Health Assessments will be administered within 120 days prior to deployment, after 120 days in theater and after redeployment within 3 timeframes (3-6, 7-18, and 18-30 months). Assessments should be at least 90 days apart. Additional requirements may be required during deployment. * Air Force personnel: The Deployment Related Health Assessment #2 (DRHA 2) will be completed prior to departing the AOR to meet In-Theater Mental Health Assessment requirements.

ii. Currently administered periodic and other person-to-person health assessments, such as the Post-Deployment Health Reassessment, will meet the time requirements if they contain all behavioral health and social questions IAW REF Y and Z

iii. Mental Health Assessment guidance does not directly apply to DoD contractors unless specified in the contract or there is a concern for a mental health issue. All related mental health evaluations will be at the contractor's expense.

f. **POST-DEPLOYMENT HEALTH RE-ASSESSMENT** (DD2900). All personnel who were required to complete a Pre- and Post-Deployment Health Assessment will complete a Post-Deployment Health Reassessment (DD2900) 90 to 180 days after return to home station. See https://health.mil/military-health-topics/health-readiness/reserve-health-readiness-program/our-services/pdhra. For additional information on Pre- and Post-Deployment Health Assessments. The DD2900 must be completed electronically in the medical readiness system designated by DoD component or agency. If a deployer does not have access to the medical readiness system designated by the DoD component, the DD2900 can be transcribed into the readiness system by a medical personnel with access. Contact DHA for paper use of DD2796, email: dha.ncr.bus-ops.mbx.dha-formsmanagement@health.mil.. See REF C.

i. Deployed medical record. The DD2766, total force health readiness flowsheet, or equivalent, will be used instead of deploying an individual's entire medical record. The deployed DD2766 should be re- integrated into the main medical record as part of the redeployment process.

ii. Deployed personnel (more than 30 days). DD2766 is required.

iii. TDY personnel (15 – 30 days). DD2766 is highly encouraged, especially for those who travel frequently to theater, to document theater- specific vaccines and chemoprophylaxis, as required.

iv. TDY personnel (less than 15 days). DD2766 is not required.

v. PCS personnel. Follow service guidelines for medical record management.

12. MEDICAL INFORMATION. The following health information must be part of an accessible electronic medical record for all personnel (service members, civilians and contractors), or be hand-carried as part of a deployed medical record).

a. Annotation of blood type and Rh factor, G6PD, HIV, and DNA.

b. Current medications and allergies. Include any Force Health Protection Prescription Product (FHPPP) prescribed and dispensed.

c. Special duty qualifications.

d. Annotation of corrective lens prescription.

e. Summary sheet of current and past medical and surgical conditions.

f. Most recent DD2795, pre-deployment health assessment.

g. Documentation of dental status classes 1 or 2.

h. Immunization record. Medical deployment sites will enter immunization data into service electronic tracking systems, (Army-MEDPROS, Air Force-ASIMS, Coast Guard-MRRS, Navy-MRRS (ashore) or SAMS (afloat) and Marine Corps-MRRS).

i. All approved medical waivers.

13. PRE-DEPLOYMENT TRAINING. See REF AA.

a. Scope. General issues to be addressed: information regarding known and suspected health risks and exposures, health risk countermeasures and their proper employment, planned environmental and occupational surveillance monitoring, and the overall operational risk management program.

b. Content. Should include, but not be limited to, the following areas: combat/ operational stress control and resilience; Tactical Combat Casualty Care (TCCC), post- traumatic stress and suicide prevention; mild traumatic brain injury risk, identification and tracking; nuclear, biological, chemical threats; endemic plant, animal, reptile and insect hazards and infections; communicable diseases; vector borne diseases; environmental conditions; safety; occupational health.

c. Medical CBRN Defense Materiel (MCDM) / Chemical Biological Radiological Nuclear (CBRN) response. See Tab D.

d. Theater force health protection.

14. DISEASE RISK ASSESSMENT.

a. Malaria risk assessment and guidelines. In the absence of a local risk assessment conducted IAW the guidance provided in PARA 14.E the following countries and timeframes require chemoprophylaxis. These are minimum requirements.

i. Afghanistan: year-round.

ii. Pakistan: year-round.

iii. Yemen: year-round.

b. Local Component/JTF Surgeons are encouraged to conduct evidence-based entomological and epidemiological assessments of malaria risk at fixed bases where significant numbers of personnel are assigned for prolonged periods. In conducting such a risk assessment, Surgeons should review the most recent assessments and risk maps produced by the national center for medical intelligence. These can only be found on SIPR at https://www.dia.smil.mil/source/web/?topic=Medical.

c. Based on National Center for Medical Intelligence (NCMI) risk assessments and in consultation with the theater preventive medicine consultant, recommendations for modified chemoprophylaxis policy may be provided to commanders using REF AA or similar risk analysis.

d. Maneuver forces with intermittent and unpredictable exposures to risk areas should employ chemoprophylaxis based on the highest risk areas. Units and individuals with very short-term exposure (i.e., aircrew not stationed in the AOR) should have risk and chemoprophylaxis use determined IAW service policy.

e. Assessment of disease threats and near real-time disease outbreak information should be obtained prior to deployment by accessing the DHA's Armed Forces Health Surveillance Center's Health Surveillance Explorer (HSE) dynamic map application. The HSE is FOUO and is located on a CAC-enabled site as follows:
NIPR: https://www.health.mil/hse or https://portal.geo.nga.mil/portal/home/
SIPR: https://portal.geo.nga.smil.mil/portal/home or https://portal/geo.nga.smil.mil/portal/apps/webappviewer/index.html?id=53258902ff2e4d9587c7ff379b22a39b.

f. Malaria chemoprophylaxis utilization.

i. All therapeutic/chemoprophylactic medications, including antimalarials and MCDM will be prescribed IAW FDA guidelines, REF BB, CC, DD.

ii. Doxycycline or atovaquone/proguanil are generally acceptable as a primary malaria chemoprophylactic agent. Mefloquine should be considered the drug of last resort for personnel with contraindications to doxycycline or atovaquone/proguanil, should be used with caution in persons with a history of TBI or PTSD, and is contraindicated in personnel with some behavioral health diagnoses. Each mefloquine prescription will be issued with a wallet card and current FDA safety information indicating the possibility that the neurologic side effects may persist or become permanent IAW Ref DD. Other FDA-approved agents may be used to meet specific situational requirements.

iii. Personnel should deploy with either their entire primary prophylaxis course in hand (excluding terminal primaquine) or with enough medication to cover half of the deployment with plans to receive the remainder of their medication in theater based on unit preference. Terminal prophylaxis (primaquine) should be distributed upon redeployment and only after verifying G6PD status (see PARA 10.B). A complete course of primary prophylaxis begins 2 days prior to entering the risk area for doxycycline and atovaquone/proguanil (2 weeks for mefloquine) and completes after 4 weeks of doxycycline or mefloquine after leaving the at-risk area, or (1 week of atovaquone/proguanil). Terminal prophylaxis is required and consists of taking primaquine for 2 weeks after leaving the risk area. Individuals who are noted to be G6PD-deficient, IAW PARA 10.B will not be prescribed primaquine.

iv. Missing one dose of medication or not using the DoD insect repellent system will place personnel at increased risk for malaria.

v. Commanders and supervisors at all levels will ensure that all individuals for whom they are responsible have terminal prophylaxis issued to them immediately upon redeployment from the at-risk malaria area(s).

g. **PERSONAL PROTECTIVE MEASURES.** A significant risk of disease caused by insects and ticks exists year-round in the AOR. The threat of disease will be minimized by using the DoD insect repellant system and bed nets; https://www.acq.osd.mil/eie/afpmb/. See Ref R and EE.

i. Permethrin treatment of uniforms. Uniforms are available for issue which are factory-treated with permethrin. The uniform label indicates whether it is factory treated. Uniforms which are not factory treated should be treated with the individual dynamic absorption (IDA) kit (NSN: 6840-01-345-0237) or 2-gallon sprayer permethrin treatment. Both are effective for approximately 50 washings. A matrix of which uniforms may be effectively treated is available on the AFPMB website at https://www.acq.osd.mil/eie/afpmb/

ii. Apply deet cream (NSN: 6840-01-284-3982) to exposed skin. One application lasts 6-12 hours; more frequent application is required if

heavy sweating and/or immersion in water. A second option is 'sunsect cream' (20% deet/spf 15), NSN: 6840-01-288-2188.

iii. Wear treated uniform properly to minimize exposed skin (sleeves down and pants tucked into boots).

iv. Use permethrin treated bed nets properly in at risk areas to minimize exposure during rest/sleep periods. Permethrin treated pop up bed nets are available. See DoD pest management materiel other than pesticides at https://www.acq.osd.mil/eie/afpmb/

15. HEALTH SURVEILLANCE. See REF C and FF.

a. Automated Information Discovery Environment (aide) Medical Common Operation Picture (MEDCOP).

b. Deployed units will use aide MEDCOP, SIPR access required, as the primary data entry point for disease and injury (DI) reporting. Units will ensure all subordinate units complete joining and departing reports as required within MEDCOP. Shipboard units should utilize SAMS or TMIP-m for DI reporting and fixed MTF's should utilize MHS-Genesis.

c. Units will coordinate aide MEDCOP training prior to deployment for appropriate personnel to the maximum extent possible. Coordination for training currently can be made through JOMIS at: dha.ncr.peo-ipo.mbx.jomis- training@mail.mil; please also cc MEDCOP Help desk at medcophelp@afs.com.

d. DI surveillance, see REF FF, GG.

i. The list of DI reporting categories, their definitions, and the essential elements of the standard DI report can be found in REF GG.

ii. Component and JTF Surgeons are responsible for ensuring units within their AOR are collecting the prescribed data and reporting that data through the Joint Medical Workstation JMeWS or other standardized reporting processes on a weekly basis.

iii. Medical personnel at all levels will analyze the DI data from their unit and the units subordinate to them and make changes and recommendations as required to reduce DI and mitigate the effects of DI upon operational readiness.

e. Occupational And Environmental Health Surveillance (OEHSA).

i. **Authority**. An OEHSA is a joint approved product used to provide a comprehensive assessment of both occupational and environmental health hazards associated with deployment locations and activities and missions that occur there established by REF C and FF.

ii. **Timeframe**. An OEHSA is initiated within 30 days of date of establishment and completed within three months for all permanent and semi-permanent base camps. OEHSA are conducted to validate actual or potential health threats, evaluate exposure pathways, and determine courses of action and countermeasures to control or reduce the health threats and protect the health of deployed personnel.

iii. **Classification/publication/access.** OEHSA will be sent by the completing unit through the designated service component or JTF pm/FHP officer for review and submitted directly to the Defense Occupational And Environmental Readiness System (DOEHRS) at https://DOEHRS-ih.csd.disa.mil/ . See Reference FF for DOEHRS requirements. If the submitter does not have access to DOEHRS submit the OESHA to the Military Exposure Surveillance Library (MESL) https://mesl.apgea.army.mil/mesl/ If the MESL is not available, email the document to oehs.data@us.army.mil. Classified exposure data should be submitted directly to MESL-S https://mesl.csd.disa.smil.mil. If access to the MESL- S is not available, email the document to https://phc.army.smil.mil .

iv. **Responsibilities.** Service components and JTFs are responsible for approving OESHA completion and will submit a monthly report IAW procedures outlined in REF FF.

f. **Periodic Occupational and Environmental Monitoring Summary (POEMS).**

i. **Authority.** POEMS is a joint approved product used to address environmental exposure documentation requirements established by REF C and FF.

ii. **Timeframe.** POEMS will be created and validated for every major deployment site as soon as sufficient data is available. In general, POEMS are a summary of information reflecting a year or more of environmental and occupational health data to ensure adequate collection of exposure information.

iii. **Classification/publication/access.** POEMS will be unclassified but posted on the password protected deployment occupational and environmental health surveillance data portal at https://mesl.apgea.army.mil/mesl/ where joint occupational and environmental health surveillance data and reports are stored. The poems template can be found at http://phc.amedd.army.mil .

iv. **Responsibilities.** Service components and JTFs are responsible for ensuring poems are completed for sites in their respective AOR. They should develop site prioritization lists and enlist the support of service public health organizations (e.g., U.S. Army Public Health Center

(USAPHC)) to draft the content of a site POEMS. The USAPHC oversees the data archival website for publication of final POEMS and associated documents; however, approval of "final" POEMS must come from the service component/JTF FHP officer with input from preventive medicine resources in direct or general area support.

g. **Reportable medical event (RME) surveillance.** See REF M and FF.

i. The list of diseases and conditions that must be reported can be found in the tri-service reportable events guidelines and case definitions at https://www.health.mil/military-health-topics/health-readiness/afhsd or REF FF.

ii. Component and JTF Surgeons are responsible for ensuring units within their AO are collecting the appropriate RME data and reporting that data through their service specific reporting mechanisms.

iii. It is only required to copy CCSG for the following RMES at ccsg-pmo@centcom.smil.mil or centcom.macdill.centcom-hq.mbx.ccsg-waiver@mail.mil ; anthrax; botulism; CBRN and toxic industrial chemical/material (TIC/TIM) exposure; severe cold weather/heat injuries; dengue fever; hantavirus disease; hemorrhagic fever; hepatitis b or c, acute; HIV; malaria; measles; meningococcal disease; middle eastern respiratory syndrome coronavirus (MERS-COV); norovirus; outbreak or disease cluster; plague; pneumonia, eosinophilic; q- fever; rabies, human; severe acute respiratory infections (sari); streptococcus, invasive group a; tetanus; tuberculosis, active; tularemia; typhoid fever; varicella.

iv. RME reporting is to occur as soon as reasonably possible after the event has occurred. Events with bioterrorism potential or rapid outbreak potential are considered urgent RME and immediate reporting is required (within four hours).

h. **Health risk communication.** See REF C.

i. During all phases of deployment, provide health information to educate, maintain fit forces, and change health related behaviors for the prevention of disease and injury due to risky practices and unprotected exposures.

ii. Continual health risk assessments are essential elements of the health risk communication process during the deployment phase. Medical personnel at all levels will provide written and oral risk communication products to commanders and deployed personnel for medical threats, countermeasures to those threats, and the need for any medical follow-up.

i. DI, RME, and Occupational and Environmental Health (OEH) risk assessments with recommended countermeasures will be provided to commanders and deployed personnel on a regular basis as well as a situational basis when a significant change in any assessment occurs.

16. HEALTH CARE MANAGEMENT.

a. Joint trauma system (JTS) Clinical Practice Guidelines (CPGs) may be obtained here https://jts.health.mil/index.cfm/PI_CPGs/cpgs.

b. Documentation of all medical and dental care received while deployed will be IAW CENTCOM medical information management guidelines. See REF C, HH.

c. It is a commander's responsibility to ensure that all personnel potentially affected by a blast or other potentially concussive event are evaluated for traumatic brain injury (TBI) by a medical provider and documentation is completed IAW REF II. Joint trauma analysis & prevention of injury in combat (JTAPIC) TBI reporting link: https://jincs.army.mil/.

17. UNIT MASCOTS AND PETS.

a. Per CENTCOM general order 1.c., deployed personnel will avoid contact with local animals (e.g., livestock, cats, dogs, birds, reptiles, arachnids, and insects) in the deployed setting and will not feed, adopt, or interact with them in any way.

b. Any contact with local animals, whether initiated or not, that results in a bite, scratch or potential exposure to the animal's bodily fluids (saliva, venom, etc.) will be immediately reported to the chain of command and medical personnel for evaluation and follow-up.

18. FOOD AND WATER SOURCES.

a. All water (including ice) is considered non-potable until tested and approved by appropriate medical personnel (army or navy preventive medicine, air force bioenvironmental engineering, independent duty medical technician/corpsman). Commercial sources of drinking water must also be approved by designated sources in the directory of DoD approved sources for the USCENTCOM AOR.

b. No food sources will be utilized unless inspected and approved by USCENTCOM/USARCENT Command Veterinarian. Food and Water Risk Assessments (FWRA) is a program conducted under specific circumstances by veterinary or PH personnel to assess food operations to identify and mitigate risk from intentional and unintentional contamination. They may be conducted to identify foodborne and waterborne hazards and facilitate the communication of associated health risks to U.S. Forces during missions where approved sources of food and water may not exist.

c. Commanders will ensure the necessary security to protect water and food supplies against tampering based on recommendations provided in food/water vulnerability assessments. Medical personnel will provide continual verification of quality and periodic inspection of storage and preparation facilities.

19. ENVIRONMENTAL EXPOSURES OF CONCERN.

a. Cold injury risk will depend on the specific region. Hypothermia, a life-threatening condition, mostly occurs up to 55 degrees Fahrenheit air temperature. Risk of cold injury increases for persons who are in poor physical condition, dehydrated, wet, or at increased altitude. Countermeasures include proper wear of clothing and cover. Exposed skin is more likely to develop frostbite. Ensure clothing is clean, loose, layered, and dry. Cover the head to conserve heat.

b. Heat stress/ solar injuries/illness. Heat injuries may be the greatest overall threat to military personnel deployed to warm climates. Acclimatization to increased temperature and humidity may take 10 to 14 days. Heat injuries can include dehydration, sunburn, heat syncope, heat exhaustion and heat stroke. Ensure proper work-rest cycles, adequate hydration, and command emphasis on heat injury prevention. Ensure availability and use of individual protection supplies and equipment such as sunscreen, lip balm, sun goggles/glasses, and potable water.

c. Altitude. Operations at high altitudes (over 9,888 ft) can cause a spectrum of illnesses, including acute mountain sickness; high altitude pulmonary edema, high altitude cerebral edema, or red blood cell sickling in service members with sickle cell trait. Ascend gradually, if possible. Try not to go directly from low altitude to >9,888 ft (3,013 m) in one day. A health care provider may prescribe acetazolamide (Diamox) or dexamethasone (Decadron) to speed acclimatization if abrupt ascent is unavoidable. Treat an altitude headache with simple analgesics; more serious complications require oxygen and immediate descent.

d. Good field sanitation practices are essential to maintain force health. They include frequent handwashing, proper dental care, clean and dry clothing (especially socks, underwear, and boots), bathing and dental care with water from a potable source. Change socks frequently, foot powder helps prevent fungal infections.

20. ALL OTHER INSTRUCTIONS AND GUIDANCE SPECIFIED IN INITIAL POLICY MESSAGE REMAIN IN EFFECT. MOD 17 IS NOW INVALID.

21. The USCENTCOM POC for preventive medicine/force health protection is CCSG, DSN 312-529-0345; comm: 813-529-0345; centcom.macdill.centcom-hq.mbx.ccsg-waiver@mail.mil/

REFERENCES

A. ORIGINAL USCINCCENT INDIVIDUAL PROTECTION AND INDIVIDUAL UNIT DEPLOYMENT POLICY MESSAGE
B. MOD SEVENTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND UNIT DEPLOYMENT POLICY MESSAGE. MOD SEVENTEEN IS NO LONGER VALID AND IS SUPERSEDED BY MOD EIGHTEEN
C. DODI 6490.03 DEPLOYMENT HEALTH
D. DODI 6025.19 INDIVIDUAL MEDICAL READINESS
E. CH-2 TO COMDTINST M6000.1F COAST GUARD MEDICAL MANUAL
F. AFI 48-133 DUTY LIMITING CONDITIONS
G. AR 40-501 STANDARDS OF MEDICAL FITNESS
H. NAVMED P-117MANUAL OF THE MEDICAL DEPARTMENT (MANMED)
I. DODI 6490.07 DEPLOYMENT-LIMITING MEDICAL CONDITIONS FOR SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES
J. DODI 3020.41 OPERATIONAL CONTRACT SUPPORT
K. DTM 17-004 DOD CIVILIAN EXPEDITIONARY WORKFORCE
L. DODI 1100.21 VOLUNTARY SERVICES IN THE DEPARTMENT OF DEFENSE
M. DODI 6200.05 FORCE HEALTH PROTECTION QUALITY ASSURANCE (FHPQA) PROGRAM
N. AR 40-562, BUMEDINST 6230.15B, AFI 48-110 IP, CG COMDTINST M6230.4G IMMUNIZATIONS AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES
O. DEPUTY SECRETARY OF DEFENSE MEMO CLARIFYING GUIDANCE FOR SMALLPOX AND ANTHRAX VACCINE IMMUNIZATION PROGRAMS
P. DEPUTY SECRETARY OF DEFENSE MEMO/ANTHRAX VACCINE IMMUNIZATION PROGRAM
Q. ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL POLICY FOR THE ADMINISTRATION OF THE ANTHRAX VACCINE ABSORBED
R. TECHNICAL GUIDE NO. 36/PERSONAL PROTECTIVE MEASURES AGAINST INSECTS AND OTHER ARTHROPODS OF MILITARY SIGNIFICANCE
S. DODI 6485.01 HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN MILITARY SERVICE MEMBERS
T. ASSISTANT SECRETARY OF DEFENSE MEMO/POLICY FOR PRE AND POST DEPLOYMENT SERUM COLLECTION
U. DODI 6465.01 ERYTHROCYTE GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY (G6PD) AND SICKLE CELL TRAIT SCREENING PROGRAMS
V. ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDELINE FOR TUBERCULOSIS SCREENING AND TESTING
W. EXECUTIVE SERVICES DIRECTORATE/DEPARTMENT OF DEFENSE FORMS 2795 AND 2796
X. EXECUTIVE SERVICES DIRECTORATE/DEPARTMENT OF DEFENSE FORM 2900
Y. DODI 6490.13 COMPREHENSIVE POLICY ON TRAUMATIC BRAIN INJURY-RELATED NEUROCOGNITIVE ASSESSMENTS BY THE MILITARY SERVICES
Z. DODI 6490.03 DEPLOYMENT HEALTH
AA. DODI 1322.24 MEDICAL READINESS TRAINING (MRT)
BB. DODI 6420.01 NATIONAL CENTER MEDICAL INTELLIGENCE (NCMI)
CC. ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDANCE ON MEDICATIONS FOR PROPHYLAXIS OF MALARIA

DD. ASSISTANT SECRETARY OF DEFENSE MEMO/NOTIFICATION FOR HEALTHCARE PROVIDERS OF MEFLOQUINE BOX WARNING
EE. PERSONAL PROTECTIVE MEASURES AGAINST INSECTS AND OTHER ARTHROPODS OF MILITARY SIGNIFICANCE
FF. CCR 40-2 DEPLOYMENT FORCE HEALTH PROTECTION
GG. ARMED FORCES REPORTABLE MEDICAL EVENTS GUIDELINES & CASE DEFINITIONS
HH. CCR 40-5/MEDICAL INFORMATION SYSTEMS
II. DODI 6490.11 DOD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY/ AND CONCUSSION IN THE DEPLOYED SETTING
JJ. ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL PRACTICE GUIDELINES FOR DEPLOYMENT LIMITING MENTAL DISORDERS AND PSYCHOTROPIC MEDICATIONS
KK. STIMULANT AND RELATED MEDICATIONS: U.S. FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS AND DOSAGES FOR USE IN ADULTS
LL. AFI 31-126/DOD MILITARY WORKING DOG (MWD) PROGRAM
MM. DODI 6130.03, VOL1 MEDICAL STANDARDS FOR MILITARY SERVICE: APPOINTMENT, ENLISTMENT, OR INDUCTION
NN. MEMORANDUM FOR SENIOR PENTAGON LEADERSHIP, COMMANDERS OF THE COMBATANT COMMANDS, DEFENSE HEALTH AGENCY AN DOD FIELD ACTIVITY DIRECTORS, IMPLEMENTING POLICY ON PRIORITIZING MILITARY EXCELLENCE AND READINESS 08 MAY 2025.
OO. DODI 6480.04 ARMED SERVICES BLOOD PROGRAM