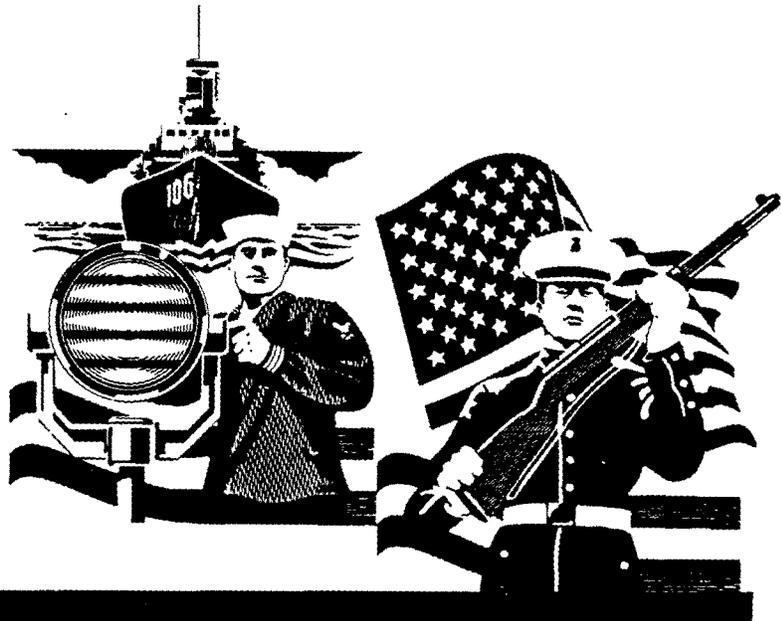


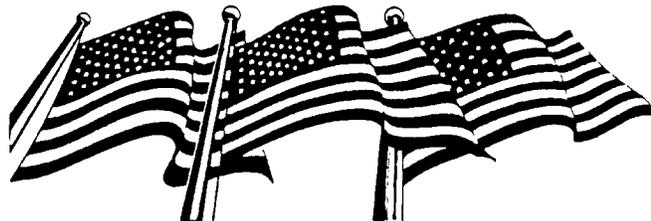
Chapter 18

Medical Boards



Chapter 18

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Article	Page
18-1 Purpose	18-4
18-2 Convening Authority	18-4
18-3 Responsibilities of the Convening Authority	18-5
18-4 Composition	18-5
18-5 Convening of a Medical Board	18-6
18-6 Health Record Entry	18-6
18-7 Medical Board Report Preparation	18-6
18-8 Medical Board Report Cover Sheet (NAVMED 6100/1)	18-8
18-9 Convening Authority Actions	18-10
18-10 Counseling the Member and Subsequent Processing	18-11
18-11 Notification of Parent Command	18-12
18-12 Report Routing and Disposition	18-12
18-13 Processing Time	18-14
18-14 Automatic Data Processing Procedures	18-15
18-15 Departmental Review	18-15
18-16 Medical Boards on Officers	18-15
18-17 Recruit Evaluation Unit	18-16
18-18 Determination of Fitness of Recruits for Service	18-16
18-19 Medical Boards on Recruits	18-17
18-20 Medical Boards on Reservists	18-18
18-21 Return to Duty-Aviation, Submarine, and Other Special Duty Personnel	18-18
18-22 Members Who Refuse Medical, Dental, or Surgical Treatment	18-19

18-23	Board With Disciplinary or Punitive/Misconduct Administrative Action	18-20
18-24	Medical Boards Involving Waivers of Entry Standards	18-20
18-25	Conditions Not Considered a Physical Disability	18-21
18-26	Medical Boards for Members Medically Waived from the Physical Readiness Test	18-21
18-27	EPTE Physical Defects	18-21
18-28	Mental Competency and Incapacitation Evaluation	18-22
18-29	Temporary Limited Duty (TLD) Medical Boards	18-23
18-30	Light Duty	18-25
18-31	Triservice Medical Boards	18-26
18-32	Medical Boards from Other Than DoD Sources	18-27
18-33	Providing Additional Medical Information and Line of Duty and Misconduct Investigation Reports	18-27
18-34	Surgical Procedures on Members in the Disability Evaluation System	18-28
18-35	Withdrawing a Medical Board from the DES	18-28
18-36	Medical Board Quality Control Checklist	18-29
18-37	Cognizant MTFs for Triservice Medical Boards	18-30
18-38	Acronyms	18-35

18-1

Purpose



(1) Medical boards identify members whose physical qualification to continue on full duty is in doubt or whose physical limitations preclude their return to full duty within a reasonable period of time. They are convened to evaluate and report on the diagnosis; prognosis for return to full duty; plan for further treatment, rehabilitation, or convalescence; estimate of the length of further disability; and medical recommendation for disposition of such members.

(2) The findings of a medical board may affirm the physical qualification of a member for assignment to duty (*fit for duty*). A determination of *unfit for duty* is not within the cognizance of a medical board. This determination is made only by the Physical Evaluation Board (PEB) upon review.

(3) The information contained in a medical board report plays an important role in determining the rights of an individual to certain benefits (such as pensions, compensation, promotion, retirement, income tax exemptions, etc.). The report must include all available information with adequate documentation concerning the origin, nature, aggravation by service, and other significant facts concerning each of the member's conditions.

18-2

Convening Authority



(1) Commanding officers of all naval hospitals and commanding officers of naval medical clinics (NAVMEDCLINIC,

may convene a medical board upon any member of the Armed Forces. The Chief of Naval Operations (CNO), Commandant of the Marine Corps (CMC), fleet commanders in chief (FLTINCs), Chief, Naval Personnel (CHNAVPERS), Commander, Naval Reserve Force (COMNAVRESFOR), the Chief, Bureau of Medicine and Surgery (BUMED), or the Officer in Charge, Naval Office of Medical/Dental Affairs (MEDDEN AFFAIRS GREAT LAKES, IL) may order medical boards to be convened.

(2) A convening authority (CA) may delegate, in writing, signatory responsibility for approving or disapproving recommendations and findings of board members. Delegation may not be granted below the directorate level in a hospital command or below the level of the executive officer at a naval medical clinic.

18-3 Responsibilities of the Convening Authority

(1) The CA, as a senior naval officer with detailed knowledge of the standards of medical physical qualification for full duty, disposition of member patients, and disability evaluation procedures, serves as an objective reviewer of the form and content of the medical board report. Approval of the medical board report by the CA ensures the completeness and adequacy of the report and ensures the disposition recommendations made are consistent with Navy and Marine Corps policy. Because of the CA's responsibilities as an objective reviewer, the CA or designee, may not be a member of the board.

(2) The CA is responsible for assuring adequate training of members serving on a medical board. Those officers assigned to serve as the senior member of a convened board will be thoroughly oriented and familiar with policy and procedures of disability processing by the PEB per SECNAVINST 1850.4 series.

(3) The CA will ensure that patients being evaluated are afforded adequate counseling regarding the proceedings, as well as the findings, opinions, and recommendations made by the medical board.

18-4 Composition

(1) Physician members of a medical board must be oriented in medical board procedures and have an understanding of the workings of the Navy's Disability Evaluation System (DES). CAs must ensure that physicians receive adequate orientation before they are permitted to be a member of a medical board.

(2) Ordinarily, medical boards will be composed of two privileged staff members in active clinical practice (physicians) on the staff of a uniformed services medical treatment facility (USMTF). The CA may assign a third member.

(3) The senior member of a medical board will be a privileged staff member in active clinical practice of a USMTF and should be the department head (or designated representative) of the primary specialty for which the patient is being evaluated. The senior member will ensure that the procedures of the board conform to established procedures, and that the report conforms to accepted practices and principles of medicine. Refer administrative questions to the Patient Administration Department.

(4) When the basis for the board is a dental treatment matter, the senior member should be a privileged dentist of a USMTF or uniformed services dental treatment facility (USDTF). The other primary member must be a physician.

(5) When neither member of the medical board has training in the specialty of the patient's primary impairment, obtain appropriate specialty consultations before preparing the medical board report. When this occurs, indicate on the medical board report that the clinical information is taken from consultation with the appropriate specialty.

(6) When the party before the board is an active or inactive reservist, the board will include active or inactive Reserve representation. The CA will indicate in a forwarding endorsement when Reserve members are not available.

(7) If the member being evaluated is mentally incapable of managing personal and financial affairs, an incapacitation board will be convened immediately consisting of three uniformed service or Department of Veterans Affairs (DVA) (formerly Veterans Administration) physicians, or civilian physicians licensed and privileged to practice in a military MTF, at least one of whom will be a psychiatrist (37 USC 602 and the Judge Advocate General (JAG) Manual refer). Place a (P) after the psychiatrists name on the medical board report. Convene incapacitation boards per article 18-28.

(8) When an opinion about mental capacity to stand trial or mental responsibility for charged offenses is ordered by appropriate authority, the board composition will follow the Rules for Court Martial (RCM) 706. The board will consist of

one or more psychiatrists or clinical psychologists designated on the report with (P) or (CP) after their name, respectively.

(9) A psychologist who participates in a member's evaluation may sign a medical board report as the third member except as stated in article 18-4(7). The psychologist will be designated on the medical board with (CP) after the name.

18-5

Convening of a Medical Board

(1) Convene a medical board when any physician trained and certified to be a member of a medical board determines that:

(a) A member has a condition which may permanently interfere with his or her ability to fulfill the purpose of service on active duty.

(b) A member is temporarily unable to perform full duty, but return to full duty is anticipated and it is necessary to follow the patient for more than 30 days before final disposition is made, i.e., temporary limited duty (TLD) boards.

(c) Continued military service would probably result in extended hospitalization or other close medical supervision, or be likely to aggravate the existing condition.

(d) The member's condition includes the presence of mental incompetency or incapability to manage personal or financial affairs.

(e) The member's condition requires permanent assignment limitations; i.e., specific geographic assignment, etc.

(f) The member suffers significant illness or injury which may impact on future service, even though the member may now appear to be physically qualified for full duty.

(g) The member refuses reasonable medical, dental, or surgical treatment and the member's ability to perform full duty is suspect.

(h) The member is an inactive reservist with an injury or illness incurred in or aggravated during a period of active service and the period of required treatment, rehabilitation, or convalescence is expected to exceed 12 weeks.

(2) CAs may convene a medical board to report on members of other branches of the military service.

(3) The following guidelines suggest situations in which evaluation by a medical board may be considered, regardless of whether the member is attached to a shore base command or a deployable unit.

(a) Inpatient care will exceed 30 days.

(b) Total time away from parent command is likely to exceed 60 days.

(c) Member not likely to ever return to full duty.

(d) Physician cannot estimate prognosis or outcome for 45 days.

(e) Member can return to duty but in a limited or restricted capacity.

(f) Member requires assignment near an MTF with specialty services.

(g) Member requires multiple surgeries.

(h) Member requires extensive or prolonged therapy.

(4) A medical board is not appropriate in cases of service members temporarily unable to perform full duty due to pregnancy or complications from pregnancy. Follow OP-NAVINST 6000.1 series for guidance on managing pregnant service members.

18-6 Health Record Entry

(1) When a medical board is initiated, the attending physician will make an entry in the member's health record on the SF 600 (Chronological Record of Medical Care) and NAVMED 6150/4 (Abstract of Service and Medical History) noting the name of the examining facility, date of evaluation, diagnosis, and recommended disposition. The physician will also note the diagnosis on the Problem Summary List.

(2) File a copy of each medical board report in the member's Health Record. Route the original for appropriate review, action, and disposition. Be sure the copy in the medical record is legible and signed.

18-7 Medical Board Report Preparation

(1) Submit medical board reports on the NAVMED 6100/1 (Medical Board Report Cover Sheet) produced by the Medical Board Tracking System (MBTS). An SF 502 (Narrative Summary) may be used for the body of the board's report provided the SF 502 includes all pertinent data about the member. Otherwise, prepare the body of the report on plain white bond paper.

(a) The cover sheet will be completed following article 18-8 and the MBTS user manual.

(b) Present in narrative form in the report body, the results of the complete physical examination or review of systems and all pertinent data on each complaint, symptom, disease, injury, or disability presented by the member which causes or is alleged to cause impairment of health. Present the facts briefly and concisely. Place emphasis on the detailed recording of each physical disability so subsequent evaluation by adjudicative bodies can be made on the basis of the records alone.

(c) The narrative section of board reports should be no more and certainly no less than a well written narrative summary and should answer the following questions: (Use the checklist in article 18-36 to ensure the medical board contains sufficient documentation).

(1) Why was patient hospitalized or treated? The dates of events are very important throughout the narrative. State clearly circumstances of any injury in the medical board. This information may be critical to the PEB's determination of whether the injury was incurred in the line of duty (LOD) or was combat related as defined in 26 U.S.C. 104b(3) (see SECNAVINST 1850.4 series.) This information is important to the member as it affects the tax status of any disability pay awarded. Physicians are cautioned about making opinions on whether the injury was incurred in line of duty or due (or not due) to misconduct.

(2) What was the physical condition of the patient at the time the medical board report was written?

(3) What physical conditions (negative and positive) were found? Provide the height and weight of the member.

(4) What were the results of pertinent laboratory, x-ray, and other tests?

(5) What were the results of consultations?

(6) What and when medical or surgical treatment was given?

(7) What is the board's prognosis and recommendations on the disposition?

(8) What specific physical limitations are recommended for the patient? Description of physical limitations should, when possible, relate to the patient's current duties or duties to which he or she may be assigned.

(9) What instructions were given to the patient, such as medication to be taken, physical restriction, etc.?

(10) Have all conditions and abnormalities been recorded?

(11) How has the member cooperated with the treatment plan?

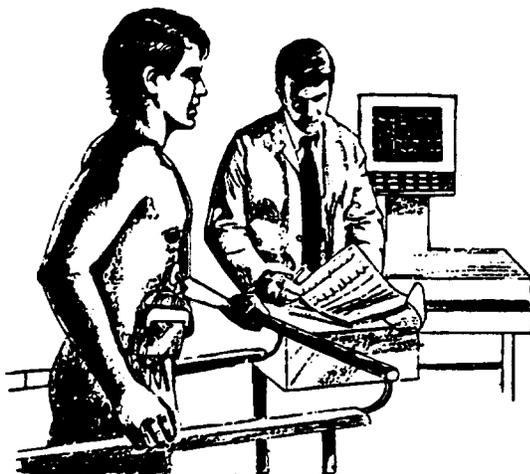
(12) Is there a statement indicating whether or not the medical records of the member reflect a previous determination of mental incompetence? This statement is mandatory. The absence of this statement from the medical board report is cause for the PEB's rejection of the board.

(13) Are there apparent contradictions in the records, such as disagreement with a report or consultation? Thoroughly explain any contradictions.

(d) Since the medical board report eliminates the requirement for a separation or retirement physical examination when the member is to be medically discharged from the service, the medical board members must ensure a complete physical examination has been conducted during the evaluation of the member's condition. Mention of this in the narrative is mandatory as is inclusion of the physical examination or review of systems in the medical board package. Future DVA benefits may be jeopardized by an incomplete medical history upon separation.

(e) If a previous medical board report has been prepared, the detailed past history information is not necessary. Invite attention to the previous report and the description of the present illness restricted to the interval history and current data. When referring to previous boards, be sure the information being referred to is actually contained in the previous boards. Include a copy of all previous board reports in the new medical board report package.

(f) Any information not a matter of record or personal knowledge to a member of the board that is based on the member's own statement should be recorded as "according to the member's own statement." Obtain such data for the benefit of the patient in diagnosis and treatment and use the data to question the patient further. Any additional history so obtained, from the patient or from other sources contacted



as a result of "lead information," may become part of the history.

(g) Pay particular attention to references to "left" and "right." Erroneous dictation or transcription can mislead the PEB as to which side of the patient's body is actually affected by an injury or illness and may affect disability awards.

(2) In the following instances, include a statement in the board's report on the member's capability to manage personal or financial affairs. An incapacitation board must be convened following article 18-28.

(a) All psychoses, unless resolved.

(b) Organic brain disorders when the board's report indicates impairment of judgment.

(c) Severe psychoneuroses when possible impairment of judgment is indicated.

(d) Any situation in which a member has been previously declared incapable of managing personal or financial affairs.

(e) All psychiatric illnesses of sufficient severity to require further hospitalization or commitment upon release from active duty.

(3) Submission of photographs is encouraged for severe disfigurement or chronic skin conditions.

18-8 Medical Board Report Cover Sheet (NAVMED 6100/1)

(1) Use the following guidelines when completing the Medical Board Report Cover Sheet (NAVMED 6100/1). When entering this information into the data base provided by the Naval Medical Data Services Center (NAVMEDATASERVGEN), use the guidance published in appendix F of the users manual.

Block 1, FROM. Enter the name and address of the medical facility where the medical board was convened. Medical boards on Navy and Marine Corps members are considered to be convened by the cognizant Navy MTF per article 18-37)

TO. Enter CHNAVPERS or CMC, as applicable, COMNAVRESFOR, or DNCPB.

VIA. Enter the name and location of other administrative commands in the chain of command, if applicable.

Block 2, NAME. Enter last name, first name, and middle initial of the member appearing before the board.

Block 3, DUTY STATION. Enter the official name and address of the duty station to which the member was permanently attached at the time the board was convened. For second and subsequent boards, note present duty station

but also indicate, under remarks, the member's duty station when the initial board was held (if other than the present duty station.)

Block 4, SOCIAL SECURITY NUMBER. Enter the member's 9-digit social security number.

Block 5, SEX/RACE. Enter "M" for male or "F" for female, and enter one of the following as applicable for race: C=Caucasian, N=Negroid, G=Mongolian, I=American Indian, or M=Malayan.

Block 6, DATE OF BIRTH. Enter numeric date, month (numeric symbols not authorized), and year of birth of member (DDMMYY), e.g., 10 Sep 55.

Block 7, LENGTH OF SERVICE. Enter length of service in years and months. All active duty service time will be counted. Example: For less than 12 months active service, use 00 (No) years and numbers of months completed. If less than 1 month active service, use 00 (No) years and 00 (No) months. For 12 months active service use 01 (one) year and 00 (No) months. This must be the same as the length of service in the narrative statement.

Block 8, GRADE/RATE, BRANCH, AND DESIGNATOR/MOS

(1) Grade/Rate. Enter the grade or rate abbreviation of the member. For Navy and Coast Guard enlisted personnel include the rate, i.e., a hospital corpsman, second class, enter HM2.

(2) Branch. Enter branch of service; i.e., USN, USMC, USA, USAF, USCG, and Reserve components. Inactive reservists must be designated by "-R" after their branch of service (e.g., USNR-R).

(3) Designator/MOS. This item must be completed for naval officers and all Marine Corps members as shown below.

(a) Navy Officer/Warrant Officer. Enter the 4 digit designator from the Register of Commissioned and Warrant Officers of the Navy and Marine Corps and Reserve Officers on Active Duty, NAVPERS 15018.

(b) Marine Corps Officer and Enlisted. Enter the 4 digit Military Occupational Specialty (MOS) number from the Military Occupational Specialty Manual (Marine Corps Order P-1200.7).

(c) Midshipmen, Cadets, and Members of the Coast Guard, Army, and Air Force. Leave blank.

Block 9, CAUSE OF INJURY. If the condition entered in block 19A (Primary Diagnosis) is not the result of an accident, violence, or poisoning, enter "Not applicable"; otherwise enter one of the following:

(1) Battle casualty. (Self-explanatory.)

(2) Motor vehicle. (Includes automobile and motorcycle accidents.)

(3) Falls. (Includes falls either on the same or different levels on land or on ship.)

(4) Athletics and sports. (Includes situations involving accidents in organized recreation whether for training purposes or not.)

(5) Assault by another. (Includes situations involving injuries received as a result of fighting with or attack by another person.)

(6) Self-inflicted. (Includes situations involving both accidental and intentionally self-inflicted wounds.)

(7) Extrahazardous activities. Includes instances where the member incurs a disability while participating in extrahazardous activities under conditions simulating war.

(8) Other external cause. (Includes situations involving accidents, violence, or poisoning with causes not classifiable above.)

Block 10, MILITARY THEATER OF OPERATION. Use only when directed by BUMED. Enter the military theater of operation to identify the geographic origin of the disease or injury and indicate whether or not the condition necessitating a medical board was a result of hostile or nonhostile action.

Block 11, MEMBER'S STATUS. Record the appropriate number in the box. The term recruit applies to Navy or Marine Corps personnel undergoing basic training. Midshipmen and aviation cadets will be indicated as "Active Duty Navy."

Block 12, DATE AND PLACE OF ENTRANCE PHYSICAL. Enter the name and location of facility that conducted the entrance physical examination if the member has less than 1 year of active service; otherwise leave blank.

Block 13, EAOS/AOS. Enter the date of expiration of active obligated service. For officers enter "INDEFINITE" if applicable.

Block 14a, ADMITTED TO SICKLIST. Place an "X" in the appropriate box to indicate whether or not the member was admitted to the sicklist (hospitalized) for the condition for which the medical board was held. This includes hospitalization in a civilian hospital.

Block 14b, DATE OF DISPOSITION. Enter numeric date member was discharged from the hospital (DDMMYY). Use alphabetic, not numeric characters for the month. If not admitted enter "NA". If still an inpatient, enter "current inpatient."

Block 15, DATE OF BOARD. Enter the date (DDMMYY) that the board report was dictated. Do not record the date the report was typed, signed, or forwarded.

Block 16, EPTE (ORIGIN). Enter the appropriate numbers to be used in blocks 19A through 19F. In determining the proper entry, refer to article 18-27.

Block 17, LOD INVESTIGATION. Place an "X" in the appropriate box in cases where an LOD investigation was indicated. A copy of the investigation must accompany the medical board report when submitted.

Block 18, DISCIPLINARY ACTION PENDING. Place an "X" in the appropriate box. Enter the name of the command pro-

cessing this action in the "Remarks" section. Where "YES" is indicated, forward the board for departmental review.

Blocks 19A through 19F, DIAGNOSIS/DIAGNOSES.

(1) **General.** Document all diagnoses whether or not related to the condition for which the board was convened. The diagnostic nomenclature used in recording these diagnoses will be based on and consistent with current medical terminology. Use the International Classification of Diseases, 9th Rev., Clinical Modification (ICD-9-CM) and Diagnostic and Statistical Manual of Mental Disorders (DSM), current editions for establishing diagnoses. When recording diagnoses, make them as complete and definite as possible. Avoid vague and general expressions.

(2) **Order of Diagnoses.** Space has been reserved to record six diagnoses. The first diagnosis listed-PRIMARY DIAGNOSIS should be the major diagnosis or condition for which the medical board was convened. Where there is more than one diagnosis or condition to be recorded, the following rules apply.

(a) If the diagnoses are unrelated, the primary should be the most significant.

(b) If there is a combination of related causes, the primary diagnosis should be the one which was determined to be the precipitating factor for the other diagnosis or diagnoses. For example, in a diagnosis of "schizophrenic reaction acute, undifferentiated type due to drug ingestion, LSD and Mescaline," the diagnosis "drug ingestion" will be considered the primary diagnosis.

(c) Record the second through sixth diagnoses in order of importance.

(d) If there are more than six diagnoses, record the seventh and succeeding diagnoses on a separate sheet of paper appended to the cover sheet.

(3) **EPTE Origin.** From block 16, enter the appropriate number in the box provided for the origin of each diagnosis entered. Refer to article 18-27 for guidance.

Block 20, INDICATED DISPOSITION.-Enter the appropriate number in the box provided. **Do not use disposition number 2, Discharge Physical Disability, or number 4, Discharge COG.**

Block 21, REMARKS.-Indicate the DDMMYY that the period of TLD automatically expires. Compute expiration date from the date of the report. For second and subsequent periods of TLD, calculate expiration of the TLD from the expiration date of the previous TLD period. This block may also be used to enter amplifying information from preceding blocks. When the recommended disposition is TLD, the board will set the major physical limitation imposed by the member's condition and the length of time the member should be retained in a TLD status. Use an additional sheet of paper if necessary. Be sure that physical limitations are also indicated in the body of the medical board report, since this block contains insufficient space to detail limitations.

Block 22, BOARD MEMBERS AND SIGNATURES. Type the name, grade, corps, and branch of service of each member. Signatures of each member will appear in the space provided. Indicate a psychiatrist by placing a (P) after the typed name. Indicate a clinical psychologist by placing a (CP) after the typed name. Do not use facsimile signature stamps.

Block 23, ENCLOSURES. Place an "X" in the appropriate box or boxes as indicated.

Block 24, CONVENING AUTHORITY ACTION. Type the name, grade, corps, and branch of service of the CA. The CA must indicate approval or disapproval and whether any administrative involuntary separation action is pending.

Block 25, MEMORANDUM ENDORSEMENT UPON RE-EVALUATION. When an enlisted member is found physically qualified for full duty after a period of TLD, the attending physician will ensure the completion of the remainder of the form. Record examination findings, to include residual effects, on an SF 600. Record the summary findings, physical qualification for duty, and date returned to full duty in this block. Commissioned and warrant officers require the convening of a new medical board for their return to duty from a limited duty status.

(1) Type the examining physician's name, grade, corps, and service. The physician signs and provides date signed.

(2) Type the member's name, grade, rate, and service. Once the member signs and provides the date signed, the member has acknowledged counseling and understands the finding of fit for full duty.

(3) If the physician returning the member to full duty is a civilian physician, the department head or directorate must countersign in the appropriate block. Type the name of the directorate or department head, grade, corps, and service. Obtain the signature and date signed.

Block 26, MEMBER TRANSFERRED TO. Indicate activity to which the member has been transferred to await final action, if different than current duty station.

concurrence and afford them an opportunity to change the board report. It is not appropriate for the CA to direct the board be changed. The CA will then forward the medical board report, the member's signed statement, and a full statement setting forth the reasons for nonconcurrence (if the board report was not changed) to CHNAVPERS or CMC, as appropriate, or DNCPB, for determination of the disposition. The member will be provided a copy of the CA's non-concurrence statement.

(3) Where the indicated disposition of the medical board is other than the PEB:

(a) And the indicated disposition of the board is to place an officer of the Navy or Marine Corps on TLD or return to full duty and the CA concurs, forward the report for departmental review.

(b) And the indicated disposition of the board is to place an enlisted Navy or Marine Corps member on 6 through 12 months TLD, the CA may approve the board's report without departmental approval provided the total period of TLD for the current condition does not exceed 12 months; it is reasonably expected that the member will be able to return to full unrestricted duty on a worldwide basis in the member's rate or MOS in 12 months or less; and the member did not submit a statement in rebuttal to the board's findings or recommendation.

(Note: For Marine Corps enlisted members approved for TLD greater than 6 but less than 12 months, forward a copy of the medical board report to CMC/departmental review.)

(1) The CA will refer all board reports to CHNAVPERS or CMC for departmental review when the period of TLD is for more than 12 months.

(2) Refer subsequent periods of TLD (i.e., total TLD exceeding 12 months) for departmental review.

(3) In all other situations not meeting the above criteria or when the CA does not approve the board's recommendation for TLD, refer the board's report for departmental review.

(c) In all medical board reports, (those medical boards convened at activities authorized to take action following the special instructions published in BUMEDINST 1910.2 series need not be forwarded for departmental review where the indicated disposition is that a commission be revoked by reason of erroneous commission or discharge by reason of erroneous enlistment, forward the board's report together with the applicable NAVMED 6100/3, Medical Board Certificate Relative to a PEB Hearing or the member's NAVMED 6100/2, Medical Board Statement of Patient for departmental review.

(4) In those medical board reports where the member refuses medical, dental, or surgical treatment for a condition or defect which interferes with the performance of duty (see art. 18-22), forward the board's report directly to the PEB.

18-9

Convening Authority Actions

(1) Where the CA of the medical board concurs with the medical board report, the CA will endorse and forward the original medical board report, one copy of the health record, and one copy of any other required documents.

(2) Where the CA of the medical board does not concur, the CA will advise the board members concerned of the non-

18-10

Counseling the Member and Subsequent Processing

(1) Each active duty member receiving or being referred to a medical board will be afforded competent and timely counseling by a Disability Evaluation System counselor or a member of the Medical Department specifically trained and knowledgeable to provide such counseling.

(2) Read the medical board's report and recommendations to and discuss them with the member, if competent medical authority determines that such discussion will not adversely affect the member's health.

(3) Unless the information contained in the board's report might have an adverse affect on the member's physical or mental health:

(a) Furnish the member with a completed copy of the board's report.

(b) Counsel the member on the findings, opinions, and recommendations of the board, and the potential for reclassification into another specialty.

(c) Afford the member the opportunity to discuss findings and recommendations with each member of the board.

(d) Afford the member an opportunity to submit a statement in rebuttal to any portion of the board's report or, to present additional relevant information.

(1) Members should be allowed ample time to complete a rebuttal. Generally, 5 working days from the date the member reads the board report should be sufficient time to complete a rebuttal. Members should have the opportunity to request an extension of this time limit if they can show a reasonable need. Note: No medical board report will exceed 30 calendar days from the dictation of the report to the time the completed package is mailed.

(2) Medical Department personnel will assist members with their requests, rebuttals, or submission of new information. Rebuttals, however, should be the product of the member's free expression and not the words of the counselor.

(3) If a member submits a statement in rebuttal, the board will review the rebuttal and make any change to the medical board report considered appropriate. In these instances, the patient may withdraw his or her rebuttal and the board report will be forwarded without surrebuttal.

(4) In all cases where a medical board report is forwarded to higher authority with a member's rebuttal, a surrebuttal MUST be included. The surrebuttal must specifically address any new information or issues raised by the patient in the rebuttal. A statement such as "I have reviewed the member's rebuttal and the opinions and recommendations made by the medical board still stand" is not sufficient when previously unaddressed information is presented by the patient in the rebuttal.

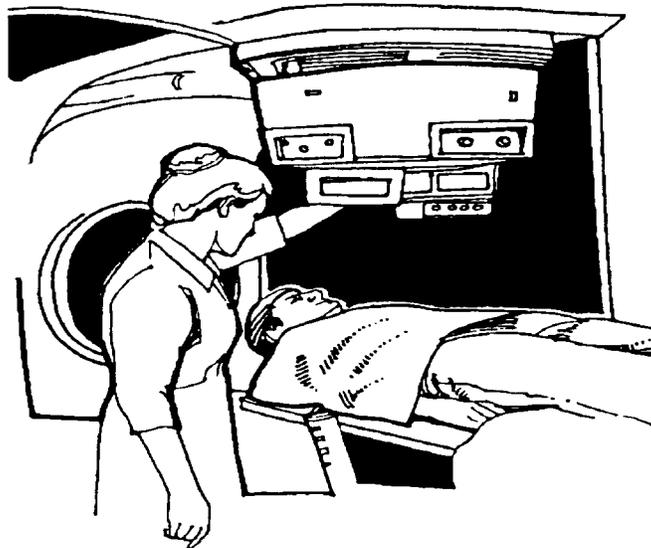
(5) Rebuttals and surrebuttals will become part of the medical board report package. Forward or file, as applicable, the original or a copy with the medical board report to which they refer.

(4) NAVMED 6100/2, Medical Board Statement of Patient, is a statement concerning contents, opinions, and recommendations of the medical board and will be completed, referred to the member for signature, and witnessed. Upon signing the form, members will enter their grade or rate and service status, either Regular or Reserve, and social security number. This form and the statement in rebuttal and surrebuttal will accompany the board's report.

(5) The medical board report may be amended with new or additional findings or recommendations by submission of an addendum to the original board report. The member must be allowed to read and make a statement on any addendum or additional medical information

submitted if he or she desires.

(6) When the indicated disposition is discharge by reason of erroneous enlistment or commission because of a physical condition which existed prior to entry and is not aggravated by service, the member will sign a NAVMED 6100/3, Medical Board Certificate Relative to a PEB Hearing, which indicates that the member has been informed of the board's findings and does or does not desire to submit a statement in rebuttal and does or does not desire to have his or her case presented before the PEB. If the NAVMED 6100/3 produced by MBTS is used, a NAVMED 6100/2 is not required.



(7) When findings are issued by the Records Review Panel (RRP) and a member requests a formal hearing, the DNCPB will issue orders for a personal appearance before a hearing panel. Transfer personnel who are in an inpatient status from their hospital to the hospital located near the formal hearing panel for personal appearance before a PEB per the Joint Federal Travel Regulations. Coordinate these transfers with the Patient Administration Department of the receiving hospital.

(8) When further hospitalization is indicated, retain the member on the sicklist until recommended findings have been made by the PEB. If further hospitalization is not indicated, the member may be discharged from the sicklist and transferred per provisions of the ENLTRANSMAN or the Officer Transfer Manual to await findings of the PEB.

(9) The member will not normally be sent home awaiting orders, or transferred to another activity until the recommended findings of the PEB have been received and accepted by the member. If special circumstances warranting this action occur, contact BUMED (MED-331) for guidance. In situations where a medical board has been initiated at a military MTF away from the member's home port or station, and the member has not already been issued temporary duty (TEMDU) orders to that MTF, it is permissible to return the member to his or her home port or station. Close coordination is required between the MTF originating the medical board action and the MTF nearest the member's home port or station. The continuation of the medical board process can then be assumed by the receiving MTF.

(10) To guarantee separation under the proper provisions of law, members who expect to be separated from the service by medical board action may request that CHNAVPERS or CMC, as appropriate, amend or stop the medical board process to allow separation under another more appropriate provision of law. Such requests may be honored only if received before the final decision of the PEB is released.

(11) Detailed information about counseling members are found in SECNAVINST 1850.4 series and the Disability Evaluation System Counselors' Handbook.

ical board on a Navy or Marine Corps member is being convened at a nonnaval MTF, the naval MTF with medical cognizance over the member will make this notification. The notification will request information on any administrative or disciplinary action pending.

(2) When the medical board is convened as a result of an injury that might result in permanent disability or caused an inability to perform duties for more than 24 hours, the member's command must make a determination of whether the injuries were incurred in the line of duty or due to misconduct. The JAG Manual contains guidance on line of duty (LOD) determinations. If the member's medical condition requires LOD and misconduct findings, the investigation report must accompany the medical board report forwarded to the PEB. The CA should request, as soon as possible, a copy of the command's findings, in appropriate cases. See article 18-34 for additional guidance.

18-12

Report Routing and Disposition

(1) In preparing medical board reports for mailing for departmental review or referral to the PEB, all pages must be right side up and facing in the right direction. Punch two holes at the top of each page in the package and fasten the entire package together with a paper compressor such as those used to assemble medical records. The package will be assembled as follows:

- (a) The original current medical board report. Place a copy in the member's health record.
- (b) Single copy of previous board reports relating to current conditions.
- (c) Single copy of Health Record.
- (d) Single copy of clinical records.
- (e) Color photographs (2 x 2 inch (5.08 x 5.08 cm) color slides are acceptable) should be provided in instances of scarring with disfigurement, pigmentation changes, or when unusual deformities such as ankylosis of individual fingers are present.
- (f) A copy of the investigative or injury report, when appropriate.
- (g) A Notice of Eligibility (NOE), in cases of medical boards on Inactive Reserve members and those on active duty for 30 days or less and a copy of the orders under which the member was ordered to the active duty period.
- (h) An incapacitation or incompetency board report, if applicable.

18-11

Notification of Parent Command

(1) In all cases where a medical board is convened on a service member, the Patient Administration Department of the MTF convening the medical board will notify the member's parent commands by message with BUPERS or CMC, as appropriate, as information addressees. If the med-

(2) Refer the original medical board report on Coast Guard members to the commanding officer of the member's unit. A copy of the member's health record and clinical record (if any) will also accompany the medical board report. A copy of the medical board report is filed in the health record and in the clinical record.

(3) Refer the original medical board report on Army and Air Force members to the local liaison officer or to the cognizant service MTF CA listed in article 18-37.

(4) Forward the original medical board report on commissioned officers of the Public Health Service to U.S. Public Health Service, Office of the Surgeon General, Division of Commissioned Personnel, ATTN: Medical Branch, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20852.

(5) Forward the original medical board report on commissioned officers of the National Oceanic and Atmospheric Administration (NOAA) to Director, Office of NOAA Corps Operations, ATTN: Chief Medical Officer, NOAA/NC, Rockwall Building 5th Floor, 11400 Rockville Pike, Rockville, MD 20852.

(6) For all Navy enlisted members placed on TLD for 12 months or less or returned to full duty, and all Marine Corps enlisted members placed on TLD for less than 12 months, a copy of the complete medical board report is placed in the clinical record, if applicable. The original is placed in the Health Record.

(7) When forwarding a medical board report via departmental review, forward the entire package to:

(a) Chief of Naval Personnel (PERS-281)(formerly NMPC-242), Washington, DC 20370-5000 for Navy enlisted members and officers.

(b) Commandant of the Marine Corps (MMSR-4), Washington, DC 20380 for Marine Corps enlisted members and officers and members of the Marine Corps Reserve.

(c) Commander, Naval Reserve Force (Code 003), 4400 Dauphine Street, New Orleans, LA 70146-5000, for naval selected reservists.

(8) When a member is separated by reason of an EPTE condition that is not service aggravated and regardless of length of service, the separation activity will forward copies of the following documents to Commander, U.S. Military Entrance Processing Command, 2500 Green Bay Road, North Chicago, IL 60064.

(a) Original enlistment SF 88 and 93.

(b) Separation SF 88 and 93, if completed.

(c) Medical Board Report Cover Sheet, NAVMED 6100/1.

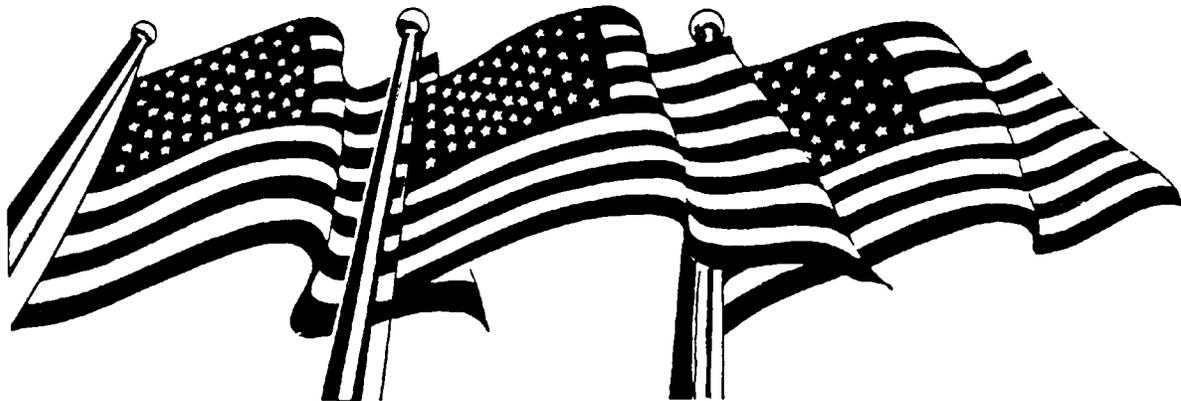
(d) Medical board narrative.

(9) On all Navy and Marine Corps aviation officers and aviation enlisted personnel, regardless of disposition or other submissions, forward one copy of the medical board report and, if required, the original flight physical examination report (SF 88), to the Naval Aerospace Medical Institute (NAMI-42), Pensacola, FL 32508.

(10) On all submarine officers and submarine enlisted personnel regardless of disposition or other submissions, provide BUMED (MED-21), Washington, DC 20372-5120 with one copy of the medical board report, the original submarine physical examination report (SF 88), the original report of medical history (SF 93), and any required consultations.

(11) Forward one copy of incapacitation or competency reports (and any accompanying medical board report, if completed) to the Office of the Judge Advocate General, Code 323, 200 Stovall Street, Alexandria, VA 22332-2400.

(12) Forward medical board reports on cadets or midshipmen assigned to Department of Defense Military Academies to:



(a) The Superintendent, U.S. Naval Academy, via BUMED (Physical Qualifications and Review Division), for naval personnel.

(b) The Superintendent, U.S. Military Academy, via the Commanding Officer, Keller Army Community Hospital, West Point, NY, for Army personnel.

(c) The Superintendent, U.S. Air Force Academy, via the Commanding Officer, U.S. Air Force Academy Hospital, USAFA, CO, for Air Force personnel.

(13) The table below provides assistance and guidance to field activities about the disposition of medical board reports on active duty Navy and Marine Corps members following the CA's action.

(14) For guidance in handling the exceptions, refer to applicable articles in this chapter and the special provisions of BUMEDINST 1910.2 series.

Disposition of Medical Board Reports

Medical Board Recommends	Member Rebutals	Disposition
Referral to PEB because of a question of fitness (ENL/OFF)	Yes/No	Note 1
TLD (1st period; 6 through 12 months) (ENL)	No	Note 3
TLD (1st period; 6 through 12 months) (ENL)	Yes	Note 2
TLD (1st period; 6 through 12 months) (OFF)	Yes/No	Note 2
TLD (initial or subsequent periods exceeding total of 12 months TLD) (ENL/OFF)	Yes/No	Note 2
Retain in PLD status (ENL/OFF)	Yes/No	Note 1
Return to full duty (ENL)	Yes/No	Note 3
Return to full duty (OFF)	Yes/No	Note 2
Discharge, Erroneous Enlistment/Commission (Did not waive rights to PEB) (ENL/OFF)	Yes/No	Note 1
Discharge, Erroneous Enlistment (waived rights to PEB) (ENL)	N/A	Note 4
Discharge, Erroneous Commission (waived rights to PEB) (OFF)	N/A	Note 2
Any board on ENL/OFF with disciplinary action pending	Yes/No	Note 2

Notes

Note 1: Forward to President, Physical Evaluation Board, 801 N. Randolph Street, Arlington, VA 22203-1989.

Note 2: Forward to BUPERS (PERS-281), Washington, DC 20370-5000 or CMC, Headquarters Marine Corps (MMSR-4), Washington, DC 20380.

Note 3: File in member's health record and have member report to Personnel Support Detachment (PSD) or Marine Corps administration office for submission of availability report as required by ENLTRANSMAN. For Marine Corps enlisted members recommended for an initial period of 12 months LIMDU follow Note 2. For Marine Corps enlisted members approved for TLD greater than 6 but less than 12 months, forward copy of medical board report to CMC/departmental review.

Note 4: Forward with closed health record after endorsement by separation activity.

18-13 Processing Time



(1) For each individual medical board, the processing time between dictation and signature by CA will not exceed 20 calendar days. No medical board will exceed 30 calendar

days from the dictation of the medical board report and the time the completed package is mailed. This includes the time it takes to obtain accompanying documentation such as LOD investigation reports or copies of clinical records.

18-14**Automatic Data
Processing
Procedures**

(1) The MTF originating the medical board report on a Navy or Marine Corps member will enter that member into the Medical Board Tracking System (MBTS). If a member is transferred from that MTF prior to completion of the medical board action, the transferring MTF will obtain the necessary information from the receiving MTF to complete the automated file on the member, or will electronically forward the incomplete file to the receiving MTF.

(2) Use the data base program provided by the NAVMEDATASERVcen to prepare each NAVMED 6100/1, Medical Board Report Cover Sheet.

(3) Transmit this data to NAVMEDATASERVcen monthly on each case finalized in that month. Finalization of a case includes acceptance of findings for members whose medical boards were forwarded to the PEB, placement on limited duty of members recommended for a period of limited duty, or return to full duty.

(4) Any MTF finalizing action on a medical board, including return to full duty after TLD, must enter the information on the member in the required data fields of the automated NAVMED 6100/1.

18-15**Departmental
Review**

(1) Departmental review is an administrative examination of the medical board report's disposition recommendation based on the clinical presentation, submissions by the active duty member and other involved parties, and needs of the particular service at the time of the report.

(2) Departmental review is held at PERS-281 for active duty Navy members and Headquarters Marine Corps for active duty Marines. Article 18-12 gives guidance on which medical boards should be sent for departmental review.

18-16**Medical Boards
on Officers**

(1) Convene a medical board on an officer of the uniformed service in any situation described in 18-5.

(2) Appearance before a medical board is appropriate whenever a condition is detected that may adversely affect the officer's selection for promotion.

(3) When an officer is hospitalized as a result of a defect or disability noted in an officer's triennial or annual physical examination, refer the officer to a medical board before returning him or her to duty.

(4) After a medical board on a class 1 or class 2 aviation officer finds the officer physically qualified to return to full duty, a flight surgeon will conduct a complete aviation physical examination and report on an SF 88. A flight physical examination is not required when a medical board is held incident to an officer's pending separation from the active list or when the indicated disposition is TLD or referral to the PEB. Submit the medical board report for departmental review. In addition, in every case involving a class 1 or 2 aviation officer, submit a copy of the board report, along with the original flight physical examination if required, to the Naval Aerospace Medical Institute (NAMI-42), Naval Air Station, Pensacola, FL 32508.

(5) When an active duty officer of the Navy or the Marine Corps (Regular or Reserve) with less than 3 years continuous service as an officer is considered physically disabled by reason of a condition which was incurred while the officer was not in receipt of basic pay, and which has not been aggravated by a period of active service, the officer will be ordered before a medical board. Should the medical board recommend the officer's separation by reason of erroneous commission, advise the officer of his or her right to a full and fair hearing before a PEB. If the officer does not desire to waive these rights to a full and fair hearing, refer the medical board report to the PEB. Should the officer waive the rights to a full and fair hearing, the officer will certify in writing on NAVMED 6100/3, Medical Board Certificate Relative to a PEB Hearing, that such a hearing is not demanded.

(6) Refer active duty officers of the Navy or the Marine Corps (Regular or Reserve) with more than 3 years continuous service as an officer who are considered to be disabled by reason of a physical disability to a medical board with subsequent referral to the PEB.

(7) When an officer is to be returned to duty after undergoing treatment for a severe or possibly incapacitating condition, particularly when it may affect the officer's reasonable performance of duty during further convalescence, refer the

officer to a medical board before returning him or her to duty.

(8) If an officer candidate or midshipman is undergoing treatment for any impairment likely to recur or progress or become incapacitating prior or subsequent to appointment, refer the member to a medical board before returning him or her to duty. Evaluate the physical qualification of such members as to probable ability to perform duty in commissioned grade and to continue in training. Final determination of the member's physical qualification for appointment to commissioned grade will be held in abeyance pending departmental review of the board's report. Forward the medical board report to the U.S. Naval Academy via BUMED (Physical Qualifications and Review Division), Washington, DC 20372-5120 for Naval Academy midshipmen; and to the Commander, Naval Education and Training Command via BUMED (Physical Qualification and Review Division), Washington, DC 20372-5120 for NROTC midshipmen. Submit medical board reports of officer candidates to the commanding officer of their respective officer candidate school via BUMED (Physical Qualifications and Review Division), Washington, DC 20372-5120.

18-17

Recruit Evaluation Unit

(1) Commanding officers of naval medical facilities having primary responsibility for medical support of recruit training centers (RTCs) or Marine Corps recruit depots (MCRDs) will establish a recruit evaluation unit (REU) as a branch of the mental health department. The REU is a professional, advisory, and consultant unit to which recruits with possible mental health problems are to be referred for appropriate mental health examinations. The REU and the medical clinic serving the recruit command are responsible for identifying physical or mental defects which may impair a recruit's ability to complete successfully recruit training and to perform any future assigned duties. Defects or functional disturbances which existed prior to enlistment, such as mental illness or inadequacy, emotional immaturity or other personality defects, lack of stamina, enuresis, and somnambulism, among others, are to be given careful consideration for interference with ability to perform assigned duties.

(2) The commanding officer of the supporting medical facility is responsible for organization and general supervision of the REU. This includes arrangement for appropriate equipment and space for the administrative functions of the unit, as well as sufficient space to ensure that examinations

provide adequate privacy to preserve the rights of the recruit. The medical facility will provide the REU with sufficient bed space for the proper observation and care of recruits who need these services.

(3) Functions of Members of the REU

(a) The psychiatrist or clinical psychologist assigned as head of the REU is responsible for conducting the mental health examinations and providing guidance and supervision to the other members of the unit. Decisions within the unit will be made by the branch head. Further referral of reports for disposition will be based upon his or her recommendation and will be subject to the approval of the head of the psychiatry department of the medical facility.

(b) Hospital corps members assigned to the unit will perform outpatient functions, record keeping, and obtain life histories of recruits being evaluated by the unit.

(4) Mental Health Examinations

(a) When practicable, an REU psychiatrist or clinical psychologist will examine briefly each recruit as part of the initial examination. Examiners may schedule and conduct more extensive examinations at a later date, if indicated. After initial examinations, recruits may be referred, through the normal chain of command, to the REU at any time during the training period by company commanders, drill instructors, division officers, or branch clinic personnel.

(b) At any time during the training period, a recruit with obvious and serious mental handicaps will be sent to the psychiatric service of the medical facility pending further disposition. Recruits with less obvious or less serious handicaps, or those whose fitness for service is in doubt, will be returned to a trial of duty. They will be observed under drill and training conditions in a regular recruit company with the understanding that the REU examiner will have the opportunity for further examination if necessary.

18-18

Determination of Fitness of Recruits for Service

(1) The evaluation of each recruit's fitness for service is a necessary function of the recruit training centers. This evaluation process will be conducted with a view to separating from service those personnel determined not suited for military service because they cannot be expected to perform useful duty. Every reasonable effort will be made to detect those recruits who present defects or tendencies which were concealed or not detected at the time of enlistment or induction. The evaluation of each recruit's psychological fitness is determined by the REU. The preliminary evaluation of physi-

Physical fitness will be conducted by the Medical Department personnel assigned to the MTF serving the recruit command.

(a) To develop a data base to assist in the study of recruit attrition, each Medical Department facility providing treatment to recruits on a routine basis will maintain a record system that provides information on:

- (1) Identification of recruits requesting care.
- (2) Defects detected that warrant release of a recruit.
- (3) Whether the problem for which the recruit requested care existed prior to entrance (EPTE).
- (4) Whether the problem was caused or exacerbated by the training. If exacerbated by training, will the condition revert to the same as existed prior to entry when the aggravating activity ceases.
- (5) Whether the recruit knew of the problem prior to recruitment.
- (6) Whether the recruit tried to conceal the problem.
- (7) Whether BUMED recommended a waiver prior to entry for the disqualifying condition.

(b) The seven items of information above will be maintained at treatment facilities and will be monitored by BUMED. If significant problems occur repeatedly at any facility, the MTF should forward a letter report to BUMED (Physical Qualifications and Review Division) requesting assistance in the coordination of corrective action with:

- (1) The Commander, Navy Recruiting Command and Commander, Military Entrance Processing Station (MEPS) for Navy members.
- (2) The Commandant of the Marine Corps (Code MRRE) for Marine Corps members.

Conditions considered disqualifying for enlistment are subject to referral for administrative discharge processing by reason of defective enlistment (erroneous enlistment).

(3) Conditions or defects not considered to be a physical disability per SECNAVINST 1850.4 series normally do not require an evaluation by a medical board. Medical certification in the health record with an established diagnosis is sufficient. These conditions include somnambulism, enuresis, personality disorder, motion or air sickness, allergies, excessive height, and obesity among others.

(4) Conditions or defects considered to be a physical disability are referred to a medical board for evaluation.

(5) Minor physical conditions or defects described in this article need not be reason for separation when considered not to interfere with training and not expected to interfere with the recruit's ability to perform full duties. An evaluation of these minor conditions will be recorded on an SF 600 with the recommendation for continued service. No further action is required unless the condition interferes with the recruit's training.

(6) Physical conditions or defects discovered during recruit training should be evaluated with consideration for the recruit's ability to adjust to military service and demonstrated capability to perform and function effectively when transferred to full service. Questionable cases may be determined by a trial period of duty in the regular recruit training schedule.

(7) Only recruits diagnosed as personality disorders will be immediately separated at the RTC's.

(8) Recruits diagnosed as having adjustment disorders will not be discharged any sooner than three weeks into their training. During this period attendance at group therapy will be mandatory. The therapy session will be 3 times a week for one and one-half hours. If at the end of this period the recruit continues to be unable to adapt, he or she will then be separated.

(9) Recruits incurring an illness or injury while on active duty or incurring an aggravation to a condition that existed prior to entry on active duty will be referred to a medical board if that condition interferes with ability to perform assigned duties.

(10) Surgical procedures to correct minor physical defects may be performed on a recruit if the recruit can be returned to duty within 2 weeks of the procedure and has potential for naval service. The attending medical officer, after consultation with the recruit's commanding officer, makes the decision to perform surgery or refer the recruit to a medical board. Examples of conditions for which surgical procedures may be performed on recruits include, but are not limited to: pilonidal cysts, pilonidal sinus, hemorrhoids, varicoceles, hydroceles, hernia, deviated nasal septum, gynecomastia, phimosis, hypertrophic tonsils, undescended testicle (unilateral), and ingrown toenails.

18-19

Medical Boards on Recruits

(1) A recruit will be processed for separation because of physical or mental defect when it is determined he or she will be unable to perform military duties. Company commanders, drill instructors, division officers, or other cognizant personnel may assist by referring for medical attention those recruits who are not adjusting well to training conditions. A recruit manifesting severe emotional disabilities such as a psychotic episode, may be referred for separation via a medical board after an adequate period of observation and indicated treatment.

(2) Recruits found to have physical conditions or defects which, had they been known at the time of entry, would have

18-20**Medical Boards
on Reservists**

(1) Refer to SECNAVINST 1770.3 series for management and disposition of disabilities and disability benefits for Navy and Marine Corps Reserve Components.

(2) When a NOE has been issued by COMNAVRESFOR or CMC to a member of the Naval or Marine Corps Reserve receiving treatment for a condition incurred in or aggravated by a period of active duty and the attending physician is of the opinion that return to full duty is anticipated only after a lengthy course of treatment (normally 12 weeks or more), a medical board will be convened immediately. Unlike active duty members who may have medical boards convened after treatment has been given and the outcome can be estimated, Inactive Reserve members must have medical boards convened as soon as there is indication that the treatment will be extensive.

(3) The medical board report will contain a medical opinion about the member's ability to perform military duties. If appropriate, include a separate recommendation on the member's ability to perform civilian employment.

(4) Submit medical board reports on members of the Marine Corps Reserve to CMC. A copy of the NOE must accompany any medical board report sent to the DES. Also include a copy of the orders under which the member was ordered to active duty. Provide a copy of the report to the member's parent Reserve unit.

(5) Submit medical board reports on Navy selected reservists recommended for PEB action directly to the PEB if the package contains a valid NOE, a LOD determination (if applicable), and a copy of the member's health record. Forward a copy of the board report to COMNAVRESFOR (Code 006).



(6) There is no permanent or temporary limited duty status for Inactive Reserve members. Reservists who have achieved the maximum benefit of acute medical care, but need an additional period of rehabilitation or observation to determine the extent of recovery or who may require additional treatment at a later time, will be identified in the narrative summary of the report. Also include in the board report the recommended period of rehabilitation or observation, or estimated date of future additional care. Forward the medical board report to the PEB via COMNAVRESFOR or CMC, as appropriate.

(7) Drilling reservists with conditions existing prior to entry onto active duty not aggravated by service will be released from active duty and referred to their drill site Medical Department representative for retention determination per MILPERSMAN 3220275.

18-21**Return to Duty
for Aviation,
Submarine, and
Other Special
Duty Personnel**

(1) **General.** A finding of *physically qualified* by a medical board does not in itself constitute a finding of physical qualification for special duty assignment. Personnel requiring a determination of physical qualification for specialized duty will be evaluated upon completion of the medical board proceedings. In the interest of expeditious processing, member's requiring determination of physical qualification for specialized duty should be scheduled for such exams at the same time as their scheduled TLD reevaluation. Medical records for these personnel must be flagged for the ease of identification and to indicate additional requirements for qualification of special duty per other directives.

(2) Aviation Personnel

(a) Officer aviation personnel will be processed following article 18-16.

(b) Refer aeronautically designated enlisted personnel to the nearest naval activity with an assigned flight surgeon to determine physical qualification for duty involving flying. The personnel support detachment (PSD) or Marine Corps administration office of the member should handle this administrative action which is separate from the medical board proceedings.

(3) **Submarine Personnel.** Submarine personnel found physically qualified for return to full duty following a period of TLD but prior to being made available for detailing, must have an undersea medical officer perform a health record re

Medical Care (SF 600). If the condition for which the member was placed on TLD was psychological in nature, initiate a request for a waiver of physical standards following the guidance provided in chapter 15.

(4) **Occupational Exposure to Ionizing Radiation Personnel.** A medical officer knowledgeable about the effects of ionizing radiation will review the physical qualifications of members in positions or billets requiring occupational exposure to ionizing radiation before making the member available for detailing. This ensures that such members continue to meet requirements of the Radiation Health Protection Manual (NAVMED P-5055). The medical officer will make an entry reflecting this examination in the member's health record on an SF 600. If the review indicates that the member may not be qualified, a medical officer will perform a new occupational exposure to ionizing radiation physical examination following NAVMED P-5055 before returning the member to duty.

(5) **Nuclear Field Personnel.** Active duty personnel in the nuclear power program or the nuclear weapons program will have the review noted in article 18-4(4), and where the condition for which the member was placed on TLD was psychological in nature, initiate a request for a waiver of physical standards following the guidance provided in chapter 15.

(6) **Other Special Duty Personnel.** When found physically qualified for return to duty after a period of TLD, other personnel requiring special duty qualifications will be evaluated following appropriate governing directives prior to being made available for detailing.

disabilities, will be transferred to a naval hospital for further evaluation and appearance before a medical board.

(b) After further counseling by the board, the member will be asked to sign a completed NAVMED 6100/4, Medical Board Certificate Relative to Counseling on Refusal of Surgery and/or Treatment. The board will study all pertinent information, inquire into the merits of the individual's refusal to submit to treatment, and report the facts with appropriate recommendations.

(c) Where surgical procedures are in contention, the board's report will answer the following questions:

(1) Is surgical treatment required to relieve the incapacity and restore the individual to a duty status, and may the surgery be expected to do so?

(2) Is the proposed surgery an established procedure that qualified and experienced surgeons ordinarily would recommend and undertake?

(3) Considering the risks ordinarily associated with surgical treatment, the patient's age and general physical condition, and the member's reasons for refusing treatment, is the refusal reasonable or unreasonable? (Fear of surgery or religious scruples may be considered, along with other evidence.)

(2) As a general rule, refusal of minor surgery should be considered unreasonable in the absence of substantial contraindications. Refusal of major surgical operations may be reasonable or unreasonable, according to the circumstances. The age of the patient, previous unsuccessful operations, existing physical or mental contraindications, and any special risks should all be taken into consideration.

(3) The board should show the need for and risk of the recommended procedure.

(4) If a medical board decides that a diagnostic, medical, dental, or surgical procedure is indicated, these findings must be made known to the patient. The board's report will show that the patient was afforded an opportunity to submit a written statement explaining the grounds for refusal, and any statement submitted will be forwarded with the board's report. The patient will be advised that even if the disability originally arose in line of duty, its continuance would be attributable to the member's unreasonable refusal to cooperate in its correction; and that the continuance of the disability might result in the member's separation without benefits.

(5) The patient will be advised that section 1207 of Title 10, U.S. Code, precludes disposition under chapter 61 of Title 10, U.S. Code, if such a member's disability is due to intentional misconduct, willful neglect, or if it was incurred during a period of unauthorized absence. Advise the member that benefits from the DVA will be dependent upon a finding that the disability was incurred in line of duty and is not due to the member's willful misconduct. Also advise the member that the Social Security Act contains special provisions relating to benefits for "disabled" persons and certain provisions

18-22

Members Who Refuse Medical, Dental, or Surgical Treatment

(1) Medical, dental, and surgical treatment will not be performed on a mentally competent member who does not consent to the recommended procedure. When a member refuses to submit to therapeutic measures for a remediable defect or condition which interferes with the member's performance of duty that, following prescribed therapy, would result in the member's physical qualification for duty, the following procedures will apply:

(a) After being counseled on the matter, any member of the Navy or Marine Corps who refuses to submit to recommended medical, surgical, dental, or diagnostic measures, other than routine treatment for minor or temporary

relating to persons disabled "in line of duty" during service in the Armed Forces. In many instances persons with "remediable" disorders have been held not "disabled" within the meaning of that term as used in the statute and Federal courts have upheld that interpretation. A person who unreasonably refuses to undergo available surgical procedures may be considered both "not disabled" and "not in the line of duty."

(6) Forward the board's report directly to PEB.

18-23

Board with Disciplinary or Punitive/ Misconduct Administrative Action

(1) When a member is being processed for disability evaluation and, at the same time, administrative involuntary separation which may result in an other than honorable discharge is pending, so note in the closing statement of the report and in block 24 of the medical board cover sheet. Submit the medical board report to CHNAVPERS or CMC to await completion of the disciplinary or administrative action. As these actions take precedence over medical board processing, the member will be separated without benefit of the DES when the results of the disciplinary or administrative action is to separate the member from active duty. Do not hold up processing the medical board report at the local level while disciplinary action is ongoing. Message the member's parent command when a medical board has been sent and include a copy of the message in the medical board package. When members have been transferred to a hospital in a TEMDU status, patient administration officers must coordinate the disposition of disciplinary charges with the former parent command and the hospital's legal officer to resolve charges expeditiously and fairly.

(2) Members who receive an administrative discharge as a result of misconduct or a punitive discharge, without confinement, will not be afforded medical board action (unless directed by higher authority) as these discharges take precedence over medical disability separations or TLD considera-

tions. In such instances, complete the SF 88 or SF 93, noting physical defects, and place in the member's Health Record.

(3) If a member becomes subject to disciplinary action or is awarded a punitive discharge or involuntary administrative separation as a result of misconduct after the medical board report has been submitted, immediately notify CHNAVPERS or CMC, as appropriate, by message.

18-24

Medical Boards Involving Waivers of Entry Standards

(1) Current regulations permit the acceptance into the Navy or Marine Corps of a physically unqualified individual provided BUMED (Physical Qualification and Review Division) determines the individual has, in the pursuit of a civilian occupation, profession, or avocation, demonstrated that satisfactory active service can be performed; and a waiver of the physical standard is recommended by BUMED and granted by CHNAVPERS or CMC, as appropriate. The member may later be unable to perform satisfactory service because of the previously-waived defect. In such situations, follow the procedures below.

(a) Appropriate evaluation is required with subsequent appearance before a medical board. The board's report will include statements from the member's division officer, department head, or executive officer describing any functional impairment that might be attributed to the previously waived defect.

(b) The medical board will make appropriate recommendations on the member's physical qualification to perform satisfactory active service.

(c) When endorsing the board's report, the CA will indicate concurrence or nonconcurrence with the board's findings and recommendations, and make other comments that may be considered pertinent to the member's defect or ability to perform satisfactory service.

(d) Send the board's reports to CHNAVPERS or CMC, as appropriate.

18-25

Conditions Not Considered a Physical Disability

(1) Initial enlistment and commissioning physical standards must not be confused with physical capability to perform duty. Once enlisted or commissioned, the fact that a member may later fall below initial entry standards does not necessarily require referral to a medical board. Similarly, there are prescribed minimum physical standards for special duties such as flying. Disqualification for special duties does not necessarily imply physical unfitness unless the disqualifying defect would also interfere with the performance of other duties.

(2) SECNAVINST 1850.4 series directs disposition of members with conditions not considered a physical disability. These conditions include but are not limited to: alcoholism; allergy to uniform clothing; character disorders; enuresis; heat intolerance with disturbances of thermal regulation; homosexuality; inability to be fitted in uniform clothing; medical contraindication to administration of small pox, yellow fever, or cholera immunization; motion or travel sickness; obesity; overheight; primary mental deficiency; pseudofolliculitis barbae of the face or neck; somnambulism; stuttering or stammering; systemic or marked allergic reactions following stings by red ants, bees, wasps, or other stinging insects; unsanitary habits including repeated venereal disease infection. NAVMILPERSCOMINST 1910.1 and 1910.2 series, and MCO P1900.16 series apply. A medical board is not required in such cases. Members with these conditions are subject to administrative separation. Submit a report of the medical findings surrounding the member's condition to the member's parent command identifying the defect with a medical evaluation of any condition which may impair the member's ability to function effectively in the naval service.

18-26

Medical Boards for Member's Medically Waived from the Physical Readiness Test

(1) OPNAVINST 6110.1 series outlines requirements of the Navy's Physical Readiness Program.

(2) When a medical waiver is granted for any portion (or all) of the physical readiness test (PRT) for three consecutive official PRTs (over a minimum of 13 months), the member's commanding officer may refer the member for a medical board.

(3) If it is determined that the member's medical condition does not interfere with his or her ability to perform presently assigned duties or duties normally assigned to members in his or her rate, rating, grade, or designator, forward a report of a medical evaluation to the member's commanding officer. The commanding officer will take administrative action as appropriate per OPNAVINST 6110.1 series.

(4) If the member's medical condition does interfere with ability to perform duties, the member will be placed on TLD if the prognosis for recovery within 24 months is favorable. Send the medical board report to the PEB (via departmental review, when applicable) if return to full duty within 24 months is not likely.

18-27

EPTE Physical Defects

(1) Any member of the naval service may be processed for separation when diagnosed as having a physical defect which existed prior to entry (EPTE) on active service when the defect would have disqualified the member if discovered at the time of enlistment or induction. The mere presence of a physical defect is not, of itself, necessarily reason for separation. For members with more than 180 days active service, it must be shown that the defect interferes with the member's ability to perform current duties or duties to which they are likely to be assigned before a medical board is considered.

(2) Enlisted members with less than 180 days active service found to have a physical defect listed in chapter 15, section III may be referred to a medical board for disposition. Follow NAVMILPERSCOMINST 1910.2 series or MCO

P1900.16 series for guidance on separation of these members by reason of defective enlistment or enlisted in error when the condition has not been aggravated or worsened by service and would have been considered physically disqualifying and not waivable if discovered at the time of enlistment. Enlisted members who have a physical defect that does not meet accession physical standards, but does not interfere with training should be medically evaluated and continued in training unless contraindicated. Consider for retention purposes possible aggravation of the existing condition while in training or on full active duty and future possibility of interference with full active duty assignments.

(3) Should the medical board recommend a member's separation by reason of erroneous enlistment, advise the member of his or her right to have their board report forwarded to the PEB. If the member does not waive these rights, refer the medical board report to the PEB. The member certifies his or her desires on the NAVMED 6100/3, Medical Board Certificate Relative to a PEB Hearing.

(4) When EPTE conditions are discovered and not service aggravated, drilling reservists, including those on active duty for special work, should be released from active duty and referred to their drill site Medical Department representative for retention determination per MILPERSMAN 3620275.

(5) When an active duty officer of the Navy or the Marine Corps (Regular or Reserve) with less than 3 years continuous service as an officer is considered physically disabled by reason of a condition which occurred while the officer was not in receipt of basic pay and the condition was not aggravated by a period of active service, convene a medical board on the officer. Should the medical board recommend the officer's separation by reason of erroneous commission, advise the officer of his or her rights to have their board report forwarded to the PEB. If the officer does not waive these rights, refer the medical board report to the PEB. The officer certifies his or her desires to waive the rights on NAVMED 6100/3, Medical Board Certificate Relative to a PEB Hearing.

(6) Active duty officers of the Navy or the Marine Corps (Regular or Reserve) with 3 or more years continuous service as an officer who are disabled by reason of a physical disability will be referred to a medical board with subsequent referral to the PEB.

(7) Refer all Navy and Marine Corps members to a medical board for a recommendation on disposition when found to have conditions considered physically disabling and which may have been aggravated or worsened by service. SECNAVINST 1850.4 series, contains more specific guidance on EPTE conditions.

18-28

Mental Capacity, Mental Responsibility, and Incapacitation Evaluations

(1) To avoid confusion on the terminology used in these examinations, which are separate and distinct, the following distinctions should be noted:

(a) The term "mental capacity" should be reserved for use in the context of mental capacity or competency to stand trial. These examinations are discussed in article 18-28(2).

(b) The term "mental responsibility" should be reserved for use in the context of a forensic examination referring an opinion as to the mental responsibility at some time in the past, usually at the time for which an offense under the Uniform Code of Military Justice is charged. These examinations are discussed in article 18-28(2).

(c) The term "mental incapacitation" should be reserved for use in the context of competency evaluations to perform an act such as handle financial affairs or consent to medical treatment. These examinations are discussed in article 15-28(3).

(2) Inquiry into Mental Capacity or Mental Responsibility for Rules for Court Martial (RCM) 706 "Sanity Boards"

(a) Examinations to determine mental capacity (competency) or mental responsibility are governed by RCM 706 and will be conducted following that rule. Inquiries into mental capacity or responsibility must be ordered by appropriate authority, per RCM 706(b)(2). Board composition will follow RCM 706(c)(1) and will consist of one or more persons who will be either a psychiatrist or clinical psychologist designated on the board's report with (P) or (CP) after their name, respectively.

(b) In conducting mental capacity or responsibility evaluations, the examiner will usually not be someone with whom the evaluatee has had a treatment relationship. Before beginning a forensic evaluation, the examiner should inform the evaluatee that although he or she is a doctor, psychiatrist, or clinical psychologist, he or she is not the evaluatee's "doctor." The examiner should indicate that the examination is being performed pursuant to RCM 706 and what will be done with the information obtained in the examination. There is a continuing obligation to be sensitive to the fact that although such warning has been given, there may be slip-page, and a treatment relationship may develop in the mind of the examinee.

(c) The consent of the subject of a forensic evaluation obtained when possible. When consent is not obtained, notice must be given to the evaluatee of the nature of the examination.

(d) Ethical considerations prevent forensic evaluation of any person charged with criminal acts before he or she has access to legal counsel. Examination for the purpose of rendering emergency medical care and treatment is an exception.

(e) The forensic examiner functions as an expert within the legal process and must adhere to the principles of impartiality and objectivity. The clinical evaluation and the application of the data obtained to the legal criteria are performed in the spirit of impartiality and objectivity. The opinion given must reflect this impartiality and objectivity.

(f) Service members being considered for medical board action and also charged with violations of the Uniform Code of Military Justice should have RCM 706 evaluations, if required, handled separately from the medical board action. The RCM 706 evaluation should be conducted per RCM 706 and the medical board report per this chapter. Board findings and recommendations should otherwise be unchanged.

(3) Mental Incapacitation/Restoration of Capacity Evaluation

(a) An incapacitation board will be convened when a member demonstrates impairment of judgment severe enough to raise a question of incapacity and such impairment is secondary to physical or mental disorders, excluding personality disorders. The requirement for this incapacitation board is in addition to and separate from the medical board procedures in SECNAVINST 1850.4 series and elsewhere in this manual.

(b) Mental incapacitation may result from temporary or permanent physical or mental instability as a result of injury, disease, or other mental condition. Per the JAG Manual, an incapacitation board will be IMMEDIATELY convened and submitted to the Office of the Judge Advocate General (JAG) when an individual is determined to be mentally incapable of managing his or her personal or financial affairs. The incapacitation board should be mailed immediately to Office of the Judge Advocate General, Code 323, 200 Stovall Street, Alexandria, VA 22332-2400; Defense Switched Network (DSN) (formerly AUTOVON) 221-9752 or (703) 325-9752. Or, telefax the incapacitation board report to DSN 221-9152 or (703) 325-9152. The incapacitation board will not be held at the MTF waiting to convene an ordinary medical board, the completion of a medical board report, or the completion of an LOD investigation.

(c) The Naval Office of MEDDEN Affairs will ensure that this article is applied to those cases where active duty Navy and Marine Corps members are hospitalized in nonnaval medical facilities.

(d) The incapacitation board will consist of three military or DVA physicians, or civilian physicians privileged to practice in a military MTF, one of whom will be a psychiatrist (37 U.S.C. par. 602(b) and the JAG Manual refer). The psychiatrist will be designated on the medical board with (P) after his or her name.

(e) Obtain consent of the subject of an evaluation to determine incapacitation, if possible. If consent cannot be obtained, notice should be given to the evaluatee of the nature of the evaluation.

(f) The format of the incapacitation board report will be a naval letter with the subject "REPORT OF INCAPACITATION EVALUATION ICO (patient's name, grade, SSN)." The report will include, as a minimum, a history, mental status examination, diagnosis, and opinion or findings. If possible, include a prognosis for the duration of incapacitation. A NAVMED 6100/1, Medical Board Cover Sheet, need not be attached if required signatures are on the report itself.

(g) Place a copy of the incapacitation board report into the health record and inpatient chart, and forward the original to Fiduciary Affairs (Code 323), JAG (see article 18-28(2)(b)) per the JAG Manual. The commanding officer's endorsement should include the name, address, and telephone numbers of the member's next-of-kin. JAG will appoint a trustee provided one has not already been appointed by a court of competent jurisdiction.

(4) Accomplishment of Restoration. A finding of restoration of capability to manage personal or financial affairs may be done by one or two physicians, one of whom must be a psychiatrist. JAG liaison is required. Provide a copy of this finding to JAG (Code 323) per 18-28(2)(b)

18-29

Temporary Limited Duty (TLD) Medical Boards

(1) The following definitions apply when discussing limited duty:

(a) Temporary Limited Duty (TLD). A specified period of limited duty, not to exceed 24 months, authorized by CHNAVPERS or CMC (or at an MTF by a medical board) for cases in which the prognosis is that the member can be restored to full duty within the specified period.

(b) Permanent Limited Duty (PLD). A specified period of limited duty authorized by the CHNAVPERS or CMC for active duty members found unfit for duty by the PEB.

(2) General. When a medical board recommends TLD, state the limitation imposed by the member's disability in the board's report. With the exception noted in article 18-29(5), if

there is a probability that the member will not be physically qualified for full duty after 24 months of TLD, refer the member's case to the PEB. Forward for departmental review all medical boards recommending TLD for an officer or extending an officer's period of TLD.

Note: Maintain all medical records on TLD personnel separately to assist in identification and processing purposes.

(3) Temporary Limited Duty of 6 through 12 Months. The minimum period of TLD will be 6 months. However, the medical board report may be written for any monthly period from 6 through 24 months. This does not prevent the medical board from requiring the member to return for reevaluation at specified intervals during the period or from returning the member to full duty earlier. Record followup visits on an SF 600 and file in the member's health record. To avoid premature reevaluations, the provider should include 60 days reevaluation and medical and administrative processing time within the TLD period. Medical boards recommending an initial period of 12 months TLD for a Marine Corps enlisted member must be forwarded to CMC for departmental review. For Marine Corps enlisted members approved for TLD greater than 6 but less than 12 months, forward copy of medical board report to CMC/departmental review.

(a) To aid the TLD process, each MTF must appoint in writing a TLD coordinator who will meet monthly with coordinators from servicing PSDs and local commands to review the process and discuss (potential) problems.

(b) Reevaluation. No later than 2 months before the end of the TLD period, the attending physician must determine if the member will be physically qualified for full duty. If still physically unqualified, the attending physician need only evaluate the member and make a decision to continue the member on another period of TLD or refer the case to the PEB.

(c) TLD reevaluation appointments must be given priority to expedite resolution of members TLD status. Members commands must be notified by message within 10 days (provide information copy to servicing PSDs) of scheduled reevaluation appointments. Also, notify members commands, BUPERS or CMC and the servicing PSDs of reevaluation results (including missed appointments) and anticipated dispositions via weekly message.

Note: For Marine Corps enlisted members approved for a second period of TLD not exceeding a total of 12 months TLD, forward a copy of the original medical board report with a copy of the SF 600 verifying need for the second period of TLD to CMC/departmental review.

(d) Second period of TLD

(1) When the attending physician determines an enlisted member needs an additional period of TLD, not to exceed a total of 12 months TLD, he or she will make a health record entry on the SF 600 verifying the need for a

second period of TLD with a progress note outlining the treatment plan and expected prognosis. Officers must have a new medical board convened and forwarded for departmental review.

(2) The attending physician will instruct the member to hand carry his or her health record to the Patient Administration Department/TLD coordinator. The hospital will submit a report per article 18-20(3)(c). The member's parent command will be an information addressee. The member's new projected rotation date (PRD) will be computed from the expiration date of the member's last assigned PRD.

(3) The above procedures do not require departmental review for enlisted members. If the CA determines that departmental review is appropriate for any member in the TLD system, a complete medical board report will be submitted to BUPERS or CMC.

(4) These procedures may not be used for any case that requires an initial period of TLD exceeding 12 months or a second or later period of TLD which will result in the member being on TLD for more than 12 months for the same or similar condition. In all such cases departmental review is required.

(e) Temporary Limited Duty Greater than 12 Months. Some major injuries or illnesses require more than 12 months TLD. The CA may recommend TLD for greater than 12 months for injuries or illnesses requiring longer periods of rehabilitation or treatment (e.g. neoplasms, tuberculosis, or thopedic problems). The board membership must agree that a finding of "physically qualified for full duty" is likely at the conclusion of treatment and the treatment regimen is likely to exceed 12 months but not longer than 24 months. Forward these medical board reports for departmental review. Reevaluations will be conducted 2 months prior to the expiration of the PRD.

(1) If a member has been on TLD for over 12 months for a given medical condition, even if there has been an interval of full duty for less than 1 year, the medical board report will be referred for departmental review. An additional period of TLD may be requested with sufficient justification to show the member will be physically qualified for full duty within 6 months.

(2) If an additional period of TLD is required, not to exceed a total of 24 months, forward a new medical board report for departmental review.

(3) If the member is unlikely to be physically qualified for full duty after 24 months on TLD, a new medical board must be convened and the report forwarded to the PEB.

(f) Return to Full Duty after LIMDU. The physician may return an enlisted member to full duty at the conclusion of the TLD period, or anytime prior to the conclusion, by recording on an SF 600 the findings, prognosis, and any residual effects that may be apparent. A note stating "Fit for F.

"duty" is not sufficient. (See article 18-16 for instructions on returning officers to full duty.) Counsel the member and complete blocks 25 and 26 at the bottom of the original Medical Board Report Cover Sheet (NAVMED 6100/1). The medical or surgical department heads or directors signature is required if the physician returning the member to full duty is a civilian physician. Provide results of this action to the PSD or CMC (MMSR-4), as appropriate.

(g) **Contesting Return to Full Duty Recommendations.** Return to full duty from a TLD status is not an adverse action, but a member may question this action. If a member does not agree with a physician's decision of return to full duty, resolution should first be attempted between the member, the attending physician, and the physician's directorate or department head, the same as with any other difference of opinion about medical care. Should this review uphold the return to full duty status, the enlisted member will be made available for assignment and must be informed of the right to submit an appeal through the chain of command. If the member elects to contest the finding of physically qualified for full duty, the member may concurrently submit a request to the commanding officer of the naval MTF returning that member to full duty, via the member's commanding officer. The appeal package should include statements about the condition upon which the appeal is based; copies of all pertinent medical records, including the latest and all previous medical boards on the current condition; and any nonmedical documentation, e.g., a statement by the member's commanding officer on the member's ability to perform full duty. Availability for assignment to full duty will not be held in abeyance during these procedures.

(h) **Referral to PEB.** If during any TLD period the physician recognizes that the member will not be physically qualified for full duty within 24 months, a new medical board will be completed and the case immediately referred to the PEB.

(i) **Departmental Review.** An initial period of TLD of 6 through 12 months may normally be approved for enlisted personnel without departmental review. Departmental review is required when:

- (1) The recommended period of TLD is greater than 12 months.
- (2) An initial period of 12 month TLD is recommended for a Marine Corps enlisted member.
- (3) A second or later TLD recommendation is made in which the member's total TLD will exceed 12 months.
- (4) The member submits a statement in rebuttal to the board's findings or recommendation.
- (5) The medical board involves other than an enlisted member.
- (6) The medical board is ordered by other than the CA.

18-30**Light Duty**

(1) Members will be placed on light duty when they have a temporary medical condition which limits their ability to perform certain activities or when limitation of certain activities is advised for the member to recover adequately from the condition and the member is expected to be physically qualified for full duty within 30 days.

(2) Light duty is a recommendation to the member's command. The command is under no obligation to either accept the member in a light duty status or to conform to the recommendations after accepting such a member. When a command cannot accommodate a member in a light duty status with the physical limitations and restrictions prescribed, a TLD board will be convened.

(3) Members may be placed on light duty by any privileged provider on the staff of an MTF or DTF.

(4) Members may be assigned to light duty for no more than a total of 30 days for the same condition.



(5) The DD 689, Individual Sick Slip, or equivalent local form, will be used to recommend light duty and completed in triplicate. The original will be placed in the member's health record, one copy will be delivered to the member's command, and the third will be retained in the Patient Administration Department (PAD) (or Administration Department of a clinic or DTF). Under "Disposition of Patient," the "other" block will be checked and "light duty" written in. Under the "Remarks" section, the physician will record the restrictions and limitations advised for the member.

(6) Members placed on light duty will be instructed to bring their light duty chit (DD 689) to the PAD. The PAD will determine if the medical condition is due to an injury requiring an LOD determination, and inform the member's command if such a requirement exists. The PAD will liaison with the member's command on the light duty recommendation and plans for further treatment. If the member's command cannot effectively employ the member with the recommended restrictions, a TLD medical board will be convened.

(7) If the member is still not fit for full duty after 30 days on light duty for the same medical condition, a medical board will be convened.

18-31

Triservice Medical Boards

(1) Any uniformed services MTF empowered to convene medical boards may convene a medical board on a member of the Navy or Marine Corps when the board is convened following current directives.

(2) While being treated at another service facility, any Navy CA, or any command empowered to order a medical board may request that a medical board be convened on a Navy or Marine Corps member. By triservice agreement, such requests will routinely be honored, but they are not binding or mandatory when another service MTF believes a medical board is not appropriate.

(3) The other service MTF will forward the completed medical board report to the cognizant MTF (see 18-37) for each member who requires a medical board.

(4) The CA of the cognizant Navy MTF must review medical board reports or narrative summaries for accuracy, completeness, and acceptability for use within the Navy DES. This requirement does not prevent the physician's recommendations on physical limitations from being honored. The CA of the cognizant Navy MTF will elect one of the following options:

(a) Accept and process the medical board report.

(b) Return the medical board report to the MTF originating the board with a request for further information or clarification. If the medical board report is over 30 days old upon receipt by the Navy MTF, and the patient's condition was indicated in the report as unstable, additional information must be obtained as to the current medical condition of the patient.

(c) Reject the medical board report and process a de novo (new) medical board if such action is in the best interest of the member and parent service. (Note: Member may need to be transferred to a Navy MTF for a de novo board).

(5) Service members not expected to return to full duty and who require regulating for medical reasons to another service's MTF will be moved to the uniformed service MTF nearest the member's home capable of providing the required care and disposition. If a medical board has been initiated, the transferring MTF will forward the completed medical board report to the receiving activity. (Note: Exceptions may be required for members who are undergoing

dual processing, such as medical disability and administrative separation, courts-martial proceedings, or those who require special psychiatric examination for competency or receipt of pay.)

(6) Army and Air Force facilities use profiles for temporary limited duty dispositions of active duty members. Profiles, by themselves, are not acceptable for use within the Navy. A narrative summary should be used. A Medical Board Report Cover Sheet (NAVMED 6100/1) signed by the CA of the naval MTF will be attached to the board.

(7) If the CA of the cognizant Navy MTF accepts the medical board report and concurs with its findings, he or she may submit it for consideration. The medical board report will be endorsed by the CA of the Navy MTF and forwarded. (Note: The 30 day limit for submission to the PEB applies.)

(8) All medical board reports on Navy and Marine Corps members accepted from other services must have a completed Medical Board Report Cover Sheet (NAVMED 6100/1) attached. Cover sheets must be signed by the CA of the cognizant Navy MTF. If a narrative summary signed by a physician is being forwarded, the NAVMED 6100/1 must contain the signatures of at least one physician in addition to the CA. Endorsement of the medical board report should include any necessary information required for the PEB to make a determination.

(9) When another service convenes a medical board on a Navy or Marine Corps member, proposed PEB findings will be forwarded to the cognizant parent service. (Note: Army and Air Force medical evaluation boards may not function in the same manner.)

(10) The member's parent service has the primary responsibility for counseling members on proposed PEB findings; however, on a case by case basis and by mutual agreement between the treating facility and the cognizant Navy MTF, the treating facility may provide counseling with guidance by the Navy.

(11) When a medical board is convened on a Navy or Marine Corps member by another service and an appearance before a hearing panel is required, the Navy will ensure that appropriate orders are prepared transferring the member on temporary additional duty (TAD) to the nearest hearing panel designated by the PEB. If the member requires inpatient care, transfer the patient to the military MTF nearest the location of the hearing panel. The PEB will provide the accounting data. Funding requirements remain a parent service responsibility.

(12) Medical board reports on cadets or midshipmen assigned to Department of Defense Military Academies will be forwarded to:

(a) The Superintendent, U.S. Naval Academy, via the Chief, Bureau of Medicine and Surgery (Physical Qualifications and Review Division), for naval personnel.

(b) The Superintendent, U.S. Military Academy, via the commanding Officer, Keller Army Community Hospital, West Point, NY, for Army personnel.

(c) The Superintendent, U.S. Air Force Academy, via the Commanding Officer, U.S. Air Force Academy Hospital, USAFA, CO, for Air Force personnel.

(13) Navy medical officers should refrain from discussing any possible disposition in medical boards convened on cadets assigned to military academies. The superintendent of the respective service academy is responsible for this. The medical board report in these instances will reflect "referral to Superintendent for appropriate disposition."

18-32

Medical Boards from Other Than DoD Sources

(1) Narrative summaries may be prepared and forwarded to the cognizant parent service MTF in lieu of a medical board report for Navy and Marine Corps members hospitalized in civilian or DVA MTF. The cognizant naval MTF will forward narrative summaries with a Medical Board Report Cover Sheet (NAVMED 6100/1) signed by at least two physicians and the CA. The Naval Office of MEDDEN Affairs will coordinate this process.

(2) When active duty members are receiving care from the DVA for spinal cord injuries, head injuries, or blindness under the provisions of the DoD and DVA memorandum of understanding, the DVA accepts responsibility for conducting and preparing medical boards on members who received expedited transfers to the DVA. Navy Medical Department MTFs may be required to provide the DVA with medical information, LOD and misconduct investigation reports, and other assistance.

18-33

Providing Additional Medical Information and Line of Duty and Misconduct Investigation Reports

(1) DIRNCPB may ask Navy Medical Department facilities to provide additional medical information on individuals being processed by the PEB. The action addressee will:

(a) Provide the information requested within 10 working days.

(b) If the requested information requires further evaluation of the member or some other procedure, schedule the appointments on a priority basis.

(c) If unable to comply, provide a message response to DIRNCPB to include the reason for noncompliance.

(2) Timely and complete reports of LOD and misconduct findings are essential to proper physical evaluations. The PEB will not accept medical board reports without an accompanying LOD and misconduct reports when they are required.

(a) Immediately inform the member's command by message when an active duty member is admitted under circumstances in which a LOD determination must be made. State the requirement for an LOD determination in the message. This request precedes the determination of whether or not a medical board will be convened.

(b) If an investigation is required and has not been initiated, the hospital commanding officer will promptly report the matter to the area coordinator or designated subordinate commander who will ensure that the required investigation is initiated. The area coordinator or designated subordinate commander will comply with the JAG Manual and immediately convene the necessary investigation and furnish required reports.

(c) Responsible individuals or commands will, upon receipt of a request from a medical board CA, promptly provide such boards with copies of completed LOD and misconduct investigations for transmittal with medical board reports to the PEB. Requests for LOD and misconduct investigation reports will be initiated when a member sustains an injury which may result in permanent disability or prevents the member from performing duties for more than 24 hours.

(d) For medical board purposes, a full LOD investigation is not always required. A NAVJAG 5800/15, Injury Report, may suffice. In cases where it is obvious the injury was incurred in the line of duty/not due to misconduct, a simple statement of circumstances of the injury included in the medical board report itself is generally sufficient. Such cases in-

clude sport injuries, slips, trips, and falls; injuries occurring to members doing work around the house (e.g., members injured with hand tools); or injuries occurring to members working on their motor vehicles.

(e) In cases where the accident or injury occurred 6 months (or longer) before the medical board, an LOD determination or investigation may have been done by the member's command, but they may not have retained a copy. Suggest to the member's command that if a copy of the LOD was not retained (or if the LOD was done by another command), they may obtain a copy from JAG (Code 9S25).

(f) If a medical board report submission is delayed while waiting for additional information, an endorsement attesting to the patient's current medical condition must be attached before submission if the board report is:

(1) Thirty or more days old in cases of patients with unstable conditions, or

(2) Sixty or more days old in cases of patients with stable conditions.

(g) Notify DNCPB if an LOD cannot be completed after extensive attempts.

(a) When considering an elective procedure, seek the advice of the patient administration officer to assist in assessing whether:

(1) The outcome will alter findings of the board.

(2) The outcome will interfere with the member's anticipated disposition, i.e., separation, retirement, or return to duty.

(3) The member will have sufficient time remaining on active duty for appropriate followup care. Do not assume that the DVA will accept responsibility for this care unless the member has already been accepted as a DVA beneficiary.

(b) If a physician believes that an elective procedure should be performed after obtaining the above advice, provide message notification to DNCPB and BUMED (MED-331) on the planned procedure explaining:

(1) Justification for procedure.

(2) Estimated period of hospitalization and recovery.

(3) Estimated impact of the planned procedure on the physical qualification of the member for continued service on active duty.

(c) While the decision on whether to perform an elective or nonelective procedure rests with the member and the attending physician, consideration must also be given to the interests of the Government.

18-34

Surgical Procedures on Members in the Disability Evaluation System

(1) Any elective surgical procedure that may affect a member's physical qualification for duty should be completed before initiation of a medical board (except in the case of members of the Inactive Reserve per article 18-20). When future surgery is anticipated, attending physicians must annotate the medical board report to include this information.

(2) If a nonelective surgical procedure is necessary after a medical board report is submitted to PEB, send a message to DIRNCPB requesting proceedings be held in abeyance. Make both BUMED (MED-331) and the appropriate personnel command information addressees.

(3) After forwarding medical board reports to PEB, physicians must assess any decision to perform surgery considered to be in the best interest of the member.

18-35

Withdrawing a Medical Board from the DES

(1) With the consent of the member, the CA of a medical board may, for good and sufficient reason, withdraw any medical board report the CA referred to the PEB if the report is still before the PEB and recommended findings have not been made. The CA may also, with the consent of the member concerned, request the CHNAVPERS or CMC, as appropriate, to withdraw the entire report per part XI of SECNAVINST 1850.4 series.

(2) To guarantee separation under the proper provisions of law, members who expect to be separated from the service by medical board action may request that CHNAVPERS or CMC, as appropriate, amend or stop the medical board process to allow separation under another more appropriate provision of law. Such requests may be honored only if received before the final decision of the PEB is released.

18-36

Medical Board Quality Control Checklist

	YES	NO	NA
1. Results of the physical examination or review of systems.			
2. Pertinent data concerning each complaint, symptom, disease, injury, or disability presented by the member which causes or is alleged to cause impairment of health.			
3. Why the patient was hospitalized or treated.			
4. Dates of all pertinent events.			
5. Circumstances of any injury.			
6. Physical findings (negative and positive) including the height and weight of the member.			
7. Results of pertinent laboratory and x-ray tests.			
8. What and when medical or surgical treatment was rendered.			
9. The current physical condition of the patient at the time the medical board report was written.			
10. Prognosis and recommendations concerning the disposition to be effected.			
11. Specific physical limitations recommended for the patient. Description of physical limitations should, when possible, relate to the patient's current duties or duties to which he/she may be assigned.			
12. Instructions given to the patient, such as medication to be taken, physical restriction, etc.			
13. How the member has cooperated with the treatment plan.			
14. Reports of consultations.			
15. Apparent contradictions in the records, such as disagreement with a report or consultation.			
16. If a previous medical board report has been prepared, it is not necessary to repeat the detailed information contained therein pertaining to past history. Attention may be invited to the previous report and the description of the present illness restricted to the interval history and currently pertinent data.			
17. Any facts which are not a matter of record or personal knowledge to a board member, but which are based on the member's own statement, should be recorded as "according to the member's own statement."			
18. References to "left" and "right" are consistent throughout the report.			
19. The report contains a statement concerning the member's capability to manage personal affairs. (Required for all psychoses; organic brain disorders when the board's report indicates impairment of judgment; psychoneuroses, severe, when possible impairment of judgment is indicated; any situation in which a member has previously been declared incapable of managing personal affairs; all psychiatric illnesses of sufficient severity to require further hospitalization.			
20. In those instances enumerated above, the board membership consists of 3 members, one of whom is a psychologist or psychiatrist.			
21. The disposition recommended is appropriate and consistent with Navy and Marine Corps policy and procedures.			

18-37

**Cognizant MTFs for Triservice Medical Boards
Service Coordination Channels**

**Patient Evaluated in
Air Force MTF**

**Contact for Navy
and Marine Corps Personnel**

Contact for Army Personnel

42 Strategic Hospital, Loring AFB, ME
 380 Strategic Hospital, Plattsburgh AFB, NY
 416 Strategic Hospital, Griffiss AFB, NY
 USAF Hospital, Dover, DE
 Malcolm Grow USAF Medical Center,
 Andrews AFB, MD
 1 Medical Group, Langley AFB, VA
 363 Medical Group, Shaw AFB, SC
 354 Medical Group, Myrtle Beach AFB, FL
 USAF Hospital, Robins AFB, GA
 347 Medical Group, Moody AFB, GA
 AFSC Hospital, Patrick AFB, FL
 31 Medical Group, Homestead AFB, FL
 56 Medical Group, MacDill AFB, FL
 325 Medical Group, Tyndall AFB, FL
 AFSC Regional Hospital, Eglin AFB, FL
 USAF Medical Center, Keesler AFB, MS
 Air University Regional Hospital,
 Maxwell AFB, AL
 USAF Hospital, Columbus AFB, MS
 USAF Medical Center, Wright-Patterson AFB, OH
 379 Strategic Hospital, Wurtsmith AFB, MI

 410 Strategic Hospital, K.I. Sawyer AFB, MI

 USAF Hospital, Chanute AFB, IL

 351 Strategic Hospital, Whiteman AFB, MO

 USAF Medical Center, Scott AFB, IL

 97 Strategic Hospital, Eaker AFB, AK
 23 Medical Group, England AFB, LA
 USAF Hospital, Tinker AFB, OK
 USAF Hospital, Altus AFB, OK
 USAF Regional Hospital, Sheppard AFB, TX
 USAF Hospital, Reese AFB, TX
 96 Strategic Hospital, Dyess AFB, TX
 R.L.Thompson Strategic Hospital, Carswell AFB, TX
 67 Medical Group, Bergstrom AFB, TX
 2 Strategic Hospital, Barksdale AFB, LA
 4 Medical Group, Seymour Johnson AFB, NC
 Wilford Hall USAF Medical Center, Lackland AFB, TX

NH Newport, RI
 NH Groton, CT
 NH Groton, CT
 NMCL Philadelphia, PA
 NATNAVMEDCEN Bethesda, MD

 NAVMEDCEN Portsmouth, VA
 NH Charleston, SC
 NH Charleston, SC
 NH Charleston, SC
 NH Jacksonville, FL
 NH Orlando, FL
 NH Orlando, FL
 NH Orlando, FL
 NH Jacksonville, FL
 NH Pensacola, FL
 NH Pensacola, FL
 NH Charleston, SC

 NH Charleston, SC
 NH Great Lakes, IL
 NH Great Lakes, IL

 NH Great Lakes, IL

 NH Great Lakes, IL

 NH Great Lakes, IL

 NH Memphis, TN
 NH Pensacola, FL
 NH Memphis, TN
 NH Memphis, TN
 NH Corpus Christi, TX
 NH Memphis, TN
 NH Camp Lejeune, NC
 NH Corpus Christi, TX

Cutler ACH, Ft Devens, MA
 Cutler ACH, Ft Devens, MA
 Cutler ACH, Ft Devens, MA
 Kimbrough ACH, Ft Meade, MD
 Walter Reed AMC, Wash, DC

 McDonald ACH, Ft Eustis, VA
 Moncrief ACH, Ft Jackson, SC
 Moncrief ACH, Ft Jackson, SC
 Martin ACH, Ft Benning, GA
 Martin ACH, Ft Benning, GA
 Winn ACH, Ft Stewart, GA
 Winn ACH, Ft Stewart, GA
 Winn ACH, Ft Stewart, GA
 Lyster ACH, Ft Rucker, AL
 Lyster ACH, Ft Rucker, AL
 Lyster ACH, Ft Rucker, AL
 Martin ACH, Ft Benning, GA

 Noble ACH, Ft McClellan, AL
 Ireland ACH, Ft Knox, KY
 Gen. Leonard Wood ACH,
 Ft Leonard Wood, MO
 Reynolds ACH, Ft Sill, OK
 Bayne-Jones ACH, Ft Polk, LA
 Reynolds ACH, Ft Sill, OK
 Reynolds ACH, Ft Sill, OK
 Darnall ACH, Ft Hood, TX
 Bayne-Jones ACH, Ft Polk, LA
 Womack ACH, Ft Bragg, NC
 Brooke AMC, Ft Sam Houston, TX

JSAF Hospital, Laughlin AFB, TX
 JSAF Hospital, Kirtland AFB, NM
 27 Medical Group, Cannon AFB, NM
 833 Medical Group, Holloman AFB, NM
 832 Medical Group, Luke AFB, AZ
 USAF Hospital, Williams AFB, AZ
 836 Medical Group, Davis-Monthan AFB, AZ
 842 Strategic Hospital, Grand Forks AFB, ND
 857 Strategic Hospital, Minot AFB, ND
 812 Strategic Hospital, Ellsworth AFB, SD
 Ehrling Berquist Strategic Hospital, Offutt AFB, NE
 USAF Academy Hospital, Aurora, CO
 384 Strategic Hospital, McConnell AFB, KS
 USAF Hospital, Hill AFB, UT
 90 Strategic Hospital, Francis E. Warren AFB, WY
 554 Medical Group, Nellis AFB, NV
 22 Strategic Hospital, March AFB, CA
 831 Medical Group, George AFB, CA
 AFSC Hospital, Edwards AFB, CA
 1 Strategic Hospital, Vandenberg AFB, CA
 93 Strategic Hospital, Castle AFB, CA
 USAF Hospital, Mather AFB, CA
 9 Strategic Hospital, Beale AFB, CA
 David Grant USAF Medical Center Travis AFB, CA
 366 Medical Group Hospital, Mountain Home AFB, ID
 341 Strategic Hospital, Malstrom AFB, MT
 92 Strategic Hospital, Fairchild AFB, WA
 JSAF Regional Hosp, Elmendorf AFB, AK
 7206 ABG Hospital, Hellenikon, GR
 36 TFW Hospital, Bitburg AB, GE
 50 TFW Hospital, Hahn AB, GE
 39 TAC Group Hospital, Incirlik, TU
 USAF Hospital, Lajes FLD, Azores
 48 TFW Hospital, Lakenheath, UK
 20 TFW Hospital, Upper Heyford, UK
 401 TFW Hospital, Torrejon AB, SP
 7100 CSW Medical Center, Wiesbaden, GE
 13 Medical Center, Clark AB, RP
 8 Medical Group, Kunsan AB, Korea
 432 Medical Group, Misawa AB, JA
 475 Medical Group, Yokota AB, JA
 51 Medical Group, Osan AB, Korea

NH Corpus Christi, TX
 NAVMEDCEN San Diego, CA
 NH Great Lakes, IL
 NAVMEDCEN Oakland, CA
 NH Great Lakes, IL
 NAVMEDCEN San Diego, CA
 NAVMEDCEN Oakland, CA
 NAVMEDCEN Oakland, CA
 NAVMEDCEN Oakland, CA
 NAVMEDCEN Oakland, CA
 NH Bremerton, WA
 NH Bremerton, WA
 NH Bremerton, WA
 NH Bremerton, WA
 USNH Naples Italy
 USNH Naples Italy
 USNH Naples Italy
 USNH Naples Italy
 USNH Rota Spain
 USNH Naples Italy
 USNH Subic Bay RP
 USNH Yokosuka JA
 USNH Yokosuka JA
 USNH Yokosuka JA
 USNH Yokosuka JA

Brooke AMC, Ft Sam Houston, TX
 Wm Beaumont AMC, El Paso, TX
 Wm Beaumont AMC, El Paso, TX
 Wm Beaumont AMC, El Paso, TX
 R.W.Bliss ACH, Ft Huachuca, AZ
 R.W.Bliss ACH, Ft Huachuca, AZ
 R.W.Bliss ACH, Ft Huachuca, AZ
 Evans ACH, Ft Carson, CO
 Evans ACH, Ft Carson, CO
 Evans ACH, Ft Carson, CO
 Irwin ACH, Ft Riley, KS
 Evans ACH, Ft Carson, CO
 Irwin ACH, Ft Riley, KS
 Evans ACH, Ft Carson, CO
 Evans ACH, Ft Carson, CO
 Letterman AMC, San Francisco, CA
 Silas B. Hays ACH, Ft Ord, CA
 Letterman AMC, San Francisco, CA
 Letterman AMC, San Francisco, CA
 Letterman AMC, San Francisco, CA
 Madigan AMC, Tacoma, WA
 Madigan AMC, Tacoma, WA
 Madigan AMC, Tacoma, WA
 Bassett ACH, Ft. Wainwright, AK
 2nd Gen Hospital, Landstuhl, GE
 Tripler AMC, HI
 21st Evac Hosp, Seoul, Korea
 Tripler AMC, HI
 Tripler AMC, HI
 121st Evac Hosp, Seoul, Korea

Patient Evaluated In Navy MTF

NH Newport, RI
 NH Groton, CT
 NMCL Philadelphia, PA
 NATNAVMEDCEN, Bethesda, MD
 NAVMEDCEN Portsmouth, VA

Contact for Air Force Personnel

Malcolm Grow USAF Medical Center I
 Andrews AFB, MD
 Malcolm Grow USAF Medical Center
 Andrews AFB, MD
 Malcolm Grow USAF Medical Center
 Andrews AFB, MD
 Malcolm Grow USAF Medical Center
 Andrews AFB, MD
 1 Medical Group, Langley AFB, VA

Contact for Army Personnel

Cutler ACH, Ft Devens, MA
 Cutler ACH, Ft. Devens, MA
 Kimbrough ACH, Ft. Meade, MD
 Walter Reed AMC, Washington, DC
 McDonald ACH, Ft Eustis, VA

NH Charleston, SC
 NH Jacksonville, FL
 NH Orlando, FL
 NH Pensacola, FL
 NH Great Lakes, IL

NH Memphis, TN
 NH Corpus Christi, TX

NH Camp Lejeune, NC
 NAVMEDCEN San Diego, CA
 NAVMEDCEN Oakland, CA

NH Bremerton, WA
 NH Lemoore, CA

NH Long Beach, CA
 NH Camp Pendleton, CA
 NH Beaufort, SC
 NH Cherry Point, NC
 NH Patuxent River, MD

NMCL Port Hueneme, CA
 NMCL Key West, FL
 NMCL Annapolis, MD

NMCL Pearl Harbor, HI
 USNH, Naples, IT
 USNH, Rota, SP
 USNH, Subic Bay, RP
 USNH, Yokosuka, JA
 USNH Okinawa, JA
 USNH Guam, MI
 NH Roosevelt Roads, PR

USNH Guantanamo Bay, Cuba

Patient Evaluated in Army MTF

Cutler ACH, Ft Devens, MA
 Kimbrough ACH, Ft Meade, MD

Walter Reed AMC, Washington, DC

McDonald ACH, Ft Eustis, VA
 Moncrief ACH, Ft Jackson, SC
 Martin ACH, Ft Benning, GA

Winn ACH, Ft Stewart, GA

Lyster ACH, Ft Rucker, AL

363 Medical Group, Shaw AFB, SC
 ATSC Regional Hospital, Eglin AFB, FL
 56 Medical Group, MacDill AFB, FL
 USAF Medical Center, Keesler AFB, MS
 USAF Medical Center, Scott AFB, IL

USAF Medical Center, Scott AFB, IL
 Wilford Hall USAF Medical Center,
 Lackland AFB, TX

363 Medical Group, Shaw AFB, SC
 22 Strategic Hospital, March AFB, CA
 David Grant USAF Medical Center,
 Travis AFB, CA

92 Strategic Hospital, Fairchild AFB, WA
 David Grant USAF Medical Center,
 Travis AFB, CA

22 Strategic Hospital, March AFB, CA
 22 Strategic Hospital, March AFB, CA
 363 Medical Group, Shaw AFB, SC
 363 Medical Group, Shaw AFB, SC
 Malcolm Grow USAF Medical Center,
 Andrews AFB, MD

22 Strategic Hospital, March AFB, CA
 56 Medical Group, Macdill AFB, FL
 Malcolm Grow USAF Medical Center
 Andrews AFB, MD

15 Medical Group, Hickam AFB, HI
 7100 CSW Medical Center, Wiesbaden, GE
 7100 CSW Medical Center, Wiesbaden, GE
 13 Medical Center, Clark AB, RP
 475 Medical Group, Yokota AB, JA
 13 Medical Center, Clark AB, RP
 15 Medical Group, Hickam AFB, HI
 56 Medical Group, Macdill AFB, FL

56 Medical Group, Macdill AFB, FL

Contact for Air Force Personnel

Malcolm Grow USAF Medical Center,
 Andrews AFB, MD

Malcolm Grow USAF Medical Center,
 Andrews AFB, MD

1 Medical Group, Langley AFB, VA
 363 Medical Group, Shaw AFB, SC
 Air University Regional Hospital,
 Maxwell AFB, FL

AFSC Regional Hospital,
 Eglin AFB, FL

AFSC Regional Hospital,
 Eglin AFB, FL

Moncrief ACH, Ft Jackson, SC
 Winn ACH, Ft Stewart, GA
 Winn ACH, Ft Stewart, GA
 Lyster ACH, Ft Rucker, AL
 Gen. Leonard Wood ACH,
 Ft Leonard Wood, MO
 Blanchfield ACH, Ft Campbell, KY
 Brooke AMC, Ft Sam Houston, TX

Womack ACH, Ft Bragg, NC
 Silas B. Hays ACH, Ft Ord, CA
 Letterman AMC, San Francisco, CA

Madigan AMC, Tacoma, WA
 Silas B. Hays ACH, Ft Ord, CA

Silas B. Hays ACH, Ft Ord, CA
 Silas B. Hays ACH, Ft Ord, CA
 Winn ACH, Ft Stewart, GA
 Womack ACH, Ft Bragg, NC
 Dewitt ACH, Ft Belvoir, VA

Silas B. Hays ACH, Ft Ord, CA
 Winn ACH, Ft Stewart, GA
 Kimbrough ACH, Ft Meade, MD

Tripler AMC, HI
 2nd Gen Hospital, Landstuhl, GE
 2nd Gen Hospital, Landstuhl, GE
 Tripler AMC, HI
 Tripler AMC, HI
 Tripler AMC, HI
 Tripler AMC, HI
 Dwight David Eisenhower AMC
 Ft Gordon, GA
 Dwight David Eisenhower AMC,
 Ft Gordon, GA

Contact for Navy and Marine Corps Personnel

NH Newport, RI
 NATNAVMEDCEN Bethesda, MD

NATNAVMEDCEN Bethesda, MD

NH Portsmouth, VA
 NH Charleston, SC
 NH Charleston, SC

NH Charleston, SC

NH Pensacola, FL

Ioble ACH, Ft McClellan, AL	Air University Regional Hospital, Maxwell AFB, FL	NH Pensacola, FL
Ireland ACH, Ft Knox, KY	USAF Medical Center, Scott AFB, IL	NAVMECEN Portsmouth, VA
Gen. Leonard Wood ACH, Ft Leonard Wood, MO	USAF Medical Center, Scott AFB, IL	NH Memphis, TN
Reynolds ACH, Ft Sill, OK	USAF Regional Hospital, Sheppard AFB, TX	NH Corpus Christi, TX
Bayne-Jones ACH, Ft Polk, LA	USAF Medical Center, Keesler AFB, MS	NH Pensacola, FL
Darnall ACH, Ft Hood, TX	Wilford Hall USAF Medical Center, Lackland AFB, TX	NH Corpus Christi, TX
Wornack ACH, Ft Bragg, NC	363 Medical Group, Shaw AFB, SC	NH Camp Lejeune, NC
Evans ACH, Ft Carson, CO	USAF Academy Hospital, CO	NAVMECEN San Diego, CA
Silas B. Hays ACH, Ft Ord, CA	David Grant USAF Medical Center, Travis AFB, CA	NAVMECEN Oakland, CA
Letterman AMC, San Francisco, CA	David Grant USAF Medical Center, Travis AFB, CA	NAVMECEN Oakland, CA
Madigan AMC, Tacoma, WA	92 Strategic Hospital, Fairchild AFB, WA	NH Bremerton, WA
Bassett ACH, Ft Wainwright, AK	7206 ABG Hospital, Elmendorf AFB, AK	NH Bremerton, WA
Tripler AMC, HI	5 Medical Group, Hickam AFB, HI	NMCL Pearl Harbor, HI
Keller ACH, West Point, NY		NH Groton, CT



18-38

Acronyms

BUMED	Bureau of Medicine and Surgery
BUPERS	Bureau of Naval Personnel
CA	Convening Authority
CMC	Commandant of the Marine Corps
COMNAVRESFOR	Commander, Naval Reserve Force
DES	Disability Evaluation System
DNCPB	Director, Naval Council of Personnel Boards
DSM	Statistical Manual of Mental Disorders
DTF	Dental Treatment Facility
DVA	Department of Veteran Affairs (formerly Veterans Administration)
EAOS	End of Active Obligated Service
ENLTRANSMAN	Enlisted Transfer Manual
EPTE	Existed Prior To Entry
ICD-9-CM	International Classification of Diseases, 9th Rev., Clinical Modification
ICO	In Case Of
JAG/OJAG	Judge Advocate General/Office of the Judge Advocate General
LOD/LODI	Line of Duty/Line of Duty Investigation
MBTS	Medical Board Tracking System
MCO	Marine Corps Order
MCRD	Marine Corps Recruit Depot
MEDDEN Affairs	Office of Medical/Dental Affairs
MEPS	Military Entrance Processing
MILPERSMAN	Naval Military Personnel Manual
MOS	Military Occupational Specialty
MTF	Medical Treatment Facility
NAMI	Naval Aerospace Medical Institute
NAVMEINFOMGMTCCN	Naval Medical Information Management Center
NEC	Navy Enlisted Classification
NOE	Notice of Eligibility
PAD	Patient Administration Department
PEB	Physical Evaluation Board
PLD	Permanent Limited Duty
PRT	Physical Readiness Test
PSD	Personnel Support Detachment
RCM	Rules for Courts-Martial
REU	Recruit Evaluation Unit
RRP	Records Review Panel
RTC	Recruit Training Command
TDRL	Temporary Disability Retired List
TEMDU	Temporary Duty
TLD	Temporary Limited Duty
USDTF	Uniformed Services Dental Treatment Facility
USMTF	Uniformed Services Medical Treatment Facility