DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
WASHINGTON 25, D. C.

20 May 1952

The Manual of the Medical Department is issued in accordance with United States Navy Regulations. It contains detailed instructions and information pertaining to matters under the control of the Chief of the Bureau of Medicine and Surgery for the guidance of persons in the Naval Establishment.

Approved:

[Signature]
Secretary of the Navy

[Signature]
Chief, Bureau of Medicine and Surgery
MANUAL OF THE MEDICAL DEPARTMENT

CHECK LIST OF PAGES IN EFFECT

This list is to be used to verify the completeness of the manual after insertion of Page Change 10. "0" indicates a page from the original printing, "1" a page from Page Change 1, etc. Right hand pages are listed if they bear a change number identical to or later than that on the following left hand page. Left hand pages are listed instead if they carry a later page change number, and are underscored for easy identification. Missing pages should be requested from the Bureau of Medicine and Surgery (Code 4522).

<table>
<thead>
<tr>
<th>Page</th>
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<td>6-18</td>
<td>7</td>
<td>9-1</td>
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<td>9</td>
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The Record of Page Changes shall be retained.
The changes listed herein are effective upon receipt. Insert this change in front of the Manual of the Medical Department, and mark "12-1" opposite the below-listed articles and subarticles in the Manual text. The symbol "12-1" indicates that this is the first advance change issued in advance of Page Change 12.

E. C. KENNEY
Chief of Bureau

Summary of Articles and Subarticles Affected

Chapter 7
7-1-7-30
15-7(2)(b)
15-8(2)
15-10(2)(a)
15-22(2)(e)
15-29(2)(e) 15-29(2)(g)
16-25
20-11(3)
23-215, NAVMED 1334
23-215, NAVMED 1362
23-215, NAVMED 1353
16-25
20-11(3)
23-215, NAVMED 1334
23-215, NAVMED 1362
23-215, NAVMED 1353
23-215, NAVMED 1334
23-215, NAVMED 1362
23-215, NAVMED 1353
23-215, NAVMED 1334
23-215, NAVMED 1362
23-215, NAVMED 1353
23-215, NAVMED 1334
23-215, NAVMED 1362
23-215, NAVMED 1353
23-215, NAVMED 1334
23-215, NAVMED 1362
23-215, NAVMED 1353
23-215, NAVMED 1334
23-215, NAVMED 1362
23-215, NAVMED 1353

Chapter 7 revised.

Chapter 7
MEDICAL SERVICE CORPS

Sections

I. Establishment
II. Appointments
III. Employment
IV. Education and Training

Articles
7-1 through 7-3
7-4 through 7-7
7-10 through 7-13

Section I. ESTABLISHMENT

Enabling Legislation
Grades and Authorized Strength
Chief of the Medical Service Corps

7-1. Enabling Legislation

(1) The Medical Service Corps was established as a staff corps of the United States Navy on 4 August 1947 by the Army-Navy Medical Services Corps Act of 1947 (34 USC 30 a-j). This staff corps was created as a component of the Medical Department of the Navy to complement the functions of the Medical and Dental Corps. Members of the Medical Service Corps are governed by all laws and regulations pertaining to commissioned officers of other staff corps, except when specific exceptions are set forth.

(2) The act provided for the corps to consist of sections in the various administrative, professional, and scientific specialties. The corps currently consists of the Medical Allied Sciences, Optometry, Pharmacy, Podiatry, Supply and Administration, and Women's Specialists Sections. The Medical Allied Sciences Section includes specialists such as bacteriologists, chemists, entomologists, industrial hygienists, physiologists, and psychologists. The Women's Specialists Section includes dietitians, physical therapists, and occupational therapists.
7-2. Grades and Authorized Strength

(1) The Medical Service Corps consists of officers in the grades of ensign through captain. These officers take precedence next after officers of the Dental Corps serving in the same grade and having the same dates of rank (10 USC 5508).

(2) The authorized strength of the Medical Service Corps on the active list is 13/100 of 1 percent of the sum of the total authorized number of commissioned officers of the Navy and Marine Corps (exclusive of commissioned warrant officers) on the active list, the total authorized number of enlisted men of the Regular Navy and Regular Marine Corps, the total authorized number of midshipmen at the Naval Academy, the actual number of commissioned warrant officers and warrant officers holding permanent appointments as such in the Regular Navy and the Regular Marine Corps exclusive of retired officers, and the actual number of midshipmen on active duty for flight training. The Secretary of the Navy computes the authorized strength of the Medical Service Corps as of 1 January of each year. This authorized strength represents a maximum strength (30 USC 5644). The number actually on the active list and on active duty varies from year to year in accordance with requirements and allocation of funds.

### Section II. APPOINTMENTS

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<table>
<thead>
<tr>
<th>Qualifications</th>
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#### 7-4. Source

(1) Chief medical or dental service warrants, medical or dental service warrants, and persons in the Hospital Corps of the Navy in the rates of hospital corpsman first class or dental technician first class, or senior, who possess such qualifications as may be prescribed by the Secretary of the Navy, and other persons who possess such requisite qualifications and who are graduates of accredited schools of pharmacy, optometry, or other schools or colleges with degrees in sciences allied to medicine or such degrees as may be approved by the Surgeon General, may be appointed to commissioned grades in the Medical Service Corps.

#### 7-5. Qualifications

(1) Officer procurement programs for the Medical Service Corps are open to men and women, except that appointment in the Women’s Specialists Section is restricted to women.

(2) Applicants must be found physically, mentally, morally, and professionally qualified prior to appointment to commissioned grades as Regular or Reserve officers. The general and specific requirements for appointment are set forth in the Bureau of Naval Personnel manual, in BUMERS Instructions (1120 series), and in the U.S. Navy Recruiting Service manual. Requirements vary with the specific programs, with the sections of the corps in which appointments are sought, and with the status of the candidates.

7-6. Grades

(1) Original appointments will be in the grade of ensign, except that persons holding or who have completed requirements for doctoral degrees in approved specialties may be appointed in the grade of lieutenant (junior grade).

7-7. Augmentation Program

(1) The augmentation program provides an opportunity for Reserve officers of the U.S. Navy and Regular Navy temporary commissioned officers to request permanent appointments as commissioned officers in the Medical Service Corps of the Regular Navy. Eligibility requirements are contained in BUMERS Instructions (1120 series). Each officer who is recommended for transfer will be assigned a lineal position on the appropriate lineal list according to his date of rank in the grade in which serving at the time of transfer and will be permanently appointed in a grade appropriate thereto. Each officer permanently appointed in a lower grade than the grade in which serving will also be temporarily reappointed in a higher grade. No permanent appointment will be above the grade of lieutenant.
General Duties

Specific Duties

7-6. General Duties

(1) Medical Service Corps officers render support to the Medical Department by performing primary duties in administration and various professional and scientific specialties allied to medicine. In addition to the primary duties prescribed for the billet to which a Medical Service Corps officer is detailed, such officer may be assigned any additional duties which he is qualified to perform and which contribute to the proper functioning of the command, except those duties contravening the provisions of international agreements such as the Geneva Conventions (art. 1355 of NAVREGS (1948)).

7-9. Specific Duties

(1) Subject to the direction of the commanding officer or other proper authority, the specific employment of Medical Service Corps officers, by Section, follows:

(a) Medical Allied Sciences.—Under the administrative supervision of senior officers of the Medical Corps, when available, perform professionally independent duties within the various sciences allied to medicine. Such assignments are affected in both the operational and research areas of emphasis in a wide variety of installations. Initial assignment can be expected in the various Navy and Marine training and hospital settings. With the development of military-professional skills and experience, assignments requiring a greater degree of sophistication in research design and methodology may be anticipated. Billets are located in medical centers, hospitals, medical research activities, disease vector control centers, Medical Department schools, dispensaries, preventive medicine units, foreign groups with medical detachments, and a wide variety of Marine Corps activities.

(b) Ophthalmology.—Perform duty under the direction of the medical officer; conduct external examination of the eye and their appendages; determine visual acuity, oculomotor, or ocular refractive errors or defects, and prescribe and fit appropriate lenses therefor; bring to the attention of the medical officer all patients who have or who are suspected of having pathological or abnormal conditions or who may require medical or surgical treatment; sign prescriptions for corrective lenses and orthoptic training; instruct assigned personnel in ophthalmologic fabrication and allied techniques; have immediate supervision of the professional services rendered in an optical unit; and supervise ophthalmic technicians in fabricating and dispensing spectacles. Billets are located in medical centers, hospitals, dispensaries, Marine Corps components, and the Bureau.

(c) Pharmacy.—Supervise pharmaceutical services; participate in research and investigations concerning pharmaceutical items, material procedure, and industrial mobilization; advise medical and dental officers in matters of pharmacology; and engage in the instruction of Medical Department personnel. Billets are located in medical centers, hospitals, medical research activities, dispensary, the Armed Services Medical Material Coordination Committee, the Military Medical Supply Agency, and the Bureau.

(d) Podiatry.—Perform duty under the direction of the medical officer; be responsible for the prevention and treatment of specified foot disorders; and maintain constant alert for conditions of a local nature and manifestations in the foot of systemic conditions that require prompt referral to the medical officer for investigation and/or treatment. Podiatrists may be assigned any written authority by the commanding officer, officer in charge, or medical officer of a Navy medical facility to prescribe certain specified medications which are intended for external application to the foot. Billets are located in Navy training centers, Marine Corps recruit depots, and other appropriate commands.

(e) Supply and Administration.—Administer nonprofessional aspects of medical and dental departments ashore and afloat; manage administrative functions such as fiscal and supply, personnel, records, food service, security, maintenance, and special services in support of missions of activities under the management control of the Bureau; manage environmental sanitation programs functions under the direction of the medical officer; administer and serve as instructors in designated training programs in Medical Department schools and other activities; perform medical service planning and logistic duties in major staff; and serve as assistants to inspectors in reviewing administrative organization and operations of medical and dental activities. Billets are located in designated vesels, Marine Corps components, unified and specified staffs, district and fleet staffs, the Military Medical Supply Agency, the Navy Department, medical centers, hospitals, medical research activities, Medical Department schools, station hospitals, dispensaries, dental clinics, and preventive medicine units.

(f) Women's Specialties.—Dietitians, occupational therapists, and physical therapists perform duties in the specialties in which qualified; supervise assigned personnel; and engage in the instruction and training of Medical Department personnel. Billets are located in medical centers and hospitals.

(2) An officer of the Medical Service Corps may be detailed as commanding officer or officer in charge of such activity as appropriate to this corps (art. 1351 of NAVREGS (1948); 10 USC 5945). For temporary succession to command see article 1977 of Navy Regulations (1948).
7-10. Purpose

(1) The authority and responsibility for the professional education and training of Medical Department military personnel are vested in the Bureau of Medicine and Surgery by articles 0431 and 0432 of Navy Regulations. Since the mission of the Medical Service Corps is to support the Medical Department in discharging its worldwide obligation as part of the United States Navy, the training program for the corps is designed to provide officers with appropriate qualifications to fulfill that purpose. This is the fundamental justification for such a training program and, while other benefits accrue, they are secondary.

7-11. Basic

(1) The qualification standards for appointment in the Medical Service Corps establish a presumption that an appointee is qualified to embark on a career in the corps and to perform the general duties required of a junior officer.

(2) Either before or immediately subsequent to commissioning, Medical Service Corps officers undergo basic orientation and indoctrination. The objective is to orient them in naval customs, traditions, and regulations, and to develop skills in naval leadership, administration, and related subjects.

7-12. Operational

(1) On completion of the basic indoctrination course, continued instruction of Medical Service Corps officers then becomes a command responsibility. Subject to the concurrence of the commanding officer, the administrative officer, or senior Medical Service Corps officer, as appropriate, shall establish, coordinate, and maintain an organized training program for Medical Service Corps officers. He shall instruct junior officers in their duties and responsibilities and shall familiarize them with the mission, responsibility, and scope of the command. Organized instruction on pertinent military and Medical Department subjects is vital to the success of the program. The broadening of mental outlook and resultant increase in professional knowledge will enable the officers to better meet the duties, responsibilities, and complexities of higher rank.

(2) Experience acquired through an officer's dedicated performance of duty, coupled with progressive assignments involving greater responsibilities, is most significant to his professional development. Concurrently, participation in part- time academic courses taken either by correspondence or in person during off-duty hours is encouraged. Courses offered by civilian educational institutions, when of service benefit, can in part be underwritten financially under the terms of current BUPERS and BURED Instructions. Further, attendance at professional and scientific meetings, which are held in most localities, provides an effective means whereby an officer may keep abreast with advances in his specialty.

(3) Each officer has a major share in the management and planning of his own career. He has a primary responsibility for his own military character and professional competence.

7-13. Formal

(1) A formal training program for Medical Service Corps officers, encompassing full-time academic training in service and civilian institutions, is administered by the Bureau. The general objectives are:

(a) To provide for the manning of every billet by an officer of appropriate qualifications in order that the maximum effectiveness of each position may be achieved.

(b) To satisfy the normal desire for self-improvement.

(c) To advance the Navy's contribution to the fields in which Medical Service Corps officers operate and receive training.

(2) The following are general points of philosophy guiding the administration of the Medical Service Corps training program:

(a) Each training assignment must result in demonstrable benefit to the service.

(b) In each assignment, the qualifications of the individual to pursue the training and to apply its fruits must be maximal.

(c) Each assignment must be consistent with the individual's career pattern.

(d) Such resources as are available may be devoted to the training program but not to the detriment of the continuing fulfillment of the corps' responsibilities in operating billets.

(e) In order that maximum service benefit may be assured, the choice of institutions in which training is to be given and decisions about the curriculum content are the functions of the Bureau, due regard being given to the wishes of individuals concerned.

(3) The current curriculums available, eligibility requirements, and processing procedures are set forth in a BURED Instruction (1520 series).
(b) Medical officers shall be on the watch for any of the following: ** *; a history of enuresis persisting into late childhood or adolescence (see also art. 15-22(2)(e)); ** *.

** * Addition (underscored).

15-29(2)(e) revised.

(e) Ears.—A thorough otoscopic examination of the auditory canal and membranes tympani shall be made. Acute or chronic disease of the middle or internal ear or ruptured eardrums shall disqualify. For all candidates the audiogram is the only acceptable test of auditory acuity. A hearing loss in excess of 15 decibels in either ear in frequencies 250, 512, 1024, 2048 is disqualifying.

15-29(2)(g) revised.

(g) Respiratory System.—Particular effort shall be made to detect tuberculosis or other chronic diseases of the lungs. The examination must include a review of the medical history, a 14 x 17-inch chest X-ray, and a tuberculin test done in accordance with article 15-91. A positive tuberculin reaction (induration over 5 mm.) shall cause for further study before the candidate is accepted for submarine duty. Submarine candidates are required to complete buoyant submarine escape training. In the course of this training any impairment of pulmonary ventilation is likely to produce traumatic air embolism. In view of this, candidates with chronic inflammatory diseases of the lungs and ventilatory impairment cannot be accepted. Chronic inflammatory diseases are considered disqualifying in any case where activity can be definitely demonstrated or reasonably assumed; for example, in tuberculosis, histoplasmosis, coccidiosis, sarcoidosis, bronchiectasis, or abscess. Those candidates who can be reasonably presumed to have ventilatory impairment must be disqualified; for example, in perennial bronchial asthma, pulmonary interstitial fibrosis, extensive parenchymal scarring or calcification, emphysema, cystic disease, fixation of the bony thorax or deformity thereof (severe pectus excavatum, Still's disease), history of extensive thoracic surgical procedures, spontaneous pneumothorax (within past 5 years), or extensive pleural scarring.

15-29(1)—In line 8 "when available" inserted following "and" so that the phrase reads "and, when available, the blood type and Rh factor."*

20-11(3) deleted.

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23-215 Items added as follows:

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<td>Certificate of Internship</td>
<td>Issued by the Bureau upon satisfactory completion of intern training</td>
<td>Provided by the Bureau to naval hospitals approved for medical intern training.</td>
</tr>
<tr>
<td>1340*</td>
<td>Certificate for Dental Officer Training.</td>
<td>Issued by the Bureau upon satisfactory completion of a postgraduate course in dentistry.</td>
<td>Provided by the Bureau to dental activities conducting postgraduate training for dental officers.</td>
</tr>
<tr>
<td>1362*</td>
<td>Certificate of Residency</td>
<td>Certificate of satisfactory completion of dental residency training.</td>
<td>Provided by the Bureau to activities approved for dental residency training.</td>
</tr>
<tr>
<td>1363*</td>
<td>Certificate of Internship</td>
<td>Certificate of satisfactory completion of dental intern training.</td>
<td>Provided by the Bureau to naval hospitals approved for dental intern training.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau
ADVANCE CHANGE 12-1

23-215 items added as follows—continued:

<table>
<thead>
<tr>
<th>NAVED No</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
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<tbody>
<tr>
<td>1372*</td>
<td>Certificate of Merit</td>
<td>Issued by the Bureau when it has been determined that the individual is entitled to upon retirement.</td>
<td>Self-explanatory.</td>
</tr>
<tr>
<td>1372*</td>
<td>Certificate of Exceptional Service.</td>
<td>Issued by the Bureau when it has been determined that the individual is entitled to.</td>
<td>Self-explanatory.</td>
</tr>
<tr>
<td>1399*</td>
<td>Certificate of Residency</td>
<td>Issued by the Bureau to U.S. Navy Medical Corps personnel upon satisfactory completion of residency training.</td>
<td>Provided by the Bureau to U.S. naval hospitals approved for residency training.</td>
</tr>
<tr>
<td>1399*</td>
<td>Certificate of Residency (Medical Corps), U.S. Military Medical Corps Other Than Navy.</td>
<td>Issued by the Bureau to U.S. military Medical Corps personnel, other than Navy, upon satisfactory completion of residency training in naval hospitals.</td>
<td>Provided by the Bureau to naval hospitals approved for residency training of non-Navy military medical personnel.</td>
</tr>
<tr>
<td>1427*</td>
<td>Register of Medical Equipment Development Projects (register sheet).</td>
<td>Maintain DOD Register of Medical Equipment Development Projects being accomplished and/or considered by the military services.</td>
<td>Armed Services Medical Material Coordination Committee.</td>
</tr>
<tr>
<td>1428*</td>
<td>Medical Equipment Development Projects.</td>
<td>To provide data as to projects established, proposed, and terminated for inclusion in DOD Register.</td>
<td>Do.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau.

23-303(6)(d) item 616.1a revised.

<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>616-</td>
<td>X-rays, medical:</td>
<td></td>
</tr>
<tr>
<td>* * *</td>
<td>1. Navy personnel:</td>
<td>a. Transfer all X-rays to Navy Branch, Military Personnel Records Center, St. Louis, Mo., as soon as local purposes are served. (Navy and Marine Corps recruiting stations shall immediately forward entrance X-rays of personnel with the SF 86 and 89 to the appropriate training center or other first duty station. The first duty station shall forward the X-rays to St. Louis as soon as local purposes are served.)</td>
</tr>
</tbody>
</table>
MANUAL OF THE MEDICAL DEPARTMENT

ADVANCE CHANGE 11-1

The changes listed herein are effective upon receipt. Insert this change in front of the Manual of the Medical Department, and mark "11-1" opposite the below-listed articles and subarticles in the Manual text. The symbol "11-1" indicates that this is the first advance change issued in advance of Page Change ll.

E. C. KENNEY
Chief of Bureau

Summary of Articles and Subarticles Affected

<table>
<thead>
<tr>
<th>Chapter 9</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-1-13</td>
<td>23-217, DD 1322</td>
</tr>
<tr>
<td>11-12A(3)</td>
<td>23-217, DD 1323</td>
</tr>
<tr>
<td>11-12A(4)</td>
<td>Chapter 23, Section VIII</td>
</tr>
<tr>
<td>17-5</td>
<td>23-310-314</td>
</tr>
</tbody>
</table>

Chapter 9 revised.

Chapter 9

THE HOSPITAL CORPS

Sections

I. Structure of the Hospital Corps

II. Hospital Corpsmen, Group X Medical

Article

9-1. Establishment

(1) The Hospital Corps as it is now known was established within the Medical Department of the Navy by the act of 17 June 1898 (ch. 463, sec. 1, 30 Stat. 474).

9-2. Strength

(1) The strength of the Hospital Corps is determined by the Chief of Naval Personnel, within personnel allocations authorized by the Chief of Naval Operations. It is limited to an equitable share of the appropriated strength of the Navy and Marine Corps as a whole as authorized by Congress.

9-3. Rating Structure

(2) Female, WAVV, personnel constitute approximately 5 percent of the total strength of the Hospital Corps.

(3) Hospital corpsmen constitute 89 percent of the Hospital Corps strength, and dental technicians 11 percent.

9-5. Narrow Enlisted Classification Structure

See chapter 6 (section VIII) for Dental Technicians, Group XI Dental.
established two rating groups within the Hospital Corps of the Navy: Group X Medical and Group XI Dental.

(2) Group X Medical constitutes the general service hospital corpsman rating groups, including the allied medical apprentice rates. The hospital corpsman and allied apprentice rates are as follows:

<table>
<thead>
<tr>
<th>Rate</th>
<th>Rate abbreviation</th>
<th>Pay grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital recruit</td>
<td>HR</td>
<td>E-1</td>
</tr>
<tr>
<td>Hospital apprentice</td>
<td>HA</td>
<td>E-2</td>
</tr>
<tr>
<td>Hospitalman</td>
<td>HH</td>
<td>E-3</td>
</tr>
<tr>
<td>Hospital corpsman, third class</td>
<td>HM3</td>
<td>E-4</td>
</tr>
<tr>
<td>Hospital corpsman, second class</td>
<td>HM2</td>
<td>E-5</td>
</tr>
<tr>
<td>Hospital corpsman, first class</td>
<td>HM1</td>
<td>E-6</td>
</tr>
<tr>
<td>Chief hospital corpsman</td>
<td>HMCS</td>
<td>E-7</td>
</tr>
<tr>
<td>Senior chief hospital corpsman</td>
<td>HMCM</td>
<td>E-9</td>
</tr>
</tbody>
</table>

(3) Group XI Dental constitutes the general service dental technicians rating group, including the allied dental apprentice rates. The dental technicians and allied apprentice rates are as follows:

<table>
<thead>
<tr>
<th>Rate</th>
<th>Rate abbreviation</th>
<th>Pay grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental recruit</td>
<td>DR</td>
<td>E-1</td>
</tr>
<tr>
<td>Dental apprentice</td>
<td>DA</td>
<td>E-2</td>
</tr>
<tr>
<td>Dentalman</td>
<td>DT</td>
<td>E-3</td>
</tr>
<tr>
<td>Dental technician, third class</td>
<td>DT3</td>
<td>E-4</td>
</tr>
<tr>
<td>Dental technician, second class</td>
<td>DT2</td>
<td>E-5</td>
</tr>
<tr>
<td>Dental technician, first class</td>
<td>DT1</td>
<td>E-6</td>
</tr>
<tr>
<td>Chief dental technician</td>
<td>DTCS</td>
<td>E-7</td>
</tr>
<tr>
<td>Senior chief dental technician</td>
<td>DTCM</td>
<td>E-9</td>
</tr>
</tbody>
</table>

9-4. Navy Enlisted Classification Structure

(1) Navy enlisted classification (NEC) codes identify both personnel and requirements. They are used to supplement rates by identifying special skills not identifiable by rates or rating alone. Hospital corpsman rates are supplemented by NEC's in the HN-6400 series, and dental technician rates by codes in the DT-8700 series. When an NEC has been assigned it becomes an integral part of the rate and shall be so recorded in all personnel records and correspondence.

(2) There is no priority list of NEC's within the HN-6400 and DT-8700 series. An NEC code is primary or secondary solely in relation to the individual to which assigned. An NEC code that is primary for one person may be secondary for another person. Not more than two NEC codes may be assigned to one person.

(3) The Chief, Bureau of Medicine and Surgery, through delegated authority, controls assignment of NEC codes in the HN-6400 and DT-8700 series. The commanding officers of Hospital Corps schools and activities having established courses are authorized to assign the appropriate NEC code to graduates. Once assigned, an NEC code in the HN-6400 or DT-8700 series may not be revoked or changed without specific authority from the Chief, Bureau of Medicine and Surgery.

(4) Rate and NEC job requirements for each command are determined by the Chief of Naval Personnel and published in the Manpower Authorization, NAVPER 956. Commanding officers should request modification of their Manpower Authorization when necessary to reflect their actual NEC job requirements. Training requirements for technicians are determined from the job requirements as written into Manpower Authorizations.

Section II. HOSPITAL CORPSMAN, GROUP X MEDICAL

Article

9-5. Qualifications

(1) Applicants for the hospital corpsman rating should be volunteers, motivated for duties involving care of the sick and injured, show aptitude for and be temperamentally adapted for such duty, and have General Classification Test scores and educational background necessary to progress in the hospital corpsman rating. Although rigid educational qualifications have not been established, it is desirable that applicants be high school graduates; however, applicants without high school graduation who are voluntarily motivated and have mental capacity to learn may be accepted. Applicants should be evaluated by a Classification Interviewer, PN-2612, or by an officer of the Medical Department. Applicants showing evidence of unusual immaturity, emotional instability, or low moral character should be rejected regardless of other qualifications.

9-6. Procurement

(1) Candidates for hospital corpsmen are procured from volunteers enlisted directly into the Hospital Corps rating as hospital recruits; volunteers undergoing recruit training selected by Classification Interviewers, PN-2612; volunteer applicants or "strikers"; and volunteers transferring from the United States Marine Corps.
Hospital recruits are high school or junior college graduates who, by agreement at the time of enlistment, are guaranteed training in a class A school.

"Strikers" are enlisted men who have completed recruit training, are serving in apprentice ratings, and request transfer to the Hospital Corps after a period of observation in the medical departments of activities ashore or afloat.

Under regulations prescribed by the Secretary of the Navy, enlisted members of the Marine Corps are eligible for transfer to the Hospital Corps of the Navy, and enlisted members of the Hospital Corps are eligible for transfer to the Marine Corps (10 USC 6061).

Hospital corpsmen may be assigned to any unit or activity of the Naval Establishment where their services are required. They shall be assigned to the medical departments of the ship or station to which attached. Under terms of the Geneva Conventions, hospital corpsmen may not be assigned to tanks or a combat nature. WAVES hospital corpsmen may be assigned to the major distribution commands of the Shore Establishment, to fleet activities shore-based in the United States, to overseas in selected locations where suitable quarters are available for women, and to a few billets afloat on dependent-carrying vessels of the Military Sea Transportation Service. Information relative to duty assignments of hospital corpsmen is contained in the Enlisted Transfer Manual, NAVMED 1909.

Technicians should be assigned to commands having the same NMC requirements written into their enlisted manpower authorization.

Hospital corpsmen are prescribed by the Surgeon General as set forth in this Manual and BUMED directives. Detailed duties on any specific ship or station are prescribed by the commanding officer, the senior medical officer, or other competent authority. In addition to the military duties common to all enlisted personnel, hospital corpsmen shall perform medical department functions of the ship or station to which attached. These medical department functions embrace the broad fields of preventive medicine; first aid; tentative diagnosis and emergency treatment; diagnosis, nursing care, and definitive treatment; and the administrative procedures relative thereto. These duties are performed under the supervision of Medical Department officers except when serving on independent duty.

Qualified petty officers in the hospital corpsman rating perform all duties of the medical department on small vessels and shore stations to which no medical officer is attached. All chief hospital corpsmen and hospital corpsmen, first class, are considered qualified for independent duty unless evidence to the contrary is at hand in the individual case. When no personnel in these ratings are available, hospital corpsman, second class, who have completed courses of instruction in advanced Hospital Corps school, may be assigned to independent duty. Hospital corpsmen on independent duty are responsible to their commanding officers for the sanitation of the command; the health of personnel; care of the sick and injured; procurement, storage, and custody of medical department property; and preparation of medical reports and Health Records. They perform the administrative duties and, to the extent for which qualified, the professional duties prescribed for medical officers of ships and stations. They shall not attempt or be required to perform medical duties for which they are not professionally qualified. When it is necessary to perform physical examinations, sign original entries in Health Records, and undertake other professional and administrative duties normally performed by medical officers, hospital corpsmen shall perform these duties only when a medical officer is not available.

Specific duty assignments should be rotated to provide diversified training and job experience. However, this rotation should be planned on an individual rather than a routine basis, thus considering the varying degrees of individual adaptability as well as job and training requirements. A careful balance must be maintained between the advantages of increased job efficiency resulting from permanency of personnel and training advantages derived from rotation. Too rapid rotation nullifies both advantages. Ward corpsmen can advantageously be rotated from a.m. to 4 p.m. to night duty on the same ward or nursing service, thereby achieving equitable rotation without sacrificing job continuity.

Hospital corpsmen should not perform night duty periods in excess of 1 month and should not be assigned night duty more often than 1 month out of 3. In tropical climates particularly and elsewhere when feasible, tour of night duty should be of 2 or 3 week's duration. Hospital corpsmen should be granted 48 hours' liberty immediately preceding and subsequent to a tour of night duty.

Duties of Hospital Corpsmen

(1) The general duties of hospital corpsmen are prescribed by the Surgeon General as set forth in this Manual and BUMED directives. Detailed duties on any specific ship or station are prescribed by the commanding officer, the senior medical officer, or other competent authority. In addition to the military duties common to all enlisted personnel, hospital corpsmen shall perform medical department functions of the ship or station to which attached. These medical department functions embrace the broad fields of preventive medicine; first aid; tentative diagnosis and emergency treatment; diagnosis, nursing care, and definitive treatment; and the administrative procedures relative thereto. These duties are performed under the supervision of Medical Department officers except when serving on independent duty.

(2) Qualified petty officers in the hospital corpsman rating perform all duties of the medical department on small vessels and shore stations to which no medical officer is attached. All chief hospital corpsmen and hospital corpsmen, first class, are considered qualified for independent duty unless evidence to the contrary is at hand in the individual case. When no personnel in these ratings are available, hospital corpsman, second class, who have completed courses of instruction in advanced Hospital Corps school, may be assigned to independent duty. Hospital corpsmen on independent duty are responsible to their commanding officers for the sanitation of the command; the health of personnel; care of the sick and injured; procurement, storage, and custody of medical department property; and preparation of medical reports and Health Records. They perform the administrative duties and, to the extent for which qualified, the professional duties prescribed for medical officers of ships and stations. They shall not attempt or be required to perform medical duties for which they are not professionally qualified. When it is necessary to perform physical examinations, sign original entries in Health Records, and undertake other professional and administrative duties normally performed by medical officers, hospital corpsmen shall perform these duties only when a medical officer is not available.

Specific duty assignments should be rotated to provide diversified training and job experience. However, this rotation should be planned on an individual rather than a routine basis, thus considering the varying degrees of individual adaptability as well as job and training requirements. A careful balance must be maintained between the advantages of increased job efficiency resulting from permanency of personnel and training advantages derived from rotation. Too rapid rotation nullifies both advantages. Ward corpsmen can advantageously be rotated from a.m. to 4 p.m. to night duty on the same ward or nursing service, thereby achieving equitable rotation without sacrificing job continuity.

Hospital corpsmen should not perform night duty periods in excess of 1 month and should not be assigned night duty more often than 1 month out of 3. In tropical climates particularly and elsewhere when feasible, tour of night duty should be of 2 or 3 week's duration. Hospital corpsmen should be granted 48 hours' liberty immediately preceding and subsequent to a tour of night duty.

Duties of the Hospital Corpsman Rates

(1) Hospital Recruit (HR).—Hospital recruits are new enlistees in the Hospital Corps. Upon completion of recruit training their rate is changed to hospital apprentice and they are assigned duty under instruction at a class A Hospital Corps school.

(2) Hospital Apprentice (HA).—After graduation from Hospital Corps school, hospital apprentices shall be assigned duties directly related to patient care at naval hospitals, station hospitals, larger shore activities, or large ships. They should be assigned to wards for duty and on-the-job training in elementary nursing procedures.

(3) Hospitalman (HM).—Hospitalmen should be assigned to wards or other clinical services for duty and on-the-job training in the more advanced nursing procedures, or for duty and on-the-job training in elementary clinic procedures.

(4) Hospitalman, Third Class (HN).—Hospitalmen, third class, are normally assigned to wards, clinical services, or administrative units; for duty as senior ward corpsman; for duty and on-the-job training in the more advanced
(5) Hospital Corpsman, Second Class (HM2).—Hospital corpsman, second class, are normally assigned duty as senior ward corpsman, or duty in clinics or administrative units and further on-the-job training.

(6) Hospital Corpsman, First Class (HM1).—Hospital corpsman, first class, are normally assigned supervisory duty on wards, as assistants to the chief of a clinical service, or as petty officer in charge of an administrative unit.

(7) Chief Hospital Corpsman (HC).—Chief hospital corpsmen are normally assigned supervisory duties as senior assistant to the chief of a clinical service, or as chief petty officer in charge of an administrative section, or as the assistant to the chief of an administrative division.

(8) Senior Chief Hospital Corpsman (HCMS).—Senior chief hospital corpsmen are normally assigned as senior assistant to a chief of service or division or as senior petty officer in charge of an administrative branch.

(9) Master Chief Hospital Corpsman (HCMC).—Master chief hospital corpsmen are normally assigned in billets requiring qualifications at the highest enlisted level in duties requiring top leadership, supervisory and training skill, and professional qualifications.

9-10. Utilization

(1) Utilization of hospital corpsmen shall be in accordance with the following guide which should be deviated from only to the extent necessary to effect maximum efficiency of the command as a whole:

(a) The maximum number of hospital corpsmen consistent with the overall needs of the activity shall be assigned to wards and clinical services. WAVS hospital corpsman shall be utilized in billets involving direct and indirect contact with female patients to the maximum extent feasible.

(b) The requirement for assigning qualified personnel to patient care is paramount; therefore, all hospital corpsman performing duties in the nursing service shall be assigned en bloc to the nursing service.

(c) Ward corpsmen should be assigned to three section watches. Watches should be equitable for all in the same rate with progressively fewer watches with each advancement in rating.

(d) Within reasonable limits, the average work hours shall be the same for all corpsmen, regardless of rate. The average workweek should be no more strenuous than necessary to insure high quality of patient care.

(e) Trained petty officers should be utilized in patient care functions to the maximum extent feasible.

(f) Hospital corpsmen should be rotated to various duties within the command to the minimum extent necessary for training purposes in order to achieve maximum efficiency resulting from permanency of personnel.

(g) Hospital corpsmen who cannot perform effectively under proper supervision on ward duty or other professional services should be recommended for administrative discharge or change in rating as appropriate, rather than reassigning them to nonpatient care functions.

(2) Hospital corpsmen should not be considered eligible for reassignment from patient care to nonpatient care functions solely because they have completed a given number of months on ward duty.

(4) Hospital corpsmen shall be rotated to various duties within the command to the extent necessary to prepare them for advancement in rating as appropriate, rather than reassigning them to nonpatient care functions.

9-11. Training

(1) The Chief of the Bureau of Medicine and Surgery is responsible for the professional training of personnel of the Hospital Corps. To discharge this responsibility, basic and advanced Hospital Corps schools have been established and technical training courses instituted in naval hospitals and other naval medical facilities. Training consists of formal schools and courses, on-the-job training, instruction training, and outservice training. Upon successful completion of a course of instruction appropriate entries shall be made in service records, training certificates issued, and Navy Enlisted Classification codes assigned. Detailed training information is contained in Instructed in the I000 and 1510 series.

(2) Basic Hospital Corps Schools, Class A.—The mission of the basic Hospital Corps schools, class A, is to instruct and train enlisted personnel in the basic subjects and procedures required to qualify them for duties as general service hospital corpsman. The curriculum is designed to prepare enlisted personnel to perform the general duties normally required of hospital corpsmen in the first 4 years of their naval service. The curriculum emphasizes direct patient care. This school, together with inservice training, prepares hospital corpsmen for advancement in rating through hospital corpsman, third class. It is mandatory for all personnel upon first entering the Hospital Corps, except that waiver of this requirement may be requested from the Bureau of Medicine and Surgery for individuals considered qualified as a result of civilian training. Certificates of graduation from basic Hospital Corps schools are issued to graduates, but graduates are not assigned an NEC.

(3) Advanced Hospital Corps School, Class B.—The mission of advanced Hospital Corps school, class B, is to give advanced training to petty officers of the Hospital Corps to prepare them for duty as senior general service hospital corpsman and for duty independent of a medical officer. The curriculum emphasizes first aid, tentative diagnosis and emergency treatment of disease and injury, personal hygiene and environmental sanitation, and medical department administration. Students are normally enrolled in this school at the time of
see/shore or shore/sea rotation. The maximum possible number of career hospital corpsmen are trained in this school prior to assignment to independent duty. Certificates of graduation from advanced Hospital Corps schools are issued and graduates are assigned the NEC HM-8405.

(4) Technical Training Courses, Class C.—The purpose of technicians courses is to train selected hospital corpsmen at the appropriate time in their naval careers to perform duties as technical assistants in specialized fields including diagnostic procedures, specialized treatment, preventive medicine, submarine medicine, medical research, and medical department administration. Courses are 16 to 50 weeks in duration and are continuously under review to meet changing medical department requirements. Students are selected by the Bureau of Medicine and Surgery on a competitive basis from among qualified volunteers. Normally, hospital corpsmen are not selected for training in more than one technical specialty; however, waivers of this factor may be requested. Normally, candidates for advanced Hospital Corps school, class B, and for Medical Administration Technician training are selected without regard for Navy Enlisted Classifications previously assigned. The course in Medical Field Technic is mandatory at the time of first assignment to duty with the Fleet Marine Force and requests for this training are not desired. Requests for other technical training are desired from hospital corpsmen serving ashore or afloat. To the extent feasible, selected candidates are ordered to duty under instruction as technicians at the time of sea/shore or shore/sea rotation. The manual of Navy Enlisted Classifications, NAVPERS 15105 (series), lists the broad duties of technicians and code numbers assigned to each. Detailed information relative to submission of applications for training, school and course locations, and convening date and qualifications are contained in Instructions in the 1510 series. Certificates of Special Instruction are issued and graduates are assigned an appropriate NEC.

(5) Inservice Training.—The purpose of inservice training is to provide a continuing, organized training program at each duty station to supplement the formal training received in Hospital Corps schools. This program is designed to broaden knowledge and skills, to keep hospital corpsmen abreast of the rapid advances in medical procedures, to provide well trained hospital corpsmen for duty of their rate, and to qualify them for advancement in rating. Instruction shall be continuous and progressive and shall cover subjects outlined in the appropriate training courses for advancement in rating. On-the-job training in the duties of general service hospital corpsmen shall be an integral part of the inservice training program. Instructors shall be officers of the medical department or petty officers instructing under their supervision.

(6) On-the-Job Training of Technicians.—On-the-job training of technicians is necessary to supplement the number graduated from schools and courses in order to meet local and total requirements. Naval hospitals and other naval medical facilities shall conduct on-the-job training of technicians to the extent feasible. When vacant technicians billets cannot be filled, it is incumbent upon the commanding officer to assign general service hospital corpsmen to the vacant billets and to institute on-the-job training to meet the needs of his own command. Technicians so trained shall be reported to the Bureau of Medicine and Surgery. Certificates of On-the-Job Training will be forwarded with the letter authorizing assignment of the appropriate NEC.

(7) Outsersice Training.—

(a) The Bureau encourages Medical Department personnel to take advantage of part-time outservice training in accredited civilian institutions and will authorize tuition aid, provided funds are available, for courses directly related to areas of Medical Department responsibility. Such areas are considered to be the physical, chemical, clinical, biological, and sociopsychology sciences and the fields of Medical Department administration.

(b) Consideration will also be given to requests for courses outside those areas if they can be shown to be a necessary part (required credits or prerequisites to desired courses) of a fully planned program leading to a degree or certificate which will enable the applicant to assume increased responsibility or to function more effectively toward accomplishing the mission of the Medical Department.

9-12c. Advancement in Rating

(1) To be eligible to compete in examinations for advancement in rating, hospital corpsmen must first fulfill service requirements, complete the prescribed training courses and practical factors, and be recommended by their commanding officer. Detailed information relative to advancement in rating is contained in the Bureau of Naval Personnel Manual, the Manual of Qualifications for Advancement in Rating (NAVPERS 16063), and NAVPERS Instructions in the 1400 series.

(2) Qualifications for advancement in rating include both military and professional requirements. The Manual of Qualifications for Advancement in Rating lists minimum qualifications. Examinations are prepared with the assumption that all candidates possess minimum qualifications. The purpose of the examination is to determine the candidates best qualified; therefore, examination questions are designed to be quite comprehensive for each rate. Examinations become broader in scope and more thorough with each advancement in rating. The Handbook of the Hospital Corps is the best single reference in preparing for advancement in rating; however, the appropriate Navy training courses are the best guides from which to determine the breadth and depth of knowledge expected of each rate. NAVPERS 16066B lists all reference documents necessary in preparation for the military and professional examinations for advancement in rating.

(3) Hospital corpsmen who are technicians take the same military and professional examinations as their contemporaries who are not technicians. For this reason and because technicians may be called upon at any time to perform the general duties of their rate including independent duty, technicians must maintain professional competence in the general duties of hospital corpsmen.
Chapter 23, section VIII revised.

CHAPTER 23. REPORTS, FORMS, AND RECORDS

Section VIII. RELEASE OF INFORMATION FROM RECORDS

By U.S. Naval Hospitals and U.S. Naval Dispensaries

17-8 deleted. (Now 23-314)

23-310. By U.S. Naval Hospitals and U.S. Naval Dispensaries

(1) The Surgeon General has been designated by the Secretary of the Navy as the official responsible for the execution of Department of Defense policies in releasing medical records of members or former members of the Navy, Marine Corps, or the Reserve components thereof and for determining the extent of and the form in which medical information will be furnished.

(2) Commanding officers of the U.S. naval hospitals and U.S. naval dispensaries (only those designated as separate field command activities) are authorized to release information from medical records physically located within the command in accordance with the provisions of this article and articles 23-312 and 313. The requesting office or individual shall be advised that such information is considered to be of a private and confidential nature and directed to treat it accordingly. Only that information will be furnished which is necessary to the accomplishment of the legitimate purpose for which the information is required. Service, employment, pay, or medical records of personnel of the Navy, civilian employees, and others may be produced in Federal, State, or territorial courts including local courts upon order of the court, and in accordance with appropriate regulations subject to current restrictions on release of classified information and subject to the exception noted in subarticle 23-310(6) with respect to release of information concerning civilian employees. When certified copies of records are produced, they shall be forwarded direct to the clerk of the court issuing the order.

(3) The information necessary to the accomplishment of the legitimate purpose for which required and, if so required, a complete transcript of the member's or former member's medical record may be furnished upon request to the following:

(a) Department of the Treasury.
(b) Department of the Army.
(c) Department of Justice.
(d) The Post Office Department.
When the insane or is dead. Next of kin shall be furnished adequate proof of death of the member or former member in cases where proof of death is not on file.

A representative, other than a physician or legal representative, specifically authorized in writing by the individual whose records are involved, who is to perform a service for such individual. The next of kin may likewise authorize a representative, where the member or former member is insane or dead. The purpose for which the information is to be used and the nature of the service to be performed must be furnished.

Requests from others than those listed above shall be forwarded to the Bureau accompanied by a copy of the information requested. The requesting party shall be promptly notified of the forwarding of the request without being furnished a copy of the information requested.

Commanding officers of naval hospitals are authorized to release information from medical records physically located within the command to members of their staff who are conducting research projects and to military research projects. All other requests from research groups will be forwarded to the Bureau for appropriate action.

Nothing in this article is intended to preclude the release of appropriate information concerning the current health and welfare of the individuals in the armed services, or vital statistical data, including proof of death, concerning such personnel, nor to preclude compliance with court orders calling for the production of medical records in connection with litigation or criminal prosecutions, nor to preclude release of information from medical records when required by law. For further information concerning proof of death, refer to subarticle 23-314(3).

Release of medical reports or information concerning civilian appointees or employees is controlled by the following provision of Navy Civilian Personnel Instruction 290.5-7R:

"b. Disclosure of medical information. Copies of medical certificates may be requested by the prospective appointee or employee himself, by other Federal agencies, or by agencies or individuals (such as corporations, State governmental organizations, or private individuals) who are not concerned in the original action. Courts or State law departments may ask for the presentation of medical certificates. These requests should be handled as prescribed below:

"(1) Whenever possible, an appointing officer shall refer to the Civil Service Commission (central or regional office) any requests he receives for medical certificates and for information from medical certificates and other medical reports retained by the activity. The medical certificate or other medical reports concerned should accompany the referral. The Civil Service Commission decides when and to what extent to comply with requests."

Attention is invited to articles 1250 through 1252 and 1509 through 1510, U.S. Navy Regulations 1948, and sections 0716 and 0727, chapter 7.
ADVANCE CHANGE 11-1

VII, Naval Supplement to the Manual for Courts-Martial, United States, for additional information concerning the release of information from naval medical records.

23-311. By Medical Activities Other Than Hospitals and U.S. Naval Dispensaries

(1) When approved by the commanding officer, medical officers may complete blank forms or furnish certificates for persons in the Naval Establishment, except death reports, which are submitted by insurance companies and beneficial organizations and societies, but only upon the request of the individual concerned or his legal representative.

(2) Medical officers are authorized to furnish any individual in the naval service a copy of his Health Record, upon his signed request, except information contained therein which would prove injurious to his physical or mental health.

(3) All other requests for information from the medical records of members or former members of the naval service shall be forwarded to the Bureau accompanied by a copy of the information requested. The requesting party shall be promptly notified of the forwarding of the request without being furnished a copy of the information requested.

23-312. Records of Supernumeraries

(1) Requests for information from the medical records of supernumeraries hospitalized or treated at naval activities as beneficiaries of other Federal agencies should be referred to the agency under whose cognizance hospitalization was effected.

(2) Requests for information from the medical records of supernumerary patients of the Navy who were not beneficiaries of other Federal agencies shall be treated in the same manner as is prescribed for information from the medical records of members or former members of the naval service. (See arts. 23-310 and 23-311.)

23-313. Show of Authority

(1) Prior to the furnishing of information noted in articles 23-310 through 23-312, a proper show of authority must be established in regard to each request. The application may be made in person or in writing.

23-314. Death Forms for Civilian Agencies and Individuals

(1) All requests received from next of kin, relatives, insurance agencies, companies, fraternal organizations, etc., for completion of blank forms relative to death of either naval, military, or civilian personnel in naval medical activities, except in Veterans' Administration cases, shall be forwarded to the Bureau for action.

(2) Requests for completion of such forms in cases of beneficiaries of the Veterans' Administration will be forwarded to the Manager of the Veterans' Administration Regional Office authorizing the admission of the patient.

(3) Nothing in this article is intended to preclude furnishing information essential to proof of death. Such information shall be limited to identification of decedent and time, date, place, and cause of death.
To: Holders of the Manual of the Medical Department

1. Material Included in Change. This page change incorporates Advance Change 11-1, a revised chapter 6, and modifications to articles 1-3(4); 1-6; 1-7(2) and (4); 1-12(2), (11), (17), and (18)(f); and 15-30(1)(f).

2. Action To Be Taken

   a. Remove Advance Change 11-1.

   b. Insert the attached pages in their proper place in the Manual and remove the old pages of the same number. Also remove old pages 6-40a and b, 6-65, and 13 of the index, for which there are no replacement pages.

   c. Record this Page Change 11 in the Record of Page Changes.

   d. Verify completeness of the Manual by using the enclosed Check List of Pages in Effect.

E. C. Kenney
Chief, Bureau of Medicine and Surgery
Department of the Navy
Washington 25, D.C.
TABLE OF CONTENTS

**Chapter 1—The Medical Department**

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Functions of the Medical Department</td>
<td>1-1 through 1-4</td>
</tr>
<tr>
<td>II. Organization of the Medical Department</td>
<td>1-5 through 1-11</td>
</tr>
<tr>
<td>III. Organization of the Bureau of Medicine and Surgery</td>
<td>1-12</td>
</tr>
<tr>
<td>IV. Research</td>
<td>1-13 through 1-19</td>
</tr>
<tr>
<td>V. Nomenclature and Definitions for Medical Treatment Facilities</td>
<td>1-20 through 1-23</td>
</tr>
<tr>
<td>VI. General</td>
<td>1-24</td>
</tr>
</tbody>
</table>

**Chapter 2—Medical Corps: Organization, Appointments, and Advancement in Grade**

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Organization</td>
<td>2-1 through 2-2</td>
</tr>
<tr>
<td>II. Appointments</td>
<td>2-3 through 2-5</td>
</tr>
<tr>
<td>III. Advancement in Grade</td>
<td>2-6 through 2-8</td>
</tr>
</tbody>
</table>

**Chapter 3—General Duties of Medical Corps Officers**

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The Medical Officer and His Duties</td>
<td>3-1 through 3-15</td>
</tr>
<tr>
<td>II. Assistant Medical Officers</td>
<td>3-16 through 3-17</td>
</tr>
<tr>
<td>III. General Duties of All Medical Corps Officers</td>
<td>3-18 through 3-30</td>
</tr>
<tr>
<td>IV. Duties With Regard to Narcotics, Alcohol, Alcoholic Beverages, and Dangerous and Habit-Forming Drugs</td>
<td>3-31 through 3-36</td>
</tr>
</tbody>
</table>

**Chapter 4—Duties of Medical Officers Afloat**

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Fleet, Force, and Division Medical Officers</td>
<td>4-1 through 4-11</td>
</tr>
<tr>
<td>II. The Medical Officer of a Ship</td>
<td>4-12 through 4-19</td>
</tr>
<tr>
<td>III. Medical Department Duties in Emergencies</td>
<td>4-20 through 4-45</td>
</tr>
</tbody>
</table>

**Chapter 5—Duties of Medical Officers Ashore**

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Duties of the Inspector Naval Medical Activities</td>
<td>5-1 through 5-3</td>
</tr>
<tr>
<td>II. Duties of the District Medical Officer</td>
<td>5-3 through 5-5</td>
</tr>
<tr>
<td>III. The Medical Officer of a Shore Station</td>
<td>5-6 through 5-17</td>
</tr>
<tr>
<td>IV. Medical Inspection of Naval Activities</td>
<td>5-18 through 5-23</td>
</tr>
<tr>
<td>V. Civilian Physicians</td>
<td>5-24 through 5-29</td>
</tr>
</tbody>
</table>

**Chapter 6—Dental Corps**

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Function, Organization, and Responsibility</td>
<td>6-1 through 6-2</td>
</tr>
<tr>
<td>II. Dental Division, Bureau of Medicine and Surgery</td>
<td>6-3 through 6-12</td>
</tr>
<tr>
<td>III. Dental Corps</td>
<td>6-13 through 6-21</td>
</tr>
<tr>
<td>IV. General Duties of Dental Officers</td>
<td>6-22 through 6-36</td>
</tr>
<tr>
<td>V. Dental Officers Afloat</td>
<td>6-37 through 6-44</td>
</tr>
<tr>
<td>VI. Dental Officers Ashore</td>
<td>6-46 through 6-58</td>
</tr>
<tr>
<td>VII. Dental Officers With the Marine Corps</td>
<td>6-59 through 6-82</td>
</tr>
<tr>
<td>VIII. Dental Technicians</td>
<td>6-63 through 6-83</td>
</tr>
<tr>
<td>IX. Dental Service Warrant Officers, Medical Service Corps Officers, and Nurse Corps Officers in Dental Facilities</td>
<td>6-69 through 6-73</td>
</tr>
<tr>
<td>X. Civilian Employees in Dental Facilities</td>
<td>6-74</td>
</tr>
<tr>
<td>XI. Naval Dental Clinics</td>
<td>6-75 through 6-81</td>
</tr>
<tr>
<td>XII. Fleet Marine Force Dental Companies</td>
<td>6-82 through 6-85</td>
</tr>
<tr>
<td>XIII. Dental Standards</td>
<td>6-86 through 6-97</td>
</tr>
<tr>
<td>XIV. Dental Examination and Treatment</td>
<td>6-98 through 6-106</td>
</tr>
</tbody>
</table>

*Change 11*
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Section</th>
<th>Title</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>6—Dental Corps—Continued</td>
<td>XV.</td>
<td>The Dental Record and Other Standard Forms</td>
<td>6-107 through 6-121</td>
</tr>
<tr>
<td></td>
<td>XVI.</td>
<td>Dental Officer Training</td>
<td>6-122 through 6-132</td>
</tr>
<tr>
<td></td>
<td>XVII.</td>
<td>Dental Research</td>
<td>6-133 through 6-134F</td>
</tr>
<tr>
<td></td>
<td>XVIII.</td>
<td>U.S. Naval Dental School</td>
<td>6-135 through 6-139</td>
</tr>
<tr>
<td></td>
<td>XIX.</td>
<td>U.S. Naval Dental Technicians Schools</td>
<td>6-139 through 6-144</td>
</tr>
<tr>
<td></td>
<td>XX.</td>
<td>Publications and Files in Dental Facilities</td>
<td>6-145 through 6-147</td>
</tr>
<tr>
<td></td>
<td>XXI.</td>
<td>Reports, Records, and Correspondence</td>
<td>6-148 through 6-158</td>
</tr>
<tr>
<td></td>
<td>XXII.</td>
<td>Dental Supplies and Equipment</td>
<td>6-160 through 6-174</td>
</tr>
<tr>
<td></td>
<td>XXIII.</td>
<td>Dental Fiscal Matters</td>
<td>6-175 through 6-177</td>
</tr>
<tr>
<td></td>
<td>XXIV.</td>
<td>Planning Dental Facilities</td>
<td>6-178 through 6-192</td>
</tr>
<tr>
<td></td>
<td>XXV.</td>
<td>Survey of Dental Activities and Facilities</td>
<td>6-193 through 6-197</td>
</tr>
<tr>
<td></td>
<td>XXVI.</td>
<td>Dental Corps of the Naval Reserve</td>
<td>6-198 through 6-209</td>
</tr>
<tr>
<td>7—Medical Service Corps</td>
<td>I.</td>
<td>Establishment</td>
<td>7-1 through 7-4</td>
</tr>
<tr>
<td></td>
<td>II.</td>
<td>Appointments</td>
<td>7-5 through 7-13</td>
</tr>
<tr>
<td></td>
<td>III.</td>
<td>Advancement in Grade</td>
<td>7-19 through 7-21</td>
</tr>
<tr>
<td></td>
<td>IV.</td>
<td>Duties</td>
<td>7-27 through 7-30</td>
</tr>
<tr>
<td>8—The Nurse Corps</td>
<td>I.</td>
<td>Organization</td>
<td>8-1 through 8-5</td>
</tr>
<tr>
<td></td>
<td>II.</td>
<td>Appointment and Training</td>
<td>8-6 through 8-7</td>
</tr>
<tr>
<td></td>
<td>III.</td>
<td>Promotion</td>
<td>8-8 through 8-9</td>
</tr>
<tr>
<td></td>
<td>IV.</td>
<td>Duties</td>
<td>8-10 through 8-14</td>
</tr>
<tr>
<td>9—The Hospital Corps</td>
<td>I.</td>
<td>Structure of the Hospital Corps</td>
<td>9-1 through 9-4</td>
</tr>
<tr>
<td></td>
<td>II.</td>
<td>Hospital Corpsmen, Group X Medical</td>
<td>9-5 through 9-13</td>
</tr>
<tr>
<td>10—Civilian Employees and Positions</td>
<td>I.</td>
<td>Civilian Employees</td>
<td>10-1 through 10-4</td>
</tr>
<tr>
<td></td>
<td>II.</td>
<td>Civilian Positions</td>
<td>10-5 through 10-6</td>
</tr>
<tr>
<td>11—Naval Hospitals</td>
<td>I.</td>
<td>Mission and Organization</td>
<td>11-1 through 11-5</td>
</tr>
<tr>
<td></td>
<td>II.</td>
<td>Office of the Commanding Officer</td>
<td>11-6 through 11-11</td>
</tr>
<tr>
<td></td>
<td>III.</td>
<td>Military and Administrative Functions</td>
<td>11-12 through 11-21</td>
</tr>
<tr>
<td></td>
<td>IV.</td>
<td>Professional Functions</td>
<td>11-22 through 11-30</td>
</tr>
<tr>
<td></td>
<td>V.</td>
<td>Hospital Ships</td>
<td>11-31 through 11-33</td>
</tr>
<tr>
<td>12—Special Hospitals and Special-Treatment Centers</td>
<td>I.</td>
<td>Special-Treatment Centers</td>
<td>12-1 through 12-4</td>
</tr>
<tr>
<td>13—Naval Medical Centers</td>
<td>I.</td>
<td>The National Naval Medical Center, Bethesda, Md</td>
<td>13-1 through 13-11</td>
</tr>
<tr>
<td></td>
<td>II.</td>
<td>U.S. Naval Aviation Medical Center, Pensacola, Fla</td>
<td>13-12 through 13-18</td>
</tr>
<tr>
<td>14—Special Activities</td>
<td>I.</td>
<td>Amphibious Operations and Field Service</td>
<td>14-1 through 14-2</td>
</tr>
<tr>
<td></td>
<td>II.</td>
<td>Aviation Service</td>
<td>14-3 through 14-9</td>
</tr>
<tr>
<td></td>
<td>III.</td>
<td>Submarine and Diving Services</td>
<td>14-10 through 14-17</td>
</tr>
<tr>
<td></td>
<td>IV.</td>
<td>Naval Advanced Base Organization</td>
<td>14-18 through 14-23</td>
</tr>
</tbody>
</table>
The Record of Page Changes shall be retained.
<table>
<thead>
<tr>
<th>Page change</th>
<th>Date of change</th>
<th>Date entered</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>27 August 1952</td>
<td>11 February 1958</td>
<td>Included in reprint</td>
</tr>
<tr>
<td>2</td>
<td>21 August 1953</td>
<td>11 February 1958</td>
<td>Included in reprint</td>
</tr>
<tr>
<td>3</td>
<td>10 November 1954</td>
<td>11 February 1958</td>
<td>Included in reprint</td>
</tr>
<tr>
<td>4</td>
<td>27 April 1956</td>
<td>11 February 1958</td>
<td>Included in reprint</td>
</tr>
<tr>
<td>5</td>
<td>18 January 1957</td>
<td>11 February 1958</td>
<td>Included in reprint</td>
</tr>
<tr>
<td>6</td>
<td>5 November 1957</td>
<td>11 February 1958</td>
<td>Included in reprint</td>
</tr>
</tbody>
</table>

Change 1
# RECORD OF PAGE CHANGES—Continued

**MANUAL OF THE MEDICAL DEPARTMENT**

<table>
<thead>
<tr>
<th>Page change</th>
<th>Date of change</th>
<th>Date entered</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Change 1*
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Medical Department</td>
<td>I. Functions of the Medical Department</td>
<td>1–1 through 1–4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>II. Organization of the Medical Department</td>
<td>1–5 through 1–11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>III. Organization of the Bureau of Medicine and Surgery</td>
<td>1–12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV. Research</td>
<td>1–13 through 1–19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>V. Nomenclature and Definitions for Medical Treatment Facilities</td>
<td>1–20 through 1–23</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VI. General</td>
<td>1–24 through 1–25</td>
</tr>
<tr>
<td>2</td>
<td>Medical Corps: Organization, Appointments, and Advancement in Grade</td>
<td>I. Organization</td>
<td>2–1 through 2–2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>II. Appointments</td>
<td>2–3 through 2–5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>III. Advancement in Grade</td>
<td>2–6 through 2–13</td>
</tr>
<tr>
<td>3</td>
<td>General Duties of Medical Corps Officers</td>
<td>I. The Medical Officer and His Duties</td>
<td>3–1 through 3–15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>II. Assistant Medical Officers</td>
<td>3–16 through 3–17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>III. General Duties of All Medical Corps Officers</td>
<td>3–18 through 3–30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV. Duties With Regard to Narcotics, Alcohol, Alcoholic Beverages, and Dangerous and Habit-Forming Drugs</td>
<td>3–31 through 3–36</td>
</tr>
<tr>
<td>4</td>
<td>Duties of Medical Officers Afloat</td>
<td>I. Fleet, Force, and Division Medical Officers</td>
<td>4–1 through 4–11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>II. The Medical Officer of a Ship</td>
<td>4–12 through 4–19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>III. Medical Department Duties in Emergencies</td>
<td>4–20 through 4–45</td>
</tr>
<tr>
<td>5</td>
<td>Duties of Medical Officers Ashore</td>
<td>I. Duties of the Inspector, Naval Medical Activities</td>
<td>5–1 through 5–2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>II. Duties of the District Medical Officer</td>
<td>5–3 through 5–5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>III. The Medical Officer of a Shore Station</td>
<td>5–6 through 5–17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV. Medical Inspection of Naval Activities</td>
<td>5–18 through 5–23</td>
</tr>
<tr>
<td>6</td>
<td>The Navy Dental Service</td>
<td>I. The Navy Dental Service</td>
<td>6–1 through 6–3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>II. Dental Division, Bureau of Medicine and Surgery</td>
<td>6–4 through 6–12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>III. The Dental Corps</td>
<td>6–13 through 6–21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV. General Duties of Dental Officers</td>
<td>6–22 through 6–36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>V. Dental Officers Afloat</td>
<td>6–37 through 6–44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VI. Dental Officers Ashore</td>
<td>6–45 through 6–58</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VII. Dental Officers With the Marine Corps</td>
<td>6–59 through 6–62</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VIII. Dental Technicians</td>
<td>6–63 through 6–68</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IX. Dental Service Warrant Officers, Medical Service Corps Officers, and Nurse Corps Officers in Dental Facilities</td>
<td>6–69 through 6–73</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X. Civilian Employees in Dental Facilities</td>
<td>6–74</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XI. Naval Dental Clinics</td>
<td>6–75 through 6–81</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XII. Fleet Marine Force Dental Companies</td>
<td>6–82 through 6–85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XIII. Dental Standards</td>
<td>6–86 through 6–97</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XIV. Dental Services</td>
<td>6–98 through 6–106</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XV. The Dental Record and Other Standard Forms</td>
<td>6–107 through 6–121</td>
</tr>
<tr>
<td></td>
<td></td>
<td>XVI. Dental Officer Training</td>
<td>6–122 through 6–132</td>
</tr>
</tbody>
</table>
Chapter 6—The Navy Dental Service—Continued

XVII. Research ................................................................. 6-133 through 6-134
XVIII. U. S. Naval Dental School ......................................... 6-135 through 6-138
XX. Publications and Files in Dental Facilities ......................... 6-139 through 6-144
XXI. Reports, Records, and Correspondence ............................. 6-145 through 6-147
XXII. Dental Supplies and Equipment .................................... 6-148 through 6-159
XXIII. Dental Fiscal Matters ................................................ 6-160 through 6-174
XXIV. Planning Dental Facilities .......................................... 6-175 through 6-177
XXV. Inspection of Dental Activities and Facilities .................... 6-178 through 6-192
XXVI. Dental Corps of the U. S. Naval Reserve ......................... 6-193 through 6-197

Chapter 7—Medical Service Corps
Section I. Establishment .................................................... 7-1 through 7-4
Section II. Appointments ................................................... 7-5 through 7-18
Section III. Advancement in Grade ....................................... 7-19 through 7-26
Section IV. Duties ............................................................... 7-27 through 7-30

Chapter 8—The Nurse Corps
Section I. Organization ....................................................... 8-1 through 8-5
Section II. Appointment and Training ...................................... 8-6 through 8-7
Section III. Promotion .......................................................... 8-8 through 8-9
Section IV. Duties ................................................................. 8-10 through 8-14

Chapter 9—The Hospital Corps
Section I. Organization ........................................................ 9-1 through 9-6
Section II. Hospital Corps, Group X, Medical ......................... 9-7 through 9-13
Section III. Hospital Corps, Group XI, Dental .........................

Chapter 10—Civilian Employees
Section I. Organization ........................................................ 10-1 through 10-3
Section II. Personal Services ............................................... 10-4 through 10-5
Section III. Classification and Wage Administration ................. 10-6 through 10-8
Section IV. Employment ....................................................... 10-9 through 10-12
Section V. Training ............................................................... 10-13 through 10-15
Section VI. Employee Relations and Employee Services .............. 10-16
Section VII. Personnel Instructions and Records ....................... 10-17 through 10-18

Chapter 11—Naval Hospitals
Section I. Mission and Organization ...................................... 11-1 through 11-5
Section II. Office of the Commanding Officer .......................... 11-6 through 11-11
Section III. Military and Administrative Functions ................. 11-12 through 11-21
Section IV. Professional Functions ........................................ 11-22 through 11-30
Section V. Hospital Ships ...................................................... 11-31 through 11-33

Chapter 12—Special Hospitals and Special-Treatment Centers
Section I. Special-Treatment Centers .................................... 12-1 through 12-4

Chapter 13—Naval Medical Centers
Section I. The National Naval Medical Center, Bethesda, Md .......... 13-1 through 13-11

Chapter 14—Special Activities
Section I. Amphibious Operations and Field Service .................. 14-1 through 14-2
Section II. Aviation Service ................................................... 14-3 through 14-9
Section III. Submarine and Diving Services .............................. 14-10 through 14-17
Section IV. Naval Advanced Base Organization ......................... 14-18 through 14-23

Change 6
Chapter 15—Physical Examinations

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Physical Standards</td>
<td>15-1 through 15-25</td>
</tr>
<tr>
<td>II. Physical Standards for Special Personnel Groups</td>
<td>15-26 through 15-34A</td>
</tr>
<tr>
<td>III. Physical Defects and Waiver</td>
<td>15-35 through 15-38</td>
</tr>
<tr>
<td>IV. Physical Examinations</td>
<td>15-39 through 15-58A</td>
</tr>
<tr>
<td>V. Aviation</td>
<td>15-59 through 15-73</td>
</tr>
<tr>
<td>VI. Reserve Components of the Navy and Marine Corps</td>
<td>15-74 through 15-80</td>
</tr>
<tr>
<td>VII. Reporting Results of Physical Examinations</td>
<td>15-81 through 15-84</td>
</tr>
<tr>
<td>VIII. Methods of Examination</td>
<td>15-85 through 15-91</td>
</tr>
</tbody>
</table>

Chapter 16—Health and Identification Records

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Purpose</td>
<td>16-1 through 16-2</td>
</tr>
<tr>
<td>II. Opening of Health Record</td>
<td>16-3 through 16-7</td>
</tr>
<tr>
<td>III. Termination of Health Record</td>
<td>16-8 through 16-15</td>
</tr>
<tr>
<td>IV. Custody of Health Record</td>
<td>16-17 through 16-23A</td>
</tr>
<tr>
<td>V. Change in Rank, Rating, or Status</td>
<td>16-24 through 16-28</td>
</tr>
<tr>
<td>VI. NAVMED-H-1 (Cover)</td>
<td>16-29 through 16-30</td>
</tr>
<tr>
<td>VII. NAVMED-H-2 (Physical Examination and Identification Records)</td>
<td>16-31 through 16-42</td>
</tr>
<tr>
<td>VIII. NAVMED-H-3 (Immunization Record)</td>
<td>16-43 through 16-44</td>
</tr>
<tr>
<td>IX. NAVMED-H-3a (Special Duty Abstract)</td>
<td>16-45</td>
</tr>
<tr>
<td>X. NAVMED-H-4 (Dental Record)</td>
<td>16-46 through 16-47</td>
</tr>
<tr>
<td>XI. NAVMED-H-5 (Abstract of Service and Abstract of Medical History)</td>
<td>16-48 through 16-49</td>
</tr>
<tr>
<td>XII. NAVMED-H-6 (Venereal Disease Abstract)</td>
<td>16-50</td>
</tr>
<tr>
<td>XIII. NAVMED-H-7 (Abstract of Antiluetic Treatment)</td>
<td>16-51</td>
</tr>
<tr>
<td>XIV. NAVMED-H-8 (Medical History)</td>
<td>16-52 through 16-59</td>
</tr>
<tr>
<td>XV. NAVMED-H-9 (Aviation Medical Abstract)</td>
<td>16-60</td>
</tr>
<tr>
<td>XVI. NAVMED-H-10 (Sick Call Treatment Record)</td>
<td>16-61 through 16-65</td>
</tr>
<tr>
<td>XVII. Army, Air Force, and Coast Guard Personnel</td>
<td>16-66</td>
</tr>
</tbody>
</table>

Chapter 17—Deaths

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Recording and Reporting of Death</td>
<td>17-1 through 17-14</td>
</tr>
<tr>
<td>II. Death Occurring Away From Command</td>
<td>17-15</td>
</tr>
<tr>
<td>III. Death of Inactive Personnel at Other Than Naval Activities</td>
<td>17-16 through 17-19</td>
</tr>
<tr>
<td>IV. Civil Death Certificates</td>
<td>17-20</td>
</tr>
<tr>
<td>V. Missing Personnel</td>
<td>17-21</td>
</tr>
<tr>
<td>VI. Investigation of Death</td>
<td>17-22 through 17-25</td>
</tr>
<tr>
<td>VII. Notification of Next of Kin</td>
<td>17-26 through 17-28</td>
</tr>
<tr>
<td>VIII. Preparation of Remains</td>
<td>17-29 through 17-32</td>
</tr>
<tr>
<td>IX. Transportation of Remains</td>
<td>17-33 through 17-41</td>
</tr>
<tr>
<td>X. Corpse Escort</td>
<td>17-42 through 17-45</td>
</tr>
<tr>
<td>XI. Funeral Expenses</td>
<td>17-46 through 17-48</td>
</tr>
<tr>
<td>XII. Funerals and Funeral Flags</td>
<td>17-49 through 17-51</td>
</tr>
<tr>
<td>XIII. Coast Guard, Army, and Air Force</td>
<td>17-52 through 17-55</td>
</tr>
<tr>
<td>XVI. Military Sea Transportation Service Personnel</td>
<td>17-56 through 17-67</td>
</tr>
<tr>
<td>XVII. Cemeteries</td>
<td>17-68 through 17-77</td>
</tr>
</tbody>
</table>

Chapter 18—Medical Disposition

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Psychiatric Unit</td>
<td>18-1 through 18-2</td>
</tr>
<tr>
<td>II. Aptitude Board</td>
<td>18-3 through 18-6</td>
</tr>
<tr>
<td>III. Medical Survey Board</td>
<td>18-7 through 18-10</td>
</tr>
<tr>
<td>IV. Clinical Board</td>
<td>18-11 through 18-23</td>
</tr>
</tbody>
</table>

Chapter 19—Misconduct and Line of Duty

Chapter 20—Medical and Dental Treatment Other Than Naval

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Treatment and Hospitalization Other Than Naval</td>
<td>20-1 through 20-3</td>
</tr>
<tr>
<td>II. Services of Specialists</td>
<td>20-4 through 20-11</td>
</tr>
<tr>
<td>III. Special Dental Treatment</td>
<td>20-12 through 20-16</td>
</tr>
</tbody>
</table>
### Chapter 21—Medical Care of Supernumeraries

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. General</td>
<td>21-1 through 21-3</td>
</tr>
<tr>
<td>II. Dependents' Medical Care</td>
<td>21-4 through 21-8</td>
</tr>
<tr>
<td>III. Service Patients Not on Active Naval Duty</td>
<td>21-12 through 21-21</td>
</tr>
<tr>
<td>IV. Other Than Service Patients</td>
<td>21-22 through 21-32</td>
</tr>
<tr>
<td>V. Charges, Collections, and Reports</td>
<td>21-33</td>
</tr>
</tbody>
</table>

### Chapter 22—General Provisions Concerning Preventive Medicine

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. General</td>
<td>22-1 through 22-3</td>
</tr>
<tr>
<td>II. Sanitation and Industrial Hygiene</td>
<td>22-4 through 22-6</td>
</tr>
<tr>
<td>III. Sanitary Standards for Living Spaces</td>
<td>22-7 through 22-11</td>
</tr>
<tr>
<td>IV. Lighting, Heating, and Ventilation</td>
<td>22-12</td>
</tr>
<tr>
<td>V. Food and Water Supply</td>
<td>22-13 through 22-14</td>
</tr>
<tr>
<td>VI. Garbage, Refuse, and Sewage Disposal</td>
<td>22-15 through 22-16</td>
</tr>
<tr>
<td>VII. Communicable Disease Control</td>
<td>22-17 through 22-20</td>
</tr>
<tr>
<td>VIII. Immunization</td>
<td>22-21 through 22-30</td>
</tr>
<tr>
<td>IX. Insect, Pest, and Rodent Control</td>
<td>22-31 through 22-32</td>
</tr>
<tr>
<td>X. Quarantine Procedures</td>
<td>22-33 through 22-39</td>
</tr>
<tr>
<td>XI. Field Sanitation</td>
<td>22-40 through 22-41</td>
</tr>
</tbody>
</table>

### Chapter 23—Reports, Forms, and Records

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Bureau Reporting Requirements</td>
<td>23-1 through 23-2</td>
</tr>
<tr>
<td>II. Reports Submitted on NAVMED Forms</td>
<td>23-3 through 23-90</td>
</tr>
<tr>
<td>III. Reports Submitted on Other Than NAVMED Forms</td>
<td>23-100 through 23-199</td>
</tr>
<tr>
<td>V. NAVMED, Standard Federal, and Department of Defense Forms</td>
<td>23-214 through 23-249</td>
</tr>
<tr>
<td>VI. Records Maintained on Other Than NAVMED or Standard Federal Forms</td>
<td>23-250 through 23-299</td>
</tr>
<tr>
<td>VII. Records Retirement</td>
<td>23-300 through 23-309</td>
</tr>
<tr>
<td>VIII. Release of Information From Records</td>
<td>23-310 through 23-319</td>
</tr>
</tbody>
</table>

### Chapter 24—Fiscal Management

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Bureau Responsibility</td>
<td>24-1</td>
</tr>
<tr>
<td>II. Appropriations</td>
<td>24-2 through 24-4</td>
</tr>
<tr>
<td>III. Budget Estimates</td>
<td>24-5 through 24-9</td>
</tr>
<tr>
<td>IV. Allotments, Obligations, and Expenditures</td>
<td>24-10 through 24-19</td>
</tr>
<tr>
<td>V. Procurement</td>
<td>24-20 through 24-25</td>
</tr>
<tr>
<td>VI. Accounting</td>
<td>24-26 through 24-29</td>
</tr>
<tr>
<td>VII. Sale of Services or Materials to Private Parties</td>
<td>24-30 through 24-31</td>
</tr>
<tr>
<td>VIII. Miscellaneous Reports and Returns</td>
<td>24-32 through 24-33</td>
</tr>
</tbody>
</table>

### Chapter 25—Property Management

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. General</td>
<td>25-1 through 25-11</td>
</tr>
<tr>
<td>II. Property Custody</td>
<td>25-12 through 25-18</td>
</tr>
<tr>
<td>III. Property Issue and Disposition</td>
<td>25-19 through 25-22</td>
</tr>
<tr>
<td>IV. Naval Medical Supply System</td>
<td>25-23 through 25-26</td>
</tr>
<tr>
<td>V. Medical and Dental Stores</td>
<td>25-27 through 25-29</td>
</tr>
</tbody>
</table>

### Chapter 26—Health Program for Civil Service Employees

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. General</td>
<td>26-1 through 26-3</td>
</tr>
<tr>
<td>II. Organization</td>
<td>26-4</td>
</tr>
<tr>
<td>III. Functions</td>
<td>26-5 through 26-10</td>
</tr>
</tbody>
</table>

**Index**

1 through 17
PAGE CHANGE 7

MANUAL OF THE MEDICAL DEPARTMENT

27 February 1959

To: All Holders of the Manual of the Medical Department

1. Material Included in Change. This page change supersedes and incorporates advance changes 7-1 through 7-10. It also includes the addition, revision, or deletion of the items listed on the reverse of this page.

2. Action To Be Taken
   a. Remove advance changes 7-1 through 7-10 and the 24 January 1958 check list.
   b. Insert the attached pages in their proper places in the Manual and remove the old pages of the same number. Also remove old pages 1-2a, 1-8a, 11-4a, 15-66 a and b, 21-8 a and b, 21-10a, 23-17, 24-5 through 24-11, and Index pages 15, 16, and 17, for which there are no replacement pages.
   c. Record this Page Change 7 in the Record of Page Changes.
   d. Verify completeness of the Manual by using the enclosed Check List of Pages in Effect.

F. P. GILMORE
Assistant Chief of Bureau
Bureau of Medicine and Surgery
Department of the Navy
Washington 25, D.C.
This Page Change 7 includes the addition, revision, or deletion of the following items not previously included in advance changes:

1-5 (3), (4), (5) 23-40 (see art. 6-159)
1-8 23-215, NAVMED-D
1-10 23-214, HF-25
1-12 18
1-19 53
1-24 64
3-25 146
3-26A (old 1-24) 147
6-34 (2), (3) 656
6-37(1) 703
6-38(1) 1178
6-47(1) 1285
6-49(1) 1323
6-50(1) 1336
6-71 1345
6-77 1347
6-79 1352
6-99 (8), (9) 1352A
6-100(2) 1353
6-149(1) 1353A
6-150 (5) (f) (10) (b) 1358
6-159 1382
15-11 (2), (3), (8) 1383
15-29(2) (c) 1394
15-90 1395
17-14 23-216, SF-510
21-3, part I (1) (a), (6), (7) 511
21-3, part II (3), (5) 519
23-2, MED-1080-2 519A
6010-1 520
6120-3 522
6224-1 534
6224-2 535
# TABLE OF CONTENTS

Chapter 1—The Medical Department

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Functions of the Medical Department</td>
<td>1–1 through 1–4</td>
</tr>
<tr>
<td>II. Organization of the Medical Department</td>
<td>1–5 through 1–11</td>
</tr>
<tr>
<td>III. Organization of the Bureau of Medicine and Surgery</td>
<td>1–12</td>
</tr>
<tr>
<td>IV. Research</td>
<td>1–13 through 1–19</td>
</tr>
<tr>
<td>V. Nomenclature and Definitions for Medical Treatment Facilities</td>
<td>1–20 through 1–23</td>
</tr>
<tr>
<td>VI. General</td>
<td>1–24</td>
</tr>
</tbody>
</table>

Chapter 2—Medical Corps: Organization, Appointments, and Advancement in Grade

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Organization</td>
<td>2–1 through 2–2</td>
</tr>
<tr>
<td>II. Appointments</td>
<td>2–3 through 2–5</td>
</tr>
<tr>
<td>III. Advancement in Grade</td>
<td>2–6 through 2–13</td>
</tr>
</tbody>
</table>

Chapter 3—General Duties of Medical Corps Officers

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The Medical Officer and His Duties</td>
<td>3–1 through 3–15</td>
</tr>
<tr>
<td>II. Assistant Medical Officers</td>
<td>3–16 through 3–17</td>
</tr>
<tr>
<td>III. General Duties of All Medical Corps Officers</td>
<td>3–18 through 3–30</td>
</tr>
<tr>
<td>IV. Duties With Regard to Narcotics, Alcohol, Alcoholic Beverages, and Dangerous and Habit-Forming Drugs</td>
<td>3–31 through 3–36</td>
</tr>
</tbody>
</table>

Chapter 4—Duties of Medical Officers Afloat

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Fleet, Force, and Division Medical Officers</td>
<td>4–1 through 4–11</td>
</tr>
<tr>
<td>II. The Medical Officer of a Ship</td>
<td>4–12 through 4–19</td>
</tr>
<tr>
<td>III. Medical Department Duties in Emergencies</td>
<td>4–20 through 4–45</td>
</tr>
</tbody>
</table>

Chapter 5—Duties of Medical Officers Ashore

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Duties of the Inspector, Naval Medical Activities</td>
<td>5–1 through 5–2</td>
</tr>
<tr>
<td>II. Duties of the District Medical Officer</td>
<td>5–3 through 5–5</td>
</tr>
<tr>
<td>III. The Medical Officer of a Shore Station</td>
<td>5–6 through 5–17</td>
</tr>
<tr>
<td>IV. Medical Inspection of Naval Activities</td>
<td>5–18 through 5–23</td>
</tr>
<tr>
<td>V. Civilian Physicians</td>
<td>5–24 through 5–29</td>
</tr>
</tbody>
</table>

Chapter 6—The Navy Dental Service

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The Navy Dental Service</td>
<td>6–1 through 6–3</td>
</tr>
<tr>
<td>II. Dental Division, Bureau of Medicine and Surgery</td>
<td>6–4 through 6–12</td>
</tr>
<tr>
<td>III. The Dental Corps</td>
<td>6–13 through 6–31</td>
</tr>
<tr>
<td>IV. General Duties of Dental Officers</td>
<td>6–22 through 6–36</td>
</tr>
<tr>
<td>V. Dental Officers Afloat</td>
<td>6–37 through 6–44</td>
</tr>
<tr>
<td>VI. Dental Officers Ashore</td>
<td>6–45 through 6–58</td>
</tr>
<tr>
<td>VII. Dental Officers With the Marine Corps</td>
<td>6–59 through 6–92</td>
</tr>
<tr>
<td>VIII. Dental Technicians</td>
<td>6–63 through 6–88</td>
</tr>
<tr>
<td>IX. Dental Service Warrant Officers, Medical Service Corps Officers, and Nurse Corps Officers in Dental Facilities</td>
<td>6–69 through 6–73</td>
</tr>
<tr>
<td>X. Civilian Employees in Dental Facilities</td>
<td>6–74</td>
</tr>
<tr>
<td>XI. Naval Dental Clinics</td>
<td>6–75 through 6–81</td>
</tr>
<tr>
<td>XII. Fleet Marine Force Dental Companies</td>
<td>6–82 through 6–85</td>
</tr>
<tr>
<td>XIII. Dental Standards</td>
<td>6–86 through 6–97</td>
</tr>
<tr>
<td>XIV. Dental Services</td>
<td>6–98 through 6–100</td>
</tr>
<tr>
<td>XV. The Dental Record and Other Standard Forms</td>
<td>6–107 through 6–121</td>
</tr>
<tr>
<td>XVI. Dental Officer Training</td>
<td>6–122 through 6–132</td>
</tr>
</tbody>
</table>

Change 7
Chapter 6—The Navy Dental Service—Continued

XVII. Research .......................................................... 6-133 through 6-134
XVIII. U.S. Naval Dental School ...................................... 6-135 through 6-138
XIX. U.S. Naval Dental Technicians Schools ...................... 6-139 through 6-144
XX. Publications and Files in Dental Facilities ................... 6-145 through 6-147
XXI. Reports, Records, and Correspondence ...................... 6-148 through 6-159
XXII. Dental Supplies and Equipment ............................... 6-160 through 6-174
XXIII. Dental Fiscal Matters ........................................ 6-175 through 6-177
XXIV. Planning Dental Facilities .................................... 6-178 through 6-192
XXV. Inspection of Dental Activities and Facilities ............. 6-193 through 6-197
XXVI. Dental Corps of the Naval Reserve ......................... 6-198 through 6-210

Chapter 7—Medical Service Corps

Section I. Establishment ............................................... 7-1 through 7-4
II. Appointments .......................................................... 7-5 through 7-18
III. Advancement in Grade .............................................. 7-19 through 7-26
IV. Duties .................................................................... 7-27 through 7-30

Chapter 8—The Nurse Corps

Section I. Organization .................................................. 8-1 through 8-5
II. Appointment and Training ......................................... 8-6 through 8-7
III. Promotion ............................................................... 8-8 through 8-9
IV. Duties .................................................................... 8-10 through 8-14

Chapter 9—The Hospital Corps

Section I. Organization .................................................. 9-1 through 9-6
II. Hospital Corps, Group X, Medical ............................... 9-7 through 9-13
III. Hospital Corps, Group XI, Dental ............................... 9-14 through 9-19

Chapter 10—Civilian Employees

Section I. Organization .................................................. 10-1 through 10-3
II. Personal Services ...................................................... 10-4 through 10-5
III. Classification and Wage Administration ...................... 10-6 through 10-8
IV. Employment ............................................................ 10-9 through 10-12
V. Training .................................................................. 10-13 through 10-15
VI. Employee Relations and Employee Services ................. 10-16
VII. Personnel Instructions and Records ........................... 10-17 through 10-18

Chapter 11—Naval Hospitals

Section I. Mission and Organization ................................ 11-1 through 11-5
II. Office of the Commanding Officer ............................... 11-6 through 11-11
III. Military and Administrative Functions ....................... 11-12 through 11-21
IV. Professional Functions ............................................. 11-22 through 11-30
V. Hospital Ships ............................................................ 11-31 through 11-33

Chapter 12—Special Hospitals and Special-Treatment Centers

Section I. Special-Treatment Centers ................................. 12-1 through 12-4

Chapter 13—Naval Medical Centers

Section I. The National Naval Medical Center, Bethesda, Md. 13-1 through 13-11
II. U.S. Naval Aviation Medical Center, Pensacola, Fla. ....... 13-12 through 13-18

Chapter 14—Special Activities

Section I. Amphibious Operations and Field Service .......... 14-1 through 14-2
II. Aviation Service ....................................................... 14-3 through 14-9
III. Submarine and Diving Services ................................ 14-10 through 14-17
IV. Naval Advanced Base Organization ............................. 14-18 through 14-23

Change 7
Chapter 17—Deaths

Section I. Recording and Reporting of Death

II. Death Occurring Away From Command

III. Death of Inactive Personnel at Other Than Naval Activities

IV. Civil Death Certificates

V. Missing Personnel

VI. Investigation of Death

VII. Notification of Next of Kin

VIII. Preparation of Remains

IX. Transportation of Remains

X. Corpse Escort

XI. Funeral Expenses

XII. Funerals and Funeral Flags

XIII. Coast Guard, Army, and Air Force

XVI. Military Sea Transportation Service Personnel

XVII. Cemeteries

Chapter 18—Medical Disposition

Section I. Psychiatric Unit

II. Aptitude Board

III. Medical Survey Board

IV. Clinical Board

Chapter 19—Misconduct and Line of Duty

Chapter 20—Medical and Dental Treatment Other Than Naval

Section I. Treatment and Hospitalization Other Than Naval

II. Services of Specialists

III. Special Dental Treatment

Change 6
Chapter 21—Medical Care of Supernumeraries

Section I. General
II. Dependents' Medical Care
III. Service Patients Not on Active Naval Duty
IV. Other Than Service Patients
V. Charges, Collections, and Reports

Chapter 22—General Provisions Concerning Preventive Medicine

Section I. General
II. Sanitation and Industrial Hygiene
III. Sanitary Standards for Living Spaces
IV. Lighting, Heating, and Ventilation
V. Food and Water Supply
VI. Garbage, Refuse, and Sewage Disposal
VII. Communicable Disease Control
VIII. Immunization
IX. Insect, Pest, and Rodent Control
X. Quarantine Procedures
XI. Field Sanitation

Chapter 23—Reports, Forms, and Records

Section I. Bureau Reporting Requirements
II. Reports Submitted on NAVMED Forms
III. Reports Submitted on Other Than NAVMED Forms
IV. NAVMED, Standard Federal, and Department of Defense Forms
V. Records Maintained on Other Than NAVMED or Standard Forms
VI. Records Retirement
VII. Release of Information From Records

Chapter 24—Fiscal Management

Section I. General

Chapter 25—Property Management

Section I. General
II. Property Custody
III. Property Issue and Disposition
IV. Naval Medical Supply System
V. Medical and Dental Stores

Chapter 26—Health Program for Civil Service Employees

Section I. General
II. Organisation
III. Functions

Index

VI

Change 7
PAGE CHANGE 9

MANUAL OF THE MEDICAL DEPARTMENT

20 April 1960

To: Holders of the Manual of the Medical Department

1. Material Included in Change. In addition to incorporating advance changes 9–1 and 9–2, this page change provides completely revised chapters 10 and 16. Cross references have been changed to reflect the revision.

2. Action To Be Taken

   a. Remove advance changes 9–1 and 9–2 and the 25 February 1960 check list.

   b. Insert the attached pages in their proper place in the Manual and remove the old pages of the same number. Also remove old pages 10–3 through 10–7, 16–8a, and 16–18a, for which there are no replacement pages.

   c. Record this Page Change 9 in the Record of Page Changes.

   d. Verify completeness of the Manual by using the enclosed Check List of Pages in Effect.

E. C. Kenney
Acting Chief
Bureau of Medicine and Surgery
Department of the Navy
Washington 25, D.C.
# TABLE OF CONTENTS

## Chapter 1—The Medical Department

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Functions of the Medical Department</td>
<td>1-1 through 1-4</td>
</tr>
<tr>
<td>II</td>
<td>Organization of the Medical Department</td>
<td>1-5 through 1-11</td>
</tr>
<tr>
<td>III</td>
<td>Organization of the Bureau of Medicine and Surgery</td>
<td>1-12</td>
</tr>
<tr>
<td>IV</td>
<td>Research</td>
<td>1-13 through 1-19</td>
</tr>
<tr>
<td>V</td>
<td>Nomenclature and Definitions for Medical Treatment Facilities</td>
<td>1-20 through 1-23</td>
</tr>
<tr>
<td>VI</td>
<td>General</td>
<td>1-24</td>
</tr>
</tbody>
</table>

## Chapter 2—Medical Corps: Organization, Appointments, and Advancement in Grade

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Organization</td>
<td>2-1 through 2-2</td>
</tr>
<tr>
<td>II</td>
<td>Appointments</td>
<td>2-3 through 2-5</td>
</tr>
<tr>
<td>III</td>
<td>Advancement in Grade</td>
<td>2-6 through 2-8</td>
</tr>
</tbody>
</table>

## Chapter 3—General Duties of Medical Corps Officers

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The Medical Officer and His Duties</td>
<td>3-1 through 3-15</td>
</tr>
<tr>
<td>II</td>
<td>Assistant Medical Officers</td>
<td>3-16 through 3-17</td>
</tr>
<tr>
<td>III</td>
<td>General Duties of All Medical Corps Officers</td>
<td>3-18 through 3-30</td>
</tr>
<tr>
<td>IV</td>
<td>Duties With Regard to Narcotics, Alcohol, Alcoholic Beverages, and Dangerous and Habit-Forming Drugs</td>
<td>3-31 through 3-36</td>
</tr>
</tbody>
</table>

## Chapter 4—Duties of Medical Officers Afloat

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Fleet, Force, and Division Medical Officers</td>
<td>4-1 through 4-11</td>
</tr>
<tr>
<td>II</td>
<td>The Medical Officer of a Ship</td>
<td>4-12 through 4-19</td>
</tr>
<tr>
<td>III</td>
<td>Medical Department Duties in Emergencies</td>
<td>4-20 through 4-45</td>
</tr>
</tbody>
</table>

## Chapter 5—Duties of Medical Officers Ashore

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Duties of the Inspector Naval Medical Activities</td>
<td>5-1 through 5-2</td>
</tr>
<tr>
<td>II</td>
<td>Duties of the District Medical Officer</td>
<td>5-3 through 5-5</td>
</tr>
<tr>
<td>III</td>
<td>The Medical Officer of a Shore Station</td>
<td>5-6 through 5-17</td>
</tr>
<tr>
<td>IV</td>
<td>Medical Inspection of Naval Activities</td>
<td>5-18 through 5-23</td>
</tr>
<tr>
<td>V</td>
<td>Civilian Physicians</td>
<td>5-24 through 5-29</td>
</tr>
</tbody>
</table>

## Chapter 6—The Navy Dental Service

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The Navy Dental Service</td>
<td>6-1 through 6-3</td>
</tr>
<tr>
<td>II</td>
<td>Dental Division, Bureau of Medicine and Surgery</td>
<td>6-4 through 6-12</td>
</tr>
<tr>
<td>III</td>
<td>The Dental Corps</td>
<td>6-13 through 6-21</td>
</tr>
<tr>
<td>IV</td>
<td>General Duties of Dental Officers</td>
<td>6-22 through 6-30</td>
</tr>
<tr>
<td>V</td>
<td>Dental Officers Afloat</td>
<td>6-37 through 6-44</td>
</tr>
<tr>
<td>VI</td>
<td>Dental Officers Ashore</td>
<td>6-45 through 6-58</td>
</tr>
<tr>
<td>VII</td>
<td>Dental Officers With the Marine Corps</td>
<td>6-59 through 6-62</td>
</tr>
<tr>
<td>VIII</td>
<td>Dental Technicians</td>
<td>6-63 through 6-68</td>
</tr>
<tr>
<td>IX</td>
<td>Dental Service Warrant Officers, Medical Service Corps Officers, and Nurse Corps Officers in Dental Facilities</td>
<td>6-69 through 6-73</td>
</tr>
<tr>
<td>X</td>
<td>Civilian Employees in Dental Facilities</td>
<td>6-74</td>
</tr>
<tr>
<td>XI</td>
<td>Naval Dental Clinics</td>
<td>6-75 through 6-81</td>
</tr>
<tr>
<td>XII</td>
<td>Fleet Marine Force Dental Companies</td>
<td>6-82 through 6-85</td>
</tr>
<tr>
<td>XIII</td>
<td>Dental Standards</td>
<td>6-86 through 6-97</td>
</tr>
<tr>
<td>XIV</td>
<td>Dental Services</td>
<td>6-96 through 6-100</td>
</tr>
<tr>
<td>XV</td>
<td>The Dental Record and Other Standard Forms</td>
<td>6-107 through 6-121</td>
</tr>
<tr>
<td>XVI</td>
<td>Dental Officer Training</td>
<td>6-122 through 6-132</td>
</tr>
</tbody>
</table>

---

Change 9
Chapter 6—The Navy Dental Service—Continued

Section XVII. Dental Research

Section XVIII. U.S. Naval Dental School

Section XIX. U.S. Naval Dental Technicians Schools

Section XX. Publications and Files in Dental Facilities

Section XXI. Reports, Records, and Correspondence

Section XXII. Dental Supplies and Equipment

Section XXIII. Dental Fiscal Matters

Section XXIV. Planning Dental Facilities

Section XXV. Inspection of Dental Activities and Facilities

Section XXVI. Dental Corps of the Naval Reserve

Chapter 7—Medical Service Corps

Section I. Establishment

Section II. Appointments

Section III. Advancement in Grade

Section IV. Duties

Chapter 8—The Nurse Corps

Section I. Organization

Section II. Appointment and Training

Section III. Promotion

Section IV. Duties

Chapter 9—The Hospital Corps

Section I. Organization

Section II. Hospital Corps, Group X, Medical

Section III. Hospital Corps, Group XI, Dental

Chapter 10—Civilian Employees and Positions

Section I. Civilian Employees

Section II. Civilian Positions

Chapter 11—Naval Hospitals

Section I. Mission and Organization

Section II. Office of the Commanding Officer

Section III. Military and Administrative Functions

Section IV. Professional Functions

Section V. Hospital Ships

Chapter 12—Special Hospitals and Special-Treatment Centers

Section I. Special-Treatment Centers

Chapter 13—Naval Medical Centers

Section I. The National Naval Medical Center, Bethesda, Md

Section II. U.S. Naval Aviation Medical Center, Pensacola, Fla

Chapter 14—Special Activities

Section I. Amphibious Operations and Field Service

Section II. Aviation Service

Section III. Submarine and Diving Services

Section IV. Naval Advanced Base Organization
Chapter 15—Physical Examinations

Section I. Physical Standards .................................................. 15-1 through 15-25
II. Physical Standards for Special Personnel Groups ...................... 15-26 through 15-34A
III. Physical Defects and Waiver ........................................ 15-35 through 15-38
IV. Physical Examinations .................................................. 15-39 through 15-58A
V. Aviation ........................................................................... 15-59 through 15-73
VI. Reserve Components of the Navy and Marine Corps .............. 15-74 through 15-80
VII. Reporting Results of Physical Examinations ......................... 15-81 through 15-84
VIII. Methods of Examination .............................................. 15-85 through 15-91

Chapter 16—Health Record

Section I. General .............................................................. 16-1 through 16-4
II. Opening the Health Record .............................................. 16-5 through 16-8
III. Termination and Closure of the Health Record .................... 16-9 through 16-17
IV. Custody of the Health Record ......................................... 16-18 through 16-27
V. DD Form 732, Health Record Jacket, and DD Form 732-1, Dental Folder .................................................. 16-28 through 16-29
VI. NAVMED 10, Sick Call Treatment Record ....................... 16-30 through 16-36
VII. Standard Form 88, Report of Medical Examination .............. 16-37 through 16-40
VIII. Standard Form 89, Report of Medical History .................. 16-41 through 16-43
IX. Standard Form 900, Chronological Record of Medical Care .......... 16-44 through 16-48
X. Standard Form 801, Immunisation Record .......................... 16-49 through 16-51
XI. Standard Form 802, Syphilis Record .................................. 16-52 through 16-53
XII. Standard Form 803, Dental ........................................... 16-54
XIII. NAVMED 1406, Abstract of Service and Medical History .......... 16-55 through 16-57
XIV. NAVMED 1346, Special Duty Medical Abstract ................. 16-58 through 16-60
XV. DD Form 1141, Record of Exposure to Ionizing Radiation .... 16-61 through 16-64
XVI. Adjunct Health Record Forms and Reports ..................... 16-65 through 16-66
XVII. DD Form 889, Individual Sick Slip, and Cross Medical Service Notification .............................................. 16-70 through 16-73
XVIII. Illustrations of Component Forms of the Health Record ....... 16-74

Chapter 17—Deaths

Section I. Recording and Reporting of Death .............................. 17-1 through 17-14
II. Death Occurring Away From Command ............................... 17-15 through 17-19
III. Death of Inactive Personnel at Other Than Naval Activities .......... 17-20 through 17-23
IV. Missing Personnel .......................................................... 17-24 through 17-27
V. Investigation of Death ..................................................... 17-28 through 17-31
VI. Notification of Next of Kin .............................................. 17-32 through 17-34
VII. Preparation of Remains .................................................. 17-35 through 17-38
IX. Transportation of Remains .............................................. 17-39 through 17-42
X. Corpse Escort .................................................................... 17-43 through 17-45
XI. Funeral Expenses ........................................................... 17-46 through 17-49
XII. Funerals and Funeral Flags ............................................. 17-50 through 17-53
XIII. Coast Guard, Army, and Air Force ................................ 17-54 through 17-56
XVI. Military Sea Transportation Service Personnel ................. 17-74 through 17-77
XVII. Cemeteries ................................................................. 17-78 through 17-81

Chapter 18—Medical Disposition

Section I. Psychiatric Unit ...................................................... 18-1 through 18-2
II. Aptitude Board .................................................................. 18-3 through 18-6
III. Medical Survey Board ..................................................... 18-7 through 18-15

Chapter 19—Misconduct and Line of Duty

Chapter 20—Medical and Dental Treatment Other Than Naval

Section I. Treatment and Hospitalization Other Than Naval .......... 20-1 through 20-8
II. Services of Specialists ..................................................... 20-9 through 20-11
III. Special Dental Treatment ................................................ 20-12 through 20-16

Change 9
PAGE CHANGE 10

MANUAL OF THE MEDICAL DEPARTMENT

27 February 1961

To: Holders of the Manual of the Medical Department

1. Material Included. In addition to incorporating advance changes 10-1 through 10-8, this page change includes a revised section I (The National Naval Medical Center, Bethesda, Md.) to chapter 13 and revisions to articles 15-90(1), (2)(a), (5), (6)(a)(2), and (6)(f)(1) and (4); 22-19(1)(b); and 23-1(2).

2. Action To Be Taken
   a. Remove advance changes 10-1 through 10-8.
   b. Insert the attached pages in their proper place in the Manual and remove the old pages of the same number. Also remove old pages 15-68a, 17-3, 17-4, 17-4a, 17-13 through 17-34, and 23-41 through 23-53, for which there are no replacement pages.
   c. Record this Page Change 10 in the Record of Page Changes.
   d. Verify completeness of the Manual by using the enclosed Check List of Pages in Effect.

E. C. Kenney
Chief, Bureau of Medicine and Surgery
Department of the Navy
Washington 25, D.C.
Chapter 15—Physical Examinations

Section I. Physical Standards.................................................... 15–1 through 15–25
II. Physical Standards for Special Personnel Groups...................... 15–26 through 15–34A
III. Physical Defects and Waiver................................................ 15–35 through 15–38
IV. Physical Examinations.......................................................... 15–39 through 15–55A
V. Aviation...................................................................................... 15–59 through 15–73
VI. Reserve Components of the Navy and Marine Corps................. 15–74 through 15–80
VII. Reporting Results of Physical Examinations............................ 15–81 through 15–84
VIII. Methods of Examination...................................................... 15–85 through 15–91

Chapter 16—Health Record

Section I. General...................................................................... 16–1 through 16–4
II. Opening the Health Record.................................................... 16–5 through 16–8
III. Termination and Closure of the Health Record.......................... 16–9 through 16–17
IV. Custody of the Health Record................................................ 16–18 through 16–27
V. DD Form 722, Health Record Jacket, and DD Form 722–1, Dental Folder........................................................................ 16–28 through 16–29
VI. NAVMED 10, Sick Call Treatment Record................................. 16–30 through 16–35
VII. Standard Form 88, Report of Medical Examination...................... 16–36 through 16–40
VIII. Standard Form 99, Report of Medical History........................ 16–41 through 16–43
IX. Standard Form 600, Chronological Record of Medical Care........ 16–44 through 16–48
X. Standard Form 601, Immunization Record................................ 16–49 through 16–51
XI. Standard Form 602, Syphilis Record........................................ 16–52 through 16–53
XII. Standard Form 603, Dental Record........................................ 16–54
XIII. NAVMED 1406, Abstract of Service and Medical History.......... 16–55 through 16–57
XIV. NAVMED 1346, Special Duty Medical Abstract........................ 16–58 through 16–60
XV. DD Form 1141, Record of Exposure to Ionizing Radiation........ 16–61 through 16–64
XVI. Adjunct Health Record Forms and Reports.............................. 16–65 through 16–69
XVII. DD Form 680, Individual Sick Slip, and Cross Medical Service Notification.................................................. 16–70 through 16–73
XVIII. Illustrations of Component Forms of the Health Record.......... 16–74

Chapter 17—Deaths

Section I. Recording and Reporting of Death.................................. 17–8 through 17–14
II. Death Occurring Away From Command.................................... 17–15
III. Death of Inactive Personnel at Other Than Naval Activities........ 17–16 through 17–19
V. Missing Personnel...................................................................... 17–21
VI. Investigation of Death............................................................... 17–24
XI. Funeral Expenses..................................................................... 17–66
XVI. Military Sea Transportation Service Personnel......................... 17–75 through 17–77
XVII. Cemeteries............................................................................ 17–78 through 17–81

Chapter 18—Medical Disposition

Section I. Psychiatric Unit............................................................. 18–1 through 18–2
II. Aptitude Board......................................................................... 18–3 through 18–6
III. Medical Survey Board............................................................ 18–7 through 18–15

Chapter 19—Misconduct and Line of Duty

Chapter 20—Medical and Dental Treatment Other Than Naval

Section I. Treatment and Hospitalization Other Than Naval.............. 20–1 through 20–8
II. Services of Specialists............................................................. 20–9 through 20–11
III. Special Dental Treatment........................................................ 20–12 through 20–16
Chapter 21—Medical Care of Supernumeraries

Section I. General

II. Dependents’ Medical Care

III. Service Patients Not on Active Naval Duty

IV. Other Than Service Patients

V. Charges, Collections, and Reports

Chapter 22—General Provisions Concerning Preventive Medicine

Section I. General

II. Sanitation and Industrial Hygiene

III. Sanitary Standards for Living Spaces

IV. Lighting, Heating, and Ventilation

V. Food and Water Supply

VI. Garbage, Refuse, and Sewage Disposal

VII. Communicable Disease Control

VIII. Immunization

IX. Insect, Pest, and Rodent Control

X. Quarantine Procedures

XI. Field Sanitation

Chapter 23—Reports, Forms, and Records

Section I. Bureau Reporting Requirements

II. NAVMED, Standard Federal, and Department of Defense Forms

III. Records Maintained on Other Than Standardized Forms

VII. Records Retirement

VIII. Release of Information From Records

Chapter 24—Fiscal Management

Section I. General

Chapter 25—Property Management

Section I. General

II. Property Custody

III. Property Issue and Disposition

IV. Naval Medical Supply System

V. Medical and Dental Stores

Chapter 26—Health Program for Civil Service Employees

Section I. General

II. Organization

III. Functions

Index
Chapter 1

THE MEDICAL DEPARTMENT

Sections

I. Functions of the Medical Department ........................................... 1–1 through 1–4
II. Organisation of the Medical Department ........................................ 1–5 through 1–11
III. Organisation of the Bureau of Medicine and Surgery ............... 1–12
IV. Research ........................................................................ 1–13 through 1–19
V. Nomenclature and Definitions for Medical Treatment Facilities ... 1–20 through 1–23
VI. General .............................................................................. 1–24

Section I. FUNCTIONS OF THE MEDICAL DEPARTMENT

General ........................................................................... 1–1
Promotion of Physical Fitness ................................................... 1–2
Prevention and Control of Diseases .......................................... 1–3
Treatment and Care of the Sick and Injured ......................... 1–4

1–1. General

(1) The Medical Department of the Navy embraces personnel trained in medical, dental, and collateral sciences, and the facilities and the administrative structure necessary to provide efficient medical and dental services for the Navy. The mission of the Medical Department can be stated broadly as “the maintenance of the health of the Navy and the care of the sick and injured.” The integration necessary to accomplish this mission is attained through the efforts of Medical Department personnel to achieve a common purpose under the guidance of the Bureau of Medicine and Surgery, which has the responsibility and the authority for the direction of the medical and dental services of the Navy.

(2) The Medical Department is charged with and is responsible for maintaining the health of the Navy through the promotion of physical fitness, the prevention and control of diseases and injuries, and the treatment and care of the sick and injured. In order to fulfill this responsibility, the Medical Department is actively concerned with all phases of life in the Navy and makes recommendations to and advises all departments of the Navy on matters which may affect the health of naval personnel.

(3) The administration of all professional medical, dental, and allied services of the Navy is centered in the Bureau. The responsibility for coordinating and integrating the administrative and professional functions of the Medical Department is vested in the Surgeon General, who is the Chief of the Bureau (10 USC 5137, 5138). He is assisted by the Deputy and Assistant Chief of Bureau, and other staff personnel. In accordance with the statutory organization of the Navy Department, the duties of the Bureau are performed under the authority of the Secretary of the Navy; thus, orders issued by the Bureau in fulfilling its responsibilities have the full force and effect of orders issued by the Secretary (10 USC 5132).

1–2. Promotion of Physical Fitness

(1) It is the duty of the Medical Department to provide for physical examinations of persons applying for entry into the Navy and of officers and enlisted personnel of the Navy for the purpose of selecting or retaining only those whose physical and mental condition is such as to maintain or improve the military efficiency of the service.

(2) It is a further responsibility of the Medical Department to see that the sanitary, hygienic, and dietetic standards of the Navy are such as to maintain and improve the physical fitness of the personnel.

(3) Through indoctrination, and by means of inspections, reports, and recommendations, the Medical Department attempts to decrease the hazards

Change 7
of injuries which threaten the safety of military and civilian personnel of the Naval Establishment.

1–3. Prevention and Control of Diseases

(1) The Medical Department fulfills its responsibility in matters relating to the prevention and control of diseases by means of inspections, research, reports, and recommendations regarding sanitary conditions and problems, by planning and effecting necessary quarantine, immunization, and other preventive measures, and by training personnel in the various fields of preventive medicine.

(2) Sanitation has an important bearing upon the health of the Navy. The Medical Department is concerned with the determination of sanitary standards and advice on sanitary problems in cooperation with other bureaus and offices of the Navy Department, and other Government agencies.

(3) Immunization and quarantine likewise are not the responsibility solely of the Medical Department, but it is necessary for personnel trained in medical and related sciences to participate in these matters so that the health of the Navy may not be endangered. The Medical Department, therefore, establishes immunization procedures and adopts essential quarantine practices, both of which are effected under the supervision of Medical Department personnel.

(4) The Medical Department keeps itself informed on threats of disease and other potential health problems which are encountered in various parts of the world. By means of research and through the publication of information on the living conditions of native populations, and on food, water, disease vectors, and other environmental factors in areas where naval personnel are or may be required to go, the Medical Department attempts to prevent, to control, or to remove dangers to the physical efficiency of the personnel of the Navy. Necessary preventive measures are effected by or under the direction of such Medical Department organizations and personnel as preventive medicine units, fleet epidemic disease control units, vector control groups, and quarantine officers.

1–4. Treatment and Care of the Sick and Injured

(1) A primary responsibility of the Medical Department is to provide adequate medical and dental treatment and care for the sick and injured. To accomplish this end the Medical Department develops or adopts and standardizes effective professional principles and methods of medical and dental treatment and care and trains its personnel in the application of these principles and methods. The success of naval practice in the treatment and care of the sick and injured is given continuous review by inspections, reports, and statistical analyses. Appropriate improvements are made and additional training is given as required.

(2) It is a further responsibility of the Medical Department to assure that naval medical and dental facilities are adequate to meet the needs of the Navy. The location, size, design, and other factors controlling the efficiency of these facilities are studied continuously and plans and recommendations made by the Medical Department.

Section II. ORGANIZATION OF THE MEDICAL DEPARTMENT

<table>
<thead>
<tr>
<th>Bureau of Medicine and Surgery</th>
<th>Article</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspectors of Naval Medical Activities</td>
<td>1–5</td>
</tr>
<tr>
<td>District Medical Officers and District Dental Officers</td>
<td>1–6</td>
</tr>
<tr>
<td>Medical Department Activities</td>
<td>1–7</td>
</tr>
<tr>
<td>Commanding Officers and Officers in Charge of Medical Department Activities</td>
<td>1–8</td>
</tr>
<tr>
<td>Medical and Dental Officers in Field Activities</td>
<td>1–9</td>
</tr>
<tr>
<td>Medical Department Personnel</td>
<td>1–10</td>
</tr>
</tbody>
</table>

1–5. Bureau of Medicine and Surgery

(1) The Bureau of Medicine and Surgery is the central agency of the Medical Department. Its basic functions are to develop Medical Department plans, policies, and practices and to direct the organization and operations of medical and dental activities ashore and afloat, with the goal of attaining the highest quality of medical and dental care and maximum efficiency in Medical Department operations.

(2) In the overall organization of the Navy Department, the Chief of the Bureau of Medicine and Surgery is a technical assistant and advisor to the Secretary of the Navy, the Civilian Executive Assistants, and the Chief of Naval Operations in the formulation of policies and procedures governing the administration of the Naval Establishment on medical and dental matters. He has direct access to the Secretary of the Navy on all matters concerning the health of the Navy and the performance of the Medical Department in providing for the medical and dental needs of the Navy and maintaining health standards at the highest possible levels. He is responsible to the Chief of Naval Operations for the medical support of the Operating Forces and to the Civilian Executive Assistants in all matters affecting the business and logistic administration of the Medical Department.

1–2

Change 11
(3) The Bureau, in directing the work of the Medical Department, cooperates and maintains liaison, as appropriate, with other bureaus and offices of the Navy Department, field commands, the other armed services, the Department of Defense, other governmental agencies, and quasi-public and private organizations.

(4) The Bureau participates with the Offices of the Surgeons General, Departments of the Army and Air Force, in operating the various joint medical agencies established by the Secretary of Defense; such as, the Armed Forces Institute of Pathology and the Armed Services Medical Regulating Office. In addition, the Bureau is responsible for administrative support of the Armed Services Medical Material Coordination Committee.

(5) The specific functions of the Bureau, and the organizational unit responsible for each, are listed in section III of this chapter.

1-6. Inspectors of Naval Medical Activities

(1) The regional medical officers assigned to perform inspections and related duties in an area comprising more than one naval district shall have the title “Inspector, Naval Medical Activities.” The specific duty of this inspector is enumerated in chapter 5.

1-7. District Medical Officers and District Dental Officers

(1) The senior medical officer and the senior dental officer assigned to the staff of a commandant of a naval district shall be designated “District Medical Officer” and “District Dental Officer,” respectively. The Navy Department assigns a district medical officer and district dental officer for each naval district.

(2) The district medical officer and the district dental officer are liaison officers for the commandant with the Bureau, the Inspectors General, Medical and Dental, and the medical officer and dental officer of each naval activity in the district on medical or dental logistic and technical matters under the cognizance of the commandant; and with civilian medical, dental, and public health authorities on sanitary (and other public health) matters affecting naval activities and personnel.

(3) The district medical officer shall advise and assist the commandant concerning all professional, technical, logistics, and administrative matters, relating to the medical services of the district; administer naval medical Reserve matters; coordinate and aid medical activities within the district in the effective execution of their assigned functions; and inspect such activities to assure their compliance with the policies, standards, and practices established by the Bureau. The specific duties of the district medical officer are enumerated in chapter 5.

(4) The district dental officer shall advise and assist the commandant concerning all professional, technical, logistics, and administrative matters relating to the dental service of the district; administer naval dental Reserve matters; coordinate dental activities within the district; and visit such activities to assure their compliance with the policies, standards, and practices established by the Bureau.

(5) When discharging their responsibilities, the district medical officer and the district dental officer are, in effect, field representatives of the Bureau overseeing the Medical Department interests within each district.

1-8. Medical Department Activities

(1) The Medical Department comprises a wide variety of field activities, some of which are under both the management and technical control of the Bureau, while others are under its technical control only.

(2) The Bureau has direct management and technical control over naval medical centers; U.S. naval hospitals; medical research laboratories, institutes, and units; preventive medicine units; disease vector control centers; medical units at nonnaval activities; medical and dental technical schools, including schools for aviation medicine and hospital administration; the Field Branch, Bureau of Medicine and Surgery; and those naval dispensaries and dental clinics having their own commanding officers.

(3) The Bureau has technical control over medical and dental departments ashore and afloat, including dispensaries and station hospitals; medical and dental field units with the Marine Corps; advanced base medical and dental components; hospitals in hospital ships; the Military Medical Supply Agency; and medical and dental research conducted in field activities under the management control of other bureaus and offices of the Navy Department.

1-9. Commanding Officers and Officers in Charge of Medical Department Activities

(1) A medical officer, dental officer, or Medical Service Corps officer, as appropriate, is assigned as commanding officer or officer in charge of each activity over which the Bureau has management and technical control. He is responsible for the direction and coordination of all functions of the activity, subject to U.S. Navy Regulations, the orders and instructions of the Bureau, and those of other competent higher authority.
1-10. Medical and Dental Officers in Field Activities

(1) The medical officer and the dental officer of a naval activity are responsible to the commanding officer for the medical and dental services, respectively, of that activity. The functions of the medical and dental departments of a naval activity are administered by the medical and dental officers and their staffs in accordance with U.S. Navy Regulations, this Manual, Bureau instructions, and the orders of the commanding officer.

Section III. ORGANIZATION OF THE BUREAU OF MEDICINE AND SURGERY

1-12. Bureau of Medicine and Surgery

(1) As the headquarters organization of the Medical Department, the Bureau controls and directs the medical and dental services of the Navy; initiates, coordinates, and effectuates the policies, standards, and practices of the Medical Department; and is responsible for the operation of all Medical Department activities under its management control.

(2) The Bureau organization is depicted on the following chart. The functions of each office and division are listed below.

(3) The Chief of Bureau (Surgeon General) is responsible for the immediate supervision, direction, and coordination of all administrative and professional functions of the Bureau and through it the activities of the Medical Department ashore and afloat, in accordance with U.S. Navy Regulations, General Orders, and other orders and directives of the Secretary of the Navy, the Under Secretary, the Assistant Secretaries, and the Chief of Naval Operations.

(4) The Consultant Groups, comprised of nationally recognized specialists in the fields of medicine, dentistry, nursing, or allied sciences, assist and advise the Chief of Bureau in the execution of his professional responsibilities.

(5) The Policy Board advises the Chief of Bureau on policy matters relating to current and planned operation of the Bureau and Medical Department activities.

(6) The Deputy and Assistant Chief of Bureau ranks next to the Chief of Bureau in authority and is responsible for the projection of his policy control throughout the Bureau and the Medical Department, and acts with full responsibility and authority for him in his absence. He serves as Chairman of the Budget Advisory Council of the Bureau and of the Policy Board of the Bureau.

1-11. Medical Department Personnel

(1) The Medical Department comprises five separate corps, each of which is composed of specialized personnel required to perform the designated duties for that corps. These corps are the Medical Corps, Dental Corps, Medical Service Corps, Nurse Corps, and Hospital Corps. The medical, dental, and related services and health programs for which the Medical Department is responsible are carried out by the personnel of the several corps, and by civilians in the Bureau and the field activities.

1-12. Bureau of Medicine and Surgery

(7) The Legal Assistant to the Surgeon General provides legal consultation and advice to the Chief of Bureau, the Deputy and Assistant Chief of Bureau, other Bureau officials, boards and offices, and commanding officers of Bureau field activities. He represents the Bureau on legislative clearance and liaison matters.

(8) The Inspector General, Medical, plans, coordinates, and directs the medical inspection program; conducts such special inspections and investigations as the Chief of Bureau may direct; reviews and appraises inspection reports of Medical Department facilities, other than dental, submitted by field inspectors; and maintains liaison with the office of the Naval Inspector General.

(9) The Technical Information Officer coordinates the preparation and release of information which will promote knowledge of and interest in the activities and accomplishments of the Medical Department.

(10) The Comptroller is special advisor and consultant to the Chief of Bureau in all areas of financial management, and serves as the Director, Comptroller Division.

(11) Deleted.

(12) The Research Advisor cooperates with the Director, Research Division, and the Assistant Chief for Research and Military Medical Specialties in developing an integrated research program for the Medical Department.

(13) The Naval Medical News Letter Liaison Officer complies and edits an informational newsletter to medical and dental officers containing digests from current literature and research reports in the fields of medicine and dentistry.

(14) The Assistant Chief for Personnel and Professional Operations advises the Chief of Bureau on personnel policies and needs, and coordinates Bureau personnel operations relating to active duty and Reserve components of the Medical Corps, Medi-
nal Service Corps, Nurse Corps, and Hospital Corps; is responsible for the development and maintenance of professional standards and policies relating to hospitalization and patient-care practices; directs the development and application of physical qualification standards for Navy and Marine Corps personnel; directs the Bureau's program for the medical care of Navy dependents; and develops policies governing, and is responsible for, the editorial management of Bureau medical and dental publications.

(a) The Professional Division determines the professional needs of the Medical Department (except dental); establishes professional standards and policies relating to medical practices and hospitalization, and evaluates performance thereof; develops and advises on recommended Medical Corps officer personnel programs and policies, and directs implementation of approved programs and policies; coordinates and administers programs for the training of Medical Department personnel (except dental); provides liaison service with the American National Red Cross; develops plans for and advises on measures necessary for Navy implementation of the Dependents' Medical Care Act; and administers the program for medical care of Navy dependents in areas outside the United States, Hawaii, and Puerto Rico.

(b) The Nursing Division develops, coordinates, evaluates, and advises or recommends on matters pertaining to personnel policy, military requirements, and professional qualifications of Nurse Corps officers. It initiates and recommends action pertaining to procurement, distribution, separation, career planning, training, and accounting for these personnel in consultation with cognizant program directors.

(c) The Physical Qualifications and Medical Records Division reviews, makes recommendations, and takes action on all reports or requests involving physical examinations and physical qualifications of all past or present Navy or Marine Corps personnel, except for certain specific categories of aviation personnel; files and preserves all medical records; acts on requests for copies of and information from these medical records; and reviews and takes action on reports of survey and retiring boards, reports of Naval Courts and other communications relating to medico-legal matters.

(d) The Hospital Corps Division develops, coordinates, evaluates, and advises or recommends on matters pertaining to personnel policy, military requirements, and professional qualifications of Hospital Corps personnel. It initiates and recommends action pertaining to procurement, distribution, separation, career planning, training, and accounting for these personnel in consultation with cognizant program directors.

(e) The Medical Service Corps Division develops, coordinates, evaluates, and advises or recommends on matters pertaining to personnel policy, military requirements, and professional qualifications of Medical Service Corps officers and Medical Service Warrant Officers. It initiates and recommends action pertaining to procurement, distribution, separation, career planning, training, and accounting for these personnel in consultation with cognizant program directors.

(f) The Naval Reserve Division plans and administers the Naval Medical Reserve Program of the Medical Corps, Medical Service Corps, Nurse Corps, and Hospital Corps, Group X, to provide adequately trained Medical Department reserve personnel to meet the overall requirements of the Navy in time of emergency or mobilization.

(g) The Publications Division advises on medical and dental publications policies and needs; edits Bureau publications; and directs the collection and preparation of material for naval medical and dental histories.

(15) The Assistant Chief for Planning and Logistics develops plans for providing effective medical facilities and logistic support to the Department of the Navy; directs the program for improved business management and nonprofessional administration of naval hospitals and other Bureau-managed activities; directs administrative support operations including the comptroller function, civilian personnel management, administrative reporting, directives control, and administrative and medical statistics; directs the program for providing nonnaval medical and dental care; and directs the Navy's decedent affairs program.

(a) The Planning Division develops and coordinates Medical Department planning in support of basic operational plans of the Department of the Navy; determines requirements and makes recommendations relative to the Medical Department position on real estate matters, and on the scope, location, design, construction, alteration, improvement, and maintenance of medical and dental spaces and installations afloat and ashore; and supervises the physical aspects of fire protection and security of Bureau-managed activities.

(b) The Materiel Division develops technical policies governing Navy medical and dental matériel programs; determines requirements for such matériel; and recommends policies and procedures relative to initial outfitting, and research and development of medical and dental materials, including adoption, modification, or deletion of items cataloged.

(c) The Hospital Administration Division advises on, and develops guides and procedures pertaining to, the business management and nonprofessional administrative operations of hospitals and other Bureau-managed activities including the areas of food service, organization, records management, office equipment, and other laborsaving de-
cies and facilities; collects, evaluates, and disseminates information on new administrative methods and techniques; and maintains liaison with other military and civilian hospital administration organizations relative to management improvement.

(d) The Administration Division performs administrative functions including local building maintenance and office services, printing, forms control, civilian personnel administration, administrative reporting, Bureau internal correspondence and records management and administrative procedures, reports, and directives control; physical security services and Bureau fiscal services; directs the program for providing nonnaval medical and dental care of active duty and retired personnel; directs the Navy's decedent affairs program; and maintains Bureau organization manuals.

(e) The Comptroller Division develops and executes fiscal policies; prepares and presents Medical Department budgets; performs appropriation, reimbursement, and cost accounting functions; prescribes accounting and fiscal procedures, systems, guides, and criteria for control of funds; administers the program review and analysis function; and acts in an advisory capacity to other divisions of the Bureau on fiscal matters.

(f) The Medical Statistics Division operates a general nonbudgetary reporting system relating to medical facility workloads, staffing, and the overall health of the Navy; analyzes data collected from the field and prepares statistical summaries, reports, and publications on the activities of the Medical Department; and provides a statistical consulting service.

(16) The Assistant Chief for Aviation Medicine is responsible for all phases of Medical Department programs relating to aviation medicine and directs those aspects relating to selection, training, and qualifications of naval personnel for aviation duties and to the design of aeronautical systems and equipment.

(a) The Aviation Medicine Operations Division determines and advises on naval aviation medical needs, policies, standards, and practices; plans and directs Medical Department activities relative to physical qualifications, selection, and training for naval aviation personnel; advises on assignment of aviation medical personnel; and cooperates with appropriate divisions of the Bureau and other bureaus and offices on aviation medical personnel administration.

(b) The Aviation Medicine Technical Division studies, evaluates, and provides technical advice on the design and development of aeronautical systems and equipment in consideration of human physiological and psychological capacities; coordinates and advises on aeromedical research; and cooperates with appropriate bureaus in the development of protective and survival equipment, and flight safety and training programs, including Marine Corps aviation requirements.

(17) The Assistant Chief for Dentistry formulates policy for, and directs all phases of, the dental program to provide dental services required by the Navy and Marine Corps; and serves as advisor for the Bureau on all matters pertaining directly to dentistry.

(a) The Dental Division plans and administers dental programs, including the dental Reserve program; establishes and maintains professional standards and policies governing dental practice; develops and recommends standards and policies governing qualifications, complement, advancement, training, and transfer of dental officer and enlisted personnel; and conducts surveys of dental activities and facilities. (See art. 6-5.)

(18) The Assistant Chief for Research and Military Medical Specialties coordinates and correlates the various phases of research; preventive and occupational medicine; dispensary medical activities; the military medical aspects of atomic, biological, and chemical warfare defense; and submarine, amphibious, and Marine Corps field operations.

(a) The Research Division initiates and coordinates medical and dental research programs; evaluates proposals for research; continuously reviews the latest scientific medical developments for application to Navy medical operations; and disseminates the results of medical and dental research projects.

(b) The Preventive Medicine Division determines and advises on the preventive medicine needs, policies, standards, practices, and performance requirements of the Medical Department, and directs the preventive measures necessary to maintain the health of the Navy.

(c) The Occupational Medicine and Dispensary Division is responsible for the occupational health program of the Navy, and for the technical direction of dispensaries at naval stations, air stations, shipyards, etc., and at medical activities afloat.

(d) The Special Weapons Defense Division plans and develops those aspects of atomic, biological, and chemical warfare defense policies and programs including radiological safety, training, and research, which come under the cognizance of the Medical Department; and insures the dissemination of information concerning them.

(e) The Submarine Medicine Division studies, evaluates, and develops recommendations on medical requirements and policies, standards, practices, and training procedures of the submarine forces, and deep-sea diving and underwater swimming units.

(f) The Amphibious and Marine Corps Medicine Division studies, evaluates, and makes recommendations concerning medical needs, policies, practices, and training procedures relating to the amphibious and Marine Corps field forces.
(g) The Astronautical Division plans, directs, and coordinates operations in the field of astronomical medicine, biology, and human factors; and in coordination with the Research Division, institutes and directs the Bureau's astronautical medical research program.

Section IV. RESEARCH

1-13. Statement of Policy

(1) The fundamental policy of the Bureau is to encourage and support research and development in medical, dental, and allied sciences directed toward the solution of problems affecting the health, safety, selection, and efficiency of the personnel of the Department of the Navy and other branches of the Department of Defense.

(2) The direction of the research activities of the Medical Department of the Navy shall be centralized in the Research Division of the Bureau. The direction of dental research facilities shall be coordinated with the Dental Division.

(3) The Director of the Research Division shall act as Bureau Coordinator for Research and Development (art. 1-12(18)(a)) and shall be responsible for research testing, evaluation, and development.

(4) There shall be no fixed apportionment of basic research and applied or developmental research.

(5) Research laboratory commanding officers shall ensure that medical and dental officers assigned to research duties are utilized maximally in accordance with their professional qualifications and with a minimum responsibility for routine administrative functions. Maximal assignment of administrative duties shall be accorded to supportive personnel.

(6) Commanding officers of research laboratories under the management control of the Bureau whose personnel-allowance structure contains a civilian technical director shall engender the utmost rapport to the end that the technical director actively participates in the planning of the research program of the laboratory. The responsibilities of the technical director shall be defined in writing.

(7) All research laboratories under the management control of the Bureau shall prepare a statement of mission expressed in broad general terms to provide for flexibility, and the work programs of laboratories shall be reviewed periodically with Bureau representatives.

(8) Commanding officers of research laboratories shall exploit all avenues of enhancing the attractiveness of laboratory employment in an effort to produce a creative atmosphere and conditions conducive to conscientious scientific productivity. Employee development programs shall be effected and the professional-grade personnel shall be encouraged to participate in the activities of professional societies.

1-14. Scope

(1) The fields of research studies in medicine, dentistry, and allied sciences shall include the broadest aspects of medical and dental problems related to submarine, shipboard, aviation, amphibious, and field activities, sea transport, and military personnel.

(2) Research, development, testing, and evaluation shall be concerned principally with pertinent Naval Research Requirements as promulgated by the Chief of Naval Research. A continuous program of research in the basic sciences that affect military medicine and dentistry, and their ancillary branches, shall be maintained. In time of war and national emergency, the major effort and attention shall be directed to the practical application of improved methods of medical and dental defenses against the weapons, health hazards, and agents of modern warfare.

(3) Naval hospitals and other naval medical activities are encouraged to conduct clinical research, including studies of diseases and injuries, statistical records of series of cases, appropriate therapeutic trials, and other phases of clinical investigation. The research projects and the therapeutic trials must be authorized by and reported to the Bureau of Medicine and Surgery, through its Research Division. Application may be made on form NAVMED-98 or on other official forms that may be provided for this purpose.

1-15. Laboratories and Facilities

(1) In addition to the usual installations, in hospitals and dispensaries, and in the medical and dental facilities of ships and stations, the Bureau will maintain research laboratories and facilities separately and in cooperation with other bureaus, the Office of Naval Research, and the Marine Corps.

1-16. Projects

(1) Projects for research will be established by the Bureau in accordance with Naval Research Re-
requirements as promulgated by the Chief of Naval Research. Tasks under the project will be assigned to research activities by the Bureau or at the request of the activity. Proposals for research will be submitted by individual investigators via official channels for consideration and technical approval. Cooperation with other services may be effectuated by individual investigators upon the Bureau's approval or direction.

(2) The selection and approval of research proposals will depend on the desires, initiative, and competence of the research workers; the available facilities; and the special opportunities offered by the location and environment of particular establishments. In the conduct of their studies, investigators will be given the greatest possible freedom consistent with naval policies and the security regulations as administered by their commanding officers. Investigators will be encouraged to arrange through the Bureau for consultation with civilian scientists, for collaboration with civilian institutions of learning and research, and for interservice cooperation. The Bureau will cooperate in facilitating the exchange of information, the authorization of contract research through the Office of Naval Research, and provision of medical and dental intelligence to proper authorities, via official channels, and will maintain liaison with research activities in foreign countries.

(3) At command research units and/or laboratories under the Bureau's management control, pilot studies may be undertaken at the discretion of the commanding officer, who shall be responsible for the conduct of such studies and reporting of same to the Chief of the Bureau.

1-17. Experimentation on Personnel

(1) Experimental studies of a medical nature involving persons in the Naval Establishment are forbidden except when the experimental design in each case has received the prior approval of the Secretary of the Navy. All such requests shall be forwarded via the Bureau for consideration and recommendation to the Secretary of the Navy. In the case of military personnel or their legal dependents, recommendations on requests received shall be made by the Bureau and forwarded to the Chief of Naval Personnel, the Commandant of the Marine Corps, or the Commandant of the Coast Guard, as appropriate, prior to submission to the Secretary of the Navy.

(2) Participation by personnel of the Naval Establishment (military and civilian) shall be on a voluntary basis only. Volunteers will not be required to execute a release from future liability for negligence attributable to the Navy. Such studies shall in no way interfere with the training or other performance of normal duties of the personnel involved.

(3) For each instance a statement shall be entered into the individual's Health Record indicating the project number and the physical and psychological effect, or lack of same, resulting from the investigation. In case of civilian volunteers, the commanding officer shall cause a similar entry to be recorded in the individual's personnel file.

1-18. Trials of Commercial Items, Specialties, and Pharmaceutical Products

(1) Authority to conduct clinical, laboratory, or field trials at naval medical activities of drugs, materials, or devices presented by commercial firms may be granted by the Bureau provided specific scientific conditions are met. The term commercial firm includes firms, companies, corporations, individuals, or groups which have a financial interest in the product or process to be tested. Trials or tests will be conducted only when they are entirely objective and promise to yield unequivocal results. To meet the objectives of the Bureau, the following conditions are specified:

(a) The method of diagnostic tests or of treatment must be fully explained.

(b) There must be no secrecy as to the process of manufacture or chemical composition of the agent.

(c) Diagnosis must have been made by a competent doctor of medicine or dentistry and verified by complete clinical and laboratory criteria.

(d) Complete records of patients or experimental subjects made under qualified medical or dental supervision must be submitted.

(e) Results must be based on well-controlled scientific methods of investigation rather than on individual case reports.

(f) If methods of treatment are proposed, the supervised clinical records indicated above must show that no other definitive treatment was used.

(g) Materials for treatment, diagnosis, or other biological testing must be provided in adequate quantities without cost to the Bureau. Devices must be complete in all details and ready for operation.

(h) The proposer must agree that whenever the Bureau deems it advisable, the request and the complete data may be submitted to the National Research Council for advice. (The Bureau is not committed to compliance with the advice so provided.)

(i) Any definitive action on the part of the Bureau will depend on the availability of suitable personnel, the provision of adequate facilities, and the operational requirements of the Navy and the Medical Department.

(j) All reports shall become the property of the Bureau, which assumes no obligation to or for any commercial firm.
1-19. Technical Reports and Public Releases

(1) The Bureau requires interim and final reports on all tasks or subtasks conducted under a project. Interim reports are required upon the accomplishment of any significant achievement or scientific breakthrough regarding the problem under investigation. Final reports shall be submitted at the earliest practicable time after completion, cancellation, or suspension of a task or a specific subtask thereunder. Interim and final reports shall be of a scientific-professional type in the general style of reporting that is used for the scientific journals and shall bear the marking For Official Use Only. Current Instructions in the 5570 series provide for expeditious removal of such restrictive statements. When submitting an interim or final report to the Bureau, a suggested distribution list for copies (for official use) should be forwarded for consideration.

(2) An annual RPR Task Report (OPNAV Report Symbol 3910-1) shall be submitted in accordance with article 23-43. This report is used administratively to summarize the advancement made by medical research in the Navy and as justification for budgetary purposes.

(3) The Bureau, in recognizing the great importance of disseminating the information gained from medical research, testing, and development, heartily encourages not only wide distribution of reports via official channels but also presentation of appropriate reports through public media such as lecture, discussion, or publication, whenever security and/or established policy are not breached. Therefore, all reports destined for distribution to or by public media must be cleared and approved for release by the commanding officer of the unit from which they emanate. All persons, including civilian and military attached to Bureau of Medicine and Surgery managed laboratories and research facilities, shall sign such articles and attach the disclaimer statement of article 1252.3 of Navy Regulations. A similar procedure applies to speeches and public discussions, in which cases the individual shall inform his listeners of his unofficial status. Where doubt exists, manuscripts, classified or unclassified, may be submitted to the Bureau for clearance or review prior to publication.

(4) As soon as practicable after publication of an article, military authors from research facilities shall submit three reprints (not manuscripts) of the article, via official channels, to the Chief, Bureau of Medicine and Surgery; all other authors (civilian from Bureau managed activities, and other military authors) shall submit two reprints. The Bureau will forward one copy of each reprint by military author to the Secretary of the Navy; one copy will be retained in Bureau files; a third copy (when applicable) will be retained by the Research Division.

(5) A minimum of 10 copies of scientific and technical reports pertaining to medical and dental research and development shall be furnished to the Armed Services Technical Information Agency, Arlington Hall Station, Arlington 12, Va., subject to the provisions of the current OPNAV Instruction in the 5510.17 series.

Section V. NOMENCLATURE AND DEFINITIONS FOR MEDICAL TREATMENT FACILITIES

<table>
<thead>
<tr>
<th>Article</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20</td>
<td>Nomenclature and Definitions Pertaining to Fixed Medical Treatment Facilities</td>
</tr>
<tr>
<td>1-21</td>
<td>Nomenclature and Definitions Pertaining to Nonfixed Medical Treatment Facilities</td>
</tr>
<tr>
<td>1-23</td>
<td>Nomenclature and Definitions Pertaining to Battle Casualty Reporting</td>
</tr>
</tbody>
</table>

II. POLICY. The policy of the Department of Defense is that there will be two basic types of fixed medical treatment facilities, and that the nomenclature and definitions applicable to the classification of these facilities, used herein, will be used by the three military departments.

III. DEFINITIONS.

A. Dispensary: A dispensary is a medical treatment facility primarily intended to provide outpatient medical service for non-hospital type ambulatory patients. Examination and treatment and first aid for emergency cases are types of services rendered. A dispensary is also intended to perform certain nontherapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, and other preventive medical and sanitary measures necessary to support a primary military mission. A dispensary will be equipped with the necessary supporting services to perform its assigned mission. A dispensary may be equipped with beds (normally less than 25) for observation of patients awaiting transfer to a hospital, and for care of “quarters” type cases which cannot be cared for on an outpatient status, but which do not
require hospitalization. Patients whose expected duration of illness exceeds 72 hours will not occupy dispensary beds for periods longer than are necessary to arrange transfer to a hospital.

B. Hospital: A hospital is a medical treatment facility primarily intended to provide inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission. A hospital may, in addition, discharge the functions of a dispensary.

(b) Support and Care Provided.—

(1) Hospitals.—Hospitals primarily support the operational military needs of naval air commands, major Marine Corps commands, naval districts, and sea frontiers and forces afloat, including the needs of overseas commands for continental hospital services. Hospitals also support on a reciprocal basis the operational military needs of the Departments of the Army and Air Force.

(2) Dispensaries.—

(a) Dispensaries normally care for patients from the local military command and from the immediate vicinity.

(b) In subarticle 1-21(1) (a) IIIA, reference is made to beds for care of “quarters” type cases. This applies to Army and Air Force but not to Navy.

(c) Subarticle 1-21(1) (a) IIIA, in the last sentence, states that “patients whose expected duration of illness exceeds 72 hours will not occupy dispensary beds for periods longer than are necessary to arrange transfer to a hospital.” An exception to this general rule should be made, particularly at isolated bases, for those patients whose required treatment is within the professional capability of the admitting dispensary and whose transfer to a hospital would be uneconomical and not in the best interests of the patients. Sound professional judgment must be the predominating factor in determining which patients can be adequately treated in a dispensary as opposed to those requiring more extensive medical care.

(c) Administrative Titles.—To differentiate between the various administrative types of hospitals and dispensaries, the following titles shall be utilized:

(1) U.S. Naval Hospital (Location), for a hospital that is an established activity with a commanding officer, under the management control of the Bureau of Medicine and Surgery.

(2) Station Hospital (Activity, Location), for a hospital that is a component of a medical department at an activity under the management control of a bureau or office other than the Bureau of Medicine and Surgery.

(3) U.S. Naval Dispensary (Location), for a dispensary that is an established activity with a commanding officer, under the management control of the Bureau of Medicine and Surgery.

(4) Dispensary (Activity, Location), for a dispensary that is a component of a medical department at an activity under the management control of a bureau or office other than the Bureau of Medicine and Surgery.

(2) Beds.—Department of Defense Instruction 6015.1 of 25 September 1958 is quoted below:

I. PURPOSE.—To provide standard nomenclature and definitions to be used in the Department of Defense in accounting for bed capacity, bed status, and bed occupancy in fixed medical treatment facilities.

II. STATEMENT.—In accounting for bed capacity, bed status, and bed occupancy in fixed medical treatment facilities, the three military departments will use the nomenclature and definitions set forth herein. Uniform requirements for collection of data by the military departments will be established by separate action.

III. TERMS AND DEFINITIONS

A. With respect to bed capacity:

1. NORMAL BED CAPACITY, or capacity for normal peacetime use, is space for patients’ beds and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients’ beds, spacing beds eight feet between centers (approximately 100 square feet per bed). Former ward space which has been disposed of or has been so altered that it cannot be readily reconverted to ward space is not included in computing bed capacities. Space for beds used only in connection with examination or brief treatment periods, such as in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity but is accounted for separately in terms of the number of bassinets it accommodates.

2. EXPANDED BED CAPACITY, is space for patients’ beds and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients’ beds, spacing beds six feet between centers (approximately 72 square feet per bed). Former ward space which has been disposed of or has been so altered that it cannot be readily reconverted to ward space is not included in computing bed capacities. Space for beds used only in connection with examination or brief treatment periods, such as in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity but is accounted for separately in terms of the number of bassinets it accommodates.

B. With respect to bed status:

1. OPERATING BED. A medical treatment facility bed, with space and equipment, that is currently set up and in all respects ready for the care of a patient, and that the facility is staffed to operate under normal circumstances. The definition excludes: nursery bassinets; transient patients’ beds.

2. INACTIVE BED. A medical treatment facility bed, with space (within expanded bed capacity) and equipment, that is in all respects other than the provision of medical staff ready for the care of a patient; that is, that the facility is equipped but not staffed to operate under normal circumstances. The bed need not necessarily be set up.

3. TRANSIENT PATIENT’S BED. A bed that a designated medical treatment facility operates for the care of a patient who is being moved between medical treatment facilities and who must stop over for a short period of time while en route to his final destination.

C. With respect to bed occupancy:

1. OCCUPIED BED. A bed that is assigned as of midnight to a patient, to include a patient on pass
or liberty not in excess of 72 hours, and any bassinet assigned to a newborn infant whose mother has been discharged from the hospital. The definition excludes: any bed assigned to a patient subsisting out, on leave, or absent without leave; any bed occupied by a transient patient; any bassinet assigned to a newborn infant whose mother is still a patient in the hospital.

2. BED OCCUPIED BY TRANSIENT PATIENT. A bed assigned as of midnight to a patient who is being moved between medical treatment facilities and who stops over en route to his final destination.

3. It is recognized that bed requirements of a small medical treatment facility may not be indicated fully by data collected according to definitions 1 and 2 above. Under these circumstances, a military department or medical treatment facility may find it useful to compile information on its bed utilization that cannot be accounted for under either definition 1 or 2.

1-22. Nomenclature and Definitions Pertaining to Nonfixed Medical Treatment Facilities

(1) Nonfixed medical treatment facilities are:

(a) Medical facilities for field service with the Marine Corps; such as, aid stations, clearing stations, and division field and force evacuation hospitals.

(b) Medical facilities afloat (hospital ships, sick bays aboard ship).

(c) The medical advance base component contained within mobile type units; such as, construction battalions, cargo handling battalions, etc.

(2) Designated Bed Capacity.—The bed capacity of land-based, nonfixed, medical treatment facilities providing bed care, and of medical treatment facilities afloat, is referred to as the designated bed capacity, defined as follows:

(a) Designated bed capacity is the number of patients' beds which is specified in a table of organization and equipment, advanced base catalog, or ship's specifications to be the number of beds a stated type of medical treatment facility is designed to provide; whenever these basic capabilities of a medical treatment facility have been modified by competent higher headquarters so that the bed capacity of the facility is either augmented or diminished, the modified capacity thereupon becomes the designated bed capacity.

(b) Operating Beds are those beds in a functioning* medical treatment facility which are set up, equipped, staffed, and in all respects ready for the care of patients.

(4) Occupied Beds are those beds currently assigned to patients.

* A functioning medical treatment facility is one which is partially or completely set up and ready to receive patients, as distinct from a nonfunctioning facility which is one not set up and not ready to receive patients due to such conditions as being in transit, in transit, staging, or held in tactical reserve.

(5) Operating Beds Available are those of the operating beds not currently assigned to patients.

(6) Base Hospitals.—Although Navy base hospitals are fundamentally different from the nonfixed type of medical treatment facilities and from medical facilities afloat as to their missions and military operational use, their wartime bed capacities are nevertheless established in the same way. Therefore, in wartime or in time of a large-scale military mobilization, the terms defined in subarticles 1-22(2) through 1-22(5) will be used in determining and reporting the bed capacities and bed status of all these types.

1-23. Nomenclature and Definitions Pertaining to Battle Casualty Reporting

(1) Battle Casualty.—A battle casualty is any person lost to his organization because of death, wound, missing, capture, or internment provided such loss is incurred in action. "In action" characterizes the casualty status as having been the direct result of hostile action; sustained in combat and related thereto; or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. However, injuries due to the elements or self-inflicted wounds are not to be considered as sustained in action and are thereby not to be interpreted as battle casualties.

(2) Wounded in Action.—The term "wounded in action" will be used to describe all battle casualties other than the "killed in action" who have incurred a traumatism or injury due to external agent or cause. Thus broadly used it encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetrating or perforating wound, or none, as in a contused wound; all fractures; burns, blast concussions; all effects of gases and like chemical warfare agents; and the effects of exposure to radioactive substances.

(3) Died of Wounds Received in Action.—The term "died of wounds received in action" will be used to describe all battle casualties who die of wounds or other injuries received in action, after having reached any medical treatment facility. It is essential to differentiate these cases from battle casualties found dead or who died before reaching a medical treatment facility (the "killed in action" group). It should be noted that reaching a medical treatment facility while still alive is the criterion.

(4) Killed in Action.—The term "killed in action" will be used to describe battle casualties who are killed outright or who die of wounds or other injuries before reaching any medical treatment facility.
1-24. American National Red Cross

(1) General.—The American National Red Cross was reincorporated by the act of Congress of 5 January 1905 as amended (36 USC 1 et seq.) as the agency of the Government for the fulfillment of certain treaty obligations into which the United States entered when it became signatory to the treaty of the Red Cross, or the treaty of Geneva of 22 August 1864. The number of national Red Cross societies officially recognized by the International Red Cross Committee is 63, including the American National Red Cross. The International Red Cross Committee is entrusted with the maintenance of fundamental Red Cross principles and its essential characteristic is its absolute neutrality under the Geneva conventions. Under these conventions the national societies are recognized by their governments as auxiliaries to the medical departments of their fighting services. They are pledged to prepare themselves in peacetime for necessary wartime work.

(2) Welfare Program.—Pursuant to the request of the Secretary of the Navy, the American National Red Cross, in times of peace, conducts a welfare program for members of the Navy and their dependents, including home service by local chapters, and hospital and recreation services for patients in establishments under the management control of the Bureau. In times of war the Secretary of the Navy may request that these programs be expanded or new services appropriate to the functions of the American National Red Cross be provided.

(3) Representatives.—American National Red Cross representatives assigned to naval establishments are considered to be members of the staff of the establishment for organizational purposes. The American National Red Cross will designate the representative who, acting under the commanding officer, is responsible for coordinating all Red Cross activities of the establishment.

(4) Volunteer Aid.—In conformity with U.S. Navy Regulations, volunteer aid for Medical Department establishments shall be accepted only through the agency of the American National Red Cross. The foregoing, however, does not prohibit individuals and representatives of other organizations from visiting Medical Department establishments, or when approved by the commanding officer, acceptance by patients of personal gifts or services tendered by individuals.

(5) Requests for Services.—Requests for Red Cross services in new establishments, and matters relating to the functioning of Red Cross representatives within an establishment or affecting general policy which are not provided for in current instructions, shall be referred to the Bureau for appropriate action.
American National Fire Code

CHAPTER 39. Medical Occupations


1. Scope and application.

2. Exemption.

3. Duration of compliance.

4. Enforcement.

5. Penalties.

6. Applicability of other codes.

7. Adoption of model codes.

8. Enforcement of codes.

9. Inspections and hearings.

10. Appeals.

11. Ancillary provisions.

12. Definitions.

13. Effective date.


15. Repeal of other codes.

16. Compliance with national codes.

17. Interpretation.

18. Enforcement of regulations.

19. Enforcement by city officials.

20. Enforcement by state officials.

21. Enforcement by federal officials.

22. Enforcement by local officials.

23. Enforcement by municipal officials.

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99. Enforcement by county officials.
Chapter 2

MEDICAL CORPS: ORGANIZATION, APPOINTMENTS, AND ADVANCEMENT IN GRADE

Sections

I. Organization................................................................. 2-1 through 2-2
II. Appointments............................................................... 2-3 through 2-5
III. Advancement in Grade................................................... 2-6 through 2-8

Section I. ORGANIZATION

Number................................................................................. 2-1
Grades.................................................................................. 2-2

2-1. Number

(1) Section 420, Title IV, of the Act of 7 August 1947 (34 U.S.C. 3), provides that the total authorized number of commissioned officers of the Medical Corps shall be sixty-five one-hundredths of one per centum of the sum of the total authorized number of commissioned officers of the Navy and Marine Corps (exclusive of commissioned warrant officers), the total authorized number of enlisted men of the Navy and Marine Corps, the total authorized number of midshipmen at the Naval Academy, the actual number of commissioned warrant officers and warrant officers on the active list of the Navy and Marine Corps, and the actual number of midshipmen on active duty for flight training. The Act further requires that the Secretary of the Navy shall make computations to determine the authorized strength of the Medical Corps as of January 1 of each year and the number of officers so determined shall be considered the authorized number of officers for the corps until a subsequent computation is made for the next year. This authorized strength of the Medical Corps represents a maximum strength. The number actually on the active list and on active duty varies from year to year in accordance with the allocation of funds available in the annual appropriations acts for the Navy. This number on an annual basis constitutes the “appropriated strength.”

2-2. Grades

(1) Section 405, Title IV, of the Act approved 7 August 1947 (34 U.S.C. 10A) established for all staff corps grades above that of commissioned warrant officer similar to those established for the line of the Navy. Officers of the Medical Corps shall be distributed in various grades in that corps but the number of rear admirals in the Medical Corps exclusive of any such rear admiral serving as chief of bureau shall not exceed five-tenths of one per centum of the officers in that corps serving on active duty at any one time.
Section II. APPOINTMENTS

2-3. How Made

(1) Appointments as officers of the Medical Corps are made by the President by and with the advice and consent of the Senate except for the appointments of lieutenants (junior grade) for temporary service (34 U.S.C. 11). In addition to the number of officers of the Medical Corps of the Navy otherwise authorized, the President may appoint, without the advice and consent of the Senate, for temporary service in such corps, lieutenants (junior grade) who shall, while so serving, receive the pay and allowances prescribed by the law for that grade (34 U.S.C. 21).

2-4. Regulations Governing Appointments

(1) Applications for appointment in either the Medical Corps of the Navy or the Medical Corps of the Naval Reserve are to be submitted through designated Navy recruiting stations. These offices are located in various large cities of the continental United States. Reference should be made to the current procurement directives issued by the Bureau of Naval Personnel relative to the procedure for filing an application for appointment.

2-5. Acceptance and Oath of Office

(1) Every person, on accepting an appointment as an officer in the Medical Corps, shall immediately forward a letter of acceptance to the Chief of Naval Personnel, together with the oath of office duly signed and certified.

Section III. ADVANCEMENT IN GRADE

2-6. Eligibility for Advancement in Grade

(1) An officer in the Medical Corps shall become eligible for consideration by a selection board for promotion to the next higher grade when his running mate of the line becomes eligible for such selection, except that an officer in the grade of lieutenant (junior grade) or lieutenant shall not be eligible for such selection unless he is in the promotion zone in such grade or is senior to officers in the promotion zone in the grade in which he is serving.

2-7. Examinations Required

(1) Medical officers, to be eligible for promotion, must pass such professional, moral, mental, and physical examination as the Secretary of the Navy may from time to time prescribe. Failure to pass the physical examination shall not exclude from promotion, to which he would otherwise be regularly entitled, any officer in whose case a board of medical examiners may report that he is not physically qualified for his duties at sea, but that such physical disqualification was occasioned by wounds received in line of duty and does not incapacitate him for other duties in the grade to which he shall be promoted.

2-8. Professional Examinations for Advancement

(1) When professional examinations for advancement in grade are prescribed by the Secretary of the Navy, the nature and scope of such examinations will be in accordance with current directives.
2-9. Professional Examination for Advancement to Grade of Lieutenant Commander

This examination is similar in scope to that for lieutenant, both written and practical. The candidate is expected to have greater practical knowledge and ability in professional subjects. In addition, the candidate shall be examined in his specialty when applicable.

2-10. Professional Examination for Advancement to Grade of Commander

This examination shall be predominantly professional, both written and practical, comprehending all fields of medicine, the naval aspects of medicine, questions pertaining to Medical Department organization and administration, and medical logistics. The candidate shall also be examined in his specialty when applicable.

2-11. Professional Examination for Advancement to Grade of Captain

This examination shall include the fields of Medical Department organization and administration, medical-logistics planning, hygiene and sanitation, naval hospital administration, Navy Regulations, and Manual of the Medical Department. The candidate shall also be examined in his specialty when applicable.

2-12. Professional Examination for Advancement to Grade of Rear Admiral

Captains selected for advancement to the grade of rear admiral shall be examined on their record only.

2-13. Failure to Pass the Professional Examination

A medical officer who upon examination for promotion is found not professionally qualified shall be suspended from promotion for a period of 6 months, upon the termination of which he shall be reexamined. Upon twice failing the professional examination, he shall be subject to provisions of law relating to discharge or retirement of those twice failing of selection.
Chapter 3

GENERAL DUTIES OF MEDICAL CORPS OFFICERS

Sections

I. The Medical Officer and His Duties 3-1 through 3-15
II. Assistant Medical Officers 3-16 through 3-17
III. General Duties of All Medical Corps Officers 3-18 through 3-30
IV. Duties With Regard to Narcotics, Alcohol, Alcoholic Beverages, and Dangerous and Habit-Forming Drugs 3-31 through 3-36

Section I. THE MEDICAL OFFICER AND HIS DUTIES

3-1. The Medical Officer
(1) The head of the medical department of a command or other activity shall be the senior officer of the Medical Corps attached for duty and so assigned. He shall be designated the medical officer.

3-2. General Responsibility
(1) In addition to the duties prescribed in United States Navy Regulations for the head of a department, the medical officer shall be responsible, under the commanding officer, for maintaining the health of the personnel of the command, making inspections incident thereto, and advising the commanding officer with respect to hygiene and sanitation affecting the command. He shall direct and administer the medical department and shall supervise the services of his subordinates, requiring of them a proper and efficient performance of their duties.

3-3. Care of the Sick and Injured
(1) The medical officer shall provide for the sick and injured the most careful professional attention and care consistent with the highest standards of modern medicine. He shall make arrangements for the proper messing of patients, the proper stowage and safeguarding of patients' effects, and shall be attentive to the patients' well-being at all times.

3-1

Change 8
3-3  MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY 3-10

(3) He shall require that daily reports of the sick be submitted in accordance with chapter 23.

(4) In complicated cases, the medical officer shall provide for consultations with other officers of the Medical Corps of the Navy present concerning diagnosis, treatment, and patient management.

3-4. Health Standards

(1) The responsibility of the medical officer in matters of health extends into fields under the cognizance of other departments. Nutritional adequacy; food; food handling; food preparation; lighting; heating; ventilation; air conditioning; housing; insect, pest, and rodent control; water supply; and waste disposal all have a direct bearing in the health of naval personnel. The medical officer, because of his special qualifications, must assume the initiative in maintaining health standards in these spheres. The medical officer must assure adequate provision, including spaces, for the care of the sick. His responsibility in preventive medicine is discussed in chapter 22.

(2) The medical officer shall recommend to the commanding officer that drugs, devices, and other medical items not be sold in Navy or Marine Corps exchanges or ship's stores when considered to be medically susceptible to inappropriate uses. In case medical suitability is in doubt or in controversy, the facts should be referred to the Bureau of Medicine and Surgery via the Navy Ship's Store Office and Bureau of Supplies and Accounts or the Commandant of the Marine Corps, as appropriate, for decision and appropriate action.

3-5. Physical Fitness of Personnel

(1) The medical officer shall make appropriate recommendations to the proper authority for the promotion of health and the physical fitness of personnel. The physical and mental benefits derived from athletics, recreational, and other measures to improve or maintain a satisfactory state of physical fitness should be emphasized.

(2) The medical officer shall, with the approval of the commanding officer, conduct or direct examination of personnel of the command whenever there is reason to believe that diseases are being concealed. During such examinations the physical condition and personal hygiene of personnel shall be observed.

3-6. Physical Examination Before Transfer

(1) The medical officer shall provide for the physical examination of all enlisted personnel prior to their transfer. If no medical officer is available, other representatives of the Medical Department present shall conduct such physical examination as may be within their capacity. Appropriate entries shall be made in the individual's Health Record. In the event of an outbreak of communicable disease, the medical officer shall evaluate the hazard to other personnel which would be created by the transfer of individuals who have suffered exposure to communicable disease. If a definite hazard of further propagation of the disease exists, transfer of personnel from one ship or station to another shall be withheld. Except in an emergency, no member who is suffering from a communicable disease shall be transferred unless to a hospital for treatment. When an emergency requires the transfer of persons with communicable disease, a message report shall be forwarded to the ship or station to which transfer is made. If such cases are retained, they shall be admitted for treatment and a prompt report made to the commanding officer.

3-7. Standing Orders

(1) The medical officer of each Medical Department activity or facility on shore (other than expeditionary forces) shall publish standing orders containing instructions and information for the guidance of all Medical Department personnel.

3-8. Medical Journal

(1) Each medical activity or facility shall maintain a journal in which shall be entered a complete, concise, chronological record of events of importance, or which may be of historical value, concerning the Medical Department, other than medical histories of individuals.

3-9. Reports to the Officer of the Deck or Day

(1) Injuries or deaths of personnel, damage, destruction or loss of Medical Department property, and any important occurrence shall be reported by the medical officer to the officer of the deck or other proper official for entry in the log or journal of the command or activity.

(2) Patients in a serious or critical condition shall be the subject of a report to the commanding officer or officer of the deck or day, together with the necessary information for the notification of next of kin.

3-10. Educational Measures

(1) The medical officer, with the approval of the appropriate authority, shall conduct health educational programs, including the dissemination of information regarding the prevention of diseases and other subjects pertaining to hygiene and sanitation.

(2) The medical officer shall supervise the instruction of personnel regarding venereal diseases, and advise them of the associated dangers. Information which is distributed by the Bureau relative to social hygiene shall be utilized.

(3) The medical officer, with the approval of the appropriate authority, shall conduct a program of
first-aid instruction for officers and men attached to the command which will insure knowledge and ability in the principles of first aid.

(4) The medical officer shall provide for the instruction of hospital corpsmen as set forth in chapter 9.

(5) The medical officer shall make provisions for the indoctrination of personnel under his charge in Navy and Medical Department regulations and administrative procedures.

3-11. Preparation for Emergency

(1) The medical officer shall insure that the medical department is at all times prepared to meet medical emergencies.

3-12. Cooperation With Other Agencies

(1) The medical officer shall cooperate with the United States Public Health Service and other Federal, State, and local agencies for the prevention of disease, the reporting of communicable diseases, and the collection of vital statistics.

(2) The medical officer shall attempt to determine all sexual contacts of naval personnel infected with a venereal disease for that period of time in which they could have acquired or transmitted their infection. A separate Venereal Disease Epidemiologic Report (Mzn-6222-5) shall be prepared on each of the alleged contacts and forwarded to State, Territorial, or local health authorities in accordance with the current Bureau Instruction in the 6222 series.

(3) When a person with tuberculosis or other infectious disease considered to be a public menace is discharged from the service, report shall be made in accordance with article 11-7(2) (b).

(4) Reporting Births and Deaths.—

(a) In accordance with local health laws and regulations, medical officers at stations (other than naval hospitals in the United States) or on ships and aircraft shall report births (including stillbirths) occurring within their professional cognizance. It shall be the duty of the medical officer to determine the requirements of local civil authority for these reports.

(b) Births occurring on aircraft or ships operating beyond the political boundaries shall be reported by the medical officer responsible for delivery as follows:

(1) To the commanding officer or master of the ship or to the officer in command of any aircraft, in every case to be recorded in the ship or aircraft log.

(2) For births occurring on course inbound to the United States, to local civil authorities in the first port of entry if required by law and regulation of such authorities. The medical officer shall furnish the parents with appropriate certificates and shall, if the report is not accepted by the local registrar of vital statistics or other civil authority, or in any case in which local authority has indicated in writing that such a report will not be accepted, advise the parents to seek the advice of the cognizant District Director, Immigration and Naturalization Service, at the earliest practicable time. Officers of the Immigration and Naturalization Service are usually located in ports of entry and in major cities of the United States.

(3) For births occurring on courses outbound and beyond the continental limits of the United States, to the United States consular representative at the next appropriate foreign port. In any case in which the aircraft or ship does not enter a foreign port, procedure described in subarticle 3-12(4) (b) (2) shall be followed.

(4) Attention is invited to the fact that reports of birth may be forwarded to the Bureau of Health Statistics, Department of Health, Honolulu, Hawaii, for any births occurring on courses destined for islands in the Pacific Ocean over which the United States has jurisdiction as well as for those births which are otherwise accepted by civil authorities for Hawaii.

(c) Registration of vital statistics of Armed Forces members and dependents of members on duty overseas with an appropriate foreign government may be of distinct advantage to the persons concerned should documentary evidence acceptable in all courts be required at any time in the future. Department of Defense policy is that military services will require their members to make official record of births, deaths, marriages, and so forth with local civil authorities in whose jurisdiction such events occur. If the medical officer has knowledge of such a birth or death, he shall refer the matter to the commanding officer for assurance of compliance with the Department of Defense policy.

(d) When a death occurs at a naval activity in any State, Territory, or insular possession of the United States, the commanding officer or his designated representative shall report the death promptly to the civil authorities. If requested by the civil authorities, the civil death certificate may be prepared and signed by a naval medical officer. Local agreements concerning reporting and preparation of death certificates should be made between the commanding officer, or his designated representative, and the civil authorities.

3-13. Cooperation With Intelligence Officers

(1) The medical officer of a command or activity, particularly if in a foreign port, shall cooperate with the intelligence officers and furnish such data as may be required from a medical or sanitary standpoint.

(2) Medical intelligence information shall be submitted to the Bureau in accordance with article 25-124.

Change 10
3-14. Compulsory Medical or Surgical Treatment

(1) Reference should be made to General Order No. 3 for instructions concerning disposition of naval personnel who refuse medical, dental, or surgical treatment.

3-15. Dental Treatment

(1) Except in an emergency, the medical officer of a command or activity having no officer of the Dental Corps attached shall make an appointment in advance when it becomes necessary to send patients elsewhere for dental services.

(2) When the medical officer sends a patient to another command or activity for dental services, he shall make the patient's Dental Record available to the dental officer of such command or activity. After the necessary entries have been made, the dental officer shall return the Dental Record to the person having custody of the Health Record.

(3) The medical officer shall notify the dental officer whenever a person suffering from syphilis or any other disease in a communicable stage is sent to him for dental treatment.

(4) When officers or enlisted personnel are ordered to a command or activity where the services of an officer of the Dental Corps are not available, the medical officer shall refer such persons to an officer of the Dental Corps for examination and treatment prior to their departure.

(5) The medical officer shall be guided by the recommendations of the dental officer concerning discharge or granting of liberty to dental patients on the sick list.

(6) When the Health Record of an individual has been lost, the medical officer shall request the dental officer to prepare a new Dental Record.

(7) The medical officer of a command or activity having a dental department shall send to the dental department the Dental Records of officers and enlisted personnel who arrive for duty or training.

(8) The medical officer, or other person who has custody of the Health Record, shall be responsible for the inclusion of a current Dental Record when the Health Record is transferred.

(9) When officers of the Medical Corps record dental examinations on Dental Records or other forms, in the absence of officers of the Dental Corps, they shall be guided by the instructions contained on the Dental Record in chapter 6. When recording dental examinations on Standard Form 88, they shall be guided by instructions contained thereon.

Section II. ASSISTANT MEDICAL OFFICERS

3-16. Assistant Medical Officers

(1) Assistant medical officers are those officers of the Medical Corps assigned to the command or activity for duty who serve as assistants to the medical officer. In the absence of the medical officer, the next senior officer of the Medical Corps shall, with the approval of the commanding officer, assume this duty temporarily.

3-17. Duties of Assistant Medical Officers

(1) Assistant officers of the Medical Corps shall perform those duties assigned them by the medical officer of the command or activity. They shall conform to the directions of the medical officer with regard to the professional treatment, care, and comfort of the sick and injured, and shall exact from those serving under their supervision a similar performance of duty.

(2) They shall assure themselves that the treatments prescribed for patients are properly administered by members of the Medical Service Corps, Nurse Corps, and Hospital Corps, and that the administration of such treatment is recorded in writing.

(3) They shall keep the medical officer fully informed as to the condition of all patients and shall frequently consult with him in regard to their professional treatment.

(4) They shall, subject to the direction of the medical officer, keep the Health Records and supervise the preparation of the reports and returns.

(5) They shall, in applying for permission to be absent from their duties, submit such application to the medical officer for his action or recommendation.
3-18. General Responsibility

(1) All officers of the Medical Corps are charged with responsibility for the treatment of sick and injured personnel, for prevention and control of disease, for promotion of health, and for giving advice on such matters as hygiene, sanitation, and safety. Every officer of the Medical Corps must, therefore, keep himself informed in all fields of general and naval medicine.

3-19. Official Correspondence

(1) Detailed instructions for the preparation and routing of official correspondence are contained in Navy Regulations and in the Navy Correspondence Manual.

3-20. Articles on Professional Subjects

(1) Medical Corps officers shall be guided by Navy Regulations in the preparation and publication of articles on professional subjects.

3-21. Physical Examinations

(1) Officers of the Medical Corps shall conduct physical examinations of persons in the naval service and of candidates for enlistment or appointment therein. The dental examination shall be conducted by officers of the Dental Corps if available. Complete instructions concerning physical examinations are contained in chapter 15.

(2) Commanding officers are allowed discretionary authority to permit officers of the Medical Corps to conduct physical examinations of naval personnel for the purpose of obtaining commercial life insurance in cases where a doctor in the employ of the insurance company is not available and where delay would be detrimental to the interests of the applicant.

3-22. Transfer of Patients

(1) Sick or injured persons may be recommended for transfer to an Armed Forces medical facility capable of providing the required care and disposition. (See art. 11-30 and chs. 12 and 18 for further information concerning transfer of patients.)

(2) In the absence of Armed Forces medical facilities, the facilities of other agencies or civilian sources may be utilized in accordance with the instructions in chapter 20.

3-23. Unofficial Certificates

(1) Officers of the Medical Corps shall not give an unofficial certificate of ill health or of inability to perform duty, except as may be granted in the following subarticle (2).

(2) Requests for certificates from persons in the Naval Establishment to enable them to receive compensation from lodges, benevolent societies, and the shipyard relief associations, may be granted unofficially in conformance with the instruction applicable to transcripts of Health Records (sec. VIII, ch. 23).

3-24. Examination for Evidence of Intoxication

(1) Upon request by competent authority, officers of the Medical Corps shall examine personnel for evidence of intoxication in accordance with the instructions outlined in chapter 19.

3-25. Misconduct Entries

(1) Officers of the Medical Corps making entries in the Health Records or reports of medical survey shall state whether the disease or injury was or was not in line of duty and was or was not due to own misconduct. Detailed information on this subject is contained in chapter 16.

3-26. Treatment of Casualties of Atomic, Biological, or Chemical Warfare

(1) Officers of the Medical Corps shall keep informed regarding the proper methods for the treatment of casualties which may result from these types of warfare, so that they will be prepared to act in such emergencies.
3-26A. Private Practice

(1) Private practice by Medical Corps officers is subject to policies heretofore stated by the Chief of the Bureau of Medicine and Surgery and also is subject to policies applicable to all members of the naval service as stated by the Chief of Naval Personnel (art. C-11101, Bureau of Naval Personnel Manual).

(2) The Bureau of Medicine and Surgery does not condone private practice except under the following circumstances:

(a) When emergency circumstances verging on community hardship exist.

(b) Private practice shall not interfere with the practice of medicine by physicians in the locality and shall not be permitted to be offensive to medical associations or to reflect discredit to the service.

(c) Private practice must be voluntary as to the officer.

(d) The efficiency of the officer shall not be impaired by activity in private practice.

(e) Private activity may not involve expense to the Department.

(f) The private practice which is authorized is "off-duty" or "outside-working-hours" practice.

(g) The officer shall not be granted liberty or leave for the sole purpose of practicing.

(3) Medical Corps officers whose private practice may lead to appearances in court as expert witnesses in private litigation shall make this appearance privately, out of uniform if possible, and shall establish carefully the character of appearance as appearance and testimony other than on behalf of the Navy.

(4) Medical Corps officers shall not under any circumstances examine or treat their private patients in Medical Department facilities.

(5) The Bureau considers that the authority is in the commanding officer of the Medical Corps officer concerned to determine either that private practice interferes or does not interfere with the officer's performance of duty in the command. Professional liaison with local and national medical associations having to do with relationship between physicians who have status as officers of the Medical Department of the Navy and private practitioners is a matter of technical control by the Bureau.

(6) The responsibility for meeting local licensing requirements is a personal matter for Medical Corps officers who wish to engage in private practice.

3-27. Medical Aid to Civilians

(1) The senior officer present may require officers of the Medical Department under his authority to render aid to persons not in the naval service, when such aid is necessary and demanded by the laws of humanity or the principles of international courtesy.

(2) The services to be rendered to civilian employees, supernumeraries, and applicants for pension are outlined in chapters 15 and 21.

3-28. Restrictions Relative to Prospective Applicants

(1) Officers of the Medical Corps on active duty shall not undertake to operate upon or treat prospective applicants for the Navy or Marine Corps, Regular or Reserve, with a view to correcting defects, disqualifications and disabilities barring them from enlistment or appointment.

3-29. Civil Actions

(1) Procedure.—If an officer of the Medical Corps is apprised of any civil litigation or legal proceedings being brought against him wherein the United States is in legal effect the defendant, he shall immediately advise the commanding officer so that a report can be made as set forth in the Naval Supplement to the Manual for Courts-Martial, United States. A copy of the report shall be submitted to the Bureau. The Navy Department does not recommend for or against insurance of individuals by commercial insurers against negligence which may occur in line of duty or scope of employment.

(2) Ambulances.—Navy ambulances and Navy ambulance drivers are susceptible to efforts or requests by local police officers or other persons for aid in cases of accidents or emergencies. Operators of ambulances, either members of the Hospital Corps or civil employees, should be thoroughly indoctrinated:

(a) To adhere strictly to orders for picking up and transporting the patient for whom dispatched.

(b) To remain with vehicle and never to stop or to leave ambulance out of curiosity when halted by traffic conditions at the scene of an accident when the driver by reason of orders to pick up and carry a Navy patient is not in a position to offer the services of himself or the ambulance.

(c) To recognize that the Medical Department is expected as a matter of policy to cooperate with local authorities in emergencies when this cooperation will not interfere with a Medical Department operation, and that operators of Navy ambulances which are not carrying patients or proceeding under orders to pick up patients are expected to offer, in humanitarian emergency situations, such assistance as they are qualified to render.

(d) In any case in which an ambulance carrying a patient or proceeding under orders to pick up a patient is stopped or otherwise subjected to interference by State or other local authorities for any reason whatever, including aid to an emergency humanitarian patient: to give courteous informa-
tion about current orders; to courteously request that compliance with these orders not be subjected to interference; and to report to the commanding officer, for transmittal by the commanding officer to the Judge Advocate General of the Navy, any measures applied by State or local authorities which prevent direct compliance with orders.

Section IV. DUTIES WITH REGARD TO NARCOTICS, ALCOHOL, ALCOHOLIC BEVERAGES, AND DANGEROUS AND HABIT-FORMING DRUGS

3-31. Prescription Form
(1) When writing official prescriptions, officers of the Medical and Dental Corps and civilian physicians employed by the Navy shall use the Department of Defense Prescription Form, DD 1289.
(2) The complete address of the person for whom the prescription is written is mandatory when narcotics are prescribed.
(3) On all prescriptions for children 12 years of age and under, the age shall be specified.
(4) The use of brand names of drugs and medical stores in prescription writing shall be avoided. Generic names shall be used wherever possible.

3-32. Prescribing Narcotic Drugs
(1) An officer of the Medical Corps or Dental Corps, or a civilian medical officer employed by the Navy, when prescribing in his official capacity any of the narcotic drugs coming within the scope of chapter 2, sections 2550-2564, 3220-3228, of the act of 10 February 1939 (Internal Revenue Code) as amended (26 U.S.C. 2550-2564 and 3220-3228) is exempt from registration and payment of special tax under the provisions of this act. An officer, or civilian medical officer employed by the Navy, who has been designated by a command as requiring authorization to purchase narcotic drugs or preparations for official use shall file with the local district director of internal revenue a certificate on Treasury Form 1964, obtained from his commanding officer, showing his name, official address, and official status. As a result of such filing, the district director of internal revenue will assign the officer an exemption identification number. At the time of his original certification the officer will be issued, without charge or request, a book of official narcotic order blanks. Each order for the purchase of taxable narcotic drugs by such official shall be prepared on one of these order blanks. Certificates must be renewed on or before 1 July of each year to remain effective.
(2) The exemption specified in subarticle 3-32 (1) does not apply when the officer renders professional treatment outside of his official duties. In such event the officer is required to register and in all other respects comply with the provisions of the law and regulations governing private practice.
(3) In order to comply with the law and the regulations, exempt officials in charge of narcotic drugs shall require that accurate records be maintained of the amounts of such drugs purchased, or obtained by
# Chapter 4

## DUTIES OF MEDICAL OFFICERS AFLOAT

### Sections

<table>
<thead>
<tr>
<th>Articles</th>
<th>Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>4–1 through 4–11</td>
<td>I. Fleet, Force, and Division Medical Officers</td>
</tr>
<tr>
<td>4–12 through 4–19</td>
<td>II. The Medical Officer of a Ship</td>
</tr>
<tr>
<td>4–20 through 4–45</td>
<td>III. Medical Department Duties in Emergencies</td>
</tr>
</tbody>
</table>

### Section I. FLEET, FORCE, AND DIVISION MEDICAL OFFICERS

<table>
<thead>
<tr>
<th>Article</th>
<th>4–1</th>
<th>4–2</th>
<th>4–3</th>
<th>4–4</th>
<th>4–5</th>
<th>4–6</th>
<th>4–7</th>
<th>4–8</th>
<th>4–9</th>
<th>4–10</th>
<th>4–11</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Fleet Medical Officer</td>
<td></td>
<td></td>
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<tr>
<td>Inspections, When Made</td>
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<tr>
<td>Scope of Inspections</td>
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<td>Outline of General Inspection</td>
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<td>Special Inspections</td>
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<td>Battle Plans</td>
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<tr>
<td>Information Concerning Epidemic Diseases, Etc</td>
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<tr>
<td>Medical Meetings</td>
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<td>Force and Division Medical Officers</td>
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### 4–1. The Fleet Medical Officer

1. The fleet medical officer shall keep himself informed of all matters pertaining to the medical personnel and medical matériel of the fleet and shall assist the fleet commander in preparing the medical aspects of operational and logistic plans. Subject to the approval of the fleet commander he shall have general supervision over safeguarding the health of and providing care for the sick and injured personnel of the fleet.

### 4–2. Inspections, When Made

1. The fleet medical officer shall inspect ships of the fleet when directed by the fleet commander.

### 4–3. Scope of Inspections

1. When fleet operations permit, the fleet medical officer shall make a detailed inspection of the medical department and medical organization of each ship with respect to medical efficiency including facilities for shipboard care of the sick and injured, communicable diseases, emergencies, and the adequacy of the medical preparations for battle and disasters. He shall examine the entire ship to determine sanitary conditions and the sufficiency of sanitary regulations.

2. When operational activities prevent general inspections being made, the fleet medical officer shall inspect the facilities for rendering efficient medical supervision and care provided in the type ships representing the various groups and components of the fleet when such units are available. Such inspections may be informal and should be performed on an advisory and constructive basis. Type ships, representative of force organizations, should be boarded for inspections when at rendezvous for fueling, supplies, or repairs.

### 4–4. Outline of General Inspection

1. Items of Inquiry.—When it is practicable to make a general inspection, inquiry should be made into the following:

   a. **Personnel of the Medical Department.**—Number of officers of the Medical Corps, Medical Service Corps, and Nurse Corps, and enlisted personnel of the Hospital Corps detailed for duty with the medical department of the ship; efficiency of the organization; number of other ratings detailed for duty in the medical department; and the instruction given to hospital corpsmen, stretcher bearers, and other personnel of the ship in their duties pertaining to the medical department.

   b. **Material of the Medical Department.**—Location, arrangements, cleanliness, and equipment of the sick-bay spaces; provisions for the use of Medical Department matériel in emergencies including sterile packs, the antidote locker, and first-aid kits; and defects in supplies and equipment.

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*Change 2*
(c) Medical records, reports, and returns.—Health Record files for purposes of determining whether or not records are maintained as required by directives, including records of immunization; prescription file, narcotic record, Medical Department property journal and records; methods of stock keeping and issue, with due regard for economy; disposition of overage records; general correspondence and files; safety regulations; and sanitary reports submitted.

(d) Sanitary conditions of the ship.—Cleanliness of the ship as a whole; ventilation, heating, and lighting; food inspection, preparation, and service to the crew and to the sick; physical examination of food handlers; bathing facilities; educational measures for prevention of venereal and other diseases; supply and protection of drinking water; ratio of sanitary fixtures to personnel; the cleanliness and suitability of the crew’s clothing; sanitary precautions used in the barber shop and ship’s store; measures taken to prevent rat and vermin infestation aboard ship, and measures to destroy them if present; facilities for sterilization of bedding, and similar material; sanitary condition of the laundry; records of immunization; and evidence of overcrowding of standards as set forth in chapter 22 and in the Manual of Naval Preventive Medicine shall be used as a guide in making inspections of the sanitary conditions of ships.

(e) Other items.—First-aid supplies at battle stations; station bills for general quarters, damage control, gas defense, flight quarters, fire quarters, collision, fire and rescue party, abandon ship, man overboard, taking aboard and handling rescued personnel, and landing force problems; provisions for removal of dead and wounded from various parts of the ship; identification tags (wartime only); care of the mental patients; statements of health conditions for preceding 12 months; instructions relative to poisons and distilled spirits; instructions in first aid to division officers and crews; and property accountability.

(2) Recommendations.—When defects within the medical department or in the sanitary conditions of the ship are found, the inspecting officer shall make recommendations to the fleet commander for their correction. He shall make recommendations to the Bureau, via official channels, for changes in medical department equipment and supplies, particularly in regard to those items in which the prescribed minimum stock is out of proportion to the current rate of use, and to the elimination of items which have fallen into disuse. The fleet medical officer shall recommend to the fleet commander the transfer of medical department supplies from a ship carrying an excess stock to a vessel requiring such supplies.

4-5. Special Inspections

(1) When directed, the fleet medical officer shall investigate the sanitary condition of any ship of the fleet where excessive sick rates exist, and he shall examine the different parts of the ship for insanitary conditions. He shall make any other inspections necessary to ascertain the reasons for increase of disease and recommended such steps as may be necessary.

4-6. Written Report

(1) Following each inspection, the fleet medical officer shall make a concise written report to his commander. When conditions are found to be satisfactory, a statement to that effect will suffice.

(2) When necessary he shall make to his commander recommendations or reports concerning sanitary conditions of the fleet or force, the prevention of disease or means for checking its spread, and the care of the sick and wounded.

Note.—There is no article 4-7.

4-8. Battle Plans

(1) The fleet medical officer shall prepare a specific plan for the care and transportation of the sick and wounded of the fleet during an action and shall keep himself informed of the facilities available for this purpose in the ships of the fleet. He shall prepare medical department contributory plans for the fleet commander’s basic operating plans.

(2) After an action, a report of the number killed, missing, and wounded in the fleet shall be compiled by the fleet medical officer and sent to the fleet commander.

4-9. Information Concerning Epidemic Diseases, Etc.

(1) The fleet medical officer shall coordinate and disseminate to unit medical officers all pertinent medical information.

4-10. Medical Meetings

(1) The fleet medical officer shall stimulate interest in professional subjects by arranging meetings of officers of the Medical Corps for the discussion of professional subjects. Officers of the Medical Corps shall be encouraged to attend meetings of professional interest in the ports visited and on board hospital ships.

4-11. Force and Division Medical Officers

(1) The duties of force and division medical officers shall be similar to those of the fleet medical officer insofar as they relate to their organizations.

(2) Force and division medical officers shall see that expenditures from the medical stores of ships of their organization are made with economy and shall report to the force or division commander instances of wastefulness or unauthorized expenditures.
4-12. General

(1) Head of the Medical Department.—The head of the medical department of a ship is designated the medical officer. In addition to those general duties prescribed in Navy Regulations for the head of a department, the medical officer shall be responsible, under the commanding officer, for maintaining the health of the personnel of the ship, making inspections incident thereto, and advising the commanding officer with respect to hygiene and sanitation affecting the ship. He shall have charge of all medical material aboard and shall be in direct charge of the treatment of the sick and wounded. He shall take charge of the personnel of the medical department and of the men on the sick list, and shall report the medical department at quarters.

(2) Complements and Allowances.—When it is believed that the complement or allowance of the medical department personnel should be modified, the medical officer shall make a request to the commanding officer for modification.

(3) Miscellaneous Duties.—Regulations which apply to the medical officer of a ship in regard to the following are covered in other parts of this Manual as indicated:

- Deaths ........................................... 17
- Health Records .................................. 16
- Instruction of hospital corpsmen ............... 9
- Medical surveys .................................. 18
- Quarantine ....................................... 22
- Sanitary reports .................................. 23
- Sanitation ....................................... 22
- Treatment and hospitalization other than naval ........................................... 29

(4) Absence or Disability.—In the absence, or during the disability, of the medical officer of the ship, unless otherwise directed by the commanding officer, the officer of the Medical Corps next in grade on board shall perform his duties.

4-13. Fitting Out

(1) After reporting, the medical officer shall examine the sick-bay spaces and equipment, and other accommodations for the sick and wounded, and report any defects to the commanding officer.

(2) The medical officer shall examine the crew in order to verify the descriptive lists and Health Records, and to ascertain if the crew are physically qualified to perform their duties. If any are found disqualified, he shall, with the approval of the commanding officer, admit such personnel to the sick list and transfer them to a naval hospital. He shall immunize the ship’s complement against diseases in the manner prescribed in chapter 22 and in current directives.

4-14. Medical Stores and Supplies

(1) The medical officer shall have charge of all material and stores on board under the control of the Bureau, except those under the charge of the dental officer.

4-15. Medical Storerooms

(1) The medical officer shall take charge of the medical storeroom and keep the key in his own custody or in the custody of his representative, but in any case the medical officer is responsible for the security of the contents of the storeroom. Medical storerooms shall not be used as sleeping compartments, and only medical stores shall be kept therein. Narcotics, habit-forming and dangerous drugs, alcoholic beverages, and poisonous chemicals shall be kept in separate lockers, and the keys to these lockers shall always be in the custody of an officer.

4-16. Physical Inspection of the Crew and Other Inspections

(1) Personnel.—Subject to the approval of the commanding officer, inspection of the crew shall be held whenever the presence of communicable or concealed disease is suspected.

(2) Food and Water.—Regulations in regard to inspection of food and water appear in chapter 22. The Manual of Naval Hygiene and Sanitation may be used as a guide.

(3) Compartments, Cells, Bedding, Etc.—Regulations concerning inspections of compartments, cells, bedding, etc., appear in chapter 22. The Manual of Naval Hygiene and Sanitation may be used as a guide.

4-17. Transfer of Patients

(1) Subject to the approval of the commanding officer, patients may be transferred to a hospital at any time.

(2) Each patient who is transferred to a naval hospital shall be accompanied by his Health Record; his personal effects including money, articles of value, papers, keepsakes, and other similar effects shall be inventoried and prepared for transfer. Sub-
j ect to the approval of the commanding officer, serious cases shall be accompanied by a medical officer.

(3) (a) When a patient is transferred to other than a United States naval hospital, the date of transfer shall be noted in his Health Record, and the clinical history continued therein until the patient returns to duty or is transferred from the ship.

(b) On the departure of a ship, if in a foreign port, the medical officer shall forward, through the commanding officer, to another United States naval vessel or shore-based naval activity, or if neither is present, to the local American consular officer, the Health Records of all patients referred to in article 4-17 (3) (a) who remain hospitalized. The record, if transferred to a consular officer, shall state that it is to accompany the patient, if he is transferred elsewhere, or to be forwarded to the commanding officer of the next ship arriving in port. The consular officer shall be furnished with a history of the case and requested to cooperate with the official in charge of the hospital.

(c) Upon arrival of a ship in a foreign port, the medical officer shall take charge of cases referred to in article 4-17 (3) (b), who are not under the charge of a medical officer, and continue their Health Records. The medical officer shall frequently visit these patients. He shall interest himself in their welfare, report their progress to the commanding officer, and suggest measures necessary for their benefit.

(4) (a) When an enlisted person of the Navy is sent from a ship to a United States naval hospital for treatment, his accounts and other papers shall be sent directly to that hospital.

(b) When transfer is made to a hospital in the United States other than a naval hospital, his accounts and other papers shall be retained on board. Upon departure of his ship, the patient's Service Record, Health Record, and pay accounts shall be transferred to the commandant of the naval district in which the hospital is situated.

(5) If an enlisted person is transferred to a civil hospital in a foreign country, his records and accounts will be forwarded with full statement of fact to the nearest American consul.

4-18. First-Aid Instruction

(1) The medical officer shall recommend to the commanding officer a schedule of instruction in first aid by Medical Department personnel in order that the ship's officers and crew may administer to the wounded in battle when no medical personnel are available. Requirements for this instruction are:

(a) Division officers.—Knowledge of the degrees of proficiency of their men in first aid, and knowledge of the location and use of available first-aid material.

(b) Hospital corpsmen.—Knowledge that will qualify them to become assistant instructors.

(c) Stretcher bearers.—Knowledge of handling and transportation of casualties and basic factors of first aid.

(d) Crew.—A practical knowledge of fundamental first-aid treatment of wounds and fractures, methods of resuscitation, and handling of unconscious persons.

4-19. Transport Duty

(1) Medical officers on transport duty shall be guided by article 4-13 and chapter 14, section I, of this Manual.

Section III. MEDICAL DEPARTMENT DUTIES IN EMERGENCIES

Drills and Emergencies................................................. 4-30
Preparation for Emergencies........................................ 4-31
Condition I, General Quarters....................................... 4-32
Condition II........................................................................... 4-33
Condition III......................................................................... 4-34
Damage Control.................................................................... 4-35
Defense Against Special Methods of Warfare...................... 4-36
Flight Quarters..................................................................... 4-37
Fire Quarters........................................................................ 4-38
Collision................................................................................ 4-39
Fire and Rescue Party.......................................................... 4-40
Abandon Ship........................................................................ 4-41
Man Overboard...................................................................... 4-42
Taking Aboard and Handling Rescued Personnel.................. 4-43
Landing Force....................................................................... 4-44
Duty in Battle....................................................................... 4-45
Battle Dressing Stations.................................................... 4-46
First-Aid Boxes and Other Medical Containers.................. 4-47
Medical Stores at Battle Dressing Stations......................... 4-48
Water Supply of Battle Dressing Stations............................ 4-49
Light for Battle Dressing Stations...................................... 4-50

4-4

Change 3
4–20. Drills and Emergencies

(1) The medical department shall be prepared for emergencies. Personnel of the medical department shall be available to render medical care at all times. The medical officer shall be guided by fleet regulations and orders as to special drills and emergencies and by ship’s regulations for routine drills.

(2) The sections of the watch, quarter, station, and other bills which apply to the medical department shall be posted in the sick-bay spaces, and personnel of the medical department shall be continually instructed to insure that each individual is familiar with his station and his prescribed duties. These bills shall be kept up to date.

(3) The instructions contained in the following articles shall govern the organization of the medical department for emergency, subject, however, to the approval of the commanding officer.

4–21. Preparation for Emergencies

The medical officers is responsible for the proper dispersion of medical department personnel. He shall make necessary preparations for the proper distribution of medical supplies and equipment to the battle dressing stations, first-aid stations, collecting stations, decontamination station, and repair parties. He shall arrange in advance for space assignment to care for any overflow of personnel casualties.

4–22. Condition I, General Quarters

General quarters are the battle stations of the officers and crew. The term is also used to designate the evolution in which all hands assume battle stations. In Condition I, all hands are at battle stations (general quarters) and engagement with the enemy is imminent. All medical department personnel shall proceed immediately to their assigned stations. Crew personnel who have been assigned as stretcher bearers proceed to their assigned stations, where they are available for transportation of the wounded. Efficient organization for the removal and transportation of the sick and wounded shall be provided.

4–23. Condition II

This condition is maintained when enemy forces may be encountered. Medical department personnel man battle stations in a condition of readiness.

4–24. Condition III

The third condition of readiness for action is maintained when contact with surface ships is not imminent, but submarines may be present. The medical department prepares to assume Condition I or II, but carries on in a routine manner, unless otherwise directed by the commanding officer.

4–25. Damage Control

The confinement below decks of the medical department by damage control measures makes the knowledge of first aid among crew members, and particularly among the stretcher bearers, an essential of the medical department in the preparations for battle. Ability of nonmedical personnel to administer first aid, ability of stretcher bearers to transport the wounded, and availability of medical facilities at battle dressing stations are three conditions of the preparation of the medical department for battle that must be coordinated. Each factor shall receive attention from inspection officers. Hospital corpsmen shall be assigned to accompany repair parties to assist in first aid and to supervise the transportation of casualties.

4–26. Defense Against Special Methods of Warfare

(1) The medical officer must keep himself informed of the nature and effects of atomic, biological, and chemical warfare. He shall be guided by published manuals and current directives in matters concerning medical aspects of these types of warfare.

(2) The medical officer shall advise the commanding officer concerning medical preparations for defense, and shall provide a specific plan for the handling and transportation of casualties.

(3) The medical officer shall train the hospital corpsmen in the medical aspects of these special types of warfare, and shall conduct drills for the purpose of developing efficient performance during and following an attack. He shall supervise the instruction of the ship’s company in matters pertaining to self-aid and first aid.

(4) The medical officer shall maintain adequate supplies for the effective decontamination and treatment of casualties. When the ship or its personnel has been exposed to any of the above-mentioned agents, he shall, when directed, make a thorough inspection, paying especial attention to possible contamination of food and water.

4–27. Flight Quarters

The procedures for medical attendance in case of emergencies during flight operations is provided for in ship’s organization.
4-28. Fire Quarters

(1) The medical department personnel shall assemble at the sick bay and prepare to remove the sick and carry out other prescribed evolutions.

(2) One stretcher party, with an officer of the Medical Corps or hospital corpsman in charge, shall report at the scene of the fire.

(3) The medical officer shall remove to a place of safety, or throw overboard, flammable liquids under his custody.

4-29. Collision

(1) The medical department personnel shall assemble at the sick bay and prepare to remove the sick and the Health Records.

(2) Stretcher bearers shall be kept by the beds of the patients and preparations made to transport patients to stations on the weather decks.

(3) During collision drill, bed patients with necessary attendants shall remain in the sick bay with the doors and air ports thereto being closed as required. However, other medical department personnel and ambulatory patients shall assemble at their assigned stations. Stretcher bearers shall practice transportation measures by transporting members of their own group to the weather decks and abandon-ship stations.

4-30. Fire and Rescue Party

(1) The watch, quarter, and station bill shall provide that an officer of the Medical Corps and a hospital corpsman be detailed for duty with the fire and rescue party. Medical personnel shall always have medical emergency outfits available and shall accompany the party whenever it is called away. Stretcher bearers shall be provided.

(2) Training in the use of the rescue-breathing apparatus shall be carried on but undertaken only in the presence of a medical officer.

4-31. Abandon Ship

The medical officer shall detail personnel of his department for the following duties:

(1) Passing out boat boxes or other medical equipment provided for abandoning ship.

(2) Transporting the sick to their proper stations.

(3) Salvaging records.

4-32. Man Overboard

Upon sounding of the alarm, the medical officer or one of his assistants shall stand by. A hospital corpsman with first-aid pouch shall be detailed to board the lifeboat to be lowered.

4-33. Taking Aboard and Handling Rescued Personnel

The medical officer shall stand by when personnel are being rescued. When it is advisable, in his opinion, he shall accompany any boat which is launched for rescue purposes. Proper facilities shall be readily available at all times in order that immediate treatment may be begun when rescued personnel are brought aboard.

4-34. Landing Force

Fleet orders provide for medical department participation and scope of medical readiness for landing force organization.

4-35. Duty in Battle

In battle, the primary duty of the medical officer is to insure that prompt treatment is rendered to those wounded who may be able to return to their stations.

4-36. Battle Dressing Stations

(1) Two or more battle dressing stations shall be provided. These shall be dispersed and located in areas affording the maximum protection consistent with availability of care to the wounded. Auxiliary battle dressing stations shall be located as required by the ship's battle plans in areas where emergency medical care may be given.

(2) The main battle dressing stations offering the best facilities for surgical operations after battle shall be equipped for this purpose. Adequate surgical and sterilizing equipment shall be placed at these stations.

4-37. First-Aid Boxes and Other Medical Containers

(1) First-aid boxes, gun bags, and other medical equipment containers are located on recommendation of the medical department with the approval of the commanding officer. Supplying these containers and instructing the crew as to their location and use are the responsibilities of the medical officer. First aid is directed by the officer in charge of the battle station, when no medical personnel are present.

(2) Turrets, masts, handling rooms, on-deck gun stations; torpedo, fire, and engine rooms; fire control; and other stations not readily accessible, in which officers and enlisted men are stationed in battle, shall be provided with first-aid supplies and equipment. They shall be plainly labeled and readily available.

4-38. Medical Stores at Battle Dressing Stations

(1) The storeroom or locker at each battle dressing station shall contain sufficient medical supplies and equipment for emergency and battle use.

(2) The contents of the storeroom or locker shall be made a matter of record and carried as a reserve stock.

(3) The contents of these lockers shall not be depleted under any circumstances other than in battle or emergency.
4-39. Water Supply of Battle Dressing Stations

The forward and after battle dressing stations should be equipped with a fresh-water tank of 200-gallon capacity in vessels with total ship and troop complement over 500, and 100-gallon capacity in vessels with total ship and troop complement less than 500, except in destroyers and small vessels, which should be equipped with a tank of 50-gallon capacity. On ships having an amidships battle dressing station, this station should be equipped with a tank of 100-gallon capacity.

(2) Each battle dressing station should be provided with a lavatory connected with the water system. Prior to action, buckets shall be filled with water, as the connections with gravity tanks may be shot away. Drinking water may be augmented by portable scuttlebutts.

4-40. Light for Battle Dressing Stations

(1) A suitable surgical light shall be connected with both the day and battle lighting circuits and installed over the operating table at each battle dressing station.

(2) Hand electric-battery lanterns shall be provided for each station.

4-41. Sterilizers at Battle Dressing Stations

(1) Sterilizers shall be installed at all stations.

(2) All surgical supplies shall be sterilized before they are placed in the battle dressing lockers.

4-42. Routes To Be Marked

Routes leading to battle dressing stations shall be indicated on bulkheads and hatches by the approved marking prescribed in General Specifications of the Bureau of Ships.

4-43. Final Preparation for Battle

(1) In addition to the usual equipment transferred from the sick bay and operating room and distributed in the battle dressing stations, the following articles shall be provided for battle lockers: electric fans with proper connections, water buckets, sand, closed stools, swabs and brooms, washing stands, tables for apparatus, and bedding and mattresses for the wounded.

(2) The supply of dressings at each station shall be dispersed prior to an engagement in order to guard against total loss in case of accident.

(3) All officers and enlisted men shall wear their identification tags.

(4) Emergency medical tags shall be made available and the personnel instructed carefully in their use.

4-44. Removal of the Dead and Wounded

When opportunity presents, the first-aid parties shall remove the injured to the battle dressing stations and a list of the dead and wounded shall be prepared and submitted to the commanding officer. A place shall be assigned for the collection of the dead.

4-45. Transfer of the Wounded to Hospital Ships

When a medical transport or a hospital ship is at hand, the seriously wounded shall be transferred as promptly as is consistent with their welfare. A fighting ship should be cleared of such casualties as soon as possible after action. Patients who will probably soon be fit for duty may be retained on board.
Chapter 5

DUTIES OF MEDICAL OFFICERS ASHORE

Sections

I. Duties of the Inspector, Naval Medical Activities 5-1 through 5-2
II. Duties of the District Medical Officer 5-3 through 5-5
III. The Medical Officer of a Shore Station 5-6 through 5-17
IV. Medical Inspection of Naval Activities 5-18 through 5-23
V. Civilian Physicians 5-24 through 5-29

Section I. DUTIES OF THE INSPECTOR, NAVAL MEDICAL ACTIVITIES

Designation

5-1. Designation

(1) The regional medical officer assigned to perform inspections and related duties in an area comprising more than one naval district shall be a senior officer of the Medical Corps specifically assigned to that duty, as hereinafter defined, and shall have the title of Inspector, Naval Medical Activities (Atlantic Coast, Pacific Coast, or as the case may be). He reports to the commandant of the naval district in which he is located for military command and coordination control and may have additional duty as the medical officer on the staff of the sea frontier commander. However, his primary duty is that of Inspector.

Duties

5-2. Duties

(1) The Inspector, Naval Medical Activities, shall have the below listed duties. In their execution he shall work through and obtain the concurrence of the sea frontier commander or the commandant of the naval district as the case may be in matters of concern to each.

(a) To act as advisor to the Bureau on Medical Department affairs other than dental in the region.

(b) To represent the Bureau in matters pertaining to Medical Department coordination and correlation other than dental, with particular reference to professional matters and physical plant facilities in the region.

(c) To perform such inspections, investigations, and inquiries as may be directed by the Chief of the Bureau or other competent authority.

(d) To have cognizance of the conduct of inspections of the Medical Department activities other than dental, to determine the adequacy and effectiveness of such inspections by examination of the reports submitted, and to advise the Inspector General, Medical, Bureau of Medicine and Surgery, accordingly.

(e) To exercise over-all coordination of the Regular Navy Medical Department personnel-training programs other than dental in the naval districts within the region.

(f) To collaborate with the respective district medical officers in procurement of suitable Medical Department personnel (Medical Corps, Medical Service Corps, Nurse Corps, Hospital Corps), for induction into the Naval Reserve and to support their efforts in furthering the development of various elements of the Reserve.

(g) To review and make recommendations from the standpoint of the region on war plans and postwar plans for medical facilities and services within the respective naval districts; to eliminate duplication, provide for integration where possible, and insure their adequacy as subsidiary plans of the sea frontier of which they are a part.

(h) To act in an advisory capacity to the Bureau and the sea frontier commander on all phases of medical logistic support required from shore activities within the region, and on medical-supply requirements originating from forces and bases beyond the regional limits.
5-3. Designation

(1) The senior officer of the Medical Corps assigned to the staff of a commandant of a naval district shall be designated the district medical officer.

5-4. Duties

(1) The district medical officer has among those assigned him by the commandant the following duties:

(a) To act as liaison officer for the commandant with the Bureau, with the regional inspector of medical activities, with the medical officer of each medical activity in the district on all medical logistics matters under the cognizance of the commandant.

(b) To keep the commandant informed of all recommendations or plans for increases in or modifications of naval medical facilities within the district, whether originated locally or received from sources outside the district.

(c) To advise the commandant on the medical aspects of matters pertaining to operational and logistical plans.

(d) To advise the commandant concerning coordination of medical activities of the district with each other, with those of adjacent districts, and with other Federal and local medical agencies. To act as liaison officer for the commandant with civilian and public health authorities.

(e) To investigate, inspect, and report on the stock levels of medical materials maintained in the medical activities of the district and to consult with the commandant relative thereto, to insure that supplies and equipment are in accord with the current strategic situation and with the stock levels prescribed by the Bureau.

(f) To advise the commandant with respect to the adequacy and assignment of the civilian and military personnel allowances of medical activities of the district, and to make recommendations in regard to increases or reductions therein.

(g) To correlate and insure expeditious medical services by district medical activities to operating forces afloat and overseas bases, particularly with respect to hospitalization, ambulance service, special examinations and treatments, and issue of medical stores to ships.

(h) To conduct inspections of all medical activities, except Fleet Marine Force medical activities, and sanitary inspections within the district, including naval and Marine Corps Reserve activities, naval recruiting stations, offices of naval officer procurement, vessels of the Military Sea Transportation Service, and miscellaneous craft, as directed by the commandant, or by the Bureau with the concurrence of the commandant; to make reports of these inspections; and to continuously advise the commandant concerning sanitary conditions and prevalence of diseases, and make recommendations that will insure adequate training or other programs essential to the maintenance of sanitation standards and health within the district.

(i) In conjunction with the assistant chief of staff for personnel, to maintain a roster of all Medical Department personnel in the district, including those of the Naval Reserve; but, excepting personnel of activities commanded by or in charge of officers of the Dental Corps, personnel of the dental departments of activities in the district, and dental personnel of the Naval Reserve.

(k) To coordinate the administration of the Naval Reserve in all matters affecting the procurement, maintenance, and training of Medical Department personnel, except dental.

(l) To advise the commandant concerning communications pertaining to medical activities forwarded to or through the commandant.

(m) To inform appropriate local organizations, insofar as security regulations permit, concerning the activities of the Medical Department of the Navy in order to promote cooperative effort.

5-5. River Command Medical Officer

(1) The duties outlined above for the district medical officer shall also apply to the senior officer of the Medical Corps assigned to the staff of a commandant of a river command. The officer of the Medical Corps so assigned shall be designated the river command medical officer.
### Section III. The Medical Officer of a Shore Station

<table>
<thead>
<tr>
<th>Title</th>
<th>Article</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Responsibilities</td>
<td>5–6</td>
</tr>
<tr>
<td>Complement of the Medical Department</td>
<td>5–7</td>
</tr>
<tr>
<td>Care of Dependents</td>
<td>5–8</td>
</tr>
<tr>
<td>Physical Examination and Medical Treatment of Civil Employees</td>
<td>5–9</td>
</tr>
<tr>
<td>Examination of Applicants, Candidates, and Reservists</td>
<td>5–10</td>
</tr>
<tr>
<td>Accountability for Property</td>
<td>5–11</td>
</tr>
<tr>
<td>Inspection of Medical Supplies</td>
<td>5–12</td>
</tr>
<tr>
<td>Suggestions to the Commandant</td>
<td>5–13</td>
</tr>
<tr>
<td>Muster and Discipline of Enlisted Personnel</td>
<td>5–14</td>
</tr>
<tr>
<td>Inspection of Ships</td>
<td>5–15</td>
</tr>
<tr>
<td>Fitness Reports on Subordinates</td>
<td>5–16</td>
</tr>
<tr>
<td>Care of Dependents</td>
<td>5–17</td>
</tr>
<tr>
<td>Complement of the Medical Department</td>
<td>5–8</td>
</tr>
<tr>
<td>Physical Examination and Medical Treatment of Civil Employees</td>
<td>5–10</td>
</tr>
<tr>
<td>Examination of Applicants, Candidates, and Reservists</td>
<td>5–11</td>
</tr>
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<td>5–12</td>
</tr>
<tr>
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<td>5–13</td>
</tr>
<tr>
<td>Suggestions to the Commandant</td>
<td>5–14</td>
</tr>
<tr>
<td>Muster and Discipline of Enlisted Personnel</td>
<td>5–15</td>
</tr>
<tr>
<td>Inspection of Ships</td>
<td>5–16</td>
</tr>
<tr>
<td>Inspection of Ships</td>
<td>5–17</td>
</tr>
</tbody>
</table>

#### 5–6. Title

(1) The officer of the Medical Corps detailed for duty as the head of the medical department of a shore station shall be designated the medical officer.

#### 5–7. General Responsibilities

(1) The medical officer of a shore station shall be responsible, under the commanding officer, for the preservation of the health of personnel assigned to the station and for the care of the sick and injured. He shall supervise the hygiene and sanitation of the station and shall recommend measures to prevent or diminish disease or injuries. Reference should be made to chapter 3 for additional basic responsibilities not specified in this chapter.

(2) He shall inspect or cause to be inspected periodically, and monthly shall note in the journal the sanitary condition of all public buildings, the drainage, the sewerage, the adequacy and quality of the water supply, the clothing of the men, the nutritional value of the ration, food preservation, cooking, and food service, and make such recommendations to the commanding officer as he may deem proper for the preservation of health. He shall immediately notify the commandant or commanding officer in writing of any hygienic or sanitary hazard existing in areas adjacent to the station which in his opinion bears adversely on the health of the personnel of the station.

#### 5–8. Complement of the Medical Department

(1) Whenever circumstances indicate that the complement or allowance of medical department personnel should be modified, the medical officer shall submit a request for modification, with justification, to the commandant or commanding officer.

#### 5–9. Care of Dependents

(1) The medical officer shall provide authorized medical care for dependents in those activities which have suitable facilities, including necessary personnel, and which have been designated by the Bureau to provide inpatient and/or outpatient medical care for dependents. Service shall be limited to eligible dependents as authorized by current directives. (For further information, see ch. 21, sec. II.)

#### 5–10. Physical Examination and Medical Treatment of Civil Employees

(1) Detailed information on this subject is included in chapters 15 and 21, and in Navy Civilian Personnel Instructions 10, 88, 90, 185, and 190.

#### 5–11. Examination of Applicants, Candidates, and Reservists

(1) The medical officer shall examine at the station all candidates for appointment or enlistment in the Navy or Marine Corps, or the Reserve components thereof, who may present themselves under proper authority, and all members of the Naval Reserve or Marine Corps Reserve who appear for physical examination for any purpose and/or orders or letters from proper authority directing or requesting that the Reservist undergo physical examination.

#### 5–12. Accountability for Property

(1) The medical officer is responsible and accountable for all property belonging to the Medical Department of the Navy and in his custody.

#### 5–13. Inspection of Medical Supplies

(1) The medical officer shall inspect medicines and other medical department supplies, or require an assistant medical officer or a Medical Service Corps officer under his direction to do so.
5-14. Suggestions to the Commandant

(1) The medical officer shall make to the commandant or commanding officer such suggestions in connection with his official duties as he considers to be in the interest of the service.

5-15. Fitness Reports on Subordinates

(1) The medical officer shall report to the commanding officer on the fitness of his subordinate officers of the medical department for the commanding officer's use in making fitness reports.

Section IV. MEDICAL INSPECTION OF NAVAL ACTIVITIES

5-18. General Instructions

(1) Each medical activity of the Navy shall be inspected in detail once each calendar year (every 12 months), by a district or a staff medical officer, at such times as may be directed by appropriate administrative commanders. Special inspections shall be conducted when considered essential or when ordered by competent authority.

(2) The medical officer conducting such inspections shall submit to the Bureau, on 31 December and 30 June of each year, a schedule of the inspections to be made during the succeeding 6 months.

(3) A standard form and outline of basic subjects of inspection for purposes of uniformity and as an aid to the inspector when he compiles his questionnaire and plan of action for inspecting medical activities and medical functions is presented in the following articles.

5-19. Scope of Inspection

(1) The general scope of the inspection shall include all matters prescribed by law, Navy Regulations, and current directives and orders, for the activity to be inspected. Major emphasis throughout an inspection shall be placed upon determining whether specific units of a medical activity are organized, equipped, and manned to fulfill the assigned mission and to what degree. A most searching inquiry is required in order to present a complete picture of the components and of the activity as a whole.

5-16. Muster and Discipline of Enlisted Personnel

(1) The medical officer shall be responsible for the muster and the maintenance of discipline of personnel within his department.

5-17. Inspection of Ships

(1) The medical officer shall, or require his subordinates to do so, when directed, inspect ships going into commission to determine the adequacy of medical commissioning allowances of equipment and supplies.

5-20. Inspection Objectives for Activities Under the Management Control of the Bureau

(1) The objective of inspection of these activities is to promote efficiency and economy by observing and reporting upon the mission of the activity, the state of work and discipline, and the condition and preparedness of the activity to fulfill the mission, by determining whether the laws and regulations are being complied with, and by reporting upon the general, economic, and administrative efficiency of the activity in order that the factors controlling the efficiency of medical facilities may be given continuous review and study by the Bureau.

(2) Inspection of General Administration.—Inspection of the general administration of a medical activity under the management control of the Bureau includes inquiry and comment on the following:

(a) The organization and organization chart of the activity, order books, and other internal directives affecting administration, including adequate provisions for:

1. Peacetime operation.
2. Disaster and emergency.
4. Development of procedures to the end that the activity will operate according to a functional plan consistent with best possible utilization of personnel and available funds.
5. Continuing review of organizational units.
(6) Study of personnel requirements.

(7) Maintenance of equipment and appliances in a high state of efficiency.

(8) Performance standards. (Comparative relationship statistics on work-load factors.)

(9) Development of manuals of standard procedures governing administrative actions or general procedures to be followed to accomplish work processes in the various administrative billets.

(10) Planning board, to insure proper administrative and material status of the activity, and to review and conduct special investigations as directed and recommend changes in personnel requirements, administrative organizations, and operating methods.

(b) The appearance and bearing of military personnel.

(c) The cleanliness, sanitation, and appearance of the medical activity as a whole.

(d) Adequacy of public relations.

(e) Internal and external security.

(f) The communication system.

(g) Details of the muster system.

(h) Maintenance of discipline and administration of justice.

(i) Brig administration.

(j) Dissemination of information to personnel of the command.

(k) Coordination of the personnel training program in all departments.

(l) Indoctrination of newly reported personnel.

(m) General educational facilities for personnel of the command.

(n) The operation of the general mess, officers' mess, chief petty officers' mess, and special diet mess, including the preparation, quality, quantity, and variety of food, and the adequacy of the food service.

(o) The comfort and convenience of living spaces for housing personnel including adequacy of light, heat, ventilation, and fresh water, with due regard to economy.

(p) The administration of morale activities including provisions for athletics, crew's library, motion picture shows, Navy exchange, post office arrangements, religious activities, welfare, and recreation. Whether the welfare and recreation programs are efficiently administered for both personnel of the command and for patients.

(q) Administration of request mast.

(r) Placement and classification of military personnel of the command.

(s) Provision for advancement in rating of enlisted personnel.

(t) Leave and liberty, transportation facilities to nearby cities and towns, method of issuing and collecting liberty cards, and provision to prevent duplication and forging of liberty cards.

(u) Maintenance of personnel and financial records.

(v) Civilian personnel management, including training program.

(w) Security, custody, and care of Government property, including the security and accountability of narcotics and alcoholic liquors.

(x) Liaison with other agencies.

(y) Method of handling prisoner patients (naval hospitals).

(z) Other items as may fall within the scope of the general administration of a medical activity.

(3) Inspection of Specific Organisation Units of a Medical Activity.—Inspection of the administration of each organizational unit shall include examination of the following (as applicable):

(a) Organization chart.

(b) Planning and coordination of activities.

(c) Orders, instructions, procedures, and other directives, concerning matters under the cognizance of the specific organizational unit, including adequacy for peacetime mission.

(d) Administration and effectiveness of training of military and civilian personnel for current and prospective duties.

(e) Care of the patient.

(f) Dissemination of information within the organizational unit.

(g) Assignment of personnel, watches, Sunday and holiday routine, and fire stations.

(h) Safety precautions, including machinery-operating instructions.

(i) Procedures established for procurement, accounting, inventory, and economy (conservation), in the use of all consumable supplies, and spare parts.

(j) Security, care, and custody of Government property including the security and accountability of narcotics and alcoholic liquors.

(k) Procedures in connection with maintenance and preservation of the physical lay-out.

(l) Provision for maintaining the alteration, repair, and improvement program.

(m) Handling and accounting for correspondence, documents, and other material.

(n) Maintenance of records, including patients' records and hospital case records.

(o) Availability and correctness of publications, Navy Department Bulletins, directives, and technical instructions.

(p) Storage facilities for supplies, spare parts, etc.

(q) Other items as may fall within the category of the administration of a specific organizational unit.

(4) Material Inspections.—Inspection of material is made to: (1) determine actual condition of the equipment, etc., in each specific organizational unit, with respect to adequacy to perform all functions for which the items are separately and interrelatedly designed, and (2), recommend the changes or modifications necessary to insure material readiness of the unit to carry out the mission for which it was established. If considered desirable to determine the material condition, the inspecting officer should have the machinery, equipment, apparatus, etc.,
operated before reporting on the condition. Other items of inspection include:

(a) The item and priorities assigned, for approved projects in the current replacement or maintenance program to accomplish changes, additions, improvements, etc., within the unit.

(b) The care of equipment, inventory procedures, and custody responsibility.

(c) The effectiveness of the methods of upkeep, and preservation of the structure housing the unit, and of conditions which may lead to future deterioration.

(d) Adequacy of allowance list for equipment and supplies with particular emphasis on material readiness. Review of stock levels and stock controls to determine whether or not Bureau directives are being complied with.

(e) Adequacy of fire-fighting equipment, and the presence of hazards.

(f) Any other factors affecting material readiness.

5–21. Inspection Objectives for Medical Activities Not Under the Management Control of the Bureau

(1) At naval shipyards, air activities, stations, bases, and other naval activities, medical inspections include: (1) an evaluation of the condition and preparedness of the medical department to fulfill its primary mission in connection with the care of the sick and injured, and (2), a review and evaluation of the medical organization and programs relating to the prevention and control of diseases with particular emphasis upon sanitary, hygienic, and dietetic standards, industrial health, and safety measures.

(2) Care of the Sick and Injured.—Inspection of a naval activity dispensary includes the following broad subjects:

(a) Location of dispensary.

(b) Mission and organization.

(c) Personnel of the naval activity entitled to medical care.

(d) Medical department personnel.

(e) Facilities for the care of the sick.

(f) Equipment, stores, and stock levels.

(g) Records, reports, returns, accounts, etc.

(h) Log, journal, and standing order book.

(i) Security, care, and custody of Government property, including the security and accountability of narcotics and alcoholic liquors.

(j) Inventory and Plant Account.

(k) Medical services and work-load statistics.

(l) Wards, laboratory, pharmacy, X-ray, etc.

(m) Ward narcotic book and clinical records.

(n) Diets and messing for the sick.

(o) Disaster and emergency plans. Safety measures and extent of cooperation of medical department in the station safety programs.

(p) Other items, including hospitalization facilities.

(3) General Provisions Concerning Hygiene and Sanitation.—The responsibility of the medical officer of a naval activity in matters of sanitation extends into fields under the cognizance of other departments. To ascertain the actual hygienic and sanitary measures in force, personal observation is made by the medical inspector into matters including:

(a) Nutrition.

(b) Sanitary standards of living spaces, barracks, and berthing spaces, including lighting, heating, ventilation, and air conditioning.

(c) Water supply.

(d) Sanitary standards for food supply, messing, food handling, preservation, and food serving in general messes, cafeterias, snack bars, and Navy exchanges.

(e) Sewage disposal.

(f) Waste disposal, garbage, refuse, and trash.

(g) Insect and rodent control.

(h) Communicable disease control.

(i) Swimming sites.

(j) Brig sanitation (and medical care of prisoners).

(k) Industrial health.

(l) Immunization.

(m) Epidemiological matters.

(n) Physical exercises, athletics, recreational measures.

(o) Review of monthly sanitary recommendations contained in the medical department journal.

(p) Education of personnel in matters concerning health and first aid.

(q) Venereal disease control.

(r) Other matters which may lead to disease or injury or threaten the physical well-being and safety of command personnel.

(s) Cooperation with Federal, State, and local agencies.

(4) Other General Provisions.—Air facilities, shipyards, submarine bases, ammunition bases, and other types of naval activities require specific inspection subjects concerning the responsibilities of the medical department. The organization of the medical department of an air station must contain provisions for attending crashes and the handling of crash injuries. At submarine bases there are special medical problems connected with illness due to occupational hazards and the medical aspects of operations involving diving. At ammunition depots, the medical organization must include provisions for accidents and hazards connected with the storage and the handling of ammunition. Such items as the above are supplementary to the routine inspection subjects mentioned elsewhere in this chapter.
5-22. Inspection Conferences

(1) The condition sheets (rough work sheets of administrative, personnel, and material inspections) and notes collected by the inspector and his staff are used at a conference held at the activity upon completion of the inspection to insure that the activity may derive the greatest benefit from the inspection. At the conference, observations not considered of sufficient importance to be included in the report but which merit attention by the command or by the medical officer, are discussed in order that corrective action may be taken. It is the duty of all medical inspectors to assist medical department personnel in the performance of their duties by supplying information when appropriate and by suggesting ways and means to improve conditions.

5-23. Reporting

(1) Reports of Medical Inspection.—Reports of inspection shall be prepared at the earliest practicable date following the inspection and forwarded through the commanding officer of the activity, or of the naval hospital inspected, and thence, via chain of command, to the Chief of the Bureau.

(2) Report Procedure.—The inspection report shall be prepared in letter form. Paragraphs of the report shall be numbered consecutively in one series throughout a report. The authority for making the inspection, the name and location of the activity inspected, the date of the inspection, the date of the preceding annual medical inspection, and the name of the medical officer of the activity being inspected shall be indicated in the first paragraph. For reports of inspection of naval hospitals, naval medical supply depots, naval dispensaries, and the larger medical activities, the subsequent paragraphs of the report shall be arranged, first by the comments on the general medical administrative inquiry, followed by the remarks on the various organizational units. Either preceding or following this, the inspectors’ facts and conclusions are presented. Recommendations, if any, shall follow the facts and conclusions. Recommendations are to be prepared in two parts: (1) those requiring decision within command, and (2) those requiring decision by higher authority. The last item in the report will be the grading. This percentage grading will be in addition to the current practice of submitting statements in the report with reference to command management, remarks on the handling of various situations, or other matters considered worthy of special comment. Percentage grading shall be based upon the inspection of the medical activity as a whole.

(3) Enclosures to Reports.—In the interest of reducing the volume of inspection reports, a Personnel-Patient Data Sheet is the only enclosure desired. Sample forms for preparation of this data sheet have been supplied and are on file in the offices of district and staff medical officers. Unless considered desirable by the inspector as justification to support a recommendation or comment, other statistical data, maps, and charts should not be submitted.

Section V. CIVILIAN PHYSICIANS

General................................................................. 5-24
Methods of Obtaining Services...................................... 5-25
Selection................................................................. 5-26
Bureau Approval..................................................... 5-27
Security Clearances.................................................. 5-28
Duties................................................................. 5-29

5-24. General

(1) The absence or nonavailability of a Navy Medical Corps officer, or the nonavailability of a Medical Corps officer with a particular qualification, may at times necessitate the employment of the procurement of the medical services of a civilian physician.

(2) Civilian physicians may be utilized on a part-time basis in the continental United States at U.S. naval hospitals and U.S. naval dispensaries to augment the military medical staff.

(3) Civilian physicians may be utilized on a full-time or part-time basis, under the general supervision of a Navy medical officer, at industrial and industrial-type activities of the Navy and Marine Corps. At certain isolated locations, it may be necessary to utilize the services of civilian physicians in the absence of a Navy medical officer.

(4) Chapter 20 contains instructions for obtaining services of civilian physicians when required on an individual case basis.

5-25. Methods of Obtaining Services

(1) Regular Civil Service Appointment to Classified Positions.—Each activity is expected to employ civilian physicians pursuant to Navy Civilian Personnel Instructions, which cover procedures for classification, appointment, and compensation. In the event that there are no acceptable applicants for appointment or if applicants do not accept ap-
appointments for one reason or another, activities may consider under justifiable circumstances a method described below.

(2) Employment of Experts or Consultants Under Personal Service Contracts.—Employment of experts or consultants under personal service contracts is governed by the provisions of NAVPERS 35.

(3) Contracts for Nonpersonal Services.—Contracts for nonpersonal services may be considered only in the event that there are neither acceptable applicants for regular civil-service positions nor acceptances of offers for employment, as experts, under personal service contracts. In this event, appropriate requests for authority for the procurement of professional medical services of physicians on a “when needed” basis shall be forwarded by the requiring activity on NAVSANDA Form 76 for approval by the management control bureau via the Chief of the Bureau of Medicine and Surgery. Procurements pursuant to this subarticle are governed by SECNAV Instruction 6260.1A and existing procedures for obtaining nonpersonal services by contract.

5–26. Selection

(1) Careful selection of civilian physicians is required to insure the highest standards of professional service. Physicians selected for special clinical services must have the particular qualifications required for the position including board eligibility or board certification by an American Specialty Board where appropriate.

(2) Physicians selected for general practice type of medical service must be acceptable to the local profession as having the required qualifications.

(3) Civilian physicians selected must (a) be graduates of an accredited medical school; (b) be currently licensed to practice in a State or Territory of the United States; (c) possess high moral, professional, and ethical standards; and (d) be in good professional standing in their community.

5–27. Bureau Approval

(1) U.S. naval hospitals and U.S. naval dispensaries requiring the services of civilian physicians as provided in this section shall submit requests for authorization to the Bureau for approval prior to employment. Such request shall contain the following information:
   (a) Justification for the request.
   (b) Name and qualifications of the civilian physician.
   (c) Schedule of proposed employment.
   (d) Method of payment.

5–28. Security Clearances

(1) Security investigations for physicians who are employed or furnish professional medical services under the provisions of this section shall meet the requirements of the Navy Civilian Personnel Instructions and the Department of the Navy Security Manual for Classified Information (OPNAVINST 5510.1B). (Security clearances are not required when the services of civilian physicians are obtained under the provisions of chapter 20.)

5–29. Duties

(1) Civilian physicians may be utilized to perform any professional duties for which they are qualified.

(2) Under the direction of a Navy Medical Corps officer, they may perform general medical duties involving military personnel with the exception of those purely military in nature such as:
   (a) Physical examinations of candidates for duty involving flying, submarine and diving, or any other specialized duty.
   (b) Physical examinations for promotion of active duty officers or applicants for appointment to commission status in the Regular Navy or Marine Corps.
   (c) Physical examinations of applicants to officer candidate training programs.
   (d) Physical examinations of officers of Reserve components incident to reporting for active duty other than training duty.
   (e) Exercise of military command and administration over naval uniformed personnel.
   (f) Duties as member of boards of medical survey, medical boards, or physical evaluation boards.
# Chapter 6
## DENTAL CORPS

### Sections

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Function, Organization, and Responsibility</td>
<td>6-1 through 6-2</td>
</tr>
<tr>
<td>II. Dental Division, Bureau of Medicine and Surgery</td>
<td>6-3 through 6-12</td>
</tr>
<tr>
<td>III. Dental Corps</td>
<td>6-13 through 6-21</td>
</tr>
<tr>
<td>IV. General Duties of Dental Officers</td>
<td>6-22 through 6-36</td>
</tr>
<tr>
<td>V. Dental Officers Afloat</td>
<td>6-37 through 6-44</td>
</tr>
<tr>
<td>VI. Dental Officers Ashore</td>
<td>6-46 through 6-58</td>
</tr>
<tr>
<td>VII. Dental Officers With the Marine Corps</td>
<td>6-59 through 6-62</td>
</tr>
<tr>
<td>VIII. Dental Technicians</td>
<td>6-63 through 6-68</td>
</tr>
<tr>
<td>IX. Dental Service Warrant Officers, Medical Service Corps Officers, and Nurse Corps Officers in Dental Facilities</td>
<td>6-69 through 6-73</td>
</tr>
<tr>
<td>X. Civilian Employees in Dental Facilities</td>
<td>6-74</td>
</tr>
<tr>
<td>XI. Naval Dental Clinics</td>
<td>6-75 through 6-81</td>
</tr>
<tr>
<td>XII. Fleet Marine Force Dental Companies</td>
<td>6-82 through 6-85</td>
</tr>
<tr>
<td>XIII. Dental Standards</td>
<td>6-86 through 6-97</td>
</tr>
<tr>
<td>XIV. Dental Examination and Treatment</td>
<td>6-98 through 6-106</td>
</tr>
<tr>
<td>XV. The Dental Record and Other Standard Forms</td>
<td>6-107 through 6-121</td>
</tr>
<tr>
<td>XVI. Dental Officer Training</td>
<td>6-122 through 6-132</td>
</tr>
<tr>
<td>XVII. Dental Research</td>
<td>6-133 through 6-134F</td>
</tr>
<tr>
<td>XVIII. U.S. Naval Dental School</td>
<td>6-135 through 6-138</td>
</tr>
<tr>
<td>XIX. U.S. Naval Dental Technicians Schools</td>
<td>6-139 through 6-144</td>
</tr>
<tr>
<td>XX. Publications and Files in Dental Facilities</td>
<td>6-145 through 6-147</td>
</tr>
<tr>
<td>XXI. Reports, Records, and Correspondence</td>
<td>6-148 through 6-159</td>
</tr>
<tr>
<td>XXII. Dental Supplies and Equipment</td>
<td>6-160 through 6-174</td>
</tr>
<tr>
<td>XXIII. Dental Fiscal Matters</td>
<td>6-175 through 6-177</td>
</tr>
<tr>
<td>XXIV. Planning Dental Facilities</td>
<td>6-178 through 6-192</td>
</tr>
<tr>
<td>XXV. Survey of Dental Activities and Facilities</td>
<td>6-193 through 6-197</td>
</tr>
<tr>
<td>XXVI. Dental Corps of the Naval Reserve</td>
<td>6-198 through 6-209</td>
</tr>
</tbody>
</table>

### Section I. FUNCTION, ORGANIZATION, AND RESPONSIBILITY

<table>
<thead>
<tr>
<th>Article</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Function</td>
</tr>
<tr>
<td>Organization and General Responsibility</td>
</tr>
</tbody>
</table>

*Change II*
6-1. Primary Function
(1) The primary function of the Navy Dental Corps is to provide such care for active duty Navy and Marine Corps personnel as will prevent or remedy diseases, disabilities, and injuries of the teeth, jaws, and related structures, which may directly or indirectly interfere with the performance of military duties.

6-2. Organization and General Responsibility
(1) The Assistant Chief for Dentistry and Chief of the Dental Division, Bureau of Medicine and Surgery, is responsible to the Chief of the Bureau for the supervision, direction, and coordination of the Navy dental service and programs.
(2) The Inspector General, Dental, is responsible to the Chief of the Dental Division for planning, coordinating, and conducting the survey program of the Navy dental service to assure efficiency and conformance with Bureau policies and for advising the Chief of the Bureau via the Chief of the Dental Division regarding the results of surveys which he makes or which are reported to him.
(3) The Director, U.S. Naval Dental Activities, Field Branch, Bureau of Medicine and Surgery, Pacific Coast, represents the Bureau in that area on all professional, technical, and administrative matters related to dentistry; directs, coordinates, supervises, and surveys dental activities and support as assigned by the Chief of the Bureau; and maintains liaison with various dental organizations in the area.
(4) District and staff dental officers are responsible for advising their respective commanders and first line commanders on all dental matters within their commands. They are responsible for assuring the support of Department of the Navy policies which pertain to the Navy dental service in the districts or commands to which they are attached.
(5) The head of a dental department, the chief of a dental service, and the commanding officer or officer in charge of a dental activity is responsible to the commanding officer or superior in the chain of command for the dental service provided by the command or activity to which attached.

Section II. DENTAL DIVISION, BUREAU OF MEDICINE AND SURGERY

Establishment and Responsibility
Organization Chart, Dental Division
Chief of the Dental Division
Assistant Chief of the Dental Division
Professional Branch
Planning and Logistics Branch
Personnel Branch
Reserve Branch
Research Branch
Inspector General, Dental

6-3. Establishment and Responsibility
(1) Establishment.—The Secretary of the Navy, on 28 June 1946, established the Dental Division within the Bureau of Medicine and Surgery, in accordance with the act approved 28 December 1945 (10 USC 5138).
(2) Responsibility.—All matters relating to dentistry are required by law to be referred to the Dental Division and that Division is responsible for the study, planning, and direction of all matters coming within its cognizance.
(a) Specifically, the Dental Division is required to:
(1) Establish professional standards and policies for dental practice.
(2) Conduct inspections and surveys for maintenance of such standards.
(3) Initiate and recommend action pertaining to complements, appointments, advancement, training, assignment, and transfer of dental personnel.
(4) Serve as the advisory agency for the Bureau on all matters relating directly to dentistry.

6-4. Organization Chart, Dental Division
(1) See next page.

6-5. Chief of the Dental Division
(1) The Chief of the Dental Division is responsible for the performance of all the functions of the Dental Division. He is detailed from among the officers of the Dental Corps in the grade of rear admiral, in accordance with act approved 28 December 1945, as amended (10 USC 5138).
(2) The Chief of the Dental Division, while so serving, receives the pay and allowances provided by law for rear admirals of the upper half and is entitled, in all respects, to the same privileges of retirement and retired pay benefits as are provided...
by law for chiefs of bureaus of the Navy Department.
(3) The Chief of the Dental Division is assisted by the staff of the Dental Division in carrying out his responsibilities.

6–6. Assistant Chief of the Dental Division
(1) The Assistant Chief of the Dental Division is the dental officer next in authority to the Chief of the Dental Division and as such is responsible for the projection of his policies. In the absence of the Chief of the Dental Division and the Inspector General, Dental, the Assistant Chief of the Dental Division acts for them.

6–7. Professional Branch
(1) The Professional Branch is comprised of a Standards Section, a Training Section, and a Statistics Section. This Branch advises the Chief of the Dental Division on the establishment of professional standards and policies for dental practice, development and coordination of training programs for dental officers and dental enlisted personnel, and develops dental statistical data for the use of the Dental Division.

6–8. Planning and Logistics Branch
(1) The Planning and Logistics Branch is comprised of a Planning Section and a Logistics Section. This Branch advises the Chief of the Dental Division on matters related to dental finance, materiel, logistics, organization, and planning.

6–9. Personnel Branch
(1) The Personnel Branch is composed of an Appointment and Assignment Section, Complement and Allowance Section, and Technicians Section. This Branch advises the Chief of the Dental Division on the requirements, qualifications, procurement, assignment, and distribution of dental personnel.

6–10. Reserve Branch
(1) The Reserve Branch is comprised of a Personnel Section and a Training Section. This Branch advises the Chief of the Dental Division on planning, coordinating, and directing those aspects of the Naval Dental Reserve Program which are the responsibility of the Bureau.

6–11. Research Branch
(1) The Research Branch advises the Chief of the Dental Division on research matters which pertain to Navy dentistry. This Branch maintains liaison for the Dental Division with the Research Division of the Bureau, the Office of Naval Research, and other offices and agencies that have an interest in dental research.

6–12. Inspector General, Dental
(1) The Inspector General, Dental, plans, coordinates, and conducts dental surveys; conducts special investigations, as directed; and maintains liaison with the Naval Inspector General and inspectors general of other bureaus. (See sec. XXV.)
(2) The Inspector General, Dental, ranks next to the Assistant Chief for Dentistry and Chief of the Dental Division and acts with full responsibility and authority for him in his absence.

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### Section III. DENTAL CORPS

<table>
<thead>
<tr>
<th>Establishment</th>
<th>Grades and Strength</th>
<th>Appointments</th>
<th>Duty Assignments</th>
<th>Eligibility for Promotion</th>
<th>Requirements for Promotion</th>
<th>Written Examinations and Exemptions</th>
<th>Written Examination Subjects</th>
<th>Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article</td>
<td>6–13</td>
<td>6–14</td>
<td>6–15</td>
<td>6–16</td>
<td>6–17</td>
<td>6–18</td>
<td>6–20</td>
<td>6–21</td>
</tr>
</tbody>
</table>

6–13. Establishment
(1) The Naval Dental Corps was established by provisions of an act of 22 August 1912 (now codified by act approved 10 Aug. 1956, 10 USC 9027). This act authorized the appointment of not more than 30 assistant dental surgeons to serve professionally the personnel of the naval service and to perform such other duties as may be prescribed by competent authority.

6–14. Grades and Strength
(1) The Naval Dental Corps consists of officers in the grades of lieutenant, junior grade; lieuten-
6–14 CHAPTER 6. DENTAL CORPS 6–15

ant; lieutenant commander; commander; captain; and rear admiral.

(2) The total authorized number of officers of the Dental Corps on the active list is \( \frac{7}{10} \) of 1 percent of the sum of—

(a) the authorized strengths of the active lists of officers of the Navy and the Marine Corps authorized by 10 USC 5403, 5404, and 5405;

(b) the authorized strengths of the Regular Navy and the Regular Marine Corps in enlisted members authorized by 10 USC 5401 and 5402;

(c) the authorized strength of the Navy in midshipmen at the Naval Academy;

(d) the actual number of officers holding permanent appointments in warrant officer grades in the Regular Navy and the Regular Marine Corps, excluding retired officers; and

(e) the actual number of aviation midshipmen on active duty as appointed under 10 USC 6906 (10 USC 5404).

(3) The Secretary of the Navy computes the authorized strength of the active list of the Navy in officers in the Dental Corps as of 1 January of each year (10 USC 5404). The terms “active list of the Navy” and “active list of the Marine Corps” as used in this article mean the lists of officers of the Regular Navy and the Regular Marine Corps, other than retired officers, holding permanent appointments in grades above chief warrant officer, W–4 (10 USC 5001 (8) (9-10)).

6–15. Appointments

(1) Original Appointments.—Generally, original appointments in the Dental Corps, U.S. Navy, are made in the grade of lieutenant (junior grade). Appointments are made as vacancies occur, in order of the candidates’ group lineal position, as shown by competitive examination or as otherwise determined by the Chief of Naval Personnel.

(2) Appointments in the Dental Corps of the U.S. Navy.—

(a) Qualifications for Appointment.—

(1) Sex—male or female.

(2) Citizenship—United States citizen.

(3) Appointees in the grade of lieutenant (junior grade) in the Dental Corps shall be citizens of the United States between 21 and 33 years of age. (Codified by act approved 10 Aug. 1956, 10 USC 5571, 5578.)

(4) A limited number of qualified civilian dentists (including those who may hold Reserve commissions) of other ages may be appointed. (Codified by act approved 10 Aug. 1956, 10 USC 5578.) The grade in which appointed will be determined by the professional age, experience, and attainments of the individual.

(5) All appointees shall be graduates of approved dental schools.

(6) Candidates for such appointment must meet certain physical, mental, moral, and professional qualifications before medical and professional examining boards appointed by the Secretary of the Navy. Medical examining boards for the examination of candidates are appointed by the Secretary of the Navy. The Secretary has prescribed that the candidates shall be examined for professional qualifications by a board of officers of the Dental Corps. An applicant for appointment may be required to demonstrate his professional qualifications by written, oral, or practical examinations.

(7) Women may be appointed in the Dental Corps of the Navy as determined by the Secretary of the Navy (act of 12 Jun 1949, now codified by act approved 10 Aug. 1956 (10 USC 5590); act of 24 Jun 1952, now codified as 10 USC 5578).

(8) Additional qualifications may be promulgated by the Chief of Naval Personnel from time to time.

(b) Application for Appointment.—

(1) Inactive Reserve officers, former dental officers, and other civilians must submit an application for appointment to the nearest Navy recruiting station in the form prescribed by the Chief of Naval Personnel.

(2) A senior dental student may submit an application for an appointment as a lieutenant (junior grade) to be issued after his graduation, in accordance with current Bureau of Naval Personnel instructions.

(3) Reserve officers on active duty should submit letter requests for consideration to the Chief of Naval Personnel via their commanding officer.

(c) Consideration of Candidate for Appointment.—

(1) Qualifications.—The professional qualifications of a candidate for appointment will be considered by a board of dental officers. If the candidate is to appear in person for consideration, he will be authorized to appear before a board of medical examiners for determination of his physical qualifications, and a naval examining board for determination of his mental, moral, and professional qualifications at a time and place designated by the Chief of Naval Personnel. The military qualifications shall be determined by the Chief of Naval Personnel.

(2) Expenses.—No allowance is made for travel or other expenses incurred by the candidate in appearing for examination.

(3) Physical Examination.—A thorough physical examination, conducted by a board of medical
examiners, shall precede the professional examination. The candidate shall be required to certify that he is free from any bodily or mental ailments. If the candidate is found to be physically disqualified, the examination shall be concluded.

(4) **Professional Examination.**—When a candidate is required to appear in person for examination, the professional examination will include:

(a) Written and oral examinations on oral diagnosis and roentgenology, operative dentistry, periodontics, prosthodontics, and oral surgery.

(b) Clinical examination on operative dentistry, prosthodontics, and roentgenology.

(c) Oral examination on subjects of preliminary education.

(5) **Termination of Examination.**—The naval examining board may conclude the examination at any time and may deviate from the plan as outlined above as may seem best for the interests of the naval service.

(6) **Withdrawal From Examination.**—Upon written request and with the consent of the board, a candidate may withdraw from further examination without prejudice as to eligibility for subsequent examination.

(7) **Disqualification.**—Any candidate who knowingly gives a false certificate of age or character, or knowingly makes a false statement to a board of examiners shall be disqualified.

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**6-16. Duty Assignments**

(1) Dental officers are assigned to duty in the larger naval activities within the continental limits of the United States, to duty afloat in the large combatant and auxiliary ships of the fleet, to foreign shore duty, and to duty with the Marine Corps within and beyond the continental limits of the United States. The normal rotation pattern is an initial short tour of duty within the continental limits of the United States and then sea duty or foreign shore duty, followed by another tour of duty within the continental limits of the United States, after which the officer is assigned to foreign shore or sea duty, dependent upon the officer's first tour of duty beyond the continental limits of the United States.

(2) Duty tour lengths are influenced by several factors. These include, but are not limited to, the ratio of sea and foreign shore billets to those ashore in continental United States, number of officers on active duty for limited periods, requirements for officers with special qualifications, billets of an unusually arduous nature or in isolated areas, and training requirements. The tour lengths indicated below are considered to be normal.

(a) Cruises afloat—2 years.

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**6-17. Eligibility for Promotion**

(1) Officers of the Dental Corps become eligible for consideration by a selection board for promotion to the next higher grade with their running mates in the line, in accordance with pertinent provisions of the act of 7 August 1947 (now codified by act of 10 Aug 1956, 10 USC 5753).

---

**6-18. Requirements for Promotion**

(1) Officers of the Dental Corps who have been selected for promotion must be found qualified by a naval examining board before being promoted. The type of examination which is given by the examining board is specified by the Secretary of the Navy. It may be either an examination on official records only, or it may be a written examination.

(2) There are three broad areas of knowledge in which officers of the Dental Corps must be qualified in order to be promoted.

(a) **Executive Area.**—Understanding of the basic principles and policies in the organization of the Department of Defense and in the planning, control, and administration of the Naval Establishment.

(b) **Operations Area.**—Knowledge of the professional subjects essential to the efficient operation, management, and logistic support of the dental facilities throughout the naval service.

(c) **Technical Area.**—Knowledge of the professional subjects essential to provide dental care to the personnel of the Navy and Marine Corps.

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**6-19. Written Examinations and Exemptions**

(1) **Examinations.**—When written examinations are required, the subjects and scope of examination for dental officers in the various grades shall be in accordance with current directives.

(2) **Exemptions.**—Exemptions from written examinations for dental officers in the various grades
shall be in accordance with current directives which list schools and courses effecting exemptions in the executive, operations, and technical areas.

6-20. Written Examination Subjects

<table>
<thead>
<tr>
<th>Subject</th>
<th>LT/G to LT</th>
<th>LT to LCDR</th>
<th>LCDR to CDR</th>
<th>CDR to CAPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART I—EXECUTIVE AREA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Naval Orientation</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Administrative Organization and Regulations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. Personnel Administration and Leadership</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Military Justice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART II—OPERATIONS AREA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Operation of a Dental Department</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Administration of Dental Departments Ashore at afloat</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Operation of a U.S. Naval Dental Clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6-21. Retirement

(1) The several types of retirement for officers of the Regular Navy are explained in chapter 14 of the Bureau of Naval Personnel Manual and current directives (see also 10 U.S.C. 6406 concerning furlough).

Section IV. GENERAL DUTIES OF DENTAL OFFICERS

The Dental Officer.................................................. 6-22
Assistant Dental Officer........................................... 6-23
Principal Duty of All Dental Officers........................... 6-24
Proficiency in All Fields of Dentistry.......................... 6-25
Duties Upon Reporting to a Ship or Station....................... 6-26
Duties in Care of Mass Casualties............................... 6-27
Organization and Instruction Books.............................. 6-28
Maintenance of Dental Department Log........................... 6-29
Official Correspondence.......................................... 6-30
Prescription of Drugs........................................... 6-31
Knowledge of Official Directives................................ 6-32
Publication of Professional Articles............................. 6-33
Participation in Civilian Professional Activities.............. 6-34
Private Practice.................................................. 6-35
Civil Suits....................................................... 6-36

6-22. The Dental Officer

(1) The Secretary of the Navy shall prescribe regulations for dental services on ships and at shore stations; such services shall be under the senior dental officer, who is responsible to the commanding officer of the ship or station for all professional, technical, and administrative matters concerning dental services (sec. 4 of act of 28 Dec 1945, now codified by act approved 10 Aug 1956 (10 U.S.C. 6029)). Therefore, the head of the dental department of a command or other activity shall be the senior officer of the Dental Corps permanently attached for duty and so assigned. He shall be designated the dental officer.

(2) The dental officer is responsible for the general duties prescribed in Navy Regulations for a head of a department as well as the duties prescribed for a head of a dental department.

(3) The dental officer of a ship or station shall advise the commanding officer of the number and grades or ratings of dental personnel needed for efficient operation of the dental department whenever the requirements are altered appreciably because of personnel, physical facilities, or workload changes.

6-23. Assistant Dental Officer

(1) Assistant dental officers shall conform to the policies established by the dental officer with regard
to the professional treatment and care of patients. They shall perform such other duties as may be assigned them by the dental officer or other competent authority.

6-24. Principal Duty of All Dental Officers

(1) The principal duty of all officers of the Dental Corps is to treat and prevent diseases, disabilities, and injuries of the jaws, teeth, and related structures. Although it is essential for dental activities to be administered properly, it is desirable that all dental officers keep the time required for administration and supervision at an absolute minimum in order to increase their professional accomplishment.

(2) The dental officer shall be responsible for conducting an organized program of preventive dentistry and dental health education for all personnel dependent on him for dental service. In larger dental activities, the dental officer shall designate one dental officer as the preventive dentistry officer, who shall implement the preventive dentistry program.

6-25. Proficiency in All Fields of Dentistry

(1) It is desirable that all dental officers have an opportunity to become proficient in the various fields of dentistry which are practiced in the naval service. The dental officer should, insofar as may be practicable, afford assistant dental officers the opportunity to acquire experience in the various dental fields. This may be accomplished in two ways:

(a) Permit all dental officers to conduct a general practice and perform all types of dental operations and treatments.

(b) Rotate dental officers for limited periods in the various fields of dentistry.

(2) When appropriate, qualified dental officers should act as consultants and advisors to dental officers with lesser experience.

6-26. Duties Upon Reporting to a Ship or Station

(1) As soon as possible after reporting, the dental officer of a ship or station shall examine the dental operating spaces, the equipment therein, and other accommodations provided for the dental department. He shall make a detailed written report to the commanding officer if any defects or deficiencies are discovered which interfere with the efficient operation of the dental department.

(2) The Bureau desires full knowledge of the functioning of the Navy Dental Corps ashore and afloat in order to be prepared to anticipate and meet needs for personnel and material and be informed of the adequacy of dental treatment facilities as related to the need or demand for dental treatment. Dental officers are, therefore, encouraged to submit to the Bureau, via official channels, well-considered suggestions for the betterment of the Navy Dental Corps.

6-27. Duties in Care of Mass Casualties

(1) Dental officers shall be qualified to perform first aid procedures in order that they may treat or assist in the treatment of mass casualties.

6-28. Organization and Instruction Books

(1) Each dental activity and dental department of a ship or station shall publish an "Organization Book" and "Instruction Book." These may be combined into a single publication. All Organization and/or Instruction Books should be brought into the Navy Directives System through identification or conversion. Standard dental department organization manuals or books may be used as a guide. Reference should be made to Organization Planning for Naval Units (NAVPERs 18371).

6-29. Maintenance of Dental Department Log

(1) The dental officer of a ship or station shall keep a rough watch log or journal which shall be a chronological record of pertinent matters within the province of the dental department.

(2) Any important occurrence coming under the cognizance of the dental officer such as damage, destruction, or loss of dental department property, or breaches of discipline by dental department personnel, shall be reported to the officer of the deck or other proper officer for entry in the log, report book, or journal of the ship or station.

6-30. Official Correspondence

(1) All official correspondence on dental department matters shall be signed or cleared by the dental officer and forwarded through official channels.

(2) Dental reports shall be prepared and forwarded by the dental officer of a ship or station, in accordance with sections XV and XXI of this chapter, chapter 23, and current directives.

6-31. Prescription of Drugs

(1) The dental officer of a ship or station shall not permit alcoholic beverages or solutions, habit-forming drugs, and poisonous drugs under his charge to be placed in the possession of any person, except in small quantities for use in the treatment of patients (see arts. 3-33 and 3-34).
(2) Officers of the Dental Corps shall use only the standard prescription form for official prescriptions.

(3) Prescriptions for alcoholic beverages or solutions, habit-forming drugs, and poisonous drugs, to be used in the dental department shall be signed by a dental officer. Prescriptions for these drugs shall be properly signed, numbered, and filed.

6–32. Knowledge of Official Directives

(1) Instructions set forth in this manual are but a portion of the general instructions with which officers of the Dental Corps must be familiar. They shall also study various other official publications such as the BuMed Instructions and Notices; U.S. Navy Regulations; Manual for Courts-Martial, United States, 1951, and the Navy Supplement; Navy Department General Orders; Bureau of Naval Personnel Manual; and other current orders and instructions.

6–33. Publication of Professional Articles

(1) Officers of the Dental Corps are encouraged to contribute to professional literature. They shall be guided by Navy Regulations and other current directives relative to publishing such articles.

(2) Dental officers desiring to publish articles through public media shall be guided by the provisions of articles 1–19(3), (4), and (5).

(3) Dental officers who are authors of published articles should not send reprints to the Chief of Naval Personnel for inclusion in their official records, but should enter pertinent information on the Officer Qualifications Questionnaire, NAVPERS-549.

6–34. Participation in Civilian Professional Activities

(1) Officers of the Dental Corps shall make every effort to establish and maintain the highest standards of ethical and professional practice, to keep themselves informed in all fields of dentistry, and to improve their professional abilities. When practicable, they should attend professional meetings of dental societies, seminars, clinics, lectures, study courses, and other similar means of acquiring additional knowledge.

Section V. DENTAL OFFICERS AFOAT

<table>
<thead>
<tr>
<th>The Fleet Dental Officer</th>
<th>6–37</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Force Dental Officer</td>
<td>6–38</td>
</tr>
<tr>
<td>Dental Officer in a Ship</td>
<td>6–39</td>
</tr>
<tr>
<td>Dental Officer in an Aircraft Carrier</td>
<td>6–40</td>
</tr>
<tr>
<td>Dental Officer in a Tender or Repair Ship</td>
<td>6–41</td>
</tr>
<tr>
<td>Dental Officer in a Hospital Ship</td>
<td>6–42</td>
</tr>
<tr>
<td>Dental Officer in a Transport</td>
<td>6–43</td>
</tr>
<tr>
<td>Dental Officer Embarked With Troops in a Transport</td>
<td>6–44</td>
</tr>
</tbody>
</table>

6–35. Private Practice

(1) The Bureau recognizes that certain mental and physical demands are peculiar to the practice of dentistry. The volume of dental care needed by Navy and Marine Corps personnel on active duty requires the expenditure of maximum effort by all Navy dental officers. The additional strain involved in an afterhours or weekend private practice cannot but interfere with the proper and efficient treatment of patients in Navy dental facilities. Therefore, dental officers on active duty shall not engage in private or civilian practice.

6–36. Civil Suits

(1) If an officer of the Dental Corps is apprised of any civil litigation or legal proceedings being brought against him wherein the United States is in legal effect the defendant, he shall immediately advise the commanding officer so that a report can be made as set forth in the Naval Supplement to the Manual for Courts-Martial, United States. A copy of the report shall be submitted to the Bureau.
6-37. The Fleet Dental Officer

(1) The fleet dental officer is the adviser to the fleet commander on all matters pertaining to fleet dental matters. He shall, by means of surveys, visits, and review of dental service reports and reports of surveys, keep himself informed of all matters pertaining to the dental service, dental personnel, and dental material of the fleet. In addition to these general responsibilities, the fleet dental officer shall:

(a) Assist the fleet commander in preparing the dental aspects of operational and logistic plans.

(b) Coordinate dental services administered in subordinate units of the fleet, conferring with force dental officers as necessary to insure maximum coordination.

(c) Advise the fleet commander regarding establishment, expansion, or reduction of dental facilities in ships of the fleet and the adequacy of fleet-supporting shore-based dental facilities.

(d) Recommend to the fleet commander, for submission to the Bureau, information, observations, and recommendations on matters under the Bureau's purview which would improve dental service to the fleet.

(e) Promote professional interest by the timely dissemination of information to dental officers of the fleet; and by arranging meetings of officers of the Dental Corps within the fleet, when practicable, for discussion of appropriate subjects.

(2) Surveys, When Made.—
(a) The fleet dental officer shall, when directed by the fleet commander, make comprehensive surveys of dental facilities of ships of the fleet and of dental facilities of fleet shore-based activities as required.

(b) The fleet dental officer shall, when practicable, make limited surveys of dental facilities in ships of the various groups and components of the fleet and of dental facilities of fleet shore-based activities as required.

(c) The fleet dental officer may, subject to the approval of the fleet commander, visit dental facilities of fleet shore-based activities to give or obtain technical information or assistance.

(3) Scope of Surveys.—
(a) When the fleet dental officer is directed to survey the dental organization of a ship or shore-based activity he shall make a comprehensive survey to determine the efficiency of the dental organization and dental service.

(b) When the fleet dental officer makes a limited survey of, or a familiarization visit to, a fleet unit or activity, he shall do so on an advisory and constructive basis with a view toward possible improvement of the dental service.

6-38. The Force Dental Officer

(1) The duties of the force dental officer shall be similar to those of the fleet dental officer insofar as they relate to his organization.

6-39. Dental Officer in a Ship

(1) The head of the dental department of a ship is designated the dental officer and shall be the senior officer of the Dental Corps attached for duty. In his absence, his duties shall be performed by the next senior dental officer attached for duty and on board. The responsibilities and duties of a head of department are prescribed in Navy Regulations and by the commanding officer.

(2) The primary responsibility of the dental officer is to maintain the dental health of the personnel of the ship. The dental officer and his assistants will provide the dental treatment necessary to achieve this objective. Other parts of this responsibility include:

(a) Conducting dental examinations when practicable on personnel who report for duty to determine need for dental treatment and to verify their dental records.

(b) Instructing ship's personnel in preventive dentistry and instituting any measures required to control dental disease.

(c) Treating personnel from other commands who may be dependent upon him for dental service.

(d) Preparing and submitting required reports on dental treatment.

(e) Performing the duties of a division officer when assigned as such by the commanding officer. The division dental officer shall be responsible for carrying out the requirements of chapter 10, section 5, of U.S. Navy Regulations. The dental division shall include all personnel assigned duty with the dental department.
(f) Providing professional advice to the commanding officer concerning proper action to be taken on requests for dental treatment to be obtained from civilian sources outside the continental United States and the payment of expenses for such treatment.

6-40. Dental Officer in an Aircraft Carrier

(1) The provisions of article 6-39 shall apply to the dental officer in an aircraft carrier.

(2) In addition, he shall be responsible for the dental records of squadron personnel when embarked.

(3) He shall take special measures to assure that dental officers are assigned to troop personnel when embarked with the squadron when detached from the ship.

6-41. Dental Officer in a Tender or Repair Ship

(1) In addition to compliance with the provisions of article 6-39, the dental officer in a tender or repair ship shall make advance arrangements and allocate time for the personnel from other ships dependent on him for dental care.

6-42. Dental Officer in a Hospital Ship

(1) The dental officer in a hospital ship shall be the Chief of the Dental Service.

(2) His duties are dependent upon the current employment of the ship and, besides the applicable responsibilities assigned by article 6-54, may include those of a dental officer in a tender or transport.

Section VI. DENTAL OFFICERS ASHORE

Table:

<table>
<thead>
<tr>
<th>Position</th>
<th>Article</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director, U.S. Naval Dental Activities, Field Branch, Bureau of Medicine and Surgery, Pacific Coast</td>
<td>6-46</td>
</tr>
<tr>
<td>Director, Dental Activities, and District Dental Officer</td>
<td>6-47</td>
</tr>
<tr>
<td>Staff Dental Officer of River Command or Advanced Base</td>
<td>6-48</td>
</tr>
<tr>
<td>Commanding Officer of a Dental Activity</td>
<td>6-49</td>
</tr>
<tr>
<td>Officer in Charge of a Dental Activity</td>
<td>6-50</td>
</tr>
<tr>
<td>Dental Officer in a Shore Station</td>
<td>6-51</td>
</tr>
<tr>
<td>Dental Officer in a Training Center or Recruit Depot</td>
<td>6-52</td>
</tr>
<tr>
<td>Dental Officer in a Naval Shipyard</td>
<td>6-53</td>
</tr>
<tr>
<td>Chief of the Dental Service in a U.S. Naval Hospital</td>
<td>6-54</td>
</tr>
<tr>
<td>Chief of the Dental Service in a U.S. Naval Dispensary</td>
<td>6-55</td>
</tr>
<tr>
<td>Dental Officer in a Naval Aviation Unit</td>
<td>6-56</td>
</tr>
<tr>
<td>Dental Officer in a Mobile Dental Unit</td>
<td>6-57</td>
</tr>
<tr>
<td>Dental Officer in a Research Activity or Facility</td>
<td>6-58</td>
</tr>
</tbody>
</table>

6-43. Dental Officer in a Transport

(1) The provisions of article 6-39 shall apply to the dental officer in a transport.

(2) The dental officer in a transport shall, in addition:
   (a) Provide emergency and routine dental treatment to passenger personnel who are eligible for dental treatment in accordance with article 6-98, if a troop dental officer is not aboard.
   (b) Schedule the use of dental department facilities of the ship so that troop dental officers may provide emergency and routine dental treatment to troop personnel.

6-44. Dental Officer Embarked With Troops in a Transport

(1) The senior dental officer embarked with troops in a transport shall:
   (a) Report to the dental officer of the transport upon embarkation and arrange for the use of the facilities of the dental department.
   (b) Be responsible for the dental health of the embarked troops while they are aboard the transport.
   (c) Advise the troop commander regarding the availability of dental treatment for embarked troops.
   (d) Establish a duty schedule for other troop dental officers.
   (e) Advise the troop commander regarding the assignment of troop dental enlisted personnel to duties in the dental department of the ship.

NOTE.—There is no article 6-45.

6-46. Director, U.S. Naval Dental Activities, Field Branch, Bureau of Medicine and Surgery, Pacific Coast

(1) This activity is under the military command of the Commander, Western Sea Frontier, and under the management control of the Chief, Bureau of Medicine and Surgery.

(2) The Director is the officer detailed as such by the Department of the Navy from the officers of the active list of the Dental Corps.

(3) The Director shall:
   (a) Represent the Bureau in all matters concerning professional, technical, and administrative fields related to dentistry in the area.

6-11

Change II
(b) Direct and coordinate the dental support for the operating forces through the Commander, Western Sea Frontier.

c) Direct and coordinate through the district commandants the following tasks related to dentistry:

(1) Professional standards and performance of the various dental activities in accordance with the policies of the Chief of the Bureau.

(2) Planning to meet current and mobilization requirements for personnel and facilities to insure development of efficient dental care programs.

(3) Procurement of suitable personnel for the Navy Dental Corps.

(4) Training programs for dental personnel.

(5) Development and guidance of the Naval Reserve Program.

(d) Conduct surveys and visits to naval and Marine Corps activities, when directed by the Bureau, to insure maintenance of professional standards and policies relating to dental practice.

(e) Maintain liaison and collaborate with other governmental agencies, the deans of dental schools, and professional organizations.

(f) Advise the Bureau on all matters pertaining to dental activities in the area.

6-47. Director, Dental Activities, and District Dental Officer

(1) Directors of dental activities and district dental officers are detailed as such by the Navy Department from the officers of the active list of the Dental Corps.

(2) They shall:

(a) Advise the commandant concerning all professional, technical, and administrative matters relating to the dental service of the district.

(b) Plan for the establishment, maintenance, or reduction of dental facilities in accordance with the commandant’s plan for the operation of the district.

(c) Coordinate dental activities within the district.

(d) Advise local naval authorities relative to dental matters.

(e) Visit dental activities when directed by competent authority.

(f) Represent the interests of the Bureau in civilian dental societies and associations, dental schools, and other agencies within the district.

(g) Have cognizance of and maintain records and information concerning dental matters relative to the Naval Reserve.

(h) Review dental reports which are forwarded to the Bureau via the commandant for errors and inconsistencies and expedite action for correction or resubmission when necessary.

(i) Advise dental officers within the district of short postgraduate and refresher courses which may be available in the district and which may be applicable to the practice of dentistry in the Navy.

(j) Recommend to the commandant the officer and enlisted personnel needed for the operation of mobile dental units attached to the district. Prepare operating schedules for use of such units. (See art. 6-47.)

(k) Maintain liaison with the Bureau, via official channels, and with representatives of fleet and Marine Corps units located in the district. Assist and advise base dental officers, dental officers of Marine Corps units, and dental officers of fleet units in coordinating dental services to forces afloat.

(l) Collaborate in the preparation of code logistic plans.

(m) Within the continental United States, for the commandant, provide coordination and technical control of the program for obtaining dental care for Navy and Marine Corps personnel from civilian non-Federal sources and authorize and approve for payment the expenses of such care furnished within the district.

6-48. Staff Dental Officer of River Command or Advanced Base

(1) The provisions of article 6-47 shall apply, where pertinent, to dental officers serving on the staff of river commands or advanced bases.

6-49. Commanding Officer of a Dental Activity

(1) The commanding officer of a dental activity is detailed as such by the Navy Department from the officers of the active list of the Dental Corps.

(2) The commanding officer is charged with the direction of the professional and command functions of the activity. He shall be guided by the naval regulations and instructions governing commanding officers.

(3) In the event of the incapacity, death, or absence of a commanding officer of a dental activity, he will be succeeded by an officer of the Dental Corps next in rank and regularly attached and on board, until relieved by competent authority or until the regular commanding officer returns.

6-50. Officer in Charge of a Dental Activity

(1) The officer in charge of a dental activity is detailed as such by the Navy Department from the officers of the active list of the Dental Corps.

(2) The officer in charge of a dental activity shall be guided, where pertinent, by the provisions set forth in article 6-49(2).
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attached for duty. In his absence, his duties shall
be performed by the next senior dental officer
regularly attached to and serving on board for duty.
(2) In addition to those general duties prescribed
in U.S. Navy Regulations and by the commanding
officer for the head of a department, the dental
officer shall:
(a) Be responsible for maintaining the dental
health of the personnel attached to the shore
station.
(b) Conduct dental examinations on all per­
sonnel, if practicable, when they report for duty to
determine their requirements for dental treatment
and verify their dental records.
(c) Be responsible for the instruction of station
personnel in preventive dentistry and institute any
measures required to control dental disease.
(d) Be responsible for the treatment of person­
nel from other commands who may be dependent
upon him for dental service.
(e) Supervise the performance of duty of all
personnel assigned to the dental department.
(f) Conduct a program of in-service training for
all personnel on duty in the dental department
on appropriate subjects for improving their knowl­
dge and increasing their efficiency.
(g) In a shore activity outside the continental
United States, provide professional advice to the
commanding officer concerning proper action to be
taken on requests for dental treatment to be ob­
tained from civilian sources outside the continental
United States and the payment of expenses for such
treatment.

6-50 CHAPTER 6. DENTAL CORPS

(3) Unless otherwise directed by the Secretary
of the Navy, in the event of incapacity, death, or
absence of an officer in charge of a dental activity,
the assistant officer in charge shall succeed him.

6-51. Dental Officer in a Shore Station
(1) The head of the dental department of a
shore station is designated the dental officer and
shall be the senior officer in the Dental Corps at­
tached for duty. In his absence, his duties shall
be performed by the next senior dental officer
regularly attached to and serving on board for duty.

6-52. Dental Officer in a Training Center
or Recruit Depot
(1) The provisions of article 6–51 shall apply to
the dental officer in a training center or recruit
depot.
(2) The dental officer in a training center or
recruit depot in addition shall insure that:
(a) Each recruit is given the type of dental
examination prescribed by current instructions as
soon as practicable after arrival at the training
center, or, in any event, within 60 days of entry
into the Navy or Marine Corps.
(b) A notation of every dental condition is made
in the Dental Record (see art. 6–108).
(c) Every effort is made to complete as much
dental treatment as possible before the recruit is
transferred.
(d) Priority is given to dental treatment of
defects which may interfere with the performance
of naval duties.
(e) Insofar as possible, only emergency treat­
ment is provided those recruits who are to be dis­
charged from the service prior to completion of
recruit training. It is important that recruits in
this category do not have teeth extracted in prepa­
ration for prosthetic treatment and then be dis­
charged from the service prior to the time dentures
are provided.

6-53. Dental Officer in a Naval Shipyard
(1) The provisions of article 6–51 shall apply to
the dental officer in a naval shipyard.
(2) The dental officer in a naval shipyard shall, in
addition:
(a) Make every effort to provide dental care
for personnel of ships which are dependent upon
the facilities of the naval shipyard.
(b) Provide dental repair service to dental
equipment of ships present as required.
(c) Provide working space, if available, for
dental officers afloat, if their dental facilities become
untenable due to ship’s overhaul procedures.

6-54. Chief of the Dental Service in a U.S.
Naval Hospital
(1) The senior dental officer attached for duty
in a U.S. naval hospital shall be the chief of the
dental service. He shall have the same status in
his relation to the commanding officer, and to the
executive officer, as other chiefs of service on the
hospital staff.
(2) The primary function of the dental service
is to treat patients, and all other activities, except
essential training, shall be minimized.
(3) The chief of the dental service shall:
(a) Provide dental care for patients and per­
sonnel of the staff and for such other personnel
listed in article 6–98 as are dependent upon the
hospital for dental care.
(b) Provide care for diseased or traumatized
conditions of the oral region, mandibular or max­
illary fractures, cysts and tumors of dental origin,
cysts and tumors involving the teeth and surround­
ing structures, and closures of maxillary antral
openings of dental origin. He shall consult with
medical officers whenever the interest of patients so
requires, particularly when mutual professional
fields are involved.
(c) Act in an advisory capacity to the com­
manding officer in all matters relating to dentistry
and the dental service.

6–13

Change 11
6–55. Chief of the Dental Service in a U.S. Naval Dispensary

(1) The provisions of article 6–54, where appropriate, shall apply to the chief of the dental service in a U.S. naval dispensary.

6–56. Dental Officer in a Naval Aviation Unit

(1) The provisions of article 6–51 shall apply to the dental officer in a naval aviation unit (fleet aircraft squadrons, composite squadrons, air transport squadrons, etc.). He shall make all reports in accordance with current directives. (See art. 6–150 for instructions regarding submission of DD–477.)

(2) The dental officer in a naval aviation unit shall, in addition, report to the dental officer of the station where the aviation unit is based, for the purpose of integration with the dental department of the station. Personnel of these units shall receive dental treatment on the same basis as personnel of the station providing the dental facility.

6–57. Dental Officer in a Mobile Dental Unit

(1) The senior dental officer ordered to a mobile dental unit is responsible to the officer exercising operational control of the unit (usually the district commandant with the advice of the district dental officer) for conforming to the operating schedule and carrying out his policies and orders.

(2) In general, the dental officer of a mobile dental unit shall examine and treat the personnel of each station visited by the unit with a view to accomplishing the greatest good for the greatest number within the period of time allotted.

(3) Upon reporting to the commanding officer or officer in charge of an activity designated in the operating schedule, the dental officer shall consider himself under the military command of such officer until departure of the unit.

(4) Upon assuming charge of the unit, the dental officer shall check equipment and supplies and take steps necessary to remedy any deficiencies.

(5) Upon completion of an operating schedule, the dental officer shall submit a brief report to the commandant on accomplishments, problems, and any recommendations that would improve the dental service provided by the mobile dental unit.

(6) The provisions of article 6–51 shall apply to a dental officer in a mobile dental unit insofar as they may be applicable to the activity for which the unit is providing dental support.

6–58. Dental Officer in a Research Activity or Facility

(1) A limited number of dental officers with research ability or training may be assigned to research facilities.

(2) In addition to the policy and general duties prescribed in chapter 1, section IV, dental officers assigned to research facilities shall:

(a) Conduct scientific investigations related to problems in dentistry and the allied sciences or as may be prescribed by the commanding officer.

(b) Act in an advisory capacity to the commanding officer, through the chain of command, on all dental and oral research matters.

Section VII. DENTAL OFFICERS WITH THE MARINE CORPS

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6–55</td>
<td>Dental Officer on the Staff of the Commandant of the U.S. Marine Corps</td>
</tr>
<tr>
<td>6–56</td>
<td>Dental Officer on the Staff of the Commanding General, Fleet Marine Force, or the Commanding General, Aircraft, Fleet Marine Force</td>
</tr>
<tr>
<td>6–57</td>
<td>Commanding Officer of a Force Dental Company</td>
</tr>
<tr>
<td>6–58</td>
<td>Dental Officer in a Marine Corps Support Establishment</td>
</tr>
</tbody>
</table>

6–59. Dental Officer on the Staff of the Commandant of the U.S. Marine Corps

(1) The staff dental officer is a member of the special staff of the Commandant of the Marine Corps and advises the Commandant and his staff on all matters pertaining to dental services. In coordination with appropriate members of the Commandant's staff, he shall:

(a) Determine requirements for, receive, review, and make recommendations concerning utilization of dental support assigned the Marine Corps.

Change II
(b) Initiate action as appropriate to obtain dental personnel and material requirements to meet Marine Corps needs.

d) Plan and formulate landing-force and field-dental procedures, doctrines, and programs.

d) Survey dental organizations attached to the Marine Corps Supporting Establishment in coordination or conjunction with the Inspector General, Marine Corps, and the Inspector General, Dental.

e) Keep the Assistant Chief for Dentistry and Chief of the Dental Division informed on all matters relative to the dental support to the Marine Corps.

6-60. Dental Officer on the Staff of the Commanding General, Fleet Marine Force, or the Commanding General, Aircraft, Fleet Marine Force

(1) The force dental officer of a Fleet Marine Force, or Aircraft, Fleet Marine Force, is a member of the special staff of the force commander and as such advises the force commander relative to the efficient employment of force dental companies. He shall insure that recommendations are provided for adequate dental service in all appropriate instructions and plans. He is responsible for the inspection of dental units attached to the Force.

6-61. Commanding Officer of a Force Dental Company

(1) The dental officer in command of a force dental company, in his status as a member of the special staff of the division, aircraft wing, or force troops, to which attached, shall advise the commanding officer on all dental technical, professional, and administrative matters pertaining to dental health. The commanding officer of a dental company shall:

a) Insure that maximum dental treatment is provided consistent with assigned duties, in accordance with current Bureau directives.

b) Conduct such field training as to insure unit readiness to support appropriate Fleet Marine Force units under field conditions.

c) Insure that records are kept and required reports are submitted.

d) Coordinate the operations of the force dental company with the overall plans, procedures, and operations of the command to which attached.

e) Coordinate with the medical officer of the command to which attached for the temporary integration of dental personnel to assist in the care, treatment, and evacuation of casualties in combat and disaster.

6-62. Dental Officer in a Marine Corps Support Establishment

(1) The Dental Officer in a Marine Corps Support Establishment is a member of the Commanding General’s Special Staff. His duties are similar in character to those duties required of the dental officer in any shore station.

Section VIII. DENTAL TECHNICIANS

Article

6-63. Establishment of Dental Technician Rating, Group XI Dental

(1) The Dental Technician Rating, Group XI Dental, was established as a separate occupational group in the rating structure by the Secretary of the Navy on 12 December 1947. This group is comprised of personnel trained to assist naval dental officers in providing dental care for the personnel of the Navy and Marine Corps. This group consists of the single general service rating of dental technician. Dental recruit, dental apprentice, and dentalman are general apprenticeships which lead to the dental technician rating.

6-64. Authorized Strength of Dental Technician Rating, Group XI Dental

(1) Not less than 11 percent of the authorized strength of the Hospital Corps shall be in Group XI Dental. The authorized strength of the Hospital Corps is 3½ percent of the authorized enlisted strength of the Regular Navy and Marine Corps.
(2) The Hospital Corps (see art. 9-3) includes dental service warrant officers, 818, and enlisted dental technicians.

(3) The ratio of dental technicians assigned to duty in dental activities is based on an estimate of one and three quarters technicians for each officer of the Dental Corps. This is an overall ratio which necessarily will vary among the individual dental facilities of ships and stations.

6–65. Entry Into Dental Technician Rating, Group XI Dental

(1) Candidates for the Dental Technician Rating, Group XI Dental, must be qualified in accordance with current Bureau of Naval Personnel and Bureau of Medicine and Surgery directives. Candidates are procured from the following sources:
(a) Applicants for enlistment in a dental rate
(b) Quotas of recruit trainees at naval training centers
(c) Volunteer applicants ( strikers) from within the naval service.

(2) Completion of a basic course of instruction at a class A naval dental technician school is a prerequisite for assignment to Dental Technician Rating, Group XI Dental, except in time of national emergency. Waivers may be granted for certain reserves or inductees who have had previous training equivalent to the basic course.

(3) Qualifications for entrance to a class A naval dental technicians school are contained in current Bureau of Naval Personnel and Bureau of Medicine and Surgery directives.

6–66. Training of Dental Technician Rating, Group XI Dental

(1) The Bureau maintains the following schools for training enlisted men in dental technology:
(a) Class A school—Basic Course for Dental Technician, General.
(b) Class B school—Course for Dental Technician, Advanced General.
(c) Class C school—Course for Dental Technician, Prosthetic.
(d) Class B school—Course for Dental Technician, Advanced Prosthetic.
(e) Class C school—Course for Dental Technician, Repair.

(2) Enlisted men receive their initial training in dental technology in the class A school.

(3) Completion of the class A school is normally a prerequisite for dental technicians to apply for specialized or advanced training in the class B and C schools.

(4) The availability of specialized and advanced courses of instruction, qualification requirements, and location of schools are contained in current Bureau of Naval Personnel and Bureau of Medicine and Surgery directives.

(5) In addition to the training provided in basic, specialized, and advanced dental technicians schools, enlisted dental personnel, up to and including dental technician, first class, should receive organized inservice training and instruction, in accordance with current Bureau of Medicine and Surgery directives.

(6) Officers of the Medical Service Corps attached to dental activities, dental service warrant officers, and dental technicians may be utilized as instructors in the inservice training program.

(7) Information regarding training for dental technicians may be found in the Catalog of Dental Technicians Schools and Courses (NAVMED P-5029) and articles 6-139 through 6-144.

6–67. Advancement in Dental Technician Rating, Group XI Dental

(1) Enlisted dental personnel shall be examined for advancement in rating in accordance with current Bureau of Naval Personnel directives. When examinations for advancement in rating are prepared locally, the membership of the examining board shall, when practicable, consist of at least one of the following: a dental officer, a Medical Service Corps officer assigned to a dental activity, or a dental service warrant officer, 818.

(2) Enlisted dental personnel should prepare themselves for advancement in rating in accordance with the Bureau of Naval Personnel Manual, the Manual of Qualifications for Advancement in Rating, and current Bureau of Naval Personnel directives.

(3) Enlisted dental personnel who have a designated technical specialty will be given technical examinations for advancement in rating as prescribed in the Manual of Qualifications for Advancement in Rating, and current directives.

6–68. Assignment and Duties of Enlisted Dental Personnel

(1) Assignment.—Enlisted dental personnel are assigned to naval dental activities, dental departments of ships and stations, and to dental services of U.S. naval hospitals and U.S. naval dispensaries, as technical assistants to dental officers. They are assigned to such duties as may be indicated by their special qualifications and by current requirements for dental care. They may be assigned duty with dental companies, detachments, and other units of the Marine Corps.

(2) General Duties.—Members of the dental rating group shall be qualified to perform the following duties:
(a) Keep dental appointment and office records.
(b) Prepare dental records including dental charts, under the direction of dental officers.

c) Prepare routine and special reports and forms.

(d) Keep precious metal records and prepare reports in connection therewith.

(e) Perform oral prophylactic treatments under the supervision of dental officers.

(f) Instruct patients in oral hygiene.

(g) Render dental first aid.

(h) Expose and process dental X-ray films.

(i) Prepare materials and medications utilized by dental officers.

(j) Sterilize and sharpen instruments.

(k) Provide preventive maintenance of dental equipment.

(l) Maintain cleanliness of dental spaces.

(m) Perform such other duties in caring for dental patients and dental department facilities as may be directed by those in authority.

3 Dental Recruit (DR). — A dental recruit, when enlisted, will be sent to a naval training center with other recruits for indoctrination and basic training. Upon completion of recruit training and if considered to have satisfactory aptitude, the individual will be sent to a class A school for the Basic Course for Dental Technician, General.

4 Dental Apprentice (DA). — Dental apprentices are personnel in training for advancement to dentalman. They shall perform elementary routine duties as dental operating room and clerical assistants.

5 Dentalman (DN). — Dentalmen are personnel in training for advancement to the rating of dental technician, third class. In addition to acting as dental operating room assistants, they shall perform duties such as equipping dental cabinets, cleaning and maintaining dental equipment, preparing trays for impressions, boxing and pouring impressions, polishing simple prosthetic appliances, and performing routine clerical duties.

6 Dental Technician, Third Class (DT3). — Dental technicians, third class, shall perform various types of dental clinical and clerical duties such as assisting dental officers in the treatment of patients, performing prophylactic treatments under the supervision of dental officers, rendering dental first aid, and carrying out dental department administrative assignments. As junior petty officers, they may assist with dental property records and may be placed in charge of dental supplies issue rooms.

7 Dental Technician, Second Class (DT2). — Dental technicians, second class, shall perform duties commensurate with their rate. They shall render dental first aid, perform dental prophylactic treatments under the supervision of dental officers; perform routine clerical, property, and clinical duties; take charge of dental watch sections; act as

mate of the day; and supervise and instruct lower rated men in their duties. They may be assigned duty as instructors in dental technician schools.

8 Dental Technician, First Class (DT1). — Dental technicians, first class, shall perform duties commensurate with their rate. They may be placed in charge of a dental ward, record office, property section, or dental prosthetic laboratory. They may be assigned duty as instructors in dental technician schools. They may prepare watch, quarter, and station bills; instruct and supervise lower rated men; perform clinical duties; render dental first aid and administer dental prophylactic treatments under the supervision of dental officers. They may serve as mate-of-the-day or assistant chief-of-the-day. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

9 Chief Dental Technician (DTC). — Chief dental technicians shall perform duties commensurate with their rate. They may be placed in charge of a dental ward, record office, property section, or dental prosthetic laboratory. They may be assigned duty as instructors in dental technician schools. They may serve as chief master at arms. They may prepare watch, quarter, and station bills; detail enlisted personnel with a view to their most efficient employment; and instruct lower rated men. They may supervise certain technical procedures, render dental first aid, and perform dental prophylactic treatments under the supervision of dental officers. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

10 Senior Chief Dental Technician (DTCS). — Senior chief dental technicians shall be assigned duties commensurate with their rate. They may be assigned duties greater in scope and of greater responsibility than those of a chief dental technician. They may be utilized in the larger dental facilities. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

11 Master Chief Dental Technician (DTCM). — Master chief dental technicians shall be assigned duties commensurate with their rate. They may be assigned duties greater in scope and of greater responsibility than those of a senior chief dental technician. They may be utilized in the larger dental facilities where their capabilities and advanced experience as administrative and technical assistants are required to provide a more efficient dental service. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

12 Specialty Assignments. — Dental technicians trained and designated in dental specialties should be assigned to duty involving their technical specialty. They may, when needed, however, be as-

Change II
signed to the general duties required of all dental technicians.

(13) Qualifications.—The qualifications for performance of duties of dental technicians by rate or rating shall be in accordance with Manual of Qualifications for Advancement in Rating, Manual of Navy Enlisted Qualifications, and other current directives.

Section IX. DENTAL SERVICE WARRANT OFFICERS, MEDICAL SERVICE CORPS OFFICERS, AND NURSE CORPS OFFICERS IN DENTAL FACILITIES

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-69</td>
<td>Dental Service Warrant Officers</td>
</tr>
<tr>
<td>6-70</td>
<td>Duties of Dental Service Warrant Officers</td>
</tr>
<tr>
<td>6-71</td>
<td>Appointment of Medical Service Corps Officers</td>
</tr>
<tr>
<td>6-72</td>
<td>Assignment and Duties of Medical Service Corps Officers in Dental Facilities</td>
</tr>
<tr>
<td>6-73</td>
<td>Assignment of Nurse Corps Officers in Dental Facilities</td>
</tr>
</tbody>
</table>

6-69. Dental Service Warrant Officers

(1) The warrant officer category "Dental Service Warrant 818" was established on 15 November 1954 for Hospital Corps warrant officers assigned to Dental Corps facilities (originally P.L. 379, 83d Congress, now codified by act approved 10 Aug. 1956, 10 USC 555). Note.—Original appointment to warrant officer grade W-1 was discontinued on 1 July 1960.

6-70. Duties of Dental Service Warrant Officers

(1) Dental service warrant officers are normally assigned to the following nonprofessional duties:
   (a) Serve as administrative officers in dental facilities.
   (b) Serve as personnel officers in dental facilities.
   (c) Serve as finance officers in dental facilities.
   (d) Supervise and perform clerical procedures.
   (e) Supervise dental prosthetic laboratories.

(2) Dental service warrant officers shall be thoroughly familiar with dental property accounting and personnel management. They shall be accountable for all equipment and stores in their charge, shall exercise personal supervision over the condition and economical expenditure thereof, and report any deficiencies directly to the dental officer. When attached to a unit or an activity going into or out of commission, they shall personally supervise the checking and testing of all dental equipment.

(3) When officers of the Medical Service Corps are assigned to duty in dental facilities, dental service warrant officers may serve as assistants to such officers.

6-71. Appointment of Medical Service Corps Officers

(1) Chief dental service warrants, dental service warrants, chief dental technicians, and dental technicians, first class, when eligible, may take examinations for appointment to the grade of ensign in the Medical Service Corps as set forth in current directives.

6-72. Assignment and Duties of Medical Service Corps Officers in Dental Facilities

(1) Assignment.—Medical Service Corps officers are assigned to dental facilities to supervise nonprofessional administrative procedures so that dental officers can devote more time to professional duties. They normally are assigned as:
   (a) Administrative officers in large dental facilities.
   (b) Administrative officers to dental officers on staffs of major commands.
   (c) Executive Assistant to the Inspector General, Dental.
   (d) Instructors in naval dental technicians schools and in the inservice training programs of dental facilities.

(2) Duties.—The duties of Medical Service Corps officers require that they keep informed on regulations, policies, and instructions pertaining to the nonprofessional support of dental facilities. They shall:
   (a) Manage administrative functions for dental activities and facilities including budgeting, accounting, property procurement and distribution and preparation of required records, reports, and returns.
   (b) Assist in dental service planning and logistic duties on major staffs.
   (c) Assist the Inspector General, Dental, and designated assistant inspectors general in the nonprofessional administrative aspects of surveys of dental activities and facilities.
   (d) Act as supervisor of the inservice training program in dental facilities and act as an instructor in dental department administration at dental facilities and dental technicians schools.
6-73. Assignment of Nurse Corps Officers in Dental Facilities

(1) Where feasible, officers of the Nurse Corps should be assigned to the oral surgery branch of teaching hospitals.

(2) The Bureau considers that such assignments directly benefit the patients through the promotion of high professional standards of oral surgical treatment, and permit maximum professional utilization.

Section X. CIVILIAN EMPLOYEES IN DENTAL FACILITIES

6-74. General Information

(1) Instructions for the employment of civilian personnel are contained in chapter 10.

(2) A few selected dental facilities require the employment of training, technical, and editorial personnel; otherwise the employment of civilians is normally limited to clerks, stenographers, or custodial-type employees.

(3) Care should be taken to assure that the employment of civilians does not interfere with the duties, rotation, and training of naval personnel.

Section XI. NAVAL DENTAL CLINICS

6-75. Establishment

(1) Authority.—U.S. naval dental clinics are established by authority of the Secretary of the Navy.

(2) Command Relationships.—

(a) U.S. naval dental clinics are under the military command and coordination control of the naval district, river command, or Marine Corps base in which located. When a clinic is a component of a naval base, this authority is exercised by the commander of the naval base.

(b) Management and technical control is exercised by the Bureau.

(c) The clinics are not self-sustaining activities and receive necessary logistic support from nearby activities.

(3) Justification.—Establishment of a U.S. naval dental clinic is indicated when:

(a) Better dental support can be provided to the Operating Forces and to elements of the Shore Establishment for which the dental activity is responsible.

(b) An activity, such as a naval shipyard, which has relatively few military personnel of its own, is required to support and be responsible for dental treatment of personnel in numerous ships and stations without dental facilities.

(c) A separate dental activity will furnish a more effective means for the district commandant or base commander to discharge his responsibilities in providing dental support to fleet units and shore activities.

6-76. Mission

(1) To provide dental services for fleet units and shore activities, within the area, that do not have dental facilities, and to provide prosthetic dental service to units and activities which have dental departments without prosthetic laboratories.

(2) To undertake such appropriate functions as may be authorized or directed by competent authority.

6-77. Organization

(1) A sample organization chart for a U.S. naval dental clinic is shown on the following page.

(2) The sample chart shall be used as a guide, and may be varied to meet local requirements.

6-78. The Commanding Officer

(1) Professional Duties.—

(a) The commanding officer is charged with the direction of the dental service and the other professional functions of the clinic. He is responsible for the treatment of all dental patients de-
dependent on the clinic for care. Complicated surgical operations and special forms of treatment shall not be undertaken without his knowledge and approval. He shall require prompt information regarding all patients presenting unusual symptoms or whose condition is unsatisfactory.

(b) The commanding officer shall:

1. Provide for periodic conferences on professional matters. When practicable, qualified military and civilian personnel shall be invited to participate in these conferences, if they can provide information pertinent to the practice of naval dentistry.

2. Provide for indoctrination and training of personnel to maintain and increase professional proficiency.

3. Require rotation of duty within the command as far as practicable for officers and dental technicians (see art. 8-30).

4. Establish cooperative and cordial relationships with civilian professional organizations.

5. Make the facilities of the clinic available for the professional use of dental officers attached to other activities or ships whenever practical.

6. Maintain an adequate professional library of standard textbooks and current periodicals.

7. Prepare supporting code logistic plans.

(2) Military Authority and Duties.—

(a) The dental officer detailed to command, by competent authority, has authority over all officers or other persons attached to the command, whatever their rank and whether they are of the line or staff corps.

(b) The commanding officer shall:

1. Direct the dental service and other professional functions of the activity, and exercise military jurisdiction in conformity with established methods of organization. He shall be guided by the naval regulations and instructions governing commanding officers.

2. Require compliance with U.S. Navy Regulations, orders and instructions of the Secretary of the Navy, the Chief of the Bureau, and other competent authority. He shall require obedience to Federal, State, and local laws as they may apply to the administration of the command. Instructions and Notices published by the commanding officer constitute the regulations of the command.

3. Administer disciplinary matters and keep records thereof.

4. Exert every effort to maintain his command in a state of maximum readiness for mobilization.

5. Be responsible to the commandant of the district in which his activity is located, or the commander of the naval base, when a component thereof, for the execution of tasks, in case of emergencies, disasters, or defense plans.

6. Make necessary inspections of the clinic to determine whether it is adequately manned and equipped, and that all departments and facilities are well managed and maintained.

3) Administrative Duties.—The commanding officer shall:

(a) Be responsible for the administration of the clinic so that it may effectively carry out its assigned mission. To accomplish this requires the administration of personnel so that the professional capabilities of dental officers and dental technicians may be effectively utilized, and so that the personnel assigned to clerical, fiscal, and property functions will effectively support and expedite dental care.

(b) Detail an officer to be in charge of each professional department who, as head of department, will have professional cognizance of the dental care given in his department.

(c) Detail Medical Service Corps officers or dental service warrant officers as administrative officers to supervise the personnel of the clerical, fiscal, and property functions of the clinic. The administrative officer will be assigned sufficient dental technicians and civilian personnel to assist him in his functions.

6-79. The Executive Officer

(1) Professional Duties.—The executive officer shall:

(a) Aid the commanding officer in every way possible to efficiently accomplish the mission of the clinic. In general, his duties embrace the supervision of all professional departments.

(b) Be responsible for coordinating the functions of the various professional departments. He may be assigned as the head of a professional department.

(c) Keep the commanding officer advised of the condition of patients, particularly if any unusual condition is observed. He shall make arrangements for the proper emergency and postoperative care of patients during all hours.

(d) Coordinate the professional training programs of the clinic.

(2) Military Authority and Administrative Duties.—

(a) The dental officer detailed as such by competent authority shall serve as executive officer. His orders shall be regarded as proceeding from the commanding officer.

(b) The executive officer shall keep himself fully informed regarding policies of the commanding

Change 11
officer. He shall carry out the administrative duties assigned to him by the commanding officer.

6–80. Heads of Departments

(1) The number and designation of professional departments will be determined by the commanding officer in the light of local conditions.

(2) The head of a department shall:
   (a) Distribute patients and coordinate their care to accomplish the greatest amount of dental treatment for the greatest number.
   (b) Insure that acceptable standards of professional care are maintained.
   (c) Advise the executive officer regarding serious or unusual conditions of patients.
   (d) Participate in staff conferences and provide consultant services as requested.
   (e) Collaborate with other professional departments to expedite the dental care of patients.
   (f) Participate in and conduct appropriate portions of the clinic training program.
   (g) Assure the adequacy, security, maintenance, and economical use of property assigned to the department.
   (h) Assure that prescribed records, reports, and returns are prepared and submitted.

6–81. Administrative Officer

(1) The senior Medical Service Corps officer or dental service warrant officer regularly attached to the dental clinic shall serve as the administrative officer.

(2) The administrative officer shall:
   (a) Keep the commanding officer and the executive officer informed of the effectiveness of the administrative organization.
   (b) Be responsible to the commanding officer for the organization, supervision, and administration of the administrative staff.
   (c) Keep himself informed of the laws, regulations, policies, and instructions applicable to the administrative management of the dental clinic and be in a position to provide administrative counsel to the professional departments.
   (d) Coordinate the work of the administrative staff and provide counsel as necessary for efficiency and high morale.

Section XII. FLEET MARINE FORCE DENTAL COMPANIES

6–82. Establishment

(1) Force dental companies were established by the Commandant of the U.S. Marine Corps to provide a flexible, mobile dental service for the Fleet Marine Force. The initial table of organization for force dental companies was approved by the Commandant on 17 November 1954.

6–83. Organization

(1) The force dental company is commanded by a dental officer. The company is composed of dental officers and dental technicians in sufficient strength to support a Marine division, a Marine aircraft wing, or force troops.

(2) Each dental company is organized into a headquarters and service platoon, a clinic platoon, and a prosthetic platoon. There may be one or more dental companies in each Fleet Marine Force.

6–84. Mission

(1) The mission of the force dental company is to support combat effectiveness by maintaining the dental health of the command.

6–85. Command Relationships

(1) Force dental companies, organic to a Fleet Marine Force, are responsive to directives of the force commander. When attached to a Marine division, aircraft wing, or force troops, military command and coordination control are normally passed to these commands.

(2) The commanding officer of a dental company, when attached to a division, aircraft wing, force troops, or other major Fleet Marine Force element, will be a member of the special staff of the command.
6-86. Purpose, General Provisions, and Application of Dental Standards

(1) The purpose of dental standards for entry into the Navy and Marine Corps is to:

(a) Assure that persons who enter the Navy or Marine Corps do not have serious dental defects which would permanently and significantly interfere with the performance of the duties which are expected of them.

(b) Assure that candidates for original appointment as commissioned officers do not require extensive dental treatment which will necessitate frequent or prolonged absence from primary duties.

(c) Assure that candidates for officer training programs possess a reasonable level of dental health and do not require dental treatment which will significantly interfere with their participation in the training programs.

(d) Limit, when feasible, the amount of dental treatment needed by persons entering the Navy or Marine Corps. This is desirable, since the strength of the Dental Corps is limited by law to a number which is insufficient to provide all the dental treatment required by active duty personnel.

(2) General Provisions of Dental Standards and Dental Examinations.—

(a) All dental examinations should be performed, when possible, by dental officers of the Navy or the Naval Reserve, even though the latter may not be serving on active duty. When a dental officer is not available, dental examinations of persons, other than applicants for admission to the U.S. Naval Academy as midshipmen, may be performed by naval medical officers.

(b) The dental examiner shall indicate on the examination form whether or not the examinee meets the dental standards which apply for a specific examination. Whenever an examinee does not meet the standards which apply, the dental examiner shall enter a detailed description of the disqualifying condition.

(3) Application of Dental Standards.—The appropriate dental standards shall apply to all persons entering the U.S. Navy, U.S. Naval Reserve, U.S. Marine Corps, and U.S. Marine Corps Reserve.

6-87. Dental Standards for Enlistment and Reenlistment

(1) To be accepted for original enlistment, an applicant must be free from gross dental infections and have a minimum requirement of an edentulous upper jaw and/or an edentulous lower jaw corrected or correctable by a complete denture or dentures.

(2) The dental standards for reenlistment are the same as those for enlistment.

6-88. Dental Standards for Appointment to Warrant or Commissioned Rank

(1) To qualify for appointment to warrant or commissioned rank, an applicant must have sufficient teeth, natural or artificial, in functional occlusion to insure satisfactory incision and mastication.
6-90. Dental Standards for Promotion of an Officer

(1) An officer who is a candidate for promotion shall be examined to insure that there is no oral disease or dental defect present which will prevent the performance of all duties at sea, or in the field, in the grade for which the officer is a candidate.

6-91. Dental Standards for the Annual Physical Examination

(1) A dental examination shall be conducted as a part of the annual physical examination of a commissioned or warrant officer who is on active duty. Conservation and promotion of oral health is the principal objective of this dental examination. When oral disease or dental defects are discovered, the dental examiner shall make suitable recommendations for the institution of corrective measures.

6-92. Dental Standards for Duty at a Station Not Having a Dental Officer

(1) Whenever practicable, officers and enlisted personnel who are being transferred to ships or stations where the services of a Navy dental officer are not available should receive treatment prior to transfer.

6-93. Dental Standards for Submarine and Surface Ship Nuclear Power Training Program Candidates

(1) A complete dental examination shall be conducted by a dental officer if available. If a dental officer is not available, the examination shall be conducted by a medical officer. Candidates must have sufficient teeth, natural or artificial, in functional occlusion to insure satisfactory incision and mastication. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Carious teeth shall be restored prior to transfer of individuals to the training units. A candidate who will require dental restorations during the period of training should be considered not physically qualified.
6-93A. Dental Standards for Diving Duty
(Master, First Class, Second Class, Salvage, Underwater Demolition Team, Explosive Ordnance Disposal Team, and Underwater Swimmers)

(1) A complete dental examination shall be conducted by a dental officer, if available. If a dental officer is not available, the examination shall be conducted by a medical officer. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Advanced oral diseases and generally unserviceable teeth shall be causes for rejection. Applicants with moderate malocclusion, or extensive restorations and replacements by bridges or dentures, may be accepted, if such do not interfere with effective use of self-contained underwater breathing apparatus (scuba).

6-94. Dental Standards for Women

(1) To be accepted for appointment, a candidate shall meet the same requirements as those prescribed for men.

(2) To be accepted for original enlistment, an applicant must have at least 20 teeth. Satisfactory artificial replacements may be counted in lieu of natural teeth. An applicant must have no more than five carious teeth as determined by the type 4 screening examination described in article 6-100(1). Dental examinations may be performed by personnel at Navy and Marine Corps recruiting stations.

6-95. Dental Standards for Aviation Class I, Service Group I (Pilots Under 40 Years of Age)

(1) Any dental defect which will produce indistinct speech by direct voice or radio transmission is disqualifying.

6-96. Dental Standards for Flight Training

(1) The dental standards for flight training are set forth in article 6-89. Commissioned and warrant officers of the Navy and Marine Corps, who

are candidates for flight training, should not be disqualified because of correctable dental deficiencies, unless they do not meet the requirements set forth in article 6-95.

6-97. Waivers of Dental Defects

(1) When, in the opinion of the dental examiner and the commanding officer or the officer in charge of the examining facility, a waiver of any disqualifying defect(s) is warranted, a recommendation to that effect may be submitted on the Standard Form 88 for consideration.

(2) Defects which may be waived are those which, although disqualifying in accordance with naval physical standards, will not interfere with the examinee’s ability to perform the duties in the prospective rank or rate.

(3) The recommendation for waiver shall be entered on the reverse side of the Standard Form 88. The defect(s) shall be fully described.

(4) In the case of a physical examination incident to assignment of a Navy or Marine Corps reservist to active duty, exclusive of active duty for training, the commanding officer or officer in charge is authorized, upon the recommendation of the dental examiner, to grant a conditional waiver for any defect(s) which in all probability will not interfere with the member’s performance of active duty. The conditional waiver carries with it the authority to consider the member physically qualified until remedial treatment is completed.

(5) There is a difference between a waiver and a conditional waiver. The recommendation for waiver is applicable to a candidate for appointment, enlistment, or reenlistment in any status. On the other hand, a conditional waiver is considered only when an individual, already a member of the Naval Reserve or the Marine Corps Reserve except Fleet Reserve or Fleet Marine Corps Reserve, has been examined incident to assignment to extended active duty (other than training duty) and has been found not to meet established physical standards.

Section XIV. DENTAL EXAMINATION AND TREATMENT

<table>
<thead>
<tr>
<th>Article</th>
</tr>
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<tbody>
<tr>
<td>6-98</td>
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<td>6-104</td>
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<td>6-105</td>
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</tr>
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Change 11
6-98. Availability of Dental Treatment

(1) Dental treatment shall be made available at naval activities having dental departments or services to the following:

(a) Members of the Navy and Marine Corps when on active duty, and Canadian Armed Forces personnel when on active duty in the United States.

(b) Members of the Fleet Reserve and the Fleet Marine Corps Reserve when on active duty.

(c) Members on the retired lists of the Navy and Marine Corps when on active duty.

(d) Members of the Naval Reserve and the Marine Corps Reserve when on active duty.

(e) Members of the Army and Air Force, provided that such members are either on active duty in localities where their own dental services are not available, or are assigned to detached duty with the Navy.

(f) Members of the Coast and Geodetic Survey, Public Health Service, and Coast Guard when such members are serving on active duty with the Navy under orders issued by competent authority, or are on active duty in localities where their own dental services are not available.

(g) Such other persons as are hospitalized in naval hospitals, in accordance with the law.

(h) Dependents of uniformed service personnel residing outside the United States, and in areas within the United States that have been specifically designated as remote, in accordance with current directives.

(i) Inactive-duty members and former members of the Navy or Marine Corps, or the Reserve components thereof, entitled to retired, retirement or retainer pay or equivalent pay as a result of their service, except inactive-duty members and former members of the Reserve components of the Navy or Marine Corps entitled to retired or retirement pay under sections 1331 through 1337 of title 10 of the U.S. Code who have served less than 8 years on active duty.

(f) Provided there are no dental facilities of the applicable service available in the area, inactive-duty members and former members of the Army, Air Force, Coast Guard, Commissioned Corps of the Coast and Geodetic Survey, Commissioned Corps of the Public Health Service, or the Reserve components thereof, entitled to retired, retirement or retainer pay or equivalent pay as a result of their service, except inactive-duty members and former members of such Reserve components entitled to retired or retirement pay under sections 1331 through 1337 of title 10 of the U.S. Code who have served less than 8 years on active duty.

(k) Civil personnel injured in a naval shore station.

(l) Veterans' Administration patients when hospitalized in naval hospitals.

(m) Prisoners of war.

6-99. Dental Examinations

(2) Priority in the rendering of dental treatment shall be given to members in categories (a) through (g).

(3) Treatment of members of the Naval Reserve and Marine Corps Reserve when serving on training duty and treatment of civil personnel injured in a naval activity shall be limited to emergency measures.

(4) Treatment of Veterans' Administration patients shall be limited to treatment adjunctive to medical treatment of the conditions for which they are hospitalized.

(5) Treatment of persons in category (g) shall be administered only as an adjunct to inpatient hospital care, shall be limited to the care of injuries such as fractures of the mandible or maxilla and to the treatment of acute infections, and shall not include prosthetic, orthodontic, or routine operative treatment.

(6) Nothing in this article shall preclude the rendering of emergency dental treatment to any person when such treatment is necessary and demanded by the laws of humanity or the principles of international courtesy.

(7) Receipt of payment by any dental officer or enlisted person from anyone for any dental service in a naval dental activity is prohibited.

(8) The foregoing is subject to the limitations of article 6-103, which relates to dental prosthetic treatment.
shall be taken to indicate in each case whether or not the examinee meets the dental standards for which the examination is being done. Disqualifying dental defects shall be entered in detail.

(5) Dental examinations of naval personnel shall be made at appropriate times to ascertain the need for dental treatment. Dental defects discovered when conducting such an examination shall be recorded in Standard Form 603, the Dental Record. These defects may also be recorded on NAVMED-1299, if required for local use.

(6) When practicable, a dental examination shall be conducted for each member who reports aboard a ship or station for duty, to ascertain the need for dental treatment and to verify dental records.

(7) Dental examinations of deceased personnel for the purpose of identification shall be accomplished accurately and with as little facial disturbance as possible.

(8) The dental examination of each person who reports for, or returns to, extended active duty in the Navy or Marine Corps shall be a type 2 examination, as described in article 6-100, and shall be completed within 60 days of entry into the service.

(9) The dental examination of each person being separated from the Navy or Marine Corps shall be a type 3 examination, as described in article 6-100, and shall be recorded on the Standard Form 88 only.

6-100. Specifications for Conducting Dental Examinations

(1) The following are the specifications for conducting standard types of dental examinations:

Type 1, Ideal Examination.—Mouth-mirror and explorer examination; adequate natural or artificial illumination; full-mouth intra-oral, periapical and posterior bite-wing roentgenograms; when indicated, percussion, thermal, and electrical tests, transillumination, and study models.

Type 2, Routine Examination.—Mouth-mirror and explorer examination; adequate natural or artificial illumination; posterior bite-wing roentgenograms; periapical roentgenograms, when indicated.

Type 3, Modified Routine Examination.—Mouth-mirror and explorer examination; adequate natural or artificial illumination.

Type 4, Screening Examination.—Mouth-mirror and explorer or tongue-depressor examination; available illumination.

(2) It shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient.

6-101. Dental Classification of Individuals

(1) The following standard dental classification of individuals shall be used whenever it is necessary to classify personnel for purposes of urgency or priority of dental treatment, or for availability for transfer, etc.:

(a) Class 1.—Individuals requiring no dental treatment.

(b) Class 2.—Individuals requiring routine but not early treatment of conditions; such as:

(1) Moderate calculus.
(2) Prosthetic cases not included in class 4.
(3) Caries—not excessive nor advanced.
(4) Periodontal diseases—not extensive nor advanced.
(5) Oral conditions requiring corrective or preventive measures.

(c) Class 3.—Individuals requiring early treatment of conditions; such as:

(1) Extensive or advanced caries.
(2) Extensive or advanced periodontal diseases.
(3) Pulpal or apical infection (root canal therapy).
(4) Chronic oral infections.
(5) Heavy calculus.
(6) Cases requiring removal of one or more teeth or other surgical procedures not included in class 5.

(d) Class 4.—Individuals requiring essential prosthetic appliances, including:

(1) Individuals with insufficient teeth to masticate the service ration.
(2) Other individuals in need of an appliance essential to their duty.

(e) Class 5.—Individuals requiring emergency dental treatment for conditions such as:

(1) Injuries.
(2) Acute oral infections (parietal and periapical abscesses, Vincent's infection, acute gingivitis, acute stomatitis, etc.).

(2) When recording the dental classification of an individual in a record, form, or in correspondence, the standard type of dental examination, as defined in article 6-100, shall also be recorded, in order that the value of the classification as related to the comprehensiveness of the dental examination will be apparent.

6-102. Dental Treatment

(1) Dental treatment may be rendered only by dental officers, with the following exceptions:

(a) Oral prophylactic treatment may be administered by dental technicians under the supervision of a dental officer.

(b) When a dental officer is not available, emergency dental treatment may be administered by dental technicians or by personnel of the medical department.

(c) When naval dental facilities or personnel are not available, naval personnel on active duty may obtain dental treatment from other Govern-
ment agencies or from civilian dentists, in accordance with the provisions of chapter 30.

(2) Orthodontic treatment by naval dental officers is not authorized, except in unusual circumstances.

(3) Treatment of dental diseases, disabilities, and injuries of Navy and Marine Corps personnel shall be completed whenever possible. When it is not possible to complete all treatment, priority shall be given to treating those conditions which are most likely to interfere with the performance of duties.

(4) The dental officer shall notify the medical officer when diseases or any other conditions requiring medical care or consultation are observed.

(5) Whenever, in his opinion, it is necessary to place dental patients on the binnacle list or sick list, the dental officer shall notify the medical officer in order that the entries in the Health Record may be made in accordance with chapter 16, section IX.

(6) The care of a patient admitted to the sick list, because of dental disabilities, shall be the joint responsibility of the dental officer treating the patient and the ward medical or dental officer.

(7) Consultation and dental treatment may be performed by a civilian specialist with prior approval from the approving authorities designated in current BuMed instructions concerning the obtaining of dental care from civilian nonnaval sources. If such treatment is of an emergency nature, prior approval is not required. (Refer to ch. 20, sec. II.)

(8) If a naval dental officer is not present, emergency dental treatment from a civilian dentist at Government expense may be authorized by the commanding officer or senior officer present, in accordance with article 20-12. As specified in article 20-2, emergency dental treatment is to relieve pain or to abort infection and does not include the furnishing of prosthetic appliances including crowns or inlays, or the use of gold or other precious metals for restorations. (See arts. 20-14 and 20-15.)

6-103. Dental Prosthetic Treatment

(1) Except for minor repairs or adjustments, dental prosthetic treatment, which includes the fabrication of crowns, inlays, bridges, and dentures, shall be furnished only at activities authorized by the Bureau to provide such treatment.

(2) Dental prosthetic treatment is authorized for persons in categories (a) through (k) of article 6-98(1), only when such treatment is deemed necessary by the dental officer for the restoration of extensive loss of masticatory function or the replacement of anterior teeth for esthetic reasons.

(3) Dental prosthetic treatment is furnished to Veterans' Administration patients hospitalized in naval hospitals when such treatment is clearly adjunctive to the medical treatment for which the veteran is hospitalized.

(4) Dental officers on duty at activities where no prosthetic facilities are available shall insure that all oral surgical and operative treatment has been completed on personnel being referred to other commands for prosthetic treatment.

(5) Personnel attached to activities remote from military prosthetic facilities may request approval from the commandant of their district or river command to obtain prosthetic dental treatment from a civilian source, in accordance with chapter 20, section III.

6-104. Inscription on Dentures for Identification

(1) Each dental prosthetic facility shall, when possible, incorporate into the denture base or other suitable part of each complete or partial denture, the following data pertaining to the patient:

(a) Last name and initials.

(b) Serial number or file number, followed by a dash and capital N for Navy, capital M for Marine Corps, capital A for Army, and capital AF for Air Force, whichever applies. No other information shall be inscribed.

(2) The technique for placing the inscription on complete and partial dentures is described in the Navy Training Course, Dental Technician, Prosthetic, NAVPERS 10685 series (currently chapter 17, NAVPERS 10685–A). If available, red carbon paper should be used for the inscription.

6-105. Refusal of Dental Treatment

(1) Personnel of the Navy and Marine Corps who may refuse dental treatment, which is considered necessary to keep them fit to perform their duties, shall be reported to their commanding officer. Such a report shall not be made, however, until after a conscientious effort has been made by the dental officer to convince those individuals of the value of the proposed treatment in preserving or achieving dental health. An appropriate entry regarding the refusal of dental treatment shall be made in the Standard Form 603, in accordance with article 6-112.

6-106. Dental Treatment by Other Than Naval Personnel

(1) Active duty personnel of the Navy and Marine Corps are eligible to receive dental treatment at Army and Air Force dental facilities when the services of a Navy officer are not available.

(2) Dental treatment by other than military dental officers for personnel of the Navy and Marine Corps may be provided in accordance with the provisions set forth in chapter 20.
6-107. Purpose of Standard Form 603

(1) The SF 603 provides:
   (a) An aid to diagnosis, treatment planning, and practice management.
   (b) A valuable means of identification.
   (c) A record of the initial examination of a member which shows missing teeth, existing restorations, diseases, and other abnormalities.
   (d) A record of diseases and other abnormalities which occur after the initial examination.
   (e) A chronological record of dental treatment received during the individual's period of military service.
   (f) A protection to the Government against false or fraudulent claims and a protection of veteran benefits for the individual.
   (g) A basis for dental statistical information.
   (h) A means for facilitating the appraisal of physical fitness.

6-108. General Instructions for Preparation, Distribution, and Disposition of Standard Form 603

(1) Preparation of SF 603.—
   (a) An original and duplicate shall be prepared for each individual who reports for, or returns to, extended active duty.
   (b) An original only shall be prepared to replace a lost SF 603.

(2) Distribution of SF 603.—
   (a) Both the original and the duplicate prepared at recruit training centers for recruits shall be placed in the DD 722-1, Dental Folder, after the original examination. Entries for dental treatment accomplished for a recruit during the recruit training period shall be made on both the original and duplicate. The original is to remain in the DD 722-1. The duplicate shall be attached to the recruit's SF 88 and forwarded to the Bureau when the recruit completes training.
   (b) For persons, other than recruits, who report for or return to extended active duty, the original is to remain in the DD 722-1. The duplicate copy shall be attached to the SF 88 and forwarded to the Bureau.
   (c) The SF 603 prepared when dental records are lost or destroyed shall be placed in the DD 722-1.

(3) Disposition of SF 603.—
   (a) The SF 603 shall accompany Navy and Marine Corps personnel from activity to activity during their entire period of military service. The dental officer shall assure that the Dental Folder (DD 722-1) with the SF 603, current periapical and bite-wing X-rays, and other pertinent records are forwarded to the medical officer for inclusion in the Health Record Jacket whenever an individual is transferred.
   (b) When personnel are transferred, the medical officer or medical department representative shall see that the current Dental Record (SF 603) is included before the Health Record is transferred (see art. 16-20).
   (c) Should an SF 603 or DD 722-1 not be included in the Health Record Jacket when it is transferred, the dental officer shall forward them to the individual's new duty ship or station. When this is not possible, the SF 603 shall be removed from the DD 722-1 and forwarded to the Bureau with a letter explaining the circumstances and advising what action is being taken to assure that SF 603's are included in the Health Records when individuals are transferred. The DD 722-1 may be disposed of locally in these instances.

(4) Entries.—Details regarding entries on the SF 603 are as follows:
   (a) SECTION 1, DENTAL EXAMINATION.—Box 1, PURPOSE OF EXAMINATION.—An X shall be placed in the appropriate space. In the
   (see art. 16-20).
space OTHER (Specify), indicate "Naval Academy," "Reenlistment," "Fleet Reserve," etc.

Box 2, TYPE OF EXAMINATION.—The type of examination as listed in article 6-100 shall be indicated by an X in the appropriate space.

Box 3, DENTAL CLASSIFICATION.—The dental classification as listed in article 6-101 shall be indicated by an X in the appropriate space.

Box 4, MISSING TEETH AND EXISTING RESTORATIONS.—The dental chart shall be completed in accordance with article 6-117 and appropriate data shall be entered in the spaces for REMARKS, PLACE OF EXAMINATION, DATE, and SIGNATURE OF DENTAL OFFICER COMPLETING THIS SECTION.

Box 5, DISEASES, ABNORMALITIES, AND X-RAYS.—The dental chart shall be completed in accordance with article 6-117. The appropriate data shall be placed in the spaces indicated A, B, C, D, E, DATE, PLACE OF EXAMINATION, and SIGNATURE.

(b) SECTION II, PATIENT DATA.—Appropriate data shall be placed in boxes 6, 7, 8, 11 (USN, USMC, etc.), 12, 13, and 14 (service number). Boxes 9 and 10 apply to examinations performed for Army and Air Force personnel.

(c) SECTION III, ATTENDANCE RECORD.—Box 15, RESTORATIONS AND TREATMENT (Completed during service).—Markings appropriate to the dental treatment received shall be placed on the dental chart in accordance with the provisions of article 6-117.

Box 16, SUBSEQUENT DISEASES AND ABNORMALITIES.—The chart shall be used to record dental defects and diseases found during subsequent examinations. Entries shall be made in pencil and erased when treatment is accomplished or when the condition no longer exists.

Box 17, SERVICES RENDERED.—Entries shall be made in the columns designated DATE, DIAGNOSIS—TREATMENT, CLASS, and OPERATOR AND DENTAL FACILITY, as illustrated in article 6-118. The column CLASS shall conform with article 6-101 and be maintained up to date as the work progresses. The column OPERATOR AND DENTAL FACILITY shall contain a legible signature of the dental officer and the name of the activity to which he is attached.

(d) PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME.—The space provided in the lower right margin on the reverse of the SF 603 is for the patient's name as a convenience for filing. The last name shall be in CAPITALS, and no part of the name shall be abbreviated.

(e) The entries on the dental charts in section I of the form shall not be altered after the initial examination.

(f) When an enlisted person is advanced to commissioned or warrant rank, reenlists, or extends an enlistment; or upon promotion of an officer or commissioning of a midshipman; the SF 603 shall be brought up to date by entering any unrecorded dental treatments on the chart in box 15 and any dental defects or diseases on the chart in box 16.

(g) If an individual is appointed or enlisted with dental defects which have been waived, the defects shall be described fully on SF 603 under REMARKS in section I.

6-109. Dental Folder, DD Form 722-1

(1) A Dental Folder shall be prepared for each individual on active duty in the Navy or Marine Corps. The Dental Folder shall contain the SF 603 and other information pertinent to the dental health of the individual.

(2) When an individual is attached to a ship or station having a dental facility, his Dental Folder shall be placed in the custody of, and shall be the responsibility of, the dental officer. When possible, Dental Folder files shall be checked at regular intervals with pay lists or rosters to insure that there is a folder for each person aboard and that no folders have been retained for persons who have been transferred.

(3) When an individual is attached to a ship or station to which no dental officer is attached, or is in transit, or is ordered to appear before a board necessitating a physical examination, his Dental Folder shall remain in his Health Record Jacket, DD Form 722.

(4) The contents of the Dental Folder shall be removed and placed with the medical records in the Health Record Jacket only when the Health Record is being closed or terminated. The Dental Folder shall then be disposed of locally.

(5) A new Dental Folder shall be prepared when the existent folder has been damaged or because of deterioration is approaching the point of illegibility. The old folder shall be destroyed following replacement.

6-110. Custody of Standard Form 603

(1) Custody of the SF 603 shall be the same as that described for the Dental Folder in subarticles 6-109 (2), (3), and (4).

(2) For details regarding the Health Record Jacket, DD Form 722, and the Health Record, see chapter 16.

6-111. Recovery of Lost Standard Form 603

(1) In the case of recovery of a lost SF 603, entries shall be made in the recovered record of any data recorded in a replacement record, and the replacement record shall be destroyed.

6-30

Change II
6-112. Special Entries in Standard Form SF 603

(1) When dental treatment is refused by the patient, appropriate entries shall be made in the SF 603 and signed by the dental officer.

(2) In cases involving dental injuries incurred due to own misconduct, or not in line of duty, a notation to that effect shall be made in the SF 603, signed by the dental officer and, when considered appropriate, the circumstances reported to the commanding officer. (See art. 1703, Navy Regulations.)

(3) Suitable entries shall be made in the SF 603 whenever a member of the Navy or Marine Corps returns from a hospital or station, other than the permanent duty station, where dental treatment had been received but not recorded. Likewise, entries shall be made when it is learned that treatment has been received from civilian sources.

(4) If it is determined that an individual is hypersensitive to procaine or any other substance, a statement to that effect shall be entered in red pencil across the top of the SF 603 and on the outside of the DD 722-1. Example: HYPERSENSITIVE TO PROCAINE.

6-113. Recording Dental Examinations

(1) It is very important that the charted record of dental examinations be in exact conformity with the provisions set forth in articles 6-115 through 6-117 and unquestionably accurate. The Veterans' Administration depends upon the SF 603 for accurate data when adjudicating the claim of a veteran for a service-connected dental disability. The SF 603 is extremely valuable when other means of identification fail.

(2) Any peculiarities or deviations from normal are particularly valuable for identification purposes and should be recorded under REMARKS. Such abnormalities as erosion, abrasion, mottled enamel, hypoplasia, rotation, irregularity of alignment and malocclusion of teeth, denticles, Hutchinson's teeth, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palatinus and torus mandibularis, embedded foreign bodies, and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion should be simply and clearly described. Dentures and other removable dental appliances also should be described under REMARKS.

(3) When all teeth present are free of caries and restorations, special effort shall be made to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, an entry to that effect shall be made under REMARKS.

6-114. Recording Dental Operations and Treatments

(1) All dental restorations shall be charted on the dental chart in section III of SF 603 in accordance with the instructions set forth in article 6-117 and illustrated in article 6-118. When the spaces in section III of the SF 603 have been filled by the recording of dental operations and treatments, the SF 603A, Dental-Continuation, shall be used for additional entries.

(2) Authorized abbreviations covering the operations and treatments shall be entered in section III in the spaces under SERVICES RENDERED. Such entries shall be complete, accurate, and brief, in accordance with the provisions of articles 6-115 through 6-118.

6-115. Designations and Abbreviations for Use on Standard Form SF 603

(1) For purposes of brevity and exactness, the following numerical designation of teeth shall be used in keeping the SF 603:

6-31
Change II
(3) The following designation of tooth surfaces shall be used in connection with recording restorations of defective teeth:

<table>
<thead>
<tr>
<th>Surface</th>
<th>Designation</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial (labial and buccal)</td>
<td>F</td>
<td>Pedon.</td>
</tr>
<tr>
<td>Lingual</td>
<td>L</td>
<td>Porc.</td>
</tr>
<tr>
<td>Occlusal</td>
<td>O</td>
<td>Pro.</td>
</tr>
<tr>
<td>Mesial</td>
<td>M</td>
<td>Prep.</td>
</tr>
<tr>
<td>Distal</td>
<td>D</td>
<td>Prophy.</td>
</tr>
<tr>
<td>Incisal</td>
<td>I</td>
<td>Reappt.</td>
</tr>
</tbody>
</table>

(4) Combinations of the designations shall be used to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of a right maxillary central incisor; 22-DF, the facial and distal aspects of a left mandibular cuspid; 30-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.

(5) The use of abbreviations is not mandatory but is desirable for purposes of brevity in view of the limited space available in the SF 603 for recording services rendered. Whenever there is a possibility of misinterpretation due to the use of abbreviations, dental operations shall be written in full. When abbreviations are used, they shall conform to the following:

**Operation, condition, or treatment** | **Abbreviation**
--- | ---
Abrasion | Abr.
Abscess | Abs.
Acrylic | Acr.
Adjust(ed) (ment) | Adj.
Alveolectomy | Alv.
Amsagam | Am.
Anesthesia | Anes.
Apicectomy | Apyc.
Base | B.
Bridge (denotes fixed unless otherwise noted) | Br.
Calculus | Cal.
Caries | Car.
Cement | Cem.
Crown | Cr.
Deciduous | Dec.
Defective | Def.
Denture (full unless otherwise noted) | Dtr.
Drain | Drn.
Dressing | Drs.
Equilibrating | Equil.
Eugenol | Eug.
Examination | Exam.
Extraction (ed) (uncomplicated unless otherwise noted) | Ext.
Filling (ed) | Fil.
Fluorine | Fl.
Fracture(s) | Frac.
General | Gen.
Gingivalitis (state type in parentheses) | Ging.
Gutta percha | G.P.
Impacted (ion) | Imp.
Impression | Impn.
Incised | Inc.
Inlay | Inl.
Inserted (ion) | Ins.
Maxillary | Max.
Mandibular | Man.
Maxillar y | Max.
Partial | Par.
Partial | Pr.
Periapical | Per.
Pericoronitis | Pecor.
(e) **Nonmetallic Permanent Restorations (Includes Oxyphosphate Cements).**—In the diagram of the tooth, draw an outline of the restorations showing size, location, and shape.

(f) **Gold Restorations.**—Outline and inscribe horizontal lines within the outline.

(g) **Combination Restorations.**—Outline, showing overall size, location, and shape; partition at junction of materials used and indicate each as in subarticles 6-117(1) (d) and (e) above.

(h) **Porcelain Facings and Pontics.**—Outline each aspect.

(i) **Acrylic Resin Facings and Pontics.**—Outline.

(j) **Porcelain Post Crowns.**—Outline each aspect of the crown; outline approximate size and position of the post or posts.

(k) **Acrylic Resin Post Crowns.**—Outline each aspect of the crown; outline approximate size and position of the post or posts.

(l) **Porcelain Jacket Crowns.**—Outline each aspect.

(m) **Acrylic Resin Jacket Crowns.**—Outline each aspect.

(n) **Fixed Bridges.**—Outline each aspect showing overall size, location, teeth involved, and shape; partition at junctions of materials; and indicate each as above except that gold shall be shown by the inscription of diagonal instead of horizontal lines in both abutments and pontics.

(o) **Removable Appliances.**—Place a line over numbers of replaced teeth and describe briefly in remarks.

(p) **Root Canal Fillings.**—Outline each canal filled on the diagram of the root or roots of the tooth involved and block it in solidly.

(q) **Apicoectomy.**—Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of root amputation.

(r) **Drifed Teeth.**—Draw an arrow from the designating number to the tooth that has moved, the point of the arrow to indicate the approximate position to which it has drifted. Under **REMARKS** note the relationship of the drifted tooth in respect to occlusion.

(2) **Markings on examination chart DISEASES, ABNORMALITIES, AND X-RAYS** shall be made as follows:

(a) **Caries.**—In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location, and shape, and block in solidly.

(b) **Defective Restoration.**—Outline and block in solidly the restoration involved.

(c) **Impacted Teeth.**—Outline all aspects of each impacted tooth with a single oval. The long axis of the tooth should be indicated by an arrow pointing in the direction of the crown.

(d) **Abscess.**—Outline approximate size, form, and location.

(e) **Cyst.**—Outline the approximate form and size in relative position on the dental chart.

(f) **Periodontoclasia.**—Inscribe a horizontal continuous line on the external aspect of root or roots involved in a position approximating the extent of gingival recession or the clinical depth of the pocket. If known, indicate the position of the alveolar crest by a second continuous line in relative position to the line indicating the gingival tissue level.

(g) **Extraction Needed.**—Draw two parallel vertical lines through all aspects of the tooth involved.

(h) **Fractured Tooth Root.**—Indicate fracture with a zigzag line on outline of tooth root.

(3) **Markings on the chart RESTORATIONS AND TREATMENTS** shall be made as follows:

(e) **Carious Teeth Restored.**—In the diagram of the tooth involved, draw an outline of the restoration showing size, location, and shape, and indicate material used as specified in subarticle 6-117(1); that is, amalgam restorations would be outlined and blocked in, silicate cement restorations outlined only, etc.

(b) **Extractions.**—Draw a large "X" on the root or roots of each tooth extracted.

(c) **Root Canal Fillings.**—Outline each canal filled on the diagram of the root or roots of the tooth involved and block in solidly.

(d) **Apicoectomy.**—Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of root amputation.

(e) **Bridges and Crowns.**—Outline and fill in as specified in subarticle 6-117(1).

(i) **Removable Appliances.**—Place a line over numbers of replaced teeth and give a brief description under **REMARKS**.

(g) **Unrecorded Operations and Conditions.**—Operations performed by other than naval dental officers subsequent to the original examinations shall be indicated by the dental officer discovering the condition just as if they had been done by a naval dental officer. Appropriate entries shall be made indicating the nature of the treatment and adding the abbreviation "Civ." or other abbreviation as the case may be. The date entered shall be the date of discovery. Operations known to have been performed by naval dental officers whose identity is not recorded shall be noted similarly except that the abbreviation "NDO" shall be used. The date entered shall be the date the operation is discovered. Teeth which are shown as missing in the chart **MISSING TEETH AND EXISTING RESTORATIONS** and which have erupted subsequently, shall be accounted for by an entry in the following manner: "1,32, eruption noted," with date and signature of dental officer making the notation.
Other conditions of comparable importance should be recorded in a similar manner.

(4) Markings on the chart SUBSEQUENT DISEASES AND ABNORMALITIES shall be as indicated for the chart DISEASES, ABNORMALITIES, AND X-RAYS.

6-118. Illustrations of Markings on Dental Charts

(1) See illustrations on the following three pages.

6-119. Recording of Dental Treatment on Chronological Record of Medical Care, Standard Form 600

(1) Entries of dental treatment shall be made on the SF 600 when the patient is on the sicklist, and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or dental significance may be made when appropriate.

6-120. Consultation Sheet, Standard Form 513

(1) The SF 513 may be used by dental officers requesting a medical consultation on a dental patient. The SF 513 is to be included in the patient’s clinical record.

6-121. Doctor’s Progress Notes, Standard Form 509

(1) The SF 509 may be used by dental officers for posting information on the progress made by a patient during hospitalization. This form is to be included in the patient’s clinical record.
CHAPTER 6. DENTAL CORPS

HEALTH RECORD

SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION
   X INITIAL SEPARATION OTHER (Specify)

2. TYPE OF EXAM.

3. DENTAL CLASSIFICATION
   X 4 5 6 7 8

4. MISSING TEETH AND EXISTING RESTORATIONS

REMARKS

Cast Gold Pr. Dtr. with Porc.
Teeth replacing 4, 5, 12, 13, & 14.

PLACE OF EXAMINATION
NTC, Bainbridge, Md.

DATE
29 Aug 53

SIGNATURE OF DENTIST COMPLETING THIS SECTION
W. T. Door, Captain, DC, USN

DENTAL

SECTION II. PATIENT DATA

6. SEX
   M
   F

7. RACE

8. GRADE, RATING, OR POSITION

9. ORGANIZATION UNIT

10. COMPONENT OR BRANCH

11. SERVICE, DEPT., OR AGENCY

12. PATIENT'S LAST NAME-FIRST NAME-MIDDLE NAME
   DOE, John Joseph

13. DATE OF BIRTH (DAY-MONTH-YEAR)
   1 Jun 35

14. IDENTIFICATION NO.
   200 00 00

DENTAL

Standard Form 603

Change II

6-35

NTC, Bainbridge, Md.
29 Aug 53

Signature of dentist completing this section
W. T. Door, Captain, DC, USN

7, 8, 9, & 10 overbite approximately 10 mm.
7 overlaps 8 by 2 mm.
15 & 16 tilted mesially so only distal cusps in occlusion.

Place of Examination
NTC, Bainbridge, Md.

Date
29 Aug 53

Signature of dentist completing this section
W. T. Door, Captain, DC, USN

Indicate x-rays used in this examination
X Full mouth periapical
X Posterior bite-wings
Other (Specify)
### Attendance Record

#### Section III.

**17. Services Rendered**

<table>
<thead>
<tr>
<th>Date</th>
<th>Diagnosis—Treatment</th>
<th>Class</th>
<th>Operator and Dental Facility</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1SEP53</td>
<td>Vin. Tr.</td>
<td>5</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>2SEP53</td>
<td>Vin. Tr.</td>
<td>5</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
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<tr>
<td>3SEP53</td>
<td>Vin. Tr.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>4SEP53</td>
<td>30-F-ZnO, Eug. Sed., &amp; Pro.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>10SEP53</td>
<td>30-F-ZnO, Eug.B.-Am;31-O-Cam.B.-Am. Anes.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
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<tr>
<td>15SEP53</td>
<td>28-MD-Am, Anes.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
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<tr>
<td>24SEP53</td>
<td>2-Ext, Anes.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>26SEP53</td>
<td>2-P.O.T.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>27SEP53</td>
<td>2-P.O.T.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
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<tr>
<td>29SEP53</td>
<td>2-P.O.T.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
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<tr>
<td>6OCT53</td>
<td>8-R.C. Tr.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>17OCT53</td>
<td>8-R.C. Tr.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
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<tr>
<td>29OCT53</td>
<td>8-R.C,Fill.,Appts. &amp; Apcy., Anes.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>2NOV53</td>
<td>7-Ext. Anes.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
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<td>27NOV53</td>
<td>7-P.O.T., 8-I-Am</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
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<tr>
<td>30NOV53</td>
<td>7-P.O.T.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>10DEC53</td>
<td>2,4,5,7,12,13,14—Max,Pr.Dtr.Ins.—</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient declined old Pr.Dtr. Disposed of according to current instructions</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>11DEC53</td>
<td>Max,Pr.Dtr.Adj.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>16DEC53</td>
<td>Max,Pr.Dtr.Adj.</td>
<td>3</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>20JAN54</td>
<td>Abs.,Inc.&amp;Drn.,Anterior Mand,Area Anes.</td>
<td>5</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Penicillin – 300,000 Units)</td>
<td>5</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>21JAN54</td>
<td>23to26-P.O.T.(Penicillin—300,000 Units)</td>
<td>5</td>
<td>NTC, Bainbridge, Md.</td>
<td></td>
</tr>
<tr>
<td>22JAN54</td>
<td>23to26-P.O.T.(Penicillin—300,000 Units)</td>
<td>5</td>
<td>NTC, Bainbridge, Md.</td>
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</tr>
<tr>
<td>12FEB54</td>
<td>23 to 26—P.O.T.</td>
<td>4</td>
<td>NTC, San Diego, Calif.</td>
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</tr>
<tr>
<td>13FEB54</td>
<td>23 to 26—P.O.T.</td>
<td>4</td>
<td>NTC, San Diego, Calif.</td>
<td></td>
</tr>
<tr>
<td>15FEB54</td>
<td>23 to 26—P.O.T. Su, Removed</td>
<td>4</td>
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<tr>
<td>15JUN54</td>
<td>30—Do-Am &quot;NDO&quot;</td>
<td>2</td>
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<tr>
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<td>17—Eruption noted</td>
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<tr>
<td>23JUN54</td>
<td>Sci., 17—Pecor. Tr.</td>
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</table>

**Remarks**: 6-36

Change II
CHAPTER 6. DENTAL CORPS

HEALTH RECORD

SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (Completed during service)

<table>
<thead>
<tr>
<th>DATE</th>
<th>DIAGNOSIS—TREATMENT</th>
<th>CLASS</th>
<th>OPERATOR AND DENTAL FACILITY</th>
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<tbody>
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</tr>
<tr>
<td>23AUG54</td>
<td>32-Surg. Ext., Su., Anes.</td>
<td>2</td>
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</tr>
<tr>
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<td>32-P.O.T.</td>
<td>2</td>
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</tr>
<tr>
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</tr>
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<td>25SEP54</td>
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<td>1</td>
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</tr>
<tr>
<td>21SEP55</td>
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<td>24MAR57</td>
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<tr>
<td>27MAR57</td>
<td>3-Ext. Anes.</td>
<td>4</td>
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<td>28MAR57</td>
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<td>6JUL57</td>
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<tr>
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<td>16APR59</td>
<td>Exam (Type 2)</td>
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<tr>
<td>23APR59</td>
<td>30-DO-Cem, B-Ames., Anes.</td>
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<td>NH, St. Albans, N.Y.</td>
</tr>
<tr>
<td>30APR59</td>
<td>18-Gold Cr.</td>
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<td>5MAR60</td>
<td>Exam (Type 2), 18 Recem. Cr.</td>
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<td>NH, St. Albans, N.Y.</td>
</tr>
</tbody>
</table>

16. SUBSEQUENT DISEASES AND ABNORMALITIES

<table>
<thead>
<tr>
<th>DATE</th>
<th>DIAGNOSIS—TREATMENT</th>
<th>CLASS</th>
<th>OPERATOR AND DENTAL FACILITY</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Immediate Max. Dtr. Ins. (Patient accepted old partial)</td>
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<td>USS Coral Sea</td>
</tr>
<tr>
<td>6-37</td>
<td>Change II</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section XVI. DENTAL OFFICER TRAINING

6-122. Naval Dental Internships

(1) Rotating dental internships of 12 months' duration are conducted at naval teaching hospitals. The training program which conforms to the standards of the Council on Dental Education, American Dental Association, is designed to advance the knowledge and broaden the clinical experience of the recently graduated career dental officer. Because of this objective, applicants who are selected for dental intern training must qualify for and accept an appointment in the Regular Navy.

6-123. Basic Course of Indoctrination for Dental Officers

(1) All newly appointed dental officers, except those who have received indoctrination training prior to reporting for active duty, will be ordered to designated dental activities for basic indoctrination. Such training is designed to familiarize new dental officers with the conduct of dental practice within the Navy.

6-124. General Postgraduate Course at U.S. Naval Dental School

(1) The General Postgraduate Course at the U.S. Naval Dental School, National Naval Medical Center, Bethesda, Md., is designed to broaden the knowledge and increase the clinical proficiency of dental officers of the Regular Navy. Emphasis is placed on basic science, theory and practice in clinical dentistry, dental research, naval dental administration, and leadership. The course is 10 months in length, with a class convening each September. Dental officers of the Regular Navy who have completed a tour of duty at sea or in areas considered foreign shore for rotational purposes are eligible for assignment to the course. For all officers below the grade of captain, successful completion of this course, or its equivalent, is a prerequisite for dental residencies or specialized courses in Navy facilities or long courses at civilian institutions. Applications for the course shall be made in accordance with article 6-130.

6-125. Naval Residency Training

(1) Residency in Oral Surgery.—First- and second-year residencies in oral surgery are available at selected naval hospitals. At the first-year level, training is directed into two channels: the care and treatment of patients requiring oral surgery, and the familiarization of the trainee with other hospital services. Trainees who successfully complete the first-year-level residency in oral surgery may be considered for second-year-level residencies. At this level, training in oral surgery is continued, with additional training in oral histopathology and general anesthesia. This training is primarily clinical in character. Each level of residency is normally 1 year in length. Successful completion of the General Postgraduate Course, or its equivalent, is a prerequisite to residency training for all applicants below the grade of captain. Applications shall be submitted in accordance with article 6-130.

(2) Residency Training in Prosthodontics, Periodontics, and Oral Pathology.—One year of residency training in prosthodontics, periodontics, and oral pathology is available to a limited number of applicants at selected naval dental activities. This training permits the trainee to apply his knowledge of the basic sciences to the specialty involved and to expand his knowledge of the literature relating to the specialties. Successful completion of the General Postgraduate Course, or its equivalent, is a prerequisite to this training for all officers below the grade of captain. Applications shall be submitted in accordance with article 6-130.

6-126. Specialized Courses at U.S. Naval Dental School

(1) Specialized courses in oral surgery, prosthodontics, periodontics, and other dental specialties
are presented at the U.S. Naval Dental School to meet specific needs of the Navy Dental Corps, and to provide dental officers with additional training necessary to meet the requirements of dental specialty boards. Courses are of 6 months' duration.

6-126A. Short Postgraduate Courses in Naval Activities

(1) Short postgraduate courses in various branches of dentistry are made available to dental officers of the Regular Navy at the U.S. Naval Dental School and by qualified Navy dental officers under the cognizance of naval district dental officers. Dental officers may obtain information regarding the availability of short postgraduate courses from district dental officers. Applications shall be submitted in accordance with article 6-130.

6-127. Training in Staff and Administrative Schools of the Armed Forces

(1) Senior officers of the Dental Corps are eligible for assignment to duty under instruction at the Industrial College of the Armed Forces, Washington, D.C.; Armed Forces Staff College, Norfolk, Va.; Naval War College, Newport, R.I.; and the Senior Course, Marine Corps Schools, Quantico, Va. A board is convened in the Bureau of Naval Personnel to select candidates for this training. Selections are based on the service records of eligible officers; therefore, applications are not required.

6-128. Training in Civilian Schools

(1) Long graduate and postgraduate courses of instruction at civilian institutions are made available in limited numbers to dental officers of the Regular Navy. Successful completion of the General Postgraduate Course at the U.S. Naval Dental School, or its equivalent, is a prerequisite to this training for all officers below the grade of captain. Selections are based upon evidence that applicants possess special aptitude and sufficient experience to obtain full benefits from the training.

(2) Postgraduate and refresher courses of instruction at civilian institutions of less than 1 month's full-time duration are available to all dental officers, provided commanding officers can spare their services during the period of instruction. Authorization orders may be issued for attendance at approved courses so that leave of absence for this purpose will not be necessary. Tuition will be paid from training funds of the Bureau, but travel and per diem usually will not be allowed. Dental officers may obtain information regarding the availability of short postgraduate and refresher courses from district dental officers.

6-129. Selection for Dental Professional Training

(1) The selection of dental officers for training in the General Postgraduate Course, residency and advanced training programs, and long courses in civilian schools is made by a Dental Training Committee convened in the Bureau of Medicine and Surgery.

6-130. Submission of Requests for Training

(1) Applications for dental internships must be submitted by 1 December of the applicant's senior year in dental school. The application should be made in accordance with current directives through a Navy recruiting station which is convenient to the applicant.

(2) Applications for the General Postgraduate Course, specialized courses, naval dental residencies, and long postgraduate and graduate courses at civilian institutions are considered by the Dental Training Committee in the Dental Division, Bureau of Medicine and Surgery, during the early part of March each year. Applicants are notified soon thereafter as to the action on their requests. Applications which are disapproved are not held over for reconsideration the following year. Assignments to training are made to best coincide with normal rotation of duty.

(3) Requests for short postgraduate and refresher courses should be submitted to the Bureau of Medicine and Surgery via official channels as early as possible before the convening date of the course desired. When there is insufficient time to submit a request by letter, a message request may be submitted to the Bureau with information copies to the appropriate district or fleet commands.

(4) To obtain uniformity in requests and supporting data, the following letter forms shall be used depending on the type of instruction desired:

(a) General Postgraduate Course, U.S. Naval Dental School, National Naval Medical Center, Bethesda, Md.—

From: (Name of applicant)
To: Chief, Bureau of Medicine and Surgery
Via: (1) Commanding Officer
(2) District Commandant or Fleet Commander

Subj: Postgraduate Instruction

1. It is requested that I be considered for assignment to the next available class of the General Postgraduate Course, U.S. Naval Dental School, National Naval Medical Center, Bethesda, Md. My present duty assignment commenced on (date).

2. If this request is approved, I hereby agree not to resign during the course and to serve in the Navy for at least (enter here 3 years plus any unfulfilled prior obligation) years after completion of the course.

(Signature)

6-39

Change II
(b) Residency or Advanced Training in a Naval Activity.—

From: (Name of applicant)  
To: Chief, Bureau of Medicine and Surgery  
Via: (1) Commanding Officer (2) (District commandant or fleet commander)  
Subj: Postgraduate instruction  
1. It is requested that I be considered for assignment to residency training in oral surgery, residency training in oral pathology, advanced prosthodontic training, or advanced periodontic training—specify desired course) commencing in July (year). My preference for this training is at (desired location).  
2. If this request is approved, I hereby agree not to resign during the course and to serve in the Navy for at least (enter here 3 years plus any unfulfilled obligation) years after completion of the course.  

(Signature)

(c) Long Courses of Instruction at Civilian Institutions.—

From: (Name of applicant)  
To: Chief, Bureau of Medicine and Surgery  
Via: (1) Commanding Officer (2) (District commandant or fleet commander)  
Subj: Postgraduate instruction  
1. It is requested that I be considered for assignment to a long course of instruction in (———) at a civilian institution for the period (——— to ————).  
2. If this request is approved and I am assigned to such training, I agree not to resign during the course and to serve in the Navy for at least (enter here 3 years plus any unfulfilled prior obligation) years after completion of the course.  

(Signature)

If the request is approved, the Bureau will instruct the applicant to apply to the civilian school of his choice and when accepted submit a letter to the Bureau as shown in the following example. Officers should not apply to civilian schools for admission until instructed to do so by the Bureau.

From: (Name of applicant)  
To: Chief, Bureau of Medicine and Surgery  
Via: (1) Commanding Officer (2) (District commandant or fleet commander)  
Subj: Postgraduate instruction  
Ref: (a) (Letter from the Bureau approving your request to apply to a civilian school for a long course of instruction)  
1. Reference (a) approved my request to apply for a long course (———) at a civilian institution.  
2. I have applied to the (school and location) and have been accepted for a course in (———) for the period (——— to ————) at a total cost of (———).  
3. An itemized statement of the cost is as follows:  

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuition</td>
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<tr>
<td>Books</td>
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<tr>
<td>Fees</td>
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<td>Supplies and Instruments</td>
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<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(———)</td>
</tr>
</tbody>
</table>

(Signature)

(d) Short Postgraduate and Refresher Courses of Instruction in Civilian Schools.—

From: (Name of applicant)  
To: Chief, Bureau of Medicine and Surgery  
Via: (1) Commanding Officer  

(2) (District commandant or fleet commander)  
Subj: Postgraduate instruction  
1. It is requested that I be assigned to a postgraduate course of instruction in (———) to be held at (school and location) during the period (——— to ————). I have determined that a vacancy exists for this course.  
2. The total cost of the course is (———), which is for tuition.  

(Signature)

(e) Short Postgraduate Courses of Instruction at Naval Facilities.—

From: (Name of applicant)  
To: Chief, Bureau of Medicine and Surgery  
Via: (1) Commanding Officer (2) (District commandant or fleet commander)  
Subj: Postgraduate instruction  
1. It is requested that I be assigned to a postgraduate course of instruction in (———) to be held (location) during the period (——— to ————).  

(Signature)

(f) Obligation of Service for Full-Time Training.—

(1) A dental officer assigned to training of over 1 month's duration is required to remain on active duty for a definite period of time after completing the course. Periods of obligated service following training (other than internships) are—

1. Period of training of over 1 month and less than 5 months' duration will require an obligation of service of 1 year.  
2. Periods of training of 5 to 12 months' duration will require an obligation of service of 3 years.  

(2) Dental officers assigned to dental intern training are subject to the terms of agreement contained in their request for training.

(3) Discharge of more than one period of obligated service may not be accomplished concurrently. Time spent in training courses of over 5 months' duration cannot be used to discharge previously obligated service.

6-131. Correspondence Courses

(1) A wide variety of correspondence courses is available to dental officers. These courses and instructions for enrollment are shown in the List of Training Manuals and Correspondence Courses, NAVPERS 10061, latest edition. Information on the extension courses may be obtained by writing to the Commanding Officer, U.S. Naval Dental School, National Naval Medical Center, Bethesda 14, Md.

6-132. Audiovisual Training Aids

(1) Films.—

(a) Motion picture films which have been produced or procured for the training of naval personnel are maintained on file in the district and
river command training aids libraries. Films on dental subjects may be obtained on a temporary loan basis for showing at naval facilities or before civilian dental groups by submitting a request to the commandant of the district or river command in which the films are to be shown. Film lists will be provided by the commandant on request.

(b) All proposals or requests for the production or the procurement on a permanent-loan basis of dental training films shall be referred to the Bureau.

(2) Exhibits.—Requests for U.S. Naval Dental Corps exhibits must be submitted to the Bureau.

(3) Visual Aids on Professional Subjects.—
(a) Transparencies on certain dental clinical subjects are available on a temporary-loan basis from the Commanding Officer, U.S. Naval Dental School, National Naval Medical Center, Bethesda 14, Md.
(b) Histopathological microscopic slides prepared by the Oral Pathology Section of the Naval Dental School may be obtained on a temporary-loan basis from the Commanding Officer of the U.S. Naval Dental School.
(4) Handbooks.—Handbooks for dental technicians may be obtained from the Navy Supply System.

Section XVII. DENTAL RESEARCH

6–133. Policy

(1) The fundamental policy of the Bureau is to encourage and support research and development in the field of dentistry which is directed toward the solution of problems affecting the health, safety, selection, efficiency, and combat effectiveness of personnel of the Department of the Navy and other branches of the Department of Defense.

(2) The direction of dental research facilities at the Bureau level shall be done by the Research Division in coordination with the Dental Division.

(3) Although there shall be no fixed apportionment of basic and clinical or applied research, the staffs of Navy dental research facilities are particularly well qualified to understand and solve clinical dental research problems affecting Navy personnel.

6–134. Objectives

(1) The first objective of Navy dental research is to develop dental health programs to support specific operational requirements as promulgated by the Chief of Naval Operations. These require studies in such areas as cold weather operations, submarine operations, aerospace operations, field operations, bacteriological warfare defense, operations involving nuclear radiation, and training for care of mass casualties.

(2) The second objective of Navy dental research is to provide applied or clinical research support to the patient care programs of the Navy Dental Corps. It must give direct assistance to the Navy Dental Corps in its primary mission of preventing and remediying those dental defects which interfere with the performance of official duties.

(3) The third objective of Navy dental research is to conduct basic research studies to support the clinical or applied studies.

6–134A. Facilities

(1) Dental research facilities are maintained at the U.S. Naval Dental School, Bethesda, Maryland; U.S. Naval Medical Research Institute, Bethesda, Maryland; U.S. Naval Training Center, Great Lakes, Illinois; and in certain naval medical research units.

(2) Dental officers in ships and stations are encouraged to engage in clinical research investigations compatible with their primary duty of treating patients.

6–134B. Personnel

(1) Dental research facilities may be staffed by dental officers, Medical Service Corps officers, dental service warrant officers, dental technicians, and civilians. Continuity in the basic science skills
will ordinarily be provided by civilian scientists, who are not subject to routine transfer.

(2) All dental officers are subject to rotation of duty assignments and since there are fewer ship and overseas billets in research than continental research billets it follows that a portion of research dental officers' careers will be spent in nonresearch assignments.

6–134C. Projects

(1) Dental research projects will be selected in most instances by individual investigators, who shall submit their projects, via official channels, to the Bureau for approval. However, the Bureau may assign, via official channels, projects to any dental research facility when investigations are required for specific problems.

(2) The selection of a dental research project will depend on its importance to the Navy, the qualifications of the investigators, the available facilities and the special opportunities offered by the location, and environment of the particular establishment.

6–134D. Reports

(1) Reference should be made to articles 1–19 and 23–43 for information on research reports and publication of research articles.

6–134E. Experimentation on Personnel

(1) Experimental studies of a dental nature involving persons in the Navy are forbidden, except when experimental design in each case has received prior approval of the Secretary of the Navy. Article 1–17 contains information on obtaining approval for this type of study.

6–134F. Trials of Commercial Items

(1) Authority to conduct clinical, laboratory, or field trials in Navy dental facilities of drugs, materials, or devices presented by commercial firms may be granted by the Bureau provided specific scientific conditions are met. These conditions are listed in article 1–18. (This shall in no way interfere with the "user" tests on dental items performed for the Armed Services Medical Materiel Coordination Committee.)

Section XVIII. U.S. NAVAL DENTAL SCHOOL

6–135. Establishment

(1) The U.S. Naval Dental School had its beginning in 1922 as a Department of Dentistry in the U.S. Naval Medical School at Constitution Avenue and 23d Street NW., Washington, D.C. In 1923, it became known as the Naval Dental School and began to function as a teaching institution. It was inactive from 1932 to 1936, when it was reestablished by the Secretary of the Navy as a component of the Naval Medical Center in the same location. The Naval Medical Center, including the Dental School, moved to new quarters at Bethesda, Md., and was redesignated the National Naval Medical Center on 5 February 1942.

6–136. Command Relationships

(1) The U.S. Naval Dental School is under the military command and coordination control of the Commanding Officer of the National Naval Medical Center and the management control of the Bureau.

6–137. Mission and Tasks

(1) The mission of the school is to conduct postgraduate advance instruction for Dental Corps officers in the various fields of dentistry peculiar to the needs of the naval service, to instruct and train enlisted enrollees to fit them to perform duties of Group XI dental ratings, and to provide dental support to other activities of the National Naval Medical Center.

(2) In addition to the tasks generated by the mission, other assigned tasks are to prepare audiovisual training aids for use by naval dental personnel; to prepare and administer correspondence training courses for personnel of the Regular and Reserve components of the Dental Corps; and to provide diagnostic, consultative, and histopathologic services.

6–138. Organization

(1) The School is organized under the command of an officer of the Dental Corps as designated by the Chief of Naval Personnel. The Commanding Officer is supported in his administrative and executive duties by the Executive Officer, the administrative staff, and such boards and committees as the Commanding Officer may establish.

(2) The School is organized into five departments which function as follows:
(a) Clinical Services.—This department provides oral surgical, operative, prosthodontic, periodontic, and diagnostic services for personnel in the National Naval Medical Center and other nearby naval units as a part of the clinical instruction. The department also provides a histopathologic service related to oral and dental tissues for all dental activities of the Navy.

(b) Officer Education and Training.—The divisions of this department provide courses of instruction for dental officers.

(c) Enlisted Education and Training.—Divisions of this department provide courses of instruction for dental technicians.

Section XIX. U.S. NAVAL DENTAL TECHNICIANS SCHOOLS

6–139. General Information

(1) The training program for dental technicians is divided into basic training, specialized training, and advanced training. Basic training is accomplished at class A service schools, specialized training at class C service schools, and advanced training at class B service schools.

6–140. Dental Technician, General (Class A School)

(1) Class A schools provide the basic training course for general technicians. The duration of this course is normally 16 weeks. Admission to the course is by approval of application or by direct recruitment. Any person in a naval rating except graduates of a class A school within another rating group may request admission to the course and a change of rating to the dental rating group. Such a request must include the recommendation of a dental officer, and must be addressed to the Chief of Naval Personnel via the Chief, Bureau of Medicine and Surgery. Successful completion of this training course is a prerequisite for further training and advancement in the dental rating group.

6–141. Dental Technician, General (Class B School)

(1) Upon advancement to dental technician, second class, the general technician becomes eligible for advanced training. This course is available to selected general technicians but is not a prerequisite to eligibility for advancement in rating. The purpose of the advanced course is to train the general technician to perform effectively the administrative, clinical, and military duties required of him.

(2) The qualifications for admission to the Course for Dental Technicians, Advanced General, are listed in the Catalog of Dental Technician Schools and Courses, NAVMED P–5029.

6–142. Dental Technician, Prosthetic (Class C School)

(1) The School for Dental Technicians, Prosthetic (Class C), is designed to provide specialized training necessary to qualify the dental technician, general, for the performance of duties in a dental prosthetic laboratory.

(2) Qualifications for admission in the specialized course for dental technician, prosthetic, are listed in the Catalog of Dental Technician Schools and Courses, NAVMED P–5029.

6–143. Dental Technician, Prosthetic (Class B School)

(1) After a period of on-the-job training and upon advancement to dental technician, second class, the prosthetic technician becomes eligible for the advanced course of instruction in prosthetic laboratory procedures.

Change II
(2) The purpose of this course is to develop the technician's skill in all prosthetic laboratory techniques. Instruction is patterned to the needs of the individual technician in that particular attention is given to increasing his ability in those areas in which he may be deficient. This course is available to selected prosthetic technicians but is not a prerequisite to eligibility for advancement in rating.

(3) The qualifications for admission to the course for Dental Technician, Advanced Prosthetic, are listed in the Catalog of Dental Technicians Schools and courses, NAVMED P-5029.

Section XX. PUBLICATIONS AND FILES IN DENTAL FACILITIES

6–145. Official Publications

(1) All dental facilities should have office copies of certain publications. It should not be necessary for dental officers, when transferred, to transport voluminous files of official reference material from one naval activity to another. All copies of manuals and other publications, and files for correspondence and reports, shall, at all times, be kept up to date and ready for inspection. Dental officers, upon assuming charge or command of dental facilities, should determine if all required manuals and other publications are available. They should, if any be missing, submit requests for them. They should state in the request that the publications are for official use and are not available in the activity. The following guide is provided for establishing and maintaining libraries of official publications in all dental facilities:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>How obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAVMED P-117</td>
<td>Manual of the Medical Department, U.S. Navy</td>
<td>Letter to BUMED.</td>
</tr>
<tr>
<td></td>
<td>U.S. Navy Regulations*</td>
<td>Letter to CNO.</td>
</tr>
<tr>
<td></td>
<td>Navy Department General Orders*</td>
<td>Navy Supply System.†</td>
</tr>
<tr>
<td>NAVMED P-504</td>
<td>Handbook of the Hospital Corps, U.S. Navy</td>
<td>Do.</td>
</tr>
<tr>
<td>NAVPERS 15761</td>
<td>Bureau of Naval Personnel Manual*</td>
<td>Do.</td>
</tr>
<tr>
<td>NAVPERS 10685-A</td>
<td>Dental Technician, Prosthetic</td>
<td>Do.</td>
</tr>
<tr>
<td>NAVPERS 10685-A</td>
<td>Dental Technician, General</td>
<td>Do.</td>
</tr>
<tr>
<td>NAVPERS 10847-A</td>
<td>Dental Technician, Repair</td>
<td>Do.</td>
</tr>
<tr>
<td>NAVPERS 10618</td>
<td>Register of Commissioned and Warrant Officers, USN and USMC*</td>
<td>Do.</td>
</tr>
<tr>
<td>SECONNAVST 5215.1A</td>
<td>Navy Correspondence Manual</td>
<td>Do.</td>
</tr>
<tr>
<td>SECONNAVST 5216.11</td>
<td>Navy Directives System</td>
<td>Do.</td>
</tr>
<tr>
<td></td>
<td>SECNAVST 5216.11</td>
<td>Navy-Marine Corps Standard Subject Classification System</td>
</tr>
<tr>
<td></td>
<td>Armed Services Medical Stock List</td>
<td>Do.</td>
</tr>
<tr>
<td></td>
<td>Letter to Military Medical Supply Agency, 5d Ave. and 26th St., Brooklyn, NY</td>
<td>Letter to Military Medical Supply Agency, 5d Ave. and 26th St., Brooklylyn 32, N.Y.</td>
</tr>
</tbody>
</table>

*If required and not readily available within the command.
†Requisition on DD Form 1149.

(2) Dental activities under the management control of the Bureau will require additional publications pertinent to the administration of the activity.

6–146. Personal Copies of Official Publications

(1) All dental officers should be familiar with certain publications which describe the basic duties and responsibilities of naval dental officers. Each dental officer should retain for personal use current copies of the U.S. Naval Medical News Letter, NAVMED–369, which is forwarded to all dental officers on active duty. Dental officers desiring to maintain a personal copy of U.S. Navy Regulations may do so at their own expense. This publication may be procured from the Superintendent of Docu-
6-147. Department Files

(1) The files of dental facilities shall be arranged in accordance with current instructions.

(2) The commanding officer of a dental activity or the dental officer of a ship, station, or service shall preserve all official correspondence in the files of the organization.

(3) A record of patients treated and services rendered shall be maintained at each dental activity. The NAVMED-1298, Dental Examination and Treatment Record, may be used for this purpose.

(4) Disposition of dental records of dental facilities shall be in accordance with chapter 23, section VII.

Section XXI. REPORTS, RECORDS, AND CORRESPONDENCE

General Instructions

Principal Reports Required From Dental Facilities

Dental Service Reports, DD Forms 477 and 477-1
NAVMED-952, Prosthetic Case Record
NAVMED-1298, Dental Appointments, Daily
NAVMED-1299, Dental Examination and Treatment Record
NAVMED-1300, Precious Metal Issue Record
NAVMED-1301, Statement and Inventory of Precious and Special Dental Metals
Audit Board for Precious and Special Dental Metals
Dental Records Retirement

6-148. General Instructions

(1) Reports shall be prepared and forwarded by the dental officer of a ship, station, or other activity in accordance with chapter 23 and other current directives.

(2) Official correspondence with the Bureau shall be forwarded via the commanding officer. Information copies of all official correspondence to the Bureau shall be forwarded to cognizant staff or district dental officers.

(3) Sufficient supplies of the necessary blank forms shall be maintained. Forms shall be obtained from the Navy Supply System, unless otherwise directed.

6-149. Principal Reports Required From Dental Facilities

(1) The following guide is provided for submitting principal reports required from dental facilities. Training in the preparation of these reports shall be part of the in-service training program.

<table>
<thead>
<tr>
<th>Form No.</th>
<th>Title</th>
<th>To</th>
<th>When</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD-477</td>
<td>Dental Service Report</td>
<td>BUMED (off, only)</td>
<td>Quarterly</td>
<td>Art. 6-150. Do.</td>
</tr>
<tr>
<td>DD-477-L</td>
<td>Dental Service Report, Equipment and Facilities Supplement</td>
<td>do</td>
<td>1 January</td>
<td>Ch. 6, sec. XV.</td>
</tr>
<tr>
<td>SF 603</td>
<td>Dental Record</td>
<td>Health Record, copy to BUMED</td>
<td>For each person entering Navy or Marine Corps or when Dental Record is missing</td>
<td>Ch. 9, vol. III, NAVCOMPT Manual</td>
</tr>
<tr>
<td>NAVSANDA-164</td>
<td>Survey Request, Report and Expenditure</td>
<td>Retain original in local file, copy to FLDBR-BUMED</td>
<td>As required</td>
<td></td>
</tr>
</tbody>
</table>

1 Send two copies to cognizant staff dental officer or district dental officer.
2 To be submitted by BUMED managed activities only. For other activities, these reports will be submitted by the fiscal officer performing allotment accounting.
3 Send copy to cognizant staff dental officer or district dental officer.
6–150. Dental Service Reports, DD Forms 477 and 477–1

(1) General.—The Dental Service Report consists of a quarterly report (DD Form 477) and an annual Equipment and Facilities Supplement (DD Form 477–1).

(2) Who Submits.—

(a) DD Form 477.—The responsible dental officer of each separate command shall submit a separate DD Form 477. Where dental departments of more than one command are using the same facilities the responsible dental officer of each command shall submit a DD Form 477 for the command to which attached. However, when dental officers of a fleet aircraft service squadron, aircraft early warning squadron, mobile construction battalion, etc., (except dental companies supporting major Fleet Marine Force units) are treating patients in a dental department of a ship or station, all dental procedures shall be reported on the ship or station DD Form 477 and an entry to this effect shall be made under REMARKS. In this circumstance, the DD Form 477 for the FASRON (or other unit) shall omit the entries of procedures in part I and, instead, include a statement under REMARKS indicating the ship or station DD Form 477 on which the procedures are reported. The commanding officer of a dental company shall submit a DD Form 477 for the company. The officer in charge of a detachment of a dental company, which is not located in the same geographical area, shall submit the original only of the DD Form 477 to the commanding officer of the parent dental company for inclusion in the company's report. A detachment of a dental company ordered to reinforce another dental company will become a part of the dental company to which attached for reporting purposes.

(b) DD Form 477–1.—The responsible dental officer of each separate command having dental facilities and dental equipment (except field type equipment) shall submit a DD Form 477–1. Activities having only field type equipment are not required to submit a DD Form 477–1. Dental officers attached to fleet aircraft service squadrons, mobile construction battalions, and other similar units not having dental equipment (other than field type equipment) will not submit a DD Form 477–1. When a FASRON, or similar unit, is furnished dental operating facilities, the activity providing the support will make an entry to that effect under REMARKS. Equipment in mobile dental units shall be reported in the DD Form 477–1 of the activity having operational control. An entry to that effect should be made under REMARKS. If the activity having operational control does not normally submit a DD Form 477–1, a separate report is required.

(3) When and To Whom Submitted.—

(a) DD Form 477.—This report shall be submitted quarterly. The original shall be mailed to the Bureau not later than the tenth day of the month following the quarter covered in the report. Two copies shall be sent to the district or staff dental officer responsible for reviewing the report. The preparation of a consolidated report is not required. Reviewing officers shall, if possible, correct errors on individual reports rather than return them for correction and resubmission. When corrections are made by the reviewing officer, the originating activity and the Bureau shall be advised to correct their copy of the report. Reviewing officers of subordinate commands shall forward a copy (corrected as necessary) of individual activity reports to their superior command, if such superior command has a staff dental officer.

(b) DD Form 477–1.—The Equipment and Facilities Supplement, DD Form 477–1, shall be submitted as of 1 January each year; the original shall be addressed to the Bureau and two copies to the reviewing officer.

(c) Those dental facilities not under a district or staff dental officer shall submit the original only of the DD Form 477 and 477–1 direct to the Bureau.

(4) Instructions for Preparing DD Form 477.—

(a) Heading.—

(1) REPORT CONTROL SYMBOL.—Enter MED-66002.

(2) Square Preceding NAVY.—Enter X in square.

(3) REPORTING FACILITY AND LOCATION.—Enter name of ship or station and mailing address.

(4) PERIOD COVERED.—Enter quarter and year. If report covers only part of quarter, enter inclusive dates.

(b) Part I, DENTAL PROCEDURES.—

(1) Categories of Personnel.—Enter the number of dental procedures accomplished for each category of personnel in vertical columns as follows:

(a) Column A, ARMY.—Active duty Army personnel.

(b) Column B, NAVY-MARINE.—Active duty Navy and Marine Corps personnel.

(c) Column C, AIR FORCE.—Active duty Air Force personnel.

(d) Column D, DEPENDENTS.—Dependents of active duty, retired, or deceased personnel of the U.S. Armed Forces.

(e) Column E, ALL OTHERS.—All personnel not included in A through D.

(f) Column F, TOTAL.—Total of entries in columns A through E.

(g) Column G.—Leave blank, except U.S. naval hospitals shall make entries on lines 51 and 52 (see subarts. 150 (4) (b) (2) (n) and (o)).
(2) Entries for Lines 1 Through 52, General Instructions.—

(a) Record only completed restorations, operations, or procedures. (For example, if a prophylaxis is completed in three separate appointments, only one prophylaxis is reported.)

(b) Leave blank if there is no entry in a category. Do not enter ‘O’.

(c) Blank lines are provided in each section to record procedures which cannot be described in the printed categories. Such procedures shall be totaled in each section and reported as MISCELLANEOUS in the appropriate column on lines 16, 21, 33, 43, and 49. Other blank lines shall not be used.

(d) Line 4.—Record RESIN restorations, except crowns. Do not enter bridge abutments.

(e) Lines 11 Through 14.—Record CROWNS for individual teeth only. Do not enter bridge abutments.

(f) Line 15.—Record all CROWN OR BRIDGE REPAIRS, including recementation or replacement of fillings.

(g) Line 20, OTHER MAXilloFACIAL APPLIANCES.—Include splints, obturators, skull plates, artificial eyes, and any other appliances used in connection with surgical, radiation, or plastic procedures.

(h) Line 23.—Record one ALVEOLECTOMY only for each arch in which alveolectomy was performed.

(i) Line 38.—Record one GINGIVECTOMY only for each arch in which gingivectomy was performed.

(j) Line 40.—Record as PROPHYLAXIS all cases for which the removal of supragingival calculus and polishing has been completed.

(k) Line 41.—Record as SCALING (PERIODONTAL) all cases for which the removal of subgingival calculus has been completed. (Report on both lines 40 and 41 if case involves removal of subgingival calculus and prophylaxis.)

(l) Line 47, ORTHODONTIC TREATMENT.—Since Navy dental activities are not authorized to provide orthodontic care, this line shall be left blank, except in unusual circumstances, which must be explained under REMARKS.

(m) Line 48.—Record as POSTOPERATIVE TREATMENT those followup procedures which are rendered after surgical intervention. Do not include nonsurgical followup procedures such as polishing fillings or adjusting dentures.

(n) Line 51.—U.S. naval hospitals shall, in addition to the usual entries in this line, enter in column G the total procedures accomplished during the month on hospital inpatients.

(o) Line 52.—Report the TOTAL PATIENTS TREATED in each category during the month. Count each patient only once regardless of the number of appointments during the month. A patient whose treatment extends into another month shall be reported on this line each month treatment is received. Include in TOTAL PATIENTS TREATED those patients reported on line 48 who receive examinations only. In addition, U.S. naval hospitals only shall enter in column G the number of hospital inpatients who received dental treatment during the month.

(c) PART II, LABORATORY DATA.—No entry is required from naval or Marine Corps activities.

(d) PART III, CLASSIFICATION OF ACTIVE DUTY PERSONNEL (at end of month).—

(1) MILITARY STRENGTH SERVED—

(a) Under REPORTING FACILITY column, report number of personnel attached to reporting command.

(b) Under OTHER column, report number of personnel attached to other commands, for whose routine dental care the reporting facility is responsible.

(c) On line 5, GRAND TOTAL, record combined total of REPORTING FACILITY and OTHER military strength.

(2) NUMBER CLASSIFIED, CL. 1, CL. 2, CL. 3, CL. 4, and CL. 5.—No entries required in these columns by naval or Marine Corps activities.

(e) Part IV, REMARKS.—

(1) Enter “Copy for review sent to (fill in title and address of district or staff dental officer to whom DD Form 477 is sent for review).”

(2) Report any circumstances which affect the accomplishment and/or efficiency of the dental facility and which are not included elsewhere on the DD Form 477. Include such items as the number of workdays which were lost because of leave, sick list, sick leave, temporary additional duty, and collateral duty.

(f) Part V, PROFESSIONAL ASSIGNMENT AND UTILIZATION, DD Form 477a.—There is no Bureau requirement for this report; however, cognizant district and staff dental officers may require local submission of the report for supplemental information.

(5) DD Form 477-1, Instructions for Preparing.—

(a) Heading.—

(1) REPORT CONTROL SYMBOL.—Enter MED-6600-2.

(2) REPORTING FACILITY AND LOCATION.—Insert name of ship or station and mailing address.

(3) DATE OF REPORT.—Enter 1 January.

(b) Part I, DENTAL DEPARTMENT OR FACILITY SPACE.—

(1) Items 1 Through 15.—

(a) Column A, NUMBER.—Give total number, even if located in more than one building.
(b) Column B, APPROXIMATE SIZE.—Indicate width and length. If rooms vary significantly, type data on blank sheet and attach; e.g.: 3 DOR’s.---------12’ x 12’ 1 DOR.---------10’ x 15’

(c) Column C, ADEQUATE.—Entry in “NO” space is to be made only if rooms are too small for requirements or are insufficient in number.

(d) Column D, REMARKS.—Enter significant collateral information; such as, “2 additional planned,” “1 not equipped,” “also used as classroom.”

Item 16, CLINIC UNIT.—If one or more clinics are in use, in addition to size of each, note number of dental operating rooms in each clinic and whether prosthetic laboratory is included. Designate clinics which are equipped, but are in maintenance status, as “M”; for example:

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column D</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td># 1 34’ x 160 20 days to reactivate.</td>
<td></td>
</tr>
<tr>
<td>10 DOR’s “M”</td>
<td></td>
<td></td>
</tr>
<tr>
<td># 2 34’ x 180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 DOR’s “DPL”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(e) Part II, DENTAL EQUIPMENT.—

(1) Column A, MAKE.—Enter name of manufacturer and total of each.

(2) Column B, NUMBER ON HAND.—List total number on hand, including those in store or installed in buildings that are not in use.

(3) Column C, NUMBER IN USE.—Include all items in use, even if only sporadically.

(4) Column D, CONDITION OF EQUIPMENT.—Insert number of items by categories of new, excellent, good, fair, and poor.

(5) Line 1, Column A.—Designate the manufacturer and total number of operating units of each manufacture. If military model units are on hand, designate separately and suffix with the letter “M.” For example, R-3, W-2M, SSW-3M, would indicate 3 Ritter units, 2 Weber Military Model units, and 3 S. S. White Military Model units.

(f) Line 8, STERILIZER.—Indicate in column A whether oil or water.

(7) Line 9, OTHER MAJOR EQUIPMENT.—List remaining standard and nonstandard items carried as plant property, class 3. Minor property need not be reported.

(d) Part III, PROSTHETIC DATA.—

(1) Line 1, POTENTIAL CASE CAPACITY PER MONTH.—Insert the total number of cases (including bridges, and partial and complete dentures only) that could be furnished in 1 month. Do not include crowns, inlays, or repairs. Estimate on the basis of a routine working month.

(2) Line 2, IS PROSTHETIC SERVICE PROVIDED TO OTHER ACTIVITIES.—Insert “No” or “Yes.” If yes, add number of other activities. If other activities include ships, estimate average at any one time. For example, “Yes—6 stations, 7 ships.”

(3) Line 3, ARE PRESENT PROSTHETIC FACILITIES ADEQUATE.—Enter “yes” or, if inadequate, indicate extent of support that is rendered; for example, “80 percent own, 50 percent other workload.”

(e) Part V, REMARKS AND RECOMMENDATIONS.—In addition to instructions on the form, list all projects that have been submitted for inclusion in future military construction programs. Indicate the priority and status of the project.

(f) Other portions of the DD Form 477-1 are considered to be self-explanatory.

Note.—There is no article 6-151.

6-152. NAVMED-952, Prosthetic Case Record

(1) The NAVMED-952 shall be accomplished for each case processed in a dental prosthetic facility. It shall be retained in the dental activity in an alphabetical file by name of patient until retired in accordance with article 23-303.

6-153. NAVMED-1298, Dental Appointments, Daily

(1) The following is the standard procedure for using NAVMED-1298. Entries may be made with ink or pencil.

(2) Procedure for a Dental Activity Having a Central Appointment Desk.—

(a) The following is to be accomplished at the appointment desk:

(1) ACTIVITY.—Give name of station, activity, or ship (rubber stamp may be used).

(2) DATE (on DATE line following ACTIVITY).—Enter the date.

(3) OPERATING ROOM.—Indicate numbers of rooms for which dental appointments are made.

(4) DATE (on DATE line following OPERATING ROOM).—No entry necessary unless sheet is used for more than 1 day.

(5) NAME.—Enter family name, followed by given names or initials.

(6) RANK OR RATE.—Abbreviate rank or rate.

(7) REMARKS.—Use for any local purpose.

(b) The following is to be accomplished in the rooms to which the patients are assigned for treatment:

(1) ACTIVITY.—No entry necessary.

(2) DATE (on DATE line following ACTIVITY).—No entry necessary.

(3) OPERATING ROOM.—Number of operating room.

(4) DATE (on DATE line following the number of the OPERATING ROOM).—The date for which appointments are made.

6-48

Change 11
6-153. NAVMED-1300, Precious Metal Issue Record

(1) Entries should be made as indicated in appropriate spaces on the NAVMED-1300 by activities having prosthetic dental facilities.

(2) The total quantity of precious and special dental metals USED, as computed from the Precious Metal Issue Records, should balance with column 7, CASES DELIVERED, of the Statement and Inventory of Precious and Special Dental Metals (NAV MED-1301) and should also balance with the total quantities used for cases delivered, as computed from NAVMED-952, Prosthetic Laboratory Records.

(3) The Precious Metal Issue Records, when completed and audited, should be filed in sequence of numbers for cases. They shall be available for inspection at any time until 2 years old, when they shall be destroyed locally.

6-156. NAVMED-1301, Statement and Inventory of Precious and Special Dental Metals

(1) NAVMED-1301 shall be prepared monthly only by activities having dental prosthetic facilities, in accordance with the following:

(a) Front of Statement and Inventory.—

(1) Entries may be typewritten or made by hand with black ink.

(2) ACTIVITY.—Name of station, ship, or dental activity in capitals at the left, followed by city, State, or country in capital and small letters, as may be indicated for shore stations; or post office address for ships and foreign shore stations.

(3) Column 3 plus column 4 will be the entry for column 5.

(4) Column 6, MISCELLANEOUS, under EXPENDED.—Enter quantities used for technique practice or for metals which may have been lost, etc. Explain on reverse side of form under “Explanation of expenditures of precious and special dental metals from column 6 on other side.”

(5) The total for column 6 plus column 7 is subtracted from column 5 and will be the entry for column 8.

(6) Column 9, plus column 10, plus column 11, plus column 12, is the total for the entry under column 13.

(7) The entries under column 8 and column 13 must be alike.

(8) The dental officer responsible for the precious and special dental metals shall indicate the month and year and sign the STATEMENT.

(9) The personnel of the audit board shall date and sign the INVENTORY.

(b) Reverse of Form.—

(1) Explanation of Expenditures of Precious and Special Dental Metals From Column 6 on Other Side.—Explain in detail the entries under column 6 on the front of the form.

(2) Comment and Recommendation by Audit Board.—It is the responsibility of the audit board to make recommendations for improving the accounting methods. The board may make any other comment considered pertinent.

(c) Instructions.—

(1) The original NAVMED-1301 shall be filed in monthly sequence in the dental activity record files. They shall be available for inspection at any time until disposed of in accordance with article 23-303.

(2) Copies shall not be sent to the Bureau.

(3) The total quantity of precious and special dental metals USED, as computed from the Precious Metal Issue Records, should balance with the totals of column 7, CASES DELIVERED, in the NAVMED-1301.
6–157. Audit Board for Precious and Special Dental Metals

(1) The audit board for the NAVMED–1301, Statement and Inventory of Precious and Special Dental Metals, shall consist of three commissioned officers appointed by the commanding officer from among those on duty in the activity or facility. A dental officer shall be the senior member of the board, whenever possible. The dental officer charged with the custody of the precious or special dental metals shall not be a member of the audit board.

(2) The dental officer charged with the custody of precious and special dental metals shall prepare the STATEMENT, INVENTORY, and EXPLANATION portions of the NAVMED–1301 in advance of the meeting of the audit board.

(3) The audit board shall:
   (a) Audit all records related to procurement, receipt, use, and disposition of precious and special dental metals.
   (b) Make a physical inventory of all precious and special dental metals in the dental activity.

Section XXII. DENTAL SUPPLIES AND EQUIPMENT

Responsibility for Dental Supplies and Equipment .......................................................... 6–160
Property Records ..................................................................................................................... 6–161
Procurement of Dental Supplies and Equipment ................................................................. 6–162
Procurement of Dental Supplies and Equipment Not Obtainable From Supply Points for Medical and Dental Material .......................................................... 6–163
Procurement of Nontechnical Material ............................................................................... 6–164
Invoices and Receipts ............................................................................................................ 6–165
Disposition of Material ......................................................................................................... 6–166
Report of Defective or Excess Material ................................................................................. 6–167
Transfer of Custody of Property ........................................................................................... 6–168
Transfer of Material Between Activities .............................................................................. 6–169
Dental Storerooms .................................................................................................................. 6–170
Custody of Narcotics and Precious and Special Dental Metals ....................................... 6–171
Issue of Dental Supplies and Equipment ............................................................................ 6–172
Dental Material for Naval Reserve Training Centers ....................................................... 6–173
Operation, Care, and Maintenance of Dental Property ....................................................... 6–174

6–160. Responsibility for Dental Supplies and Equipment

(1) The dental officer in each dental facility shall be charged with custodial responsibility for all property assigned or received, and it shall be his responsibility to insure that inventories are conducted and records maintained as required by chapter 6, volume III, Navy Comptroller Manual. In U.S. naval hospitals and U.S. naval dispensaries, this is the responsibility of the commanding officer.

6–161. Property Records

(1) General.—Depending upon the type of supply support furnished, a dental facility may be required to maintain property records. If property supply records are required, then they shall be maintained in such a manner that the rate of use of each item, expressed in terms of units per month to support one dental officer, may be determined. When there is a prosthetic laboratory, the usage rate for prosthetic items shall be the quantity required per month to support one dental officer performing prostodontic duties full time.

(2) Bureau of Medicine and Surgery Managed Dental Activities.—
   (a) Plant Property Records.—
      (1) When appropriate, Plant Property, Class 1 (Land), and Plant Property, Class 2 (Buildings and Improvement) records shall be maintained in accordance with chapter 6 of volume III of the Navy Comptroller Manual.

(c) Reconcile the audit of the records and the inventory with the NAVMED–1301 submitted by the dental officer.
(d) Make any pertinent comment or recommendation on the reverse of the NAVMED–1301.
(e) Date and sign the NAVMED–1301.
(f) Submit the NAVMED–1301 to the commanding officer for approval.

6–158. Dental Records Retirement

(1) When a ship is decommissioned, or an activity is disestablished, all official correspondence and records shall be disposed of in accordance with article 23–301.

(2) When a ship is placed in a reserve status or an activity is placed in an inactive or maintenance status, all official records shall be processed in accordance with the instructions in article 23–301 and other current directives insofar as they apply to dental activities.

Note.—There is no article 6–159.
6–161

(2) Plant Property records shall be maintained for items of issued equipment, Plant Property, Class 3 (Equipment). The plant property record card, NAVCOMPT Form 278, shall be utilized and prepared in accordance with chapter 6 of volume III of the Navy Comptroller Manual and shall be filed in visible index-type cardex, using a title insert for each card.

(3) Physical inventory and reconciliation with Bureau held records shall be on a triennial cycle, in accordance with chapter 6 of volume III of the Navy Comptroller Manual. Inventory and reconciliation with local records shall be held at least annually.

(b) Property Records for Supplies.—Property records for supplies shall be maintained in accordance with current directives, as applicable to the type of supply support furnished to the activity.

(3) Dental Service in a U.S. Naval Hospital or U.S. Naval Dispensary.—Property records in a U.S. naval hospital or U.S. naval dispensary are maintained as may be directed by the commanding officer, in accordance with article 6–160.

(4) Dental Departments in Ships.—Technical dental equipment and supplies records shall be maintained by the dental officer in accordance with current directives.

(5) Dental Department in Other Shore Stations.—Records of Plant Property, Class 3, are maintained in the fiscal office of the activity. The dental officer, as custodian of the technical dental equipment, shall maintain departmental records to support custodial responsibility.

6–162. Procurement of Dental Supplies and Equipment

(1) All dental activities and facilities (except at U.S. naval hospitals and U.S. naval dispensaries) shall obtain medical and dental supplies and equipment by means of timely requisitions upon the designated supply point. In U.S. naval hospitals and U.S. naval dispensaries, all supplies and equipment, including those for the dental service, are requisitioned from the designated supply point by the hospital supply officer or the property officer, respectively.

6–163. Procurement of Dental Supplies and Equipment Not Obtainable From Supply Points for Medical and Dental Materiel

(1) Supplies, equipment, and services not obtainable from supply points for technical medical and dental materiel may be procured by the dental officer, in accordance with volumes II and III of the Bureau of Supplies and Accounts Manual, and other current directives, except at U.S. naval hospitals and U.S. naval dispensaries, where this is the function of the hospital supply officer and property officer, respectively.

6–164. Procurement of Nontechnical Material

(1) Nontechnical materiel and services (office equipment, housekeeping supplies, utilities, laundry, etc.) procured by Bureau managed activities from other activities or agencies shall be on a reimbursable basis.

(2) The dental officer of a ship or of a station not under Bureau control and not the financial responsibility (except for technical items) of the Bureau shall obtain nontechnical items required for operation of the dental department from appropriate departments of the command on a custody basis or upon requisitions approved by the commanding officer and funded by the bureau exercising management control.

6–165. Invoices and Receipts

(1) The dental officer of a ship or station (except at a U.S. naval hospital or a U.S. naval dispensary) will be provided with invoices of all articles of supplies and equipment received for use in the dental department.

(2) Discrepancies in property invoices shall be corrected and/or reported as prescribed by current instructions.

(3) A file of property invoices shall be maintained.

6–166. Disposition of Material

(1) Equipment on charge in the dental department shall not be disposed of or replaced unless by approved survey or transferred on an approved transfer voucher. A survey of large amounts of consumable supplies shall also be conducted when they have become unusable because of deterioration, or lost as a result of pilferage, fire, etc.

(2) In January and July of each year, or upon decommissioning or disestablishment, the commanding officer or officer in charge of a naval dental activity, the dental officer of a ship or station, and the commanding officer of a U.S. naval hospital or U.S. naval dispensary shall forward, for disposal, all material of the following types to the Naval Supply Depot, Bayonne, N.J. (ships and stations east of the Mississippi River) or Naval Supply Center, Oakland, Calif. (ships and stations west of the Mississippi River): (a) Silver amalgam scrap, (b) gold and gold-alloy scrap, (c) platinum scrap, (d) precious metal bench grindings and sweepings, and (e) precious metal polishing residue. Materials of each type shall be weighed, packaged, and marked separately, and shipped either by registered mail or
on a Government bill of lading. Do not ship by airmail.

(3) Any precious metal taken from a patient's mouth shall be given to the patient. Should the patient decline to accept the precious metal, it shall be handled in accordance with current instructions for the disposition of precious metal scrap. An entry of the action taken in each case shall be made in the Dental Record.

6-167. Report of Defective or Excess Material

(1) Any materiel found to be defective shall be reported as prescribed in the current joint PB-BUMED & MMSA Instruction. Excess property shall be reported to the Bureau in accordance with current property disposal instructions.

6-168. Transfer of Custody of Property

(1) When the dental property of a ship or station is transferred to a relieving dental activity representative, inventory of narcotics, precious and special dental metals, and alcohol is required (see ch. 25).

(2) If a complete verification of the property inventory cannot be made before the departure of the transferring officer, a spot inventory of a random selection may be made as prescribed in subarticle 25-17(3). A complete inventory of narcotics, precious dental metals, alcohol, and alcoholic beverages is required.

(3) The receiving officer shall make a complete inventory at the earliest practicable date and, in any event, within 30 days after taking charge (art. 0098.3, U.S. Navy Regulations, 1948). He shall, in the event of any shortage, submit a request to the commanding officer for a property survey to balance the records and be relieved of responsibility for the shortage.

(4) Officers concerned will not be relieved of responsibility for the custody of equipment or supplies unless the expenditures have been authorized by competent authority.

(5) If a dental officer is detached and no other dental personnel are attached, the commanding officer will designate the representative of the medical department, or, if there is no such representative, another officer, to accept the custody of the dental property.

6-169. Transfer of Materiel Between Activities

(1) Dental equipment or supplies transferred to other activities will be properly invoiced in the account in which carried and such invoices shall be used as expenditure documents to clear through the accounting records.

(2) Equipment and supplies received from another activity shall be taken up on accounting records in the account in which received by means of invoices prepared by the transferring activity.

6-170. Dental Storerooms

(1) The dental officer of a ship shall take charge of and be responsible for the dental storeroom, keeping the key in his own custody or in the custody of his representative.

(2) Custody of dental storerooms at other activities is dependent upon the regulations governing the stores account in which the material is carried.

6-171. Custody of Narcotics and Precious and Special Dental Metals

(1) Custodial responsibility, except for small "in use" or "working" quantities of narcotics, alcohol, alcohol beverages, and precious and special dental metals, shall be vested in a commissioned officer.

(2) All dental personnel having custody of narcotics, alcohol, alcoholic beverages, and precious and special dental metals shall insure that proper protection, preservation, and accounting procedures are afforded this material, in accordance with articles 3-35 and 25-13(9).

(3) Losses, thefts, or irreconcilable differences between physical inventory findings and the narcotic accounting records shall be reported in accordance with article 25-13(9)(c).

6-172. Issue of Dental Supplies and Equipment

(1) Dental supplies and equipment shall be issued for use on properly authenticated issue documents applicable to the stores account or end-use status in which the material is carried at individual activities concerned. Issue documents utilized for this purpose shall be properly priced and cleared through accounting records as expenditures.

6-173. Dental Materiel for Naval Reserve Training Centers

(1) The initial outfitting list of dental materiel for Naval Reserve training centers is published in BUMED Instructions. Requirements for initial outfitting and replenishment materiel shall be requisitioned from the Navy Supply System via the naval district or river command commandant.

6-174. Operation, Care, and Maintenance of Dental Property

(1) The responsible dental officer shall require all cognizant persons to properly discharge their responsibilities in connection with the care, conser-
vation, and maintenance of Government property. All instructions, manuals, wiring diagrams, parts listings, and pictorials received with equipment shall be clearly labeled and retained as long as the equipment is in operation or on the ship or station in an operable status.

(2) A preventive maintenance program should be established in each activity. This program should be administered by a dental repair technician, if one is attached. The program should include:
   (a) Periodic cleaning and lubrication of moving parts.
   (b) Protection of painted, plated, or other surfaces.
   (c) Adjustments, calibration, and necessary repairs.
   (d) Reporting defects and operational hazards.

(3) Personnel operating or using dental equipment shall:
   (a) Familiarize themselves with instructions furnished by the manufacturer or other competent source before attempting to operate the equipment.
   (b) Operate the equipment within its rated capacity.
   (c) Comply with safety regulations for the operation of electrical equipment.
   (d) Properly secure the apparatus, when not in use.
   (e) Report promptly any defects, conditions which tend to increase the hazards of operation, or need for repairs, adjustment, or calibration. (See arts. 0712, 0903.9, 1220, U.S. Navy Regulations, 1948.)
   (f) When equipment requires repainting, such refinishing shall be accomplished in the standard cream color (Hue 2ca, Color Harmony Manual of Container Corporation of America) or the original standard olive green, as determined by the senior dental officer.

Section XXIII. DENTAL FISCAL MATTERS

6-175. Budget

(1) The commanding officer or the officer in charge of each naval dental activity under the management control of the Bureau is responsible for the development of a sound financial plan and the submission of annual estimates of budgetary requirements, in accordance with current instructions.

(2) The dental officer at U.S. naval hospitals and U.S. naval dispensaries shall prepare estimates of budgetary requirements, in accordance with directives of the commanding officer, for inclusion in the combined medical and dental requirements of the activity. The estimates should be supported by workload data, past experience, and adequate justification of specific requirements.

(3) The dental officer of other shore stations shall submit estimates of budgetary requirements to support the dental department, in accordance with the directives of the commanding officer and the management bureau.

(4) The dental officer of a ship or fleet operating unit is not required to submit an annual estimate of budgetary requirements. Funds for the procurement of technical dental material and services are provided in an open allotment, maintained in the Bureau. Instructions relative to utilization of these funds are contained in current Bureau directives.

6-176. Allotments

(1) Bureau of Medicine and Surgery allotments are granted to Bureau managed activities. The commanding officer or officer in charge is responsible for the administration of the allotment, and this responsibility may not be delegated. However, the commanding officer may direct the dental officer to perform the administrative details involved with the dental segment of the allotment.

(2) Regulations pertaining to allotments and control of the appropriated funds are contained in the Navy Comptroller Manual and Navy Comptroller Instructions.

6-177. Accounting

(1) All allotment accounting records shall be maintained in accordance with the Navy Comptroller Manual.
Section XXIV. PLANNING DENTAL FACILITIES

6-178. Bureaus' Responsibility

(1) By Navy Regulations, the Bureau of Yards and Docks is responsible for the design, planning, construction, alteration, cost estimate, and inspection of public works at all shore activities of the Naval Establishment. The Bureau of Medicine and Surgery establishes the technical requirements for medical and dental facilities.

(2) The Bureau of Yards and Docks is responsible for cooperating with the Bureau of Medicine and Surgery in preparing annual budgets and military construction programs as required to provide for dental facilities. This involves the preparation of estimates, the provision of technical advice on all projected facilities, and the administrative work incurred in the numerous steps toward the approval of budgets or individual projects through higher authority. Following the authorization and appropriation of military construction funds for dental facilities, the Bureau of Yards and Docks is responsible for expenditure and accounting of such funds.

(3) The design and planning for new dental facilities and the alteration or expansion of existing facilities involves the development of standards and the preparation of schematic plans, working drawings, specifications, and cost estimates. The size and arrangement of individual elements within a facility is determined by collaboration between the Bureau of Yards and Docks and the Bureau of Medicine and Surgery, under the policies established by the Department of Defense.

(4) It is the responsibility of the Dental Division of the Bureau of Medicine and Surgery to (a) recommend the accomplishment of all dental projects that are justifiable and urgently required, (b) recommend disapproval of projects that will not increase efficiency or improve standards of care commensurate with the expenses involved, (c) provide guidance to dental activities through the development of standard plans, and (d) render such technical assistance as is indicated in planning for specific projects. The Bureau desires to review all proposed plans for major construction or alterations to dental spaces, afloat and ashore.

6-179. District and Staff Dental Officers' Responsibility

(1) District and staff dental officers shall maintain a continuing review of all dental facilities under their cognizance, and shall assist in the planning for the orderly development and expansion of facilities to meet current requirements. They shall serve as technical advisors to the shore station development boards and insure that necessary dental projects are submitted for inclusion in the Shore Station Development Program. This Program provides justification and pertinent data necessary for the presentation of the annual Military Construction Program, Navy. Projects must be included in the Shore Station Development Program before they can be considered for the annual Military Construction Program, Navy. District and staff dental officers shall keep the Bureau advised of all major projects for new construction expansions, or alterations of dental facilities at activities coming under their cognizance.

6-180. Fleet and Force Dental Officers' Responsibility

(1) Fleet and force dental officers shall advise the Bureau on all matters pertaining to dental facilities coming under their cognizance. They shall maintain a continuing review of dental facility projects, and shall make necessary recommendations, and provide assistance and guidance as indicated, in all matters pertaining to dental facilities. Fleet and force dental officers shall review proposals for ship alterations and for major alterations to fleet activities ashore, as they pertain to dental
facilities. They shall maintain records indicating the status of approved ship alterations and probable date of accomplishment.

6-181. Dental Officers' Responsibility

(1) Each dental officer in an activity shall submit to the senior dental officer recommendations for improving the physical plant of the dental facility. It is the responsibility of the senior dental officer of an activity to recommend to the commanding officer necessary modifications for improving the efficiency of the dental treatment facility. The senior dental officer should refer to the Bureau of Yards and Docks' and the Bureau of Ships' technical publications concerned with the criteria and design in planning dental facilities. The senior dental officer at a shore station, in conjunction with the public works officer, shall develop plans for dental facilities for inclusion in the Shore Station Development Program. The senior dental officer shall inform the responsible district, fleet, or staff dental officer of all dental facility projects under construction.

6-182. Location of Dental Facilities Ashore

(1) Certain principles should be observed in selecting the location of a dental treatment facility. The facility should be located at or near the center of the military population. Care should be taken, in selecting a dental site, to avoid areas such as power plants, shop buildings, incinerators, and industrial areas. Adequacy of available space for parking should be considered in site selection.

(2) A dental department of less than six dental operating rooms is normally incorporated as part of a building housing other departments of the station, frequently the medical department. In this type building, it is desirable to locate the dental department in an area away from the general run of traffic to avoid congestion and confusion. A separate entrance is desirable. Joint use of auxiliary spaces (waiting room, locker rooms, heads, etc.) with the medical or other department may be necessary in this type facility. A separate dental officer's office, and a separate dental records and appointment office should be provided; however, these may be combined in small facilities.

(3) Dental departments of six or more dental operating rooms are best housed in a separate building. If this is not feasible, the dental department should be housed in a separate wing of a building. The dental wing should contain all necessary auxiliary spaces for efficient operations.

6-183. Dental Buildings

(1) A dental facility of six or more dental operating rooms should be planned as a separate building. The concentration of dental services in one building permits a more efficient operation and provides economies in administration functions.

(2) The general design for a dental building should always provide for future expansion. Area and terrain, in relation to the size of the facility planned, will determine, to a great extent, the design for the buildings, and whether single or multistoried construction is necessary.

(3) The Bureau of Yards and Docks maintains definitive drawings for 4 sizes of dental clinic buildings, 6-chair, 12-chair, 18-chair, and 24-chair, each expandable by 4 dental operating rooms. These plans shall be used for guidance in developing plans for dental buildings. Copies of the definitive drawings are available from the Bureau of Yards and Docks, district public works offices, and public works officers to activities with a specific requirement.

6-184. Dental Operating Rooms Ashore

(1) Determination of Requirements.—

(a) The primary unit of planning for dental facilities is the dental operating room (DOR). There are several factors to be considered in arriving at the total number of DOR's that will be required at an activity, the most important of these being the number of personnel to be supported. Dental operating rooms should be provided for dental officers attached to activities not having dental facilities, such as fleet aircraft service squadrons, mobile construction battalions.

(b) In determining the requirements for dental facilities, a sufficient number of dental operating rooms should be provided so that dental officers will have more than one room available for their use. The use of two dental operating rooms by a dental officer can greatly increase the capabilities of the activity in providing dental care. For this reason, multiple DOR's should be made available for dental officers whenever the situation permits. Following is a general guide for use in determining the number of dental operating rooms required at an activity:

<table>
<thead>
<tr>
<th>Strength Served</th>
<th>DOR's</th>
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<tr>
<td>1,000</td>
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<td>11,000</td>
<td>26</td>
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<td>12,000</td>
<td>28</td>
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</tbody>
</table>

(c) Staffing and support requirements at recruit training facilities and U.S. naval hospitals differ from those of other activities, and DOR re-
quirements are determined on an individual activity basis.

(2) Dimensions.—The minimum requirement for a standard dental operating room is a space 12 feet wide by 11 feet 6 inches deep, a total of 138 square feet. Oral surgery (SDOR) and prosthesis (PDOR) dental operating rooms should be 13 feet 6 inches wide by 11 feet 6 inches deep, a total of 155 square feet, when space permits. The greater area is necessary to accommodate additional equipment required in these rooms.

(3) Arrangement.—Major items of equipment should be arranged in accordance with Bureau of Yards and Docks dental operating room plans. Measurements indicated may be varied slightly to suit existing room dimensions; however, extreme care should be taken in positioning the dental unit, as it is the key to the proper arrangement of the entire room.

(4) Structural Features.—
(a) Wall partitions between dental operating rooms should be solid and extend from floor to ceiling.
(b) Dental operating rooms should not be connected by an inner passage, except where a suite (such as surgical, prophylaxis, or oral diagnosis) is planned. In these spaces, individual units should be partitioned to the degree necessary to provide privacy for the operator and patient.
(c) A sliding door between dental operating rooms should be provided for the multiple use of operating rooms.

(5) Natural and Artificial Illumination.—
(a) Dental operating rooms should face the best natural illumination. Northern exposure is preferred because it provides the most constant quality of natural illumination, with less exposure to direct sunlight. The standard dental operating room provides a window in front of the dental operating chair.
(b) Artificial illumination is provided by the concentrated light of the dental operating lamp and the general lighting from the overhead lights. The contrast between these two should be kept at a minimum to reduce eyestrain.
(c) Bureau of Yards and Docks publications should be reviewed for proper guidance in the scientific selection of paint colors and their relationship to overall lighting.

(6) Air Conditioning.—Provisions should be made for air conditioning dental spaces, whenever justified.

6–185. X-ray Exposure Room and Darkroom

(1) A separate dental X-ray exposure room (or cubicle) should be planned in each facility. The X-ray room should be provided with a dental chair, one or more dental X-ray machines (as required), a film dispenser, a lead-lined storage cabinet, an X-ray filing cabinet, and a wall-mounted view box, plus a lavatory, cuspidor, and desk. More than one X-ray room may be required at larger activities.

(2) The X-ray exposure room should be adjacent and directly accessible to the examining room. Structural shielding should be provided when needed to protect personnel.

(3) The darkroom should communicate directly with the X-ray exposure room, or be located in the immediate vicinity. A maze or lightlock permits a more efficient use of the darkroom than does a door. A switch for an overhead light should be placed at the entrance to the maze. The darkroom should be equipped with a refrigerated processing tank, a film dryer, a safelight mounted over a work counter topped with soapstone or metal, and a deep-well sink. An access door should be planned for the installation or removal of equipment. Electrical outlets are required for safelights, fans, exhaust system, view box, film dryer, and for the processing tank. Water inlets and drains are required for the tank and sink.

(4) In small activities, the darkroom may be used jointly by the medical and dental departments. Where medical and dental spaces are not adjacent, separate darkrooms should be provided.

6–186. Prosthetic Laboratory

(1) When authorized by the Bureau, a dental prosthetic laboratory may be established at an activity. The design and layout of the laboratory is a local determination based on the number of dental prosthetic technicians to be accommodated and the available floor space. Because each laboratory varies in size and shape, it is not practical for the Navy Supply System to stock major bench assemblies such as plaster, boltcut, casting, and soldering benches. These must be procured by open purchase from civilian sources or constructed locally to fit the available space. Technician work benches and prosthetic laboratory equipment are available from the Medical Stock List. If additional guidance is required, information may be obtained from the Bureau.

6–187. Auxiliary Spaces

(1) Adequate auxiliary spaces should be included in the planning of dental facilities. These spaces may include all or several of the following: dental officer's office, administrative and personnel office, records and appointments office, property and accounting office, storerooms, linen rooms, utility rooms, cleaning gear closets, staff and patient

6–56

Change 11
toilets, locker rooms, duty rooms, conference room, lecture and training room, library, sterilizing rooms, recovery room, repair shop, gold room, pharmacy, etc.

6-188. Planning for Utilities

1. It is the dental officer's responsibility to provide technical advice to the public works officer regarding the number and location of electrical, gas, water, and air outlets required for dental spaces. Readily accessible main cutoff valves and switches for all utilities should be located at a central point for use in emergencies.

6-189. Field Dental Facilities

1. Portable field dental equipment is used by activities such as Fleet Marine Force units and construction battalions under certain operating conditions. Adequate housing in temporary or semi-permanent structures should be utilized whenever possible so that field dental equipment may be efficiently utilized. Dental officers attached to activities having field equipment shall arrange to use nearby permanent dental facilities, when available.

6-190. Dental Facilities in U.S. Naval Hospitals

1. Dental facilities in U.S. naval hospitals are planned on the basis of 1 dental operating room (DOR) for each 250 beds, plus 2 or more surgical dental operating rooms (SDOR), and 1 or more prosthetic dental operating rooms (PDOR). Additional DOR's may be required for dental interns and residents. If dental support is to be provided to personnel other than regularly assigned staff and patients, DOR's shall be provided on the basis of 3 for each 1,000 personnel to be supported. DOR's designed for oral surgical use shall have minimum dimensions of 13 feet 6 inches width and 11 feet 6 inches depth. Arrangements within these rooms shall be generally in accordance with the standard dental operating room plan with consideration being given to the additional requirements for surgical tables, surgical cabinets, etc.

2. In addition to the standard facility requirements, hospital dental spaces should be equipped with scrub-up space, a patient recovery room with head, autoclave and sterilizing room, and surgical consultation office.

6-191. Dental Facilities in Ships

1. Dental spaces in ships are allocated by the Bureau of Ships in accordance with the dental support requirements of the particular type of vessel. The Bureau of Ships establishes the location of the dental department, the overall space requirements, and the general plan for the dental spaces. The Bureau of Medicine and Surgery collaborates with the Bureau of Ships in these determinations.

2. The Bureau of Ships maintains General Type Plans for dental operating rooms, dental prosthetic laboratory, dental technician workbench, dental officer's office, dental utility cabinet, etc. These plans are used for guidance in developing detail specifications and plans for dental facilities in new ships and in alterations to existing dental facilities. In new construction, a dental officer is usually assigned to the ship in sufficient time to supervise the outfitting of the dental spaces.

3. The Bureau of Ships publication, General Specifications for Ships, contains requirements for fitting and equipping dental spaces aboard ship. The Bureau of Ships has supply responsibility for material which is permanently attached to the hull structure, such as desks, laboratorie, file cabinets, general lighting fixtures. Additionally, the Bureau of Ships furnishes certain items of fixed dental equipment including the standard dental prosthetic laboratory assembly (to ships authorized to provide prosthetic dental service).

4. The arrangement of the dental operating room in ships is essentially the same as the standard plan for DOR's ashore; however, modifications may be necessary due to space limitations. Dental chairs aboard ship should be positioned athwartship and face outboard.

6-192. Ship Alterations

1. Modification to the dental spaces of ships is accomplished by a ship alteration. In ships with inadequate dental facilities, it is the responsibility of the dental officer to initiate action to correct the deficiency by presenting a proposal for alteration to the commanding officer. If the commanding officer concurs in the need for the alteration, the command will submit a request to the Bureau of Ships that a ship alteration be issued. The Bureau of Ships will normally refer the request to the Bureau of Medicine and Surgery for technical review. If the request is approved following final review by the Bureau of Ships, a ship alteration will be issued. In advance of scheduled overhauls, the Bureau of Ships reviews outstanding ship alterations and prepares an authorized list of alterations to be accomplished during the overhaul period.

2. During alterations to the dental facilities, the dental officer should provide technical advice and assistance as required.

Change II
6-193. Survey Objectives

(1) The objectives of a survey of a dental facility are:
   (a) To determine to what degree personnel, material, and the administration contribute toward the accomplishment of the mission of the command.
   (b) To promote efficiency and economy.
   (c) To provide a searching examination of the performance of the dental tasks and functions in support of the Operating Forces.
   (d) To provide management control agencies with facts which might affect the continuation, expansion, reduction, or elimination of the dental functions.

6-194. General Instructions

(1) The Naval Inspector General is responsible for directing, coordinating, planning, and scheduling all comprehensive surveys on an annual cycle, keyed to a fiscal year.
(2) Dental facilities shall be surveyed or visited as follows:
   (a) Shore establishments and shore based fleet activities shall normally be surveyed or visited annually by the Inspector General, Dental, or his designated representative.
   (b) The Naval Operating Forces shall normally be surveyed or visited annually by the cognizant force dental officer.
   (c) Marine Corps activities shall normally be surveyed or visited annually by the cognizant force dental officer.
(3) Duly authorized representatives may visit an activity to give or obtain technical information or assistance, provided such visits concern matters not included in the comprehensive survey, or when a situation develops which, in the opinion of the chief of the bureau or office concerned, cannot wait for the next regularly scheduled comprehensive survey.
(4) Dental survey teams shall be guided by current Instructions in the performance of their duties.

6-195. Scope of Surveys

(1) Bureau Managed Dental Activities.—Survey of a dental activity under the management control of the Bureau should include, but not be limited to, the following:
   (a) Management and Administration.—
      (1) Performance of the assigned mission.
      (2) Organization and organization chart of the activity, order books, and other internal directives.
      (3) Development of procedures to the end that the activity will operate according to a functional plan consistent with best possible utilization of personnel and available funds.
   (4) Cleanliness, sanitation, and appearance of the dental activity.
   (5) Internal and external security.
   (6) Adequacy of public relations.
   (7) Dissemination of information to personnel of the command.
   (b) Personnel.—
      (1) Study of personnel requirements.
      (2) Maintenance of discipline and administration of personnel.
      (3) Appearance and bearing of military personnel.
      (4) Adequacy of military professional and technical training programs (residencies, advanced training, technician training).
      (5) General educational facilities for personnel of the command.
      (6) Physical education facilities, athletics, and recreational programs.
      (7) Indoctrination of newly reported personnel.
   (8) Maintenance of personnel records, officer and enlisted.
   (c) Dental Services, Operations, and Readiness.—
      (1) Adequacy of professional care.
      (2) Professional standards.
      (3) Peacetime operation.
      (4) Disaster and emergency plans.
      (5) Condition of materiel readiness.
(d) Materiel.—
(1) Security and custody of Government property, including the security and accountability of precious metals, alcohol, and narcotics.
(2) Stock levels.
(3) Condition of all equipment and material.
(e) Facilities.—
(1) Adequacy of dental facilities.
(2) Planned changes or modifications to the dental facility.

(2) Dental Service in U.S. Naval Hospitals.—Surveys of the dental service in a U.S. Navy hospital should include, but not be limited to, the following:

(a) Management and Administration.—
(1) Performance of the assigned mission.
(2) Assurance that the maximum effort is placed on dental care and that other activities except essential training are kept to a minimum.
(3) Organization, order books, and other internal directives of the service.
(4) Cleanliness, sanitation, and appearance of the dental service.
(5) Internal and external security.
(b) Personnel.—
(1) Personnel requirements.
(2) Maintenance of discipline.
(3) Appearance and bearing of military personnel.
(4) Adequacy of the dental intern and residency programs when such are being conducted, and technician training.
(5) Indoctrination of newly reported personnel.
(c) Dental Services, Operations, and Readiness.—
(1) Adequacy of professional care.
(2) Professional standards.
(3) Peacetime operation.
(4) Disaster and emergency plans.
(5) Condition of materiel readiness.
(d) Materiel.—
(1) Security and accountability of precious metals, alcohol, and narcotics.
(2) Adequacy of supply support.
(3) Condition of all equipment and material.
(e) Facilities.—
(1) Adequacy of space assigned to the dental service.
(2) Planned changes or modifications to the dental facility.

3 Dental Departments.—Surveys of dental departments at naval shipyards, air activities, stations, bases, and other activities not under the management control of the Bureau, should include the following broad subjects:

(a) Management and Administration.—
(1) Mission and organization.
(2) Location in relation to center of population.
(3) Records and reports.
(4) Log or journal and department organization and instruction book.
(b) Personnel.—
(1) Personnel requirements.
(2) Adequacy of professional and technical training programs.
(c) Dental Services, Operations, and Readiness.—
(1) Personnel dependency upon the activity for dental care.
(2) Adequacy of professional care.
(d) Materiel.—
(1) Stock levels.
(2) Security, care, and custody of property, including narcotics and alcohol.
(3) Condition of all equipment and material.
(e) Facilities.—
(1) Adequacy of facilities.
(2) Planned changes or modifications to dental facility.

6-196. Survey Conferences

(1) In order that the Naval Inspector General may report to the Secretary of the Navy and the Chief of Naval Operations on the effectiveness of dental activities in the area, the Naval Inspector General confers, at the end of the survey period, with the Inspector General, Dental, or his designated representative in the area being surveyed.

(2) These conferences are intended to give the Naval Inspector General an opportunity to take under advisement all matters which are beyond the scope of the surveying officer, to assist the surveying officer in formulating sound and effective recommendations, and to effect close coordination of the final efforts of the various survey teams in the area.

6-197. Survey Reports

(1) Upon completion of surveys or visits during a survey period, the Inspector General, Dental, shall submit reports containing observations and recommendations to the Surgeon General, via the Chief of the Dental Division. A report is submitted also to the Naval Inspector General covering the salient points of matters disposed of during the survey.
6–198. Establishment

(1) The Naval Dental Reserve was established in 1916 when an act of 29 August 1916 authorized a “Naval Dental Reserve Corps” to be organized and operated. The present organization of the Naval Dental Reserve is maintained under authority of ch. 11, act approved 10 August 1956, 10 USC 261 et seq. Information and instructions pertaining to the Naval Dental Reserve are incorporated in the Bureau of Naval Personnel Manual and other current directives.

6–199. Mission

(1) The mission of the Naval Dental Reserve is to provide qualified dental personnel in time of war or national emergency to augment the active duty forces.

6–200. Grades and Strength

(1) The Dental Corps of the U.S. Naval Reserve consists of officers in the grades of lieutenant (jg) through rear admiral. The Secretary of the Navy determines the number of Reserve dental officers necessary in each grade to meet mobilization requirements.

6–201. Appointments

(1) Appointment as Dental Officer in the Naval Reserve.—

(a) Qualifications for Appointments.—

(1) Sex—Male or female.

(2) Must be at least 21 and under 48 years of age, unless otherwise provided for by current law.

(3) Must be a graduate of an approved dental school or be currently licensed to practice dentistry in a State or Territory of the United States or the District of Columbia.

(4) Must be found to be physically qualified.

(5) Must be a citizen of the United States, unless otherwise provided for by current law.

(b) Application for Appointment.—Applications for appointment should be obtained from and submitted to a U.S. Navy recruiting station convenient to the applicant.

(2) Appointment of Dental Students as Ensign (Dental) in the Naval Reserve.—

(a) Qualifications for Appointment.—

(1) Sex—Male or female.

(2) Age.—

(a) Men with no prior military service must be at least 19 years of age and under 28 1/2 years of age at time of application. The maximum age limit for men with prior active military service may be adjusted on a month-for-month basis depending on the number of months of active military service during the combat period of a war or a national emergency, but in no case will an application be accepted from any person who will have passed his 36th birthday when he becomes eligible for superseding appointment in the grade of lieutenant, junior grade.

(b) Women must be at least 19 and under 28 1/2 years of age at time of application.

(3) Education.—

(a) Must be in attendance or have been accepted for and be within 6 months of the date of the next entering class at an approved dental school.

(b) Must not be within 6 months of graduation from dental school.

(b) Application for Appointment.—Applications for appointment must be obtained from and submitted to the U.S. Navy recruiting station nearest the applicant’s residence.

6–202. Promotion

(1) Dental officers of the Naval Reserve on active duty become eligible for promotion to the next higher grade with their running mates in the line. Selection for promotion is made by the same selection board that selects dental officers of the Regular Navy.

(2) Dental officers of the Naval Reserve on inactive duty become eligible for promotion to the next higher grade with their running mates of the line.
Selection for promotion is made by a separate board to fill vacancies required to meet mobilization requirements.

3. Reserve officers on inactive duty shall not be promoted to a higher grade until found qualified by such moral, professional, and physical examinations as the Secretary of the Navy may prescribe, and until the required minimum number of promotion points has been attained.

6–203. Retirement

1. Officers of the Dental Corps of the Naval Reserve are eligible for retirement under several provisions of laws. For further details see pertinent statutory provisions and regulations issued thereunder.

6–204. Definitions Applicable to Dental Officers of the Naval Reserve

1. Ready Reserve.—Members are liable for active duty either in time of war, in time of national emergency declared by the Congress or proclaimed by the President, or when otherwise authorized by law.

2. Standby Reserve, Active Status.—Members are liable for active duty only in time of war or national emergency declared by the Congress or when otherwise authorized by law.

3. Standby Reserve, Inactive Status.—Members are liable for active duty only in time of war or national emergency declared by the Congress or when otherwise authorized by law.

4. Retired Reserve.—Members are liable for active duty only in time of war or national emergency declared by the Congress, or when otherwise authorized by law upon determination by the Secretary of the Navy with approval of the Secretary of Defense that adequate numbers of qualified members of the Naval Reserve in an active status in the required category are not readily available. Reserve officers may be transferred to the Inactive Status List for any of the following reasons:

(a) At own request.
(b) Lack of progress.
(c) Lack of interest.
(d) Nonavailability for active duty.

5. Active Duty.—Full time with the active military service of the United States other than active duty for training.

6. Active Duty for Training is full-time duty with the active military service of the United States for training purposes.

7. Inactive-Duty Training is any of the training, instruction, duty, appropriate duties, or equivalent training, instruction, duty or hazardous duties performed with or without compensation by members of the Naval Reserve as is prescribed by the Secretary of the Navy and in addition thereto includes the performance of special additional duties, as may be authorized by competent authority of such members on a voluntary basis in connection with the prescribed training or maintenance activities of the unit to which reservists are assigned. Work or study performed by such reservists in connection with approved correspondence courses shall be deemed inactive-duty training for which compensation is not authorized.

8. Appropriate Duty is that duty authorized to enable the commandants to accomplish various special tasks in connection with the Naval Reserve programs.

9. Inactive Status List (ISL) includes Naval Reserve personnel who have earned less than the required annual number of promotion or retirement points in accordance with the regulations prescribed by the Secretary of the Navy.

6–205. Organization of the Naval Reserve

1. See chart on the following page.

6–206. Training Categories

1. The following training categories are prescribed by the Secretary of Defense:

(a) Group I indicates the highest priority of requirements for training to meet mobilization needs (known as "Brigades," "Battalions," "Air Wing Staffs," "Squadrons," "Auxiliary Ground Units," and "Auxiliary Air Units").

(b) Group II indicates the second highest priority of requirements for training to meet mobilization needs (known as "Companies" and " Platoons").

(c) Group III indicates the third priority of requirements for training to meet mobilization needs (this includes those reservists who do not participate in any drills or periods of appropriate duty with pay but take active duty for training, correspondence courses, extension courses, and those that do not participate in inactive-duty training). Personnel who do not participate in inactive duty training are retained in this group until such time as they are placed on the Inactive Status List or are transferred to the Retired Reserve.

6–207. Participation of Dental Officers in the Organized Reserve

1. Active Duty.—

(a) A Naval Reserve dental officer may request orders to extended active duty via the commandant of the naval district in which he resides. Approval
of such request will depend primarily on whether a requirement exists for an active duty dental officer with his grade and qualifications.

(b) Dental officers in the Ready Reserve may be ordered to active duty in event of war or national emergency declared by the Congress or proclaimed by the President. In the case of an emergency proclaimed by the President, however, Congress reserves the right to determine the number to be called.

(c) Dental officers in the Standby Reserve are subject to active duty only in time of war or emergency declared by the Congress.

(2) Naval Reserve Dental Companies (Nonpay).—Dental companies of the Naval Reserve are distinct drill units, which may be comprised of Reserve officers with designations 1925, 2205, 2305, 8185, 8186, and Reserve enlisted personnel with a rating of dental technician (DT) or dentalman (DN).

(3) Naval Reserve Composite Companies.—Reserve dental officers may participate in composite companies, which are drill units composed of Naval Reserve officers and enlisted men of any designation. Composite companies are general composed of selected technical specialties, in those localities where there are insufficient numbers of officers to form separate technical groups, such as the Naval Reserve dental company.

(4) Appropriate Duty Orders.—

(a) With Pay.—Reserve dental officers may be issued appropriate duty orders with pay for the purpose of conducting dental examinations for naval units that do not have dental officers regularly assigned. Points may also be earned by Reserve dental officers by instructing naval reservists, or by attending approved professional symposia conducted by the Armed Forces. Budgetary requirements limit the number of appropriate duty orders with pay that may be issued.

(b) Without Pay.—Reserve dental officers may be issued appropriate duty orders without pay for the same purpose as (a) above.

(5) Association With Pay Units.—Pay Units (Group I) are those who receive the highest priority for training to meet mobilization needs. Reserve dental officers and enlisted technicians may be assigned to such units, either in a pay or nonpay status, under quotas authorized by the Bureau of Naval Personnel. Annual active duty for training is required for those Reserve dental officers and enlisted technicians in a pay status who are attached to, or associated with, a pay unit of the Naval Reserve. Within budgetary limitations, Reserve dental officers may be ordered to active duty for training with pay. Active duty for training without pay or allowances may be authorized where appropriate billets are available.

6-208. Accrual of Points by Dental Officers of the Naval Reserve

(1) As provided in 10 USC 1332 and 1333, each Reserve dental officer is credited with 50 retirement points for each year of "Satisfactory Federal Service" performed before 1 July 1949. If during this period, extended active duty was performed, one retirement point is credited for each day of active duty in lieu of the 50 points. After that date the officer must earn at least 50 points each anniversary year to be eligible for retirement.

(2) Retirement point credits may be earned in any one or combination of the following ways:

(a) One point for each day of active duty or training duty including travel time.

(b) One point for each authorized drill equivalent or appropriate duty performed.

(c) Point credit as evaluated for completion of correspondence courses.

(d) Fifteen points, which are gratuitously credited for each year of Reserve service while in an eligibility status.

(3) Promotion points earned in grade under previous instructions remain in effect. Effective 1 July 1955, promotion points shall be awarded to Naval Reserve officers for:

(a) Completion of approved correspondence courses, or normally creditable portions of correspondence courses. The number of promotion points to be credited for such courses, or the creditable portions of the course, may be evaluated and assigned by the Chief of Naval Personnel.

(b) Participation in an inactive duty training program by attending at least 75 percent of the number of drills prescribed in the tables of organization (nonpay dental companies schedule a minimum of 24 drills per year); or for satisfactory completion of at least 14 periods of appropriate duty; or for satisfactory completion of at least 14 days active duty, including training duty: 12 promotion points. No more than 12 promotion points per fiscal year may be awarded to an officer under the provisions of this article.

(c) Extended active duty (not including training duty) between 1 July 1950 and 1 July 1955: one promotion point for each month of continuous active duty during the stated period. For each month subsequent to 30 June 1955: two promotion points.

(d) Satisfactory completion of each course in which enrolled in a "Naval Reserve Officers School." The number of promotion points to be credited for such course may be evaluated and assigned by the Chief of Naval Personnel.

(e) Satisfactory completion of other approved training or instruction. The number of promotion points to be credited for such training or instruction
may be evaluated and assigned by the Chief of Naval Operations.

(4) A Reserve dental officer on the Inactive Status List cannot be granted credit toward nondisability retirement, nor can he be considered for promotion by selection boards until he is restored to active status. He will, however, be granted promotion points for appropriate courses completed while on the Inactive Status List.

6–209. Correspondence Courses

(1) A wide variety of officer correspondence courses concerning the Naval Establishment are available to Reserve dental officers. These courses are in two categories, basic and general courses, and professional courses.

(2) The basic and general courses are administered by the U.S. Naval Correspondence Course Center, Scotia 2, N.Y. The professional courses are administered by the Commanding Officer, U.S. Naval Dental School, National Naval Medical Center, Bethesda 14, Md. Requests for enrollment should be forwarded through official channels.

(3) All courses are listed in the List of Training Manuals and Correspondence Courses, NAVPERS 10061, latest edition, which includes the number of assignments and points to be credited upon completion.
(2) The basic and general courses are administered by the U.S. Naval Correspondence Course Center, Scotia 2, N.Y. The professional courses are administered by the Commanding Officer, U.S. Naval Dental School, National Naval Medical Center, Bethesda 14, Md. Requests for enrollment should be forwarded through official channels.

(3) All courses are listed in the List of Training Manuals and Correspondence Courses, NAVPERS 10061, latest edition, which includes the number of assignments and points to be credited upon completion.

6–210. Inactive Status List

(1) The Chief of Naval Personnel has established an Inactive Status List within the Standby Reserve. Reservists in an inactive status shall not be eligible for pay, promotion, or award of retirement points, while in such status. Reserve officers may be transferred to the Inactive Status List for any of the following reasons:

(a) At own request.
(b) Lack of progress.
(c) Lack of interest.
(d) Nonavailability for active duty.
Chapter 7

MEDICAL SERVICE CORPS

Sections

I. Establishment .................................................. 7-1 through 7-4
II. Appointments .................................................. 7-5 through 7-18
III. Advancement in Grade .......... 7-19 through 7-26
IV. Duties .......................................................... 7-27 through 7-30

Section I. ESTABLISHMENT

Establishment ................................................... 7-1
Number .......................................................... 7-2
Distribution ..................................................... 7-3
Grade .............................................................. 7-4

7-1. Establishment
(1) A Medical Service Corps was established as a staff corps within the Medical Department of the Navy by the provisions of Title II of the Army-Navy Medical Services Corps Act of 1947 (34 U. S. C. 30aj). This Corps consists of personnel trained in administration and supply, pharmacy, optometry, sciences allied to medicine, and in such other fields as may be deemed necessary by the Secretary of the Navy.

7-2. Number
(1) The authorized strength of the Corps shall be 20 per centum of the authorized strength of the Medical Corps of the Navy.

7-3. Distribution
(1) Normally, the distribution of officers of the Medical Service Corps in the several special fields or sciences allied to medicine shall be in accordance with the needs of the service.

7-4. Grade
(1) The Medical Service Corps shall consist of officers in the grades of ensign to captain. These officers shall take precedence next after officers of the Dental Corps serving in the same grade and having the same date of rank. The authorized number of captains on the active list of the Corps shall not exceed 2 per centum of the total number of officers in the Corps on the active list of the Navy at any one time.

Section II. APPOINTMENTS

Conditions Governing Appointment ................................ 7-5
Qualifications Governing Appointment .......................... 7-6
Educational Requirements for Appointment .................... 7-7
Revocation of Appointment ....................................... 7-8
Application ....................................................... 7-9
Authorization for Examination ................................... 7-10
Physical Examination ............................................. 7-11
Professional Examination for Admission ....................... 7-12
Withdrawal from Examination ................................... 7-13
No Allowance for Expenses ..................................... 7-14
Failure in Professional Examination ............................ 7-15
Acceptance and Oath of Office ................................ 7-16
Postgraduate Courses .......................................... 7-17
Naval Reserve Officers ......................................... 7-18

7-1
Change 1
7-5. Conditions Governing Appointment

(1) All appointments in the Medical Service Corps are made by the President, by and with the advice and consent of the Senate, in the grade of ensign, from those persons serving as commissioned warrant and warrant officers of the Hospital Corps of the Regular Navy, from such persons serving as chief hospital corpsmen, hospital corpsmen first class, chief dental technicians, and dental technicians first class of the Regular Navy who possess such physical and other qualifications for appointment as may be prescribed by the Secretary of the Navy, and from other persons not serving in the Regular Navy who possess such physical and other qualifications for appointment as may be prescribed by the Secretary of the Navy and who are graduates of accredited schools of pharmacy, optometry, or other schools or colleges with degrees in sciences allied to medicine or such degrees as may be approved by the Surgeon General. Persons holding a doctorate degree in sciences allied to medicine approved by the Surgeon General at time of appointment in the Medical Service Corps may, subject to regulations to be prescribed by the Secretary of the Navy, be appointed in the grade of lieutenant (jg).

7-6. Qualifications Governing Appointment

(1) An appointee to the Medical Service Corps must be a citizen of the United States, between the ages of 21 and 32 years and shall establish his mental, moral, and professional qualifications to the satisfaction of the Secretary of the Navy.

7-7. Educational Requirements for Appointment

(1) Applications must be accompanied by a statement of the commanding officer certifying that, in his opinion, the applicant possesses the necessary moral, professional, and officer-like qualities; that he recommends him for appointment; and that he would be pleased to have him as a subordinate if commissioned. Certified copies of any documents attesting to the completion of special training or of courses pursued in the fields of administration, pharmacy, optometry, or science must also accompany the application.

(2) Applicants from other sources than the Regular Navy must be graduates of accredited schools of pharmacy, optometry, or other schools or colleges and hold degrees in sciences allied to medicine or such other degrees as may be approved by the Surgeon General.

7-8. Revocation of Appointment

(1) The Secretary of the Navy may revoke the commission of any officer appointed under the provisions of paragraph 175 (34 U. S. C. 30e) who at the date of revocation has had less than three years of continuous service as a commissioned officer (34 U. S. C. 405a).

Provided, That any officer whose commission is so revoked and who at the time of his appointment under 34 U. S. C. 30e held permanent status as a commissioned warrant or warrant officer may be reappointed by the President without examination to such permanent status with the same lineal position and other rights and benefits which he would have had, or would have attained in due course, had he not been appointed in the Medical Service Corps.

7-9. Application

(1) The applications of candidates from the Hospital Corps of the Regular Navy shall be submitted in official letter form, via the commanding officer and the Bureau of Medicine and Surgery to the Chief of Naval Personnel, stating their qualifications, length and type of service, service schools attended, and civil schools attended since entering the naval service. This should be accompanied by any credentials the applicant desires to submit. The commanding officer shall endorse the application with a statement of his opinion of the fitness and desirability of the applicant for a commission. A fitness report shall also accompany the application.

(2) Applicants from sources other than the Hospital Corps of the Regular Navy for appointment shall submit the following documents:

(a) NavPers-953 application for commission, two copies.

(b) Birth certificate, one copy.

(c) Evidence of naturalization, whenever necessary, one copy.

(d) Evidence of change of name affidavit, whenever necessary, one copy.

(e) Evidence of prior military service, one copy.

(f) Letter from dean of the school from which graduated, certifying to the conduct and scholastic standing, if a student, or a certificate of graduation if a graduate. (Do not submit diplomas; photostatic copies are acceptable if properly notarized.)

(g) Certificate of formal experience or evidence of licensure if required for civilian practice in applicant's field.

7-10. Authorization for Examination

(1) If the credentials of the applicant are found to be satisfactory, the Bureau will recommend that authorization be issued to the applicant to appear before a board of medical examiners and a naval examining board for physical and professional examinations. An effort will be made to select a place for the examination as near as possible to the candidate's place of residence.

7-11. Physical Examination

(1) A thorough physical examination shall precede the professional examination, and the candidate shall be required to certify that he has informed the board of medical examiners of all physical or mental ailments which he has suffered and
that at the time of the examination, to the best of his knowledge and belief, he is free from any bodily or mental ailment.

(2) If a candidate is found to be physically unqualified, he shall not be examined otherwise.

7-12. Professional Examination for Admission

The general professional examination shall be designed to determine the applicant's academic knowledge and what he may reasonably be expected to know of the basic sciences for the professional pursuit of his own field. The word "specialty" as used below denotes any one of the various fields for which the candidate seeks to qualify.

(1) Candidates From the Hospital Corps for Appointment as Ensign in Administration and Supply.—A written professional examination shall be given, which shall include Medical Department administration, including that of naval hospitals; finance and property; personnel administration, military and civilian; commissary management; Navy Regulations; bureau manuals and publications; general naval procedures; and customs and usages of the Medical Department and the Navy.

(2) Candidates for Appointment as Ensign in Pharmacy.—Candidates holding a baccalaureate degree in pharmacy shall be examined in general inorganic, organic, and pharmaceutical chemistry; materia medica and toxicology; principles of pharmacy; incompatibilities; dispensing; and history and literature of pharmacy and pharmacognosy.

(3) Candidates for Appointment as Ensign in Optometry.—Candidates holding a baccalaureate degree in optometry shall be examined in the subjects of anatomy, ocular pathology, theoretical optometry, theoretical and practical optics, visual fields, physiology, orthoptic treatment and procedures. The practical and oral examination shall include examination of the eyes and their appendages, orthoptic procedure, plotting of visual fields, and prescription writing.

(4) Candidates for Appointment as Ensign in Medical Allied Sciences.—Candidates holding a baccalaureate degree in a science allied to medicine shall be examined in mathematics, chemistry, physics, biology, and general and advanced specialty, including experimental design in specialty.

(5) Candidates Holding a Doctorate Degree, for Appointment as Lieutenant (jg).—These candidates for appointment in pharmacy, optometry, or medical allied sciences, shall be examined in the same subjects as candidates for ensign as outlined in subarticles (2), (3), and (4), but candidates holding a doctorate degree will be expected to show greater practical knowledge and ability. In addition, they shall be examined in the following: biometrics, physiology, hygiene, and such other subjects as are pertinent to their educational and professional training for the degree held in a special field of science.

7-13. Withdrawal From Examination

(1) With the consent of the naval examining board, a candidate may withdraw at any time from further examination upon written request to the board and may at a future time present himself for reexamination.

7-14. No Allowance for Expenses

(1) No allowance shall be made for expenses of persons undergoing examination for appointment from civil life in the Medical Service Corps.

7-15. Failure in Professional Examination

(1) A candidate falling in the professional examination may apply for reexamination, but such reexamination will not be granted until after a period of 6 months has elapsed since the last examination.

7-16. Acceptance and Oath of Office

(1) Every person, on receiving an appointment from the Navy Department to an office in the Medical Service Corps, shall immediately forward a letter of acceptance, together with the oath of office duly signed and certified.

7-17. Postgraduate Courses

(1) Appointees in the Medical Service Corps, insofar as practicable, will be given a course of instruction and indoctrination prior to their assignment to general duty. They may, in order to advance themselves in their chosen field, request a postgraduate course in such subjects or fields as may serve this end.

7-18. Naval Reserve Officers

(1) Regulations relating to the appointment of officers in the Medical Service Corps of the Naval Reserve are contained in the Bureau of Naval Personnel Manual.

(2) The requirements for appointment in the Medical Service Corps of the Naval Reserve shall be the same as those for the regular service. All applications shall be forwarded to the Chief of the Bureau of Medicine and Surgery, who shall review their professional qualifications and attainments, and make appropriate recommendations to the Chief of Naval Personnel. It must be recognized that in order to maintain professional proficiency in a scientific specialty, the officer must be actively employed in scientific research. Any Reserve officer who, after accepting a Reserve commission ceases active participation in the field of science or profession under which he originally qualified, is subject to discharge from the Naval Reserve.
Section III. ADVANCEMENT IN GRADE

7-19. Eligibility
(1) Officers of the Medical Service Corps above the grade of ensign become eligible for consideration by selection boards for advancement in grade as set forth in the provisions of the Officer Personnel Act of 1947 (34 U.S.C. 306b), and are promoted in accordance with the recommendations of such selection boards.

7-20. Examinations Required
(1) Before being advanced in grade, officers of the Medical Service Corps are required to establish their professional specialties or sciences allied to medicine or dentistry for which the individuals are qualified, to the satisfaction of the Secretary of the Navy.

7-21. Professional Examinations for Advancement
(1) When professional examinations for advancement in grade are prescribed by the Secretary of the Navy, the nature and scope of such examinations will be in accordance with current directives.

Section IV. DUTIES

7-27. General Duties
(1) The primary duties of officers of the Medical Service Corps are in correlation with Medical Department administration and logistics and the professional specialties or sciences allied to medicine or dentistry for which the individuals are qualified.

7-28. Specific Duties

7-29. Articles on Professional Subjects

7-30. Postgraduate Training

because of the unavailability of such an officer, they shall carry out the functions of the Medical Department insofar as they are qualified to do so. They shall prepare themselves for these emergency duties by acquiring such information regarding the principles, practices, and techniques for the care of the sick and injured and in administrative procedures as will increase their abilities generally in this respect. They shall not be required to undertake or assume the professional duties or responsibilities of an officer of the Medical Corps or of the Dental Corps.

(5) When detailed to duty in activities engaged in the field of preventive medicine, they shall assist in discharging the functions of such activities as outlined in chapter 22, insofar as their training and experience permits.

(6) When detailed to duty in the medical supply system, they shall serve in their professional specialty; and their duties shall include:
(a) Supervision of purchase, procurement, and contracts; and preparation and standardization of general specifications.
(b) Inspection, testing, assaying, receipt, storage, distribution, and shipment of medical, dental, optical, and scientific materials.
(c) Transportation control.
(d) Stock control.
(e) Estimating and forecasting material requirements.
(f) Preparation of supply catalogs of medical, dental, optical, and scientific materials.
(g) Assembling of medical, dental, optical, and scientific outfits.
(h) Accounting for materials.
(i) Control of personnel.
(j) Coordination of work cost accounting procedures.
(k) Contingent duties which may arise.

(7) When detailed to duty in charge of medical supply storehouses or other analogous units of the medical supply system, or optical units, or field laboratories, they shall be responsible for the proper and expeditious support of the medical and dental material logistics or other requirements of activities and forces at sea or in the field.

(8) They shall familiarize themselves with Medical Department property and accountability and with budgetary responsibilities and financial accountability for Medical Department funds. They shall assume responsibility for all equipment and stores placed in their charge, including alcohol, narcotics, and poisons, exercising personal supervision over their condition, safekeeping, and economical expenditure. (Reference should be made to the section in chapter 3 concerning “Duties With Regard to Drugs, Narcotics, and Alcohol,” the provisions of which shall also apply to officers of the Medical Service Corps.) When attached to a unit or an activity going into or out of commission, they shall personally supervise the checking and testing of all equipment in their particular department. They shall furnish the appropriate authority over them with detailed lists of equipment and supplies required for the operation of the services rendered by any activity under their immediate supervision.

(9) They shall use every opportunity to train their subordinates, and shall conduct classes and instruct enlisted personnel in their duties and supervise their study of regulatory and professional publications and courses for advancement in rating, in conformity with the educational program of the ship, station, or activity.

7–28. Specific Duties

(1) Officers assigned to duty in connection with administration functions shall, subject to the direction of the commanding officer, or other superior authority:

(a) Plan, supervise, participate in, and coordinate the general administration functions of any activity under the management and/or technical control of the Bureau.

(b) Advise and make recommendations as to policies, standards, practices, and requirements with regard to administration matters.

(c) Assist in determining the administrative and personnel needs for the proper accomplishment of the mission of any activity of the Medical Department.

(d) Assure that correspondence, records, reports, and other official papers conform to the prescribed system; that filing systems of such papers are efficient and properly installed and protected.

(e) Maintain an adequate library of official publications, directives, orders and similar material for ready reference.

(2) Officers assigned to duty in connection with pharmacy functions shall, subject to the direction of the commanding officer or other superior authority:

(a) Plan, supervise, and participate in pharmaceutical activities and have charge of the pharmacy in any activity of the Medical Department.

(b) Advise and make recommendations as to policies, standards, practices, and requirements with regard to pharmaceutical matters.

(c) Assist in determining and accomplishing the pharmaceutical needs of medical, dental, and nursing personnel for the discharge of their duties.

(d) Keep the officers of the Medical Corps and of the Dental Corps fully informed concerning medicinal and biological substances useful in the treatment of disease.

(e) When indicated, determine quality, purity, and strength of pharmaceuticals in accordance with specifications in the United States Pharmacopeia, National Formulary, and other compendia.

(f) Prepare reports and recommendations based upon research, and investigations bearing upon the economical and efficient use of drugs and pharmaceutical supplies.

(g) Maintain an adequate pharmaceutical reference library.

(h) Have immediate supervision of the professional services rendered by the pharmacy, and be responsible for the observance of the following precautions:

(1) That prescriptions and orders upon the pharmacy are in proper form, and correct as to requirements, dosage and other details.

(2) That all compounding is properly carried out.

(3) That no unauthorized issues are made.

(4) That only properly qualified and authorized pharmacy technicians are permitted to compound prescriptions or fill orders.

(5) That adequate stocks of medicinal substances, stock solutions, and other supplies are maintained.

(6) That other functions usually performed by the pharmacy are properly carried out.

(i) Keep themselves informed at all times of the type and the specific items of pharmaceutical, chemical, and biological supplies on hand under their charge; and keep a current, accurate record of such supplies including alcohol, narcotics and poisons, as used, and of issues from the pharmacy or pharmacy storeroom, together with issue rates for stated periods, and account for such stores remaining.

(j) Keep all alcohol and alcoholic solutions, narcotics, and poisons in their charge under lock and key and in a safe place, retaining the keys in...
their own possession or that of their designated assistant. A copy of the combination of a safe, if used, shall be sealed in an envelope and deposited with the officer designated by the commanding officer.

(3) Officers assigned to duty in connection with optometry functions shall:
   (a) Perform duty under the direction of the medical officer.
   (b) Conduct external examination of the eyes and their appendages.
   (c) Determine visual acuity, oculomotor, or oculorefractive errors or defects, and prescribe and fit appropriate lenses thereafter.
   (d) Render such other attention or treatment as may be delegated to them.
   (e) Keep the medical officer fully informed as to the condition of patients attended by them.
   (f) Bring to the attention of the medical officer all patients in whom they may discover or suspect pathological or abnormal conditions or who may require medical or surgical treatment.
   (g) Make appropriate entries, relative to optometric examinations and treatments, in the clinical and health records of patients, signing their name and rank to such entries.
   (h) Sign their own prescriptions for corrective lenses and orthoptic training.
   (i) Have immediate supervision of the professional services rendered by an optical unit if there be one.

(4) Officers assigned to duty in functions in sciences allied to medicine or dentistry shall:
   (a) Originate, initiate, plan, develop, coordinate, perform, or supervise, in the particular field or fields in which they are especially qualified, the following: research, scientific investigations and examinations; practical testing and control measures; and conduct administrative tasks pertaining to these functions.
   (b) Evaluate the details of proposals, ideas, devices and research findings on subjects related to the health of the Navy and make recommendations concerning them.
   (c) Advise and make recommendations as to the professional needs, policies, standards, practices, procedures, investigations, or research in all matters that relate to the sciences allied to medicine and dentistry.
   (d) When so designated, act as liaison in all matters pertaining to their specialty in a science allied to medicine or dentistry with civilian and other agencies to promote cooperative effort.
   (e) Advise and recommend appropriate policies, standards, practices, and procedures with regard to measures in the field of preventive medicine, and assist in solving problems in the field.
   (f) Have immediate supervision of the professional services rendered by a field laboratory or similar scientific unit, if there be one.

7–29. Articles on Professional Subjects
(1) Officers of the Medical Service Corps shall be guided in the preparation and publication of articles on professional subjects by Navy Regulations and General Orders.

7–30. Postgraduate Training
(1) All officers of the Medical Service Corps shall avail themselves of opportunities to enhance their professional abilities and to enlarge their usefulness to the Navy. They shall keep themselves informed in all phases of, and advances in, their specialty and its relation to the needs of the Navy. They shall attend professional meetings of learned societies whenever practicable, and shall take advantage of seminars, clinics, study courses, or similar means of acquiring additional knowledge.
(2) That all compounding is properly carried out.
(3) That no unauthorized issues are made.
(4) That only properly qualified and authorized pharmacy technicians are permitted to compound prescriptions or fill orders.
(5) That adequate stocks of medicinal substances, stock solutions, and other supplies are maintained.
(6) That other functions usually performed by the pharmacy are properly carried out.

(1) Keep themselves informed at all times of the type and the specific items of pharmaceutical, chemical, and biological supplies on hand under their charge; and keep a current, accurate record of such supplies including alcohol, narcotics and poisons, as used, and of issues from the pharmacy or pharmacy storeroom, together with issue rates for stated periods, and account for such stores remaining.

(2) Keep all alcohol and alcoholic solutions, narcotics, and poisons in their charge under lock and key and in a safe place, retaining the keys in their own possession or that of their designated assistant. A copy of the combination of a safe, if used, shall be sealed in an envelope and deposited with the officer designated by the commanding officer.

(3) Officers assigned to duty in connection with optometry functions shall:
(a) Perform duty under the direction of the medical officer.
(b) Conduct external examination of the eyes and their appendages.
(c) Determine visual acuity, oculomotor, or oculorefractive errors or defects, and prescribe and fit appropriate lenses therefor.
(d) Render such other attention or treatment as may be delegated to them.
(e) Keep the medical officer fully informed as to the condition of patients attended by them.
(f) Bring to the attention of the medical officer all patients in whom they may discover or suspect pathological or abnormal conditions or who may require medical or surgical treatment.

(4) Officers assigned to duty in functions in sciences allied to medicine or dentistry shall:
(a) Originate, initiate, plan, develop, coordinate, perform, or supervise, in the particular field or fields in which they are especially qualified, the following: research, scientific investigations and examinations; practical testing and control measures; and conduct administrative tasks pertaining to these functions.
(b) Evaluate the details of proposals, ideas, devices and research findings on subjects related to the health of the Navy and make recommendations concerning them.
(c) Advise and make recommendations as to the professional needs, policies, standards, practices, procedures, investigations or research in all matters that relate to the sciences allied to medicine and dentistry.

(d) When so designated, act as liaison in all matters pertaining to their specialty in a science allied to medicine or dentistry with civilian and other agencies to promote cooperative effort.
(e) Advise and recommend appropriate policies, standards, practices, and procedures with regard to measures in the field of preventive medicine, and assist in solving problems in the field.

(f) Have immediate supervision of the professional services rendered by an optical unit if there be one.

7-29. Articles on Professional Subjects
Officers of the Medical Service Corps shall be guided in the preparation and publication of articles on professional subjects by Navy Regulations and General Orders.

7-30. Postgraduate Training
All officers of the Medical Service Corps shall avail themselves of opportunities to enhance their professional abilities and to enlarge their usefulness to the Navy. They shall keep themselves informed in all phases of, and advances in their specialty and its relation to the needs of the Navy. They shall attend professional meetings of learned societies whenever practicable, and shall take advantage of seminars, clinics, study courses or similar means of acquiring additional knowledge.
Chapter 8
THE NURSE CORPS

Sections

I. Organization......................................................... 8-1 through 8-5
II. Appointment and Training........................................ 8-6 through 8-7
III. Promotion....................................................... 8-8 through 8-9
IV. Duties............................................................ 8-10 through 8-14

Section I. ORGANIZATION

Establishment...................................................... 8-1
Authorized Strength............................................... 8-2
Grade.................................................................. 8-3
Director of the Nurse Corps...................................... 8-4
Authority.............................................................. 8-5

8-1. Establishment
(1) The Nurse Corps (Female), the fore-runner of the present-day Nurse Corps, was created by the Act of May 13, 1908 (35 Stat. 127, 146). The present Nurse Corps, a component of the Medical Department, was established as a Staff Corps of the Navy by the Act of April 16, 1947 (as revised and reenacted 10 USC 6027). Provisions for the service of officers of the Naval Reserve with the Nurse Corps were contained in the Naval Reserve Act of 1938 (52 Stat. 1175). The present-day Nurse Corps Reserve is authorized by the Reserve Officer Personnel Act of 1954 (50 USC 1181, 1305).

8-2. Authorized Strength
(1) The total authorized number of Regular officers of the Nurse Corps shall be ⁷⁄₉ of 1 percent of the sum of: (a) the authorized commissioned-officer strengths of the active lists of the Regular Navy and of the Regular Marine Corps; (b) the authorized strength of the enlisted personnel of the Regular Navy and the Regular Marine Corps, exclusive of retired personnel and personnel on furlough without pay; (c) the authorized strength of the Brigade of Midshipmen at the Naval Academy; (d) the actual number of permanent chief warrant officers and warrant officers in the Regular Navy and the Regular Marine Corps, excluding retired chief warrant officers and retired warrant officers; and (e) the actual number of midshipmen in the Regular Navy on active duty for flight training (10 USC 5404).

8-3. Grade
(1) The Nurse Corps shall consist of officers commissioned in the grade of ensign, lieutenant (junior grade), lieutenant, lieutenant commander, commander, and captain.

8-4. Director of the Nurse Corps
(1) There is a Director of the Nurse Corps appointed by the Secretary of the Navy, upon the recommendation of the Surgeon General, from among the officers on the active list of the Navy in the Nurse Corps holding permanent appointments of lieutenant commander and above. The director shall be appointed for a term of not more than 4 years, to serve at the pleasure of the Secretary. While so serving she has the rank of Captain in the Navy and is entitled to the pay and allowances of an officer serving in that rank. Her permanent status as a commissioned officer in the Nurse Corps is not disturbed by her appointment as director. (10 USC 5140.)

8-5. Authority
(1) Officers in the Nurse Corps have authority in medical and sanitary matters and other work within the line of their professional duties in activities of the Medical Department. They may exercise such military authority, other than command, as the Secretary of the Navy prescribes. (10 USC 8050.) They may not exercise command (10 USC 5945).
8–6  MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY

Section II. APPOINTMENT AND TRAINING

8–6. General

(1) The general and specific requirements for appointment in the Nurse Corps are outlined in the Bureau of Naval Personnel Manual and instructions to the naval service and to offices of naval officer procurement. Candidates shall submit their applications through the nearest office of naval officer procurement.

(2) The Secretary of the Navy, under regulations prescribed by the President, may terminate the appointment of any Regular officer in the Nurse Corps (10 USC 6393).

8–7. Training

(1) Indoctrination.—An indoctrination course shall be given all newly appointed officers of the Nurse Corps. This course shall last 5 to 6 weeks or longer as the Chief of the Bureau may direct to insure (a) familiarity with the organization of the Navy and the Medical Department, (b) understanding and appreciation of Navy regulations, customs, and usages, and (c) orientation to military nursing and other subjects relative to military service. Newly commissioned Nurse Corps officers shall be rotated to as many duties in nursing service as practicable to obtain maximum understanding of their duties and responsibilities as well as a knowledge of the organization and administration of Medical Department activities.

(2) Professional Practice.—Officers of the Nurse Corps shall make every effort to establish and maintain the highest standards of ethical and professional practice, to keep themselves informed of progress in all spheres of nursing, and to advance their professional knowledge. To this end, they shall attend professional meetings of civilian nursing associations when practicable. They may request participation in short-term courses which comprise workshops, institutes, and seminars given at civilian institutions as well as those given by professional associations. Nurses are encouraged to participate in these courses whenever feasible in order to enhance their professional background. Requests for such training shall be submitted to the Chief of the Bureau.

(3) Educational Opportunities.—

(a) Full-Time Instruction.—Full-time instruction in civilian educational institutions is planned for nurses in the Navy who have shown excellent potentialities for further professional development, particular qualities of leadership and adaptability to naval service, and evidence of intention to make the Navy a career. Fields of specialization include nursing service administration, supervision, teaching, and the clinical specialties of medicine, surgery, psychiatry, obstetrics, pediatrics, operating room management, course in anesthesia, and the inscription blood bank and flight nursing courses. The university or school to which nurses are assigned for instruction is designated by the Bureau on the basis of the program content which will best prepare them in their special fields to carry out future assignments in the Navy. In general, the number that may be selected for such courses is limited by availability of funds, the need for persons qualified in the specialties, and other pertinent factors. Nurses are advised to apply for a program of instruction in an area in which they have had some clinical experience and interest, requesting specifically the field of nursing they prefer. All applications for training shall be directed to the Chief of the Bureau.

(b) Form of Request.—To obtain uniformity in requests and supporting data, the following form shall be used in applying for full-time courses of instruction:

From: (Grade, name, file number, NC, U.S. Navy)
To: Chief, Bureau of Medicine and Surgery
Via: Commanding Officer
Subj: Course of instruction in (--------------------);
       request for
       Encl: (1) Two passport-type photographs

1. I request assignment to a full-time course of instruction in (list area of specialization).
2. My experience and educational qualifications include (incorporate the names of schools and universities where part-time work was taken on own).
3. If this request is granted, I hereby agree not to resign during the course of instruction, and to serve in the U.S. Navy for a period of (--------) after completion of this course.

Section III. PROMOTION

Eligibility for promotion

Qualification for Promotion

8–2

Change 6
8–8. Eligibility for Promotion

(1) Officers of the Nurse Corps above the grade of ensign are assigned running mates in the Line of the Navy and become eligible for selection when their running mates become eligible.

8–9. Qualification for Promotion

(1) Prior to promotion, officers of the Nurse Corps are required by law to pass physical, mental, moral, and professional examinations prescribed by the Secretary of the Navy.

(2) The general qualifications for promotion include:

(a) To Lieutenant (Junior Grade)—Skill and interest in bedside nursing and all phases of patient care; interest and competence in ward management; ability and interest in ward conferences and on-the-job training for enlisted Hospital Corps personnel; evidence of leadership potential. Evidence of continued interest in professional progress through completion of correspondence courses, workshops, and short courses in military and professional subjects. Good personal and military characteristics, emotional stability, and the capacity to work well with others.

(b) To Lieutenant—Skill and interest in all phases of patient care; interest and competence in ward management with evidence of potential for assuming more responsibility; a developing leadership potential; demonstrated ability to direct a ward teaching program for younger nurses or for enlisted Hospital Corps personnel; demonstrated competence in specialty if specially qualified. Evidence of interest in continued professional progress through completion of correspondence courses, workshops, institutes, part-time study, and courses in military and professional subjects, including subjects related to the specialty if designated as a specialist. Good personal and military characteristics with evidence of good emotional adjustment and maturity.

(c) To Lieutenant Commander—Skill and interest in all phases of patient care; demonstrated interest and competence in performance of duties on a supervisory and administrative level; ability to counsel and guide junior personnel; ability to promote good working relationships; good adjustment to varied assignments and duty stations; ability to participate in the formulation of an inservice or other teaching program and to guide such a program; demonstrated leadership capacity; competence in personnel administration. Evidence of continued interest in professional growth through advanced study in military and professional subjects; formal preparation and duty rotation for on-the-job experience to assure knowledge of and competence in personnel administration, hospital staffing patterns, evaluation of personnel performance, planning and maintaining programs for inservice education, and nursing administrative techniques. Outstanding personal and military characteristics; emotional maturity and integrity.

(d) To Commander—Skill and interest in all phases of patient care; demonstrated skill and ability in nursing supervision and administration; proficiency in counseling, guidance, and conference techniques; active and progressive participation in administrative and professional planning in both the military situation and in the nursing profession as a whole. Demonstrated high quality of leadership competence. Formal and on-the-job training and experience for top-level professional nursing administrative and military assignments. Continued professional growth through advanced study in professional and military subjects. Outstanding personal and military characteristics; emotional maturity and integrity.

(e) To Captain—Commanders selected for advancement shall be examined on their records only.

Section IV. DUTIES

General Duties

Chief of Nursing Service

Supervisor

Charge Nurse

Specific Duties

8–10. General Duties

(1) The general duties and responsibilities of officers of the Nurse Corps are those prescribed by Navy Regulations, this Manual, and the Chief of the Bureau.

(2) The mission of the Nurse Corps is to provide nursing service in the prevention and treatment of illness, and the restoration to normal activity, of sick and injured whose treatment is authorized by law and regulations; and to provide instructions in nursing to enlisted members of the Hospital Corps and other personnel assigned to enable them to perform their duties in the care of the sick and injured.

(3) Normally officers who are to perform supervisory and/or administrative duties in a Medical Department activity shall be selected from grades of lieutenant commander and above. All other Nurse Corps officers shall be engaged in general nursing activities such as bedside nursing, staff and patient teaching, ward management and/or supervision, and administration in naval hospitals and elsewhere.

Change 7
in the naval service, commensurate with their capacities and the grade in which they are serving. However, nurses of all ranks when necessary shall be available for nursing duties as prescribed by the commanding officer.

8–11. Chief of Nursing Service

(1) The senior officer of the Nurse Corps assigned to an activity and detailed as chief of nursing service shall:

(a) Be responsible to the commanding officer of a naval hospital or to the medical officer of a naval station, ship, or other activity for the proper performance of all administrative duties in connection with general supervision of the nursing service; keep informed of all policies of the commanding or medical officer in relation thereto; and supervise the execution of policies and regulations affecting the nursing service.

(b) Inform the executive officer of a naval hospital or the medical officer of a naval station, ship, or other activity of all conditions and circumstances which may affect the nursing service; and normally accompany the commanding or executive officer on routine inspections and on such other inspections as he may direct.

(c) Make recommendations to the executive officer of a naval hospital or the medical officer of a naval station, ship, or other activity regarding the maintenance and suitability of quarters, messing facilities, provision of recreational time and facilities, and other matters which contribute to the health, contentment, and general welfare and morale of officers of the Nurse Corps.

(d) Assess the nursing needs and plan the staffing pattern for nursing service. Prepare schedules of duty assignments and watch lists, exercising special care to insure adequate coverage for the 24 hour period and an equitable distribution of duty assignments and of rotation for career development.

(e) Attend and participate in the chiefs of services conference and other staff conferences and encourage and provide for the attendance of any other member of the Nurse Corps who may desire to attend the staff conferences; and arrange timely conferences for the Nurse Corps staff for the discussion of problems, current procedures, policies, directives, and any other conditions or circumstances which pertain to the nursing service or to the morale of the nursing staff.

(f) Strive, by precept, and example, to maintain high standards in the nursing service; and, by indoctrination, training, counseling, guidance, and placement, encourage and develop professional competence, leadership, morale, and good discipline.

(g) Take the necessary steps to insure that Nurse Corps officers understand the proper operation, care, preservation, and maintenance of equipment, supplies, and other materials assigned to wards and space devoted to care of the sick and to which Nurse Corps officers normally are assigned.

(h) Provide for nursing personnel an active inservice educational program and other opportunities for professional growth; make available information regarding advanced study opportunities, using guidance and counseling techniques to encourage enrollment in educational opportunities the community may present to further professional development; and encourage Nurse Corps officers to participate in short courses, workshops, and institutes in professional and military subjects.

(i) Provide for instruction in nursing for enlisted members of the Hospital Corps and other personnel assigned, conducting, if so directed, examinations in this subject, the results of which shall be reported to proper authority.

(2) When the senior officer of the Nurse Corps is absent, the Nurse Corps officer next in rank and otherwise eligible shall perform the duties of chief of nursing service.

8–12. Supervisor

(1) An officer of the Nurse Corps assigned as supervisor in a medical activity shall:

(a) Maintain general supervision of nursing and specialized care given to patients, of special services by nursing service personnel, and of all nursing activities.

(b) Analyze the kind and amount of nursing service required in the units, and plan for effective administration of each unit.

(c) Plan with the medical staff for the care of patients.

(d) Insure by personal attendance and frequent inspection that orders relative to patient care and treatment prescribed by medical and/or dental officers are properly performed.

(e) Be acquainted with, and interpret to the nursing staff, administrative policies, regulations, orders, and directives.

(f) Assist in the study of methods of patient care and service for the purpose of promoting continuous improvement, and in research in nursing and allied fields.

(g) Plan for and participate in the teaching of professional and nonprofessional nursing personnel in a program for their orientation, inservice education, and on-the-job training.

(h) Evaluate and record the quality of service given by the individual members of the nursing staff in the unit.

(i) Provide for the health teaching of patients, and participate in it as indicated.

(j) Coordinate the service rendered by other professional personnel with those of the nursing
personnel within the units in the interest of adequate patient care.

(k) Keep the nursing service administration informed of the needs of the nursing unit and of any special problems.

(l) Secure supplies and equipment, oversee their use and care, and assist in budget preparation as indicated.

(m) Help to provide a comfortable, orderly, clean, and safe environment for patients and staff.

(n) Assist in the maintenance of good discipline of staff and patients, reporting any circumstances interfering with the proper performance of duty as related to medical, nursing, and other factors of patient care and to administration.

8-13. Charge Nurse

(1) An officer of the Nurse Corps assigned to duty as charge nurse of a ward shall:

(a) Insure that the highest standard of nursing practice and patient care is given by personnel assigned to nursing duties; diligently carry out, or see that they are carried out, all written orders of the medical and/or dental officers relating to the care of patients; and be acquainted with all such orders and other conditions pertaining to prescribed routine for efficient performance of duties.

(b) Promptly inform the medical officer in charge, or in his absence, the medical officer of the day, of circumstances pertaining to the watch as necessary for the proper performance of duty.

(c) Carry out administrative orders of the ward; where junior Nurse Corps officers are assigned, instruct them in naval procedure and administration, and delegate specific duties; organize, detail to specific duties, and instruct enlisted members of the Hospital Corps, and other personnel assigned, in the performance of their duties attendant upon nursing care, and other duties relative to satisfactory environment of the ward, and insure the proper performance of such duties.

(d) Keep all narcotics, potent poisons, and alcoholic liquors on the ward under lock and key when not in use. The narcotic book shall contain a record of all receipts and issues, including the name of the patient, dosage, time, date, medical officer's name, and by whom issued. Instructions concerning the care, custody, and use of poison containers shall be enforced.

(e) Be responsible for keys assigned for the safeguarding of narcotics and other medicines as prescribed by the commanding officer of a naval hospital or the medical officer of a naval station, ship, or other activity; and, when properly relieved, turn the keys over to the relieving officer.

(f) Comply with orders and instructions of the medical activity, Navy Regulations, and manuals regarding:

(1) Maintenance and inventory of equipment and material.

(2) Control of issuance of supplies.

(3) Economy in the use of supplies and utility services.

(4) Safeguarding of valuables and personal effects of patients.

(5) Safety precautions and security measures.

(g) Maintain ward records and reports, inventory records, and such other records, reports, and forms as prescribed, in accordance with this Manual and current instructions.

8-14. Specific Duties

(1) Officers of the Nurse Corps normally shall not be required to perform night duty for a period exceeding 1 month, and ordinarily shall not be called upon to stand night duty more frequently than 1 month out of 3. In tropical stations and aboard ships the period of night duty shall be of shorter duration. Except in an emergency an interval of 24 hours shall be permitted officers before assignment to night duty, and an interval of 48 hours before reassignment when relieved from night duty.
Chapter 9
THE HOSPITAL CORPS

Sections

I. Structure of the Hospital Corps .............................................................................. 9–1 through 9–4
*II. Hospital Corpsmen, Group X Medical ................................................................. 9–5 through 9–13

Section I. STRUCTURE OF THE HOSPITAL CORPS

Establishment .................................................................................................................. 9–1
Strength ............................................................................................................................ 9–2
Rating Structure ............................................................................................................. 9–3
Navy Enlisted Classification Structure ......................................................................... 9–4

9–1. Establishment
(1) The Hospital Corps as it is now known was established within the Medical Department of the Navy by the act of 17 June 1898 (ch. 463, sec. 1, 30 Stat. 474).

9–2. Strength
(1) The strength of the Hospital Corps is determined by the Chief of Naval Personnel, within personnel allocations authorized by the Chief of Naval Operations. It is limited to an equitable share of the appropriated strength of the Navy and Marine Corps as a whole as authorized by Congress.
(2) Female, WAVE, personnel constitute approximately 5 percent of the total strength of the Hospital Corps.
(3) Hospital corpsmen constitute 89 percent of the Hospital Corps strength, and dental technicians 11 percent.

9–3. Rating Structure
(1) Personnel and personnel requirements are identified by occupational rating groups and by rates which distinguish the degrees of skill within the group. Pursuant to the Army-Navy Medical Services Corps Act of 1947, the Secretary of the Navy established two rating groups within the Hospital Corps of the Navy: Group X Medical and Group XI Dental.
(2) Group X Medical constitutes the general service hospital corpsman rating groups, including the allied medical apprentice rates. The hospital corpsman and allied apprentice rates are as follows:

<table>
<thead>
<tr>
<th>Rate</th>
<th>Rate abbreviation</th>
<th>Pay grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital recruit</td>
<td>HR</td>
<td>E-1</td>
</tr>
<tr>
<td>Hospital apprentice</td>
<td>HA</td>
<td>E-2</td>
</tr>
<tr>
<td>Hospitalman</td>
<td>HN</td>
<td>E-3</td>
</tr>
<tr>
<td>Hospital corpsman, third class</td>
<td>HM3</td>
<td>E-4</td>
</tr>
<tr>
<td>Hospital corpsman, second class</td>
<td>HM2</td>
<td>E-5</td>
</tr>
<tr>
<td>Hospital corpsman, first class</td>
<td>HM1</td>
<td>E-6</td>
</tr>
<tr>
<td>Chief hospital corpsman</td>
<td>HMC</td>
<td>E-7</td>
</tr>
<tr>
<td>Senior chief hospital corpsman</td>
<td>HMCM</td>
<td>E-8</td>
</tr>
<tr>
<td>Master chief hospital corpsman</td>
<td>HMCM</td>
<td>E-9</td>
</tr>
</tbody>
</table>
(3) Group XI Dental constitutes the general service dental technicians rating group, including the allied dental apprentice rates. The dental technicians and allied apprentice rates are as follows:

<table>
<thead>
<tr>
<th>Rate</th>
<th>Rate abbreviation</th>
<th>Pay grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental recruit</td>
<td>DR</td>
<td>E-1</td>
</tr>
<tr>
<td>Dental apprentice</td>
<td>DA</td>
<td>E-2</td>
</tr>
<tr>
<td>Dentalman</td>
<td>DN</td>
<td>E-3</td>
</tr>
<tr>
<td>Dental technician, third class</td>
<td>DT3</td>
<td>E-4</td>
</tr>
<tr>
<td>Dental technician, second class</td>
<td>DT2</td>
<td>E-5</td>
</tr>
<tr>
<td>Dental technician, first class</td>
<td>DT1</td>
<td>E-6</td>
</tr>
<tr>
<td>Chief dental technician</td>
<td>DTC</td>
<td>E-7</td>
</tr>
<tr>
<td>Senior chief dental technician</td>
<td>DTCS</td>
<td>E-8</td>
</tr>
<tr>
<td>Master chief dental technician</td>
<td>DTCM</td>
<td>E-9</td>
</tr>
</tbody>
</table>

*See chapter 6 (section VIII) for Dental Technicians, Group XI Dental.

Change II
9-4. Navy Enlisted Classification Structure

(1) Navy enlisted classification (NEC) codes identify both personnel and requirements. They are used to supplement rates by identifying special skills not identifiable by rates or rating alone. Hospital corpsman rates are supplemented by NEC's in the HM-8400 series, and dental technician rates by codes in the DT-8700 series. When an NEC has been assigned it becomes an integral part of the rate and shall be so recorded in all personnel records and correspondence.

(2) There is no priority list of NEC's within the HM-8400 and DT-8700 series. An NEC code is primary or secondary solely in relation to the individual to which assigned. An NEC code that is primary for one person may be secondary for another person. Not more than two NEC codes may be assigned to one person.

Section II. HOSPITAL CORPSMEN, GROUP X MEDICAL

9-5. Qualifications

(1) Applicants for the hospital corpsman rating should be volunteers, motivated for duties involving care of the sick and injured, show aptitude for and be temperamentally adapted for such duty, and have General Classification Test scores and educational background necessary to progress in the hospital corpsman rating. Although rigid educational qualifications have not been established, it is desirable that applicants be high school graduates; however, applicants with limited education who are positively motivated and have mental capacity to learn may be accepted. Applicants should be evaluated by a Classification Interviewer, PN-2612, or by an officer of the Medical Department. Applicants showing evidence of unusual immaturity, emotional instability, or low moral character should be rejected regardless of other qualifications.

9-6. Procurement

(1) Candidates for hospital corpsmen are procured from volunteers enlisted directly into the Hospital Corps rating as hospital recruits; volunteers undergoing recruit training selected by Classification Interviewers, PN-2612; volunteer applicants or "strikers"; and volunteers transferring from the United States Marine Corps.

(2) Hospital recruits are high school or junior college graduates who, by agreement at the time of enlistment, are guaranteed training in a class A school.

(3) "Strikers" are enlisted men who have completed recruit training, are serving in apprentice ratings, and request transfer to the Hospital Corps after a period of observation in the medical departments of activities ashore or afloat.

(4) Under regulations prescribed by the Secretary of the Navy, enlisted members of the Marine Corps are eligible for transfer to the Hospital Corps of the Navy, and enlisted members of the Hospital Corps are eligible for transfer to the Marine Corps (10 USC 6014).

9-7. Distribution and Detail

(1) Hospital corpsmen may be assigned to any unit or activity of the Naval Establishment where their services are required. They shall be assigned...
to the medical departments of the ship or station to which attached. Under terms of the Geneva Conventions, hospital corpsmen may not be assigned to tasks of a combat nature. WAVE hospital corpsmen may be assigned to the major distribution commands of the Shore Establishment, to fleet activities shore based in the United States, to overseas in selected locations where suitable quarters are available for women, and to a few billets afloat on dependent-carrying vessels of the Military Sea Transportation Service. Information relative to duty assignments of hospital corpsmen is contained in the Enlisted Transfer Manual, NAVPERS 15909.

(2) Technicians should be assigned to commands having the same NEC requirement written into their enlisted Manpower Authorization.

9–8. Duties of Hospital Corpsmen

(1) The general duties of hospital corpsmen are prescribed by the Surgeon General as set forth in this Manual andBUMED directives. Detailed duties on any specific ship or station are prescribed by the commanding officer, the senior medical officer, or other competent authority. In addition to the military duties common to all enlisted personnel, hospital corpsmen shall perform medical department functions of the ship or station to which attached. These medical department functions embrace the broad fields of preventive medicine; first aid; tentative diagnosis and emergency treatment; diagnosis, nursing care, and definitive treatment; and the administrative procedures relative thereto. These duties are performed under the supervision of Medical Department officers except when serving on independent duty.

(2) Qualified petty officers in the hospital corpsman rating perform all duties of the medical department on small vessels and shore stations to which no medical officer is attached. All chief hospital corpsmen and hospital corpsmen, first class, are considered qualified for independent duty unless evidence to the contrary is at hand in the individual case. When no personnel in these ratings are available, hospital corpsmen, second class, who have completed a course of instruction in advanced Hospital Corps school, or have successfully passed the servicewide examination for hospital corpsman, first class, may be assigned to independent duty. Hospital corpsmen on independent duty are responsible to their commanding officers for the sanitation of the command; the health of personnel; care of the sick and injured; procurement, storage, and custody of medical department property; and preparation of medical reports and Health Records. They perform the administrative duties and, to the extent for which qualified, the professional duties prescribed for medical officers of ships and stations. They shall not attempt or be required to perform medical duties for which they are not professionally qualified. When it is necessary to perform physical examinations, sign original entries in Health Records, and undertake other professional and administrative duties normally performed by medical officers, hospital corpsmen shall perform these duties only when a medical officer is not available.

(3) Specific duty assignments should be rotated to provide diversified training and job experience. However, this rotation should be planned on an individual rather than a routine basis, thus considering the varying degrees of individual adaptability as well as job and training requirements. A careful balance must be maintained between the advantages of increased job efficiency resulting from permanency of personnel and training advantages derived from rotation. Too rapid rotation nullifies both advantages. Ward corpsmen can advantageously be rotated from a.m. to p.m. to night duty on the same ward or nursing service, thereby achieving equitable rotation without sacrificing job continuity.

(4) Hospital corpsmen should not be required to perform night duty periods in excess of 1 month and should not be assigned night duty more often than 1 month out of 3. In tropical climates particularly and elsewhere when feasible, tour of night duty should be of 2 or 3 weeks' duration. Hospital corpsmen should be granted 48 hours' liberty immediately preceding and subsequent to a tour of night duty.

9–9. Duties of the Hospital Corpsman Rates

(1) Hospital Recruit (HR).—Hospital recruits are new enlistees in the Hospital Corps. Upon completion of recruit training their rate is changed to hospital apprentice and they are assigned duty under instruction at a class A Hospital Corps school.

(2) Hospital Apprentice (HA).—After graduation from Hospital Corps school, hospital apprentices shall be assigned duties directly related to patient care at naval hospitals, station hospitals, larger shore activities, or large ships. They should be assigned to wards for duty and on-the-job training in elementary nursing procedures.

(3) Hospitalman (HN).—Hospitalmen should be assigned to wards or other clinical services for duty and on-the-job training in the more advanced nursing procedures, or for duty and on-the-job training in elementary clinic procedures.

(4) Hospital Corpsman, Third Class (HM3).—Hospital corpsmen, third class, are normally assigned to wards, clinical services, or administrative units; for duty as senior ward corpsman; for duty and on-the-job training in the more advanced clinic procedures; or for duty and on-the-job training in elementary administrative procedures.

Change II
9-10. Utilization

(1) Utilization of hospital corpsmen shall be in accordance with the following guide which should be deviated from only to the extent necessary to effect maximum efficiency of the command as a whole:  
(a) The maximum number of hospital corpsmen consistent with the overall needs of the activity shall be assigned to wards and clinical services. WAVE hospital corpsmen shall be utilized in billets involving direct and indirect contact with female patients to the maximum extent feasible.  
(b) The requirement for assigning qualified personnel to patient care is paramount; therefore, all hospital corpsmen performing duties in the nursing service shall be assigned en bloc to the nursing service.  
(c) Ward corpsmen should be assigned to three section watches. Watches should be equitable for all in the same rate with progressively fewer watches with each advancement in rating.  
(d) Within reasonable limits, the average work hours shall be the same for all corpsmen regardless of rate. The average workweek should be no more strenuous than necessary to insure high quality of patient care.  
(e) Trained petty officers should be utilized in patient care functions to the maximum extent feasible.  
(f) Hospital corpsmen should be rotated to various duties within the command to the minimum extent necessary for training purposes in order to achieve maximum efficiency resulting from permanency of personnel.  
(g) Hospital corpsmen who cannot perform effectively under proper supervision on ward duty or other professional services should be recommended for administrative discharge or change in rating as appropriate, rather than reassigning them to nonpatient care functions.  
(h) Hospital corpsmen should not be considered eligible for reassignment from patient care to nonpatient care functions solely because they have completed a given number of months on ward duty.  
(i) Technicians should be utilized in the duties of their specialties to the maximum extent feasible. However, technicians must maintain proficiency in the general duties of their rate and may be so assigned to general duty when that need is greater.

9-11. Training

(1) The Chief of the Bureau of Medicine and Surgery is responsible for the professional training of personnel of the Hospital Corps. To discharge this responsibility, basic and advanced Hospital Corps schools have been established and technical training courses instituted in naval hospitals and other naval medical facilities. Training consists of formal schools and courses, on-the-job training, inservice training, and outservice training. Upon successful completion of a course of instruction appropriate entries shall be made in service records, training certificates issued, and Navy Enlisted Classification codes assigned. Detailed training information is contained in Instructions in the 1500 and 1510 series.

(2) Basic Hospital Corps Schools, Class A.—The mission of the basic Hospital Corps schools, class A, is to instruct and train enlisted personnel in the basic subjects and procedures required to qualify them for duties as general service hospital corpsmen. The curriculum is designed to prepare enlisted personnel to perform the general duties normally required of hospital corpsmen in the first 4 years of their naval service. The curriculum emphasizes direct patient care. This school, together with inservice training, prepares hospital corpsmen for advancement in rating through hospital corpsman, third class. It is mandatory for all personnel upon first entering the Hospital Corps, except that waiver of this requirement may be requested from the Bureau of Medicine and Surgery for individuals considered qualified as a result of civilian training. Certificates of graduation from basic Hospital Corps schools are issued to graduates, but graduates are not assigned an NEC.

(3) Advanced Hospital Corps School, Class B.—The mission of advanced Hospital Corps school, class B, is to give advanced training to petty officers of
the Hospital Corps to prepare them for duty as senior general service hospital corpsmen and for duty independent of a medical officer. The curriculum emphasizes first aid, tentative diagnosis and emergency treatment of disease and injury, personal hygiene and environmental sanitation, and medical department administration. Students are normally enrolled in this school at the time of sea/shore or shore/sea rotation. The maximum possible number of career hospital corpsmen are trained in this school prior to assignment to independent duty. Certificates of graduation from advanced Hospital Corps schools are issued and graduates are assigned the NEC HM-8495.

(4) Technical Training Courses, Class C.—The purpose of technicians courses is to train selected hospital corpsmen at the appropriate time in their naval careers to perform duties as technical assistants in specialized fields including diagnostic procedures, specialized treatment, preventive medicine, submarine medicine, medical research, and medical department administration. Courses are 16 to 60 weeks in duration and are continuously under review to meet changing medical department requirements. Students are selected by the Bureau of Medicine and Surgery on a competitive basis from among qualified volunteers. Normally, hospital corpsmen are not selected for training in more than one technical specialty; however, waivers of this factor may be requested. Normally, candidates for advanced Hospital Corps school, class B, and for Medical Administration Technician training are selected without regard for Navy Enlisted Classifications previously assigned. The course in Medical Field Technician is mandatory at the time of first assignment to duty with the Fleet Marine Force and requests for this training are not desired. Requests for other technician training are desired from hospital corpsmen serving ashore or afloat. To the extent feasible, selected candidates are ordered to duty under instruction as technicians at the time of sea/shore or shore/sea rotation. The Manual of Navy Enlisted Classifications, NAVPERS 15105 (series), lists the broad duties of technicians and code numbers assigned to each. Detailed information relative to submission of applications for training, school and course locations, and convening date and qualifications are contained in Instructions in the 1510 series. Certificates of Special Instructions are issued, and graduates are assigned an appropriate NEC.

(5) Inservice Training.—The purpose of inservice training is to provide a continuing, organized training program at each duty station to supplement the formal training received in Hospital Corps schools. This program is designed to broaden knowledge and skills, to keep hospital corpsmen abreast of the rapid advances in medical procedures, to provide well-trained hospital corpsmen for duty of their rate, and to qualify them for advancement in rating. Instruction shall be continuous and progressive and shall cover subjects outlined in the appropriate training courses for advancement in rating. On-the-job training in the duties of general service hospital corpsmen shall be an integral part of the inservice training program. Instructors shall be officers of the medical department or petty officers instructing under their supervision.

(6) On-the-Job Training of Technicians.—On-the-job training of technicians is necessary to supplement the number graduated from schools and courses in order to meet local and total requirements. Naval hospitals and other naval medical facilities shall conduct on-the-job training of technicians to the extent feasible. When vacant technicians billets cannot be filled, it is incumbent upon the commanding officer to assign general service hospital corpsmen to the vacant billets and to institute on-the-job training to meet the needs of his own command. Technicians so trained shall be reported to the Bureau of Medicine and Surgery. Certificates of On-the-Job Training will be forwarded with the letter authorizing assignment of the appropriate NEC.

(7) Outservice Training.—

(a) The Bureau encourages Medical Department personnel to take advantage of part-time outservice training in accredited civilian institutions and will authorize tuition aid, provided funds are available, for courses directly related to areas of Medical Department responsibility. Such areas are considered to be the physical, chemical, clinical, biological, and sociopsychology sciences and the fields of Medical Department administration.

(b) Consideration will also be given to requests for courses outside those areas if they can be shown to be a necessary part (required credits or prerequisites to desired courses) of a fully planned program leading to a degree or certificate which will enable the applicant to assume increased responsibility or to function more effectively toward accomplishing the mission of the Medical Department.

9-12. Advancement in Rating

(1) To be eligible to compete in examinations for advancement in rating, hospital corpsmen must first fulfill service requirements, complete the prescribed training courses and practical factors, and be recommended by their commanding officer. Detailed information relative to advancement in rating is contained in the Bureau of Naval Personnel Manual, the Manual of Qualifications for Advancement in Rating (NAVPEERS 18068), and BUPERS Instructions in the 1400 series.

(2) Qualifications for advancement in rating include both military and professional requirements. The Manual of Qualifications for Advancement in
Rating lists minimum qualifications. Examinations are prepared with the assumption that all candidates possess minimum qualifications. The purpose of the examination is to determine the candidates best qualified; therefore, examination questions are designed to be quite comprehensive for each rate. Examinations become broader in scope and more thorough with each advancement in rating. The Handbook of the Hospital Corps is the best single reference in preparing for advancement in rating; however, the appropriate Navy training courses are the best guides from which to determine the breadth and depth of knowledge expected of each rating. Training Publications for Advancement in Rating (NAVPERS 10052) lists all reference documents necessary in preparation for the military and professional examinations for advancement in rating.

3 Hospital corpsmen who are technicians take the same military and professional examinations as their contemporaries who are not technicians. For this reason and because technicians may be called upon at any time to perform the general duties of their rate including independent duty, technicians must maintain professional competence in the general duties of hospital corpsmen.

9–13. Path of Advancement to Officer Status

1 The normal path of advancement for hospital corpsmen is to ensign, Medical Service Corps. However, hospital corpsmen may apply for any of the officer candidate training programs or officer procurement programs for which they consider themselves qualified. WAVE hospital corpsmen may apply for training leading to a commission as ensign, Nurse Corps. Instructions relative to qualifications, procedures for submitting requests, and scope of these programs are outlined in chapter 7 of this Manual, in the Bureau of Naval Personnel Manual, and in Instructions in the 1120 series.
Chapter 10
CIVILIAN EMPLOYEES AND POSITIONS

Sections

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Civilian Employees</td>
<td>10-1 through 10-4</td>
</tr>
<tr>
<td>II. Civilian Positions</td>
<td>10-5 through 10-6</td>
</tr>
</tbody>
</table>

Section I. CIVILIAN EMPLOYEES

General

10-1. General

(1) This section contains general instructions pertaining to the administration of civilian personnel programs at activities under the management control of the Bureau. More specific and detailed civilian personnel policies, regulations, and procedures are issued by the U.S. Civil Service Commission, the Office of Industrial Relations (Navy), and the Bureau, in the Federal Personnel Manual, Navy Civilian Personnel Instructions (NcPI's), and Bureau Instructions and Notices.

(2) NcPI 125 sets forth the Navy's basic organization for the administration of the civilian personnel management (industrial relations) program. The Navy policy for personnel administration is that each commanding officer must provide for sound management control, direction, and support of the personnel program to assure consistent, efficient, and equitable personnel management throughout the Navy. The essential elements or functions of a comprehensive personnel program in the Federal Government are (a) policy formulation and issuance, (b) position classification and pay administration, (c) staffing, (d) employee performance evaluation, (e) employee development, (f) employee relations and services, (g) employee recognition and incentives, (h) personnel records and reporting, and (i) program evaluation. These essential elements or functions are described in detail in chapter A4 of the Federal Personnel Manual. The extent of the delegation of authority and responsibility to carry out these functions varies among Federal agencies. The assignment of responsibility for carrying out the activities of the personnel program and delegation of authority in personnel program areas within the Navy are contained in various subject-matter chapters of the Navy Civilian Personnel Instructions and in O&I and Bureau Instructions and Notices.

10-2. Bureau Policy

(1) The Bureau of Medicine and Surgery adheres to the concept that the responsibility for the administration of personnel policies and programs is inherent in command responsibility.

(2) The Bureau considers that the most effective organization for operation of the civilian personnel program can best be achieved by the recognition that each commanding officer must exercise control, direction, and support of the personnel program and that this responsibility can best be accomplished by providing personnel staff services within the command.

(3) It is recognized, however, that size and location may make it economically impracticable for certain activities to maintain a technical staff to provide the full range of personnel services with maximum effectiveness. In such cases, it may be desirable to secure staff assistance by arranging for cross-serving between activities for specified services and in some instances by participation in Consolidated Industrial Relations Offices (OIRO's). The procurement of services through such sources does not relieve the command of its responsibility for control, direction, and support of its personnel policies and programs.

10-3. Organizational Location and Staffing

(1) General.—In conformity with the requirements of NcPI 125 and the Bureau policy stated

Change 9
above, Medical Department activities employing civilian personnel shall make provision for adequate staff services in the civilian personnel program area. This shall normally be accomplished at naval medical centers and naval hospitals, other than those that are components of medical centers, by establishing and adequately staffing a civilian personnel office within the activity. This office shall be headed by a technically qualified civilian employee with the title of Civilian Personnel Officer or Civilian Personnel Assistant, as appropriate to the classification of the position.

(2) Exceptions.—In consideration of size, certain naval hospitals and other medical activities may determine that it is not feasible to establish a position of full-time civilian personnel assistant. Provision should be made for adequate staff services through such means as (a) combining the civilian personnel functions with other appropriate administrative duties with assignment to such position of a person having administrative judgment and technical competence to carry out program responsi-

Section II. CIVILIAN POSITIONS

### 10-5. Funds and Ceilings

(1) Funds for personal services are provided in the annual allotments to each activity for operation and maintenance. Overall civilian ceiling allowances are established by the Bureau which include all employees of the activity paid from appropriated funds. Within the funds and ceilings allotted, the command is authorized to establish individual civilian positions which best suit the needs of the activity, subject to the limitations set forth in article 10-6.

### 10-6. Establishment of Positions

(1) All civilian positions must be established in accordance with applicable laws and regulations.

(2) Positions in grade GS-12 and above shall be submitted for prior approval by the Bureau. Requests for approval shall be accompanied by a job description and shall indicate the grade level proposed and whether the position is a new or modified one. Bureau review will be primarily for conformance with the program assigned to the activity. Final classification action will normally be taken by the classification office servicing the activity, subject to Bureau comment or activity requests for Bureau classification review.

(3) The establishment of civilian positions which are classified to the GS-600-0 group shall be submitted for prior approval by the Bureau. With the exception of nurse and nursing assistant positions, requests for establishment should be accompanied by position descriptions.

(4) The Bureau authorizes the number and use of supervisory ratings in all non–IVb (ungraded) categories. Requests for the establishment of ungraded supervisory positions shall be submitted to the Bureau accompanied by descriptions of duties in the form prescribed for ungraded ratings. Positions of master, foreman, and others which require the prior approval of the Office of Industrial Relations shall be submitted via the Bureau in accordance with current NCrP procedures.

(5) Positions of guard and firefighter shall be approved in advance by the Bureau.

(6) In addition to the foregoing, the Bureau may control the establishment, filling, or classification of particular types of positions through the issuance of specific Instructions and Notices.

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10-3  MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY  10-6

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Change 9
(c) Maintaining copies of current organization charts and functional and occupational data.
(d) Instructing employees and supervisors in the procedures to be followed in preparing position descriptions, and advising employees and supervisors as to the appropriate Special Question Lists and other aids to be used in describing specific positions.
(e) Securing, through instructional meetings and individual contacts, an understanding on the part of supervisors and employees of the principles of position classification.
(f) Maintaining file of current position descriptions.
(g) Serving as liaison agent and point of reference for the Area Wage and Classification Office.

10-8. Wage Board Positions

(1) The procedures outlined in NCPI 250 shall be followed in securing approval of new ratings and in fixing rates of pay for non-IVb positions in the field service.

(2) Under present NCPI provisions, the supervisory mechanical service ratings which may be authorized at naval hospitals are foreman mechanic, naval hospital; assistant foreman mechanic, naval hospital; and heads of one or more trades and occupations as appropriate. Rates of pay for foreman mechanic, naval hospital, are established by the Office of Industrial Relations on a continental-wide basis for positions in the United States and on an area basis for positions outside the continental limits. The rates of pay for assistant foreman mechanics, naval hospital, and heads are fixed in accordance with differentials over appropriate basic rates as prescribed by the Office of Industrial Relations.

(3) Medical Department activities are responsible for the performance of certain functions in wage administration. Activities shall furnish assistance to Area Wage and Classification Offices in the conduct of wage surveys. On request, activities shall designate a representative to serve on wage committees and to organize within the activity a working subcommittee to carry out the activity's share of the survey work. In addition, the following functions shall be carried on in the Civilian Personnel Branch:

(a) Analyzing wage board jobs and preparing descriptions as may be required to establish new ratings or to correct deficiencies in descriptions currently in use.
(b) Making periodic review of wage board positions to determine whether employees are actually performing the duties normally expected of their rating.
(c) Furnishing assistance as required to wage committees and to the activity's subcommittee in gathering wage data and in furnishing descriptions of jobs authorized for use by the activity.
(d) Maintaining liaison with the Area Wage and Classification Office.
(e) Maintaining file of descriptions of jobs currently authorized for use by the activity.
(f) Maintaining file of area schedule of wages.
(g) Securing an understanding on the part of supervisors and employees of the Navy wage setting process.

Section IV. EMPLOYMENT

General.
Recruitment and Placement.
Separations.
Reporting Personnel Actions.

10-9. General

(1) The medical or dental officer in command Is delegated authority under existing regulations for effecting personnel actions involving accessions, changes, and separations. As the appointing officer he is responsible for compliance with certain restrictions and requirements established by law and rules and regulations of the U. S. Civil Service Commission and Navy Department. These restrictions and requirements are set forth in the Navy Civilian Personnel Instructions issued by the Navy Department and in the Federal Personnel Manual issued by the U. S. Civil Service Commission. These restrictions incident to the execution of this responsibility shall be carried out in the Civilian Personnel Branch.

(2) Before an accession or change can be effected, there must be an established position for the employee to occupy. Group IVb positions must be allocated to grades under the provisions of the Classification Act of 1923, as amended (see sections II and III above and NCPI 158). Ratings and rates of pay for positions in groups I, II, III, IVa and Native and Alien Schedules must be authorized in accordance with the provisions of sections II and III above and NCPI 250. In addition the civilian personnel ceiling assignment for the current period and the authorized funds shall not be exceeded.

10-10. Recruitment and Placement

Whenever there is need for filling a civilian position in a Medical Department activity, it is the responsibility of the command to secure personnel in accordance with rules and regulations of the Civil Service Commission. The methods of securing personnel are as follows:
10-10 MANUAL OF THE MEDICAL DEPARTMENT, U. S. NAVY

10-11. Separations

Actions which must be taken in effecting separation of an employee from the rolls of an activity are covered in pertinent chapters of Navy Civilian Personnel Instructions and the Federal Personnel Manual. The types of separation actions which may be requested by the employee are transfer, optional retirement, entry in military or merchant marine service, and resignation. Separation actions which may be initiated by an employee's supervisor, the command, or in some instances required by the Civil Service Commission include: reduction in force; termination of temporary definite or excepted appointment; displacement; abandonment of position; removal; separation for disqualification, inefficiency, disability, legal incompetence, failure to return from military or merchant marine service, or war transfer; retirement for age or disability; and death.

10-12. Reporting Personnel Actions

Instructions for the preparation and processing of notification of personnel action are set forth in NCPI 135 and chapter R1 of the Federal Personnel Manual. Standard terminology prescribed by the Civil Service Commission shall be used in reporting nature of action in all cases.

Section V. TRAINING

<table>
<thead>
<tr>
<th>General</th>
<th>10-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training in Medical Department Activities</td>
<td>10-14</td>
</tr>
<tr>
<td>Scope of Program</td>
<td>10-15</td>
</tr>
</tbody>
</table>

10-13. General

The provisions of the Navy Work Improvement Program as outlined in NCPI 230 apply to all training provided by the Navy for civilian employees of the Navy Department with the exception of that training coming under the cognizance of the Office of Naval Research. The Work Improvement Program is a training plan for the development of naval civilian personnel at all levels of employment.

10-14. Training in Medical Department Activities

In order to comply with the basic requirements for training, the plan outlined below shall apply to Medical Department activities.

(1) Activities employing 300 or more civilians shall conduct the Supervisor Training section of the Navy's Work Improvement Program unless the activity has been exempted from participation in the program by the Department or unless arrangements have been made for joint participation with a neighboring activity. The medical officer in command shall utilize the Training Staff Complement Table shown in NCPI 230 in determining the training staff required to conduct the Supervisor Training Program and any other types of training authorized by NCPI 230 which the activity may conduct.

(2) In activities employing less than 300 civilians, the medical officer in command shall, if practicable, secure supervisor training through participation in the Work Improvement Program of a neighboring naval activity. Additional training shall be provided by or under the supervision of the Personnel Officer in the objectives, policies, and operating methods of the activity.

(3) In activities employing less than 300 civilians where participation in the supervisor training conducted by another activity is not feasible, the medical officer in command shall, through the Personnel Officer, establish and conduct a training program to meet the needs of the activity.

10-15. Scope of Program

The scope of the training program in each Medical Department activity will vary according to the needs of the activity. Each activity shall adapt the Work Improvement Program to its particular needs. A minimum program should include the following types of training:

(1) Indoctrination.—A well-planned standardized procedure for the indoctrination of new employees shall be established by the command and executed under the direction of the Personnel Officer. Indoctrination shall be given to new employees as soon as possible after appointment. Instructional material should be developed following the general outline given in NCPI 230. Activities may find it desirable to develop information handbooks containing material developed for indoctrination.

(2) Supervisor Training.—The Personnel Officer, assisted by the Civilian Personnel Branch, is respon-
sible for contributing to the improvement of supervision in the activity through advisory service to supervisors on personnel matters and through an organized training program. NCPI 230 sets forth the basic requirements for a supervisor training program.

(3) On-the-job Training.—On-the-job training shall be conducted in the actual work environment by the immediate supervisors with the exception of 10 per cent of the total training time which shall be utilized in classroom instruction in related subjects. The Personnel Officer shall provide assistance to supervisors in making analyses of jobs to determine what training may be required and to develop training materials as needed. The specific purposes of on-the-job training are:

(a) To improve performance ability.
(b) To broaden employee's work experience.
(c) To improve work methods and increase production.
(d) To provide training in the application of basic skills to specific work assignments.

(4) Safety.—Instruction in safety practices shall be included as a part of the training given under (a), (b), and (c) above as set forth in NCPI 190.

Section VI. EMPLOYEE RELATIONS AND EMPLOYEE SERVICES

10-16. Employee Relations and Employee Services

(1) Scope.—The Civilian Personnel Branch shall assist in carrying out personnel programs and policies concerned with incentives, beneficial suggestions, employee services, and efficiency ratings, as well as serve as a central source of information, guidance, and assistance in fostering improved supervisory-employee relationships through proper attention to grievances and complaints, disciplinary action, removal, fair employment practices, political activity, solicitations and collections, retirement, and injury compensation and treatment.

(2) Beneficial Suggestions.—The beneficial suggestion program as outlined in NCPI 25 is designed to increase the efficiency of the service by stimulating employee participation through the submission of ideas. Under the program employees receive cash awards or other recognition for adopted suggestions. The Department attaches great importance to the submission of constructive suggestions by civilian employees, both supervisory and non-supervisory, and looks to each activity to institute and conduct a suggestion program as an integral part of its civilian personnel program.

(3) Disciplinary Actions, Removals, and Prohibitions.—Medical and dental officers in command are responsible for the administration of disciplinary matters concerning employees under their jurisdiction and are responsible for delegating authority for such administration to subordinate line officers. The Civilian Personnel Branch shall assist and advise supervisors and officials at all levels in civilian disciplinary matters. General provisions and procedures governing disciplinary actions, removals, and prohibitions are outlined in NCPI 45.

(4) Efficiency Ratings.—It is the responsibility of the medical or dental officer in command, acting for the Secretary of the Navy, to obtain full compliance with the efficiency rating system by all personnel who participate in the preparation, review, or administration of efficiency ratings.

(a) All Navy Department employees wherever located who occupy group IVb or similar positions shall be rated in accordance with provisions of the Uniform Efficiency Rating System as outlined in NCPI 55.

(b) The Shop Efficiency Rating System as set forth in NCPI 56 applies to all employees in the field service who occupy positions in groups I, II, III, and IVa or similar positions, whether within or outside the continental limits of the United States.

(5) Employee (Group) Relations.—It is the policy of the Department that Navy officials having responsibility for the management of civilian employees should deal with their employees on a group basis when such is the desire of the employees represented. Normally medical officers in command are expected to deal personally with organized employee groups. However, on strictly routine matters or in other day-to-day problems arising out of the particular work situation at the activity concerned, the medical officer in command may designate the Personnel Officer, a supervisory officer nearer the work situation, or a responsible staff member of the Civilian Personnel Branch to perform this function. The Navy's relationship with organized employee groups and the activity of supervisors in these groups, and with shop committees, is outlined in NCPI 60.

(6) Employee Services.—It is desirable that each activity establish an adequate program to provide the services and facilities that are essential to the personal requirements of the employees. The needs of the activity should determine the services to be provided. In developing an adequate employee services program, it is not necessary that all the services described in NCPI 60 be adopted; conversely, there may be other services which an activity may deem necessary to include in its program.

(7) Fair Employment Practice.—Executive Order 9880 of 26 July 1948 provides that in all person-
nel actions there shall be no discrimination because of race, color, religion, or national origin and establishes a general procedure for handling alleged violations. The Chief of the Office of Industrial Relations has been appointed Fair Employment Officer for the Department of the Navy. Medical and dental officers in command in their capacities of appointing officers have been appointed Deputy Fair Employment Officers for their respective commands with the responsibility for receiving and investigating complaints based on alleged discrimination and for taking corrective action in accordance with NCPI 78.

(8) Grievances and Complaints.—The medical or dental officer in command is responsible for establishing and publicizing a uniform procedure for acting upon employee grievances in accordance with NCPI 80. The command shall insure that all levels of supervisors are trained in their responsibilities concerning employee grievances and that all actions in this connection are taken in strict compliance with the provisions of NCPI 80.

(9) Incentives.—Medical Department activities shall develop and utilize an incentive program in the interest of securing maximum production. The Department has developed for Navy-wide use certain incentive programs as provided in NCPI 20. The incentive program as set forth in this Instruction should be closely coordinated with beneficial suggestions and the provisions of NCPI 195, Salary and Wage Changes.

(10) Injury Compensation and Treatment.—Medical Department activities shall establish procedures and facilities to insure that all employees who become ill while at work or are injured in the performance of their duties are provided with the necessary medical care. NCPI 90 contains provisions concerning treatment and compensation for injury, as well as death compensation.

(11) Political Activity.—It is the policy of the Department not to consider the political opinions or affiliations of applicants and employees in matters of employment, except where membership in a political party or organization legally constitutes a disqualification for Government employment. The provisions and procedures governing political activity are outlined in NCPI 150.

(12) Retirement.—The Civilian Personnel Branch shall (a) inform all employees of their rights, benefits, and obligations under the Civil Service Retirement System; (b) answer questions presented by employees; and (c) notify employees who have reached compulsory retirement age. General provisions and coverage of the Civil Service Retirement Act are set forth in NCPI 185 and in chapter R5 of the Federal Personnel Manual.

(13) Solicitations and Collections.—Medical and dental officers in command are responsible for approving the procedures for local solicitations and collections of funds within their respective establishments. NCPI 215 provides basic instructions in this matter which includes political contributions, personal contributions, gifts, and advertising.

Section VII. PERSONNEL INSTRUCTIONS AND RECORDS

Personnel Instructions
Personnel Records

10-17. Personnel Instructions

The Civilian Personnel Branch shall maintain on a current basis at least one copy of the basic personnel instructions listed below. Each activity shall insure that copies of these personnel instructions are routed immediately on receipt to the Civilian Personnel Branch. Arrangements should be made with the cognizant issuing office for a sufficient number of copies so that other staff offices may be furnished copies of instructions relating to the work of the office.

(1) Federal Personnel Manual.—The Federal Personnel Manual is the official medium of the U. S. Civil Service Commission for issuing its personnel regulations, instructions, and suggestions to other agencies.

(2) U. S. Civil Service Commission Departmental Circulars.—Departmental circulars have been used to issue regulations, instructions, and suggestions on topics not covered by chapters in the Federal Personnel Manual. Each manual chapter as it is published will supersede previously issued departmental circulars on the same subject. Departmental circulars will continue to be used for issuing temporary or informational material not appropriate for inclusion in the manual.

(3) Navy Civilian Personnel Instructions.—Navy Civilian Personnel Instructions, NAVEXOS-P-122, are the means by which over-all civilian personnel instructions, policies, and procedures for the Naval Establishment are prescribed. These instructions are issued in conformity with U. S. Navy Regulations for the guidance of all persons in the Naval Establishment in the conduct of civilian personnel matters.

(4) Civilian Personnel Letters and Dispatches.—Instructions of temporary interest and effect are issued in the form of dispatches, circular letters, or multiple address letters and assigned a CPL&D number. This means is also used by the Office of Industrial Relations for issuing advance changes to Navy Civilian Personnel Instructions and for supplying or requesting information.
10-18. Personnel Records

(1) The Civilian Personnel Branch shall maintain personnel records and files necessary to the performance of personnel activities. The major purposes of these files and records are to provide convenient sources of information necessary for day-to-day actions, to provide a medium for the recording of data for reporting and future reference, and to provide a repository for official documents. There are widely varying requirements and uses for civilian personnel records. The tendency to build up a separate record for each purpose encourages duplication and results in wasted man-hours due to excessive paperwork. The number of different records required in a personnel office should be kept to a minimum.

(2) The records and files discussed in this section are those which are to be maintained on a continuing basis. Records and files which are an integral part of some personnel procedure or action (e.g. reports on certificates of eligibles, typed lists of retention registers used for a reduction in force, etc.) are covered in chapters of the Navy Civilian Personnel Instructions and the Federal Personnel Manual dealing with such procedures and actions. The basic personnel records and files which are considered necessary to the proper conduct of personnel activities are:

(a) Official personnel folder.—Each activity is required to maintain an official personnel folder on each employee. The folder shall be maintained in accordance with instructions in NCPI 135 and chapter R1 of the Federal Personnel Manual.

(b) Service Record Card (Standard Form 7).—The Service Record Card (SF-7) has been prescribed by the U. S. Civil Service Commission as the record of an employee’s service to be maintained in personnel offices. A discussion of the installation and uses of the Service Record Card is presented in NCPI 135.

(c) Retention records.—Activities are responsible for maintaining current records of information necessary for determining retention preference of employees. NCPI 170 prescribes the data required in determining retention preference.

(d) Position descriptions.—The maintenance of approved position descriptions on a current basis is essential to the proper administration of the classification program and the basis for the assignment of employees to valid positions in the activity.

(e) Chronological file of personnel actions.—The Civil Service Commission requires that a chronological file be maintained of copies of personnel actions in order that information will be available to representatives of the Commission as may be required to make a complete audit of the actions taken.
# Chapter II
## NAVAL HOSPITALS

### Sections

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Mission and Organization</td>
<td>11-1 through 11-5</td>
</tr>
<tr>
<td>II. Office of the Commanding Officer</td>
<td>11-6 through 11-11</td>
</tr>
<tr>
<td>III. Military and Administrative Functions</td>
<td>11-12 through 11-21</td>
</tr>
<tr>
<td>IV. Professional Functions</td>
<td>11-22 through 11-30</td>
</tr>
<tr>
<td>V. Hospital Ships</td>
<td>11-31 through 11-33</td>
</tr>
</tbody>
</table>

### Section I. MISSION AND ORGANIZATION

#### Article 11-1. Mission

(1) The primary mission of a naval hospital is:

(a) The care and treatment of sick and injured military personnel with the object of their expeditious return to duty.

(b) The prompt disposition of those patients who require special treatment not satisfactorily available or who are found physically unfit for retention in the military service.

(2) The secondary mission of a naval hospital includes:

(a) The instruction of Medical Department personnel, including intern and resident training when authorized.

(b) The care and treatment of nonmilitary patients, when authorized.

(c) Research in medicine, dentistry, and related specialties when authorized.

(d) Cooperation with military and civil authorities in matters pertaining to health and sanitation and in the event of local disasters or emergencies.

#### Article 11-2. Direction

(1) The Bureau of Medicine and Surgery is charged with the operation and maintenance of all naval hospitals.

#### Article 11-3. Command

(1) A naval hospital shall be commanded by a naval medical officer. The executive officer of the hospital shall be that medical officer, eligible to succeed to command, who is next in rank to the commanding officer. In the event of the incapacity, death, absence, or detachment without relief of the commanding officer, the medical officer next in rank who is regularly attached to the hospital for duty shall succeed to command.

#### Article 11-4. Organization

(1) A naval hospital is a self-contained command unit under the military command of the commandant of the naval district or the commander of the group activity as designated in current publications. As such, it shall be organized and administered in accordance with law, U.S. Navy Regulations, and the orders of competent authority.

(2) It is the responsibility of the commanding officer of each naval hospital to effect an efficient and effective organization which shall provide for both the clinical and administrative functions of the hospital. Since naval hospitals vary in size, personnel, and facilities, an inflexible plan of organization is not feasible. The chart in subarticle 11-4(3) illustrates an approved organization for naval hospitals which may be modified when local conditions or special missions justify deviation therefrom. The Organization Guide for Naval Hospitals, NAVMED-P-1335, provides supplemental information on the internal organization of the various administrative divisions and clinical services, as well as on the assignment and distribution of functions therein.

(3) Organization Chart.—See next page.

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11-1 Change 7
ORGANIZATION CHART — NAVAL HOSPITAL

OFFICE OF THE COMMANDING OFFICER

COMMANDING OFFICER

EXECUTIVE OFFICER AND COORDINATOR OF
ADMINISTRATIVE AND PROFESSIONAL SERVICES

BOARDS AND
COMMITTEES

CHAPLAINS
RED CROSS DIRECTOR
OTHER SPECIAL ASSISTANTS

PROFESSIONAL SERVICES

DIRECTOR OF CLINICAL SERVICES
(EXECUTIVE OFFICER)

SURGICAL
SERVICE

MEDICAL
SERVICE

UROLOGY
SERVICE

NEUROPSYCHIATRY
SERVICE

E.E.N.T.
SERVICE

DENTAL
SERVICE

ORTHOPEDIC
SERVICE

NURSING
SERVICE

RADIOLOGY
SERVICE

LABORATORY
SERVICE

DEPENDANTS
SERVICE

PHARMACY SERVICE
(MSC OFFICER)

OTHER CLINICAL SERVICES
AS REQUIRED

ADMINISTRATIVE DIVISIONS

ADMINISTRATIVE OFFICER
(MEDICAL SERVICE CORPS OFFICER)

PERSONNEL AND RECORDS
DIVISION
(MSC OFFICER)

FINANCE
DIVISION
(MSC OFFICER)

FOOD SERVICE
DIVISION
(MSC OFFICER)

HOSPITAL SUPPLY
DIVISION
(MSC OFFICER)

SECURITY AND M.A.A.
DIVISION
(MSC OFFICER)

MAINTENANCE
DIVISION
(MSC OR CEC OFFICER)

DISBURSING
DIVISION
(SUPPLY CORPS OFFICER)

SPECIAL SERVICES
DIVISION
(MSC OFFICER)

NAVY EXCHANGE
DIVISION
(SUPPLY CORPS OFFICER)

NOTES:
The executive officer will also serve as chief of a clinical service in certain hospitals.
*A specialty may be organized as a service when it is headed by a board-certified specialist.

8 MARCH 1956
11-5. Instructions and Notices

The commanding officer shall issue such hospital instructions and notices as may be required for the guidance of staff and patients. Directives governing patients shall not be more stringent than necessary to ensure efficient administration.

Section II. OFFICE OF THE COMMANDING OFFICER

The Office
Commanding Officer
Executive Officer
Special Assistants
Boards and Committees

11-6. The Office

The office of the commanding officer shall consist of a commanding officer, an executive officer, and such other special assistants and personnel as may be required.

11-7. Commanding Officer

(a) General Duties.—

The commanding officer is charged with the command, organization, and management of the hospital. He shall require the timely and economical performance of the functions and operations of the hospital in accordance with U.S. Navy Regulations, the Manual of the Medical Department, and other directives issued by competent authority. He shall be responsible for the professional care and services provided to the patients in the hospital and for the safety and well-being of the entire hospital command. Subject to the orders of higher authority, he shall exercise complete military jurisdiction within the hospital reservation.

(b) The commanding officer shall be responsible for the sound and legal expenditure of the funds allotted to the hospital for its operation. He shall issue instructions concerning the use, expenditure, and conservation of equipment and supplies which shall define the responsibilities of the heads of the administrative divisions and clinical services regarding the correctness of inventories and the transfer of property upon their detachment.

(c) The commanding officers shall be responsible for the maintenance of orders for the administration of discipline within the hospital command. He shall afford necessary assistance and provide facilities for inspections, investigations, and courts-martial held at the hospital on orders issued by competent authority. The commanding officer of a naval hospital is empowered by the Secretary of the Navy to exercise summary or special courts-martial jurisdiction over, and by the Uniform Code of Military Justice to impose nonjudicial punishments upon, members of the naval service, staff and patient, of his command. This authority may not be delegated; but, in the temporary absence of the commanding officer, it may devolve on the medical officer succeeding to command. Punishments shall be recorded in accordance with instructions generally applicable throughout the Navy.

(d) The commanding officer, unless specifically authorized, shall not act as a recruiting officer. He may reenlist or extend the enlistments of the enlisted personnel attached to his command for duty. He may reenlist patients, physically and otherwise qualified, who desire to reenlist within 24 hours following discharge.

(e) The commanding officer shall be responsible for the public information program of the hospital, which shall embrace all areas of public relations applicable to and in the interest of the hospital. He shall establish, preserve, and promote good relations with local professional, civic, welfare, and business organizations.

2) Relations With Civil Authorities.—

(a) The commanding officer shall require obedience from all persons coming under his jurisdiction to Federal statutes, and, to the extent conflict does not exist, shall observe penal and civil law of the State, Territory, or district in which the naval hospital is located. Service of subpoena or other civil process upon members of the service or civilians within a hospital reservation shall be in accordance with instructions of the Department of the Navy applicable to all commands in the Navy.

(b) The commanding officer shall cooperate with civil authorities in the control of communicable diseases. He shall report all persons discharged from the service with an infectious disease which is considered to be a public menace. Such reports shall be made to the health department of the State which is the prospective residence of the individual being discharged. The report, in letter form with duplicate attached, shall include only the following information: Name, prospective place of residence (address), diagnosis, date of discharge and place of discharge. The report shall emphasize that the information given is confidential. In all cases of tuberculosis, the commanding officer of the activity in which discharge from the service is culminated shall notify the Tuberculosis Control Division, U.S. Public Health Service, Bethesda 14, Md., giving the information as stated above.
In accordance with local health laws and regulations, the commanding officer shall report to the proper civil authorities all births, including stillbirths, and deaths occurring in his command. For further information, see article 3-12(4).

Patients.—

(a) The commanding officer shall be responsible for the professional care and treatment of all patients in the hospital. Except in emergencies, major surgical operations and special forms of treatment shall not be undertaken without his approval.

(b) When a patient (other than a dependent—for whom see arts. 21-4 through 21-8) being provided inpatient or outpatient care at a naval hospital requires medical or dental care beyond the capabilities of the hospital and of other Federal medical facilities in the area, the commanding officer may authorize and direct the utilization of supplemental services and supplies from civilian non-Federal sources. This may include, but is not limited to, the services of a physician, dentist, specialist, or technician, and the procurement of special tests, examinations, treatments, or hospitalization. Costs incurred are chargeable to the hospital’s maintenance and operation allotment.

Personnel.—

(a) The commanding officer shall submit requests for necessary adjustments in the military personnel allowance of his command, with full justifications therefor, to the Bureau of Naval Personnel, via the Bureau of Medicine and Surgery, through official channels. Requests for necessary adjustments in the civilian personnel allowance of the command shall be submitted through official channels to the Bureau of Medicine and Surgery.

(b) The commanding officer shall provide for the military indoctrination and professional and technical training, including authorized intern and residency training, as appropriate, of all Medical Department personnel attached to the hospital for duty.

(c) The commanding officer shall hold periodic staff conferences to discuss professional and administrative subjects. When practicable, qualified military and civilian personnel shall be invited to participate in these conferences.

(d) The commanding officer shall arrange for civilian consultants to confer with the hospital staff on consultations, professional training, and other matters. He shall establish and promote cooperative relationships with civic professional organizations in order that the staff may profit from such associations.

(e) The commanding officer shall facilitate the use of the professional and instructional services of the hospital by Medical Department personnel attached to other activities. He shall insure the maintenance of a professional library adequate to meet the requirements of the hospital.

(f) The commanding officer shall prohibit the unauthorized collection of funds within the command, and unofficial pecuniary dealings between patients and Medical Department personnel.

5. Reports, Records, and Correspondence.—

(a) The commanding officer shall require the preparation and submission of official reports and returns and the maintenance and disposition of hospital records as prescribed by competent authority.

(b) Correspondence dealing with the internal administration of the hospital shall be forwarded directly to the Bureau. Correspondence involving military policy, medical policy, logistics, increases or modifications of hospital facilities, and military personnel allowances shall be forwarded via the chain of command.

6. Inspections.—

(a) The commanding officer shall make, or cause to be made, necessary inspections to determine that the hospital is adequately equipped and staffed, that it is functioning economically and effectively, that the clinical services and administrative divisions are well managed and maintained, and that pertinent laws, regulations, directives, and orders are being enforced.

(b) Personnel and matériel inspections shall be governed by the following:

1. When circumstances permit, personnel of the hospital shall be inspected weekly, but not on Sundays.

2. Buildings and grounds, exclusive of private quarters, shall be inspected weekly, but not on Sundays.

3. Periodic inspections shall be made of storage facilities and their contents to insure compliance with the policies of the Department of the Navy and the Bureau regarding adequacy, stock levels, maintenance, overhaul, and replacement.

4. Periodic sanitary inspections shall be made of all buildings and grounds, with particular attention to the maintenance of maximum standards of food preservation and handling.

7. Emergency Precautions.—

(a) Local disasters or emergencies shall be provided for by appropriate disaster plans and procedures for handling casualties. Personnel assigned disaster-relief duties shall be drilled regularly and instructed continually in their assigned duties. Emergencies which may result from enemy attacks shall be provided for by appropriate bills, procedures for handling casualties, and regular drills.

(b) In time of war, the hospital shall fly the Red Cross flag, and, when considered necessary by the commanding officer, shall have other signs of its noncombatant status in evidence.
(8) Delegation of Duties.—The commanding officer may, at his discretion and when not contrary to law or regulations, delegate duties to the executive officer, administrative officer, and other subordinates, as appropriate, to the maximum extent consistent with effective administration. Such delegations of authority, however, shall in no way relieve him of his responsibility for the efficient performance of his functions and the safety, well-being, and efficiency of his command.

11–8. Executive Officer

(1) General Duties.—

(a) The executive officer shall serve as the direct representative of the commanding officer. As
such, all orders issued by him shall be regarded as proceeding from the commanding officer and shall govern all persons within the command. While executing the orders of or serving as the commanding officer, the executive officer shall take precedence over all other officers attached to the command. His primary function shall be to assist the commanding officer in the discharge of his responsibility for the professional care of patients and the training of the staff, in the formulation of professional policies, standards and directives, and in the coordination of all internal administration of the hospital dealing with professional matters.

(b) The executive officer shall direct the administrative officer regarding matters of common interest and responsibility. Nothing herein is to be construed as relieving the executive officer of his responsibility in matters under the purview of the administrative officer or of the necessity of keeping himself informed in such matters to the extent that he may be able to assume command in the absence of the commanding officer.

(2) Clinical Services and Care and Treatment of Patients.—

(a) The executive officer shall organize and coordinate the various clinical services to ensure the highest quality of medical care and the most efficient utilization of Medical Department personnel.

(b) He shall exercise general supervision over the care and treatment of all patients in the hospital, both inpatient and outpatient, and shall keep the commanding officer informed regarding the condition of all patients on the serious and critical lists.

(c) He shall issue instructions for the guidance and administration of all patients, inpatient and outpatient, and designate the hours when visitors may be received.

(d) He shall secure the services of a chaplain or other clergyman when a patient expresses a desire for spiritual ministrations. Whenever practicable, patients who are too ill to request spiritual ministrations shall be provided the services of a chaplain or other clergyman of their faith.

(e) He shall coordinate and have published the times for consultations and special examinations.

(f) He shall make recommendations concerning the appointment to, and keep the commanding officer advised of the actions and recommendations of, the tumor board, the boards of medical survey and clinical boards, the tissue committee, the medical records committee, and such other boards and committees that have to do with patient care.

(g) He shall assure that the professional functions of the hospital are carried on in such manner as to merit accreditation by the various professional accrediting bodies.

(h) He shall assure that the necessary directives governing professional practices are issued and are observed.

(3) Professional Training.—

(a) He shall organize a professional training committee from among the chiefs of the various clinical services, including the administrative officer, and shall himself be an active member of the committee representing the commanding officer whenever he is absent. This training committee shall supervise and coordinate all of the training programs for medical officers and interns. The training committee shall also evaluate each request for training received from any medical officer on the staff.

(b) He may make recommendations, when deemed desirable, to the chief nurse for the training of nurses, and to the administrative officer for the training of hospital corpsmen.

(c) He shall arrange the schedule for all professional staff meetings, and shall coordinate the interservice conferences, ward rounds, seminars, and consultant lectures.

(d) He shall assist the chiefs of service in the selection and utilization of civilian and reserve lecturers in connection with the intern and residency training programs.

(e) He shall appoint a medical officer to have supervision over the Medical Library.

(4) Assignment of Staff Personnel.—He shall direct the assignments of staff officer personnel to those duties which will assure the most effective use of the officer's training, experience and capabilities, in the best interests of patient care. He shall approve watch lists affecting these personnel.

(5) Inspections.—

(a) The executive officer shall arrange for all inspections. He shall conduct or designate an officer to conduct those which the commanding officer cannot attend. A report shall be made to the commanding officer of any deficiency detected during the course of the inspection or of any area in which corrective action is considered necessary.

(b) The executive officer shall require the officer of the day to inspect the meals served in the mess, including the special diets, to insure that the food is properly prepared, of good quality, sufficient in amount and served in an appetizing way, and in the case of special diets adheres to the therapeutic regimen prescribed for the patient.

(6) Officer of the Day.—

(a) The executive officer shall approve the officer of the day watch list. He shall take steps to insure that all officers assigned to the officer of the day's watch list are properly indoctrinated in hospital instructions and notices, hospital practices and procedures, as well as pertinent parts of
11-8 MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY 11-11

the Manual of the Medical Department, Navy Regulations, and such other local orders and instructions that apply.

(b) He shall closely supervise the functioning of the officer of the day's office, the admission section, and the outpatient treatment branch to be assured that patients are promptly admitted or treated as the case may be.

(7) Morale and Discipline.—

(a) The executive officer shall insure that all laws, regulations and instructions issued by proper authority are complied with and shall report all such violations to the commanding officer.

(b) He shall constantly endeavor to maintain a high state of morale among all staff and patient personnel. Continued and sympathetic attention to all details affecting the welfare of these personnel shall be one of his chief concerns.

(c) He shall insure that all instances of commendable conduct and meritorious acts performed by the staff or patients, as well as the names of members of the staff showing outstanding ability, are brought to the attention of the commanding officer.

(d) He shall make recommendations to the commanding officer concerning the granting of leave to staff officers, and act on requests of staff officers to be absent from duty for short periods of time or from morning quarters.

(e) He shall insure that the officer of the day or some other designated medical officer makes a daily inspection of the brig, or disciplinary ward, and the physical condition of patients confined to the brig or disciplinary ward.

(8) Civil Defense, Disaster, and Mobilization Planning.—

(a) He shall participate in and advise the commanding officer concerning the medical aspects of civil defense and disaster planning with local, State, and Federal authorities.

(b) He shall advise and make recommendations to the commanding officer concerning medical mobilization planning and requirements.

(9) Chief of a Clinical Service.—The executive officer when so designated by Bureau action may serve as the chief of a clinical service. Notice.—There is no article 11-9.

11-10. Special Assistants

(1) General.—The senior chaplain, the senior representative of the American National Red Cross, and such other persons as the commanding officer may appoint, shall serve as special assistants to the commanding officer.

(2) Chaplains.—

(a) The senior officer of the Chaplains Corps ordered to such duty by proper authority, normally shall be in charge of the Chaplains' Office.

(b) The Chaplains' Office shall:

(1) Be responsible for the religious activities of the hospital, conduct divine services as appropriate, and give spiritual counsel to patient and staff personnel.

(2) Make ward visits to bed patients, especially those on the serious and critical lists, and periodic visits to prisoners confined in the brig.

(3) Consult with and advise the executive officer on matters relating to the general morale of patient and staff personnel.

(4) Maintain relations and work with civilian religious groups in the community.

(3) American National Red Cross.—Services rendered by the American National Red Cross are governed by U.S. Navy Regulations and current directives to which reference shall be made under all circumstances.

11-11. Boards and Committees

(1) There shall be established such local boards and committees, of temporary or permanent nature, as are necessary to maintain the professional standing of the command, to assure the competence of the staff, and to satisfy various administrative requirements. Such boards and committees may be established by the commanding officer or on the orders of other competent authority.

Section III. MILITARY AND ADMINISTRATIVE FUNCTIONS

<table>
<thead>
<tr>
<th>Article</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of Watches</td>
</tr>
<tr>
<td>Administrative Officer...</td>
</tr>
<tr>
<td>Administrative Divisions...</td>
</tr>
<tr>
<td>Disbursing Division</td>
</tr>
<tr>
<td>Finance Division</td>
</tr>
<tr>
<td>Food Service Division</td>
</tr>
<tr>
<td>Maintenance Division</td>
</tr>
<tr>
<td>Navy Exchange Division</td>
</tr>
<tr>
<td>Personnel and Records Division</td>
</tr>
<tr>
<td>Security and Master at Arms Division</td>
</tr>
<tr>
<td>Special Services Division</td>
</tr>
</tbody>
</table>

11-6 Change 7
11–12. Establishment of Watches

(1) The commanding officer shall establish an officer-of-the-day watch, an administrative watch, and such other watches as may be necessary for the safety, proper operation, and security of the command and the care and treatment of its patients.

(2) Officer of the Day.—The officer of the day shall be regularly assigned as the officer on watch to stand the day’s duty. He shall serve as the representative of the commanding officer who shall prescribe his duties and to whom he shall be responsible for the proper discharge of the functions of his office. No officer shall be assigned as officer of the day until he is thoroughly familiar with the hospital and its management and administration.

(3) The tour of duty of the officer of the day shall be a period of 24 hours, normally beginning at 0000, during which time he shall remain on the reservation. Before assuming duty as officer of the day, he shall acquaint himself with all matters and conditions in the hospital of which he should be aware for the proper performance of his duties. He shall remain in charge of his station until regularly relieved. He shall maintain an officer-of-the-day log of accurate, clear, and complete entries describing every circumstance and occurrence of importance and interest which concern the hospital or its personnel, or which may be of historical value. The log shall be prepared in the manner and form prescribed by U.S. Navy Regulations and the instructions of the Bureau. The officer of the day shall sign only that part of the log which he has written. Any entries made by another officer temporarily relieving the officer of the day shall be signed by that officer.

(4) Administrative Watch.—In addition to the officer of the day, the commanding officer also shall establish an administrative watch to perform the administrative and clerical duties required outside of normal working hours. The officers or enlisted men assigned to this watch shall be thoroughly familiar with the administrative and clerical functions of the hospital.

(5) Other Watches.—The commanding officer may establish a watch consisting of senior officers of the Medical Corps to act in an advisory capacity to the officer of the day on professional matters and other problems which may arise. No officer shall be assigned as senior watch officer until he is thoroughly familiar with the management and administration of the hospital.

11–12A. Administrative Officer

(1) The administrative officer shall be responsible to the executive officer and commanding officer for all administrative matters, including the coordination of the internal administration of the hospital. All orders of the administrative officer shall be regarded as proceeding from the commanding officer, whose policies and orders he shall conform to and effectuate. He shall advise the commanding officer and the executive officer regarding the nonprofessional functions and management of the hospital, and shall assist them in the formulation of administrative policies, standards, and directives. He shall act independently on those matters which do not require the personal attention of the commanding officer or the executive officer, but he shall keep them informed of the action which he takes. The administrative officer shall advise the executive officer regarding matters of common interest and responsibility. He shall exercise due caution to assure that all matters of a professional nature which require action and which may come to his attention are promptly referred to the executive officer. Neither the administrative officer nor any of the personnel subject to his supervision shall assume any responsibility or authority in professional matters. The administrative officer shall be an officer of the Medical Service Corps.

(2) The administrative officer shall:

(a) Establish methods for improving operating procedures, solving administrative problems, and correcting unsatisfactory conditions of an administrative nature.

(b) Be responsible for the coordination and efficient operation of the administrative divisions.

(c) Maintain current information regarding laws, regulations, policies, and instructions pertaining to naval administration in general and to the management of naval hospitals in particular.

(d) Provide for the preparation, promulgation, and maintenance of the directives necessary to meet the operating requirements of the hospital. He shall have general orders, orders from higher authority, and all other directives and information which concern or are of interest to personnel of the command posted on conveniently located bulletin boards, or otherwise brought to the attention of the personnel concerned. Copies of the Uniform Code of Military Justice shall be made readily accessible to all personnel. He shall assure that all infractions of law or U.S. Navy Regulations and violations of discipline are promptly reported to the executive officer and commanding officer.

(e) In consultation with the Chief, Finance Division, and other appropriate officers, formulate fiscal policies for presentation to and approval by the executive officer and commanding officer.

(f) Promulgate directives concerning safety measures and precautions, including procedures for protecting personnel and safeguarding Government property.

(g) Prescribe the time at which the weekly fire drill shall be held and take charge of all such drills and fire-fighting operations.

Change 7
11-13 Administrative Divisions

11-13. Administrative Divisions

(1) Certain administrative divisions shall be established in each naval hospital to transact the hospital’s business and conduct its administrative functions. These divisions shall include a finance division, a food service division, a maintenance division, a personnel and records division, a security and master at arms division, a special services division, and a hospital supply division. A disbursing division and a Navy exchange division may also be included.

(2) The heads of the administrative divisions shall be responsible for their effective operation and for the performance of the following general administrative functions and such collateral duties as may be assigned:

(a) Plan, direct, and supervise the work and training of assigned personnel.

(b) Prepare and maintain accurate functional organization charts and position descriptions, documenting the organizational breakdown and the assignment of personnel to positions and duties.

(c) Insure the proper security, custody, use, conservation, maintenance, expenditure, and correct inventory of all Government property charged to the division and require the economical use of utilities and supplies.

(d) Insure that required reports and returns are prepared and submitted in accordance with instructions and that prescribed records are both current and accurate.
11-13  CHAPTER 11. NAVAL HOSPITALS

(e) Observe all prescribed and necessary precautions for safety and indoctrinate assigned personnel in safety and accident prevention.

(f) Be thoroughly conversant with the fire bill and other emergency or disaster bills and instruct personnel in their requirements.

(g) Maintain current information on the laws, regulations, and instructions pertaining to the accomplishment of assigned duties and functions.

(h) Insure the proper cleanliness and maintenance of assigned spaces and grounds.

(i) Conduct periodic inspections of assigned personnel, materials, and spaces.

(j) Perform such specific duties as are outlined in the succeeding articles.

11-14. Disbursing Division

(1) In those instances in which an officer of the Supply Corps has been ordered to the hospital to serve as disbursing officer, he shall be responsible for the performance of the functions of the disbursing division. If a Supply Corps officer has not been so assigned or, having been assigned, is detached without relief, the commanding officer shall make official request upon proper authority that an officer of the Supply Corps attached to a nearby activity be delegated to assume the disbursing functions.

(2) The disbursing division shall:

(a) Keep the pay accounts of naval personnel attached to the hospital and pay such personnel upon presentation of appropriate records and vouchers.

(b) Disburse civilian employee payrolls.

(c) Pay travel claims of and, when authorized, issue transportation requests and meal tickets to personnel attached to the hospital, and pay such designated public vouchers as are authorized by the Bureau of Supplies and Accounts Manual and approved by the commanding officer upon presentation of such by the finance officer.

(d) Procure, issue, and account for clothing and small stores.

(e) Hold patients’ money and valuables for safekeeping as requested.

(f) Receive, maintain custody of, and account for public moneys collected by the collection agent for the sale of meals, telephone service, and dependents’ hospitalization.

(g) Perform such other duties as may be prescribed by the Bureau of Supplies and Accounts Manual.

11-15. Finance Division

(1) The finance division shall:

(a) Be responsible for the procurement, receipt, storage, issue, accounting for, and, while in its custody, security and maintenance of the equipment and stores of the hospital.

(b) Be responsible for the accurate accounting of all funds allotted to the hospital. Hospital accounting procedures include appropriation, allotment, cost, and property accounting, and the preparation of civilian payrolls.

(c) Compile the financial plan of the hospital and annual estimates of expenditures, including supporting data, as required.

(d) Keep higher authority informed concerning the status of allotted funds, budgetary procedures, and other matters pertaining to the financial condition of the hospital.

(e) Conduct physical inventories of hospital property, supplies, and equipment, as required.

(f) Prepare instructions defining the responsibilities of the chiefs of services and heads of divisions for the custody and inventory of the non-expendable equipment charged to them and its transfer upon their detachment.

(g) Prepare records of the nonexpendable property charged to the divisions and services of the hospital, including the offices, auxiliary spaces, and wards assigned thereto, and furnish them with copies of these records.

(h) Recommend measures for the conservation of supplies and equipment in order to prevent improper or excessive use and avoid unnecessary procurement and repair bills.

11-16. Food Service Division

(1) The food service division shall:

(a) Be responsible for the proper and efficient operation of the hospital mess.

(b) Administer the therapeutic diet program and maintain liaison with the professional staff on matters of diet therapy.

(c) Supervise the operation and maintenance of food service spaces and equipment.

(d) Maintain the highest standards of sanitation in the preparation and service of meals and diets. Inspect or provide for the inspection of all meals and diets prior to serving.

(e) Prepare, submit for approval, and post the regular and therapeutic diet menus for the hospital mess.

(f) Assist the hospital supply division, as required, in the procurement, receipt, inspection, storage, security, and issue of subsistence items necessary to the operation of the hospital mess.

(g) Maintain security of subsistence items which have been expended to use but not yet consumed. Insure that the inventory of such items is maintained at the lowest level consistent with efficient operation of the mess.

(h) Take necessary measures to conserve food and prevent waste in its preparation, service, and consumption.

(i) Maintain a daily and cumulative record of meals and diets served, and prepare and submit the monthly Food Service Performance Analysis report (MED-10110-2).

(j) Serve meals and diets only to those persons authorized to subsist in the hospital mess. The privileges of the mess shall be limited to patients.
Armed Forces personnel, civilian employees, accredited Red Cross field representatives attached to the hospital, and occasional guests of military personnel. Persons authorized to subsist but who are not entitled to subsistence in kind shall pay cash, at the prescribed rate, for each meal taken prior to being served.

(k) Administer all special messes authorized by the commanding officer, including dining rooms for duty officers, officer patients, chief petty officers, and students attached to Hospital Corps schools. Insure that rations issued to special messes are identical with those issued to the hospital mess and that no distinction in quality or quantity is made in favor of any special mess.

11–17. Maintenance Division

(1) The maintenance division shall:

(a) Be responsible for the maintenance of the hospital's grounds and buildings.

(b) Be responsible for the maintenance and operation of the heating plant, maintenance shops, laundry, motor pool, garage, and elevators.

(c) Conduct the safety and accident-prevention programs of the hospital and provide necessary safeguards against industrial and traffic hazards. The maintenance officer shall have collateral duty as safety officer.

(d) Conduct frequent, periodic inspections of the hospital's buildings and appurtenances to insure the safety and preservation of the structures and the timely discovery of defects and deterioration, and to detect waste and reduce maintenance costs to a minimum. Close attention shall be given to the operation and maintenance of all machinery, utility lines, distributing systems, elevators, and refrigeration equipment. The inspection procedure shall cover the general reservation and grounds, including lawns, trees, shrubbery, plants, drainage facilities, waste and refuse disposal systems, and general sanitary conditions.

(e) Conduct periodic waste surveys of heat, light, water, and power.

(f) Prepare preliminary plans, specifications, and estimates for public works contracts, and furnish the finance officer with budgetary data pertaining to the public-works program.

(g) Be responsible, under the direction of the commanding officer, for maintaining satisfactory sanitary conditions throughout the hospital and conduct routine sanitary inspections.

(h) Insure adequacy of heating, lighting, and ventilation in working and living spaces.

(i) Maintain liaison with the district public works officer and assist him in his inspection of the public works and public utilities of the hospital.

11–18. Navy Exchange Division

(1) An officer of the Supply Corps, ordered to such duty by proper authority, normally shall be in charge of the Navy exchange division.

(2) The Navy exchange division shall:

(a) Manage the Navy exchange activities in accordance with the instructions of the Bureau of Supplies and Accounts.

(b) Determine stock requirements and procure stock for the Navy exchange operations.

(c) Account and be responsible for the proper security of property and stores belonging to the Navy exchange.

(d) Be responsible for the receipt, custody, and accounting for all cash received from the sale of Navy exchange stock and services.

11–19. Personnel and Records Division

(1) The personnel and records division shall:

(a) Be responsible for matters pertaining to the administration of the military and civilian personnel attached to the hospital, both staff and patient.

(b) Insure the proper custody, security, and current maintenance of the personnel and medical records of the staff and patients.

(c) Coordinate the assignment of civilian and enlisted personnel within the hospital to insure the most effective utilization of personnel both in terms of their individual qualifications and abilities and the total work to be accomplished.

(d) Provide advice and assistance to the clinical services and administrative divisions on personnel policies and procedures.

(e) Evaluate the training requirements of Hospital Corps personnel attached to the command for duty and assist in the development and implementation of appropriate training programs for them.

(f) Carry out the provisions of the information and education program for staff and patient enlisted personnel, as prescribed by current directives.

(g) Submit to the office of the commanding officer a daily personnel report to contain such staff and patient data as may be required.

(h) Prepare liberty lists and issue passes to patient and enlisted personnel of the command and prescribe the method of checking the departure and return of those granted liberty.

(i) Exercise general administrative supervision over admission procedures.

(j) Supervise the operation of the bagroom and insure the proper storage, security, and disposition of the effects stored therein.

(k) Plan and carry out the recruiting, employment, training, wage, and classification activities of the hospital and such employee-services programs as may be appropriate for the civilian employee requirements of the activity. (Regulations pertaining
to civilian employees at naval hospitals are contained in chapter 10.)

(1) Administer the cross-index system for clinical records.

(2) Make arrangements for funerals and the disposition of the remains of the dead, including their personal effects. This includes, where applicable, the maintenance of plot plans and interment records for the naval cemetery or naval plot over which the hospital has cognizance.

11-20. Security and Master at Arms Division

(1) The security and master at arms division shall:

(a) Insure the security of the hospital grounds and buildings and the safeguarding of Government property.

(b) Supervise the operation of the fire department, inspect the fire-fighting apparatus, including fire-alarm boxes, and provide safeguards against fire hazards.

(c) Prepare, post, and maintain an adequate fire bill and fire prevention and other security orders and instructions and indoctrinate station personnel in the duties required of them under the fire bill and security regulations.

(d) Maintain liaison with the district fire marshal and assist him in his annual inspections of the hospital's fire-prevention and fire-fighting facilities.

(e) Maintain good order and discipline and enforce observance of current uniform regulations and naval customs by patient and staff personnel on the hospital reservation.

(f) Supervise and direct a civil and Marine guard force, including a master at arms detail. If no Marine guard is attached to the hospital and the hospital is not a unit of a naval reservation, the master at arms force shall be organized to insure that the grounds and Government property are adequately guarded.

(g) Maintain a record of punishments involving confinement and report all cases of the confinement or release of prisoners to the officer of the day for entry in the officer-of-the-day log.

(h) Maintain custody of persons in confinement, except as modified by the commanding officer in the case of court-martial prisoners in the custody of a Marine guard, and visit such persons as necessary, but at least every four hours, to ascertain their condition and needs. Court-martial prisoner patients shall be guarded, whenever practicable, by a Marine detachment or by a special guard detailed for that purpose. An armed guard of hospital corpsmen shall not be organized unless it is impossible to guard such prisoners in any other manner.

(i) Conduct the daily muster of the enlisted personnel of the hospital.

(j) Accompany the commanding officer on routine inspections.

(k) Promulgate traffic and parking regulations on the station and enforce observance of them.

(l) Advise and assist in all matters pertaining to the protection of hospital personnel and facilities in the event of fire, attack, flood, storm, or other catastrophe.

11-21. Special Services Division

(1) The special services officer shall be appointed in writing by the commanding officer and shall be bonded in accordance with current directives of the Department of the Navy.

(2) The special services division shall:

(a) Provide and administer a well-balanced program of indoor and outdoor recreation for staff and patient personnel.

(b) Operate the recreational library, theater, gymnasium, athletic fields, and other recreational facilities.

(c) Provide for the publication and circulation of a hospital newspaper if appropriate.

(d) Consult with the chiefs of the clinical services regarding the activities included in the recreation program to determine the advisable extent of individual patient and group participation in them.

(e) Coordinate the recreation program of the division with that of the American National Red Cross.

(f) Account for and maintain proper custody of recreation funds and equipment and administer these funds in accordance with the instructions of the Secretary of the Navy and supplemental regulations issued by the Bureau of Naval Personnel, the Bureau of Medicine and Surgery, and the commanding officer.

(g) Provide recreational library services for staff and patient personnel, catalog and account for books and publications received in the library, and maintain an effective charge-out system for the loan of books. A limited number of new books of general interest are shipped quarterly and without request by the Bureau of Naval Personnel to most naval hospitals. Such books are not charged against allotments made to the districts or to the hospitals. Books not automatically supplied may be requested by a letter addressed to the Chief of Naval Personnel. The provisions of the Bureau of Naval Personnel Manual governing library records, quarterly reports, inventories, surveys, and reconditioning of books shall be observed.

(h) Establish and promote good relations with approved organizations which desire to contribute to the welfare of the personnel of the Navy.
3) Profits from the Navy Exchange and any other welfare funds (nonappropriated) available to the commanding officer may be used for welfare and recreation purposes. For information concerning the administration of and accounting for these funds, see U.S. Navy Regulations and the Bureau of Naval Personnel Manual.

Section IV. PROFESSIONAL FUNCTIONS

Clinical Services .................................................. 11–22
Director of Clinical Services ............................... 11–22A
Chiefs of Services .............................................. 11–23
Ward Medical and Dental Officers ......................... 11–24
Junior Medical Officers .................................. 11–25
Residents .............................................................. 11–26
Nurse Corps Officers ........................................... 11–27
Hospital Corpsmen ............................................... 11–28
Patients ............................................................... 11–29
Disposition of Patients ......................................... 11–30

11–22. Clinical Services

(1) Certain clinical services shall be established in each naval hospital to provide medical and dental care and treatment for sick and injured patients and to perform such other professional functions as may be required by law and regulations. The number and designations of these services shall be determined by the commanding officer in the light of local conditions, except that a dental service shall be established whenever a dental officer is attached to the hospital for duty. In some hospitals, for example, the size and character of the patient load may warrant the establishment of a separate urology service. In others, it may be determined that this specialty should be located as a branch of the surgical service. Similarly, it may appear practicable to establish an ophthalmology service and an otorhinolaryngology service in a very large hospital even though these specialties are found in a single organizational unit in most institutions. A specialty may be organized as a service when it is headed by a board-certified specialist. Each clinical service that is established should be an independent unit, reporting to the commanding officer through the director of clinical services.

(2) Each clinical service shall have the following functions in common:

(a) Insure that the highest standards of professional practice are maintained.

(b) Inform and advise the executive officer regarding all activities, including the care and condition of patients, especially the seriously and critically ill.

(c) Participate in staff conferences and provide consultant services as requested.

(d) Collaborate with the other clinical services and the administrative divisions, as appropriate, to promote patient comfort and welfare, and to speed patient recovery.

(e) Exercise general administrative control over assigned wards and supporting facilities.

(f) Participate in and conduct appropriate portions of the hospital training program.

(g) Confer with civilian consultants on appropriate problems, including the education and training of residents and interns.

(h) Initiate and conduct research and/or clinical studies, as appropriate.

(i) Insure the adequacy, security, maintenance, economical and proper use, and proper accounting of supplies and equipment.

(j) Insure the proper preparation and maintenance, and the prompt completion and submission of prescribed records, reports, and returns.

(k) Insure the prompt and proper disposition of patients as provided by law and regulations.

(l) Perform such collateral duties as may be assigned.

11–22A. Director of Clinical Services

(1) The executive officer of the hospital shall serve as the director of clinical services and, as such, directly supervises and coordinates the various clinical services, assuring that the highest standards of professional care are maintained. (See art. 11–8 for related responsibilities.)

11–23. Chiefs of Services

(1) Whenever practicable, the chief of a clinical service shall be the senior officer attached to the service and especially trained and competent in the professional field under his supervision.

(2) An officer designated by the commanding officer shall be assigned collateral duty as chief of research. It shall be his duty to organize, stimulate, and supervise clinical investigation pertaining to any and all of the clinical services, and to encourage Medical Department officers, including residents and
11-24. Ward Medical and Dental Officers

(1) Medical and dental officers in charge of wards, under the supervision of their respective chiefs of service, shall be responsible for their wards and shall have administrative authority over the staff and patient personnel assigned thereto. They shall be responsible for the neatness and orderliness of the wards under their charge and appurtenances thereto. They shall exercise personal supervision over the sick and require officers of the Nurse Corps and hospital corpsmen to be considerate and attentive in the care of all patients and punctilious in the administration of medicines. They shall be responsible for doctor’s orders, ward books, records, and forms. They shall sign the doctor’s orders, and morning reports of the sick and shall report to the proper authority all patients who, in their opinion, are ready for duty, convalescent detail, or survey. They shall be responsible for the careful and proper use and correct inventory of all ward property. They shall verify the ward inventory monthly, when relieving another officer in charge of the ward and upon relief from ward duty. They shall require compliance with all instructions or orders regarding the custody, issue, and administration of alcohol, narcotics, and poisons in the wards under their charge.

(2) They shall visit the sick at prescribed hours and shall make additional visits whenever necessary. They shall consult with the chief of service as necessary and keep him advised regarding the patients in their wards. (In an emergency, any available medical or dental officer may be called in consultation.) They shall accompany inspection parties through their wards and invite attention to matters of professional or administrative interest. They shall inform the officer of the day before leaving the hospital of the condition of the patients under their care who may need special attention during their absence. They shall prepare a daily list of the seriously or critically ill under their care for submission to the executive officer and the commanding officer.

(3) They shall familiarize themselves with the fire bill and instructions and orders regarding procedures to be followed in case of fire. In the event of fire, they shall supervise and assist in the removal of helpless and bed-ridden patients from the wards under their charge, using any personnel available.

(4) They shall give personal supervision to the diets and messings of patients, exercising care to keep special diets to a minimum consistent with the patients’ welfare and frequently observing the food service in their wards.

11-25. Junior Medical Officers

(1) Junior medical officers, when not serving as ward medical officers, shall perform such duties as may be assigned.

(2) All junior medical officers, except interns, shall be detailed for duty as officer of the day.

(3) Junior medical officers serving internships at the hospital shall stand instruction watches, attend lectures and meetings, and perform such duties as may be prescribed.

11-26. Residents

(1) Medical residents shall not be considered as having regular working hours. They must be regarded as being on duty 24 hours a day except that they may be permitted to be off watch every other night. It is mandatory that residents make ward rounds, attend autopsies, present medical papers, and attend staff or departmental medical conferences. The working hours and the general and special duty requirements for dental residents shall be prescribed by the committee on graduate medical and dental training.

(2) The resident-training program shall be the responsibility of the commanding officer and the committee on graduate medical and dental training. This committee shall consist of the commanding officer, the executive officer, the chief of the surgical service, the chief of the medical service, a member of the lecturer staff, the senior member of the intern committee, and the chief of the dental service when a dental residency program is being conducted in the hospital.

11-27. Nurse Corps Officers

(1) The chief of the nursing service shall be responsible to the commanding officer of the hospital for the proper performance of administrative duties in connection with general supervision of the nursing service. Her duties are enumerated in article 8-11.

(2) Nursing supervisors shall be responsible to the chief of the nursing service for the administration of nursing in all of the wards under their supervision. Their duties are enumerated in article 8-12.

(3) Ward charge nurses shall be responsible to the ward medical or dental officer for the execution of his orders concerning the administration of and patient care on the ward. Such nurses are further responsible through the nursing supervisors to the Chief of Nursing Service for the administration of nursing service in their respective wards. Their duties are enumerated in article 8-13.

11-28. Hospital Corpsmen

(1) Enlisted personnel of the Hospital Corps shall perform such duty as the commanding officer may
direct. They shall familiarize themselves with the orders and instructions relating to the work of the wards, offices, or special details to which they may be assigned. They shall familiarize themselves with their stations and duties in connection with fire drills and with all regulations for the safeguarding of patients and Government property and the maintenance of order.

(2) When on ward duty or other duty in the clinical services, hospital corpsmen shall be under the immediate supervision of the senior Nurse Corps officer on duty, if one is present, but subject to the authority of the medical and dental officers attached to the service, ward, or clinical facility. When not on duty, they shall be under the supervision of the executive officer, represented for this purpose by the officer of the day and the master at arms.

11–29. Patients

(1) For administrative purposes, patients are attached to the hospital and come under the direct supervision of the medical or dental officer in charge of their ward. They shall be required to comply with all lawful orders and instructions governing their conduct and treatment.

(2) Convalescent service patients may be detailed for light duty. A patient shall be assigned duty only with the approval of the ward medical or dental officer in charge of the case. The nature of the duties the patient is to perform shall be carefully defined and clearly understood by the ward medical or dental officer who approves the detail and by the person who will be in charge of the patient's work.

(3) Patients may be granted sick leave only in accordance with the current directives of the service concerned.

11–30. Disposition of Patients

(1) Discharge to Duty.—Military personnel on active duty shall be discharged to duty promptly upon recovery, and shall be transferred in accordance with the current directives of the service concerned. As soon as it is determined that an enlisted person in the naval service will not be returned to the command from which received, the commanding officer of the hospital shall promptly notify the command concerned, stating the reasons therefor.

(2) Transfer for Medical Reasons.—Patients may be transferred between Armed Forces medical facilities to facilitate recovery or to effectively use available bed spaces. Detailed transfer procedures are contained in current Instructions in the 6320 series concerning the subjects of medical regulating within continental United States, dependents' medical care, and transfer of patients to Veterans Administration hospitals. Although Armed Forces patients are normally transported by aircraft, travel by other means (including privately owned vehicles) may be permitted when travel by air is medically contraindicated. Travel by private means, including privately owned vehicles, if not medically contraindicated may be permitted when requested, but at no additional expense to the Government other than that authorized for travel by Government aircraft.

(3) Transfer for Personal Reasons.—When an active-duty, inactive-duty, or retired member of the naval service desires for personal reasons to be transferred from one Armed Forces medical facility to another, he may submit a request for transfer. The request shall include a statement to the effect that he agrees to pay all transportation and subsistence expenses involved in the transfer without reimbursement by the Government. An inactive-duty or retired member shall include in his request a statement to the effect that he is willing to pay any return transportation and subsistence costs involved upon his subsequent disposition from the sick list. An active-duty member of the naval service should address his request to the Chief of Naval Personnel, or the Commandant of the Marine Corps as appropriate, via the commanding officer of the hospitalizing medical facility (who shall make appropriate recommendations and state the probable date the patient will be available for duty), via any command carrying his records and accounts, and via the Chief, Bureau of Medicine and Surgery. An inactive-duty or retired member of the naval service should address his request to the Bureau of Medicine and Surgery via the commanding officer of the hospitalizing medical facility, who shall make appropriate recommendations. Intradistrict naval hospital transfers of members of the naval service may be effected upon approved request to the local district commandant.

(4) Restriction.—To safeguard against possible later additional travel being required, transfers for medical and personal reasons shall be contingent upon the adequacy of the proposed receiving facility to provide required care and disposition. In determining the adequacy of the receiving facility to provide required disposition, careful consideration should be given to the possibility that a service member may be required to appear before a board of medical survey in accordance with article 18–10 or a physical evaluation board in accordance with article 18–19.

(5) Orders and Travel.—The instructions governing orders for and travel of naval patients and attendants will be found in the Bureau of Naval Personnel Manual, the Marine Corps Manual, U.S. Navy Travel Instructions, and other current directives.

11–14

Change 7
11-31. Regulations

(1) Hospital ships which are designated as such by the Department of the Navy shall be employed for the purpose of caring for the sick and wounded. They shall be under the general cognizance of the Bureau so far as matters pertaining to the distinctly hospital features of the ships are concerned. They shall be governed by the orders of the Secretary of the Navy and other competent authority and by the Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of August 12, 1949 (see art. 3-30).

11-32. The Naval Hospital

(1) The naval hospital in a hospital ship shall embrace all of the persons attached to the hospital for duty or treatment, all activities within the ship which are devoted to the care and treatment of the sick and injured, and all parts of the ship which are used for the care and treatment of the sick and injured, including living quarters for persons attached to the hospital for duty and spaces for the storage of the supplies and equipment belonging to the hospital.

11-33. The Officer in Command

(1) The officer in command of the hospital in a hospital ship shall be the senior officer of the Medical Corps attached thereto. He shall be guided by the instructions in this chapter for the administration of a naval hospital ashore insofar as applicable and shall exercise control over its administration and organization, the assignment of its personnel and the establishment of technical methods and procedures. He shall be under the military command of the commanding officer of the ship. (Also, see U.S. Navy Regulations.)
Chapter 12
SPECIAL HOSPITALS AND
SPECIAL-TREATMENT CENTERS

Sections

I. Special-Treatment Centers ........................................ 12-1 through 12-4

Section I. SPECIAL-TREATMENT CENTERS

General ................................................................. 12-1
Aural Rehabilitation .................................................. 12-2
Oncology ............................................................... 12-3
Neuropsychiatry ...................................................... 12-4

12-1. General

(1) The Bureau, by current directives, designates certain naval hospitals to receive patients who require specialized treatment. When patients require definitive treatment and specialized medical care they may be transferred from naval hospitals not having adequate facilities to such special-treatment centers. Authority for the transfer of patients to these hospitals shall be requested in accordance with the provisions of article 11-30.

12-2. Aural Rehabilitation

(1) Patients requiring aural rehabilitation shall not be transferred to a special-treatment center unless the true loss of hearing in the better ear is more than 30 decibels in the conversational range (256–2048) or unless the hearing of the whispered voice in the better ear is less than 3/15. Authority for transfer shall be requested as soon as it is determined that these conditions exist.

12-3. Oncology

(1) Patients requiring treatment by radium or related procedures shall be transferred to the appropriate special-treatment center as soon as practicable. If available, slides and portions of the tissues should be forwarded with each patient. If no biopsy has been performed, a statement to that effect shall accompany the patient.

12-4. Neuropsychiatry

(1) Preliminary Evaluation, Treatment, and Transfer.—Whenever a member of the naval service is thought to be suffering from a neuropsychiatric disorder, he shall be referred to the nearest naval psychiatrist for evaluation and treatment recommendation. If it is recommended that the person be hospitalized or if the services of a naval psychiatrist are not available, he shall be transferred to the nearest naval hospital for diagnosis, treatment, and disposition. If during this hospitalization, it is found that he is in need of intensive and prolonged study and treatment, he shall then be transferred to a special-treatment center.

(2) Attendants.—When transfer of neuropsychiatric patients has been approved and attendants are considered necessary, orders for officers in the Medical Corps, Medical Service Corps, or Nurse Corps, and hospital corpsmen assigned as attendants shall be requested from the appropriate administrative command.

(3) Security of Patients During Transfer.—During the transfer of neuropsychiatric patients, necessary precautions shall be taken to assure supervision at all times, and to prevent injury to the patients themselves, or to others. Strong-rooms shall be used only in the event they are required for the management of acutely disturbed or suicidal patients. Cages or other confining facilities which impose unnecessary restrictions or which are incompatible with humane care shall not be used. For air transportation of neuropsychiatric patients, see article 14-9 (2). Instructions for the security and handling of court-martial prisoners are issued by the Navy Department from time to time. Reference should be made to these Instructions when psychiatric patients who have been sentenced or who are awaiting action by court martial are transferred or received.

12-1

Change 5
(4) Information To Be Obtained Prior to Transfer.—When recommending the transfer of a neuropsychiatric patient, medical officers shall transmit with the patient details of the precipitating incident or incidents, the significant personal history as related to the symptomatology characterizing the diagnosis and such other pertinent or supporting information as may have been gathered during admission and initial diagnostic procedures.

(5) Notification of Next of Kin.— Upon transfer of a psychiatric patient to one of the neuropsychiatric centers, the next of kin shall be notified by the transferring hospital, and informed that the transfer is in the best interest of the patient and that correspondence should be directed to the commanding officer of the designated center. This notification shall be by letter from naval hospitals within the continental limits and by dispatch from hospitals outside the continental limits of the United States. Medical terminology of a disturbing nature to lay personnel shall not be used. On the contrary, only a general indication of the patient's illness which has necessitated hospitalization shall be transmitted.

(6) Personal Effects and Valuables.—When a neuropsychiatric patient is to be transferred, his personal effects including money, articles of value, papers, and keepsakes shall be inventoried. Upon the actual transfer of the patient, his valuables shall accompany him. It is imperative that particular care be exercised to insure that the proper receipts are obtained in all instances and that these receipts are duly authenticated and filed. It is the responsibility of each command to promulgate and exact compliance with standing orders covering the receipt, recording, custody, safeguarding, and transfer of neuropsychiatric patients, their personal effects and valuables.

(7) Notification of Final Disposition.—When it appears that a member of the naval service, who requires further observation or treatment for a neuropsychiatric disorder, may not be entitled to such further observation or treatment under the cognizance of the Department of the Navy, the next of kin shall be notified by the naval hospital sufficiently in advance to permit the next of kin to indicate preference for the alternative methods of disposition available. When the effective date of separation has been determined and if the patient is not to be discharged into the immediate custody of the next of kin, the latter shall be notified of the following: Date and place of discharge; whether the patient will be discharged into his own custody or into the custody of the Veterans' Administration, or a State or private facility; and the address of the facility to which he is being transferred if he is not to be discharged into his own custody. The next of kin shall further be informed that correspondence should be directed to the facility to which the patient is being transferred after his anticipated date of arrival.
Chapter 13
NAVAL MEDICAL CENTERS

Sections

<table>
<thead>
<tr>
<th>Articles</th>
<th>Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-1 through 13-11</td>
<td>I. The National Naval Medical Center, Bethesda, Md.</td>
</tr>
<tr>
<td>13-12 through 13-18</td>
<td>II. U.S. Naval Aviation Medical Center, Pensacola, Fla.</td>
</tr>
</tbody>
</table>

Section I. THE NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.

<table>
<thead>
<tr>
<th>Article</th>
<th>Establishment</th>
<th>Organization and Command Relationships</th>
<th>Consultation Service</th>
<th>Administrative Activities of the Center Command</th>
<th>U.S. Naval Hospital</th>
<th>U.S. Naval Medical School</th>
<th>U.S. Naval Medical Research Institute</th>
<th>U.S. Naval Dental School</th>
<th>U.S. Naval School of Hospital Administration</th>
<th>U.S. Navy Toxicology Unit</th>
<th>Library Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-1</td>
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13-1. Establishment

(1) By authority of the Secretary of the Navy, the Naval Medical Center, Washington, D.C., was established on 20 June 1935. At that time the Center consisted of the Naval Hospital and the Naval Medical School. On 17 March 1936, the Naval Dental School was established as a separate command under the jurisdiction of the Medical Center. In fiscal year 1939 Congress provided for the construction, in the District of Columbia or in the immediate vicinity thereof, of buildings and facilities to replace the Center and its subordinate activities. As a result of congressional action and directives of the Department of the Navy, the National Naval Medical Center was established at its present location in Bethesda, Md., on 5 February 1942. Two additional component commands, the Naval Medical Research Institute and the Naval School of Hospital Administration, were established in 1942 and 1945, respectively. The Navy Toxicology Unit was established in 1959.

13-2. Organization and Command Relationships

(1) The National Naval Medical Center, Bethesda, Md., commanded by an officer of the Medical Corps, is the parent activity of the following component commands:
   (a) U.S. Naval Hospital.
   (b) U.S. Naval Medical School.
   (c) U.S. Naval Medical Research Institute.
   (d) U.S. Naval Dental School.
   (e) U.S. Naval School of Hospital Administration.
   (f) U.S. Navy Toxicology Unit.

Each of these activities is headed by a Commanding Officer with the exception of the Toxicology Unit, which is under an Officer in Charge.

(2) The Commanding Officer of the Hospital has additional duty as Deputy Commanding Officer of the Medical Center.

(3) This organization, which functions as a medical, dental, diagnostic, educational, and research center, is under the management control of the Bureau of Medicine and Surgery and under the military command of the Commandant, Potomac River Naval Command.

13-3. Consultation Service

(1) The Medical Center maintains liaison with other institutions to facilitate promotion of common professional interests. It is prepared to fur-
nish certain consultation and diagnostic services. Requests for professional assistance should be addressed directly to the component command concerned.

13-4. Administrative Activities of the Center Command

(1) As the parent activity of the various component commands, the Medical Center command exercises direct control over certain administrative and logistic activities, including fiscal, public works, personnel, security, disbursing, supply, Navy exchange, officers' quarters and messes, legal affairs, communications, sanitation, special services, religious services, civilian personnel, transportation, maintenance, laundry, information and education, service information (in collaboration with the component commands), radiological safety, fire protection, and Naval Reserve training.

13-5. U.S. Naval Hospital

(1) The Hospital, the major component command of the Medical Center, was established as a general hospital for the diagnosis, treatment, and hospitalization of active and retired personnel of the Navy and Marine Corps and their dependents. Hospitalization is also afforded those patients authorized by the Veterans' Administration, and to certain groups of government officials, such as Members of Congress and the naval attaches of foreign countries on duty in Washington. The Hospital has been especially designated to provide definitive treatment and specialized medical care in the following areas: deaf, surgery for; keratoplasty; neurology; neurosurgery; ocular prosthesis, acrylic; oncology; open-heart surgery; plastic surgery; nuclear medicine and radioisotope laboratory facilities; thoracic and cardiovascular surgery; and tropical diseases.

(2) The administrative organization of the Hospital differs from that of other naval hospitals in that the Hospital is a component command of the Medical Center, and receives certain administrative and logistic support from the parent organization. The Hospital provides its own Military Staff and Patient Personnel Records Division, Security Division, Administrative Division, and a Food Service Division which serves all commands of the Center. The Commanding Officer of the Hospital, as Deputy Commanding Officer of the Medical Center, is responsible to the Commanding Officer of the Center for coordinating those administrative and professional functions of the Center which have a direct bearing on the patient-care mission of the Hospital. The organization of the professional services is essentially the same as that of other naval hospitals, except that laboratory services are provided by the Naval Medical School, and dental services are furnished by the Naval Dental School.

13-6. U.S. Naval Medical School

(1) The Medical School is fundamentally a postgraduate institution that encompasses a number of special activities. Its chief mission in peacetime is the training of Medical Corps officers, Nurse Corps officers, Medical Service Corps officers, and hospital corpsmen of the Navy for service ashore and afloat, with special emphasis upon certain phases and branches of medicine and surgery of particular importance and peculiar to the Navy. Secondary missions in the specialties include some research, the performance of special tests for the Navy as a whole, medical photography, audiovisual services, closed-circuit television project, the publication and production of manuals, correspondence courses, and audiovisual texts.

(2) Courses for Medical Corps officers include: residency training in pathology, including clinical pathology; applied basic sciences for residents; radioisotopes and nuclear medicine; tissue banking for surgical and orthopedic residents; military medicine and special weapons for reserve officers of all the Armed Forces; and various special refresher symposia, seminars, and workshops in military medicine, entomology, biochemistry, parasitology, bacteriology, and nuclear medicine.

(3) Courses for Nurse Corps officers include: blood bank administration and technique; nuclear nursing; and Navy nurse practice and nursing service administration for foreign nurses.

(4) Courses for Medical Service Corps officers include: nuclear physics in the department of nuclear medicine; and graduate clinical traineeships in bacteriology or chemistry.

(5) Courses for enlisted personnel include: blood bank; chemistry; medical photography; optician (laboratory); occupational therapy; physical therapy; radioactive isotopes; tissue bank; X-ray; and clinical laboratory and medical illustration.

(6) Also, many microscopic slide collections, topic slide presentations, and collections of specimens such as entomology are available for use.

(7) Although the school is not primarily a research facility, some basic and development research is necessary in highly specialized fields, such as nuclear medicine, electrophoresis, tissue chemistry and culture, and autoradiography.

(8) All general laboratories required to supplement the work of the adjoining Naval Hospital are within the Medical School. These laboratories also serve as a consultation center for the Navy at large, wherever a local laboratory of a naval hospital, dispensary, or ship desires assistance. The general laboratories include the facilities of pathology, parasitology, hematology, serology, bacteriology, entomology, epidemiology, physiological chemistry, general chemistry, toxicology, blood collecting, and blood bank. The School prepares for the naval
service at large certain biologicals and chemicals such as Kahn antigen, diagnostic bacterial antigens, and colloidal gold solution. In the Tissue Bank the freeze-dry principles and other methods are applied to the preservation of human grafts so that viable and nonviable tissue can be made available to other facilities for use. The Bank supplies skin, bone, fascia, dura, blood vessels, cartilage, and cornea on an international basis.

The Edward Rhodes Stitt Library consisting of approximately 35,000 medical books, journals, and pamphlets is the central medical library for the Navy Medical Department and comes within the purview of Medical School's administration. The services of the Library are available to other facilities in the area and as noted in article 13-11.

The Duplication, Medical Illustration, and Medical Photography Divisions provide the other necessary services for completing a well-knit organization dedicated to advancing professional knowledge in the Medical Department of the Navy.

13-7. U.S. Naval Medical Research Institute

The Institute conducts basic and applied research in all branches of the biological sciences as well as the medical aspects of the utilization of atomic energy. The scientific organization of the Institute consists of facilities and scientific personnel for conducting research in atomic defense, aviation medicine, biochemistry, chemistry, personnel equipment and design thereof, nutrition, pathology, physiology, submarine and diving medicine, virology, bacteriology, biophysics, experimental dentistry, hematology, parasitology, pharmacology, toxicology, psychology, and experimental surgery. In addition, there are such service units as animal laboratories, technical shops, a glass apparatus laboratory, and instrumentation laboratory. The Institute trains medical personnel in modern research methods and offers opportunities for interested and qualified personnel of the Medical Department to conduct or participate in research projects. Research projects, as at other research units, are conducted with the approval of the Chief of the Bureau of Medicine and Surgery and are under the administrative direction of the Research Division of the Bureau. The Institute, upon occasion, sends research teams to the field and aboard ships to conduct specific investigations, such as those of outbreaks of dysentery.

13-8. U.S. Naval Dental School

The Dental School is primarily concerned with postgraduate instruction for Dental Corps officers. Its mission is to conduct postgraduate advanced instruction for Dental Corps officers in the various fields of dentistry peculiar to the needs of the naval service, to instruct and train enlisted personnel to fit them to perform duties of Group XI dental ratings, and to provide dental support to other activities of the Medical Center.

Courses of instruction for Dental Corps officers include: general postgraduate course; residencies in oral surgery, prosthodontics, periodontics, and oral pathology; specialized courses in oral surgery, prosthodontics, crown and bridge, maxillofacial prosthesis, periodontics, and oral pathology; and short inservice training in oral surgery, endodontics, oral roentgenology, oral pathology, partial dentures, periodontics, high speed orientation, casualty care, crown and bridge, and complete dentures.

Courses of instruction for enlisted personnel include: class B advanced general, class B advanced prosthetics, class C repair, and class C maxillofacial prosthesis.

The School conducts all Bureau-administered extension and correspondence courses taken by dental officers and correspondence courses taken by enlisted personnel.

The School prepares manuals, handbooks, motion picture films, illustrations, and models suitable for instructional purposes.

The School has also been designated as the histopathology center for oral and dental tissues.

13-9. U.S. Naval School of Hospital Administration

This School provides advanced instruction in the modern theory and practice of hospital administration for Medical Service Corps officers of the Navy and such other officers as may be assigned. To fulfill this task the curriculum is formed each year with the objective of preparing officers for positions of responsibility in the administrative management functions of military hospitals.

This School also conducts such other courses of indoctrination and instruction for officers of the Medical Service Corps as may be directed from time to time.

13-10. U.S. Navy Toxicology Unit

The Toxicology Unit provides technical and specialized services in the fields of operational toxicology and health engineering as related to toxicity problems encountered aboard ships and in the design and use of new weapon systems. The Unit conducts field studies and laboratory evaluations of potentially toxic air contaminants which may result in the degradation of performance of personnel. It also develops and provides biological data necessary for determining permissible limits so that precautionary measures, conducive to good health practices, may be prescribed. Operational investigations are conducted with the approval of the Chief of the Bureau of Medicine and Surgery, and are under the
administrative direction of the Research Division of the Bureau.

13–11. Library Service

(1) Applications from Medical Department personnel of ships and stations for the temporary loan of books and duplicate copies of current periodicals in the Edward Rhodes Stitt Library, or obtainable from other sources, should be addressed to the U.S. Naval Medical School. It is desired that the library of the school be utilized generally, but possibility of loss in transit prevents issue of unbound periodicals. There are certain books which are so valuable or in such current demand that they may not be issued on a loan basis. When originals cannot be furnished, it may be possible to supply photostatic copies of particular articles.

Section II. U.S. NAVAL AVIATION MEDICAL CENTER, PENSACOLA, FLA.

13–12. Establishment

(1) By authority of the Secretary of the Navy, the U.S. Naval Aviation Medical Center located at the U.S. Naval Air Station, Pensacola, Fla., was established on 8 April 1957. Component commands of the Center are the Naval Hospital and the Naval School of Aviation Medicine located within the geographical boundaries of the Naval Air Station at Pensacola.

13–13. Mission

(1) The Mission of the Naval Aviation Medical Center is to administer the Naval School of Aviation Medicine and the Naval Hospital by direction, coordination, and professional supervision concerning aviation medical training, clinical and hospitalization services, aviation medical research, and evaluation of aeromedical equipment.


(1) The Naval Aviation Medical Center is under the command of an officer of the Medical Corps and is the parent activity of the U.S. Naval Hospital and the U.S. Naval School of Aviation Medicine.

(2) The Center is under the military command of the Chief of Naval Air Training and the management control of the Bureau of Medicine and Surgery. Each commanding officer of the component commands exercises authority commensurate with his responsibilities subject to the limitations prescribed by law and Navy regulations and contributes to the effectiveness of the Center as a whole.

(3) Official correspondence of a routine or technical nature requiring no action, review, or comment by office in the chain of command may be forwarded directly to the component command concerned.

13–15. Consultation Service

(1) The Commanding Officer of the U.S. Naval Aviation Medical Center maintains close liaison with the Chief of Naval Air Training in his additional capacity as Staff Medical Officer of the Naval Air Training Command. Consultation and diagnostic services are available to all naval air activities through joint utilization of the Naval School of Aviation Medicine and the Naval Hospital. Requests for professional assistance should be addressed directly to the Commanding Officer of the U.S. Naval Aviation Medical Center.

13–16. Administrative Activities of the Center

(1) The Center Command consists of an Office of the Commanding Officer, a Special Assistant for Training and Research, a Special Assistant for Public Information, a Finance Division, a Maintenance Division, a Personnel Division, and a Supply Division.

(2) The Finance Division provides complete financial and fiscal support to the Center Command, the Naval Hospital, and the School of Aviation Medicine. This support includes financial planning and property and cost accounting and reporting.

(3) The Maintenance Division provides the maintenance, safety, and plans programs for selected components of the Center. The division is
responsible for the maintenance of designated buildings, grounds, and associated machinery and equipment. The division establishes and provides for inspection and safety procedures and prepares plans and budgetary data for public works programing.

(4) The Personnel Division administers the military personnel program for the Center Command and the civilian personnel program for the Center and for its component activities.

(5) The Supply Division provides complete supply support to the Center and to its component activities. In addition, it provides medical supply support to selected naval activities located in the Pensacola area.

13-17. The Naval Hospital

(1) The Naval Hospital provides (a) general clinical and hospitalization services for the naval shore activities and fleet units of the Operating Forces; (b) joint hospitalization services for Armed Forces personnel; (c) general clinical and hospitalization services for dependents of armed services personnel and other authorized supernumeraries; (d) for the reception, screening, treatment, and transfer of casualties; (e) for the indoctrination and training of Medical Department personnel in clinical techniques and specialties and in naval procedures and functions; and (f) on-the-job and technical training for Hospital Corpsmen.

(2) With the exception of the finance, maintenance, supply, and civilian personnel activities which are administered by the Center Command, the administrative organization of the Hospital is similar to that of other naval hospitals.

(3) Academic instruction in the clinical specialties is afforded to the student naval flight surgeons.

13-18. The Naval School of Aviation Medicine

(1) The Naval School of Aviation Medicine conducts training and research in aviation medicine.

(a) Training.—The training program consists of training medical officers in aviation medicine, qualifying them for the designation of Naval Flight Surgeon or Naval Aviation Medical Examiner; training enlisted personnel as technical assistants for flight surgeons, qualifying them for the designation of Aviation Medical Technician; providing postgraduate instruction in aviation medicine with particular emphasis on refresher courses for reserve flight surgeons; providing special courses in aviation physiology for Medical Service Corps officers for designation as Aviation Applied Physiologists; assisting in the training of student naval aviators by conducting instruction in, and supervision of, the physiological and aeromedical aspects of high altitude and night flying, and of survival and related equipment. In addition, the School conducts a residency training program for the preparation of applicants for eligibility for certification in Aviation Medicine by the American Board of Preventive Medicine.

(b) Research.—The School of Aviation Medicine conducts basic and applied research in aviation medicine and allied fields. The Research Department is staffed with scientific personnel and is equipped for conducting research studies in the following program areas: Stress due to acceleration and deceleration; stress due to high altitude; stress due to high intensity noise; standards for aviation personnel; aviation safety; escape and rescue; training and reeducation of aviation personnel; psychophysiology including sensations and illusions; and human engineering.
Chapter 14
SPECIAL ACTIVITIES

Sections

I. Amphibious Operations and Field Service .................................................. 14–1 through 14–2
II. Aviation Service ......................................................................................... 14–3 through 14–9
III. Submarine and Diving Services ................................................................. 14–10 through 14–17
IV. Naval Advanced Base Organization ......................................................... 14–18 through 14–23

Section I. AMPHIBIOUS OPERATIONS AND FIELD SERVICE

Medical Service for Amphibious Operations .................................................. 14–1
Field Service .................................................................................................. 14–2

14–1. Medical Service for Amphibious Operations

(1) The function of the Amphibious and Marine Corps Field Medicine Division of the Bureau is to supply information on logistics and operations and to make recommendations regarding technical personnel for this special work. This division maintains liaison with the Headquarters, U. S. Marine Corps.

14–2. Field Service

(1) The responsibilities of the Medical Department in field service are included in the Landing Force Manual 16. Therefore, reference should be made to that publication for instructions.

Section II. AVIATION SERVICE

Flight Surgeons and Aviation Medical Examiners ....................................... 14–3
Flight Surgeons Assigned to Ships or Stations ............................................. 14–4
Flight Surgeons Assigned to Aviation Units ............................................... 14–5
Functions of Flight Surgeons ....................................................................... 14–6
Reports and Recommendations ................................................................. 14–7
Emergency Care of Casualties ................................................................. 14–8
Transportation of Sick and Wounded Personnel by Air ......................... 14–9

14–3. Flight Surgeons and Aviation Medical Examiners

(1) Flight surgeons and aviation medical examiners assigned to aviation activities, in addition to their responsibilities as naval medical officers, have cognizance over the aero medical considerations encountered within their units. They shall be specifically concerned with the physical fitness and welfare of all flying personnel, their aero medical indoctrination in high altitude flight, the use of special personal airborne equipment, the ejection seat, night vision and other physiological and psychological aspects of aviation.

(2) The term “flight surgeon” is used throughout the remainder of this section as applying to both flight surgeons and aviation medical examiners. Ordinarily aviation medical examiners are under the preceptorship of flight surgeons.

(3) Flight surgeons are assigned to the following type commands:

(a) Naval and Marine Corps air stations, auxiliary air stations, and air facilities.

(b) Aircraft carriers.

(c) Seaplane tenders.

(d) Fleet air wings.

(e) Carrier air groups or squadrons afloat, ashore, or at advanced bases.

(f) Fleet Marine Force aircraft wings, groups, or squadrons ashore, at advanced bases, or afloat.

(g) Advanced aircraft support or maintenance bases.

(h) Fleet logistic wings, Marine aircraft transport groups, and the Military Air Transport Service.

14–1

Change 5
(i) Air-sea rescue squadrons.

(j) Certain of the commands listed above, as staff medical officers. They may also be assigned to aviation operational billets as required or administrative positions in aviation medicine as medical liaison officers. When circumstances permit, flight surgeons may be ordered to naval hospitals to supplement their training in clinical medicine or to courses in preventive medicine as required for certification in aviation medicine. Flight surgeons with special training may be assigned duty in aeromedical research and development at various laboratories and operational activities.

14-4. Flight Surgeons Assigned to Ships or Stations

(1) In general, flight surgeons are assigned as medical officers in air commands afloat or ashore. If the flight surgeon is junior in rank to the medical officer of the ship or station, he shall be an assistant to the latter. He shall, however, be given every opportunity and all possible assistance in the performance of his primary duties in the practice of aviation medicine and in the acquisition of additional information relative to the special problems of flying. The physical fitness of all flying personnel attached to the command and their physical and psychological readiness for duty must be his concern. Through the application of his interests and training in aviation medicine, the flight surgeon shall insure that all pilots and aircrewmen are adequately trained in the physiological aspects of flight and continually maintain a high level of proficiency in the use of personal airborne and survival equipment. The senior flight surgeon shall be responsible to the commanding officer in matters relating to aviation medicine and he shall be cognizant of the aeromedical considerations involved in the flight-safety program. When required, he shall be a member of the Aircraft Accident Board, utilizing available facilities in aviation pathology and toxicology.

14-5. Flight Surgeons Assigned to Aviation Units

(1) When an aviation unit such as an air group or squadron is embarked on a ship or is based on a naval aviation shore facility, the flight surgeon assigned as the medical officer of the unit shall be under the administrative cognizance of the medical officer of the ship or aviation shore facility. The unit flight surgeon shall, however, be recognized as an integral part of the command to which he is attached and shall advise his commanding officer on all matters relating to aviation medicine, as it affects the operational mission of the unit. His knowledge and understanding of personnel within his activity will permit the assessment of aviators and aircrewmen as to their aeronautical adaptability for any mission which may be assigned to them. Frequent flights with pilots of his unit will assist the flight surgeon in formulating such evaluations. As required, the unit flight surgeon shall serve as a member of the Aircraft Accident Board established within his activity.

14-6. Functions of Flight Surgeons

(1) The flight surgeon, to discharge his primary duties in connection with aviation medicine within his command, shall associate himself with the immediate environment of the pilot as closely as possible. He shall attempt to know intimately each pilot, aircrewman, and their families in order to learn of any unusual circumstances which might adversely affect their flight proficiency. He must be familiar with the operational missions his unit may be called upon to undertake and must insure that every effort is made to apply aeromedical considerations to the human factors involved to improve, if possible, the military capabilities of the command. The flight surgeon should be conversant with the flight characteristics of the aircraft assigned to his unit and should gain an understanding of individual pilot reactions to these aircraft. Unusual anxiety or apprehension resulting from assignment to specific aircraft should be recognized and evaluated in connection with the background, training, and capabilities of the aviator. Particular note must be made of the sum total of stresses to which flying personnel are subjected during the course of a mission; such as, fatigue, noise and vibration, repeated changes of altitude, unfavorable weather, navigational difficulties, combat, and night carrier operations.

(2) Flight surgeons assigned to operational duties have specific responsibilities and shall participate actively in the aviation physiology training program. Flight surgeons in charge of physiological training units shall be responsible for the content of lectures and demonstrations presented to aviation personnel. They shall keep adequate records of the activities of the unit and make appropriate entries in the Health Records of personnel completing the training syllabus. In accordance with current instructions, training shall be presented in the physiological aspects of reduced barometric pressure, acceleration, temperature effects, noxious gases, airsickness, disorientation, fatigue, first aid, ionizing radiation, night vision and other factors which apply to operational missions. In addition, indoctrination shall be given in the use and physiological implications of airborne personal equipment; such as, antiblackout suits, oxygen systems with particular emphasis on regulators and masks, antixexposure suits, survival equipment, pressure suits, parachutes, crash helmets, noise protective devices, ejection seats, escape capsules, and other protective and safety equipment as developed. To insure that all aviation personnel
are capable of coping satisfactorily with the hazards of flight to which they may be exposed, it is necessary that flight surgeons maintain the physiological training program on a continuing basis through lectures, demonstrations, low pressure chamber runs, applicable motion pictures presented at appropriate intervals, and other training aids.

(3) The physical examinations of all flying personnel shall be performed by flight surgeons in accordance with the provisions and instructions outlined in the aviation section of chapter 15.

(4) Flight surgeons attached to operational commands shall be concerned with the maintenance of personal airborne equipment in a supervisory capacity and shall make frequent inspections of the equipment in use by flying personnel. In addition, they shall examine existing facilities and maintenance practices in oxygen shops and parachute lofts.

(5) The physical well-being of flying personnel is a prime responsibility of the flight surgeon and he shall make every effort to insure that all flying personnel are physically and psychologically fit prior to flight.

(6) The flight surgeon shall maintain an active interest and participation in the flight safety program. The analysis of aircraft accidents from the standpoint of the human factors involved shall be formulated by the flight surgeon and integrated with existing engineering data. The major emphasis, however, shall be on the prevention of accidents and the recognition of incipient unsafe conditions.

14-7. Reports and Recommendations

(1) Based on his technical knowledge and special training, the flight surgeon shall make appropriate reports and recommendations to the commanding officer, via the medical officer when necessary, concerning the following:

(a) Physical fitness of flying personnel, collectively and individually, as determined by observation and physical examinations.

(b) Measures to promote the physical welfare of flying personnel with particular reference to physical exercise, recreation, and rest and leave periods.

(c) Measures to promote flight safety.

(d) Maintenance practices in connection with personal airborne equipment to prevent the possibility of malfunction in flight.

(e) Human engineering and design factors pertaining to cockpits and other related equipment to improve operational effectiveness.

(f) The presence of toxic or potentially hazardous factors having biological effects; such as, cockpit contamination, high intensity noise, microwave radiation emanating from high-powered radar equipment, and other conditions having an unfavorable influence upon flight operations.

14-8. Emergency Care of Casualties

(1) Care and Training.—Flight surgeons shall be responsible for providing adequate medical facilities for the emergency care of casualties. Hospital Corps personnel assigned to aviation activities shall be thoroughly trained in first aid, with special emphasis on injuries most likely to occur during flight operations. Such training shall include the removal and handling of aircraft casualties, artificial respiration, and the use of resuscitators.

(2) Aviation Activities Ashore.—Emergency bills shall be prepared to enable the medical department to render prompt and effective assistance in the event of an aircraft crash. Medical aid shall be available at all times during flight operations. When flight operations are performed at distant or outlying fields, a medical officer or hospital corpsman shall be in attendance until flying is secured.

(3) Aviation Activities Afloat.—Emergency bills shall be prepared to cover flight operations. Specific and routine duties of medical personnel are outlined in the ship’s flight quarters bills.

14-9. Transportation of Sick and Wounded Personnel by Air

(1) Bureau Responsibility for Programs.—The Bureau has responsibility for the development and employment of medical facilities, techniques, and procedures for air transportation of patients in aircraft. It provides for the training of specialized personnel for assignment to medical duties in connection with air transport, the operational maintenance and improvement of medical services and facilities required, the preparation of estimates of medical requirements, and the maintenance of necessary records.

(2) Air Transportation of Patients.—Medical officers desiring to transfer patients by air shall submit requests for transportation in accordance with current directives, indicating by class the number of patients for which air transportation is desired. In coordinating the transport of patients by air, the Bureau maintains appropriate liaison with the Deputy Chief of Naval Operations (Air), the fleet logistic air wings, Marine aircraft transport groups, and the Military Air Transport Service.
14–10. General Duty

(1) The submarine medical officer plays a major role in maintaining a state of peak operational efficiency among personnel engaged in submarine, diving, and underwater-swimming activities. He does so by constantly devising and implementing improved personnel-selection procedures, detecting and proposing measures to minimize the effects of personnel exposures to innumerable health and safety hazards, playing an active role in the field of human engineering to better fit the man to his environment, and prescribing definitive therapeutic measures for restoration and maintenance of good physical and mental health. Submarine, diving, and underwater-swimming personnel have correlated duties and are generally exposed to common environmental conditions; principally, repeated underwater sojourns within a confined space with exposures to variable barometric pressures in an atmosphere whose composition changes frequently and often becomes adulterated by toxic or noxious gases and vapors. Problems of air conditioning and the physiological effects of increased air pressure are of great importance. It is essential that medical officers detailed to submarine or diving duty thoroughly familiarize themselves with these conditions, their effects, and the required protective measures. This understanding should include a clear appreciation of the relative importance of air temperature, humidity, and turbulence as they affect a satisfactory air condition; factors peculiar to submarines that affect air condition; the physiology of respiration under increased air pressure; safety measures provided for personnel; and the principle and proper mode of operation of the mechanism, and the method of effective inspection of personnel safety devices.

(2) Personnel detailed to submarine and diving duty represent a select group working under stress of hazard. In submarines their work requires close personal contact and a high degree of cooperation. The morale of such a crew demands men physically and mentally fit and functioning without friction. The submarine medical officer has a major responsibility in maintaining this morale. He should make a conscientious effort to acquire the trust and confidence of the crew. He should become sufficiently familiar with the personnel to detect and treat early signs of physical disease or mental deterioration and should critically inspect incoming personnel for any factors detrimental to the physical or mental health of the crew. The obviously unfit should be hospitalized and reevaluated. Doubtful cases should be held for observation.

(3) The submarine medical officer is in a position to observe submarine and diving activities in actual practice. He should observe them critically from the point of view of detecting defects or recommending improved appliances or practices affecting the health of personnel, and should report upon them to the Bureau for analysis and development.

(4) In addition to these specialized duties at sea, submarine medical officers may also be assigned as medical liaison officers and, as circumstances permit, to naval hospitals to supplement their training and practice in clinical medicine. For assignments ashore they are especially qualified to conduct medical research studies at various laboratories. They may also be assigned to training courses in the preventive aspects of medicine which is a requirement toward their certification in occupational medicine. Should their interests lean toward certification in one of the clinical specialties, training courses and residency programs are available for that purpose.

14–11. Inspections and Related Functions

(1) In addition to making routine inspections of personnel and materiel, the medical officer attached to a submarine squadron shall, with the approval of his commanding officer or superior officer, frequently make inspections of each submarine with regard to the adequacy and condition of supplies for first aid; the proficiency of personnel assigned to administer first aid; condition of submarine-escape equipment; readiness for use of oxygen cylinders and carbon-dioxide absorbent and submarine compartment noxious gas detection equipment; supply and condition of emergency rations and drinking water in each compartment; condition of living spaces as to cleanliness, bedding and vermin, and air condition; methods and practices utilized in the preparation and serving of food, and in garbage disposal; sanitary protection of the potable water supply; readiness of equipment for administering
oxygen for resuscitation; readiness of rescue-breathing apparatus, etc.

(2) The medical officer attached to a submarine squadron should observe the submarine under operating conditions to familiarize himself with the living and working conditions on board and to obtain a direct knowledge of the methods provided for the protection of the personnel against all possible atmospheric and other hazards under both surface and submerged conditions. Reference should be made to current Bureau instructions and the Bureau of Ships Manual.

(3) When indicated the medical officer shall examine all personnel prior to a patrol run or prolonged cruise to detect physical or mental conditions likely to lead to disability during the cruise. Upon the completion of such a patrol run or prolonged cruise, the medical officer shall confer with the commanding officer and the hospital corpsman regarding the physical state and psychological behavior of the crew during patrol. He shall perform a complete physical examination and have performed a thorough dental examination of all members, giving particular attention to the psychological, including the emotional, state of each individual. These observations and remedial procedures are also applicable to members of underwater demolition or explosive ordnance disposal teams who are required to perform hazardous missions under combat conditions. In evaluating such examinations consideration must be given to possible accumulative effects of several stresses in combination such as fatigue, isolation and other claustrophobic factors, noise, vibration, monotony and underwater blast effects, barometric and thermal fluctuations, adverse weather effects, night operations, underwater-swimming navigational difficulties, enemy actions, and the like.

(4) With an expanding nuclear powered submarine program underway, the submarine medical officer is required to advise with regard to detection and prevention of nuclear radiation hazards. Such a program is particularly important during inspection or repair procedures which must be performed in the lower reactor compartment or when replacement of the reactor become necessary during scheduled overhaul periods. Because of prospective longer runs under nuclear power with no opportunity for replenishing the fresh air supply, the effects of low concentrations of trace elements in a continuously closed space become an increasingly important problem.

14-12. Instruction of Personnel

(1) The medical officer shall actively support an instruction program for all submarine personnel, both officers and men, in first aid and submarine hygiene, emphasizing artificial respiration; treatment of thermal, flash, oil, and acid burns; protection of the ears against increased air pressure and high-intensity noise; protection of the eyes from electric flash; protection against ambient atmospheric hazards such as chlorine gas, carbon monoxide, increased carbon dioxide, oxygen deficiency, arsenic, stibine, hydrogen, vapors of hydrocarbons, amines, refrigerant gases and their breakdown products, and heat prostration; protection from nuclear radiation hazards; air conditioning; handling of accidents occurring during the use of submarine-escape equipment; use of rescue and survival equipment; decompression illness; and day and night vision.

(2) Hospital corpsmen attached to submarines should receive special instruction for independent duty, with particular emphasis on the indications for, and the technique of, the administration of blood substitutes and other intravenous therapy. It must be borne in mind that the hospital corpsman is the only Medical Department representative aboard a submarine in operational areas and thus must be carefully selected and as highly trained as practicable for any exigency which may arise.

14-13. Venereal Diseases

(1) Active venereal disease cases generally should not be retained on board submarines. Cases of gonococcus infection, urethra, that develop after sailing shall be treated at the discretion of the commanding officer as advised by the hospital corpsman when transfer is not practicable. Treatment shall conform to the generally accepted therapy. Treatment-resistant cases and those developing complications shall be transferred to Medical Department facilities as soon as practicable.

(2) (a) If open genital lesions develop after sailing, and it will be impracticable to transfer the patient within 2 weeks to a ship or station where diagnostic facilities are available, the presumption will be made that the patient has syphilis and the necessary treatment and followup begun. The recommended treatment is as follows in order of preference:

1. Benzathine penicillin G in a dose of 1,200,000 units given once a week for 4 weeks.
2. Procaine penicillin G in oil with 2 percent aluminum monostearate in eight intramuscular injections of 600,000 units each at 48- to 72-hour intervals.
3. Procaine penicillin G in aqueous suspension in a dose of 600,000 units given intramuscularly once daily for 10 days.

(b) Because of the possibility of chancroid or other disease which is unresponsive to penicillin, concurrent treatment with either sulfadiazine tablets in a dosage of 1.0 gram four times daily or a broad spectrum antibiotic of the tetracycline family in a dosage of 500 milligrams four times daily for 1 week is also recommended.
This may be delayed until the response to penicillin is determined and omitted if the lesion heals promptly with penicillin therapy.

(c) All such cases should be referred or transferred to an adequate medical facility as soon as is practicable.

(3) Cases of venereal diseases so transferred shall be returned to duty aboard submarines when in the opinion of the medical officer such cases are no longer infectious and medical facilities are adequate to continue treatment.

(4) Men who contract syphilis after being trained in submarines may be returned to duty aboard submarines when in the opinion of the medical officer no further treatment is indicated (see also art. 15-29 (2) (f)).

(5) Venereal disease inspections, prophylactic procedures, and venereal disease education programs should be carried out in accordance with existing instructions and regulations.

14-14. Reports and Recommendations

(1) The medical officer shall observe carefully the effects of submarine duty on the personnel and as each occasion arises report by letter (Effects of Submarine Duty on Personnel, Reports Symbol Med-6420-2) to the Bureau the results of his observation and the steps taken and recommendations made to remedy the effects found. The following are examples of subjects which may be covered in the report:

(a) Physical and psychological effects on personnel of protracted service in submarines.

(b) Conditions arising from deleterious atmospheric conditions.

(c) Diseases or disabilities peculiar to duty in submarines.

(d) Excessive exposures to nuclear radiation.

(e) Ventilation, use of air-purification apparatus, etc.

(f) Eye strain in relation to periscope work; effects of electric welding on the eyes.

(p) The submarine ration and potable water sanitation.

(h) Dark adaptation and night visual acuity.

(i) Radiologic exposures and monitoring data.

(j) Principles of sanitation in living and messing stations.

14-15. Physical Examinations

(1) Physical examinations of submarine and diving personnel shall be conducted in accordance with instructions contained in this manual. In the physical examination and treatment of such personnel, particular emphasis shall be placed upon dental, otological, and nasopharyngeal conditions and upon the emotional stability of the individual.

(2) A medical and a dental officer shall examine all officers and enlisted men who are candidates for the course of instruction at the Naval School, Deep Sea Divers, Naval Gun Factory, Washington, D. C., or at the U. S. Naval Submarine School, Submarine Base, New London, Conn., prior to transfer.

(a) Applicants for the Submarine School and for the designation of first class diver must meet the physical requirements for diving duty as set forth in chapter 15. Scrupulous care should be taken that the physical standards are satisfied in order that rejections at the respective school may be avoided as far as possible.

(b) Candidates for training or participation in duty involving diving (master diver, second class diver, salvage diver, underwater demolition team personnel, explosive ordnance disposal team personnel, underwater swimmer school personnel, or any other category of underwater swimmer) shall meet the physical requirements prescribed for diving duty in chapter 15.

(3) Each qualified diver shall undergo a complete physical examination in accordance with chapter 15 in January of each year to determine his physical qualification for continuation in the field of diving. A notation to this effect shall be placed on the Navmed-1946 and Standard Form 600 of the Health Record. Under ordinary circumstances divers over 40 years of age are automatically disqualified for diving in open waters beyond the optimum time for dives of more than 28 fathoms.

(4) Divers shall ordinarily be examined prior to each unusually hazardous dive. Examination of divers shall be made at the discretion of the medical officer prior to the start of extensive rescue, salvage or diver-training operations. The medical officer should make observations, by personal interview if possible, of all divers prior to their initial dive each day.

14-16. Illness Due to Occupational Hazards

(1) All cases of disease or injury that can be directly attributed to factors related to submarine or diving duty should be admitted to the sick list, even if for “record purposes only,” in order that useful statistical data may be available.

14-17. Special Reports

(1) When special rescue or salvage operations involve extensive diving, the medical officer shall report the medical aspects of the operation to the officer in charge for inclusion in the salvage report. The medical officer shall include a summary of the number and duration of dives per diver, depth, decompression schedules and departures therefrom, and the number of diving accidents.
When a medical officer makes a cruise on a submarine for which the commanding officer is required to submit a report, the medical officer shall prepare a report for the commanding officer concerning the appropriate matters of interest to the Medical Department.

Section IV. NAVAL ADVANCED BASE ORGANIZATION

<table>
<thead>
<tr>
<th>Definition</th>
<th>14–18</th>
</tr>
</thead>
<tbody>
<tr>
<td>G-Components</td>
<td>14–19</td>
</tr>
<tr>
<td>Hospitals</td>
<td>14–20</td>
</tr>
<tr>
<td>Staff Medical Officer</td>
<td>14–21</td>
</tr>
<tr>
<td>Staff Dental Officer</td>
<td>14–22</td>
</tr>
<tr>
<td>Training</td>
<td>14–23</td>
</tr>
</tbody>
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14–18. Definition

(1) Advanced Base Organization is a generic term meaning any advanced base functional component, advanced base unit, or advanced base assembly either in standard or modified form.

14–19. G-Components

(1) G components (i.e., advanced base medical and dental components) of appropriate size and number are generally included in advanced base units and advanced base assemblies, and become the functioning medical and dental facilities of the organization when put into operation.

14–20. Hospitals

(1) In the larger advanced base organizations, G1A, G2, or G4 components are generally included and, upon assuming an operational status, are designated as base hospitals. The facilities are designed to support land-based and fleet personnel in the area and to provide general hospital facilities.

(2) Dental support for a G1A component is provided by the addition of a G29 component; for a G2 component, by the addition of a G13 and G13A component; and for a G4 component, by the addition of a G13 component.

14–21. Staff Medical Officer

(1) There is normally a staff medical officer for each advanced base command. For administrative purposes he should be the senior medical officer of the area and should begin to function with the earliest establishment of the base. In general the staff medical officer's duties are similar to those of a district medical officer but specifically he should:

(a) Supervise and coordinate all Medical Department activities of the command except dental activities.

(b) Advise and make recommendations to the commanding officer on all medical matters affecting the command.

(c) Initiate and supervise a coordinated program for the reception and evacuation of casualties and sick.

(d) Maintain close liaison with other U.S. and Allied military activities in the local areas.

(e) Coordinate, through liaison or otherwise, all activities of interest to the public health of the area such as malaria control and quarantine.

(f) Maintain liaison with the force medical officer.

14–22. Staff Dental Officer

(1) At advanced bases, the senior dental officer in the area may be assigned additional duty on the staff of the advanced base commander. The staff dental officer shall advise and make recommendations to the base commander on all matters pertaining to the dental support.

(2) Detailed duties of the staff dental officer are outlined in chapter 6.

14–23. Training

(1) The tactical training of all personnel on assignment for advanced base activities is under the cognizance of the Chief of Naval Operations. This training is carried out in well-planned instructional courses designed to indoctrinate the personnel in sound military tactics, to familiarize them with their equipment and the organizational setup, and to acquaint them with the conditions under which advanced base activities operate. Medical Department personnel who are interested in advanced bases and desire further information should refer to the Catalogue of Advanced Base Functional Components (OPNAVINST P04040.22 series), the publication Base Development (NWIR 11–23), and the Catalog of Advanced Base Initial Outfitting Lists (abridged) (BUSANDINST 04040.31 series).
15–1. Responsibility for Prescribing Standards

(1) No person shall be enlisted, appointed, or commissioned who does not conform to the physical standards prescribed by the Chief of the Bureau of Medicine and Surgery and approved by the Secretary of the Navy. While the Bureau of Medicine and Surgery takes the initiative in their development, the standards represent the concurrence of all the interested bureaus within the Department of the Navy, and of the Commandant of the Marine Corps where applicable.

15–2. Purpose of Physical Standards

(1) Physical standards are established to secure uniformity in conducting physical examinations and...
in interpreting physical fitness of candidates for, and persons in, the naval service. The object is to procure and retain personnel who are physically fit and temperamentally adaptable to the conditions of military life. This is intended to preclude from acceptance those individuals who present contagious or infectious disease which would be likely to endanger the health of other personnel, those who are likely to require repeated admissions to the sicklist, prolonged hospitalization, or invaliding from service, and those who present any condition which would be likely to form the basis of a claim for physical retirement benefits. The standards are intended to insure that applicants who are accepted for enlistment or induction without waiver of physical defects will conform to profile serial 1 (one), 2 (two), or 3 (three) of the physical profile system which is used in physically classifying individuals for enlistment or induction into military service under the Selective Service Act. The profile system is based primarily upon the functional ability of an individual to perform military duties. The standards therefore are intended to delineate a degree of physical fitness in acceptable applicants that will best meet the needs of the naval service and yet involve an acceptable minimum of incurred risk as concerns liability in regard to health hazards, repeated or prolonged medical care or hospitalization, assignment problems, and eventual pension or retirement benefits. This required degree of physical fitness is correlated with the available supply of applicants for military service and normal service needs. Depending upon the personnel needs of the naval service at any given time, these standards are subject to change by direction of the Secretary of the Navy.

15-3. Application of Physical Standards

(1) To determine whether the applicant for enlistment, appointment, or commission meets the prescribed standards, he or she shall be physically examined. All applicants for entry into the naval service shall be required to conform to these physical standards as they apply to the program and rate, rank, or grade involved. In applying these basic standards set forth herein, the examiner should consult current directives pertaining to the particular program involved for further orientation as to policy applications. Any applicant who does not conform to the standards shall be rejected unless a waiver is obtained (see sec. III of this chapter). In submitting a recommendation for waiver it must be understood there are certain physical defects which under the established standards are absolutely disqualifying for appointment to commissioned rank (example: loss of an extremity or of useful vision); whereas there are defects which are considered to be disqualifying but for which a recommendation for waiver may be appropriate. In the latter category are such defects as dental caries; absence acquired, teeth; hernia; flat feet; or certain degrees of defective vision. The decision as to whether such defects are disqualifying rests upon many considerations, including the amount of investment by the Government in the applicant, the need of the naval service for such additional personnel at the time of consideration, the relative professional qualifications of the applicant, and equity responsibilities of the service.

(2) To be acceptable an applicant must possess the physical and mental fitness and the personality and behavior characteristics necessary for adjustment to service life. The total fitness of the applicant shall be carefully considered in relation to the character of the duties which the applicant may be called upon to perform. The examiner must appreciate the difference in requirements between applicants for various programs. An applicant for an expensive long-term training program (for instance, such as for admission to the Naval Academy or the regular NROTC program, which are designed to produce line officers) must meet a higher standard of physical fitness than an applicant who is to be accepted for a short-term period of service. The presence of slight defects in those who have matured may be of less import than in less mature persons and may not necessarily be cause for rejection. Slight physical defects in applicants who have had prior military service have less significance than in those who have not demonstrated their ability to function satisfactorily under service conditions. In general, it is considered that relatively minor defects which would be disqualifying for original commission direct from civilian life are not disqualifying for appointment of an applicant from an officer candidate training program such as the Naval Reserve Officers Training Corps (Regular), the U.S. Naval Academy, or the Platoon Leaders Class, U.S. Marine Corps. Similarly, minor defects which would be disqualifying for original commission direct from civilian life are not disqualifying for appointment of an applicant from temporary commissioned rank or from Reserve status to commissioned rank in the Regular Navy or Marine Corps, provided such an applicant has matured sufficiently and has demonstrated by satisfactory service that the defect or disability has not interfered with the applicant's performance of duty. In the cases of applicants for Marine Corps officer candidate programs on appointment to commissioned grade, it should be borne in mind that all newly commissioned Marine officers, Regular and Reserve, initially are expected to be able to perform all duties normally required under field conditions of infantry officers or pilots, as appropriate.

(3) The physical defects or disabilities of applicants for reenlistment which ordinarily would be cause for rejection for original enlistment, are a proper subject for request of waiver, provided it has
15-5 CHAPTER 15. PHYSICAL EXAMINATIONS

15-6. Physical Standards for Entrance into the Naval Service in All Categories

(1) The remaining articles in this section set forth the physical standards for entrance into the naval service. Where the standard differs for different groups of personnel as in commissioning and enlistment, male and female, Regular and Reserve, Navy and Marine Corps, the differences will be noted under the particular system, or in separate articles in this chapter. Unless otherwise stated, the standard is applicable to all personnel groups. In addition to the statement of the standard, there is included under each system a list of causes for rejection and where indicated, a brief résumé of the method for conducting the examination. The lists of causes for rejection are not intended to be complete, but are representative. A specific cause for rejection as listed is usually to be considered disqualifying while such condition persists. When it is necessary to describe the method of examination at length, reference will be made to a specific article in section VIII of this chapter.

(2) If an applicant is regarded by the medical examiners as physically unfit for naval service by reason of a condition not specifically noted in the succeeding articles as a cause for rejection, he or she shall, nevertheless, be rejected, and a full statement of the reason therefor entered on the report.

(3) The law specifically forbids the enlistment in the naval service of any insane or intoxicated person.

(4) The term "medical examiners" as used in this chapter shall be construed to include an officer of the Dental Corps when assigned to the duty of conducting the dental examination part of a physical examination. Likewise, the term "physical examination" shall be construed to include the dental examination unless otherwise indicated.

15-7. The Psyche

(1) In order to evaluate the adequacy of the applicant's personality for adjustment to the conditions of military service, it is essential to estimate his capacity for sustained duty under conditions of separation from home and family, restricted environment aboard ship, necessity for obedience to military discipline, lack of privacy, extremes of climate, exhaustion, and the possibility of bodily injury. The fitness of the individual must be judged according to the probable ability to remain effective despite subjecttion to such unusual or abnormal circumstances. The civilian ordinarily has not been trained to accept an environment such as this; those lacking the ability or adaptability to absorb the necessary training and to adjust to such changes in living will not qualify for service. It is necessary, therefore, that the examiner be on the alert throughout his contact with the individual to detect any sign of disorders of the psyche.

(2) (a) The diagnosis of most psychiatric disorders depends upon an adequate longitudinal history, supplemented, if necessary, by information obtained from other sources as family physicians, schools, churches, hospitals, social service or welfare agencies, and courts.

(b) Medical Officers shall be on the watch for any of the following: inability to understand and execute commands promptly and adequately; lack of normal response; abnormal anxiety; silly inappropriate laughter; instability; seclusiveness; sulkiness;
discontent; lonesomeness; depression; shyness; suspicion; overboisterousness; timidity; personal uncleanliness; stupidity; dullness; resentfulness to discipline; a history of enuresis persisting into late childhood or adolescence; significant nail biting; sleeplessness or night terrors; lack of initiative and ambition; sleepwalkings; queerness; suicidal tendencies, whether bona fide or feigned; and homosexual proclivities. Abnormal autonomic nervous system responses (giddiness, fainting, blushing, excessive sweating, shivering or goose-flesh, excessive pallor, or cyanosis of the extremities) are also occasionally significant. Note also the lack of such normal anxiety or autonomic responses as might reasonably be expected under the circumstances.

(c) Mental and personality difficulties are most clearly revealed in the examinee’s behavior toward those with whom he feels relatively at ease. The most successful approach is one of straightforward professional inquiry, coupled with real respect for the individual’s personality and due consideration for his feelings, which does not mean indifference.

(d) The psychiatric examination shall be made out of easy hearing of other persons. Matter of diagnostic significance is often concealed when the individual feels that he must be impersonal and give replies that will not impress listeners with his peculiarity. Questioning will begin with something that is obviously relevant to the immediate situation. The examiner will try to elicit the difficulties which the individual has been experiencing in his relationship with others in his work and in his spare-time activities. The examiner will pay close attention to the content and implication of everything said and to any other clues, and, in a matter-of-fact manner, will follow up whatever is not self-evident nor commonplace.

(e) The psychiatric member of the Board of Physical Examination for Entrance to the U.S. Naval Academy shall administer the “Reading Aloud Test,” outlined below as follows: (1) have the candidate stand erect, face the medical examiner across the room and read aloud, as if he were confronting a class of students; (2) if he pauses, even momentarily, on any phrase or word the medical examiner immediately and sharply says, “What’s that?”, and requires the examinee to start over again with the first sentence of the test; (3) on the second trial, the true stammerer usually will halt again at the same word or phonetic combination and will often reveal serious stammering.

Reading Aloud Test

You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock-coat, usually minus several buttons; yet he still thinks as swiftly as ever. A long, flowing beard clings to his chin, giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in the winter when the ooze or snow or ice is present, he slowly takes a short walk in the open air each day. We have often urged him to walk more and smoke less, but he always answers, “Banana Oil.” Grandfather likes to be modern in his language.

(3) The following conditions are causes for rejection:

(a) Psychotic disorders:
   (1) Schizophrenic reactions.
   (2) Affective reactions.
   (3) Paranoid reactions.

(b) Psychiatric disorders with demonstrable physical etiology or associated structural changes in the brain:
   (1) Psychotic disorders with demonstrable physical etiology or associated structural changes in the brain.
   (2) Nonpsychotic mental disorders with demonstrable physical etiology or associated structural changes in the brain.

(c) Psychoneurotic disorders:
   (1) Anxiety reaction.
   (2) Dissociative reaction.
   (3) Conversion reaction.
   (4) Phobic reaction.
   (5) Obsessive-compulsive reaction.
   (6) Neurotic-depressive reaction.
   (7) Somatization reaction.
   (8) Hypochondriacal reaction.

(d) Character and behavior disorders:
   (1) Pathological personality types:
      (a) Schizoid personality.
      (b) Paranoid personality.
      (c) Cyclothymic personality.
      (d) Inadequate personality.
      (e) Antisocial personality.
      (f) Asocial (amoral) personality.
      (g) Sexual deviate.
   (2) Immaturity reactions:
      (a) Emotional-instability reaction.
      (b) Passive-dependency reaction.
      (c) Passive-aggressive reaction.
      (d) Aggressive reaction.
      (e) Immaturity with symptomatic habit reaction.
   (3) Alcoholism.
   (4) Addiction (state drug).
   (5) Primary childhood behavior reaction.

(e) Disorders of intelligence:
   (1) Mental deficiency, primary.
   (2) Mental deficiency, secondary.
   (3) Specific learning defect.

(4) Candidates for officer rank, or for training programs leading to appointment and commission, shall be subject to the standards set forth in this article except as to mentality which shall be as prescribed in other naval regulations.
15–8. The Weight, Height, and Miscellaneous Considerations

(1) Weight.—The applicant shall be weighed on a standard set of scales which are known to be correct. The weight shall be recorded in pounds (fractions of pounds shall not be recorded). The applicant’s weight should be well distributed and in proportion to age, sex, height, and skeletal structure. The purpose of the standard is to facilitate detection and disqualification of the unduly obese and to avoid disqualifying muscular, healthy applicants. The following tables No. 1, No. 2, and No. 3 shall be used as a general guide.

Table No. 1. Standards for male officers and enlisted men

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight according to age and height</th>
<th>Minumum</th>
<th>Maximum</th>
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<td>132</td>
<td>147</td>
<td>184</td>
<td>150</td>
</tr>
</tbody>
</table>

Vehicle standards for male officers and enlisted men:

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight according to age and height</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-20</td>
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<td>105</td>
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<td>51-64</td>
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<td>121</td>
<td>137</td>
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</table>

Notes.—1. The standard weight for each height for the age group 25-30 is the ideal one to maintain thereafter. For age after this group, the minimum allowance will be that for the age group 26-30.

2. A candidate whose weight falls at the extremes of either the minimum or maximum range is acceptable, only when he is obviously active, of firm musculature, and evidently vigorous and healthy.

3. See Table No. 2 for physical proportions of midshipmen, U.S. Naval Academy; midshipmen and reserve midshipmen, U.S. Naval Reserve Officers Training Corps; midshipmen Merchant Marine Reserve, U.S. Naval Reserve; and other candidates for officer training.

Table No. 2. Standards for candidates for the U.S. Naval Academy, Naval Reserve Officers Training Corps, and certain other male candidates for training leading to commissioned rank in the naval service.

(For naval aviation cadets and aviation officer candidates, see Note 2 below.)

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight (pounds): Minimum</th>
<th>Maximum</th>
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<tbody>
<tr>
<td>64</td>
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<td>157</td>
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<tr>
<td>78</td>
<td>135</td>
<td>160</td>
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</tbody>
</table>

Notes.—1. The figures in the table above are for growing youths and are for the guidance of medical officers in connection with the other data obtained at the examination, a consideration of which will determine the candidate’s physical eligibility.

2. In the case of a candidate for the U.S. Naval Academy, Aviation Officer Candidate, USNR, and Aviation Officer Candidate, USMCR, the minimum height is 66 inches, the maximum height is 76 inches, and the weight should fall within the limits of Table No. 2 for the applicant’s height, except that any candidate for flight training whose weight exceeds 300 pounds (see art. 15-67(1)(d)) or whose weight exceeds the allowable weight prescribed by article 15-62(4) shall be considered not physically qualified.

Change 7
(2) **Height.**—The applicant's height shall be measured in inches to the nearest one-half inch, without shoes, by a measuring scale known to be accurate. The table below sets forth the minimum and maximum heights acceptable for the several categories of naval service.

**Minimum and maximum standards of height**

<table>
<thead>
<tr>
<th>Category</th>
<th>Minimum (inches)</th>
<th>Maximum (inches)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male enlisted:</td>
<td></td>
<td></td>
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<tr>
<td>USN and USNR</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>USMC and USMCR</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Male: Candidates for appointment to U.S. Naval Academy, NROTC, Reserve Officer Candidates, Officer Candidate School, and Midshipmen Merchant Marine.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Male: Candidates for Naval Aviation Cadet.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Aviation Officer Candidates, USN.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Candidates for Platoon Leaders Class.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>If under 18 years of age.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Marine Corps Officer Candidate Course</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Aviation Officer Candidate, USNMC.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Candidates for original appointment U.S. Navy and U.S. Naval Reserve.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Candidates for original appointment U.S. Marine Corps and U.S. Marine Corps Reserve.</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Females: All.</td>
<td>60</td>
<td>70</td>
</tr>
</tbody>
</table>

(3) **Miscellaneous.**—The following miscellaneous conditions are causes for rejection:

(a) Any deformity which is repulsive or which prevents the proper functioning of any part to a degree interfering with military efficiency.

(b) The height requirements for male applicants for enlistment in the regular Marine Corps shall come within the heights of 64 to 75 inches, inclusive. Male applicants if under 19 years of age who come within the heights of 63 to 75 inches, inclusive, may be accepted, provided their acceptance is recommended by a medical officer.

(c) Deficient muscular development or deficient nutrition.

(d) Evidences of physical characteristics of congenital asthenia, such as slender bones, a weak ill-developed thorax, nephroptosis, gastroptosis, constipation, and “drop” heart, with its peculiar attenuation and weak and easily fatigued musculature.

(e) All acute communicable diseases.

(f) All diseases and conditions which are not easily remediable or that tend physically to incapacitate the individual, such as: chronic malaria or malarial cachexia; tuberculosis; leprosy; actinomycosis; recurrent attacks of rheumatic fever within the previous 5 years; rheumatoid arthritis; osteomyelitis; malignant diseases of all kinds in any location; hemophilia; purpura; leukemia of all types; pernicious anemia; sickle cell anemia; trypanosomiasis; filariasis which has produced permanent disability or deformity, history of an acute attack of filariasis within 6 months of date of examination, or the finding of microfilaria in the blood stream; chronic metallic poisoning; allergic diathesis and/or allergic manifestations thereof, such as: (1) hay fever, if more than mild or if likely to cause more than minimal loss of time from duty or if associated with nasal polyps or hyperplastic sinusitis; (2)
asthma or a history of asthma, including so-called "childhood" asthma, unless there is a trustworthy history of freedom from seizures since 6 or 7 years of age and provided that seizures prior to that time were not severe or prolonged and did not require extensive therapy; (3) allergic conjunctivitis, allergic dermatoses, allergic rhinitis, particularly if there is associated hyperplastic sinusitis or nasal polyps, or a history thereof when, in the opinion of the examiner, the condition is likely to frequently recur, or to cause more than minimal loss of time from duty or otherwise is of present or future clinical significance.

15-9. The Endocrine Glands and Metabolism

(1) Endocrine and metabolic disorders are so varied in their manifestations and frequently so interrelated that recognition of the pathological process is often difficult. In this field the diagnostician has become increasingly dependent upon laboratory investigations for aid in corroboration of a clinical diagnosis. It should be emphasized that an accurate and comprehensive medical history may be of great value in pointing to subclinical endocrine or metabolic disorders.

(2) The following conditions are causes for rejection:

(a) Toxic goiter; thyroid adenoma with pressure symptoms or of such size as to interfere with wearing a uniform.

(b) Cretinism; hypothyroidism; myxedema, spontaneous or postoperative (with clinical manifestations and diagnosis not based solely on low basal metabolic rate).

(c) Gigantism or acromegaly; diabetes insipidus; Simmonds's disease; Cushing's syndrome; other diseases because of a disorder of the pituitary gland.

(d) Frohlich's syndrome, if severe.

(e) Hyperparathyroidism and hypoparathyroidism when the diagnosis is supported by adequate laboratory studies.

(f) Addison's disease.

(g) Glycosuria if persisting; diabetes mellitus; a history of diabetes mellitus in both parents. If sugar is found in the urine, further specimens, voided in the presence of the physician or authorized assistant, should be examined. In doubtful cases the fasting blood sugar and glucose tolerance tests should be obtained. In the presence of diabetes mellitus in a parent, sibling, or more than one grandparent, a standard glucose tolerance test is a requirement for any program leading to appointment to commissioned rank.

(h) Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are severe or not readily remediable or in which permanent pathological changes have been established.

(i) Gout.

(j) Hyperinsulinism when established by adequate investigation and if regarded by the examiners as of sufficient degree to disqualify for military service.

15-10. The Eyes

(1) The Armed Forces-National Research Council Vision Committee has formulated two manuals on methods of examination for use by the armed services. These manuals are reprinted in articles 15-86 and 15-87.

(2) Table of Visual Acuity Standards for Procurement of Personnel for the Naval Service.—The minimum visual acuity requirement for appointment, enlistment, or reenlistment in the naval service shall be as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. OFFICER TRAINING PROGRAMS</td>
<td></td>
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<tr>
<td>NAVY:</td>
<td></td>
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<tr>
<td>Appointment Naval Academy</td>
<td>20/20</td>
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<tr>
<td>Enlistment aviation officer candidate, USNR</td>
<td></td>
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<tr>
<td>Appointment NROTC (regular and contract)</td>
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<tr>
<td>Enlistment officer candidate (MM), USNR</td>
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<tr>
<td>Assignment Naval Academy Preparatory School</td>
<td></td>
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<tr>
<td>Assignment ROC (f) (men)</td>
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<tr>
<td>Assignment ROC (f) (men)</td>
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<tr>
<td>Assignment to regular NROTC from contract</td>
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<tr>
<td>Assignment OCS (women)</td>
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<tr>
<td>Retention OCS (women)</td>
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<tr>
<td>Assignment OCS 1136 and 1138</td>
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<tr>
<td>Assignment OCS staff or special service</td>
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<tr>
<td>MARINE CORPS:</td>
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<tr>
<td>Enlistment aviation officer candidate, USMC</td>
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<td>Assignment PLC</td>
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<td>Assignment OCC</td>
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<td>Assignment OCRC</td>
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<tr>
<td>Assignment WOTC</td>
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<tr>
<td>B. OFFICER (WO, and COMMISSION):</td>
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<tr>
<td>Appointment USN and USNR line and line LDO, deck and ordinance (men)</td>
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<tr>
<td>Appointment WO (W-1) USN and USNR</td>
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<tr>
<td>Original appointment as W-2, W-3, or W-4, USN or USNR, in the case of a candidate without prior naval service</td>
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<tr>
<td>Appointment USN line (LDO) (men) other than deck and ordinance</td>
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<tr>
<td>Appointment USN and USNR restricted line (men)</td>
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</tbody>
</table>

(20/20) (Request for waiver of minor visual acuity defect may be submitted by the candidate after the report of formal physical examination has been submitted.)

20/20. Do.

20/100 correctable to 20/20. Do.

20/40 correctable to 20/20. Do.

20/100 correctable to 20/20. Do.

20/40 correctable to 20/20. Do.

20/20. Do.

20/20 correctable to 20/20. Do.

20/30 correctable to 20/20. Do.

20/100 correctable to 20/20. Do.

20/40 correctable to 20/20. Do.

20/20. Do.

20/20 correctable to 20/20. Do.

20/30 correctable to 20/20. Do.

20/100 correctable to 20/20. Do.
## Change 4

(2) (a) Any student in the U. S. Naval Academy whose vision has dropped below 20/100 (4/20) shall be reported upon by a board of medical survey; and any midshipman fourth class, or those in the third class prior to the commencement of their academic year in September, whose vision has dropped below 20/40 (10/20) shall be reported upon by a board of medical survey.

(b) Any student in the Naval Reserve Officers Training Corps whose vision in either eye during his period of service falls below 20/40 (10/20) shall be recommended for reclassification, except if specifically designated for staff corps. In every case where the student's vision has dropped below 20/100 (4/20), he shall be recommended for rejection.

(c) These requirements as given above are considered necessary in order to graduate midshipmen with vision sufficiently serviceable to enable them to carry out their duties at sea in inclement weather, without the aid of glasses or when the wearing of glasses would prove a handicap. During late adolescence it is quite common for developmental myopia to become manifest to such an extent that the resulting myopic visual defect is sufficient to disqualify the student. It is therefore imperative that a careful examination for visual acuity be performed.

(4) Refraction under cycloplegic is required for all candidates for flight training as indicated in subarticle 15-67 (1) (b) and for certain naval aviators as indicated in subarticle 15-62 (21). Refraction is not required for entrance into any other component of the naval service unless medically indicated.

(5) For promotion of officers, the nature of the duties of the candidate shall be considered, but, as a general rule, a general service officer shall be found visually qualified for promotion unless faulty vision is of such degree as to interfere with proper performance of duty at sea and on foreign shore for U. S. Navy or at sea and in the field for U. S. Marine Corps. An officer of a staff corps or one assigned to engineering or other specialized duty only shall be found visually qualified for promotion unless faulty vision is of such degree as to interfere with proper performance of assigned duties.

(6) The following conditions are causes for rejection:

- (a) Trachoma.
- (b) Chronic conjunctivitis, or xerophthalmia.
- (c) Pterygium encroaching upon the cornea.
- (d) Complete or extensive destruction of the eyelids, disfiguring cicatrices, adhesions of the lids to each other or to the eyeball.
- (e) Inversion or eversion of the eyelids, or lagophthalmus.
- (f) Trichiasis, ptosis, blepharospasm, or chronic blepharitis.
- (g) Epiphora, chronic dacryocystitis, or lachrymal fistula.
- (h) Chronic keratitis, ulcers of the cornea, staphyloma, or corneal opacities encroaching on the pupillary area and reducing the acuity of vision below the standard.
- (i) Irregularities in the form of the iris, or anterior or posterior synechiae sufficient to reduce the visual acuity below the standard.
- (j) Opacities of the lens or its capsule sufficient to reduce the acuity of vision below the standard, or progressive cataract of any degree.
- (k) Extensive coloboma of the choroid or iris, absence of pigment (albino), glaucoma, iritis, or extensive or progressive choriditis of any degree.
- (l) Retinitis, detachment of the retina, neuro- retinitis, optic neuritis, or atrophy of the optic nerve.
- (m) Loss or disorganization of either eye, or pronounced exophthalmos.
15-10

CHAPTER 15. PHYSICAL EXAMINATIONS 15-11

(n) Pronounced nystagmus or well-marked strabismus.
(o) Diplopia, or night blindness.
(p) Abnormal condition of the eye due to disease of the brain.
(q) Malignant tumors of lids or eyeballs.
(r) Asthenopia.
(s) Any organic disease of either eye.

15-11. Color Perception

(1) Applicants for enlistment and reenlistment in all branches of the naval service, Regular or Reserve, male or female, shall be considered qualified irrespective of defects of color perception. Color perception tests shall be administered and recorded in order that the results may be available in the event an individual is considered for assignment to a school service or for a specialized rate.

(2) Personnel listed below in this subarticle shall be considered qualified if they pass one of the pseudoisochromatic plate test sets listed in subarticle 15-11(9) or if they pass the Farnsworth Lantern test. Applicants who fail to pass the pseudoisochromatic plate test shall be considered qualified if they pass the Farnsworth Lantern test. (See subart. 15-11(7).)

(a) Applicants for appointment as commissioned officers of the line of the Navy or Naval Reserve.

(b) Applicants for appointment as commissioned officers of the line, in a restricted or special-duty program, may be granted waiver of this requirement depending upon the restriction or category involved.

(c) Applicants for appointment as commissioned officers, commissioned warrant officers, and warrant officers of the Marine Corps and Marine Corps Reserve.

(d) Applicants for all officer candidate programs the primary mission of which is the training of candidates for appointments in the categories referred to in subarticles 15-11(2) (a), (b), and (c).

(e) Enlisted applicants for special duties requiring a higher degree of color perception than is required for original enlistment.

(3) All candidates for training leading to the designation of naval aviator or naval aviation pilot or for training in diving, submarine, or other specialized schools requiring normal color vision shall be required to pass the Farnsworth Lantern test, if possible, as part of the initial screening examination; and if such is not possible, they shall be examined initially with pseudoisochromatic plates and with the Farnsworth Lantern upon their arrival at their respective training schools.

Candidates who fail to pass the pseudoisochromatic plate test must pass the Farnsworth Lantern test in order to qualify for retention in any such schools.

(4) Applicants for programs other than those listed above in subarticles 15-11 (2) and (3) shall be considered qualified irrespective of defects of color perception. Color perception tests shall be administered, but for record purposes only.

(5) The significance of defective color perception in commissioned or enlisted personnel on active duty in special assignments shall be evaluated with due regard to duties and service experience of the individual concerned.

(6) The results obtained with the Farnsworth Lantern test in order that the results may be available in the event an individual is considered for assignment to a school service or for a specialized rate.

(7) Detailed instructions for the administration of the Farnsworth Lantern test, as well as the criteria for passing the test, are engraved on a metal plate which is permanently attached to the instrument and shall be followed without exception. The results shall be recorded as a permanent Health-Record entry in the REMARKS block on the NAVMED 1346 (Special Duty Medical Abstract) as "Passed FaLant" or "Failed FaLant." In completion of SF 88, the results of the test shall be recorded in box 84 as "Passed FaLant" or "Failed FaLant."

(8) When pseudoisochromatic test plates are used for determination of color perception, a color vision test lamp with a daylight filter or a fluorescent light with a daylight tube shall be used for illumination. The examinee shall not be allowed to trace the patterns or otherwise touch the test plates. The plates shall be shown at a distance of 30 inches and 2 seconds allowed to identify each plate. If the examinee hesitates, he should be asked again to "read the numbers." If he fails to respond, the examiner must turn to the next plate without comment.

(9) Qualification of examinees using test plates is ascertained as follows:

(a) When the old 20-plate test set (former stock number N3-886-980) is used and the examinee reads correctly 17 of the 20 plates, demonstration plates excluded, he is qualified.

(b) When the 18-plate test set (number 6515-388-6606) is used and the examinee reads correctly 14 of the 18 plates, demonstration plate excluded, he is qualified.

(c) When the 15-plate test set (number 6515-299-8186) is used and the examinee reads correctly 10 of the 14 plates, demonstration plate excluded, he is qualified.

15-9

Change 7
15–12. The Ears

(1) To determine the acuity of hearing, place the applicant, with the ear to be tested opposite the assistant, 15 feet distant, and direct him to repeat promptly the words whispered by the assistant. If the applicant cannot hear the words at 15 feet, the assistant should approach foot by foot, using the same tone of voice, until the words are repeated correctly. Examine each ear separately, closing the other ear by pressing the tragus firmly against the meatus; the examiner may face in the same direction as the applicant and close one of his own ears in the same way as a control. The assistant should speak in a whisper, just plainly audible to the examiner, and should use numerals, names of places, or other words or sentences until the condition of the applicant's hearing is evident. The acuity of hearing should be expressed in a fraction, the numerator indicating the distance in feet at which the words are heard by the candidate, and the denominator 15, indicating the normal distance. If any doubt arises as to the correctness of the answer given, the applicant may be blindfolded and a clock or coin click used to determine the distance at which it can be heard, care being taken that the applicant does not know the distance from the ear at which it is being held. The clock used should be the one listed as SN 6846–775–4700 (7–754–700), CLOCK SHELF, Nurse, in the Armed Services Medical Stock List. Hearing shall be expressed as a fraction, of which the numerator shall be the distance in inches at which the ticking of the clock is heard, and the denominator 40. The voice is a more reliable method of determining the acuteness of hearing than the clock test, as it allows for variations in hearing with the modifications produced by changes in pitch and tone, and the voice can be raised if there are noises in the vicinity of the examining room. In every case, whether the hearing is normal or defective, the medical examiner shall make a careful otoscopic examination of the auditory canal and tympanic membranes to detect cases of otitis media and perforated drums.

(2) The following conditions are causes for rejection:

(a) The total loss of an external ear, marked hypertrophy or atrophy, or disfiguring deformity of the organ.
(b) Atresia of the external auditory canal, or tumors of this part.
(c) Acute or chronic supplicative otitis media, or chronic catarrhal otitis media.
(d) Mastoiditis, acute or chronic.
(e) Existing perforation of either membrana tympani.
(f) Deafness of one or both ears.
(g) Any diminution of auditory acuity in either ear, below 15/15 by whispered voice, below 40/40 by standard clock, or below 20/20 by coin click; or a significant auditory acuity loss as demonstrated by audiogram if such test has been performed.
(h) Any acute or chronic disease of the external, middle, or internal ear.

15–13. The Skin

(1) The skin shall be carefully inspected for evidence of disease. The examination should be conducted in a well-lit room, preferably by daylight. The condition of the skin often reflects the presence of pathology in other parts of the body as well, and for this reason the dermatological examination is important in evaluating the general physical condition of the individual and as a clue to the existence of lesions elsewhere in the body. As a general rule, applicants who are extensively infested with vermin, and filthy in person and clothing, should be rejected as unsuited for military service.

(2) The following conditions are causes for rejection:

(a) Eczema of long standing or which is resistant to treatment; allergic dermatosis, if severe.
(b) Chronic impetigo; sycosis; carbuncle; acne upon face or neck which is so pronounced as to amount to positive deformity.
(c) Actinomycosis; dermatitis herpetiformis; mycosis fungoides.
(d) Extensive psoriasis; ichthyosis; chronic lichen planus.
(e) Elephantiasis.
(f) Scabies; pediculosis (if indicative of unhygienic habits).
(g) Ulcerations of the skin not amenable to treatment, or those of long standing or of considerable extent, or of syphilitic or malignant origin.
(h) Extensive, deep, or adherent scars that interfere with muscular movements, or that show a tendency to break down and ulcerate.
(i) Naevi and other erectile tumors if extensive, disfiguring, or exposed to constant pressure.
(j) Obscene, offensive, or indecent tattooing.
(k) Pilonidal cyst or sinus if evidenced by presence of readily palpable tumor mass, or if there is a history of inflammation or of purulent discharge.
(l) Lupus vulgaris; other tuberculosis skin lesions.
(m) Lupus erythematosus, discoid or generalized; scleroderma.
(n) Epidermolysis bullosa; pemphigus.
(o) Plantar warts on weight-bearing areas, if of significance.

15–14. The Head and Face

(1) The head shall be carefully inspected, and palpated for evidence of injury, deformity and tumor growth. The cause of scars and deformity should be inquired into.
(2) The following conditions are causes for rejection:

(a) Tinea in any form.

(b) All benign tumors which are of sufficient size to interfere with the wearing of military headgear, or subject to chronic irritation.

(c) Imperfect ossification of the cranial bones or persistence of the anterior fontanelle.

(d) Extensive cicatrizes, especially such adherent scars as show a tendency to break down and ulcerate.

(e) Depressed fractures or other depressions, or loss of bony substance of the skull, unless the examiner is certain the defect is slight and will cause no future trouble.

(f) Monstrosity of the head, or hydrocephalus.

(g) Hernia of the brain.

(h) Deformities of the skull of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

(i) Extreme ugliness.

(j) Uninsight deformities, such as large birthmarks, large hairy moles, extensive cicatrizes, mutilations due to injuries or surgical operations, tumors, ulcerations, fistulae, atrophy of a part of the face, or lack of symmetrical development.

(k) Persistent neuralgia, tic douloureux, or paralysis of central nervous origin.

(l) Ununit fractures of the maxillary bones, deformities of either maxillary bone interfering with mastication or speech, extensive exostosis, necrosis, or osseous cysts.

(m) Chronic arthritis of the temporomandibular articulation, badly reduced or recurrent dislocations of this joint, or ankylosis, complete or partial.

15–15. The Mouth, Nose, Pharynx, Larynx, Trachea, and Esophagus

(1) A complete examination by reflected light shall be made of the anterior and posterior nares, the nasopharynx, and the pharynx, and when necessary, the larynx. When considered necessary, transillumination and X-ray shall be employed.

(2) The following conditions are causes for rejection:

(a) Harelip, unless adequately repaired, loss of the whole or a large part of either lip, unsightly mutilations of the lips from wounds, burns, or disease.

(b) Malformation, partial loss, atrophy, or hypertrophy of the tongue, split or bifid tongue, or adhesions of the tongue to the sides of the mouth, provided these conditions interfere with mastication, speech, or swallowing, or appear to be progressive.

(c) Malignant tumors of the tongue, or benign tumors that interfere with its functions.

(d) Marked stomatitis, or ulcerations, or severe leukoplakia.

(e) Ranula, if at all extensive, or salivary fistula.

(f) Perforation or extensive loss of substance or ulceration of the hard or soft palate, extensive adhesions of the soft palate to the pharynx, or paralysis of the soft palate.

(g) Loss of the nose, malformation, or deformities thereof that interfere with speech or breathing (unless readily correctible upon enlistment), or extensive ulcerations.

(h) Perforated nasal septum if considered causative of symptoms or local pathology, or likely to do so.

(i) Nasal obstruction due to septal deviation, hypertrophic rhinitis, or other causes, and particularly if sufficient to produce mouth breathing.

(j) Acute or chronic inflammation of the accessory sinuses of the nose, hay fever (see subart. 15–8 (3) (f)), or allergic rhinitis (see subart. 15–8 (3) (f)).

(k) Atrophic rhinitis.

(l) Malformations or deformities of the pharynx of sufficient degree to interfere with function.

(m) Postnasal adenoids interfering with respiration or associated with middle-ear disease.

(n) Marked enlargement of the tonsils or markedly diseased tonsils.

(o) Laryngitis from any cause.

(p) Paralysis of the vocal chords, or aphonia.

15–16. The Neck

(1) The examination of the neck shall include careful inspection and palpation for glandular enlargement, deformity, crepitus, limitation of motion and asymmetry. If grossly enlarged, the circumference may be measured and the figure recorded.

(2) The following conditions are causes for rejection:

(a) Cervical adenitis of other than benign origin, including cancer, Hodgkin’s disease, leukemia, tuberculosis, syphilis, etc.

(b) Adherent or disfiguring scars from disease, injuries, or burns.

(c) Thyroid adenoma interfering with breathing or with the wearing of clothing; exophthalmic goiter (see art. 15–9 (2)) or thyroid enlargement from any cause associated with toxic symptoms or which is disfiguring.

(d) Benign tumors or cysts which are so large as to interfere with the wearing of a uniform or military equipment.

(e) Torticollis.

(f) Tracheal openings, thyroglossal or cervical fistulae.

(g) Restricted motility sufficient to limit the normal range of motion.
15–17. The Spine

(1) Have the applicant perform the exercises described in article 15–89. Examine carefully for evidence of intervertebral disc syndrome, myositis and traumatic lesions of the low back (lumbo-sacral and sacroiliac strains). If the examination gives any indication of congenital deformity, arthritis, spondylolisthesis, or significant degree of abnormal curvature, special orthopedic consultation and X-ray examination should be obtained.

(2) The following conditions are causes for rejection:
   (a) Lateral deviation of the spine from the normal midline of such degree that it impairs normal function or is likely to do so.
   (b) Curvature of the spine (scoliosis, kyphosis, or lordosis) of such degree that function is interfered with, or is likely to be interfered with, or of a degree sufficient to interfere with the wearing of a uniform or military equipment.
   (c) Fracture or dislocation of the vertebræ.
   (d) Vertebral caries (Pott’s disease).
   (e) Abscess of the spinal column or its vicinity.
   (f) Osteoarthritis of the spinal column, partial or complete.
   (g) Fracture of the coccyx, spondylolisthesis; other congenital anomalies of the lumbosacral spine if associated with symptoms of a chronic or recurrent nature or if in the opinion of the examiner of such a degree or type as to predispose to mechanical instability.
   (h) Coccydynia of a chronic type associated with acute angulation of the coccyx.
   (i) Active arthritic processes from any cause.
   (j) Herniation of intervertebral disc (nucleus pulposus) or history of operation for this condition.
   (k) Residual paralysis (as sequela to poliomyelitis) resulting in impaired function.

15–18. The Thorax

(1) A history pertaining to past pulmonary diseases shall be obtained from the applicant; the chest shall be examined by inspection, palpation, percussion and auscultation; and finally a photofluorographic or roentgenographic examination of the chest shall be made (see art. 15–90) as part of the examination to determine physical fitness for entry into the service.

(a) History.—The applicant shall be questioned regarding contact with tuberculosis. Familial tuberculosis may indicate a constitutional predisposition to the disease as well as opportunity for infection. Since pleurisy, with or without effusion, is a frequent indication of early tuberculosis, the greatest care should be taken in examining applicants who have apparently recovered from pleurisy. An occupational history of mining, sandblasting or other enclosed exposure to dust should make the pneumoconioses suspect. A history of any of the following symptoms, especially when protracted, should give suspicion of significant pulmonary pathology: fever, malaise, night sweats, cough and expectoration, hemoptysis, wheezing, dyspnea, hoarseness, loss of appetite, loss of strength or loss of weight.

(b) Examination.—The applicant should be seated in a comfortable relaxed position with direct light falling upon the chest. Careful comparison of the findings elicited over symmetrical areas on the two sides of the chest gives the most accurate information regarding the condition of the underlying structures.

(c) Inspection.—Observe for asymmetry of the thoracic cage, abnormal pulsations, atrophy of the shoulder girdles or pectoral muscles, limited or lagging expansion on forced inspiration. The large, rounded, relatively immobile “barrel” chest is to be regarded as evidence of significant pulmonary emphysema.

(d) Palpation.—Observe for tumors of the breast or thoracic wall, enlarged cervical, supraclavicular, or axillary lymph nodes, deviation of the trachea in the suprasternal notch, and thrills associated with inspiration or the cardiac cycle. Instruct the examinee to repeat such a word as “moon” or “ninety-nine” in a deep voice and palpate symmetrical areas over the two lungs for differences in the intensity of tactile fremitus.

(e) Percussion.—Light percussion should be used with the pleximeter finger held lightly against the chest parallel to the ribs. Thus slight changes in the percussion note are best felt and heard when symmetrical areas of the two lungs are percussed. Note mobility of the diaphragm by percussing the lung bases at forced inspiration and again at forced expiration.

(f) Auscultation.—Instruct applicant to breathe freely but not deeply through his mouth. Listen to an entire respiratory cycle before moving the stethoscope bell to another area. Note wheezing, rales or friction rubs. Compare the pitch and intensity of breath sounds heard over symmetrical areas of the two lungs. Instruct applicant to whisper such words as “one-two-three.” Note increase or decrease in intensity of whispered voice conduction over symmetrical areas of the two lungs. There is normally an increase in pitch and intensity of the breath sounds and whispered voice over the apex of the right lung as compared to the left because of the closer proximity of the trachea to the former. Instruct applicant to exhale, cough lightly and immediately inhale. Auscultate the chest during this process. Note any rales, paying particular attention to moist rales that “break” with the cough or fine rales heard at the beginning of inspiration immediately after cough.
(2) The following conditions are causes for rejection:
   (a) Congenital malformations or acquired deformities which result in reducing the chest capacity and diminishing the respiratory function to such a degree as to interfere with vigorous physical exercise or to produce disfigurement when the applicant is dressed.
   (b) Pronounced contractions or markedly limited mobility of the chest wall following pleurisy or empyema.
   (c) Deformities of the scapulae sufficient to interfere with the carrying of equipment.
   (d) Absence or faulty development of the clavicle.
   (e) Old fracture of the clavicle where there is much deformity or interference with the carrying of equipment; ununited fractures, or partial or complete dislocation of either end of the clavicle.
   (f) Suppurative periostitis or caries or necrosis of the ribs, the sternum, the clavicles, or the scapulae.
   (g) Old fractures of the ribs with faulty union, if interfering with function.
   (h) Benign tumors or cysts of the breast or chest wall which are so large as to interfere with the wearing of a uniform or of equipment.
   (i) Unhealed sinuses of the chest wall.
   (j) Scars of old operations for empyema unless the examiner is assured that the respiratory function is entirely normal.
   (k) Pneumococcosis, extensive pulmonary fibrosis or pulmonary emphysema.
   (l) Acute or chronic pleurisy or empyema.
   (m) Pneumothorax, hydrothorax, or hemothorax.
   (n) Tumors of the lung, pleura or mediastinum.
   (o) Chronic bronchitis, bronchiectasis, abscess of the lung, pulmonary infiltration of undetermined origin, asthma (see subart. 15-8 (3) (f)), cystic disease of the lung.
   (p) Actinomycosis, nocardiosis, blastomycosis, coccidioidomycosis, aspergillosis or histoplasmosis if there is reason to suspect recent activity of the disease process.
   (q) Sarcoïdosis.
   (r) Hydatid or echinococcus cysts of the lung.
   (s) Disqualifying defects demonstrable by a roentgenographic examination of the chest, such as:
      (1) Evidence of reinfection (adult) type tuberculosis, active or inactive, other than slight thickening of the apical pleura or thin solitary fibroid strands.
      (2) Evidence of active primary (childhood) type tuberculosis.
      (3) Extensive calcification of the pleura, lung parenchyma or hilum, if of questionable stability or of such size and extent as to interfere with pulmonary function.

(4) Evidence of fibrous or saccular pleuritis, except moderate diaphragmatic adhesions with or without blunting or obliteration of the costophrenic sinus.

15-19. The Heart and Blood Vessels

(1) For the methods of examination refer to article 15-88.

(2) The following conditions are causes for rejection:
   (a) All diastolic murmurs.
   (b) Apical systolic murmurs, when persistent in both the recumbent and upright positions, when moderate in intensity, when transmitted to the axilla, and when not abolished nor significantly diminished in intensity by forced breathing.
   (c) Harsh systolic murmurs, heard at aortic area, even of less than moderate intensity with diminished or absent second sound.
   (d) Pulmonic systolic murmurs, blowing or rough, low pitched, of more than moderate intensity.
   (e) All valvular diseases of the heart, congenital heart disease, or pathological murmurs.
   (f) Hypertrophy or dilatation of the heart.
   (g) History or evidence of pericarditis, endocarditis, myocarditis, angina pectoris, coronary occlusion, or coronary atherosclerosis.
   (h) A heart rate of 100 or over, or of 50 or under, when these are proved to be persistent in the recumbent posture and on observation and reexamination over a sufficient period of time.
   (i) Marked cardiac arrhythmia or irregularity, or an authenticated history of paroxysmal tachycardia, or auricular fibrillation or flutter.
   (j) Arteriosclerosis.

(k) (1) For enlistment.—A persistent systolic blood pressure above 150, or in a person under 25 years of age a persistent systolic pressure above 140; a persistent diastolic pressure over 90 before or after exercise.

   (2) For appointment.—Arterial hypertension, essential hypertension (hypertensive vascular disease). The diagnosis of essential hypertension, especially in the earlier phases when blood pressure is still variable, requires judgment tempered by experience and with evaluation of any family history of hypertension, the vascular reaction to special tests, and repeated blood pressure and pulse rate determinations. In general, a persistent systolic blood pressure above 130 or a persistent diastolic blood pressure above 84 (fifth phase) is cause for rejection, particularly if associated with a labile pulse rate or evidence of vasomotor lability, or with positive family history of hypertensive vascular disease (sitting blood pressure values). The objective is to disqualify those applicants who are most likely to develop severe and incapacitating hypertension within a relatively short time. Generally, youthful applicants with a healthy vascular system are to be
considered qualified even though blood pressure values sometimes exceed the standard. These blood pressure levels are established as a general standard and the persistency of an elevated finding is listed as a factor because the standard applies to all age groups. In the older examinees with a more aged vascular bed the higher blood pressure levels are of greater significance, and less deviation from the standard is allowed without recourse to waiver; whereas in youthful applicants in the absence of malignant hypertension greater leeway is accorded the examiner in qualifying those with slight deviation from the standard.

(i) Aneurysm of any variety in any situation.

(n) Intermittent claudication.

(o) Raynaud’s disease, acrocyanosis.

(p) Thrombophlebitis of one or more extremities, if there is a persistence of the thrombus or any evidence of obstruction to circulation in the involved veins or veins.

(q) An authenticated history of rheumatic fever or chorea within the past 5 years, or a history of more than one attack of rheumatic fever.

(g) Arterial hypotension if it is causing, or has caused, symptoms.

15–20. The Abdomen

(1) The abdomen shall be examined by inspection and palpation and, if necessary, by percussion and auscultation. When indicated, X-ray study and laboratory tests shall be made.

(2) The following conditions are causes for rejection:

(a) Wounds, injuries, cicatrices, or muscular ruptures of the abdominal walls sufficient to interfere with function.

(b) Fistulae or sinuses from visceral or other lesions or following operation.

(c) Hernia of any variety.

(d) Large tumors of the abdominal wall.

(e) Scar pain, if severe or causing persistent or recurring complaints.

(f) Chronic diseases of the stomach or intestine or a history thereof, including such diseases as peptic ulcer, regional ileitis, ulcerative colitis and diverticulitis.

(g) Gastric resection, gastroenterostomy, or bowel resection.

(h) Chronic appendicitis.

(i) Pitis of the stomach or intestines.

(j) Acute or chronic disease of the liver, gall bladder, pancreas, or spleen.

(k) Chronic peritonitis or peritoneal adhesions.

(l) Chronic enlargement of the liver.

(m) Chronic enlargement of the spleen if marked.

(n) Jaundice.

15–21. The Perineum and the Pelvis Including the Sacroiliac and Lumbar Sacral Joints

(1) To inspect the anal region, the examiner shall direct the applicant to bend forward from the hips and draw apart the buttocks with both hands. Digital examination of the rectum should be performed and proctoscopy shall be used if necessary.

(2) The following conditions are causes for rejection:

(a) Malformation and deformities of the pelvis sufficient to interfere with function.

(b) Disease of the sacroiliac or lumbar sacral joints.

(c) Urinary fistula.

(d) Stricture or prolapse of the rectum.

(e) Fissure of the anus or pruritus ani.

(f) Fistula in ano or ischiorectal abscess.

(g) External hemorrhoids sufficient in size to produce marked symptoms; internal hemorrhoids, if large or accompanied by hemorrhage, or protruding intermittently or constantly.

(h) Incontinence of feces.

15–22. The Genitourinary System and Venereal Disease

(1) Methods of Examination.—Evidence of venereal disease or malformation shall be searched for. The glans penis and corona shall be exposed and the penis stripped. Both sides of the scrotum and the inguinal glands shall be palpated. The urine of all applicants shall be examined for albumin and sugar, the specific gravity shall be measured, and a microscopic examination of the sediment shall be made, the urine being voided in the presence of one of the examiners. All applicants for the naval service shall receive a serologic test for syphilis. This test shall be conducted at the time of application if the individual is a suspect or presents clinical evidence of venereal disease or has a history thereof. If this test is not conducted at the time of application for enlistment, it shall be conducted as soon as practicable after reporting to first duty station or Reserve activity, as appropriate.

(a) Procedure when albumin or casts are found.—The term “albuminuria” shall not ordinarily be used as a cause for rejection. Its presence alone does not justify a diagnosis of nephritis. When albumin, casts, hemoglobin, or red blood cells are found in the urine, the applicant shall not be accepted unless further study proves such findings to be of no significance. Such further study, if desired, should include daily complete examinations of the urine for at least 3 days and such other tests as are necessary, unless the presence of albumin and casts is associated with enlargement of the heart, high blood pressure, or other evidence of cardiovascular disease of such degree that a diagnosis of renal
disease may be made immediately. When albumin is constantly or intermittently present, the underlying pathological condition should, if possible, be determined and stated as the cause for rejection; but if albuminuria be present daily during a period of 3 days, it should be regarded as reason for rejection, even if the origin cannot be determined.

(b) Procedure When Glycosuria Is Detected.—If glucose is found in the urine, further observation is indicated, including an estimation of the 24-hour amount of urine and the employment of other tests to demonstrate the possible existence of diabetes. Blood-sugar values and blood-sugar tolerance tests must be normal if such an applicant is to be found qualified; the glycosuria must be shown to have been transient and not a persistent condition.

(c) Procedure When Specific Gravity Is Abnormally Low.—When the specific gravity of the specimen first examined is under 1.010, further observation of the applicant and repeated complete urinary examinations are indicated.

(d) Procedure When Serological Test for Syphilis Is Positive.—All applicants giving a positive serum reaction shall after several days be sufficiently checked, preferably by another laboratory, to assure persistence of reaction and to minimize chance of error. If required, the facilities of local or State health departments may be utilized for performing serological tests at the time of application. Care shall be exercised at the time of obtaining serum to insure that applicants neither have, nor are convalescent from, any acute infectious disease, or recent fever from any cause. The possibility of a false positive serologic test for syphilis should be considered. All applicants who are suspects, or who have clinical evidence of venereal disease, and all personnel with a positive serological test resulting from syphilis which existed prior to entrance in the naval service shall be reported (Mem-6222-4) to the U.S. Public Health Service and the State health department, in accordance with the current Bureau Instruction in the 6222 series.

(2) The following conditions are causes for rejection:

(a) Acute or chronic nephritis, diabetes mellitus or insipidus, a history of diabetes mellitus in both parents, or glycosuria if persisting. In the presence of diabetes mellitus in a parent, sibling, or more than one grandparent, a standard glucose tolerance test is a requirement for any program leading to appointment to commissioned rank.

(b) Blood, pus, or albumin in the urine, if persistent.

(c) Floating kidney, hydronephrosis, pyonephrosis, pyelitis, tumor of the kidney, renal calculi, or absence of one kidney.

(d) Acute or chronic cystitis.

(e) Vesical calculi, tumors of the bladder, incontinence of urine, enuresis, or retention of urine.

(f) Hypertrophy, abscess, or chronic infection of the prostate gland.

(g) Urethral stricture of urinary fistula.

(h) Epispadias or hypospadias, except for minor displacements of the urethral orifice with no impairment in function of micturition, and no symptoms of irritation.

(i) Phimosis when prepuce is adherent in whole or in part to the glans.

(j) Hermaphroditism.

(k) Amputation of the penis.

(l) Varicocele, if large and painful, or hydrocele, upon original appointment, but such conditions are not disqualifying for enlistment if correctable by surgery after enlistment.

(m) Atrophy of both testicles or loss of both.

(n) Undescended testicle (acceptable if abdominal and unassociated with hernia); infantile genital organs.

(o) Chronic orchitis or epididymitis.

(p) A persistently positive serologic test for syphilis. (See biologic false positive (BFP) reaction, art. 15–22(1)(a).)

(q) Syphilis in any stage, or a clearly defined history thereof upon original commission. Syphilis is a cause for rejection for enlistment in the presence of cardiovascular, cerebral, or visceral changes or active syphilis requiring treatment.

(r) Any active venereal infection, acute or chronic, or any active infectious process resulting therefrom.

(s) Reiter's disease.

15–23. The Extremities

(1) The extremities shall be carefully examined for deformities, old fractures and dislocations, amputations, partially flexed orankyloled joints, impaired functions of any degree, varicose veins, and edema. The feet shall be especially examined for flatfoot, corns, ingrowing nails, bunions, deformed or missing toes, hyperhidrosis, bromhidrosis, color changes, and clubfoot. When any degree of flatfoot is found, the strength of the feet should be ascertained by requiring the applicant to hop on the toes of each foot for a sufficient time and by requiring him to alight on the toes after jumping up several times. To distinguish between disqualifying and nondisqualifying degrees of flatfoot, the examiner shall consider the extent, impairment of function, progressive or stationary nature, appearance in uniform, and presence or absence of symptoms. In this connection it should be remembered that it is usually not the flatfoot condition itself which causes symptoms but an earlier state in which the arches are collapsing and the various structures are undergoing readjustment of their relationships. In reporting flatfoot, angles of excursion, or limitation, and comparative measurements should be stated, and X-rays forwarded when made. The series of
exercises described in article 15–89 will often bring to light defects of the extremities not otherwise discernible.

(2) The following conditions are causes for rejection:

(a) All anomalies in the number, the form, the proportion, and the movements of the extremities which produce noticeable deformity or interfere with function.

(b) Atrophy of the muscles of any part, if progressive or if sufficient to interfere with function.

(c) Benign tumors if sufficiently large to interfere with function.

(d) Ununited fracture, fractures with shortening or callus formation sufficient to interfere with function; old dislocations unreduced or partially reduced, complete or partial ankylosis of a joint, or relaxed articular ligaments permitting of frequent voluntary or involuntary displacement.

(e) Reduced dislocation or united fractures with incomplete restoration of function.

(f) Amputation of any portion of a limb (except fingers or toes if there is no interference with military activities), or resection of a joint.

(g) Excessive curvature of a long bone or extensive, deep, or adherent scars interfering with motion.

(h) Severe sprains.

(i) Disease of the bones or joints.

(j) Chronic synovitis, or floating cartilage, or other internal derangement in a joint (particularly of knee joint with history of disability).

(k) Varicose veins in an extremity when they cover a large area or are markedly tortuous or much dilated, or are associated with edema or hemorrhoids, or are accompanied by subjective symptoms.

(l) Varices of any kind situated in the leg below the knee, if associated with varicose ulcers or scars from old ulcerations; chronic edema of a limb.

(m) Chronic or obstructive neuralgias, particularly sciatica.

(n) Deviation of the normal axis of the forearm to such a degree as to interfere with the proper execution of the manual of arms.

(o) Adherent or unit fingers (web fingers).

(p) (1) Permanent flexion or extension of one or more fingers, as well as irremediable loss of motion of these parts, if sufficient to interfere with proper execution of duties.

(2) Total loss of either thumb.

(3) Mutilation of either thumb to such an extent as to produce material loss of flexion or strength of the member.

(4) Loss of more than one phalanx of the right index finger.

(5) Loss of the terminal and middle phalanges of any two fingers on the same hand.

(6) Entire loss of any finger except the little finger of either hand or the ring finger of the hand not used in writing.

(q) Perceptible lameness or limping.

(r) Knock-knee, when the gait is clumsy or ungainly, or when subjective symptoms of weakness are present; bowlegs if so marked as to produce noticeable deformity when the applicant is dressed.

(2) Loss of either great toe or loss of any two toes on the same foot.

(3) Overriding or superposition of any of the toes to such a degree as will produce pain when wearing the military shoe.

(4) Bunions sufficiently pronounced to interfere with locomotion or when accompanied by a painful bunion.

(5) Excessive curvature of a long bone or extensive, deep, or adherent scars interfering with motion.

(6) Severe sprains.

(7) Disease of the bones or joints.

(8) Chronic synovitis, or floating cartilage, or other internal derangement in a joint (particularly of knee joint with history of disability).

(9) Varicose veins in an extremity when they cover a large area or are markedly tortuous or much dilated, or are associated with edema or hemorrhoids, or are accompanied by subjective symptoms.

(10) Varices of any kind situated in the leg below the knee, if associated with varicose ulcers or scars from old ulcerations; chronic edema of a limb.

(11) Chronic or obstructive neuralgias, particularly sciatica.

(12) Deviation of the normal axis of the forearm to such a degree as to interfere with the proper execution of the manual of arms.

(13) Adherent or unit fingers (web fingers).

(14) (1) Permanent flexion or extension of one or more fingers, as well as irremediable loss of motion of these parts, if sufficient to interfere with proper execution of duties.

(15) Total loss of either thumb.

(16) Mutilation of either thumb to such an extent as to produce material loss of flexion or strength of the member.

(17) Loss of more than one phalanx of the right index finger.

(18) Loss of the terminal and middle phalanges of any two fingers on the same hand.

(19) Entire loss of any finger except the little finger of either hand or the ring finger of the hand not used in writing.

(20) Perceptible lameness or limping.

(21) Knock-knee, when the gait is clumsy or ungainly, or when subjective symptoms of weakness are present; bowlegs if so marked as to produce noticeable deformity when the applicant is dressed.

(22) Clubfoot unless the defect is so slight as to produce no symptoms during vigorous exercise.

(23) Pes cavus if extreme and causing symptoms.

(24) Flatfoot when accompanied with symptoms of weak foot or when the foot is weak on test. Pronounced cases of flatfoot attended with decided eversion of the foot and marked bulging of the inner border, due to inward rotation of the astragalus, are disqualifying, regardless of the presence or absence of subjective symptoms.

(25) Loss of either great toe or loss of any two toes on the same foot.

(26) Overriding or superposition of any of the toes to such a degree as will produce pain when wearing the military shoe.

(27) Bunions sufficiently pronounced to interfere with function.

(28) Hammertoes when existing to such a degree as to interfere with function when wearing shoes.

(29) Webbing of all the toes.

(30) Corns or calluses on the sole of the foot when they are tender or painful.

(31) Hallux valgus when sufficiently marked to interfere with locomotion or when accompanied by a painful bunion.

(32) Hyperhidrosis or bromidrosis when present to a marked degree.

(33) Habitually sodden feet with blistered skin.

(34) Unusually large or deformed feet for which proper shoes cannot be readily obtained.

(35) Severe fungoid infection of nail-beds.

(36) Surgical procedures involving joints, unless at least a 6-month period since operation has elapsed and full function has been restored.

15–24. The Nervous System

(1) The neurological examination shall be conducted as follows: The individual shall walk a straight line at a brisk pace with his eyes open, stop, and turn around. He shall then return in the same manner with his eyes closed, stop, and turn around. Look for spastic, ataxic, incoordinate, or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movements; undue difference in performance with the eyes open and closed. The individual shall then stand erect, feet together, arms extended in front. Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements. With eyes closed, the candidate shall then touch his nose with the right and then the left index finger. Look for ataxia, tremors, overshooting, particularly at the end of the
movement. Examine joint and spine movements and muscle condition. Look for muscle atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement, and spine stiffness. As to pupils, look for irregularity, inequality, diminished or absent contraction to light, movements of eyes, facial muscles, and tongue. Look for strabismus, ptosis, sustained nystagmus, tremors of retracted lips, asymmetry or tremors of face or tongue. Sensation shall be examined by pricking lightly each side of the forehead, bridge of nose, and chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists by tuning fork. With eyes closed, the candidate shall move each heel down the other leg from knee to ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and sense of position, and ataxia. Knee jerks and plantar reflexes should be tested. When indicated, appropriate laboratory tests and X-ray examinations shall be made.

(2) The following conditions are causes for rejection:

(a) Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).
(b) Degenerative disorders (multiple sclerosis, encephalomyelitis, cerebellar and Friedreich's ataxia, ataxies, Huntington's chorea, muscular atrophies and dystrophies of any type, cerebral arteriosclerosis).
(c) Residuals of infection (moderate and severe residuals of poliomyelitis, meningitis and abscesses, paralysis agitans, postencephalic syndromes, Sydenham's chorea).
(d) Peripheral nerve disorder (chronic or recurrent neuritis or neuralgia of an intensity which is periodically incapacitating, multiple neuritis, neurofibrmatosis).
(e) Residuals of trauma (residuals of concussion or severe cerebral trauma, posttraumatic cerebral syndrome, incapacitating severe injuries to peripheral nerves).
(f) Paroxysmal convulsive disorders and disturbances of consciousness (grand mal, petit mal, and psychomotor attacks, syncope, narcolepsy, migraine).
(g) Miscellaneous disorders (tics, spasmodic torticollis, spasms, brain and spinal cord tumors, whether operated upon or not, cerebrovascular disease, congenital malformations, including spina bifida if associated with neurological manifestations and meningocele even if uncomplicated, Ménière's disease, motion sickness to a disabling degree).

15–25. The Teeth

(1) Purpose of Dental Standards.—The purpose of dental standards for entry into the Navy or Marine Corps is to:

(a) Assure that persons who enter the naval service or Marine Corps do not have serious dental defects which would permanently and significantly interfere with the performance of the duties which are expected of them.
(b) Assure that candidates for original appointment as commissioned officers do not require extensive dental treatment which will necessitate frequent or prolonged absence from primary duties.
(c) Assure that candidates for officer training programs possess a reasonable level of dental health and do not require dental treatment which will significantly interfere with their participation in the training programs.
(d) Limit, when feasible, the amount of dental treatment needed by persons entering the naval service or Marine Corps. This is desirable since the strength of the Dental Corps is limited by law to a number which is insufficient to provide all the dental treatment required by active duty personnel.

(2) General Provision of Dental Standards and Dental Examinations.—

(a) All dental examinations should be performed, when possible, by dental officers of the Navy or the Naval Reserve, even though the latter may not be serving on active duty. When a dental officer is not available, dental examinations of persons, other than applicants for admission to the U.S. Naval Academy as midshipmen, may be performed by naval medical officers.
(b) The dental examiner shall indicate on the examination form whether or not the examinee meets the dental standards which apply. Whenever an examinee does not meet the standards which apply for a specific examination, the dental examiner shall enter a detailed description of the disqualifying condition.


(4) Standards for Enlistment and Reenlistment.—

(a) To be accepted for original enlistment, an applicant must be free from gross dental infections and have a minimum requirement of an edentulous upper jaw and/or an edentulous lower jaw corrected or correctable by full denture or dentures.
(b) The dental standards for reenlistment are the same as those for enlistment.

(5) Standards for Appointment to Warrant or Commissioned Rank.—To qualify for appointment to warrant or commissioned rank, an applicant must have sufficient teeth, natural or artificial, in functional occlusion to insure satisfactory incision and mastication.

(6) Standards for Appointment, Enrollment, or Appointment to Warrant or Commissioned Rank as Midshipmen, U.S. Naval Academy;
Naval Aviation Cadet; Aviation Officer Candidate; Officer Candidate and Midshipman, Merchant Marine Reserve; Regular and Contract Student, Naval Reserve Officers Training Corps; Naval Academy Preparatory School; Reserve Officer Candidate Course; Platoon Leaders Class and Officers Candidate Course, U.S. Marine Corps Reserve; Officer Candidate School, U.S. Naval Reserve; and Other Similar Officer Candidate Training Programs.—

(a) The dental examiner shall familiarize himself with article 15-3.

(b) A candidate for appointment to one of the above listed officer candidate training programs must have a minimum of 16 natural permanent teeth of which a minimum of 8 must be in each arch. He must have all missing teeth which cause unsightly spaces or significantly reduce masticatory or incisal efficiency replaced by bridges or partial dentures which are well designed and in good condition. He must have received all required dental treatment including permanent restoration of teeth damaged by dental caries except minor or questionable carious areas.

(c) Disqualifying defects:

1. Lack of satisfactory incisal or masticatory function.

2. Failure to have a minimum of 8 natural permanent teeth in each arch.

3. Unreplaced teeth which cause unsightly spaces or significantly reduce masticatory function.

4. Curious teeth except minor or questionable carious areas. Active-duty enlisted personnel who are candidates should not be disqualified for caries but appointments arranged for remedial treatment.

5. Infections or chronic diseases of the soft tissue of the oral cavity.

Section II. PHYSICAL STANDARDS FOR SPECIAL PERSONNEL GROUPS

General.......................................................................................................................... 15–26
Inductees......................................................................................................................... 15–27
Aviation Personnel........................................................................................................... 15–28
Submarine Personnel....................................................................................................... 15–29
Surface Ship Nuclear Power Training Program Enlisted Candidates.................................. 15–29A
Diving Duty....................................................................................................................... 15–30
Motor Torpedo Boat Training and Duty............................................................................. 15–31
Women............................................................................................................................... 15–32
NROTC Candidates........................................................................................................... 15–34A

15–26. General

(1) Certain groups of personnel, by reason of the particular type of duty to which they will be assigned, are required to meet physical standards which differ somewhat from those stated in the preceding section. Some of these groups and the special physical standards which are in effect are considered separately in the articles that follow.

15–18
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15–27. Inductees

(1) The physical standards for inductees from Selective Service are contained in Army Regulations No. 40–503, dated 9 May 1956, Physical Standards and Physical Profiling for Enlistment and Induction.

15–28. Aviation Personnel

(1) See section V of this chapter.
15–29. Submarine Personnel

(1) In view of the special conditions characteristic of the submarine service, all officers and enlisted men who are candidates for submarine training shall conform to the standards herein set forth. Particular care must be exercised in the preliminary examination on ships and at shore stations in order that a large number of candidates may not be rejected as a result of reexamination at the Submarine School, New London, Conn., thus avoiding needless cost of transportation, loss of service, and incomplete quota of classes.

(2) Standards for the submarine service are the same as those for general duty with especial attention to the following conditions:

(a) Psychiatric.—Because of the nature of the duties and responsibilities of each officer and man in a submarine, the psychological fitness of applicants for submarine training should be carefully appraised. The man should have arrived at his decision to volunteer for submarine training after mature deliberation and should be motivated by real desire for this duty. Emotional maturity and stability, dependability, and at least normal intelligence are necessary. Psychiatric conditions or personality traits which might militate against satisfactory adjustment under conditions aboard this type of ship shall disqualify.

(b) Vision.—For first acceptance, the minimal visual acuity for all categories of prospective submarine personnel shall be 20/70 each eye uncorrected, correctable to 20/20, except that in the case of officers and enlisted men of the deck group such correction shall contain no more that 0.75 diopters cylindrical correction in any meridian. Both eyes must be free from acute or chronic disease. The minimal visual standards for continuation of submarine duty shall be the same as indicated for first acceptance.

(c) Color Vision.—Normal color perception is essential in all submarine candidates. Preliminary screening in ships or stations shall be conducted with the Farnsworth Lantern or one of the pseudosochromatic plate test sets if the Lantern is not available. Candidates are required to qualify in accordance with subarticle 15–11.

(d) Nose and Throat.—The nares, nasopharynx, and pharynx shall be carefully examined by reflected light. Obstruction to breathing such as marked deviation of the nasal septum, or any chronic inflammatory condition such as sinusitis, or hypertrophied tonsils, shall be sufficient to reject until such defects are remedied.

(e) Ears.—Acute or chronic disease of the middle or internal ear or ruptured eardrums shall disqualify. A thorough otoscopic examination of the auditory canal and membrana tympani shall be made. The acuity of hearing in each ear shall be normal, according to the audiometer, or if an audiometer is not available the acuity shall be 15/15 by the whispered voice test, 20/20 by coin click.

(f) Teeth.—A complete dental examination shall be conducted by a dental officer if available. If a dental officer is not available, the examination shall be conducted by a medical officer. Candidates must have sufficient number of natural and/or artificial teeth to insure satisfactory masticatory and incisal function. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Individuals with caries shall have all required dental treatment completed before transfer to the submarine training unit. A candidate who will require dental prosthetic restorations during the period of training should be considered not physically qualified. Malocclusion (crossbite, overjet, or overbite with or without impingement) is not cause for physical disqualification unless it interferes with incisal or masticatory function to such degree that adequate nutrition cannot be obtained from food normally served as a regular diet by a general food service. Missing teeth replaced by satisfactory bridges or dentures shall not be considered disqualifying.

(g) Respiratory System.—Particular effort shall be made to detect latent tuberculosis or other chronic diseases of the lungs which are disqualifying.

(h) Cardiovascular System.—A systolic blood pressure over 145 or a diastolic blood pressure over 90 mm., if persistent, shall disqualify. Persistent tachycardia, marked arrhythmia except of the sinus type, or other significant disturbance of the heart or vascular system shall disqualify.

(i) Gastrointestinal System.—Candidates with a history of disease such as colitis, peptic ulcer, obstinate constipation, or diarrhea shall be excluded.

(j) Venereal Disease.—No candidate with any form of active venereal disease at the time of the examination or with a history of repeated venereal disease infection shall be accepted. No candidate with a history of a second relapse to antiluetic treatment or a history of neurologic, visceral, or osseous syphilis shall be accepted.

(k) Offensive Body Odor.—Offensive breath and offensive perspiration, if persistent, are sufficient to exclude.

(l) Disease of the Skin.—Any chronic skin disease other than mild acne shall be disqualifying.
(m) Obesity.—In general candidates should present no greater than 20 percent variation in weight from the standard set forth in the age-height-weight tables, unless the overweight is due mainly to muscular and bony tissue.

(3) Medical officer candidates for submarine training shall comply with the officer standards on first acceptance. Subsequent physical requirements are the same as for general duty.

(4) All officers and men on arrival at the Submarine School, New London, Conn., shall again be given a complete physical examination. This is intended to supplement the examination carried out by the medical and dental officers of the ship or station and not to replace it. All candidates shall be tested as to their ability to clear the ears effectively and otherwise to withstand an air pressure of 50 pounds to the square inch in a recompression chamber. This requirement must be satisfied in order that personnel shall be qualified for training with the submarine-escape appliance. It should be remembered, however, that there may be temporary difficulty due to acute congestion of the Eustachian tube incident to coryza or pharyngitis. All officers and enlisted men of such ratings as may be assigned to listening duties are required only to supplement the examination carried out by the audiometer. The only permissible variation from the normal will be in the wave lengths of 128 and 4096 double frequencies.

15–29A. Surface Ship Nuclear Power Training Program Enlisted Candidates

(1) All accepted enlisted candidates for surface ship nuclear power training shall conform to the following standards:

(a) Age.—Candidates beyond the age of 30 shall not be considered for initial training in this program.

(b) Vision.—Candidates must have vision correctable with lenses to 20/40 in each eye and essentially normal visual fields. Each eye must be free from any active or progressive organic disease. Additional causes for rejection are listed in article 15–10(6).

(c) Color Vision.—Normal perception is required only in EM, IC, and ET ratings.

(d) Teeth.—A complete dental examination shall be conducted by a dental officer if available. If a dental officer is not available, the examination shall be conducted by a medical officer. Candidates must have sufficient teeth, natural or artificial, in functional occlusion so as to insure satisfactory incision and mastication. Carious teeth should be restored prior to transfer of individuals to the training units. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed.

(e) Genitourinary System.—A candidate who has active venereal disease at the time of the application physical examination shall not be accepted for the training program. Additional causes for rejection are listed in article 15–22.

(f) The Psyche.—Particular emphasis must be given to insure that acceptable candidates fully meet the standard in article 15–7.

(2) In addition to the foregoing requirements, acceptable candidates must meet the physical standards contained in articles 15–8, 15–9, and 15–12 through 15–24.

(3) Waivers.—An exception may be considered and waiver recommended in the case of an individual who does not meet the above standards if he has had previous training and experience which render him an outstanding candidate, provided the defect is not organic and will not interfere with the satisfactory performance of duties to which the candidate may be assigned. Recommendations for such waivers shall be submitted on a completed, current SP 88 accompanied by a completed, current SP 89 in accordance with section III of this chapter.

15–30. Diving Duty

(1) All accepted candidates for duty which involves diving (master, first class, second class, salvage, underwater demolition team, explosive ordnance disposal team, underwater swimmers) shall conform to the following standards:

(a) History of Disease.—Any of the following shall be disqualifying: (1) Tuberculosis, asthma, chronic pulmonary disease; (2) Chronic or recurrent sinusitis, otitis media, otitis externa; (3) Chronic or recurrent orthopedic pathology; (4) Chronic or recurrent gastrointestinal disorder; (5) Chronic alcoholism; (6) No candidate shall be accepted with a history of syphilis, unless there has been adequate treatment and no signs of activity or organic involvement are discovered.

(b) Age.—Candidates beyond the age of 30 years shall not be considered for initial training in diving, the most favorable age being 20 to 30. All divers upon reaching the age of 40 shall be examined in accordance with subarticle 15–30(3). For officers undergoing training in deep sea diving for the specific purpose of becoming diving supervisors or salvage officers, the upper age limit shall be 39 years. In cases where the candidate's age is 40 or more, the provisions of subarticle 15–30(3) below shall apply.

(c) Weight.—Diving candidates should be rugged individuals without tendency toward obesity. Fat absorbs about five times the volume of nitrogen as does lean tissue and due to the low circulatory rate of fatty tissue the nitrogen is eliminated very slowly, thus acting to increase the incidence of bends. It is considered in general that candidates
should present no greater than 10 percent variation from standard age-height-weight tables. Consideration will be given, however, to applicants whose overweight is considered to be due to heavy bone and muscular structure.

(d) Vision.—A minimum of 20/30 vision bilateral, corrected to 20/20 shall be required. This requirement is not made for underwater work but for the retention of relatively high physical standards for hazardous work in connection with diving and salvage operations. Ophthalmoscopic examination shall be normal.

(e) Color Vision.—Normal color perception is required of all candidates. Candidates are required to qualify in accordance with the provisions of article 15-11.

(f) Teeth.—A complete dental examination shall be conducted by a dental officer, if available. If a dental officer is not available, the examination shall be conducted by a medical officer. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Advanced oral diseases and generally unserviceable teeth shall be cause for rejection. Applicants with moderate malocclusion, or extensive restorations and replacements by bridges or dentures, may be accepted, if such do not interfere with effective use of self-contained underwater breathing apparatus (scuba).

(g) Ears.—Acute or chronic disease of the auditory canal, membrana tympani, middle or internal ear shall be disqualifying. Perforation or marked scarring and/or thickening of the drum shall be disqualifying. The Eustachian tubes must be freely patent for equalization of pressure changes. Hearing of each ear shall be normal.

(h) Nose and Throat.—Obstruction to breathing or chronic hypertrophic or atrophic rhinitis shall disqualify. Septal deviation is not disqualifying in the presence of adequate ventilation. Chronically diseased tonsils shall be disqualifying pending tonsillectomy. Presence or history of chronic or recurrent sinusitis is cause for rejection.

(i) Respiratory System.—The lungs shall be normal as determined by physical and X-ray examination.

(j) Cardiovascular System.—The cardiovascular system shall be without significant abnormality in all respects as determined by physical examination and tests as may be indicated. The blood pressure shall not exceed 145 mm., systolic or 90 mm., diastolic. In cases of apparent hypertension repeated daily blood pressure determinations should be made before final decision, bearing in mind that a valuable indication of undesirable excitable temperament is often revealed by vasomotor manifestations (see (n) below). Persistent tachycardia and arrhythmia except of sinus type, evidence of arteriosclerosis (an ophthalmoscopic examination of the retinal vessels shall be included in the examination), varicose veins, marked or symptomatic hemorrhoids, shall be disqualifying.

(k) Gastrointestinal System.—Candidates subject to gastrointestinal disease shall be disqualified.

(l) Genitourinary System.—The following shall be disqualifying:

1. Chronic or recurrent genitourinary disease or complaints (normal urinalysis required).
2. Active venereal disease or repeated venereal infection.
3. History of clinical or serological evidence of active or latent syphilis within the past 5 years, or of cardiovascular or central nervous system in-
volvement at any time. An applicant who has had syphils more than 5 years before must have negative blood and spinal fluid serology.

*(m) Skin.—There shall be no active acute or chronic disease of the skin on the basis of infectiveness and/or offensiveness in close working conditions and interchange of diving apparel.

**Temperament**.—The special nature of diving duties requires a careful appraisal of the candidate's emotional, temperamental, and intellectual fitness. Past or recurrent symptoms of neuropsychiatric disorder or organic disease of the nervous system shall be disqualifying. No individual with a history of any form of epilepsy, or head injury with sequelae, or personality disorder shall be accepted. Neurotic trends, emotional immaturity or instability and asocial traits, if of sufficient degree to militate against satisfactory adjustment shall be disqualifying. Stammering or other speech impediment which might become manifest under excitement is disqualifying. Intelligence must be at least normal.

*(o) Ability to equalize pressure.—All candidates shall be subjected in a recompression chamber to a pressure of 50 pounds per square inch to determine their ability to clear their ears effectively and otherwise to withstand the effects of pressure. Due consideration must be given to the presence of an upper respiratory infection which temporarily may impair the ability to equalize owing to congestion of the Eustachian tube.

*(p) Individual susceptibility to oxygen shall be tested by determining candidate's ability to breathe oxygen without untoward effects at a pressure of 60 feet (27 pounds) for a period of 30 minutes.

(2) Annual physical examination of all divers shall be conducted in accordance with standards set forth above.

(3) Qualified divers who desire to continue in that specialty and are about to reach the age of 40 shall be examined by a board of medical officers appointed by the senior officer present. At least one member of the board shall be qualified as a deep-sea diver or in submarine medicine. The report of the examination on Standard Form 88 with the recommendation of the board as to whether the individual is or is not physically qualified to continue as a diver shall be forwarded to the Bureau of Medicine and Surgery for final decision and in time to reach the Bureau before the man attains the age of 40. A certain latitude may be allowed for a diver of long experience and a high degree of efficiency in diving. He must be free from any diseases of the cardiovascular, respiratory, genitourinary, and gastrointestinal systems, and of the ear. His ability to equalize air pressure must be maintained. A moderate degree of overweight may be disregarded if the diver is otherwise vigorous and active.

**Note.**—There is no article 15-31.

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**15-32. Motor Torpedo Boat Training and Duty**

(1) In view of the special conditions of motor torpedo boat operations, all candidates for training for this type of duty shall conform to the standards herein. Motor torpedo boats operate almost wholly at night, are extremely rough riding, and are of a size which makes it necessary for all ratings to carry on assignments other than in their own specialty and to live in very crowded conditions. Care must be exercised in the preliminary examination on ships and stations in order that candidates may not be rejected upon arrival at the Torpedo Boat Training School, or during training, for readily discoverable defects.

(2) Physical requirements are those for general duty with special attention to the following conditions:

*(a) Age.—Men between the ages of 19 and 35 shall be selected for this duty. Candidates must have a high degree of physical stamina.

*(b) Vision.—The vision of officers shall be a minimum of 20/20 in each eye; enlisted men of the deck group, ordnance group, seamen, and radiomen also 20/20 in each eye; all other candidates shall have a minimum vision of 20/20 in each eye, including motor machinist's mates, radiomen, ship's cooks, and firemen.

*(c) Color vision.—Normal color perception is required of all personnel. Qualification shall be determined in the manner set forth in article 15-11.

*(d) Teeth.—A complete dental examination shall be conducted by a dental officer, when available, and applicants shall meet the dental standards set forth in article 15-25 (6).

*(e) Nose and throat.—The nose and throat shall be carefully examined; chronic inflammatory conditions shall be sufficient to reject until such defects are remedied.

*(f) Ears.—Acute or chronic disease of the middle or internal ear or ruptured eardrums shall disqualify. The acuity of hearing in each ear shall be 15/15 by the whispered voice, and 20/20 by coin click.

*(g) Skeletal system.—Marked or symptomatic defects of feet, knees, or back shall disqualify.

*(h) Gastrointestinal system.—Ulcers, "emotional stomach," or intestinal disorders shall disqualify.

*(i) Disease of the skin.—Any definitely chronic skin disease shall be disqualifying. Mild acne is not disqualifying.

*(j) Nervous system.—A neuropsychiatric examination shall be given to determine the temperamental fitness for this type of duty. A history of train-car-air-sickness, chronic sea-sickness, or any type of motion sickness, shall disqualify. Motivation shall be real and wholly voluntary, and stability
and normal intelligence are required. Personality traits which might militate against satisfactory adjustment under close living conditions for extended periods in advanced combat areas shall disqualify.

(3) The above standards are to be adhered to rigidly in determining physical fitness prior to entry into motor torpedo boat training. In the determination of subsequent physical fitness, however, minor or temporary deficiencies should be waived when their existence does not preclude expectation of satisfactory performance of duty.

Note.—There is no article 15-33.

15-34. Women

(1) The enlistment and appointment of women in all branches of the naval service shall be subject to the standards stated in section I, wherever appropriate. The medical history shall include the menstrual history of all applicants. This will include the age of the applicant at the time of onset of menses, the regularity, duration, and amount of flow at each period, length of cycle, abnormalities and occurrence of associated symptoms. The date of onset of the last period and all pregnancies and sequela will be recorded. In the report of medical history (Standard Form 89) there shall be entered, by the applicant, the number of hours or days lost from usual endeavor because of dysmenorrhea and any treatment for same. The physical examination of females shall be conducted with due regard for privacy and in the presence of a third person whenever practicable. Whenever such examination requires exposure of the body, and particularly in conducting chest and pelvic examinations, the presence of a nurse or female attendant is required. Drapes and gown shall be used when appropriate. The scope of examination shall be the same as that prescribed for male personnel insofar as is applicable. In general, physical examinations for female personnel shall include inspection of the external genitalia and the condition of the pelvic organs shall be determined by either vaginal or rectal bimanual palpation as may be appropriate. Visualization of the cervix and vaginal canal by speculum shall be made in all cases except where rectal examination is required because of a nonelastic hymen. Examination of the cervix by means of a virginal-type speculum is essential in all instances where this can be done without injury to patient.

(2) Height and Weight.—Refer to article 15-8. The minimum height for acceptance is 60 inches, the maximum 70 inches. The minimum weight for acceptance is 95 pounds. The weight must be in proportion to general body build. Overweight and underweight may be considered not disqualifying provided the defect is stable, physiological, and not likely to interfere with the full performance of duty.

(3) Eyes.—The visual acuity requirements and causes for disqualification are set forth in article 15-10.

(4) Teeth.—

(a) To be accepted for appointment, a candidate shall meet the same requirements as those prescribed for men.

(b) To be accepted for original enlistment, an applicant must have at least 20 teeth. Satisfactory artificial replacements may be counted in lieu of natural teeth. An applicant must have no more than five carious teeth as determined by the Type 4 screening examination described in article 6-100(1). Dental examinations may be performed by personnel at Navy and Marine Corps recruiting stations.

(5) Psychiatric.—In applying the psychiatric standards, due attention will be paid to differences in the manifestation of psychiatric disorders in men and women. Emphasis will be given to elicitation and evaluation of evidence of emotional instability since a sufficiently mature emotional reaction is a necessary prerequisite for successful adjustment to military service.

(6) In addition to the causes for rejection common both to men and women, the following conditions peculiar to women are disqualifying. The list is not intended to be complete. Such physical conditions are merely representative of the defects which are considered to be disqualifying for military service. Diseases and defects which are not included herein must be evaluated individually and a decision made on the basis of well-established medical principles.

(a) Pregnancy, or generalized enlargement of the uterus due to any cause.

(b) Endocervicitis, more than mild.

(c) Cervical polyps, cervical ulcer, or marked cervical erosion.

(d) Bartholinitis; Bartholin cyst; skeneitis.

(e) Vaginitis, acute or chronic.

(f) Salpingitis, acute or chronic; oophoritis, acute or chronic.

(g) Any venereal infection.

(h) Ovarian cysts if persistent and considered to be of clinical significance.

(i) New growths of the genitalia except uterine fibroid, single, subserous, asymptomatic, less than 3 cm. in diameter with no general enlargement of the uterus.

(j) Congenital abnormalities or lacerations of the birth canal if symptomatic or which, in the opinion of the medical examiner, are of such a degree as to cause incapacity for duty.
(k) Tuberculosis of pelvic organs or breasts, or confirmed history thereof.
(l) Dysmenorrhea, incapacitating to a degree which necessitates recurrent absence of more than a few hours from routine activities.
(m) Irregularities of the menstrual cycle including menorrhagia if excessive; metrorrhagia; polymenorrhea; amenorrhea, except as noted below.
(n) Menopausal syndrome, either physiologic or artificial, if manifested by more than mild constitutional or mental symptoms; artificial menopause if less than 12 months has elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis shall be recorded; if an operation was performed, the pathologic report shall be obtained and recorded.

Section III. PHYSICAL DEFECTS AND WAIVER

15–35. Physical Defects
(1) The term physical defect is intended to include all defects, disorders, disabilities, or conditions which may be of significance in determining an applicant's physical fitness to perform the duties of his rank, grade, or rating.
(2) When applicants are accepted, all physical defects which have been noted shall be recorded. Each defect shall be recorded in sufficient detail as to show clearly its character, degree, and significance.
(3) When an applicant is rejected, the cause or causes must be clearly established and so recorded as to be conclusive regarding the propriety of the rejection. Symptoms of disease are not to be noted as cause of rejection if it is possible to arrive at a definite diagnosis.
(4) A number of physical defects are listed under specific system headings as causes for rejection. Such defects should ordinarily be considered disqualifying unless a waiver is approved. The various lists of defects are not all inclusive and are not intended to be; they contain most of the more frequently recurring causes of unfitness for performance of duties and indicate the type of defects which are to be considered disqualifying.

15–36. Definition of Organic Defect
(1) Any applicant who does not meet the established physical standards shall be disqualified. Applicants who are otherwise qualified but who have other than organic physical defects which will not interfere with the performance of general or special duties to which they may be assigned, may be accepted provided the defects are waived. An organic defect is defined as (a) any defect which might constitute a menace to the health of the individual's associates, or (b) any defect which might jeopardize the general welfare or safety of the individual's associates, or (c) any defect of such nature that the performance of active naval service might jeopardize the health or welfare of the individual himself, or (d) any defect of such nature that the individual could not reasonably fulfill the purpose of his employment.

15–37. Relative Significance of Physical Defects
(1) Waiver Is Not Required.—When the examiner, after evaluating a defect in accordance with the standards set forth in this chapter, considers it to be of little present or future significance and not to be disqualifying, he need only record and describe the defect on the report of physical examination.
(2) Waiver Required.—When a defect is considered to be disqualifying in accordance with the standards, but is of such nature as not to preclude the performance of duty, a waiver may be recommended.
(3) Waiver Not Appropriate.—When a defect which is organic in nature or otherwise wholly disqualifying for service is discovered, a waiver shall not be recommended nor requested.

15–38. Procedure for Recommending Waiver
(1) See subarticles 15–32 (5) and (6).
15-39. General

(1) Physical examinations, unless otherwise provided for, shall be conducted by officers of the Naval Medical Corps, except that dental examinations shall be conducted by officers of the Naval Dental Corps if available. The naval examining officers, unless otherwise provided for, shall sign original entries on reports of such examinations. Medical examiners, regardless of their clinical specialties, shall be familiar with the physical standards pertaining to naval personnel.

(2) Boards of medical examiners shall be guided by instructions contained in the Naval Supplement to the Manual for Courts-Martial, United States, 1951.

(3) The applicant or candidate shall be questioned carefully about his past and present physical condition, especially with regard to any serious illness, injury, or operation he may have had. Reference to the completed Standard Form 89 will materially assist the examiner in developing the medical history. All examiners are enjoined to exercise the greatest care in conducting a physical examination and shall assure themselves that all findings are fully and accurately recorded. In doubtful cases, medical examiners should employ any additional available diagnostic procedure which is indicated in an effort to determine the true physical status of the person being examined. In reporting the results of the examination on Standard Form 88, all reports of special examinations shall be included or appended irrespective of whether or not the reports indicate the presence or absence of disease or abnormality.

15-40. Enlistment or Reenlistment

(1) Enlistment.—The physical examination of applicants for enlistment in the Navy or Marine Corps, Regular or Reserve, shall be made by naval medical and dental officers, if available; otherwise, by medical and dental officers of the Department of the Army or of the Department of the Air Force, or by civilian physicians when authorized by the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, upon the recommendation of the Chief, Bureau of Medicine and Surgery. Civilian physicians may be utilized only on a no-cost-to-the-Navy basis. The results of the examination shall be recorded on the Health and Service Records. Applicants unfit for service by reason of a defect or disability not of a serious nature and which can be corrected or cured within a short time may be advised to seek treatment with a view to enlistment upon correction or recovery as the case may be; however, no promise or assurance shall be made to such applicants that they will thereafter be accepted. When applicants are accepted all physical abnormalities shall be recorded. No applicant shall be accepted for enlistment, except as provided in article 15-3, who does not conform to the standards. The applications of persons desiring to reenlist who have defects or disabilities which would be cause for rejection for original enlistment, but not such as to prevent the performance of the duties to be expected of them, shall be referred to the Bureau of Naval Personnel or the Commandant of the Marine Corps, via the Bureau of Medicine and Surgery, with appropriate recommendation regarding waiver (subart. 15-82(5)).
(2) **Reenlistment.**—This pertains to an enlistment in the Navy or in the Marine Corps of a person who has had prior service in the Navy or in the Marine Corps, respectively. Enlistment in either the Navy or Marine Corps, of a person without such prior service, subsequent to service in any other branch of the Armed Forces does not constitute reenlistment. The physical examination shall be conducted as for original enlistment but in exceptional cases where medical officers of the Department of Defense are not available such physical examinations, for the purpose of extension of enlistment, or re-enlistment within 24 hours following discharge, may be waived by either the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, upon recommendation of the Chief of the Bureau of Medicine and Surgery, provided that in case of reenlistment it is in the same Regular or Reserve status.

15-41. **Former Members Physically Disqualified for Reenlistment When Separated**

(1) No former enlisted man who was discharged by medical survey or who at time of last discharge was not recommended for reenlistment due to physical disability shall be enlisted without authority from the Navy Department. In requesting authority for the enlistment, the medical officer shall submit a complete report of notations made on the last discharge and a statement of the applicant's present physical condition, together with the request for waiver.

15-42. **Candidates for Commission or Warrant**

(1) The physical examination of candidates for commissioned or warrant rank should be conducted, if practicable, by two medical officers and one dental officer of the Regular Navy or Naval Reserve or both. In instances where two medical officers and one dental officer are not readily available, the examination may be conducted by one medical officer and one dental officer, or by one medical officer if a dental officer is not available. The services of medical officers of the Department of the Army or of the Department of the Air Force may be utilized only in instances where the services of an active or inactive naval medical officer are not available. The services of civilian physicians may be utilized only when authorized by the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, upon recommendation of the Chief, Bureau of Medicine and Surgery. Civilian physicians may be utilized only on a no-cost-to-the-Navy basis. Reports of examinations, recorded on Standard Form 88 (Report of Medical Examination) and Standard Form 89 (Report of Medical History), shall be submitted to the Bureau for review or for consideration by the board of medical examiners convened by the Chief, Bureau of Medicine and Surgery, as appropriate.

(2) Candidates for, or individuals enrolled in, certain officer training programs who are not on active duty may be admitted to a naval medical facility for the purpose of conducting special physical examination procedures when the requirements of article 21-21 are met.

15-43. **Candidates for the U.S. Naval Academy, and for the U.S. Naval Preparatory School**

(1) **General.**—

(a) Candidates are appointed to the Naval Academy by the President, by the Vice President, and by the Secretary of the Navy. Candidates may be appointed by the Secretary of the Navy, either upon his own nomination or upon nomination by members of Congress, Presidential, Vice-Presidential, and Congressional candidates may be civilians or members of one of the Armed Forces.

Retrarial candidates are members of the Navy or Marine Corps and Naval Reserve or Marine Corps Reserve. Those Presidential, Vice-Presidential, and Congressional candidates from Armed Forces other than the Navy may be transferred by their service to the Naval Preparatory School upon authorization by the Bureau of Naval Personnel. Navy or Marine Corps personnel and Naval Reserve or Marine Corps Reserve personnel on active duty who have been selected to compete in the entrance examination to the United States Naval Academy are assigned to the United States Naval Preparatory School.

(b) The Department of the Navy must be reasonably certain that candidates for assignment to the Naval Preparatory School will be able to qualify physically for admission to the Naval Academy (or other officer candidate courses, if appropriate) upon completion of their training at the School. The Department also must be reasonably certain that candidates for admission to the Naval Academy will be physically able to undergo training, and will be able to qualify physically for appointment to commission upon completion of their training at public expense.

(c) Official sponsors of civilian candidates (such as Congressmen, and the parents or guardians of Presidential candidates) desire information as to whether the candidates in whom they are interested are likely to meet the physical qualifications for admission to the Naval Academy upon reporting for enrollment. For the reasons stated above, provisions for preliminary physical examinations are established in subarticle 15-43(2).
(d) Preliminary physical examinations are done at a variety of places. They are performed by many medical officers, each of whom is more familiar with one phase of medicine than with others, and each of whom varies materially from others in the amount of recent experience he has had in administering physical examinations under Naval Academy standards. The preliminary physical examination precedes the time for enrollment by an interval which varies in length from one applicant to another, and which may be considerable in the case of some applicants. In order to equalize these variations, provisions for final physical examination of candidates for the Naval Academy and for the Naval Preparatory Schools are established in subarticle 15-43 (3).

(2) Preliminary Physical Examinations.—

(a) Object of examination.—The examiners shall bear in mind that the primary purpose of the preliminary examination is to review the candidate's past and present history, conduct a thorough physical examination in order to be in a position to advise him whether or not he appears to meet, at the time examined, the physical standards required for entrance to the U. S. Naval Academy. The candidate should be informed whether or not he meets the standards. He should be further advised, if disqualified, of those defects and medical illnesses subject to remedial measures, or which are considered to be of a temporary nature. A high standard of physical excellence is essential for all candidates presenting themselves for admission to the U. S. Naval Academy. The examiner should always keep in view the fact that the physical efficiency of future officers of the Navy will depend largely upon the manner in which this important and exacting duty is performed.

(b) Naval Preparatory School.—

(1) Candidates for assignment to the Naval Preparatory School, regardless of source of appointment or branch of service, shall be given a complete physical examination.

(2) Applicants who are active-duty members of the Navy or Marine Corps may be given a screening physical examination by the medical and dental officer of their ship or station. Then if they appear to be physically qualified, they may be ordered to report to a board of preliminary physical examination (art. C-1203 (7) (c), Bureau of Naval Personnel Manual). The screening-examination reports shall be referred to the commanding officer for his guidance in determining which men shall be ordered to take the preliminary physical examination. No other reporting of the screening examinations is required. Borderline cases, and men with remediable defects, shall be allowed to take the preliminary examination. Time permitting, remediable defects shall be corrected prior to preliminary examination. The preliminary physical examination must be conducted prior to the candidate's participation in the written examination.

(c) Naval Academy.—

(1) Civilian candidates.—For the information of official sponsors and of the Department of the Navy activities concerned, civilian candidates shall be given a preliminary physical examination, in accordance with subarticle 15-43 (8) (a) (1) or 15-43 (8) (a) (2), upon presenting a letter of request from the member of Congress, or from the parent or guardian of a Presidential candidate.

(3) Final Physical Examination.—

(a) Naval Preparatory School.—Candidates assigned to the Naval Preparatory School shall receive a complete and detailed physical examination by a board of medical examiners at the naval hospital nearest the School as soon as possible after reporting for enrollment, in strict accordance with physical standards for admission to the Naval Academy. Disqualification is final unless a candidate requests permission to appear before the Permanent Board of Medical Examiners at the Naval Academy for further consideration. If the candidate is also disqualified upon reexamination by the Permanent Board of Medical Examiners at the Naval Academy, that disqualification shall be final.

(b) Naval Academy.—Final physical examination of candidates for admission to the Naval Academy shall be performed by boards of medical examiners in May of each year, and at such other times as may be necessary, at the Naval Academy, or at naval hospitals, infirmaries, dispensaries, naval air stations, or other naval medical activities designated by the Department of the Navy. Appointment of a statutory board of medical examiners for this purpose is not required. Medical Department facilities for final physical examination, other than by the Permanent Board of Medical Examiners at the Naval Academy, will be designated by the Bureau of Medicine and Surgery in accordance with existing requirements. When available, additional Medical Department personnel will be furnished on a temporary-additional-duty basis at the appointed time to those designated medical or dental activities which require and request them. In the interest of consistency, two members from the Permanent Board of Medical Examiners at the Naval Academy, one of whom will be a dental officer, shall be detailed to each of the above-named activities at examination time, on a temporary-additional-duty basis, to assist the senior member of the local board of medical examiners in reviewing reports of physical examination, to afford counsel in cases which are not clear-cut, and to resolve differences of opinion on candidates when necessary. The senior member of the board of medical examiners at each designated activity shall be responsible for the examination procedure, correctness of reports of physical examination, and compliance with existing physical

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standards for admission to the Naval Academy. Requests or recommendations that physical defects be waived shall not be submitted.

(4) Physical Qualifications.—Except where otherwise noted in the standards, by systems, as prescribed in section I of this chapter, the physical qualifications of candidates for the Naval Academy and for the Naval Preparatory School shall be the same as those for appointment to commission. Strict adherence to the physical standards for admission to the Naval Academy is directed at both preliminary and final physical examinations. Equivocal items of history or of physical findings shall be fully elucidated by securing statements from physicians or institutions who have provided treatment, review of current Health Records, and special and auxiliary examination procedures when indicated. Care shall be exercised not to find persons physically qualified who currently present or have authenticated histories of disabilities, which are of a progressive or recurrent nature, which are likely to occasion frequent episodes on the sick list or limitation of duty, or which predispose to premature termination of service because of physical disability.

(5) Reporting Physical Examinations.—

(a) Preliminary Physical Examinations.—

(1) The preliminary physical examinations of Presidential and Congressional candidates, whether civilians or members of the Armed Forces, shall be reported upon Standard Form 88 (Report of Medical Examination) in triplicate and upon Standard Form 89 (Report of Medical History) in the candidate's own handwriting. The Report of Medical Examination shall be distributed as follows: a copy to the Congressman, parent, or guardian who requested the examination; a copy to the Chief of Naval Personnel (Naval Academy Branch); and the original Standard Form 88 with Standard Form 89 to the Bureau.

(2) The name of the Senator or Representative who requested the examination, or a statement that the man examined is a Presidential, Vice Presidential, or Secretarial candidate, shall be reported in item 16 of the Standard Form 88. This report shall also contain a definite statement of the opinion of the examiner as to whether the candidate is or is not physically qualified or is considered borderline.

(3) Physical examinations of candidates for the Naval Preparatory School shall be reported on Standard Form 88 (Report of Medical Examination) in duplicate, and upon Standard Form 89 (Report of Medical History) in the candidate's own handwriting. The report of physical examination, Standard Form 88 in duplicate and Standard Form 89, shall be expeditiously forwarded (via air-mail where indicated) to the Chief of Naval Personnel.

(4) On the reverse side of the Standard Form 88, or appended to that form, the following statement shall be made: "I certify that the candidate is (is not) physically qualified for admission to the U.S. Naval Academy at this time and have so informed the candidate." If the candidate has been found physically qualified the following statement shall be added to the above: "He has been advised that this examination is only preliminary, and that his physical qualification for admission to the Naval Academy will not be established until he has received final physical examination by a board of medical examiners." The required statement, or statements, shall be signed by the senior medical officer on the board. (When examination is made by only one medical officer, in accordance with subarticle 15-43(b)(1), the statement, or statements shall be signed by that medical officer.)

(5) There must in every case be appended to the Standard Form 88, a certificate, sworn to by the candidate, as follows:

I certify that I have informed the medical examiner(s) of all bodily or mental ailments, which I have suffered, and that, to the best of my knowledge and belief, I am at present free from any bodily or mental ailments (except

Name

Rate

Sworn and subscribed before me this ___ day of ___ 19__

Name

Rate

(6) Standard Form 88 (Report of Medical Examination) prepared in accordance with the foregoing shall be authenticated by signature of the dental examiner upon the dental portion of the report, and by signature of the senior member and the recorder of the board for preliminary physical examination. Standard Form 88 so prepared and authenticated will suffice for purposes of recording and reporting the action of the board.

(b) Final or Admission Physical Examination.—

(1) Final physical examinations of candidates assigned to the Naval Preparatory School shall be reported upon Standard Form 88 in duplicate and upon Standard Form 89 in the candidate's own handwriting, and shall be forwarded to the Chief of Naval Personnel.

(2) Final physical examination for admission to the Naval Academy shall be reported upon Standard Form 88 (Report of Medical Examination) in quadruplicate, one copy to be furnished to the Bureau of Naval Personnel (Attention: Naval Academy Branch) and another to the Superintendent of the U.S. Naval Academy, Annapolis, Md.; and upon Standard Form 89 (Report of Medical History) in the applicants' own handwriting. For candidates who are accepted, Standard Form 603 shall be opened in duplicate. All reports (Standard Form 88 in duplicate and Standard Form 89, Standard Form 603 in duplicate in the case of all accepted candidates; and Standard Form 88 and Standard
Form 89 in the case of rejected candidates shall be forwarded directly to the President, Permanent Board of Medical Examiners, U.S. Naval Academy, Annapolis, Md. Prompt submission of all forms is directed.

(3) Upon the enrollment of a candidate in the Naval Academy, the Permanent Board of Medical Examiners shall forward original Standard Forms 88 and 89, and carbon copy of Standard Form 603 to the Bureau. The fact and date of enrollment shall be prominently marked on the face of the original Standard Form 88. The board shall forward Standard Form 88 and Standard Form 89 of physically qualified candidates who are not enrolled, and of candidates rejected for physical reasons, to the Bureau. The Standard Form 88's shall first be prominently marked upon the face to show the words “Not enrolled” or “Not physically qualified,” as appropriate, together with the words “For record only.”

(6) Information To Be Given Candidates After Physical Examination.—

(a) Preliminary physical examination.—

(1) Candidates for assignment to the Naval Preparatory School shall be advised as to whether they are considered physically qualified, are considered borderline, or are considered not physically qualified. In the event they are considered physically qualified or borderline, they shall be informed that that decision is not final until it has been approved by the Bureau of Medicine and Surgery and the Bureau of Naval Personnel, and that, in any case, they will be required to pass a final physical examination, approved by those Bureaus, to determine physical fitness for retention in the school.

(2) Civilian (Presidential or Congressional) candidates shall be informed of the opinion of the medical examiners as to whether they are physically qualified, are considered borderline, or are considered not physically qualified. Applicants who are considered physically qualified or borderline shall be further informed that the examination is only preliminary, and that they will be required to pass a final physical examination by a board of medical examiners before admission to the Naval Academy.

(b) Final or admission physical examinations.—

(1) Candidates assigned to the Naval Preparatory School shall be advised whether or not they are considered physically qualified. They shall be further informed that this decision is not final until approved by the Bureau of Medicine and Surgery and the Bureau of Naval Personnel. In the event they are considered not physically qualified, they shall be advised of the provisions of subarticle 15–43(7)(a).

(2) Candidates for admission to the Naval Academy shall be informed by the senior member of the board of medical examiners of the result of the physical examination for admission, and the decision of the board shall be final when resulting in the acceptance of the candidate. A rejected candidate shall be informed by the senior member of the board of medical examiners, that he may request a reexamination under the provisions of subarticle 15–43(7)(b).

(7) Reconsideration Upon Rejection at Final Physical Examination.—

(a) A candidate rejected upon final physical examination at the Naval Preparatory School may request permission to appear before the Permanent Board of Medical Examiners at the Naval Academy at his own expense. The action of the Permanent Board of Medical Examiners shall be final.

(b) A candidate rejected upon final physical examination for the Naval Academy may request permission to appear before the Board of Medical Review at the U.S. Naval Academy, Annapolis, Md. The primary purpose of the provisions for a reexamination at the Naval Academy is to afford candidates with remediable defects that caused their rejection an opportunity to have such defects corrected and for reexamination thereafter. Such opportunity for further examination does not imply ultimate acceptance. Candidates with other than remediable defects may also be reexamined by the Board of Medical Review at the Naval Academy, at their own expense for travel, housing, and subsistence. In all instances of reexamination, the decision of the Board of Medical Review shall be final.

(8) Activities Designated for Administering Physical Examinations.—

(a) General.—

(1) Civilian candidates.—For the information of official sponsors, and of the Department of the Navy activities concerned, medical and dental officers of the naval service are required to perform a preliminary physical examination upon any candidate for the Naval Academy who presents a letter of request from the member of Congress, or from the parent or guardian of a Presidential candidate. However, in lieu of an examination by a single medical and/or dental officer, all civilian candidates should be encouraged to secure examination in accordance with subarticle 15–43(8)(a)(2). Civilian candidates may also be examined at other Armed Forces medical activities as described in subarticle 15–43(8)(a)(7).

(2) A board for preliminary physical examination for civilian candidates for the Naval Academy, and for candidates from the Armed Forces for assignment to the Naval Preparatory School, shall be designated at each naval hospital and aboard each naval hospital ship, to conduct and report the preliminary physical examination of candidates for the Naval Academy. The board will examine physically any such candidate presenting a request in
writing from the Bureau of Naval Personnel or from his commanding officer.

(3) Composition of Board.—The board, where practicable, shall consist of a general surgeon, an orthopedic surgeon, an internist, an ophthalmologist, an otolaryngologist, a neurosurgeon, a neurologist, a urologist, a dermatologist, a clinical laboratory officer, and a dental officer.

(4) Examination Procedure.—The candidate, either civilian or military, upon reporting for a preliminary examination shall first be required to complete Standard Form 89 (Report of Medical History). He shall then be required to remove all clothing and to don a bathrobe and slippers and report with Standard Forms 88 and 89 to the various members of the board for his physical examination. The examiner completing that part of the Standard Form 88 assigned to him, shall initial the portion completed by him and direct the candidate to the next examiner. The neurosurgeon as part of his examination shall test the candidate for speech defects by requiring him to perform the "Reading Aloud Test" (art. 15-7(2)(c)). The results of psychiatric studies, roentgenographic chest study, the serologic test for syphilis, and the study of dental roentgenograms when made, shall be recorded. When the examination has been completed, the candidate shall then report to the senior member of the board for a review of the rough Standard Form 88, and of the Standard Form 89, for decision as to whether he meets the physical standards for entrance to the Naval Academy.

(5) Object of Examination.—The examiners should bear in mind that the primary object of this examination is to eliminate those who are obviously disqualified, rather than to give assurance to any candidate that he will subsequently pass the official examination. A high standard of physical excellence is essential for all candidates presenting themselves for admission to the Naval Academy. Acceptance of candidates should always keep in view the fact that the physical efficiency of future officers of the Navy will depend largely upon the manner in which this important and exacting duty is performed.

(6) The board shall similarly examine civilian and Armed Forces candidates for the Military Academy at West Point.

(7) Similar preliminary medical examining facilities have been established at medical activities of the Army and of the Air Force, their locations being listed in the current issue of "Regulations Governing Admission of Candidates into the U.S. Naval Academy as Midshipmen and Sample Examination Questions."

(b) Preliminary Physical Examinations.—

(1) Preliminary physical examinations of candidates for assignment to the Naval Preparatory School shall be administered at one of the naval hospitals or on a hospital ship, or at a similar Army or Air Force medical activity when so authorized by the Bureau of Naval Personnel, when possible. When these candidates are in isolated or combattant zones, they may be examined, in lieu of the foregoing, by the medical officer or facility most accessible to their ship or unit. Standard Form 88 shall then show the place of examination as "At sea" or "In the field" as appropriate.

(2) (a) Civilians or Armed Forces personnel who are Presidential or Congressional candidates for admission to the Naval Academy who present a request from their Congressman or parent or guardian, in writing, shall be given a preliminary physical examination by any naval medical officer, or by any of the boards of preliminary physical examination at naval hospitals, in accordance with subarticle 15-43(8)(a).

(b) The Army and Air Force have designated similar facilities for preliminary physical examination of Naval Academy candidates as noted in subarticle 15-43(8)(a). (7).

(c) Final Physical Examinations.—

(1) Men reporting for assignment at the Naval Preparatory School shall receive a detailed final physical examination by a board of medical examiners at the naval hospital nearest the School.

(2) Candidates for the Naval Academy shall receive a final physical examination for admission by the Permanent Board of Medical Examiners at the Naval Academy, or at such other facility to which they may be assigned by the Bureau of Naval Personnel in accordance with subarticle 15-43(8)(a).

15-44. Retired Members Ordered to Active Duty

(1) A member on the retired list who is ordered to active duty, except for short periods of temporary active duty, shall be required to complete Standard Form 89 (Report of Medical History) and shall be examined physically by a medical officer who shall submit a report on Standard Form 88 in duplicate listing all defects or disabilities and expressing an opinion as to the type duty the member is physically qualified to perform. The Standard Form 89 shall accompany the original of Standard Form 88. The examinee may be found physically qualified for active duty if considered physically qualified to perform the duties to which he or she may be assigned.

15-45. Annual Physical Examination of Officers

(1) Purpose.—The purpose of the examination is to detect disease processes in their incipiency, thereby permitting earlier therapy; and to maintain current the centralized medical records regarding physical fitness of officer personnel. To attain the maximum benefits from annual physical examinations, scrupulous care in conducting the examination is required as well as the exercise of sound
clinical judgment in interpreting results. In view of the increased incidence of certain disease processes in various age groups, special attention should be directed toward the detection of such diseases. Insofar as practicable, medical officers conducting examinations should establish a personal doctor-patient relationship with each examinee and should assume responsibility for explaining the primary purpose of the examination, for enlisting the cooperation of the officers examined, for insuring that all necessary followup studies are conducted, for discussing and interpreting the results of the examination, and for counseling with respect to any measure considered necessary to preserve and restore health.

(2) When Conducted.—
(a) Officers on active duty shall be examined annually as required by U.S. Navy Regulations. This examination shall be conducted within 30 days of the anniversary of the officer's date of birth. A complete physical examination (such as flight physical, art. 15-71(1), or examination incident to permanent promotion, appointment, or discharge from hospital upon report by a board of medical survey) conducted and reported to the Bureau during the preceding 12 months will obviate the need for the annual physical examination, except in the case of flag and general officers. The annual physical examination prescribed by this article shall be conducted in the case of all flag and general officers regardless of previous examinations during the year.

(b) Commanding officers are responsible for instituting whatever procedures may be necessary to verify officers' Health Records periodically and to ensure compliance with the requirements of this article.

(3) Conducted By.—Annual physical examinations may be conducted by medical officers of the Regular Navy or Naval Reserve or, where the exigencies of the service require, by medical officers of another department of the armed services. Whenever possible, and particularly in the older age groups, the examination should be conducted by a qualified internist (and such other specialists as may be advisable). In the case of aviation personnel at least one of the examining medical officers shall be a flight surgeon or aviation medical examiner. Under exceptional circumstances, in foreign countries, other than flight physical examinations may be conducted and reported on by a civilian physician.

(4) Scope of the Examination.—
(a) Flag and General Officers.—In the case of flag and general officers, the following special procedures shall be carried out in addition to clinical and laboratory procedures otherwise indicated herein:

(1) Filling out of a medical questionnaire. The Bureau will mail copies of this questionnaire to all flag and general officers for completion prior to reporting for the annual physical examination.

(2) General physical examination by medical and surgical examiners.

(3) Thorough EENT examination. This shall include an audiogram and when available the Speech Discrimination Score.

(4) X-rays, using 14 x 17 film, of chest in inspiration and expiration in the posteroanterior view and left lateral view.

(5) Stool examination for occult blood using guaiac test.

(6) Urinalysis including sugar, albumin, bilirubin, urobilinogen, and microscopic.

(7) Blood sugar drawn an hour after breakfast or lunch.

(b) All Officers.—In the case of all officers the examination shall be sufficiently thorough, including history-taking, to permit appraisal of the work, recreation, rest, exercise, social and service-adjustment pattern of the individuals, to elicit and afford evaluation of any symptoms of illness and evaluation of any previous entry suggestive of possible disease, and to be reasonably certain the individual is free of incipient disease or functional impairment. Clues which might mean functional impairment or maladjustment are to be followed with such diagnostic, consultant, or hospitalization procedures as are indicated. Hospitalization should be effected whenever necessary for completion of indicated studies or for evaluation of the significance of abnormalities noted. Except when prolonged hospitalization is anticipated, arrangements therefor should be effected locally; however, in special instances a request for orders effecting hospitalization may be directed to the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, with the Bureau an information addressee. There are routine, time-consuming measurements which, in the absence of any special indication, need not be repeated annually, such as measurements of color perception, blood pressure and pulse rate response to exercise or to position change, and detailed physical examination of the lungs when chest X-ray study and auscultatory findings are negative. The annual physical examination of naval aviation personnel is subject to the special requirements of article 15-71.

(5) System Examination, Special Considerations.—The purpose of the examination requires
only that it be practical and directed toward maintenance of physical fitness for service. The need for use of special procedures is left largely to the discretion of the examiners. The following is for directional guidance and is not all-inclusive:

(a) **Vision.**—Visual acuity shall be tested as outlined in article 15-86. If impairment exists, its degree, cause, and correctability shall be stated. If possible, the prescription for lenses necessary to correct errors of refraction shall also be recorded.

(b) **Color Vision.**—Testing of color perception is not required routinely. If there is reason to suspect cause for change, such as optic atrophy, retrobulbar neuritis, multiple sclerosis, chronic poisoning, or other condition, tests shall be conducted.

(c) **Auditory Acuity.**—The ear drums are to be examined. Whispered and spoken voice tests are sufficient for screening. If impairment of auditory acuity is present, or suspected, audiometric study is required.

(d) **Dental.**—Bite-wing and periapical roentgenograms shall be made when indicated for an adequate dental examination. When oral disease or dental defects or disabilities are discovered, the dental examiner shall make suitable recommendations for the institution of corrective measures. An officer shall be required to be free of oral disease and dental defects or disabilities that may prevent the performance of duties at sea and on foreign shore (or in the field for Marine Corps officers).

(e) **Lungs.**—Roentgenographic chest study is required annually (art. 15-90); a careful physical examination of the lungs will frequently reveal evidence of pulmonary pathology obscured in the roentgenogram by the denser structures of the thorax, and incipient infiltrates not detectable by X-ray.

(f) **Cardiovascular.**—Roentgenographic chest study gives some information as to heart size and position. Make special mensuration studies where indicated. The finding of abnormalities, such as murmurs, suggests need for study as to cause, with full report. The standard blood pressure determination required is in the sitting position. Further study and report is usually indicated when that value persistently exceeds 130/84 or when there is present symptomatic hypotension or other abnormality such as increased or decreased pulse pressure. Make other tests where required, particularly such as electrocardiographic tracings (an exercise tolerance or anoxemia test if indicated) in those with arterial hypertension, obesity, impaired carbohydrate metabolism, family history of coronary artery disease, or symptoms suggestive of impairment of sufficiency or coronary artery blood flow and especially where any such conditions are present in persons over 45 years of age.

(g) **Urine.**—Specific gravity determination is required. If under 1.016 collect further specimen under conditions designed to concentrate the urine and test concentrated specimen for albumin, ordinarily by using nitric acid or heat test. The Fehling or Benedict test shall be used for detection of sugar in urine. Other tests shall be made when indicated.

(h) **Rectal.**—Rectal examination shall be made when appropriate, as when there is a history of change of bowel habit, rectal bleeding, or urinary difficulties, and in all cases when the examinee is over 50 years of age.

(i) **Pelvic and Vaginal.**—Pelvic examination shall be made when appropriate. It is desirable that women in the military services be afforded, when feasible, an examination of the breasts and genital tract at 12-month intervals. This examination should be designed to detect malignancy, infectious disease, or other abnormalities of the organs. Whenever possible it should be conducted by a qualified specialist. The pelvic examination shall, with the consent of the individual concerned, be included in all scheduled periodic physical examinations. All women are to be encouraged to request special examination in the event they note:

1. Appearance of a mass or masses in a breast, or bleeding from a nipple.
2. Occurrence of irregularity of menses.
3. Vaginal discharge.
4. Abnormal bleeding from the vagina.

The pelvic examination shall include bimanual study, care being taken to make such examination rectally when vaginal examination cannot be carried out because of nonelastic hymen. Visualization of the cervix and vaginal canal by speculum is to be made in all cases except where rectal examination is required because of a nonelastic hymen. Examination of the cervix by means of a vaginal-type speculum is essential in all instances where this can be done without injury to the individual being examined.

(j) **Blood Count and Serologic Test for Syphilis.**—Blood count and serologic test for syphilis shall be given when indicated. As an example, the blood count is more essential in those exposed to roentgen rays or radioactive elements or in those with unexplained lymphadenopathy; splenomegaly, pulmonary hilar enlargement, etc. A serologic test for syphilis is required at the following ages: 23, 26, 29, 32, 35, 40, and 45 years, as attained during the calendar year of the examinations, and in those with a history of urethritis, venereal disease, or nonspecific penile lesion within the previous year, or with unexplained lymphadenopathy or other suggestive findings.

(k) **Evaluation.**—An abnormality or deviation from the normal may be asymptomatic, nonprogressive, and of no present or future clinical significance and require recording only, or it may require follow-up observation, consultation, or hospital study. The significance of such conditions must be interpreted in light of the individual's status in service, age,
rank or grade, corps, waiver or notation of an entry
into officer status, actual performance of duty,
motivation, and action taken upon recent reports of
medical survey or clinical boards. Conditions which
are likely to be progressive or lead to functional
impairment require discussion with the officer con­
cerned as to significance and may require hospital­
ization for study. When the condition interferes
with the proper performance of duty or is likely to
do so in the near future, it is appropriate to consider
the individual unfit for duty. In borderline cases,
particularly at small stations or aboard ships, it is
proper to consult with the commanding officer as
to an officer's duty performance before expressing
an opinion that he is physically unfit for perform­
ance of duty. In general if the examinee meets the
qualifications for permanent promotion, he should
not be considered as being unfit for performance of
duty. Even in the presence of defects, remedial or
potentially disabling, which if not corrected might
be held to be disqualifying for permanent promotion,
the specific rule for fitness for duty is ability to
perform assigned duty.

(7) Disposition.—Disposition depends upon many
factors, any number of which may apply in a case.
The object is to institute indicated measures early
enough to protect the individual's health, to protect
the command against continuing to depend upon
an officer who is unable properly to perform duty by
reason of physical disability, and yet to interfere
in the least possible manner with the activities of
the officer concerned. When no conditions of im­
port are noted, no action, other than reporting, is
required. The discovery of conditions of import
may only require imparting of appropriate clinical
advice; or it may require consultations, or contin­
uing observation, or ambulatory treatment in a duty
status, or hospitalization either immediately or at
some opportune time in the future. Indiscriminate
or repeated transfers to a hospital are to be avoided
with preference given to consultant studies from a
duty status. However, hospitalization at an early
date in the course of such progressive disease as
arterial hypertension may aid its control. When
complete study has been accomplished, annual re­
hospitalization is usually not required. A condition
which impairs ability to perform duty, or which is
likely to do so, is usually cause for hospitalization
and if such disposition cannot be effected, a report
should be made by letter to the commanding officer,
including recommendations for such corrective or
remedial measures as may be deemed appropriate.
(Arta. 9971, 9977, 1380-2, 1361-2, and 1703, Navy
Regulations.)

(8) Reporting Of.—Should the examination not
be required, the reason shall be entered on Standard
Form 600 (Chronological Record of Medical Care).
In each case which requires examination, the report
of the examination shall include specific comment
about the physical fitness to perform all the duties
to which officers of the examinee's grade and cate­
gory might reasonably be expected to be assigned.
(As used herein, "category" means an officer's
classification as an officer of the line not restricted
in performance of duty; as an officer of the Navy
designated for engineering duty, aeronautical engi­
neering duty, special duty, or limited duty; as an
officer of the Marine Corps designated for supply
duty or limited duty; or as an officer of the res­
pective staff corps.) All defects or disabilities regarded
as sufficient to impair the examinee's ability to per­
form duty shall be recorded. In any instance where
unfitness is considered to exist, or where conditions
exist which require continued observation or study
(such as a chronic or progressive disease condition
or a condition which might militate against selection
or be construed as possibly unfitting for permanent
promotion, the specific rule for fitness for duty is ability to
perform assigned duty.

15-30b
Change 10
15-45A. Annual Physical Examination of Enlisted Female Personnel

(1) Background.—The existing morbidity and mortality rate from malignant lesions of the breast and reproductive organs in women has caused the medical profession at large to seek and utilize every possible method of early diagnosis. To bring about a reduction in the mortality rate from cancer in women, it is essential to instill into the minds of our female personnel the necessity on their part to seek periodic physical examinations.

(2) Examination Encouraged.—Enlisted female personnel on active duty shall be encouraged to request an annual physical examination similar to that provided for female officers as set forth in article 15-45.

(3) Reporting.—Although report of such examination is not required by the Bureau, any significant or potentially significant defects or disabilities shall be recorded on Standard Form 89. It then shall be the responsibility of the examining medical officer to forward a letter to the member's commanding officer with specific recommendation for such corrective or remedial measures as may be deemed appropriate.

15-46. Annual Physical Examination of Midshipmen and NROTC Students

(1) The annual physical examination of midshipmen shall be conducted in accordance with the regulations governing the Naval Academy and at such time as may be determined by the Superintendent.

(2) The annual physical examination of Naval Reserve Officers Training Corps students shall be held each year on a date set by the Professor of Naval Science, who will request whatever medical or dental assistance may be required for the physical examinations from the commandant of the naval district. Standard Form 88 in duplicate and a completed Standard Form 89 shall be forwarded to the Bureau of Medicine and Surgery via the Chief of Naval Personnel. Students not meeting physical standards in accordance with the requirements set forth in this manual for appointment to commissioned grade from the Naval Academy shall be recommended for disenrollment.

(3) Graduating students must complete their annual physical examination during the period at least 90 but not more than 180 days prior to graduation. The examination shall be conducted with a view to determining the candidate's physical fitness for appointment and commission in the Regular Service with recommendation made accordingly.

15-47. Promotion of Officers (Other Than Warrant Officers)

(1) No officer of the Regular Navy or Marine Corps shall be promoted to a grade above that of ensign or second lieutenant, except as otherwise provided for in this article, until he has been examined and determined to be physically qualified to perform the duties to which officers of his category might reasonably be expected to be assigned in the grade for which he is a candidate for promotion. "Category" means an officer's classification as an officer in the line not restricted in performance of duty; as an officer of the Navy designated for engineering duty, aeronautical engineering duty, special duty, or limited duty; as an officer of the Marine Corps designated for supply duty or limited duty; or as an officer of the respective staff corps. "Limited duty" as used in this paragraph means limited duty only in the technical fields as distinguished from limited duty for physical reasons.

(2) The foregoing requirement shall not exclude from promotion, to which he would otherwise be entitled, any officer who is determined to be not physically qualified to perform the duties to which officers of his category might reasonably be expected to be assigned in the grade for which he is a candidate for promotion and in whose case it is further determined by the Chief of the Bureau of Medicine and Surgery that his physical disqualification was occasioned by wounds received in line of duty and that such wounds do not incapacitate him for the performance of useful service in the higher grade.

(3) Candidates for promotion shall, when directed by competent authority, report for physical examination for promotion.

(4) The physical examination shall be conducted by two medical officers and one dental officer of the naval service on active duty whenever such officers are available. In the case of a naval aviator, at least one of the medical officers, if practicable, shall be a flight surgeon or aviation medical examiner. If such officers are not available in the number prescribed, the examination may be conducted by one medical officer of the naval service on active duty. If it is impracticable, because of undue delay or expense, for the examination to be conducted as prescribed, the examination may be conducted by medical officers on active duty of any of the uniformed services of the United States. If none of the above prescribed medical examiners are available, request for authorization for the physical examination to be conducted by other qualified physicians should be made to the Chief of Naval Personnel or Commandant of the Marine Corps, as appropriate, by way of the Chief of the Bureau of Medicine and Surgery. Request for such authorization shall be made by the commanding officer of the officer concerned or by other competent authority, who shall make a complete report of the circumstances requiring such action.

(5) The examination shall be completed in all respects and the results shall be reported on Standard Form 88 (Report of Medical Examination). The original and one copy of the report shall be
forwarded to the Bureau of Medicine and Surgery, together with the report of such additional medical studies as may have been conducted, and one copy shall be retained in the candidate's health record.

(6) Considering the nature of the duties required in the higher grade and the candidate's particular classification, the examiners, following complete examination, shall express an opinion whether the candidate is or is not physically qualified to perform the duties to which officers of his category might reasonably be expected to be assigned in the grade for which selected. In the case of a candidate reported not physically qualified, the medical examiners shall express an opinion whether the candidate's disqualification is temporary or permanent. The medical examiners shall express no opinion about the physical qualifications for promotion of a candidate in one of the following statuses:

(a) Undergoing hospitalization.
(b) On sick leave.
(c) Assigned physical limited-duty status pursuant to action on a report by board of medical survey.
(d) Awaiting final action on the recommended findings of a physical evaluation board.

The report of examination shall indicate that the candidate is in such status. If and when a candidate in one of the foregoing statuses, who is otherwise eligible, is returned to full duty, his commanding officer then directs him immediately to report for physical examination. The results of this examination shall be reported in the same manner as results would have been in the first instance.

(7) (a) An officer not undergoing hospitalization whose promotion is delayed for more than 6 months because of physical disqualification may request that the Secretary of the Navy determine whether or not he is physically qualified for promotion. The request shall be forwarded to the Secretary of the Navy via the officer's commanding officer, the Chief of the Bureau of Medicine and Surgery, and the Chief of Naval Personnel or Commandant of the Marine Corps, as appropriate. The decision of the Secretary of the Navy regarding the candidate's physical qualification for promotion is final. 

(b) Whenever a determination is made pursuant to (a) above in the case of an officer with defective or possibly defective color perception, such determination shall be final about the question of the effect of the officer's color perception on his physical qualification for promotion in all subsequent promotions of the officer concerned.

(8) When an officer becomes eligible for selection for promotion and has, since his last examination for promotion, been subject to severe illness, or whose medical record shows that chronic disability may exist, he may request orders to appear for a physical examination as provided in paragraphs (4) and (5) above. The original report of medical examination shall be forwarded to the selection board considering the officer for selection, with copies to the Chief of the Bureau of Medicine and Surgery, as provided in the Manual of the Medical Department.

(9) Officers having been found physically qualified for temporary promotion to a grade pursuant to the regulations of this article or by a statutory board of medical examiners shall not again be examined for permanent appointment in that grade.

(10) The foregoing provisions do not apply to officers eligible for promotion under the provisions of title 10, USC, section 5787, including ensigns eligible for temporary promotion to lieutenant (junior grade) or female second lieutenants eligible for temporary promotion to first lieutenant.

(11) Except as provided in subparagraphs (7) and (10), final determination of the candidate's physical qualification for promotion shall be made by the Chief of the Bureau of Medicine and Surgery. The determination shall be based on the report of examination as prescribed in this article, together with the candidate's medical record, and such determination will be reported to the Chief of Naval Personnel or Commandant of the Marine Corps, as appropriate.
15-48. Discharge, Transfer to Fleet Reserve, or Retirement of Enlisted Personnel

(1) Prior to discharge or retirement from active service every enlisted member on active duty, not discharged or retired for physical disability, shall be given a thorough physical examination by a Medical Corps officer. The examination of female members shall include inspection of the external genitalia and the condition of the pelvic organs shall be determined by either vaginal or rectal bimanual palpation as may be appropriate. Whenever practicable, each member should be examined by two medical officers and a dental officer. A careful note of all physical defects or disabilities shall be made in the Health Record. Standard Form 88 shall be submitted to the Bureau except when members being discharged are to be immediately reenlisted. If a physical disability is found which is sufficient to disqualify the individual for reenlistment or for continuation in the service, the member must be reported upon by a board of medical survey or clinical board before discharge or release from active duty.

(2) The nature of any defect or disability shall be stated in the Health Record, and in the report of medical survey or clinical board when such report is submitted.

(3) When an enlisted member is examined for transfer to the Fleet Reserve, a report of the physical examination shall be submitted to the Bureau.
If the member is physically qualified for duty at sea (or at sea and in the field for the U.S. Marine Corps) this report shall be submitted on Standard Form 68, but if the member is not so qualified physically, this report will be submitted as appropriate on a report of medical survey.

(4) The member who has appeared before a physical evaluation board and who, as a result of action subsequently taken on the proceedings and recommended findings thereof, is placed upon a retired list or discharged unless the member is still on duty at a naval activity or presents himself and requests such additional examination.

(5) Venereal Disease.—No person with venereal disease in a communicable state shall be released from the naval service until the individual has been rendered noninfectious and not a menace to the public health. The following policies shall be strictly adhered to:

(a) A presumptive and/or standard serologic test for syphilis shall be made on all persons about to be discharged or released from active duty. This test must be made within 7 days of the expiration of enlistment or date of discharge and the results recorded in the NAVMED-H-8 or Standard Form 600.

(b) Personnel who on physical examination have signs, symptoms, or findings of a venereal disease in an infectious state should be retained in service and transferred to a naval hospital for further diagnostic study and treatment, if necessary.

(c) All Health Records shall be thoroughly checked and those containing an entry indicating that the individual has or has had a venereal disease, or that the blood test made just prior to separation is reported as positive or doubtful, shall be reviewed by a medical officer and the individual grouped in one of the following categories and handled accordingly.

(1) Category A.—Includes all personnel with a history of venereal infection who have completed recommended treatment and have had some follow-up examinations including spinal fluid examinations as well as serologic test. These individuals shall be personally interviewed and given both verbal and printed advice (NAVMED-P-5012) relative to their status and previous treatment.

(b) Indicate on NAVMED-P-5012 the exact follow-up examinations required and when these should be done. (Refer to NAVMED-P-5052-11, Treatment and Management of Venereal Diseases, for the exact follow-up requirements for specific diseases.)

(c) For syphilis cases only, complete the Separation Epidemiologic Report (MED-6222-7) in accordance with the current BUMED Instruction in the 6222 series.

(3) Category C.—Includes all personnel who have a positive or doubtful separation blood test but no history of venereal infection and whose physical examination reveals no clinical signs or symptoms of venereal disease.

(a) These individuals shall be personally interviewed and given both verbal and printed advice (NAVMED-P-5013) relative to their status. They should be given either the privilege of receiving hospitalization and treatment or separation from the service. They should be informed, however, that if complications develop and they have not received treatment while in service, it is probable they will be declared ineligible for benefits of service-connected disability.

(b) If treatment in the service is elected, transfer to a naval hospital for diagnostic study. If indicated, treatment in the hospital should consist of a standard course of therapy. An individual need not be held for follow-up examinations but should be instructed to consult his private physician or report to a Rapid Treatment Center, Veterans Administration Representative, or Venereal Disease Clinic near his place of residence. Upon discharge from the hospital, handled as in Category B.

(c) If treatment in the service is not elected, an individual should be referred to his private physician, to a Rapid Treatment Center, Veterans Administration Representative, or to a Venereal Disease Clinic for treatment and follow-up examinations.

(d) Complete the Separation Epidemiologic Report (MED-6222-7). A notation of any pertinent information (recent malaria, smallpox vaccination, infectious mononucleosis, etc.) contained in the Health Record that might explain the serological reaction should be placed under "Remarks" on this form.

(6) When referring patients to civilian health agencies, reference should be made to the latest Directory of Venereal Disease Clinics as published by the U.S. Public Health Service.
15–49. Separation of Officers From the Active List

(1) In general, the type of examination to be given to officers prior to separation from the active list is that prescribed for enlisted members prior to discharge or retirement (art. 15–48)(1) except that officers (not including midshipmen) shall appear before two or more Medical Corps officers and a Dental Corps officer; in extreme instances, however, as on detached service the examination may be conducted by one Medical Corps officer. The pelvic examination required of female enlisted members shall also be made of female officers. The examination may be conducted at a naval hospital if the officer so elects. If unfitness for service by reason of physical disability does not exist, the report shall be submitted on Standard Form 88 to the Bureau, and the results of the examination entered in the Health Record. Whenever physical conditions are discovered which may have serious import, the officer shall be transferred to a naval hospital for appropriate study. If it be considered that unfitness for service by reason of physical disability may be present or is present, or if the officer concerned so alleges and there is any reasonable evidence in support of his claim (arts. 15–48) except that officers may be screened in accordance with the procedure set forth in article 15–48(5).

(2) Officers with active venereal disease shall be screened in accordance with the procedure set forth in article 15–48(5).

15–50. Transfer of Enlisted Personnel

(1) Every enlisted member about to be transferred from one ship or station to another shall be subjected to a physical examination conducted by the medical officer, or to such physical examination as may be within the capacity of other representatives of the Medical Department present if no medical officer is available. Appropriate entries shall be made in the member’s Health Record. Except in an emergency, no one who has been exposed to any communicable disease or who is suffering from such disease shall be transferred except for treatment in a medical facility or passage thereto. When an emergency requires the transfer of personnel with communicable disease or other physical disability, a report shall be forwarded through official channels to the ship or station to which transfer is made. If such cases are retained, they shall be promptly admitted for treatment and a report of the facts made to the commanding officer.

15–51. Detachment to Sea Duty or Duty Outside the Continental Limits

(1) Officers.—Officers ordered for duty outside the continental limits of the United States shall be given a complete physical examination prior to detachment. If the wording of orders is such that there is not sufficient time available to accomplish this physical examination, the commanding officer shall endorse the orders to that effect, stating the reason the officer was not physically examined. A flight physical examination shall be given to aviators. The results of such examinations shall be entered in the officer's Health Record. In determining an individual's physical fitness for transfer to duty outside the continental limits, the effect of any physical conditions which may be found should be evaluated and considered in relation to his age, experience, motivation, and the type of duty to which he may be assigned. Should conditions be discovered which are considered sufficient to impair the officer's ability to perform the duties to which he is being assigned, the medical officer shall report the findings to the commanding officer, who shall immediately notify the Bureau of Naval Personnel or the Commandant of the Marine Corps, as appropriate, making appropriate recommendations. The findings shall be forwarded to the Bureau on Standard Form 88. For the purpose of this examination, defects or disabilities which were waived at the time of original appointment or upon reporting for active service shall not be considered disqualifying unless substantial changes have occurred.

(2) Enlisted.—When an enlisted member is designated for transfer to sea duty or to duty outside the continental limits of the United States, he shall be physically examined. The medical examiner shall record in the Health Record any physical or dental defects which would make him unfit for, or become aggravated by, the duty for which designated, and make appropriate recommendations to the commanding officer. Personnel who have had syphilis but who do not need further treatment shall be considered physically qualified for such duty if physically fit in all other respects.

(3) Immunization.—The immunization requirements for such transfer are set forth in section VIII of chapter 22 and current BUMED Instructions in the 6230 series.

(4) Notification of Noncompliance.—When personnel are received at ports of embarkation, on board ship, or at overseas bases without required physical examinations, immunizations, or dental treatment, or with incomplete Health Records, the
deficiencies shall be reported to the commanding officer with a recommendation that the matter be brought to the attention of the losing military command so that deficiencies with respect to future transfers may be corrected promptly.

Note.—There is no article 15–52.

15–53. Enlisted Applicants for Assignment to Service Schools

(1) Enlisted applicants for assignment to service schools shall be given the physical examination required by article 15–50 and shall meet physical standards as set forth in current instructions. Members requiring medical attention or who may require extensive dental treatment during the period of instruction are to be considered not physically qualified for transfer to such schools.

15–54. Applicants for Steward Ratings

(1) When practicable, applicants for steward ratings shall be examined for the presence of intestinal parasites, which, if found, shall constitute cause for rejection. They shall also be examined for venereal disease and shall not be accepted while such disease exists. To be accepted for this rating, applicants must not be subject to recurring skin disease, must be neat in appearance and clean in habits, and must be free of dental diseases, especially such conditions as heavy calculus deposits, Vincent’s infection, gingivitis, and periodontoclasia.

15–55. Prisoners

(1) An officer of the Medical Corps shall examine each member who has been sentenced by a court martial to be confined for a period exceeding 10 days on diminished rations or on bread and water. The Medical Corps officer shall state his opinion as to whether the infliction of such sentence would produce serious injury to the health of the person sentenced.

(2) All prisoners arriving at a naval place of confinement shall be examined by a Medical Corps officer.

15–56. Deserters

(1) The physical examination of a deserter shall conform to the standards prescribed for entrance into the Navy, with special reference to the individual’s mental condition including, if possible, an examination by a psychiatrist. The Medical Corps officer making the examination shall furnish the commanding officer a report thereof, including a statement of the nature and cause of any defects or disability found.

15–57. Civil Employees

(1) The commandant or commanding officer of each naval activity having a board of U.S. Civil Service Examiners shall recommend to the Civil Service Commission, through the regional director, a Medical Corps officer of the Navy to be designated a member of that board for the purpose of conducting physical examinations and executing medical certificates free of charge for applicants for, and in some cases, occupants of, Groups I, II, III, and IV(a) and IV(b) positions. The duties imposed on Medical Corps officers are primarily for the protection of the Government, and therefore, no fee shall be exacted for such examinations. In view of the liability under the Employees’ Compensation Act and the Civil Service Retirement Act, careful execution of this work is important.

(2) Physical examinations of civilian employees shall be made in accordance with existing rules and regulations of the United States Civil Service Commission, and with instructions issued by or under the direction of the Secretary of the Navy in regard thereto.

(3) Reports of physical examinations shall be submitted on such forms as are required by the United States Civil Service Commission, and by or under direction of the Secretary of the Navy.

(4) Medical Corps officers shall make physical examinations of civilian employees or annuitants in connection with disability retirement under the Civil Service Retirement Act when requested to do so by the commandant or commanding officer or by the Civil Service Commission. It shall be understood that in no event shall a Medical Corps officer be required to leave his station for the purpose of making such an examination, since only in cases where the applicant is able to appear will a Medical Corps officer be requested to make an examination. (For duties of Medical and Dental Corps officers in connection with the Employees’ Compensation Act, reference should be made to art. 21–26.)

(5) (a) The routine roentgenographic examination of the chest of civilian employees of the Naval Establishment is authorized by law as part of the program for promoting and maintaining the health of Federal employees.

(b) Whenever practicable, a roentgenographic examination of the chest shall be made as part of the physical examination for employment within the Naval Shore Establishment. If it is impracticable to obtain the examination or to have the examination interpreted, arrangement for such examination shall be made at the first opportunity. Roentgenographic examination of the chest of all persons employed within the Naval Shore Establishment shall, if practicable, be made at least once a year on a voluntary basis. Routine annual chest X-ray examinations are mandatory for all persons employed within the Naval Shore Establishment located in the Far East and in any other area where the incidence rate of chest diseases is considered high. Personnel who have roentgenographic findings of possible future clinical significance shall re-
receives the examination every 6 months, where possible, using 14 x 17 inch film. Roentgenographic examination of the chest of all persons employed within the Naval Shore Establishment shall be made, when practicable, immediately prior to leaving employment, except when such examination has been made, and recorded as without defect, within the previous 6 months.

(c) Individuals in whom the photofluorographic film discloses abnormal conditions shall be reexamined by means of 14 x 17 inch film prior to final action in their cases. The Office of Industrial Relations will issue instructions as to the procedure in handling the disposition of persons with active disease by leave or separation of the employee, in accordance with instructions contained in Navy Civilian Personnel Instructions (NAVEXOS-P-122) Instruction No. 88.

(d) For processing reports and records, see article 15-90.

15-58. Evidence of Intoxication

(1) When a request is made by competent authority, Medical Corps officers shall examine naval personnel for evidence of intoxication in accordance with the provisions of chapter 19.

15-58A. Members on Temporary Disability Retired List

(1) A periodic physical examination is required at intervals of 18 months or less in the case of any member who is carried on the temporary disability retired list. The physical examination shall be conducted in accordance with the established administrative procedure set forth in chapter 9 of the Disability Separation Manual. The medical board, in conducting and reporting the examination, should give express consideration to the purpose therefor; i.e., to furnish concise information upon which a determination can be predicated with respect to the current state of health of the member and, if noted, to any change in the degree of the disability by reason of which the member was temporarily retired. The examination shall include such special examinations and/or tests as are considered essential in formulating a considered conclusion.

(2) Issuance of orders to the member concerned for a periodic physical examination, with a copy thereof to the commanding officer of the examining authority, is accomplished by the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate. The complete medical record in each case will be furnished by the Bureau of Medicine and Surgery to the examining activity for clinical reference by the medical board without request and in advance of the probable time of examination. If for any reason the medical record is not received by the commanding officer of a continental examining authority within 10 working days following receipt of the copy of the member's orders, the Bureau shall be requested to furnish the record. In the case of an extracontinental activity, the commanding officer, at his discretion, may request the record should he consider that the receipt thereof is inordinately overdue. Such request should be submitted by deferred message. In the event of change of the member's orders following receipt of the medical record by the activity originally scheduled to conduct the examination, the record shall be immediately forwarded to the newly designated activity.

(3) Upon completion of a periodic physical examination, the findings thereof in clinical report form, together with the medical record, shall be submitted via the commanding officer of the examining authority to the Physical Review Council, Department of the Navy, Washington 25, D.C.
General Provisions

(1) To provide uniformity and completeness, a flight physical examination may be performed only by a flight surgeon or aviation medical examiner authorized, by the Chief of Naval Personnel or by proper authority of the Army or Air Force, to conduct such examinations. Only medical officers who have successfully passed a course at a U. S. Service School of Aviation Medicine leading to the designation of Aviation Medical Examiner or Flight Surgeon are so designated.

(2) The object of the aviation examination, and the instructions incident thereto, is to select for flying duty only those individuals who are physically and mentally qualified for such duty, and to remove from flying duty those who may become temporarily or permanently unfit for such duty because of physical or mental defects. Basic physical qualifications shall conform to the standards prescribed for general service in previous sections. In addition to the general service requirements, certain special requirements as embodied within this section must be met by the various groups of individuals concerned with aviation.

(3) (a) A flight physical examination, therefore, is an examination conducted to determine whether or not a person is physically qualified and aeronautically adapted to engage in frequent aerial flights. The extent of the examination is determined by the character of the duty to be performed by the person who will make such flights.

(b) The flight physical examination of a candidate for flight training will be more extensive than that required for a naval aviation observer. Furthermore, the physical standards upon which qualification is based will obviously be more rigid for the candidate for flight training leading to the designation of naval aviator than those for a naval aviation observer. It is obvious, therefore, that the term “flight physical examination” is technically incomplete unless the duty which the examinee is to perform is specified.

(c) There are roughly 15 classifications of aviation personnel ranging from naval aviator to combat aircrewman. The extent of the examination and the standards set are technically different for each classification. Through general usage it has become the custom in the naval service to use the term “flight physical examination” as an entity. When so used, consideration of the duties of the person concerned is presumed. For example, a candidate for flight training is required to take a “flight physical examination” and a naval aviation observer is required to take a “flight physical examination” but the extent of examination and the standards on which “pass” or “fail” is based in each case is different.

(4) Equipment and personnel for conducting the physical examination for flying have been provided aboard aircraft carriers and the large aircraft tenders, at fleet air bases and within certain flag commands to which staff flight surgeons are attached; and at naval air stations, Navy and Marine Corps air bases, and at other shore activities and commands within the several naval districts to which flight surgeons or aviation medical examiners are attached.

(5) Aviation personnel includes all individuals who in the performance of their duty are required to make frequent aerial flights. Aviation personnel are divided into two classes.

(a) Class I.—Aviation personnel engaged in the actual control of aircraft, which includes naval aviators, student naval aviators, naval aviation pilots, student naval aviation pilots, naval aviation cadets, and lighter-than-air pilots. In this class is also included student naval flight surgeons who are chosen to perform solo flights.

(1) Class 1 is further divided into service groups I, II, and III, based on the age and flying experience of the aviator concerned and certain
15–60. Restrictions Until Physically Qualified

(1) Each individual in the naval service who is assigned to duty which requires the performance of frequent aerial flights must, regardless of classification, pass a flight physical examination within 12 months of the time such duty is performed. In some cases more frequent examination is required. Naval aviation personnel in Class 1 are considered to have passed a flight physical examination when a flight surgeon or a board of medical officers, one of which is a flight surgeon, finds that in consideration of the standards prescribed in this manual, the examinee is physically qualified and aeronautically adapted for actual control of aircraft. Naval aviation personnel in Class 2 are considered to have passed a flight physical examination when such flight surgeon or board finds that in consideration of the prescribed standards the examinee is physically qualified and aeronautically adapted for flying. Except as authorized under subarticle 15–60 (5), no person shall assume duty involving the actual control of aircraft until notification has been received from the Bureau of Medicine and Surgery that such person is physically qualified for that duty.

(2) Candidates for flight training who fail to attain the qualifying scores on psychological tests, as specified in technical memoranda and directives of the Bureau of Medicine and Surgery will not be recommended for assignment to flight training.

(3) All candidates for flight training whether or not they are already in the naval service, must pass the physical examination for flying before assignment to training duty. The examination must not antedate the application by more than 6 months. When in rare instances a candidate for flight training is not in the vicinity of one of the ships or stations where the physical examination for flying can be made, he shall be examined in accordance with the instructions governing the examination of candidates for commission and shall be expected to meet the standards set forth as acceptable for a commissioned officer. Before being assigned to duty involving flying leading to the designation of naval aviator, all candidates, regardless of source, must be given the complete physical examination for flying at the station to which they may be attached for training.

(4) Pilots of the Volunteer Naval Reserve and Volunteer Marine Corps Reserve who apply for permission to pilot naval aircraft shall be subjected to the examination prescribed for Class 1 herein unless they present satisfactory evidence that they have passed such an examination within 6 months of the date on which flight is desired. For Organized Reserve pilots and for certain Volunteer Reserve pilots who serve under and are so authorized by the Chief of Naval Air Reserve Training or Commander, Marine Air Reserve Training, the interval shall be not greater than 12 months.

(5) Pending receipt of the approved copy of the record of physical examination, or certificate from the Chief of Naval Personnel that the record of physical examination has been approved, aviation personnel may be considered physically qualified if
15-60

CHAPTER 15. PHYSICAL EXAMINATIONS

an authorized flight surgeon or aviation medical examiner certifies that the individual has no physical or mental defect that would disqualify him for flying.

(6) When the flight status of any member of the aeronautical organization has been restricted by letter from the Chief of Naval Personnel or Commandant of the Marine Corps, such restriction remains technically in effect until it is changed by subsequent letter from the same authority. However, in order to avoid delay in the return to flight status of persons who are clearly qualified to perform such duties, commanding officers are authorized, after consideration of the recommendation of a flight surgeon, to waive this technical restriction pending the final action of the Chief of Naval Personnel or the Commandant of the Marine Corps. When the Chief of Naval Personnel or the Commandant of the Marine Corps places or lifts flight restrictions because of the results of a flight physical examination, his action is always based on the opinion of the Chief of the Bureau of Medicine and Surgery. The original and one copy of Standard Form 88 (Flight Physical Examination), submitted directly to the Bureau of Medicine and Surgery, is all that is necessary to accomplish reconsideration by the Chief of Naval Personnel or the Commandant of the Marine Corps of any restriction, based on physical condition or lack of aeronautical adaptability, placed by him, on persons in the aeronautical organization. See article 15-73 (2) (b).

15-61. Policies on Service Groups for Naval Aviators

(1) Service Group Assignments of Pilots of Naval Aircraft.—The following policies shall, in general, be followed in the assignment of pilots of naval aircraft to flight duties:

(a) Service Group I.—Pilots under 50 years of age who meet the physical standards for service group I. These pilots may be assigned to flight duties of an unlimited or unrestricted nature.

(b) Service Group II.—Pilots between 35 and 50 years of age, or those pilots under 35 years of age who have accumulated 10 or more years of active flying service since date of designation as a Naval Aviator, who meet the physical standards for service group II, and pilots of service group I who temporarily meet only the physical standards for service group II. Pilots of service group II are restricted from carrier operations except in helicopters or LTA ships.

(c) Service Group III.—Pilots over 50 years of age who meet the physical standards of service group I, II, or III; and those pilots under 50 years who (1) are recovering from illness or injury, or (2) meet the standards of service group III but are not physically qualified for the other service groups when the needs of the service and the individual’s flying experience specifically justify their employment in such a limited pilot status. Those pilots assigned because of temporary physical defects shall be retained in service group III for a period up to 6 months at the end of which time they shall be reexamined for classification. Should the temporary disability warrant a longer period in order to fully recuperate they can be retained in this group for additional 6-month periods before final classification is effected. Those pilots assigned for the needs of the service shall be retained in service group III for only as long as the need exists. Upon change of station this need will be assumed to have terminated. The Chief of Naval Personnel, or the Commandant of the Marine Corps in the case of Marine Corps personnel, will effect appropriate redesignation or reassignment to service group III as needs of the service then require. Restrictions for service group III pilots apply as follows:

(i) Normally operate only aircraft equipped with dual controls and be accompanied on all flights by a pilot of service group I or II qualified in model aircraft operated.

(ii) With the approval of the Deputy Chief of Naval Operations (Air), pilots in service group III who meet the physical standards for service group I or II may solo such aircraft as is commensurate with physical and service qualifications of each pilot.

(iii) Pilots in this group are authorized to maintain a standard instrument card provided all other requirements are met.

(2) Physical Standards and Disposition.—

(a) The physical standards for aviation personnel in each of the foregoing service groups are set forth in articles 15-62, 15-63, and 15-64.

(b) Should any pilot fail to meet the prescribed physical requirements for flying of his service group, such failure will be set forth in the report of physical examination for flying (Standard Form 88) and the report forwarded to the Chief of the Bureau of Medicine and Surgery, who will submit his recommendation to the Chief of Naval Personnel via DCNO (Air), or the Commandant of the Marine Corps (Code DFH) direct in the case of Marine Corps personnel, in which case disposition shall be as follows:

(1) Permitted to continued unrestricted flight status of his service group subject to waiver of defects by the Chief of Naval Personnel, or the Commandant of the Marine Corps in the case of Marine Corps personnel.

(2) Restricted to flight duties of next service group; that is, from I to II, or II to III.

(3) Restricted to flight duties of lessened tempo commensurate with present temporary physical condition (limited to pilots recuperating from injuries or illness).
(4) Restricted to flight duties of service group III, requiring the presence of a co-pilot qualified in service group I or II.

(5) Flight status ceases where revocation of flying authority and change of designator appear necessary. Pilot shall be ordered before a formal board of medical officers for further evaluation of physical disqualifications.

(e) In reference to the disposition of a naval aviator stated in subarticle 15–61 (2) (b) (5), the Chief of Naval Personnel, or the Commandant of the Marine Corps in the case of Marine Corps personnel, will request the nearest air command to appoint a formal board consisting of three flight surgeons and/or aviation medical examiners. At least one member must be a flight surgeon. The board shall submit its report to the Chief of the Bureau of Medicine and Surgery, who in turn will submit recommendation to the Chief of Naval Personnel via DCNO (Air), or the Commandant of the Marine Corps (Code A2Z) direct in the case of Marine Corps personnel, for disposition by any of the methods stated in subarticles 15–61 (2) (b), (1), (2), (3), (4), and (5).

(d) In cases where recommendation is made to terminate flight status, the Chief of Naval Personnel, or the Commandant of the Marine Corps in the case of Marine Corps personnel, will determine if the individual shall be retained within the aeronautical organization or assigned to duty outside the aeronautical organization.

(e) For those cases where appeal of the recommendation or decision is requested, the Chief of Naval Personnel, or the Commandant of the Marine Corps in the case of Marine Corps personnel, will convene a formal board of senior flight surgeons and/or aviation medical examiners at the Naval Air Station, Anacostia, Washington, D. C. This board will consist of five members, three of whom shall be flight surgeons. The decisions of this board will be final. Individuals appealing may request appearance before this board. Upon such request for appearance the individual may be issued temporary additional duty orders authorizing Government air travel, at no additional expense to the Government, in accordance with current directives.

15–62. Examination and Standards for Class I, Service Group I

(1) General Examination.—Except as modified by addition of the provision of this article, the basic physical examination and basic physical standards shall be the same as those prescribed for officers of the general service.

(2) History.—History of any of the following shall be considered as disqualifying: epilepsy, repeated attacks of acute allergy, recent attacks of malaria, paroxysmal tachycardia, any organic heart disease, recurrent attacks of any of the rheumatic group, recent renal calculus, encephalitis lethargica or any illness accompanied by diplopia and lethargy, or a second relapse to antiluetic treatment. For persons already in the Navy, a complete review of the examinee's Health Record is most important. Flight surgeons are authorized to postpone the examination of persons who fail to present their Health Record at the time of examination. In exercising this prerogative, due consideration must be made in cases where access to the individual’s Health Record is administratively impracticable. In such cases the examinee shall be required to complete Standard Form 69. When Standard Form 69 is employed as part of a physical examination (mandatory for all candidates) some comment must be made by the flight surgeon when any significant item is checked by the examinee.

(3) Drugs.—In general, the flight physical examination shall not be performed on any individual under treatment with drugs which might affect his flying proficiency.

(a) Syphilis.—Individuals acquiring syphilis shall not be permitted to fly while undergoing treatment. They may be returned to flying duty after completion of treatment, if in the opinion of the flight surgeon or medical examiner the individual is free of clinical sequelae and is qualified for flying.

(4) Height and Weight.—The minimum height is 66 inches. The maximum height is 76 inches. Examinees weighing in excess of 200 pounds may be found physically qualified if such excess weight is not above the maximum shown in the standard table for height and age for officers and enlisted men contained in article 15–8. Five percent excess above the maximum standard may be considered temporarily acceptable, if the flight surgeon considers the examinee capable of reducing his weight to the maximum standard within 6 months.

(5) Chest.—Any condition that serves to impair respiratory function may be cause for rejection. The examinee, if an average-sized individual, should normally have not less than 3 inches of chest expansion. A variation of 1/2 inch is allowable if the individual is otherwise acceptable.

(6) Cardiovascular System.—Cardiac arrhythmia, or heart murmur, or other evidence of cardiac abnormality shall be the cause of careful study, including recourse to an electrocardiographic examination when indicated. Evidence of organic heart disease shall be cause for rejection.

(7) (a) Blood Pressure and Pulse Rate.—In considering the blood pressure, the examiner must give due regard to the age of the candidate and to physiological causes such as excitement, recent exercise, and digestion. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as must also the relation between the systolic and diastolic pressures. No examinee shall...
be rejected as the result of a single reading. When the blood pressure estimation at the first examination is regarded as abnormal, or in the case of doubt, the procedure shall be repeated twice daily (in the morning and in the afternoon) for a sufficient number of days to enable the examiner to arrive at a definite conclusion.

(b) In conducting the neurocirculatory efficiency test (Schneider Index) the examinee shall be afforded every opportunity to relax. Loud noises, conversation, and other distracting influences which may serve to excite or adversely affect the examinee, are to be avoided. Smoking, fatigue and intercurrent infections will affect the score. Before taking the test, the subject should recline in a quiet environment for not less than 5 minutes, after which the examination proceeds as follows:

(1) Heart rate is counted for 15 seconds, when two consecutive counts are the same, the 15-second rate is multiplied by 4 and recorded.

(2) The blood pressure is taken by auscultation and recorded. Take two or three readings to be certain.

(3) The subject then stands. After 30 seconds the standing blood pressure is taken and recorded.

(4) The subject continues to stand. When two consecutive 15-second counts are the same, multiply by 4 and record. If after standing for 2 minutes, the pulse has not become constant, record the standing pulse rate at that time.

(5) Standing pulse minus the reclining pulse gives the increase on standing.

(6) The subject steps upon a chair 18 1/2 inches high, five times in 15 seconds. To make this uniform, the subject should stand with one foot on the chair at the count of one. This foot remains on the chair and is not brought to the floor. At each count he brings the other foot on the chair and at the word "down" replaces it on the floor. This should be timed accurately so that at the 15-second mark on the stop watch both feet are on the floor.

(7) Start counting the pulse immediately at the 15-second mark on the stop watch and count for 15 seconds. Multiply by 4 and record.

(8) Continue to take pulse in 15-second counts until the rate has returned to the normal standing rate. Note the number of seconds it takes for this to return and record. In computing this return, count from the end of the 15 seconds of exercise to the beginning of the first 15-second normal standing pulse count. If the pulse has not returned to normal at the end of 2 minutes, record the number of beats above normal and discontinue counting.

(9) Check up points and enter final rating as indicated in the table.

(10) Consider the history of the case, including amount of recent sleep, amount of smoking, time since last meal, any personal worries or any recent consumption of alcoholic beverage before final interpretation of the score. If after considering these items, the flight surgeon feels that the recorded score is distorted by these factors, an entry to that effect should be made under "Remarks" on Standard Form 88.

Table for grading cardiovascular changes

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<tr>
<th>Section</th>
<th>Points</th>
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<tbody>
<tr>
<td>A. Reclining pulse rate</td>
<td>Points</td>
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<td>Rate</td>
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<td>C. Pulse rate increase on standing</td>
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<td>When reclining rate is</td>
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<td>D. Pulse rate increase immediately after exercise</td>
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<td>When standing rate is</td>
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<td>E. Return of pulse rate to standing normal after exercise</td>
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<td>After 120: 2-10 beats above normal</td>
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<td>After 120: 11-30 beats above normal</td>
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<td>F. Systolic pressure, standing, compared with reclining</td>
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(c) Interpretation of Findings.—

(1) Blood Pressure.—If the examinee is over 25 years of age, the systolic blood pressure shall not
persistently exceed 150 mm. If the examinee is 25 years or younger, the systolic pressure shall not persistently exceed 140 mm. A diastolic blood pressure persistently above 95 mm is disqualifying. When, after changing from the recumbent to the standing position and remaining in that position for 30 seconds, the systolic blood pressure is found to be persistently more than 10 mm. below that of the recumbent position, the examinee is disqualified.

(d) Neurocirculatory Index.—This index shall be regarded as a valuable check on the physical condition of the examinee. An index below eight shall be regarded as unsatisfactory. No individual shall be rejected because of a single failure to pass the test satisfactorily, but shall be recalled for further observation and study. When the index is persistently below the acceptable limit and is indicative of neurocirculatory asthenia, or other abnormalities of the circulatory system, the examinee shall be disqualified.

(8) Teeth.—Any dental defect which will produce indistinct speech by direct voice or radio transmission is disqualifying.

(9) Psychiatric Examination.—Following the completion of the general examination, the examiner shall make a careful study of the examinee’s family history for evidence of insanity, familial traits of psychoneurotic manifestations, degenerations, and inherited deficiencies. A candidate’s personal history shall be searched for significant factors which relate to the formative years that affect his personality trend. The infantile period shall be searched for evidence of retardation. Consideration shall be given to examination of the family life, play life, school life, sex life and a careful search for epileptic equivalents. Determine the family attitude toward flying and the examinee’s reaction to the stresses of life and his general emotional response and control. The object of the examination shall be to determine the individual’s basic stability, motivation, and capacity to react favorably to the special stresses encountered in flying. Although this phase of the examination shall be performed routinely only on candidates for flight training who are otherwise physically qualified, it may, at the discretion of the flight surgeon be made a part of the examination of any aviation personnel. Any significant personality change in an experienced aviator should be reported when the examiner knows the pilot well enough to note such a change.

(10) Neurological Examination.—A careful neurological examination shall be made, attention being given to the following examinations and report of findings.

(a) Pupils.—Regular, irregular, equal, unequal, do or do not react to light and accommodation.

(b) Deep Sense (Romberg).—Negative, slightly positive or pronouncedly positive.

(c) Deep Reflexes: Patellar, Biceps, etc.—Absent (0), diminished (—), normal (+), hyperactive (++), and exaggerated (+++).

(d) Superficial Reflexes: Abdominal, Cremasteric, etc.—Any abnormalities found.

(e) Sensory Disturbances.—Any abnormalities found.

(f) Motor Disturbances.—Evidence of muscle weakness, paresis, or any other abnormality.

(g) Trophic Disturbances.—Evidence of atrophy, compensatory hypertrophies, or any other abnormality.

(h) Tremors.—State whether fine or coarse, and name parts affected.

(i) Tics.—Specify parts affected. State whether they are considered to be permanent or due to fatigue or nervous tension.

(j) Cranial Nerves.—Examine carefully for evidence of impaired function or paresis. It should be remembered that some of the cranial nerves are subject to frequent involvement in a number of important diseases, such as syphilis, meningitis, encephalitis lethargica, and injuries to the cranium.

(k) Psychomotor Tension.—Ability to relax voluntarily. This shall be tested by having the examinee rest his forearm upon palm of examiner and then testing the tendon reflexes of the forearm with a percussion hammer. The flight surgeon should also keep himself informed regarding all indications of staleness in order to recognize the earliest manifestations of that condition.

(l) Peripheral Circulation.—Examine for flushing, mottling and cyanosis of face, trunk and extremities. Question as to the presence of localized sweating (armpits and palm) and cold extremities. Any abnormalities disclosed on the neurological examination should be carefully studied and an opinion expressed as to their cause and significance and whether they are sufficient cause for rejection.

(11) Visual Acuity.—

(a) See articles 15–86 for special instructions.

(b) Interpretation of Findings.—Visual acuity of less than 20/30 is disqualifying.

(12) Depth Perception.—

(a) The Verhoeff Stereopter will be used as the test for depth perception. This is a binocular test. The apparatus provides for shifting, with each exposure, of the relative position of three vertical rods in such a manner that one rod is always nearer to, or farther away from, the examinee, than the other two.

One or two positions are shown at close range to the examinee to clearly demonstrate that one rod is always at difference from the other two. It is pointed out that the size of the rods is not a clue to the relative distances. The examinee is now ready for the test. The apparatus is held 1 meter from the examinee. Eight different rod relations are possible and all eight are shown.
(b) Interpretation of Findings.—The examinee should answer for each of the eight positions correctly. Three separate runs may be made and the examinee must report eight out of eight correctly in two of the three trials. Failure to do so is disqualifying.

(13) Ocular Motility.—
(a) The Maddox-rod screen test at 20 feet and 13 inches shall be performed. See article 15-87 for detailed instructions.
(b) Prism Divergence at 20 Feet.—In addition to the method of taking phoria readings as indicated in article 15-87, the prism divergence for a 20-foot stimulus is required in cases in which esophoria is present.

(1) Apparatus.—The phorometer trial frame and a spotlight 1 cm. in diameter shall be used.
(2) Procedure.—The examinee is seated facing the spotlight 20 feet away. The rotary prism of the phorometer trial frame is adjusted before one eye so that by turning the milled hand the prism will be acting base in. With the prism set at zero on the scale, the examinee should see but one spot of light. As the prism is slowly rotated, base in, diplopia will be produced. The number of prism dipters which causes the onset of diplopia is read from the scale and entered on the record as prism divergence for 20-foot stimulus.
(3) Precautions.—The test cannot be made if the examinee has diplopia when the prism is set at zero on the scale. If this condition exists, the examinee has diplopia in the primary position which should be verified by a red lens test.

(c) (1) Interpretation of Findings in Ocular Motility for 20-Foot Stimulus.—An esophoria of greater than 10 prism dipters disqualifies. If the esophoria is greater than 5 prism dipters, a red lens test is required. Furthermore, if any esophoria is present for a 20-foot stimulus, it must be balanced by an equal amount of prism divergence for a 20-foot stimulus. Hyperphoria greater than 1 prism diopter is disqualifying. Exophoria greater than 5 prism dipters is disqualifying.

(2) Interpretation of Findings for 13-Inch Stimulus.—A prism divergence for a 13-inch stimulus of less than 12 prism dipters is disqualifying. There is no upper limit for prism divergence for a 13-inch stimulus.

(14) Red Lens Test.—
(a) Apparatus.—A spectacle trial frame, a red lens from the trial lens case, a small light such as an ophthalmoscope with head removed, and metric rule or tape shall be used.
(b) Procedure.—The examinee is seated in the darkroom facing the dark wall or tangent curtain at 75 cm. distance. The spectacle trial frame is adjusted into position and the red lens from the trial lens case is placed in one cell of the trial frame. With the examinee’s head in a fixed position, the small lamp is held directly before the center of the dark wall or tangent curtain at 75 cm. distance from the eyes. The presence or absence of diplopia in this position (primary) is noted. The light is then slowly moved from the central position toward the right for a distance of 50 cm. in the horizontal plane. In the same manner, the light is moved in the remaining five cardinal directions, up and to the right, up and to the left, down and to the left, and down and to the right. The presence or absence of diplopia in any of these positions should be noted. Normally diplopia should not occur in any meridian within 50 cm. of the primary position. In the presence of diplopia, notation should be made as to whether it is crossed, homonymous, or vertical and the distance in centimeters from the central position at which diplopia first occurs should be recorded. When diplopia is suspected and the examinee has been coached to deny its presence, a prism of 3 or 4 D. may be placed, either base up or base down, in one cell of the trial frame. If diplopia is still denied, the statement is obviously untrue.
(c) Precautions.—The head of the examinee must remain fixed and the movement of the light followed only by the eyes. No tilting or rotation of the face shall be permitted.

(d) Interpretation of Findings.—Diplopia first occurring within 50 cm. of the primary position, in any meridian, disqualifies.

(15) Inspection of the Eyes.—
(a) Procedure.—Whenever possible, the eyes are inspected by bright daylight. Every pathologic condition and congenital anomaly is recorded. The following conditions may be found by this procedure:
(1) Lids.—Ptosis, blepharitis, trichiasis, entropion, eckropion, and chalazion.
(2) Tear Sacs.—Imperfect drainage.
(3) Lower Puncta.—Failure of contact with bulbar conjunctiva.
(4) Conjunctivae.—Trachoma and old scars.
(5) Cornes.—Scars, pannus and pterygium.
The wearing of contact lenses should be disclosed at this stage of the examination.
(b) Pupils.—Unequal size, irregular shape, and failure to react to light or accommodation.

(b) Interpretation of Findings.—Any pathologic condition which may become worse or interfere with the proper functioning of the eyes under the fatigue and exposure of flying disqualifies.

(16) Test for Accommodation.—
(a) Procedure.—Accommodation is measured from the anterior focus of the eye, which is about 11.5 mm. in front of the cornea. Using the millimeter rule, make a pencil mark on each side of the examinee’s nose 11.5 mm. in front of the right and left cornea, respectively. In measuring the accommodation of the right eye, lay the flat side of the Prince rule against the right side of the examinee’s...
nose, with the end of the rule at the pencil mark. The rule is held horizontally and extends directly to the front, edge up. The card of test letters is held not more than 5 cm. in front of the examinee’s right eye. His left eye is screened from sight of the letters by the flat side of the rule. The card of test letters is now carried slowly away from the eye and the examinee instructed to begin reading the letters aloud as soon as they become legible. The card is halted the instant he begins to read the letters correctly and the point on the rule opposite the card is read off in diopters. This is the measure of accommodation of the right eye. To test the left eye, change the rule to the left side of the nose and repeat the above procedure, using a different line of letters.

(b) Precautions.—The examinee is placed with his back to good light, with the card well illuminated. The card is started from close to the eyes and carried away from them. The letters of the test card are read aloud. The same line of letters is not used for testing both eyes.

(c) Interpretation of Findings.—The following table gives the mean values of accommodation in diopters from 18 to 50 years of age. Accommodation may be regarded as within normal limits provided it is not more than 3 D. below the mean for the examinee’s age. The examinee is disqualified if his accommodation falls more than 3 D. below the mean for his age, but before an examinee is disqualified, his accommodation should be taken on three successive days and an average of the three findings determined. Accommodation may be affected by fatigue, staleness, or other debilitating conditions. No individual having less than 2.5 D. of uncorrected accommodation will be considered qualified for service group I.

Table of mean values of accommodation power (Duane)

<table>
<thead>
<tr>
<th>Age</th>
<th>Diopeters</th>
<th>Age</th>
<th>Diopeters</th>
<th>Age</th>
<th>Diopeters</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>11.9</td>
<td>27</td>
<td>9.6</td>
<td>35</td>
<td>7.3</td>
</tr>
<tr>
<td>19</td>
<td>11.7</td>
<td>28</td>
<td>9.4</td>
<td>36</td>
<td>7.1</td>
</tr>
<tr>
<td>20</td>
<td>11.5</td>
<td>29</td>
<td>9.2</td>
<td>37</td>
<td>6.8</td>
</tr>
<tr>
<td>21</td>
<td>11.2</td>
<td>30</td>
<td>8.9</td>
<td>38</td>
<td>6.2</td>
</tr>
<tr>
<td>22</td>
<td>10.8</td>
<td>31</td>
<td>8.6</td>
<td>39</td>
<td>6.2</td>
</tr>
<tr>
<td>23</td>
<td>10.6</td>
<td>32</td>
<td>8.3</td>
<td>40</td>
<td>5.9</td>
</tr>
<tr>
<td>24</td>
<td>10.4</td>
<td>33</td>
<td>8.0</td>
<td>45</td>
<td>3.7</td>
</tr>
<tr>
<td>25</td>
<td>10.2</td>
<td>34</td>
<td>7.7</td>
<td>50</td>
<td>2.0</td>
</tr>
</tbody>
</table>

(17) Near Point of Convergence (PC).—The Prince rule and a pin with a white head 2 mm. in diameter shall be used. The end of the Prince rule is placed edge up, at the mark on the right side of the nose, 11.5 mm. in front of the cornea. The white-headed pin is held 23 cm. away in the median line above the edge of the rule and the examinee is instructed to look at it intently. If both eyes are seen to converge upon the pin, it is then carried in the medial line, along the edge of the rule, toward the root of the nose. The examinee’s eyes are carefully watched and the instant one is observed to swing outward, the limit of convergence has been reached. The point on the rule opposite the pin is then read in millimeters. This test is repeated until a fairly constant reading is obtained. Both eyes must converge upon the pin at the start of the test. The examinee’s observation of the onset of diplopia is not relied upon to determine the near point, although he is asked to state when he sees double.

(18) (a) Interpupillary Distance (PD).—A small millimeter rule is used. The examiner stands with his back to the light, and faces the examinee. The rule is held in the examiner’s right hand and laid across the examinee’s nose in line with his pupils, as close to the two eyes as possible. The examiner closes his right eye and instructs the examinee to fix his eyes on the open left eye. With the eyes in this position, a predetermined mark on the rule is placed in line with the nasal border of the examinee’s right pupil. The rule must be held steadily in this position while the examiner opens his right eye and closes his left. The examinee is then instructed to look at the open right eye. The point on the rule in line with the temporal border of the examinee’s left pupil is read in millimeters and the exact difference in millimeters between the two points on the rule is the interpupillary distance.

(b) Interpretation of Findings.—A point of convergence (PC) greater than the interpupillary distance (PD) is disqualifying.

(19) Color Vision.—Normal color perception is required. Color perception shall be determined and findings interpreted in accordance with the standards and procedures set forth in article 15-11.

(20) Field of Vision.—

(a) Procedure.—The examiner faces the examinee at a distance of 2 feet. He instructs the examinee to close his left eye and to fix his right eye on the examiner’s left eye, the examiner’s right eye being closed. The examiner then brings his moving fingers in from the periphery, midway between himself and the examinee. The examinee is instructed to say when he sees the fingers, and how many. He should see them as soon as the examiner, if normal. The fingers are brought in from all cardinal directions. The test is then repeated for the left eye. Any evidence of abnormality should be given detailed study on the perimeter. Normal fields are as follows: temporally 90°; supero-temporally 82°; infero-temporally 85°; infero-nasally 55°; infero-nasally 70°; supero-nasally 60°.

(b) Interpretation of Findings.—The field of vision for each eye shall be normal as determined by the finger fixation test. When there is evidence of
abnormal contraction of the field of vision in either eye, the examinee shall be subject to perimetrical study for form. Any contraction of the form field of 15° or more in any meridian shall disqualify.

(21) (a) Refraction.—Refraction of the eyes shall usually be required only on the original examination, but should also be performed in special cases when visual acuity is below 20/30 and refraction has not been reported to the Bureau within 2 years.

(b) Procedure.—The tension of both eyes must be taken by palpation and found normal before instilling a cycloplegic. The fundus of both eyes must also be examined with the ophthalmoscope, and if stiltations have been made. At the end of 1 hour from the time of the first instillation, the examinee is ready for refraction. Retinoscopic examination is conducted in the darkroom and the results of the refraction are then verified by having the examinee read the Snellen Charts. The minimum correction required to enable the examinee to read 20/20 under cycloplegic is recorded for each eye. For persons over 40, or when cycloplegic is contraindicated, a manifest refraction is acceptable.

(c) Interpretation of Findings.—The examinee is disqualified if he cannot be corrected to 20/20 for each eye.

(d) After the use of a cycloplegic, the examinee must wear dark glasses until the effects have disappeared. The instillation into each eye of 1 per cent solution of pilocarpine hydrochloride in distilled water will contract the pupil and thus relieve the photophobia.

(22) Ophthalmoscopic Examination.—Any abnormality disclosed on ophthalmoscopic examination that materially interferes with normal ocular function disqualifies. Other abnormal disclosures indicative of disease, other than those directly affecting the eyes, shall be considered with regard to the importance of those conditions.

(23) Ear, General.—The external auditory canals and membranes tympani are examined by means of a speculum and good light. A perforation or evidence of present inflammation disqualifies. The presence of a small scar caused by trouble several years previously, which has not recurred and with which there is no deficiency of hearing and no evidence of other inflammation, does not disqualify. Actual perforation, or marked retraction of a drum membrane following chronic ear disease, disqualifies.

(24) Hearing Tests.—To determine auditory acuity, the following test shall be used. A quiet room is essential:

(a) Whispered Voice Test.—The examinee should stand 15 feet from the examiner with the ear being tested turned toward him, the other ear being covered or closed. The examiner, after full expiration, will whisper a number or word and require the examinee to repeat it after him. Each ear shall be tested in turn. If the examinee is unable to hear at 15 feet, the examiner shall approach until he is able to distinguish the words or numbers, the distance being recorded in feet with 15 as the denominator.

(b) Interpretation of Findings.—15/15 whispered voice in each ear is qualifying without further test. If the auditory acuity is less than 15/15 whispered voice in either ear, the spoken voice should be recorded for record and an audiogram shall be obtained. In any doubtful case, final decision as to qualification will be made on the basis of the audiogram. Auditory acuity poorer than the degree allowed below is disqualifying:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>256</th>
<th>512</th>
<th>1024</th>
<th>2048</th>
<th>4096</th>
<th>8192</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better ear</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>(*)</td>
<td>(*)</td>
</tr>
<tr>
<td>Worse ear</td>
<td>20</td>
<td>40</td>
<td>40</td>
<td>(*)</td>
<td>(*)</td>
<td>(*)</td>
</tr>
</tbody>
</table>

*Total of these 4 frequency readings not to exceed 160.

(25) Naso-Pharynx.—Any abnormality disclosed on examination indicating an estimated 50 percent or more of nasal obstruction, acute or chronic sinusitis, acute or chronic tonsillitis, nasal blockage, mechanical obstruction to drainage of accessory sinuses, occlusion of one or both Eustachian tubes, or other abnormalities which may seriously interfere with normal function, shall be cause for rejection.

(26) Equilibrium.—

(a) Self-Balancing Test.—The candidate stands erect, without shoes, with heels and large toes touching. He then flexes one knee to a right angle, being careful not to support it against the other leg, closes his eyes, and endeavors to maintain this position for 15 seconds. The test is then repeated on the other foot. The findings are recorded as "Steady," "Fairly Steady," "Unsteady," or "Failed." The candidate should be instructed that this is an equilibrium test; there is no objection to his assisting his balance by moving and bending back and forth.

(b) Interpretation of Findings.—Inability to pass this test for equilibrium satisfactorily shall be cause for rejection.

15–63. Standards for Service Group II

(1) Physical requirements for Service Group II shall be the same as those prescribed for Service Group I, with the following variations:

15–41

Change 5
(a) Visual acuity shall be not less than 20/50 for each eye. When the visual acuity of either eye is less than 20/30, each eye shall be corrected to 20/20 and that correction shall be worn at all times while flying.

(b) When accommodation is tested, any correction that is required by (a) above must be worn. The test may be done binocularly. When accommodation under these conditions is less than 2.5 diopters, it must be corrected by sufficient addition to accomplish 2.5 diopters of accommodation. This correction must be available at all times while flying.

(c) Moderate defects of hearing may be permitted, but when less than the 7/15 whispered voice binaural, the audiometer test shall be done and the standard for qualification shall be as follows:
15–64. Standards for Service Group III

(1) Physical requirements for Service Group III shall be the same as for Service Group I, with the following variations:

(a) Visual acuity shall be not less than 20/100 in either eye. When the visual acuity is less than 20/30 in either eye, each eye must be corrected to 20/20 and the correction must be worn while flying.

(b) There shall be no muscle imbalance (phoria of sufficient degree to result in diplopia within 50 cm. of the central position of the tangent curtain).

(c) Defects of hearing may be permitted but shall not exceed the minimum of 8/15 spoken voice binaural.

(d) Accommodation.—When accommodation is tested, any correction that is required by (a) above must be worn. The test may be done binocularly. When accommodation under these conditions is less than 2.5 diopters, it must be corrected by sufficient addition to accomplish 2.5 diopters of accommodation and the correction must be available at all times while flying.

(e) The diastolic blood pressure shall not regularly exceed 100 mm. The systolic blood pressure shall not regularly exceed 165 mm.

15–65. Reporting Examination of Class 1 Personnel

(1) After the examination has been completed, the examiner shall make an assessment of the individual’s qualifications for flying, based upon either a review of previous entries in the Health Record or the report of Standard Form 89, the physical findings, and the result of the neuropsychiatric examination. While no individual will possess all good traits, or all bad ones, the examiner shall summarize his impressions of the individual’s aeronautical adaptability, which shall be recorded as favorable or unfavorable. When an individual is found to be physically qualified but his aeronautical adaptability is regarded as unfavorable, the entry of findings on Standard Form 88, as finally recorded, shall be “Physically qualified but not aeronautically adapted.” When an individual is found not aeronautically adapted, sufficient comment and information shall be furnished under “remarks” or “notes” to justify such a conclusion. When the report of examination of Class 1 personnel is made to the Bureau, the flight surgeon shall specify an appropriate service group. The flight surgeon may make any further recommendation or comment which he considers proper.

(2) Flight surgeons are directed to use freely the space on the Standard Form 88 entitled “remarks” or “notes.” In this space, the flight surgeon may feel free to express his opinion on both specific defects and the overall capabilities of the examinee. Proper use of this space often converts a mere recording of a mechanical examination to a valuable vital estimation of the qualifications of the examinee. Comments by the examinee or of his immediate superiors are occasionally most valuable especially when removal from flight status is recommended. Flight surgeons should enclose such comments in writing as addenda to the formal report whenever such information is considered relevant to making a final recommendation.

15–66. Special Reporting on Personnel in Flight Training

(1) The standards for personnel in flight training are the same as Class 1, Service Group I, except that whenever the uncorrected visual acuity of a person in flight training falls permanently below 20/20 in either eye, or whenever any other defect which is permanently disqualifying for appointment to ensign develops, a complete flight physical examination, including refraction under cycloplegic for cases of defective vision, will be done and the report shall be forwarded to the Bureau. It is the policy of the Bureau to advise the commanding officer concerned, by message, when a person already in flight training is considered, by the Bureau, to be disqualified.

15–67. Standards for Candidates for Flight Training

(1) Candidates for flight training shall meet all the requirements of Class 1, Service Group I, with the following additions or limitations:

(a) Visual acuity must be not less than 20/20 in each eye.

(b) While under the effects of a 4 percent homatropine and ½ percent cocaine cycloplegic, the candidate must read 20/20 with each eye with:

(1) Not less than plano or more than +2.50 diopters correction in any meridian.

(2) Not more than 0.75 diopter of cylindrical correction in any meridian.

(c) Height must be not less than 66 inches nor greater than 76 inches (in stocking feet).

(d) Weight must not be over 200 pounds (without clothing).

(e) Color Vision.—Normal color perception is required. Qualification shall be determined in the manner set forth in article 15–11.
(f) **Hearing.**—For all candidates the audiogram is the only acceptable test of auditory acuity. A loss of more than 15 decibels in either ear in frequencies 256, 512, 1024, 2048 is disqualifying. Furthermore, when the decibel loss in frequencies 4096 and 8192 in each ear are totaled, a final sum greater than 160 decibels is disqualifying.

**Table of maximum allowable audiometric loss in decibels for candidates**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>256</th>
<th>512</th>
<th>1024</th>
<th>2048</th>
<th>4096</th>
<th>8192</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better ear</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>(*)</td>
<td>(*)</td>
</tr>
<tr>
<td>Worse ear</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>(*)</td>
<td>(*)</td>
</tr>
</tbody>
</table>

*Total of these 4 frequency readings not to exceed 160.*

(g) **Blood Pressure.**—Systolic blood pressure must not be above 130 mm. Diastolic blood pressure must not be above 84 mm. When the blood pressure estimation at the first examination is regarded as abnormal, or in the case of doubt, the procedure shall be repeated twice daily (in the morning and in the afternoon) for a sufficient number of days to enable the examiner to arrive at a definite conclusion. In the case of civilian candidates repeated blood pressure readings on one day will be acceptable when return on subsequent days is impractical.

(h) **The Teeth.**—Commissioned or warrant officers need meet only the standard set forth in article 15-62(8). All other candidates are required to meet the standard set forth in article 15-25(f).

(i) Must pass certain psychological tests promulgated by the Bureau of Medicine and Surgery and administered in accordance with the current instructions of the Bureau.

(j) Must demonstrate, in an interview with the flight surgeon, a personality make-up of such traits and reactions as will indicate that the candidate will successfully survive the rigors of the flight training program and give satisfactory performance under the stress of duty involving flying.

15–68. **Reporting on Candidates for Flight Training**

(1) The importance of the physical examination of a candidate should be recognized not only by the examining surgeon but also by the medical department personnel assisting in the procedure and preparing the report. Candidates often come from a great distance or from isolated ships. If the examination is not completed in every detail at the time of presentation it may be extremely difficult to have the individual report for further examination. If the examination cannot be completed in one working day, the assistance of the commanding officer in making it possible for the candidate to remain available for a second working day shall be elicited. Careful planning should keep such cases to a minimum. If a report upon reaching the Bureau of Medicine and Surgery is found to be incomplete and must be returned, the candidate will suffer unjust delay in receiving orders and in some cases will lose entirely his opportunity to follow his chosen career. The preparation of the Standard Form 88 in the case of a candidate warrants the execution of extreme care of all concerned.

(2) The Dental Corps officer who performs the dental portion of the examination shall make an entry over his signature, in the space set aside on Standard Form 88 for remarks of the dental officer, to the effect that the examinee "does" or "does not" meet the dental standards. The dental officer shall record disqualifying dental defects clearly and in such a manner as will preclude any doubt as to the character or degree of the defect.

(3) When in the process of examination of a candidate, a permanent disqualification has been revealed, either in the history or the physical examination, such examination may be stopped at that point.

(4) In the report of the examination of a candidate, rigid adherence to set standards is expected. The examining officers are authorized to use freely that portion of the report form which provides for the "remarks" or "notes" of the board or any one member of the board. Comments made under "remarks" are for the opinion of the examiner or examiners. No restriction is made as to the source of information which might be molded into an expression of professional opinion. A final recommendation of the examiner or board of examiners must be made. When such recommendation is not consistent with standards set by the Bureau, the examiner shall note that fact on the form under "remarks" or "notes" and a reasonable explanation shall be made. When space set aside on Standard Form 88 for any special purpose is inadequate, extra sheets shall be used as addenda.

(5) Failure to detect disqualifying defects at the place of the first examination of a candidate for flight training can result in great monetary loss to the government due to unnecessary travel, and disappointment for the candidate.

15–69. **Standards for Class 2 Personnel**

(1) **Technical Observer.**—Candidates for orders as, and those ordered to duty involving flying as, technical observers shall meet the standards of Class 1, Service Group I, in regard to neurocirculatory efficiency and the neuropsychiatric examination. In all other respects they shall meet the standards of the designation for which they are in training.
(2) Naval Aviation Observers (Navigation, Aerology, Controller, Radar, and Tactical).—Candidates and aviation personnel already designated shall be physically qualified and aeronautically adapted for duty involving flying in accordance with the physical standards as prescribed for Class I, Service Group II (under 50 years of age) or Service Group III (over 50 years of age).

(3) Naval Flight Surgeons and Aviation Medical Examiners.—When ordered to duty involving flying (not in control of aircraft), naval flight surgeons and aviation medical examiners shall meet the physical requirements of the appropriate Service Group according to their age as prescribed for Class I, except for visual acuity, which requirement shall be the same as for staff officers of the general service.

(4) Student Naval Flight Surgeons.—Physical standards for student naval flight surgeons are those prescribed for qualified naval flight surgeons except that the visual acuity shall be not worse than 20/100 in each eye correctable to 20/20 in each eye and further provided that for flight indoctrinal training, to be physically qualified to solo elementary aircraft, visual acuity shall be not worse than 20/30 in each eye, unaided by glasses, and correctable to 20/20 in each eye. Failure to meet visual standards for solo flight shall serve to disqualify only for solo flying but shall not disqualify for other indoctrinal training involving flying as a special crew member leading to the designation of flight surgeon.

(5) Student Flight Nurse and Flight Nurse.—The standards of flight nurse and student flight nurse are the same as for flight surgeon.

(6) Aircrewmen Candidates.—Unless otherwise directed by the Chief of Naval Personnel, no person will be permitted to undergo training leading to the designation of aircrewman unless he has been found qualified for such training by a flight surgeon. Such candidates shall in general meet the standards of Class I, Service Group II. Should it be desirable, for exceptional reasons, to place in training a candidate who does not meet the above standards, a report shall be made to the Chief of the Bureau of Medicine and Surgery on a Standard Form 88 including sufficient information under item 73 to justify recommendation made. The action taken on such a report will be transmitted to the commanding officer through the Chief of Naval Personnel.

(7) Aircrewmen.—Aircrewmen shall meet the same basic physical requirements as those designated for Class I, Service Group III, except for age.

(8) Student Parachute Jumper.—The standards for student parachute jumper shall be the same as those prescribed for Class I, Service Group II, except for age. In addition there shall be no limitation of normal joint motion.

(9) Parachute Jumper.—The standards for a designated parachute jumper are the same as for student parachute jumper except that limitation of joint motion, which would be disqualifying for the student, may be considered as not disqualifying if, in the opinion of the flight surgeon, the experience of the jumper adequately compensates for the degree of immobility.

(10) U.S. Navy Air Controlmen, Tower Controlmen, Ground Control Approach Operators, Marine Corps Air Traffic Controller, MOS 6711, Marine Corps Air Traffic Controller Radar, MOS 6713, and Marine Corps Ground Control Approach Controller, MOS 6715 shall meet the following physical standards in addition to the general physical requirements for enlistment:

(a) Articulation.—Must speak clearly and distinctly without accent or impediment of speech which would interfere with radio conversation. Voice must be well modulated and pitched in medium range. Stammering, poor diction, or other evidences of speech impediments which become manifest or aggravated under excitement shall be cause for rejection.

(b) Vision.—Candidates shall have not less than 20/50 vision in each eye, corrected to 20/20. Those personnel already designated in the above ratings shall have not less than 20/100 vision in each eye corrected to 20/30 in each eye and the correction shall be worn while on duty. Experienced aircontrolmen whose vision falls below these standards may not engage in the control of air traffic in a control tower but may be otherwise employed in the duties of their rating.

(c) Color Vision.—Must pass the Farnsworth Lantern Test.

(d) Depth Perception.—Verhoeff scores of 16/24 or better, with or without correction, are required.

(e) Diplopia.—No diplopia in any meridian when tested by the red lens test.

(f) Other.—In all other respects the complete physical requirements of Class I, Service Group II, excluding age, apply.

(11) Other Personnel.—When ordered to duty involving flying for which special requirements have not been prescribed, personnel shall, prior to engaging in such duties, be examined to determine their physical fitness for aerial flights. The examination shall relate primarily to the circulatory system, equilibrium, neuropsychiatric stability, patency of the Eustachian tubes, with such additional consideration as the individual's specific flying duties may indicate. The examination and its evaluations shall be entered on the NAVMED-1346 (Special Duty Abstract) of the individual's Health Record and the commanding officer officially notified. Submission to the Bureau of Medicine and Surgery of physical examination reports on personnel in this category is not required.
15-70. Reexamination for Physical Capacity

(1) A reexamination of any individual, to determine his physical fitness to continue flying duty or flight training, shall be made whenever such is considered necessary by the Bureau, the Deputy Chief of Naval Operations for Air, the Commandant of the Marine Corps, or the commanding officer. Upon recommendation by the flight surgeon, the commanding officer may relieve from flying duty, or suspend the flight training of, any individual reported physically incapacitated for such duty. When the individual is subsequently reported physically fit by the flight surgeon, the commanding officer may authorize resumption of such duty or training.

(2) Aviation personnel of Class 1, upon reporting for duty following absence due to serious injury or illness, or upon return to duty from a protracted leave of absence, or when otherwise indicated, shall be given such physical examination as may be required to determine their physical fitness to resume their flying duty.
(3) When certified as fit for duty by a board of medical survey or a clinical board, a naval aviator or naval aviation pilot shall be examined by a flight surgeon prior to return to duty involving flying.

15–71. Annual and Promotion Physical Examinations

(1) Annual.—Since all persons who actually control Navy aircraft and those who perform frequent aerial flights must pass a flight physical examination every 12 months, the annual physical examination of aviation personnel must be a flight physical examination. Persons who have passed a flight physical examination during the calendar year are considered to have fulfilled the requirements of an annual physical examination.

(2) Promotion.—Except when the availability of a flight surgeon is administratively impracticable, the flight surgeon must be a complete flight physical examination.

15–72. Boards of Flight Surgeons

(1) A board of flight surgeons shall consist of two medical officers, at least one of whom must be a flight surgeon or an aviation medical examiner, and one a dental officer. When no dental officer is available, a medical officer may serve in place of a dental officer.

(2) When the action of a board of flight surgeons is specified by the Bureau of Medicine and Surgery for any purpose and the formation of such a Board is not administratively possible, a statement to that effect by the senior officer present will accompany the report requiring the action of a board of flight surgeons. Under such circumstances, a single flight surgeon or single aviation medical examiner may be considered the minimum, sufficient to constitute a board of flight surgeons.

15–73. Recording and Forwarding of Flight Physical Examinations

(1) When a flight physical examination of aviation personnel (Class 1 or Class 2) is performed, it shall be recorded on Standard Form 88 in accordance with current Bureau instructions. This form, completed in rough, shall be retained in the files of the medical department at which the examination is performed. The result of such examination on aviation personnel shall be recorded on NAVMED–1346 of the examinee’s permanent Health Record, and on Standard Form 300 or NAVMED–H–6 of the examinee’s current Health Record. As has been indicated in subarticle 15–68 (3), the recording of the examination of a candidate for flight training may be stopped if and when a permanent disqualifying defect has become manifest and recorded. However, it is essential that the Bureau of Medicine and Surgery have on file a record of the results of examination of all candidates as far as they have progressed. In the case of candidates who are qualified, the Standard Form 88 must be typewritten and forwarded as indicated below. In the case of those candidates who fail, the examining flight surgeon must forward to the Bureau of Medicine and Surgery a copy of Standard Form 88 bearing the name, place and date of birth of candidate and the place of examination in type. The remainder of the Standard Form 88 in the case of a disqualified candidate need not be typewritten and need not necessarily be complete. However, the cause for rejection or failure must be clearly indicated in rough. Only one copy of such a report is required by the Bureau and that may be the rough copy used as far as the examination was carried.

(2) In the following situations, when a flight physical examination is completed and recorded in rough, the results of the examination shall be typewritten and the original and one copy of this completed report (Standard Form 88) shall be forwarded to the Bureau of Medicine and Surgery:

(a) When any individual has received his or her first complete flight physical examination by which he or she has been found qualified—except for candidates for combat aircrewman and enlisted parachute jumpers.

(b) When, as a result of a complete flight physical examination of Class 1 personnel, the flight surgeon recommends continuation in Service Group II or Service Group III, or any change in status of Class 1 personnel, provided, however, he considers that such change should be in effect for longer than 30 days. (Note—every person in Class 1 must be in one of the following states: nonflying status (grounded), Service Group I, Service Group II, or Service Group III.)

(c) When report to the Bureau is specifically directed by proper authority.

(d) When naval aviation personnel, Class 2 are found disqualified and the status of disqualification is expected to be in effect longer than 30 days.

(e) When naval aviation personnel of Class 2 who were disqualified and so reported to the Bureau of Medicine and Surgery, are subsequently found to be qualified.

(f) When an aviator of the U. S. Naval or Marine Corps Reserve reports for active duty, if such duty is expected to continue in excess of 15 days.

(g) When a flight physical examination is completed for purposes of promotion of any officer or to fulfill the requirement of a semiannual, annual, or quadrennial physical examination of Reserve officers.

(h) When, after the examination of aviation personnel of any classification, the flight surgeon or board of flight surgeons considers a review of the findings by the Bureau of Medicine and Surgery advisable.

(i) When Class 1 personnel have appeared before a board of medical survey or a clinical board and have been found fit for duty.

(j) When any person in flight training demonstrates a visual acuity of less than 20/20 in either eye or when such person develops any other disqualifying defect which is considered permanent.

Change 2
(3) When in compliance with the above instructions, a report of a flight physical examination is forwarded to the Bureau of Medicine and Surgery, the original and one copy of Standard Form 88 is required by the Bureau. Normally, such reports are sent via the commanding officer direct to the Bureau. Although a medical officer may be authorized to add the forwarding endorsement of the commanding officer on Standard Form 88 “by direction,” it is recommended that any report of a flight physical examination bearing unusual remarks or recommendations be reviewed by the commanding officer personally. When higher authority directs that a report of a flight physical examination be forwarded through a chain of command, it shall be the responsibility of that higher authority to assure the arrival of the original and one copy of Standard Form 88 at the Bureau. This is necessary to permit the Bureau to return an endorsed flight examination to the place of examination for compliance with article 15–73(4).

Section VI. RESERVE COMPONENTS OF THE NAVY AND MARINE CORPS

15–74. Physical Standards

(1) The physical standards for appointment and enlistment in the Naval or Marine Corps Reserve are the same as those prescribed for the Regular Service. Appointment and enlistment standards of the Regular Service are also applicable in the cases of reservists who are physically examined incident to active duty other than active duty for training.

(2) The physical standard for retention of personnel (officer and enlisted) in the Naval and Marine Corps Reserve is physical fitness to perform all the duties of his rate/grade/rank and category to a degree which would reasonably fulfill the purpose of his employment on active duty. “Category” means an officer’s classification as an officer in the line not restricted in performance of duty; as an officer of the Naval Reserve designated for engineering duty, aeronautical engineering duty, special duty, or limited duty; as an officer of the Marine Corps Reserve designated for supply duty or limited duty; or as an officer of the respective staff corps. Personnel not physically qualified to perform all their duties are not physically qualified for retention in the Naval or Marine Corps Reserve, EXCEPT those officers in whose cases the Chief of the Bureau of Medicine and Surgery has determined that the physical disqualification was occasioned by wounds received in line of duty and such wounds do not incapacitate them for performance of useful service.

(4) Transfer of Records.—Whenever an individual in aviation Class 1 or 2 or a candidate for flight training is transferred from one ship or station to another, the certified copy of his current Standard Form 88, shall be forwarded with his Health Record, to the medical officer of his new ship or station. The current Standard Form 88 is the report of the most recent physical examination which has been endorsed by the Bureau of Medicine and Surgery regardless of its date.

(5) Inspection of Records.—The physical examination records of aviation personnel in Class 1 shall be inspected by the medical and dental officers annually at the end of January. If a medical or dental record is missing or incomplete in any particular, the medical or dental officer shall so inform the commanding officer, who shall direct the individual to report to the medical or dental officer for the necessary examination to complete his records.

15–48 Change 10
(3) The physical standards for various categories of personnel in the Naval or Marine Corps Reserve are summarized in the following table, in which the numbers refer to the notes below the table:

<table>
<thead>
<tr>
<th>Physical requirements (USNR, USMCR)</th>
<th>Officer</th>
<th>Enlisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment</td>
<td>1 or 5</td>
<td>2 or 6</td>
</tr>
<tr>
<td>Enlistment (USMCR-W &amp; USNR-W)</td>
<td>1 or 5</td>
<td>2 or 4</td>
</tr>
<tr>
<td>Active duty</td>
<td>1 or 5</td>
<td>4</td>
</tr>
<tr>
<td>Transfer to pay unit</td>
<td>1, 5, 6</td>
<td>2, 5, 6</td>
</tr>
<tr>
<td>Promotion</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Quadrennial</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Active duty for training</td>
<td>1, 5, 6</td>
<td>2, 5, 6</td>
</tr>
</tbody>
</table>

Explanation of Notes

1. Must meet the physical standards for appointment in the Regular Navy and Marine Corps.

2. Must meet the physical standards for enlistment in the Regular Navy, or Regular Marine Corps in the case of a Marine Corps reservist, as set forth in this chapter.

3. Must meet the physical standards for retention as set forth in article 15-74(2).

4. Acceptable if the physical standards described in Army Regulation 40-501 are met.

5. Defects that would disqualify for appointment or enlistment in the Regular Navy or Marine Corps must be waived. Disqualifying defects which are organic in nature will not be waived. An organic defect is any defect (a) which might constitute a menace to the health of the individual's associates, (b) which might jeopardize the general welfare or safety of the individual's associates, (c) of such nature that the performance of active naval service might jeopardize the health or welfare of the individual himself, or (d) of such nature that the individual could not reasonably fulfill the purpose of his employment.

6. Defects must be such that a naval reservist is within physical risk category A, B-1, or B-2, or a Marine reservist is within physical risk category A or B-1.

7. Must have no infectious disease and must be immunized in accordance with section VIII of chapter 22.

15-75. Physical Examinations for Appointment, Enlistment, and Promotion

(1) Physical Examination for Appointment.—For appointment in the Naval Reserve or Marine Corps

Change 10
Reserve, the physical examination of candidates should be conducted, if practicable, by two medical officers and one dental officer of the Regular Navy or Naval Reserve or both. In instances where two medical officers and one dental officer are not readily available, the examination may be conducted by one medical officer and one dental officer, or by one medical officer if a dental officer is not available. The services of medical officers of the Department of the Army or of the Department of the Air Force may be utilized only in instances where the services of an active or inactive naval medical officer are not available. The services of civilian physicians may be utilized only when authorized by the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, upon the recommendation of the Chief, Bureau of Medicine and Surgery. Civilian physicians may be utilized only on a no-cost-to-the-Navy basis.

(2) Physical Examination for Enlistment.—
(a) The physical examination of applicants for enlistment, reenlistment, or extension of enlistment in the Naval Reserve or Marine Corps Reserve shall be made by naval medical and dental officers, if available; otherwise, by medical and dental officers of the Department of the Army or of the Department of the Air Force, or by civilian physicians when authorized by the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, on the recommendation of the Chief, Bureau of Medicine and Surgery. Civilian physicians may be utilized only on a no-cost-to-the-Navy basis. The physical examination for enlistment, reenlistment in the same branch of the service within 24 hours of discharge therefrom, may, under special circumstances, be waived by the Chief of Naval Personnel or Commandant of the Marine Corps, as appropriate.

(b) For entry into a Reserve component in an enlisted status other than on active duty, the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, may waive the requirement for physical examination at time of enlistment or reenlistment. In event of such waiver, Reservists who were not examined physically at time of enlistment or delayed reenlistment shall not receive any training or perform any duties whatsoever in their Naval Reserve status until their physical fitness therefor is first determined, based on the standards prescribed for enlistment or reenlistment. Failure to meet prescribed standards at such time is cause for discharge.

(3) Physical Examination for Promotion of Officers.—
(a) For promotion, officers of the Naval Reserve and Marine Corps Reserve, not on extended active duty, are to be examined, if practicable, by a board of medical examiners, the members of which may be officers of the Regular Navy or Naval Reserve. If impracticable to assemble a board of medical examiners, the examination may be conducted by one medical officer of the Regular Navy or of the Naval Reserve. One dental officer of the Regular Navy or of the Naval Reserve shall be included on the board if such a dental officer is available. In the absence of available medical officers of the Regular Navy, or of the Naval Reserve, such examinations may, upon authorization of the cognizant commandant or Chief of Naval Air Reserve Training or Marine Corps district director of Reserve, in each case, be conducted by Regular or Reserve medical and dental officers of the Department of the Army or of the Department of the Air Force; or in special instances, upon authorization, as above, the physical examination may be conducted by civilian physicians.

(b) For promotion of officers of the Naval Reserve and Marine Corps Reserve on extended active duty, the physical examination shall be conducted in the same manner as for promotion of officers of the Regular Navy.

(c) In determining the physical fitness of officers of the Reserve for promotion, the same standards shall apply as govern the determination of the physical fitness for promotion in the Regular services; that is, general duty officers must be physically qualified for duty at sea and on foreign shore (at sea and in the field for officers of the U.S. Marine Corps Reserve) and other officers must be physically qualified for special service duties.

15-76. Physical Examinations Incident to Active Duty Other Than Training Duty

(1) Upon Reporting for Active Duty Other Than Training Duty.—Officers and enlisted personnel of the Reserve shall be examined completely and in detail incident to assignment to such duty. This examination shall be as thorough and as critical as is the physical examination for original appointment to commissioned rank or for original enlistment, as the case may be, excepting that any Reserve officer who has received a complete physical examination incident to appointment to commissioned rank during the previous 6 months need not be reexamined on reporting for active duty providing the results thereof have been reported to the Bureau and no material change in physical condition has occurred. (For aviation personnel, the provisions of articles 15-59 and 15-60 shall be observed.) It shall include photofluorographic or X-ray examination of the chest, in accordance with the provisions of article 15-90; a serologic test for syphilis; and in the case of women a pelvic examination. All defects noted, whether considered disqualifying or not, shall be reported and all blood pressure readings shall be recorded. Such examinations shall, wherever practicable, be conducted by a board of medical examiners of the Regular Navy, or of the Naval Reserve if on active duty, including a dental officer if a
dental officer is available. If it is not practicable to assemble a board of medical examiners, these physical examinations should, whenever practicable, be conducted by a medical officer of the Regular Navy, or of the Naval Reserve on active duty. However, where exigencies require, they may be conducted by a medical officer of any of the Departments within the Department of Defense. A member who fails to meet the respective physical standards established for original entry into the U. S. Navy or U. S. Marine Corps through either appointment or enlistment, as the case may be, shall be found not to meet physical standards for entry into active-duty status, and such opinion shall be set forth on Standard Form 88. However, should the disqualifying defect(s) be considered of such minor significance that the member, notwithstanding, can reasonably be expected to perform the duty to which he is being ordered, a conditional waiver of the defect(s) may be recommended and granted locally in accordance with the provisions contained in subarticle 15-82 (5), providing that the member is not in need of further study of an extensive nature and does not require major surgical treatment. A substantiating physical examination shall be conducted at the first duty station to which a member reports if it appears that a pronounced change in physical condition has occurred or whenever a lapse of time exceeding 60 days has transpired between the date of initial physical examination for active duty and the actual reporting date. In either case, a conditional waiver may be recommended and granted in the same manner and subject to the same provisions applicable to the initial physical examination. Such waiver may be in addition to a prior conditional waiver granted at the time of the initial examination. Established reporting procedure for waivers is set forth in article 15-82. When the initial examination was conducted by other than a naval medical officer, the medical officer of the first duty station shall review the opinion and recommendation regarding fitness for duty, and when appropriate, he shall submit further recommendations.

(2) Upon Release From Active Duty Other Than Training Duty.—Officers and enlisted personnel so released shall be examined physically in the same manner as are officers and enlisted personnel of the Regular Service being separated from the active list. An X-ray examination of the chest and a serological examination of the blood shall be made and recorded as a part of the separation physical examination. When facilities for X-ray examination of the chest and for serological examination of the blood are not available at the active duty station or separation activity, the use of the facilities of any Federal medical or Public Health activity is authorized. The Navy medical activity at which separation is accomplished shall submit NAVMED--U in each individual case when the services of other United States Government X-ray and serological facilities are obtained.

15-77. Physical Examination Incident to Training Duty

(1) Personnel ordered to training duty such as annual training duty, training duty with pay, or training duty without pay excepting repeated periods of training without pay, are required to undergo a physical examination prior to or upon reporting for such duty. An extensive physical examination is not required to determine that a Reservist is physically qualified to perform such duty. The Reservist must be physically qualified to perform the duties to which he is to be assigned, must be free of infectious and contagious disease, and must receive, or have received, the required vaccination and inoculations. Such examination may be conducted by any qualified Medical Department representative of any of the Departments of the Department of Defense, or in special cases by a civilian physician if authorized by the cognizant commandant, Chief of Naval Air Reserve Training, or the director of the Marine Corps Reserve District, whoever has jurisdiction. No expense to the Government is authorized in connection with this examination. The results of such examinations are to be entered in the Health Record of the individual concerned. The completion of a Standard Form 88 and report thereon to the Bureau of Medicine and Surgery is required when the examinee is found not physically qualified for such training duty, and also in the case of any Reservist who has a disability compensation claim pending or is in receipt of disability compensation. A request for waiver of defects or disability is not required if the Reservist is physically qualified to perform the duties assigned.

(2) Personnel ordered to training duty such as regular drills, appropriate duty, equivalent instruction or duty, group training duty, repeated periods of training or other duty without pay, need not be physically examined in each instance prior to their participation in repeated periods of training duty or other duty or group training. However, if there is reason to believe that physical unfitness exists, the Reservist should be sufficiently thoroughly examined to determine his physical fitness. In such cases an appropriate entry shall be made in the Health Record and, if unfitness to perform the duties of the appropriate grade, rank, or rating exists, a report on Standard Form 88 shall be forwarded to the Bureau of Medicine and Surgery. It is required that such Reservists receive the required vaccination and inoculations annually. Those members of the Reserve whose physical fitness was not established at enlistment shall be physically examined as required for enlistment prior to their receiving any training or performing any duties whatsoever in their Naval or Marine Corps Reserve status. These Reservists...
who are members of organizations under the jurisdiction of the Chief of Naval Air Reserve Training and who are authorized to perform duty involving the actual control of aircraft, shall have passed a flight physical examination within 12 months immediately preceding any of the training duty specified above. In the case of other Reservists the interval between flight physical examinations shall be 6 months.

(3) (a) Personnel in a nonpay status of the Naval Reserve or Marine Corps Reserve who are requesting transfer to, or association in a pay status with, a pay unit of the Naval or Marine Corps Reserve, shall be physically examined and must meet the physical standards prescribed in article 15-74 before such transfer or association becomes effective. For aviation flight personnel, the provisions of articles 15-59 and 15-60 shall be observed. In the case of officers, applications and reports of physical examinations shall be submitted via the Bureau of Medicine and Surgery. In the case of enlisted personnel applying for membership in a pay unit, a physical examination shall be conducted in the same manner as is required for enlistment in the Regular Navy or Marine Corps. Applications of enlisted men shall be submitted in accordance with the prescribed administrative procedures, but such applications shall not be processed until after completion of satisfactory physical examinations in accordance with the standards for enlistment in the Regular Navy, or Regular Marine Corps in the case of Marine Corps Reservists, as set forth in this chapter.

(b) Physical examinations shall be reported on Standard Forms 88 and 89, as prescribed in article 15-82, except that items 48, 49, 55, 61, 62, 63, 66, 67, 68, 69, and 71 may be omitted from the Standard Form 88; but item 48 shall be completed when possible if the applicant is over 45 years of age, and item 71 shall be completed when possible whenever defective auditory acuity is presented. However, in the case of a member receiving a flight physical examination, all items required thereby shall be completed.

(c) When the applicant has undergone as extensive a physical examination as is required by sub-articles 15-77 (3) (a) and (b) within 1 year prior to application for attachment to, or association in a pay status with, a pay unit, for any of the usual purposes—appointment, promotion, enlistment, re-enlistment, quadrennial, previous application for a pay unit—for aviation flight personnel, a flight physical examination and a completed report of such examination on both Standard Forms 88 and 89 are filed in the Health Record or were forwarded to the Bureau, a report on and submission of these forms is not required. If only one of the forms completed within the 1-year period is contained in the Health Record, the other form must be completed and submitted with the application. However, if a reasonable indication exists that there has been any adverse change in the physical condition of the applicant, even though he may meet the physical standards, a current Standard Form 88 and 89 shall be prepared and submitted.

(d) In all cases where an applicant for membership in a pay unit is found to be physically unfit, or when the applicant has a disability compensation claim pending, is in receipt of such compensation, or is known to be classified as a B-2 or C physical risk, a complete report of the physical examination shall be submitted to the Bureau in accordance with the prescribed procedure set forth in article 15-82.

(e) In cases where either the Standard Form 88 or the Standard Form 89, or both, are omitted, the following certification shall be substituted:

A physical examination has been completed within the past year incident to [purpose of examination]. I hereby certify that to the best of my knowledge there has been no material change in my physical condition since completion of that examination.

(Signature)
(4) (a) Upon release from active duty for training, officers and enlisted personnel of the Reserve are required to undergo an extensive physical examination only if they have suffered disability in line of duty from injury while so employed, or if they allege that such is the case. The scope of the examination shall be sufficient to allow complete presentation of all data pertaining to the consequences of the injury.

(1) Disability, as used herein, shall be construed to mean a temporary or permanent physical or mental impairment resulting in an inability to perform the duties to which the Reservist would normally be assigned and which would customarily require admission to the sick list.

(2) Active duty for training means training duty performed in accordance with the provisions of articles H-5303, H-5306, and H-5307, Bureau of Naval Personnel Manual, or paragraphs 24309, 24311, 24312, and 24313, Marine Corps Manual.

(3) Inactive duty training means any of the training, instruction, duty, appropriate duties, or equivalent training instruction duty, appropriate duty, or hazardous duty, performed with or without compensation by members of the Naval Reserve or of the Marine Corps Reserve as is prescribed by the Secretary of the Navy.

(4) Line of duty for the purpose of the regulations in this paragraph includes injury incurred when the Reservist was, at the time the injury was suffered, employed on active duty for training or on authorized leave or liberty therefrom, or on inactive-duty training, unless the injury was the result of his own willful misconduct. This does not include injury suffered during travel to or from active duty for training or inactive-duty training.

(b) Upon release from active duty for training, and when there is no question of injury incurred during such training, the physical examination to be given shall be sufficient for the medical examiner reasonably to determine with the facilities at hand whether or not the health of the individual had been adversely affected by such training duty. For this purpose it should usually be sufficient to question the individual and examine into any impairment that would be likely to have resulted from disease or injury to which the individual was exposed during such period of service.

(c) Those members who have incurred disease in line of duty which requires treatment and/or hospitalization shall be given such treatment in accordance with the provisions of chapter 21.

15-78. Quadrennial Physical Examination and Certificates of Fitness

(1) When not on active duty, a member of the Naval or Marine Corps Reserve other than the Retired Reserve, shall be physically examined at least once every 4 years or more often if deemed necessary. Such 4-year period shall be considered to commence on the day following the date of completion of the last extensive physical examination, the findings of which were reported on Standard Form 88. Jurisdiction for such examination is assigned to the commanding officer of the cognizant district or river command, or the Chief of Air Reserve Training or the cognizant district director or Commander, Marine Air Reserve Training, as appropriate. The examinations shall be conducted by a medical officer of the Regular Navy or Naval Reserve, if available, otherwise by comparable members of other medical departments within the Department of Defense. In special cases, and when authorized by the cognizant authority, the examination may be conducted by a civilian physician at no expense to the Government. In view of the lapse of time between examinations, it is incumbent upon the medical examiner(s) to describe in detail any defect(s) or disability(ies) noted. All quadrennial examinations shall be reported in accordance with the provisions contained in article 15-5. Proper completion of Standard Form 88 (rev. Aug. 1950) other than in flight physical examinations does not require that information be furnished for items 7, 8, 46, 47, 48, 49, 53, 54, 55, 61, 62, 63, 65, 66, 67, 68, 69, and 71, unless the examination discloses an existent condition or history thereof, the recording of which is considered to be warranted. However, in the case of a member receiving a flight physical examination, all required items shall be completed. Immediately preceding a quadrennial physical examination, the examinee shall complete and sign the Standard Form 89 in duplicate, to which the medical examiner(s) shall add such clarifying or supplementary information as is essential to the reviewing authority in evaluating the data. Articles 15-5 and 15-82 set forth respectively the established procedure for obtaining and reporting the medical history.

(a) Opinion or recommendation.—

(1) U. S. Naval Reserve and U. S. Marine Corps Reserve.—This is to be based upon the relative fitness of the member for active duty since the examination is for the purpose of establishing fitness to fill a mobilization billet. In determining physical qualifications for active duty, due consideration is to be given to the character of the duty to which the member may be assigned in the event he should
be ordered to active duty pursuant to law, with due consideration being given to the purposes of the physical standards (art. 15–2). Those who are unfit for active duty, or who may reasonably be expected to be unfit in the near future, or whose condition is such as to constitute an unwarrantedly high health risk if accepted for active duty, shall be reported to be physically unfit for retention in the service. When a member meets the respective physical standards for original appointment or enlistment and is considered to be physically qualified for the performance of duty, the medical examiner should consider the member to be physically qualified for retention and for active duty. When a member does not meet such standards but is considered to be physically qualified for performance of full duty, a waiver of the defect(s) should be recommended. However, if the member is not physically qualified to perform full duty, or if a poor health risk designation is warranted, the decision as to physical classification and disposition should be deferred to the Navy Department in the case of officer personnel, and to the cognizant command authority in the field in the case of enlisted personnel, in order that service need may be considered in determining appropriate disposition. Medical examiners and reviewing authorities are to bear in mind that the purpose of the examination is to maintain a healthy and physically fit personnel force and, therefore, those who are not physically qualified for retention in the Reserve are to be recommended for separation therefrom.

(2) Fleet Reserve and Fleet Marine Corps Reserve.—

(a) In the case of a member of the Fleet Reserve, the medical examiner(s) shall employ the symbols and respective classifications set forth in subarticle 15–78 (3).

(b) In the case of a member of the Fleet Marine Corps Reserve, the medical examiner(s) shall specify the type of duty for which the member is fit for assignment, that is, shore duty, sea duty, field duty and/or duty involving flying.

(2) During the period between quadrennial examinations each member of the Naval Reserve and the Marine Corps Reserve, other than those in the Retired Reserve or in the Fleet Reserve or Fleet Marine Corps Reserve, shall submit annually a certificate of physical condition. This shall be accomplished by the member's forwarding to the appropriate field command a completed and signed Standard Form 89. In completing the form (rev. Aug 1950) for this purpose the member may omit items not subject to change, or which are not pertinent, as 4, 5, 7, 8, 9 through 16, 23, 24, 25, 26, or 40, and the space for typed or printed names. In completing items 20, 21, 22, and 27 through 30 the member is required to check those portions thereof wherein a change has occurred since the submission of the last previous report. The annual certificate of physical condition will be considered to be due on the first, second, and third anniversaries of the day following the date when an extensive physical examination was conducted. In the event that the annual report of physical condition of any such member indicates the possibility of a disqualifying defect which has not been waived, or of the progression of any defect for which a waiver is in effect, a special examination may be authorized.

(3) The Chief of Naval Personnel after review of the report of the physical examination of the personnel of the Fleet Reserve will classify such personnel in one of the following classifications:

L-2.—Disqualified for duty involving flying or for duty in submarines, but qualified for all other types of duty.

L-3.—Disqualified for all combatant vessels, duty involving flying, and submarine duty, but qualified for auxiliary vessels, foreign shore, and U. S. shore.

L-4.—Disqualified for all combatant vessels, duty involving flying, submarines, and auxiliary vessels, but qualified for foreign shore and U. S. shore.

L-5.—Disqualified for all combatant vessels, duty involving flying, submarines, auxiliary vessels, and foreign shore, but qualified for U. S. shore.

L-6.—Disqualified for assignment from the area or activity to which last assigned, unless ordered by name by the Chief of Naval Personnel or the administrative or type commander who issued last assignment.

15–79. Physical Examination for Actual Control of Aircraft

(1) For the actual control of aircraft, candidates for appointment, active duty other than training duty, or training duty involving the actual flying of aircraft, must be examined by medical and dental officers of the Regular Navy or Naval Reserve, or Regular or Reserve medical and dental officers of the other Departments of the Department of Defense, who are qualified to conduct physical examinations for flying and who are on active duty or associated with an organized training unit. Such examination is required:
CHAPTER 15. PHYSICAL EXAMINATIONS

(a) In every instance, prior to reporting for extended active duty in excess of 30 days.
(b) For personnel who are members of organizations under the jurisdiction of the Chief of Naval Air Reserve Training within 12 months preceding training duty, drills, or other such duty.
(c) For other personnel of aviation classification within 6 months preceding training duty, drills, or other such duty.

15-80. Physical Defects, Reporting, and Disposition

(1) Appointment.—Applicants for appointment who are definitely not physically qualified need be examined only to the point of discovery of the disqualifying defect whereupon the examination may be discontinued. A report of physical examination in duplicate, completed to and including the qualifying defect whereupon the examination may be discontinued. A report of physical examination may, at the discretion of the medical examiner(s), be removed and destroyed, with the exception of the following cases:

(a) Persons who are enlisted or reenlisted in a Reserve component and retained on inactive duty, in which cases the reports of medical examination and medical history if required, shall be completed singly and be retained in the Health Record. Initial physical examinations and physical examinations conducted following a period of inactive duty of 1 year or more require, in addition, that the examinee's prior or intervening medical history be recorded upon Standard Form 89 (Report of Medical History) in duplicate. The original and duplicate should bear the signatures of both the examinee and the medical examiner(s). The original shall be forwarded to the Bureau together with the original and copy of Standard Form 88. The duplicate shall be incorporated in the Health Record. It is preferable that the Health Record contain only the signed copy of Standard Form 88 and the duplicate of Standard Form 89, recording respectively the most recent physical examination and reported medical history. Upon insertion of either or both of the latter, the previous copy and/or duplicate may, at the discretion of the medical examiner(s), be removed and destroyed, with the exception of the following cases:

(b) NROTC and Merchant Marine Midshipmen when examined annually for retention in these programs, in which cases the signed copies of Standard Form 88 and signed duplicates of Standard Form 89 for each respective year shall be retained in the Health Records during the entire academic period of training and may be removed and destroyed, at the option of the medical examiner(s), only after being replaced by those covering the physical examinations for precommissioning.

(2) Enlistment.—Disposition of applicants not physically qualified will be in accordance with current recruiting instructions. Attention is invited to article 15-3, which applies in respect to defects that are not clearly disqualifying.

(3) Active Duty and Retention.—

(a) Disposition of officers and enlisted personnel on extended active duty under orders to active service in excess of 30 days, who are found not physically qualified for active duty, shall be in accordance with existing instructions for disposition of similarly disqualified Regular service personnel.

(b) A physical examination by reason of which any Reserve member not on active duty is found to be not physically qualified for active duty shall be reported on Standard Form 88 in accordance with the provisions of article 15-82 and an appropriate recommendation shall be entered on the report. In determining upon an appropriate recommendation, consideration shall be given to the provisions of articles 15-2 and 15-3, and the recommendations shall be in accordance with the provisions contained therein, if appropriate. The examinee may be recommended for discharge from the naval service.

Section VII. REPORTING RESULTS OF PHYSICAL EXAMINATIONS

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
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<tbody>
<tr>
<td>15-81</td>
<td>General</td>
</tr>
<tr>
<td>15-82</td>
<td>Medical</td>
</tr>
<tr>
<td>15-83</td>
<td>Service</td>
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<tr>
<td>15-84</td>
<td>Other</td>
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</tbody>
</table>

15-81. General

(1) Standard Forms for use by all medical military establishments have been adopted for the purpose of preserving and utilizing information obtained from physical examinations. These forms, when completed, shall be forwarded to the cognizant bureaus, offices, or agencies concerned.

15-82. Medical Records

(1) When not otherwise indicated, each physical examination shall be recorded on Standard Form 88 (Report of Medical Examination) in triplicate. The original and one copy shall be forwarded to the Bureau; and the remaining copy, signed by the medical examiner(s), shall be inserted in the Health Record. Initial physical examinations and physical examinations conducted following a period of inactive duty of 1 year or more require, in addition, that the examinee's prior or intervening medical history be recorded upon Standard Form 89 (Report of Medical History) in duplicate. The original and duplicate should bear the signatures of both the examinee and the medical examiner(s). The original shall be forwarded to the Bureau together with the original and copy of Standard Form 88. The duplicate shall be incorporated in the Health Record. It is preferable that the Health Record contain only the signed copy of Standard Form 88 and the duplicate of Standard Form 89, recording respectively the most recent physical examination and reported medical history. Upon insertion of either or both of the latter, the previous copy and/or duplicate may, at the discretion of the medical examiner(s), be removed and destroyed, with the exception of the following cases:

(a) Persons who are enlisted or reenlisted in a Reserve component and retained on inactive duty, in which cases the reports of medical examination and medical history if required, shall be completed singly and be retained in the Health Record until the member is physically examined incident to reporting for active duty, at which time these prior reports shall be submitted to the Bureau together with the report of medical examination and report of medical history completed at that time.

(b) NROTC and Merchant Marine Midshipmen when examined annually for retention in these programs, in which cases the signed copies of Standard Form 88 and signed duplicates of Standard Form 89 for each respective year shall be retained in the Health Records during the entire academic period of training and may be removed and destroyed, at the option of the medical examiner(s), only after being replaced by those covering the physical examinations for precommissioning.

(2) Termination and closing entries shall be entered on the Standard Form 600 as the final entry thereon.

15-52a

Change 2
(3) Specific requirements for submittal and disposition of the forms in the major categories are tabulated in subarticle 15-82 (7). Instructions referable to the reporting of physical examinations for various special categories are outlined in other portions of this chapter.

(4) Preliminary physical examinations for the U.S. Naval Academy shall be recorded on Standard Form 88 in quintuplicate. Reporting procedure is the same as above except that the two additional copies shall be signed by the medical examiner(s) and be forwarded respectively to the Superintendent of the U.S. Naval Academy and to the sponsor; i.e., congressman, commanding officer, or, in the cases of Presidential appointees, the parent or guardian.

(5) (a) When, in the opinion of the medical examiner and the commanding officer or the officer-in-charge of the examining facility, a waiver of any disqualifying defect(s) is warranted, a recommendation to this effect may be submitted on the Standard Form 88 for consideration for the following:

1. Appointment or reappointment of an officer in the Navy, Marine Corps, Naval Reserve, or Marine Corps Reserve.

2. Enlistment or reenlistment of a member in the Navy, Marine Corps, Naval Reserve, or Marine Corps Reserve. Waiverable defects are to be construed as those defects which, although actually disqualifying in accordance with naval physical standards, are nevertheless considered, upon evaluation, to be such as not to interfere with the examinee's ability to perform duty.

3. A candidate for appointment, enlistment, or reenlistment in any status, whereas a conditional waiver is to be considered only in the case of an individual who is already a member of the Naval Reserve or of the Marine Corps Reserve, other than the Fleet Reserve or Fleet Marine Corps Reserve, and who has been examined incident to assignment to active duty other than training duty and been found not to meet established physical standards.

4. ... etc...

(7) Reports of Examination Requirements:

<table>
<thead>
<tr>
<th>Item</th>
<th>Purpose of physical examination</th>
<th>Reporting requirements (number of copies)</th>
<th>Report disposition</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SF 88</td>
<td>SF 89</td>
</tr>
<tr>
<td>1</td>
<td>Appointment to NROTC and Merchant Marine Midshipmen Reserve when considered by medical examiner to be: Physically qualified</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Not physically qualified</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Appointment to Naval Academy including preliminary examination.</td>
<td>See sub-art. 15-82 (4)</td>
<td>See sub-art. 15-82 (4)</td>
</tr>
<tr>
<td>3</td>
<td>Annual physical examination for retention in NROTC and Merchant Marine Midshipmen Reserve when considered by medical examiner to be: Physically qualified</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Not physically qualified</td>
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<td>1</td>
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<tr>
<th>Item</th>
<th>Purpose of physical examination</th>
<th>Reporting requirements (number of copies)</th>
<th>Report disposition</th>
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<tbody>
<tr>
<td>4</td>
<td>Precommissioning examination NROTC and Merchant Marine Midshipmen, when considered by medical examiner to be:</td>
<td>SF 88: 3, SF 89: 2</td>
<td>SF 88: Original and one copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
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<tr>
<td></td>
<td>Physically qualified</td>
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<td></td>
<td>Not physically qualified</td>
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<td>5</td>
<td>Preliminary for entrance OCS, OCC, OCSG, PLC, WOTC, or for NAVCAD training; from civilian status; when considered by medical examiner to be:</td>
<td>SF 88: 2, SF 89: 1</td>
<td>SF 88: Original and one copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
</tr>
<tr>
<td></td>
<td>Physically qualified</td>
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<td></td>
<td>Not physically qualified</td>
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<td>6</td>
<td>Entrance OCS, OCC, OCSG, PLC, WOTC, or for NAVCAD training; from civilian status; when considered by medical examiner to be:</td>
<td>SF 88: 2, SF 89: 1</td>
<td>SF 88: Original and one copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
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<tr>
<td></td>
<td>Physically qualified</td>
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<td>Not physically qualified</td>
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<td>7</td>
<td>Entrance into ROC2 and PLC2 when considered by medical examiner to be:</td>
<td>SF 88: 2, SF 89: 1</td>
<td>SF 88: Original and one copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
</tr>
<tr>
<td></td>
<td>Physically qualified</td>
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<td></td>
<td>Not physically qualified</td>
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<td>8</td>
<td>Entrance ROC1 and PLC1 when considered by medical examiner to be:</td>
<td>SF 88: 3, SF 89: 1</td>
<td>SF 88: Original and one copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
</tr>
<tr>
<td></td>
<td>Physically qualified</td>
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<td></td>
<td>Not physically qualified</td>
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<tr>
<td>9</td>
<td>Original appointment to commissioned or warrant grade when considered by medical examiner to be:</td>
<td>SF 88: 3, SF 89: 1</td>
<td>SF 88: Original and one copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
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<td></td>
<td>Physically qualified</td>
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<td></td>
<td>Not physically qualified</td>
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<tr>
<td>10</td>
<td>Promotion USN, USMC, USNR, and USMCR, ACTIVE when considered by medical examiner to be:</td>
<td>SF 88: 3, SF 89: 0</td>
<td>SF 88: Original and one signed copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
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<tr>
<td></td>
<td>Physically qualified</td>
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<td></td>
<td>Not physically qualified</td>
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<td>11</td>
<td>Promotion USNR, USMCR, INACTIVE, when considered by medical examiner to be:</td>
<td>SF 88: 3, SF 89: 0</td>
<td>SF 88: Original and one signed copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
</tr>
<tr>
<td></td>
<td>Physically qualified</td>
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<td></td>
<td>Not physically qualified</td>
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<tr>
<td>12</td>
<td>Annual USN, USNR, USMC, and USMCR (ACTIVE) in case of officers of flag rank and in the grade of CAPT and COl when considered by medical examiner to be:</td>
<td>SF 88: 2, SF 89: 1</td>
<td>SF 88: Original and one copy to Bureau; signed duplicate to Health Record. SF 89: Do.</td>
</tr>
<tr>
<td></td>
<td>Physically qualified</td>
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<tr>
<td></td>
<td>Not physically qualified</td>
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<td></td>
<td>Findings on other officers will be entered only on the SF 600 in duplicate whether or not considered physically qualified by medical examiner, excepting when completed SF 88 is required by special regulation; original to Bureau and copy to Health Record.</td>
<td>SF 88: 1, SF 89: 0</td>
<td>SF 88: Original to Bureau; notation of findings entered on the SF 860. SF 89: Do.</td>
</tr>
</tbody>
</table>

See footnotes at end of table.

Change 2
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<tr>
<th>Item</th>
<th>Purpose of physical examination</th>
<th>Reporting requirements (number of copies)</th>
<th>Report disposition</th>
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</thead>
<tbody>
<tr>
<td>13</td>
<td>Original enlistment, USN, USMC; original enlistment, USNR, USMCR for immediate active duty; reenlistment all above categories after a period of 90 days since last active duty when considered by medical examiner to be: Physically qualified.</td>
<td>SF 88 SF 99</td>
<td>SF 88 SF 99</td>
</tr>
<tr>
<td></td>
<td>Not physically qualified.</td>
<td>2 2</td>
<td>Original and one copy to Bureau via appropriate naval training center or Marine Corps recruit depot; one signed copy to Health Record. Original to Bureau via appropriate naval training center or Marine Corps recruit depot; signed duplicate to Health Record.</td>
</tr>
<tr>
<td>14</td>
<td>Original enlistment USNR, USMCR, all classifications, not for immediate active duty, when considered by medical examiner to be: Physically qualified.</td>
<td>SF 88 SF 99</td>
<td>SF 88 SF 99</td>
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<tr>
<td></td>
<td>Not physically qualified.</td>
<td>2 1</td>
<td>Original and one copy to Bureau. Original to Bureau.</td>
</tr>
<tr>
<td>15</td>
<td>Immediate reenlistment USN, USMC; immediate reenlistment USNR, USMCR while on active duty when considered by medical examiner to be: Physically qualified.</td>
<td>SF 88 SF 99</td>
<td>SF 88 SF 99</td>
</tr>
<tr>
<td></td>
<td>Not physically qualified.</td>
<td>2 1</td>
<td>Original and one copy to Bureau; signed copy to Health Record. Original to Bureau.</td>
</tr>
<tr>
<td>16</td>
<td>Reenlistment, whether or not immediate, USNR, USMCR, while on active duty when considered by medical examiner to be: Physically qualified.</td>
<td>SF 88 SF 99</td>
<td>SF 88 SF 99</td>
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<tr>
<td></td>
<td>Not physically qualified.</td>
<td>1 0</td>
<td>Original to Health Record. Original to Bureau.</td>
</tr>
<tr>
<td>17</td>
<td>Active duty or active duty for training, period in excess of 14 days, USNR, USMCR, when considered by medical examiner to be: Physically qualified.</td>
<td>SF 88 SF 99</td>
<td>SF 88 SF 99</td>
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<tr>
<td></td>
<td>Not physically qualified.</td>
<td>2 1</td>
<td>Original to Bureau; signed copy to Health Record. Original to Bureau.</td>
</tr>
<tr>
<td>18</td>
<td>Release from active duty or active duty for training, period in excess of 14 days, USNR, USMCR, when considered by medical examiner to be: Physically qualified.</td>
<td>SF 88 SF 99</td>
<td>SF 88 SF 99</td>
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<tr>
<td></td>
<td>Not physically qualified.</td>
<td>2 1</td>
<td>Original and one copy to Bureau. Required only if no active duty within 1 year preceding present duty. Original to Bureau; signed duplicate to Health Record. Original to Bureau.</td>
</tr>
<tr>
<td>19</td>
<td>Active duty for training, period of 14 days or less, USNR, USMCR, when considered by the medical examiner to be: Physically qualified.</td>
<td>SF 88 SF 99</td>
<td>SF 88 SF 99</td>
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<tr>
<td></td>
<td>Not physically qualified.</td>
<td>2 1</td>
<td>Original and one copy to Bureau; one signed copy to Health Record. Original to Bureau.</td>
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See footnotes at end of table.
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<tr>
<th>Item</th>
<th>Purpose of physical examination</th>
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<th>Report disposition</th>
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<tr>
<td></td>
<td></td>
<td>SF 88</td>
<td>SF 89</td>
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<tr>
<td>20</td>
<td>Release from active duty for training, period of 14 days or less or inactive duty training, USNR, USMCR, when considered by medical examiner to be: Physically qualified.</td>
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<td>0</td>
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<td>21</td>
<td>Inactive duty training. Such personnel are subject to reporting requirements outlined in subart. 15-77(2).</td>
<td>2</td>
<td>1</td>
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<td>22</td>
<td>Quadrennial, USNR and USMCR when considered by medical examiner to be: Physically qualified.</td>
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<td>23</td>
<td>Discharge, except for immediate recallment; release from all duty to statutory retired list; when considered by medical examiner to be: Physically qualified.</td>
<td>1</td>
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<tr>
<td>24</td>
<td>Request for transfer to, or association in a pay status with a pay unit, USNR and USMCR, when considered by medical examiner to be: Physically qualified.</td>
<td>3</td>
<td>2</td>
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<td>25</td>
<td>Transfer to Naval Fleet Reserve or Fleet Marine Corps Reserve, when considered by the medical examiner to be: Physically qualified.</td>
<td>3</td>
<td>0</td>
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**Explanation of Footnotes**

1. Duplicate Standard Form 89 to Health Record if lapse of more than 3 months since preliminary examination.
2. Duplicate Standard Form 89 to Health Record not required if candidate is to be appointed from enlisted status and has completed 5 years' continuous active duty prior to examination.
3. If not physically qualified, remove all prior Standard Forms 88 and 89 from Health Record and forward to Bureau with currently completed forms.
4. Not required in case of any Reserve officer who has received a complete physical examination, reported to the Bureau, incident to appointment to commissioned rank during the previous 6 months, providing no material change in physical condition has occurred.
5. Remove all prior Standard Forms 88 and 89 from the Health Record and forward to the Bureau with currently completed forms.
6. Required only if more than 1 year has elapsed since last active duty was performed or last examination was reported, or if there has been any adverse change in physical condition; otherwise, notation on Standard Form 600 only. See article 15-77(3).
15–83. Service Records

(1) When the examination for enlistment has been concluded and the candidate found qualified for the service, the medical examiner shall enter the descriptive list of physical characteristics upon the blank Service Record furnished by the Bureau of Naval Personnel or the Commandant of the Marine Corps. The medical examiner shall then sign and transmit the record to the commanding officer.

(2) When the enlistment of any person having physical disabilities has been authorized by the Navy Department, his physical condition shall be fully described in the Service Record.

Section VIII. METHODS OF EXAMINATION

15–85. General

(1) This section presents more detailed methods of examination which could not conveniently be included in the section on physical standards. The Army-Navy-National Research Council Vision Committee has prepared two manuals for use by all military services. One is entitled "Manual of Instructions for Testing Visual Acuity," the other "Manual for Testing Heterophoria and Prism Divergence at Near." The contents of these manuals are incorporated in articles 15–86 and 15–87.

15–86. Testing Visual Acuity

(1) General.—Visual defects are one of the major causes for physical disqualifications from the Armed Services of the United States. Methods of testing vision have varied greatly among the Services and from place to place in each Service. In consequence, visual test results are not comparable. A candidate presenting himself for examination at one center might be qualified for visual acuity while at another center he would be disqualified. The purpose of this article is to describe the conditions and facilities necessary and the procedure to be followed in order to correct this situation. The procedures outlined in this article are to be followed by every person who administers visual tests. It shall be the duty of the medical officer in charge to supervise and inspect the proper administration of procedures outlined in this article.

(2) The Examination.—
(a) Necessary Conditions.—
(1) Physical Equipment.—Tests shall be given in a room where arrangements, charts, and illumination are in good order and as described in subarticle 15–86(3). If the arrangements do not meet the requirements of this subarticle, the fact shall be brought to the attention of the medical officer in charge.

(b) Condition of Candidates.—Every effort should be made to examine men who are in normal physical condition.

(b) Testing Acuity for Distant Vision.—
(1) Procedure.—
(a) If the candidate wears glasses, they must be removed before he enters the examining room. Each man shall be tested without unnecessary delay after he has entered the room. In order to prevent personnel from memorizing the charts, only one candidate shall be permitted to view the targets at a time. Candidates awaiting test must be kept out of hearing.

(b) The candidate is directed to the indicated 20-foot mark. The examiner holds the occluder (see drawing) and covers the candidate's left eye, while instructing the candidate to keep both eyes open and focus on the given mark.
eyes open without squinting. The occluder must not be permitted to touch any part of the eye to be shielded, but should be held in contact with the side of the nose.

SUGGESTED DESIGN FOR OCCLUDER
(to fashion occluder, multiply each of the above dimensions by 2.)

(c) The candidate is directed to begin with the first (visible) line and to read as many lines as possible. (The larger and less used lines should be kept covered in accordance with the suggestions in subarticle 15-86(3)(c)).

(d) The smallest line read on the chart from the 20-foot distance shall be recorded as the vision for the right eye (O.D.) in accordance with regulations in effect.

(e) The acuity for the left eye (O.S.) is then tested, using a different chart and recorded in the same manner.

(f) Finally, the visual acuity for both eyes (O.U.) may be taken, if regulations require it, with a third chart and recorded.

(g) A candidate who normally wears glasses all the time is tested again with them in place. The same procedure is followed as without glasses, for right eye, left eye and both eyes, changing charts for each test.

(h) When there is suspicion that the candidate has memorized the charts, he is to be directed to read the letters of targets in reverse order or will be shown a different chart. When suspicion still remains, the candidate should be referred to the medical officer in charge.

(i) The candidate is expected to read the letters promptly. No precise time limit should be applied but 1 or 2 seconds per letter is ample time.

(j) When a candidate fails a letter or target he should not be asked to read it again. If the candidate is a rapid reader and his mistakes are obviously careless ones, he should be cautioned to "slow down" and the test should be repeated on another chart.

(k) Some men give up easily. They may need encouragement to do their best. However, no coaching shall be given by the examiner.

(l) Score recording.—

(a) Vision is recorded in the form of a fraction (see subarticle 15-86(4)(b)).

(b) When glasses are worn the record should read as follows:

<table>
<thead>
<tr>
<th>Without glasses</th>
<th>With glasses</th>
</tr>
</thead>
<tbody>
<tr>
<td>O.D. 20/--------</td>
<td>O.D. 20/------</td>
</tr>
<tr>
<td>O.S. 20/--------</td>
<td>O.S. 20/------</td>
</tr>
<tr>
<td>O.U. 20/--------</td>
<td>O.U. 20/------</td>
</tr>
</tbody>
</table>

(3) Suggested useful phrases for use by examiner.—

(a) "Please stand here (indicating the place). Hold your head still and straight. Keep both eyes open when I cover your left eye."

(b) "When I cover your eye, don’t close it, for that interferes with the test."

(c) "Start at the top and read as many lines as you can."

(d) "Don’t squint. Don’t screw up your eyelids or frown."

(e) "Lock straight ahead."

(f) "Don’t rub your eyes."

(g) "Read promptly—too much effort will tire your eyes and make it harder."

(h) "Don’t hurry—get each one right that you can because you won’t have another chance."

(i) "The next line may be hard but try it anyway."

(j) "If you’re not quite sure, make a guess—play your hunches."

(4) Precautions to be observed on conducting tests for visual acuity.—

(a) It may be extremely difficult to obtain an accurate measure of visual acuity. The examiner must bear in mind that men who are anxious to pass tests of visual acuity will resort to deception in certain cases. Similarly, other men may take any
means in order to fail a visual test when undesirable duties are in prospect. Hence, the examiner must be prepared to cope with either possibility so that he can uncover and recognize visual defects without the obvious cooperation of the person being tested. If the examiner is not a medical officer, such examinees should be referred to one. Various tests for malingering are described in the Flight Surgeon’s Handbook or the Aviation Medicine Technician's Manual.

(b) The examiner must watch the candidate, not the chart which he is reading. The occluder must be held in such a manner that the candidate cannot peer around it. The most frequently used method of increasing visual acuity is to squint with the eyelids (screw up the eyelids). This is not to be permitted. Some people with astigmatism will be able to read the letters better by tilting the head to one side; do not allow them to do this.

(c) Another well known method used to pass a test for visual acuity is to obtain eyedrops beforehand which contract the pupils. If the pupils are unusually small, the attention of the medical officer must be called to the fact.

(d) The occluder must not be pressed against the eyeball or lids, but rather it should be held against the side of the nose. The eye shielded by the occluder should be open in order to avoid pressure and to discourage squinting.

(e) Some men may appear to be malingering when they are not, and, on the other hand, the most innocent-appearing person may be the worst malingerer. If malingering is suspected, the candidate should be referred to the medical officer at once.

(5) The examiner.

(a) The examiner must be neat in uniform and professional in manner.

(b) Test results determine the duties to which personnel will be assigned; therefore, too much care cannot be taken in tests for visual acuity if every man is to be utilized to the best purpose.

(c) The examiner must be unhurried and persevering if accurate results are to be secured. A patient, tolerant and painstaking attitude on the part of the examiner will reassure the candidates and increase the accuracy of the visual acuity test. Haste and irritation are to be avoided.

(d) The examiner should undertake to memorize the test targets. If necessary, he may hold in his hand a small card on which the targets are reproduced, in order to verify the responses. In any event some accurate check of the responses should be made.

(e) The routine of examination must be followed carefully in the order described. The vision for each eye should be recorded as soon as it is determined so that errors and omissions will be avoided.

c) Retests.—

(1) The effects of fatigue and alcohol may make a certain amount of retesting necessary. In questionable cases one retest shall be given not less than the day after the initial test.

(2) Occasionally an excuse is given for failure to pass the test due to temporary injury to the eyes. Examples are: that the candidate has gotten something in one or both eyes, that he has been exposed to welding flash, to bright sun, etc. Such cases are to be referred to the medical officer.

(3) Testing Room and Equipment.—

(a) The room.

(1) Size.—The room used for testing visual acuity must provide a distance of 20 feet between the eyes of the person being examined and the targets. (See drawing on page 15-56.)

(2) Equipment.—A desk, stand, or high shelf shall be placed so that the examiner can observe the candidate while recording the responses. The 20-foot mark must be carefully measured and clearly marked. (See room plan.)

(3) Ventilation.—Provision must be made for adequate ventilation of the testing room. This is of paramount importance.

(4) Color.—Walls shall be painted with flat Navy Number 9 Pearl Gray (reflectivity 46%) paint. Walls must not be black. Ceilings shall be painted white in order to approximate 76% of reflection. It is important that the trim, frame, or panel on which the charts may be mounted should be painted a gray which is not darker than the walls. The general room trim, casings, etc., shall be painted with semigloss Navy Number 19 Light Navy Gray (reflectivity 28%) paint. The standard Navy Number paints referred to in this paragraph are those listed in the Navy Department manual, “The application of Color to Shore Establishment.” Windows and glass doors shall be completely covered or curtained with material which is not in contrast with the color of the walls.

(b) Illumination.

(1) Room brightness.—The brightness of the walls of the testing room at head height shall be not less than 3-foot lamberts nor greater than the brightness of the test charts. Light from fixtures or openings must be shielded so that it does not shine in the candidate’s eyes. There must be no glare sources or areas of high contrast in the field of view around the test charts. The quality of light is immaterial; Mazda incandescent, or fluorescent is suitable.

(2) Target brightness.—The brightness of the charts shall average 12 foot-lamberts and shall be not less than 10 or more than 15 foot-lamberts.
Under no circumstances shall there be shadows or reflections visible on the charts.

(3) Lighting the room.—

(a) If means are not available for measuring foot-lamberts of brightness, the room should be painted as directed in subarticle 15-86 (3) (a) (4), and lighted as described in the following subarticle. The brightness of the chart and walls will then approximate the requirements of 12 and 4 foot-lamberts respectively.

(b) A room is assumed about 24 feet long, 8 feet wide, and 10 feet high as shown in the illustrated room plan. Such a room should be lighted by three 200-watt incandescent lamps placed at a height of about 9 feet from the floor. One lamp may be over or just behind the examinee’s head. One lamp should be approximately in the middle of the room. One lamp should be exactly 5 feet diagonally from the 20/20 line of the chart and incident upon this part of the chart at an angle of 45° (i.e., 3½ feet above the 20/20 line and 3½ feet in front of it). All lamps must be shielded from the direct vision of the examinee by opal shades (not clear glass) or metal reflectors; or a 4-inch strip of tin can be nailed to the ceiling in front of each lamp so as to accomplish the same purpose.

(c) Test Charts.—

(1) At least three charts must be available.

As rapidly as they are made available, only targets approved by the Army-Navy-National Research Council Vision Committee shall be used.

(2) In order to conserve the examiners’ time and prevent immediate recognition of charts which may have been memorized, the large letters above 20/30 normally may be covered by a white cardboard which can be swung aside or pulled up with a cord when it is necessary to use the larger test targets.

(d) Occluder.—A rigid occluder, constructed of a material such as wood, translucent plastic, or metal, shall be provided to shield the eye not being tested. An excellent design to discourage cheating is illustrated in subarticle 15-86 (2) (b) (1).

(4) Score Reading.—

(a) Test charts or targets approved by the Army-Navy-National Research Council Vision Committee will replace vision testing charts presently in use as rapidly as they become available.

(b) Permanent Reporting of Test Scores.—Vision test scores shall be expressed as a fraction in which the upper number is the distance in feet from the targets, and the lower number is the value of the smallest test-chart line read correctly. Thus a person reading at a distance of 20 feet the 30 foot test-chart line is given a score of 20/30. 20/20 indicates that a person reads at a distance of 20 feet the test-chart line marked 20. Similarly,
20/200 means a person can read at a distance of 20 feet only the test-chart line marked 200.

15–87. Testing Heterophoria and Prism Divergence at Near

1. Testing Heterophoria.—
   a. General.—Heterophoria is a condition in which the eyes have a constant tendency to deviate but are prevented from so doing by fusion. When a person looks at an object, an image of that object is formed separately in both the right and the left eye. These separate images are sent to the brain where they are associated and interpreted as a single image; this process is known as fusion. Fusion is responsible for the two eyes working together in harmony and when anything prevents this, fusion is disrupted and one eye deviates. Since heterophoria is only a tendency of the eyes to deviate, no actual deviation is apparent when the eyes are being used together under ordinary conditions. The deviation becomes visible only when fusion control is weakened or abolished. When deviation occurs, its exact amount can be estimated with some accuracy by neutralizing the deviation with prisms of varying strength. If the deviating eye turns in (toward its fellow), the deviation is known as exophoria; if it turns out (away from its fellow), the deviation is known as esophoria; if the deviating eye turns up or down, the deviation is called hyperphoria or hypophoria, respectively.

2. Breaking up Fusion.—For the purpose of heterophoria measurement, fusion can be disrupted by placing a Maddox rod in front of one eye. The image of a spot of light, when viewed through a Maddox rod, is converted into a line of light. When the two eyes see unlike images of the same object (one eye sees a spot of light while the other eye, the one behind the Maddox rod, sees a line of light), this disrupts fusion and prevents the two eyes from working together. Thus, when heterophoria is present, one eye (the eye behind the Maddox rod) will deviate when its fellow eye continues to look at or fixate the spot of light.

3. Standardization of the Test.—The measurement of heterophoria is one of the most difficult problems that the inexperienced examiner can meet. The reason is simple. There are many factors which influence the test and only a few of these are actually known. For example, it is just as important to have the examinee seated comfortably during the test so that his neck muscles are not strained as it is to have the testing equipment in good condition. Strained positions of the head and neck have a definite effect upon the measurement of heterophoria. Unless the test is performed in exactly the same way at every testing station, an examinee may pass the test at one station on one day and fail it on the next day at another station. A uniformly standardised testing technique must be used at every station. This article has for its purpose the description of the testing technique to be followed at all testing stations.

b. Necessary Equipment.—(1) A testing room long enough to provide a distance of 20 feet between the muscle light and the eyes of the seated examinee.

(2) A comfortable testing chair located at one end of the room.

(3) A muscle light (spot of light), 1 centimeter in diameter, placed at a distance of 20 feet from the eyes of the seated examinee and facing him.

(4) An ophthalmoscope with a removable, May-type head.

(5) Either (a) a binocular phorometer with Risley rotary prisms, white Maddox rods, and Stevens phorometer (graduated in tenths of a prism diopter from 0 to 2.0 attached; or) a monocular, portable phorometer with a Risley rotary prism and white Maddox rod attached; or (c) a trial frame with a white Maddox rod and graduated and accurately calibrated prisms, either loose or arranged vertically in a prism bar.

(6) Some method of measuring exactly 13 inches from the front of the phorometer. A cord tied to the phorometer and either looped or knotted at the proper length is satisfactory. Some phorometers have a metal rod attached to which a small light may be fixed in order to accurately measure heterophoria at 13 inches.

(7) Testing With the Binocular Phorometer.—
   a. Seating the Examinee.—The examinee should first be comfortably seated in a chair. A straight backed chair with arms is preferable to a stool. If there is a head rest on the chair, it should be accurately and comfortably adjusted.

b. Adjusting the Phorometer.—The phorometer should be carefully adjusted to the examinee, not the examinee to the phorometer. He should never be told to “come forward a little” to “stretch your neck a bit,” or “move your head sideways (to right or left) a little bit.” The examiner must make these adjustments himself with the various controls on the phorometer; that is why they are there. (See drawing.) Don’t make the examinee adjust himself to the phorometer. Adjusting the phorometer means several things. It means:

(a) Having the entire length of the brow-piece touching the examinee’s forehead and exerting gentle but firm pressure.

(b) Having the bubble in the spirit level accurately centered between the two markers.

(c) Having the interpupillary distance reading set on the scale and the phorometer high enough so that each of the examinee’s pupils is exactly centered behind its respective frame.

15–87.
(d) Having the examinee so seated and the phorometer so placed that both are exactly and directly facing the muscle light across the room.

(e) The examinee’s glasses. If the examinee wears glasses all the time, any test of heterophoria should be made with the equivalent of his lenses inserted in the phorometer. If prisms are incorporated in the examinee’s regular glasses, these must be omitted from the lenses inserted in the phorometer. If the examinee wears glasses all the time, any measurement of his heterophoria without his glasses is utterly worthless and entirely dependable.

(3) The Maddox Rod.—The examinee’s attention is directed to the muscle light which is a spot of light 1 cm. in diameter located at a distance of 20 feet across the room. To insure his seeing it, the examiner should flash it on and off a time or two by means of a remote control switch located conveniently near at hand, if this is available. There must be no other sources of light except the muscle light visible to the examinee. There may be other lights in the room as long as the examinee cannot see them. All reflecting surfaces should also be removed from the examinee’s range of vision. If this is not done, the overhead light which the examinee cannot see directly may nevertheless be reflected into his eyes from any shiny metal or glass objects in the room.

15–58
Change 6
If this reflection occurs, more than a single line is liable to be seen through the Maddox rod and will prove to be a disturbing factor if not a source of actual error in the test. Once the examinee has definitely located the muscle light, a white multiple Maddox rod attached to the phorometer should be rotated into position. This means rotating it on its hinge as far as it will go. It should be placed before the right eye. The axes of the small rods which make up the multiple Maddox rod should be in the horizontal meridian. With the rod in this position, when the examinee looks at the muscle light, he sees a vertical white line with his right eye (which has the Maddox rod in front of it) and a spot of light with his left eye. He is thus seeing unlike images of the same object, i.e., the spot of light. The examinee should now be specifically questioned as to whether he sees both the vertical white line of light and a white spot of light. If he does, the testing may proceed. If he does not see both the line and light at the same time, one of several things may have happened:

(a) The phorometer frames may not be exactly centered before each eye.

(b) Although properly centered, the phorometer may not be aimed exactly at the light.

(c) The examinee may have closed one eye. Both eyes must be kept open at all times during the test.

(d) The examinee may be unconsciously suppressing vision in one eye (see subarticle 15-87 (1) (c) (4)).

(e) Visual acuity may be poor in one eye.

(f) One eye may be turned far in or far out; if one eye is deviating a great deal ("cross-eyed" or "wall-eyed"), this fact should have been noted on external examination. The presence of a manifest deviation is known as heterotropia, and no heterophoria measurement is accurate or is usually even possible in such cases.

(4) Suppression.—Double vision is usually avoided by the natural impulse to line up the two eyes so that they work together. In the presence of heterophoria, the examinee fuses the two images into one but to do this requires effort (whether he is aware of it or not). If the required effort is too great, one of the two images may be ignored by the brain and when this happens, it is known as suppression. In the case of the Maddox rod test, it is somewhat annoying to look at a spot of light, yet see a line of light with one eye and a spot of light with the other. The image of the line is often suppressed (ignored) by the brain, which means that it seems to fade in brightness and may disappear entirely. If the examinee sees only the line, or only the light, or the line and then the light alternately, it may be assumed that he is suppressing, provided:

(a) The phorometer is properly adjusted.

(b) Visual acuity is normal or anywhere near equal in the two eyes.

(c) There is no gross deviation of the eyes on external examination (inspection).

If the examinee sees only the spot of light (using his left eye), the left eyepiece of the phorometer should be covered with an occluder until the light is seen by the right eye. If the cover is then removed, the line and light will usually be seen simultaneously. Likewise, if only the line is seen (using the right eye, which has the Maddox rod in front of it), the occluder should be placed over the right eyepiece of the phorometer until the spot of light is seen by the left eye. It may then be removed.

(5) The Risley rotary prism.—Once the examinee sees the line and light simultaneously, the next step is the removal of the Maddox rod from its position before the eye and the rotation of the Risley rotary prism attached to the phorometer into position before the right eye. It will be noted that its location is behind the Maddox rod, between the Maddox rod and the examinee’s eye. The handle of the rotary prism should be rotated into the vertical position (at 90°). By means of this same handle, the line indicating the position of the prism base should be rotated on or near zero. Some of the older phorometers have the handle so placed that it is to one side when horizontal muscle balance is being tested. Others have it at an angle. The proper position should be determined by the examiner beforehand.

(a) Marking the prism.—

(1) It is a difficult problem for the inexperienced examiner to remember whether prism base indicates exophoria, prism base down hyperphoria, etc. For this reason, a very simple and practical solution may be found in the use of a little adhesive tape. One piece should be stuck on the fixed frame of the rotary prism over the muscle light, and another over the right eyepiece. With pen and ink, a line representing the three marks which have been covered should be drawn. (See drawing.) On the tape over the 90° mark on the prism before the right eye, the letter "X" should be printed on the tape on the side of the line toward the nose; similarly, a letter "S" may be printed on the opposite side of the line (toward the temple). When heterophoria is being measured, if the prism base marker is set on the "X" side of the 90° mark, exophoria is present (prism base in); if the marker has been set on the "S" side, esophoria is present (prism base out).

(2) In the same manner, the tape at 180° and at 0° can be lined. Above the line on the right prism, print the letter "L" and below the line the letter "R." When vertical heterophoria is being tested and the rotary prism handle is set at 180° (right eye), if the prism marker has been set above
the line (in the "L" area), then left hyperphoria is present. If the marker has been set below the line (in the "R" area), then right hyperphoria is present. This is true for the right eye. For the left eye, as is shown in the diagram, all markings are reversed.

(b) Instructions to the examinee.—

1. Having assured himself that the examinee sees both the line of light (seen through the Maddox rod) and the spot of light, the examiner is ready to begin the test. Since the examiner adjusts the Risley prism, the examinee need only be instructed to tell the examiner when the line of light runs through or bisects the spot of light. The instructions would therefore be something like this: "I am going to move the line. I want to adjust it so that it runs right through the center of the spot of light." The examiner then slowly turns the knob controlling the Risley prism in one direction or the other, meanwhile asking, "Is the line moving toward the light or away from it?" If the examinee replies that the line is moving away from the light, the examiner immediately begins turning the Risley prism control knob in the opposite direction, meanwhile asking, "Now is the line going toward the light?" When the examinee indicates that the line is moving toward the light, the examiner continues to turn slowly, saying, "Now when the line runs through the exact center of the light, tell me to stop." When the examinee states that the line is running through the center of the light, the Maddox rod is rotated out of position in order that the calibrated scale on the Risley prism may be easily read. The scale reading is recorded.

2. The examinee may often state in one breath that the line is running through the light and in the next breath state that this is no longer the case. The examiner should reassure him by telling him that it often happens and continue adjusting the prism until the line stops moving and an accurate reading can be made.

6. The Maddox rod test at 20 feet.—

(a) Lateral heterophoria.—

1. The examiner should always begin the test with the Risley prism set "off" of zero in one direction or the other, preferably on the "X" side (exophoria) so that some adjustment will have to be made in every case.

2. When the reading is completed, if lateral heterophoria was being measured, then if the prism marker is on the side of the line toward the examinee's nose (in the "X" area), exophoria is present; if on the side toward the examinee's temple (in the "S" area), esophoria is present.

3. Doubtful cases.—If any doubt exists in the mind of the examiner about the results of the test, the examinee should be referred to the medical officer in charge. The Maddox rod and rotary prism before the examinee's right eye should be rotated out of position and the rod and prism on the other side of the phorometer rotated into position before the left eye. The procedure described previously should then be repeated. If there is a great difference between the readings with the Maddox rod before the right eye and before the left eye, both should be repeated again. If there is only a small difference, i.e., 2 or 3 prism dipters, the larger of the two should be recorded as the lateral heterophoria (esophoria or exophoria as the case may be) for the examinee. A consistently large difference between the readings for the right and left eye indicates a partial paralysis of one of the extraocular muscles and calls for a repeated examination of the extraocular movements and a red lens test with charting of diplopia fields.

(b) Vertical heterophoria.—

1. When the lateral heterophoria has been tested, the next step is the measurement of vertical heterophoria. With the Maddox rod before the right eye, the rod should be adjusted so that the axes of its component glass rods are in the vertical. When the Maddox rod is rotated out of position in order that the calibrated scale on the Risley prism may be easily read. The scale reading is recorded. The examiner then slowly turns the knob controlling the Risley prism in one direction or the other, meanwhile asking, "Is the line moving toward the light or away from it?" If the examinee replies that the line is moving away from the light, the examiner immediately begins turning the Risley prism control knob in the opposite direction, meanwhile asking, "Now is the line going toward the light?" When the examinee indicates that the line is moving toward the light, the examiner continues to turn slowly, saying, "Now when the line runs through the exact center of the light, tell me to stop." When the examinee states that the line is running through the center of the light, the Maddox rod is rotated out of position in order that the calibrated scale on the Risley prism may be easily read. The scale reading is recorded.

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6. The Maddox rod test at 20 feet.—

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1. The examiner should always begin the test with the Risley prism set "off" of zero in one direction or the other, preferably on the "X" side (exophoria) so that some adjustment will have to be made in every case.

2. When the reading is completed, if lateral heterophoria was being measured, then if the prism marker is on the side of the line toward the examinee's nose (in the "X" area), exophoria is present; if on the side toward the examinee's temple (in the "S" area), esophoria is present.

3. Doubtful cases.—If any doubt exists in the mind of the examiner about the results of the test, the examinee should be referred to the medical officer in charge. The Maddox rod and rotary prism before the examinee's right eye should be rotated out of position and the rod and prism on the other side of the phorometer rotated into position before the left eye. The procedure described previously should then be repeated. If there is a great difference between the readings with the Maddox rod before the right eye and before the left eye, both should be repeated again. If there is only a small difference, i.e., 2 or 3 prism dipters, the larger of the two should be recorded as the lateral heterophoria (esophoria or exophoria as the case may be) for the examinee. A consistently large difference between the readings for the right and left eye indicates a partial paralysis of one of the extraocular muscles and calls for a repeated examination of the extraocular movements and a red lens test with charting of diplopia fields.

(b) Vertical heterophoria.—

1. When the lateral heterophoria has been tested, the next step is the measurement of vertical heterophoria. With the Maddox rod before the right eye, the rod should be adjusted so that the axes of its component glass rods are in the vertical. The eye behind the rod now will see the spot of light as a horizontal line. The Risely prism is turned down and out of position and the Steven's phorometer is turned up into its vertical position. Set the index of the Steven's phorometer at 2.00 LH (Left Hyperphoria). The examinee is told that he should see a horizontal line below the spot of light. The examiner grasps the controlling lever of the Steven's phorometer and moves the lever up slowly until the examinee states that the line bisects the spot of light. If the examinee reports that he also sees another spot of light he is told to ignore the faint spot and to watch the line until it bisects the bright spot. When this is done the examiner reads the scale in tenths of prism dipters of hyperphoria. As indicated on the Steven's phorometer, if the index is set below the zero position, the measurement is of left hyperphoria (LH), and if it is set above the zero position the measurement is of right hyperphoria (RH). When testing the left eye, the relative positions of the line and spot of light are reversed. That is, with the index set at "X" or some adjustment will have to be made in every case.

2. Only hyperphoria is recorded.—It has been previously stated that the eyes may deviate upward (hyperphoria) or downward (hypophoria). In most cases, when one eye turns up, its fellow eye tends to turn down. For simplification, only hyperphoria is recorded. Thus, if the right eye tends to turn upward, it is right hyperphoria. If the right eye tends to turn downward, the left eye would tend to turn upward in the majority of cases and so left hyperphoria would be recorded. The proper finding, whether the Maddox rod is before the right or left eye is always indicated on the Steven's phorometer.
by the letters RH or LH for right or left hyperphoria respectively.

3. Doubtful cases.—If there is any doubt about the measurement in the mind of the examiner, the left eye should be tested in a similar fashion. This is done by placing the Maddox rod before the left eye instead of the right eye and by using the Steven's phorometer as described above. The only apparent change is the reversal of the relative positions of the line and the spot of light at the beginning of the test. A difference of more than 0.5 prism diopeters between the right and left eye measurements should be the cause for a recheck of the hyperphoria measurements for each eye. In this case it would be well to begin the test with the index set at 2.0 RH (Right Hyperphoria), the examiner moving the line in the opposite direction as described above until the line bisects the spot of light. The averages for the settings "from below" and "from above" when the Maddox rod is before the right and the left eyes should be compared. If the difference is greater than 1.0 prism diopter there is, in all probability, a slight paralysis of one or more of the extraocular muscles and a red lens test with the charting of the diplopia fields is indicated.

4. Cases with more than 2.0 prism diopters of hyperphoria.—Occasionally an examinee may have more than this amount of hyperphoria. This will be indicated at the beginning of the test by the examinee reporting that the line appears above the spot of light instead of below when the index of the Steven's phorometer is set at 2.0 RH. Remove the Steven's phorometer and place the Risley prism in position with its handle in the horizontal and toward the examinee's temple. The line is then adjusted so that it runs through or bisects the spot of light. When this is done, set the index of the Risley to the nearest whole division toward zero and bring the Steven's phorometer into position. Now adjust the lever of this phorometer until the line bisects the spot of light. The sum of the readings on the Risley and the Steven's phorometer gives the total hyperphoria, and the position of the index of the Steven's phorometer indicates whether it is right or left hyperphoria that has been measured.

7. The Maddox rod test at 13 inches.—

(a) When the test has been completed at the 20-foot testing distance, the muscle light is turned off. The test should then be performed at 13 inches, using an ophthalmoscope with its head removed at the muscle light. The light should be held exactly in the midline and 6 inches below the level of the examinee's eyes; thus the eyes are in the reading position. It may be necessary to lower the phorometer slightly in order to keep the eyes accurately centered. The light should be held at distance of exactly 13 inches from the phorometer. A string tied to the center bar of the phorometer and looped at 13 inches will serve nicely. If the ophthalmoscope neck is slipped into the loop and the cord drawn taut, the light will be exactly 13 inches from the phorometer each time the test is performed.

(b) The technique of testing lateral and vertical heterophoria at 13 inches is exactly the same as that used at 20 feet. Occasionally the examinee may complain that he sees more than one line at the 13-inch distance. If the source of this annoying reflex cannot be found, he should be instructed to pay attention only to the brightest line while it is adjusted so that it runs through or bisects the spot of light.

(d) Testing with the monocular, portable phorometer.—The principle of measuring heterophoria with a Maddox rod and prisms may be applied in several different ways. Because the equipment available for the test varies from one station to the next, two additional testing methods will be described. At some installations there may not be a binocular phorometer available; instead, there may be only the monocular, portable type. This consists of a stick which has an eyepiece mounted at one end in a fixed position. Rotating on an axle attached to the eyepiece are a Risley rotary prism and a white Maddox rod. The instrument is held in position before the right eye by the examinee and the test is carried out exactly as has been previously described. It is the responsibility of the examiner to make certain that the instrument is held in the proper position at all times during the test. If the right eye is being tested, the examinee should hold the instrument, with its handle vertical before the right eye with his left hand. The examiner adjusts the prism as before.

(e) Testing with a trial frame and loose prisms.—If no phorometer is available, a trial frame should be carefully adjusted on the examinee's eyes. A white Maddox rod from the trial case is placed in the cell before the right eye; its component rods should be placed with their axes horizontal if lateral heterophoria is to be tested first. Once the examinee has located both the line and the light, the examiner should select a weak prism and hold it before the Maddox rod with its base either in or out. Care must be taken to keep the base of the prism exactly vertical if lateral heterophoria is being tested or exactly horizontal if vertical heterophoria is being tested. Several prisms will probably need to be tried (both base in and base out) before one is found which causes the line to run through or bisect the spot of light. The rest of the procedure should be carried out exactly as has been described previously.

Checking the Maddox rod.—Two defects may occasionally be found in a Maddox rod:

1. The line of light may be indistinct rather than sharp.

2. There may be a prism effect which acts to deflect the line of light from its true position. A Maddox rod which is found to have either of these
defects should be discarded. If the line of light formed by the rod is sharp and clear, any prism can be readily detected by holding the rod before one eye so that a horizontal line of light is seen while the other eye sees a spot of light. The position of the line in relation to the light is observed. The rod is then rotated through a full 180° and the line and light relationship observed again. If no prism is present, the relationship should be identical in the two observation positions described.

Checking prisms.—
(1) If a phorometer with a Risley rotary prism attached is not available for heterophoria testing, it will be necessary to use loose prisms. These may be available either in a trial case or in a special box (prism set). The strength of each prism should be etched upon the prism itself. The prismic unit being one used throughout the armed forces. Unfortunately, not all prisms are marked in these units, some are not marked at all, and still others are marked incorrectly. It therefore becomes necessary to check the strength of each prism before it is used in the measurement of heterophoria. This can be very easily and very simply done.

(2) A diagram (see drawing) is made on a white sheet of paper 8½ x 11 inches in size. A heavy black line is drawn about 1 inch from and parallel to one edge. A second, lighter line is drawn perpendicular to the heavy line in such a way that it roughly bisects it. Using a meter stick, units of 1 cm. are laid off on the second line. These units should be numbered consecutively, the mark closest to the heavy line being numbered “1.” This chart or diagram should then be tacked in place on the wall in such a manner that the heavy black line is vertical while the line with the centimeter markings runs to the left of the heavy line. A series of arrowheads added to the heavy line below the point of the intersection will facilitate the checking.

(3) The prism to be checked is held at a distance of exactly 1 meter from the diagram on the wall and in a plane parallel to the plane of the wall. The base of the prism should be held in the vertical, toward the right, and parallel to the heavy black line on the chart. The examiner should then place his eye at a distance of about 4 inches from the prism in such a position that he can view the heavy black line through it. As shown in the drawing, the top edge of the prism should be held so that it is just below but almost coincides with the lighter marked line on the diagram. The position of the heavy black line above the intersection of the two lines should be such that it strikes the prism’s upper edge at about its center. If the left eye is now closed and one looks through the prism, held in the position described, the heavy black line will appear to break at the prism edge and continue its downward course in a position to the left of its original one. The centimeter mark-

(4) Two things must always be known about a prism:
(a) Its strength in prism diopters,
(b) The position of its base.

In testing heterophoria, the prism base is placed in the following positions:
For exophoria, prism base in (toward the nose).
For esophoria, prism base out (toward the temple).
For hyperphoria, prism base down (toward the cheek).
For hypophoria, prism base up (toward the eyebrow).

(2) Testing Prism Divergence at Near (13 Inches).—A test of prism divergence is essentially a test of fusion. Tests for heterophoria depend upon breaking up fusion as much as possible. If prism divergence is tested before heterophoria is measured, the heterophoria measurements will be affected. It is therefore important always to test heterophoria before testing prism divergence.

(a) Equipment.—The equipment for testing prism divergence is the same as that described for testing heterophoria in a previous section of this article.

(b) Procedure for testing prism divergence at near.—The procedure of seating the examinee and adjusting the phorometer is also identical with that for testing heterophoria, previously described. The only difference is that the Maddox rod is not used. The Risley rotary prism is rotated into position before the right eye. The handle of the rotary prism should be rotated to the vertical (90°). By means of this same handle, the line indicating the position of the prism base should be set at 0 on the scale.

(1) The muscle light.—This is a May-type ophthalmoscope with the head removed. It should be held in the midline between the examinee’s eyes in a depressed position (below the horizontal) at a distance of 13 inches from the eyes. An easy and practical method for securing the proper distance is to use a string tied to the center of the phorometer which is 13 inches long. The free end of the string should have a loop tied in it. The stem of the ophthalmoscope (which contains the bulb) can then be slipped through the loop and the string drawn taut. This insures a 13-inch testing distance. The
The appearance of the test chart when viewed through a prism whose strength is 2 diopters, at a distance of exactly 1 meter.

light should be held in the midline at such an angle below the horizontal that the corneal reflection of the light is just able to form by rays passing over the bottom of the phorometer trial frame. If the examiner holds the light in the midline on a level with the examinee's eyes, a corneal reflection of the light will be seen located roughly over the center of each pupil. If the light is now slowly lowered, still being kept in the midline, a point will be reached where the phorometer trial frame will prevent rays of light from reaching the cornea and the corneal reflex will suddenly disappear from both eyes. The desired position of the light is one of depression below the horizontal, in the midline, to a point just short of one producing disappearance of the corneal reflection.
(2) Testing procedure.—

(a) With the Risley rotary prism in position before the right eye as described, and with the muscle light held in the prepared position, the examiner's attention is directed to the light. He is told to watch the light carefully and to inform the examiner at the instant that the light appears to double. He is warned that the light may blur before it doubles. It is not the point of blurring but the point of doubling that is wanted.

(b) The examiner then grasps the handle of the rotary prism and turns it in such a manner that the zero mark on the prism moves inward toward the examiner's nose. The rate of movement should be smooth rather than jerky and fairly slow. The examiner is cautioned to avoid undue blinking, if this is present.

(c) The rotation is stopped at the point where the light appears double to the examiner. A reading is then taken from the calibrated scale on the rotary prism and is recorded as prism divergence at 13 inches. The average normal figure in this test is around 19 prism dipters. The examiner must have a reading of 12 prism dipters or better to qualify.

15–88. Examination of Heart and Blood Vessels

(1) (a) General.—The applicant should stand before the examiner with direct light falling upon his chest. He should stand at ease, with the arms relaxed and hanging by his sides. The examiner should not permit the applicant to move his body from side to side or twist it in an endeavor to assist in the examination, as these maneuvers may distort landmarks and increase muscular resistance of the chest wall. The heart should be examined by the following method: Inspection, palpation, percussion, auscultation, and when considered necessary, by mensuration. Blood-pressure readings and palpation of the pulse are required for candidates for commission and for applicants for enlistment. Electrocardiograms and X-rays for cardiac mensuration should be made in doubtful cases.

(b) Inspection.—Begin from above and go downward, with special reference to the following: condition and color of skin and mucous membranes; eyes for areas seniles; visible pulsations of the vessels of the neck; enlargement of the thyroid gland; the shape of the chest, for any malformation which might change the normal relations of the heart; pulsations in the suprasternal notch, and in the second interspaces to right and left of the sternum; character of the precordial impulse, and the location and character of the maximum impulse, epigastric pulsations or pulsations in the hepatic region, and any pulsations or retractions in the back.

(c) Palpation.—Palpate first for the detection of thrills over the carotids, thyroid gland, suprasternal notch, apex of heart, and at the base. Use palms of hands in palpat ing and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the applicant stoop and throw his shoulders slightly forward, thus bringing the heart into the closest possible relation with the chest wall. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Place the palm of one hand over the heart and fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate to determine the degree of tension or compressibility of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered and a rate of 90 may be considered normal, provided the heart responds normally to the exercise test. A rate of 50 or below should excite suspicion of heart block and be made the subject of further investigation. Rates of 100 or over should be investigated with a view to the exclusion of heart lesions and hyperthyroidism.

(d) Percussion.—Light mediate percussion should be used. The right and left cardiac borders, as well as the diameter of the transverse arch, may be determined by percussion. In doubtful cases in which it is important to determine the actual cardiac boundaries, teleradiography should be employed.

(e) Mensuration.—Draw a line down the midsternum, from the suprasternal notch to the tip of the ensiform cartilage. Measurements are made at right angles to this line, at the second interspace (aortic dullness), at the fourth interspace to the right for any increase in the right border, and at the fifth interspace to the left for any increase in the left border. The following measurements may be considered normal for the average young adult:

(1) From midsternal line to right border at fourth interspace, 3 cm.

(2) From midsternal line to left border along fifth interspace, 8½ cm.

(3) The normal aortic dullness at the second interspace to the right and left of the midsternal line is 5½ cm.

(f) Auscultation.—In auscultating the heart, the examiner should bear in mind the four points where the normal sounds of the heart are heard with maximum intensity:

(1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.

(2) Tricuspid area, at the junction of the fifth right rib with the sternum. Here the first sound is distinct.

(3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.

(4) Mitral area, fifth interspace to left of sternum. Here the first sound is most clearly heard.
No auscultatory examination is to be considered complete unless the subject is examined in the upright, recumbent, and left lateral recumbent positions and after exercise, and in the different phases of respiration. The examiner should ascertain whether the applicant has had any of the following diseases: scarlet fever, diphtheria, chorea, rheumatic fever, tonsillitis, hemolytic streptococcal infection, syphilis, or tuberculosis.

(2) **Examination after exercise.**—Examiners shall use judgment and discretion in applying the exercise test to those who present evidence of incompetency of the heart. An exercise test is required in order to determine the efficiency of the heart muscle. The applicant should be required to hop 20 times on one foot not faster than one hop per second, clearing the floor about 1 inch at each hop. Record sitting pulse rate and blood pressure before exercise. Immediately after exercise, record pulse rate, and 2 minutes after exercise record pulse rate and blood pressure. Immediately after the exercise auscultation should be repeated with particular reference to the detection of murmurs previously inaudible. Note should be made of the degree of dyspnea and other symptoms of circulatory failure.

(b) **Consideration of blood pressure.**—In considering the blood pressure, the examiner should give due regard to the age of applicant and to physiologic causes, such as excitement, recent exercises, loss of sleep, and digestion. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure. No applicant shall be rejected as a result of a single reading. When the blood pressure estimation at the first examination is regarded as abnormal, or in case of doubt, the procedure shall be repeated twice daily (in the morning and in the afternoon) for a sufficient number of days to enable the examiner to arrive at a definite conclusion. For those individuals with elevated blood pressure an average of the readings taken, with the individual as free from stress as possible, should be reported rather than the results of a single high or low reading. However, a representative sample of the highest and lowest readings shall also be recorded.

(e) **Resting blood pressure.**—The resting blood pressure is to be taken with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The systolic blood pressure reading is to be taken as the level at which the first clear tapping sound appears during slow decompression of the blood pressure cuff. As the blood pressure cuff is further decompressed the auscultatory sound becomes murmur-like, then it becomes clearer and louder, and finally it becomes muffled in character. The diastolic blood pressure reading is to be taken as the level at which this fourth phase (the muffled sound) abruptly drops in intensity or disappears.

(d) **Interpretation of abnormal signs and symptoms.**—The following principles are laid down for the guidance of examiners in their interpretation of abnormal signs and symptoms. It should be constantly borne in mind that the excitement of the examination may produce violent and rapid heart action, often associated with a transient systolic murmurs. Such conditions may erroneously be attributed to the effects of exertion; they usually disappear promptly in the recumbent posture, but the examiner must endeavor to recognize the excitable individuals to take measures to eliminate psychic influences from the test so far as possible.

(e) **Hypertrophy and dilatation.**—An apex beat located at or beyond the left nipple line, or below the sixth rib, suggests an enlargement sufficient to disqualify for military service. Its cause, either valvular disease or hypertension in the majority of cases, should be sought. Clear cut radiologic evidence of heart enlargement is cause for rejection. A horizontal position of the heart must be distinguished from left ventricular enlargement. Fluoroscopy and teleroentgenography are important adjuncts in the diagnosis of enlargement of the cardiac chambers, particularly the left auricle. The left oblique position may reveal early enlargement of the latter chamber. Enlargement, however, should not be made a primary diagnosis unless careful examination fails to reveal a cause.

(f) **Physiological murmurs.** Cardiac murmurs are the most certain physical signs by which valvular disease may be recognized and its location determined. The discovery of any murmurs demands diligent search for other evidence of heart disease. Murmurs may occur, however, in the absence of valvular lesions or other cardiac disease. Such physiological murmurs are not causes for rejection. The following characteristics of physiological murmurs will enable the medical examiner to differentiate them from organic murmurs:

1. They are always systolic in time.
2. They are usually heard over a small area, the most common places being over the pulmonic valve and the mitral valve.
3. They change with position of the body, disappearing in certain positions. They are loudest usually in the recumbent position and are sometimes heard only in that position.
4. They are transient in character, frequently disappearing after exercise.
5. They are usually short, rarely occupying all of a systole, and are soft and of a blowing quality.
6. There is no evidence of heart disease or cardiac enlargement.

The most frequent types of physiological murmurs are:

1. Those heard over the second and third left interspaces during expiration, disappearing during forced inspiration. These are particularly com-
mon in men with flexible chests, who can produce extreme forced expiration. Under such circumstances, murmurs may be associated with a vibratory thrust.

(2) Cardio-respiratory murmurs occasioned by movements of the heart against air in a part of the lung overlapping the heart. They usually vary in different phases of respiration, and at times disappear completely when the breath is held.

(3) Prolongations of the apical first sound, which are often mistaken for murmurs.

15–89. Examination of Range of Motion

(1) The applicant shall be put through a series of movements similar to those described below, which will bring into action the various joints and muscles of the body. The purpose is best accomplished by requiring the applicant to follow the movements as made by the examiner or an assistant.

(a) Bring the elbows firmly to the sides of the body with the forearms extended to the front, palms of the hands uppermost; extend and flex each finger separately; bring the tips of the thumbs to the base of the little fingers; close the hands, with the thumbs covering the fingers; extend and flex the hands on the wrists; rotate the hands so that the fingernails will first be up and then down; move the hand from side to side. Extend the arms and forearms fully to the front and rotate them at the shoulders with the fists. Extend the arms at right angles with the body; place the thumbs on the points of the shoulders; raise and lower the arms, bringing them sharply to the sides at each motion. Let the arms hang loosely by the sides; swing the right arm in a circle rapidly from the shoulder, first to the front and then to the rear; swing the left arm in the same manner. Extend the arms fully to the front, keeping the palms of the hands together and the thumbs up; carry the arms quickly back as far as possible, keeping the thumbs up, and at the same time raise the body on the toes. (Question the candidate regarding any previous dislocations of the shoulder.) Extend the arms above the head, locking the thumbs, and bend over to touch the ground with the hands, keeping the knees straight. Perform two push-ups from the floor. (Question the candidate as to wrist injury for possible scaphoid fracture.)

(b) Extend one leg, lifting the heel from the floor, and move all the toes freely; move the foot up and down and from side to side, bending the ankle joint, the knee being kept rigid; bend the knee freely; kick forcibly backward and forward; throw the leg out to the side as far as possible, keeping the body squarely to the front; repeat all these movements with the other foot and leg; strike the breast first with one knee and then with the other; stand upon the toes of both feet; squat sharply several times; kneel upon both knees at the same time. If the man comes down on one knee after the other there is reason to suspect infirmity, such as injury to menisci. Question the candidate as to previous injury.

(c) Take the position “to fire kneeling”; stand erect, present the back to the examiner, and then hold up to view the sole of each foot; leap directly up, striking the buttocks with both heels at the same time, hop the length of the room on the ball of first one foot and then the other; make a standing jump as far as possible and repeat it several times; run the length of the room several times.

(2) While the exercises prescribed may cause some breathlessness and accelerated throbbing of the blood vessels, they should not cause manifest exhaustion or great distress in a healthy man. Lack of ability to perform any of these exercises indicates some defect or deformity that should be investigated further.

15–89A. Orthopedic Examination of Major Joints

(1) The Shoulder.—With the patient stripped to the waist, inspect both anteriorly and posteriorly for asymmetry or abnormal configuration or muscle atrophy. From the back, with the applicant standing, observe the scapulo-humeral rhythm as patient elevates the arms from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particularly careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction, and rotation. Compare each shoulder in this respect. Test muscle power of abductors, adductors, flexors and extensors of the shoulder, as well as power in internal and external rotation. Have the patient attempt to lift a heavy weight with arm at the side to establish integrity of the acromioclavicular joint.

(2) The Back.—

(a) With the candidate standing stripped, note the general configuration of the back, the symmetry of the shoulders and hips and any abnormal curvature including scoliosis, abnormal dorsal kyphosis or excessive lumbar lordosis. Palpate the spinous processes and the erector spinae muscle masses for tenderness. Determine absence of pelvic tilt by palpating iliac crests. Have patient flex, extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion. Test rotary motion by gripping the pelvis on both sides and having the patient twist to each side as far as is possible. Measure chest expansion. With the patient sitting on the examining table, test patellar and ankle reflexes and fully extend the knee, noting complaints of pain. (This corresponds to a 90-degree straight leg raising test in supine position.) With the patient supine, test dorsiflexor muscle power of the foot and toes, with particular attention to power of the extensor hallucis longus. Weakness may indicate nerve root pressure on L1. Flex hip fully on abdomen with knee flexed and determine presence or
absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbosacral sprains of chronic nature, pain is experienced on these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbosacral abnormality. With the patient prone, have him extend back (arch the back) and test strength in extension by noting degree to which this is possible.

(b) If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back X-rays, including the pelvis, should be obtained. These should include an anteroposterior, lateral, and oblique views.

(3) The Knee.—
(a) With trousers, shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature. Have patient squat, sitting on heels, and observe hesitancy, weakness, and presence or absence of pain or crepitus. With patient sitting, test for ability to extend the knee fully and test power in extension by making pressure on lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness.

(b) With the applicant still sitting on the table’s edge, sit and grasp his heel between the knees; then test for cruciate ligament stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur (the so-called “Drawer sign”). With the patient supine, mark on each leg a distance 1” above the patella and 6” above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.

(c) In the presence of any history of “locking,” recurrent effusion or instability, as well as when atrophy measured is more than ½” or when limitation of motion or ligamentous instability is detected, suitable X-rays should be obtained which should include an anteroposterior, lateral, and intercondylar view.

(4) The Elbow.—With the candidate stripped to the waist and holding the upper arms against the body with the forearms extended and fully supinated, observe for presence of a normal carrying angle. Have the patient flex the elbows to a right angle and keeping the elbows against the body note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator and pronator muscles by having the patient contract these muscles against manual resistance of the examiner. If indicated, X-rays should include an anteroposterior and lateral views.

(5) The Wrist and Hand.—
(a) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare range of motion of the wrists in flexion, extension, radial deviation, and ulnar deviation. Test muscle power in each of these positions.

(b) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor indicating possible underlying organic disease. Have the candidate flex and extend the fingers making sure the distal interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palms. Observe the contour of the palm for possible atrophy of the thenar and hypothenar eminences, have the candidate touch the thumb tip to each finger tip and test the strength of pinch between the thumb and forefinger. With the hands pronated observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves. With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers together. Test also by pulling apart adjacent fingers against the resistance of the candidate. If indicated, anteroposterior and lateral X-rays of the wrist as well as anteroposterior and oblique views of the hand should be obtained.

(6) The Hip.—With the candidate stripped and standing observe from behind for symmetry of the buttocks, the intergluteal cleft and the infragluteal fold. Palpate the iliac crests and greater trochanters for symmetry. Have the candidate stand first on one foot and then the other, flexing the non-weight-bearing hip and knee and observing for ability to balance as well as for possible weakness of hip muscles or instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (i.e., the non-weight-bearing) hip. This, if present, is a positive Trendelenburg sign and necessitates X-ray evaluation. With the patient supine have patient flex the hip, abduct, and adduct the hip and rotate the leg inward. Observe for hesitance in performing these motions, incomplete range of motion or facial evidence of pain on motion. Test muscle strength in each position.

With candidate prone test for ability to extend each leg with knee extended and test for power in each hip in extension. If abnormalities are detected requiring X-rays, an anteroposterior view of each hip and a lateral view of each hip should be obtained so that the abnormal hip can be compared with the normal for possible evidence of disease or abnormality.
15–90. Roentgenographic Examination of Chest

(1) Whenever practicable, roentgenographic examination of the chest shall be made as a part of the physical examination to determine physical fitness for original entry into the service and for active duty, and of candidates for entrance to the Naval Academy as midshipmen or candidates for officer training, either as a part of the examination to determine their fitness for training or upon reporting to the School. If it is impracticable to obtain the roentgenographic examination or to have the examination read or to send the examination with the Standard Form 88, a statement to this effect shall be made on the Standard Form 88 with an explanation of why it was impracticable, with a request that roentgenographic examination be obtained if and when the applicant reports for active duty. The following entry shall be made on NAVMED–H–8 (Medical History Sheet) of the individual concerned: “Chest X-ray study has not been conducted in this case. It should be conducted at the first opportunity and a report thereof entered on one of the last two lines on NAVMED–H–2 and on NAVMED–H–8.” A recruit who has received roentgenographic examination of the chest during his physical examination for enlistment or induction with negative findings does not require another roentgenographic study upon arrival at a naval training station or Marine recruit depot. However, recruits received from Armed Forces induction stations who have doubt or positive tuberculin test reactions, done in accordance with article 15–91, shall receive another roentgenographic examination of the chest. The interpreter of the X-ray film shall be informed of the reason for the examination.

(2) Chest examinations of personnel on active duty shall, if practicable, be made at least once a year. Causes for further clinical study to determine the significance of lesions noted shall be those listed in article 15–18 (2) (a); such clinical study is best accomplished on the chest service of a naval hospital. Personnel who have X-ray findings of possible fu-
absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbar-sacral sprains of chronic nature, pain is experienced on these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbar-sacral abnormality. With the patient prone, have him extend back (arch the back) and test strength in extension by noting degree to which this is possible.

(b) If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back X-rays, including the pelvis, should be obtained. These should include an anteroposterior, lateral, and oblique views.

(3) The Knee.—

(a) With trousers, shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature. Have patient squat, sitting on heels, and observe hesitancy, weakness, and presence or absence of pain or crepitation. With patient sitting, test for ability to extend the knee fully and test power in extension by making pressure on lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness.

(b) With the applicant still sitting on the table’s edge, sit and grasp his heel between the knees; then test for cruciate ligament stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur (the so-called “drawer sign”). With the patient supine, mark on each leg a distance 1” above the patella and 6” above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.

(c) In the presence of any history of “locking,” recurrent effusion or instability, as well as when atrophy measured is more than ½” or when limitation of motion or ligamentous instability is detected, suitable X-rays should be obtained which should include an anteroposterior, lateral, and intercondylar view.

(4) The Elbow.—With the candidate stripped to the waist and holding the upper arms against the body with the forearms extended and fully supinated, observe for presence of a normal carrying angle. Have the patient flex the elbows to a right angle and keeping the elbows against the body note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator and pronator muscles by having the patient contract these muscles against manual resistance of the examiner. If indicated, X-rays should include an anteroposterior and lateral views.

(5) The Wrist and Hand.—

(a) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare range of motion of the wrists in flexion, extension, radial deviation, and ulnar deviation. Test muscle power in each of these positions.

(b) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor indicating possible underlying organic disease. Have the candidate flex and extend the fingers making sure the distal interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palms. Observe the contour of the palm for possible atrophy of the thenar and hypothenar eminences, have the candidate touch the thumb tip to each finger tip and test the strength of pinch between the thumb and forefinger. With the hands pronated observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves. With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers together. Test also by pulling apart adjacent fingers against the resistance of the candidate. If indicated, anteroposterior and lateral X-rays of the wrist as well as anteroposterior and oblique views of the hand should be obtained.

(6) The Hip.—With the candidate stripped and standing observe from behind for symmetry of the buttocks, the intergluteal cleft, and the infragluteal fold. Palpate the iliac crests and greater trochanters for symmetry. Have the candidate stand first on one foot and then the other, flexing the non-weight-bearing hip and knee and observing for ability to balance as well as for possible weakness of hip muscles or instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (i.e., the non-weight-bearing) hip. This, if present, is a positive Trendelenburg sign and necessitates X-ray evaluation. With the patient supine have patient flex the hip, abduct, and adduct the hip and rotate the leg inward. Observe for resistance in performing these motions, incomplete range of motion or facial evidence of pain on motion. Test muscle strength in each position. With candidate prone test for ability to extend each leg with knee extended and test for power in each hip in extension. If abnormalities are detected requiring X-rays, an anteroposterior view of each hip and a lateral view of each hip should be obtained so that the abnormal hip can be compared with the normal for possible evidence of disease or abnormality.

15–87
Change 7
15-90. Roentgenographic Examination of Chest

(1) Whenever practicable, roentgenographic examination of the chest shall be made as a part of the physical examination to determine physical fitness for original entry into the service and for active duty, and of candidates for entrance to the Naval Academy as midshipmen or candidates for officer training, either as a part of the examination to determine their fitness for training or upon reporting to the School. If it is impracticable to obtain the roentgenographic examination or to have the examination read or to send the examination with the Standard Form 88, a statement to this effect shall be made on the Standard Form 88 with an explanation of why it is impracticable, with a request that roentgenographic examination be obtained if and when the applicant reports for active duty. The following entry shall be made on Standard Form 600 of the individual concerned: “Chest X-ray study has not been conducted in this case. It should be conducted at the first opportunity and a report thereof entered on block 46 of Standard Form 88, and on Standard Form 600.” A recruit who has received roentgenographic examination of the chest during his physical examination for enlistment or induction with negative findings does not require another roentgenographic study upon arrival at a naval training station or Marine recruit depot.

(2) (a) Chest examinations of personnel on active duty shall, if practicable, be made at least once a year. Causes for further clinical study to determine the significance of lesions noted shall be those listed in article 15-18(2)(a); such clinical study is best accomplished on the chest service of a naval hospital. Personnel who have X-ray findings of possible future significance shall receive this examination every 6 months, where possible, using 14- x 17-inch film.

(b) Navy and Marine Corps personnel stationed in the Far East should have roentgenographic chest examinations prior to return to the United States. If this is impracticable, then X-ray examinations shall be performed at the point of debarkation or at the first duty station upon arrival within the United States. This does not include shipboard personnel not home ported in the Far East.

(3) Roentgenographic examination of the chests of all Navy and Marine Corps personnel shall be made and the interpretation entered in the Health Record during the physical examination at the time of release from active duty or discharge from the service, except discharges for immediate reenlistment or release from active duty with a view to immediate recall to active duty, unless such examination has been made and the interpretation entered in the Health Record during the previous 6 months.

15-68

Change 10

(4) All Navy and Marine Corps activities with the necessary X-ray equipment shall be considered as available for these examinations, and whenever practicable, the examinations shall be made by the photofluorographic technique for convenience and economy. Photofluorographic units are located in the naval shipyards for the examination of the personnel of naval vessels and naval personnel of the shipyard, and at other shore stations where the number of such examinations is sufficiently great. The services of mobile photofluorographic units are available for annual survey to those activities which do not have access to a stationary photofluorographic unit. Requests for the services of a mobile unit should be directed to the district commandant. The equipment and personnel of each photofluorographic unit will be adequate to examine 125 to 150 persons per hour.

(5) Individuals in whom the photofluorographic film discloses abnormal conditions or any recruit or midshipman whose tuberculin test reaction, done in accordance with article 15-91, is positive shall be reexamined by means of a 14- x 17-inch film prior to final action in their cases. The interpreter of such reexaminations shall be informed of the reason for the reexaminations. Transfer to a naval hospital solely for this reexamination is not necessary if means for obtaining it are otherwise available. When individuals are not available for reexamination, their commanding officers shall be notified by letter making reference to photofluorographic examination number, name in full, service or file number, and date and place of birth, with the request that a reexamination be made at the first opportunity. The results of the reexamination shall be entered in the Health Record or Jacket in accordance with article 15-90(6)(d) and (e).

(6) The results of photofluorographic and roentgenographic examinations of the chest shall be recorded and reported as follows:

(a) Identification and Forwarding of Photo­fluorographic Film.—Upon each photofluorogram must appear the following data:

(1) Station symbol of the station (or of the mobile unit) on which examination is made.

(2) The film number (place capital “C” after film number when a civilian employee is examined; capital “D” in case of dependents; and capital “O” to indicate other military).

(3) Date of examination.

Examples.—(1) (2) (3)

NY1-99,999 3-5-61

or

MU12-99,999C 3-5-61

In order that films filed in the rolls may be quickly found upon request, it is essential that all photofluorographic film be numbered in consecutive numerical order. Numbering shall progress from 1 to 99,999 and then repeat. The rolls should contain
approximately 500 70-millimeter films or 1,000 35-
millimeter films. Splicing shall be done with a view
to permitting ready passage of the finished roll
through the viewer. Splicing is easily done by using
narrow strips of cellophane adhesive tape on both
sides of the splice. Films which show positive find-
ings or which are considered to be technically unsat-
sfactory shall be left in the roll. Technically
unsatisfactory film shall be defaced by crossed lines
made with a colored wax penell or other means.
Entries shall be made in the Health Records and
Jackets as indicated in subarticles 15-90(6) (d) and
(e) below.

(b) Reviewing Photofluorographic Films.—
Photofluorographic films shall be reviewed and read
twice when taken, when personnel trained in inter-
pretation are available. Photofluorographic films
taken by stationary and mobile photofluorographic
units which do not have personnel trained in inter-
pretation available shall be forwarded to an inter-
pretation center designated by the district, river
command, or fleet medical officer, as applicable.
Photofluorographic films taken in naval training
centers or Marine Corps recruit depots shall be
viewed and read twice. Those taken elsewhere shall
be viewed and read twice when feasible. Naval
hospitals or other naval activities designated by
the district, river command, or fleet medical of-

cice. Add film number and place of examination for

(c) Identification and Filing of 14- x 17-Inch
Roentgenograms.—When 14- x 17-inch roentgeno-
grams are made, the same data shall be entered, and
whenever possible the same film number shall be
used which appears on the corresponding photo-
fluorogram. The 14- x 17-inch roentgenograms
shall be disposed of in accordance with article
23-303(6) (d).

(d) Health Record.—
(1) The place, date, film number, and a re-
port of interpretation shall be entered on Standard
Form 600 of the Health Record. The station and
film number mentioned above must be entered with-
out fail, for without this information the film can-
not be located in the files.
(2) In addition, the date and interpretation
shall be recorded (a) upon block 46 of Standard
Form 88 if the examination is for original entry
into the service and (b) under REMARKS AND
RECOMMENDATIONS upon Standard Form 601
for examinations required later during active serv-
ice. Add film number and place of examination for
identification.

(e) Health Jacket (Civilian Employees).—The
place, date, film number, and report of interpreta-
tion shall be recorded in the health jacket in the
case of civilian employees. When reexamination by
14- x 17-inch roentgenogram is made of a civilian
employee, the report of this reexamination shall
also be filed in the health jacket of the individual.

(f) Logs and Films.—Naval hospitals or other
naval activities designated to review photofluoro-
graphic films shall upon completion of their review
forward the logs, together with the photofluoro-
graphic films, at 90-day intervals (quarterly during
the calendar year), to the Navy Branch, Military
Personnel Records Center, 9700 Page Boulevard,
St. Louis 14, Mo.

(1) NAVMED-1161 (Photofluorographic Log)
and NAVMED-1161a (Following Sheet) as Neces-
sary.—The log shall contain the photofluorogram
number, name in full, rate or rank, service or file
number, date and place of birth of the individual
examined, ship or duty station, the interpretation,
and upon each sheet the name and signature of the
roentgenologist. The examination of all personnel
shall be recorded in the same log and be included
in the same serial numerical numbering, except that
films on other than Navy and Marine Corps personal-
nel will be identified in accordance with article
15-90(6) (a) (2). At those activities making routine
roentgenographic examinations of the chests of
recruits and midshipmen, the following statement
shall be inserted on the log: “All recruits (midship-
men) reported above have received a tuberculin
test and the provisions of subarticles 15-90(1) and
(5) have been complied with.”

(2) Copies of the Reports of 14- x 17-Inch
Roentgenograms Made of Service Personnel Whose
Photofluorograms Are in the Roll.—These reports
shall contain the place and date of examination, the
14- x 17-inch film number, the corresponding photo-
fluorogram number, the name of the examinee in
full, the service number, rate or rank, ship or duty
station, date and place of birth, the interpretation,
disposition of the case, and signature of the roent-
genologist. In order that appropriate followup
procedures can be initiated in the case of service
personnel, every effort should be made to reexamine
by 14- x 17-inch roentgenogram those persons
whose photofluorograms disclose suspicious findings.
Reports of these reexaminations should be for-
warded without delay to the Bureau (Code 72).

(3) Copies of Notification to Commanding
Officers as prescribed in subarticle 15-90(6).

(4) NAVMED-618, Report of Photofluoro-
graphic Chest Survey, MED-6224-5.—A separate
NAVMED-618 summarizing the photofluorographic
and roentgenographic findings shall be prepared
and appropriately identified for military personnel,
civilian employees, dependents, and other personnel.
It is essential that units preparing NAVMED-618 enter
upon the reverse side of the form the photofluoro-
gram numbers of persons who are reexamined by
14- x 17-inch films, and place an asterisk before the
appropriate photofluorogram number when the re-
examination resulted in a recommendation for fur-
ther clinical study or disqualification. The NAVMED-
618 shall be forwarded to the interpretation center
along with the films and logs for review. Upon
completion of review, the interpretation centers
shall forward the NAVMED-618 to the Bureau (Code
72) on a monthly basis.

15-90
Change 10
15–91. Tuberculin Testing of Recruits, Midshipmen, and Other Special Personnel

(1) Testing Activities.—A tuberculin test shall be made of all Navy and Marine Corps recruits, women enlistees, officer candidates, and midshipmen in accordance with provisions of subarticle 15–91(3) as soon as practicable after reporting to the Naval Training Center at Bainbridge, Great Lakes, or San Diego; the Marine Corps Recruit Depot at Parris Island; the Marine Corps Recruit Depot at San Diego; or the Naval Academy Command at Newport; the Marine Corps Schools at Quantico; or the Naval Academy at Annapolis. The “Single Test” (5 tuberculin units, or 0.0001 mgm. per test dose) tuberculin test material is available for issue at appropriate medical supply stock points.

(2) Recording and Reporting.—
(a) Health Record Entry.—The result of the test shall be entered in the Health Record on Standard Form 601 under SENSITIVITY TESTS. The entry shall contain the place and date of test, the material and strength of dilution used, and the results recorded in millimeters of induration at the widest diameter transversely across the arm. The entry shall be signed by the individual responsible for the performance and interpretation of the test.

(b) Tuberculin Testing of Recruits, Midshipmen, and Other Special Personnel, MED–6224–1, Report.—A record of all such tests shall be maintained and reported by letter to the appropriate unit at the end of each calendar year, giving the number of tests and the number of negative and positive reactors. The negative reactors shall be subdivided into two groups: the number with zero mm. of induration, and the number with 1–5 mm. of induration. The positive reactors shall be subdivided into the following groups: the number with 6–10 mm. of induration, the number with 11–15 mm. of induration, those with 16–20 mm. of induration, and those with more than 20 mm. of induration.

(3) The Tuberculin Test.—
(a) Materials.—(Stock numbers are from the Armed Services Medical Stock List.)
(1) Purified Protein Derivative Test Kits.—Stock No. 6505–153–8290, 50-test size. Solutions shall be prepared according to directions in the kit. Solutions shall be stored in a refrigerator (not frozen) for not longer than 4 days, after which they must be discarded. When properly prepared, each 1/10 cc. test dose contains 0.0001 mgm. PPD.
(2) Syringes.—Stock No. 6515–282–9600. Syringes shall have been used for no other purpose, and shall be tightly fitted, chemically clean, and sterile. They may be reused, with proper precautions as to cleanliness and sterility, for these tests or other purposes. Once used for any other purpose, however, they shall not again be used for these tests.

(3) Needles.—Stock No. 6515–349–5900. A chemically clean and sterile needle which has been used for no other purpose shall be used for each test. Needles may be reused for these tests, after cleansing and sterilizing, if they have not been used for any other purpose.

(4) Ordering.—Items should be ordered and reordered only in quantities sufficient to equal the planned usage rate for the next 6 months. If, for any reason, it becomes apparent that an excess of any of the tests, syringes, or needles has developed the excess should be promptly returned to the nearest medical supply depot if suitable for reissue.

(b) Technique.—The testing and interpreting shall be performed by a medical officer or by adequately trained personnel of the Medical Department under the supervision of a medical officer. Following aseptic preparation of the skin an intradermal injection of one-tenth cubic centimeter of the tuberculin solution shall be made upon the volar aspect of the left forearm. (The point of the needle should be plainly visible just within the outer layers of the epidermis.) The result, immediately after injection, should be a definite wheal, pale and sharply demarcated. Great care must be exercised to avoid subcutaneous injection. (Note.—When the tuberculin test is read the forearm should be in a good light and flexed a little at the elbow. Tautness of underlying muscles may be sufficient to obliterate the redness and edema. It is well, also, to look across the forearm rather than down upon it. Pass the finger over the test area; the induration caused by the edema can be felt even if it does not produce an elevation that can be seen.)

(c) Result of Test.—The test shall be examined after an interval of not less than 48 hours nor more than 72. Redness without induration does not constitute a reaction. Response to injection is classified according to the extent of the induration measured in millimeters at its widest diameter transversely across the arm. The result is recorded in the following form: “Date ------. Tuberculin test material was administered, PPD units, concentration mm. of induration.” Absence of induration is reported as “zero mm.” When induration is present, the widest diameter measured transversely across the arm is recorded, using Arabic numerals; e.g., “9–17–58 PPD intermed, 6 mm. induration” or “9–17–58 0.0001 mgm. PPD zero mm. induration.” Induration more than 5 mm. in diameter will be regarded as a positive test, while that of 5 mm. or less will be regarded as negative.

(4) Potency.—All persons administering tuberculin tests are cautioned that the “Single Test” prescribed for this program is five times as potent as the usual “First Test” tuberculin test, and one-fiftieth as potent as the “Second Test” tuberculin test.

15–70
Change 7
Chapter 16

HEALTH RECORD

Sections

I. General
II. Opening the Health Record
III. Termination and Closure of the Health Record
IV. Custody of the Health Record
V. DD Form 722, Health Record Jacket, and DD Form 722-1, Dental Folder
VI. NAVMED 10, Sick Call Treatment Record
VII. Standard Form 88, Report of Medical Examination
VIII. Standard Form 89, Report of Medical History
IX. Standard Form 600, Chronological Record of Medical Care
X. Standard Form 601, Immunization Record
XI. Standard Form 602, Syphilis Record
XII. Standard Form 603, Dental
XIII. NAVMED 1406, Abstract of Service and Medical History
XIV. NAVMED 1346, Special Duty Medical Abstract
XV. DD Form 1141, Record of Exposure to Ionizing Radiation
XVI. Adjunct Health Record Forms and Reports
XVII. DD Form 689, Individual Sick Slip, and Cross Medical Service Notification
XVIII. Illustrations of Component Forms of the Health Record

Section I. GENERAL

16-1. Purpose of Health Record

(1) The purpose of the Health Record is to provide an individual chronological record of medical and dental examinations, evaluations, and treatment afforded members of the naval service. The record has significant medicolegal value to the member concerned, his beneficiaries, and the Government. Accuracy is of the utmost importance in the recording of all entries.

16-2. Contents of Health Record

(1) Each member's Health Record shall consist of the DD 722, Health Record Jacket, with the following dental records on the left side of the jacket, and with the following medical records on the right side arranged in top-to-bottom sequence:

(a) Left Side, Dental—

DD Form 722-1 Dental Folder, containing the
Standard Form 603 Dental

(b) Right Side, Medical—

NAVMED 10 Sick Call Treatment Record
Standard Form 88 Report of Medical Examination
Standard Form 89 Report of Medical History
Standard Form 600 Chronological Record of Medical Care

*Standard Form 502 Narrative Summary
*Standard Form 513 Consultation Sheet
*NAVMED M Report of Board of Medical Survey

*Letter Report NAVMED 1406

Standard Form 601 Immunization Record
†NAVMED 1346 Special Duty Medical Abstract
†Standard Form 602 Syphilis Record
†DD Form 1141 Record of Exposure to Ionizing Radiation

*If included as authorized by section XVI.
†When required.

16-1

Change 9
16-2. Officers shall consist of 16-6. Officers shall be forwarded to the district headquarters of Corps initial place of active duty.

16-3. Verification of Health Record

(1) When practicable, verification of the Health Record shall be conducted in conjunction with that of the Service Record and Pay Record on 1 September of each year. Otherwise, verification should be accomplished upon reporting, at the time of physical

16-4. Release of Information From Health Record

(1) The policy relative to release of information from Health Records is contained in chapter 23.

Section II. OPENING THE HEALTH RECORD

General

16-5. General

(1) A Health Record shall be opened whenever an individual becomes a member of the naval service, or in the event the original record has been lost or destroyed. All applicable spaces on each of the component forms designated for personal identification data shall be completed. Official abbreviations of rank or rating shall be used. The file numbers of officers shall be followed by the designator code or MOS, as appropriate. The file or service number of female members shall be followed by a capital W.

(2) When the initial Health Record is opened it shall consist of (a) DD 722-1 (Dental Folder) containing the original SF 693, and (b) DD 722 (Health Record Jacket) containing component forms assembled in top-to-bottom sequence as follows: NAVMED 10, SF 88, SF 99, SF 600, NAVMED 1406, and SF 601.

16-6. Officers

(1) A Health Record for individuals appointed to commissioned or warrant rank from civil life shall be opened at the time of acceptance of appointment at the Navy recruiting station or activity designated by either the Chief of Naval Personnel or the Commandant of the Marine Corps to deliver the appointment.

(2) The Health Record shall be forwarded to the initial place of active duty. If the member is appointed and retained on inactive duty, the record shall be forwarded to the district headquarters of the area commandant or the Director of the Marine Corps Reserve and Recruitment District in which the member will actually reside.

(3) When a midshipman or enlisted member is appointed to commissioned or warrant rank, the examination, and upon detachment. Each record shall be carefully reviewed, and any errors or discrepancies noted shall be corrected. Special attention shall be given to insure the accuracy of the name, service or file number, designator or military occupational specialty, date and place of birth, blood type, Rh factor, and recording of any newly acquired marks or scars. A signed entry to the effect that the verification has been accomplished shall be recorded in the designated space on the left inner surface of the Health Record Jacket.

16-7. Naval Academy Midshipmen, Officer Candidates, and Student Officers

16-8. Enlisted Members

(1) Health Records of civilian candidates selected for appointment to the Naval Academy shall be prepared at the Naval Academy by the Permanent Board of Medical Examiners at the time of appointment.

(2) Health Records for civilian applicants selected for an officer candidate program shall be opened upon enrollment in the particular program. The Health Record shall be opened in accordance with instructions contained in article 16-5, the U.S. Navy Recruiting Service Manual, and U.S. Naval Reserve Recruiting Instructions.

(3) The existing Health Record shall be continued in use when Navy and Marine Corps members are (a) assigned to the Naval Preparatory School, (b) appointed to the Naval Academy, or (c) enrolled in an officer candidate program. Entries shall be made by the activity having custody of the record to indicate the change in the member’s status.

16-8. Enlisted Members

(1) The Health Record shall be opened by the activity executing the enlistment contract upon original enlistment in the naval service.
(a) The original SF 88 and SF 89 with all carbon copies shall be forwarded with the Health Record to the appropriate naval training center or Marine Corps recruit depot. Upon completion of recruit training the originals of these forms together with a copy of SF 603 shall be forwarded to the Bureau. The original SF 603 and a copy of the SF 88 and 89 shall be retained and incorporated in the Health Record (see art. 15-82(7)).

(b) The Health Record of persons who are enlisted or reenlisted in a Reserve component and retained on inactive duty shall be forwarded to the appropriate naval or Marine Corps district headquarters of the area in which the member will actually reside. However, when such enlistment is for assignment to a pay unit of the Naval or Marine Corps Reserve, the Health Record shall be forwarded to the unit to which assigned. The Health Record of each member of the Reserve component shall be verified at the initial active duty station upon reporting for active duty.

(c) If an individual is appointed, enlisted, or reenlisted with disqualifying physical defects which have been waived by the Chief of Naval Personnel or the Commandant of the Marine Corps, extreme care must be taken to insure that a description of each defect with authority for waiver is recorded on the SF 88 and SF 600.

Section III. TERMINATION AND CLOSURE OF THE HEALTH RECORD

16-9. General Instructions

(1) Termination.—The Health Record shall be terminated upon separation of a member from the naval service; that is, upon discharge, death, resignation, or upon the disenrollment of a midshipman or officer candidate (for exception, see art. 16-16(1)).

(2) Closure.—The Health Record shall be closed when a member is (a) released to inactive duty, (b) retired, (c) transferred to the Fleet Reserve and released to inactive duty, (d) declared missing or missing in action, or (e) declared a deserter.

(3) Entries.—Termination and closing entries shall be appropriately recorded on SF 600 and NAVMED 1406. The entries shall include the (a) date, (b) title of servicing activity, (c) résumé of fact and explanatory circumstances as may be indicated, (d) authority, and (e) applicable notation “Health Record Closed” or “Health Record Terminated.”

(4) Disposition.—Except as otherwise provided in the following articles, a terminated record, or designated contents of a closed record, shall be forwarded to the Bureau within 5 days after the official closing or termination date. The DD 722 (Health Record Jacket) and DD 722-1 (Dental Folder) need not be forwarded to the Bureau (see art. 16-14(3)). All forms shall be securely stapled together with the current SF 88 uppermost. Prior to forwarding, each of the component forms shall be checked for accuracy, completeness of full name, rank or rate, and service or file number.

16-10. Disappearance, Missing, or Missing in Action

(1) Whenever a member disappears and the available information is insufficient to warrant an administrative determination of death, a summary of the relevant circumstances shall be entered on the SF 600. The entry shall include circumstances pertaining to the presumed disappearance of the individual, as supported by the available evidence; i.e., missing or missing in action. The record shall then be closed and forwarded to the Bureau.

16-11. Desertion

(1) When a member is officially declared a deserter, an explanatory entry of this fact shall be recorded on the SF 600 and NAVMED 1406. The record shall then be closed and forwarded to the Bureau, except for a declared deserter at an extracontinental command where the record may be retained for a period of 2 months from the date on which the unauthorized absence commenced.

(2) A deserter shall be physically examined at the first activity assuming jurisdiction of the member following his surrender or apprehension. A statement shall be prepared by the medical examiner setting forth the purpose and findings of the examination. A specific opinion about the member’s physical fitness for confinement, and ability to perform active duty at sea, on foreign service, or in the field, as appropriate, shall be included in each case. The statement shall be recorded on SF 600, for inclusion in the member’s Health Record.

Change 9

16-12. Discharge, Resignation, and Death

(1) The Health Record shall be terminated and forwarded to the Bureau upon discharge, resignation, or death. However, upon discharge of enlisted members for purposes of immediate reenlistment, only NAVMED 10 and Standard Forms 88, 89, and 600 (or other forms containing chronological record of medical care—sec. XVI) accrued during the member's former enlistment shall be forwarded to the Bureau together with the original Standard Form 88 completed at the time of discharge and reenlistment. The remainder of the component forms shall be retained in the new Health Record.

16-13. Discharge of Member Convicted by Civil Authorities

(1) When discharge of a member convicted by civilian authorities is directed by the Chief of Naval Personnel or the Commandant of the Marine Corps, arrangements for the physical examination and report thereof shall be made by the commanding officer or the area district or river command in which the member is confined. In the interest of precluding the inaccuracy of unnecessary travel by the examiner with attendant expense and loss of time from his regular duties, the physical examination may be conducted and reported by any of the following: (a) Medical officer of the Armed Forces or other Federal Government agency, (b) penal institution physician, or (c) in the absence of the services of the foregoing listed physicians, a certificate signed by the official in charge of the penitentiary reflecting an opinion about the present state of health of the person to be discharged will ordinarily suffice. The original SF 88, or the statement received from the prison official, shall be forwarded to the Bureau with the terminated Health Record.

16-14. Release to Inactive Duty

(1) The Health Record shall be closed: (a) Whenever members of the Reserve components are released from active duty, (b) upon transfer to Naval or Marine Corps Reserve and release to inactive duty of Regular Navy and Marine Corps personnel, and (c) upon transfer to the Fleet Reserve and release to inactive duty.

(2) All forms NAVMED 10; SF 88, 89, 603, and 600 (and other forms containing a chronological record of medical care—sec. XVI); and SP 602 and DD 1141 (when included as a component part of the record) shall be appended to the original SF 88 completed at the time of release to inactive duty, and forwarded to the Bureau.

(3) The remainder of the Health Record, including the DD 722 and 722-1, shall be forwarded to the commandant of the naval district or headquarters of the Marine Corps reserve and recruitment district in which the member will actually reside after release to inactive duty. In the case of Naval Reserve members who reside within the geographical limits of the Potomac and Severn River Naval Commands, the record shall be forwarded to the Commandant of the Fifth Naval District. (The DD 722 of Fleet Reserve members shall be prominently marked "FLEET RESERVE" at the lip of the jacket.)

16-15. Retirement

(1) When, for any reason, a member of the naval service is placed on the retired list, the Health Record shall be closed and forwarded to the Bureau. A record in the custody of the director of a Marine Corps reserve and recruitment district shall be forwarded via the district medical officer of the cognizant naval district or river command for preparation of closing entries and transmission to the Bureau. Upon release to inactive duty of a retired member performing active duty, the Health Record shall be closed and forwarded to the Bureau. Closing entries on the SF 88 and NAVMED 1406 should indicate that the member is being released to inactive duty on the retired list.

16-16. Disenrollment of Midshipmen or Naval Reserve Officers Training Corps Members

(1) When for any reason a midshipman's connection with the naval service is terminated, his Health Record shall be terminated and forwarded to the Bureau. This includes midshipmen who graduate from the Naval Academy but do not receive commissions. In the case of midshipmen who retain a status in the naval service after disenrollment from the Naval Academy, the Health Record shall be forwarded to the member's prospective commanding officer.

(2) When for any reason an Naorc member's connection with the naval service is terminated, his Health Record shall be forwarded by the commanding officer of the member's Naorc Unit to the area district medical officer for termination and transmission to the Bureau. In the case of mem-

16-4

Change 9
bers of the Nmoc who retain a status in the naval service after disenrollment, the record shall be forwarded to the members' prospective commanding officer.

16-17. Supernumeraries

(1) When a patient in a naval hospital is separated from the naval service, but subsequently retained in the hospital for further treatment and hospitalization, the Health Record shall be terminated on the effective date of the separation and forwarded to the Bureau. In such cases a new Health Record shall not be prepared. However, the medical history shall be continued on SF 800, and forwarded to the Bureau upon disposition of the former member from the hospital.

(2) The original copy of a clinical summary prepared incident to the hospitalization of a supernumerary naval patient (discharged and retained, retired inactive, and humanitarian) shall be forwarded to the Bureau upon termination of hospitalization. All forms, in each case, shall show the individual's birthplace in addition to other personal identification data required in the form.

(3) When a member of the Fleet Reserve, not on active duty, is hospitalized at a naval hospital, the Health Record (if required) shall be requested from either the commandant of the cognizant naval district or the director of the Marine Corps reserve and recruitment district. The recording of clinical data in the Health Record shall be accomplished in the same manner as for a member on active duty.

Upon discharge from the hospital a copy of the clinical summary shall be inserted in the Health Record, when available; otherwise a copy of the clinical summary shall be forwarded to the cognizant district headquarters for insertion in the Health Record. The original clinical summary shall be forwarded to the Bureau.

Section IV. CUSTODY OF THE HEALTH RECORD

Responsibility for Custody
Cross-Servicing Health Records
Transfers to Ships or Stations
Hospitalization at Naval Medical Facilities
Hospitalisation and Transfer to Federal Medical Facilities Other Than Naval
Emergency Hospitalization and Direct Admission at Federal Medical Facilities Other Than Armed Forces
Hospitalization at Non-Federal Medical Facilities
Admission to a Hospital of a Foreign Nation
Reserve Members Not on Active Duty
Unidentified, Lost, Damaged, or Destroyed Health Records

16-18. Responsibility for Custody

(1) The Health Record shall be retained in the custody of the medical officer of the ship or station to which the member is attached. When the member is attached to a ship or station having a dental facility, the DD 722-1 containing the SF 603 shall be placed in the custody of the dental officer. On ships or stations having no medical officer, the Health Records may be placed in the custody of the Medical Department representative at the discretion of the commanding officer. Where Medical Department personnel are not assigned, the commanding officer may assign custody of the Health Record to other local representatives of the Medical Department who generally furnish medical support.

(2) Health Records shall be subject to inspection at any time by the commanding officer, his superiors in the chain of command, the fleet medical officer, or other duly authorized medical inspectors. Otherwise, the Health Record is for official use only and adequate security and custodial care are required.

(3) When a Health Record is received, it shall be carefully examined to determine that all errors are corrected and that no omissions exist. Appropriate corrective action shall be taken if additional data is required.

(4) A Health Record Receipt, File Charge-Out and Disposition Record, NAVMED 1345, shall be maintained for each Health Record by Medical Department personnel having custody of Health Records.

(5) All signatures in the Health Record shall be signed in blue-black or black ink. The name, rank, or rating of Medical Department officers and other authorized Medical Department personnel making entries in the Health Record shall be typed, printed, or stamped under their signature. Stamped facsimile signatures shall not be used on any medical or dental forms of the Health Record unless so authorized by the Bureau. In signing, the individual assumes responsibility for the correctness of the entry over his signature.

(6) The senior medical officer of the ship or station shall approve or enter reason for disapproval of all entries made in the forms (except SF 603) of the Health Records in his custody.

(7) If an erroneous entry is made in a Health Record, it shall not be stricken out. An additional article may be placed to correct the error. Any additional article may be stricken out and may not be entered in any other Health Record.

16-5 Change 9
entry shall be made showing wherein and to what extent the original entry is erroneous.

(8) Each medical officer or Medical Department representative is responsible for the completeness of any required Health Record entries while the record remains in his custody.

16–19. Cross-Servicing Health Records

(1) Policy.—Both the Army and the Air Force have Health Records for their personnel. In general, their procedures for maintaining and transferring the records are similar to those of the Navy. Full cross-servicing of Health Records is intended. However, when Army, Navy, and Air Force procedures differ, Navy custodians of Health Records shall comply with Navy Instructions. Similarly, Army and Air Force custodians will follow Army and Air Force procedures.

(2) Procedure When Army and Air Force Personnel Are Treated at Navy Facilities.—

(a) When Army and Air Force personnel are attached to Navy facilities for primary medical care (sick call) or dental care, the Navy medical facility will assume custody of their Health Records when appropriate.

(b) When Army and Air Force personnel are treated in naval hospitals, commanding officers shall request that the patients' Health Records be forwarded whenever they are needed in connection with treatment.

(c) When Army and Air Force personnel are treated in Navy facilities, and their Health Records are not available, commanding officers shall forward the documents ordinarily included in Navy Health Records to the appropriate commanding officers for insertion in the Health Records.

(3) Procedure When Navy and Marine Corps Personnel Are Treated at Army and Air Force Facilities.—

(a) Commanding officers shall forward Navy Health Records to Army and Air Force medical officers concerned when (1) members of the naval service are attached for primary medical or dental care to Army or Air Force facilities, or (2) the records are required in connection with treatment.

(b) Health Record documents received for Navy personnel from Army and Air Force facilities shall be inserted in Navy Health Records.

16–20. Transfers to Ships or Stations

(1) It is not intended to prescribe specific regulations applicable to all activities for a standard filing sequence of component forms in the Health Record during custody; however, when a record is transferred, the forms shall be chronologically assembled as set forth in article 16–2(1).

(2) When a member is transferred, the medical officer or Medical Department representative shall ascertain that all necessary entries have been recorded in the Health Record, including (a) the date of detachment on NAVMED 1406 (see art. 16–56 (3)), and (b) completion of any required physical examinations (see arts. 15–50 or 15–51). When the Dental Folder and NAVMED 10 (or other component forms) have been maintained on file elsewhere than in the Health Record, they shall be included, prior to transfer.

(3) When an officer is ordered to active duty or transferred to another ship or station, he may be allowed to deliver his Health Record in person; otherwise, the record shall be forwarded via official channels. When an enlisted member is transferred, the Health Record shall be forwarded with the service record and pay record to the receiving command, except as otherwise noted below in subarticles (5) and (6).

(4) Unless otherwise directed, an officer ordered to the Navy Department for duty, and personally carrying his Health Record, shall deliver it to the Personnel Officer, U.S. Naval Dispensary, Navy Department, Washington, D.C.

(5) When a member is ordered to participate in a foreign service expedition and the possibility of loss or seizure of the record makes it inadvisable that the record accompany him, it shall be retained in the staging area. Interim entries shall then be recorded on an SP 600 or 603, for subsequent insertion in the Health Record.

(6) If a member is ordered to independent duty where there is no Medical Department representative, or if the duty destination is not obvious, the Health Record shall be forwarded to the Bureau with an explanatory letter.

(7) When practicable, the Health Record shall accompany any member conveyed by the Military Sea Transportation Service.

(8) In cases of unauthorized absence prior to departure of a ship or other unit from the continental limits of the U.S. and the Canal Zone or on an extended cruise, the Health Record of the absentee shall be forwarded to the nearest receiving station or naval activity. A copy of the letter of transmittal shall be sent to the Bureau.

(9) Upon receipt of notification concerning the apprehension or voluntary return to naval custody of an absentee who because of circumstances cannot be returned to his unit, immediately transfer the Health Record to the intermediate activity or advise about the location of the record.

(10) When a patient is received aboard ship for the purpose of transportation, the medical officer or the Medical Department representative shall maintain the Health Record. It is essential that the record of the chain of events remain unbroken; therefore, a patient received from transfer must be taken up as "From Transfer" with the same diagnosis under which transferred. Any subsequent entries or change of diagnosis shall be recorded in the prescribed manner.
16–21. Hospitalization at Naval Medical Facilities

(1) When a patient is transferred to a naval medical facility the Health Record shall be delivered with the patient.

(2) In event of emergency, if a member on active duty is admitted directly to a naval medical facility while away from his duty station, the Health Record shall be forwarded as soon as practicable to the admitting facility.

(3) Upon completion of treatment the Health Record shall be returned to the member's duty station. However, the member shall not be retained after completion of treatment solely for the completion of any pending entries or adjunct reports. In such instance appropriate information will be included on the transfer authorization to indicate that the member's Health Record or related reports will be furnished as soon as practicable.

(4) When any member is discharged from treatment at a naval hospital and is directed to proceed home and await final action on the recommended findings of a physical evaluation board, an entry to this effect shall be recorded in the Health Record. Such entry shall indicate the address of the member's actual residence. The senior medical member of the physical evaluation board shall enter the board's findings in the Health Record, SF 600, after which it shall be forwarded by the hospital to the command exercising administrative control of the individual.

16–22. Hospitalization and Transfer to Federal Medical Facilities Other Than Naval

(1) Upon transfer of a Navy or Marine Corps patient to any Federal medical facility to which a naval medical unit or Navy liaison officer is attached, the Health Record shall accompany the patient, or be forwarded as soon as practicable.

(2) Upon transfer of a Navy or Marine Corps patient to an Armed Forces or a Federal medical facility to which no naval medical unit or Navy liaison officer is attached, the following shall apply:

(a) Army or Air Force Facilities.—The Health Record shall accompany the patient, or be forwarded as soon as practicable, for direct cross-servicing (see art. 16–19). The Health Record is returned to the member's duty station upon disposition of the case.

(b) Veterans' Administration Hospitals.—The Health Record of a patient transferred to a VA hospital shall be forwarded to the commandant of the naval district in which the hospital is located or to the activity designated by the Commandant of the Marine Corps for Marine Corps personnel. The activity receiving the Health Record shall take up the record and continue maintenance thereof until disposition of the patient is accomplished. Prior to forwarding the record an entry shall be recorded on SF 600 to indicate the name and location of the VA hospital to which the patient has been transferred. If the member has appeared before a physical evaluation board, the recommended findings shall be recorded on the SF 600. The VA hospital shall be furnished with a duplicate or photocopy of the current SF 600 for inclusion in the member's Clinical Record at that activity. Upon completion of treatment or separation from the naval service, a clinical summary will ordinarily be forwarded by the VA hospital to the activity maintaining the Health Record. However, if it is apparent that the period of hospitalization will not exceed 7 days and the unit to which the member is attached is not scheduled to depart the area, the Health Record shall be retained by the activity having custody. (See art. 16–19.)

(3) Upon return of a patient to duty where the Health Record is retained by the custodial activity, the clinical records received from the medical facility shall be incorporated in the Health Record or a summary regarding hospitalization shall be requested and entered in accordance with the instructions set forth in article 16–47.

16–23. Emergency Hospitalization and Direct Admission at Federal Medical Facilities Other Than Armed Forces

(1) When it is expected that hospitalization will not exceed 7 days and the unit to which the member is attached is not scheduled to depart the area, the Health Record shall be forwarded by the cognizant activity to the command exercising administrative control of the individual.

(2) When the parent command is not expected to remain in the area during the period of hospitalization, or when it is anticipated that the hospitalization will exceed 7 days, the Health Record shall be forwarded to the commandant of the naval district in which the hospital is located or to the activity designated by the Commandant of the Marine Corps for Marine Corps patients. The activity receiving the Health Record shall take up the case and continue it until disposition is accomplished.

(3) Upon return of a patient to duty where the Health Record is retained by the custodial activity, the clinical records received from the medical facility shall be incorporated in the Health Record or a summary regarding hospitalization shall be requested and entered in accordance with the instructions set forth in article 16–47.

16–24. Hospitalization at Non-Federal Medical Facilities

(1) When a member is admitted directly to a non-Federal medical facility for treatment involving brief periods of hospitalization, the Health Record shall be retained by the activity having custody. However, if it is apparent that the period of hospitalization will exceed 48 hours or the cognizant activity is a vessel or unit scheduled for deployment, the Health Record shall be transmitted to the commandant of the area in which that hospital is located or to the activity designated by the Commandant of the Marine Corps for a Marine Corps patient. The activity receiving the Health Record
shall take up the case and continue it until disposition is accomplished. Upon return of the patient to duty in those cases in which the Health Record was retained by the parent activity, the procedure outlined in article 16-47, pertaining to recording of information in the record, is applicable.

16–25. Admission to a Hospital of a Foreign Nation

(1) When a member is hospitalized at a medical facility of a foreign nation, an entry of this fact shall be made in the Health Record; however, this entry shall not be designated as an official transfer to that hospital. The Health Record shall be retained on board and continued until the patient either returns to duty or is transferred to another U.S. Navy vessel or U.S. military activity. Upon departure of the vessel from the port, the member shall be transferred in a patient status to any other U.S. naval vessel remaining in the port. The medical department of the vessel to which the patient is transferred shall assume responsibility for custody of the case and continue the Health Record. If, upon departure, there is no other U.S. naval vessel remaining in the port, the cognizant medical department official shall forward the Health Record via the commanding officer to the nearest U.S. embassy or consul. The letter of transmittal shall contain information and instructions that the Health Record must accompany the patient in the event of transfer or be forwarded to the commanding officer of the next U.S. naval vessel which arrives in port. Upon arrival of a U.S. naval vessel in such a foreign port, the ship’s medical officer shall, if practicable, assume medical cognizance of the patient and continue the Health Record.

16–26. Reserve Members Not on Active Duty

(1) Health Records of members of the Naval Reserve and Fleet Reserve on inactive duty shall be maintained by the commandants of naval districts. In the case of members residing or traveling for periods in excess of 6 months in areas outside a naval district, other than an area listed below, records will be maintained by the Commandant, Ninth Naval District. Records of reservists traveling or residing in an area listed below for a period in excess of 6 months will be transferred for maintenance and custody to the appropriate command shown:

<table>
<thead>
<tr>
<th>Reside or travel in</th>
<th>Records maintained by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>Commander, U.S. Naval Forces, Japan</td>
</tr>
<tr>
<td>Korea</td>
<td>Commander, U.S. Naval Forces, Japan</td>
</tr>
<tr>
<td>Ryukyu</td>
<td>Commander, U.S. Naval Forces, Philippines</td>
</tr>
<tr>
<td>Guam</td>
<td>Commander in Chief, U.S. Naval Forces, Europe</td>
</tr>
<tr>
<td>Caroline Islands</td>
<td>Commander, U.S. Naval Forces, Marianas</td>
</tr>
<tr>
<td>All other Asiatic countries.</td>
<td></td>
</tr>
<tr>
<td>Eastern Atlantic and Mediterranean Area.</td>
<td></td>
</tr>
</tbody>
</table>

Records of members assigned to Selected Reserve units of the Naval Reserve shall be maintained by the activity to which attached.

(2) The Health Records of members of the U.S. Marine Corps Reserve or Fleet Marine Corps Reserve on inactive duty—other than of members of the Ready Reserve assigned to pay units whose records shall be maintained by their units—shall be maintained by the director of the cognizant Marine Corps reserve and recruitment district in which the members actually reside. Health Records of Marine Corps Reserve personnel who reside outside the continental United States or its Territorial possessions, and not within a designated Marine Corps reserve district, shall be forwarded to the Fifth Marine Corps Reserve and Recruitment District, Washington, D.C.

(3) Health Records of all retired personnel not on active duty are in the files of the Bureau.

16–27. Unidentified, Lost, Damaged, or Destroyed Health Records

(1) If a Health Record is lost or destroyed, the cognizant custodian shall notify the Bureau, by speedletter, giving the name in full, file or service number, rank or rating, and date and place of birth, together with a summary of the circumstances. A replacement Health Record shall be opened. The designation REPLACEMENT shall be prominently entered on the jacket and all forms replaced. A synopsis of the circumstances requiring a replacement and date accomplished shall be set forth as a note on the replacement SF 600. If the missing record is subsequently recovered the additional information or entries contained in the replacement record shall be inserted in the original record. Since the Bureau does not maintain a copy of current Health Records, it is unable to furnish replacements for original records either lost or destroyed.

(2) A Health Record or any portion thereof shall be duplicated whenever it approaches a state of illegibility or deterioration which may possibly endanger its future use or value as a permanent record. The duplicate Health Record or duplicate portion thereof shall be a like reproduction of the original insofar as possible. Particular attention to detail shall be employed in the actual transcription. When an entire Health Record is duplicated the designation DUPLICATE shall be prominently entered on the jacket and all forms duplicated. When only component forms are duplicated the new forms shall be individually identified as DUPLICATE. The circumstances necessitating the duplication and date accomplished shall be set forth as a note on the SF 600. The original Health Record, or any portion thereof, which is replaced by a duplicate shall be forwarded to the Bureau as an enclosure to an explanatory letter of transmittal. (For exception, see art. 16–28.)
(3) In the event a Health Record or component form thereof is held for a member of the armed services whose present duty station, status, or location cannot be determined, it shall be forwarded to the Bureau with an explanatory letter of transmittal.

Section V. DD FORM 722, HEALTH RECORD JACKET, AND DD FORM 722-1, DENTAL FOLDER

16-28. General

(1) A new Health Record Jacket (DD 722) or Dental Folder (DD 722-1), in addition to being prepared upon the entry or reentry of a member into the naval service, shall also be prepared when either the existent jacket or folder has been damaged or because of deterioration is approaching the point of illegibility. In the latter instance, the old jacket or folder shall be destroyed following replacement.

16-29. Preparation

(1) The member's full name, completely recorded in capitals, shall be typewritten on the lip of each form, reading horizontally from left to right, with surname first followed by the first and middle names, the service number for enlisted personnel, the file and designator numbers for officer personnel, the date of birth (recorded in order of day, month, and year), the State or nation of birth, and the blood type and Rh factor (recorded by letter designation). In the event there is no middle name, an entry as "(n)" shall not be recorded. Such designations as "JR" or "II" shall follow the middle name or, in the absence of such, the first name. Examples of a properly prepared jacket lip are as follows—reading horizontally from left to right:

JONES, HARRY WILLIAM, JR 212 40 49 3 AUG 1925 MASS O Rh-NEG
FORD, FRANK 138076/2100 22 SEP 1930 CANADA A Rh-NEG
SMITH, MARY JANE 989 40 26W 9 MAY 1938 TEXAS B Rh-POS

16-30. General

(1) The purpose of the NAVMED 10, Sick Call Treatment Record, is to provide a complete chronological record of all outpatient medical treatment and associated examinations received by a member at sick call. The record shall include conditions or complaints presented by the member regardless of whether or not treatment was administered.

16-31. Preparation and Entries

(1) A NAVMED 10 shall be prepared simultaneously with opening of the Health Record. Entries in the personal-identification-data section at the top of the form, whenever possible, shall be typewritten; if ink entries are necessary, they shall be printed.

(2) Sufficient space shall be reserved at the top of each side of the form to record information relative to the member's sensitivity to any drugs or chemicals. When recording this information the entry shall be made in bold type or printed letters and underlined in red ink.

(b) Treatment Facility.—The name of the treating facility shall be entered in the upper portion of the same line in which the complaint is recorded.

16-32. Change 9
Diagnostic Nomenclature of Diseases and Injuries (NAVMED P-1294).

(c) Signature and Rank/Rate of Person Administering Treatment.—These items shall be recorded on the line below each entry on the right side of the form.

(d) Miscellaneous.—Abbreviations and symbols of general usage in medicine as well as any official abbreviations authorized in military records may be used. Legibility of ink entries is essential. Both sides of each sheet shall be used.

16-32. Line-of-Duty and Conduct Entries

(1) An entry regarding the origin of the disease or injury with respect to conduct and line-of-duty determination shall be made only in those instances when, in the opinion of the responsible medical officer, there is a possibility of permanent disability or future claim upon the Government.

16-33. Maintenance of File

(1) The NAVMED 10 shall be maintained in an alphabetical file containing only the forms currently in use. Completed forms shall be retained in the Health Record in the respective sequence, with the most recent one on top. Generally, the current NAVMED 10 will be located in the outpatient-treatment-records section at the medical facility to which members report for outpatient care.

16-34. Transfer Action

(1) The current NAVMED 10 shall be fastened as the top sheet in the Health Record upon transfer of a member.

16-35. Unavailability of Health Record

(1) Whenever outpatient treatment is furnished to a member of the Armed Forces whose Health Record is not available, the information shall be reported on a DD 689, Individual Sick Slip. (Instructions concerning use and preparation of this form are contained in section XVII.)

(2) When a DD 689 is received at the treatment facility that provides medical care for the member, the facts and treatment date(s) shall be transcribed to the member's NAVMED 10. This entry should include name and status of the individual who administered the treatment, and signature and rank or rate of the person responsible for the transcription.

16-36. Disposition

(1) The NAVMED 10's shall be forwarded to the Bureau together with other designated forms upon closure or termination of the Health Record (art. 16-9).

Section VII. STANDARD FORM 88, REPORT OF MEDICAL EXAMINATION

General
Preparation
Identifying Body Marks
Disposition

16-37. General

(1) SP 88, Report of Medical Examination, is to be prepared whenever a complete report of physical examination is required by the Bureau for Health Record purposes. When not otherwise indicated each physical examination shall be recorded on SP 88.

16-38. Preparation

(1) Specific requirements for submittal and disposition of the forms in the major categories are tabulated in article 15-82(7).

(2) Details of Entries.—

(a) Item 1, Last Name—First Name—Middle Name.—The surname shall be recorded in capitals. The Christian name(s) shall be recorded in full without abbreviation. If the individual's first or middle name consists only of an initial, each initial shall be enclosed with quotation marks. Designations such as "JR" or "IT" shall appear after the middle name or initial. In the absence of a middle name or initial, and if "JR" or "IT" is applicable, the "JR" or "IT" shall be entered in the space.

(b) Item 2, Grade and Component or Position.—Use official abbreviation of current rank or rate, branch of service, class and status; i.e., regular, reserve, or retired and if active or inactive.

(c) Item 3, Identification No.—Enter the official home address as reported in the current service record or enlistment contract.

(d) Item 4, Home Address.—Enter the official home address as reported in the current service record or enlistment contract.

(e) Item 5, Purpose of Examination.—Use phraseology similar to that contained in the second column of article 15-82(7). Avoid use of nonstandard abbreviations. When necessary continue under "Notes."

(f) Item 6, Date of Examination.—Actual date of examination is to be written in the format of 5 JAN 59. Abbreviations for months shall consist of the first three letters of the month only.

(g) Item 7, Sex.—Spell out; do not abbreviate.
(h) Item 8, Race.—Entries shall be confined to one of the following five classifications:
(1) Caucasian. (Puerto Rican (White) shall be recorded as Caucasian.)
(2) Negroid. (Puerto Rican (Negro) shall be recorded as Negroid.)
(3) Mongolian. (Chinese, Japanese, Korean, and Eskimo shall be recorded as Mongolian.)
(4) Indian (American).
(5) Malayan. (Filipino, Samoan, Chamorro, and Hawaiian shall be recorded as Malayan.)

(i) Item 9, Total Years Government Service.—In "Military" block enter the time (expressed in years and months) served in any branch of the U.S. military services, to include both active and inactive service; i.e., USAF 3y 3m, USA 3y 3m, USNR & USN 3y 3m. The "Civilian" block shall ordinarily be left blank.

(j) Item 10, Agency.—Leave blank for military personnel.

(k) Item 11, Organization Unit.—List name of ship or station to which examinee is attached.

(l) Item 12, Date of Birth.—Use format of 6 JUN 40.

(m) Item 13, Place of Birth.—Enter city, town, or village; and State. If rural, the name of the county may be used. For foreign born, enter the name of the country as known at the time of the individual's birth.

(n) Item 14, Name, Relationship, and Address of Next of Kin.—List as reported on the member's current Record of Emergency Data, DD 93-1.

(o) Item 15, Examining Facility or Examiner, and Address.—Record official title and location of the activity or office at which the examination was conducted.

(p) Item 16, Other Information.—Religion shall be shown in this block as "P" for Protestant, "C" for Catholic, or "H" for Hebrew. The specific denomination of any of the religions (i.e., Baptist, Lutheran, Methodist, Presbyterian) although desirable, is not required, unless requested by the individual. The religion of persons belonging to other religious faiths shall be fully recorded. If a person does not desire to state his religious preference the space will be left blank. The word "None" is to be used only when the person claims no religious convictions.

(q) Item 17, Rating or Specialty.—Use only for designated aviation personnel and for qualified submarine and diving personnel. For aviation personnel enter type (for example, NA for Naval Aviator, and NAO(N) for Naval Aviation Observer (Navigator)). Following type, enter date of designation as naval aviator or class 2 aviation personnel. In block "Time in Capacity" enter total flight hours and hours flying time in last 6 months. For submarine and diving personnel, record respective specialty for which qualified; i.e., "Qualified for Submarine Duty orQualified Diver 1st Class."

(r) Items 18-43 (Inclusive), Clinical Evaluation.—Check each item in appropriate column. Enter "NE" for any item not evaluated. The medical examiner shall describe each abnormality in detail in the space designated "Notes" on the face of the form; if additional space is required, continue in item 73. Marks and scars indicated in block 39 shall also be shown under "Notes" using descriptive designations as outlined in article 16-39.

(s) Item 44, Dental.—If a dental officer is not available, the examinee's dental qualifications, other than of candidates of the U.S. Naval Academy, shall be determined by the medical officer and entered under "Remarks" of item 44 with the statement, "Examination not performed by dental officer."

(t) Items 45-50, Laboratory Findings.—Report findings of laboratory tests or other examinations required incident to a physical examination, insert in item 47 the date of any serological examinations of the blood, and in 49 enter Rh factor and record blood group by use of international classification letters O, A, B, or AB. In the absence of proper facilities to accomplish any of the foregoing examinations or any other portion of the physical examination, a notation to this effect shall be entered in block 73 of the form, followed by the stipulation that the examination(s) shall be completed at the member's first active/training duty station where adequate medical facilities are available. The result of any special tests conducted incident to the physical examination shall be continued in item 73 or on additional sheets if necessary. Specify any tests which are listed but not required and those which are required but not accomplished.

(u) Item 51, Height.—Record in inches, to the nearest one-half inch, except for aviation physicals on which height must be accurately recorded.

(v) Item 52, Weight.—Record in numerals to the nearest pound.

(w) Item 53, Color Hair.—The color of the hair shall be entered as flaxen, sandy (yellow-red), auburn (red-brown), brown (light, medium, or dark), black, gray, etc. Race classification shall not be used in connection with color description.

(x) Item 54, Color Eyes.—In entering color do not use race classification with color description.

(y) Item 55, Build.—Indicate by X in appropriate block.

(z) Item 56, Temperature.—Record degree; use Fahrenheit scale.

(aa) Item 57-72, Physical Evaluation.—To provide uniformity and completeness in the recording of information in these items, reference shall be made to chapter 15 or current directives which prescribe the nature and scope of each physical examination and the application of these items to the particular program and rate, rank, or grade involved.

(bb) Item 73, Notes and Significant or Interval

Change 9
16-38  MANUAL OF THE MEDICAL DEPARTMENT, U. S. NAVY  16-40

History.—Indicate any pertinent medical history; include résumé for any condition which is likely to recur or cause more than minimal loss of time from duty. An accurate and comprehensive history may be of great value in pointing to future diagnosis. Also include any information acquired incident to special referral or consultation. On all aviation posthospitalization physical examinations, give a résumé of hospitalization and include name of hospital, date of admission and discharge, diagnosis, and a brief summary of treatment; also, prognosis if not completely recovered.

Item 74, Summary of Defects and Diagnoses.—All defects and diagnoses found must be recorded and described adequately. The defects shall be listed in the summary in the order of their importance. The irreparable, disqualifying, and permanent defects shall be listed first. All minor defects noted shall be recorded to protect the Government in the event of future claims for disability compensation. When an individual has a disease or other physical condition that, although not disqualifying, requires medical treatment, the nature of the condition and the need for treatment shall be clearly stated.

Item 75, Recommendations.—Indicate any medical or dental recommendations. Specify the particular type of any further medical or dental specialist examination indicated (continue in item 73 or use additional sheets if necessary).

Item 76, Physical Profile.—The (1) physical profile serial and (2) physical category classification shall be assigned and recorded in accordance with the prescribed designations and instructions contained in Army Regulations No. 40-503, Physical Standards and Physical Profiling for Enlistment and Induction. This classification shall be done upon enlistment or induction of male members by the examining medical officer at the station of entry.

Item 77, Examinee’s Qualification.—Regardless of the purpose of the examination, a determination about an examinee’s physical ability to perform active duty at sea, and/or on foreign service, or in the field, as appropriate, and such other information as may be required by current instructions shall be stated.

Item 78, Disqualifying Defects.—Indicate item number only.

Item 79-82, Signature.—The name, rank, branch of military service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign with blue-black or black ink in the right section. Facsimile signature stamps shall not be used. When attachment sheets are used as a supplement or continuation to the report, they shall be serially numbered (both sides); however, only the actual number of attached sheets shall be indicated in the bottom right block of SF 88.

16-39. Identifying Body Marks
(1) The medical examiner shall make a careful inspection of the body, front and rear, on each side of the median line separately, commencing with the scalp and ending at the foot, and record under the “Notes” section of the face of the SF 88 all body marks, tattoos, and scars of value for purposes of identification. If no marks or scars are found, this fact shall be stated.

(2) The sizes of scars, moles, warts, birthmarks, etc., shall be indicated in inches or fractions thereof, except in the case of pinhead moles for which the abbreviation “p.m.” shall be used. Pinhead moles are those presenting a diameter of less than one-eighth of an inch. When recording the location of a tattoo mark, a narrative description of the design shall be included. Tattoo transcriptions of words or initials shall be recorded in capital letters. The size of a tattoo need be described only regarding its general dimension. A statement relative to color or pigment is not required. Amputations and losses of parts of fingers and toes should be noted, showing the number of the particular digit injured and the extent or level of absence.

(3) The following are authorized abbreviations for the descriptions or conditions indicated: amputation, f.—flat, fl.—fleshy, h.—hairy, l.—linear, m.—moles, p.—pitted, p.m.—pinhead mole, r.—raised, s.—scar or smooth, var.—varicose veins or varicocle, va.—vaccination scar, w.—wart. Combinations of the above abbreviations are permissible; such as p.s. f.p.s.—flattened scar ¼ inch long and ⅛ inch wide, r.h.m. f.p.s.—raised hairy mole ⅛ inch in diameter. Abbreviations shall not be used in description of tattoo marks since they are likely to be mistaken as signifying tattooed letters on the individual’s body.

16-40. Disposition
(1) Upon termination or closure of a Health Record all copies of SF 88 contained therein shall be forwarded to the Bureau (art. 16-9).
16-41. General

(1) The purpose of the SF 89, Report of Medical History, is to provide a complete personal medical history report and a source of information supplemental to that reported on the SF 88. Since the Health Record is not prepared until the person enters the service, the SF 89 provides a current, concise, and comprehensive record of a member's personal medical history, prior to entrance into the naval service and any subsequent change in his status.

16-42. Preparation

(1) The personal-information items 1 through 16 of the SF 89 shall be completed (ink, indelible pencil, or typewritten) in accordance with the instructions applicable to corresponding items of the SF 88 (art. 16-38).

Section IX. STANDARD FORM 600, CHRONOLOGICAL RECORD OF MEDICAL CARE

16-44. General

(1) The SF 600, Chronological Record of Medical Care, provides a current, concise, and comprehensive record of a member's military medical history. Properly maintained, the SF 600 should facilitate the evaluation of patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of medical treatment, care, and physical examinations received.

(2) Every assistance shall be afforded to the examinee in order that he may fully and clearly comprehend the terminology appearing in items 17 through 39, thereby enabling him to provide a concise and accurate history.

(3) Item 40 (Summary) shall be prepared and signed by the medical examiner and in no instance shall this item be left blank.

(4) Preparation of carbon copies is authorized subject to the requirement that all copies bear the signature of the examinee and the medical examiner and that complete legibility is maintained.

16-45. Entries Upon Admission to Sick List or Binnacle List

(1) Entries shall be made on SF 600 when an individual is admitted to the sick list or binnacle list.

(a) Daily entries are not required in such cases; however, entries should be made as often as necessary (at least once a week) reporting all essential details concerning the diagnosis, origin, symptoms, course, special examinations, and treatment. If the medical officer considers the condition reported upon to have existed prior to entrance into service, entry on the SF 600 shall show whether, in the opinion of the medical officer, the condition was aggravated by service. Whenever a conflicting opinion is subsequently expressed by the same or another medical officer, the reason for such change shall be fully stated.

(b) The reporting of the circumstances of occurrence of injuries and poisoning shall be made in accordance with current instructions governing

(c) The entries for each case from admission, including method of taking up a patient (A, RA, FT, REV, REM) to disposition (D, T, DD, RAN, or CON). shall be complete with regard to place, dates, diagnosis of all disabilities for which treated, and signature of medical officer or Medical Department representative. For further explanation of the abbreviations for taking up or disposition of a patient, see the current BUMED Instruction in the 6310.5 series.

(2) Upon admission of an active duty patient to the sick list the medical officer or the Medical Department representative shall enter information on SF 600 regarding whether the disease or injury was or was not suffered in line of duty and was or was not due to the patient's own misconduct. (See articles 0971 and 1703 of Navy Regulations, 1948.)

(3) When a person has been reported on the binnacle list for treatment, an entry shall be made on SF 600 showing date, diagnosis, and a résumé of treatment.

16-46. Physical Examination Entries

(1) Information concerning the purpose, result, and any physical defects noted incident to a physical examination which is prescribed in chapter 15 or current Bureau directives, conducted upon members of the naval service, including the Reserve components, shall be recorded on a current SF 600. Similar entries are required for examinations pertaining to qualifications for special duty assignment (aviation, diving, submarine service, etc.) and other prescribed periodic physical, laboratory, X-ray, or special examinations conducted.

(2) Each of the above examinational entries shall bear the signature of the medical examiner(s) and shall also indicate the date of the particular examination, and title of the examining activity.

16-47. Other Entries

(1) When a member of the naval service is injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's Health Record, the medical officer or Medical Department representative having custody of the record shall ascertain the facts in the case and make the necessary entries.

(2) When, for any reason, an enlisted member undergoing treatment at a naval hospital is held in the custody of civil authorities, every effort shall be made to ascertain the length of time he will be held pending disposition of his case. Upon receipt of information that the individual will be retained in the custody of civil authorities for a period in excess of 7 days, he shall be officially transferred to an intermediate naval activity. This activity should be the nearest naval command which has facilities to receive and process personnel discharged from treatment. Complete information regarding the case and the need for further hospitalization shall be entered in the Service Record for naval personnel, and the Service Record Book for Marine Corps personnel. A letter setting forth all the facts in the case shall be forwarded to the Bureau of Naval Personnel or the Commandant of the Marine Corps, as appropriate, and to the intermediate activity to which the transfer is made. The current SF 600 shall be closed as to D (Discharged From Sick List). This procedure prevents charging the health of the Navy with the sick days not actually incurred as a result of service conditions.

(3) Dental treatments shall be recorded on SF 600 as required (article 6-119).

(4) Results of physical and laboratory examinations made on personnel exposed to radiological hazards shall be entered on SF 600 listing any abnormalities and indicating action taken.

(5) When prescription for spectacles is entered on SF 600 additional data concerning frame measurements shall be entered in detail. In case the applicant is found not to be in need of spectacles as a result of an examination, an entry to that effect shall be made and signed by the examiner.

(6) When a patient is transferred and roentgenograms are transferred with him, a notation to that effect shall be entered on SF 600.

(7) Each time a photofluorographic examination of the chest is made the place, date, film number, and report of the interpretation shall be entered on SF 600.

(8) Any hypersensitivity to drugs or chemicals known to exist shall be indicated on a separate SF 600 which is to be retained permanently in the Health Record. The "Page No." entry shall be "Special." This page shall be placed on top of all other SF 600's. The first entry therein shall be "RETAIL PERMANENTLY IN HEALTH RECORD" in typewritten capital letters. Appropriate entries regarding any hypersensitivity should then be made on the same page.

16-48. Disposition

(1) The SF 600 (or related reports containing chronological record of medical care) shall be forwarded to the Bureau upon:

(a) Closure or termination of a Health Record.

(b) Commissioning of a midshipman or an officer candidate.

(c) Integration to regular status.

(d) Completion of annual physical examination in case of all officers or, if exempt from annual physical examination, not later than 31 December of the calendar year in which the exemption oc-
Chap. 16. Health Record

16-48

Section IX. STANDARD FORM 601, IMMUNIZATION RECORD

16-49. General

(1) The purpose of the SF 601, Immunization Record, is to record information which pertains to prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, foods, and allergies; and blood typing, as prescribed in chapter 22, article 15-91, and current directives of the Bureau. The recordings shall be continued on the current record until additional space is required under any single category. In such cases it shall then be removed, forwarded to the Bureau, and a new SF 601 inserted; concurrently, a thorough verification of all immunization entries shall be made and the most recent date of each immunization received by the member shall be transcribed to the replacement form. Where it is shown that any immunization is not current, the required immunization shall be administered and recorded on the new SF 601. Replacement of an existent SF 601 is not required because of change of rank, rating, or status of the member concerned.

16-50. Entries

(1) The name of the medical officer or the name of the Medical Department representative administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or a rubber stamp used. Signatures on SF 601 are not required; however, in the event of their use, care shall be taken to ensure complete legibility.

(2) The medical officer or the Medical Department representative administering the immunizations shall be responsible for the completion of all entries in the appropriate section of SF 601, including required entries on reactions.

(3) Information concerning a determined hypersensitivity to a drug or chemical shall be indicated under "Remarks and Recommendations." Appropriate entries (such as HYPERSENSITIVE TO ASPIRIN, HYPERSENSITIVE TO PROCAINE) shall be typed in capitals. This is in addition to a similar entry required on the NAVMED 10 and the SF 600, which are retained in the Health Record.

16-51. Foreign Travel

(1) Naval and Marine Corps personnel, civilians, and dependents traveling to foreign countries under the cognizance of the Navy Department shall be immunized as indicated in chapter 22 and current directives of the Bureau. The following immunization certificates properly accomplished and authenticated shall be in their possession prior to embarkation:

(a) Naval and Marine Corps personnel—DD Form 737, Department of Defense Immunization Certificate.
(b) Civilians and Dependents—PHS Form 731, International Certificate of Vaccination.

Section XI. STANDARD FORM 602, SYPHILIS RECORD

16-52. General

(1) The SF 602, Syphilis Record, shall be prepared upon the occurrence of a syphilitic infection, including any complication or sequela thereof. This record shall be retained as a permanent component part of the member's Health Record until termination or closure of the Health Record (art. 16-9). The above procedure is applicable regardless of whether or not more than one SF 602 is required during the member's term of service. An entry shall be made covering each course of treatment given and each luetic examination or test conducted.

16-53. Explanation to Patient

(1) The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation, and the repeated performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in section II of SF 602.
16-55. Purpose
(1) The NAVMED 1406, Abstract of Service and Medical History, provides (a) a chronological history of the ships and stations to which a member is assigned for duty and treatment and (b) an abstract of medical history for each admission to the sicklist.

16-56. Entries
(1) **SHIP OR STATION Column.**—Enter the name of the ship or activity to which attached for duty or treatment.
(2) **DIAGNOSIS, DIAGNOSIS NO., AND REMARKS Column.**—Enter the diagnosis title and number each time an individual is admitted to the sicklist.
(3) **DATE Column.**—Indicate in the FROM and TO subcolumns all dates of reporting and detachment for duty, or dates of admission and discharge from the sicklist. Upon transfer for temporary duty, an entry shall be made only if the Health Record is to accompany the individual to the place of temporary duty.

16-57. Disposition
(1) The NAVMED 1406 shall be retained as a permanent component part of the Health Record until termination or closure of the record (art. 16-9). The entry upon closure or termination shall indicate date, title of activity, reason or cause, and authority in each instance.

16-58. General
(1) The purpose of the NAVMED 1346, Special Duty Medical Abstract, is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performance of special duty, such as aviation, submarine, and diving. The object of the special duty examination, and instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performance of a special duty. Therefore, accuracy and content of information are essential in the reporting of information applicable to these categories.

16-59. Entries
(1) The entries shall be recorded upon completion of each physical examination and completion of designated special training. When a previously qualified member is suspended from special duty for physical reasons the period of suspension and reason thereof shall be entered on the NAVMED 1346.
(2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers who are familiar with their scope and nature.
16-60. Disposition

(1) The current NAVMED 1346 shall be retained as a component part of each Health Record. Procedures for disposition, when necessary upon termination or closure of a record, are outlined in article 16-9.

Section XV. DD FORM 1141, RECORD OF EXPOSURE TO IONIZING RADIATION

16-61. General

(1) This section provides for the method of recording exposure to ionizing radiation of all personnel who work in a radioactive environment, handle radioactive materials, or enter a radioactive area. (Exception: Ionizing radiation incurred by patients undergoing diagnostic procedures and treatments.) The DD 1141, Record of Exposure to Ionizing Radiation, also shall include any recorded exposures to ionizing radiation from nuclear explosions. The form shall be initiated when military personnel are first exposed to ionizing radiation. Thereafter it shall become a permanent part of the member’s Health Record.

(2) The commander of any project dealing with radioactive materials or facility with equipment capable of producing ionizing radiation shall require that all personnel who may be exposed to a radiation hazard as defined in this section wear a dosimetric device and that their exposures are recorded. Periodically, at least once a month, such exposures shall be recorded on DD 1141. Any record of overexposure is to be immediately reported to the medical officer. On special occasions, the Chief, Bureau of Medicine and Surgery, may waive the requirement at naval installations for personnel dosimetry in areas exceeding this limit, following a radiation protection survey by qualified personnel.

16-62. Definitions

(1) Radiation Hazard.—Any situation where individuals may be exposed to radiation in excess of one-quarter of the maximum permissible exposure established for the particular type of radiation involved.

(2) Radioactive Area.—Any area where there is any reasonable possibility that the external weekly radiation intensity would exceed 0.075 rep (75 millirep), or where there is any possibility of deposition of any radioactive material within the body.

(3) Roentgen.—For the purpose of this section the roentgen is the unit of measurement of x- or gamma radiation.

(4) Rad (Roentgen Absorbed Dose), Rep (Roentgen Equivalent Physical), and Rem (Roentgen Equivalent Man).—For the purposes of this section, the rad and the rep are units of measurement of all forms of ionization radiation. The rem may be defined in terms of: dose in rem equals dose in rad (or dose in rep) times RBE (relative biological effectiveness). For the purpose of this section, the neutron has a relative biological effectiveness equal to unity; thus, the neutron film badge readings may be expressed in rem.

(5) Milliroentgen, Millirep, and Millirad.—A submultiple equivalent to one-thousandth of a roentgen, a rep, or a rad, respectively.

(6) X-ray Area.—Any area where X-radiation hazard exists.

(7) Equivalent Units.—For the purpose of this section the roentgen, rep, and rad may be considered equivalent units.

16-63. Method of Recording

(1) Columnar Entries.—(a) Inclusive Dates.—Enter the date or dates of the measured exposure. For example: If an individual is exposed continuously or intermittently throughout the month, make one entry as “1–31 MAY 55.” However, if the individual received an overexposure on 18 MAY 55, make the entries “1–17 MAY 55,” “18 MAY 55,” and “19–31 MAY 55.” Where a single record of exposure is reported for the month, indicate the date or inclusive dates of the exposure.

(b) Type of Radiation.—Enter the type radiation, as “x-,” “gamma,” “beta-gamma,” “alpha,” etc.

(c) Method of Measure.—Record the method of measuring the dose. For example: The method might be entered as “film badge” or “pocket chamber.” If the dose has been estimated, enter the word “estimated.” For Air Force and Navy personnel, enter DT-60 readings only in column “DT-60 Readings (AF and Navy only)” as explained below in article 16-63(2).

(d) Place of Exposure.—Enter the name of the facility and its geographical location or other acceptable method of designating the location. For example: “Oak Ridge National Laboratories, Oak Ridge, Tenn.”

(e) Dose (In rep, rad, or r).—Enter the actual reading in rep, rad, or r. For example: “0.3” would be the recording for an exposure of 200 milliroentgens.
(f) **Accumulative Total Dose.**—Enter the total dose received, starting from the time records have been kept on the individual. For example: If the first exposure recorded for this individual is 0.2 rad, record "0.2" in column "Dose (In rep. rad. or r)," and also in column "Accumulative Total Dose." If on some future date the individual receives a dose of 3.4 rad, enter "3.4" in column "Dose (In rep. rad. or r)," and enter "3.5" in column "Accumulative Dose."

(2) **DT-60 Readings (AF and Navy Only).**—Enter all DT-60 readings in this column only. Since in many instances, an additional method of measurement may be utilized (such as a film badge), keep DT-60 readings separate in this column so as not to enter the same exposure twice, thereby recording double the actual dose received. Whenever the DT-60 is read, make a completely separate entry. On initial issue, record the serial number of the DT-60 in column "Place of Exposure." For example: On initial issue of the DT-60 on 5 January 1955 at the Oak Ridge National Laboratories the reading was 3r, columnar entries would be as follows:

<table>
<thead>
<tr>
<th>Column</th>
<th>Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusive Dates</td>
<td>Initial 5 JAN 55</td>
</tr>
<tr>
<td>Type of Radiation</td>
<td></td>
</tr>
<tr>
<td>Method of Measure</td>
<td></td>
</tr>
<tr>
<td>Place of Exposure</td>
<td>Enter the serial number of the DT-60</td>
</tr>
</tbody>
</table>

Section XVI. ADJUNCT HEALTH RECORD FORMS AND REPORTS

16-65. General

(1) This section provides instructions for the use of certain forms in the Health Record in lieu of transcribing data therefrom to the SF 600, Chronological Record of Medical Care.

16-66. Standard Form 502, Narrative Summary

(1) The purpose of the SF 502 is to summarize pertinent clinical data relative to treatment received during periods of hospitalization. The original (typewritten) of the SF 502 may be incorporated in the Health Record in lieu of transcribing the information therefrom to the SF 600. When this procedure is used, however, appropriate chronological entries shall be made on the SF 600 showing

<table>
<thead>
<tr>
<th>Column</th>
<th>Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose (In rep. rad. or r)</td>
<td></td>
</tr>
<tr>
<td>Accumulative Total Dose</td>
<td></td>
</tr>
<tr>
<td>DT-60 Readings (AF and Navy Only).</td>
<td></td>
</tr>
</tbody>
</table>

If on 10 January 1956 the DT-60 is again read, and the reading is 10r with no known exposure, make the following entries:

<table>
<thead>
<tr>
<th>Column</th>
<th>Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusive Dates</td>
<td>5 JAN 55 to 10 JAN 56</td>
</tr>
<tr>
<td>Type of Radiation</td>
<td>Unknown</td>
</tr>
<tr>
<td>Method of Measure</td>
<td></td>
</tr>
<tr>
<td>Place of Exposure</td>
<td>Oak Ridge National Laboratories, Oak Ridge, Tenn.</td>
</tr>
<tr>
<td>Dose (In rep. rad. or r)</td>
<td></td>
</tr>
<tr>
<td>Accumulative Total Dose</td>
<td></td>
</tr>
<tr>
<td>DT-60 Readings (AF and Navy Only)</td>
<td>10.0</td>
</tr>
</tbody>
</table>

(3) **Accident.**—In case of a radiation accident, enter on the form the date; internal dose in rep. rad.; and quality and quantity (estimated) of internal deposition of radioactive substances; and give a brief narrative summary of the accident.

16-64. Disposition

(1) The DD 1141 shall be retained as a permanent part of the Health Record until termination or closure of the record (art. 16-9). Upon discharge and immediate reenlistment, extension of enlistment, or change in status, the current form shall be incorporated in the new Health Record.

16-67. Standard Form 513, Consultation Sheet

(1) When a report of consultation on an outpatient is recorded on SF 513, it may be incorporated directly in the Health Record, thereby eliminating transcription to the SF 600.

(2) The SF 513 may be used by dental officers requesting a medical consultation on a dental patient. The SF 513 is to be included in the member's Health Record.

16-68. Report of Board of Medical Survey (NAVMED M) and Medical Board Report

(1) Whenever a member of the naval service is reported upon by a board of medical survey or a medical board, a signed legible copy of the respective report may be placed in the Health Record in
lieu of transcribing the clinical data to the SF 600. However, if the report does not contain required chronological data and all diagnoses for which treated, or opinion regarding the origin of the disease or injury with respect to conduct and line-of-duty status, such information shall be entered on the current SF 600 as outlined in article 16-45(1). A notation shall also be made on the current SF 600 to indicate that the clinical data is contained in the copy of the respective report which has been incorporated in the Health Record.

16-69. Disposition of Adjunct Forms or Reports

(1) Disposition of the above noted adjunct standard forms and reports contained in a Health Record shall coincide with the schedules prescribed in the case of the SF 600 (art. 16-48).

Section XVII. DD FORM 689, INDIVIDUAL SICK SLIP, AND CROSS MEDICAL SERVICE NOTIFICATION

16-70. General

(1) The DD 689, Individual Sick Slip, is devised for the purpose of cross medical service notification between the armed services. The DD 689 may also be used to exchange information between the medical officer concerned and unit commander within the naval establishment. When a member, following treatment, is unable to return to his organization either for duty or reporting purposes, use of the form does not preclude the immediate notification of a member's unit commander by telephone or message, if practicable, and considered necessary.

(2) The DD 689 may be initiated for an individual who has requested and/or received medical treatment of a sick call nature. It serves as an interim document to furnish information from which subsequent entries shall be recorded in the Health Record.

(3) The DD 689 is not a record document and should be disposed of as soon as it accomplishes its primary purpose, except where further use is indicated such as in connection with line-of-duty determination, or within purview of article 16-32.

16-71. Initiation and Completion

(1) The DD 689 consists of three sections:

(a) Personal Identification Data.—This section may be filled in by or for the patient either at his place of duty or at the medical treatment facility, depending upon local arrangements.

(b) Unit Commander's Section.—When completed by the individual's commanding officer, any additional information may be entered under "Remarks" which the unit commander feels may aid the medical officer, or any specific request made of the medical facility, or information which may be of value in determining line-of-duty status.

(c) Medical Officer's Section.—This section is to be completed by the medical officer or Medical Department representative administering treatment.

If it appears that line-of-duty determination will be predicated on a medical opinion, the "line-of-duty" block shall be completed. The disposition of the patient shall be indicated by a check mark in the appropriate box. An individual excused from duty shall be reported under one of the following dispositions:

(1) Sick Bay or Dispensary.
(2) Hospital.
(3) Other (specify).

The ship or station rendering medical treatment shall be indicated under "Remarks" of the Medical Officer's Section. Any additional information or instructions which the medical officer wishes to convey to the patient's unit commander may be entered under "Remarks."

16-72. Use for Army and Air Force Personnel

(1) When an Army or Air Force member reports at a naval facility for medical treatment of a sick-call nature and action is taken to have him excused from duty, a DD 689 shall be completed by the naval facility, indicating one of the dispositions listed in article 16-71(1)(c), and forwarded to the individual's commanding officer.

16-73. Use for Naval Personnel

(1) At Army or Air Force Medical Facilities.—Naval activities will receive DD 689 for members of their units who receive medical treatment of a sick-call nature at Army or Air Force facilities. When circumstances preclude direct cross-serving of the Health Record, appropriate entries shall be made on the NAVMED 10 from DD 689.

(2) At Navy Medical Facilities.—If it is impracticable to remove the NAVMED 10 from the Health Record, as in the case of a member who is carried in transient status, the information ordinarily entered thereon shall be recorded on DD 689. The DD 689 may likewise be used when a member at-
attached to a command equipped with several dispens­saries receives treatment at a dispensary other than that at which his Health Record and NAVMED 10 are on file. The information shall be transcribed to the NAVMED 10 as soon as possible, and in all cases prior to transfer of the member.

Section XVIII. ILLUSTRATIONS OF COMPONENT FORMS OF THE HEALTH RECORD

Illustrations

16-74. Illustrations

1. NAVMED 10, Sick Call Treatment Record.
2. Standard Form 88, Report of Medical Examination (Front).
2A. Standard Form 88, Report of Medical Examination (Back).
3A. Standard Form 89, Report of Medical History (Back).
4. Standard Form 600, Chronological Record of Medical Care (Front).
4A. Standard Form 600, Chronological Record of Medical Care (Back).
5. Standard Form 601, Immunization Record (Front).
5A. Standard Form 601, Immunization Record (Back).
6. Standard Form 602, Syphilis Record (Front).
6A. Standard Form 602, Syphilis Record (Back).
7. NAVMED 1406, Abstract of Service and Medical History.
8. NAVMED 1346, Special Duty Medical Abstract (Front).
8A. NAVMED 1346, Special Duty Medical Abstract (Back).
9. DD 1141, Record of Exposure to Ionizing Radiation.
### SICK CALL TREATMENT RECORD

#### CHAPTER 16. HEALTH RECORD

<table>
<thead>
<tr>
<th>DATE</th>
<th>NAME OF TREATING FACILITY</th>
<th>COMPLAINT</th>
<th>TREATMENT ADMINISTERED</th>
<th>SIGNATURE AND RANK/RATE OF PERSON ADMINISTERING TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 MAR 1957</td>
<td>USS DESTRUCTOR (DD-600)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 NOV 1958</td>
<td>USS FT. BLISS (AB-1000)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To duty.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 JAN 1958</td>
<td>USS FT. BLISS (AB-1000)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To duty.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Illustration 1.** Sick Call Treatment Record. (See sec. VI for details.)

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Change 9
**REPORT OF MEDICAL EXAMINATION**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>LAST NAME—FIRST NAME—MIDDLE NAME</td>
</tr>
<tr>
<td>2.</td>
<td>Grade and Component or Position</td>
</tr>
<tr>
<td>3.</td>
<td>Identification No.</td>
</tr>
<tr>
<td>4.</td>
<td>HOME ADDRESS (Number, street or RFD, city or town, state and phone)</td>
</tr>
<tr>
<td>5.</td>
<td>PURPOSE OF EXAMINATION</td>
</tr>
<tr>
<td>6.</td>
<td>DATE OF EXAMINATION</td>
</tr>
<tr>
<td>7.</td>
<td>SEX</td>
</tr>
<tr>
<td>8.</td>
<td>TOTAL YEARS GOVERNMENT SERVICE</td>
</tr>
<tr>
<td>9.</td>
<td>AGENCY</td>
</tr>
<tr>
<td>10.</td>
<td>ORGANIZATION UNIT</td>
</tr>
<tr>
<td>11.</td>
<td>DATE OF BIRTH</td>
</tr>
<tr>
<td>12.</td>
<td>PLACE OF BIRTH</td>
</tr>
<tr>
<td>13.</td>
<td>EXAMINING FACILITY OR EXAMINER, AND ADDRESS</td>
</tr>
<tr>
<td>14.</td>
<td>OTHER INFORMATION</td>
</tr>
<tr>
<td>15.</td>
<td>RATING ON SPECIALTY</td>
</tr>
<tr>
<td>16.</td>
<td>TIME IN THIS CAPACITY (Total)</td>
</tr>
<tr>
<td>17.</td>
<td>LAST SIX MONTHS</td>
</tr>
</tbody>
</table>

**CLINICAL EVALUATION**

- **Head, Face, Neck, and Scalp**
- **Nose**
- **Nose**
- **Sinuses**
- **Mouth and Throat**
- **Ears—General**
- **Drugs (Perforation)**
- **Eyes—General**
- **Ophthalmoscopic**
- **Nose**
- **Lungs and Chest (Include breasts)**
- **Heart**
- **Vascular System**
- **Abdomen and Viscera (Include breasts)**
- **Genitalia and Rectum**
- **Endocrine System**
- **G-U System**
- **Upper Extremities**
- **Feet**
- **Lower Extremities**
- **Spine**
- **Other Musculoskeletal**
- **Identifying Body Marks, Scars, Tattoos**
- **Skin, Lymphatic**
- **Neurologic** (Extensive tests under item 7f)
- **Psychiatric** (Specify any personality deviation)
- **Pelvic** (Femoral only)

**LABORATORY FINDINGS**

- **Urinalysis**
- **Specific Gravity**
- **Albumin**
- **Sugar**
- **Microscopic**
- **Electroencephalogram**
- **Blood Type and RH Factor**
- **Other Tests**

**ILLUSTRATION 2. Report of Medical Examination (Front).** (See sec. VII for details.)
16-74 CHAPTER 16. HEALTH RECORD

MEASUREMENTS AND OTHER FINDINGS

<table>
<thead>
<tr>
<th>Item</th>
<th>Measurement</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.</td>
<td>HEIGHT</td>
<td>70 4/8</td>
</tr>
<tr>
<td>52.</td>
<td>WEIGHT</td>
<td>160</td>
</tr>
<tr>
<td>53.</td>
<td>COLOR HAIR</td>
<td>Lt. Brown</td>
</tr>
<tr>
<td>54.</td>
<td>COLOR EYES</td>
<td>Brown</td>
</tr>
<tr>
<td>55.</td>
<td>BUILD</td>
<td>SLENDER</td>
</tr>
<tr>
<td>56.</td>
<td>TEMPERATURE</td>
<td>98.6</td>
</tr>
<tr>
<td>57.</td>
<td>BLOOD PRESSURE (Arm at heart level)</td>
<td>A. SITTING 110/110 B. RECLINING 118/118 C. STANDING [2 min.] 108/108</td>
</tr>
<tr>
<td>58.</td>
<td>PULSE (Arm at heart level)</td>
<td>A. SITTING 80 B. AFTER EXERCISE 120 C. 2 MIN. AFTER 84 D. RECLINING 72 E. AFTER STANDING 1 min. 96</td>
</tr>
<tr>
<td>59.</td>
<td>DISTANT VISION</td>
<td>60. REfraction</td>
</tr>
<tr>
<td>60.</td>
<td>NEAR VISION</td>
<td>61.</td>
</tr>
<tr>
<td>61.</td>
<td>COLOR VISION</td>
<td>(Test used and result)</td>
</tr>
<tr>
<td>62.</td>
<td>FIELD OF VISION</td>
<td>Normal</td>
</tr>
<tr>
<td>63.</td>
<td>ACkommodation</td>
<td>Right LEFT</td>
</tr>
<tr>
<td>64.</td>
<td>COLOR VISION</td>
<td>(Test used and result)</td>
</tr>
<tr>
<td>65.</td>
<td>DEPTH PERCEPTION</td>
<td>(Test used and score)</td>
</tr>
<tr>
<td>66.</td>
<td>FIELD OF VISION</td>
<td>Normal</td>
</tr>
<tr>
<td>67.</td>
<td>NIGHT VISION</td>
<td>(Test used and score)</td>
</tr>
<tr>
<td>68.</td>
<td>RED LENS TEST</td>
<td>UnCORRECTED</td>
</tr>
<tr>
<td>69.</td>
<td>INTRAOCULAR TENSION</td>
<td>Normal</td>
</tr>
<tr>
<td>70.</td>
<td>HEARING</td>
<td>(Test used and score)</td>
</tr>
<tr>
<td>71.</td>
<td>AUDIOMETER</td>
<td>Right LEFT</td>
</tr>
<tr>
<td>72.</td>
<td>PSYCHOLOGICAL AND PSYCHOMOTOR</td>
<td>Normal</td>
</tr>
</tbody>
</table>

SUMMARY OF DEFECTS AND DIAGNOSES (List diagnosis with item numbers)

SUMMARY OF DEFEcTS AND DIAGNOSES (List diagnosis with item numbers)

RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

ARTICLE 16-38 (2) (cc)

ARTICLE 16-38 (2) (ee)

ARTICLE 16-38 (2) (ff)

Illustration 2A. Report of Medical Examination (Back).
I am in excellent health.

18. FAMILY HISTORY

<table>
<thead>
<tr>
<th>RELATION</th>
<th>AGE</th>
<th>STATE OF HEALTH</th>
<th>IF DEAD, CAUSE OF DEATH</th>
<th>AGE AT DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>FATHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROTHERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SISTERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILDREN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. HAS ANY BLOOD RELATION (Parent, brother, sister, other) OR INDIAN ON BOTH SIDES

<table>
<thead>
<tr>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarlet Fever</td>
<td></td>
<td>Rheumatic Fever</td>
<td></td>
<td>Septicemia</td>
<td></td>
<td>Trench Fever</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td>Trich or locked knee</td>
<td></td>
<td>Foot trouble</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Ear Infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression or excessive worry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous trouble of any sort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or narcotic habit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or narcotic habit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexual tendencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. HAVE YOU EVER HAD OR DO YOU NOW (Place check at left of each item)

<table>
<thead>
<tr>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work glasses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work an artificial eye</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work hearing aids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with toxic gases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work a brace or back support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work in a dangerous occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work in a dangerous occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. HAVE YOU EVER (Check each item)

<table>
<thead>
<tr>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work glasses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work an artificial eye</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work hearing aids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with toxic gases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work a brace or back support</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. FEMALES ONLY: A. HAVE YOU EVER — COMPLETE THE FOLLOWING:

<table>
<thead>
<tr>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoy the company of men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of both</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?

<table>
<thead>
<tr>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoy the company of men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of both</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?

<table>
<thead>
<tr>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoy the company of men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of both</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25. WHAT IS YOUR UsUAL OCCUPATION?

<table>
<thead>
<tr>
<th>(Check each item)</th>
<th>YES/NO</th>
<th>(Check each item)</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoy the company of men</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the company of both</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Illustration 3. Report of Medical History (Front). (See sec. VIII for details.)
### Chapter 16. Health Record

**YES**  
**NO**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.</td>
<td>Have you been unable to hold a job because of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Sensitivity to chemicals, dust, sunlight, etc.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Disability to perform certain motions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Disability to assume certain positions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Other medical reasons (if yes, give reasons)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Have you ever worked with radioactive substance?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Did you have difficulty with school studies or teachers? (If yes, give details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Have you ever been refused employment because of your health? (If yes, state reason and give details)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Have you ever been denied life insurance? (If yes, state reason and give details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>Have you ever been a patient (conscindic or voluntary) in a mental hospital or sanatorium, prison hospital, workmen's compensation hospital, or hospital of any kind? (If yes, specify which, why, and name of doctor, and complete address of hospital or clinic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Have you consulted or been treated by clinics, physical healers, or other practitioners within the past 5 years? (If yes, give complete address of doctor, hospital, clinic, and details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>Have you treated yourself for illnesses other than minor colds? (If yes, which illnesses)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unserviceability)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>Have you ever received, is there pending, have you applied for, or do you intend to apply for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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

I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the government a complete transcript of my medical record for purposes of processing my application for this employment or service.

**Physician's Summary and Elaboration of All Pertinent Data**

- **Type or Printed Name of Physician or Examiner:** John James Doe

**Signatures**

- **Doctor:** John James Doe

---

- **Physician's Summary:**
  - Mumps and pertussis, childhood. No comp.; no seq.
  - Tonsillectomy and adenoidectomy, childhood; no comp.; no seq.
  - Boils, 1949. No comp.; no seq.
  - Fracture, simple, rt. fibula, 1954 (H. S. Football). No comp.; no seq.
  - Glasses worn for reading since childhood.

---

**Signed:** William R. Stack, Lt. MC USN  
**Date:** 1 Nov 56

**Number of Attached Sheets:** 0

---

Illustration 3A. Report of Medical History (Back).
<table>
<thead>
<tr>
<th>HEALTH RECORD</th>
<th>CHRONOLOGICAL RECORD OF MEDICAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</td>
</tr>
<tr>
<td>1 NOV 56</td>
<td>U.S. NAVAL STATION, BLANK, VA. Examined this date and found physically qualified for (enlistment - reenlistment) in the (U.S. Navy - Marine Corps) Serology (VDRL) Negative. Chest X-ray (Mobile Unit #15) Film No. 01756 - Negative. C. T. BAIRD, LT MC USN</td>
</tr>
<tr>
<td>15 MAR 57</td>
<td>U.S. NAVAL STATION, BLANK, VA. Physically qualified for transfer. C. T. BAIRD, LT MC USN</td>
</tr>
<tr>
<td>8 APR 57</td>
<td>To duty. Well. C. T. BAIRD, LT MC USN</td>
</tr>
<tr>
<td>21 AUG 57</td>
<td>USS CARRIER (CV-60) DIAGNOSIS: Diagnosis undetermined (Contusion, left thoracic region). DIAGNOSIS NO. 7955 Line of duty. Not due to own misconduct. While descending hatchway, slipped and fell, striking left chest against hatch combing. Patient complains of shortness of breath with pain and discomfort in left thoracic region. Examination indicates possibility of internal injuries, and as this ship is leaving port tomorrow on extended operation, it is deemed medically advisable to transfer this patient to a hospital. Transferred to US Naval Hospital, BLANK, VA. A. A. BAIRD, LT MC USN</td>
</tr>
</tbody>
</table>

Illustration 4. Chronological Record of Medical Care (Front). (See sec. IX for details.)

Change 9
CHAPTER 16. HEALTH RECORD

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 AUG 57</td>
<td>Examination of entire right and left thoracic regions, reveals</td>
</tr>
<tr>
<td></td>
<td>no evidence of fracture or bone pathology.</td>
</tr>
<tr>
<td></td>
<td>TREATMENT: Heat application and bed rest.</td>
</tr>
<tr>
<td>22 AUG 57</td>
<td>DIAGNOSIS CHANGED by reason of established.</td>
</tr>
<tr>
<td></td>
<td>CONFUSION, left thoracic region #8263.</td>
</tr>
<tr>
<td></td>
<td>Line of duty. Not due to own misconduct.</td>
</tr>
<tr>
<td></td>
<td>1. Within Command - Work.</td>
</tr>
<tr>
<td></td>
<td>2. While descending hatchway, slipped and fell, striking left chest</td>
</tr>
<tr>
<td></td>
<td>against hatch combing.</td>
</tr>
<tr>
<td>24 AUG 57</td>
<td>Slight pain with motion. Discomfort subsiding.</td>
</tr>
<tr>
<td></td>
<td>Patient has developed acute sore throat.</td>
</tr>
<tr>
<td></td>
<td>Temp. 101.2; pharynx injected, tonsils inflamed.</td>
</tr>
<tr>
<td>26 AUG 57</td>
<td>DIAGNOSIS CHANGED by reason of intercurrent diagnosis.</td>
</tr>
<tr>
<td></td>
<td>TONSILLITIS, acute, staphylococci - #4130.</td>
</tr>
<tr>
<td></td>
<td>Line of duty. Not due to own misconduct.</td>
</tr>
<tr>
<td></td>
<td>Placed on an antibiotic therapy. (Penicillin.)</td>
</tr>
<tr>
<td></td>
<td>Alkaline aromatic gargles q4h.</td>
</tr>
<tr>
<td>28 AUG 57</td>
<td>Temp. 98.6; all medication discontinued. Slight discomfort and tenderpass</td>
</tr>
<tr>
<td></td>
<td>remain in left thoracic region. Ward privileges authorized.</td>
</tr>
<tr>
<td>29 AUG 57</td>
<td>DIAGNOSIS CHANGED by reason of return to former status.</td>
</tr>
<tr>
<td></td>
<td>CONFUSION, left thoracic region #8263.</td>
</tr>
<tr>
<td></td>
<td>Line of duty. Not due to own misconduct.</td>
</tr>
<tr>
<td></td>
<td>Circumstances of occurrence as stated upon C&amp;EC on 22 AUG 57.</td>
</tr>
<tr>
<td>31 AUG 57</td>
<td>No complaints.</td>
</tr>
<tr>
<td></td>
<td>To duty. Well.</td>
</tr>
</tbody>
</table>

APPROVED:

M. E. BEAL, CAPT MC USN
CHIEF, SERVICE
USS CARRIER (CV-39)

15 NOV 57 | Annual chest X-ray: Film #12315 - Negativa.}

Illustration 4A. Chronological Record of Medical Care (Back).
**Health Record**

### Immunization Record

#### Vaccination Against Smallpox

<table>
<thead>
<tr>
<th>Date</th>
<th>Origin</th>
<th>Batch Number</th>
<th>Result</th>
<th>Station</th>
<th>Physician's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Jan 56</td>
<td>Eli Lilly</td>
<td>292 856</td>
<td>Vacciolo Primary</td>
<td>NTC Bainbridge, Md.</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>10 Feb 57</td>
<td>Parkes-Davida</td>
<td>464 25</td>
<td>Accel. Accel.</td>
<td>USS GOOD SHIP</td>
<td>T. P. Brown</td>
</tr>
<tr>
<td>5 Jan 58</td>
<td>Eli Lilly</td>
<td>P 311 421</td>
<td>Immune Immune</td>
<td>USS GOOD SHIP</td>
<td>T. P. Brown</td>
</tr>
</tbody>
</table>

#### Health Record

**Immunization Record**

<table>
<thead>
<tr>
<th>Date</th>
<th>Dose</th>
<th>Untoward Reaction</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Dose</th>
<th>Untoward Reaction</th>
<th>Physician's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Jan 56</td>
<td>0.5 cc</td>
<td>None</td>
<td>J. A. Jones</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Jan 56</td>
<td>0.5 cc</td>
<td>None</td>
<td>J. A. Jones</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Jan 56</td>
<td>0.5 cc</td>
<td>None</td>
<td>J. A. Jones</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Mar 57</td>
<td>0.5 cc</td>
<td>Mod. Systemic</td>
<td>T. P. Brown</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vaccination Against Typhoid**

<table>
<thead>
<tr>
<th>Date</th>
<th>Dose</th>
<th>Reaction</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Dose</th>
<th>Reaction</th>
<th>Physician's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Jan 57</td>
<td>1.0 cc</td>
<td>Positive</td>
<td>A. M. Doe</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Mar 57</td>
<td>0.1 cc</td>
<td>None</td>
<td>A. M. Doe</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tetanus Toxoid**

<table>
<thead>
<tr>
<th>Date</th>
<th>Dose</th>
<th>Untoward Reaction</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Dose</th>
<th>Untoward Reaction</th>
<th>Physician's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Jan 56</td>
<td>0.5 cc</td>
<td>None</td>
<td>J. A. Jones</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Feb 56</td>
<td>0.5 cc</td>
<td>Mod. Local</td>
<td>J. A. Jones</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Jan 56</td>
<td>0.5 cc</td>
<td>Mod. Local</td>
<td>A. M. Doe</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Schick Testing and Diphtheria Immunization**

<table>
<thead>
<tr>
<th>Test</th>
<th>Dose</th>
<th>Reaction</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Dose</th>
<th>Reaction</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Dose</th>
<th>Reaction</th>
<th>Physician's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1 cc</td>
<td>0.1 cc</td>
<td>None</td>
<td>A. M. Doe</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tuberculosis Vaccine**

<table>
<thead>
<tr>
<th>Date</th>
<th>Dose</th>
<th>Reaction</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Dose</th>
<th>Reaction</th>
<th>Physician's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Jan 57</td>
<td>1.0 cc</td>
<td>None</td>
<td>A. M. Doe</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Jan 57</td>
<td>1.0 cc</td>
<td>None</td>
<td>A. M. Doe</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cholera Vaccine**

<table>
<thead>
<tr>
<th>Date</th>
<th>Origin</th>
<th>Batch No.</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Origin</th>
<th>Batch No.</th>
<th>Physician's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Jan 57</td>
<td>Lederle</td>
<td>A 1945</td>
<td>A. M. Doe</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Jan 57</td>
<td>Lederle</td>
<td>A 5555</td>
<td>A. M. Doe</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Jan 57</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Yellow Fever Vaccine**

<table>
<thead>
<tr>
<th>Date</th>
<th>Origin</th>
<th>Batch No.</th>
<th>Station</th>
<th>Physician's Name</th>
<th>Date</th>
<th>Origin</th>
<th>Batch No.</th>
<th>Identification No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Jan 57</td>
<td>National Drug Co.</td>
<td>Y 001</td>
<td>NavBase, Norfolk, Va.</td>
<td>A. M. Doe</td>
<td>9 May 56</td>
<td></td>
<td>123 45 67</td>
<td></td>
</tr>
</tbody>
</table>

Illustration 5. Immunization Record (Front). (See sec. X for details.)

16-28

Change 9
### OTHER IMMUNIZATIONS

<table>
<thead>
<tr>
<th>DATE</th>
<th>TYPE</th>
<th>DOSE</th>
<th>REACTION</th>
<th>REMARKS</th>
<th>PHYSICIAN’S NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>27DEC56</td>
<td>Poliomyelitis</td>
<td>1.0cc</td>
<td>None (lt arm)</td>
<td>#E 7474-Eli Lilly</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>25JAN57</td>
<td>Poliomyelitis</td>
<td>1.0cc</td>
<td>None (rt arm)</td>
<td># A 4111-Eli Lilly</td>
<td>A. H. Doe</td>
</tr>
<tr>
<td>15OCT57</td>
<td>Poliomyelitis</td>
<td>1.0cc</td>
<td>None (lt arm)</td>
<td>#F 4521-Eli Lilly</td>
<td>T. P. Brown</td>
</tr>
<tr>
<td>15NOV57</td>
<td>Influenza</td>
<td>1.0cc</td>
<td>None</td>
<td>T. P. Brown</td>
<td></td>
</tr>
<tr>
<td>17MAR58</td>
<td>Plague</td>
<td>0.5cc</td>
<td>None</td>
<td>T. P. Brown</td>
<td></td>
</tr>
<tr>
<td>15APR58</td>
<td>Plague</td>
<td>1.0cc</td>
<td>None</td>
<td>T. P. Brown</td>
<td></td>
</tr>
</tbody>
</table>

### SENSITIVITY TESTS (Tuberculin, etc.)

<table>
<thead>
<tr>
<th>DATE</th>
<th>TYPE (PDD)</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>RESULTS</th>
<th>PHYSICIAN’S NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2FAB56</td>
<td>Tuberculin</td>
<td>5.0u</td>
<td>Intracutaneous</td>
<td>Negative</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2MAR56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2APR56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2MAY56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2JUN56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2JUL56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2AUG56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2SEP56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2OCT56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2NOV56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2DEC56</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2JAN57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2FEB57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2MAR57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2APR57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2MAY57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2JUN57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2JUL57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2AUG57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2SEP57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2OCT57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2NOV57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2DEC57</td>
<td>Tuberculin</td>
<td>1.0cc</td>
<td>Intradermal</td>
<td>Positive</td>
<td>J. A. Jones</td>
</tr>
</tbody>
</table>

### REACTIONS (To transfusions, drugs, sera, foods, allergens, etc.)

<table>
<thead>
<tr>
<th>DATE</th>
<th>AGENT</th>
<th>TYPE OF REACTION</th>
<th>SEVERITY</th>
<th>PHYSICIAN’S NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2JAN57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2FEB57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2MAR57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2APR57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2MAY57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2JUN57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2JUL57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2AUG57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2SEP57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2OCT57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2NOV57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2DEC57</td>
<td>AB</td>
<td>Nonspecific</td>
<td>Moderate</td>
<td>J. A. Jones</td>
</tr>
</tbody>
</table>

### BLOOD TYPING

<table>
<thead>
<tr>
<th>DATE</th>
<th>TYPE (international)</th>
<th>Rh FACTOR</th>
<th>PHYSICIAN’S NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>5JAN56</td>
<td>AB</td>
<td>Negative</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2FEB57</td>
<td>AB</td>
<td>Negative</td>
<td>J. A. Jones</td>
</tr>
<tr>
<td>2MAR57</td>
<td>AB</td>
<td>Negative</td>
<td>J. A. Jones</td>
</tr>
</tbody>
</table>

### REMARKS AND RECOMMENDATIONS (Including history of diseases for which any of the above immunising agents were given with year and place of attack)

1. **Hypersensitive to Aspirin.**

2. **History moderately severe reaction to parenteral penicillin in 1955.**

Illustration 5A. Immunization Record (Back).
## HEALTH RECORD

### SECTION I. HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS

<table>
<thead>
<tr>
<th>DATE</th>
<th>DISEASE (Give stage)</th>
<th>PRIOR TO MIL. SERVICE</th>
<th>YES</th>
<th>NO</th>
<th>TREATMENT (Give type, amount and dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TREATING AGENCY</th>
<th>PLACE</th>
<th>INFORMATION FROM (Patient, records, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                          |                                      |                          |

### SECTION II. HISTORY OF PRESENT INFECTION

- **CAME TO MEDICAL ATTENTION BY:** VOLUNARY
- **CONTACT REPORT**
- **PHYSICAL INSPECTION**
- **FOOD HANDLER**

**IDENTIFICATION DATA** (Specify stage and diagnosis no.)

**DIAGNOSIS ESTABLISHED**

**LESION (Type and location):**

**SYPHILIS, primary, seronegative #0210**

- **(chancre, glans penis).**

**OUTPATIENT TREATMENT**

- **LEYFIELD**
- **DARK FIELD**
- **SPINAL FLUID (If indicated)**

**OTHER PROCEDURES**

**CLINICAL DATA** (Include chief complaint, physical findings—eyes, cardiovascular and nervous system, even in early syphilis)

- Hard "sore" on penis for 3 days. No other symptoms. In addition to a 1 cm. ulcer with markedly indurated base on glans penis has slightly enlarged, non-tender, hard inguinal lymph nodes.

**RECOMMENDED TREATMENT AND FOLLOW-UP**

**Penicillin Therapy - Standard 2-year followup.**

**I HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYphilis AS INDICATED ABOVE. THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION (INCLUDING CERTAIN PRESCRIBED TESTS) FOR THE CARE OF THIS DISEASE.**

**SIGNATURE OF PATIENT AND DATE**

**John James Doe, 18 Jan 57**

**SECTION III. TREATMENT**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>(Specify type and vehicle)</th>
<th>DATES (from-to)</th>
<th>AMT. PER DOSE</th>
<th>INTERVAL</th>
<th>TOTAL DOSE</th>
<th>SIGNATURE AND STATION OF PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procaine Penicillin</td>
<td>10 Jan 57 to 17 Jan 57</td>
<td>600,000U, Daily</td>
<td>4,800,000</td>
<td>Navsta, Blank, Va.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TREATMENT REACTIONS (Give date, type, severity and disposition)**

**SIGNATURE OF PHYSICIAN**

**SECTION IV. IDENTIFICATION DATA**

- **PERMANENT HOME ADDRESS** (Street or APO, city, State)
- **SEX**
- **RACE**
- **GRADE, RATING OR POSITION**
- **ORGANIZATION UNIT**
- **COMPONENT OR BRANCH**
- **SERVICE, DEPT. OR AGENCY**

**PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME**

**DATE OF BIRTH (DAY-MONTH-YEAR)**

**IDENTIFICATION NO.**

**DOE, John James**

*Illustration 6. Syphilis Record (Front). (See sec. XI for details.)*

16-30

Change 9
### SECTION V. CUMULATIVE LABORATORY SUMMARY

#### RESULTS OF DARKFIELD EXAMINATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Results</th>
<th>Source of Specimen</th>
<th>Laboratory</th>
<th>Name of Confirming Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Jan 57</td>
<td>Positive</td>
<td>NS, Blank, Va</td>
<td>W. T. Hatch, LT MC USN</td>
<td></td>
</tr>
<tr>
<td>15 Jan 57</td>
<td>Negative</td>
<td>NS, Blank, Va</td>
<td>W. T. Hatch, LT MC USN</td>
<td></td>
</tr>
</tbody>
</table>

#### RESULTS OF SEROLOGICAL TESTS FOR SYphilIS

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Result (inc. titer)</th>
<th>Laboratory</th>
<th>Date</th>
<th>Type</th>
<th>Result (inc. titer)</th>
<th>Laboratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Jan 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>NS, Blank, Va</td>
<td>15 Dec 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>NS, Blank, Va</td>
</tr>
<tr>
<td>15 Feb 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>NS, Blank, Va</td>
<td>15 Mar 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>NS, Blank, Va</td>
</tr>
<tr>
<td>15 Apr 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER</td>
<td>15 Sep 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER (CVA-0)</td>
</tr>
<tr>
<td>18 May 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>NMG, Bethesda</td>
<td>10 Dec 58</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS APA (APA-0)</td>
</tr>
<tr>
<td>19 Jun 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>NAF, Blank, N.Y</td>
<td>15 Sep 59</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER (DD-0)</td>
</tr>
<tr>
<td>17 Jul 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>NAF, Blank, N.Y</td>
<td>18 Aug 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER</td>
</tr>
<tr>
<td>17 Sep 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER</td>
<td>19 Oct 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER</td>
</tr>
<tr>
<td>19 Nov 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER</td>
<td>17 Dec 57</td>
<td>VDRL</td>
<td>Negative</td>
<td>USS CARRIER</td>
</tr>
</tbody>
</table>

#### RESULTS OF SPINAL FLUID EXAMINATIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Cells</th>
<th>Total Protein</th>
<th>Complement Fixation</th>
<th>Colloidal</th>
<th>Laboratory Where Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Jul 57</td>
<td>0-1</td>
<td>31 mg</td>
<td>0.1 0.25 0.5 1.0</td>
<td>0</td>
<td>NH, Blank, N.Y.</td>
</tr>
</tbody>
</table>

### SECTION VI. EVALUATION OF THERAPY

<table>
<thead>
<tr>
<th>Date</th>
<th>Facility Where Evaluated</th>
<th>Result</th>
<th>Date of Retirement</th>
<th>Physician's Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Jul 57</td>
<td>NH, Blank, N.Y.</td>
<td>X</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>15 Mar 57</td>
<td>NS, Blank, Va.</td>
<td>X</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>15 Apr 57</td>
<td>USS CARRIER (DD-0)</td>
<td>X</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>28 Dec 59</td>
<td>NS, Blank, Fla.</td>
<td>X</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

*Satisfactory result cannot be reported without normal spinal fluid findings*

*Specify: Infectious relapse, sero-relapse, neuro-relapse, incomplete data on spinal fluid. OTHER (Specify)*

### SECTION VII. REMARKS (Include significant post treatment clinical findings)

#### PATIENT'S HOME ADDRESS ON SEPARATION

2619 Flower St., Any Town, U.S.A.

#### CIVILIAN HEALTH DEPT. TO WHICH CASE RESUMES WAS SENT

Any Town, U.S.A.

#### INSPECTION (Give date new record was opened)

**SECTION VIII. MEDICAL OFFICER CLOSING THIS RECORD**

A. A. FINE, CDR MC USN

**SECTION IX. MEDICAL OFFICER SENDING ABSTRACT TO VETERANS ADMINISTRATION ON DISCHARGE**

A. A. FINE, CDR MC USN

Illustration 6A. Syphilis Record (Back).
## ABSTRACT OF SERVICE AND MEDICAL HISTORY

**MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY**

<table>
<thead>
<tr>
<th>SHIP OR STATION</th>
<th>DIAGNOSIS, DIAGNOSIS NUMBER AND REMARKS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. NAVSTA BLANK, VA</td>
<td>Duty</td>
<td>FROM TO</td>
</tr>
<tr>
<td>USS CARRIER (CV-00)</td>
<td>Tonsillitis, Acute Staphylococci - #4130</td>
<td>1 NOV 56</td>
</tr>
<tr>
<td></td>
<td>Diagnosis Undetermined #7955 (Contusion, Lt. Thoracic Region)</td>
<td>15 MAR 57</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
<td>21 AUG 57</td>
</tr>
<tr>
<td>US NAVAL HOSPITAL, BLANK, VA, Treatment</td>
<td>DU (Contusion, Lt. Thoracic Region) #7955</td>
<td>21 AID 56</td>
</tr>
<tr>
<td></td>
<td>Contusion, Left Thoracic Region #8263</td>
<td>22 AID 56</td>
</tr>
<tr>
<td></td>
<td>Tonsillitis, Acute Staphylococci - #4130</td>
<td>26 AID 56</td>
</tr>
<tr>
<td></td>
<td>Contusion, Lt. Thoracic Region #8263</td>
<td>29 AID 56</td>
</tr>
<tr>
<td>USS CARRIER (CV-00)</td>
<td>Duty</td>
<td>31 AID 56</td>
</tr>
<tr>
<td>USS LST (LST-00)</td>
<td>Duty</td>
<td>1 NOV 57</td>
</tr>
</tbody>
</table>

**NAME (Last, first and middle)**

DOE, John James

**BIRTH DATE**

9 MAY 36

**BRANCH OF SERVICE**

USN

**IDENTIFICATION NO.**

123 45 67

Illustration 7. Abstract of Service and Medical History. (See sec. XIII for details.)

16-32

Change 9
### HEALTH RECORD

#### SPECIAL DUTY MEDICAL ABSTRACT

<table>
<thead>
<tr>
<th>DATE</th>
<th>PLACE</th>
<th>PURPOSE</th>
<th>RESULT—RECOMMENDATION (DEFECTS—WAIVERS)</th>
<th>MEDICAL ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5SEP57</td>
<td>SubBase</td>
<td>Physically qualified, (Defect: vision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>USN Div</td>
<td>NNonConn</td>
<td>Physically qualified, (Defect: vision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3MAY58</td>
<td>Wash DC</td>
<td>Physically qualified for continuance for max age std 1 JUN 58</td>
<td>DivDuty, Waiver granted - BuPers</td>
<td></td>
</tr>
<tr>
<td>1.5SEP57</td>
<td>Wash DC</td>
<td>Physically qualified and aeronautically adapted for duty invol the actual control of aircraft. Service Group I</td>
<td>Appwd</td>
<td></td>
</tr>
</tbody>
</table>

#### SUSPENSION FROM SPECIAL DUTY

<table>
<thead>
<tr>
<th>DATE (FROM)</th>
<th>DATE (TO)</th>
<th>NO. OF DAYS</th>
<th>REASON FOR SUSPENSION</th>
<th>SIGNATURE OF MEDICAL OFFICER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7JAN58</td>
<td>9JAN58</td>
<td>3</td>
<td>Common cold</td>
<td>A.L. Seaw</td>
</tr>
<tr>
<td>1.1NOV58</td>
<td>10NOV58</td>
<td>10</td>
<td>Influenza</td>
<td>B.L. Seaw</td>
</tr>
<tr>
<td>3.5JUN58</td>
<td>13JUN58</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5JUN58</td>
<td>13JUN58</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PERIODIC SPECIAL DUTY REQUALIFICATION

<table>
<thead>
<tr>
<th>DATE</th>
<th>SIG. OF M. O.</th>
<th>DATE</th>
<th>SIG. OF M. O.</th>
<th>DATE</th>
<th>SIG. OF M. O.</th>
</tr>
</thead>
</table>

Illustration 8. Special Duty Medical Abstract (Front). (See sec. XIV for details.)
### Altitude Training, Air Compression and Oxygen Tolerance

<table>
<thead>
<tr>
<th>Date</th>
<th>Station</th>
<th>Type of Run—Reaction</th>
<th>Sig. of M. O</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 SEP 57</td>
<td>SubBase Blank, Conn.</td>
<td>Equalized 501bs press. and tolerated 100% oxygen 60' for 30 min.</td>
<td>W. D. Feil</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low pressure indoctrination 45,000 ft.</td>
<td>R. J. Seim</td>
</tr>
</tbody>
</table>

### Explosive Decompression Training

<table>
<thead>
<tr>
<th>Date</th>
<th>Station</th>
<th>Altitudes—Reaction</th>
<th>Type of Run—Reaction</th>
<th>Sig. of M. O</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 MAR 57</td>
<td>US, NAS Blank, Texas</td>
<td>8-10 M</td>
<td>None</td>
<td>C. T. Ellen</td>
</tr>
<tr>
<td>12 MAR 58</td>
<td>US, NAS Blank, Texas</td>
<td>8-10 M</td>
<td>Dysbarism shoulder</td>
<td>M. Seifert</td>
</tr>
</tbody>
</table>

### Submarine Escape and Diving Training

<table>
<thead>
<tr>
<th>Date</th>
<th>Station</th>
<th>Type of Run—Reaction</th>
<th>Sig. of M. O</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 FEB 58</td>
<td>USS SALVAGE (ARS-00)</td>
<td>Completed buoyant ascent escape.</td>
<td>R. C. Bee</td>
</tr>
<tr>
<td>4 MAR 58</td>
<td>Underwater Swimmers’ School, Blank, Fla.</td>
<td>100 ft. free ascent 18/20 feet.</td>
<td>J. N. Git</td>
</tr>
</tbody>
</table>

### Night Vision Training

<table>
<thead>
<tr>
<th>Date</th>
<th>Station</th>
<th>Two Dimensional</th>
<th>Three Dimensional</th>
<th>Sig. of M. O</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 MAR 57</td>
<td>US, NAS Blank, Va</td>
<td>X</td>
<td></td>
<td>W. Back</td>
</tr>
<tr>
<td>8 APR 58</td>
<td>US, NAS Blank, Calif.</td>
<td>X</td>
<td></td>
<td>J. Allen</td>
</tr>
<tr>
<td>15 MAY 59</td>
<td>US, NAS Blank, Md</td>
<td>X</td>
<td></td>
<td>R. Jerna</td>
</tr>
</tbody>
</table>

### Centrifuge and Ejection Seat Training

<table>
<thead>
<tr>
<th>Date</th>
<th>Station</th>
<th>Type of Run—Reaction</th>
<th>Sig. of M. O</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 MAR 58</td>
<td>US, NAS Blank, Pa, (AMAL)</td>
<td>4.2G - Radial forces (None)</td>
<td>W. D. Doh</td>
</tr>
</tbody>
</table>

**Remarks:**

Illustration 8A. Special Duty Medical Abstract (Back).

16-34

Change 9
## Record of Exposure to Ionizing Radiation

<table>
<thead>
<tr>
<th>Exclusive Dates</th>
<th>Type of Radiation</th>
<th>Method of Measure</th>
<th>Place of Exposure</th>
<th>Dose (In rep, rad, or r)</th>
<th>Accumulative Total Dose</th>
<th>DT-60 Readings (AF and Navy only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-31 May 55</td>
<td>&quot;x-&quot;</td>
<td>Film badge</td>
<td>NH, BLANK, VA</td>
<td>0.1</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>1-30 Jun 55</td>
<td>&quot;x-&quot;</td>
<td>Film badge</td>
<td>NH, BLANK, VA</td>
<td>0.1</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>See Sub-article 16-63(1)(a) thru (f) for method of recording columnar entries.</td>
</tr>
<tr>
<td>Initial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DT-60 Serial - 123456</td>
</tr>
</tbody>
</table>

**DT-READINGS (AF and Navy only)** - Whenever DT-60 readings are recorded, make separate entry. See article 16-63(2) regarding procedure for recording of DT-60 readings.

### Illustration 9
Record of Exposure to Ionizing Radiation. (See sec. XV for details.)

<table>
<thead>
<tr>
<th>Last Name - First Name - Middle Initial</th>
<th>Grade, Rating, or Position</th>
<th>Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOE, John James</td>
<td>HML USN</td>
<td>1234567</td>
</tr>
</tbody>
</table>
Chapter 17
DEATHS

Sections

I. Recording and Reporting of Death.......................... 17-9A through 17-14
II. Death Occurring Away From Command........................... 17-15
III. Death of Inactive Personnel at Other Than Naval Activities.............. 17-16 through 17-19
V. Missing Personnel............................................. 17-21
VI. Investigation of Death......................................... 17-24
XI. Funeral Expenses.............................................. 17-26
XVI. Military Sea Transportation Service Personnel.......................... 17-75 through 17-77
XVII. Cemeteries..................................................... 17-78 through 17-81

Section I. RECORDING AND REPORTING OF DEATH

17-9A. NAVMED-601 (Report of Burial, MED-5360-2).......................... 17-9A
17-9B. NAVMED-609 (Report of Disposition and Expenditures—Remains of Dead, MED-5360-3).............. 17-9B
17-10. NAVMED-N (Certificate of Death), General............................... 17-10
17-11. NAVMED-N, Copies to Bureau.................................. 17-11
17-12. NAVMED-N, Copies to Other U.S. Government Activities............... 17-12
17-13. NAVMED-N, Copies to Other Than U.S. Government Activities......... 17-13
17-14. NAVMED-N, Detailed Instruction for Preparing.......................... 17-14

Note.—There are no articles 17-1 through 17-8.

17-9A. NAVMED-601 (Report of Burial, MED-5360-2)

(1) The officer in charge of the burial in each case of burial at sea, or burial or reburial ashore outside the United States or in Alaska or Hawaii, shall submit this report in triplicate to the Bureau. An additional copy shall be forwarded to the Bureau for a deceased person of a foreign nation. Further instructions for the preparation of the report are printed on the form.

17-9B. NAVMED-609 (Report of Disposition and Expenditures—Remains of Dead, MED-5360-3)

(1) This form shall be submitted to the Bureau by each Navy and Marine Corps activity or unit which handles the remains of deceased Navy or Marine Corps personnel for any purpose, even though no expenses are incurred.

17-10. NAVMED-N (Certificate of Death), General

(1) The NAVMED-N is designed primarily to meet the administrative needs of the Navy in substantiating deaths and for statistical purposes relative to the causes of deaths. It shall be prepared by the medical officer, or in the absence of a medical officer by the medical department representative, in all deaths, including stillbirths, occurring at a naval activity or on board a naval vessel or aircraft. (A stillbirth is defined as any fetus weighing 401 grams or more which, after expulsion or extraction from its mother, does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or movement of voluntary muscles.) In addition, the preparation and submission of a NAVMED-N is required in all cases of death of active duty personnel, personnel in an active duty for training status, and personnel in an inactive duty training status when death occurs at places other than a naval activity or on board a

Change II
naval vessel or aircraft. The medical department of the command to which the individual was attached is responsible for the preparation of the NAVMED-N, termination of the Health Record, and submission of other medical department reports relative to the death. The preparation and submission of NAVMED-N is also required in certain cases of service personnel whose death occurs while in inactive status as outlined in succeeding articles.

17-11. NAVMED-N, Copies to Bureau

(1) The original and four legible copies of NAVMED-N shall be prepared and forwarded to the Bureau in cases of death of:
   (a) Personnel of the Navy, Naval Reserve, Marine Corps, or Marine Corps Reserve who are in an active duty status.
   (b) Personnel of the Naval and Marine Corps Reserve in an active duty for training and inactive duty training status as defined in the articles of the Bureau of Naval Personnel Manual and the Marine Corps Manual.
   (c) Active and inactive members of the Fleet Reserve and Fleet Marine Corps Reserve.
   (d) Active and inactive retired members of the Navy and Marine Corps.
   (e) Active and inactive retired members of the Naval and Marine Corps Reserve, including those who are on the Honorary Retired List, receiving retired pay.

(2) The original and one legible copy shall be forwarded to the Bureau in the case of death of all persons in a status not listed above whose death occurs at a naval activity or in a naval vessel.

17-12. NAVMED-N, Copies to Other U.S. Government Activities

(1) U.S. Air Force.—In case of death of a member of the U.S. Air Force occurring at a naval activity or aboard a naval vessel, a signed copy of the NAVMED-N shall be forwarded to the Office of the Surgeon General, U.S. Air Force, Washington, D.C.

(2) U.S. Coast Guard.—In each case of death of a member of the U.S. Coast Guard occurring at a naval activity or aboard a naval vessel, a signed copy of the NAVMED-N shall be forwarded to the Commandant, U.S. Coast Guard, Washington, D.C., marked to the attention of the Personnel Military Morale Division.

(3) U.S. Army.—In case of death of a member of the U.S. Army occurring at a naval activity or aboard a naval vessel, a signed copy of the NAVMED-N shall be forwarded to the Office of the Adjutant General, Department of the Army, Washington, D.C., marked to the attention of the Personnel Bureau.

(4) Regional Offices of the Veterans Administration.—In cases of death of beneficiaries of the Veterans Administration, local arrangements may be made between the commanding officer of the naval hospital where death occurs and the local regional office of the Veterans Administration authorizing the admission of the patient, as to the number of copies of NAVMED-N to be furnished routinely to the regional office. However, the original and one copy of the NAVMED-N shall be forwarded to the Bureau in accordance with the instructions set forth in article 17-11(2).

17-13. NAVMED-N, Copies to Other Than U.S. Government Activities

(1) All requests for copies of NAVMED-N, other than requests from the activities listed in article 17-12, shall be promptly forwarded to the Bureau for action. The requesting activity shall be informed of the action taken.

17-14. NAVMED-N, Detailed Instruction for Preparing

"From" line.—On the first line of the NAVMED-N, the name and address of the ship or station and the

Note.—There are no pages 17-3 and 17-4.
17-5. Civilian Employees of the Navy, Army, and Air Force
(1) When the death of a civilian employee of the Navy occurs at a naval activity or on board a naval vessel, the commanding officer of the activity or ship were death occurred, whether within or beyond the continental limits of the United States, shall notify the Secretary of the Navy by message. The message shall include:
   (a) Identifying information.
   (b) Cause of death.
   (c) Name, address, and relationship of next of kin.
   (d) Whether or not next of kin has been notified by the Navy, or if contract employee, by the contractor, and if so, disposition of remains desired.
   (e) In deaths occurring beyond continental United States, additional information should be furnished concerning the date and place the decedent was appointed.

If the employee was not permanently attached to the activity where death occurred, the commanding officer shall make the employee's permanent duty station an information addressee on the message to the Secretary of the Navy. When a commanding officer is cognizant of the death of a civilian employee of the Navy having occurred near his command, while the employee was traveling on official orders away from his regular place of employment, he shall report the death by message to the Secretary of the Navy. The activity to which the employee was attached shall be made an information addressee on the message.

(2) When the death of a civilian employee of the Department of the Army occurs at a naval activity or on board a naval vessel, the procedure prescribed in subarticle 17-5(1) shall be accomplished, except that an additional information addressee of the message report shall be the Adjutant General's Office, Personnel Actions Branch, Department of the Army, Washington, D.C.

(3) When the death of a civilian employee of the Department of the Air Force occurs at a naval activity or on board a naval vessel outside the continental United States, the procedure prescribed in subarticle 17-5(1) above shall be accomplished, except that an additional information addressee of the message report shall be the Chief of Staff, U.S. Air Force, Attention: Casualty Branch, Washington, D.C. The Department of the Air Force does not desire to be an information addressee on message reports of death in the case of civil employees within the continental United States.

17-6. Other Deaths
(1) All other deaths, except stillbirths, that occur at naval activities and in naval vessels shall be reported to the Secretary of the Navy by message. In cases not covered in preceding articles, the message shall furnish identifying information, cause of death, name and address of next of kin, whether or not next of kin has been notified, and disposition that has been or will be made of remains.

17-7. Reporting Deaths to Civil Authorities
(1) When a death occurs at a naval activity in any State, Territory, or insular possession of the United States, the commanding officer or his designated representative shall report the death promptly to the civil authorities. If requested by the civil authorities, the civil death certificate may be prepared and signed by a naval medical officer. Local agreements concerning reporting and preparation of death certificates should be made between the commanding officer, or his designated representative, and the civil authorities.

(2) Reference should be made to article 3-12(4) concerning the recording with local civil authorities of overseas deaths of members and their dependents.

17-8. Death Forms for Civilian Agencies and Individuals
(1) All requests received from next of kin, relatives, insurance agencies, companies, fraternal organizations, etc., for completion of blank forms, relative to death of either naval, military, or civilian personnel in naval medical activities, except in Veterans Administration cases, shall be forwarded to the Bureau for action.

(2) Requests for completion of such forms in cases of beneficiaries of the Veterans Administration will be forwarded to the Manager of the Veterans Administration Regional Office authorizing the admission of the patient.

(3) Nothing in this article is intended to preclude furnishing information essential to proof of death. Such information shall be limited to identification of decedent and time, date, place, and cause of death.

17-9. Reports Summary
(1) Following is a resume of the reports and letters relative to deceased persons which shall be prepared and forwarded when applicable:

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-40</td>
<td>Dispatch to consignee concerning arrival of remains.</td>
</tr>
<tr>
<td>17-1</td>
<td>Dispatch reports to the Secretary of the Navy:</td>
</tr>
<tr>
<td>17-2</td>
<td>General</td>
</tr>
<tr>
<td>17-3</td>
<td>Active-duty personnel.</td>
</tr>
<tr>
<td>17-4</td>
<td>Merchant seamen.</td>
</tr>
<tr>
<td>17-5</td>
<td>Civilian employees of Navy, Army, and Air Force.</td>
</tr>
<tr>
<td>17-6</td>
<td>Other deaths.</td>
</tr>
<tr>
<td>17-7</td>
<td>Death away from command.</td>
</tr>
<tr>
<td>17-16</td>
<td>Retired Inactive personnel.</td>
</tr>
<tr>
<td>17-17</td>
<td>Inactive Fleet Reservists.</td>
</tr>
<tr>
<td>17-21</td>
<td>Missing personnel.</td>
</tr>
<tr>
<td>17-25</td>
<td>Military Sea Transportation Service personnel.</td>
</tr>
<tr>
<td>17-76</td>
<td>17-77 through 17-77.</td>
</tr>
<tr>
<td>17-55</td>
<td>Dispatch request for disposition instructions.</td>
</tr>
</tbody>
</table>

Change 7
17-9. NAVMED-601 (Report of Burial)

(1) The officer in charge of the burial in each case of burial at sea, or burial or reburial ashore beyond the continental limits of the United States, including Alaska, shall submit this form in triplicate to the Bureau. An additional copy shall be forwarded to the Bureau in the case of burial at sea, or burial or reburial ashore beyond the continental limits of the United States, including Alaska, shall submit this form in triplicate to the Bureau. An additional copy shall be forwarded to the Bureau.

17-9B. NAVMED-609 (Report of Disposition and Expenditures—Remains of Dead)

(1) This form shall be submitted to the Bureau by each Navy and Marine Corps activity or unit which handles the remains of deceased Navy or Marine Corps personnel for any purpose, even though no expenses are incurred.

17-10. NAVMED-N (Certificate of Death), General

(1) The NAVMED-N is designed primarily to meet the administrative needs of the Navy in substantiating deaths and for statistical purposes relative to the causes of deaths. It shall be prepared by the medical officer, or in the absence of a medical officer by the medical department representative, in all deaths, including stillbirths, occurring at a naval activity or on board a naval vessel. In addition, the preparation and submission of a NAVMED-N is required in all cases of death of active duty personnel, personnel in an active duty for training status, and personnel in an inactive duty training status when death occurs at places other than a naval activity or on board a naval vessel. The medical department of the command to which the individual was attached is responsible for the preparation of the NAVMED-N, termination of the Health Record, and submission of other medical department reports relative to the death. The preparation and submission of NAVMED-N is also required in certain cases of service personnel whose death occurs while in inactive status as outlined in succeeding articles.

17-11. NAVMED-N, Copies to Bureau

(a) Personnel of the Navy, Naval Reserve, Marine Corps, or Marine Corps Reserve who are in an active duty status.

(b) Personnel of the Naval and Marine Corps Reserve in an active duty for training and inactive duty training status as defined in the articles of the Bureau of Naval Personnel Manual and the Marine Corps Manual as listed in article 17-2 of this Manual.

(c) Active and inactive members of the Fleet Reserve and Fleet Marine Corps Reserve.

(d) Active and inactive retired members of the Navy and Marine Corps.

(e) Active and inactive retired members of the Naval and Marine Corps Reserve, including those who are on the Honorary Retired List, receiving retired pay.

(2) The original and one legible copy shall be forwarded to the Bureau in the case of death of all persons in a status not listed above whose death occurs at a naval activity or in a naval vessel.

17-12. NAVMED-N, Copies to Other U.S. Government Activities

(1) U.S. Air Force.—In case of death of a member of the U.S. Air Force occurring at a naval activity or aboard a naval vessel, a signed copy of the NAVMED-N shall be forwarded to the Office of the Surgeon General, U.S. Air Force, Washington, D.C.

(2) U.S. Coast Guard.—In each case of death of a member of the U.S. Coast Guard occurring at a naval activity or aboard a naval vessel, a signed copy of the NAVMED-N shall be forwarded to the Commandant, U.S. Coast Guard, Washington, D.C., marked to the attention of the Personnel Military Morale Division.

(3) U.S. Army.—In case of death of a member of the U.S. Army occurring at a naval activity or aboard a naval vessel, a signed copy of the NAVMED-
17-12

N shall be forwarded to the Office of the Adjutant General, Department of the Army, Washington, D. C., marked to the attention of the Personnel Bureau.

(4) Regional Offices of the Veterans Administration.—In cases of death of beneficiaries of the Veterans Administration, local arrangements may be made between the commanding officer of the naval hospital where death occurs and the local regional office of the Veterans Administration authorizing the admission of the patient, as to the number of copies of NAVMED-N to be furnished routinely to the regional office. However, the original and one copy of the NAVMED-N shall be forwarded to the Bureau in accordance with the instructions set forth in article 17-11 (2).

17-13. NAVMED-N, Copies to Other Than U. S. Government Activities

(1) All requests for copies of NAVMED-N, other than requests from the activities listed in article 17-12, shall be promptly forwarded to the Bureau for action. The requesting activity shall be informed of the action taken.

17-14. NAVMED-N, Detailed Instruction for Preparing

"From" line.—On the first line of the NAVMED-N, the name and address of the ship or station and the
name and address of other activities submitting the certificate shall be recorded. Do not use such expressions as “Commanding Officer,” “Medical Officer,” etc.

**Number Space for Unidentified Cases.—** In the upper right corner of the NAVMED-N there is an unnumbered item whereby unidentified cases may be assigned consecutive numbers preceded by capital letter “X.” It is not intended that this space be used during peace time. During and following combat many remains may be found that cannot be identified locally. In this type of case the activity handling the unidentified remains will assign a number to the remains and complete the NAVMED-N as far as practicable, and will make a rolled fingerprint impression of all fingers on the reverse side of the NAVMED-N. Each fingerprint should be so marked as to the finger from which it was taken. Upon receipt of the NAVMED-N, the Bureau will take necessary steps to have the remains identified.

**Item 1, Name.—** Record full name, last name first in capital letters, followed by full given names.

**Item 2, Sex.—** Record capital letter “X” in appropriate block.

**Item 3, Race.—** Record the race in the appropriate block as Caucasian, Negroid, or in the OTHER block as Mongolian, Indian (American), or Malayan.

(a) Puerto Rican (white) shall be recorded as Caucasian, and Puerto Rican (Negro) shall be recorded as Negroid.

(b) Chinese, Japanese, and Korean shall be recorded as Mongolian.

(c) Filipino, Samoan, Chamorro, and Hawaiian shall be recorded as Malayan.

**Item 4, Status.—**

(a) If deceased was an active duty member of the Regular Navy or Marine Corps at time of death, record an “X” in block marked “Regular Active.”

(b) If a member of the Naval Reserve or Marine Corps Reserve on active duty, record an “X” in block marked “Reserve Active.”

(c) If on the retired list of the Navy, Naval Reserve, Marine Corps, or Marine Corps Reserve, record an “X” in block marked “Retired.” Further qualification of status of retired personnel is required by indicating in block marked “Other” the word “Active” in case the deceased was on active duty at time of death or the word “Inactive” if the deceased was not on active duty.

(d) If the deceased was an Honorary Retired member of the Naval Reserve or Marine Corps Reserve, record an “X” in block marked “Retired” and further qualify his status by recording “HonRet” and word “Active” or “Inactive” as applicable, in block marked “Other.”

(e) If deceased was a dependent of a member of the National naval or military establishment, record an “X” in block marked “Dependent” and record in block marked “Other” the department of which the member is a part; i.e., Navy, Army, Air Force.

(f) If deceased was a Veterans Administration Beneficiary, record an “X” in block marked “VAP.”

When it is determined that a Veterans Administration Beneficiary was also an inactive member of the Navy Reserve, Marine Corps Reserve, Fleet Reserve, Fleet Marine Corps Reserve, or was a retired member of the Navy, Naval Reserve, Marine Corps or Marine Corps Reserve, items 7, 8, 9 (if applicable), and 10 shall be completed. The word “Inactive” shall be recorded in the block marked “Other” in item 4. If retired record an “X” in block marked “Retired” in item 4.

(g) If deceased was an inactive member of the Fleet Reserve or Fleet Marine Corps Reserve, record the word “Inactive,” in block marked “Other.”

(h) If deceased was a member of the Naval Reserve or Marine Corps Reserve on training or drill duty, at time of death, record “Training Duty” or “Drill Duty,” as applicable in block marked “Other.”

(i) The status of other deceased persons shall be recorded in block marked “Other” in item 4, as in cases of “USAF-Act,” “USCG-Ret,” “Humanitarian,” etc.

**Item 5, Length of Service.—** The length of service to be recorded is for active duty only, including active duty for training and drill periods.

**Item 6, Aviation.—** To be completed for personnel on active duty (including training duty and drill periods). Cause or circumstances of death are not
to be considered in this item. The only question to be answered is: Was the deceased at the time of admission to the sick list serving under orders involving flying? Record an “X” in the appropriate box.

<table>
<thead>
<tr>
<th>7. FILE OR SERVICE NO.</th>
<th>8. RANK OR RATE</th>
<th>9. CORPS</th>
<th>10. BRANCH OF SERVICE</th>
<th>11. PLACE OF BIRTH (City)</th>
<th>(State or Country)</th>
</tr>
</thead>
<tbody>
<tr>
<td>243 60 72</td>
<td>AOOC</td>
<td>USN</td>
<td>Dumas</td>
<td>Arkansas</td>
<td></td>
</tr>
</tbody>
</table>

Item 7, File or Service Number.—Record file number in case of officer personnel and service number in case of enlisted personnel.

Item 8, Rank or Rate.—Use approved abbreviations (see article C-2102, Bureau of Naval Personnel Manual). In the case of Reserve personnel, include also their classification; i.e., V6, O1, F4D, F6, etc.

Item 9, Corps.—Abbreviate the corps; i.e., “MC” for Medical Corps officers, “SC” for Supply Corps officers, etc.

<table>
<thead>
<tr>
<th>12. DATE OF BIRTH (Month)</th>
<th>(Day)</th>
<th>(Year)</th>
<th>13. AGE (Years)</th>
<th>(Months)</th>
<th>(Days, if under 1 year)</th>
<th>14. RELIGION</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>23</td>
<td>1924</td>
<td>2</td>
<td>7</td>
<td></td>
<td>P</td>
</tr>
</tbody>
</table>

Item 12, Date of Birth.—The month shall be spelled out, and the day and year recorded in numerals; i.e., July 23, 1924.

Item 13, Age.—If deceased was over 1 year of age, record age in years and months. For infants under 1 year of age, record the age in months and days.

<table>
<thead>
<tr>
<th>15. COLOR OF EYES</th>
<th>16. COLOR OF HAIR</th>
<th>17. COMPLEXION</th>
<th>18. HEIGHT</th>
<th>19. WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown</td>
<td>Medium Brown</td>
<td>Ruddy</td>
<td>67&quot;</td>
<td>145 lbs</td>
</tr>
</tbody>
</table>

Item 15, Color of Eyes.—Record color of eyes as blue or brown, as applicable. Do not use expressions such as “Negro,” “Filipino,” etc.

Item 16, Color of Hair.—Record the color of the hair as flaxen, sandy (yellow-red), auburn (red-brown), brown (light, medium, or dark), black, gray, etc. Do not use expressions such as “Negro,” “Filipino,” etc.

Item 17, Complexion.—Record complexion as pale, sallow, fair, ruddy, florid, dark, very dark, etc. Do not use expression such as “Negro,” “Filipino,” etc.

Item 18, Height.—Record the height in inches.

Item 19, Weight.—Record the weight in pounds.

Item 20, Marks and Scars.—Record marks and scars as noted on the body.

Item 21, Fingerprint.—Make rolled impression of right index finger. If for any reason a fingerprint of the right index finger cannot be made, make a rolled impression of one of the other fingers. State which finger was used in making the fingerprint. Use fingerprint ink, or else stamp pad ink will suffice. When positive identification cannot be established, rolled impressions of all 10 fingers, if possible, or of all fingers available, shall be taken and forwarded to the Bureau on the reverse side of the
17-14  

CHAPTER 17. DEATHS  

NAVmed-N or on a blank sheet with each digit properly marked. In taking fingerprints of men who have been recovered from water, the skin on the

22. NEXT OF KIN OR FRIEND

(Wife): Mrs. Minnie Parker Doe 2213 E. Elm Street

Oakdale, Pennsylvania

Item 23, Next of Kin or Friend.—Record relationship, name, and address of the next of kin or in cases where there is no known next of kin, the name

and address of a friend as recorded in the decedent’s records.

23. ADMITTED TO SICK LIST FROM (If on active duty, last duty station before current admission to sick list)

U. S. NAVAL AIR STATION, SAN DIEGO, CALIFORNIA

March 7 1949

Item 23, Admitted to Sick List From.—To be completed only in cases of personnel on active duty, training duty, or drill status. Record the name of the ship or activity to which the individual was assigned (i.e., his duty station) at the time he was first admitted to the sick list and from which admission he was continuously carried on the sick list until death. Example: A man on leave or liberty from the USS Chicago, becomes ill or is injured while

ashore and is admitted directly to the U. S. Naval Hospital, Long Beach, Calif., and from that hospital is transferred as a patient to U. S. Naval Hospital, Bethesda, Md., where he died; “USS CHICAGO” should be recorded in item 23.

Item 24, Date Admitted to Sick List.—Record the month, day, and year the individual was admitted to the sick list for the continuous stay that terminated in death.

24. DATE ADMITTED TO SICK LIST (MM/DD/YYYY)

March 7 1949

Item 25, Place of Death.—If the death occurred on board a naval vessel or within the confines of a naval activity, record the name of the ship or activity as the place of death. If death occurred outside a naval activity, record the name of the geographic unit within which death occurred; i.e.,

“Chicago, Illinois,” “Ventura County (Near Oxnard) Calif.”

Item 26, Time of Death.—Record the month, day, and hour that death occurred, using local time not zone time. If the exact time of death is not known, record the probable date of death based on all known facts, and amplify in item 30.

26. TIME OF DEATH (MM/DD/YYYY HH/MM)

March 7 1949 11:40

Item 27, Cause of Death.—(a) The medical certification section of NAVmed-N is that recommended by the National Office of Vital Statistics and is in use throughout the United States. It provides space for the recording of the sequence of events leading to death and for other unrelated morbidity conditions, together with space for indicating the time relationships of the various diagnoses. For the tabulation of statistics in the Bureau, the underlying cause of death, as selected by the medical officer, is used. Although the cause of death is established only for statistical and administrative purposes within the Navy Department it is essential that great care be exercised in the proper completion of the medical certification.

27. CAUSE OF DEATH

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e.g., heart failure, suicide, etc. It means the disease, injury, or complication which caused death.)

<table>
<thead>
<tr>
<th>Antecedent Cause</th>
<th>Approximate Interval Between Onset and Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture, Compound, Skull</td>
<td>None</td>
</tr>
</tbody>
</table>

2. OTHER SIGNIFICANT CONDITIONS. (Conditions contributing to death but not related to the disease or condition causing death.)

<table>
<thead>
<tr>
<th>Other Significant Condition</th>
<th>Approximate Interval Between Onset and Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Item 28, Admitted to Sick List.—(b) To be completed only in cases of personnel on active duty, training duty, or drill status. Record the name of the ship or activity to which the individual was attached (i.e., his duty station) at the time he was first admitted to the sick list and from which admission he was continuously carried on the sick list until death.
(b) In box (a) of Part I enter the name of the condition leading directly to death. This does not mean symptoms (such as toxemia, convulsions, etc.), or the particular manner of dying (heart failure, respiratory arrest, etc.). It means the disease, injury, or complication that caused death. If the body is not recovered, enter “Cause Unknown.” If advanced post mortem changes prevent determination of the cause of death, “Cause Unknown” shall be entered on this line. In boxes (b) and (c) enter the conditions, if any, which gave rise to the condition (a), stating the underlying cause last. The underlying cause of death is defined as the disease or injury which initiated the train of events leading to death.

(c) In Part II enter the name of any other significant condition which may have contributed to death but which was not related to the condition or conditions included in Part I. For all causes entered in either part, the approximate duration should be given in the appropriate box.

Examples of Medical Certification:

1. A man dies instantaneously following an automobile accident in which he sustained a compound fracture of the skull.
   I (a) Fracture, depressed, compound, skull, duration 0
   (b) ________
   (c) ________

2. A patient admitted with a teratoma of the left testis is found to have metastasis to both lungs. Six months later he develops broncho-pneumonia and dies in 5 days.
   I (a) Broncho-pneumonia, 5 days.
   (b) Carcinoma, metastatic, lungs, 6 months plus
   (c) Teratoma, testis, left, 8 months plus

3. A patient with known arteriosclerotic heart disease of 2-years duration has a coronary thrombosis. Two weeks later it is discovered that he has pulmonary tuberculosis, active. Six days later he dies a cardiac death.
   I (a) Thrombosis, coronary artery, 20 days
   (b) Arteriosclerotic heart disease, 2 years
   (c) ________
   II (a) Tuberculosis, pulmonary, active, moderately advanced, duration unknown

4. A patient with known diabetes of 10-years duration develops gangrene of the right great toe. Five days later he develops a staphylococcic septicemia and on the third day thereafter, dies.
   I (a) Septicemia, staphylococcus, 3 days
   (b) Gangrene, rt. great toe, 8 days
   (c) Diabetes mellitus, 10 years

5. A patient with acute appendicitis develops peritonitis 24 hours after the onset of symptoms, and 3 days later dies with signs of toxemia. At autopsy he is found also to have moderately advanced pulmonary tuberculosis.
   I (a) Peritonitis, Acute, 3 days
   (b) Appendicitis, Acute, 4 days
   (c) ________
   II (a) Tuberculosis, pulmonary, active, moderately advanced, duration unknown

Item 28.—This item is for Bureau use only and will not be written in by the field.

(Continued)

25. NAME

DOE, John James 2h3 60 72

Item 29, Name.—Record decedent’s name in full, as in item 1. Also record file or service number.
While deceased was performing his assigned duties as a member of the crew of TBMQ3 airplane, Bureau No. 1900003, on an authorized gunnery practice flight, the plane crashed near the north runway shortly after becoming airborne.

Death was instantaneous. Examination of the remains by the medical officer revealed a depressed fracture of the skull in the right temporal region with a jagged 2-inch laceration of the scalp at the site of the fracture. No other evidence of external violence was noted.

NO AUTOPSY PERFORMED.

Identity of the remains was established by comparison with marks and scars and dental records, and identification by several shipmates.

Item 30, Summary of Facts Relating to Death.—Record pertinent facts concerning the origin of the disability causing death, important diagnostic data including significant ante mortem and post mortem findings, character and date of operations, duration and principal points in the course of the fatal disease, injury, or poisoning, and other facts in support of items 26 and 27 where indicated. In cases of active duty personnel when death occurs away from command, information relative to leave or liberty status shall be included. A brief résumé of the circumstances resulting in death shall be included in all cases of unnatural death. Whenever an autopsy or toxicological examination is performed, the findings shall be recorded. If no autopsy is performed, record “NO AUTOPSY PERFORMED.” Information as to how remains were identified shall be recorded.

Transferred to U. S. Naval Hospital, San Diego, California, for preparation and disposition.

Item 31, Disposition of Remains.—Enter information as to the disposition that has been or will be made of the remains, at time the NAVMED-N is prepared. In cases where the remains were not recovered, enter “Not Recovered” in this space.

Item 32.—The NAVMED-N shall be signed by the medical officer, or in the absence of a medical officer, by the medical department representative. The signature of the medical officer or the medical department representative shall be his usual signature and shall be affixed above his typewritten name. The rank or rate of the individual signing the NAVMED-N and the date he signs it shall be recorded in the appropriate spaces.

Item 33.—The commanding officer will verify the NAVMED-N in accordance with Navy Regulations, and complete item 33 indicating if a Court of Inquiry or Board of Investigation will be held. This information shall be recorded in every death report. The commanding officer shall sign his usual signature in the appropriate space above his typewritten name; his rank and the date he signs the certificate shall be recorded in the appropriate spaces.
Section II. DEATH OCCURRING AWAY FROM COMMAND

17-15. Death Occurring Away From Command

(1) When a member of the Navy or Marine Corps in an active duty status dies while away from his duty station and the services of a medical officer of the Navy are not available, the medical officer, or in the absence of a medical officer, the medical department representative of the ship or station to which the individual was attached, shall obtain a certificate of death from the proper civil authorities. The assistance of the commandant of the naval district in which the death occurred should be requested, in procuring the civil death certificate. If the civil death certificate does not furnish all necessary information, the commandant of the naval district in which the death occurred should be requested to obtain the additional information. If death occurs abroad and no naval activity is available, the nearest United States consular officer should be requested to obtain a certificate of death. Upon obtaining the certificate of death and other necessary information, the medical officer or medical department representative shall prepare NAVMED-N and forward it to the Bureau together with the supporting papers and the terminated Health Record.

(2) Deleted.

(3) If a member of the Navy or Marine Corps dies while on detached duty, or awaiting orders, the medical officer of the naval district within which the individual dies, shall prepare NAVMED-N from such facts as he may be able to obtain.

Section III. DEATH OF INACTIVE PERSONNEL AT OTHER THAN NAVAL ACTIVITIES

17-16. Death of Retired Inactive Personnel

(1) When a district medical officer receives information indicating that a member of the naval service, retired with pay, has died at other than a naval activity, he shall procure a copy of the civil death certificate and submit it together with NAVMED-N to the Bureau. Staff medical officers of commandants of river commands and force commanders shall act in the same manner as district medical officers.

17-17. Death of Inactive Fleet Reservists

(1) When a district medical officer receives information indicating that an inactive member of the Fleet Reserve or Fleet Marine Corps Reserve has died, he shall procure a copy of the civil death certificate and submit it together with NAVMED-N to the Bureau. Staff medical officers of commandants of river commands and force commanders shall act in the same manner as district medical officers. Records of inactive Fleet Marine Corps Reserve personnel are administered by directors of Marine Corps Reserve districts, and whenever a district medical officer submits NAVMED-N on a member of the Fleet Marine Corps Reserve, a signed copy of the NAVMED-N shall be forwarded to the director of the Marine Corps Reserve district so that that officer may properly terminate the individual's records and forward them to Headquarters, Marine Corps. For Fleet Reserve personnel, the terminated Health Record shall accompany the NAVMED-N to the Bureau; for Fleet Marine Corps Reserve personnel, it shall be forwarded to the Bureau by the director of the Marine Corps Reserve district on receipt of signed copy of NAVMED-N.

Note.—There is no article 17-18.

17-19. Death at St. Elizabeths Hospital

(1) Upon the death of an officer or enlisted person of the Navy or Marine Corps in St. Elizabeths Hospital, Washington, D.C., or of a former member of the Navy or Marine Corps who was continued as a patient in that hospital from date of discharge from the service, NAVMED-N shall be prepared by the Navy Medical Department representative assigned to duty in that institution.

Note.—There is no section IV or article 17-20.

Section V. MISSING PERSONNEL

17-21. Missing Personnel

(1) A NAVMED-N shall not be prepared if the person is reported as "missing."

Section VI. INVESTIGATION OF DEATH

Note.—There are no articles 17-22 through 17-23.

17-24. Post Mortem Examinations and Autopsies

(1) When a member of the uniformed services in an active duty status dies aboard a naval vessel, at a naval station, in a naval aircraft, or outside the jurisdiction of local civil authorities of the United States, and (a) death occurs under unnatural or suspicious circumstances, (b) there is reason to believe that the cause of death might constitute a menace to the public health, (c) the
cause of death is unknown, or (d) death occurs while serving as an aircrew member in a military aircraft, the medical officer will recommend to the commanding officer having custody of the remains that a post mortem examination be authorized to determine the cause of death. Under these circumstances the commanding officer may authorize such a post mortem examination.

(2) Except as set forth in subarticle 17-24(1), autopsies may be performed only with the consent of the person or persons having the right of custody of the remains for burial or upon request of the local coroner or medical examiner. When authorization for a post mortem examination is required such authorization shall be obtained on Standard Form 523 (Authorization for Post Mortem Examination).

(3) Whenever an autopsy is performed it shall be done promptly and with a minimum of disfiguration. The expeditious release of remains for preparation, encasement, and shipment to the next of kin is of utmost importance. All autopsies shall be reported on Standard Form 503 (Autopsy Protocol) and a copy thereof shall be attached to the original of the NAVMED-N which is forwarded to the Bureau.

Note.—There are no sections VII through X or articles 17-26 through 17-65.

Section XI. FUNERAL EXPENSES

17-66. Burial at Sea of Inactive Personnel or Civilians

(1) Requests to conduct burials at sea of the remains of inactive service personnel or civilians shall be referred by the senior officer present to the Chief of Naval Operations for authorization, with a statement as to the practicability of complying with the request. If authority is granted, arrangements for the burial shall be made directly with authorized persons having charge of the remains. The date of burial will be determined by the availability of the naval vessel concerned.

(2) The following papers shall be presented to the commanding officer concerned before the remains are taken into the custody of the Navy:

Section XVI. MILITARY SEA TRANSPORTATION SERVICE PERSONNEL

17-75. Civil Service Employees Other Than Civilian Marine Employees

(1) through (3) deleted.

(4) NAVMED-N (Certificate of Death).—The original and one copy of NAVMED-N shall be prepared and forwarded to the Bureau of Medicine and Surgery in accordance with articles 17-11(2) and 17-14. An information copy shall be forwarded to the Commander, Military Sea Transportation Service.

17-76. Civilian Marine Employees

(1) through (4) deleted.

(5) Other Reports.—

(a) Deleted.

(b) NAVMED-N (Certificate of Death).—Instructions contained in article 17-75(4) are applicable.

17-77. Military Crewmembers and Military or Civilian Passengers of Military Sea Transportation Service Vessels.—

(a) The request and authorization from the authorized person having charge of the remains.

(b) A transit permit or burial permit issued by the responsible civil authorities at the place of death, whether or not the remains are cremated. Appropriate entry regarding the presentation of such papers, together with specific identifying data regarding them, shall be entered in the log.

(3) After the burial, the above-mentioned papers shall be appropriately endorsed by the commanding officer of the ship concerned as to the fact of the burial, and forwarded to the Secretary of the Navy.

(4) There is no authority for the direct expenditure of Government funds for materials in connection with disposition of remains in such cases.

Note.—There are no sections XII through XV or articles 17-67 through 17-74.

Note.—There are no pages 17-12 through 17-34.
these individuals shall be dispatched to the Bureau for prior approval.

17-23. Courts of Inquiry, Boards of Investigation, and Administrative Reports

(1) Attention is invited to the Naval Supplement to the Manual for Courts-Martial, United States, 1951, relative to investigative procedure to be taken whenever loss of life occurs.

17-24. Post Mortem Examinations and Autopsies

(1) When a member of the uniformed services in an active duty status dies aboard a naval vessel, at a naval station, in a naval aircraft, or outside the jurisdiction of local civil authorities of the United States, and death occurs (a) under unnatural or suspicious circumstances, or (b) when there is reason to believe that the cause of death might constitute a menace to the public health, or (c) when the cause of death is unknown, or (d) when death occurs while serving as an aircrew member in a military aircraft, the medical officer shall recommend to the commanding officer that such post mortem examination be done as may be required to determine the cause of death.

(2) Except as set forth in subarticle 17-24 (1), autopsies may be performed only with the consent of the person or persons having the right of custody of the remains for burial or upon request of the local coroner or medical examiner. When authorization for a post mortem examination is required such authorization shall be obtained on Standard Form 523 (Authorization for Post Mortem Examination).

(3) Whenever an autopsy is performed it shall be done promptly and with a minimum of disfiguration. The expeditious release of remains for preparation, encasement, and shipment to the next of kin is of utmost importance. All autopsies shall be reported on Standard Form 503 (Autopsy Protocol) and a copy thereof shall be attached to the original of the Navmed-N which is forwarded to the Bureau.

17-25. Relations With Civil Authorities

(1) When death of a person in the naval service occurs outside the limits of a naval reservation, the body shall not be moved by naval personnel until permission has been obtained from the proper civil authorities. In order that there may be full understanding and accord between naval and civil authorities, appropriate procedure should be developed for each command area, in consultation with the civil authorities, covering deaths of naval personnel both within and without the limits of naval commands. In general and except where the state has retained concurrent jurisdiction with the United States, civil authorities have no jurisdiction over deaths occurring on naval reservations. However, a transit or burial permit, issued by the proper civil authority, is required for removal of a body from a naval reservation either for shipment or burial.

Section VII. NOTIFICATION OF NEXT OF KIN

Continental Activity Having Contract

Extracontinental Ships and Stations

17-26. Continental Activity Having Contract

(1) When death occurs in a naval hospital or at a shore station within the continental limits of the United States having a contract for the care of the dead, or when such activity has taken charge of the remains, the commanding officer shall notify by dispatch the next of kin or legal representative of the deceased, if residing within the United States, and, without reference to the Bureau, make such disposition of the remains as may be requested, unless transportation beyond the continental limits of the United States is involved or the deceased is not entitled by law to burial or transportation at public expense. When the address of the next of kin is outside the continental limits of the United States, the next of kin will be notified by the Department of the Navy on receipt of the dispatch addressed to the Secretary of the Navy required by article 17-1. Disposition of remains in such cases shall await the instructions of the Bureau of Medicine and Surgery or the Commandant of the Marine Corps, as the case may be. Reference should be made to article 17-55 (3).

(2) Immediately after notifying the next of kin by dispatch that death has occurred, the commanding officer shall send a letter to the next of kin. The letter shall contain only (a) expression of condolences; and (b) any details concerning the death which the commanding officer deems appropriate for inclusion. No reference of an unfavorable nature shall be made to line of duty or conduct status, nor shall details be included which would be likely to aggravate the distress of the next of kin. Neither the dispatch nor the letter to the next of kin shall contain any information which will in any manner disclose movements of ships or jeopardize communication security.

(3) The following form of dispatch shall be employed to notify the next of kin of the death of any person (a) on active duty in the Regular Navy or Marine Corps; (b) on the retired list of the Navy or Marine Corps who was on active duty at the time
of death; and (e) of the Naval Reserve or Marine Corps Reserve who was on active duty or training duty at the time of death:

(a) In cases where commercial air freight for transportation of remains is available from the point of departure:

WITH DEEP REGRET I OFFICIALLY REPORT THE DEATH OF YOUR (relationship, name, grade or rate, branch of service) FROM (brief statement of cause of death) ON (date) AT (or ABOARD) (activity, place, or ship) X YOU WILL RECEIVE DETAILS BY LETTER X HIS (or HER) REMAINS WILL BE PREPARED AND FITTINGLY ENCASED AND HELD UNTIL YOU NOTIFY (appropriate person or activity) OF YOUR WISHES BY COLLECT TELEGRAM X BURIAL MAY BE MADE IN ANY OPEN NATIONAL CEMETERY YOU SELECT OR REMAINS WILL BE DELIVERED ELSEWHERE IF DESIRED X REMAINS WILL BE SHIPPED BY RAIL UNLESS COMMERCIAL AIR FREIGHT IS REQUESTED AND AVAILABLE TO DESTINATION X WHEN RAIL TRANSPORTATION IS USED IF REQUESTED AND PRACTICABLE ONE PERSON CIVILIAN OR MILITARY CAN ESCORT REMAINS TO PLACE OF BURIAL X AN ESCORT CANNOT BE AUTHORIZED WHEN SHIPMENT IS MADE BY COMMERCIAL AIR X ALL WITHOUT COST TO YOU X YOU WILL BE ALLOWED A SUM NOT TO EXCEED ONE HUNDRED AND TWENTY-FIVE DOLLARS FOR FUNERAL AND BURIAL SERVICES PRIOR TO BURIAL IN A NATIONAL CEMETERY IF SUCH SERVICES ARE REASONABLE AND NECESSARY AND NOT Duplicated NOR FURNISHED BY THE GOVERNMENT X YOUR (relationship) DIED WHILE SERVING HIS (or HER) COUNTRY AND I EXTEND MY SINCERE SYMPATHY IN YOUR GREAT LOSS X (Signed by commanding officer, showing name, grade, and title.)

(b) In cases where commercial air freight for transportation of remains is not available from point of departure:

WITH DEEP REGRET I OFFICIALLY REPORT THE DEATH OF YOUR (relationship, name, grade or rate, branch of service) FROM (brief statement of cause of death) ON (date) AT (or ABOARD) (activity, place, or ship) X YOU WILL RECEIVE DETAILS BY LETTER X HIS (or HER) REMAINS WILL BE PREPARED AND FITTINGLY ENCASED AND HELD UNTIL YOU NOTIFY (appropriate person or activity) OF YOUR WISHES TO COLLECT TELEGRAM X BURIAL MAY BE MADE IN ANY OPEN NATIONAL CEMETERY IF SUCH SERVICES ARE REASONABLE AND NECESSARY AND NOT Duplicated NOR FURNISHED BY THE GOVERNMENT X YOUR (relationship) DIED WHILE SERVING HIS (or HER) COUNTRY AND I EXTEND MY SINCERE SYMPATHY IN YOUR GREAT LOSS X (Signed by commanding officer, showing name, grade, and title.)

(4) The following form of dispatch shall be employed to notify next of kin of death of a retired officer or enlisted person of the Navy or Marine Corps who was on inactive duty at the time of death; of an officer or enlisted person of the Naval or Marine Corps Reserve on inactive duty, except an individual retained for treatment following expiration of active duty period:

WITH DEEP REGRET I OFFICIALLY REPORT THE DEATH OF YOUR (relationship and name) FROM (brief statement of cause of death) ON (date) X YOU WILL RECEIVE DETAILS BY LETTER X PLEASE TELEGRAPH NAVAL HOSPITAL (address) IMMEDIATELY WHAT DISPOSITION YOU DESIRE MADE OF REMAINS X REGRET NAVY CANNOT DEFRAy ANY EXPENSES OF PREPARATION ENCASEMENT OR TRANSPORTATION X SINCEREST SYMPATHY EXTENDED X (Signed by commanding officer, showing name, grade, and title.)

(5) The following form of dispatch shall be employed to notify next of kin of the death of (a) any person of the Naval or Marine Corps Reserve who was transferred to a naval hospital during a period of active duty or training duty, but whose death occurred in a hospital after expiration of such training or active duty; (b) a former enlisted person of the Navy or Marine Corps retained in a naval hospital for treatment after discharge from service; and (c) an accepted applicant for enlistment in the Marine Corps:

WITH DEEP REGRET I OFFICIALLY REPORT THE DEATH OF YOUR (relationship, name, grade or rate, branch of service) FROM (brief statement of cause of death) ON (date) AT (or ABOARD) (activity, place, or ship) X YOU WILL RECEIVE DETAILS BY LETTER X HIS (or HER) REMAINS WILL BE PREPARED AND FITTINGLY ENCASED AND HELD UNTIL YOU NOTIFY (appropriate person or activity) OF YOUR WISHES TO COLLECT TELEGRAM X BURIAL MAY BE MADE IN ANY OPEN NATIONAL CEMETERY IF SUCH SERVICES ARE REASONABLE AND NECESSARY AND NOT Duplicated NOR FURNISHED BY THE GOVERNMENT X YOUR (relationship) DIED WHILE SERVING HIS (or HER) COUNTRY AND I EXTEND MY SINCERE SYMPATHY IN YOUR GREAT LOSS X (Signed by commanding officer, showing name, grade, and title.)

17-14

Change 5
SEVENTY-FIVE DOLLARS FOR SERVICES PRIOR TO BURIAL IN A NATIONAL CEMETERY IF SUCH SERVICES ARE REASONABLE AND NECESSARY AND NOT DUPLICATED NOR FURNISHED BY THE GOVERNMENT X REGRET ESCORT CANNOT BE DELEGATED TO ACCOMPANY REMAINS X SINCEREST SYMPATHY EXTENDED X (Signed by commanding officer, showing name, grade, and title.)

(6) The following form of dispatch shall be employed to notify the next of kin of the death of a Veteran Administration patient:

WITH DEEP REGRET I REPORT THE DEATH OF YOUR (relationship and name) A VETERANS ADMINISTRATION PATIENT FROM (brief statement of cause of death) ON (date) X ADDITIONAL INFORMATION WILL BE SENT TO YOU BY REGIONAL MANAGER VETERANS ADMINISTRATION (place) WITH WHOM ALL ARRANGEMENTS FOR DISPOSITION OF REMAINS SHOULD BE MADE X SINCEREST SYMPATHY EXTENDED X (Signed by commanding officer, showing name, grade, and title.)

(7) The following form of dispatch shall be employed to notify the next of kin of death of a pensioner or destitute patient:

WITH DEEP REGRET I REPORT THE DEATH OF YOUR (relationship and name) FROM (brief statement of cause of death) ON (date) X YOU WILL RECEIVE DETAILS BY LETTER X PLEASE TELEGRAPH NAVAL HOSPITAL (address) IMMEDIATELY WHAT DISPOSITION YOU DESIRE MADE OF REMAINS X INTERMENT CAN BE MADE BY NAVY IN (name of cemetery) AT GOVERNMENT EXPENSE BUT LAW PROHIBITS PAYMENT OF EXPENSES FOR TRANSPORTATION HOME OR TO ANOTHER LOCALITY X SINCEREST SYMPATHY EXTENDED X (Signed by commanding officer, showing name, grade, and title.)

17–27. Continental Activity Not Having Contract

(1) When a death occurs on board a ship in a port within the continental limits of the United States or at a station within the continental limits not having a contract for care of the dead, and transfer of the remains to an activity having a contract is not practicable, the medical officer shall prepare a dispatch as indicated below for delivery to the proper authority for transmittal to the next of kin or legal representative of the deceased:

(a) In cases where commercial air freight for transportation of remains is not available from the point of departure:

WITH DEEP REGRET I OFFICIALLY REPORT THE DEATH OF YOUR (relationship, name, grade or rate, branch of service) FROM (brief statement of cause of death) ON (date) AT (or ABOARD) (activity, place, or ship) X YOU WILL RECEIVE DETAILS BY LETTER X NAVY (or MARINE CORPS) LIABILITY FOR PREPARATION AND ENCASEMENT OF REMAINS IS LIMITED TO THREE HUNDRED DOLLARS X REMAINS WILL BE HELD UNTIL YOU NOTIFY BUREAU OF MEDICINE AND SURGERY DEPARTMENT OF NAVY WASHINGTON D C (or cognizant Marine Corps activity as appropriate) OF YOUR WISHES BY COLLECT TELEGRAM X BURIAL MAY BE MADE IN ANY OPEN NATIONAL CEMETERY YOU SELECT OR REMAINS WILL BE DELIVERED ELSEWHERE IF DESIRED X REMAINS WILL BE SHIPPED BY RAIL UNLESS COMMERCIAL AIR FREIGHT IS REQUESTED AND AVAILABLE TO DESTINATION X WHEN RAIL TRANSPORTATION IS USED AND IF REQUESTED AND PRACTICABLE ONE PERSON CIVILIAN OR MILITARY CAN ESCORT REMAINS TO PLACE OF BURIAL X AN ESCORT CANNOT BE AUTHORIZED WHEN SHIPMENT IS MADE BY COMMERCIAL AIR X ALL WITHOUT COST TO YOU X YOU WILL BE ALLOWED AN ADDITIONAL SUM NOT TO EXCEED ONE HUNDRED AND TWENTY-FIVE DOLLARS FOR FUNERAL AND BURIAL SERVICES IN A PRIVATE CEMETERY OR SEVENTY-FIVE DOLLARS FOR SERVICES PRIOR TO BURIAL IN A NATIONAL CEMETERY IF SUCH SERVICES ARE REASONABLE AND NECESSARY AND NOT DUPLICATED NOR FURNISHED BY THE GOVERNMENT X YOUR (relationship) DIED WHILE SERVING HIS (or HER) COUNTRY AND I EXTEND MY SINCERE SYMPATHY IN YOUR GREAT LOSS X (Signed by commanding officer, showing name, grade, and title.)

(b) In cases where commercial air freight for transportation of remains is not available from the point of departure:

WITH DEEP REGRET I OFFICIALLY REPORT THE DEATH OF YOUR (relationship, name, grade or rate, branch of service) FROM (brief statement of cause of death) ON (date) AT (or ABOARD) (activity, place, or ship) X YOU WILL RECEIVE DETAILS BY LETTER X NAVY (or MARINE CORPS) LIABILITY FOR PREPARATION AND ENCASEMENT OF REMAINS IS LIMITED TO THREE HUNDRED DOLLARS X REMAINS WILL BE HELD UNTIL YOU NOTIFY BUREAU OF MEDICINE AND SURGERY DEPARTMENT OF NAVY WASHINGTON D C (or cognizant Marine Corps activity as appropriate) OF YOUR WISHES BY COLLECT TELEGRAM X BURIAL MAY BE MADE IN ANY OPEN NATIONAL CEMETERY YOU SELECT OR REMAINS WILL BE DELIVERED ELSEWHERE IF DESIRED X REMAINS WILL BE SHIPPED BY RAIL UNLESS COMMERCIAL AIR FREIGHT IS REQUESTED AND AVAILABLE TO DESTINATION X WHEN RAIL TRANSPORTATION IS USED AND IF REQUESTED AND PRACTICABLE ONE PERSON CIVILIAN OR MILITARY CAN ESCORT REMAINS TO PLACE OF BURIAL X AN ADDITIONAL SUM NOT TO EXCEED ONE HUNDRED AND TWENTY-FIVE DOLLARS FOR FUNERAL AND BURIAL SERVICES IN A PRIVATE CEMETERY OR SEVENTY-FIVE DOLLARS FOR SERVICES PRIOR TO BURIAL IN A NATIONAL CEMETERY IF SUCH SERVICES ARE REASONABLE AND NECESSARY AND NOT DUPLICATED NOR FURNISHED BY THE GOVERNMENT X YOUR (relationship) DIED WHILE SERVING HIS (or HER) COUNTRY AND I EXTEND MY SINCERE SYMPATHY IN YOUR GREAT LOSS X (Signed by commanding officer, showing name, grade, and title.)

17–15

Change 4
SUM NOT TO EXCEED ONE HUNDRED AND TWENTY-FIVE DOLLARS FOR FUNERAL AND BURIAL SERVICES IN A PRIVATE CEMETERY OR SEVENTY-FIVE DOLLARS FOR SERVICES PRIOR TO BURIAL IN A NATIONAL CEMETERY IF SUCH SERVICES ARE REASONABLE AND NECESSARY AND NOT DUPLICATED NOR FURNISHED BY THE GOVERNMENT X YOUR (relationship) DIED WHILE SERVING HIS (or HER) COUNTRY AND I EXTEND MY SINCERE SYMPATHY IN YOUR GREAT LOSS X (Signed by commanding officer, showing name, grade, and title.)

The letter shall conform to instructions in article 17-26 (2). Neither the dispatch nor the letter to the next of kin shall contain any information which will in any manner disclose movements of ships or jeopardize communication security.

(2) When the remains have been transferred to a naval hospital or shore station having a contract for the care of the dead, the forms of dispatch shown in articles 17-26 (3) (a) and 17-26 (3) (b) shall be used, with the next of kin being requested to communicate directly with the commanding officer of such hospital or shore station.

17-28. Extracontinental Ships and Stations

(1) In time of peace when death occurs at a station or on board a ship in a port outside the continental limits of the United States, or at sea, the Department of the Navy will notify the next of kin, if residing in any place other than the locality where death occurs, on receipt of the dispatch notification of death addressed to the Secretary of the Navy, and disposition of the remains shall await instructions of the Bureau of Medicine and Surgery or Commandant of the Marine Corps, as appropriate. Should the address of the next of kin be near the station or port, the ship or station shall notify the next of kin and inform the Bureau of Medicine and Surgery by dispatch as to disposition of remains desired by the next of kin and whether the next of kin is returning to the United States with the remains and if so, the home address.

(2) In time of war appropriate instructions will be issued by the Secretary of the Navy regarding disposition of remains of Navy, Marine Corps, and Coast Guard dead. The Department of the Navy will notify the next of kin upon receipt of the dispatch notification of death addressed to the Secretary of the Navy.

(3) When transfer ashore cannot be accomplished within reasonable time limitations or is inadvisable, burial at sea is permissible. Remains shall not be cremated, except as a sanitary measure, without prior approval of the Bureau.

Section VIII. PREPARATION OF REMAINS

17-29. Embalming and Inspection

(1) The remains of naval dead shall be prepared for interment or shipment under the supervision of a naval medical officer, and when prepared by naval personnel, shall be embalmed in conformity with instructions contained in the Handbook of the Hospital Corps.

(2) When embalming cannot be immediately accomplished, failure to properly refrigerate and care for remains may result in their not being viewable upon arrival at destination. Therefore, when death occurs aboard a ship at sea and embalming facilities are not available, or when death occurs at a naval hospital and embalming will be delayed, the remains should be refrigerated, if suitable facilities are available, at a temperature of from 34 to 40°F, to prevent decomposition. If refrigeration is not practicable, such reason shall be set forth in detail on the NAVMED-N.

(3) The officer supervising the preparation of remains shall determine by final inspection in each instance that embalming, cleansing, shaving, and dressing of the body have been properly performed, and that the clothing and encasement meet the requirements of the occasion. If practicable, there should be two inspections: the first, after embalming has been completed, but before the body has been clothed, to determine the efficacy of the embalming process; the second, after the body has been clothed and encased, to determine the general appearance, completeness, correctness, and condition of the uniform and clothing, position in casket, and condition of casket. The conditions noted on such inspections should be made the subject of a memorandum report for file with the clinical record of the deceased. New clothing shall be obtained, if necessary, and charged to the appropriation "Medical Care, Navy."

(4) In no instance shall a body be released for shipment until the inspecting officer is satisfied it is so preserved that it may be reasonably expected to reach its destination in proper condition. Whenever necessary, the body should be held for repeated attention until its condition is satisfactory. If for any unusual reason satisfactory results cannot be obtained, the relatives of the deceased shall be informed in advance, and the casket shall be sealed and plainly marked "NOT TO BE OPENED."

Note.—There are no articles 17-30 and 17-31.
17–32. Preparation and Encasement in Cases of Death by Violence

(1) In cases of aviation or other accident involving death of naval personnel by violence, the commandant having jurisdiction shall take measures to insure the proper preparation, clothing, encasement, and disposition of the remains, including detailed instructions to the undertaker having charge and provision for necessary inspection prior to release for shipment. The instructions in subarticle 17–32 (2) should be issued in such cases.

(2) In the event of advanced decomposition, maceration, mutilation, or dismemberment of bodies, the remains should be treated by any or all of the following procedures as found necessary:

(a) Evisceration, in order to minimize leaking and facilitate preservation by either pickling or injection of vessels.

(b) Filling the body cavities with cotton or similar material saturated with formalin, followed by suturing of skin.

(c) Pickling by injection of vascular trunks and along bones, and by massive infiltration of muscles and other portions of the body, using full strength formalin, and wrapping parts in cotton soaked in formalin.

(d) Closure of all wounds by sewing and by supplementary bandaging if necessary.

(e) Use of the usual fungistatic and insect sprays as described in the Handbook of the Hospital Corps.

(f) When sawdust is used to absorb moisture or leakage, place beneath the body enclosed in a porous bag to form a mattress.

(g) Obtain the best structural restoration and cosmetic results possible.

(h) Obtain and clothe or shroud with proper uniform clothing of the rank or rate and provide a national flag to accompany the remains.

(i) Notify both next of kin and undertaker at destination that, due to circumstances of death, the remains are not in condition to be viewed and, therefore, that the casket should not be opened.

Section IX. TRANSPORTATION OF REMAINS

Rules Regarding Transportation of Remains................................................................. 17-32
Method of Transportation............................................................................................. 17-33
Express Shipment by Rail............................................................................................. 17-34
Shipments by Air........................................................................................................... 17-35
When Accompanied by Escort.................................................................................... 17-36
Arrangements To Be Made at Transfer Points......................................................... 17-37
Shipments of Personal Effects..................................................................................... 17-38
Information for Next of Kin or Consignee................................................................. 17-39
Transportation of Remains to Arlington National Cemetery.................................. 17-40

17–33. Rules Regarding Transportation of Remains

(1) Rules regarding transportation of the dead require:

(a) Remains of persons who have died of smallpox, plague, Asiatic cholera, typhus fever, diphtheria, and scarlet fever, or other contagious or communicable diseases shall be placed at once in a metal-lined casket which shall be hermetically and permanently sealed.

(b) No disinterred body shall be transported by common carrier unless approved by the health authorities having jurisdiction at the place of disinterment. Disinterment and transportation of remains of persons who have died of the communicable diseases named in subarticle 17–33 (1) above shall not be allowed except by special permission of the health authorities at both the place of disinterment and the point of destination. All disinterred remains shall be enclosed in metal or metal-lined boxes, hermetically sealed; provided, that the bodies in a receiving vault, when prepared by licensed embalmers, shall not be regarded as disinterred bodies until after the expiration of 30 days.

(c) A transit permit and a transit label issued by the proper health authorities shall be required for each body transported by common carrier.

(d) The outside case may be omitted when the casket is transported in a hearse.

17–34. Method of Transportation

(1) When transportation of remains of an individual of the Navy or Marine Corps is to be effected, the shipment, if by rail, shall be either on two first-class passenger tickets procured by transportation request or by express on Government bill of lading; by commercial air, on Government bill of lading; and if by commercial steamship, on minimum first-class fare. When remains have been cremated, and no escort is to accompany them, shipment shall be by mail or express at the usual rate according to weight; if an escort is to carry them, only the ticket for the escort is required (article 17-48).

17-17
17-35. Express Shipment by Rail

(1) When remains are not to be accompanied by an escort, shipment shall be effected by express on Government bill of lading, Standard Form-1103, and companion forms. On the face of all copies shall be typed or stamped in capital letters, preferably in red ink, the following notations: "NO CHARGES WILL BE COLLECTED ON THE SHIPMENT. TRANSPORTATION CHARGES WILL BE PAID BY THE DEPARTMENT OF THE NAVY." These forms shall be prepared and disposed of as follows:

(a) The original bill of lading (Form 1103) shall be tendered to the express agent who will forward it with the shipment. On delivery of remains by express agency at destination, it shall be signed by consignee and returned to the express agent. One yellow copy (Form 1103a), accompanied by the following letter, shall be forwarded immediately by special delivery to the consignee, enclosing an addressed and franked envelope for return of the yellow copy:

Dear Sir:

There is enclosed hereewith a copy of the Government bill of lading covering transportation of the remains of ___________ which will be forwarded on train No. ______ (R. R.) ___________ (date and hour) ___________.

When delivery has been made, please sign this copy and return it to this station in the enclosed addressed envelope which requires no postage.

On delivery of the remains, the original bill of lading will be presented to you by the express agent. Please fill in the consignee's certification of delivery appearing near the bottom of the form, sign, and return it to the agent.

Please note the instructions printed on the face of the form directing that you pay no charges.

Very truly yours,

(b) Forms 1104, 1105, and 1106 shall be left with the agent of the express company at the time Form 1103 is signed.

(c) Two yellow copies (Form-1103a) shall be delivered to the undertaker for further delivery to the agent of the express company, one copy to be retained by the agent and one copy to be returned promptly to the naval activity making the shipment with the weight and cost entered thereon.

(d) One yellow copy (Form-1103a), with the weight and cost of shipment indicated, shall be filed in the case paper jacket of the deceased.

(e) One yellow copy (Form-1103a), with the weight and cost of shipment indicated, shall be furnished the finance officer for entry in the appropriate accounting records.

(f) One yellow copy (Form-1103a) shall be securely pasted on the shipping case to indicate to the transportation company that transportation charges are payable by the Government and must not be collected from the consignee.

(g) One yellow copy (Form-1103a), with the weight and cost of shipment as obtained from the express company, shall be mailed to the Quartermaster General, United States Marine Corps, for Marine Corps dead only. In the case of Army and Air Force personnel, this copy shall be mailed to the Quartermaster General, U. S. Army, and in the case of Coast Guard personnel it shall be mailed to Headquarters, U. S. Coast Guard.

(2) In addition to the copy of the bill of lading, a special label, prohibiting collection of express charges from consignee, shall be obtained from the local express agent and attached to the outside case.

(3) On express shipment, when weight of encased remains does not exceed 500 pounds, corpse transportation will be double the standard one-way, first-class passenger rate, but never less than $3.30 for any distance. When the weight exceeds 500 pounds, either by express or on two first-class tickets, the excess is charged for at the regular first-class rate.

17-36. Shipment by Air

(1) Shipment by Commercial Air Freight.—Bills of lading for shipment of remains by commercial air freight shall be prepared in accordance with instructions contained in article 17-35. The letter described in article 17-35 (1) (a) shall be modified as necessary and forwarded to the consignee by special delivery airmail.

(2) Shipment by Government Air.—

(a) In cases where death occurs outside the continental United States, surface transportation shall be utilized for movement of remains of deceased naval personnel to the United States. However, in any case where Government air transportation is readily accessible, such may be utilized with the Bureau of Medicine and Surgery being so informed, together with information as to the date and time of departure and the place and time of arrival in the United States. When death occurs at a place where facilities for embalming or encasement are not available, transportation by airplane to another overseas military activity, within practicable flying distance, where such services are available, may be effected through the local command. Similarly, transfer of remains by air to another overseas activity for return to the United States by surface vessel may be arranged locally and the Bureau of Medicine and Surgery so informed.

(b) Government air transportation for the remains of the dead normally will not be requested nor provided within the continental United States. However, if final destination is outside the continental United States, authority for use of Government air, if readily accessible, may be requested from the Bureau of Medicine and Surgery from shipping point in the United States to the air terminal in the area in which interment is to be made.

17-18

Change 4
17-37. When Accompanied by Escort

(1) If the body is to be shipped by rail on transportation request, an escort must accompany the remains. The transportation request issued for the shipment of the corpse will call for a one-way first-class adult ticket. When the weight is in excess of 500 pounds, the officer issuing the transportation request shall enter on the face thereof the total weight of the encased remains, and the carrier will bill the
Department of the Navy for the excess weight. The transportation request issued for the escort will call for the class of ticket determined by the status of the traveler as provided by the United States Navy Travel Instructions. The corpse will be transported by baggage service. One escort may accompany more than one corpse.

17–38. Arrangements To Be Made at Transfer Points

(1) When a body is shipped by express, it will be handled by the carrier from the point of origin to final destination. The party performing final transfer at a junction point will bill against the carrier whose baggage agent arranges for the services, and the carrier will present the bill to the Department of the Navy, in the usual manner, accompanied by transfer certificates.

(2) When shipment is by transportation request, the disbursing officer shall advance cash to the escort to cover transfer of remains between railroad stations, as follows:

(a) For each transfer required, a sum sufficient to cover all costs in connection therewith shall be advanced.

(b) The escort shall be instructed to secure receipts from the transfer company to cover the transfer of the corpse, and on return to his station shall return these receipts, together with unused cash, to the disbursing officer. Civilian escorts shall be similarly instructed.

(3) When the final destination is at a point not on a railroad, shipment shall be made to the nearest shipping point and the consignee shall be notified to arrange for receipt of remains at that point and for delivery of the remains to the final destination. The consignee shall be informed that he may submit the carrier's certified bill for reasonable transportation of such nature to the Bureau or that he may pay the charges and submit the certified bill to the Bureau for reimbursement.

(4) When a body is shipped by air, it must be handled by carrier from point of origin to final destination. In the event it is necessary to change the schedule, routing, or mode of transportation, the carrier shall notify the activity which made shipment, and that activity will advise the next of kin of the delay, if any, and issue new instructions, if necessary. Expenses in connection therewith, other than notification to the next of kin, will be borne by the carrier.

17–39. Shipment of Personal Effects

(1) Navy Personnel.—The commanding officer shall, upon the death of any Navy personnel under his command, cause all of the effects of the decedent, including money, articles of value, papers, keepsakes, and other similar effects, to be collected and inventoried. If the deceased was an officer, this shall be done by two officers; if a member of the crew or other person, it shall be done by the officer of the deceased's division or by one detailed for that purpose, and a petty officer. The inventory shall be prepared in triplicate, attested and signed by the officers making the inventory. One copy shall be retained by the commanding officer, one copy shall be delivered to the supply officer together with the package containing the effects, and the third copy shall be sent to the Chief of Naval Personnel. Upon completion of the inventory, the effects, if not of a perishable nature, shall be put in packages of a convenient size and sealed. Transportation of effects of deceased officers and enlisted personnel of the Navy and of officers and enlisted personnel of the Naval Reserve who die while on duty is authorized. When the remains are shipped by express and when personal effects accompany the remains the Railway Express Agency allows up to 150 pounds as free transportation. Therefore, in packing effects which are to move by express with the remains, the weight shall be kept within 150 pounds. Any effects in excess of 150 pounds shall be separately packed and shipped under Government bill of lading. When the remains are shipped by air, shipment of personal effects shall be made by Railway Express unless they are excessively bulky, in which case they should be shipped by freight. When there is no doubt as to the next of kin of the deceased, personal effects within the continental United States shall be shipped as soon as possible without awaiting specific authorization from the Department of the Navy. Personal effects returned from points outside the continental United States in the Atlantic Ocean area shall be forwarded to the Supply Officer, Naval Supply Center, Norfolk, Virginia, and in the Pacific Ocean area to the Personal Effects Distribution Center, Naval Supply Depot, Clearfield, Ogden, Utah. If the next of kin or legal heirs are present, all effects may be delivered to them and receipt obtained.

(2) Marine Corps Personnel.—

(a) Upon the death of any person in the Marine Corps, the commanding officer shall cause all of the effects of the deceased to be collected and inventoried. If the deceased was an officer, this shall be done by two officers detailed for that purpose; if an enlisted man, by an officer detailed for that purpose. The inventories shall be made in quadruplicate and signed by the officer or officers making them.

(b) The commanding officer shall retain one copy of the inventory; one copy shall be delivered to the organization supply officer, who shall take charge of the effects; two copies shall be forwarded to the Commandant of the Marine Corps, one of which shall be marked for the Quartermaster General of the Marine Corps, and the other for the Director of Personnel. In the cases of enlisted personnel, the second copy shall be securely attached to the service record book of the deceased.

(c) In cases where the deceased at the time of death resided with his next of kin in private or public quarters, inventorying the personal effects in these quarters and which remain in possession of the
next of kin is not necessary. A statement of the circumstances should be incorporated in the inventory of the effects located in other places, or if there are no personal effects, such statement should be prepared and distributed in lieu of an inventory.

(d) All money, articles of value, papers, keepsakes, and other similar effects shall be forwarded to the legal representative or next of kin, and should accompany the remains whenever practicable if the weight of the effects does not exceed the limit carried free by commercial carriers. When an escort accompanies the remains, he shall assure safe delivery of the effects to the next of kin and obtain a receipt therefor which shall be forwarded to the Commandant of the Marine Corps (Code: O). If any of the effects of deceased personnel are determined to be perishable or deteriorating, they may, in the discretion of the commanding officer, be sold at auction and the proceeds of the sale disposed of in the same manner as other money found in the effects. Detailed information concerning disposition of personal effects of Marine Corps personnel can be found in Chapter 13 of the Marine Corps Manual.

(3) Coast Guard Personnel.—
(a) Upon the death of an individual of the Coast Guard under the jurisdiction of the Navy within the continental United States, a request shall be made to the Commandant, Coast Guard, Washington, D. C., for instructions relative to the disposition of personal effects.
(b) Upon the death of an individual of the Coast Guard under the jurisdiction of the Navy outside the continental United States, all money, articles of value, papers, keepsakes, and other similar effects shall be forwarded to the Commandant, Coast Guard. All other personal effects shall be forwarded to the nearest personal effects distribution center (art. 17–39 (1)).

(4) Army Personnel.—Upon the death of an individual of the Army under the jurisdiction of the Navy within the continental United States, when there is no doubt as to the next of kin of the deceased, personal effects shall be shipped directly to the next of kin. If there is any question as to the next of kin, the effects shall be forwarded to the nearest Army activity for further disposition. This procedure shall also be followed in case of death under the jurisdiction of the Navy outside the continental United States.

(5) Air Force Personnel.—Instructions contained in subarticle 17–39 (4) are applicable to Air Force personnel when death occurs under the jurisdiction of the Navy either within or outside the continental United States.

(6) Former Enlisted Personnel.—The personal effects of former enlisted personnel, discharged at naval hospitals and remaining as inmates until death, shall not be shipped at Government expense. When the remains of such patients are to be shipped home, however, personal effects weighing not more than the amount carried free may accompany the remains. The effects so forwarded should be those articles of greatest value, such as money, papers, keepsakes, jewelry, etc. The next of kin shall be informed of the character and cost of shipment of any remaining effects and required to advance transportation charges. If unclaimed, the effects shall be held for a period of not less than 1 year and then destroyed or otherwise disposed of as the commanding officer may direct.

(7) Veterans Administration Patients.—The effects (including safekeeping deposits) of Veterans Administration patients who die in naval hospitals shall be delivered to the Veterans Administration regional manager (or his authorized representative) having jurisdiction of the case. Receipt, in duplicate, shall be obtained from the manager or representative of the Veterans Administration to whom the effects are delivered. The duplicate of the receipt shall be retained in the files of the naval hospital. The original shall be mailed to the Bureau of Naval Personnel for former members of the Navy or Naval Reserve; to the Commandant of the Marine Corps, for former members of the Marine Corps; or to the nearest personal effects distribution center for Marine Corps Reserve; to the Secretary of the Navy, via the Judge Advocate General, in all other cases.

17–40. Information for Next of Kin or Consignee

(1) The next of kin, family, legal representative of the deceased, or any other party serving as consignee shall be informed by telegram of the time and method of forwarding the body, and, if practicable, the routing and scheduled time of arrival. The consignee also shall be advised of any special attending circumstances, such as communicable disease and the advisability of opening the casket for the purpose of viewing the remains.

17–41. Transportation of Remains to Arlington National Cemetery

(1) Transportation of Navy and Marine Corps dead to Arlington National Cemetery shall be governed by the following provisions:
(2) The shipping case shall be marked "Officer in Charge, Arlington National Cemetery, Fort Meyer, Virginia," and the bill of lading or transfer request shall be marked "Washington, D. C." The transit
CHAPTER 17. DEATHS

permit shall be issued to show Fort Myer, Virginia, as the terminal point. This will avoid the necessity and delay of obtaining a permit for transfer of the body through the District of Columbia.

(3) A telegram shall be sent at the earliest possible moment to the officer in charge of the cemetery, giving the full name and rank or rate of the deceased, the date and place of death, dimensions of the outside box, and the date, hour, name of railroad and number of the train on which the body will reach Washington. Whenever practicable, the shipment of the remains should be timed so as to arrive in Washington between the hours of 0800 and 1600 week days. Arrival on Sundays or holidays should be avoided.

(4) Upon receipt of the telegram the officer in charge will give instructions to have the remains met at the railroad station by a Government hearse, conveyed to Arlington, and placed in the receiving vault pending subsequent arrangements for interment. The services of an undertaker in Washington are not required in these cases, nor is there any expense attached to the opening and closing of the grave in Arlington.

(5) Interment will not be made in Arlington National Cemetery on Saturdays, Sundays, or holidays, or after 1500 on other days.

(6) As military honors are provided at every burial, an additional telegram shall be addressed to the Chief of Naval Personnel or the Commandant of the Marine Corps, as appropriate, giving the full name, rank or rate, time of arrival of the body, stating whether or not relatives accompany the body, the date on which it is desired that the services be held, and whether complete or simple military services are desired. At least 24 hours are required to complete funeral arrangements. If relatives are to be in attendance, they shall be instructed, upon arrival in Washington, to communicate immediately with the aide to the Chief of the Bureau of Naval Personnel, Department of the Navy, or the Commandant of the Marine Corps, as may be appropriate.

Section X. CORPSE ESCORT

<table>
<thead>
<tr>
<th>Authority</th>
<th>17-42</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Furnished</td>
<td>17-43</td>
</tr>
<tr>
<td>Selection and Detail</td>
<td>17-44</td>
</tr>
<tr>
<td>Travel Instructions</td>
<td>17-45</td>
</tr>
</tbody>
</table>

17-42. Authority

(1) An escort, not to exceed one person, may be provided to accompany to place of burial the remains of naval personnel who have lost their lives in the naval service (Act of May 26, 1928, 34 USC 923). The escort furnished under this authority may be a relative or friend (not in the service) of the deceased. As the law provides for an escort of only one person, when a civilian accompanies the remains as escort a service escort shall not be detailed.

17-43. When Furnished

(1) If requested and practicable, a service or civilian escort of one person shall be assigned to accompany the remains to place of burial. An escort need not be furnished unless specifically requested by the next of kin.

17-44. Selection and Detail

(1) The escort, if of the service, shall be of equivalent rank or rate of the deceased as nearly as may be practicable, and, when possible, a friend or associate. The escort will be detailed and the necessary orders issued by the commandant of the naval district or a command authorized to issue orders to officer or enlisted personnel when shipment of the remains is made from a naval hospital. If the remains have been transferred to the hospital from a ship in port, the commanding officer of the ship should, when
(3) When remains are returned to the United States from a point outside the continental limits, an escort is not authorized from such point to the port of entry in the United States, except that a dependent who may be otherwise legally entitled to transportation under the provisions of Navy Travel

Instructions may act as escort. The commanding officer of the activity designated to assume charge of the remains shall arrange for an escort from the port of entry to final destination of remains.

Note.—There are no articles 17-46 through 17-54.

Section XI. FUNERAL EXPENSES

Disposition of Remains at Activities Having Burial Contracts

17-55. Disposition of Remains at Activities Having Burial Contracts

(1) Before making disposition of remains, the hospital or station having a contract for care of the dead shall definitely determine the status of the deceased in relation to the laws governing funeral and burial expenses, and shall determine that the instructions for disposition come from the designated next of kin or legal representative of the deceased, or are given by some person acting in accordance with the wishes of such next of kin or legal representative.

(2) A copy of NAVMED-61, or, for marines, NAVMC-817-SD (Information for Next of Kin) shall be sent to the next of kin or consignee and, whenever practicable, shall be sent so as to arrive in advance of remains.

(3) When the next of kin cannot be located, when the body is not claimed by the next of kin or legal representative, when there are conflicting claims, or when, for any reason, there is doubt as to the proper disposition to be made of the body, the facts shall be reported by dispatch to the Bureau or to Headquarters, Marine Corps, with request for instructions.

17-56. Limitation of Expenses

(1) All expenses shall be held to the lowest amount consistent with decent preparation and encasement or to meet the requirements of laws governing transportation.

Note.—There are no articles 17-57 through 17-60.

17-61. Burial Prior to Ascertaining Wishes of Next of Kin

(1) When a body has been buried prior to ascertaining the wishes of the next of kin, or if burial has been rendered necessary, for any reason, when the next of kin has requested shipment, the body may be exhumed and forwarded later, at Government expense, to the place designated by the next of kin. When burial has been made in compliance with the request of the next of kin, the expenses of exhumation and transportation may not be defrayed by the Government.

17-62. Transportation to a Place Outside the United States

(1) Transportation of remains to a place not within the United States may be allowed upon the prior authority of the Bureau or Headquarters, U. S. Marine Corps.

Note.—There are no articles 17-63 through 17-65.

17-66. Burial at Sea of Inactive Personnel or Civilians

(1) Requests to conduct burials at sea of the remains of inactive service personnel or civilians shall be referred by the senior officer present to the Chief of Naval Operations for authorization, with a statement as to the practicability of complying with the request. If authority is granted, arrangements for the burial shall be made directly with authorized persons having charge of the remains. The date of burial will be determined by the availability of the naval vessel concerned.

(2) The following papers shall be presented to the commanding officer concerned before the remains are taken into the custody of the Navy:

(a) The request and authorization from the authorized person having charge of the remains.

(b) A transit permit or burial permit issued by the responsible civil authorities at the place of death, whether or not the remains are cremated. Appropriate entry regarding the presentation of such papers, together with specific identifying data regarding them, shall be entered in the log.

(3) After the burial, the above-mentioned papers shall be appropriately endorsed by the commanding officer of the ship concerned as to the fact of the burial, and forwarded to the Secretary of the Navy.

(4) There is no authority for the direct expenditure of Government funds for materials in connection with disposition of remains in such cases.

Change 4
17-67. Funeral Ceremonies
(1) Funeral ceremonies are conducted in accordance with the provisions of chapter 21 (section 10), Navy Regulations.

17-68. National Flag
(1) Commanders of shipyards, commanding officers of vessels, senior officers present, and commanding officers of naval hospitals are authorized to issue the national flag (United States National Ensign No. 8, cotton, Specification MIL-F-1392—Flags, National Ensigns, U. S. Interment, dated 31 Oct. 1949) to accompany all bodies of Navy or Marine Corps personnel forwarded or delivered to the next of kin or relatives for private interment, in order that the flags may be available for use at the time of burial. A flag will be issued in each case where a request is received for the remains. The flag shall be enclosed in a suitable canvas bag or sack and securely attached to the casket, or placed inside the shipping box, in which case the box shall be labeled "Flag Inside" or the consignee otherwise notified. At activities where flags are not carried by the supply department, they may be obtained, as required, from the Veterans Administration by application to local post offices. When flags are procured in this manner, application for their replacement will be made to the Bureau by the Veterans Administration.

(2) Flags used for draping caskets of personnel of the Navy which are issued to relatives, schools, patriotic orders, or societies, in accordance with the Naval Appropriation Act of June 30, 1914, as amended (34 U.S.C. 551) shall be requisitioned, as a charge to the Medical Department appropriation current at time requisition is submitted and to Program Allotment 30000 and Expenditure Account 79020. Flags for draping caskets of Marine Corps personnel will be issued by commanding officers of Marine Corps posts and stations in accordance with article 13061 of the Marine Corps Manual. Retired officers and enlisted personnel, and also members of the Naval Reserve and Marine Corps Reserve when on active duty, are officers and enlisted personnel within the meaning of Title 34 U. S. C. 551.

17-69. Care of Dead
(1) Coast Guard Personnel.—Whenever deaths of Coast Guard personnel occur in naval activities or whenever naval hospitals are requested to assume charge of Coast Guard dead, the care, transportation, and burial of the remains shall be arranged in the same manner as for Navy dead except that all expenses, including cost of funeral flags, shall be billed to the Coast Guard and all reports transmitted to Coast Guard Headquarters, Washington, D. C. When services in connection with the care of Coast Guard dead are procured under a Navy contract, payment should be made in the usual manner by public voucher drawn directly under the appropriation "General Expenses, Coast Guard," of the applicable fiscal year. In practical cases, the Coast Guard shall be requested to notify the next of kin of deaths among its personnel and obtain all instructions for the disposition of the bodies.

(2) Army and Air Force Personnel.—In cases of death of Army and Air Force personnel under the jurisdiction of the Navy, reimbursements for the cost to the Medical Department of supplies and services required in connection with the preparation of the remains will be made at Bureau level by the respective Departments. All Medical Department activities furnishing such supplies (caskets, burial flags, other mortuary supplies) and services (care of the dead contract) shall submit to the Bureau the following information on NAVMEDA-127 in quadruplicate:

(a) Name, grade, serial number and organization of decedent.
(b) Itemized list of supplies and services furnished, with the cost of each.
(c) A certification of receipt of such supplies and services signed by a responsible Army or Air Force officer, as appropriate.

Notes.—Sections XIV and XV and articles 17-70 through 17-73 have been deleted.
Section XVI. MILITARY SEA TRANSPORTATION SERVICE PERSONNEL

17-74. General

(1) See, in general, article 17-71. For the purpose of these instructions, the Military Sea Transportation Service is composed of shore based activities, commissioned vessels of the Navy (USS), and civil service manned vessels (USNS) under the administrative control of the Commander, Military Sea Transportation Service. Personnel of the Military Sea Transportation Service includes:

(a) Civil service employees other than civilian marine employees.

(b) Civilian marine employees (which include that category of employees referred to in previous Military Sea Transportation Service regulations as civilian seamen).

(c) Military crewmembers and military or civilian passengers.

As the result of an agreement between the Bureau and the Commander, Military Sea Transportation Service, the Medical Department of the Navy has assumed responsibility for the care and disposition of the remains of deceased civilian marine employees on a reimbursable basis. The care, disposition, and transportation of remains of military crewmembers and military passengers is the same as prescribed in sections VIII through XII of this chapter. The recording and reporting of death is the responsibility of the master of the vessel in the case of civilian crewmembers, and of the commanding officer or the commanding officer of the military department in the case of military crewmembers and military or civilian passengers unless otherwise assumed by a Military Sea Transportation Service shore-based activity or other naval medical activity.

17-75. Civil Service Employees Other Than Civilian Marine Employees

(1) At Shore Based Activities.—When the death of a civilian employee of the Navy occurs at a Military Sea Transportation Service shore-based activity, the Military Sea Transportation Service area commander or other Military Sea Transportation Service activity head shall accomplish the dispatch report to the Secretary of the Navy and shall notify the next of kin of the death and the circumstances under which death occurred and where the remains are being held until appropriate arrangements are made by the family for removal and interment.

(2) In a Travel Status in the United States Away From Their Stations.—

17-24

Change 4

(a) Report of death.—When a commanding officer of a naval activity, a Military Sea Transportation Service area commander, or other Military Sea Transportation Service representative is cognizant of the death of a civilian employee of the Military Sea Transportation Service having occurred near his command while the employee was traveling on official orders away from his official place of employment, he shall report the death by dispatch to the Secretary of the Navy giving:

(1) Full name of employee.

(2) Date, place, and cause of death.

(3) Name, address, and relationship of the next of kin.

(4) The disposition that has been or will be made of the remains.

(5) The Military Sea Transportation Service activity to which the employee was attached.

The Bureau of Medicine and Surgery; the Military Sea Transportation Service activity to which the employee was attached; and the Commander, Military Sea Transportation Service shall be made information addresses of the dispatch.

(b) Notification of next of kin.—The Military Sea Transportation Service activity to which the employee was attached shall notify the next of kin unless the next of kin resides outside the continental United States. When the address of the next of kin is outside the continental United States, the next of kin will be notified by the Bureau of Medicine and Surgery on receipt of the dispatch report to the Secretary of the Navy. Under no circumstances will the dispatch refer to line of duty or conduct status of the deceased. If unable to notify the next of kin promptly, the Secretary of the Navy shall be notified by dispatch, with the Bureau of Medicine and Surgery and the Commander, Military Sea Transportation Service, as information addresses, giving the reasons the next of kin cannot be notified. The Bureau will then take the necessary further action.

(c) Letter to next of kin.—Immediately after notifying the next of kin that death has occurred, the Military Sea Transportation Service commander shall send a letter to the next of kin in accordance with article 17-28 (2).

(d) Expenses allowed.—Instructions contained in article 17-72 are applicable. All allowable expenses incident to care of the remains are chargeable to the appropriation “Medical Care, Navy.”

(3) Performing Official Duties Outside the United States or in a Foreign Country.—
(a) Notification of Next of Kin.—Upon receipt of the dispatch report of death, the Bureau of Medicine and Surgery will notify the next of kin.

(b) Expenses Allowed.—Instructions contained in article 17-73 are applicable. Expenses incident to care, preparation, embalming, clothing, and encasement or cremation of the remains and of transportation to the place of interment and/or local burial are chargeable to the appropriation “Medical Care, Navy.”

(4) NAVMED—N (Certificate of Death).—The original and one copy of NAVMED—N shall be prepared and forwarded to the Bureau of Medicine and Surgery in accordance with articles 17-11 (2) and 17-14. An information copy shall be forwarded to the Commander, Military Sea Transportation Service.

17-76. Civilian Marine Employees

NOTE.—Subarticles 17-76 (1), (2), and (3) have been deleted.

(4) Expenses Allowed.—

(a) When death occurs within the United States while a civilian marine employee is in a duty status away from his home port, instructions contained in article 17-72 are applicable. Expenses are chargeable to the appropriation “Medical Care, Navy,” subject to reimbursement from the Military Sea Transportation Service.

(b) When death of a civilian marine employee occurs while he is in a duty status outside the United States, or in a foreign country, or in transit thereto or therefrom, instructions contained in articles 17-73 (3) and 17-73 (4) shall be followed, with the exception that the maximum allowance of $300 imposed by article 17-73 (4) in cases where the remains are not cared for under a contract for care of the dead may be exceeded to the extent compelled by due regard for decent burial. Whenever possible, the remains shall be placed in the custody of a naval activity having a contract for care of the dead for transfer to the contract undertaker for preparation and encasement. A corpse escort is not authorized. All authorized expenses are chargeable to the appropriation “Medical Care, Navy,” subject to reimbursement from Military Sea Transportation Service funds.

(c) Expenses in cases of civilian marine employees of the Military Sea Transportation Service who die on Military Sea Transportation Service vessels or while accompanying troops in the field may be allowed, provided that death occurs away from the home or official residence of the employee.

5. Other Reports.—

(a) NAVSANDA-127.—All expenditures from Medical Department funds shall be reported to the Bureau of Medicine and Surgery on NAVSANDA-127 in quadruplicate, with copies to the Commander, Military Sea Transportation Service, and the Military Sea Transportation Service area commander of the home port of the vessel. This form shall contain the following information:

1. Name, grade, serial number, and organization of the deceased.

2. Itemized list of supplies and services furnished, with the cost of each.

3. Certification of receipt of such supplies and services, signed by a responsible civilian Marine officer.

(b) NAVMED—N (Certificate of Death).—Instructions contained in article 17-75(4) are applicable.

6. Inventory and Disposition of Personal Effects.—The master of the vessel shall cause all of the effects of the deceased civilian marine employee to be inventoried and shipped in accordance with instructions contained in chapter 1 of the NAVSANDA Publication 239, Military Sea Transportation Service Supply and Disbursing Instructions (For Civilian Manned Vessels).

17-77. Military Crewmembers and Military or Civilian Passengers

1. Military Personnel (Navy) Attached Ashore.—

(a) The recording and reporting of death occurring to naval personnel attached to Military Sea Transportation Service shore-based activities shall be as prescribed in article 17-2, except that the Commander, Military Sea Transportation Service, shall be included as an additional information addressee of the dispatch report.

(b) The Military Sea Transportation Service area commander or other Military Sea Transportation Service activity head to which the individual was assigned shall notify the next of kin with the Bureau of Naval Personnel, the Bureau of Medicine and Surgery, and the Commander, Military Sea Transportation Service, as information addressees. The form of dispatch to the next of kin shall be in accordance with article 17-26 (3) or article 17-27.

(c) In case of death occurring to personnel of shore-based activities outside the continental United States, notification of next of kin will be accomplished by the Bureau of Naval Personnel.

(d) The Military Sea Transportation Service activity to which the individual was attached shall send a letter of condolence to the next of kin as prescribed in article 17-26 (2).

2. Military Crewmembers and Military or Civilian Passengers of Military Sea Transportation Service Vessels.—

(a) Report of Death.—

1. In case of death occurring to a military crewmember or a military or civilian passenger of a

Change 6,
Military Sea Transportation Service vessel, the commanding officer or the commanding officer of the military department shall immediately report by dispatch to the Secretary of the Navy with information to the Bureau of Naval Personnel or Headquarters, U. S. Marine Corps, as appropriate, the Bureau of Medicine and Surgery, the Commander, Military Sea Transportation Service, and the Military Sea Transportation Service area commander of the home port, giving the following information:

(a) Full name.

(b) Rank, rate, position title, or dependent status; officer designator, file, service and/or other identifying number; branch of service or organization.

(c) Status (active, inactive, drill, or training duty; if training duty, number of days authorized); crew member or passenger.

(d) Type of casualty (missing or dead).

(e) Date, place, circumstances, and cause (diagnosis, when applicable).

Note.—There are no pages 17–27 through 17–32.
(f) Full name, relationship, and address of next of kin.

(g) Whether or not the next of kin has been notified (notification ordinarily will be made by the commanding officer or the commanding officer of the military department only if the next of kin and the vessel are in the immediate area where death occurred).

(h) Disposition that has been made or will be made of remains.

* (i) Line of duty and misconduct status. If in nonpay status because of unauthorized absence, state date and hour absence commenced, and whether or not declared a deserter.

* (j) Current rate of pay.

* (k) Whether United States Government Life Insurance or National Service Life Insurance is carried, giving amount and date to which insurance premiums have been paid.

* (l) Name and address of designated beneficiary for death gratuity.

(m) Whether or not there are adequate facilities aboard ship for proper preservation of remains.

(n) What next port of call will be and estimated date of arrival at that port.

(2) In addition to the information addresses listed in subarticle 17-77 (2) (a) (1) above, an information copy of the dispatch report to the Secretary of the Navy shall also be furnished to the Adjutant General, Department of the Army, attention AGPS, and to the Army port commander, in case of Army personnel or their dependents; to the Chief of Staff, U. S. Air Force, attention Casualty Branch, in case of Air Force personnel or their dependents; to the Commandant, U. S. Coast Guard (P/S), Washington, D. C., in case of Coast Guard personnel or their dependents; to the U. S. Office of the Intergovernmental Committee for European Migration, Washington, D. C., in case of Intergovernmental Committee for European Migration staff members or their dependents or migrant persons; and to the American Red Cross Headquarters, Washington, D. C., in case of Red Cross employees or their dependents.

(3) If full information must await later investigation or determination, the dispatch report shall be sent with whatever data is available, to be supplemented with complete information at the earliest possible date.

(b) Notification of next of kin.

(1) The next of kin will be notified as follows:

(a) Naval and Marine Corps personnel or their dependents.—When death occurs and next of kin resides within continental United States, by the Military Sea Transportation Service area commander of the home port; when death occurs or next of kin resides outside continental United States, by the Bureau of Naval Personnel or Headquarters;

(b) Army personnel or their dependents.—By the Adjutant General, Department of the Army, or the Army port commander of the home port. The Military Sea Transportation Service area commander of the home port will confirm and insure that the Commander, Military Sea Transportation Service, is made an information addressee.

(c) Air Force personnel or their dependents.—By the Director of Military Personnel, Headquarters, U. S. Air Force; the Commander, Military Sea Transportation Service, will confirm.

(d) Coast Guard personnel or their dependents.—By the Commandant, U. S. Coast Guard; the Commander, Military Sea Transportation Service will confirm.

(e) Civil Service passengers or their dependents.—By the Bureau of Medicine and Surgery; the Commander, Military Sea Transportation Service will confirm.

(f) Intergovernmental Committee for European Migration staff members or their dependents or migrant persons.—By the U. S. Office of the Intergovernmental Committee for European Migration; the Commander, Military Sea Transportation Service will confirm.

(g) American Red Cross employees or their dependents.—By the American Red Cross Headquarters; the Commander, Military Sea Transportation Service will confirm.

(h) Civilian contract employees or their dependents.—By the Military Sea Transportation Service area commander of the home port, usually through the contractor, with information to the Bureau of Medicine and Surgery and to the Commander, Military Sea Transportation Service.

(i) U. S. or Foreign Government officials or their dependents and such personnel categories not otherwise herein defined.—By the Commander, Military Sea Transportation Service.

(2) Notification of next of kin normally will be made by dispatch with information addressees as described in subarticles 17-77 (2) (a) (1) and (2) above. Under no circumstances will the dispatch refer to line of duty or conduct status. When notification is made by a Military Sea Transportation Service activity, the form of dispatch used for notification of next of kin of the death of active duty Navy or Marine Corps personnel described in articles 17-26 (3) and 17-27 (1) shall be used with necessary modifications; however, commercial air transportation may be offered only for shipment of remains of active-duty Navy or Marine Corps personnel if the next of kin cannot be notified promptly, a dispatch shall be sent to the Secretary of the Navy, with the Bureau of Naval Personnel or Headquarters, U. S. Marine Corps, as appropriate, the Bureau of Medicine and Surgery, the Commander, Military Sea Transportation Service, and the Military Sea Transportation Service area com-

*Applicable only to military personnel of the Navy, Marine Corps, Army, and Air Force.
mander as information addressees, giving reasons why the next of kin cannot be notified. The Department of the Navy will then take the necessary further action.

(c) Letter to next of kin.—At the earliest practicable time the commanding officer or the commanding officer of the military department shall write a letter to the next of kin in accordance with instructions contained in article 17-26. Copies of this letter shall be forwarded promptly to the Bureau of Naval Personnel or Headquarters, U. S. Marine Corps, as appropriate, to the Commander, Military Sea Transportation Service, and to the Military Sea Transportation Service area commander.

(d) Entry in logs and records.—The commanding officer or the commanding officer of the military department will obtain from medical personnel, if assigned, any additional information necessary for entry in his log or other records and will furnish the master of the ship (USNS) with necessary information for entry in the ship’s log.

(e) Other reports.—On each vessel having a medical officer, a civilian ship’s doctor or a Medical Department representative, such medical personnel will provide the commanding officer or the commanding officer of the military department with the assistance necessary to accomplish the other reports required by this Manual. Where no such medical personnel are on board, the Military Sea Transportation Service area commander at the home port will assign responsibility for preparation and submission of the necessary reports to the medical division.

(1) NAVMED-N (Certificate of Death).—NAVMED-N shall be prepared and submitted in accordance with articles 17-11 (2) and 17-14. An information copy shall be forwarded to the Commander, Medical Sea Transportation Service and to the Military Sea Transportation Service area commander of the home port. In case of Army, Air Force or Coast Guard active duty personnel, a copy shall also be forwarded directly to the Surgeon General, Department of the Army; Surgeon General, Department of the Air Force; or U. S. Coast Guard Headquarters, Washington, D. C., as appropriate. One copy shall accompany the remains when they are transferred to another activity. In cases of missing personnel when death is not definitely established or circumstances do not justify a conclusion of death, NAVMED-N shall not be prepared. Final action will be taken by the Bureau of Medicine and Surgery in such cases.

(2) NAVMED-601 (Report of Burial).—The officer in charge of the burial in each case of burial at sea, or burial or reburial ashore beyond the continental limits of the United States, including Alaska, shall submit this form in triplicate to the Bureau. An additional copy shall be forwarded to the Bureau for a deceased person of a foreign nation. Information copies shall be sent to the Commander, Military Sea Transportation Service, and to the Military Sea Transportation Service area commander of the home port, in each case of burial at sea or in a foreign country.

(3) NAVMED-609 (Report of Disposition and Expenditures—Remains of Dead).—This form shall be submitted to the Bureau by each Navy and Marine Corps activity or unit which handles the remains of deceased Navy or Marine Corps personnel for any purpose, even though no expenses are incurred. Information copies shall be forwarded to the Commander, Military Sea Transportation Service, and to the Military Sea Transportation Service area commander of the home port.

(4) NAVMED-F (Individual Statistical Report of Patient).—NAVMED-F should be completed and forwarded to the Bureau of Medicine and Surgery to report termination of diagnosis in case of death of military personnel in accordance with current instructions.

(f) Disposition of remains.—When death occurs at sea or in a port outside the continental United States, the remains shall be embalmed, whenever possible, and retained on board awaiting instructions from the Bureau of Medicine and Surgery or other competent authority, and burial shall not be made in a foreign port or at sea in advance of instructions from the Department of the Navy, except when preservation or retention of the remains is impossible. If there are no facilities for embalming, the remains should be placed under proper refrigeration (34-40° F.) until instructions concerning disposition have been received. In case of death away from the home port within the continental United States, the Military Sea Transportation Service activity or other naval activity at port of destination will assume charge of the remains for care and disposition unless otherwise directed by the Bureau of Medicine and Surgery or the Military Sea Transportation Service area commander of the home port. When death occurs in the home port, the Military Sea Transportation Service area commander will assign responsibility for removal and disposition of remains.

(g) Inventory and disposition of personal effects.—The commanding officer or commanding officer of the military department shall cause all effects of deceased personnel of the Navy, Marine Corps, Army, Air Force, and Coast Guard to be inventoried and shipped in accordance with instructions contained in article 17-39. The disposition of personal effects of deceased personnel, other than those listed above, shall be accomplished in accordance with instructions contained in paragraph 17-312, volume I, chapter 7 of the Bureau of Supplies and Accounts Manual.

17-34
Change 2
17-78. General

(1) National Cemeteries.—The majority of national cemeteries are under the jurisdiction of the Department of the Army; however, a few are under the Department of the Interior. The Quartermaster General, under the direction and control of the Assistant Chief of Staff, Logistics, is responsible for the general supervision of all national cemeteries under the jurisdiction of the Department of the Army and establishes and promulgates the regulations and policies on all matters pertaining thereto. Regulations governing burials in these cemeteries also apply to the national cemeteries under the jurisdiction of the Department of the Interior.

(2) Naval Plots and Cemeteries.—Naval plots and cemeteries are under the control of the Department of the Navy, and with the exception of the Naval Plot, Mount Moriah Cemetery, Philadelphia, Pa., and the Naval Academy Cemetery, Annapolis, Md., the Bureau of Medicine and Surgery is responsible for their care and maintenance. The Naval Plot in the Mount Moriah Cemetery and the Naval Academy Cemetery are under the jurisdiction of the Bureau of Naval Personnel.

17-79. National Cemeteries

(1) Eligibility.—Burial in national cemeteries of the remains of the following classes of persons is authorized under such regulations as the Secretary of the Army may prescribe:

(a) Any member or former member of the armed forces of the United States whose last service was terminated honorably by death or otherwise.

(b) Any citizen of the United States who during any war in which the United States has been or may hereafter be engaged, served in the armed forces of any government allied with the United States during such war, and whose last service was terminated honorably by death or otherwise.

(c) The wife, husband, widow, widower, minor child, and, at the discretion of the Secretary of the Army, unmarried adult dependent child of any of the persons enumerated in subarticles (a) and (b) above, provided that the remains of such dependents may, at the discretion of the Secretary of the Army, be removed from a national cemetery proper and interred in the post section of a national cemetery or in such other military burial ground as the Office of the Quartermaster General may select if, upon the death, the related member of the armed forces of the United States or allied government is not buried in the same or adjoining gravesite. As used in this section, the term “widow” includes the widow of any member of the armed forces of the United States lost or buried at sea or officially determined to be permanently absent in a status of missing or missing in action.

(2) Post Sections.—Post sections exist in certain national cemeteries for burial of the remains of certain categories of personnel who are not entitled to burial in national cemeteries; such as, general prisoners whose discharges have been executed and who die while under the jurisdiction of the Department of Defense, prisoners of war and interred aliens, and unclaimed remains which cannot be transferred to the custody of civil authorities.

(3) Storage.—Except at Arlington National Cemetery, Fort Myer, Va. (see art. 17-41); Golden Gate National Cemetery, San Bruno, Calif.; and Long Island National Cemetery, Farmingdale, N. Y., the national cemeteries have no facilities for storage of remains, services being limited to the opening and closing of the grave. Relatives should be apprised of these limitations and informed that they must make all funeral arrangements with the superintendent of the national cemetery.

(4) Honors.—Naval honors may be provided at cemeteries within a radius of 50 miles of a naval activity having sufficient personnel to furnish the honors provided such participation can be supplied without expense to the Government other than for furnishing such personnel Government means of transportation to place of burial.

(5) List of Cemeteries.—The following national cemeteries are available for burial of the remains of personnel described in subarticle 17-79 (1). Except where instructions to the contrary appear, remains shipped to a cemetery should be consigned to the superintendent. The cemeteries in which post sections exist are marked with an asterisk.

17-81. Change 2

*Contains post section.

Colorado.—
*Port Logan (Denver).

District of Columbia.—
*Soldiers Home.

Florida.—
*Parrancas.

Georgia.—
Andersonville.
*Marietta.

Hawaii.—
National Memorial Cemetery of the Pacific.

Illinois.—
Alton.
Camp Butler (Springfield).
Mound City.
Quincy.
*Rock Island.

Indiana.—
New Albany.

Iowa.—
*Keokuk.

Kansas.—
*Port Leavenworth.

Kentucky.—
Camp Nelson (Nicholasville).
Lebanon.
Mills Springs (West Somerset).
Zachary Taylor (Louisville).

Louisiana.—
*Alexandria (Pineville).

Maryland.—
*Baltimore.
* Loudon Park (Baltimore).

Minnesota.—
*Fort Snelling (Minneapolis–St. Paul).

Mississippi.—
Corinth.
Natchez.
Vicksburg.

Missouri.—
*Jefferson Barracks (St. Louis).

Montana.—
Custer Battlefield (Crow Agency).

Nebraska.—
*Fort McPherson (Maxwell).

New Jersey.—
*Beverly.

New Mexico.—
*Banta Fe.

New York.—
*Long Island (Farmingdale).

North Carolina.—
New Bern.
*Raleigh.
Sailsbury.

Oklahoma.—
Fort Gibson.

Oregon.—
*Williamette (Portland).

Puerto Rico.—
*Puerto Rico National Cemetery (San Juan).

South Carolina.—
*Beaufort.
Florence.

South Dakota.—
*Black Hills (Sturgis).

Tennessee.—
Andrew Johnson (Greenville).

Texas.—
*Port Bliss (El Paso).

West Virginia.—
Grafton.

17–80. Naval Plots and Cemeteries

(1) General.—The following shall apply to burials in naval cemeteries located on naval reservations and naval plots located in civilian cemeteries:

(a) Expansion of naval plots in civilian cemeteries is not authorized. When all grave spaces have been filled, individual grave sites in civilian cemeteries shall be purchased as needed, with specific provision for perpetual care being made at time of purchase.

(b) Expansion of naval cemeteries located on naval reservations will be considered by the Bureau when necessary and upon request of the commanding officer of the activity which has jurisdiction provided there is sufficient space adjacent to the cemetery.

(c) Burials in naval plots and cemeteries shall be restricted to the following categories of personnel:

(1) Those individuals who are not eligible for burial in a national cemetery and for whose remains the Navy has responsibility, such as general court martial prisoners.

(2) Pensioners, destitute patients and unclaimed bodies (refer to subart. 17–53 (2), provided they are not entitled to burial in a national cemetery or a national cemetery is not available for local burial.

(3) To avoid any breach of faith on the part of the Medical Department of the Navy, in any

*Contains post sections.
case where commitment was made prior to 20 April 1953, such commitment shall be honored.

(2) Reports.—In each case of burial in a naval plot or cemetery, either a MED-5360-1 or a NAVMED-601, as applicable, shall be submitted to the Bureau in accordance with articles 17-9A, 17-77 and 23-153.

(3) List.—Open naval plots and cemeteries are listed below:

California.—
- Naval Plot, Greenwood Memorial Park, San Diego.
- Naval Plot, Cedar Grove Cemetery, New London.
Cuba.—
- Naval Cemetery, Guantanamo Bay.
Florida.—
- Naval Plot, City Cemetery, Key West.
Guam.—
- Naval Cemetery, Agana.
Hawaii.—
- Naval Plot, Ohau Cemetery.
Illinois.—
- Naval Cemetery, Great Lakes.
Massachusetts.—
- Naval Plot, Woodlawn Cemetery, Everett.
New Hampshire.—
- Naval Cemetery, Portsmouth.
New York.—
- Naval Plot, “The Evergreens” Cemetery, Brooklyn.

Republic of the Philippines.—
- Naval Cemetery, Sangley Point.
Rhode Island.—
- Naval Plot, Island Cemetery, Newport.
Samoa.—
- Naval Cemetery, Satala, Tutuila.
Texas.—
- Naval Plot, Rose Hill Park Cemetery, Corpus Christi.
Virginia.—
- Naval Plot, Evergreen Memorial Cemetery, Portsmouth.
Washington.—
- Naval Plot, Ivy Green Cemetery, Bremerton.

17-37

Change 5
Chapter 18

MEDICAL DISPOSITION

Sections

<table>
<thead>
<tr>
<th>Articles</th>
<th>Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-1 through 18-2</td>
<td>I. Psychiatric Unit</td>
</tr>
<tr>
<td>18-3 through 18-6</td>
<td>II. Aptitude Board</td>
</tr>
<tr>
<td>18-7 through 18-15</td>
<td>III. Medical Survey Board</td>
</tr>
</tbody>
</table>

Section I. PSYCHIATRIC UNIT

The Psychiatric Unit

Fitness of Recruits for Service, Determination of

18-1. The Psychiatric Unit

1) The commanding officer of each recruit training center or depot will have, as part of his medical organization, a psychiatric unit consisting of at least one psychiatrist, one clinical psychologist, one psychiatric social worker, and the necessary number of hospital corpsmen.

2) The medical officer of the command is charged with the responsibility of organizing the psychiatric unit and of general supervision of its functioning. He shall arrange for the proper place and equipment for the administrative functions of the unit as well as sufficient space to insure the conduct of the preliminary psychiatric examination in such manner that conversation between the examiner and recruit will not be overheard. Without privacy, the recruit will not react freely enough to enable the psychiatrist or clinical psychologist to make a satisfactory examination. The medical officer also shall put at the disposal of the unit a psychiatric observation ward, with sufficient bed space for the proper observation and care of those recruits who are deemed by the psychiatrist to need such observation. These facilities shall amount to not less than 35 beds per thousand incoming recruits per month except on stations where past experience has demonstrated that this is not proportionate to the actual need.

3) Functions of Various Members of the Psychiatric Unit.—

(a) The psychiatrist shall conduct the neuropsychiatric examinations of recruits and shall be charged with the responsibility for the work of the other members of the unit. Decisions within the unit rest solely with the psychiatrist and further referral of cases for disposition shall be based upon his recommendation, subject to approval by the medical officer of the station.

(b) The clinical psychologist shall function as an adjunct to the psychiatrist. He shall not act independently of the psychiatrist.

(c) The hospital corpsmen shall perform the duties necessary for maintenance of the psychiatric observation ward, and shall keep the records of the unit.

(d) The psychiatric social worker's duties shall be to obtain data pertaining to the life histories of recruits under consideration by the unit and function as liaison agent between the naval service and the civilian community in arranging any necessary aid to recruits discharged from service.

4) The psychiatric unit is a professional, advisory, and consultant unit to which neuropsychiatric problems among recruits are to be referred. It is charged with the responsibility of selecting neuropsychiatric cases and unsuitable recruits for consideration by the aptitude board or board of medical survey.

5) Neuropsychiatric Examination of Recruits.—

(a) When practicable, each recruit shall be examined by the psychiatrist. This examination shall be conducted as a part of the initial physical examination, and usually should be brief (from 3 to 5 minutes), so as not to interfere with the routine procedure to which the incoming recruit is subjected. If indicated, the psychiatrist shall request a psychological or other special examination.

(b) A recruit with obvious or serious neuropsychiatric handicaps shall be sent to the psychiatric observation ward pending disposition. Recruits with less obvious or serious handicaps or about whose fitness for service there is doubt, should be returned
to a trial of duty and observed under drill and training conditions in a regular recruit company, with the understanding that the psychiatrist shall have opportunity for further examination of the recruit if he deems it necessary.

(c) A recruit may be referred to the psychiatric unit for examination and observation at any time during the training period at the station. During this period of neuropsychiatric observation, he shall be admitted to the sick list if patient status is desirable.

18–2. Fitness of Recruits for Service, Determination of

(1) The evaluation of each recruit's fitness and suitability for service is a necessary function of the activities which serve as centers for training of recruits for the United States Navy and United States Marine Corps. This evaluation should be conducted with a view to separating personnel from service when it is determined that they are unsuitable for service because they cannot be expected to perform useful duty. In this connection reasonable effort shall 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 preliminary evaluation of each recruit's physical fitness shall be conducted by the Medical Department representatives at the station and the evaluation of each recruit's neuropsychiatric fitness and suitability for service shall be performed by the psychiatric unit. Company commanders and other cognizant authorities may assist greatly by referring for medical attention those recruits who are not adjusting well to training conditions. In determining whether or not a recruit is physically or mentally disabled, his functional ability as measured by the PULHES Classification is to be determined in accordance with Section II, Army Regulations No. 40–503, dated 9 May 1956. At the present time the minimum profile serial for induction is "3" in any column of the PULHES Chart. That is, if a candidate for induction is classed as 1, 2, or 3 in all columns, he qualifies for induction. Therefore, personnel concerned must present a sufficient decrease in functional ability, on reevaluation, to warrant being designated as Class 4 in any column of the PULHES Chart in order to fall below the minimum profile serial for induction and hence qualify for discharge from service by reason of physical or mental disability. In the event a man continues to meet the minimum profile serial for induction, he is not eligible for discharge by reason of physical disability. The only exception to these criteria are those cases in which retention would aggravate a defect permanently to the detriment of future health or well-being or would jeopardize the health or safety of service associates.

(2) In determining whether or not a recruit is unsuitable for service by reason of personality defects, emotional immaturity, mental inadequacy, lack of stamina, functional disturbances such as enuresis, or preexisting physical or mental defects which impair usefulness but do not incapacitate him for service in accordance with article 18–2 (1) his ability to benefit from training and to become functionally capable of full service must be evaluated. Such individuals may be eligible for discharge, but for administrative, rather than medical, reasons. The recruit who presents preexisting physical or mental defects which are not, of themselves, disqualifying for useful duty, may be discharged for administrative reasons but not by reason of physical disability.

(3) If the medical officer or the psychiatric unit considers that a recruit is unsuitable for service but is not unfit to perform the duties of his rate by reason of physical disability, certification shall be made to that effect and the recruit may be referred to an aptitude board for disposition.

Section II. APTITUDE BOARD

Function
Form of Report
Data in Report
Processing Report

18–3. Function

(1) It is the function of the aptitude board to consider the cases of recruits referred to it by the psychiatric unit or the medical officer of a training station or recruit depot. The term "recruit" applies to all newly enlisted or newly inducted men who are undergoing and have not completed recruit ("boot") training. The aptitude board's function is concerned with the actual disposition of cases referred to it. After weighing the evidence submitted, the board may, if it considers the recruit unsuitable for retention in service under existing standards, recommend to the commander or commanding general that the recruit be discharged from service. If the board considers the recruit fit for full duty, it may recommend that he be returned to duty. If doubt exists as to the recruit's unsuitability, or the permanency of his functional impairment, the board may recommend return to duty for further trial or admission to the sick list for additional study. No person shall be recommended by the aptitude board for discharge from service until he has appeared in person before the aptitude board and has been informed of the proposed action.

18–2
Change 6
18-4. Form of Report

(1) Forms for use by aptitude boards will not be provided by the Bureau but will be prepared in accordance with existing directives.

18-5. Data in Report

(1) The board shall not make medical diagnoses. No statement of the board's impressions is to be entered in the Health Record or on the aptitude board's report. Sufficient pertinent data shall be recorded to support the board's conclusions and recommendation. This may be in the nature of symptoms, signs, social behavior, reaction to environment and so on. The information derived from social-service studies may be considered by the board in determining appropriate disposition. However, such reports are confidential, and the information shall not be quoted nor referred to in the board's report. This information is for the individual's benefit through its value in determining proper management of his case. It may be used professionally as a guide for direct questioning of the recruit and the information elicited then becomes a part of the clinical history which may be included in the board's report.

18-6. Processing Report

(1) The processing of the reports of the aptitude board and the disposition to be effected of the individual cases coming before the board shall be in accordance with appropriate directives.

Section III. MEDICAL SURVEY BOARD

Convening Authority
Composition
Purpose
Referral of Cases
Procedure
Preparation and Routing
Form of Entries
Statement in Rebuttal
Entry in Health Record

18-7. Convening Authority

(1) A board of medical survey may be ordered by the commander of a fleet, force, squadron, or flotilla, by commanding generals of Fleet Marine Force units, or by the commandant, commander, or commanding officer of an activity of the Shore Establishment, upon any person of the naval service under his command, on the recommendation of the medical officer of the command to which such person is attached. A board of medical survey may also be ordered by the Chief of Naval Personnel upon any person in the Navy and by the Commandant of the Marine Corps upon any person in the Marine Corps.

18-8. Composition

(1) A board of medical survey, whenever practicable, shall consist of three medical officers of the Navy. When three medical officers of the Navy are not available the board may consist, in whole or in part, of medical officers of the Army, Navy, Air Force, or of the Public Health Service. In exceptional cases the board may consist of a lesser number of medical officers. When the board is reporting upon conditions which normally fall under the professional jurisdiction of the dental department, the membership of the board shall include a dental officer when one is available.

18-9. Purpose

(1) A board of medical survey is an administrative board by which the Department of the Navy obtains a considered clinical opinion regarding the physical fitness of naval personnel. There are no specific statutes or administrative holdings prescribing the procedure to be followed by boards of medical survey. Hence meetings and proceedings may be conducted informally, and it is not required that the information upon which the findings of the board are based, meet standards of admissibility as evidence in a judicial proceeding. In view of the fact that information contained in reports of boards of medical survey may, however, play an important role in determining the rights of an individual to such benefits as pensions, compensation, promotion, retirement, income tax exemptions, death gratuity, and civil service preference, it is essential that all available information concerning the origin, the nature, the conduct status, and the aggravation by service of any condition reported upon be included in the report.

18-10. Referral of Cases

(1) A request for report by a board of medical survey may be made whenever it is desirable to
obtain an opinion regarding the administrative disposition of a member of the service in connection with a matter in which the medical department is concerned but which does not pertain to separation from service or retirement of the member by reason of unfitness resulting from physical disability. Individual cases shall be referred to the board in such manner as the convening authority directs. No member serving on the active list shall be referred to a board of medical survey until he has been admitted to the sick list.

(2) In the following instances it is appropriate to refer a member to a board of medical survey:

(a) Special conditions affecting officers.—

(1) When an officer is to be returned to duty after undergoing treatment for a severe or possibly incapacitating condition, particularly when it may affect his performance of duty during further convalescence, or for a disability which may militate against his chances of selection for promotion, he shall be ordered before a board of medical survey before being returned to duty. Officers who have had a major operation or who have suffered from mental or nervous disorder, severe constitutional condition, or other severe disease or injury are particularly to be considered. The report shall contain full details relative to the case, including a specific statement as to whether the officer is considered physically qualified to perform the duties of his rank at sea and on foreign shore, or in the field when Marine Corps personnel are concerned.

(2) When an officer candidate or midshipman has been undergoing treatment for any impairment which is likely to be recurrent or progressive or to become incapacitating either prior or subsequent to appointment, he shall be ordered before a board of medical survey before being returned to duty. The physical fitness of such individuals is to be evaluated in regard to probable ability to perform duty in commissioned rank and not in regard to ability to continue in training. In such cases final determination of the individual’s physical fitness for appointment to commissioned rank shall be held in abeyance pending Navy Department action on the board’s report.

(3) When an officer is hospitalized for study or treatment of a defect or disability noted on annual physical examination except that when it is determined that the condition is of minor significance and does not warrant the officer’s appearance before a board of medical survey, a copy of the medical entries made in the Health Record shall be forwarded to the Bureau at the time the officer is returned to duty, so that the medical records on file accurately reflect his current physical fitness.

(4) Whenever, in accordance with the instructions embodied in the preceding paragraphs, a naval aviator (Class I aviation personnel) appears before a board of medical survey and is found fit for duty, such person shall be examined by a flight surgeon and a report of the flight physical examination must be made to the Bureau. Under these circumstances the individual examined shall be retained on the sick list until the required flight physical examination is completed. If retaining such an individual on the sick list under the diagnosis which prompted the survey to be held, is statistically unjustified, the individual concerned shall be retained on the sick list under the diagnosis “Examination, physical.” When it is more practicable, such an individual may be transferred under the diagnosis, “Examination, physical” to the nearest medical activity to which a flight surgeon is attached for the purpose of obtaining the required flight physical examination.

(b) Discipline cases.—

(1) When court-martial proceedings, or investigative proceedings which might lead to court martial, are pending, indicated, or have been completed, and in cases of uncompleted sentences of courts martial involving confinement where the disciplinary features of the case warrant resolution prior to or in connection with further disposition (excepting that where the primary consideration is discharge, separation, or retirement of the member because of unfitness resulting from physical disability the report is to be made by a clinical board): (a) In cases where trial is pending or where it is anticipated that disciplinary action may be directed, the board shall state fully the nature of the alleged disciplinary offenses, including the dates involved and shall express its opinion as to: The individual’s mental competency and responsibility for the acts charged; mental competency to stand trial; mental and physical fitness to undergo confinement; and ability to benefit from corrective punishment, if awarded. Such a statement should approximate the following form: “It is the opinion of the board that the accused was (not) mentally competent and responsible for the particular acts charged when the alleged offense(s) was (were) committed, that he (she) is (not) mentally competent to stand trial, that disciplinary action in the form of confinement is (not) likely to have a deleterious effect on his (her) health, and that disciplinary action probably would (not) be corrective and (or) lead to a better service adjustment.”

(b) In expressing an opinion regarding mental competency and responsibility, the board should consider whether the member was able to appreciate the nature and quality of his actions at the time of the alleged offense, and whether he was able, concerning the particular acts charged, to distinguish right from wrong. It is recognized that in certain instances insufficient information will be available for the board to arrive at an opinion in this matter, particularly when a considerable period of time has elapsed since the alleged offenses. In such instances it is proper for the board merely to state that it is not in possession of the necessary information upon which to base a considered opinion. However, the board should express an opinion
whenever possible. This does not constitute final judgment in the case since it is only a professional opinion based on the information available, and if additional considerations pertain, the findings may be modified. The opinions thus expressed are solely for guidance in administrative processing of such cases.

(c) Opinions as to mental competency to stand trial ordinarily need not be made in the case of individuals who have already been tried and are serving sentence, unless significant information is disclosed which was not available to the court martial. In cases not pending trial, usually the only opinion desired is whether discharge from the sick list for completion of the awarded disciplinary action would be likely to have a deleterious effect on the individual's health.

(d) Members who are considered not mentally competent and responsible for the particular act charged, or not mentally competent at the time of appearance before the board of medical survey, shall be recommended for disposition in the same manner as any similar case with no disciplinary action pending.

(e) Members who are considered mentally competent and responsible for the particular act charged, and mentally competent to stand trial, shall be recommended for return to duty for appropriate administrative action unless they are physically incapacitated for further service. However, if it is considered that they present personality or behavior disorders which unfit them for further useful service by reason of military unsuitability, as contrasted with unfitness from physical disability, they may be recommended for discharge from service upon completion of disciplinary action.

(f) In the case of any member involved in disciplinary problems, factors which might operate in mitigation or extenuation shall be fully described by the board in its report, so that they may be given due consideration by the Navy Department. As a general rule only the psychoses and organic cerebral deterioration may absolve one of responsibility for acts performed, whereas other disability or disease and the personality and behavior disorders may constitute mitigating or extenuating factors.

(2) Patients refusing treatment.—

(a) Members of the naval service who are mentally competent and who refuse to submit to recommended medical, surgical, dental, or diagnostic measures, other than routine treatment for minor or temporary disabilities, shall be brought before a board of medical survey consisting of not less than three medical officers. The board shall study the case, inquire into the merits of the individual's refusal to submit to treatment, and report the facts with its recommendation to the Bureau of Naval Personnel or the Commandant, United States Marine Corps, via the Bureau.

(b) In surgical cases the board's report should contain answers to the following questions:

1. Is surgical treatment required to relieve the incapacity and restore the individual to a duty status, and may it 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 his reasons for refusing treatment, is the refusal reasonable or unreasonable? (Mere fear of surgery or religious scruples are not to be considered.)
4. As a general rule, refusal of minor surgery should be considered as unreasonable in the absence of substantial contraindications. Cases of major surgery shall be given most careful individual appraisal. Refusal of major operations may be reasonable or unreasonable, according to the circumstances. The age of the patient, and existing physical or mental contraindications, previous unsuccessful operations, and any special risks, should all be taken into consideration.
5. In medical, dental, or diagnostic cases, the board should show the need and risk of the recommended procedure.
6. If a board of medical survey decides that a diagnostic, medical, dental, or surgical procedure is indicated, these findings must be made known to the patient. The report of the board shall show that the patient was afforded an opportunity to submit a written statement explaining the grounds for his refusal, and any statement submitted shall be forwarded with the report. The patient should be advised that his continued unreasonable refusal may lead to disciplinary action after review of the survey report by the Chief of Naval Personnel or the Commandant of the Marine Corps.

(c) Military unsuitability cases.—Those who present motion sickness, personality or behavior disorder, or disorder of intelligence, which impairs functional usefulness to such extent as to constitute military unfitness and providing such defects are primary and not secondary to disease or injury.

(d) Recruit's physical disability which existed prior to enlistment (EPTE).—Commanding officers of naval training stations, and commanding generals of Marine Corps recruit depots may, subject to provisions of existing directives, discharge by action upon a report of medical survey, recruits who do not meet the physical standards for entry into naval service by reason of physical disability which existed prior to enlistment.

(e) Hospital transfer.—A report by a board of medical survey is required in connection with recommendation for transfer of a member of the service to a nonmilitary medical facility. Such a report may also be submitted when, in the opinion of the medical officer, it is desirable in connection with transfer of a member from his duty station to any military medical facility; and in such instances he
shall inform the commanding officer or senior officer present, and request that appropriate orders be issued. In the latter instance the original and one copy of the board's report, with the action taken, indicated by endorsement thereon, shall be submitted to the Bureau via official channels.

(f) Members Overseas.—When a formal medical report is necessary outside the continental limits of the United States, a board of medical survey report, rather than a clinical report, should ordinarily be submitted. When the board of medical survey recommends return to duty or transfer, the convening authority is authorized to take local action as necessary to effect such disposition of the patient. Transfers to continental United States shall be accomplished in accordance with current instructions. When discharge, separation, or retirement from service is probable, and the member does not desire to return to continental United States and may be eligible for benefits under title 10, United States Code, chapter 61, refer to paragraph 0410 of the Disability Separation Manual.

g) Persons Continuously on the Sicklist.—A report of medical survey shall be submitted upon each officer, midshipman, or person in an officer candidate program who has been on the sicklist continuously for 3 months, and upon each enlisted member who has been continuously on the sicklist for a period of 6 months, regardless of any change of station which may have occurred. Thereafter a report of medical survey shall also be submitted at the expiration of each 3-month period for officers and of each 6-month period for enlisted persons. Any officer who has been previously surveyed for further treatment shall again be brought before a board of medical survey prior to return to duty or otherwise disposed of. Such report in these instances is not required, however, if it is appropriate for the member to appear before a clinical board.

(h) Members of the Service Physically Qualified Only for Return to Limited Duty.—

(1) If, in the opinion of the medical officer in charge of the case, any member is physically fit for limited duty only, such member shall be brought before a board of medical survey prior to return to duty. In the event it is considered that the disability is such that the member may be, or is permanently unfit for the duties of his rank, grade, or rating he should be reported upon by a clinical board.

(2) Members of the service previously classified by the Navy Department as fit for limited duty only who improve and are considered physically qualified for full duty shall reappear before a board of medical survey with a view to recommending reclassification. Such members should be transferred to hospitals only if active hospitalization is required; otherwise admission to the sicklist and survey at the duty station will suffice. The Bureau of Naval Personnel maintains a listing of limited duty officer personnel, and issues orders for reexaminations at appropriate times, where necessary.

(3) When a member of the service is recommended for return to limited duty, the board of medical survey shall include an estimate of the limits of duty of which the individual is capable and whether such duty is likely to aggravate the member’s disability. A signed statement of the individual as to the action he desires, shall be forwarded with the report of medical survey.

(4) During the life of the Selective Service Act no male person, whether enlisted or inducted, will be discharged for medical reasons if his physical profile serial is at the minimum, or higher than the minimum, profile serial acceptable for induction, provided his services can be used effectively. The physical profile serial or PULHES Classification system is set forth in Army Regulations No. 40-501. Male personnel, enlisted or inducted, who present a profile serial acceptable for induction in any column of the PULHES Chart and who are not physically qualified for unlimited duty, should be recommended for assignment to limited duty. Enlisted personnel with a profile serial below that acceptable for induction may be recommended for limited duty if special circumstances apply, such as qualifications based on prolonged service or specialty training, or disability incurred in combat or as a prisoner of war.

(5) In connection with recommending assignment of Navy line officers to limited duty, due consideration should be given to the requirement that they must complete 2 years of sea duty in their present grade in order to be eligible for selection to the next higher grade.

18-11. Procedure

(1) The board shall meet to consider the case of any member who is referred to it for consideration. It shall require and examine such records in the case as are necessary to formulate a considered conclusion as to the opinions and recommendation required. It shall conduct such examination of the member whose case is under consideration as is considered necessary. The member may be required to appear in person before the board. The board shall advise the member reported upon, of the findings and recommendation providing such information would not be deleterious to the physical or mental health of the member concerned. Those members who are informed of the findings and recommendation shall be afforded an opportunity to submit such comment as they desire and any such comment shall be forwarded with the survey report.

18-6

Change 10
quintuplicate. The "5-45" revision of the NAVMED-M shall be modified, on the front, by substituting in lieu of the "FROM" and "TO" lines:

FROM: Board of Medical Survey
TO: Chief, Bureau of Medicine and Surgery
VIA: Commanding Officer

and on the back of the form, immediately under the third set of double lines, insert the word "ENDORSEMENT." All copies of reports of medical survey shall be legible. When final action has been taken locally, only the original and one copy of the report need be submitted to the Bureau. Whenever an enlisted or inducted member with less than 6 months' active service is recommended for discharge by reason of a condition which existed prior to enlistment, a copy of the report of medical survey shall be forwarded by the activity initiating the report to the recruiting station which accepted the individual for enlistment. Whenever an enlisted or inducted member who is serving in his first enlistment is recommended for discharge by reason of a physical or psychiatric condition, including those considered to have existed prior to entry into service, a copy of the report of medical survey or of the clinical board shall be forwarded by the activity initiating the report to the commanding officer of the naval training center where the member was trained.

(2) Reports of medical survey on Navy and Marine Corps personnel submitted to the Bureau for action from naval hospitals within the continental United States, shall be forwarded by the commanding officer directly to the Bureau. Such report submitted from all other activities shall be forwarded to the Bureau via the commanding officer and the officer convening the board. When a board of medical survey has recommended the discharge of an enlisted Marine, the commanding officer of the Marine Corps unit carrying his service record and accounts shall be notified, so that the records will be in such form that his discharge from service may be expedited upon receipt of orders from Marine Corps headquarters. Reports of medical survey on Coast Guard personnel shall be forwarded to the Commandant, United States Coast Guard, via the commanding officer of the unit to which the individual is attached or via the district Coast Guard officer of the district in which the hospital is located. Reports involving Army personnel shall be submitted to the Adjutant General, Department of the Army, Washington, D. C. Reports on Air Force personnel shall be referred to the local Air Force liaison officer, or in his absence to the Deputy Chief of Staff, Personnel; Headquarters, United States Air Force, Washington, D. C.

(3) In the case of Navy personnel, when final action is taken locally on reports of medical survey, the original and one copy of the report shall be forwarded to the Bureau, indicating by endorsement thereon, the action taken. If the individual concerned is transferred to a separation activity for discharge, one copy of the report shall be placed in his service record. In the case of Marine Corps personnel, when the commanding officer of a naval hospital has approved a report of medical survey and he is authorized to take final action locally he shall forward the original and one copy of the report to the Bureau, indicating by endorsement thereon, the action taken. If discharge from service is recommended and final action can be taken locally only by the commanding officer of a Marine Corps activity, the commanding officer of the hospital shall forward the approved report, in original and four copies, to the commanding officer of the Marine Corps activity concerned. Upon receipt of such approved reports and when the commanding officer of the Marine Corps activity takes final action, the original and one copy of the report shall be forwarded to the Bureau and one copy returned to the hospital from which received, showing, by endorsement, the action taken.

(4) In any case where final disposition is accomplished locally, the action endorsement shall cite the specific authority therefor.
18-12. Preparation and Routing

(1) Reports of medical survey shall be made on NAVMED-M and ordinarily shall be submitted in quintuplicate. The "S-45" revision of the NAVMED-M shall be modified, on the front, by substituting in lieu of the "FROM" and "TO" lines:

FROM: Board of Medical Survey
TO: Chief, Bureau of Medicine and Surgery
VIA: Commanding Officer

and on the back of the form, immediately under the third set of double lines, inserting the word "ENDORSEMENT." All copies of reports of medical survey shall be legible. When final action has been taken locally, only the original and one copy of the report need be submitted to the Bureau. Whenever an enlisted or inducted member with less than 6 months' active service is recommended for discharge by reason of a condition which existed prior to enlistment a copy of the report of medical survey shall be forwarded by the activity initiating the report to the recruiting station which accepted the individual for enlistment. Whenever an enlisted or inducted member who is serving in his first enlistment is recommended for discharge by reason of a physical or psychiatric condition, including those considered to have existed prior to entry into service, a copy of the report of medical survey or of the clinical board shall be forwarded by the activity initiating the report to the commanding officer of the naval training center where the member was trained.

(2) Reports of medical survey on Navy and Marine Corps personnel submitted to the Bureau for action from naval hospitals within the continental United States shall be forwarded by the commanding officer directly to the Bureau. Such report submitted from all other activities shall be forwarded to the Bureau via the commanding officer and the officer convening the board. When a board of medical survey has recommended the discharge of an enlisted Marine, the commanding officer of the Marine Corps unit carrying his service record and accounts shall be notified, so that the records will be in such form that his discharge from service may be expedited upon receipt of orders from Marine Corps headquarters. Reports of medical survey on Coast Guard personnel shall be forwarded to the Commandant, United States Coast Guard, via the commanding officer of the unit to which the individual is attached or via the district Coast Guard officer of the district in which the hospital is located. Reports involving Army personnel shall be submitted to the Adjutant General, Department of the Army, Washington, D.C. Reports on Air Force personnel shall be referred to the local Air Force liaison officer, or in his absence to the Deputy Chief of Staff, Personnel; Headquarters, United States Air Force, Washington, D.C.

(3) In the case of Navy personnel, when final action is taken locally on reports of medical survey, the original and one copy of the report shall be forwarded to the Bureau, indicating by endorsement thereon the action taken. If the individual concerned is transferred to a separation activity for discharge, one copy of the report shall be placed in his service record. In the case of Marine Corps personnel, when the commanding officer of a naval hospital has approved a report of medical survey and he is authorized to take final action locally he shall forward the original and one copy of the report to the Bureau, indicating by endorsement thereon the action taken. If discharge from service is recommended and final action can be taken locally only by the commanding officer of a Marine Corps activity, the commanding officer of the hospital shall forward the approved report, in original and four copies, to the commanding officer of the Marine Corps activity concerned. Upon receipt of such approved reports and when the commanding officer of the Marine Corps activity takes final action, the original and one copy of the report shall be forwarded to the Bureau and one copy returned to the hospital from which received, showing, by endorsement, the action taken.

(4) In any case where final disposition is accomplished locally, the action endorsement shall cite the specific authority therefor.

18-13. Form of Entries

(1) Date of Survey.—The date entered shall be the date on which the survey board met and not the date the report was typed or forwarded.

(2) Identification Data and Data Concerning Service.—NAVMED-M is self-explanatory as to the required data.

(3) Admitted From and Date of Admittance.—The dispensary, hospital, or other activity from which the patient was admitted or transferred shall be stated with the date of admittance. Injuries and poisonings shall also be stated. In the case of Army personnel, the reason for using another diagnosis shall be stated with that under which the patient is carried on the sick list if concurred in by the board. Otherwise, the reasons for using another diagnosis shall be entered in the body of the report. The diagnosis number shall also be recorded. Injuries and poisonings shall be classified in accordance with instructions governing the NAVMED-F card and in the Joint Armed Forces Statistical Classification and Basic Diagnostic Nomenclature of Diseases and Injuries With a List of Surgical Operations, NAVMED-P-1294.

(4) Diagnosis.—The diagnosis shall correspond with that under which the patient is carried on the sick list if concurred in by the board. Otherwise, the reasons for using another diagnosis shall be entered in the body of the report. The diagnosis number shall also be recorded. Injuries and poisonings shall be classified in accordance with instructions governing the NAVMED-F card and in the Joint Armed Forces Statistical Classification and Basic Diagnostic Nomenclature of Diseases and Injuries With a List of Surgical Operations, NAVMED-P-1294.

(5) The following entries are required only when the member is not entitled to receive basic pay, has disciplinary action pending, or is recommended for discharge from service, release to inactive status, or revocation of temporary appointment.
(a) Conduct Status.—The board shall state whether in its opinion the condition reported upon is or is not due to the patient's own misconduct. When such condition is considered as due to the patient's own misconduct, the board shall set forth in the body of the report the reasons for its opinion. (See ch. 19.)

(b) Line-of-Duty Status.—The board shall make an entry as to the line-of-duty status in conformity with the instructions in chapter 19 and article 18-14.

(c) Existed Prior to Appointment or Enlistment.—The following conditions are considered to be inherent preexisting developmental defects of personality or the results thereof, and by definition existed prior to entry into service. In view of the foregoing it is not required to make an entry regarding the origin (EPTE or DNEPTE) in cases in which these diagnoses are the final or dispositional diagnoses.

Aggressive reaction
Antisocial personality
Asocial (amoral) personality
Cyclothymic personality
Emotional instability reaction
Inadequate personality
Immaturity with symptomatic habit reaction
Mental deficiency, primary
Motion sickness
Paranoid personality
Passive-aggressive reaction
Passive-dependency reaction
Primary childhood behavior reaction
Schizoid personality
Specific learning defect

(d) Aggravation by Service.—In cases where the board considers the condition reported upon to have existed prior to entry into service, reports shall show whether, in the opinion of the board, the condition was aggravated by service. (This entry not required in cases where the final or dispositional diagnosis is one listed in art. 18-13(5)(c).) This information is primarily for use in determining eligibility for transfer to Veterans' Administration facilities if hospitalization is necessary after discharge from service, and for pensions, outpatient treatment, and other benefits under the cognizance of the Veterans' Administration. In general, aggravation by service is construed to mean any increase in disability during service in excess of the usual rate of progression or expected incidence of transient symptomatology of that condition, basing the standard upon clinical and pathological evidence generally accepted by the medical profession and its evaluation in accordance with sound medical judgment. In this connection paragraph 1(b), part I, Veterans' Regulation numbered 1(a), as amended by section 9(b) of the act of July 13, 1943, 47 Stat. 556, states in part that "* * * every person employed in the active military or naval service shall be taken to have been in sound condition when examined, accepted, and enrolled for service except as to defects, infirmities, or disorders noted at time of the examination, acceptance, and enrollment, or where clear and unmistakable evidence demonstrates that the injury or disease existed prior to acceptance and enrollment * * * * It is to be remembered that many individuals necessarily must be given a trial under actual service conditions in order to determine whether they are suitable service material. Subsequent observation may show that individuals lacking in the resourcefulness, stamina, or ability to adjust to service conditions, may develop latent symptoms necessitating their discharge from service, but this does not necessarily mean that they will be handicapped to a greater degree following discharge from service than they were prior to entry. Discovery or notation of healed residuals of former injury or disease, without evidence of unusual change during service, does not reflect increased disability. Medical or surgical treatment furnished during service for preexisting conditions does not of itself establish evidence of an increase in disability, but increase in severity necessitating treatment may do so unless the disability is improved thereby. Mere recurrences of conditions existing prior to entry do not establish increase in the degree of disability, unless they are aggravated by certain events or conditions experienced in service.

(e) Data Concerning Enlistment Examination.—The examining facility and date of the enlistment physical examination shall be reported in the case of members recommended for discharge who have less than 6 months' service.

(f) Summary of Case History.—The facts are to be presented briefly and concisely, and should show the reason for admission to the sicklist; the diagnosis and any change thereof shall be substantiated: the board's opinion relative to misconduct, and origin of the condition reported upon shall be supported and the recommendation justified. The pertinent facts relating to the present history of the case, especially all facts and circumstances regarding the origin of the disease or injury or connecting it with the performance of duty or exposure incident thereto, and a brief description of any existing disability shall be given. If a previous report of medical survey has been submitted, it is not necessary to repeat the detailed information contained therein. In such cases attention may be invited to the previous report, and the description of the present illness restricted to the interval history and currently pertinent data. Any facts which are not a matter of record or of personal knowledge to a member of the board, but which are based on the individual's own statement, should be recorded as "according to the member's own statement." Medical-social reports are confidential and information derived from these reports shall not be entered in.
reports of medical survey. Such data are obtained primarily for the benefit of the patient in diagnosis and treatment, and may be utilized for the purpose of further interrogation of the patient if pertinent. Any additional history so obtained from the patient or from other direct sources contacted as a result of “lead information” may be incorporated as a part of the history of the case.

(7) Present Condition.—“Fit for duty,” “unfit for duty,” or “unsuitable for service” shall be the terms used. “Fit for duty” shall mean either fitness for duty or fitness for limited duty; in the latter case the recommendation shall indicate the type of duty which the patient may perform. “Unfit for duty” shall mean fitness for duty not established or temporary unfitness for duty; “unsuitability for service” shall mean permanent unsuitability for return to duty by reason of unfitness for military reasons as contrasted with that resulting from physical disability.

(8) Probable Future Duration.—When unfitness is found and is regarded as temporary, either an estimate of its duration or the term “temporary” shall be used. When unsuitability is permanent, the term “permanent” shall be used. When the probable duration of unfitness or unsuitability is very uncertain, the term “indefinite” shall be used.

(9) Recommendations.—The board may recommend that treatment be continued, that the member be detached and transferred to a hospital, or be transferred to a hospital for treatment with a view to return to the ship or station, that sick leave be granted, or that the member be released from active duty, or be discharged from service, or that a revocable commission be revoked, or that the member be returned to duty or limited duty. When the board recommends limited duty, the limitations imposed by the member’s disability shall be set forth in the recommendation of the board. For example, if strenuous exercise is medically contraindicated the board’s recommendation should specify duty not involving strenuous exertion. In the case of Marine Corps enlisted personnel, the recommended designator for indication of a limited duty status shall be in accordance with Marine Corps Directives. Limited duty as used in this article means duty limited by physical reasons as distinguished from limited duty in a technical field. In addition to or in lieu of the above recommendations, the board of medical survey may make any other recommendation it considers warranted.

(10) Endorsement Statement.—

(a) A statement shall be included in the endorsement by the commanding officer, indicating whether final action has been taken on the report of medical survey by authorized local action. If the report is submitted for Bureau action, the endorsement shall state whether the individual concerned has been retained under treatment in the hospital, or if discharged from the sicklist, the station to which he has been transferred.

(b) The forwarding authority should include in his endorsement such comment as is considered warranted about any part of the report, particularly when he does not concur in the opinions of the board. The convening or forwarding authority appropriately may discuss with the board, and advise or recommend changes in opinions or recommendations if such are contrary to law or to sound medical judgment, but it is not appropriate to direct that the board arrive at specific findings or recommendation.

18-14. Statement in Rebuttal

(1) Any individual whose case is considered by a board of medical survey may be required to appear before the board in person, provided the member is physically and mentally able to appear. Unless it is considered that the information contained in the report might have an adverse effect on the member’s health, the individual concerned shall be allowed to read the board’s report or be furnished a copy thereof. Adverse entries, in particular, those opinions that a condition was incurred through misconduct or not in line of duty, or was not aggravated by service, or that the member is unsuitable for retention in service, shall be brought to the individual’s attention, and the member shall be afforded the opportunity to submit a statement in rebuttal to any portion of the board’s report. The report of medical survey shall contain the following statement: “The patient has been informed of the contents of the board’s report and does (not) desire to submit a statement in rebuttal.” If a patient submits a statement in rebuttal, the board shall review its report and make any change which is considered appropriate or prepare a statement in surrebuttal. If the individual still wishes to submit a statement, it shall accompany the report of medical survey to the Bureau but shall not be incorporated into it. In the event the condition of the patient is such as to render it inadvisable or impracticable to inform the member of an adverse entry, this fact shall be noted on the report. Reference should be made to chapter 19 and to United States Navy Regulations, for additional information concerning adverse entries.

18-15. Entry in Health Record

(1) In all cases of medical survey the medical officer requesting the survey shall have a brief entry of the findings and recommendation of the board and the action taken thereon entered in the patient’s Health Record, except in those cases in which the member has been transferred to another command prior to receipt of final action upon the survey report. In such cases the activity at which the board was convened shall notify the medical officer who is cognizant of the case at the time final action is completed in order that the above entries may be made.
# Chapter 20
## MEDICAL AND DENTAL TREATMENT OTHER THAN NAVAL

### Sections

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Treatment and Hospitalization Other Than Naval</td>
<td>20-1 through 20-8</td>
</tr>
<tr>
<td>II. Services of Specialists</td>
<td>20-9 through 20-11</td>
</tr>
<tr>
<td>III. Special Dental Treatment</td>
<td>20-12 through 20-16</td>
</tr>
</tbody>
</table>

### Section I. TREATMENT AND HOSPITALIZATION OTHER THAN NAVAL

#### General Summary

1. Members on active duty in the Navy or Marine Corps are eligible for emergency or necessary medical or dental treatment at Government expense by any Federal activity, other than naval, having a medical service (Army, Air Force, Public Health Service, and Veterans’ Administration) under the following conditions:

   (a) When on duty at a place where appropriate facilities or personnel of the Medical Department of the Navy are not available, upon the order of the commanding officer or senior officer present or, in the absence of a superior officer, upon their own application to the Federal activity concerned.

   (b) When on authorized liberty or leave in an emergency which does not permit return to the duty station or application to another naval activity having facilities for the necessary treatment.

2. Personnel on active duty in the Navy or Marine Corps are eligible for emergency or necessary medical or dental treatment and hospitalization at Government expense in other than Federal hospitals under the following conditions:

   (a) When on duty at a place where there is no Federal medical or dental facility, upon the order of the commanding officer or senior officer present or, in the absence of a superior officer, upon their own application to a civilian physician, dentist, or hospital.

   (b) When on authorized liberty or leave they become ill or are injured and the emergency does not permit application to a Federal medical or dental facility. Under such circumstances approval of their commanding officer should be obtained or, if this is impracticable, prompt report should be made to the commanding officer in order to permit investigation and suitable arrangements for transfer of the patient to a Federal institution or other appropriate action.

   (3) The accounts of officers receiving treatment in Veterans’ Administration hospitals or in civilian hospitals at Department of the Navy expense will be checked for subsistence. When officers are hospitalized in an Army, Air Force, or U. S. Public Health Service medical facility the charge for subsistence will be collected by the facility.

#### 20-2. Limitation on Emergency Dental Treatment

1. The expense of emergency dental treatment by other than a naval dental officer shall be allowed under the conditions specified in article 20-1 only to relieve pain or abort infection and upon the approval of a naval medical officer, if one is available. Emergency treatment shall not include the furnishing of prosthetic appliances including crowns or inlays, or the use of gold or other precious metals for fillings. (See arts. 20-14 and 20-15.)

#### 20-5. Personnel on Liberty or Leave

1. Personnel who require emergency medical or dental treatment while on authorized liberty or leave shall apply, if practicable, to the nearest naval activity in the vicinity; if emergency treatment is not available application should then be made to any other Federal agency having medical services. When Federal facilities are not available, the individual concerned or someone on his behalf should, if practicable, contact his commanding officer by telephone or telegraph reporting the emergency condition and requesting permission to obtain civilian medical or dental aid. Commanding officers may authorize such necessary emergency treatment.

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as the circumstances seem to warrant, and should give appropriate instructions regarding submission of reports and bills and disposition of the patient upon completion of treatment (arts. 20-7 and 20-8).

(2) When the urgency of the situation does not permit obtaining treatment from Federal facilities or authority to obtain treatment from other sources, necessary emergency treatment may be obtained from civilian sources by or on behalf of the individual concerned, and reasonable expenses therefor may be allowed as a charge against the Navy; provided that, within a reasonable time, report is made to his commanding officer so as to permit investigation and suitable arrangements for transfer to a Federal institution or other appropriate action.

(3) Expenses for the employment of consultants or specialists shall not be allowed except when authorized in advance by the Bureau or, in extraordinary cases, when subsequently approved by the Bureau upon receipt of prompt report and satisfactory explanation as to the necessity and urgency of their employment.

(4) Civilian medical or dental treatment of personnel absent without leave is not authorized unless and until the individual comes under military or naval control.

(5) The expense of elective medical or dental treatment may be allowed under no circumstances. Civilian dental treatment, other than emergency measures to relieve pain or abort infection, is not authorized (arts. 20-2, 20-13, 20-14, and 20-15).

20-6. Inactive Retired Members

(1) Inactive-duty members and former members of the Navy or the Marine Corps, or the reserve components thereof, entitled to retired, retirement or retainer pay or equivalent pay as a result of their service, except inactive-duty members and former members of the reserve components of the Navy or the Marine Corps entitled to retired or retirement pay under Sections 1331 through 1337 of Title 10 of the U. S. Code who have served less than 8 years on active duty, may be, upon request, furnished required medical and dental care and adjuncts thereto in any medical facility of a uniformed service to the same extent as provided active duty members. Such care shall be subject to mission requirements and the availability of space, facilities, and capabilities of the medical staff or dental staff as determined by the local medical or dental authorities.

20-7. Reports Required in Cases of Emergency Medical or Dental Treatment or Hospitalization

(1) Report on NAVMED-U shall be promptly forwarded in duplicate to the Bureau in each case of any sickness or injury of personnel on active duty in the Navy or Marine Corps in which treatment is received from other than the medical or dental departments of the Navy. It is required in all cases in which medical, dental, or hospital treatment is furnished by civilian physicians or dentists, civil hospitals, or Government hospitals other than naval to Navy or Marine Corps personnel under circumstances that eventually may be used as the basis of a claim against the Navy Department. This report should be prepared by a naval medical or dental officer when practicable, and in the absence of such officers, by the senior officer present or by the individual concerned as soon as he is able.

(2) Commanding officers are responsible for bringing the foregoing to the attention of all personnel of the command who go on liberty or leave or who perform detached duty.

(3) When printed NAVMED-U Forms are not available, a typewritten report shall be made in duplicate giving the following information:

Name and rank or rating; date and place of birth; station to which attached; diagnosis; prognosis; status (leave, etc.). If on liberty or leave state exact period for which granted and the hours and dates of departure and return to station; circumstances; disposition; give dates on or between which services were rendered. By whom were the services rendered? When authority is given in writing a certified copy of same shall be attached. When authority is given verbally a certificate of the officer granting same shall be attached and shall show when and under what circumstances the services were authorized. Were the services of a naval medical or dental officer, or a naval hospital or dispensary available?

(4) A supply of NAVMED-U's may be obtained from the Navy Supply System.

20-8. Preparation of Claims

(1) All claims for expenses incurred for medicines, medical or dental attendance, or hospitalization not obtained from the Medical Department of the Navy shall be forwarded to the Bureau for adjudication. If approved by the Bureau, such claims will be forwarded to the Navy Regional Accounts Office, Washington 25, D. C. for payment. Payment of such claims may be made direct to the physician, dentist, or hospital, etc., rendering services or furnishing supplies, or reimbursement made to the individual receiving services or supplies if the cost thereof has been defrayed by him. (Refer to art. 20-8 (4).)

(2) Bills for treatment in Government hospitals other than Navy should be submitted to the Bureau for payment in accordance with existing regulations of the department or agency concerned.

(3) Unpaid bills for civilian medical or dental treatment or hospitalization of naval personnel should be forwarded to the Bureau for action. They should be prepared in duplicate, itemized to show the dates on or between which services were rendered or supplies furnished, and the nature of and
charge for each item. The bills should be certified as "Correct and just; payment not received" with the autographic signature of the payee or, in the case of a company or firm, of a responsible official thereof, whose title or connection therewith should be indicated. Receipt of the services or supplies should be acknowledged on the face of the bill, or by separate certificate, by the person receiving treatment, or by an officer having cognizance of the case. The dates, charges, etc., should be carefully checked and verified when practicable. Separate certified bills should be submitted for services of special nurses, anesthetists, or other persons on a fee basis, unless the bill including such services is accompanied by receipts to show that the expenses have been defrayed by the physician, dentist or hospital submitting the bill, or by a statement to the effect that the individual is a full-time employee of the payee.

(4) In cases where the expenses have been defrayed and receipted bills are submitted, claim for reimbursement may be made by the person defraying the expenses by placing the certificate "Correct and just; payment not received" on the face of each receipted bill and signing same, or in cases of naval personnel, by completing and signing the certificate on the reverse of the NAVMED-U. In either of these cases the complete address to which the check is to be mailed should be indicated.

Section II: SERVICES OF SPECIALISTS

20–9. When Permitted

(1) When the services of a naval medical or dental officer are available and when, in his opinion, he is not sufficiently experienced to properly treat the condition, or lacks the proper equipment or facilities for the required treatment, the Bureau should be contacted and authority obtained for the employment of a civilian physician, dentist, or other acceptable specialist, or procurement of special tests, examinations and hospitalization. In exceptional cases only, where the emergency will not permit sufficient delay to obtain advance authority, the Bureau will, upon receipt of prompt report and reasonable justification as to the necessity and urgency for the action taken, give subsequent approval therefor.

(2) The provisions of article 20–9 (1) shall apply also to the employment of specialists or procurement of special services in connection with treatment of the personnel of other Government departments or agencies who are patients in naval hospitals.

20–10. Procedure in Making Requests

(1) Advance requests for the employment of a specialist or for services of a special nature may be made by letter or dispatch to the Bureau, according to the urgency of the case, stating the nature of the illness, the condition of the patient, and the necessity for the special treatment or services, together with an itemized estimate of the cost thereof.

20–11. Refraction of Eyes and Procurement of Eyeglasses

(1) Naval personnel who need new spectacles or replacement for damage or loss in line of duty and are unable to avail themselves of Navy or other Federal facilities should, if suitable prescription is not available in their record, request the Bureau's authority for eye refraction from civilian sources, via official channels, stating the need and estimated cost. If request for refraction is approved, the prescription from the refractionist with proper facial measurements and the Bureau's authorization should be sent to the nearest Navy optical dispensing unit within the continental United States or to the nearest Navy optical service unit outside the continental limits of the United States. The optical dispensing or service unit shall fabricate or cause to be fabricated the glasses as ordered by the refractionist and shall forward them for proper checking and fitting by the civilian physician or specialist concerned.

(2) Whenever practicable in the absence of Navy facilities, eye refraction should be obtained from facilities of the Army, Public Health Service or Veterans' Administration, with the above procedure being followed in filling the prescription. The prior authority of the Bureau is not required to obtain refraction in one of these Federal facilities; however, authorization should be issued therefor by the individual's commanding officer or the senior officer present.

(3) All naval personnel attached to Naval Shore Establishments and working in trades or areas determined to be eye-hazardous shall be furnished satisfactory eye protection. When corrective-protective glasses are required by these naval personnel, all such glasses shall be furnished by the Medical Department activity of the establishment as a proper charge to the appropriation "Medical Department, Navy." In some instances prescription for such glasses may be in the individual's record; otherwise necessary refraction should be obtained from naval sources, or, if impracticable, from other sources in accordance with instructions in the preceding articles (20–11 (1) and 20–11 (2)). The furnishing of protective goggles of various types with
Plano heat-strengthened or hardened safety lenses to naval personnel, who do not require corrective lenses, is authorized as a charge to the appropriation, "Medical Department, Navy" only at activities under the management control of this Bureau. These protective goggles should be procured under authority of annual sundry purchase requisition.

(4) Bills, in duplicate, covering the cost of refraction shall be submitted in accordance with articles 20-8 (2) and 20-8 (3).

**Section III. SPECIAL DENTAL TREATMENT**

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-12</td>
<td>Treatment Other Than Naval Allowed in Emergency</td>
</tr>
<tr>
<td>20-13</td>
<td>Definition of &quot;Emergency&quot;</td>
</tr>
<tr>
<td>20-14</td>
<td>Request for Special Dental Treatment</td>
</tr>
<tr>
<td>20-15</td>
<td>Request for Dental Prosthetic Treatment</td>
</tr>
<tr>
<td>20-16</td>
<td>Reports and Claims</td>
</tr>
</tbody>
</table>

**20-12. Treatment Other Than Naval Allowed in Emergency**

(1) Personnel attached to and serving in units or commands where the services of a naval dental officer are not available should consult the naval medical officer and secure his approval and that of the commanding officer or senior officer present prior to the procurement of dental treatment as an expense against the Navy Department. Approval shall be limited to cases of emergency, and shall not include the use of precious metals or restorations by means of crowns, inlays, or prosthetic appliances (art. 20-2). If, upon reporting for emergency dental treatment, it is determined that additional services, not of an emergency nature are necessary, the Bureau's prior authority therefor should be obtained before continuing treatment.

(2) Dental expenses for personnel on detached duty or on authorized liberty or leave where neither a naval dental officer nor a naval medical officer is available shall be allowed without prior approval only when evidence is submitted that the treatment was immediately necessary to relieve pain or abort infection.

**20-13. Definition of "Emergency"**

(1) "Emergency dental treatment" is considered to include only such treatment as is necessary to relieve pain or abort infection, and shall include only such measures as are deemed necessary to provide a reasonable degree of comfort until the services of a naval dental officer can be obtained or until a report can be forwarded to the Bureau and appropriate instructions issued. Emergency dental treatment shall involve the minimum expense necessary to secure satisfactory professional service. Chronic periodontal conditions and dental prophylactic treatments are not regarded as being of an emergency nature.

**20-14. Request for Special Dental Treatment**

(1) When time will permit, requests for dental treatment where the services of a naval dental officer are not available shall be forwarded to the Bureau by the medical officer with his recommendation or, if no medical officer is available, by the senior officer present. The requests shall be forwarded via the cognizant naval district commandant. Each request shall contain a detailed statement of the disease or injury from which the necessity for treatment has arisen, together with a detailed estimate of the cost of the treatment considered to be necessary (also refer to art. 20-15). On detached duty, such as at recruiting stations, radio stations, etc., the request shall show the date on which the person for whom treatment is requested was assigned to that duty, and the approximate date of expected transfer to other duty.

(2) The request should be in, or similar to, the following form:

```
From: Commandant, -- Naval District

To: Chief, Bureau of Medicine and Surgery

Subj: Special dental treatment in the case of ____________________________

Encl: (1) Detailed statement of the disability for which authorization of treatment is required, nature of treatment, and itemized fee or cost of professional services

1. It is requested that civilian treatment at Government expense be authorized to the amount of __________, as set forth in detail in enclosure. In the case of ____________________________

(name)  
(rank or rate)

(service number)

2. The need for this treatment has arisen from the accumulation of dental defects during prolonged duty in stations not accessible to naval dental activities (or other reason cited).

3. Arrangements for dental treatment should be made with other Government agencies, if practicable, in preference to private practitioners, provided the agencies possess the required clinical and laboratory facilities.

4. Whenever dental treatment is obtained from sources other than those under the cognizance of the Bureau, a note stating the facts in detail shall be inserted in the dental record and the medical history sheet of the individual's Health Record.
```

**20-15. Request for Dental Prosthetic Treatment**

(1) Every request for authority to obtain dental prosthetic treatment shall contain a statement of the oral condition and of the necessity for the treatment, as well as a history of the case and a graphic chart showing the present condition (art. 20-14 (1)).

**20-16. Reports and Claims**

(1) Reports and claims in connection with dental treatment received from sources other than the Navy shall be made as provided in articles 20-7 and 20-8.
Chapter 21

CONTROL OF NARCOTICS, ALCOHOL, ALCOHOLIC BEVERAGES, AND OTHER DANGEROUS DRUGS AND CHEMICALS

Sections

I. Narcotics, Alcohol, and Alcoholic Beverages ........................................ 21-1 through 21-8
II. Controlled Drugs, Dangerous Drugs, and Poisons ............................... 21-20 through 21-27
III. Forms, Records, and Reports ............................................................ 21-40 through 21-49
IV. Authorized Exceptions to Control Procedures .................................... 21-50 through 21-51

Section 1. NARCOTICS, ALCOHOL, AND ALCOHOLIC BEVERAGES

General .......................... 21-1
Prescribing ........................ 21-2
Custody ........................... 21-3
Security ......................... 21-4
Loss ............................... 21-5
Deterioration ...................... 21-6
Control by the Pharmacy .... 21-7
Control by the Nursing Service ................................. 21-8

21-1. General

(1) "Narcotic drugs" as used in this manual means opium, isonipecaine, coca leaves, and opiates (whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination thereof); or any compound, manufacture, salt, derivative, or preparation thereof; or any substance chemically identical therewith; and including the "exempt narcotics" as defined below.

(a) "Opiate" means any drug proclaimed by the President to have been found by the Secretary of the Treasury or his delegate to have an addiction-forming or addiction-sustaining liability similar to morphine or cocaine.

(b) Preparations containing more than the percentages of narcotic drugs listed in subarticle (2) are not within the exemptions cited herein.

(2) "Exempt narcotics" applies to certain preparations and products exempt from taxation by stamp tax under the provisions of the Federal Narcotic Regulations. Such preparations are subject to control but in a modified manner. Federal Narcotic Regulations classify exempt narcotic pharmaceutical preparations into two categories, class X and class M.

(a) Class X products are those which do not contain more than 129.6 mgs. (2 gr.) opium, or more than 16.2 mgs. (¼ gr.) morphine, or more than 64.8 mgs. (1 gr.) codeine, or more than 32.4 mgs. (¼ gr.) dihydrocodeine, or more than 16.2 mgs. (¼ gr.) ethylmorphine, or salts of these narcotic drugs per 29.57 ml. (1 fl. oz.) or per 28.35 Gms. (1 av. oz.) of product, or more than 2.5 mg. of diphenoxylate with not less than 25 micrograms of atropine sulfate in a solid or liquid form per dosage unit.

(b) Class X products in addition contain one or more nonnarcotic active medicinal ingredients in sufficient proportions to confer upon the

21-1
Change 15
preparation valuable medicinal qualities other than those possessed by the narcotic drug alone.

(2) Paregoric, although classified as a class X exempt narcotic preparation under the provisions of Federal Narcotic Regulations, shall be received, accounted for, and dispensed in the same manner as a fully controlled narcotic.

(b) Class M products are those pharmaceutical preparations containing noscapine, papaverine, narcine, cotarnine, nalorphine, or any salts thereof.

(1) These preparations are not limited by quantity of the narcotic drug, but the preparation shall contain active or inactive nonnarcotic ingredients of the type used in medicinal preparations.

(2) Records of disposition to consumers of class M exempt narcotic preparations or maintenance of stock records of such preparations is not required.

(3) Alcohol and alcoholic beverages shall be used only in connection with the treatment of the sick or to meet the essential requirements of Medical Department facilities.

(4) Alcoholic beverages other than those obtained through medical supply sources shall not be accepted for medicinal purposes except upon approval of BUMED. When accepted these alcoholic substances shall be taken up on inventory, used for medicinal purposes only, and accounted for accordingly.

21-2. Prescribing

(1) When writing official prescriptions, officers of the Medical and Dental Corps and civilian physicians employed by the Navy, and independent-duty hospital corpsmen authorized in section IV shall use the Prescription Form, DD Form 1289.

(2) Unless prohibited by individual State laws, narcotic prescriptions may be filled by a registered civilian pharmacy although they do not bear a file number of the issuing practitioner, but do conform to the provisions of article 21-41.

(3) An officer of the Medical Corps or Dental Corps, or a civilian physician employed by the Navy, when prescribing in his official capacity any of the narcotic drugs coming within the scope of sections 4701–4707, 4721–4736, and 4771–4776 of the Internal Revenue Code of 1954 as amended (26 USC 4701–4707, 4721–4736, and 4771–4776) is exempt from registration and payment of special tax under the provisions of this act. This exemption does not apply when the officer renders professional treatment outside of his official duties. In such event he is required to register and in all other respects comply with the provisions of the law and regulations governing private practice.

(4) An officer, or civilian physician employed by the Navy, who has been designated by a command as requiring authorization to purchase narcotic drugs or preparations for official use shall file with the local District Director of Internal Revenue a certificate on Treasury Form 1964, obtained from his commanding officer, showing his name, official address, and official status. As a result of such filing, the District Director of Internal Revenue will assign the officer an exemption identification number. At the time of his original certification the officer will be issued, without charge or request, a book of official narcotic order blanks. Each order for the purchase of taxable narcotic drugs by such official shall be prepared on one of these order blanks. Certificates must be renewed on or before 1 July of each year to remain effective.

(5) Prescriptions for narcotics shall not be honored if signed by (a) a medical or dental officer serving an internship or (b) a civilian physician not employed by the Navy.

(6) Prescriptions written for narcotics, alcohol, alcoholic beverages, and controlled drugs shall be limited to one item to a prescription.

(7) Except in an emergency situation, alcoholic beverages shall not be prescribed for outpatient use.

(8) Official prescriptions for all drugs shall be signed by a military medical or dental officer or civilian physician employed by the Navy. (See art. 21-50 for deviations in the case of prescriptions issued by independent-duty hospital corpsmen.) Other prescriptions by attending civilian physicians for authorized personnel and their dependents may be filled upon approval of a representative designated by the commanding officer or the senior medical officer. (See art. 21-7(3).) Care shall be exercised to insure that prescriptions for drugs are properly written, signed, numbered, and filed.

(9) Normally, prescriptions for alcoholic beverages or solutions, habit-forming drugs, and poisonous drugs to be used in the dental department shall be signed by a dental officer.

21-3. Custody

(1) Custodial responsibility of narcotics, alcohol, alcoholic beverages, and dangerous drugs shall be vested in a commissioned officer.

(2) No officer of the Medical Department of the Navy shall take or receive into his custody on board ship or in any Navy or Marine Corps establishment any alcoholic beverages or intoxicating or narcotic substances except as may be authorized (a) for medicinal purposes, (b) for retention as evidence in disciplinary cases, or (c) by Navy Regulations and General Orders. Work-
ing stocks of these substances may be issued from time to time for dispensing purposes to the officer or enlisted person in charge of the pharmacy. Such person shall be required to keep an accurate record of receipts and expenditures and to keep these substances under lock when not in use. Except as provided above, an officer shall not permit any of these substances under his custody to be placed in the possession of any person in quantities other than the amounts required for immediate consumption by patients, or for use in emergency, such as combat. All drugs shall be dispensed under the supervision of officers of the Medical Department, or under the supervision of Medical Department representatives at activities where there are no officers of the Medical Department.

(3) Officers of the Medical Department are authorized to issue alcoholic beverages and narcotic substances, for medicinal purposes only, to commanding officers of ships and to the pilots of aircraft to which no Medical Corps officer is attached.

(4) An officer of the Medical Department, or if such an officer is not available, then an officer designated by the commanding officer, shall keep in a separate compartment, under lock, all unissued narcotics, alcohol, alcoholic beverages, drugs classified as dangerous, and habit-forming drugs in accordance with the provisions of articles 21–20 (1), (2), (3) and 21–21(1). The keys always shall be in the custody of an officer. Personnel of the Medical Department shall assure themselves that all such substances under their charge are properly labeled.

(5) The administrative officer, or other designated officer, shall arrange for the care and safe custody of all keys and require strict compliance with instructions concerning the receipt, custody, and issue of narcotics, alcohol, alcoholic beverages, poisons, and controlled drugs contained in law, U.S. Navy Regulations, and this manual.

(6) Custodians or their designated assistants shall retain the keys to the place of storage while on duty. When relieved, they shall deliver the keys to their relief or to a responsible person designated by local instructions. A copy of the combination of a safe, if used, shall be sealed in an envelope and deposited with the commanding officer or an officer designated by him.

(7) An officer of the Medical Department, or if such an officer is not available the senior Medical Department representative, shall take charge of the medical storeroom and keep the key in his own custody or in the custody of his representative. However, the medical officer, if one is assigned, or such other officer or petty officer designated by the commanding officer, shall be responsible for the security of the contents of the storeroom. Medical storerooms shall not be used as sleeping compartments, and only medical stores shall be kept therein. Narcotics, habit-forming and dangerous drugs, and alcoholic substances shall be kept in separate lockers, and the keys to these lockers shall always be in the custody of an officer.

(8) Inventories of narcotics, alcohols, and alcoholic beverages carried in the Navy Stock Account, located at wholesale stock points, Navy retail stock points, and mobile logistic support ships are not within the scope of this article. Procedures for the handling of stocks of these special materials at such activities are promulgated by the cognizant inventory manager. All quantities of narcotics, alcohol, and alcoholic beverages issued to use shall be managed in accordance with this chapter and current instructions as applicable.

(9) Custody requirements of the pharmacy service and nursing service are discussed in articles 21–7 and 21–8.

21–4. Security

(1) Narcotics, alcohol, and alcoholic beverages require special handling and accounting to provide adequate protection against carelessness, theft, and misappropriation. Accordingly, the following measures, in addition to those prescribed elsewhere in this chapter, shall be enforced in all activities except stock points of the medical and dental supply system. (The security measures for handling this material at medical and dental stock points are included in the BUSANDA Manual.)

(a) Monthly, or more frequently if circumstances warrant, the person having direct or delegated custody of narcotics, alcohol, and alcoholic beverages in store and unissued, or issued to the pharmacy for dispensing or manufacturing use, shall assure himself by physical inventory that all quantities received and expended have been properly accounted for.

(b) (1) Monthly, or more frequently if necessary, on staggered dates in succeeding months an inventory of these substances shall be made by a duly constituted board of three officers, at least one of whom shall be an officer of the Medical, Dental, Medical Service, or Nurse Corps who is not directly or by delegated authority accountable for same. In small ships or small stations, where three such officers are not available, one Medical Department representative and one commissioned officer may constitute the board provided that no person directly or by delegated authority charged with custody of alcohol, narcotics, and other items requiring special storage and issue precautions shall serve
as senior member of the board. All prescribed accounting records and prescriptions for narcotics, alcohol, and alcoholic beverages for the prescribed inventory period shall be checked for compliance with regulations, particularly as to dating, proper preparation, and signature by an authorized Medical Department representative.

(2) The inventory board shall carefully inspect the original seals on the closures of the containers of bulk stocks and unissued items.

(3) The inventory board shall also inspect the security of the places where such bulk stock or unissued items are stored. The responsible officer shall supply the inventory board with the names of all persons to whom he has made available the combination of the locks or supplied keys. The board shall also inquire into the frequency of changes in combination locks on such storage spaces, and otherwise shall include in the written and signed report to the command any recommendations which, in the board's judgment, should be made to ensure security.

(4) Losses, thefts, or irreconcilable differences between physical inventory findings and the narcotic inventory records shall be reported in accordance with article 21-5.

(2) The quantity of these substances included in battle dressing stations or first aid boxes shall be in accordance with established provisions, and shall be promptly removed to security when not required by operating conditions. The manner and degree of security and maintenance of accounting records in these instances shall be consistent with the circumstances of use and operating conditions.

(3) Reports concerning the security of narcotic and alcoholic substances shall be submitted in accordance with article 21-46.

21-5. Loss

(1) Losses, thefts, or irreconcilable differences between physical inventory findings of narcotics, and the narcotic inventory records shall be reported immediately to BUMED through official channels. Simultaneously, a copy of the report shall be supplied to the nearest field representative of Naval Intelligence for transmittal to the Supervisor of the nearest U.S. Treasury Bureau of Narcotics, District Office (Regulations No. 5, Regulatory Taxes on Narcotic Drugs, U.S. Treasury Department, Joint Regulations of the Bureau of Narcotics and Internal Revenue Service, effective 20 Mar 1959, p. 89; 26 CFR 151.472). If loss occurs through breakage or other accident, an affidavit by the person having custodial responsibility stating the kinds and quantities lost and the circumstances shall be included in the report. If the narcotics are stolen, lost, or destroyed in transit, the consignee shall file the report with a sworn statement of facts.

(2) Where such loss or unreconcilable differences occur in the case of alcohol or alcoholic beverages, the inventory board shall make such discrepancies known in their report to the commanding officer. Losses through breakage or by other accident, or if stolen, lost, or destroyed in transit, shall be handled as above for narcotics.

21-6. Deterioration

(1) Narcotics, alcohol, and alcoholic beverages that have deteriorated and are not usable, are of questionable purity or potency, or have had their identity compromised shall be the subject of a report to the commanding officer. If destruction is indicated and directed by the commanding officer, destruction shall be accomplished in the presence of a member(s) of the inventory board. A certification, signed by the officer(s) witnessing destruction, shall be submitted to the commanding officer. This certification shall include the complete nomenclature and quantity of these substances destroyed, together with the method used to accomplish destruction. After the certification is complete, it shall be retained in the files as authority for dropping the items from the appropriate record.

21-7. Control by the Pharmacy

(1) The pharmacy shall serve as the source from which wards, clinics, or other departments of a facility normally shall obtain narcotics, alcohol, and alcoholic beverages for use in connection with the treatment of inpatients. Outpatient prescriptions may be filled when authorized.

(2) Narcotic drugs, alcohol, and alcoholic beverages shall be dispensed on receipt of a prescription prepared in accordance with articles 21-2 and 21-41.

(a) Ward and clinic orders for capsules and tablets for oral use, and single-dose ampules, shall be normally dispensed in units as determined by past usage rates.

(b) Hypodermic tablets shall be normally dispensed in units of 20. Multiple-dose vials shall be dispensed as single units.

(c) Narcotics shall be dispensed in a counter-type narcotic type dispenser whenever practicable.

(d) Alcohol and alcoholic beverages shall normally be dispensed in units of 500 mls.

(3) Normally, prescriptions for narcotics signed by a civilian physician not employed by the Navy shall not be honored.

(4) Telephoned or oral prescriptions for narcotics, alcohol, and alcoholic beverages, except
in an emergency shall not be filled. Emergency prescriptions shall be reduced to writing by the prescriber as soon as practicable.

(5) Prescriptions containing narcotics, alcohol, and alcoholic beverages shall not be refilled.

(6) Prescriptions of this type, at the time of filling, shall be dated, numbered, and signed by the compounder, with his legal signature across the front of the prescription. The reverse side of the prescription shall include the wording "rec’d by" in addition to the date, address, and signature of the recipient of the drug item.

(7) Signature Card Index.—The pharmacy shall maintain a signature card file bearing the legal signature of all staff medical and dental officers and civilian physicians employed by the activity, to detect or obviate the filling of unauthorized or illegal prescriptions.

(8) A label shall be prepared for each prescription issued to individuals. Labels for narcotic drugs must also contain the following information: Name of medical facility, prescription number and date of filling, prescriber, name of patient, directions to the patient, and initials of person filling the prescription.

(9) Prescriptions for narcotics shall be given a serial file number preceded by "N" and shall be filed separately from other prescriptions. This file shall be available for inspection by the inventory board, inspectors, or Internal Revenue officials. (See art. 21-46.) Exempt narcotic prescriptions shall be handled in accordance with article 21-42.

(10) For the most part alcohol and alcoholic beverages are controlled exactly the same as required for narcotics. One exception is that prescriptions for these substances shall be given a separate serial file number preceded by "A" and shall be filed separately from all other prescriptions.

(11) The pharmacy shall prepare a separate NAVMED 1408, Perpetual Inventory of Narcotics, Alcohol and Controlled Drugs, and NAVMED 1398, Narcotic and Controlled Drug Account Record, in accordance with articles 21-44 and 21-45.

(12) NAVMED 1397, Narcotic and Controlled Drug Inventory, prepared by the nursing service, shall be initiated by the pharmacy officer or his designated representative, indicating receipt of the appropriate completed Narcotic and Controlled Drug Account Record.

(13) Prescriptions for narcotics to be used in bulk compounding of pharmaceuticals shall be signed by a medical officer designated by the commanding officer. Normally the designee will be the executive officer or the chief of professional services. Prescriptions for alcohol and alcoholic beverages to be used in bulk compounding of pharmaceuticals shall be handled in a like manner.

(14) When drugs or medicines are prescribed or issued, the last person removing them from a distinctive or distinctively marked container is responsible for their proper distribution.

21-8. Control by the Nursing Service

(1) To provide effective and adequate narcotic and alcohol protection, the nursing service shall be responsible for the following measures of control.

(a) The professional [commissioned officer of the Nurse Corps or civilian graduate] nurse to whom narcotics, alcohol, alcoholic beverages, and other controlled drugs are issued is responsible for the custody and security of these items in accordance with this article and other instructions.

(b) No professional nurse, charged with the custodial responsibility for these substances, shall permit any such substances to be placed in the possession of other personnel in quantities greater than the amount required for immediate consumption by patients.

(c) The professional nurse to whom such items are issued shall maintain a locked container, cabinet, or compartment of a nonportable nature in which all such substances shall be kept.

(d) The charge nurse is responsible for the keys to the security container as prescribed by the commanding officer of a naval hospital or the medical officer of a naval station, ship, or other activity. The keys shall remain at all times in the custody of the nurse responsible and, when properly relieved, she shall transfer the keys to the relieving professional nurse.

(2) Each ward, clinic, or other activity drawing narcotics, alcohol, alcoholic beverages, and controlled drugs from the pharmacy shall maintain a looseleaf notebook (art. 21-47), containing the Narcotic and Controlled Drug Inventory (NAVMED 1397) and the Narcotic and Controlled Drug Account Record (NAVMED 1398), in accordance with articles 21-43, 21-44, and 21-47.

(3) Narcotics, alcohol, alcoholic beverages, and controlled drugs shall be ordered from the pharmacy on DD Form 1289, Prescription Form, signed by a medical or dental officer. (See art. 21-2(4).) The prescription form shall be completed in accordance with articles 21-2 and 21-41.

(4) The delivery of narcotics, alcohol, alcoholic beverages, and controlled drugs from the pharmacy to the various charge nurses should be made by pharmacy personnel only.

(5) Upon receipt of these substances from the pharmacy, the charge nurse shall check the
amount of the drug, and compare the serial numbers on the NAVMED 1398 and the prescription. If a discrepancy exists, and cannot be resolved, a report shall be made immediately through the nursing supervisor to the chief of nursing service.

(6) The NAVMED 1398 is to be signed in the appropriate space and the reverse side of the prescription form DD Form 1289 is to be dated and signed (see arts. 21-41 and 21-44).

(7) Regulations governing the automatic stop order for controlled drugs are set forth in article 21-21(4).

NOTE.—There are no articles 21-9 through 21-19.

Section II. CONTROLLED DRUGS, DANGEROUS DRUGS, AND POISONS

<table>
<thead>
<tr>
<th>Article</th>
<th>Controlled Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-20. General</td>
<td></td>
</tr>
<tr>
<td>21-21. Controlled Drugs</td>
<td></td>
</tr>
<tr>
<td>21-22. Prevention of Overstocking and Outdating of Medicines</td>
<td></td>
</tr>
<tr>
<td>21-23. Use of Antibiotics by Hospital Corps Personnel on Independent Duty</td>
<td></td>
</tr>
<tr>
<td>21-24. Antidotes and Antidote Lockers</td>
<td></td>
</tr>
<tr>
<td>21-25. Caustic Acids</td>
<td></td>
</tr>
<tr>
<td>21-26. Methyl Alcohol</td>
<td></td>
</tr>
</tbody>
</table>

21-20. General

(1) Controlled drugs are any drugs which in the opinion of the local command require security measures similar to narcotic control procedures.

(2) Barbiturates, poisonous drugs, chemicals, and similar substances are classified as dangerous drugs.

(3) Poisons are usually considered to be chemical substances that exert an injurious action in the majority of individuals with whom they come in contact. These substances, including those in (2) above, normally do not require the control procedures of fully controlled drugs, but do require special custody and security measures to prevent accidental poisoning.

21-21. Controlled Drugs

(1) Drugs selected by the individual commands to be classified as "controlled drugs" shall be kept under lock and key at all times when not in use. Keys to the place provided for the security of these controlled items shall be retained by the designated custodians of these drugs.

(2) Drugs of a powerful or dangerous nature which may be mistaken for other drugs because of their appearance shall be kept in containers of distinctive color, size, or shape and in a special section wherever drugs are stored.

(3) Local command procedures for the security, custody, receipt, expenditure and accounting of these substances shall be based on articles 21-1 through 21-8 and 21-40 through 21-49.

(4) All drug orders for narcotics, sedatives, hypnotics, anticoagulants, and antibiotics shall be automatically discontinued after 48 hours unless (a) the order indicates an exact number of doses to be administered, (b) an exact period of time for the medication is specified, or (c) the attending physician or dentist reorders the medication. The above shall be strictly adhered to in order to comply with the requirements of the Joint Commission of Accreditation of Hospitals.

21-22. Prevention of Overstocking and Outdating of Medicines

(1) Periodic checks shall be made, at least monthly, of all ward and clinic medicine cabinets to prevent the overstocking of medicines, especially expensive antibiotics and biologicals, to assure that such items are not outdated, and to expedite the return of unneeded items to the pharmacy for redistribution or appropriate disposition. The records presently maintained covering the issue, receipt, and disposition of such items are considered adequate to record such actions.

21-23. Use of Antibiotics by Hospital Corps Personnel on Independent Duty

(1) Except under emergency conditions (such as periods of radio silence), Hospital Corps personnel on duty independent of a medical or dental officer, should not prescribe or administer chlortetracycline, oxytetracycline, or tetracycline without a specific order or directive of a medical or dental officer for each case to be treated.

(2) Chloramphenicol, streptomycin, or erythromycin should not, under any circumstances, be prescribed or administered without a specific order or directive of a medical or dental officer for each case to be treated.
21-24. Distinctive Colors and Shapes for Poisons

(1) In addition to the general provisions contained in article 21-21(2), the following specific safeguards shall be enforced:

(a) All solutions of phenol shall be tinted pink (fuchsin), and solutions of bichloride of mercury shall be tinted blue (methylene blue). This requirement shall not apply to compounded medicines prescribed for individuals and appropriately labeled as such, in which phenol or bichloride of mercury is one of the ingredients.

(b) All dangerous poisons are to be indicated by appropriate poison labels.

(2) Instructions concerning the care, custody, and use of poison containers shall be rigidly adhered to.

21-25. Antidotes and Antidote Lockers

(1) All persons in the Medical Department shall be duly warned regarding the danger of poisons and use of antidotes.

(2) A separate well-marked poison antidote locker should be located prominently in every emergency treatment room. It should be constructed so the door can be secured with a wire seal. Whenever the seal is broken the contents should be inventoried and the used antidotes replenished. In addition, supplies should be routinely inventoried and replaced as necessary. An inventory list for each shelf should be on the inside of the door together with a poison-antidote chart and the address and telephone number of the local poison control centers. As a minimum, the books, "Poisoning" by von Oettingen, "Clinical Toxicology of Commercial Products" by Gleason, Gosselin and Hodge, and "Handbook of Poisons" by Robert H. Dreisbach, M.D., should be inside the locker where they are always available. The locker should contain sufficient antidotes, supplies, and instruments required for treatment of poisonings. All personnel involved in emergency room treatments should be thoroughly familiar with the contents of the locker.

21-26. Caustic Acids

(1) Caustic acids such as glacial acetic, sulfuric, nitric, concentrated hydrochloric, or oxalic acids shall not be issued to wards or outpatients.

(2) Acids of this type are to be stored in separate lockers clearly marked as to contents.

21-27. Methyl Alcohol. [For use by medical activities.]

(1) The officer in charge of alcohol and narcotics is charged with the responsibility for receipt, custody, and issue of all methyl alcohol (methanol, wood alcohol) carried on the records of the supply division, and shall assure himself by physical inventory that all quantities received and expended are properly accounted for.

(2) Methyl alcohol shall be issued by the supply division in the same manner as other alcohols and narcotics. A prominent label shall be affixed to all permanent or temporary containers of methyl alcohol, or products containing methyl alcohol, as follows: Poison-Inflammable; Contains Methyl Alcohol (Methanol, Wood Alcohol); Do Not Take Internally; Do Not Breathe Excessive Vapors; Avoid Excessive Skin Contact.

(3) Methyl alcohol shall not be stored, used, or dispensed by the pharmacy.

NOTE.—There are no articles 21-28 through 21-39.

Section III. FORMS, RECORDS, AND REPORTS

General
Prescription Form (DD Form 1289)
Exempt Narcotic Records
Narcotic and Controlled Drug Inventory—24 Hour (NAVMED 1397)
Narcotic and Controlled Drug Account Record (NAVMED 1398)
Perpetual Inventory of Narcotics, Alcohol and Controlled Drugs (NAVMED 1408)
Narcotic and Alcohol Inventory Report
Narcotic and Controlled Drug Book
Availability of Forms
Disposition of Narcotic, Alcohol, and Controlled Drug Records

21-40. General

(1) Records shall be maintained by medical and dental facilities that will provide information of receipts, expenditures, and balances on hand of narcotics, alcohol, and alcoholic beverages. Supplementary records maintained on these substances in store must agree with the specified accounting records. (Automatic data processing equipment may be used for control procedures if the system provides substantially the same results.)

Change 15
21-41. Prescription Form (DD Form 1289)

(1) In addition to the provisions of articles 21-2 and 21-7 concerning the Prescription Form, the following prescription writing requirements shall be strictly adhered to.

(a) The complete address of the person for whom the prescription is written is mandatory when narcotics are prescribed.

(b) Each narcotic prescription shall bear the legible, legal signature, title, corps, and file number of the prescribing medical or dental officer, or of the independent-duty hospital corpsman as authorized in article 21-50. (The file number is not required if filled in a naval medical facility—only when filled in a civilian pharmacy.)

(c) On all prescriptions for children 12 years of age and under, the age shall be specified.

(d) Erasures or interlineations on narcotic and alcohol prescriptions are prohibited.

(e) The use of brand names of drugs and medical stores in prescription writing shall be avoided. Generic names shall be used whenever possible.

(f) Orders for all drugs shall be limited to one item or compound to each prescription form (DD Form 1289).

(g) Ward and clinic orders for narcotic and controlled drug capsules and tablets for oral use, and single-dose ampules, shall be written for appropriate amounts dependent upon usage rate. Hypodermic tablets shall be written for in units of 20. Multiple dose vials (i.e., 20 and/or 30 mls.) shall be ordered as individual items.

(h) Smaller quantities of the items outlined in (g) above may be ordered when the item is one not routinely stocked, or limited usage is anticipated.

(i) The quantity of drugs that may be prescribed for outpatient use shall be governed by local command policy.

(j) Prescriptions for "exempt narcotics" shall be handled as set forth in article 21-42.

21-42. Exempt Narcotic Records

(1) Federal Narcotic Regulations require that a record be kept of all of class X exempt narcotics dispensed.

(2) Narcotics used in the manufacture of bulk preparations that meet the exempt narcotic regulations shall be accounted for on a properly completed prescription and filed as a fully controlled narcotic.

(3) Prescriptions received for exempt narcotic preparations, both those prepared locally and those received from other sources, shall be serialized along with regular prescriptions, but maintained in a separate file marked "Exempt Narcotics." This file is subject to examination by the inventory board.

(4) Ward and clinic orders for exempt narcotic preparations shall be accomplished on the standard prescription form as for fully controlled narcotics. Records as to the receipt, expenditure, and inventory are not required, unless ordered by local instructions.

21-43. Narcotic and Controlled Drug Inventory—24 Hour (NA VMED 1397)

(1) The inventory shall be signed by the ward charge nurse on each watch after she has checked the drugs prior to being relieved. Where feasible and practicable, it is also strongly recommended that the drugs be checked concurrently by the nurse reporting for duty and by the nurse to be relieved. Any discrepancies noted shall be reported immediately to the nursing supervisor. The record is usable for 2 weeks, 1-week period on each side. The night nurse shall initiate the record.

(2) The serial numbers of new NAVMED 1398’s received from the pharmacy during each watch shall be entered. The serial numbers of completed NAVMED 1398’s returned to the pharmacy shall be entered and the pharmacist or his representative shall acknowledge receipt by placing his initials in the appropriate column.

(3) Supervisor’s Audit.—At the time specified in local instructions, the nursing supervisor shall audit the ward narcotic and controlled drug supplies. After the audit the nursing supervisor shall date and sign the NAVMED 1397 (fig. 1 at end of chapter).

21-44. Narcotic and Controlled Drug Account Record (NA VMED 1398)

(1) Upon receipt of a properly completed and signed prescription, a separate Narcotic and Controlled Drug Account Record shall be prepared by the pharmacy for each narcotic or controlled drug ordered.

(2) Each narcotic or controlled drug issue made to the wards or clinics shall be accompanied by a NAVMED 1398, bearing a serial number. These are filed behind divider tabs appropriately marked to denote each narcotic or controlled drug.

(3) All entries shall be made in black ink. Errors shall be corrected by drawing a single straight line through the erroneous entry together with the signature of the person making the correction. The correct entry shall be recorded on the following line if necessary.

(4) If a new issue is received before the old issue is completely expended, the new NAVMED 1398 shall be inserted in back of the record presently being used. The serial number of the new NAVMED 1398 shall be entered in the Nar-
cotic and Controlled Drug Inventory, NAVMED 1397.

(5) The heading for each NAVMED 1398 shall be completed at the time of issue. The body shall be used for recording expenditures and balances only.

(6) Each time a drug is expended, complete information shall be recorded: Date, time, patient, doctor's name, by whom given, amount expended, and balance on hand (fig. 2 at end of chapter).

(a) All amounts shall be recorded in Arabic numerals. Where the unit of measure is a milliliter (ml.) and the amount used is less than a ml., it shall be recorded as a decimal; e.g., 0.5 ml., rather than as a fraction.

(b) Where a fraction of the amount is expended to the patient, it shall be placed in parentheses before the amount recorded in the expended column; e.g., an entry of (0.010)1 on the morphine sulfate 0.016 Gm. record indicates that one tablet was expended and that 0.010 Gm. was administered; on the 0.008 Gm. record an entry of (0.010)2 indicates that two tablets of 0.008 Gm. were expended and only 0.010 Gm. was administered.

(c) If a single dose of a narcotic or controlled drug is accidentally damaged or contaminated during preparation for administration, or is refused by the patient after preparation, the dose shall be destroyed and a brief statement of the circumstances shall be entered on the NAVMED 1398.

(d) If multiple doses of narcotic or controlled drugs are damaged or contaminated, the supervisor shall record the disposition of the drug, including the date, amount of the drug, brief statement of disposition, and the new balance. Both the supervisor and the witnessing nurse shall sign the NAVMED 1398.

(e) Deteriorated drugs shall be handled as described in article 21-6.

(7) The completed NAVMED 1398, along with the counter-type dispenser, shall be returned to the pharmacy. The pharmacy officer or his designated assistant shall enter on the Perpetual Inventory of Narcotics, Alcohol and Controlled Drugs (NAVMED 1408) the date the form was returned to the pharmacy. This information shall be entered on the appropriate line bearing the same serial number (prescription number) as the NAVMED 1398.

(8) Monthly the pharmacy shall submit to the chief of nursing service a listing by ward or clinic of all NAVMED 1398's still outstanding 30 days from date of issue.

(9) Each month, the nursing supervisor shall check the listing of outstanding NAVMED 1398's submitted by the pharmacy to the chief of nursing service. These lists shall be returned to the pharmacy by the 20th of the month issued.

21-45. Perpetual Inventory of Narcotics, Alcohol and Controlled Drugs (NAVMED 1408)

(1) A separate NAVMED 1408 shall be prepared for each narcotic, alcohol, and controlled drug item. All blanks and columns except as noted below are self-explanatory (fig. 3 at end of chapter).

(a) Name of Drug.—Enter generic name of drug or proprietary name as appropriate, for example, "Codeine Sulfate."

(b) Strength.—Express as Gm., mgm.

(c) Unit.—Enter tablet or ampule as the case may be; in the case of liquids or powders enter "mls" or "Gms" as appropriate.

(d) Prescription or Requisition Number.—Enter appropriate prescription number or requisition (voucher) number. In the case of issues returned to the pharmacy, enter the source.

(e) Recipient.—Enter "pharmacy" in the case of receipts. Enter ward number, name of clinic or patient as appropriate, in the case of expenditures.

(f) NAVMED 1398 Returned.—The date the NAVMED 1398 is returned to the pharmacy shall be entered on the appropriate line bearing the same serial or prescription number.

(2) On the last day of each month the chief of pharmacy service, or his designated assistant, shall total the Quantity Received and the Quantity Expended column for inspection by the inventory board.

(3) Upon completion of inspection, one member of the board shall initial the receipts and expenditures columns.

21-46. Narcotic and Alcohol Inventory Report

(1) The Narcotic and Alcohol Inventory Report shall be prepared monthly, more frequently if necessary, by the pharmacy service, for submission to the inventory board. This report shall list each item in stock, together with its strength and unit of issue. The report shall show the Amount Remaining Last Report, Quantity Received, Quantity Expended, and Balance on Hand.

(2) The Narcotic and Alcohol Inventory Report shall be submitted for approval to the commanding officer by the inventory board, stating that the inventory was conducted in accordance with this chapter and existing local instructions. In addition this report shall state the findings of the board and any recommendations.

21-47. Narcotic and Controlled Drug Book

(1) Each ward, clinic, or other activity drawing narcotics and controlled drugs from the
pharmacy shall maintain a looseleaf notebook containing the Narcotic and Controlled Drug Inventory (NAVMED 1397) in the first section, and individual Narcotic and Controlled Drug Account Records (NAVMED 1398) in the latter sections. (See art. 21-44(2).)

(2) The nursing supervisor shall remove all filled 1397's over 3 months old from the Narcotic and Controlled Drug Book, and transfer them to the hospital archives for disposition in accordance with SECNAVINST P5212.5 series.

21-48. Availability of Forms

(1) Forms cited herein are available from the cognizance "T" forms and publications supply distribution points.

21-49. Disposition of Narcotic, Alcohol, and Controlled Drug Records

(1) All narcotic, alcohol and alcoholic beverage prescriptions and records shall be disposed of in accordance with SECNAVINST P5212.5 series.

Section IV. AUTHORIZED EXCEPTIONS TO CONTROL PROCEDURES

Hospital Corpsmen on Independent Duty
Operational or Emergency Situations

21-50. Hospital Corpsmen on Independent Duty

(1) General.—Hospital corpsmen assigned to medical department duties in small vessels, shore stations, Fleet Marine Force, and mobile field units, to which no medical officer is attached perform all the duties required of the medical department. These duties include medical department administration and, to the extent for which qualified, the professional duties prescribed for medical officers of ships and stations. To make narcotics, alcohol and alcoholic beverages, and other dangerous and controlled drugs available to hospital corpsmen assigned to duty independent of a medical officer, fleet, force or type commanders, commanding officers or other appropriate authority may authorize deviation from the control procedures established in this chapter, but NOT from the general intent concerning receipt, custody, and issue of the items. This deviation in no way relieves a command of the responsibility for controlled material.

(2) Deviations.—Directives issued by fleet, force or type commanders, commanding officers, or other appropriate authority, may authorize the following deviations from the controls established in this chapter:

(a) The senior hospital corpsman at an activity not having a medical officer may be authorized to deviate from the control procedures established by this chapter, but not the intent regarding receipt, custody and issue of narcotics, alcohol, alcoholic beverages, and other dangerous and controlled drugs.

(b) A working stock of narcotics, alcohol, alcoholic beverages, and other dangerous and controlled drugs may be in the custody of the senior hospital corpsman (medical department representative), or in the case of combat units the company aid men in order that they may carry out their professional duties.

(c) The senior hospital corpsman may prescribe and administer controlled substances, subject to limitations set by higher authority. Prescription forms (DD Form 1289) shall be prepared and filed in accordance with this chapter except that prescriptions not signed by a medical officer, dental officer, or civilian physician employed by the Armed Forces shall be countersigned by the commanding officer or his duly appointed officer representative.

21-51. Operational or Emergency Situations

(1) Special instructions should be issued by appropriate authority relative to the receipt, custody, and issue of narcotics, alcohol, alcoholic beverages, and dangerous and controlled drugs or first aid kits containing these substances, which, in the best interest of the Navy, may require deviation from the controls established in this chapter due to operational and/or emergency situations.
### CHAPTER 21. DANGEROUS DRUGS

**NARCOTIC AND CONTROLLED DRUG INVENTORY - 24 HOUR**
NAVMED 1397 (4-60)

(To be used with NAVMED 1398 (4-60)

<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>SIGNATURE OF NURSE</th>
<th>SERIAL NUMBERS OF NARCOTIC AND CONTROLLED DRUG ACCOUNT RECORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>RECEIVED FROM PHARMACY</td>
</tr>
<tr>
<td>NIGHT</td>
<td>0600</td>
<td>Jane Darwell Jr.</td>
<td>1001234</td>
</tr>
<tr>
<td>DAY</td>
<td>14:30</td>
<td>Mary Smith, R.D.</td>
<td></td>
</tr>
<tr>
<td>EVENING</td>
<td>22:00</td>
<td>Olive Brown Jr.</td>
<td></td>
</tr>
<tr>
<td>NIGHT</td>
<td>06:00</td>
<td>Jane Darwell Jr.</td>
<td>100594582</td>
</tr>
<tr>
<td>DAY</td>
<td>15:00</td>
<td>Mary Smith, R.D.</td>
<td></td>
</tr>
<tr>
<td>EVENING</td>
<td>22:00</td>
<td>Olive Brown Jr.</td>
<td></td>
</tr>
<tr>
<td>NIGHT</td>
<td>06:00</td>
<td>Jane Darwell Jr.</td>
<td>10046580</td>
</tr>
<tr>
<td>DAY</td>
<td>14:45</td>
<td>Mary Smith, R.D.</td>
<td></td>
</tr>
<tr>
<td>NIGHT</td>
<td>06:00</td>
<td>Jane Darwell Jr.</td>
<td></td>
</tr>
<tr>
<td>DAY</td>
<td>14:45</td>
<td>Mary Smith, R.D.</td>
<td></td>
</tr>
<tr>
<td>EVENING</td>
<td>23:00</td>
<td>Olive Brown Jr.</td>
<td></td>
</tr>
</tbody>
</table>

**SUPERVISOR'S AUDIT**

Date: 3 June 1960
Time: 1330

I certify that I have audited the records of narcotic and controlled drugs for this ward.

- [ ] FOUND CORRECT
- [ ] ERRORS NOTED
- [x] DATE CORRECTED

Supervisor's Signature

Figure 1

21-11
Change 15
MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY

NARCOTIC AND CONTROLLED DRUG ACCOUNT RECORD
NAVMED 1398 (6-60)
(To be used with NAVMED 1397)

TO BE FILLED IN BY PHARMACY

To: NAVMED 1397

TO BE FILLED IN BY PHARMACY

DATE ISSUED

PRESCRIPTION SERIAL NO.

AMOUNT ISSUED

1 JUNE 1960 N-106050

20

DATE

HOUR

PATIENT

ORDERED BY

GIVEN BY

AMOUNT EXPENDED

BALANCE ON HAND

1 JUNE 1960

20

MORPHINE SULFATE TAB 0.016 Gm

(To be used with NAVMED 1397)

TO BE FILLED IN BY PHARMACY

NAVY

1397

1. JUNE 1960

Mary Smith

2. 0800

3. 0930

4. 1400

5. 2300

Ward 2A

Dr. Smith

Mrs. Smith

Mr. Brown

Mr. Darwell

Inman

Mr. Smith

Mr. Darwell

Inman

Mr. Brown

Mr. Darwell

Inman

Mr. Smith

Mr. Darwell

Inman

Mr. Brown

Figure 2

PERPETUAL INVENTORY OF NARCOTICS, ALCOHOL AND CONTROLLED DRUGS
NAVMED-1408 (4-60)

U.S. Naval Hospital
Portsmouth, Virginia

MORPHINE SULFATE

0.016 Gm

Tablet

NAME OF DRUG

STRENGTH

UNIT

(8)

DATE

RX OR REG. NO.

RECIPIENT

NAVYMED-1398 RETURNED

QUANTITY RECEIVED

QUANTITY EXPENDED

BALANCE ON HAND

ENTERED BY

7-1-59

12345

Pharmacy

100

100

Mr. Smith

7-2-59

N-234

Inman, G

20

80

Mr. Brown

7-4-59

N-246

Ward 2A 9-2-59

20

60

Mr. Smith

7-31-59

TOTALS

100

40

Figure 3

21-12

Change 15

SHEET NO.
Chapter 21
MEDICAL CARE OF SUPERNUMERARIES

Sections

I. General.............................................................................................................................................. 21-1 through 21-3
II. Dependents’ Medical Care.................................................................................................................. 21-4 through 21-8
III. Service Patients Not on Active Naval Duty.................................................................................. 21-12 through 21-21
IV. Other Than Service Patients........................................................................................................... 21-22 through 21-32
V. Charges, Collections, and Reports.................................................................................................... 21-33

Section I. GENERAL

21-1. Definition of Supernumerary

(1) All patients other than members of the Navy and Marine Corps on active duty or members of the Reserve components on extended active duty shall be considered supernumeraries.

21-2. Medical Care of Supernumeraries

(1) Inpatient care and other medical services may be furnished to supernumerary patients in naval hospitals, infirmaries, and dispensaries as authorized by law, U.S. Navy Regulations, and Navy Department directives. These authorities require that medical and dental officers of the Navy may sometimes render aid to civilians and other persons not in active naval service pursuant to the laws of humanity or principles of international courtesy.

Detailed instructions regarding medical services for various classes of supernumeraries are contained in sections II through IV of this chapter. Instructions regarding charges, collections, and reports required for medical care and/or subsistence furnished supernumeraries are contained in section V and current Bureau Instructions. The term hospitalization shall include inpatient care at infirmaries and dispensaries.

(2) Supernumeraries may be furnished ambulance service when sound medical judgment indicates the necessity therefor. Such use of ambulances shall be subordinate to local needs of Navy medical activities in support of the primary mission of the Medical Department to care for active duty personnel.

21-1

Change 6
# Table of Standard Procedures Concerning Medical Services Furnished Supernumeraries

## Part I—Inpatient medical care of service patients not on active naval duty

<table>
<thead>
<tr>
<th>Classes of supernumeraries</th>
<th>Statutory authority</th>
<th>Regulations, etc.</th>
<th>Application</th>
<th>Collection</th>
<th>Rate</th>
<th>Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Members, Army and Air Force on active duty.</td>
<td>Act of 2 Sep 1948 (10 USC 1074); Act of 30 Aug 1966 (10 USC 2571).</td>
<td></td>
<td>Art. 097(1), Nav Regs 1948; art. 21-12, MANMED.</td>
<td>Member....</td>
<td>Local for officers; Bureau for enlisted.</td>
<td>Hospital ration...</td>
</tr>
<tr>
<td>(2) Members, Navy and Marine Corps, retired.</td>
<td>Rev. Stat. 161 (5 USC 22); Rev. Stat. 1407 (34 USC 389); Act of 11 Jun 1930 amended 34 USC 773.</td>
<td></td>
<td>Art. 093(4), 1314, Nav Regs 1948; art. 21-15, MANMED.</td>
<td>By member; suitable identification.</td>
<td>Local: Officers....</td>
<td>Hospital ration...</td>
</tr>
<tr>
<td>(3) Members, Reserve components, Navy and Marine Corps entitled to retired or retirement pay.</td>
<td>Rev. Stat. 161 (5 USC 22); Act of 19 Jan 1926 (24 USC 31); Act of 25 Jun 1928 as amended (34 USC 858c, 854d, 854f); Act of 27 Aug 1940 as amended (34 USC 854c-1); Act of 29 Jun 1948 as amended (34 USC 848b).</td>
<td></td>
<td>Art. 093, 1315, Nav Regs 1948; art. 21-15, MANMED.</td>
<td>By member; suitable identification.</td>
<td>Local: Officers....</td>
<td>Hospital ration...</td>
</tr>
<tr>
<td>(4) Persons on emergency officers’ retired list in receipt of retired pay (see Beneficiaries, V.A. for emergency officers without retired pay).</td>
<td>Act of 24 May 1928 as amended (38 USC 251); Sec. 6521 of Act of 13 Oct 1949 (37 USC 272).</td>
<td></td>
<td>Art. 21-11, MANMED.</td>
<td>Local: Officers....</td>
<td>Hospital ration...</td>
<td>None...</td>
</tr>
<tr>
<td>(5) Members, transferred to Fleet Reserve and Fleet Marine Corps Reserve.</td>
<td>Rev. Stat. 161 (5 USC 22); Act of 26 Jun 1928 as amended (34 USC 856, 856d).</td>
<td></td>
<td>Art. 093, 1316, Nav Regs 1948; art. 21-14, MANMED.</td>
<td>Local: Officers....</td>
<td>Hospital ration...</td>
<td>None...</td>
</tr>
<tr>
<td>(6) Members, Army and Air Force retired with pay.</td>
<td>Act of 3 Sep 1938 (10 USC 1074); Cfr. Act of 16 Aug 1966 (10 USC 2571).</td>
<td></td>
<td>Art. 21-13, MANMED.</td>
<td>Local: Officers....</td>
<td>Hospital ration...</td>
<td>None...</td>
</tr>
<tr>
<td>(7) Members, Reserve components, Army and Air Force entitled to retired or retirement pay and eligible for admission in Army or Air Force hospitals.</td>
<td>Act of 20 Mar 1938 as amended (34 USC 856c); Act of 27 Aug 1940 as amended (34 USC 856c-1); Act of 12 Oct 1948 (37 USC 272).</td>
<td></td>
<td>Art. 21-14, MANMED; art. H-730, SUPERS Manual NDE 69,498.</td>
<td>Authorization of CO naval hospital or Surgeon General.</td>
<td>Local: Officers....</td>
<td>Hospital ration...</td>
</tr>
<tr>
<td>(8) Members, Naval Reserve and Marine Corps Reserve except those retired with pay and beneficiaries of B.E.C. or V.A.</td>
<td>Act of 25 Jun 1938 as amended (34 USC 856b); Act of 27 Aug 1940 as amended (34 USC 856c-1); Act of 12 Oct 1948 (37 USC 272).</td>
<td></td>
<td>Art. 21-15, MANMED.</td>
<td>Request of member’s CO.</td>
<td>Hospital ration...</td>
<td>None...</td>
</tr>
<tr>
<td>(10) Members, Reserve components, Army and Air Force except those retired with pay and beneficiaries of B.E.C. or V.A.</td>
<td>Act of 25 Jun 1938 as amended (34 USC 856b); Act of 27 Aug 1940 as amended (34 USC 856c-1); Act of 12 Oct 1948 (37 USC 272).</td>
<td></td>
<td>Art. 21-17, MANMED.</td>
<td>Request of member’s CO.</td>
<td>Hospital ration...</td>
<td>None...</td>
</tr>
</tbody>
</table>

**Reports**

- NAVISP:
  - None
- STA HOSP or DBF: DD Form 7
- B.E.C. or V.A.: Interdepartmental
<table>
<thead>
<tr>
<th>(10) Naval pensioners</th>
<th>Art. 21–8. MANMED</th>
<th>Application of pensioner and identification.</th>
<th>None</th>
<th>None</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>(11) Beneficiaries, Naval Home</td>
<td>Art. 21–9. MANMED</td>
<td>Request of Governor, Naval Home.</td>
<td>do</td>
<td>do</td>
<td>do</td>
</tr>
<tr>
<td>(12) Former members Navy and Marine Corps retained after discharge or resignation:</td>
<td>Art. 21–20. MANMED</td>
<td>Prior status as patient.</td>
<td>Bureau</td>
<td>Hospital ration</td>
<td>Do</td>
</tr>
<tr>
<td>(a) Retained after expiration of enlistment for medical care</td>
<td>Administrative regulations approved by SECNAV; art. 21–21. MANMED</td>
<td>Request of former member.</td>
<td>Local</td>
<td>do</td>
<td>Do</td>
</tr>
<tr>
<td>(b) Maternity</td>
<td>Member</td>
<td>Request of candidate's CO</td>
<td>Bureau</td>
<td>do</td>
<td>Do</td>
</tr>
<tr>
<td>(13) Officer candidates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(14) (a) Member, U.S. Coast Guard, retired, and retired for physical disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Commissioned Officers, U.S. Coast and Geodetic Survey, retired, and retired for physical disability.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Commissioned Officers, Public Health Service, retired, and retired for physical disability.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Art. 21–15 MANMED

Rev. Stat. 161 (5 USC 22)

Rev. Stat. as amended (34 USC 180)

Act of 26 Jun 1938 (34 USC 853); Act of 13 Oct 1942 (34 USC 821); Act of 13 Aug 1946 (34 USC 1620).
### Table of Standard Procedures Concerning Medical Services Furnished Supernumeraries—Continued

**Part II. Inpatient medical care of other than service patients**

<table>
<thead>
<tr>
<th>Classes of supernumeraries</th>
<th>Statutory authority</th>
<th>Regulations, etc.</th>
<th>Application</th>
<th>Collection</th>
<th>Rate</th>
<th>Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Dependents of members or retired members of a uniformed service, or of a person who died while a member or retired member of a uniformed service.</td>
<td>Act of 7 Jun 1956 (70 Stat. 250).</td>
<td>Joint uniformed service regulation (SECNAVINST 6220.5).</td>
<td>Request of dependent or member.</td>
<td>Local.</td>
<td>Dependent's rate.</td>
<td>None.</td>
</tr>
<tr>
<td>(3) Beneficiaries, V.A. (persons on emergency officers' retired list entitled only to compensation; i.e., without retired pay, are included in this class).</td>
<td>Act of 2 Sep 1938 (58 USC 5001, 5003).</td>
<td>Art. 21-22, MANMED.</td>
<td>Request of V.A.</td>
<td>Bureau.</td>
<td>Interdepartmental.</td>
<td>Copy of SF 1080 when payment received.</td>
</tr>
<tr>
<td>(4) Beneficiaries, Public Health Service:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Employees and noncommissioned officers in the field service of the Public Health Service when injured or sick in line of duty.</td>
<td>Act of 1 Jul 1944 (42 USC 291).</td>
<td></td>
<td>do.</td>
<td>do.</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>(c) Merchant seamen including enrollees U.S. Maritime Service, and Merchant Marine Cadet Corps members.</td>
<td></td>
<td></td>
<td>do.</td>
<td>do.</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>(d) Seamen employed on vessels, U.S. Registry, or on vessels as employees U.S.</td>
<td></td>
<td></td>
<td>do.</td>
<td>do.</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>(e) Cadets State maritime academies or State training ships.</td>
<td></td>
<td></td>
<td>do.</td>
<td>do.</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>(f) Seamen, State school ships or vessels of U.S. Govt. of more than 5 tons.</td>
<td></td>
<td></td>
<td>do.</td>
<td>do.</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>(g) Seamen on vessels of Mississippi River Commission and officers and men of vessels of Fish and Wildlife Service.</td>
<td></td>
<td></td>
<td>do.</td>
<td>do.</td>
<td>do.</td>
<td>Do.</td>
</tr>
</tbody>
</table>
(7) Beneficiaries, Bureau of Employees' Compensation. Act of 7 Sep 1918 amended (5 USC 759) and other laws.¹


(9) Employees of Federal contractor outside U.S. Authorization or cognizant official. 

(10) Civilians designated by Secretary of Navy. 

(11) Civilian, humanitarian. 

(12) Persons in attendance, National Police Academy, Marine Barracks, Quantico, Va., except beneficiaries B.E.C. 

(13) Officers and employees, State Department Foreign Service 

(14) Members, foreign military or naval activities assigned duty in U.S. or required by international courtesy. 

¹ Basis for requisition under Act of 4 Mar 1915 as amended (31 USC 686).
### 21-3. Table of Standard Procedures Concerning Medical Services Furnished Supernumeraries—Continued

**PART III.—Services other than inpatient medical care**

<table>
<thead>
<tr>
<th>Classes of supernumeraries</th>
<th>Statutory authority</th>
<th>Regulations, etc.</th>
<th>Application</th>
<th>Collection</th>
<th>Rate</th>
<th>Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) (a) Employees of Federal contractor outside U.S.—Outpatient treatment.</td>
<td>Act of 10 May 1943 (24 USC. 34)</td>
<td>Art. 21-27, MANMED...</td>
<td>Request of employee...</td>
<td>Bureau...</td>
<td>Extraregional...</td>
<td>Letter...</td>
</tr>
<tr>
<td></td>
<td>Act of 4 Mar 1915 amended (31 USC 668); Act of 7 Jun 1924 amended (38 USC 690); Act of 22 Jun 1944 amended (38 USC 692b).</td>
<td>Art. 21-22(4) MANMED...</td>
<td>Request of manager, center, hospital, or regional office.</td>
<td>do...</td>
<td>Examination...</td>
<td>Do...</td>
</tr>
<tr>
<td></td>
<td>Act of 22 May 1920 amended (5 USC 710)</td>
<td>Exec. Order 4071 of 4 Sep 1924; art. 21-31, MANMED; R-3 Federal Personnel Manual.</td>
<td>Request of Civil Service - Commission or cognizant agency.</td>
<td>None...</td>
<td>None...</td>
<td>DD Form 7...</td>
</tr>
<tr>
<td></td>
<td>Act of 4 Mar 1915 amended (31 USC 668)...</td>
<td>Art. 21-31, MANMED...</td>
<td>Request of local F.B.I. official...</td>
<td>do...</td>
<td>do...</td>
<td>None...</td>
</tr>
<tr>
<td></td>
<td>Act of 8 Aug 1946 (5 USC 150)</td>
<td>Exec. Order 4071 of 4 Sep 1924; N.C.P.I. 88.</td>
<td>Appropriate referral...</td>
<td>do...</td>
<td>do...</td>
<td>Letter...</td>
</tr>
<tr>
<td></td>
<td>Act of 13 Aug 1946, amended (22 USC 1156-1158).</td>
<td>Art. 21-31, MANMED; current Navy instruction.</td>
<td>Appropriate request...</td>
<td>Bureau...</td>
<td>Examination...</td>
<td>Do...</td>
</tr>
<tr>
<td>(d) Claimants against U.S.</td>
<td>Act of 4 Mar 1915 amended (31 USC 668)...</td>
<td>Art. 21-31, MANMED...</td>
<td>Request of responsible U.S. Attorney...</td>
<td>do...</td>
<td>Examination or interdepartmental, Hospital ration...</td>
<td>Do...</td>
</tr>
<tr>
<td>(e) Disability review cases.</td>
<td>Act of 22 Jun 1944 amended (38 USC. 692b)...</td>
<td>do...</td>
<td>Instructions of SECNAV or request of cognizant Board.</td>
<td>Local...</td>
<td>None...</td>
<td>None...</td>
</tr>
</tbody>
</table>

1 Basis for requisition under Act of 4 Mar 1915 as amended (31 USC 668).
21-4. General

(1) The Dependents' Medical Care Act (Public Law 569, 84th Congress (70 Stat. 250)) authorizes certain medical care to be provided for eligible dependents of members and retired members of the uniformed services and dependents of persons who died while a member or retired member of a uniformed service.

(2) The medical service policies and procedures for administering the medical care program for dependents are promulgated by joint uniformed services regulations. Reference shall be made to these regulations (in the 6320 series of the Navy Directives System) for information and guidance with respect to the following:

(a) Definition of terms peculiar to dependent medical care program.

(b) Determination of eligibility and authorization for admission of dependents.

(c) Determination of source from which dependents are to receive medical care.

(d) Administration of medical care for dependents at medical facilities of the uniformed services.

(e) Administration of medical care obtained from civilian sources for spouses and children.

(f) Administration of medical care not otherwise provided for.

(3) The policies and procedures for guidance of naval activities with respect to the following:

(a) The medical care program.

(b) Determination of eligibility and authorization for admission of dependents.

(c) Determination of source from which dependents are to receive medical care.

(d) Administration of medical care for dependents at medical facilities of the uniformed services.

(e) Administration of medical care obtained from civilian sources for spouses and children.

(f) Administration of medical care not otherwise provided for.

21-5. Medical Care at Naval Medical Facilities

(1) Whenever requested, authorized medical care shall be provided for dependents of members and retired members of the uniformed services and dependents of persons who died while a member or retired member of a uniformed service at U.S. naval fixed medical treatment facilities designated by the Bureau to provide inpatient and outpatient medical care for dependents. Normally, medical care shall be limited to those dependents residing in the areas which the facilities have been designated to serve. The medical care shall be contingent upon the availability of space and facilities and the capabilities of the professional staff as determined by the medical officer in charge and shall be considered secondary to the primary mission of the Medical Department. This mission consists of a definite responsibility imposed on the Surgeon General through the Medical Department to maintain and restore the health of members of the Armed Forces on active duty.

(2) Except in cases of emergency or as otherwise indicated by distance traveled or other extenuating circumstances, outpatient medical care for dependents is to be routinely available only during the regular working hours of the facility.

(3) For information concerning dental care, refer to chapter 6 and current directives.

21-6. Identification

(1) Dependents requesting medical care shall be required to show satisfactory identification as prescribed by current directives.

(2) If the dependent does not possess suitable identification and is obviously in need of treatment, the medical officer concerned may determine from other evidence the individual's eligibility for medical care.

21-7. Medical Services Not Otherwise Provided For

(1) Prescriptions written by civilian physicians (non-Navy-employed) for dependents who present a valid DD 1173 (Uniformed Services Identification and Privilege Card) may be filled if: (a) the commanding officer determines that pharmacy personnel and funds are available, (b) the items are routinely stocked, (c) the amounts are reasonable and correct as to dosage, and (d) narcotics are not included. (Also see arts. 3-31 and 3-33 re prescribing and dispensing drugs.)

(2) Medications shall not be furnished by mail to retired personnel or dependents unless they are directly under the care of a naval physician. Such medications shall be limited to those regularly stocked, in reasonable amounts, correct as to dosage, and shall not include narcotics.

(3) X-ray, laboratory, physical therapy, and other ambulatory diagnostic or therapeutic measures for eligible dependents requested by non-Navy-employed civilian physicians may be provided upon approval of the commanding officer or department heads designated by him, if the rendering of such services is subordinated to and does not unduly interfere with providing adequate inpatient and outpatient care to active duty personnel and eligible supernumeraries who come to the Navy medical facility for care.
21-8. Maternity Cases

(1) The per diem charge for a maternity-case dependent shall include the mother and the newborn infant until the mother is allowed to leave the hospital or other medical activity. If further hospitalization of the infant is required, the per diem charge shall continue for the infant. The same per diem charge will apply whenever an infant under 1 year of age is hospitalized, such charge to include the mother if she is required by the activity to remain with the infant. If the mother is hospitalized, and of necessity an infant under 1 year of age accompanies or remains with her, the per diem charge for the mother shall also include such infant. For a child 1 year of age or over, the per diem charge shall be in addition to the charge for the mother. A Standard Form 535, Newborn Record, shall be prepared. The infant shall be taken up in the Register of Patients as indicated in subarticle 23-222 (1).

Note.—There are no articles 21-9 through 21-11.

Section III. SERVICE PATIENTS NOT ON ACTIVE NAVAL DUTY

<table>
<thead>
<tr>
<th>Members of Other Services on Active Duty</th>
<th>Article</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navy and Marine Corps Members Including Reserve Components Retired With Pay</td>
<td>21-13</td>
</tr>
<tr>
<td>Fleet Reserve and Fleet Marine Corps Reserve Members</td>
<td>21-14</td>
</tr>
<tr>
<td>Furnishing Medications to Retired Personnel</td>
<td>21-14A</td>
</tr>
<tr>
<td>Members and Former Members of the Other Uniformed Services Retired With Pay</td>
<td>21-15</td>
</tr>
<tr>
<td>Members of Reserve Components of the Army and Air Force Except Those Retired With Pay</td>
<td>21-16</td>
</tr>
<tr>
<td>Naval and Marine Corps Reserve Members Except Those Retired With Pay</td>
<td>21-17</td>
</tr>
<tr>
<td>Naval Pensioners</td>
<td>21-18</td>
</tr>
<tr>
<td>Beneficiaries of the Naval Home</td>
<td>21-19</td>
</tr>
<tr>
<td>Former Members</td>
<td>21-20</td>
</tr>
<tr>
<td>Officer Candidates</td>
<td>21-21</td>
</tr>
</tbody>
</table>

21-12. Members of Other Services on Active Duty

(1) The provisions of this article cover members of the Army, Air Force, Coast Guard, Commissioned Corps of the Coast and Geodetic Survey, and the Commissioned Corps of the Public Health Service (regular or reserve, appointed, enlisted, inducted, called, ordered, or conscripted) who are serving on active duty, or active duty for training pursuant to a call or order that does not specify a period of 30 days or less.

(2) Under ordinary circumstances, a member will receive medical care at the medical facility of the uniformed service which serves the organization to which he is assigned. A member away from his duty station or on duty where there is no medical facility of his own service may upon his own cognizance or when requested by his commanding officer, or in the case of a member who is also a beneficiary of the Public Health Service when requested by a Public Health Service medical officer, receive care at a medical facility of another uniformed service.

(3) Members may be admitted for medical care at naval medical facilities in accordance with the "Application" column of article 21-3, part I, item (1).

(4) (a) Referral of active duty members of the Army, Air Force, Commissioned Corps of the Coast and Geodetic Survey, and the Commissioned Corps of the Public Health Service to a naval medical facility for admission may be accomplished by letter, or by other appropriate means. Referral of active duty members of the Coast Guard for admission will ordinarily be effected by Form NCG 2522.

(b) Upon admission without referral, the member's commanding officer, or if appropriate the nearest Public Health Service medical officer, shall be immediately notified with details as to date of admission, diagnosis, condition, prognosis, circumstances of injury if applicable, anticipated duration of hospitalization, notifications made to next of kin, and any other pertinent information. The method of notification (telephone, telegraph, etc.) shall be determined by the urgency of the situation at hand. At those medical facilities to which technical service units or liaison officers of the respective service are attached, notification to such units or officers will suffice.

(5) Reference shall be made to article 6-98 concerning availability of dental treatment, to article 20-9 concerning the availability of nonnaval treatment, and to article 24-25 concerning the availability of orthopedic and prosthetic appliances for all members of the uniformed services.

21-13. Navy and Marine Corps Members Including Reserve Components Retired With Pay

(1) Members or former members of the Navy or Marine Corps, or of the Reserve components thereof entitled to retired, retirement, or retainer pay or
such pita! for treatment of any such chronic disease, except: (a) In the cases of members or former members of the naval service permanently retired for physical disability or receiving disability retirement pay or whose names have been placed on the temporary disability retired list who require hospitalization for chronic diseases as defined below, all powers, duties and functions incident to such hospitalization are vested in the Administrator of Veterans Affairs. Such cases may not be hospitalized in a naval hospital for treatment of any such chronic disease, except (1) when hospitalization is authorized by the Veterans Administration, or (2) when such members or former members have completed 20 or more years of active duty and elect not to receive hospitalization in Veterans Administration facilities and require hospitalization for any of the chronic diseases other than blindness, neuropsychiatric or psychiatric disorders, and tuberculosis, and are acceptable medically to the commanding officer of a naval hospital.

(b) For the purposes of this article “chronic diseases” shall include chronic arthritis, malignancy, poliomyelitis with disability residuals, tuberculosis, blindness and deafness requiring definitive rehabilitation, major amputees, psychiatric or neuropsychiatric disorders, neurological disabilities, degenerative diseases of the nervous system, and severe injuries to the nervous system including quadriplegics, hemiplegics, and paraplegics.

(c) Members or former members entitled to retired or retirement pay under the provisions of 10 USC 1331–1337 who have served less than 8 years of active duty (full-time duty in the active service other than active duty for training) are not eligible for outpatient or inpatient medical care in any medical facility of the uniformed services.

(2) The limitation to hospitalization contained in subarticle 21–13(1) shall not be considered to affect eligibility for hospitalization for conditions not defined as chronic diseases nor for outpatient treatment regardless of the nature of the illness for which treatment is required.

(3) Persons placed upon the emergency officers’ retired list who are receiving retired pay shall be eligible for hospitalization privileges provided by law or regulation for officers of the Regular Navy who have been retired for physical disability. Other persons placed upon the emergency officers’ retired list without retired pay and entitled only to compensation pursuant to law or regulation of the Veterans Administration may be admitted as a beneficiary of that agency.

21–14. Fleet Reserve and Fleet Marine Corps Reserve Members

(1) Members of the Fleet Reserve and Fleet Marine Corps Reserve transferred thereto after 16 or more years of active service who are not on active duty may be admitted to any naval hospital for care upon application to the commanding officer and presentation of suitable identification.

21–14A. Furnishing Medications to Retired Personnel

(1) See article 21–7(2) and (4).

21–15. Members and Former Members of the Other Uniformed Services Retired With Pay

(1) Provided there are no medical facilities of the applicable service in the area, retired or former members of the Army, Air Force, Commissioned Corps of the Coast and Geodetic Survey, and Commissioned Corps of the Public Health Service or of the reserve components thereof who are entitled to retired, retirement, or retainer or equivalent pay as a result of service in a uniformed service are entitled to medical care and adjuncts thereto in a naval medical facility to the same extent as provided for active duty members. Entitlement shall be subject to mission requirements and the availability of space, facilities, and capabilities of the medical staff as determined by the cognizant medical authority in charge of the medical facility, upon application of the individual and presentation of suitable identification. However:

(a) Members or former members entitled to retired or retirement pay under the provisions of 10 USC 1331–1337 who have served less than 8 years of active duty (full-time duty in the active service other than active duty for training) are not eligible for outpatient or inpatient medical care in any medical facility of the uniformed services.

(b) Members retired by reason of physical disability are eligible for outpatient and inpatient medical care as limited by the provisions of Executive Order 10122, 14 April 1950, as amended by Executive Order 10400, 27 September 1952, specified for naval members in article 21–13.


(1) Members of Reserve components of Navy or Marine Corps on active duty under orders contemplating extended naval service in excess of 30 days who suffer disability or death in line of duty from injury or disease shall be subject to procedures outlined in other chapters for members of the Navy and Marine Corps.

(2) Members of Reserve components called or ordered to active naval service or to perform active duty for training or inactive-duty training who suffer disability or death in line of duty while so employed also shall be entitled to hospitalization and medical care provided for members of the Navy or Marine Corps and as prescribed by Ad-
21–10
Change 8

Administrative Regulations approved by the Secretary and promulgated in Navy Department Bulletins.

(3) Members of Reserve components who become ill or contract disease in line of duty during the performance of active duty or training duty (as distinguished from inactive-duty training) with or without pay shall be entitled, at Government expense, to such medical, hospital, or other treatment as necessary for the appropriate treatment of such illness or disease until the disability resulting from such illness or disease cannot be materially improved by further hospitalization or treatment, and to the necessary transportation and subsistence incident to such medical and hospital treatment and return to their homes when discharge therefrom. Treatment or hospitalization for such illness or disease shall not be continued for more than 10 weeks following discharge from active or training duty except on the approved recommendation of a board of medical survey, consisting of one or more medical officers of the Navy, or on authorization of the Surgeon General of the Navy based on the certificate of a reputable physician that the illness or disease is a continuation of the illness or disease which was sustained or contracted during the period of active or training duty and that further benefit will result from continued treatment.

(4) If in time of peace any member of the Organized Reserve, the Volunteer Reserve, or the Merchant Marine Reserve is physically injured in the line of duty while performing active military or naval service, or dies as the result of such physical injury, he or his beneficiaries shall be entitled to all the benefits prescribed by law for civil employees of the United States who are physically injured in the line of duty who die as a result thereof, and the Bureau of Employees' Compensation shall have the jurisdiction in such cases and shall perform the same duties with reference thereto as in the cases of civil employees of the United States so disabled. Where a person who is eligible for the benefits prescribed herein under the Bureau of Employees' Compensation is also eligible for pension for disability, under the Veterans’ Administration, he shall elect which benefit he shall receive, and for the purposes of such benefits all members of the Naval Reserve shall be considered as performing active military or naval service while performing active duty with or without pay, training duty with or without pay, drills, equivalent instruction or duty, appropriate duty, or prescribed duty, or while performing authorized travel to or from such duties. For the purposes of determining the benefits to which entitled, Naval Reservists so physically injured while performing the foregoing duties in a nonpay status will be held and considered as receiving the pay and allowances they would have received if in a pay status. In no case shall sickness from disease be regarded as an injury in connection with the provisions of this article. Instructions concerning compensation for injury in the Bureau of Naval Personnel Manual should be followed in such instances.

(5) For disability resulting from personal injury or disease contracted in line of duty or for aggravation of a preexisting injury or disease contracted or suffered in line of duty when such disability was incurred in or aggravated by active military or naval service other than a period of war service as provided in part I of the Veterans Regulations, the United States shall pay to any person thus disabled and who was honorably discharged from such period of service in which said injury or disease was incurred, or preexisting injury or disease aggravated, a pension, but no pension shall be paid if the disability is the result of the person’s own misconduct: Provided, That active service, including service for training purposes, performed by a Reserve officer or member of the Enlisted Reserves of the United States Army, Navy, or Marine Corps, shall be considered as active military or naval service for the purpose of granting benefits under part II of the Veterans Regulations, and it shall not be required that such Reserve officer or enlisted person shall have been discharged from the service. Pension under this paragraph shall not be paid concurrently with active duty pay or employees’ compensation. Where a person who is eligible for pension hereunder is also eligible for the benefits of the Employees’ Compensation Act, he shall elect which benefits he shall receive.

(6) Any member of the Naval Reserve who, while performing active duty with or without pay for periods of 30 days or less, training duty with or without pay, drills, equivalent instruction or duty, appropriate duty, or prescribed duty, or while performing authorized travel to and from such duties on or after 1 December 1945 and prior to the official termination of World War II, is physically injured in the line of duty while performing any of these duties, or dies as the result of such physical injury, shall be entitled to the benefits provided under sub-articles 21–16(3), (4), and (5), for members of the Naval Reserve.

21–17. Members of Reserve Components of the Army and Air Force Except Those Retired With Pay

(1) Members of the Reserve components of the Departments of the Army and Air Force may be admitted for medical care to a naval medical activity having facilities for such care upon the written request of the individual’s commanding officer or other authorized representative of the U.S. Army or U.S. Air Force. Entitlement to medical care of
such personnel at Government expense shall be determined by the service requesting medical service.

21-18. Naval Pensioners

(1) An individual who is in receipt of a naval pension may be admitted to a naval hospital, upon application to the commanding officer and presentation of suitable identification.

21-19. Beneficiaries of the Naval Home

(1) A beneficiary of the Naval Home, Philadelphia, Pa., may be admitted to a naval hospital upon the request of the Governor of the Naval Home. If a beneficiary of the Naval Home is admitted to a naval hospital as an emergency case, the Governor of the Naval Home shall be notified immediately.
Maternity Care—

(a) Eligibility.—Female members of the Armed Forces separated from active duty or from the service are eligible for maternity care during pregnancy and confinement, and for outpatient postnatal care for such period thereafter as the commanding officer or the medical officer may deem necessary at hospitals and other activities of the Navy, Army, or Air Force, when suitable facilities are available, provided it is determined that pregnancy existed at the time of separation from active duty or from the service.

(b) Application.—In making application for maternity care, a former enlisted woman should present her discharge certificate or a photostat thereof. An officer should present a certified copy of her request for resignation (if she was separated through acceptance of resignation) and of her separation orders. A doctor’s certification will be accepted in any case where a woman has been separated from active duty or from the service under honorable conditions for reasons other than because of pregnancy and it can be reasonably determined that the condition of pregnancy existed at the time of separation. At the time of separation, such pregnant personnel shall be advised to register at a naval hospital pending the completion of the procedures for separation of its mother from the service.

(c) The Child.—The military departments assume responsibility for the care of the child only during the mother’s hospitalization, and further arrangements for the child must be made by the mother. If the mother contemplates release of the child for adoption, all such arrangements must be made by the mother with local civil authorities in advance of hospitalization.

(d) Overseas.—Women on duty overseas who become pregnant will ordinarily be returned to the continental United States by the first suitable means of transportation for separation from the service. If, however, in the opinion of the naval medical officer, the health of the woman would be endangered by such transportation, she shall be retained overseas until delivery. The following procedure shall apply in the case of naval personnel:

(1) Her commanding officer shall provide for her hospitalization at a naval medical facility if available within his command. If not available, the services of any other Federal hospital which may be available should be utilized. If naval or other Federal hospital facilities are not available, civilian hospitalization may be effected. However, such hospitalization will require the prior approval of the Bureau, and requests therefor should be submitted to the Bureau in accordance with the provisions of article 20-9. The arrangements for civilian hospitalization in all cases should provide that the hospital charge for the mother shall include the charge for the infant. The expense of civilian hospitalization or treatment may be defrayed by the Medical Department of the Navy only while the member is still on active duty.

(2) She shall be returned to the continental United States as soon after delivery as her physical condition permits, except that she may remain as a patient in proximity to her infant if the latter is certified by a naval medical officer as unfit to travel. Until the mother is separated from the service the infant shall be treated as a dependent of military personnel. Return of an infant with its mother who is in the naval service is authorized. Orders and passenger lists shall indicate the name of the infant. If circumstances warrant, both individuals shall be classified as “patients” and ordered to a naval hospital in the continental United States which can be reached by the first suitable means of transportation. Separation of the woman from the naval service shall be effected as soon as possible thereafter. The infant may be admitted to the naval hospital pending the completion of the procedures for separation of its mother from the service.

21–21. Officer Candidates

(1) A member of the Naval Reserve Officers’ Training Corps, the Platoon Leaders Class, or a Reserve officer candidate, who suffers disability from personal injury, illness, or disease occurring in line of duty while en route to or from and while participating in authorized practice cruises may be entitled at Government expense to such hospitalization, rehospitalization, medical and surgical care and treatment, in hospital or at their homes, as is necessary for the appropriate treatment of such personal injury, illness, or disease until the disability resulting therefrom cannot be materially improved by hospitalization or treatment, and to the necessary transportation and subsistence incident to such hospital and medical treatment and return to their homes when discharged therefrom.

(2) Admission to naval medical facilities of candidates for, or individuals enrolled in, the Naval
Reserve Officers Training Corps, the Platoon Leaders Class, or the Reserve Officer Candidates program, who are not on active duty, is authorized for the purpose of conducting special physical examination procedures which have been requested by the Bureau in order to determine their physical fitness for appointment to, or continuation in, such a program. Upon a request from the individual’s commanding officer or the officer in charge of the cognizant office of naval officer procurement, commanding officers of naval medical facilities are authorized to admit individuals in this category when, in their opinion, inpatient study is deemed necessary. Inpatient status should be kept to a minimum. Treatment, other than for humanitarian reasons, unless otherwise provided for, is not authorized.

Section IV. OTHER THAN SERVICE PATIENTS

21-22. Beneficiaries of the Veterans Administration

(1) A Veterans Administration beneficiary may be admitted to a naval hospital upon the authorization of the Veterans Administration official having cognizance of the case. Each such authorization must be in writing. However, an emergency admission of a Veterans Administration patient may be accomplished upon verbal authorization with written confirmation. The Veterans Administration will reimburse the Navy Department only for hospitalization of those beneficiaries for whom treatment has been authorized. In general only medical and surgical cases requiring hospital treatment are to be admitted. Neurological and certain neuropsychiatric cases without obvious evidence of psychosis and not requiring restraint, may be admitted for diagnosis. Cases of suspected tuberculosis also may be admitted for diagnosis. When diagnosed, cases of psychosis, psychoneurosis, or pulmonary tuberculosis of present clinical significance shall be reported to the cognizant Veterans Administration authority with a request for the prompt removal of the patient to a Veterans Administration facility.

(2) All problems pertaining to a beneficiary of the Veterans Administration, including admission, medical or other records, and correspondence shall be matters for resolution between the commanding officer of the hospital and the Veterans Administration regional manager authorizing admission. It should be remembered that the naval medical activity is providing medical treatment authorized by the Veterans Administration. Questions of policy and administration which cannot be resolved between the commanding officer and the regional manager shall be forwarded to the Administrator of Veterans Affairs via the Bureau for resolution.

(3) Upon admission to the hospital, each patient who is a beneficiary of the Veterans Administration shall be assigned a case number from the Register of Patients, NAVMED-39. The case number should appear on all records of the patient. Each beneficiary of the Veterans Administration hospitalized at a naval hospital shall be required to conform to regulations governing the internal administration of the hospital. Restrictive or punitive measures and assignment to working details shall conform as nearly as possible to Veterans Administration instructions.

(4) Certain naval hospitals may be designated by the Bureau to provide outpatient examinations, required in the adjudication of claims for disability compensation. Such examinations shall be performed only when properly authorized by the Veterans Administration. When the examination requires more than 1 day, the claimant shall be admitted as an inpatient from the beginning of the examination. The proper Veterans Administration authorization for such admission shall be obtained.

(5) Persons placed on the emergency officers’ retired list without retired pay and entitled only to compensation pursuant to law or to regulation of the Veterans Administration shall be admitted to
21-22
CHAPTER 21. MEDICAL CARE OF SUPERNUMERARIES

(1) Certain beneficiaries of the Public Health Service, not members of the uniformed services, may be admitted to any naval medical treatment facility upon the written request of the medical officer in charge of the nearest Public Health Service hospital or outpatient clinic. Such request should be in the form of a Treatment Authorization, form PHS-894, signed by the referring Public Health medical officer. Such authorization will be attached to three copies of form FHS-484-1 (HD), Clinical Record Brief. The date of admission shall be immediately typed on the Briefs, and one copy returned to the station which authorized the treatment. Upon completion of treatment, the original Brief shall be completed through item 37 and returned to the authorizing station. The Treatment Authorization should be forwarded to the Bureau with the DD-7.

(2) In the case of detached personnel, or those serving in a locality where a Public Health Service medical officer is not available, who require emergency medical care, a written request for hospitalization signed by either the individual or the commanding officer (or ship's master) may be accepted. Nonemergency cases shall not ordinarily be admitted until their eligibility for admission has been verified. There is no exception to the treatment members of the American Merchant Marine may receive as long as they can show proof that they have been employed as a seaman for 60 days of continuous service, a part of which time must have been during the 90 days immediately preceding application for medical care. In emergency or nonemergency cases, the medical officer in charge of the nearest Public Health Service hospital or outpatient clinic shall be immediately notified with details, and requested to verify the propriety of such request for treatment. In cases involving Military Sea Transportation Service civil service seamen, the verification may be obtained by contacting the nearest MSTS facility. The method of notification (telephone, telegraph, etc.) shall be determined by the urgency of the situation at hand. The verifying officer will forward one copy of the Treatment Authorization and three copies of the Clinical Record Brief, which will then be administratively handled as indicated in subarticle 21-23(1).

(a) In determining emergency and nonemergency classifications consideration should be given to the seaman's present status. For instance: a seaman may request treatment for what would normally be considered as a nonemergency ailment; however, it may be of such a nature that unless treated the man would not be able to sail with his ship. Such cases should be treated as emergency.

(3) The following beneficiaries of the Public Health Service may be admitted, with completion and submission of the above indicated Treatment Authorization and Clinical Record Brief:

(a) Ship's officers and members of the crews of vessels of the United States Coast and Geodetic Survey, Active and Retired.
(b) Employees and noncommissioned officers in the field service of the Public Health Service when injured or sick in line of duty.
(c) Merchant seamen including enrollees in the United States Maritime Service on active duty, and members of the Merchant Marine Cadet Corps.
(d) Seamen employed on vessels of U.S. Registry or on vessels as employees of the United States.
(e) Cadets at the State maritime academies or on State training ships.
(f) Seamen employed on State school ships or on vessels of the U.S. Government of more than 5 tons' burden.
(g) Seamen on vessels of the Mississippi River Commission and officers and crews of vessels of the Fish and Wildlife Service.

21-24. Registrants, Selective Service

(1) A Selective Service Registrant, acting upon orders issued under the Selective Service law shall be provided emergency medical care, including hospitalization, in accordance with the rules and regulations prescribed by the Director of Selective Service. Such medical care shall be requested by the local Selective Service official.

21-25. Representatives of the American Red Cross

(1) An accredited representative of the American National Red Cross assigned to a naval activity within the continental United States may be furnished medical care by naval medical activities in same manner provided for Federal employees who are not beneficiaries of the Bureau of Employees' Compensation.
21-26. Beneficiaries of the Bureau of Employees' Compensation

(1) A beneficiary of the Bureau of Employees' Compensation may be furnished inpatient medical care in accordance with regulations governing the administration of the Employees' Compensation Act. Such regulations should be consulted in handling Bureau of Employees' Compensation patients.

21-27. Officers and Employees of the Government and Employees of a Federal Contractor Outside U.S.

(1) Medical care (inpatient and outpatient) may be provided at naval activities outside the continental limits of the U.S. and in Alaska to officers and employees of any department or agency of the Federal Government, to employees of a contractor with the U.S. or of subcontractors, to dependents of such persons, and in emergencies to other persons prescribed by the Secretary of the Navy. Such medical care shall be provided in accordance with this article when not otherwise authorized by this chapter and only when reasonably accessible and appropriate nonfederal medical facilities are not available. Persons included in the above category are (a) officers and crews of the U.S. airlines, (b) shipwreck or enemy-action refugees, (c) civilian mariners of the Military Sea Transportation Service, and (d) humanitarian cases.

21-28. Civilians Under Special Circumstances

(1) Any member of the civilian population may be admitted for humanitarian reasons at the discretion of the commanding officer to any naval activity having facilities for inpatient care. Such a patient shall be classified as an indigent only after reasonable attempts to collect charges for hospitalization have been unsuccessful in the opinion of the commanding officer.

(2) First-aid treatment and emergency medical care rendered to members of the civilian population shall, in addition to such medical history as should be routinely recorded, be made the subject of an entry in the daily journal (Officer-of-the-Day Log).

(3) Persons in attendance at the National Police Academy, Marine Barracks, Quantico, Va., may be admitted to the Naval Hospital at Quantico for emergency hospitalization in the following cases:

(a) Employees of the Bureau of Investigation who are injured in the performance of duty may be entitled to medical care at the expense of the Bureau of Employees' Compensation and should be admitted and reported as beneficiaries of that Bureau. Such employees also may be admitted for treatment of disease and in this case are admitted and reported as civilian humanitarian patients.

(b) Representatives of police organizations of various states, cities, and counties who are in attendance at the National Police Academy may be hospitalized as civilian humanitarian patients with the approval of the Commanding General.

21-29. Officers and Employees of the State Department Foreign Service

(1) An officer or employee of the Foreign Service of the State Department may be admitted to a naval hospital upon specific authorization by the Bureau.

21-30. Members of Foreign Military Establishments

(1) Any member of friendly foreign military units or organizations on active duty within the continental United States who is in need of medical care may be admitted to any naval medical activity upon request of the individual's commanding officer or consular representative. In these cases, medical care may be furnished to the extent facilities are available. Should the patient's condition indicate that he should be transferred to a hospital within his own nation or to a private institution, a message or speedletter request shall be directed to the Chief of the Bureau of Medicine and Surgery who will make appropriate arrangements.

(2) Foreign military personnel not included above may be furnished medical care in naval medical activities pursuant to the laws of humanity and the principles of international courtesy. Providing the medical condition of the patient and time permit, a prior request shall be submitted to the Bureau for authority to admit the patient.

21-31. Services Other Than Inpatient Medical Care

(1) The table of standard procedures, part III, article 21-3, includes several categories of persons who may receive services other than hospitalization. This table is self-explanatory but is not intended to exclude future services required by Federal agencies not having a medical service. In any such cases instructions of the Secretary of the Navy will be
promulgated upon approval of requests by agency heads.

(2) The civil service retirement laws have been construed to impose upon all medical officers of the United States the additional duty of conducting disability retirement examinations of civilian employees. The policy of the Civil Service Commission is to send retirement claimants to naval hospitals for examination only in exceptional cases when medical officers either of naval stations or of other Government agencies are not available.

(3) Civilian employees of the Naval Establishment shall be furnished medical treatment for non-occupational injuries and illnesses occurring while at work, including minor ailments which can be relieved by moderate treatment or advice. Dental treatment shall be limited to emergency treatment for relief of pain, for contagious oral disease, or for humanitarian reasons, when such treatment is not available from any other source. Treatments are limited to outpatient dispensary service during regular working hours. In order to qualify for treatment the employee shall present a written authorization or referral from his immediate supervisor to the medical or dental officer. The final interpretation of the scope of moderate treatment or advice or emergency dental treatment shall be at the discretion of the medical or dental officer concerned. In general, however, it should be such as will result in enabling the employee to continue at work.

(4) Any member of the Navy or Marine Corps Reserve who has been released to inactive duty and whose case is being reviewed by the Naval Medical Survey Review Board or the Retiring Review Board may be admitted to a naval hospital for diagnosis and evaluation upon request of the senior member or president of the Board.

21–32. Cases Not Covered in Text

(1) Special instruction for the proper method of handling and reporting cases of supernumerary patients not covered herein shall be requested of the Bureau.

Section V. CHARGES, COLLECTIONS, AND REPORTS

21–33. Charges, Collections, and Reports

(1) Charges for hospitalization and/or subsistence furnished supernumerary patients shall be collected in the manner and at the rate indicated in the table under article 21–3. Detailed information concerning methods of collection, disposition of locally collected funds, and required reports for naval hospitals and medical centers are contained in the Financial Management Handbook (NAVMED P-5030), and Navcompt Manual and Instructions for station hospitals and dispensaries.

(2) Rates shown under the table in article 21–3 are defined as follows:

(a) Interagency.—The per diem rate prescribed by the Bureau of the Budget for reimbursement between the uniformed services when members or retired members of the uniformed service, as defined in section 102(a) of the Dependents’ Medical Care Act (as revised and reenacted in 10 USC 1072, 1074, 1076, and 1079), are hospitalized in a facility of a service other than their own. Also, for use in all cases of reimbursement between Federal agencies for patients authorized care completely at Government expense unless a different rate is established by or pursuant to a specific requirement of law.

(b) General.—The per diem rate prescribed by the Bureau of the Budget for reimbursement between the uniformed services when of dependents of members or retired or deceased members, as defined in section 102(a) of the Dependents’ Medical Care Act (as revised and reenacted in 10 USC 1072, 1074, 1076, and 1079), are hospitalized in a facility of a service other than their own. Also, for use in all cases of reimbursement between Federal agencies for patients authorized care completely at Government expense unless a different rate is established by or pursuant to a specific requirement of law.

(2) Inpatient treatment........ $5 per diem

(f) Examination.—Rate fixed by negotiation with requisitioning agency.

(3) Report of Treatment Furnished Pay Patients, Hospitalization Furnished (Part A), DD Form 7, Report Symbol MED–6322–1.—

(a) General.—This report, accompanied by appropriate substantiation if necessary, shall be submitted in accordance with existing instructions.
Preparation Instructions.—The numbered spaces on the report form shall be completed to show the following information:

1. Installation Providing Hospitalization.—Enter name and location of the Navy and/or Marine Corps activity submitting the report. Comply with current security regulations, when applicable.

2. Month and Year Covered by This Report.—Enter the calendar month and year of the report period.

3. Category of Patients.—Enter category of patient reported. A separate report shall be utilized and submitted in the case of each different category of pay patient.

4. Authority for Admission.—State regulation or directive authorizing admission. In cases where documentary authorization is required, attach copy of authorization to the DD Form 7 at time of submission of report.

5. Name and Serial Number.—Complete as appropriate.

6. Grade.—Complete as appropriate.

7. Organization.—Enter organization of each pay patient, military or other Federal agency, as applicable, unless other information is required by regulations. For merchant seamen, enter the name of vessel to which attached; if vessel is not prefixed by the letters USNS, include name of owner or operator.

8. Diagnosis.—Enter title in language commonly accepted by professional usage, preferably in terms of titles listed in the Joint Armed Forces Statistical Classification and Basic Diagnostic Nomenclature of Diseases and Injuries (NAVMED P-1294).

9. Admission Date.—Enter month, day, and year, in that order. No sick days shall be accrued for pay patients admitted and discharged from the sicklist on the same day, nor shall fractional days be considered.

10. Discharge Date.—Enter month, day, and year, in that order. If a patient is remaining on the sicklist at the end of the month being reported, enter only the notation “Remaining” in this column.

11. Total.—Enter the total days for the month reported for each individual patient. When for any reason a patient being reported is subsisted out or on leave during the period reported, information to that effect shall be so reported on the DD Form 7, to show the total days hospitalized and total days subsisted out or on leave. Use abbreviation “SO” for subsisted out and “OL” for on leave. Sick days shall be computed in all cases by excluding the day of admission and including the day of discharge.

12. Date.—Enter the date of certification of report by the commanding officer or his duly authorized representative.

13. Certified Correct.—Enter the name, grade, and organization of the commanding officer or his duly authorized representative certifying the accuracy and completeness of the report. Signature required on original form only.

14. Total Days Hospitalized.—Enter grand total of all days hospitalized irrespective of days subsisted out and/or on leave. This figure shall be verified to insure that all computations have been entered correctly.

Footnote Data for Station Hospitals and Dispensaries.—All DD Forms 7 shall show as a footnote the appropriation, subhead, allotment, budget project, and expenditure account to be credited and the accounting number of the activity accounting for the receivable.

*Special Instructions for station hospitals and dispensaries: DD Form 7 reports prepared for members of the uniformed services and their dependents shall NOT list each individual, but shall show instead in item 8 the category of patients in total and in item 14 the total for the category. Item 11 shall be blank.
Chapter 22

GENERAL PROVISIONS CONCERNING PREVENTIVE MEDICINE

Sections

<table>
<thead>
<tr>
<th>Section</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. General</td>
<td>22-1 through 22-3</td>
</tr>
<tr>
<td>II. Sanitation and Industrial Hygiene</td>
<td>22-4 through 22-6</td>
</tr>
<tr>
<td>III. Sanitary Standards for Living Spaces</td>
<td>22-7 through 22-11</td>
</tr>
<tr>
<td>IV. Lighting, Heating, and Ventilation</td>
<td>22-12</td>
</tr>
<tr>
<td>V. Food and Water Supply</td>
<td>22-13 through 22-14</td>
</tr>
<tr>
<td>VI. Garbage, Refuse, and Sewage Disposal</td>
<td>22-15 through 22-16</td>
</tr>
<tr>
<td>VII. Communicable Disease Control</td>
<td>22-17 through 22-20</td>
</tr>
<tr>
<td>VIII. Immunization</td>
<td>22-21 through 22-30</td>
</tr>
<tr>
<td>IX. Insect, Pest, and Rodent Control</td>
<td>22-31 through 22-32</td>
</tr>
<tr>
<td>X. Quarantine Procedures</td>
<td>22-33 through 22-39</td>
</tr>
<tr>
<td>XI. Field Sanitation</td>
<td>22-40 through 22-41</td>
</tr>
</tbody>
</table>

Section I. GENERAL

Article 22-1

Scope

The field of preventive medicine extends into activities, under the cognizance of other Bureaus, wherein there are conditions which affect the health of the personnel of the Navy. Instructions are issued from time to time by the Bureau, by commanders in chief and commanding officers concerning certain provisions of preventive medicine, affecting administrative and military functions.

22-2. Responsibility

The medical officer is responsible for establishing health standards and for recommending to the commanding officer the application of such measures as may be necessary to maintain the health of the command.

22-3. Procedures

The medical officer shall adhere to any procedures inaugurated by a superior authority. When no instructions have been issued by proper superior authority, the medical officer shall propose for adoption by his commanding officer, such measures as are necessary to fulfill his responsibility. Requests for special technical advice, surveys, or investigations may be forwarded via appropriate channels. Whenever conditions or circumstances arise which are unusual or require special attention, a special report shall be submitted to the Bureau.

Section II. SANITATION AND INDUSTRIAL HYGIENE

Article 22-4

Sanitation

22-4. Sanitation

The district medical officer, the medical officer, and other officers assigned as assistants in sanitation shall be responsible for the following:

1) Inspection, investigation, recommendation, and supervision of all matters pertaining to sanitation, including the sanitary aspects of food and food handling, water, sewage and waste disposal, housing, and other elements of the environment affecting health, and keeping the commanding officer informed in these matters.

2) Indoctrination of the personnel of the ship, station, or activity in the latest advances in sanitary science and preventive medicine, including accident prevention and industrial health.
(3) Cooperation with civilian personnel and governmental agencies associated with health problems that may affect naval personnel or in the vicinity of the command.

(4) Recommendations relative to the need for supplying trained sanitation officers to stations in the vicinity.

(5) Keeping records of inspection and reinspection, investigations, and recommendations.

(6) Preparing local reports and the sanitary reports to the Bureau.

22-5. Swimming Sites

(1) Recommendations.—The medical officer shall make appropriate recommendations to the commanding officer concerning the safety precautions and sanitary maintenance to be observed in and around swimming sites, and he shall further recommend that swimming be prohibited in contaminated waters.

(2) Pools.—The design and construction of swimming pools is a function of the Bureau of Yards and Docks. They are designed with due regard to the safety of swimmers and operating personnel. In addition to these safety precautions, the medical officer shall recommend that a qualified lifeguard with safety equipment shall be on duty in the area at all times when the pool is in use, and that sky-larking shall be prohibited.

(3) Sanitary Control of Pools.—
   (a) The medical officer shall at frequent intervals inspect the operational records of a pool to ascertain whether or not disinfection of the water is accomplished in an acceptable manner. When chlorine or chlorine compounds are used as a disinfectant, without the use of ammonia, he shall recommend that the residual shall be not less than 0.4 and no more than 0.6 part per million, and that when chlorine or chlorine compounds are used with ammonia the excess chloramine shall not be less than 0.7 nor more than 1.0 part per million.

   (b) The medical officer shall frequently inspect the premises of swimming pools to ascertain that the water is clean; that the pool and its equipment and surroundings are maintained in a clean condition; and that rules relative to the use of the pool are enforced.

   (c) The medical officer shall prepare such regulations as are deemed necessary to protect the health and safety of the swimmers, and shall recommend their approval by the commanding officer and their publication and posting in a conspicuous place.

(4) Bathing Loads.—The standard for the use of a recirculation type swimming pool during any 30-minute period has been established as a maximum of 28 persons for each 1,000 gallons of clean water added to the pool during that period. This ratio may be varied to maintain this standard.

22-6. Industrial Hygiene

Medical officers and other officers assigned as assistants in industrial hygiene shall have the responsibility for the planning and conducting of an effective industrial health program which shall include the following:

(1) Study of the occupational health problem of the ship, station, or activity.

(2) Determine the toxicological data in terms of their effect on workers.

(3) Conduct surveys of potential health hazards in specific activities and processes.

(4) Conduct surveys of safety precautions and devices for accident and injury prevention.

(5) Collect field and laboratory samples pertaining to occupational health exposures.

(6) Make laboratory analysis on samples taken in the field and on any material submitted with reference to causation of occupational disease.

(7) Prepare reports of findings, recommendations, and conclusions evaluating the hazards of observed occupational health conditions.

(8) Maintain records and files of studies and examinations.

Section III. SANITARY STANDARDS FOR LIVING SPACES

<table>
<thead>
<tr>
<th>Barracks</th>
<th>Berthing Spaces and Sanitary Facilities Afloat</th>
<th>Hospitals</th>
<th>Brig</th>
<th>Naval Prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 22-7</td>
<td>Article 22-8</td>
<td>Article 22-9</td>
<td>Article 22-10</td>
<td>Article 22-11</td>
</tr>
</tbody>
</table>

22-7. Barracks

(1) The medical officer shall make routine inspections of barracks in order to maintain Navy standards of sanitation.

(2) The following are minimum requirements per man in all dormitories or sleeping rooms:
   - 50 square feet of floor space per man.
   - 450 cubic feet of room space per man.
   - 5 feet minimum distance between heads of sleeping men.

(3) For units of approximately 200 men, the minimum proportions of plumbing fixtures to the number of men to be accommodated are as follows:

   Water closets... 1 for every 20 men.
   Urinals... 1 fixture for every 25 men or 1 foot of trough for every 10 men.
   Lavatories... 1 basin or 2 feet of trough lavatory or wash sink for every 5 men.
   Dental lavatories... 1 for every 15 men.
For example, the requirements for units racks of 12 men are:

In schools where men use all these facilities be increased, over the proportion allowances:

Time. The required capacity for both water storage compartments with separate entrance. The general provisions of the accessories described above, refer to Design Data, Bureau of Yards and Docks.

22-10. Brigs

The medical officer shall make daily inspections of the brig, as well as of the prisoners, and make such recommendations to the commanding officer as will assure maintenance of the best possible sanitary conditions. Navy Regulations establish the standard size of cells for the confinement of prisoners as not less than 6 feet long, and 3 feet broad, with 6 feet height between decks. The brig and brig spaces shall be properly ventilated.

22-11. Naval Prisons

The medical officer shall make routine inspections of the living spaces and sanitary facilities of naval prisons and shall be guided by the minimal requirements, wherever applicable, as stated for barracks (art. 22-7).

Section IV. Lighting, Heating, and Ventilation

22-12. Lighting, Heating, and Ventilation

(1) The medical officer shall make recommendations to the commanding officer for proper lighting, heating, and ventilation of ships and barracks.

(2) For a discussion of the factors and standards of illumination the medical officer should refer to the

acceptable unless ventilation is adequate (10 to 30 cubic feet of fresh air per person per minute). When ventilation is not adequate, the medical officer shall make appropriate recommendations with regard to it.

(3) Water closets, urinals, lavatories, and showers shall approximate requirements ashore insofar as practicable. The following standards are at present the policy of the Bureau of Ships:

Water closets... 1 for 18 crew or 25 troops.

Urinals... 1 fixture for 20 inches of trough for 40 crew or 50 troops.

Lavatories... 1 basin or 2 feet of trough for 15 men.

Showers... 1 fixture for 60 crew or 75 troops.

Dental lavatories... Not provided.

22-9. Hospitals

(1) It has been found that, for Navy purposes, a ward accommodating 30 patients is the size most satisfactorily and economically administered. In tropical climates, and in hospitals caring for a large number of convalescent patients, the number of accommodations in the ward may be increased.

(2) The following standards are the minimum per bed:

<table>
<thead>
<tr>
<th>Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor area per bed</td>
<td>100 square feet</td>
</tr>
<tr>
<td>Cubic space per bed</td>
<td>1,200 cubic feet</td>
</tr>
<tr>
<td>Height of ceiling</td>
<td>10 feet</td>
</tr>
<tr>
<td>Beds spacing</td>
<td>8 feet center to center</td>
</tr>
<tr>
<td>1 lavatory to each</td>
<td>5 patients</td>
</tr>
<tr>
<td>1 water closet to each</td>
<td>10 patients</td>
</tr>
<tr>
<td>1 urinal to each</td>
<td>15 patients</td>
</tr>
<tr>
<td>1 shower to each</td>
<td>15 patients</td>
</tr>
<tr>
<td>1 slop sink to each</td>
<td>30 patients</td>
</tr>
</tbody>
</table>

(3) These proportions may be decreased for larger units of men, but must be increased for smaller units; for example, the requirements for a detention barracks of 12 men are:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water closets</td>
<td>2</td>
</tr>
<tr>
<td>Lavatories</td>
<td>2</td>
</tr>
<tr>
<td>Urinals</td>
<td>11</td>
</tr>
<tr>
<td>Showers</td>
<td>3</td>
</tr>
</tbody>
</table>

(4) Scrub decks for clothing, when located in the latrine building, shall be in an entire separate compartment with separate entrance. The general weather conditions prevailing at a station will determine the necessity for a separate room where the clothes are dried, or for outdoor washing places and drying rigs. For additional or more detailed information concerning the requirements for installation practices of the accessories described above, reference shall be made to Design Data, Bureau of Yards and Docks.

22-8. Berthing Spaces and Sanitary Facilities Afloat

(1) The medical officer shall make routine sanitary inspections of berthing spaces, and toilet, lavatory, and bathing facilities. He shall exercise due judgment in the interpretation of applicable standards, giving careful consideration to functional design of the ship, its military requirements, the resistance to contagion of seasoned men, and the advantages derived from a high standard of individual hygiene. Desirable minimal standards are not attainable at all times due to the necessary consideration for changes in weight and moment of the ship.

(2) A berthing compartment shall have at least 16 square feet of floor space, 120 cubic feet of air space per man, and 3 feet minimal distance between the heads of sleeping men, using head to foot bunking arrangement. These dimensions will be less than
Section V. FOOD AND WATER SUPPLY

Food

22-13. Food
(1) The medical officer or his representative, in carrying out his responsibilities relative to food shall:
   (a) Inspect as to quality all fresh provisions to be used by an authorized mess; frequently inspect the character and preparation of food, and the method of serving; examine the menus to ascertain that a well-balanced diet is provided; and make appropriate reports and recommendations to the commanding officer.
   (b) Inspect all cooking and messing facilities for cleanliness, and make any necessary reports and recommendations to the commanding officer.
   (c) Make reference to the Bureau of Supplies and Accounts Manual for planning and preparation of food, and the sanitary aspects of food preparation.
   (d) Inspect personnel who handle food and the utensils connected therewith to determine their physical fitness and personal cleanliness according to the following standards:
      (1) Freedom from open lesions of the hands, face, or neck, and active acne of the face.
      (2) Freedom from evidence of communicable disease.
      (3) Freedom from evidence of acute or chronic inflammatory conditions of the respiratory tract.

Water

22-14. Water
(1) The Medical Department is charged with the responsibility for advising and making recommendations to insure an adequate supply of potable water. The medical officer shall make periodic inspections and special surveys of water supply systems, including all measures for purification, and make necessary recommendations for the correction of any sanitary defects. In the event of an acute shortage of water, the medical officer shall advise the commanding officer relative to the rationing of water.
(2) In determining the potability of water, the medical officer may use as a guide the Public Health Service Drinking Water Standards.
(3) For purification of drinking water in the field, reference should be made to the Landing Party Manual, U.S. Navy.
(4) Reference should be made to the Bureau of Ships Manual for the proper operation of water supply plants aboard ships, and to the Bureau of Yards and Docks Manual for installations ashore.

Section VI. GARBAGE, REFUSE, AND SEWAGE DISPOSAL

Garbage and Refuse Disposal

22-15. Garbage and Refuse Disposal
(1) The medical officer, or his representative, shall make the necessary inspections and recommendations to the commanding officer to insure that garbage and refuse are disposed of in an approved manner. Aboard ship, garbage and refuse may be dumped at sea, at the discretion of the commanding officer, or disposed of in accordance with the Bureau of Ships Manual. Ashore, garbage and refuse may be disposed of in a manner in conformity with the Bureau of Yards and Docks Manual.

Sewage Disposal

22-16. Sewage Disposal
(1) The medical officer, or his representative, shall make necessary inspections and recommendations to the commanding officer for the sanitary disposal of sewage and liquid waste. The medical officer shall refer to the Bureau of Yards and Docks Manual for sewage and waste disposal methods at permanent installations, and to the Landing Party Manual, U.S. Navy, for methods of disposal in the field.
Section VII. COMMUNICABLE DISEASE CONTROL

22-17. General
(1) The medical officer shall be on the alert for the early detection of infectious diseases, shall recommend the necessary control measures to the commanding officer, and shall institute the necessary restrictions of personnel and take such other action, with the approval of the commanding officer, as may be required to prevent the spread of communicable disease. He may be guided in his responsibilities for communicable disease control by Control of Communicable Diseases, current edition, reported and published by the American Public Health Association, New York City.

22-18. Venereal Disease Control
(1) District medical officers shall conduct a coordinated and comprehensive venereal disease control program throughout district activities, with close and active liaison with all personnel in this field.

(2) Medical officers and other officers assigned to venereal disease control shall be responsible for:

(a) Planning, developing, and carrying out a comprehensive educational program including lectures, visual aids, and other media.

(b) Training assistants in interviewing, contact reporting, and patient education.

(c) Administering the venereal disease contact reporting system, and evaluating contact data compiled therefrom.

(d) Establishing and maintaining prophylaxis facilities.

(e) Coordinating the venereal disease control program with other activities within the command and other organizations.

(f) Compiling records of sources of venereal disease contacts in the locality as a basis for recommendations to control liberty.

(g) Maintaining liaison between the district medical officer, other military services, and civilian health agencies for prevention and control of venereal disease and attending meetings and conferences as required.

22-19. Tuberculosis Control
(1) The medical officer shall be responsible for the following:

(a) Health Records shall be examined upon receipt and quarterly to discover those individuals who have not had X-ray examination of the chest recorded within the previous year, as required by article 15-90. At the first opportunity, arrangements shall be effected to have this X-ray examination made, utilizing the services of photofluorographic units where available. Activities having a large number of personnel requiring chest X-ray examination and which are located at such a distance from photofluorographic units as to make it impracticable to transport the personnel for examination, shall make request upon the commandant of the naval district for a visit of a mobile photofluorographic unit, for the purpose of effecting the examinations.

(b) Those individuals found to have suspicious pulmonary pathology which does not justify clinical study shall have follow-up chest X-ray examinations at 6-month intervals using 14- by 17-inch film. The results of these examinations shall be entered in the Health Records.

(c) Individuals suspected of having active tuberculosis shall be admitted to the sick list, and infectious precautions taken until the disability is found not to exist, or the disease is determined to be inactive or arrested.

(d) In activities having the care of tuberculous patients, steps shall be taken to insure that patients are instructed regarding precautions against spread of the disease. Special indoctrination shall be given nurses and personnel of the Hospital Corps regarding these precautions and the protection of their own health. Insofar as possible, only doctors, nurses, and personnel of the Hospital Corps who are 25 years of age or older and who have positive intradermal tuberculin skin tests shall be assigned to duties involving care of the tuberculous patients.

22-20. Reports
(1) The medical officer is responsible for the preparation and submission of routine reports and notices concerning the presence of communicable disease and other matters in the field of preventive medicine. Reference shall be made to chapter 23 for detailed instructions.

(2) The medical officer shall cooperate with Federal, State, and local health agencies in the prevention of disease and the reporting of communicable diseases.

(1) Definition.—Prophylactic immunization shall be construed to include the use of any virus, vaccine, toxoid, or other immunizing agent for preventive purposes.

(2) Use of Immunizing Agents.—In the employment of immunizing agents, the medical officer shall be guided by the requirements in the following paragraphs, current directives of the Bureau, and the seriousness of the threat of disease to the personnel under his care.

(3) General Requirements for Immunization.—
(a) The medical officer having custody of a Health Record shall be responsible for the immunization of the person for whom the Health Record was issued. He shall enter promptly in the Health Record each immunization, together with the date of administration. The name of the medical officer, or in the absence of a medical officer the name of the medical department representative administering the immunizations, shall be typed or rubber-stamped on the Health Record form. Written signatures on Standard Form 601 are not required; however, if used, they shall be completely legible.

(b) Naval and Marine Corps personnel, including recruits, shall not be transferred from a training station, barracks, receiving station, or other rendezvous, except in emergency, until required immunizations have been given and are recorded in their Health Records. If an emergency requires transfer of an individual prior to completion of the immunizations, or before such immunizations have been recorded in the Health Record, a statement giving the status of the immunization procedures shall be forwarded with the Health Record to the medical officer of the individual's new ship or station.

(c) All members of the Naval and Marine Corps Reserve reporting for active duty shall be vaccinated against smallpox, and initial or booster dosages of typhoid, tetanus-diptheria, poliomyelitis, cholera, and epidemic typhus prophylaxis administered in accordance with current Bureau directives in the 6230 series. Procedures to be employed in time of rapid mobilization will be issued in a separate directive. Except in time of rapid mobilization, the administration of such preventive measures may be deferred until arrival at a duty station. In meeting these initial requirements, a certificate or other record evidencing previous immunization is acceptable. This record of immunization shall be transcribed in the Health Records. However, if used, it shall be completely legible.

(d) Except in rare instances where exceptions are authorized by the district commandant or area commander, all naval, Marine Corps, and civilian personnel and their dependents traveling outside the United States under the cognizance of the Navy Department shall be immunized in accordance with current directives of the Bureau and shall have in their possession prior to embarkation a properly prepared certificate, or certificates, if required by those directives, certified by the medical officer. In all instances where exemptions have been authorized, the required immunizations shall be completed while on route or after arrival at destination. Civilian personnel and dependents shall have in their possession prior to arrival at ports of embarkation either the required certificate, or certificates, certified by a medical officer, or a statement.
22-21. CHAPTER 22. GENERAL PROVISIONS CONCERNING PREVENTIVE MEDICINE 22-22

of immunizations signed by a qualified physician; in the latter instance the entries in the statement shall be transcribed upon the appropriate certificate prior to embarkation and certified by the medical officer.

(e) The prescribed intervals between injections shall be adhered to as stringently as possible. Any dose or doses which are delayed, however, should be administered at the earliest opportunity; a new series shall not be started.

(f) A lapse in any of the booster immunizations, even of several years, does not necessitate repetition of the initial immunization procedure. It can be generally assumed that if an initial immunization has been given at any time in military service, a single booster dose ordinarily will raise immunity to a satisfactory level.

(g) Individuals should be questioned about any previous sensitivity, especially to egg or chicken protein, prior to the administration of egg or chick embryo cultivated vaccines. Extreme caution should be exercised in the immunization of individuals with a history of such sensitivity.

(h) All precautions shall be taken to avoid injections into the blood stream, and to be prepared for possible anaphylactoid reactions by having on hand, ready for injection, epinephrine solution, 1:1000.

(i) Expiration Date.—No immunizing material should be used beyond the expiration date stated on the label unless specifically authorized by current directives of the Bureau.

(4) Undesirable Reactions.—When there is doubt regarding the quality of an inoculant or whenever local or constitutional reactions of unexpected severity or frequency, local infection or abscess formation not traceable to errors in technics of administration, jaundice, encephalitis, or other significant manifestations occur which may be due to the use of a biologic product, further administration of that product shall be discontinued. Reference should be made to the current joint Fd-BUMED & Navy Instruction in the 6700.18 series re procedures for the suspension from issue and use, reporting (send copy of the report to the Bureau (Code 72)), and disposition of such inoculants.

(5) Standards and Procurement.—

(a) All vaccines, serums, and other biological materials obtained in the United States for use by the Navy shall conform to such standards as are established by the Bureau. The prior approval of the Bureau is required for the purchase of such products elsewhere.

(b) All inoculants required in this section shall be requisitioned from the nearest stock point in the wholesale medical supply system, except that smallpox and yellow fever vaccines shall be requisitioned from the nearest distribution center indicated in the latest revision of BUMED Instruction 6710.7.

22-22. Smallpox

(1) Requirement.—All personnel of the Navy and Marine Corps on active duty, regardless of age, shall be immunized or reimmunized against smallpox in accordance with current directives of the Bureau and, in addition, whenever exposed to smallpox, whenever increased hazard of exposure may exist, and at any time when doubt arises as to the protection offered by previous vaccination.

(2) Vaccination Technique.—Vaccination shall be performed by or under the direct supervision of a medical officer except that responsibility for vaccination may be delegated to other representatives of the Medical Department who are on independent duty. To avoid infection, aseptic technique shall be used cleansing the area with sterile cotton and ethyl alcohol, acetone, or ether, care being taken to avoid abrasions and permitting the area cleansed to dry thoroughly prior to vaccination. To avoid a large lesion with the increased danger of secondary infections, the virus shall be inserted by the multiple-pressure method into as small an area as possible. The area shall not cover more than one-eighth of an inch in any direction. The injection site shall be kept cool and dry. No shield or other dressing shall be used, unless complications occur. With care, multiple vaccinations may be obtained from the virus contained in a single ampule.

(3) Preservation.—Smallpox vaccine shall be kept at a temperature not over 0° C. (32° F.) at all times during storage and shipment. The medical and dental supply depots shall be responsible for the proper storing, packing, and shipping of smallpox vaccine; shall take the necessary steps to ensure that the vaccine is held within the prescribed temperatures while in transit; and shall notify the addressee of the exact time and place of arrival. A responsible person shall receive the vaccine and shall immediately place it in storage at the prescribed temperature. The freezing room of a refrigeration plant makes the safest place for storage. The freezing compartment of a mechanical refrigerator is the second choice. During defrosting, the vaccine shall be transferred to another freezing compartment of the mechanical refrigerator.

(4) Interpretation of Results.—

(a) Types of Reactions.—The spreading and the receding of the area of erythema is the essential phase of the reaction. The medical officer shall determine the type of reaction by personal inspection and shall make the proper entry in the Health
22-23. Typhoid and Paratyphoid

(1) Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

22-24. Tetanus and Tetanus-Diphtheria Toxoids, Combined

(1) Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

(2) Preservation.—The typhoid-paratyphoid vaccine is best preserved when stored at temperatures between 2° C. (35.6° F.) and 10° C. (50° F.). It will, however, withstand exposure to ordinary room and outdoor temperatures. If, because of the exigencies of the service, vaccine has been unavoidably stored or shipped at temperatures higher than those recommended, it may be used with reasonable assurance of its potency provided that upon inspection it shows no evidence of physical change. Freezing of the vaccine shall be avoided.

22-24. Tetanus and Tetanus-Diphtheria Toxoids, Combined

(1) Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

(2) Tetanus Toxoid.—This material shall not be used routinely in immunizing against tetanus. However, it may be used for routine immunization for individuals who cannot tolerate the combined toxoids because of demonstrated sensitivity to the diphtheria component. It shall be used as an emergency booster immunization when there is indication for administration of tetanus toxoid and the patient’s condition would make any complicating reaction to diphtheria toxoid undesirable.

(3) Tetanus and Diphtheria Toxoids, Combined, Precipitated (for Adult Use) —

(a) Emergency Booster Immunization.—With the exception cited in 22-24(2), an emergency stimulating dose of tetanus toxoid shall be administered as soon as practicable under the following conditions:

(1) Whenever an individual receives a wound or severe burn in battle.

(2) Whenever a patient undergoes a secondary operation or open manipulation, if, in the opinion of the medical officer, there exists the possibility of contamination with tetanus spores or bacilli.

(3) Whenever an individual incurs punctured or lacerated wounds, severe burns, or other conditions which might permit the introduction of C. tetani into the tissues.

(4) Precautions.—

(a) Tetanus and diphtheria toxoids, combined (for adult use) is NOT suitable for initial immunization of children. It can be used for a stimulating dose in children who have received a previous diphtheria toxoid series. Tetanus and diphtheria immunization may be given separately to children 5 years of age or older, or combined diphtheria-tetanus toxoids (pediatric) may be used for the initial immunization series. For infants and children under age 5, diphtheria-tetanus-pertussis-polio myelitis combination is the preparation of choice.

(b) When administering tetanus toxoid, especial care shall be exercised to assure that the
injections are deep and given intramuscularly. The preferred site of injection is the deltoid muscle, approximately half the distance from the point of the shoulder to the insertion of this muscle.

5. Use of Antitoxin.—Tetanus antitoxin shall be used only for the treatment of clinical tetanus and for the prevention of tetanus in wounded individuals who have not previously received at least two of the initial doses of tetanus toxoid. In the latter case, individuals given tetanus antitoxin prophylactically shall be immunized at the same time with tetanus toxoid.

5. Preservation.—Tetanus toxoid and tetanus-diphtheria toxoids, combined, shall be stored at temperatures between 2° C. (35.6° F.) and 10° C. (50° F.), and shall be protected against freezing. They will, however, withstand exposure to ordinary room and outdoor temperatures. If, because of the exigencies of the service, toxoid has been unavoidably stored or shipped at temperatures higher than those recommended, it may be used with reasonable assurance of the potency provided that upon inspection it shows no evidence of physical change.

22–25. Yellow Fever

1. Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

2. Civilian personnel and dependents may receive this immunization at the port of embarkation.

3. Emergency Booster Immunization.—An emergency stimulating dose of yellow fever vaccine shall be given in the presence of an epidemic and when, in the opinion of the medical officer, the risk of infection is serious.

4. Precautions.—The following precautions shall be taken in immunizing personnel against yellow fever:

(a) The vaccine shall be given subcutaneously, and injected only under the supervision of a medical officer.

(b) Only one dose is required.

(c) Every precaution must be taken to avoid giving undiluted vaccine.

(d) When an ampule of vaccine has been diluted, it shall be kept surrounded by ice or cooled by other means, and the unused portion shall be discarded after 1 hour.

(e) To minimize the possibility of an exaggerated reaction to typhoid or influenza vaccine in persons experiencing a febrile reaction to yellow fever vaccine, the administration of typhoid or influenza vaccines within a 5- to 7-day period following yellow fever inoculation shall be avoided, when practicable.

Health Record Entries.—The name of the vaccine and lot number, as well as the date of vaccination and signature of the medical officer, shall be recorded on NAVMED–H–3 or Standard Form 601 (Immunization Record) of the Health Record when yellow fever vaccine is administered.

6. Preservation.—Yellow fever vaccine shall be kept at a temperature not over 0° C. (32° F.) at all times during storage and shipment. Shipment of the vaccine from the medical and dental supply depots shall be made in vacuum jars and it is intended that jars be returned. The medical and dental supply depots shall be responsible for the proper storing, packing, and shipping of yellow fever vaccine; shall take the necessary steps to insure that the vaccine is held within the prescribed temperatures while in transit; and shall notify the addressee of the exact time and place of arrival. A responsible person shall receive the vaccine and shall immediately place it in storage at the prescribed temperature. The freezing room of a refrigeration plant makes the safest place for storage. The freezing compartment of a mechanical refrigeration plant makes the safest place for storage. During defrosting the vaccine shall be transferred to another freezing compartment as the virus becomes inactive at room temperatures. Undiluted vaccine exposed for 1 hour or more at room temperature shall not be used.

22–26. Epidemic Typhus

1. Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

2. Emergency Booster Immunization.—An emergency stimulating dose of typhus vaccine shall be given whenever any unusual threat of an outbreak of epidemic typhus appears.

3. Preservation.—Epidemic typhus vaccine shall be stored at temperatures between 2° C. (35.6° F.) and 10° C. (50° F.), and shall be protected from freezing. It will, however, withstand exposure to ordinary room and outdoor temperatures. If, because of the exigencies of the service, vaccine has been unavoidably stored or shipped at temperatures higher than those recommended, it may be used with reasonable assurance of its potency provided that upon inspection it shows no evidence of physical change.

4. Limitation of Immunization.—Epidemic typhus vaccine does not protect against flea-borne (murine) typhus, mite-borne (tsutsugamushi) typhus, or tick-borne (Rocky Mountain spotted fever) typhus. Since inoculation produces only relative immunity, it is imperative that high standards of hygiene and sanitation be maintained and that rigid control measures for lice be enforced.

22–27. Cholera

1. Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

2. Emergency Booster Immunization.—An emergency stimulating dose of cholera vaccine shall be
given whenever an outbreak of cholera is anticipated.

(3) Preservation.—Cholera vaccine shall be stored at temperatures between 2° C. (35.6° F.) and 10° C. (50° F.), and shall be protected against freezing. It will, however, withstand exposure to ordinary room and outdoor temperatures. If, because of the exigencies of the service, vaccine has been unavoidably stored or shipped at temperatures higher than those recommended, it may be used with reasonable assurance of its potency provided that upon inspection it shows no evidence of physical change.

(4) Limitation of Immunization.—Since inoculation produces only relative immunity, it is imperative that high standards of hygiene and sanitation be maintained and that rigid measures be enforced in order to insure safe water, milk, and food.

22–28. Plague

(1) Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

(2) Emergency Booster Immunization.—An emergency stimulating dose of plague vaccine shall be given in the presence of a rapidly spreading epidemic.

(3) Preservation.—Plague vaccine shall be stored at temperatures between 2° C. (35.6° F.) and 10° C. (50° F.), and shall be protected from freezing. It will, however, withstand exposure to ordinary room and outdoor temperatures. If, because of the exigencies of the service, vaccine has been unavoidably stored or shipped at temperatures higher than those recommended, it may be used with reasonable assurance of its potency provided that upon inspection it shows no evidence of physical change.

(4) Limitation of Immunization.—Since inoculation produces only relative immunity, it is imperative that high standards of hygiene and sanitation be maintained and that rigid measures be enforced in order to insure safe water, milk, and food.

22–29. Diphtheria

(1) Requirements for immunization and reimmunization are set forth in current directives of the Bureau.

(2) Selection of Personnel for Active Immunization.—Routine immunization of adults and children against diphtheria is ordinarily accomplished as described in article 22–24.

(3) Schick Test and Control.—Inject one skin test dose; i.e., 0.1 cc. of diluted diphtheria toxin (1/50 MLD for 250-gram guinea pig) intradermally in the forearm. Inject into the skin, not under it. A control consisting of inactivated toxin should always be injected in like manner in the opposite arm. The reaction should be read if possible at 48 hours and always on the fourth or fifth day. Reactions of hypersensitivity reach their maximum in about 48 hours and then begin to fade. A true positive Schick reaction, however, does not usually reach its maximum intensity until about 96 hours following injection and then slowly fades, usually leaving a small area of brownish discoloration. Four types of reactions may be distinguished.

(a) Negative Reaction.—No erythema occurs, indicating the presence of immunity to the amount of toxin injected.

(b) Positive Reaction.—An area of redness begins at the site of injection of the active toxin after 24–36 hours. At the end of 96 hours, the erythema is 0.5 cm. or more, in diameter and indicates susceptibility to diphtheria. No reaction occurs at the control site.

(c) Pseudo-Reaction.—A reaction occurs at the site of injection of both active and inactivated toxin usually within the first 24 hours, fading more rapidly than a true positive Schick reaction. If the reactions at the injection sites are of equal extent, the individual is ordinarily immune to diphtheria toxin but is hypersensitive to the bacillary protein present in the toxoid.

(d) Combined Reaction.—A reaction occurs to both active and inactive toxin, but unlike the pseudo-reaction, that to the active toxin is more marked at 96 hours. This reaction indicates hypersensitivity to bacillary protein and may also indicate susceptibility to diphtheria. However, such individuals are usually rendered immune by the stimulus of a Schick test. In an emergency they may be regarded as immune. If time permits, they should be retested at 3 weeks. Immunization of individuals showing this type of reaction should be approached with great caution.

(4) Precautions.—Toxoid must never be used in amounts larger than the dose recommended.

(5) Mass Immunization Without Schick Testing.—When it becomes necessary to immunize a
large group against diphtheria, such as an organization experiencing a high incidence rate of diphtheria, in movements of large drafts of men, or in individuals, when time or facilities do not permit the meticulous care and observation necessary for reliable results in Schick testing, a basic immunization series of injections may be given according to the schedule outlined in current directives of the Bureau, without prior Schick testing, with particular attention to the contraindications to the continuance of the schedule of injections.

(6) **Preservation.**—Diphtheria toxoid, plain or alum precipitated, and Schick test materials shall be stored at temperatures between 2° C. (35.6° F.) and 10° C. (50° F.), and shall be protected against freezing. It will, however, withstand exposure to ordinary room and outdoor temperatures. If, because of the exigencies of the service, vaccine has been unavoidably stored or shipped at temperatures higher than those recommended, it may be used with reasonable assurance of its potency provided that upon inspection it shows no evidence of physical change.

### 22-30. Poliomyelitis

(1) **Requirements.**—Requirements for immunization and reimmunization are set forth in current directives of the Bureau. In addition, immunization of dependent of naval personnel, when not required, is authorized on a voluntary basis.

(2) **Vaccination Technique.**—

(a) Vaccination shall be performed by or under the supervision of a medical officer except that responsibility for vaccination may be delegated to other representatives of the Medical Department who are on independent duty. The vaccine must be given intramuscularly with the deltoid muscle being the preferred site.

(b) **Dosage schedule** shall be in accordance with current directives of the Bureau. If for any reason more than 4 to 6 weeks have elapsed since the first dose, the second dose shall be given as soon as possible. In this event, the third dose shall be given 8 to 10 months after the first dose, provided an interval of at least 1 month is observed between the second or third doses. **Note.** It is emphasized that there is no need to repeat the first two injections because of any variation from the prescribed intervals but, where the third dose has followed in less than the prescribed interval, it should be repeated after the proper lapse of time.

(c) Maximum effectiveness of poliomyelitis vaccine is not achieved until after the third dose is given. Movements of military personnel are such that transfer of families or single personnel into hyperendemic or epidemic areas may occur at any time in the future. To delay immunization until such a transfer is imminent is to deprive the individual of maximum protection.

(d) **Individual Sensitivity.**—Vaccines containing antibodies must be used with caution. Recipients should be screened and vaccination deferred if fever or undefined illness (which might be early poliomyelitis) is present, particularly if poliomyelitis is prevalent in the community. Individuals sensitive to penicillin may be immunized with a poliomyelitis vaccine which contains 0.001 unit of penicillin or less per cubic centimeter, to minimize occurrence of an anaphylactic reaction although necessary precautions must be observed.

(3) **Use of Vaccine During Outbreaks of Poliomyelitis.**—A definite antibody response follows the first injection of vaccine. The second dose adds to this response but maximum antibody response is not achieved until the third dose, which follows the second injection at an interval of 7 months or longer. It must be expected that one or two injections will not provide a high degree of protection in all individuals and that some cases of poliomyelitis will occur following vaccination, particularly in periods of peak incidence. A high or rising incidence of poliomyelitis in the community is not considered reason to defer administration of the vaccine, however, as there has been little evidence of a "provoking" effect in the localization of paralysis following use of properly inactivated vaccine, and the reduction in total incidence of cases to be expected outweighs any risk of such a provoking effect. Administration to other members of the family within a 2- or 3-week period after occurrence of poliomyelitis in one member of the family is not recommended as family contacts are usually already infected.

(a) **Past History of Poliomyelitis.**—A past history of poliomyelitis offers no contraindication to use of the vaccine, since an individual may be at risk of contracting poliomyelitis of a type different from that of the previous episode.

(4) **Preservation.**—Poliomyelitis vaccine shall be stored at temperatures between 2° C. and 10° C. (35.6°–50° F.) and shall be protected from freezing. It will, however, withstand exposure to ordinary room and outdoor temperatures. Vaccine unduly delayed in transit is not necessarily damaged and shall be considered usable if unaltered in appearance.

(5) **Precautions.**—Vaccine must not be used if it is cloudy or turbid or if any marked deviation in color from the manufacturer's description or from the vials in the same lot is noted. (Refer to subarticle 22-30 (2) (d) for individual sensitivity.)

(6) **Record of Immunization.**—Appropriate entry shall be made on Standard Form 601, Immunization Record, of the Health Record, and on DD 737, Department of Defense Immunization Certificate, of each individual receiving vaccine, stating lot num-
Number, name of manufacturer, and date of inoculation. In case of civilians and dependents, this information shall be recorded on PHS-731, Certificates of Vaccination.

22-30A. Other Diseases

(1) Instructions concerning other immunizations are set forth in current directives of the Bureau.
22-31. Control of Disease-Bearing Insects and Pests

(1) The medical officer shall formulate plans and methods for the control of disease-bearing insects and insect pests and shall make recommendations to the commanding officer regarding steps to be taken to this end. He, and those officers assigned to insect and pest control, shall be responsible for the eradication or control of insects and other vermin to preserve property and protect the health and morale of personnel. The number of officers trained in insect and pest control will generally be small; therefore, the services of such officers must be used on an area-wide basis to give adequate protection to all naval facilities.

(2) These officers will be responsible for the following:

(a) Education of personnel in individual measures for protection against insect-borne diseases endemic in the area.

(b) Instruction and training of personnel assigned to insect and pest control activities in proper methods and precautions.

(c) Maintenance of periodic surveys to determine breeding areas and species.

(d) Supervision of insecticide dispersal and other methods of insect control.

(e) Recommendations relative to construction and maintenance of screens, ditches, surface water drains, fills and the clearing of streams.

(f) Recommendations for the location of camp sites at suitable distances from habitations where insect-borne diseases are endemic.

(g) Inspection of naval facilities, installations, and adjacent areas to assure that programs are properly executed and making recommendations for appropriate action.

(h) Cooperation with civilian and other governmental activities having problems that may affect naval personnel on or in the vicinity of a station.

(i) Reporting as required with respect to effectiveness of the recommended or instituted program.

(j) Assisting and advising on any phase of control required, keeping informed of latest methods.

(jk) Providing for procurement, storage and issuance of supplies and equipment including proper safeguards for handling of poisonous materials.

22-32. Rodent Control

(1) The medical officer is responsible for the formulation of a rodent-control program for approval and execution by the commanding officer under the supervision of the Medical Department. The number of officers trained in rodent control will generally be small; therefore, the services of such officers must be used on an area-wide basis to give adequate protection to all naval facilities.

(2) Officers assigned in rodent control shall be responsible for all phases of a complete program including the following:

(a) Supervision of all rodent-control operations on any station or ship within any command designated.

(b) Instruction and training of personnel assigned to rodent control in proper methods, and in maintaining strict sanitation as a means of control.

(c) Maintaining a readily available supply of rodent-control bait, poisons, and equipment.

(d) Inspection of ships, naval facilities, installations, and adjacent areas to assure properly executed rodent-control programs and ascertain their effectiveness.

(e) Inspection of ship-shore rat control measures to insure enforcement of proper safeguards.

(f) Correlating rodent-control operations with other phases of sanitation and maintenance to facilitate use of trained personnel on related projects.

(g) Maintaining contact with Marine Corps, Army, municipal, and native village officials and arrange cooperative rodent-control projects where required to control rodents on areas adjacent to naval facilities.

(h) Reporting periodic inspections and routine activities to the medical officer as required.

(i) Instigating precautionary measures to safeguard the handling and storage of poisonous materials used in rodent-control operations, and measures to insure that these materials shall not fall into the hands of unqualified or inexperienced personnel.
22-33. General

(1) Quarantine procedures in the Navy embrace measures designated to prevent the dissemination of human, animal, or plant disease from place to place. Basic regulations and detailed instructions concerning such procedures are published in General Orders. Additional instructions are published from time to time and may be found in current official naval publications.

22-34. Responsibilities of Medical Department

(1) It is the duty of personnel of the Medical Department, ashore or afloat, to be well informed concerning current naval quarantine regulations and instructions, to advise and make timely recommendations to commanding officers to insure compliance with these regulations, and to recommend the promulgation of additional or special quarantine measures when necessary.

(2) As regulations differ from port to port, medical officers serving aboard naval vessels shall endeavor to determine in advance the quarantine regulations of each port in which entry is contemplated in order to insure full compliance with those regulations and to minimize delay.

22-35. Quarantine Authority and Responsibility According to Locality

There are four classes of quarantine authority with which the Navy must comply:

(1) In the United States, its Territories, and possessions, quarantine authority and responsibility is assigned by Federal statute to the U. S. Public Health Service (human diseases), the Department of Agriculture (plant and animal diseases), and the Department of the Interior (wildlife). Naval regulations recognize this primary authority and responsibility
of other governmental agencies. Collaboration is effected so that the Navy carries out certain procedures in cooperation with the quarantine functions of other governmental agencies. The nature of this collaboration is set forth in detail in General Orders which pertain to quarantine.

(2) Cities, counties, and States, in certain instances, have promulgated quarantine regulations in addition to those of the Federal agencies. Full naval compliance with such local quarantine regulations is mandatory.

(3) The quarantine laws of foreign countries must be complied with in all instances. Where naval establishments are situated in a foreign country, quarantine may be a collaborative procedure, with certain responsibilities delegated to the Navy, when special arrangements for such have been effected.

(4) In naval establishments outside the United States, its Territories, and possessions, where neither Federal nor other civil authority has quarantine jurisdiction, or does not exercise such jurisdiction, the full responsibility for quarantine devolves upon the naval district commandant, or the area, or base commander.

22–36. Quarantinable and Communicable Diseases

(1) Diseases Subject to Quarantine.—By international agreement, only six diseases are classified as quarantinable:

(a) Cholera (incubation period 5 days).
(b) Plague (incubation period 6 days).
(c) Louse-borne typhus (incubation period 12 days).
(d) Smallpox (incubation period 14 days).
(e) Yellow fever (incubation period 6 days).
(f) Louse-borne relapsing fever (incubation period up to 12 days, average 7 days).

(2) Communicable Diseases.—While emphasis is placed on measures to prevent the dissemination of "quarantinable" diseases, the Medical Department is charged equally with the responsibility of recommending measures to prevent the dissemination of communicable diseases other than those classified as quarantinable both within and among naval establishments and civilian communities.

22–37. Control of Rodent and Insect Infestation Aboard Ships

(1) Certificates of Deratization or Deratization Exemption.—

(a) By international convention a "certificate of deratization," or a "deratization exemption certificate" is required of vessels entering most foreign ports, if detention for fumigation is to be avoided. A certificate to be valid must be issued by the U.S. Public Health Service.

(b) Medical officers of vessels proceeding to foreign ports must apply (as required by international convention) for a certificate of deratization or deratization exemption. These certificates may be obtained by requesting that a rodent inspection be made by a U.S. Public Health Service representative. If on inspection a rodent problem is found to be present, deratization measures will be required. After deratization, a certificate of deratization will be issued. If no rodent problem is found to be present, a certificate of deratization exemption will be issued. Either certificate is valid for 6 months. Failure to possess such a certificate may result in a quarantine and a rodent inspection.

(c) The carrying of certificates of deratization or deratization exemption is not required of naval vessels under circumstances other than those stated in articles 22–37(1) (a) and (b) because of the high state of ratproofing and rat control on board most naval vessels. Both a quarantine and a rodent inspection are required, however, upon first entering a United States port, if the vessel has made contact with a plague port within the previous 60 days.

(d) While periodic rat inspections are not required of United States naval vessels by the U.S. Public Health Service, it is appropriate and highly desirable to request inspections and recommendations of the U.S. Public Health Service or naval rodent control officers when these are available, because of their expert knowledge of the habits and methods for control of rats aboard ship. The medical officer shall recommend that the commanding officer make such requests whenever the presence of rats is suspected. For supply ships, transports, and repair ships, which are most frequently seriously infested, a routine preventive inspection every 6 months by a trained rodent control officer of the Navy or U.S. Public Health Service is indicated. Naval and/or U.S. Public Health Service rodent control officers are available in all major ports of the United States, its Territories, and possessions, and can be reached through the port director.

(e) Reference shall be made to General Orders covering quarantine regulations for naval vessels for instructions as to avoidance of rat infestation particularly in plague ports.

(2) Fumigation.—

(a) Recent developments in disinfestation and deratization render the fumigation of ships as a routine procedure rarely necessary. Rodent control will ordinarily be effected by the more simple and usually equally effective procedure of baiting and trapping. Every effort to reduce rats by trapping shall be made before resorting to more dangerous methods, unless health is immediately threatened. The destruction of insects, particularly lice, will ordinarily be carried out by the use of DDT preparations. Fumigation is never indicated for control of cockroaches, bedbugs, fleas, lice, ants, etc. In rare instances it may be used in food storerooms against flour moths, bean beetles, etc.
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Section XI. FIELD SANITATION

22-40. General

(1) The responsibilities of medical officers with regard to sanitation, when serving with personnel in the field, are essentially the same as those serving with personnel housed in permanent shore establishments (chapter 5). They shall maintain an inspection service sufficient to insure the sanitary operation of messing facilities, water purification equipment, waste disposal facilities, and other appliances in order to protect the health of all personnel. Sanitary appliances used in the field are simpler and easier to construct than those used in permanent installations, but more attention is required to maintain them in satisfactory condition.

22-41. Preparation for Field Service

(1) The medical officer shall familiarize himself with all health and sanitary data available on the area to be occupied, and formulate a plan and prepare the necessary sanitary orders for the practical solution of problems likely to be encountered and present them to the commanding officer for approval and execution. The plan shall provide for:

(a) The indoctrination of all personnel in personal hygiene, sanitation, and the special protective measures to be used.

(b) The assignment of an adequate complement of nonmedical personnel (approximately 2 percent of the command) to sanitary duties such as maintenance and care of latrines and urinals, fly control, mosquito control, rodent control, and garbage and waste disposal. In combat areas, additional personnel must be assigned for the handling and burial of the dead.

(c) The thorough indoctrination of the nonmedical personnel in their sanitary duties for efficient performance with a minimum of supervision.

(d) The assignment and enforcement of priorities for the acquisition of materials and supplies and the early construction of sanitary appliances in the field.

(e) The selection and physical examination of food handlers, and their indoctrination in personal hygiene, sanitation in the preparation of food, and the care of utensils and mess gear.

(f) The inspection and approval by the medical officer of galleys, before they are placed in operation.

(2) The planning and the indoctrination and training of personnel in the training camp or staging area in order to provide an efficient, well-trained sanitary organization upon landing.

(3) The required immunizations shall be completed in ample time to provide protection upon arrival.

(4) The medical officer shall refer to the Landing Party Manual, U.S. Navy, for preventive medicine practices in the field.
Chapter 23
REPORTS, FORMS, AND RECORDS

Sections

I. Bureau Reporting Requirements .................................................. 23-1 through 23-213
II. NAVMED, Standard Federal, and Department of Defense Forms .......... 23-214 through 23-249
III. Records Maintained on Other Than Standardized Forms ............... 23-250 through 23-299
VII. Records Retirement ................................................................. 23-300 through 23-309
VIII. Release of Information From Records ...................................... 23-310 through 23-319

Section I. BUREAU REPORTING REQUIREMENTS

General ........................................................................................................... 23-1
Neuropsychiatric Report (MED-6520-1) .................................................... 23-2
Neuropsychiatric Report (MED-6520-1) .................................................... 23-17
Aviation Physiology Training Report (MED-6410-3) ............................. 23-18
Occupational Health Report (MED-6260-1) ............................................ 23-21
Report of Decompression Sickness and All Diving Accidents (MED-6420-1) ............... 23-30
Report on Interns and Internships (MED-1520-1) ................................. 23-33
Psychiatric Unit Report (MED-6520-2) ................................................... 23-35
RDT&E Task Report (OPNAV-3910-1) .................................................... 23-43
Photofluorographic Equipment (MED-8760-1) ........................................ 23-44
Report of Naval Reserve Medical Program (MED-1050-8) ....................... 23-105
Medical Intelligence Report of Ports and Adjacent Areas Visited (MED-3820-1) ........ 23-124
Annual Report of Audiovisual Aids (MED-1551-1) ................................. 23-126
Report of Burial in Navy Cemeteries or Plots (MED-5360-1) ..................... 23-135

23-1. General

(1) Medical Department personnel are required to prepare and submit certain special and periodic reports as specified in article 23-2. Reference to official instructions for the preparation and submission of each of these reports will be found in the tabulation. Additional reports may be required of representatives of the Medical Department by U.S. Navy Regulations or other competent authority.

(2) For purposes of identification and control, each report required by the Bureau has been assigned a report symbol from the Navy-Marine Corps Standard Subject Classification System (SECNAVINST P5210.11 series).

(3) No report shall be considered as an official continuing reporting requirement of the Bureau unless it bears a report symbol. The report symbol where practicable shall be placed on all reports (letter and form) submitted to the Bureau. In addition, all correspondence referring to an official reporting requirement of the Bureau should cite the title and symbol of the report.

(4) Subarticle 23-214(5) contains data on availability and stock levels of reporting forms.

(5) The original copy only of each report shall be submitted to the Bureau unless otherwise indicated. Where practicable, signatures, as required, should appear on the reports, obviating the need for letters of transmittal.
### 23-2. Tabulation of Bureau Reporting Requirements

<table>
<thead>
<tr>
<th>Report symbol</th>
<th>Title of report</th>
<th>Format</th>
<th>Frequency</th>
<th>Requiring directive</th>
<th>Preparing activities</th>
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<tbody>
<tr>
<td>MED-1080-8</td>
<td>Report of Naval Reserve Medical Program</td>
<td>Letter</td>
<td>Q</td>
<td>Art. 23-103</td>
<td>See art. 23-105, Naval districts (less 10th, 14th, 15th, and 17th) and Naval Air Reserve Training Command.</td>
</tr>
<tr>
<td>MED-1080-9</td>
<td>Naval Reserve Dental Program</td>
<td>do</td>
<td>Q</td>
<td>BUMEDINST 1080.3</td>
<td>Naval hospitals in U.S. conducting class B or C training.</td>
</tr>
<tr>
<td>MED-1080-16</td>
<td>Performance of Appropriate Duty by Reserve Consultants</td>
<td>Letter</td>
<td>Q</td>
<td>BUMEDINST 1001.1A</td>
<td>Naval hospitals in U.S. conducting residency training.</td>
</tr>
<tr>
<td>MED-1510-2</td>
<td>On-The-Job Training of Technicians</td>
<td>do</td>
<td>M</td>
<td>BUMEDINST 1520.10A</td>
<td>Naval hospitals in U.S. conducting on-the-job training.</td>
</tr>
<tr>
<td>MED-1520-4</td>
<td>Resident's Unsatisfactory Progress</td>
<td>do</td>
<td>S</td>
<td>BUMEDINST 1520.13</td>
<td>Naval hospitals in U.S. conducting on-the-job training.</td>
</tr>
<tr>
<td>MED-1520-5</td>
<td>Non-U.S. Navy Trainees</td>
<td>do</td>
<td>A</td>
<td>BUMEDINST 1520.13</td>
<td>Naval hospitals in U.S. conducting on-the-job training.</td>
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<tr>
<td>MED-1531-1</td>
<td>Annual Report on Audiovisual Aids</td>
<td>do</td>
<td>A</td>
<td>BUMEDINST 1520.13</td>
<td>Naval hospitals in U.S. conducting on-the-job training.</td>
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<tr>
<td>MED-1560-1</td>
<td>Report of Naval Reserve Medical Program</td>
<td>Letter</td>
<td>Q</td>
<td>Art. 23-103</td>
<td>See art. 23-105, Naval districts (less 10th, 14th, 15th, and 17th) and Naval Air Reserve Training Command.</td>
</tr>
<tr>
<td>MED-1560-2</td>
<td>Naval Reserve Dental Program</td>
<td>do</td>
<td>Q</td>
<td>BUMEDINST 1080.3</td>
<td>Naval hospitals in U.S. conducting class B or C training.</td>
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<tr>
<td>MED-1560-16</td>
<td>Performance of Appropriate Duty by Reserve Consultants</td>
<td>Letter</td>
<td>Q</td>
<td>BUMEDINST 1001.1A</td>
<td>Naval hospitals in U.S. conducting residency training.</td>
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<tr>
<td>MED-1560-18</td>
<td>On-The-Job Training of Technicians</td>
<td>do</td>
<td>M</td>
<td>BUMEDINST 1520.10A</td>
<td>Naval hospitals in U.S. conducting on-the-job training.</td>
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<tr>
<td>MED-1560-21</td>
<td>Resident's Unsatisfactory Progress</td>
<td>do</td>
<td>S</td>
<td>BUMEDINST 1520.13</td>
<td>Naval hospitals in U.S. conducting residency training.</td>
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<tr>
<td>MED-1560-22</td>
<td>Non-U.S. Navy Trainees</td>
<td>do</td>
<td>A</td>
<td>BUMEDINST 1520.13</td>
<td>Naval hospitals in U.S. conducting residency training.</td>
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<tr>
<td>MED-1560-24</td>
<td>Report of Naval Reserve Medical Program</td>
<td>Letter</td>
<td>Q</td>
<td>Art. 23-103</td>
<td>See art. 23-105, Naval districts (less 10th, 14th, 15th, and 17th) and Naval Air Reserve Training Command.</td>
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<tr>
<td>MED-1560-25</td>
<td>Naval Reserve Dental Program</td>
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<td>Q</td>
<td>BUMEDINST 1080.3</td>
<td>Naval hospitals in U.S. conducting class B or C training.</td>
</tr>
<tr>
<td>MED-1560-26</td>
<td>Report of Group X Hospital Corpsmen Under Class B and Class C Training</td>
<td>NAVPERS 353</td>
<td>M</td>
<td>BUMEDINST 1080.2A</td>
<td>Naval hospitals in U.S. conducting residency training.</td>
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<td>MED-1560-27</td>
<td>Performance of Appropriate Duty by Reserve Consultants</td>
<td>Letter</td>
<td>Q</td>
<td>BUMEDINST 1001.1A</td>
<td>Naval hospitals in U.S. conducting residency training.</td>
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<td>On-The-Job Training of Technicians</td>
<td>do</td>
<td>M</td>
<td>BUMEDINST 1520.10A</td>
<td>Naval hospitals in U.S. conducting on-the-job training.</td>
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<tr>
<td>MED-1560-31</td>
<td>Resident's Unsatisfactory Progress</td>
<td>do</td>
<td>S</td>
<td>BUMEDINST 1520.13</td>
<td>Naval hospitals in U.S. conducting residency training.</td>
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### 3000-3999 OPERATIONS AND READINESS

<table>
<thead>
<tr>
<th>MED-9999-1</th>
<th>Medical Intelligence Report of Ports and Adjacent Areas Visited</th>
<th>Letter</th>
<th>S</th>
<th>Art. 29-124</th>
<th>Ships and stations outside the U.S. having a medical officer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPNAV-3910-1</td>
<td>RDT&amp;E Task Report</td>
<td>OPNAV 3910-1</td>
<td>A</td>
<td>Art. 29-43</td>
<td>Ships and stations engaged in medical or dental research.</td>
</tr>
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</table>

### 4000-4999 LOGISTICS

<table>
<thead>
<tr>
<th>MED-9999-1</th>
<th>Foreign Trainees Examined</th>
<th>Letter</th>
<th>S</th>
<th>BUMEDINST 4950.1A</th>
<th>Any medical activity within a naval district when designated by the commandant to examine foreign trainees, foreign ship transfer personnel, and ship overhauling crews.</th>
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</thead>
<tbody>
<tr>
<td>MED-9999-2</td>
<td>Foreign Trainee Having Disease</td>
<td>do</td>
<td>S</td>
<td>do</td>
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### 5000-5999 GENERAL ADMINISTRATION AND MANAGEMENT

<table>
<thead>
<tr>
<th>MED-9999-1</th>
<th>Visit to Medical Department Activity</th>
<th>Letter</th>
<th>S</th>
<th>BUMEDINST 9914.3</th>
<th>BUMED management control activities.</th>
</tr>
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<tbody>
<tr>
<td>MED-9999-2</td>
<td>Installation or Discontinuance of Data Processing Equipment</td>
<td>do</td>
<td>S</td>
<td>NAVMED P-5069</td>
<td>Naval hospitals and medical centers.</td>
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<tr>
<td>MED-9999-3</td>
<td>Receipt or Disposal of Data Processing Related Auxiliary and Accessory Items</td>
<td>do</td>
<td>Q</td>
<td>NAVMED P-5069</td>
<td>Do.</td>
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<tr>
<td>MED-9999-4</td>
<td>Report of Burial in Navy Cemeteries or Plots</td>
<td>do</td>
<td>A</td>
<td>BUMEDINST 9930.2</td>
<td>BUMED management control activities.</td>
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<td>MED-9999-5</td>
<td>Activities having jurisdiction over naval cemeteries and Navy plots in civilian cemeteries</td>
<td>do</td>
<td>S</td>
<td>Art. 29-149</td>
<td>Do.</td>
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<td>Document Type</td>
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<td>Report</td>
<td>6200</td>
<td>PREVENTIVE MEDICINE</td>
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<td>Special Epidemiological Reports</td>
<td>6220-2</td>
<td>Poliomyelitis</td>
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<td>Report of Venereal Disease in Recruits</td>
<td>6222-4</td>
<td>Report of Venereal Disease in Recruit</td>
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<td>Venereal Disease Epidemiologic Report</td>
<td>6230-2</td>
<td>Tuberculosis in Recruits</td>
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<td>Tuberculin Testing of Recruits, Midshipmen, and Other Special Personnel</td>
<td>6222-7</td>
<td>Separation Epidemiologic Report</td>
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<td>Tuberculin Testing of Recruits, Midshipmen, and Other Special Personnel</td>
<td>6224-4</td>
<td>Individual Report of Conversion of Tuberculin Test From Negative to Positive</td>
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<td>Tuberculin Testing of Recruits, Midshipmen, and Other Special Personnel</td>
<td>6246-5</td>
<td>Photofluorographic Chest Survey</td>
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<td>Occupational Health Report</td>
<td>6250-1</td>
<td>Tuberculosis Testing of Recruits, Midshipmen, and Other Special Personnel</td>
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See footnote at end of table.
### 23-2. Tabulation of Bureau Reporting Requirements—Continued

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<tr>
<td>DD-COMP(M) 237 (MED-6320)</td>
<td>Beds and Patients Report</td>
<td>DD 443</td>
<td>M</td>
<td>BUMEDINST 6320.8C</td>
<td>Hospitals, hospital ships, and activities having a station hospital or dispensary with authorized beds. Ships and stations.</td>
</tr>
<tr>
<td>MED-6320-2</td>
<td>Report of Medical Treatment, Hospitalisation, and Allied Services.</td>
<td>NAVMED U</td>
<td>S</td>
<td>Art.20-7 M BUMEDINST 6320.26</td>
<td>Ships and stations providing outpatient care (less naval/Marine Corps reserve training centers, Marine air reserve training detachments, and Navy and Marine Corps recruiting stations). Naval hospitals and medical centers. Within U.S.—U.S. naval dispensaries, activities having station hospitals or dispensaries. Outside U.S.—Activities having station hospitals or dispensaries with authorized beds. Naval hospitals; hospital ships; medical centers; activities having station hospitals or dispensaries with authorized beds; naval dispensaries; Naval Medical Unit, Tripler. Medical centers, naval hospitals, and hospital ships.</td>
</tr>
<tr>
<td>MED-6320-4</td>
<td>Outpatient Report</td>
<td>DD 444</td>
<td>M</td>
<td>BUMEDINST 6320.9D</td>
<td>Stations furnishing inpatient treatment, and certain stations furnishing outpatient care to supernumeraries.</td>
</tr>
<tr>
<td>MED-6320-6</td>
<td>Hospital Staffing Report</td>
<td>NAVMED 1355</td>
<td>Q</td>
<td>BUMEDINST 6320.1AB</td>
<td>MED-647-1</td>
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<tr>
<td>MED-6320-7</td>
<td>Staffing Report</td>
<td>NAVMED 1357</td>
<td>Q</td>
<td>BUMEDINST 6320.16B</td>
<td>Special psychiatric programs.</td>
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<tr>
<td>MED-6320-10</td>
<td>Hospitalised Active Duty Flag or General Officer Report.</td>
<td>Message</td>
<td>X</td>
<td>BUMEDINST 6320.2B</td>
<td>Naval aviation activities utilizing aviation physiology training equipment for training purposes. Ships and stations having a flight surgeon.  Naval activities having diving facilities.  Submarine medical officers.  Naval activities having a dosimetry program.  Do.  Spectacles dispensing units, ophthalmic service units, ophthalmic lens laboratories, and activities performing or ordering eye refractions for military members or their dependents. Naval hospitals and hospital ships. Naval training centers, Marine Corps recruit depots, and designated stations.</td>
</tr>
<tr>
<td>MED-6320-16</td>
<td>Report of Treatment Furnished Pay Patients, Hospitalization Furnished</td>
<td>DD 7</td>
<td>M</td>
<td>Art.21-33</td>
<td>MED-640-2</td>
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### 6400 & 6500 SPECIAL FIELDS

<table>
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<tr>
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<th>Title of report</th>
<th>Format</th>
<th>Frequency</th>
<th>Requiring directive</th>
<th>Preparing activities</th>
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<tr>
<td>MED-640-3</td>
<td>Aviation Physiology Training Report</td>
<td>NAVMED 1349</td>
<td>Q</td>
<td>Art.23-18</td>
<td>Naval aviation activities utilizing aviation physiology training equipment for training purposes. Ships and stations having a flight surgeon.  Naval activities having diving facilities.  Submarine medical officers.  Naval activities having a dosimetry program.  Do.  Spectacles dispensing units, ophthalmic service units, ophthalmic lens laboratories, and activities performing or ordering eye refractions for military members or their dependents. Naval hospitals and hospital ships. Naval training centers, Marine Corps recruit depots, and designated stations.</td>
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<tr>
<td>MED-640-4</td>
<td>Aviation Medicine Residency Quarterly Report</td>
<td>NAVMED 1326</td>
<td>Q</td>
<td>BUMEDINST 640.3</td>
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<tr>
<td>MED-643-1</td>
<td>Report of Decompression Sickness and All Diving Accidents</td>
<td>NAVMED 1316</td>
<td>S</td>
<td>Art.29-30</td>
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<tr>
<td>MED-647-2</td>
<td>Special Photodosimetry Report</td>
<td>NAVMED 1174</td>
<td>Q</td>
<td>BUMEDINST 6810.A</td>
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<td>MED-6500-2</td>
<td>Ophthalmic Dispensing and Refraction Report</td>
<td>NAVMED 1202</td>
<td>M</td>
<td>Art.23-17</td>
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<tr>
<td>MED-6500-4</td>
<td>Psychiatric Unit Report</td>
<td>NAVMED 1217</td>
<td>M</td>
<td>Art.23-35</td>
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### 6600 DENTISTRY

**MED-6600-2**
- Dental Service Report
- Dental Service Report, Equipment and Facilities, Supplement

**6700 & 6800 EQUIPMENT AND SUPPLIES**

**MED-6700-2**
- Completion of Inactivation

**MED-6700-5**
- Open Purchase High-Dollar Items

**MED-6700-6**
- Litter and Blanket Excesses

**MED-6700-7**
- MMPNC—Changes/Excesses

**MED-6700-8**
- MMPNC—Inventory

**MED-6700-1**
- Photofluorographic Equipment

**7000—7999 FINANCIAL MANAGEMENT**

**NAVCOMPT-7030-2**
- User Charges

**MED-7330-10**
- Report of Reimbursable Order Accepted

**1000—1099 GENERAL MATERIAL**

**MED-10119-2**
- Food Service Performance Analysis

**1100—1199 FACILITIES AND ACTIVITIES ASHORE**

**MED-11913-1**
- BUDOCKS 11200-3

**12000—12999 CIVILIAN PERSONNEL**

**MED-12195-1**
- CONG 48 (12500)

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Report</th>
<th>Frequency</th>
<th>Directive</th>
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</tr>
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<tr>
<td>MED-6600-2</td>
<td>Dental Service Report</td>
<td>DD 477</td>
<td>Q</td>
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<td>Navy and Marine Corps activities or units having a dental officer.</td>
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<td>DD 477-1</td>
<td>Dental Service Report, Equipment and Facilities Supplement</td>
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<td>A</td>
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<td>Do.</td>
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<tr>
<td>MED-6700-2</td>
<td>Completion of Inactivation</td>
<td>Letter</td>
<td>S</td>
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<td>Vessels assigned to the Reserve Fleets (except hospital ships and vessels required to be kept operative with a complete or partial outfit of materials on board).</td>
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<tr>
<td>MED-6700-5</td>
<td>Open Purchase High-Dollar Items</td>
<td>NAVMED 1378</td>
<td>Q</td>
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<td>For Medical Items: Naval hospitals in U.S. and naval dispensaries.</td>
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<tr>
<td>MED-6700-6</td>
<td>Litter and Blanket Excesses</td>
<td>Letter</td>
<td>S-A</td>
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<td>Naval districts and river commands, continental.</td>
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<tr>
<td>MED-6700-7</td>
<td>MMPNC—Changes/Excesses</td>
<td>do</td>
<td>Q</td>
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<td>Naval districts, river commands, and fleet commanders in chief.</td>
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<tr>
<td>MED-6700-8</td>
<td>MMPNC—Inventory</td>
<td>do</td>
<td>A</td>
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<td>Do.</td>
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<td>MED-6700-1</td>
<td>Photofluorographic Equipment</td>
<td>NAVMED 1412</td>
<td>A</td>
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<td>Activities having photofluorographic equipment.</td>
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<tr>
<td>NAVCOMPT-7030-2</td>
<td>User Charges</td>
<td>SF 4</td>
<td>A</td>
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<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>MED-7330-10</td>
<td>Report of Reimbursable Order Accepted</td>
<td>Letter</td>
<td>S</td>
<td></td>
<td>BUMED management control activities.</td>
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<tr>
<td>MED-10119-2</td>
<td>Food Service Performance Analysis</td>
<td>NAVMED 1412</td>
<td>M</td>
<td></td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>MED-11913-1</td>
<td>BUDOCKS 11200-3</td>
<td>Letter</td>
<td>Q</td>
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<td>BUMED management control activities.</td>
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<tr>
<td>MED-12195-1</td>
<td>CONG 48 (12500)</td>
<td>Letter</td>
<td>S</td>
<td></td>
<td>BUMED management control and financial responsibility activities, and all other Navy and Marine Corps activities having a BUMED ambulance allowance.</td>
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</table>
23-17. Neuropsychiatric Report (MED-6520-1)

(1) Naval hospitals and hospital ships shall submit this report monthly on NAVMED-102 to the Bureau. The report shall be forwarded to reach the Bureau by the 15th day of the month following the month covered by the report.


(1) A single copy of this report shall be submitted on NAVMED-1349 to the Bureau at the end of each quarter by each activity at which aviation physiology training devices are located. The report shall be forwarded not later than the 15th day of the month following the quarter reported upon. Instructions for the preparation of the report are printed on the form.

Note.—There are no articles 23-19 and 23-30.


(1) The Occupational Health Report consists of two parts: The Occupational Health Data Sheet, NAVMED-516, and the Narrative Portion. It shall be submitted to the Bureau quarterly as of 30 September, 31 December, 31 March, and 30 June by the medical officer of each naval activity as listed in current BUMED Instructions in the 6260 series. The original shall be mailed not later than 2400 on the 10th day of the following month.

(2) The Occupational Health Data Sheet shall be completed in accordance with current BUMED Instructions in the 6260 series.

(3) The following items shall be discussed in the Narrative Portion of the Occupational Health Report and attached to the Occupational Health Data Sheet.

(a) Occupational Medicine.—

(1) Give brief descriptions of occupational medical conditions and injuries occurring in civilian or military personnel. The description should cover those occupational medical conditions due to (a) exposure to skin irritants; (b) dusts, fumes, gases, mists, and lack of oxygen; (c) physical agents; and (d) occupational exposure to infectious agents. Of special interest are new occupational cases and those resulting in lost time. List and describe the occupational cases resulting in lost time.

(2) Briefly discuss the nonoccupational cases treated on the job and those referred to family physicians.

(3) State briefly problems of medical interest obtained from the chest X-ray, hearing conservation, and sight conservation programs. List the number of eye injuries giving the etiology and diagnosis.

(4) Make brief comments regarding physical examinations conducted, with special reference to pertinent findings in preplacement and periodic physical examinations.

(b) Industrial Hygiene.—

(1) Discuss briefly and in the order indicated by the following format any occupational health problems encountered during the report period. Any health hazard discussed under items (3) (b) (1) (a), (b), or (c) below should include the potential hazard involved, an abstract of pertinent facts, scientific data collected, and corrective action taken or contemplated; however, the names of employees, shop numbers, and information purely local in nature, should be omitted.

(a) Chemical Health Hazards.—

(1) Inhalation hazards due to gases, vapors, or fumes.

(b) Physical Health Hazards.—

(1) Exposure to excessive heat.

(2) Exposure to nonionizing radiation hazards.

(3) Exposure to excessive noise.

(c) Ionizing Radiation Health Hazards.—

(1) Exposure to mixed radiation.

(2) Exposure to X-rays.

(3) Exposure to alpha particles.

(4) Exposure to gamma particles.

(5) Exposure to isotopes.

(6) Exposure to waste materials.

(d) Substitution of Toxic Solvents by Safer Material.—Report in the columnar format indicated below any substitution of toxic substances by materials having a lower order of toxicity:

Toxic material Process Substituted by

(e) Material Composition and Analysis.—

Report composition data on new materials, whether obtained from the manufacturer or determined through analysis.

(f) Note (of General Interest to Field Medical Activities).—Include under this item brief comments on surveys and investigations conducted for other activities, educational meetings attended or conducted, and other items of general interest that cannot logically be classified under subarticles (3) (b) (1) (a) through (c) above.

Note.—There are no articles 23-22 through 23-29.

23-30. Report of Decompression Sickness and All Diving Accidents (MED-6420-1)

(1) This report shall be submitted on NAVMED-816 by the cognizant medical officer for each case of compressed air illness, air embolism, diver’s squeeze, or other type of diving accident.

Note.—There are no articles 23-31 and 23-32.
23-33. Report on Interns and Internships (MED-1520-1)

(1) This report shall be submitted to the Bureau on NAVMED-1048 annually by all naval hospitals in the United States conducting intern training. The report shall cover the period from 1 July to 30 June and shall be forwarded to reach the Bureau by 1 August. Negative reports are not required.

Note.—There are no articles 23-34 through 23-37.

23-38. Psychiatric Unit Report (MED-6520-2)

(1) All naval training centers, Marine Corps recruit depots, and other stations designated by the Bureau shall submit this report on NAVMED-1317 as of midnight the last day of each month in accordance with the instructions on the form.

Note.—There are no articles 23-39 through 23-42.

23-43. RDT&E Task Report (OPNAV-3910-1)

(1) This report shall be submitted on OPNAV Form 3910-1 annually as of 31 December by ships and stations engaged in medical and dental research. The reports must reach the Bureau no later than 1 February each year. The original and one copy are required. The original should include all the individual investigations assigned under the activity task (refer to article 1-16). (The Bureau will submit an annual report on Form DD-613 to the Department of Defense, prepared on a project basis, and supported by the RDT&E Task Reports.)

(2) Reports on RDT&E tasks are the primary source of technical information on both the active and the projected RDT&E program of the Navy, and must be adequate for the purposes of technical planning, coordination, and information exchange. Each report must cover briefly the progress of the task during the current reporting period. Specific instructions for the preparation of the report on OPNAV Form 3910-1 (Revised 7-60) are as follows:

(a) Item 1. Task Title.—Use the minimum number of words in the title to indicate, on first reading, what the task is. In addition to the brief title, include an abbreviated title in 24 typewritten spaces, including blank spaces. Immediately following the brief title and the abbreviated title, indicate the security classification of title by (U), (C), or (S).

(b) Item 2. Task Number.—The approved task number as supplied by the Bureau.

(c) Item 3. Security of Task.—The security classification of the task itself is shown in this item. The security classification of the task report, as differentiated from that of the task itself, will appear at the top and bottom of each page. These two classifications may differ depending on what is reported and how much is reported. For top secret tasks, submit a report which may be classified secret or less.

(d) Item 4. Date.—Leave blank; will be filled in by the Bureau.

(e) Item 5. Report Type.—Check appropriate block in both A and B sections.

(f) Item 6. Technical Subarea.—The title of the Naval Research Requirement which the task supports.

(g) Item 7. Task Office.—The BUREMED code that has supervisory responsibility for the task.

(h) Item 8. Contractor or Laboratory.—The contractor(s), Government laboratory(ies), activity(ies), etc., which will ultimately use the funds allotted this task. Indicate also the department or other activity entity, when known, such as Naval Medical Research Institute, Pathology Division.

(i) Item 9. Contract or Work Order.—The contract number, project order number, allotment, work order, etc., which are identified with the task, if applicable.

(j) Item 10. Principal Investigator.—The organizational designation or name of the principal investigator, technical expert, or scientist who is working on the task.

(k) Item 11. Task Duration Period.—Enter the beginning and termination dates planned for this task. Enter the abbreviation "Cont." for tasks that are continuing indefinitely.

(l) Item 12. Estimated Annual Support Level.—Check the block that indicates the estimated annual fiscal support level of the task.

(m) Item 13. Work Description.—List all active subtasks by title and principal investigator. In narrative, report on the task in entirety; do not break down into subtasks. Describe the work that is being done or planned to be done, as of 31 December; i.e., state what the work is and how it is done. If the task is completed, give a summary of the final results and accomplishments.

(n) Item 14. Reports Distributed.—A list of reports that have been distributed during the period since the previous task report was submitted. Use the following order: Author(s), Title, Report Identification.

(3) All reporting activities shall follow the above format as closely as possible so that uniformity in reporting will be obtained. It is the intent of the Bureau that reports for individual tasks will be contained on one task report only, using both sides as necessary.

23-44. Photofluorographic Equipment (MED-6760-1)

(1) Each activity having photofluorographic equipment shall submit to the Bureau, as of the last day of August, a separate report on the condition and usage of each stationary, transportable,
and bus-mounted mobile unit. The reports shall be submitted on form NAVMED-1405.

Note.—There are no articles 23–45 through 23–104.


(1) District medical officers in the United States (less Alaska and Hawaii); the Staff Medical Officer, Naval Air Reserve Training Command; the Commander, Marine Air Reserve Training; and the directors of Marine Corps reserve and recruitment districts shall submit the original only of this report to the Bureau quarterly as of 31 March, 30 June, 30 September, and 31 December.

(2) The report, in letter form, shall present the following:

(a) Alphabetical listing, regardless of rank, of all medical, medical service, nurse, and medical service warrant officers assigned to pay units of the Naval Reserve by an approved Assignment to Naval Reserve Pay Unit in a Pay Status (NavPers 989). The listing shall include the name, rank, designator number, and the unit to which assigned.

(b) The number by corps of reserve Medical Department officers (less dental) authorized to be associated with reserve pay units in a drill pay status.

(c) The number, by corps, of reserve Medical Department officers (less dental) authorized to be associated with reserve pay units in a non-drill pay status.

(d) An alphabetical listing, regardless of rank, of all medical and nurse officers authorized to perform appropriate duty with pay. The listing shall include the name, rank, designator number, and activity where appropriate duty with pay is performed.

(e) The number of Naval Reserve Medical Department officers (less dental) authorized to perform appropriate duty without pay.

(f) The number, by corps, of reserve Medical Department officers (less dental) assigned as Commandant's Representatives at colleges and medical schools.

(g) The established Hospital Corps Divisions in numerical sequence (1–1, 1–2, etc.), location of division, and the number of personnel attached to each division by corps and enlisted pay grade.

(h) The established Naval Reserve Medical Companies in numerical sequence (3–1, 3–2, etc.), location of company, and the number of personnel attached to each company by corps and enlisted pay grade.

(i) The number of reserve Medical Department officers and enlisted personnel (less dental) not attached to pay units of the Naval Reserve who performed active duty for training during the report period.

(j) The number of enlisted Hospital Corpsmen, by pay grade, who are in a "Ready" status and the number of enlisted Hospital Corpsmen, by pay grade, who are in a "Standby" status carried on the rolls of the respective reporting activity.

(3) The 30 June report shall include the following information concerning each Reserve Medical Company:

(a) The names and ranks of the commanding and executive officers.

(b) The company's mailing address.

(c) When and where the company regularly conducts its drills (i.e., 2d and 4th Wednesday each month).

Note.—There are no articles 23–106 through 23–123.

23–124. Medical Intelligence Report of Ports and Adjacent Areas Visited (MED–3820–1)

(1) When at foreign stations or when cruising in waters outside of the United States, medical officers shall contact U.S. naval attaches in foreign countries and district intelligence officers in U.S. territories in advance for briefing with regard to medical intelligence requirements in the area or areas to be visited. If the briefing reveals need for medical intelligence, the medical officer shall prepare a report containing the desired information concerning health conditions of the various ports or adjacent areas and islands visited. The following outline shall serve as a guide in intelligence briefing and compilation of data for the report to the Bureau. The report shall be submitted in quintuplicate.

From: The Medical Officer, U.S.S.----------
To: Chief, Bureau of Medicine and Surgery
Via: Commanding Officer
Ref: (a) MANNED art. 23–124
(b) MED–3820–1

Subj: Medical Intelligence Report of Ports and Adjacent Areas Visited

Port: Name of city or town.

Date: Place and date of intelligence briefing.

1. Name of city or town.

2. Location and population.


4. Communicable diseases.

5. Epidemic diseases.


7. Venereal diseases incidence and available information concerning the prevalence and status of prostitution.

8. Temperature: average day , average night , yearly maximum , yearly minimum .


11. Rainfall.

12. Drainage.

13. Sewers.

14. Height above sea level.


16. Food and alcoholic beverages: character; sanitary conditions of hotels, restaurants, etc.

17. Availability of surgical and medical supplies.

23–214. General Statement

(1) The Bureau has promulgated certain lettered and numbered forms which are designed to facilitate reporting, recordkeeping, and administrative efficiency throughout the Medical Department. These forms are tabulated in article 23–215.

(2) For purposes of identification and control, all Medical Department forms have been assigned a letter or number. All correspondence referring to a form should cite its correct letter or number and title.

(3) The Bureau also maintains administrative control over the use of certain Standard Federal forms in the Medical Department. These forms are promulgated by the Bureau of the Budget to facilitate the exchange of medical information throughout the Federal Government. These forms are tabulated in article 23–216. Department of Defense forms used by the Medical Department are listed in article 23–217.

(4) The functions of the forms are outlined in the tabulations or in the references cited therein.

(5) (a) Forms which are available for issue through the Forms and Publications Segment of the Navy Supply System should be ordered when needed from the appropriate forms and publications cognizance “I” supply distribution points in accordance with NAVSHANDA Publication—2002—Requisitioning Guide and Index of Forms and Publications, Cognizance Symbol “I”.

(b) Articles 23–215 and 23–217 indicate by asterisk those forms which are stocked in the Bureau of Medicine and Surgery. They should be requested directly from the Bureau.

(c) Stations should maintain a 3 months' and ships a 6 months' supply of forms on hand.
### 23-215. Tabulation of Medical Department Forms

<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
</table>
| M........... | Report of Board of Medical Survey | See art. 19-12... | Navy and Marine Corps activities or units having a medical officer.  
Do... |
| M1........... | Report of Board of Medical Survey (following sheet) | Do... | Do... |
| N........... | Certificate of Death | See ch. 17... | Navy and Marine Corps activities or units having a Medical Department representative.  
Navy and Marine Corps activities or units having a Medical Department representative.  
Do... |
| S........... | Binnacle List | See art. 23-218... | Navy and Marine Corps activities or units having a representative of the Medical Department, or in the absence of such by the senior officer present or the person concerned.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| T........... | Morning Report of Sick | See art. 23-219... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| U........... | Report of Medical Treatment, Hospitalization, and Allied Services | See art. 20-7... | Medical Department activities and facilities.  
Activities under Bureau management control.  
Naval hospitals, hospital ships, and station... |
| HF-25........ | Baggage Record Card | For control of baggage in barracks... | Navy medical activities conducting research.  
Naval hospitals and hospital ships.  
Navy and Marine Corps activities or units having a representative of the Medical Department.  
Navy and Marine Corps activities or units having a representative of the Medical Department, or in the absence of such by the senior officer present or the person concerned.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| HF-38........ | Burial Record | See art. 23-220... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 9........... | Ward Report | Daily report of patients to personnel and records division, including occupancy and transfer data.  
To record sick-call treatments furnished.  
Sick... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 10........... | Sick Call Treatment Record | To record sick-call treatments furnished. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 18........... | Diet Sheet | Specifies proper diets for patients as prescribed by a medical officer. Utilized by diet kitchen and ward nurse. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 20........... | Liberty List | Tally sheet of personnel on liberty, including name, rate, and time. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 21........... | Laundry List | To itemize laundry by wards for inventory purposes. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 63........... | Request for Repairs | Used by offices of an activity to request repairs by local force. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 64........... | Operations Scheduled | Local schedule of operations to be performed, including patient, doctor, anesthetist, and time of operation. See art. 1-14. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 98........... | Research Project Form | See art. 23-17 | Navy and Marine Corps activities or units having a representative of the Medical Department.  
Navy and Marine Corps activities or units having a representative of the Medical Department, or in the absence of such by the senior officer present or the person concerned.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 102........ | Neuropsychiatric Report | See art. 23-21-22... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 210........ | Emergency Medical Tag | See art. 23-22... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 570........ | Occupational Health Data Sheet | See art. 23-21... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 601........ | Report of Burial | See art. 17-9A... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 615........ | Photofluorographic Chest Survey | See art. 23-30... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 794*........ | Certificate of Graduation—Hospital Corps School | Certificate of graduation from a Hospital Corps school. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 816........ | Report of Decompression Sickness and All Diving Accidents | See art. 17-9... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 952........ | Prosthetic Case Record | See art. 17-14... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 948........ | Report en Interns and Internships | See art. 23-33... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 110........ | Photofluorographic Log | See art. 15-9-10... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 110a........ | Photofluorographic Log (following sheet) | ... | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |
| 110b........ | Case History—Gastrointestinal Illness | A summary of medical findings and treatment of gastrointestinal illness. See HUMEDINST 6810.4A. | Medical Department activities and facilities furnishing outpatient treatment.  
Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
Navy hospitals... |

*Stocked in the Bureau.

23-10

Change 10
<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1178</td>
<td>Diseases and Operations Index Card</td>
<td>Provides detailed case references for medical research.</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1295</td>
<td>Admission Record</td>
<td>To provide a standard set of admission cards offering complete coverage of admission data required of any patient.</td>
<td>Naval hospitals, hospital ships, and station hospitals providing inpatient care.</td>
</tr>
<tr>
<td>1296</td>
<td>Staff Locator</td>
<td>To provide a ready location reference to staff personnel—military and civilian.</td>
<td>Naval hospitals and hospital ships.</td>
</tr>
<tr>
<td>1298</td>
<td>Transcript of Intern Service</td>
<td>Detailed record of satisfactory service completed in the various departments attended by a medical intern while undergoing training.</td>
<td>Naval hospitals approved for medical intern training.</td>
</tr>
<tr>
<td>1299</td>
<td>Dental Appointments, Daily</td>
<td></td>
<td>Activities having a dental officer.</td>
</tr>
<tr>
<td>1300</td>
<td>Dental Examination and Treatment Record</td>
<td></td>
<td>Activities having dental prosthetic facilities.</td>
</tr>
<tr>
<td>1301</td>
<td>Precious Metal Issue Record</td>
<td></td>
<td>Naval training centers, Marine Corps recruit depots, and other designated stations.</td>
</tr>
<tr>
<td>1302</td>
<td>Statement and Inventory of Precious and Special Dental Metals</td>
<td></td>
<td>Ships and stations having a flight surgeon.</td>
</tr>
<tr>
<td>1317</td>
<td>Psychiatric Unit Report</td>
<td></td>
<td>Continential naval hospitals.</td>
</tr>
<tr>
<td>1319</td>
<td>Aviation Medicine Residency Quarterly Report</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1320</td>
<td>Individual Report of Conversion of Tuberculin Test From Negative to Positive</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1325</td>
<td>Annual Tuberculin Retesting Report</td>
<td>Control of Health Records released from files. (See art. 16-16.)</td>
<td>Do.</td>
</tr>
<tr>
<td>1326</td>
<td>Health Record Receipt, Filing Charge-Out and Disposition Record</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1327</td>
<td>Health Record Special Duty Medical Abstract</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1328</td>
<td>Request for Reimbursement or Payment of Intent Expenses</td>
<td></td>
<td>Ships and stations.</td>
</tr>
<tr>
<td>1329</td>
<td>Food Sanitation Training Certificate</td>
<td></td>
<td>Activities having a medical officer.</td>
</tr>
<tr>
<td>1331</td>
<td>Aviation Physiology Training Report</td>
<td></td>
<td>Activities having annual Navy contracts for care of dead.</td>
</tr>
<tr>
<td>1332</td>
<td>Nursing Care Plan</td>
<td>For recording recurring medications, treatments, tests, consultations, nursing measures, and patient identification.</td>
<td>Naval aviation activities utilizing aviation physiology training equipment for training purposes.</td>
</tr>
<tr>
<td>1333</td>
<td>Personnel Tabulating Card—Brown Band</td>
<td>See BUMEDINST 6290.16B.</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1334</td>
<td>Personnel Tabulating Card—Red Band</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1335</td>
<td>Hospital Staffing Report</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1336</td>
<td>Expense Account Data Sheet</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1337</td>
<td>Certificate of Instruction Dental Technical School United States Navy</td>
<td>Certificate issued to graduates of class A, B, or C dental technician schools upon satisfactorily completing the prescribed course of instruction.</td>
<td>All Medical Department officers in Washington, D.C., and vicinity.</td>
</tr>
<tr>
<td>1338</td>
<td>Staffing Report</td>
<td>See BUMEDINST 6290.16B.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1339</td>
<td>Washington Area Directory Information Card</td>
<td>Distributed annually to Medical Department officers re data for the Directory of Officers of the Medical Department on duty in Washington, D.C., and vicinity.</td>
<td>Do.</td>
</tr>
<tr>
<td>1340</td>
<td>Ward Data Record</td>
<td>To record changes occurring on the ward over a 24-hour period.</td>
<td>Naval hospitals and station hospitals.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau.
†Stocked in the Bureau and by U.S. Naval School of Aviation Medicine, Naval Aviation Medical Center, Pensacola, Fla.
<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1384-H</td>
<td>Cash-Service Journal (Carbon)</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1384-I</td>
<td>Collection Agent Ledger</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1386</td>
<td>Collection Agents Receipt</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1387</td>
<td>Night Report</td>
<td>Report of activities of the ward during the night.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1389</td>
<td>General Journal</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1370</td>
<td>Estimate of Budgetary Requirements</td>
<td>To provide estimates of budgetary requirements each fiscal year.</td>
<td>Naval activities holding BUMED allotments.</td>
</tr>
<tr>
<td>1373</td>
<td>Medication and Treatment Card</td>
<td>To furnish instant information as to medication and treatments due or about to become due.</td>
<td>Naval hospitals, and station hospitals and dispensaries.</td>
</tr>
<tr>
<td>1374</td>
<td>Medication and Treatment Card, P.R.N.</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1378</td>
<td>Open Purchase High-Dollar Items</td>
<td>See BUMEDINST 6700.301</td>
<td>For Medical Items: Continental naval hospitals, and naval dispensaries.</td>
</tr>
<tr>
<td>1380</td>
<td>Dental Appointments</td>
<td>Patient's record of dental appointments.</td>
<td>For Dental Items: Dental Clinics Brooklyn, Norfolk, and Camp Pendleton; Naval Training Centers San Diego and Great Lakes; Naval Dental School Bethesda; Naval Station Newport.</td>
</tr>
<tr>
<td>1381</td>
<td>Grounding Notice (Aeromedical)</td>
<td>See BUMEDINST 6106.3</td>
<td>Activities and units having a dental officer.</td>
</tr>
<tr>
<td>1382</td>
<td>Clearance Notice (Aeromedical)</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1383</td>
<td>Posting Advice</td>
<td>...</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1391</td>
<td>Certificate—U.S. Navy Dental Corps Casualty Treatment Training Course.</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1392</td>
<td>Certificate—U.S. Navy Dental Corps Indocitration Course.</td>
<td>...</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1393</td>
<td>Medical Appointments—Daily</td>
<td>See BUMEDINST 6770.2</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1394</td>
<td>Linen Inventory Sheet</td>
<td>See BUMEDINST 6770.2</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1396</td>
<td>Shipboard Pest Control Training Certificate</td>
<td>...</td>
<td>Preventive medicine units and disease vector control centers.</td>
</tr>
<tr>
<td>1397</td>
<td>Narcotic and Controlled Drug Inventory—24 Hour</td>
<td>See BUMEDINST 6760.45</td>
<td>Naval and station hospitals and dispensaries.</td>
</tr>
<tr>
<td>1398</td>
<td>Narcotic and Controlled Drug Account Record</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1400-C*</td>
<td>Aviation Qualification Test—Form-3</td>
<td>See BUMEDINST 1332.1D</td>
<td>Ships and stations having a flight surgeon or an aviation medical examiner and activities under cognizance of the Chief of Naval Air Reserve Training; and Navy recruiting stations, Marine Corps recruiting stations, and Marine aviation unit officers, having personnel qualified to administer the Navy Officer Qualification Test.</td>
</tr>
<tr>
<td>1400-D*</td>
<td>Aviation Qualification Test—Form-4</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1401-H*</td>
<td>Mechanical Comprehension Test—Form-8</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1401-I*</td>
<td>Mechanical Comprehension Test—Form-9</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1402-G*</td>
<td>Spatial Apperception Test—Form-7</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1402-H*</td>
<td>Spatial Apperception Test—Form-8</td>
<td>...</td>
<td>Do.</td>
</tr>
<tr>
<td>1403-B*</td>
<td>Biographical Inventory—Form-3</td>
<td>...</td>
<td>Do.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau.
<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1405</td>
<td>Photofluorographic Equipment</td>
<td>To provide condition and usage data (see art. 23-44).</td>
<td>Activities having photofluorographic equipment.</td>
</tr>
<tr>
<td>1406</td>
<td>Abstract of Service and Medical History</td>
<td>See arts. 16-55 through 16-57.</td>
<td>Ships and stations having medical personnel.</td>
</tr>
<tr>
<td>1407</td>
<td>Group Screening Audiogram</td>
<td>See BUMEDINST 630.11.</td>
<td>Naval training centers and Marine Corps recruit depots.</td>
</tr>
<tr>
<td>1407-A</td>
<td>Group Screening Audiogram—Correction Cover Sheet.</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>1408</td>
<td>Perpetual Inventory of Narcotics, Alcohol and Controlled Drugs</td>
<td>See BUMEDINST 670.45.</td>
<td>Naval and station hospitals and dispensaries.</td>
</tr>
<tr>
<td>1409</td>
<td>Certificate of Accomplishment</td>
<td>For visiting foreign trainsmen (see BUMEDINST 4950.2).</td>
<td>BUMED provides to affected stations.</td>
</tr>
<tr>
<td>1411</td>
<td>Analysis Unfunded Reimbursable Transactions.</td>
<td>Provides data for billing the uniformed services, Federal agencies, and private parties for inpatient treatment to their beneficiaries.</td>
<td>Medical centers, naval hospitals, and hospital ships.</td>
</tr>
<tr>
<td>1412</td>
<td>Food Service Performance Analysis</td>
<td>Provides food-service operation and management data.</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1413</td>
<td>Certificate of On The Job Training</td>
<td>Certificate issued to Hospital Corps personnel on completion of specialized on-the-job training.</td>
<td>Medical Department activities designated by the Bureau to conduct specialized on-the-job training.</td>
</tr>
<tr>
<td>1414</td>
<td>Certificate of Special Instruction—Hospital Corps School.</td>
<td>Certificate issued to Hospital Corps personnel on completion of a class C medical technical course of instruction.</td>
<td>Medical Department activities conducting Special courses for Hospital Corps personnel.</td>
</tr>
<tr>
<td>1415</td>
<td>Obstetrical Code Sheet</td>
<td>To uniformly summarize data on obstetrical cases in naval hospitals.</td>
<td>Naval hospitals in the U.S.</td>
</tr>
<tr>
<td>1416</td>
<td>Inquiry School of Nursing</td>
<td>To obtain personal and professional references incident to appointment in the Nurse Corps USNR.</td>
<td>U.S. Navy Nurse Corps officers.</td>
</tr>
<tr>
<td>1417</td>
<td>Biographical Summary</td>
<td>To provide a summary of education, nursing experience, and personal accomplishments.</td>
<td>U.S. Navy Nurse Corps officers.</td>
</tr>
<tr>
<td>1418</td>
<td>U.S. Navy &amp; Marine Corps Aviation Selection Tests—Answer Sheet (AQT).</td>
<td>See BUMEDINST 1321.D.</td>
<td>Ships and stations having a flight surgeon or an aviation medical examiner and activities under cognizance of the Chief of Naval Air Reserve Training; and Navy recruiting stations, Marine Corps recruiting stations and Marine aviation cadet officers, having personnel qualified to administer the Navy Officer Qualification Test.</td>
</tr>
<tr>
<td>1419</td>
<td>U.S. Navy &amp; Marine Corps Biographical Inventory—Answer Sheet (BI, MCT, SAT).</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>1420</td>
<td>Serious/Critical Condition or Death of Patient on Ward.</td>
<td>Used as an expedient to notify that a patient has been placed on or removed from the serious or critical list or has died.</td>
<td>Naval hospitals, station hospitals, hospital ships, and dispensaries providing inpatient care.</td>
</tr>
<tr>
<td>1422</td>
<td>Certificate of Graduation—Basic Hospital Corps School.</td>
<td>Certificate issued to personnel on graduation from a basic Hospital Corps school.</td>
<td>Basic Hospital Corps schools.</td>
</tr>
<tr>
<td>1423</td>
<td>Certificate of Graduation—Advanced Hospital Corps School.</td>
<td>Certificate issued to personnel on graduation from an advanced Hospital Corps school.</td>
<td>Advanced Hospital Corps schools.</td>
</tr>
<tr>
<td>1424</td>
<td>Notice of Revision or Additional Diagnoses.</td>
<td>Used locally as a notice to the patient personnel branch to supply information for form NAVMED 1644, Individual Statistical Report of Patient (F Card).</td>
<td>Naval hospitals, station hospitals, hospital ships, and dispensaries providing inpatient care.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau.
### Standard Form No. 514

<table>
<thead>
<tr>
<th>Form No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>514-A</td>
<td>Urinalysis</td>
<td>To request, report on, and record various subtests relative to a urinalysis examinatinon. Staple to SF-514.</td>
<td>Ships and stations having a medical or dental officer.</td>
</tr>
<tr>
<td>514-B</td>
<td>Hematology</td>
<td>To request, report on, and record various subtests relative to a hematology examination. Staple to SF-514.</td>
<td>Ships and stations having a medical or dental officer.</td>
</tr>
<tr>
<td>514-C</td>
<td>S.T.S.</td>
<td>To request, report on, and record various subtests relative to a s.t.s. examination. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-D</td>
<td>Blood Chemistry</td>
<td>To request, report on, and record various subtests relative to blood chemical examination. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-E</td>
<td>Gastric Analysis</td>
<td>To request, report on, and record various subtests relative to a gastric analysis. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-F</td>
<td>Feces</td>
<td>To request, report on, and record various subtests relative to an examination of feces. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-H</td>
<td>Spinal Fluid</td>
<td>To request, report on, and record various subtests relative to an examination of spinal fluid. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-I</td>
<td>Renal Function</td>
<td>To request, report on, and record various subtests relative to an examination of renal function. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-K</td>
<td>Bacteriology</td>
<td>To request, report on, and record the findings of a bacteriological examination. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-L</td>
<td>Miscellaneous</td>
<td>To request, report on, and record laboratory examinations for which a specific form is unavailable or not provided. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-M</td>
<td>Blood Bank</td>
<td>To request, report on, and record various blood tests for grouping, typing, and titration. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-N</td>
<td>Special Chemistry</td>
<td>To request, report on, and record various special chemistry tests. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-P</td>
<td>Immunology</td>
<td>To request, report on, and record various immunological tests. Staple to SF-514.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>514-Q</td>
<td>Tissue Examination</td>
<td>To request, report on, and record various pathological report. Include in patient's clinical record.</td>
<td>Facilities providing inpatient care.</td>
</tr>
</tbody>
</table>

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**Comment:**

Ships and stations having a medical or dental officer. Facilities providing inpatient care.
### Standard Form No. | Title | Function | Using activities
--- | --- | --- | ---
517 | Anesthesia | To record in chart and narrative form the administration of an anesthetic, including a preoperative and postoperative review. Include in patient's clinical record. | Facilities providing inpatient care.
518 | Blood Transfusion | To record the elements involved in giving a blood transfusion to a patient, including certification, cross-matching, reaction, etc. Include in patient's clinical record. | Do.
519 | Radiographic Reports | To serve as a stapling sheet to hold radiographic reports. Include in patient's clinical record. | Do.
519A | Radiographic Report | To request, report on and record the results of a radiographic examination, staple to SF-619. | Do.
520 | Electrocardiographic Report | To record pertinent facts and results pertinent to an electrocardiographic examination. Include in patient's clinical record. | Do.
521 | Dental... | To obtain authorization for the administration of anesthetics for operations or other procedures, and the disposal of tissues or parts which may be removed. This is required for dependents, veterans, or other nonactive-duty military personnel but shall not be used for active-duty military personnel. Include in patient's clinical record. | Naval hospitals.
522 | Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures | To obtain authorization for the administration of anesthesia, the performance of operations or other procedures, and the disposal of tissues or parts which may be removed. This form is required for dependents, veterans, or other nonactive-duty military personnel but shall not be used for active-duty military personnel. Include in patient's clinical record. | Do.
523 | Authorization for Post Mortem... | To obtain authorization for performance of a post mortem examination and preservation and study of tissues or parts which may be removed. Include in patient's clinical record. | Do.
523B | Authorization for Tissue Donation | To provide a record of roentgen therapy treatments performed. Include in patient's clinical record. | See BUMEDINST 6406.4.
524 | Roentgen Therapy... | To provide a summary of roentgen therapy treatments performed. Include in patient's clinical record. | Naval hospitals.
525 | Roentgen Therapy Summary | To provide a record of roentgen therapy treatments performed. Include in patient's clinical record. | Do.
526 | Radium Therapy... | To provide a record of radium-therapy treatments performed. Include in patient's clinical record. | Do.
527 | Group Muscle Strength... | To record a group muscle strength examination including motion measurements. Include in patient's clinical record. | Do.
528 | Muscle Evaluation—Upper Extremity... | To record a muscle evaluation of the upper extremity. Include in patient's clinical record. | Do.
529 | Muscle Evaluation—Trunk, Lower Extremity, Face... | To record a muscle evaluation of the trunk, lower extremity, and face. Include in patient's clinical record. | Do.
530 | Neurological Examination... | To record neurological examination. Include in patient's clinical record. | Do.
531 | Sensory Examination... | To record a sensory examination, supercicial and deep. Include in patient's clinical record. | Do.
532 | Pneumothorax—Pneumoperitoneum... | To record a series of pneumothorax or pneumoperitoneum treatments. Include in patient's clinical record. | Do.
533 | Prenatal and Pregnancy... | To record prenatal and pregnancy examinations, including post histories and a complete physical examination. Include in patient's clinical record. | Do.
534 | Labor... | To record labor history and post partum examinations. Include in patient's clinical record. | Do.
535 | Newborn... | To provide a complete record for the newborn, including method of delivery, initial physical examination, condition upon discharge from hospital, and follow-up examinations. Include in patient's clinical record. | Do.
536 | Pediatric Nursing Notes... | To provide a complete continuous record, including family or contact history, record of immunization, past medical and surgical history, and education. Include in patient's clinical record. | Do.
537 | Pediatric Graphic Chart... | To provide a complete pediatric history, including family or contact history, record of immunization, past medical and surgical history, and education. Include in patient's clinical record. | Do.
538 | Pediatric... | To provide an abbreviated clinical record, including pertinent history, progress notes, doctor's orders, nurse's notes, and laboratory and radiographic reports. Include in patient's clinical record. | Do.
539 | Abbreviated Clinical Record... | To provide an abbreviated clinical record, including pertinent history, progress notes, doctor's orders, nurse's notes, and laboratory and radiographic reports. Include in patient's clinical record. | Do.
540 | Basal Metabolism... | To request, report on, and record the results of a basal metabolism test. Include in patient's clinical record. | Do.
541 | Chronological Record of Medical Care... | See arts. 16-44 through 16-48. | Naval hospitals, hospital ships, U.S. naval dispensaries, and selected station hospitals.
542 | Immunization Record... | See arts. 16-49 through 16-50. | Activities or units having Medical Department representative.
543 | Syphilis Record... | See arts. 16-52 through 16-53. | Do.
545 | Dental... | See art. 16-107. | Activities or units having a dental officer.
545A | Dental—Continuation... | Continuation sheet for SF-603. | Do.
## 23-217. Tabulation of Department of Defense Forms

<table>
<thead>
<tr>
<th>DD No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Report of Treatment Furnished Pay Patients, Hospitalization Furnished</td>
<td>See art. 21-33.</td>
<td>Stations furnishing inpatient treatment, and certain stations furnishing outpatient care to supernumeraries.</td>
</tr>
<tr>
<td>183</td>
<td>Medical Followup Card</td>
<td>To follow up patients having diseases or injuries of special professional interest. Not for routine use.</td>
<td>Medical or dental officers desiring followup information on patients transferred prior to completion of treatment or final disposition.</td>
</tr>
<tr>
<td>360</td>
<td>Request for Laboratory Analysis of Food</td>
<td>Self-explanatory</td>
<td>Activities having Medical Department representative.</td>
</tr>
<tr>
<td>408</td>
<td>Medical Officers, Professional Training Record</td>
<td>To record data for committees on eligibility for American specialty boards for evaluation of experience and training acquired by medical officers while serving in the Armed Forces.</td>
<td>Any medical officer, Regular or Reserve, on active duty.</td>
</tr>
<tr>
<td>443</td>
<td>Beds and Patients Report</td>
<td>See BUMEDINST 6320.8C</td>
<td>Hospitals, hospital ships, and activities having a station hospital or dispensary with authorized beds.</td>
</tr>
<tr>
<td>444</td>
<td>Outpatient Report</td>
<td>See BUMEDINST 6320.9D</td>
<td>Navy and Marine Corps activities or units providing outpatient medical care.</td>
</tr>
<tr>
<td>477</td>
<td>Dental Service Report</td>
<td>See art. 6-150.</td>
<td>Navy and Marine Corps activities or units having a dental officer.</td>
</tr>
<tr>
<td>571</td>
<td>Blood Identification Tag</td>
<td>For use in national emergency and when directed by the Bureau.</td>
<td>Armed services blood donor centers. Any blood collecting actively if desired.</td>
</tr>
<tr>
<td>572</td>
<td>Blood Donor Record Tag</td>
<td>For use in national emergency and when directed by the Bureau. May be used currently by any medical activity which collects blood, if directed.</td>
<td>Armed services blood donor centers.</td>
</tr>
<tr>
<td>572-1</td>
<td>Weekly Report of Bleedings</td>
<td>For use in national emergency and when directed by the Bureau. Specific reporting instructions will be issued under an appropriate report control symbol when reports are required.</td>
<td>Do.</td>
</tr>
<tr>
<td>573</td>
<td>Shipping Inventory of Blood Collections</td>
<td>For use in national emergency and when directed by the Bureau.</td>
<td>Naval hospitals, station hospitals, medical centers, and hospital ships providing inpatient care.</td>
</tr>
<tr>
<td>599</td>
<td>Patients Effects Storage Tag</td>
<td>For use in national emergency and when directed by the Bureau. Local control of personal effects retained in bag room. May serve as a signed receipt for clothing and effects returned to patient.</td>
<td>Navy and Marine Corps activities or units having a Medical Department representative. Do. Do.</td>
</tr>
<tr>
<td>600</td>
<td>Patient’s Baggage Tag</td>
<td>See BUMEDINST 6150.2</td>
<td>Dependents of naval personnel prior to embarkation.</td>
</tr>
<tr>
<td>602</td>
<td>Patient’s Identity Tag</td>
<td>Do.</td>
<td>Ships and stations.</td>
</tr>
<tr>
<td>625</td>
<td>Preembarkation Certificate</td>
<td>Statement by dependent personnel of their physical condition, recent illnesses, etc., to assist medical officer in determining physical fitness to undertake voyage.</td>
<td>Activities having Medical Department representative. Do.</td>
</tr>
<tr>
<td>675</td>
<td>Receipt for Records and Patient’s Property</td>
<td>See BUMEDINST 6320.11A</td>
<td>Do.</td>
</tr>
<tr>
<td>680</td>
<td>Bacteriological Examination of Water</td>
<td>Self-explanatory</td>
<td>Do.</td>
</tr>
<tr>
<td>689</td>
<td>Individual Sick Slip</td>
<td>See art. 16-70.</td>
<td>Do.</td>
</tr>
<tr>
<td>710</td>
<td>Physical and Chemical Analysis of Water</td>
<td>Self-explanatory</td>
<td>Do.</td>
</tr>
<tr>
<td>722</td>
<td>Health Record Jacket</td>
<td>To maintain Individual Health Records.</td>
<td>Naval hospitals, station hospitals, medical centers, and hospital ships providing inpatient care.</td>
</tr>
<tr>
<td>722-1</td>
<td>Dental Folder</td>
<td>See art. 6-106.</td>
<td>Navy and Marine Corps activities or units having a dental officer aboard.</td>
</tr>
<tr>
<td>737</td>
<td>DOD Immunization Certificate</td>
<td>Provides an immunization record which the individual carries.</td>
<td>Do.</td>
</tr>
<tr>
<td>739</td>
<td>Register of Patients</td>
<td>See art. 23-222.</td>
<td>Naval hospitals, station hospitals, medical centers, and hospital ships providing inpatient care.</td>
</tr>
<tr>
<td>771</td>
<td>Spectacle Order Form</td>
<td>Issued locally upon approval of prescribing officer or officer having approval authority to furnish spectacles.</td>
<td>Navy and Marine Corps activities or units having a medical officer or Medical Service Corps (Optometry) officer aboard.</td>
</tr>
</tbody>
</table>
### Tabulation of Department of Defense Forms—Continued

<table>
<thead>
<tr>
<th>DD No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>792</td>
<td>Nursing Service—Twenty-Four Hour Patient Intake Output Worksheet.</td>
<td>To maintain standardized records of patients' intake and output.</td>
<td>Naval hospitals, and station hospitals and dispensaries.</td>
</tr>
<tr>
<td>876</td>
<td>Request for Treponemal Immobilization Test for Syphilis.</td>
<td></td>
<td>Ships and stations having medical personnel.</td>
</tr>
<tr>
<td>877</td>
<td>Request for Medical/Dental Records and Other Information.</td>
<td>Self-explanatory. (See BUMEDINST 610.23.)</td>
<td>Ships and stations having medical/dental personnel.</td>
</tr>
<tr>
<td>1141</td>
<td>Record of Exposure to Ionizing Radiation.</td>
<td>See BUMEDINST 6150.18.</td>
<td>Navy and Marine Corps activities or units having a Medical Department representative.</td>
</tr>
<tr>
<td>1191</td>
<td>Warning Tag for Medical Oxygen Equipment.</td>
<td>See BUMEDINST 5100.1B.</td>
<td>Ships and stations having medical/dental personnel.</td>
</tr>
<tr>
<td>1231</td>
<td>Nonavailability Statement Dependents Medical Care Program.</td>
<td></td>
<td>Navy and Marine Corps activities or units, United States and Puerto Rico.</td>
</tr>
<tr>
<td>1299</td>
<td>Department of Defense Prescription Form.</td>
<td>Title explanatory.</td>
<td>Activities having officers of the Medical and Dental Corps and civilian physicians.</td>
</tr>
<tr>
<td>1322</td>
<td>Aircraft Accident Autopsy Report.</td>
<td></td>
<td>Ships and stations having a medical officer.</td>
</tr>
<tr>
<td>1323</td>
<td>Toxological Examination—Request and Report.</td>
<td>do.</td>
<td>Do.</td>
</tr>
</tbody>
</table>

See BUMEDINST 6222.58 for ships and stations having medical/dental personnel.

See SECNAV INST G320.8A for Navy and Marine Corps activities or units, United States and Puerto Rico.

See NAVMED P-3065, Autopsy Manual, for activities having officers of the Medical and Dental Corps and civilian physicians.

Ships and stations having a medical officer.

Do.
23–218. NAVMED–S, Binnacle List

(1) NAVMED–S shall be prepared by the senior representative of the Medical Department on board and submitted to the commanding officer by 0930 daily. The form shall contain a list of all those recommended to be excused from duty because of illness. The list must be approved by the commanding officer, and no names may be added without his permission.

(2) When it is considered necessary to excuse a man from duty after the Morning Report of Sick has been submitted, his name shall be added to the Binnacle List; and the appropriate report shall be submitted to the commanding officer. If the man still is unfit for duty when the next Morning Report of Sick is submitted, his name shall be added thereto as of the date on which his name was first entered on the Binnacle List.

(3) Names shall not be omitted from NAVMED–T because a satisfactory diagnosis cannot be established. Such cases shall be noted as “Diagnosis Undetermined (Observation)” or with the name of the chief complaint. Cases of malingering shall be reported to the commanding officer and entered in the Report Book.

Note.—There is no article 23–220.


(1) NAVMED–T shall be prepared by the senior representative of the Medical Department on board and submitted to the commanding officer by 1000 daily. The form shall contain a list of the sick to include names, diagnoses, and conditions.

(2) When it is considered necessary to excuse a man from duty after the Morning Report of Sick has been submitted, his name shall be added to the Binnacle List; and the appropriate report shall be submitted to the commanding officer. If the man still is unfit for duty when the next Morning Report of Sick is submitted, his name shall be added thereto as of the date on which his name was first entered on the Binnacle List.

(3) Names shall not be omitted from NAVMED–T because a satisfactory diagnosis cannot be established. Such cases shall be noted as “Diagnosis Undetermined (Observation)” or with the name of the chief complaint. Cases of malingering shall be reported to the commanding officer and entered in the Report Book.

Note.—There is no article 23–220.

23–221. NAVMED–HF–38, Burial Record

(1) Each naval hospital shall maintain a Burial Record on a current basis and in as complete detail as possible. The names of all deceased personnel shall be entered in the forward section of the Burial Record upon disposition of the remains by the hospital.

(2) For cross-reference purposes, the names of deceased personnel also shall be entered in full under the appropriate alphabetical heading at the rear of the volume.

(3) The Burial Record shall be retained within the hospital to provide a permanent, chronological record of the disposition of the remains of deceased personnel by the activity.

23–222. DD Form 739, Register of Patients

(1) Each naval medical activity providing inpatient care shall maintain a Register of Patients on a current basis. A separate Register shall be established for each calendar year with register numbers continued from the previous Register. It shall include all patients (i.e., military dependents, etc.) admitted to the activity during the year. In addition, each infant born in a naval medical facility shall be recorded in both sections of the Register in the same space and above the mother's name. The infant's name, sex, and date and time of birth shall be entered within 24 hours after birth. A register number shall not be assigned to such infants. However, when the infant is retained as a patient after the mother is discharged, or when the infant is admitted as a patient subsequent to the mother's discharge, a separate entry shall be made on the Register and a register number assigned. The infant shall not be included in the patient census unless hospitalized without the mother.

(2) The Register shall consist of two sections, one numeric and one alphabetic, both to be maintained on DD Form 739. Each section shall be maintained in a suitable binder entitled “Sec. I—Numeric” and “Sec. II—Alphabetic,” respectively. In addition, the alphabetic section shall be divided by alphabetic index guides. To facilitate reference to the alphabetic section of the Register, alphabetic index tabs with 80 or more breakdowns are preferable, depending on the number of patients normally admitted to the activity during any one calendar year. The alphabetic index (e.g., Aa, Am, B, etc.) shall be entered in the block entitled “Alphabetic Index or Page Number” on the alphabetic section of the Register. The page number shall be entered in this block only on the numeric section of the Register.

(3) Upon admission, the name of each patient shall be entered in the numeric section of the Register. Register numbers shall be assigned in consecutive order. In all instances where an individual is readmitted, a new register number shall be assigned. This section of the Register provides a control on the assignment of register numbers to insure that numbers are assigned in sequence and to preclude assignment of the same number to more than one individual admitted to the activity. In addition, it provides a ready reference for identifying patients when only the register number is known.

(4) The name of each patient entered in the numeric section of the Register shall also be entered in full, together with the register number, alphabetically by last name in the alphabetic section of the Register. This section of the Register is intended primarily as a finding media for use by the Records Management Center when the clinical records are retired to that activity. Accordingly, all entries shall be typewritten using a black ribbon, or neatly printed in block letters in black ink.

Note.—There is no article 23–223.

23–224. NAVMED–210, Emergency Medical Tag

(1) NAVMED–210 is designed to serve as a record of the admission, treatment, and disposition of a
patient, including death, for use during combat or other emergency conditions under which it is impractical to prepare the forms normally prescribed. However, NAVMED-210 shall never be considered as a substitute for the normally prescribed forms when they are available.

Section III. RECORDS MAINTAINED ON OTHER THAN STANDARDIZED FORMS

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-250</td>
<td>General</td>
</tr>
<tr>
<td>23-253</td>
<td>Narcotic Book</td>
</tr>
<tr>
<td>23-254</td>
<td>Drug Book</td>
</tr>
</tbody>
</table>

23-250. General

(1) The records listed in the following articles shall be maintained by the prescribed activities or units in addition to those listed in other parts of this Manual. They shall be maintained in book or log form and in sufficient detail to serve as a complete and permanent historical record of the actions, incidents and data recorded therein.

Note.—There are no articles 23-251 and 23-252.

23-253. Narcotic Book

(1) The medical or dental officer or nurse in charge of each ward and other narcotic dispensing units of all Medical Department activities providing inpatient care shall maintain a record of all narcotics dispensed. Each entry shall include the date, the patient’s name, the drug, the dose, the time given, by whom given and the name of the doctor ordering the narcotic.

(2) The Narcotic Book shall be summarized at regular intervals to include the quantities remaining at last report, the quantities drawn from the pharmacy and the amount expended since the last report. The Narcotic Book and the summaries thereof shall be subject to inspection at any time in accordance with local directives.

23-254. Drug Book

(1) A Drug Book shall be maintained by the nurse or corpsman in charge of each ward and other drug-expending units of all Medical Department activities providing inpatient care. The Drug Book shall serve as a permanent and continuing record of all drugs expended, other than narcotics, sedatives, and alcohol routinely used.

(2) The date, drug and quantity required shall be entered by the cognizant nurse or corpsman each morning; and each entry shall be signed by the cognizant medical or dental officer. The book and any required prescriptions then shall be forward to the pharmacy as an order for the required items.

Note.—There are no articles 23-255 through 23-299.

Note.—There are no pages 23-20 through 23-54.
23-214. General Statement

(1) The Bureau has promulgated certain lettered and numbered forms which are designed to facilitate reporting, recordkeeping, and administrative efficiency throughout the Medical Department. These forms are tabulated in article 23-215.

(2) For purposes of identification and control, all Medical Department forms have been assigned a letter or number. All correspondence referring to a Medical Department or Standard Federal form should cite its correct letter or number and title.

(3) The Bureau also maintains administrative control over the use of certain Standard Federal forms in the Medical Department. These forms are promulgated by the Bureau of the Budget to facilitate the exchange of medical information throughout the Federal Government. These forms are tabulated in article 23-216.

23-215. Tabulation of Medical Department Forms

<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Report of Board of Medical Survey</td>
<td>See art. 15-12</td>
<td>Navy and Marine Corps activities or units having a medical officer. Do.</td>
</tr>
<tr>
<td>Ma</td>
<td>Report of Board of Medical Survey (following sheet)</td>
<td>do</td>
<td>Navy and Marine Corps activities or units having a Medical Department representative. Do.</td>
</tr>
<tr>
<td>N</td>
<td>Certificate of Death</td>
<td>See ch. 17</td>
<td>Naval hospitals, activities having station hospitals, and capital ships.</td>
</tr>
<tr>
<td>P</td>
<td>Report of Surgical Operations</td>
<td>See art. 23-12</td>
<td>Navy and Marine Corps activities or units having a Medical Department representative. Do.</td>
</tr>
<tr>
<td>S</td>
<td>Binnacle List</td>
<td>See art. 23-218</td>
<td>Navy and Marine Corps activities or units having a representative of the Medical Department, or in the absence of such by the senior officer present or the person concerned.</td>
</tr>
<tr>
<td>T</td>
<td>Morning Report of Sick</td>
<td>See art. 23-219</td>
<td>Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.</td>
</tr>
<tr>
<td>U</td>
<td>Report of Medical Treatment, Hospitaliza-</td>
<td>See art. 20-7</td>
<td>Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.</td>
</tr>
<tr>
<td></td>
<td>tion, and Allied Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF-23</td>
<td>Baggage Record Card</td>
<td>For control of baggage in bagroom</td>
<td></td>
</tr>
<tr>
<td>NAVMED No.</td>
<td>Title</td>
<td>Function</td>
<td>Using activities</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23-215</td>
<td>Tabulation of Medical Department Forms—Continued</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1F-38      | Burial Record                                                        | See art. 23-221                                                                               | Naval hospitals.  
| 9          | Ward Report                                                          | Daily report of patients to personnel and records division, including occupancy and transfer data. | Activities providing inpatient care.  
| 10         | Sick Call Treatment Record                                          | To record sick-call treatments furnished.                                                   | Medical Department activities and facilities.  
| 18         | Diet Sheet                                                           | Specifies proper diets for patients as prescribed by a medical officer. Utilized by diet kitchen and ward nurse. | Naval hospitals, hospital ships, station hospitals, and dispensaries providing inpatient care.  
| 20         | Liberty List                                                         | Fully sheet of personnel on liberty, including name, rate, and time.                        | Naval hospitals, hospital ships, dispensaries providing inpatient care, and other Medical Department activities ashore.  
| 21         | Laundry List                                                         | To itemize laundry by wards for inventory purposes.                                         | Medical Department activities and facilities.  
| 26         | Ration Record                                                       | Used locally as a notice to the Records Office to supply "F" Card information.               | Naval hospitals and medical units functioning in hospitals of other Government agencies.  
| 58         | Notice of Change in Diagnosis                                       | Used by officers of an activity to request repairs by local force.                          | Naval hospitals, hospital ships, and station hospitals.  
| 63         | Request for Repairs                                                 | Local schedule of operations to be performed, including patient, doctor, anesthetist, and time of operation. | Activities under Bureau management control.  
| 64         | Operations Scheduled                                                |                                               | Naval hospitals, hospital ships, and station hospitals.  
| 98         | Research Project Form                                               | See art. 1-14                                                                                | Naval medical activities conducting research.  
| 102        | Neuropsychiatric Report                                             | See art. 23-17                                                                               | Naval hospitals, hospital ships, and medical units functioning in hospitals of other Government agencies.  
| 148        | Prescription Form                                                   | Title explanatory                                                                              | Activities having a medical or dental officer on board.  
| 199*       | U.S. Navy Aviation Qualification Test—Answer Sheet                  | See BUMEDINST 132-1B                                                                         | Ships and stations having a flight surgeon or an aviation medical examiner and Navy recruiting stations, Marine Corps recruiting stations, and Marine Aviation Cadet Offices and Marine Corps Officer Selection Offices, having personnel qualified to administer the Naval Officer Qualification Test.  
| 200*       | U.S. Navy Biographical Inventory—Answer Sheet                       | do                                                                                           | Do.  
| 210        | Emergency Medical Tar                                               | See art. 23-224                                                                              | Navy and Marine Corps activities or units having a representative of the Medical Department.  
| 576        | Occupational Health Data Sheet                                       | See art. 23-21                                                                               | Naval activities employing 300 or more civilians.  
| 601        | Report of Burial                                                   | See art. 17-9A                                                                               | Officer in charge of burial at sea or burial or reburial ashore beyond the continental limits of the United States.  
| 609        | Report of Disposition and Expenditures—Remains of Dead             | See art. 17-9B                                                                               | Navy and Marine Corps activities or units having a Medical Department representative.  
| 618        | Photofluorographic Chest Survey                                     | See art. 15-30                                                                               | Naval shore activities having photofluorographic facilities.  
| 703*       | Certificate of Special Instruction—Hospital Corps—USN.              | Certificate of graduation from a Hospital Corps school of special instruction.                | Medical Department activities conducting specialized courses for Hospital Corps personnel.  
| 704*       | Certificate of Graduation—Hospital Corps School                      | Certificate of graduation from a Hospital Corps school.                                      | Hospital Corps schools designated by the Bureau.  
| 816        | Report of Decompression Sickness and All Diving Accidents           |                                               | Naval activities having diving facilities.  
| 902        | Prosthetic Case Record                                              |                                               | Do.  
| 1048       | Report on Interns and Internships                                   |                                               | Dental activities having prosthetic facilities.  
| 1161       | Photofluorographic Log                                              | do                                                                                            | Continental naval hospitals and medical units functioning in hospitals of other Government agencies.  
| 1161a      | Photofluorographic Log (following sheet)                            | A summary of medical findings and treatment of gastrointestinal illness.                      | Shore activities having photofluorographic facilities.  
| 1198       | Case History—Gastrointestinal Illness                              |                                               | Do.  

*Stocked in the Bureau.
<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1174</td>
<td>Ophthalmic Dispensing and Refraction Report.</td>
<td>See BUMEDINST 6810.3A</td>
<td>Spectacle dispensing units, ophthalmic service units, ophthalmic lens laboratories, and activities performing or ordering eye refractions for military members or their dependents.</td>
</tr>
<tr>
<td>1178</td>
<td>Diseases and Operations Index Card</td>
<td>Provides detailed case references for medical research.</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1265</td>
<td>Admission Record</td>
<td>To provide a standard set of admission cards offering complete coverage of admission data required of any patient.</td>
<td>Naval hospitals, hospital ships, and station hospitals providing inpatient care.</td>
</tr>
<tr>
<td>1266</td>
<td>Staff Locator</td>
<td>To provide a ready location reference to staff personnel—military and civilian.</td>
<td>Naval hospitals and hospital ships.</td>
</tr>
<tr>
<td>1293</td>
<td>Transcript of Intern Service</td>
<td>Detailed record of satisfactory service completed in the various departments attended by a medical intern while undergoing training.</td>
<td>Naval hospitals approved for medical intern training.</td>
</tr>
<tr>
<td>1298</td>
<td>Dental Appointments, Daily</td>
<td>See art. 6-150.</td>
<td>Activities having a dental officer.</td>
</tr>
<tr>
<td>1299</td>
<td>Dental Examination and Treatment Record</td>
<td>See art. 6-154.</td>
<td>Activities having dental prosthetic facilities.</td>
</tr>
<tr>
<td>1300</td>
<td>Precious Metal Issue Record</td>
<td>See art. 6-155.</td>
<td>Advanced Hospital Corps schools.</td>
</tr>
<tr>
<td>1301</td>
<td>Statement and Inventory of Precious and Special Dental Metals</td>
<td>See art. 6-156.</td>
<td>Naval training centers, Marine Corps recruit depots and other designated stations.</td>
</tr>
<tr>
<td>1305*</td>
<td>Certificate of Graduation—Advanced Hospital Corps School</td>
<td>Certification of graduation from an advanced Hospital Corps School.</td>
<td>Ships and stations having a flight surgeon.</td>
</tr>
<tr>
<td>1317</td>
<td>Psychiatric Unit Report</td>
<td>See BUMEDINST 6810.3A</td>
<td>Continental naval hospitals.</td>
</tr>
<tr>
<td>13261</td>
<td>Aviation Medicine Residency Quarterly Report.</td>
<td>See BUMEDINST 6243A</td>
<td>Do.</td>
</tr>
<tr>
<td>1338</td>
<td>Annual Tuberculin Retesting Report</td>
<td>See art. 23-42.</td>
<td>Air commands designated by the Bureau.</td>
</tr>
<tr>
<td>1341</td>
<td>Quarterly Report of Medical Officer Personnel.</td>
<td>Control of Health Records released from file. (See art. 16-16.)</td>
<td>Ships stations.</td>
</tr>
<tr>
<td>1345</td>
<td>Health Record Receipt, File Charge-Out and Disposition Record.</td>
<td>See arts. 16-98 through 16-60.</td>
<td>Activities having a medical officer.</td>
</tr>
<tr>
<td>1346</td>
<td>Health Record Special Duty Medical Abstract.</td>
<td>See BUMEDINST 6300.1A</td>
<td>Activities having annual Navy contracts for care of dead.</td>
</tr>
<tr>
<td>1347</td>
<td>Request for Reimbursement or Payment of Interim Expenses</td>
<td>Serves as ready identification of food-service workers who have been trained in accordance with SECNAV instructions.</td>
<td>Naval aviation activities utilizing aviation physiology training equipment for training purposes.</td>
</tr>
<tr>
<td>1349*</td>
<td>Aviation Physiology Training Report</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>1350</td>
<td>Nursing Care Plan</td>
<td>For recording recurring medications, treatments, tests, consultations, nursing measures, and patient identification.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1352</td>
<td>Personnel Tabulating Card—Brown Band</td>
<td>See BUMEDINST 6300.1B</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1352A</td>
<td>Personnel Tabulating Card—Red Band</td>
<td>Do.</td>
<td>Do.</td>
</tr>
<tr>
<td>1353</td>
<td>Hospital Staffing Report</td>
<td>Do.</td>
<td>Do.</td>
</tr>
<tr>
<td>1353A</td>
<td>Expense Account Data Sheet</td>
<td>Do.</td>
<td>U.S. naval dispensaries, continental activities having station hospitals or dispensaries, and extracontinental activities having station hospitals or dispensaries with authorized beds.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau.
†Stocked in the Bureau and by U.S. Naval School of Aviation Medicine, Naval Aviation Medical Center, Pensacola, Fla.

Change 9
### Tabulation of Medical Department Forms—Continued

<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1386*</td>
<td>Washington Area Directory Information Card.</td>
<td>Distributed annually to Medical Department officers re data for the Directory of Officers of the Medical Department on duty in Washington, D.C., and vicinity.</td>
<td>All Medical Department officers in Washington, D.C., and vicinity.</td>
</tr>
<tr>
<td>1389</td>
<td>Ward Data Record</td>
<td>To record changes occurring on the ward over a 24-hour period.</td>
<td>Naval hospitals and station hospitals.</td>
</tr>
<tr>
<td>1384</td>
<td>Cash-Service Journal</td>
<td>To provide estimates of budgetary requirements each fiscal year.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1385</td>
<td>Collection Agent Ledger</td>
<td>To furnish instant information as to medication and treatments due or about to become due.</td>
<td>Do.</td>
</tr>
<tr>
<td>1386</td>
<td>Collection Agents Receipt</td>
<td>To furnish information as to medication and treatment which can be given as needed.</td>
<td>Do.</td>
</tr>
<tr>
<td>1387</td>
<td>Night Report</td>
<td>See BUMEDINST 6010.2C.</td>
<td>Naval hospitals and medics.</td>
</tr>
<tr>
<td>1388</td>
<td>Report of Collection Agent Accountability</td>
<td>To provide estimates of budgetary requirements each fiscal year.</td>
<td>Do.</td>
</tr>
<tr>
<td>1389</td>
<td>General Journal</td>
<td>To furnish information as to medication and treatments due or about to become due.</td>
<td>Naval hospitals and stations hospitals.</td>
</tr>
<tr>
<td>1392</td>
<td>Estimate of Budgetary Requirements</td>
<td>To provide estimates of budgetary requirements each fiscal year.</td>
<td>Naval activities holding BUMED allotments.</td>
</tr>
<tr>
<td>1388</td>
<td>Medication and Treatment Card</td>
<td>To furnish instant information as to medication and treatments due or about to become due.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1394</td>
<td>Medication and Treatment Card, P.R.N.</td>
<td>To furnish information as to medication and treatment which can be given as needed.</td>
<td>Do.</td>
</tr>
<tr>
<td>1396</td>
<td>Open Purchase High-Dollar Items</td>
<td>See BUMEDINST 6700.30R.</td>
<td>Naval hospitals, continental.</td>
</tr>
<tr>
<td>1397</td>
<td>Dental Appointments</td>
<td>Patient's record of dental appointments.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1398</td>
<td>Grounding Notice (Aeroomedical)</td>
<td>See BUMEDINST 6100.2.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1393</td>
<td>Posting Advice</td>
<td>To provide a summary of educational and nursing experience.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1394</td>
<td>Professional Education Summary</td>
<td>To obtain personal and professional references incident to appointment in the Nurse Corps, U.S.N.</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1395</td>
<td>Inquiry—School of Nursing</td>
<td>To obtain personal and professional references incident to appointment in the Nurse Corps, U.S.N.</td>
<td>U.S. Navy Nurse Corps officers.</td>
</tr>
<tr>
<td>1396</td>
<td>Voucher Register</td>
<td>To obtain personal and professional references incident to appointment in the Nurse Corps, U.S.N.</td>
<td>U.S. Navy Nurse Corps officers.</td>
</tr>
<tr>
<td>1398</td>
<td>Financial Performance Record</td>
<td>Provides financial performance and operating cost data.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1399</td>
<td>Morbidity Report</td>
<td>See BUMEDINST 6310.4.</td>
<td>Naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1391*</td>
<td>Shipboard Pest Control Training Certificate</td>
<td></td>
<td>Ship and stations having a dental officer.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau.
### CHAPTER 23. REPORTS, FORMS, AND RECORDS

#### 23-215. Tabulation of Medical Department Forms—Continued

<table>
<thead>
<tr>
<th>NAVMED No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1394*</td>
<td>Linen Inventory Sheet</td>
<td>See BUMEDINST 6700.2</td>
<td>Naval hospitals.</td>
</tr>
<tr>
<td>1395</td>
<td>Modification of Allotment Request</td>
<td>See BUMEDINST 7303.5B</td>
<td>BUMED allotment holders except naval hospitals and medical centers.</td>
</tr>
<tr>
<td>1400 A*</td>
<td>Aviation Qualification Test, Form 1</td>
<td>See BUMEDINST 1521.1B</td>
<td>Ships and stations having a flight surgeon or an aviation medical examiner; and Navy recruiting stations, Marine Corps recruiting stations, and Marine Aviation Cadet Offices and Marine Corps Officer Selection Offices, having personnel qualified to administer the Naval Officer Qualification Test.</td>
</tr>
<tr>
<td>1400-B*</td>
<td>Aviation Qualification Test, Form 2</td>
<td>do</td>
<td>do</td>
</tr>
<tr>
<td>1401 F*</td>
<td>Mechanical Comprehension Test, Form 6</td>
<td>do</td>
<td>do</td>
</tr>
<tr>
<td>1401-G*</td>
<td>Mechanical Comprehension Test, Form 7</td>
<td>do</td>
<td>do</td>
</tr>
<tr>
<td>1402 A*</td>
<td>Spatial Apperception Test, Form 1</td>
<td>do</td>
<td>do</td>
</tr>
<tr>
<td>1402-B*</td>
<td>Spatial Apperception Test, Form 2</td>
<td>do</td>
<td>do</td>
</tr>
<tr>
<td>1403-D*</td>
<td>Biographical Inventory, Form 4</td>
<td>do</td>
<td>do</td>
</tr>
<tr>
<td>1405*</td>
<td>Photofluorographic Equipment</td>
<td>To provide condition and usage data (see art. 23-44)</td>
<td>do.</td>
</tr>
</tbody>
</table>

*Stocked in the Bureau.
# 23-216. Tabulation of Standard Federal Medical Forms

<table>
<thead>
<tr>
<th>Standard Form No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>Report of Medical Examination</td>
<td>See ch. 15</td>
<td>Ships and stations having a medical or dental officer.</td>
</tr>
<tr>
<td>89</td>
<td>Report of Medical History</td>
<td>do</td>
<td>Ships and stations having a medical officer.</td>
</tr>
<tr>
<td>501</td>
<td>Diagnostic Summary</td>
<td>To record summaries of clinical diagnosis, therapeutic procedures, pathological diagnosis, and other factors of clinical interest, including causes of death. Include one copy in the patient's clinical record. One copy may be included in the Health Record in lieu of written summary on SF 600. To summarize the salient facts regarding a patient's hospitalization. Include one copy in the patient's clinical record. One copy may be included in the Health Record in lieu of written summary on SF 600.</td>
<td>Facilities providing inpatient care.</td>
</tr>
<tr>
<td>502</td>
<td>Narrative Summary</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>503</td>
<td>Autopsy Protocol</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>504</td>
<td>History—Part 1</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>505</td>
<td>History—Parts 2 and 3</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>506</td>
<td>Physical Examination</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>507</td>
<td>Consultation Sheet</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>508</td>
<td>Doctor's Orders</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>509</td>
<td>Doctor's Progress Notes</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>510</td>
<td>Nursing Notes</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>511</td>
<td>Temperature—Pulse Respiration (Fahrenheit)</td>
<td>To record temperature, pulse, and respiration observations and other data. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>512</td>
<td>Floating Chart</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>513</td>
<td>Consultation Sheet</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>514</td>
<td>Laboratory Reports</td>
<td>To serve as a stapling sheet to hold laboratory report forms. Include in patient's clinical record.</td>
<td>Activities having laboratory facilities and providing inpatient care.</td>
</tr>
<tr>
<td>514-A</td>
<td>Urinalysis</td>
<td>To request, report on, and record various subtests relative to a urinalysis examination. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-B</td>
<td>Hematology</td>
<td>To request, report on, and record various subtests relative to a hematology examination. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-C</td>
<td>S.T.S.</td>
<td>To request, report on, and record various subtests relative to a serology examination for syphilis. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-D</td>
<td>Blood Chemistry</td>
<td>To request, report on, and record various subtests relative to blood chemistry. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-F</td>
<td>Gastric Analysis</td>
<td>To request, report on, and record various subtests relative to a gastric analysis. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-G</td>
<td>Feces</td>
<td>To request, report on, and record various subtests relative to an examination of feces. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-H</td>
<td>Spinal Fluid</td>
<td>To request, report on, and record various subtests relative to an examination of spinal fluid. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-I</td>
<td>Basal Metabolism</td>
<td>To request, report on, and record clinical data and findings in regard to basal metabolism. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-K</td>
<td>Bacteriology</td>
<td>To request, report on, and record the findings of a bacteriological examination. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-L</td>
<td>Renal Function</td>
<td>To request, report on, and record various subtests relative to examination of specimen in regard to renal function. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-M</td>
<td>Miscellaneous</td>
<td>To request, report on, and record laboratory examinations for which a specific form is unavailable or not provided. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-N</td>
<td>Blood Bank</td>
<td>To request, report on, and record various blood tests for grouping, typing, and titer. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-P</td>
<td>Special Chemistry</td>
<td>To request, report on, and record various special chemistry tests. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>514-Q</td>
<td>Immunology</td>
<td>To request, report on, and record various immunological tests. Staple to SF-514.</td>
<td>Do.</td>
</tr>
<tr>
<td>Standard Form No.</td>
<td>Title</td>
<td>Function</td>
<td>Using activities</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>515</td>
<td>Tissue Examination</td>
<td>To record facts pertaining to the examination of a tissue specimen, including a pathological report. Include in patient's clinical record.</td>
<td>Activities having laboratory facilities and providing inpatient care. Facilities providing inpatient care. Do.</td>
</tr>
<tr>
<td>516</td>
<td>Operation Report</td>
<td>To record pertinent and identifying data regarding a patient's operation. Include in the patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>517</td>
<td>Anesthesia</td>
<td>To record in chart and narrative form the administration of an anesthesia, including a preoperative and postoperative review. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>518</td>
<td>Blood Transfusion</td>
<td>To record the elements involved in giving a blood transfusion to a patient, including certification, cross-matching, reaction, etc. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>519</td>
<td>Radiographic Reports</td>
<td>To serve as a stapling sheet to hold radiographic reports. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>51A</td>
<td>Radiographic Report</td>
<td>To request, report on and record the results of a radiographic examination. Staple to SF-519.</td>
<td>Do.</td>
</tr>
<tr>
<td>520</td>
<td>Electrocardiographic Record</td>
<td>To record pertinent facts and results pertinent to an electrocardiographic examination. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>521</td>
<td>Dental</td>
<td>To record findings of a dental examination, treatment indicated, and treatment rendered. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>522</td>
<td>Authorization for Administration of Anesthetics and for Performance of Operations and Other Procedures</td>
<td>To obtain authorization for the administration of anesthetics, the performance of operations or other procedures, and the disposal of tissues or parts which may be removed. This form is required for dependents, veterans, or other non-active-duty military personnel but shall not be used for active-duty military personnel. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>523</td>
<td>Authorization for Post Mortem</td>
<td>To obtain authorization for performance of a post mortem examination and preservation and study of tissues or parts which may be removed. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>524</td>
<td>Roentgen Therapy</td>
<td>To provide a record of roentgen therapy treatments performed. Include in patient's clinical record.</td>
<td>Facilities providing inpatient care. Do.</td>
</tr>
<tr>
<td>525</td>
<td>Roentgen Therapy Summary</td>
<td>To provide a summary of roentgen therapy treatments performed. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>526</td>
<td>Radium Therapy</td>
<td>To provide a record of radium-therapy treatments performed. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>527</td>
<td>Group Muscle Strength</td>
<td>To record a group muscle strength examination including motion measurements. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>528</td>
<td>Muscle Evaluation—Upper Extremity</td>
<td>To record a muscle evaluation of the upper extremity. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>529</td>
<td>Muscle Evaluation—Trunk, Lower Extremity, Face</td>
<td>To record a muscle evaluation of the trunk, lower extremity, and face. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>530</td>
<td>Neurological Examination</td>
<td>To record neurological examination. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>531</td>
<td>Sensory Examination</td>
<td>To record a sensory examination, superficial and deep. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>532</td>
<td>Pneumothorax—Pneumoperitoneum</td>
<td>To record a series of pneumothorax or pneumoperitoneum treatments. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>533</td>
<td>Prenatal and Pregnancy</td>
<td>To record prenatal and pregnancy examinations, including past histories and a complete physical examination. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>534</td>
<td>Labor</td>
<td>To record labor history and post partum examinations. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>535</td>
<td>Newborn</td>
<td>To provide a complete record for the newborn, including method of delivery, initial physical examination, condition upon discharge from hospital, and follow-up examinations. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>536</td>
<td>Pediatric Nursing Notes</td>
<td>To record pediatric nursing notes. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>537</td>
<td>Pediatric Graphic Chart</td>
<td>To picture certain phases of a newborn's hospitalization in graphic form. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>538</td>
<td>Pediatric</td>
<td>To provide a complete pediatric history, including family or contact history, record of immunization, past medical and surgical history, and education. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>539</td>
<td>Abbreviated Clinical Record</td>
<td>To provide an abbreviated clinical record, including pertinent history, progress notes, doctor's orders, nurse's notes, and laboratory and radiographic reports. Include in patient's clinical record.</td>
<td>Do.</td>
</tr>
<tr>
<td>600</td>
<td>Chronological Record of Medical Care</td>
<td>See arts. 16-44 through 16-48...</td>
<td>Activities or units having Medical Department representative.</td>
</tr>
<tr>
<td>601</td>
<td>Immunation Record</td>
<td>See arts. 16-49 through 16-51...</td>
<td>Do.</td>
</tr>
<tr>
<td>602</td>
<td>Syphilis Record</td>
<td>See arts. 16-52 through 16-53...</td>
<td>Do.</td>
</tr>
<tr>
<td>603</td>
<td>Dental</td>
<td>See art. 6-107.</td>
<td>Activities or units having a dental officer. Do.</td>
</tr>
<tr>
<td>603A</td>
<td>Dental—Continuation</td>
<td>Continuation sheet for SF-603...</td>
<td>Do.</td>
</tr>
</tbody>
</table>

23-48

Change 9
### 23-216A. Tabulation of Department of Defense Forms

<table>
<thead>
<tr>
<th>DD No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Report of Treatment Furnished Pay Patients, Hospitalization Furnished.</td>
<td>See art. 21-33...</td>
<td>Medical Department activities providing inpatient care and extracranial activities providing outpatient care to certain supernumeraries as specified by the Bureau. Medical or dental officers desiring follow-up information on patients transferred prior to completion of treatment or final disposition. Activities having Medical Department representative.</td>
</tr>
<tr>
<td>183</td>
<td>Medical Followup Card</td>
<td>To follow up patients having diseases or injuries of special professional interest. Not for routine use. Self-explanatory.</td>
<td>Any medical officer, Regular or Reserve, on active duty.</td>
</tr>
<tr>
<td>409</td>
<td>Request for Laboratory Analysis of Food.</td>
<td>To record data for committees on eligibility for American specialty boards or evaluation of experiences and training acquired by medical officers while serving in the Armed Forces.</td>
<td>Hospitals, hospital ships, and activities having a station hospital or dispensary with authorized beds.</td>
</tr>
<tr>
<td>408</td>
<td>Medical Officers, Professional Training Record.</td>
<td></td>
<td>Navy and Marine Corps activities or units providing outpatient medical care.</td>
</tr>
<tr>
<td>443</td>
<td>Beds and Patients Report.</td>
<td>See BUMEDINST 6520.8C.</td>
<td>Navy and Marine Corps activities or units having a dental officer. Do.</td>
</tr>
<tr>
<td>444</td>
<td>Outpatient Report.</td>
<td>See BUMEDINST 6520.9C.</td>
<td>Armed services blood donor centers.</td>
</tr>
<tr>
<td>477</td>
<td>Dental Service Report.</td>
<td>See art. 6-150.</td>
<td>Armed services blood donor centers. Any blood collecting activity if desired.</td>
</tr>
<tr>
<td>571</td>
<td>Blood Identification Tag.</td>
<td>For use in national emergency and when directed by the Bureau. For use in national emergency and when directed by the Bureau, May be used currently by any medical activity which collects blood, if desired.</td>
<td>Navy and Marine Corps activities or units providing outpatient medical care.</td>
</tr>
<tr>
<td>572</td>
<td>Blood Donor Record Card.</td>
<td></td>
<td>Armed services blood donor centers.</td>
</tr>
<tr>
<td>572-1</td>
<td>Weekly Report of Bleedings.</td>
<td>For use in national emergency and when directed by the Bureau. Specific reporting instructions will be issued under an appropriate report control symbol when reports are required.</td>
<td>Armed services blood donor centers.</td>
</tr>
<tr>
<td>573</td>
<td>Shipping Inventory of Blood Collections.</td>
<td>For use in national emergency and when directed by the Bureau.</td>
<td>Naval hospitals, station hospitals, medical centers, and hospital ships providing inpatient care.</td>
</tr>
<tr>
<td>300</td>
<td>Patients Effects Storage Tag.</td>
<td>Local control of personal effects retained in bag room. May serve as a signed receipt for clothing and effects returned to patient.</td>
<td>Navy and Marine Corps activities or units having a Medical Department representative. Do.</td>
</tr>
<tr>
<td>401</td>
<td>Patient Evacuation Manifest.</td>
<td>do.</td>
<td>Do.</td>
</tr>
<tr>
<td>402</td>
<td>Patient's Identity Tag.</td>
<td>do.</td>
<td>Dependents of naval personnel prior to embarkation.</td>
</tr>
<tr>
<td>605</td>
<td>Preembarkation Certificate.</td>
<td>Statement by dependent personnel of their physical condition, recent illnesses, etc., to assist medical officer in determining physical fitness to undertake voyage.</td>
<td>Stations, continental United States.</td>
</tr>
<tr>
<td>675</td>
<td>Receipt for Records and Patient's Property.</td>
<td>See BUMEDINST 6520.11A.</td>
<td>Activities having Medical Department representative.</td>
</tr>
<tr>
<td>686</td>
<td>Bacteriological Examination of Water.</td>
<td>Self-explanatory.</td>
<td>Do.</td>
</tr>
<tr>
<td>690</td>
<td>Individual Sick Slip.</td>
<td>See BUMEDINST 6520.10. Self-explanatory.</td>
<td>Do.</td>
</tr>
<tr>
<td>710</td>
<td>Physical and Chemical Analysis of Water.</td>
<td></td>
<td>Do.</td>
</tr>
<tr>
<td>722</td>
<td>Health Record Jacket.</td>
<td>To maintain individual Health Records.</td>
<td>Do.</td>
</tr>
<tr>
<td>722-1</td>
<td>Dental Folder.</td>
<td>See art. 6-109.</td>
<td>Do.</td>
</tr>
<tr>
<td>731</td>
<td>DOD Immunization Certificate.</td>
<td>Provides an immunization record which the individual carries.</td>
<td>Naval hospitals, station hospitals, medical centers, and hospital ships providing inpatient care.</td>
</tr>
<tr>
<td>739</td>
<td>Register of Patients.</td>
<td>See art. 21-222.</td>
<td>Navy and Marine Corps activities or units having a medical officer or Medical Service Corps (Optometry) officer aboard.</td>
</tr>
<tr>
<td>771</td>
<td>Spectacle Order Form.</td>
<td>Issued locally upon approval of prescribing officer or officer having approval authority to furnish spectacles.</td>
<td></td>
</tr>
</tbody>
</table>
### 23-216A. Tabulation of Department of Defense Forms—Continued

<table>
<thead>
<tr>
<th>DD No.</th>
<th>Title</th>
<th>Function</th>
<th>Using activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>792</td>
<td>Nursing Service—Twenty-Four Hour Patient Intake Output Worksheet</td>
<td>To maintain standardized records of patients’ intake and output.</td>
<td>Naval hospitals, and station hospitals and dispensaries.</td>
</tr>
<tr>
<td>876</td>
<td>Request for Treponemal Immobilization Test for Syphilis.</td>
<td>See BUMEDINST 6222.5B</td>
<td>Ships and stations having medical personnel.</td>
</tr>
<tr>
<td>877</td>
<td>Request for Medical/Dental Records.</td>
<td>Self-explanatory</td>
<td>Ships and stations having medical/dental personnel.</td>
</tr>
<tr>
<td>1141</td>
<td>Record of Exposure to Ionizing Radiation.</td>
<td>See BUMEDINST 6100.18</td>
<td>Navy and Marine Corps activities or units having a Medical Department representative.</td>
</tr>
<tr>
<td>1194</td>
<td>Warning Tag for Medical Oxygen Equipment.</td>
<td>See BUMEDINST 6100.1B</td>
<td>Ships and stations having medical/dental personnel.</td>
</tr>
<tr>
<td>1201</td>
<td>Nonavailability Statement Dependent Medical Care Program.</td>
<td>See SECNAVINST 6320.8A</td>
<td>Navy and Marine Corps activities or units, United States and Puerto Rico.</td>
</tr>
</tbody>
</table>
Section VI. RECORDS MAINTAINED ON OTHER THAN NAVMED OR STANDARD FEDERAL FORMS

23-250. General

(1) The records listed in the following articles shall be maintained by the prescribed activities or units in addition to those listed in other parts of this Manual. They shall be maintained in book or log form and in sufficient detail to serve as a complete and permanent historical record of the actions, incidents and data recorded therein.

Note.—There are no articles 23-251 and 23-252.

23-253. Narcotic Book

(1) The medical or dental officer or nurse in charge of each ward and other narcotic dispensing units of all Medical Department activities providing inpatient care shall maintain a record of all narcotics dispensed. Each entry shall include the date, the patient’s name, the drug, the dose, the time given, by whom given and the name of the doctor ordering the narcotic.

(2) The Narcotic Book shall be summarized at regular intervals to include the quantities remaining at last report, the quantities drawn from the pharmacy and the amount expended since the last report. The Narcotic Book and the summaries thereof shall be subject to inspection at any time in accordance with local directives.

23-254. Drug Book

(1) A Drug Book shall be maintained by the nurse or corpsman in charge of each ward and other drug-expending units of all Medical Department activities providing inpatient care. The Drug Book shall serve as a permanent and continuing record of all drugs expended, other than narcotics, sedatives, and alcohol routinely used.

(2) The date, drug, and quantity required shall be entered by the cognizant nurse or corpsman each morning; and each entry shall be signed by the cognizant medical or dental officer. The book and any required prescriptions then shall be forwarded to the pharmacy as an order for the required items.

23-255. Hospital Atlas

(1) Each naval hospital shall maintain an atlas on a current basis to include, but not to be restricted to, summary information on the history, distinctive functions, capacity, complement, physical facilities, organization, and professional services of the hospital. More than one copy of the atlas may be found to be desirable in the larger installations.

(2) The Bureau also will maintain an atlas on each naval hospital. The main categories of information in the Bureau atlases will be compiled in a current basis from the data received through existing reporting requirements. In addition, each hospital shall submit such supplementary data as is required to keep the Bureau and hospital atlases as similar as possible. Such supplementary data shall include:

(a) Photographs of the hospital and its professional activities.

(b) Summary information on civilian consultants and methods of cooperation with local civilian health agencies.

(c) Copies of noteworthy issues of hospital newspapers or bulletins.

(d) Copies of all summaries and statements as may be incorporated into the hospital atlas from time to time.

(3) Each hospital shall maintain a brief current historical diary of major events concerning the hospital; collect, list, and preserve old deeds or other records, maps, charts, photographs, and newspaper files, which reflect the history of the hospital; and maintain clippings of newspaper and magazine references to the hospital. These materials shall be forwarded to the Bureau annually in addition to the materials written specifically for inclusion in the current hospital atlas.

(4) The Bureau and hospital atlases should be utilized:

(a) To familiarize officers assigned to the Bureau, as well as newly assigned officers and visitors to the hospitals themselves, with the historical background and facilities of each naval hospital.

(b) To assist Bureau and hospital staffs in acquainting key civilian officials, boards, and offices with the nature, capabilities, and needs of naval hospitals.

(c) To provide current information in composite form to aid in analyzing and planning the location and mission of the various naval medical activities.

(5) The Bureau will consolidate and preserve the noncurrent historical material in an historical file for each hospital, to be used as research sources at such time as definitive histories of the hospitals may be compiled.

Note.—There are no articles 23-256 through 23-299.
23-300. General Statement

(1) Section 506 of the Federal Records Act of 1950 requires the head of each Federal agency to establish and maintain an active, continuing program for the economical and efficient management of records. The program, among other things, provides for effective controls over the creation, maintenance, and use of records in the conduct of current business; the retirement of noncurrent records to economical storage; and the destruction of records not warranting further retention.

(2) It is the purpose of the following articles to secure compliance with regulations under the above-mentioned act through the retirement or destruction of all records of the Medical Department which are no longer of administrative value to make limited filing space and equipment available for records required by current operations.

(3) All correspondence and shipments to the Naval Records Management Center at St. Louis as directed below shall be addressed to:

U.S. Naval Records Management Center
9700 Page Blvd.
St. Louis 14, Mo.

23-301. Disposition of Records

(1) When a ship is decommissioned for disposal or an activity is disestablished, all medical and dental files and records, except Health Records (see sec. III of ch. 16), shall be transferred to the Naval Records Management Center at St. Louis.

(2) When a ship is placed in a reserve status or an activity is placed in an inactive status, all medical and dental files and records, except Health Records (see sec. III of ch. 16), shall be transferred to the Naval Records Management Center at St. Louis. However, the medical and dental records required to reactivate the vessel or activity, such as property and accounting records, shall be retained on board. Specific record items to be retained for reactivation purposes are indicated in current directives.

(3) Current regulations for the disposition of records that do not appear in the retirement schedule may be obtained from the nearest district management assistance office, who also should be consulted in regard to the disposition of records whenever ships are decommissioned for disposal or placed in reserve and whenever activities are disestablished or deactivated.

(4) Medical Department activities having an accumulation of inactive medical or dental records may transfer such records to the Naval Records Management Center at St. Louis for servicing.

(5) General correspondence files (administrative, financial, supply, and other nonmedical and nondental correspondence and records, etc.), except for civilian personnel records which are governed by separate instructions, shall be retained at the activity for 2 years. After 2 years or upon decommissioning or deactivation of the ship or activity, general correspondence files shall be screened and all material which has no further value shall be removed and destroyed. Only general correspondence which may have future reference, research, or historical value shall be transferred to the nearest naval records management center.

(6) Activities under the management control of the Bureau create records other than those listed in the retirement schedule (see art. 23-303). Cognizant personnel should consult the nearest district management assistance office in regard to the disposition of these records. Attention also is invited to the retirement schedules pertaining to public works, supplies and accounts, internal security, and fleet activities which have been promulgated by the Bureau of Yards and Docks, the Bureau of Supplies and Accounts, the Executive Office of the Secretary, and the Chief of Naval Operations, respectively.

23-302. Preparation of Records for Transfer

(1) Unless otherwise directed, collapsible cardboard cartons for the packaging of records to be transferred to a naval records management center shall be obtained from the nearest naval records management center or district management assistance office.

(2) The records shall be properly arranged and packaged, and the cartons shall be numbered with reference to the total number of cartons in the shipment; for example, Carton No. 1 of 20, Carton No. 2 of 20, etc. Each label also shall include the name of the preparing activity.

(3) Records packaged for transfer shall be inventoried and listed in the sequence of their arrangement in the cartons. The inventory shall include the number as listed in the retirement schedule, the name of the record, the form number (if any), the inclusive dates covered by the records, and the carton number. Inventories normally shall not reflect name lists of individuals for whom records are being retired. If records are of a nature that normally follows a numerical or alphabetical
sequence, missing records should be shown as exceptions. Only where no definite sequence exists, cannot be established, or missing files are too numerously, should the records be listed individually. The following are examples of properly prepared inventory items:

**Inpatient treatment facility**

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Name of record</th>
<th>Form No.</th>
<th>Dates</th>
<th>Carton No.</th>
</tr>
</thead>
</table>

**Outpatient treatment facility**

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Name of record</th>
<th>Form No.</th>
<th>Dates</th>
<th>Carton No.</th>
</tr>
</thead>
</table>

(4) Inventories shall be prepared in duplicate. The original shall be sent to the appropriate naval records management center, and the copy retained by the preparing activity.

(5) After the records have been packaged and inventoried, a letter of notification of shipment shall be prepared to include the total number of cartons and the approximate total number of cubic feet of records in the shipment. The letters shall be attached to the inventories and distributed as indicated above.

(6) The packaged records shall then be shipped to the appropriate naval records management center.

(7) Files and records classified as Confidential or higher shall be processed in accordance with current directives and shall be packaged and forwarded separately.

**23–303. Field Records Retirement Schedule**

(1) The Bureau of Medicine and Surgery Field Records Retirement Schedule authorizes the disposition of all NAVMED forms and certain other records in accordance with law. The schedule applies to all activities with a representative of the Medical Department on board. Forms created by other bureaus and offices of the Navy Department and standard Federal forms not listed hereafter shall be retired in accordance with the schedules of the cognizant bureaus and offices. Local forms shall be retired in accordance with the appropriate district or fleet retirement schedule.

(2) The schedule pertains to record copies only. Other copies maintained for temporary reference purposes may be destroyed at any time without authorization.

(3) If the quantity of records to be disposed of warrants, they may be turned over to supply officers for sale as waste paper; but their resale as records or documents shall be prohibited unless the records have been treated in such a manner as to destroy their record content. Records that cannot be sold advantageously should be shredded or burned if it is necessary to avoid disclosure of information that might be prejudicial to the Government. Otherwise, the material may be put in wastebaskets or other containers for disposal with the daily accumulation of trash. "Classified" records that have reached the ages specified in the schedule shall be destroyed or transferred as the case may be to a naval records management center in accordance with the current U.S. Navy Security Manual for Classified Matter. No officer shall be made liable for any items destroyed in accordance with an officially promulgated retirement schedule.

(4) Items marked "Retain" may, when inactive, be transferred to a naval records management center. The term "Retain" means that the item to which it refers is a record of permanent value that should be preserved indefinitely. It does not mean that the item must be retained at its parent ship or station. Generally, the term "Destroy when _____ years old" shall be interpreted as "Destroy _____ years from date of origin."

(5) District medical officers, district dental officers, and directors of district management assistance offices shall make periodic inspections to determine if naval medical and dental activities are disposing of their records as prescribed. In the larger Medical Department activities, central "tickler" files should be maintained to assure that records are disposed of on schedule.

(6) The Retirement Schedule.—

(a) Records on NAVMED Forms.—
<table>
<thead>
<tr>
<th>Item</th>
<th>NAVMED</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>348</td>
<td>Deleted.</td>
<td>Destroy when new custody is effected.</td>
</tr>
<tr>
<td>2</td>
<td>D</td>
<td>Transfer of Property Custody, Medical Department, USN...</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>3</td>
<td>E</td>
<td>Statement of Receipts and Expenditures of Medical Department Property.</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>Individual Statistical Report of Patient...</td>
<td>Transfer to Naval Records Management Center at St. Louis when 2 years old.</td>
</tr>
<tr>
<td>5</td>
<td>K</td>
<td>Report of Dental Operations and Treatments...</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>6</td>
<td>L</td>
<td>Report of Prosthetic Dental Treatment...</td>
<td>One copy to be filed in patient's jacket or clinical record. All other record copies to be destroyed when 1 year old. Do.</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>Report of Board of Medical Survey...</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>8</td>
<td>N</td>
<td>Certificate of Death...</td>
<td>Destroy when 6 months old.</td>
</tr>
<tr>
<td>9</td>
<td>N</td>
<td>Report of Surgical Operations...</td>
<td>Destroy when information is transferred in NAVMED H-10. Do.</td>
</tr>
<tr>
<td>10</td>
<td>R</td>
<td>Issue Voucher...</td>
<td>One copy to be filed in patient's jacket or clinical record. All other record copies to be destroyed when 2 years old. Do.</td>
</tr>
<tr>
<td>11</td>
<td>S</td>
<td>Blanche List...</td>
<td>Destroy 1 fiscal year after individual ledger sheet has been completed. Retain.</td>
</tr>
<tr>
<td>12</td>
<td>T</td>
<td>Morning Report of Sick...</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>13</td>
<td>U</td>
<td>Report of Medical, Dental, and Hospital Treatment of the Personnel of the Navy and Marine Corps by Other Than the Medical Department of the Navy.</td>
<td>Destroy 6 months after end of calendar year in which prepared. Destroy 6 months after becoming inactive. Destroy when 6 months old.</td>
</tr>
<tr>
<td>14</td>
<td>W</td>
<td>Medical Stores Ledger Sheet...</td>
<td>Destroy when 3 months old. Destroy when 6 months old.</td>
</tr>
<tr>
<td>15</td>
<td>Wa</td>
<td>Real Estate, Land and Buildings Ledger Sheet...</td>
<td>Destroy when 3 months old. Destroy when 6 months old.</td>
</tr>
<tr>
<td>16</td>
<td>X</td>
<td>Recruiting Statistics...</td>
<td>Destroy when 6 months old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>17</td>
<td>Xa</td>
<td>Recruiting File Record...</td>
<td>Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>18</td>
<td>HC-3</td>
<td>Receipt, Transfer, and Status Card...</td>
<td>Destroy when 6 months after date filed. Destroy when 1 year old. Retain.</td>
</tr>
<tr>
<td>19</td>
<td>HC-4</td>
<td>Roster Report of the Hospital Corps...</td>
<td>Destroy when 1 year old. Destroy when action is completed. Destroy when 1 month old.</td>
</tr>
<tr>
<td>20</td>
<td>HP-14</td>
<td>Ward Report...</td>
<td>Destroy when 3 months old. Destroy when 3 months old. Destroy when 6 months old.</td>
</tr>
<tr>
<td>21</td>
<td>HP-16</td>
<td>Liberty List...</td>
<td>Destroy when 3 months old. Destroy when 6 months old. Monthly record to be destroyed when 1 year old.</td>
</tr>
<tr>
<td>22</td>
<td>HP-22</td>
<td>Personal Effects Tag...</td>
<td>Destroy when 6 months old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>23</td>
<td>HP-23</td>
<td>Order and Inspection Blank...</td>
<td>Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>24</td>
<td>HP-27</td>
<td>Baggage Record...</td>
<td>Destroy when 3 months old.</td>
</tr>
<tr>
<td>25</td>
<td>HP-32</td>
<td>Pass Book...</td>
<td>Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>26</td>
<td>HP-37</td>
<td>Receipt and Expenditure Voucher...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 3 months old.</td>
</tr>
<tr>
<td>27</td>
<td>HP-38</td>
<td>Burial Record...</td>
<td>Destroy when 3 months old. Destroy when 6 months old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>28</td>
<td>I</td>
<td>Equipment Voucher...</td>
<td>Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>29</td>
<td>II</td>
<td>Inventory Sheet...</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>30</td>
<td>18</td>
<td>Diet Sheet...</td>
<td>Destroy when 3 months old. Destroy when 6 months old. Monthly record to be destroyed when 1 year old.</td>
</tr>
<tr>
<td>31</td>
<td>21</td>
<td>Laundry List...</td>
<td>Destroy when 6 months old. Destroy when 1 year old. Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>32</td>
<td>36</td>
<td>Ration Record...</td>
<td>Transfer to Naval Records Management Center at St. Louis when 1 year after last entry.</td>
</tr>
<tr>
<td>33</td>
<td>39</td>
<td>Register of Patients...</td>
<td>Destroy when 6 months old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>34</td>
<td>51</td>
<td>Notice of Change in Diagnosis...</td>
<td>Destroy when 6 months old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 6 months old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>35</td>
<td>62</td>
<td>Request for Repairs...</td>
<td>Destroy when 3 months old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>36</td>
<td>71</td>
<td>Operational Record...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>37</td>
<td>98</td>
<td>Research Project Form...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>38</td>
<td>102</td>
<td>Neuropsychiatric Report...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>39</td>
<td>168</td>
<td>Prescription Form...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>40</td>
<td>210</td>
<td>Emergency Medical Tag...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>41</td>
<td>255</td>
<td>Medical Stores Inventory...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>42</td>
<td>555</td>
<td>Spectacle Order...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>43</td>
<td>560</td>
<td>Appointment Book—Medical Department...</td>
<td>Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old. Destroy when 1 year old.</td>
</tr>
<tr>
<td>44</td>
<td>598</td>
<td>Expense Analysis Register—Register No. 2...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>45</td>
<td>599</td>
<td>Recapitation of Ledger Accounts—Register No. 3...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>46</td>
<td>570</td>
<td>Industrial Health Report Data Sheet...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>47</td>
<td>571</td>
<td>Deleted.</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>48</td>
<td>595</td>
<td>Combined Report of Railed Hospital Corps...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>49</td>
<td>601</td>
<td>Report of Rural...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>50</td>
<td>609</td>
<td>Report of Disposition and Expenditures, Remains of Dead...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>51</td>
<td>618</td>
<td>Photographic Chest Survey...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>52</td>
<td>801</td>
<td>Medical Stores Order Record...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>53</td>
<td>802</td>
<td>Medical Stores Usage Record...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>54</td>
<td>803</td>
<td>Medical Stores Receipt and Expenditures Record...</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
</tbody>
</table>

Change 5
### MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY

#### (a) Records on NAVMED Forms—Continued

<table>
<thead>
<tr>
<th>Item</th>
<th>NAVMED</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>894</td>
<td>Medical Stores Title Insert</td>
<td>Destroy when a replacement is prepared or when no longer of use to the activity, whichever is later.</td>
</tr>
<tr>
<td>56</td>
<td>895</td>
<td>Medical Stores Tally Card</td>
<td>Destroy immediately after being filled.</td>
</tr>
<tr>
<td>57</td>
<td>896</td>
<td>Equipment Location Record</td>
<td>Destroy when a replacement is prepared or when no longer of use to the activity, whichever is later.</td>
</tr>
<tr>
<td>58</td>
<td>816</td>
<td>Report of Causation Disease or Diving Accident</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>59</td>
<td>949</td>
<td>Medical Officers Under Instruction</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>60</td>
<td>952</td>
<td>Prosthetic Case Record</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>61</td>
<td>1646</td>
<td>Report on Interns and Internships</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>62</td>
<td>1693</td>
<td>Analysis of Pay and Allowances, Military Staff</td>
<td>Do.</td>
</tr>
<tr>
<td>63</td>
<td>1161</td>
<td>Photofloorograph Log</td>
<td>Do.</td>
</tr>
<tr>
<td>64</td>
<td>1189</td>
<td>Case History, Gastrointestinal Illness</td>
<td>Transfer to Naval Records Management Center at St. Louis when 3 years old. Do.</td>
</tr>
<tr>
<td>65</td>
<td>1174</td>
<td>Ophthalmic Dispensing and Refraction Report</td>
<td>Do.</td>
</tr>
<tr>
<td>66</td>
<td>1175</td>
<td>Disease and Operations Index Card</td>
<td>Do.</td>
</tr>
<tr>
<td>67</td>
<td>1183</td>
<td>Journal of Receipts and Expenditures of Medical Department Property, Equipment Section Receipts</td>
<td>Do.</td>
</tr>
<tr>
<td>68</td>
<td>1184</td>
<td>Journal of Receipts and Expenditures of Medical Department Property, Equipment Section Expenditures</td>
<td>Do.</td>
</tr>
<tr>
<td>69</td>
<td>1185</td>
<td>Journal of Receipts and Expenditures of Medical Department Property, Supplies and Services Section Receipts</td>
<td>Do.</td>
</tr>
<tr>
<td>70</td>
<td>1186</td>
<td>Journal of Receipts and Expenditures of Medical Department Property, Supplies and Services Section Expenditures</td>
<td>Do.</td>
</tr>
<tr>
<td>71</td>
<td>1265</td>
<td>Admission Record</td>
<td>File one copy in patient’s jacket or clinical record. Destroy all other record copies when 2 years old, except one copy which shall be retained in the activity’s file. Destroy when 1 year old.</td>
</tr>
<tr>
<td>72</td>
<td>1296</td>
<td>Staff Locator</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>73</td>
<td>1297</td>
<td>Voucher Register</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>74</td>
<td>1298</td>
<td>Recapitulation of Furniture, Furnishings and Equipment in Use.</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>75</td>
<td>1299</td>
<td>Transcript of Intern Service</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>76</td>
<td>1300</td>
<td>Dental Appointments, Daily</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>77</td>
<td>1301</td>
<td>Dental Examination and Treatment Record</td>
<td>Do.</td>
</tr>
<tr>
<td>78</td>
<td>1307</td>
<td>Precious Metal Issue Record</td>
<td>Destroy soon as local purpose is served and all pertinent data is entered on a SF-503. In no instance retain longer than 1 year from date of last entry. Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>79</td>
<td>1308</td>
<td>Statement and Inventory of Precious and Special Dental Metals</td>
<td>Do.</td>
</tr>
<tr>
<td>80</td>
<td>1309</td>
<td>Analysis of Nonprogram Allotment Receipts</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>81</td>
<td>1310</td>
<td>Time and Pay Card, Military Staff</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>82</td>
<td>1311</td>
<td>Cost Distribution Sheet, U.S. Naval Hospitals</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>83</td>
<td>1312</td>
<td>Allotment Record</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>84</td>
<td>1313</td>
<td>Report of Local Collections for Inpatient Care</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>85</td>
<td>1314</td>
<td>Psychiatric Unit Report</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>86</td>
<td>1315</td>
<td>Provisions Cost Summary</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>87</td>
<td>1316</td>
<td>Fiscal Work Measurement Report</td>
<td>Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>88</td>
<td>1317</td>
<td>Combined Dental Personnel Report</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>89</td>
<td>1318</td>
<td>Fleet Logistic Air Wing—Medical Air Evacuation</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>90</td>
<td>1319</td>
<td>Individual Report of Conversion of Tuberculin Tests From Negative to Positive</td>
<td>Destroy when 2 years old, if appropriate entry has been made in Health Record. Destroy when 1 year old. Do.</td>
</tr>
<tr>
<td>91</td>
<td>1320</td>
<td>Annual Report of First Tuberculin Test After Entering Naval Service</td>
<td>Do.</td>
</tr>
<tr>
<td>92</td>
<td>1321</td>
<td>Annual Tuberculin Retesting Report</td>
<td>Do.</td>
</tr>
<tr>
<td>93</td>
<td>1322</td>
<td>Quarterly Report of Medical Officer Personnel</td>
<td>Do.</td>
</tr>
<tr>
<td>94</td>
<td>1323</td>
<td>Supply Requisition</td>
<td>Do.</td>
</tr>
<tr>
<td>95</td>
<td>1324</td>
<td>Deleted</td>
<td>Do.</td>
</tr>
<tr>
<td>96</td>
<td>1325</td>
<td>Journal Voucher</td>
<td>Destroy when 6 months old.</td>
</tr>
<tr>
<td>97</td>
<td>1326</td>
<td>Special Duty Medical Abstract</td>
<td>Destroy when 6 months old.</td>
</tr>
<tr>
<td>98</td>
<td>1327</td>
<td>Aviation Physiology Training Report</td>
<td>Destroy when 6 months old.</td>
</tr>
<tr>
<td>99</td>
<td>1328</td>
<td>Nursing Care Plan</td>
<td>Destroy when 6 months old.</td>
</tr>
<tr>
<td>100</td>
<td>1329</td>
<td>Request for Treponemal Immunization Test for Syphilis</td>
<td>Destroy when 6 months old.</td>
</tr>
<tr>
<td>101a</td>
<td>1330</td>
<td>Personnel Tabulating Card</td>
<td>Retain original. Destroy all other copies when 1 year old. See section XIV, chapter 16.</td>
</tr>
<tr>
<td>101b</td>
<td>1331A</td>
<td>Personnel Tabulating Card</td>
<td>Destroy when 3 years old.</td>
</tr>
<tr>
<td>102c</td>
<td>1332</td>
<td>Hospital Staffing Report</td>
<td>Destroy when patient is discharged.</td>
</tr>
<tr>
<td>103c</td>
<td>1333</td>
<td>Expense Account Data Sheet</td>
<td>Destroy when results of test are entered in individual’s Health Record. Destroy 1 year after departure date. Do.</td>
</tr>
<tr>
<td>104c</td>
<td>1334</td>
<td>Ward Data Record</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>105c</td>
<td>1335</td>
<td>Staffing Report</td>
<td>Destroy when 2 years old. Do.</td>
</tr>
<tr>
<td>106c</td>
<td>1336</td>
<td>Directory of Office of Assistant to the Surgeon General</td>
<td>Retain on ward for 30 days, then destroy. Do.</td>
</tr>
</tbody>
</table>
### (b) Records on Standard Federal Forms.—Continued

<table>
<thead>
<tr>
<th>Item</th>
<th>Standard Form</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>300</td>
<td>88 and 89.....</td>
<td>Report of Medical Examination and Report of Medical History.</td>
<td>Retain. (See sec. VII of ch. 15.) File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>301</td>
<td>501.....</td>
<td>Diagnostic Summary</td>
<td>File one copy in patient's jacket or clinical record. Attach one copy to film. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>302</td>
<td>502.....</td>
<td>Narrative Summary</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>303</td>
<td>503.....</td>
<td>Autopsy Protocol</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>304</td>
<td>504.....</td>
<td>History, Part I</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>305</td>
<td>505.....</td>
<td>History, Parts II and III</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>306</td>
<td>506.....</td>
<td>Physical Examination</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>307</td>
<td>508.....</td>
<td>Doctor's Orders</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>308</td>
<td>509.....</td>
<td>Doctor's Progress Notes</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>309</td>
<td>510.....</td>
<td>Nurse's Notes</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>310</td>
<td>511.....</td>
<td>Temperature-Pulse-Respiration</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>311</td>
<td>512.....</td>
<td>Fletting Chart</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>312</td>
<td>513.....</td>
<td>Consultation Sheet</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>313</td>
<td>514 through 314</td>
<td>Laboratory Reports</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>315</td>
<td>515.....</td>
<td>Tissue Examination</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>316</td>
<td>516.....</td>
<td>Operation Report</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>317</td>
<td>517.....</td>
<td>Anesthesia</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>318</td>
<td>518.....</td>
<td>Blood Transfusion</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>319</td>
<td>519.....</td>
<td>Radiographic Reports</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>320</td>
<td>520.....</td>
<td>Electrocardiographic Report</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>321</td>
<td>521.....</td>
<td>Dental</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>322</td>
<td>522.....</td>
<td>Authorization for Anesthesia, Operations, Etc.</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>323</td>
<td>523.....</td>
<td>Authorization for Post Mortem</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>324</td>
<td>524.....</td>
<td>Roentgen Therapy</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>325</td>
<td>525.....</td>
<td>Roentgen Therapy Summary</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>326</td>
<td>526.....</td>
<td>Radiation Therapy</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>327</td>
<td>527.....</td>
<td>Group Muscle Strength</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>328</td>
<td>528.....</td>
<td>Muscle Evaluation—Upper Extremity</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>329</td>
<td>529.....</td>
<td>Muscle Evaluation—Trunk, Lower Extremity, Face</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>330</td>
<td>530.....</td>
<td>Neurological Examination</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>331</td>
<td>531.....</td>
<td>Sensory Examination</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>332</td>
<td>532.....</td>
<td>Pneumothorax-Pneumoperitoneum</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>333</td>
<td>533.....</td>
<td>Prenatal and Pregnancy</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>334</td>
<td>534.....</td>
<td>Labor and Post Partum</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>335</td>
<td>535.....</td>
<td>Newborn Record</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>336</td>
<td>536.....</td>
<td>Pediatric Nursing Notes</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>337</td>
<td>537.....</td>
<td>Pediatric Graphic Chart</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>338</td>
<td>538.....</td>
<td>Pediatric</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
<tr>
<td>339</td>
<td>539.....</td>
<td>Abbreviated Clinical Record</td>
<td>File one copy in patient's jacket or clinical record. Destroy all other record copies when 1 year old.</td>
</tr>
</tbody>
</table>
### Records on Department of Defense Forms

<table>
<thead>
<tr>
<th>Item</th>
<th>Form</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
</table>
| 500  | DD-6    | Report of Damaged or Improper Shipment                  | Destroy when 4 years old if transfers by commercial carrier.  
   |        |                                                         | Destroy when 2 years old if transfers by Government carrier.  
   |        |                                                         | Destroy when 2 years old.  
   | 502  | DD-386  | Request for Laboratory Analysis of Food                 | Destroy when 1 year old.  
   | 503  | DD-442  | Morbidity Report                                       | Destroy when 2 years old.  
   | 504  | DD-443  | Beds and Patients Report                                | Do.  
   | 505  | DD-444  | Outpatient Report                                      | Do.  
   | 506  | DD-477  | Dental Service Report                                   | Do.  
   | 508  | DD-600  | Patient’s Baggage Tag                                   | Destroy upon delivery of baggage to designated hospital.  
   | 508a | DD-618-1| R&D Project Card Continuation Sheet                     | Destroy when 1 year old.  
   | 509  | DD-686  | Bacteriological Examination of Water                     | Do.  
   | 510  | DD-686-1| Individual Sick Slip                                    | Destroy when appropriate entry is made in individual’s Health Record.  
   | 511  | DD-710  | Physical and Chemical Analysis of Water                  | Destroy when 1 year old.  
   | 512  | DD-722  | Health Record Jacket                                    | See section III, chapter 16.  
   | 513  | DD-722-1| Health Record Jacket (Dental)                           | Do.  
   | 514  | DD-737  | DOD Immunization Certificate                            | Retain.  
   | 515  | DD-771  | Spectacle Order Form                                    | Destroy when 1 year old.  

Change 7
## (d) Other records—

<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>600</td>
<td>Death Register</td>
<td>Retain.</td>
</tr>
<tr>
<td>601</td>
<td>Dental Officer-of-the-Day Log</td>
<td>Dental commands.—Transfer to Naval Records Management Center at St. Louis when 2 years old, Other than dental commands.—Destroy when 2 years old.</td>
</tr>
<tr>
<td>602</td>
<td>Officer-of-the-Day Log</td>
<td>Rough log.—Destroy when 1 year old.</td>
</tr>
<tr>
<td>603</td>
<td>Laboratory Log</td>
<td>Smooth log.—Transfer to Naval Records Management Center at St. Louis when 2 years old.</td>
</tr>
<tr>
<td>605</td>
<td>Drug Book (log)</td>
<td>Do.</td>
</tr>
<tr>
<td>606</td>
<td>Other Logs (such as Master Log; Nurse Log; Temperature, Pulse, and Respiration Log; Gear Log; Blood Plasma Log; Linen Log; Valuables Log; Leave and Liberty Log; Weight Log).</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>607</td>
<td>Receipt for Health Record</td>
<td>Do.</td>
</tr>
<tr>
<td>608</td>
<td>Sanitary Reports</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>609</td>
<td>Transfer Voucher (Medical Store)</td>
<td>Retain.</td>
</tr>
<tr>
<td>610</td>
<td>Transfer Vouchers Received (Land and Buildings).</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>611</td>
<td>Transfer Vouchers Received (Other Than Land and Buildings).</td>
<td>Destroy when 2 years old.</td>
</tr>
<tr>
<td>612</td>
<td>Case Records of Treponemal Immobilization Test Laboratories (related to treponemal immobilization test for syphilis).</td>
<td>Destroy when 3 years old.</td>
</tr>
<tr>
<td>613</td>
<td>VD Epidemiologic Reports (FSA Form PIS-1220).</td>
<td>Transfer to Naval Records Management Center at St. Louis when 2 years old.</td>
</tr>
<tr>
<td>614</td>
<td>Clinical Records (including electrocardiogram and electroencephalogram tracings).</td>
<td>Destroy when 1 year old.</td>
</tr>
<tr>
<td>615</td>
<td>X-ray Log</td>
<td>1. Retirement of records.—To be transferred to the Naval Records Management Center at St. Louis 2 years from date of last admission unless otherwise indicated herein. The records shall be packed and inventory lists prepared in accordance with articles 23-303. Teaching hospitals may retain records desired for residency training, research, or clinical investigations for a period up to 5 years before retirement.</td>
</tr>
<tr>
<td>616</td>
<td>Inventory lists (personnel and medical records).</td>
<td>2. Transfer from a Navy medical activity.—a. When a Navy member or dependent patient is discharged from, or dies in, a Navy medical activity, the records, including X-rays, shall be forwarded directly to the receiving activity. b. When a Navy member or dependent patient is discharged from, or dies in, an Army or Air Force medical activity, the records, including X-rays, shall be forwarded directly to the receiving activity, via the cognizant administrative or liaison unit if established; otherwise, they shall be transferred directly. c. In all cases the transferring medical activity shall make an entry “CR” (Clinical Record) and/or “X” (X-rays) in the “To where” block on the Admission Record (NAVMED-1285) showing the medical activity to which transferred. Should the receiving activity be a Navy medical activity, an entry showing receipt of the record and/or X-rays shall be made in the “other” block of “Records received” on its Admission Record. (Note.—A teaching hospital may reproduce any records considered to be of value for use in residency training, research, or clinical investigation before the original records are transferred.) 3. Transfer from an Army or Air Force medical activity.—a. When a Navy member or dependent patient is transferred to another Army or Air Force medical activity or to a Navy medical activity, the records, including X-rays, shall be transferred to the receiving activity via the Navy administrative or liaison unit if established; otherwise, they shall be transferred directly. b. When an Army or Air Force member or dependent patient is transferred to another Army or Air Force medical activity, the records, including X-rays, shall be forwarded directly to the receiving activity. c. When Navy, Army, or Air Force members or dependent patients are transferred to a Navy medical activity, the receiving activity shall make an entry showing receipt of the records in the “other” block of “Records received” on its Admission Record. A. Discharge from, or death in, a Navy medical activity.—a. When a Navy member or dependent patient is discharged from, or dies in, a Navy medical activity, the records shall be disposed of as indicated in paragraph 1 above. b. When a Navy member or dependent patient is discharged from, or dies in, an Army or Air Force medical activity, the records will be transferred to the Naval Records Management Center at St. Louis. This transfer will be accomplished through the Navy administrative or liaison unit if established; otherwise, it will be made directly. c. When an Army or Air Force patient is discharged from, or dies in, a Navy medical activity, the records shall be transferred immediately as indicated below or to the Army or Air Force administrative or liaison unit if established.</td>
</tr>
<tr>
<td>617</td>
<td>Drug Book (log) has been changed to Drug Book (log).</td>
<td>Change 4</td>
</tr>
</tbody>
</table>

(1) Army clinical records
Adjutant General
Department of the Army
Washington 25, D. C.

(AAtv: Personnel Records Branch)
<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>615</td>
<td>Clinical Records—Continued</td>
<td>(2) Air Force clinical records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Air Force Records Center</td>
</tr>
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<td></td>
<td></td>
<td>9700 Page Blvd. St. Louis 14, Mo.</td>
</tr>
<tr>
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<td></td>
<td>d. When a dependent of Army or Air Force personnel is discharged from, or</td>
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<td></td>
<td></td>
<td>dies in, a Navy medical activity, the records, including X-rays, after</td>
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<td></td>
<td></td>
<td>retention for a period of 6 months, shall be transferred as indicated</td>
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<td></td>
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<td>below or to the Army or Air Force administrative or liaison unit if</td>
</tr>
<tr>
<td></td>
<td></td>
<td>established.</td>
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<tr>
<td></td>
<td></td>
<td>(1) Army records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Army Records Center, TAGO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9700 Page Blvd. St. Louis 14, Mo.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Air Force records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Air Force Records Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9700 Page Blvd. St. Louis 14, Mo.</td>
</tr>
<tr>
<td></td>
<td>6. Veterans Administration beneficiaries.</td>
<td>a. Retain for 1 year at the activity and then transfer to the Federal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Records Center, General Services Administration, 200 E. Harmister Road,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kansas City, Mo. if disposition is made by a Navy medical installation in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the Philippines Islands, Hawaii, Puerto Rico, or Alaska, the records,</td>
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<tr>
<td></td>
<td></td>
<td>including X-rays, shall be forwarded to the Veterans Administration regional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>office in those areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. When a Veterans Administration beneficiary is transferred to another</td>
</tr>
<tr>
<td></td>
<td></td>
<td>medical activity, the records, including X-rays, shall accompany the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>individual to the receiving activity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Foreign military personnel and their dependents.—</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Attached to Navy and Marine Corps installations.— Forward to Bureau 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>months after completion of treatment or action for which the records were</td>
</tr>
<tr>
<td></td>
<td></td>
<td>created.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Attached to Army and Air Forces installations.— Two months after</td>
</tr>
<tr>
<td></td>
<td></td>
<td>completion of treatment or action for which records were created, forward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>to Office of the Surgeon General, Department of the Army (Attn: MEDCOM-IM)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Department of Air Force (Attn: AFCSG-35) as applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Civilians or personnel of Navy and Marine Corps (including non-U.S.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>citizens).— Transfer to Federal Records Center, General Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Administration, 1524 Locust Street, St. Louis, Mo., in annual installments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>when 1 year old.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. American Red Cross personnel.— When discharged, forward direct to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Director, American National Red Cross, Washington 25, D.C.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Coast Guard personnel.— When a member of the Coast Guard is discharged</td>
</tr>
<tr>
<td></td>
<td></td>
<td>from, or dies in, a Navy medical activity, forward the records, including</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X-rays, to the Commandant, U.S. Coast Guard (Attn: Medical Division),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Washington 25, D.C.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Other categories of personnel including humanitarian and foreign</td>
</tr>
<tr>
<td></td>
<td></td>
<td>civilians.— Transfer to Naval Records Management Center at St. Louis when</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 years old.</td>
</tr>
<tr>
<td>616</td>
<td>X-rays, medical:</td>
<td>All 70 mm. X-ray film, regardless of personnel examined or time of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>examination, shall be forwarded to the Navy Branch, Military Personnel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Records Center, St. Louis, Mo., when local purposes are served.</td>
</tr>
<tr>
<td></td>
<td>70 mm.</td>
<td>As indicated below, X-rays in most instances will be held at the activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>until eligible for destruction.</td>
</tr>
<tr>
<td></td>
<td>Other than 70 mm.</td>
<td>When space does not permit such retention, X-rays may be transferred to the</td>
</tr>
<tr>
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<td></td>
<td>nearest Federal records center for interim storage. (Generally, X-rays</td>
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<tr>
<td></td>
<td></td>
<td>should be disposed of by salvaging.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Transfer all X-rays to Navy Branch, Military Personnel Records Center,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>St. Louis, Mo., as soon as local purposes are served.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Retain at activity and destroy when 5 years old.</td>
</tr>
<tr>
<td>618</td>
<td>X-rays, medical:</td>
<td>Destroy when 5 years old.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>When patient is discharged from, or dies in, a Navy medical activity,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>transfer X-rays immediately to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Army X-rays</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Army Records Center, TAGO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9700 Page Blvd. St. Louis 14, Mo.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Air Force X-rays</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Air Force Records Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9700 Page Blvd. St. Louis 14, Mo.</td>
</tr>
<tr>
<td>619</td>
<td>X-rays, medical:</td>
<td>Forward with clinical records. (See item 615.)</td>
</tr>
<tr>
<td>620</td>
<td>X-rays, medical:</td>
<td>Forward with clinical records. (See item 615.)</td>
</tr>
<tr>
<td>621</td>
<td>X-rays, medical:</td>
<td>Destroy when 5 years old.</td>
</tr>
</tbody>
</table>

23–32
Change 10
<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Disposition</th>
</tr>
</thead>
</table>
| 616  | X-rays, medical—Continued | a. Destroy when 5 years old.  
|      |       | b. Retain as part of employee's industrial health jacket. (See item 619 for disposition.)  
|      |       | c. Retain only one representative X-ray as part of employee's industrial health jacket. Destroy all others when 5 years old. |
|      |       | Forward with clinical records (see item 615):  
|      |       | Destroy when 5 years old.  
|      |       | X-rays which cannot be identified with the persons to whom they pertain shall be destroyed as encountered.  
|      |       | Destroy when no longer required for current treatment, provided findings are recorded in the Health Record (such as SF-403).  
|      |       | Transfer to Naval Records Management Center at St. Louis 2 years after last treatment.  
|      |       | Transfer to the Adjutant General, Department of the Army, Washington 25, D. C., Attn: Personnel Records Branch, 1 year after last treatment.  
|      |       | Forward any records not placed in patient's Health Record or not transferred to patient's unit of assignment, to the Air Adjutant General, Headquarters USAF, Washington 25, D. C., Attn: Military Personnel Records Division. Records so forwarded shall be marked: “Records for locates service and forwarding to unit of assignment.”  
|      |       | Transfer 1 year after last treatment to:  
|      |       | (1) *Army records*  
|      |       | Army Records Center, TAGO  
|      |       | 9700 Page Blvd.  
|      |       | St. Louis 14, Mo.  
|      |       | (2) *Air Force records*  
|      |       | Air Force Records Center  
|      |       | 9700 Page Blvd.  
|      |       | St. Louis 14, Mo.  
|      |       | a. Forward to Bureau 2 months after completion of treatment or action for which records were created.  
|      |       | b. Two months after completion of treatment or action for which records were created, forward to Office of Surgeon General, Department of Army (Attn: MEDUS-FM) or Department of Air Force (Attn: APCSFG-25) as applicable. See item 619.  
|      |       | Transfer to Naval Records Management Center at St. Louis 1 year after last treatment.  
|      |       | Transfer to Federal Records Center, General Services Administration, 1724 Locust Street, St. Louis, Mo., in annual installments, the records of employees separated from the naval service over 30 days. When date of separation is not known, transfer 2 years from date of last treatment or examination. |
|      | 7. Civilian employees:  
|      | a. All X-rays, except those demonstrating positive pathological findings.  
|      | b. X-rays demonstrating positive pathological findings, except those cases where pathological conditions are demonstrated to be static in nature.  
|      | c. X-rays demonstrating positive pathological conditions which are static in nature.  
|      | 8. Coast Guard personnel.  
|      | 9. Other categories of personnel.  
|      | 10. Unidentified X-rays.  
| 617  | X-rays (Dental) |  
| 618  | Outpatient Treatment Records (including electrocardiogram and electroencephalogram tracings). (See item 615 for disposition of X-rays.) |  
| 615  | Note.—There are no articles 23-304 through 23-309. |
23–310. By U.S. Naval Hospitals and U.S. Naval Dispensaries

(1) The Surgeon General has been designated by the Secretary of the Navy as the official responsible for the execution of Department of Defense policies in releasing medical records of members or former members of the Navy, Marine Corps, or the Reserve components thereof and for determining the extent of and the form in which medical information will be furnished.

(2) Commanding officers of the U.S. naval hospitals and U.S. naval dispensaries (only those designated as separate field command activities) are authorized to release information from medical records physically located within the command in accordance with the provisions of this article and articles 23–312 and 313. The requesting office or individual shall be advised that such information is considered to be of a private and confidential nature and directed to treat it accordingly. Only that information will be furnished which is necessary to accomplish the legitimate purpose for which the information is required. Service, employment, pay, or medical records of personnel of the Navy, civilian employees, and others also may be produced in Federal, State, or territorial courts including local courts upon order of the court where litigation is pending, without obtaining authority from the Navy Department in such case in accordance with appropriate regulations subject to current restrictions on release of classified information and subject to the exception noted in subarticle 23–310(6) with respect to release of medical information concerning civilian employees. When certified copies of records are produced, they shall be forwarded direct to the clerk of the court issuing the order.

(3) The information necessary to the accomplishment of the legitimate purpose for which required and, if so required, a complete transcript of the member's or former member's medical record may be furnished upon request to the following:

(a) Department of the Treasury.
(b) Department of the Army.
(c) Department of Justice.
(d) The Post Office Department.
(e) Department of the Navy.
(f) Department of Commerce (Coast and Geodetic Survey).

(g) Department of Labor (Bureau of Employees' Compensation).
(h) Department of the Air Force.
(i) Department of State and Central Intelligence Agency (for use in considering prospective employees).
(j) Department of Health, Education and Welfare (Public Health Service).
(k) Selective Service.
(l) Veterans' Administration.

(1) In addition, X-ray films and original clinical records, including Red Cross social-history reports, which are in the custody of naval hospitals may be furnished on a loan basis to any Veterans' Administration facility, upon receipt of a specific request. The Veterans' Administration facility shall be requested in the letter of transmittal accompanying such records to return the records after the necessary action has been completed.

(2) Whenever the requested records have been transferred to another activity, the request from the Veterans' Administration shall be forwarded to the activity having custody of such records and a copy of the forwarding endorsement or letter shall be furnished the requesting Veterans' Administration facility for its information.

(m) Duly accredited representatives of the National Academy of Sciences–National Research Council, when engaged in cooperative studies undertaken at the specific request or with the consent of the Surgeon General, U.S. Army; the Surgeon General, U.S. Navy; or the Surgeon General, U.S. Air Force.

(n) Federal or State mental hospitals or penal institutions when the member or former member is a patient or inmate therein.

(o) Registered civilian physicians, upon request of the member or former member or his legal representative, when required in connection with treatment of the member or former member.

(p) The member or former member upon request, except information contained in the medical record which would prove injurious to his physical or mental health. In the latter case the medical information may be furnished to the next of kin upon request of the individual, or to his legal representative upon his furnishing a certified copy of the court order of appointment.

(q) Directly to the next of kin or legal representative (upon submission by the latter of a certi-
Change should refer to the as prescribed below:

"c. Disclosure of medical information. Copies of medical certificates may be requested by the prospective appointee or employee himself, by other Federal agencies, or by agencies or individuals (such as corporations, State governmental organizations, or private individuals) who are not concerned in the original action. Courts or State law departments may ask for the presentation of medical certificates. These requests should be handled as prescribed below:

(1) Whenever possible, an appointing officer should refer to the Civil Service Commission (central or regional office) any requests he receives for medical certificates and for information from medical certificates and other medical reports retained by the activity. The medical certificate or other medical reports concerned should accompany the referral. The Civil Service Commission decides when and to what extent to comply with requests."

(7) Attention is invited to articles 1250 through 1252 and 1509 through 1510, U.S. Navy Regulations 1948, and sections 0716 and 0717, chapter VII, Naval Supplement to the Manual for Courts-Martial, United States, for additional information concerning the release of information from naval medical records.

23–311. By Medical Activities Other Than Hospitals and U.S. Naval dispensaries

(1) When approved by the commanding officer, medical officers may complete blank forms or furnish certificates for persons in the Naval Establishment, except death reports, which are submitted by insurance companies and beneficial organizations and societies, but only upon the request of the individual concerned or his legal representative.

(2) Medical officers are authorized to furnish any individual in the naval service a copy of his Health Record, upon his signed request, except information contained therein which would prove injurious to his physical or mental health.

(3) All other requests for information from the medical records of members or former members of the naval service shall be forwarded to the Bureau accompanied by a copy of the information requested. The requesting party shall be promptly notified of the forwarding of the request without being furnished a copy of the information requested.

23–312. Records of Supernumeraries

(1) Requests for information from the medical records of supernumeraries hospitalized or treated at naval activities as beneficiaries of other Federal agencies should be referred to the agency under whose cognizance hospitalization was effected.

(2) Requests for information from the medical records of supernumerary patients of the Navy who were not beneficiaries of other Federal agencies shall be treated in the same manner as is prescribed for information from the medical records of members or former members of the naval service. (See arts. 23–310 and 23–311.)

23–313. Show of Authority

(1) Prior to the furnishing of information noted in articles 23–310 through 23–312, a proper show of authority must be established in regard to each request. The application may be made in person or in writing.

23–64

Change II
23–314. Death Forms for Civilian Agencies and Individuals

(1) All requests received from next of kin, relatives, insurance agencies, companies, fraternal organizations, etc., for completion of blank forms relative to death of either naval, military, or civilian personnel in naval medical activities, except in Veterans' Administration cases, shall be forwarded to the Bureau for action.

(2) Requests for completion of such forms in cases of beneficiaries of the Veterans' Administration will be forwarded to the Manager of the Veterans' Administration Regional Office authorizing the admission of the patient.

(3) Nothing in this article is intended to preclude furnishing information essential to proof of death. Such information shall be limited to identification of decedent and time, date, and cause of death.
Chapter 24

FISCAL MANAGEMENT

Sections

| I. General                        | 24-1 through 24-2 |

Section I. GENERAL

| Bureau Responsibility     | 24-1                        
| Guidelines               | 24-2                        

24-1. Bureau Responsibility

(1) The Chief of the Bureau of Medicine and Surgery as a Naval Technical Assistant to the Secretary of the Navy is responsible for the control, subject to the provisions of law, of funds appropriated and allocated for the performance of his work, the sound and legal expenditure of such funds, and the preparation of estimates for funds required to carry out approved plans and directives. (See Navy Reg. art. 0401.)

24-2. Guidelines

(1) Guidelines, principles, policies, and procedures pertaining to fiscal and related matters will be found in manuals, handbooks, and directives issued by the Bureau, Navy Comptroller, Bureau of Supplies and Accounts, and Bureau of Yards and Docks.
### 24-25. Procurement of Special Items

**Notes.—**Only subclause (3) remains in effect and is reprinted here pending incorporation in chapter 21.

**Orthopedic and Prosthetic Appliances.**

(a) Orthopedic and prosthetic appliances may be issued to either inpatients or outpatients of naval hospitals in accordance with subarticle 24-25(3)(b), when considered justified by the medical officer as offering substantial assistance in overcoming the physical handicap and thereby contributing to the well-being of the patient. These appliances are not to be furnished on an elective basis to members with short periods of service when the defect requiring the appliance existed prior to entry into the service and when the member is to be separated because of the defect, unless necessary for humanitarian reasons. For active-duty members, the initial allowance of orthopedic footwear and orthopedic alterations to standard footwear shall be in the same quantity as provided in the initial clothing allowance.

(b) Chart of Prosthetic and Orthopedic Appliances Supplied to Patients in Accordance With Subarticle 24-25(3)(a).

<table>
<thead>
<tr>
<th>Items</th>
<th>Active-duty personnel</th>
<th>Retired inactive and Fleet Reserve inactive</th>
<th>Army and Air Force Retired</th>
<th>Dependents of military personnel</th>
<th>Beneficiaries of other Federal agencies to whom interdepartmental rate applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial limbs...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Joint braces...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Shoes...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Eyeglasses...</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Artificial eyes...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cosmetic restorations...</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Wheelchairs...</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hearing aids...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Replacement parts for hearing aids...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Crutches...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Clothing necessary for the wearing of appliances...</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1 For the purposes of this article, active-duty personnel shall include only members of the Regular Navy and Marine Corps on active duty, members of the Reserve components on extended active duty, and members of the Reserve components receiving benefits pursuant to the Act approved 20 June 1949 (34 USC 555c-1 et seq.) and corresponding elements of the Army and Air Force.

2 For the purposes of this article, inactive retired members and inactive Fleet Reservists shall include those retired members and Fleet Reservists who are eligible for medical treatment at naval medical activities. (See arts. 21-3, 21-14, and 21-25(3).)

(c) Servicing of hearing aids and replacement of parts thereof shall be limited to the manufacturer’s guarantee and shall be based upon a personal relationship between the recipient and the manufacturer only. Replacements of hearing aids shall be upon the same basis as the initial issue and except in unusual circumstances shall not be effected within 2 years of the initial furnishing or the last replacement of the appliance and then only with prior Bureau approval. Under no circumstances shall hearing aids, and repair or replacement thereof, be provided to supernumerary patients not in an inpatient status in a naval hospital.

(d) Retired Navy and Marine Corps members and Fleet Naval and Marine Corps Reservists who served in either World War I or II, as well as persons otherwise eligible by law who have elected to receive disability compensation from the Veterans Administration for service-connected disease or injury, should be advised that they may obtain orthopedic and prosthetic appliances for service-connected disabilities from a Veterans Administration facility.

(e) The furnishing of prosthetic and orthopedic appliances to dependents at Government expense is not authorized.

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**24-23**

*Change 7*
Chapter 25

PROPERTY MANAGEMENT

Sections

<table>
<thead>
<tr>
<th>Sections</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. General</td>
<td>25- 1 through 25-11</td>
</tr>
<tr>
<td>II. Property Custody</td>
<td>25-12 through 25-18</td>
</tr>
<tr>
<td>III. Property Issue and Disposition</td>
<td>25-19 through 25-22</td>
</tr>
<tr>
<td>IV. Naval Medical Supply System</td>
<td>25-23 through 25-26</td>
</tr>
<tr>
<td>V. Medical and Dental Stores</td>
<td>25-27 through 25-29</td>
</tr>
</tbody>
</table>

Section I. GENERAL

Duties of the Bureau

25-1. Duties of the Bureau

(1) The Bureau establishes basic policies governing naval medical matériel and is responsible for the direction and coordination of all elements of the Medical Supply System. It determines the requirements of medical and dental materials used in the Naval Establishment, and has control of the preparation of specifications for, and the procurement, inspection, receipt, storage, care, custody, and issue of such materials. The Bureau is also responsible for and has control of the acquisition, storage, care, custody, issue, and disposition of materials of every kind which are specifically used for Bureau managed activities.

25-2. Property Defined

(1) Property is the term applied to lands, buildings and improvements, equipment, and supplies, which are purchased for, or donated to the Naval Establishment.

25-3. Physical Classification of Property

Property under the cognizance of the Bureau of Medicine and Surgery is classified into four major groups as follows:

(1) Land.—This property class includes:
   (a) All expenditures for, and in connection with, the acquisition of all types of land and water rights, exclusive of improvements thereto.
   (b) All expenditures such as surveyors' fees, appraisers' fees, etc., incident to the acquisition of all types of land and water rights, exclusive of improvements thereto.
   (c) All expenditures (in connection with acquisition of land) for dredging, filling, draining, clearing, and grading, etc., which are not assignable nor applicable to the cost of buildings and improvements.

(2) Buildings and Improvements.—This property class includes:
   (a) All expenditures for and in connection with the acquisition and/or installation of all types of buildings, structures, utility-distribution systems, sidewalks, roads, surfacing, sea walls, fences, etc.
   (b) All expenditures for additions, improvements, and alterations which result in enhancement of the value of these items.
   (c) All expenditures for excavating, surveying, site preparation, and similar charges incurred specifically for the purpose of erecting, constructing
or laying buildings, structures, utility-distributing systems, roads, etc.

(d) All expenditures for items which would otherwise be classed as equipment but are so built-in or installed as to form an integral part of the building, structure, or utility-distributing system.

(3) Equipment.—
(a) Consists of property other than that included under land or buildings and improvements which is adapted to continuing use with minimal impairment of its physical condition and which will ordinarily have an extended period of useful service.
(b) For administrative purposes, the Bureau may designate certain items as equipment that do not meet all of the above criteria.
(c) Accountability for two distinct categories of equipment is maintained:
   Category I is plant account property class 3, covering items having a unit cost of $100 or more, and certain medical and dental items regardless of unit cost.
   Category II is comprised of items of minor property having a unit cost of approximately $50 or more, and certain designated items regardless of unit cost that do not meet the criteria for inclusion in the plant account, property class 3 category.

The total value of Category I and Category II equals the value of equipment recorded in the equipment ledgers.

(d) Examples of nonstandard items that are to be classified as equipment are contained in volume VI, chapter 3, part D, of the Bureau of Supplies and Accounts Manual.

(4) Supplies.—Consists of property which does not meet the criteria of land, buildings and improvements, or equipment; is ordinarily consumed or expended within a comparatively short period of time; has poor custodial characteristics; is converted in the process of construction, manufacture or use, or is a replacement part for fixed or other equipment.

25-4. Services

(1) Services consist of useful technical and other labor which includes services of civil and military personnel; services rendered by consultants or others employed on a gratuitous, per diem, or fee basis; transportation of persons and incidental travel expenses; transportation of things and care of such things while being transported; communication services; rents, and utility services; printing and binding services; and other contractual services.

25-5. Reclassification

(1) Reclassification of supplies and equipment items, when necessary, shall be accomplished as directed by the Bureau.

25-6. Property Responsibility and Accountability

(1) The commanding officer or officer in charge of each activity under the management and technical control of the Bureau; the medical officer, the dental officer, the Medical Service Corps officer, or the senior Medical Department representative, as appropriate, of each other ship or station; and the officer in charge of each other activity having no representative of the Medical Department aboard; shall be held responsible and accountable for all Bureau of Medicine and Surgery cognizant property under his control. Such personnel may, for the purposes of property management, require subordinate Medical Department personnel to supervise, control, and be responsible for all such property in their custody (Navy Regulations Articles 0717, 0903, 0907, 1220, and 1318).

(2) The dental officer of a ship or station, except at naval hospitals and naval dispensaries commanded by officers of the Medical Corps, shall be in direct charge of and responsible for all supplies and equipment under the control of the Bureau, received for dental use.

(3) The dental officer of a ship or station, or the chief of the dental service of a naval hospital or a naval dispensary commanded by an officer of the Medical Corps, or an assistant dental officer under his direction, shall inspect all supplies and equipment received for dental use therein.

25-7. Unnecessary Expenditure of Property

(1) All persons having custody of property under the cognizance of the Bureau of Medicine and Surgery shall avoid any unnecessary expenditure of such property insofar as it may be within their power to do so, and they shall prevent the same in others. All such persons shall be held responsible for any wasteful or improper expenditure or unauthorized use of any property that they may direct, authorize, or knowingly condone.

(2) The degree of responsibility for custody and use of items classified as supplies or services is, in every respect, equal to that for items classified as equipment.
25–8. Property Inventory

(1) Physical inventory of all property under the management or technical control of the Bureau of Medicine and Surgery shall be conducted in accordance with article 25–15 and other applicable Bureau instructions.

25–9. Property Inventory Records

(1) All ships and stations, except activities to which no Medical Department representative is regularly attached, shall establish (on approved forms) a perpetual record of the inventory for each item of supplies carried in stock and each item of equipment carried in store or in use.

(2) Stock Levels.—In addition to current transaction data, stock records shall contain a record of minimum quantity, maximum quantity, order point, average monthly rate of use, and reserve or emergency-expansion-reserve quantities for each item of standard supplies and equipment carried in stock. Maximum, minimum, and order-point quantities shall be established and maintained for constant-use nonstandard items. These quantities of nonstandard materials shall be determined locally. Only those items of supplies and equipment which are normally required for facilities maintained by the activity shall be carried in stock. The minimum, maximum, order-point, and reserve or emergency-expansion-reserve quantities for standard items shall be computed in accordance with instructions promulgated by the Bureau.

(3) Property Location Records.—All ships and stations, except activities to which no Medical Department representative is regularly attached, shall maintain property location records for each operational unit of the medical and dental departments of such activities. The physical location and current inventory count on all nonexpendable items of Medical Department property and such expendable nonconsumable items of Medical Department property as the commanding officer may direct shall be reflected in these records. A monthly physical inventory of all such property, except items in store, shall be taken and certified as to its accuracy by all individuals who have actual physical custody of such property (article 11–24(1)). These records shall be reconciled with the centrally maintained Medical Department property location records.

25–10. Transfer and Loan of Property

(1) Property under the cognizance of the Bureau of Medicine and Surgery shall not be loaned to any State, organization, or private individual except as provided by Navy Regulations or other competent authority. Property may be loaned or transferred to other naval activities or naval vessels at the discretion of the commanding officer when such loans or transfers will serve a useful purpose. Custody receipts shall be obtained for each such loan of Government property.

25–11. Donations

(1) The Secretary of the Navy is authorized by Act approved 10 August 1956 (10 USC 2601, 7220) to accept donations of personal property and use such property in connection with the functions of naval medical activities. Secnav Instruction 4001.2 controls acceptance of donations under 10 USC 2601 except as otherwise authorized herein.

(2) (a) Acceptance.—The commanding officer of a naval hospital may accept a donation of supplies, equipment, materials, or services, not exceeding the total value of $2,500, which may be devoted to purposes stated by the donor. The offer of a donation of money, regardless of amount, or of property of value in excess of $2,500 shall be referred to the Chief of the Bureau who may process acceptance thereof by or by direction of the Secretary.

(b) Reporting.—Acceptance of any single item having a unit value in excess of $100 and acceptance of a group of like items having an estimated aggregate value in excess of $2,500 (except perishable and consumable items such as fruits, flowers, and cigarettes) shall be reported to the Bureau with a description of the donation, name of donor, and purpose. This reporting is for accounting purposes.

(3) All such donated funds and property, unless otherwise directed by the Chief of the Bureau, shall be accounted for and reported in accordance with current regulations governing the use of nonappropriated funds or of property purchased from nonappropriated funds, provided that donated equipment shall be recorded in accordance with the provisions of the Navy Comptroller Manual, paragraph 036003.5 wherever appropriate, and provided further that money received which is acceptable under 10 USC 2601 will be forwarded to the Administrative Officer, Navy Department, via the Chief of the Bureau, for deposit in the Department Fund Account, 17X6875 Suspense, Navy, pending formal acceptance and, if accepted, for deposit in or transfer to the Department of the Navy General Gift Fund 17X8716 for subsequent use in connection with the functions of naval medical activities in accordance with the terms of the gift or acceptance.

(4) Red Cross services may be accepted as here­tofore for the preparation of surgical dressings without specific approval if the commanding officer deems it advisable. But supplies and material to be processed shall be furnished by the naval medical or dental activity concerned.

(5) The foregoing instructions do not include authority to accept beverages having an alcoholic content exceeding 3.2 percent by volume.

(6) In view of the mission of naval hospitals, the recreational and welfare needs of the sick and
wounded are to be observed meticulously. Individuals and organizations donate funds and other property because they wish to aid the sick and disabled, and gifts therefore are to be devoted solely and specifically to that purpose. The acceptance of any gift shall be without restriction as to advertising or publicity by the donor. Therefore, prior to acceptance of any gift or donation, it is the responsibility of the commanding officer to ascertain the loyalty of the donor and to insure that his aims are to the best interest of the Navy and the United States.

(7) Tobacco products may be withdrawn from the factory by the manufacturer "without payment of tax, for delivery to hospitals operated by the Army and Navy, for free distribution to patients in such hospitals," pursuant to Section 3231 of the Internal Revenue Code, Regulation 34, Treasury Department. To accomplish a withdrawal the donor shall forward to the commanding officer of the selected hospital, Internal Revenue Form 663 (Requisition for Withdrawal of Articles from Factory, Free of Tax, for Use of the United States), indicating the number of cartons to be shipped and delivered (in even hundreds of packages not to exceed one carton for each patient, in the case of cigarettes). The commanding officer shall sign and transmit this Internal Revenue Form 663 in duplicate to the Commissioner of Internal Revenue, Washington, D.C. Upon accomplishment of the described procedure, the donor may ship the tobacco products to the selected hospital. A proper officer at the naval hospital receiving the donation shall complete in duplicate Internal Revenue Form 667 (Certificate of Receipt of Articles Withdrawn from Factory, Free of Tax, for Use of the United States). This certificate of receipt shall be executed and forwarded promptly to the manufacturer from whose factory the withdrawal was made.

Section II. PROPERTY CUSTODY

25-12. General

(1) All persons in the naval service shall insure that all Government property in their charge is properly cared for, preserved, and economically used.

25-13. Property Records

(1) Records shall be maintained by each naval medical or dental activity which will promptly disclose the source, date of receipt, book value, current custodial responsibility and date and authority for each disposition of each item of property under the Bureau's cognizance.

(2) Approved forms shall be utilized in maintaining all ledgers as property records required under this section. The property records to be maintained by activities are outlined in the following subarticles of this article.

(3) Land Ledger —

(a) A land ledger shall be maintained at naval hospitals, naval medical supply depots, naval medical centers and all other activities under the management control of the Bureau of Medicine and Surgery where the need for such ledger is manifest. The land ledger shall be classified and arranged in the general divisions, subdivisions, and groups according to current instructions.

(b) The term "land" includes all parcels of land and water rights and embraces all expenditures incident to acquisition; as surveyor's fees, appraisers' fees, dredging, filling, draining, clearing, and grading; which are not assignable nor applicable to buildings and improvements.

(c) Authority to record changes in the land ledger due to acquisition or transfer shall be requested of the Bureau. Approved requisitions or Bureau work requests will constitute approval to record the acquisition when the substantiating document is received, and an approved survey will constitute Bureau approval to record the sale or transfer.

(d) The accountability for property maintained in the land ledger may only be terminated by an approved survey and/or receipted transfer invoice.

(4) Buildings and Improvements Ledger —

(a) A buildings and improvements ledger shall be maintained at naval hospitals, naval medical supply depots, naval medical centers, and all other activities under the management control of the Bureau where the need for such a ledger is manifest.

(b) The buildings and improvements ledger shall be classified and arranged in general divisions, subdivisions, and groups, according to current instructions.

(c) The term "buildings and improvements" includes all buildings, structures, roadways, sidewalks, landscaping, sea and retaining walls, fencing and boundary walls, piers, wharves, bridges, reser-
25–8. Property Inventory

(1) Physical inventory of all property under the management or technical control of the Bureau shall be conducted in accordance with article 25–15 and other applicable Bureau instructions.

25–9. Property Inventory Records

(1) All ships and stations, except activities to which no Medical Department representative is regularly attached, shall establish (on approved forms) a perpetual record of the inventory for each item of supplies carried in stock and each item of equipment carried in store or in use.

(2) Stock Levels.—In addition to current transaction data, stock records shall contain a record of minimum quantity, maximum quantity, order point, average monthly rate of use, and reserve or emergency-expansion-reserve quantities for each item of standard supplies and equipment carried in stock. Maximum, minimum, and order-point quantities shall be established and maintained for constant-use nonstandard items. These quantities of nonstandard materials shall be determined locally. Only those items of supplies and equipment which are normally required for facilities maintained by the activity shall be carried in stock. The minimum, maximum, order-point, and reserve or emergency-expansion-reserve quantities for standard items shall be computed in accordance with instructions promulgated by the Bureau.

(3) Property Location Records.—All ships and stations, except activities to which no Medical Department representative is regularly attached, shall maintain property location records for each operational unit of the medical and dental departments of such activities. The physical location and current inventory count on all nonexpendable items of Medical Department property and such expendable nonconsumable items of Medical Department property as the commanding officer may direct shall be reflected in these records. A monthly physical inventory of all such property, except items in store, shall be taken and certified as to its accuracy by all individuals who have actual physical custody of such property (article 11–21(1)). These records shall be reconciled with the centrally maintained Medical Department property location records.

25–10. Transfer and Loan of Property

(1) Property under the cognizance of the Bureau shall not be loaned to any State, organization, or private individual except as provided by Navy Regulations or other competent authority. Property may be loaned or transferred to other naval activities or naval vessels at the discretion of the commanding officer when such loans or transfers will serve a useful purpose. Custody receipts shall be obtained for each such loan of Government Property.

25–11. Donations

(1) The Secretary of the Navy is authorized by Act approved 10 August 1956 (10 USC 2601, 7220) to accept donations of personal property and use such property in connection with the functions of naval medical activities. SECNAV Instruction 4001–2A controls acceptance of donations under 10 USC 2601 except as otherwise authorized herein.

(2) (a) Acceptance.—The commanding officer of a naval hospital may accept a donation of supplies, equipment, materials, or services, not exceeding the total value of $2,500, which may be devoted to purposes stated by the cited law, and cash donations acceptable under 10 USC 7220 not exceeding $25. Other cash donations or donations of property valued in excess of $2,500 shall be referred to the Chief of the Bureau, who may process acceptance thereof by (or by direction of) the Secretary. Accounts for cash donations of $25 or less which have not been reported to the Bureau will be the subject of specific examination by the Inspector General, Medical, in visits to naval medical facilities.

(b) Reporting.—Acceptance of any single item having a unit value in excess of $100 and acceptance of a group of like items having an estimated aggregate value in excess of $2,500 (except perishable and consumable items such as fruits, flowers, and cigarettes) shall be reported to the Bureau with a description of the donation, name of donor, and purpose. This reporting is for accounting purposes.

(3) All such donated funds and property, unless otherwise directed by the Chief of the Bureau, shall be accounted for and reported in accordance with current regulations governing the use of nonappropriated funds or of property purchased from nonappropriated funds, provided that donated equipment shall be recorded in accordance with current directives wherever appropriate, and provided further that money received which is acceptable under 10 USC 2601 will be forwarded to the Administrative Officer, Navy Department, via the Chief of the Bureau, for deposit in the Deposit Fund Account, 17X8716, and accepted as here­tofore for the preparation of surgical dressings without specific approval if the commanding officer deems it advisable, but supplies and material to be processed shall be furnished by the naval medical or dental activity concerned.

(4) Red Cross services may be accepted as here­tofore for the preparation of surgical dressings without specific approval if the commanding officer deems it advisable, but supplies and material to be processed shall be furnished by the naval medical or dental activity concerned.

(5) The foregoing instructions do not include authority to accept beverages having an alcoholic content exceeding 3.2 percent by volume.

(6) In view of the mission of naval hospitals, the recreational and welfare needs of the sick and
wounded are to be observed meticulously. Individuals and organizations donate funds and other property because they wish to aid the sick and disabled, and gifts therefore are to be devoted solely and specifically to that purpose. The acceptance of any gifts shall be without restriction as to advertising or publicity by the donor. Therefore, prior to acceptance of any gift or donation, it is the responsibility of the commanding officer to ascertain the loyalty of the donor and to insure that his aims are to the best interest of the Navy and the United States.

(7) Tobacco products (cigars, cigarettes and manufactured tobacco) and taxable cigarette papers (books or sets of cigarettes papers, containing more than 25 papers each) and cigarette tubes may be removed from the factory by the manufacturer, without payment of tax, for shipment or delivery to hospitals operated by the Armed Forces, for gratuitous distribution to present and former members of the Armed Forces who are patients in such hospitals, pursuant to sections 5704 and 7510 of the Internal Revenue Code of 1954; and to regulations in Part 295 of Title 26, Code of Federal Regulations. To accomplish a removal of tax-exempt tobacco products or cigarette papers or tubes for such use, the donor shall forward to the commanding officer of the selected hospital a requisition, in letter form, for removal of such articles from the factory, without payment of tax. The donor should indicate the quantity of tobacco products to be shipped or delivered (in the case of cigarettes, in even hundreds of packages not to exceed one carton for each patient) or cigarette papers or tubes to be shipped or delivered. A receipt, in letter or other form, may be forwarded to the manufacturer from whose factory the tax-exempt removal was made if such a receipt is requested. Tax-exempt tobacco products and cigarette papers and tubes must be distributed only to present or former members of the Armed Forces who are patients in the hospital.

Section II. PROPERTY CUSTODY

25-12. General

(1) All persons in the naval service shall insure that all Government property in their charge is properly cared for, preserved, and economically used.

25-13. Property Records

(1) Records shall be maintained by each naval medical or dental activity which will promptly disclose the source, date of receipt, book value, current custodial responsibility and date and authority for each disposition of each item of property under the Bureau's cognizance.

(2) Approved forms shall be utilized in maintaining all ledgers as property records required under this section. The property records to be maintained by activities are outlined in the following subarticles of this article.

(3) Land Ledger.—

(a) A land ledger shall be maintained at naval hospitals, naval medical supply depots, naval medical centers and all other activities under the management control of the Bureau where the need for such ledger is manifest. The land ledger shall be classified and arranged in the general divisions, subdivisions, and groups according to current instructions.

(b) The term "land" includes all parcels of land and water rights and embraces all expenditures incident to acquisition; as surveyor's fees, appraisers' fees, dredging, filling, draining, clearing, and grading; which are not assignable nor applicable to buildings and improvements.

(c) Authority to record changes in the land ledger due to acquisition or transfer shall be requested of the Bureau. Approved requisitions or Bureau work requests will constitute approval to record the acquisition when the substantiating document is received, and an approved survey will constitute Bureau approval to record the sale or transfer.

(d) The accountability for property maintained in the land ledger may only be terminated by an approved survey and/or receipted transfer invoice.

(4) Buildings and Improvements Ledger.—

(a) A buildings and improvements ledger shall be maintained at naval hospitals, naval medical supply depots, naval medical centers, and all other activities under the management control of the Bureau where the need for such a ledger is manifest.

(b) The buildings and improvements ledger shall be classified and arranged in general divisions, subdivisions, and groups, according to current instructions.

(c) The term "buildings and improvements" includes all buildings, structures, roads, sidewalks, landscaping, sea and retaining walls, fencing and boundary walls, piers, wharves, bridges, reser-
voirs, railways trackage, utility-distributing systems, and all fixed equipment located in buildings, such as boilers, engines, pumps, generators, heaters, tanks, dumb-waiters, elevators, fire-alarm systems, heating fixtures and piping, lighting fixtures and wiring, plumbing fixtures and piping, communication systems, ventilating systems, built-in refrigerating systems, air-conditioning systems, incinerators built in buildings, linoleum and asphalt tile floor coverings, and other items which would otherwise be classed equipment but are so built in as to form an integral part of the building, structure, utility-distributing system, etc., and nonstructural improvements (refer to Bureau of Supplies and Accounts Manual, volume 6).

(d) Authority to record changes in the buildings and improvements ledger shall be requested of the Bureau except that approved requisitions or Bureau work requests will constitute approval for acquisition when the substantiating document is received, and an approved survey will constitute Bureau approval to record the expenditure.

(e) The accountability for property maintained in the buildings and improvements ledger can only be terminated by a receipted transfer invoice or an approved survey.

(f) A record of minor improvements, additions, replacements, or repairs to buildings-and-improvements property items shall be kept on the reverse of the ledger sheet. This also includes expenditures which are not to be reflected in the buildings and improvements account for the reason that to do so would involve the writing off, by property survey, of the item replaced and the taking up of the replacement item, which in most cases would result in no change in the unit concerned.

(g) In instances wherein separate ledger sheets are maintained for components (fixed equipment) of a buildings-and-improvements property item, it will be necessary to survey the component when replacement is made. If separate ledger sheets are not maintained and replacements are made, it will not be necessary to survey for the reason noted before, and entry shall be made on the reverse of the applicable ledger sheet. All replacements of a part of a component of a buildings-and-improvements property item shall be handled as a maintenance transaction and will have no effect on the buildings and improvements property ledger.
(5) Equipment Ledger.—
(a) An equipment ledger of the approved sheet or card type shall be maintained by all naval medical and/or dental activities ashore or afloat, charged with accountability of Bureau of Medicine and Surgery cognizant property. The equipment ledger shall be classified and arranged in the general parts, classes, and stock numbers, according to current instructions.
(b) A record of all property classified as equipment, in accordance with instructions contained in this manual, shall be maintained in the equipment ledger.
(c) Changes may be recorded in the equipment ledger only upon authority of a properly approved acquisition or disposition document. Adjustments to the equipment ledger required by reason of reclassification may be recorded upon authority of a properly approved adjustment voucher.
(d) The accountability for equipment items may only be terminated by a properly approved transfer voucher or by an approved survey (refer to arts. 25-20 (2) and 25-21). It is to be noted that the issue of equipment from the storeroom for use by a department transfers the primary custodial responsibility to the officer or person responsible for the department in which such equipment is to be used.

(6) Supplies Ledger.—
(a) A supplies ledger of the approved sheet or card type shall be maintained by all medical and/or dental departments of naval activities ashore or afloat charged with accountability of Bureau cognizant property. The supplies ledger shall be classified and arranged in the general parts, classes, and stock numbers according to current instructions.
(b) Special purchases of supplies which are not stocked in the storeroom and are issued upon receipt shall be recorded on a special ledger sheet or card. Such ledger sheets or cards shall be maintained for each class of supplies under which material is received.
(c) Adjustments to the supplies ledger required by reason of reclassification of property items or inventory adjustments shall be recorded by authority of a properly approved adjustment voucher.
(d) When supplies, unlike equipment, are issued from the storerooms by authority of a properly approved issue voucher, the fiscal accountability for the material is terminated, but this in no way relieves the immediate custodian of his responsibilities to properly care for, preserve, and economically use such materials.

(7) Provisions Ledger.—A provisions ledger shall be maintained at naval hospitals and naval medical centers. The maintenance and control of the provisions ledger is the responsibility of the commissary officer. The finance officer shall maintain a provisions control sheet within the supplies ledger and shall reconcile the provisions control sheet with the provisions ledger at least monthly.

(8) Plant Account Records.—Records shall be maintained on property record cards of all items carried in the land ledger (Property Class 1), buildings and improvements ledger (Property Class 2), and equipment ledger (Property Class 3) in accordance with instructions contained in the Bureau of Supplies and Accounts Manual as modified by current Bureau directives.

(9) Narcotics, Alcohol, Alcoholic Beverages and Precious and Special Dental Metals Records.—
(a) Records shall be maintained by medical and dental activities that will provide information as to receipts, expenditures, and balances on hand of narcotic drugs, alcohol, alcoholic beverages, and precious and special dental metals in store. (Stock points of the medical and dental supply system under the management control of the Bureau of Supplies and Accounts Manual are not within the scope of this subarticle. Detailed procedures covering the handling of these materials at medical and dental stock points are included in the Bureau of Supplies and Accounts Manual.) These records are supplementary to, but must agree with, the specified accounting records. A physical inventory shall be taken monthly of all narcotics, alcohol, alcoholic beverages, and precious and special dental metals by the medical or dental activity representative responsible for their custody. The results of this inventory shall be verified by sight by a board of three officers appointed for that purpose, except that in small ships and small shore stations, where three officers are not available, one Medical Department representative and one commissioned officer may constitute the board, provided that no person directly or by delegated authority charged with custody of alcohols, narcotics, and other items requiring special storage and issue precautions, shall serve as senior member of the board. The board for inventory of dental metals shall consist of dental officers whenever practicable.
(b) All quantities of narcotic drugs, alcohol, alcoholic beverages, and precious and special dental metals not required for immediate use shall be maintained in locked storage under the direct custody of an officer.
(c) Small quantities of narcotic drugs, alcohol, and alcoholic beverages required for dispensing purposes shall be properly recorded when expended and kept in locked storage when not in use. The pharmacy, wards, and other operational units of the activity authorized to have custody of and to dispense narcotics shall also maintain detailed records of receipts, expenditures, and balances on hand. Inventory of narcotic drugs, alcohol, and alcoholic beverages in the pharmacy shall be conducted in the same manner as the inventory of bulk stocks in the storeroom. Narcotic records of a representative number of wards or other operational units of the activity shall be checked by the narcotic inventory board at the discretion of the board and the commanding officer.
25-14. Storeroom Management

1. The bulk of all medical and dental material shall be kept in storerooms officially designated as such. The quantities in the issue room, the dispensary, the sick bay, or dental-clinic rooms shall not ordinarily exceed a 1 week's supply at current rates of usage.

2. A hospital corpsman or other competent person may be placed in charge of storerooms not used for the storage of narcotic drugs, precious or special dental metals, alcohol, or alcoholic beverages.

3. Issue from storerooms shall only be made by authority of approved issue vouchers.

25-15. Property Inventory Procedures

1. Property inventories must be carefully planned in advance by:
   (a) Arranging storage and location areas for systematic inventory procedure.
   (b) Properly indoctrinating personnel involved in the fundamentals of inventory procedure.
   (c) Having control records posted as close to the inventory date as practicable.
   (d) Providing for careful reconciliation of discrepancies between records and inventory findings.

2. The following instructions shall be carried out in regards to the physical inventory of all property under the management and technical control of the Bureau:
   (a) Land and Buildings and Improvements.—
       A physical inventory of land and buildings and improvements items shall be made as directed by the Bureau of Supplies and Accounts Manual or other competent authority and reconciled with the land and buildings and improvements ledgers and the plant account records. When land and buildings and improvements items are found to be missing, a property survey shall be held immediately.

25-16. Inspection of Material

1. Medical stores items require periodic inspection to detect visible evidence of deterioration.

2. Inspection should be accomplished by physical examination of representative samples of the various age groups of stocks on hand. Field units and special outfits are included in the requirements of this article.

3. Items found to be unfit for issue shall be surveyed in accordance with current instructions.

4. The necessity for "issue of oldest stock first" cannot be overemphasized. This is true for all items, but is mandatory for deteriorable items.

5. All caskets shall be thoroughly inspected prior to being issued for use for such defects as:
   (a) Mildew of lining and excelsior stuffing.
   (b) Deterioration of closure gaskets.
   (c) Rusting of metal parts.
25-16

CHAPTER 25. PROPERTY MANAGEMENT

25-17. Transfer of Custody

(1) Bent or broken handles.
(2) Marring of the external finish.
(3) Other defects which would make the casket unfit for use.
Caskets shall not be stored on end. Disposition or repair of defective caskets shall be accomplished in accordance with current Bureau directives.

25-18. Inventory Adjustment

(1) Inventory adjustments for expendable items necessitated by physical inventory shall be prepared on an adjustment voucher by all activities and shall be properly approved prior to reflecting inventory adjustments in accounting records, except that where pilferage, loss by fire, spoilage, etc., are suspected or known, the missing or damaged material shall be disposed of by property survey.

Section III. PROPERTY ISSUE AND DISPOSITION

25-19. Issue of Supplies

(1) Supplies shall be issued from the storeroom for use or reported to the storeroom as excess upon the authority of a properly authenticated supplies-issuance voucher.

Property responsibility and custody are ended when supplies are shipped, as the carrier is presumed to act as an agent of the receiving activity rather than the shipping activity. An approved transfer voucher at time of shipment or transfer shall be used as authority to remove property from ledgers. Receipts for material by responsible representatives of the carrier, activity, or Government department shall be obtained by the issuing activity to complete the activity’s files.

25-20. Issue of Equipment

(1) Equipment shall be issued from or returned to the storeroom or transferred between components of the activity, upon the authority of a properly authenticated equipment-issue voucher. Equipment may be expended from the ledger by an approved survey or by a properly approved transfer voucher.

Property responsibility and custody are ended when equipment is shipped, as the carrier is presumed to act as an agent of the receiving activity rather than the shipping activity. An approved transfer voucher at time of shipment or transfer shall be used as authority to remove property from ledgers. Receipts for material by responsible representatives of the carrier, activity, or Government department shall be obtained by the issuing activity to complete the activity’s files.

25-21. Surveys

(1) Definition.—A survey is the procedure required by articles 1947 through 1953, Navy Regulations, when naval property must be:
(a) condemned as a result of damage or deterioration, or
(b) appraised as a result of loss of utility, or
(c) acknowledged as nonexistent as a result of loss or theft, necessitating the expenditure of the accountable material from the records of the holding activity.

(2) Purpose.—The purpose of a survey is to provide a record for:
(a) An administrative review of the condition of the material, the cause of the condition, the responsibility therefor, and the recommendation for disposition.
(b) An authorization to expend the material from the records on which carried.

(3) Types of Surveys.—Surveys are of two types, formal and informal.
(a) A formal survey shall be made by either a commissioned officer or a board of three officers, one of whom, and as many as practicable, will be commissioned officers, appointed in either instance by the commanding officer. If sufficient eligible officers

Change 8
are not available to the commanding officer, he will forward the survey request for action to his immediate superior in command, or in the absence of his immediate superior in command, to the senior officer present. The following officers are not to serve on a survey board:

(1) The commanding officer.
(2) The officer on whose records the material being surveyed is carried.
(3) The officer charged with the custody of the material being surveyed.
(b) An informal survey is to be made by the head of the department having custody of the material to be surveyed, except at hospitals where surveys shall be made by the finance officer, or in the case of provisions by the commissary officer.
(4) Formal Survey—When Required.—A formal survey will be required for Bureau cognizant material falling within the following categories:
(a) Land.
(b) Buildings and improvements.
(c) Equipment, when the book value of a single piece of equipment exceeds $100.
(d) When specifically directed by the commanding officer, if the circumstances are considered to warrant such action.
(5) Informal Survey—When Required.—An informal survey is made in all cases when a formal survey is not required or directed by the commanding officer.
(6) Phases of Survey Procedure.—The survey procedure consists of the following phases:
(a) Request for survey.
(b) Action by the commanding officer on the request for survey.
(c) Action of the survey board or officer.
(d) Preparation of the survey report.
(e) Action by the reviewing officer, normally the commanding officer, on the survey report.
(f) Expenditure of material from the records on which carried when recommended by the survey report and approved by the reviewing officer.
(7) Request for Survey.—The survey request may be originated by any department, division, or section head or by a designated subordinate as prescribed in local regulations. Normally, the survey request is originated in the department having custody of the material to be surveyed. The finance officer at naval hospitals shall be responsible for preparing the survey request for all material under Bureau cognizance, except provisions which shall be the responsibility of the commissary officer. The dental officer of a ship or station, except at naval hospitals and at naval dispensaries commanded by officers of the Medical Corps, shall prepare the request for property survey, numbered in sequence with the medical department surveys and submit it to the commanding officer for action. As prescribed by local regulations, the initial survey request may be made in rough on either a Survey Request, Report and Expenditure (Navsanda Form 154) or on a local survey request form. Included on or attached to this initial survey request shall be a statement of the opinion of the originator relative to:
(a) The condition of the material.
(b) The cause or condition surrounding the loss, damage, deterioration, or obsolescence of the material.
(c) The responsibility for the cause or condition if such can be determined or, if the responsibility cannot be determined, the reason why it cannot be determined.
(d) A recommended disposition of the material and the action to be taken.

The description of the material shall be as complete as possible and shall include the serial numbers of the items involved, if applicable. The initial survey request shall not be considered as the survey report but shall be considered as a guide to the commanding officer in determining the type of survey to be held and as an aid to the surveying officer, board, or head of department in the preparation of the survey report.
(8) Smooth Request.—A smooth survey request shall be prepared on Navsanda Form 154 in sufficient number of copies to provide for such distribution as may be required by Bureau directives and local regulations. The request part of Navsanda Form 154 shall be prepared from information obtained from the initial survey request supplemented by such other information as is available from medical stores or other records, such as the date the material was received and the book value of the material. When surveying material missing in shipment, additional information as required by the Bureau of Supplies and Accounts Manual shall be placed on the survey request.
(9) Action by the Commanding Officer.—Upon receipt of the smooth survey request, the commanding officer or his representative shall determine whether a formal or an informal survey is appropriate. This decision shall be entered on the original and copies of the smooth survey request. In the case of formal surveys, the smooth survey request shall be forwarded to the surveying officer or board as designated by the commanding officer for accomplishment of the survey report section of Navsanda Form 154. In the case of informal survey, the smooth survey request shall be forwarded to the head of the department having custody of the material to be surveyed for accomplishment of the survey report section of Navsanda Form 154.
(10) Preparation of the Survey Report.—
(a) The surveying officer, board, or head of department shall make a thorough inspection of the material being surveyed to determine its condition at the time of survey or, if missing, a thorough examination of the circumstances attending the loss, and shall fix the cause and responsibility therefor,
or, when responsibility cannot be fixed, shall make a statement showing clearly why such cannot be done. A full report shall be made on Survey Request, Report and Expenditure (NAVSANDA Form 154) in the report section including the findings as to condition, cause, and responsibility with a recommendation as to disposition, replacement, or continuance in service. The recommendation for disposition is to be specific and in accordance with sub-article 10 (d) of this article. Every facility and all pertinent information shall be given to the surveying officer, board, or head of department by persons concerned with the material under survey. When required, the services of a hospital repairman, dental technician repairman, or other qualified person should be utilized to assist in the examination of material being surveyed or in the preparation of estimate for repairs.

(b) When any loss or damage has been the subject of an independent formal investigation by the commanding officer or his superior in the chain of command, the surveying officer, board, or head of department shall make reference to the pertinent correspondence resulting from such investigation and may omit from the survey report findings as to cause and responsibility.

(c) For material missing or damaged in shipment under U. S. Government Bill of Lading (Standard Form 1103) a report as to condition, cause, responsibility, and recommendation shall be made separately for each item listed in the request section of NAVSANDA Form 154. When material is damaged in shipment, the shipping container or its contents shall not be disposed of until after the survey has been approved by the reviewing officer. Any inspection or packer's ticket found in the package shall be attached to the copy of the survey report to be retained in the files of the activity. For material missing in shipment for which the transportation company is held responsible, the survey report must state the facts under the heading “Responsibility” and must show whether the bill of lading was accomplished in full.

(d) It is the responsibility of the surveying officer, board, or head of department, to be cognizant of the current directives of bureaus, offices, and the local command to insure compliance with such requirements as apply to disposition, replacement, or continuance in service of the material. On surveys of missing items, the statement “Expended from Records” shall be included in the recommendation. The following are commonly-used recommendations but are not to be considered as complete or exclusive when the facts warrant greater detail:

**Repair.**—Repair will be recommended when economically practicable. The recommendation will specify the extent of the repairs necessary, an estimate of the time and cost involved, and whether the repairs will be made on the station or under a contract. Medical and/or dental electric equipment and other large items shall be examined by a qualified medical or dental repairman. The repair man's signed statement shall be made a part of the survey report. This report shall cover all phases of repair cited above, and shall in addition include one of the following recommended dispositions:

1. **Repair.**—(a) by own or nearby naval district or station personnel, (b) commercially.
2. **To supply department for yard scrap heap.**
3. **To supply department for sale.**

In the event the repair personnel and the survey board cannot agree to above, or repair personnel are not available, the survey shall be forwarded to the Field Branch, Bureau of Medicine and Surgery, for action. No surveyed material is to be shipped to a naval medical and dental supply depot without authority of the Chief, Field Branch, Bureau of Medicine and Surgery.

**Immediate Disposition.**—Recommendations for immediate disposition of material because of its unsanitary or dangerous condition will prescribe the specific method of destruction. Materials such as chemicals, decayed provisions, etc., the retention of which would be prejudicial to the safety and health of the community, shall not be deposited on the dump but shall be destroyed in accordance with existing instructions issued by competent authority or as prudence may demand.

**To Supply Department for Yard Scrap Heap.**—Recommendation for transfer to yard scrap heap shall be made for items of metal which are unserviceable, do not warrant repair, and have no resale value other than that of scrap. Recommendation to “scrap” shall be used only when the services of a salvage activity are not available.

**To Supply Department for Sale.**—Recommendations for transfer to supply department for sales shall be made when items do not warrant repairs and have resale value. Paragraph 26120-4 (d), Bureau of Supplies and Accounts Manual, shall be complied with.

Further reference should be made to volumes 2 and 3 of the Bureau of Supplies and Accounts Manual.

(a) For certain specific materials, such as flags, plant account property, and typewriters, reference shall be made to paragraph 26120 Bureau of Supplies and Accounts Manual.

(b) Action by the Reviewing Officer.—After action has been completed by the surveying officer, board, or head of department, the survey report shall be submitted for review to the commanding officer, or to the officer ordering the survey if the survey was ordered by higher authority. When the reviewing officer does not approve the action of the surveying officer, board, or head of department, he shall cause another survey to be held on the material. In all cases the second survey shall be...

formal. If the reviewing officer does not approve the findings of the second survey, the matter shall then be referred to the bureau or office having cognizance over the material.

(12) Final Approval of Surveys.—Final approval of surveys shall be accomplished by the reviewing officer except as noted in subarticles 25-21 (10) (d) and 25-21 (11).

(13) Distribution of Approved Surveys.—In addition to the copies of approved surveys forwarded to the Bureau of Medicine and Surgery with the accounting returns, an additional copy shall be forwarded direct to the Chief, Field Branch, Bureau of Medicine and Surgery, Sands and Pearl Street, Brooklyn 1, N. Y.

Section IV. NAVAL MEDICAL SUPPLY SYSTEM

General
Missions of Medical Supply System Activities
Standard Basic Organization for Naval Medical Supply Depots
Standard Basic Organization for Naval Medical Supply Storehouses

25-23. General

(1) The naval medical supply system is comprised of the field supply activities of the Bureau of Medicine and Surgery. It includes all organizations ashore whose primary functions are procurement, inventory control, warehousing, or distribution of medical and dental stores. Field supply activities are of two general types:

(a) Procurement and inventory-control activities:
   (1) Naval Medical Material Office.
   (2) Armed Services Medical Procurement Agency.

(b) Warehousing and distribution activities:
   (1) Naval medical supply depots.
   (2) Naval medical supply storehouses.
   (3) Medical stores sections of naval supply depots.

25-24. Missions of Medical Supply System Activities

(1) The Naval Medical Material Office is a command organization whose mission is to perform the following functions under the management and technical direction of the Bureau of Medicine and Surgery:

(a) Develop medical and dental material allowing lists and revisions thereof for naval vessels, stations, and special activities; and recommend establishment and modification of activity stock levels of medical and dental materials.

(b) Develop data pertaining to the cataloging and specifications of medical and dental material.

(c) Prepare detailed estimates of medical and dental material requirements for the operation of Medical Department facilities based on policies established by the Materiel Division.

25-10
Change 2

25-22. Decommissioning or Disestablishment

(1) Prior to decommissioning of a ship, or disestablishment of a station, unless otherwise directed by competent authority all Medical Department equipment unfit for further use shall be surveyed. The equipment not disposed of by survey, and all unopened units of supplies shall be reported to the Bureau on appropriate property disposition forms in accordance with current instructions. Opened and expended units of supplies shall be transferred on memorandum transfer invoices to any Medical Department activity that may be able to utilize the material.
no medical supply depots are located. Their mission is to warehouse and distribute specific medical and dental materials to locally based fleet units and minor stations.

(5) Medical stores sections of naval supply depots are integral units of naval supply depots, and as such, are under the management control of the Bureau of Supplies and Accounts. They serve as "filler and back-up" depots to naval medical supply depots. Stock control of medical and dental stores located in the medical stores sections of naval supply depots is vested in the Bureau of Medicine and Surgery.

25-25. Standard Basic Organization for Naval Medical Supply Depots

(1) The standard organization for naval medical supply depots provides for a standard organizational structure and standard distribution of functions to organizational components and is applicable to both continental and extracontinental depots. In-
dividual activities shall not deviate from the basic organization, including the terminology employed in titling the various organizational components, without prior approval of the Bureau; except that the commanding officer of a particular depot, dependent upon the workload at such depot, may determine locally the need for changing divisions to departments or branches to divisions, provided that the basic concept of the standard organization will not be modified thereby.

(2) Naval medical supply depots, being integral units of the Naval Establishment, are required by Navy Regulations to conform with the established form of organization and administration employed in the naval service. Accordingly, the activities of depots are grouped under the following administrative heads, special assistants, and departments: (a) commanding officer, (b) executive officer, (c) special assistants, (d) administrative department, (e) control department, and (f) warehousing department.

(3) The Commanding Officer.—The commanding officer, under the general supervision of the commanding officer of the naval district or other appropriate naval commander as to military jurisdiction and the Chief of the Bureau of Medicine and Surgery as to management and technical control, is charged with the command, organization, and management of the medical supply depot. He shall assure the timely and economical performance of the functions of the depot in compliance with its assigned mission. He is further responsible for the operation of the depot in accordance with legislation, Navy Regulations, the Manual of the Medical Department, and other pertinent orders and instructions issued by competent authority.

(4) The Executive Officer.—The executive officer is the direct representative of the commanding officer in coordinating and integrating the various internal operations of the depot and in maintaining general efficiency in the conduct of the work. In the absence of the commanding officer, the executive officer shall perform his duties and act with full responsibility and authority for him.

(5) The Special Assistants.—The commanding officer shall be assisted in the performance of his top management functions by special assistants, each of whom has special technical knowledge or other special skills in his respective field. The special assistants shall include as appropriate a dental material officer, who shall have cognizance of and advise on the technical characteristics of dental materials and other dental material matters; an optical material officer, who shall have cognizance of the technical characteristics of optical materials and shall advise on these and other optical matériel matters. The management advisory group, composed of all division heads and other officers as considered appropriate, shall be responsible for advisory staff functions. This group shall continuously review and study the organizational structure, methods and procedures of the depot and operating policies for the purpose of internal coordination and maximum efficiency. The commanding officer shall be assisted by such other special assistants as may be necessary at a particular depot, subject to the prior approval of the Bureau.

(6) The Department Heads.—The department heads shall be responsible for the supervision and coordination of all work performed by their respective departments and shall keep the commanding officer informed in all matters pertaining thereto. They shall continuously review the administrative and operating policies of their departments and recommend to the commanding officer and executive officer such changes in established organization, policies, methods and procedures as they consider will provide for maximum efficiency in internal organization, administration, and operation with due consideration of the requirements of wartime operations. The three basic departments of a medical supply depot shall be the administrative department, the control department, and the warehousing department.

(7) Administrative Department.—

(a) The administrative department shall:

(1) Keep the commanding officer and executive officer advised on and make recommendations concerning the effectiveness of administrative operations and methods.

(2) Be responsible for all matters pertaining to the administration of civilian and naval personnel.

(3) Prepare the prescribed personnel reports and accomplish required personnel actions.

(4) Compile the financial plan and the annual estimates of expenditures, and prepare and maintain budgetary data for use in developing such estimates.

(5) Maintain accounting records of all fiscal transactions, and prepare financial reports and returns.

(6) Be responsible for the maintenance, repair, and upkeep of buildings, grounds, and appurtenances, and for the procurement and custody of maintenance materials.

(7) Operate and maintain automotive equipment.

(8) Administer matters relating to office services, including office equipment and supplies, space assignments, communiation facilities, duplicating machines and processes, messenger activities, and such other services as may be required.

(9) Be responsible for the security, control, and distribution of official correspondence and maintenance of the general files.

(10) Promulgate and enforce safety regulations and instructions.
(b) The administrative department, subject to the workload of the depot, is comprised of a personnel division, a finance and property division, a maintenance and transportation division, and an office services division.

(8) Control Department.—

(a) The control department shall:

(1) Coordinate the workload of the depot, its annexes, and the supporting medical stores sections and storehouses.

(3) Provide for the timely replenishment of stock in accordance with current instructions.

(4) Maintain records of acquisitions, storage, and disposition of medical and dental materials as directed in the Bureau of Medicine and Surgery Handbook of Mechanized Stock Control and Accounting Procedures, depot orders, and other pertinent instructions.

(5) Screen and edit requisitions and other requests for items listed in the current Armed Services Catalog of Medical Matériel.

(6) Ration critical items as necessary.

(7) Keep informed of the normal and special needs of dependent activities.

(8) Obtain, compile, and correlate medical logistic data.

(9) Coordinate and supervise the physical inventory of stock.

(10) Prepare and maintain inventory records and reports and depot-level logistic records and data.

(11) Perform other related material control functions required in the proper operation of the depot.

(b) The control department, subject to the workload of the depot, is comprised of a document control division, an inventory control division, and a traffic control division.

(9) Warehousing Department.—

(a) The warehousing department shall:

(1) Receive and inspect incoming stores, including the accomplishment of the necessary receipt documents, as directed by pertinent instructions.

(2) Issue and prepare for shipment outgoing stores covered by approved disposition documents.

(3) Store all “in store” quantities of stores in the manner outlined in the current Storage Plan and other pertinent instructions.

(4) Maintain a central labor pool and furnish laborer personnel to meet the requirements of all departments within the depot.

(5) Perform other related warehousing functions required in the proper operation of the depot.

(b) The warehousing department, subject to the workload of the depot, is comprised of a receiving division, a shipping division, a storage division, a processing division, and an annex division.


(1) The basic organization of naval medical supply storehouses shall be patterned after the standard organization for naval medical supply depots, modified to suit the mission and operating conditions required of individual storehouses.

Section V. MEDICAL AND DENTAL STORES

General

Standard Unit Price

Receipt and Issue of Medical and Dental Stores

25–27. General

(1) All material for reissue procured by funds and under the cognizance of the Bureau of Medicine and Surgery received at, disposed of by, or stored in elements of the medical supply system shall be classified as medical and dental stores and shall be reported to the Bureau via proper channels in accordance with current directives.

(2) Stock control records shall be maintained for all items of medical and dental stores and shall be segregated into the following categories:

(a) Standard expendable items.

(b) Standard nonexpendable items.

(c) Nonstandard expendable items.

(d) Nonstandard nonexpendable items.

25–28. Standard Unit Price

(1) All material for reissue, stocked by elements of the medical supply system, shall be carried at standard unit prices established in accordance with current directives. Material issued by elements of the medical supply system shall be invoiced at the standard unit price unless otherwise directed by competent authority. Nonstandard items shall be invoiced at the value appearing on the contract or purchase document. In instances wherein nonstandard items are received without a price, the receiving activity shall establish the unit price at a figure that is consistent with the value of the item.

25–29. Receipt and Issue of Medical and Dental Stores

(1) Receipt and issue of medical and dental stores by elements of the medical supply system shall be handled and reported in accordance with instructions promulgated by the central supply demand control point.
Chapter 26

HEALTH PROGRAM FOR CIVIL SERVICE EMPLOYEES

Sections

<table>
<thead>
<tr>
<th>Article</th>
<th>Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-1 through 26-3</td>
<td>I. General</td>
</tr>
<tr>
<td>26-4</td>
<td>II. Organization</td>
</tr>
<tr>
<td>26-5 through 26-10</td>
<td>III. Functions</td>
</tr>
</tbody>
</table>

Section I. GENERAL

26-1. Scope

(1) A health program for naval civil service employees, based on special laws relating to federally employed civilians, is mandatory not only at the larger naval industrial activities such as shipyards, air stations, ordnance plants, and supply depots, but also at all other activities as well. The word "naval," as used throughout this chapter, includes both the Navy and Marine Corps.

(2) The program is primarily preventive in nature. The medical departments, under their respective commanding officers, are responsible for properly carrying out measures necessary for maintaining and promoting the physical and mental health of employees. On stations where safety divisions, safety offices, or less formal safety organizations exist they are responsible for the station's safety program. The services of safety engineers or other personnel, attached to safety offices, are separate from those of the medical department but occupy common ground in many places. The relationship between the medical department and safety office shall be one of sustained collaboration.

(3) The health program, for naval civil service employees as outlined in this chapter, does not apply to the Departmental Program in the District of Columbia. In this area, the health program for all Federal civil service employees is administered by the Department of Defense Civilian Employees' Health Service. It is under the technical control of the Surgeon General of the Army.

26-2. Authority and Regulations

(1) The laws authorizing health programs for naval civil service employees are as follows:

(a) Federal Employees' Compensation Act of 7 September 1916 (c. 458, 39 Stat. 742-750, as amended; 5 U. S. C. 751 et seq.).

(b) Section 4 of the Act of 10 May 1943 (c. 95, 57 Stat. 81, 24 U. S. C. 34).

(c) Sections 2 and 24(b) of the Act of 2 August 1946 (c. 756, 60 Stat. 853 and 856; 5 U. S. C. 415c and 421e(b)).

(d) Act of 8 August 1946 (c. 865, 60 Stat. 903, as amended; 5 U. S. C. 150).

(e) Executive Order 4071 of 4 September 1924.

For medical care of civilian personnel other than civil service, see articles 21-26 through 21-29.

(2) Regulations applicable to the operation of this program within the Naval Establishment are contained in various chapters of this manual (arts. 15-57, 15-90, 21-26, 21-27, 21-31, and 23-21), in Navy Civilian Personnel Instructions (10, 88, 90, 115, 135, 185, 190, and 235), and in current directives and instructions contained in a brochure published by the United States Department of Labor, entitled "Bureau of Employees' Compensation Regulations Governing Administration of the Federal Employees' Compensation Act of 7 September 1916, as Amended." The latter covers regulations governing the overall medical care program for civil service employees sustaining injuries while in the performance of duty, including diseases proximately related to their occupation.

Change 5
caused by conditions of employment. It covers rules and regulations on medical treatment, hospital service, and all other services rendered.

(3) Regulations on care of the dead are contained in chapter 17, in current SecNAV and Bureau Instructions and Notices, and the Bureau of Employees’ Compensation Manual, page XXI, paragraph 1.12.

26-3. Inspections

(1) Staff medical officers of senior command echelons, in conducting medical inspections, shall inquire into the adequacy of medical services rendered to civil service employees and make suitable recommendations for corrective action when indicated. The recommendations should provide, whenever feasible, that smaller activities obtain medical, industrial-hygiene engineering, and laboratory services from nearby larger activities, when these cannot be provided by the activity itself (see art. 26--10). Problems of cross utilization between naval activities which cannot be resolved by local arrangements should be referred to the Bureau of Medicine and Surgery via the cognizant management bureau.

Section II. ORGANIZATION

26-4. Organization of the Occupational Health Division

(1) In larger activities, subject to the concurrence of the management bureau and the commanding officer, an occupational health division or the equivalent thereof shall be established as part of the medical department of each major industrial activity. Where feasible the division shall be under the direction of a medical officer especially qualified in occupational medicine. The medical officer of the activity shall be known functionally as the occupational medical officer and shall be responsible under his commanding officer for the effective prosecution of the occupational health program.

(2) At smaller activities, where the nature of the occupational health hazards is minimal and the number of employees is small, the medical department organization may include either an occupational health division or a less formal organizational structure.

Section III. FUNCTIONS

26-5. Functions of the Occupational Health Division or Equivalent Thereof

(1) The functions of the occupational health division as outlined in the following articles are essentially applicable to larger naval activities. In activities where lesser numbers of civilians are employed and where the occupational hazards are not so extensive, the program will require such modifications as may be indicated to meet the more modest needs. These smaller activities should perform as many of the occupational health functions as possible.

26-6. Clinical and Medical Functions

(1) To the extent applicable, and as modified to meet the specific needs of each activity, the following diagnostic, therapeutic, consultative, and other clinical services essential to the various phases of the program shall be performed:

(a) Immediate treatment for occupational injuries or medical conditions incurred on duty, and subsequent treatments as required and authorized by law. Where facilities are not available at an activity prior arrangements shall be made through the district medical officer with nearby naval activities or with the Bureau of Employees’ Compensation to authorize hospitals, clinics, or physicians for the adequate care of patients who may be injured while at work or who may become ill as a result of occupational exposure.

(b) Emergency and limited care for on-the-job nonoccupational illness or injury. Where illness, injury, or dental conditions require, emergency attention may be provided before referring the employee to his private physician, dentist, or to a hospital. Moderate treatment or advice to relieve minor ailments or injuries may be provided with the objective of keeping employees at work.

(c) Prompt reporting of occupational illness and injury. Investigate all cases of alleged adverse occupational health conditions to establish whether or not the condition was due to occupational exposure. A record shall be maintained, in the indi-
26-6  CHAPTER 26. HEALTH PROGRAM FOR CIVIL SERVICE EMPLOYEES

individual’s medical record, of the findings for use in the adjudication of possible future injury compensation claims. Copies of accident records shall be forwarded to the local safety office.

(d) Physical examinations as follows:
   (1) Preplacement examinations in accordance with mental and physical job requirements.
   (2) Special examinations of employees referred by authorized personnel to determine physical and mental fitness to perform the duties of their positions, and to establish such limitations as may appear necessary to insure continuation of employment without undue hazard to the employee or others.
   (3) Physical examinations for physical-disability retirements from the Federal service.
   (4) Examinations required by the Bureau of Employees’ Compensation to determine the degree of disability for purposes of compensation.
   (5) Periodical examinations for those personnel engaged in hazardous and potentially hazardous occupations.
   (e) Health surveys and health programs (such as annual chest X-rays, health education, sight and hearing conservation).
   (f) Health counseling for civil service employees.
   (g) Rehabilitation programs for proper job placement of the physically handicapped.
   (h) Instruction of employees in the medical aspects of passive defense.
   (i) Preparation of the quarterly Occupational Health Report, NAVMED 576, in accordance with article 23-21.

26-7. Medical Records Administration

(1) The division shall maintain and have custody of civil service employees’ medical records, and assure that they are maintained as confidential medical information and released only for official action. The word “confidential” is used here to connote private.

(2) The records shall be checked to assure that complete and signed entries have been made in medical records and that required forms, reports, and correspondence pertaining to the treatment, hospitalization, and examination of civil service personnel are up to date and conform to current requirements.

(3) Medical reports for compensation purposes shall be accomplished in accordance with the rules and regulations contained in the U. S. Department of Labor’s Bureau of Employees’ Compensation Manual. Completed reports shall be submitted to an official designated by the commanding officer.

(4) Upon separation or discharge of a civilian employee of the Navy or Marine Corps the medical record jacket, including physical examination forms, all records of medical and dental examinations or treatments, and X-ray films, shall be disposed of in accordance with article 23-303.

26-8. Industrial Hygiene

(1) Stations having industrial hygiene engineers aboard, civilian or military, shall:
   (a) Evaluate occupational health hazards by conducting repeated scientific studies of workspaces and processes. These studies shall include recommended corrective measures for the elimination of occupational health hazards and prevention of diseases arising from exposure to toxic materials or from other undesirable physical conditions. Physical conditions which are hazardous to health or which tend to lower the efficiency of personnel include inadequate illumination or ventilation, excessive heat or humidity, high levels of noise, and exposure to ionizing and nonionizing radiation.
   (b) Operate an industrial hygiene laboratory for the purpose of scientifically measuring and analyzing air contaminants, environmental physical exposures, industrial ionizing radiation exposures (atmospheric, radon breath, and photodosimetry tests), potentially toxic proprietary products, and body fluids and exudates requiring highly specialized microanalyses.
   (c) Investigate the circumstances surrounding all alleged adverse occupational health conditions.
   (d) Keep the occupational medical officer informed by submitting reports of surveys which should include recommendations for corrective action. All changes in production policies which may have adverse health implications shall be brought to the attention of the occupational medical officer.
   (e) Maintain an index of all actual or potential toxicological materials in current use in the various industrial processes.
   (f) Take steps to insure that the use of new materials and processes are referred by management to the medical department prior to adoption. Unusual new health hazards should be reported in the narrative portion of the quarterly Occupational Health Report, NAVMED 576.
   (g) Compile statistics and the industrial hygiene narrative portion of the quarterly Occupational Health Report, NAVMED 576, in accordance with article 23-21. Also compile and analyze other data calculated to contribute to better understanding and control of occupational health problems.
   (h) Schedule periodic physical examinations of personnel engaged in occupations hazardous to health.
   (i) Maintain close liaison and cooperation with all departments of the activity to effect complete integration of the industrial hygiene program with all industrial activities of the station.
   (j) Prescribe requirements and procedures, under the direction of a medical officer, for the

Change 5
sterilizing of personal protective clothing and equipment such as goggles, masks, rubber gloves, and rubber boots.

26-9. Industrial Ophthalmology or Optometry

(1) The sight conservation program shall be under the immediate direction of a qualified ophthalmologist or optometrist. He shall:
(a) Perform refractions and visual analyses, or arrange for these procedures to be accomplished.
(b) Prescribe for visual inadequacies and make recommendations applicable to employees having defective vision and those working at tasks where special eye protection is required.
(c) Refer employees with nonoccupational pathological conditions detected during eye examinations to their family physicians.
(d) Render consultations on visual problems.
(e) Maintain necessary records of eye examinations, visual evaluation tests, visual surveys, ophthalmic materials, and other pertinent ophthalmologic information.
(f) Dispense, fit, and repair plano type spectacles and prescription protective eyewear.
(g) Train personnel to sterilize, dispense, and to properly fit plano protective eyewear. This is especially indicated in field activities where the central safety storeroom or the tool-crib personnel are required to perform these duties.

26-10. Program at Smaller Activities

(1) The medical officer or medical department representatives, under their commanding officers, shall be responsible for performing the functions of the health program necessary to meet the needs of the smaller activities in the prevention and care of injuries and illnesses.

(2) Optometrist or ophthalmologist services may be obtained as needed in accordance with article 26-9(2).

(3) Industrial hygiene engineering surveys shall be conducted at least once each year or more frequently depending upon the extent and nature of potential health hazards. Requests for assistance involving the services of an industrial hygienist should be made as follows:
(a) Where funds for travel and salary are available for the purpose, a request for loan of an industrial hygienist shall be made of the commanding officer of the nearest activity employing one. The request should be processed via the appropriate district commandant. Arrangements shall be satisfactory to the commanding officer of the activity to which the industrial hygienist is attached. A copy of the request shall be forwarded to the Bureau of Medicine and Surgery and to the bureau having management control of the requesting activity.
(b) Where funds for travel and salary are not available, requests for assistance in industrial hygiene matters should be made to the bureau having management control of the activity. Arrangements will be made by that bureau to obtain the services needed either from an activity nearest the origin of the request, or from the Bureau of Medicine and Surgery.

26-4
Change 5
## INDEX

### A

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandon ship</td>
<td>4-31</td>
</tr>
<tr>
<td>Abdomen:</td>
<td>15-30(1)(f)</td>
</tr>
<tr>
<td>Diving duty</td>
<td>15-32</td>
</tr>
<tr>
<td>Motor-torpedo-boat training and duty</td>
<td>15-32</td>
</tr>
<tr>
<td>(2) (h)</td>
<td>14-32</td>
</tr>
<tr>
<td>Standards</td>
<td>15-30A</td>
</tr>
<tr>
<td>Submarine personnel</td>
<td>15-30(2)(4)</td>
</tr>
<tr>
<td>Absence of medical officer, afloat</td>
<td>4-12(4)</td>
</tr>
<tr>
<td>Abstract of Service and Medical History, NAVMED 1406</td>
<td>16-55-57</td>
</tr>
<tr>
<td>Accounting, dental</td>
<td>6-177</td>
</tr>
<tr>
<td>Administrative: Divisions, hospital</td>
<td>11-13</td>
</tr>
<tr>
<td>Officer, hospital; duties</td>
<td>11-12A</td>
</tr>
<tr>
<td>Advanced base organizations: Definition</td>
<td>14-18</td>
</tr>
<tr>
<td>G-components</td>
<td>14-19</td>
</tr>
<tr>
<td>Hospitals</td>
<td>14-20</td>
</tr>
<tr>
<td>Staff dental officers</td>
<td>14-22</td>
</tr>
<tr>
<td>Staff medical officers</td>
<td>14-21</td>
</tr>
<tr>
<td>Training</td>
<td>14-23</td>
</tr>
<tr>
<td>Advancement in rating: Dental technicians</td>
<td>6-67</td>
</tr>
<tr>
<td>Hospital Corps</td>
<td>9-12</td>
</tr>
<tr>
<td>Age:</td>
<td>15-30(1)(b)</td>
</tr>
<tr>
<td>Diving duty</td>
<td>15-32</td>
</tr>
<tr>
<td>Motor-torpedo-boat training and duty</td>
<td>15-32</td>
</tr>
<tr>
<td>Nuclear power surface ship training</td>
<td>15-29A</td>
</tr>
<tr>
<td>(1) (a)</td>
<td>14-22</td>
</tr>
<tr>
<td>Aircraft carrier dental officer</td>
<td>6-40</td>
</tr>
<tr>
<td>Alcohol and alcoholic beverages:</td>
<td>3-34</td>
</tr>
<tr>
<td>Custody</td>
<td>3-33</td>
</tr>
<tr>
<td>Prescribing and dispensing</td>
<td>3-35</td>
</tr>
<tr>
<td>Security</td>
<td>3-35</td>
</tr>
<tr>
<td>Allotments:</td>
<td>6-176</td>
</tr>
<tr>
<td>Dental</td>
<td>10-5</td>
</tr>
<tr>
<td>Personal services</td>
<td>10-5</td>
</tr>
<tr>
<td>Ambulances:</td>
<td>3-29(2)</td>
</tr>
<tr>
<td>Civil authorities liaison and use of</td>
<td>1-24, 11-10(3)</td>
</tr>
<tr>
<td>American Red Cross</td>
<td>21-25</td>
</tr>
<tr>
<td>Medical treatment</td>
<td>21-25</td>
</tr>
<tr>
<td>Amphibious operations, medical service</td>
<td>14-1</td>
</tr>
<tr>
<td>Annual physical examinations:</td>
<td>14-1</td>
</tr>
<tr>
<td>Divers</td>
<td>15-30(2)</td>
</tr>
<tr>
<td>Female enlisted</td>
<td>15-48A</td>
</tr>
<tr>
<td>Midshipmen and NROTC students</td>
<td>15-46</td>
</tr>
<tr>
<td>Officers</td>
<td>15-46</td>
</tr>
<tr>
<td>Appointments:</td>
<td>15-46</td>
</tr>
<tr>
<td>Dental Corps</td>
<td>6-15</td>
</tr>
<tr>
<td>Medical Corps</td>
<td>2-3-5</td>
</tr>
<tr>
<td>Medical Service Corps</td>
<td>7-5-8</td>
</tr>
<tr>
<td>Nurse Corps</td>
<td>8-6</td>
</tr>
<tr>
<td>Apptitude board:</td>
<td>18-5</td>
</tr>
<tr>
<td>Data in report</td>
<td>18-5</td>
</tr>
<tr>
<td>Form of report</td>
<td>18-5</td>
</tr>
<tr>
<td>Functions</td>
<td>18-3</td>
</tr>
<tr>
<td>Processing report</td>
<td>18-6</td>
</tr>
<tr>
<td>Articles, professional:</td>
<td>6-33</td>
</tr>
<tr>
<td>Dental Corps</td>
<td>3-20</td>
</tr>
<tr>
<td>Medical Corps</td>
<td>7-29</td>
</tr>
<tr>
<td>Medical Service Corps</td>
<td>4-10(3)</td>
</tr>
<tr>
<td>Atomic warfare, defense against</td>
<td>4-26</td>
</tr>
<tr>
<td>Audiovisual aids report</td>
<td>23-126</td>
</tr>
<tr>
<td>Audit board for precious and special dental metals</td>
<td>6-157</td>
</tr>
<tr>
<td>Aural rehabilitation, special hospitals</td>
<td>12-2</td>
</tr>
<tr>
<td>Authorization for surgery, supernumeraries;</td>
<td>23-216</td>
</tr>
<tr>
<td>SF 522</td>
<td>17-24</td>
</tr>
<tr>
<td>Autopsies</td>
<td>13-18</td>
</tr>
<tr>
<td>Aviation personnel:</td>
<td>13-18</td>
</tr>
<tr>
<td>Physical examinations</td>
<td>15-59</td>
</tr>
<tr>
<td>Annual and promotion</td>
<td>15-71</td>
</tr>
<tr>
<td>Board of flight surgeons</td>
<td>15-72</td>
</tr>
<tr>
<td>Candidates for flight training</td>
<td>15-67</td>
</tr>
<tr>
<td>Candidates for flight training, reporting</td>
<td>15-68</td>
</tr>
<tr>
<td>Forwarding of flight physicals</td>
<td>15-73</td>
</tr>
<tr>
<td>Reexamination for physical incapacity</td>
<td>15-70</td>
</tr>
<tr>
<td>Reporting on class 1 personnel</td>
<td>15-65</td>
</tr>
<tr>
<td>Special reporting, flight training</td>
<td>15-66</td>
</tr>
<tr>
<td>Physical standards:</td>
<td>15-67</td>
</tr>
<tr>
<td>Class 1, service group I</td>
<td>15-62</td>
</tr>
<tr>
<td>Class 1, service group II</td>
<td>15-62</td>
</tr>
<tr>
<td>Class 1, service group III</td>
<td>15-64</td>
</tr>
<tr>
<td>Class 2, personnel</td>
<td>15-69</td>
</tr>
<tr>
<td>Color perception</td>
<td>15-62(19)</td>
</tr>
<tr>
<td>Depth perception</td>
<td>15-62(12)</td>
</tr>
<tr>
<td>Ears</td>
<td>15-62(23)</td>
</tr>
<tr>
<td>Equilibrium</td>
<td>15-62(26)</td>
</tr>
<tr>
<td>Eyes</td>
<td>15-62(15)</td>
</tr>
<tr>
<td>Field of vision</td>
<td>15-62(20)</td>
</tr>
<tr>
<td>Instructions</td>
<td>15-60</td>
</tr>
<tr>
<td>Interpupillary distance</td>
<td>15-62(18)</td>
</tr>
<tr>
<td>Near point of convergence</td>
<td>15-62(17)</td>
</tr>
<tr>
<td>Nose and throat</td>
<td>15-62(23)</td>
</tr>
<tr>
<td>Ocular motility</td>
<td>15-62(13)</td>
</tr>
<tr>
<td>Ophthalmoscopic examination</td>
<td>15-62(22)</td>
</tr>
<tr>
<td>Policies on service groups for aviators</td>
<td>15-61</td>
</tr>
<tr>
<td>Red lens test</td>
<td>15-62(14)</td>
</tr>
<tr>
<td>Refraction</td>
<td>15-62(21)</td>
</tr>
<tr>
<td>Restrictions until physically qualified</td>
<td>15-62(20)</td>
</tr>
<tr>
<td>Test for accommodation</td>
<td>15-62(18)</td>
</tr>
<tr>
<td>Aviation Physiology Training Report, NAVMED-1349</td>
<td>23-18</td>
</tr>
<tr>
<td>Air crew</td>
<td>15-68</td>
</tr>
<tr>
<td>Aviation unit, dental officers</td>
<td>6-56</td>
</tr>
<tr>
<td>Back, physical examination</td>
<td>15-69(2)</td>
</tr>
<tr>
<td>Barracks, sanitary standards</td>
<td>22-7</td>
</tr>
<tr>
<td>Battle casualties, definitions</td>
<td>1-23</td>
</tr>
<tr>
<td>Battle dressing stations</td>
<td>4-36</td>
</tr>
<tr>
<td>Instructions</td>
<td>4-40</td>
</tr>
<tr>
<td>Light</td>
<td>4-38</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>4-42</td>
</tr>
<tr>
<td>Routes to be marked</td>
<td>4-41</td>
</tr>
<tr>
<td>Stellillizers</td>
<td>4-39</td>
</tr>
<tr>
<td>Water supply</td>
<td>4-39</td>
</tr>
<tr>
<td>Battle, final preparation</td>
<td>4-43</td>
</tr>
<tr>
<td>Battle plans:</td>
<td>4-52</td>
</tr>
<tr>
<td>Casualties, reporting</td>
<td>15-68(2)</td>
</tr>
<tr>
<td>Transportation of sick and wounded people</td>
<td>4-8(1)</td>
</tr>
<tr>
<td>Bedding, inspection</td>
<td>4-16(3)</td>
</tr>
</tbody>
</table>

### B

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change 11</td>
<td>1</td>
</tr>
</tbody>
</table>
### INDEX

#### Beds, nomenclature
- 1-21—22

#### Beneficiaries:
- Bureau of Employees Compensation... 21-26
- Naval Home... 21-24
- Public Health Service... 21-22
- Veterans Administration... 21-22
- Berthing space, afloat, sanitary standards... 22-3
- Binnacle List, NAVMED-S... 23-218
- Biological warfare, defense against... 4-26
- Deaths, reporting... 23-18
- Death, reporting... 3-12(4)
- Board of Medical Survey Report, NAVMED-M... 16-12
- Boards and committees, hospital... 11-11
- Brief, sanitary standards... 6-175
- Budget estimates, dental... 6-175
- Bureau:
  - Organization... 1-12
  - Reporting requirements... 23-1
- Burial Record, NAVMED-HF-38... 22-221
- Burial report:
  - Navy... 17-9A
  - Navy Cemeteries or Plots... 23-153

#### C:

- Canadian Armed Forces personnel, dental treatment... 6-98(1)(a)
- Candidates, physical examinations:
  - Commission or warrant... 15-42
  - Naval Academy... 15-43
  - Naval Preparatory School... 15-43
- Casualties:
  - Aviation... 14-8
  - Mass... 6-27
- Cells, inspection... 17-78
- Chambers... 17-81
- Map or plan... 17-81
- National... 17-79
- Naval plots and cemeteries... 17-90
- Certificate of Death, NAVMED-N... 17-10
- Certificate of physical condition, annual;
  - Reserve... 17-78(2)
- Chaplains, hospital... 11-10(2)
- Charges, collections, and reports of supernumeraries... 21-33
- Chemical warfare, defense against... 4-26
- Chiefs of services, hospital... 11-23
- Cholera... 22-27
- Chronological Record of Medical Care, SF-600... 16-44—48
- Dental recordings... 6-119
- Civil authorities, cooperation with:
  - 1-7(2), 3-12, 3-29, 11-7(2)
- Civil suits... 3-29(1)
- Chairmen... 3-29(1)
- Dental officers... 6-36
- Civilian employees:
  - Administration at Bumax activities... 10-1—4
  - Dental facilities... 6-74
  - Dental treatment... 6-98(1)(c)
  - Health program... 20-1—10
  - Medical records... 26-7
  - Release of information... 23-310—314
  - Physical examination... 15-57
  - Positions... 10-5—6
- Civilian(s):
  - Agencies, death forms... 23-310—314
  - Dental professional activity... 6-34
  - Medical aid... 3-27
  - Physicians... 5-24—30
  - Claims for emergency treatment... 20-8—20-16
  - Clinical services, hospital... 11-22
  - Clinics, dental... 6-75—61
  - Coast and Geodetic Survey members, dental treatment... 6-98(1)(f), (j)
- Coast Guard members, dental treatment... 6-98(1)(f), (j)
- Collision afloat... 4-29
- Color perception:
  - Aviation personnel... 15-62(19)
  - Diving duty... 15-30(1)(e)
  - Motor-torpedo-boat; training, duty... 15-32(2)(c)
  - Nuclear power surface ship training... 15-28A(1)(c)
  - Standards... 15-11
  - Submarine personnel... 15-29(2)(c)
- Commanding officer:
  - Dental... 6-49
  - Hospital... 11-7
  - Duties... 11-7
  - Delegation... 11-7(8)
- Communicable disease control:
  - Reports... 5-12, 11-7(2)(b), 22-20
  - Responsibilities... 22-17
  - Tuberculosis control... 22-19
  - Venereal disease control... 22-18
  - Compartment, inspection... 22-17
  - Consent for surgery; supernumeraries; SF 522... 23-216
  - Consultation services:
    - Bethesda Medical Center... 13-3
    - Pensacola Medical Center... 13-15
  - Consultant Sheet, SF 518... 6-120, 16-67
  - Conventions of Geneva... 3-30
  - Correspondence:
    - Courses, dental... 6-131
    - Dental... 6-30
  - Cross-servicing Health Record... 16-19
  - Individual Sick Slip, DD 698... 16-70—73
  - Custody of property:
    - Inspection of materials... 25-16
    - Inventory adjustment... 25-15
    - Inventory procedure... 25-16
    - Records... 25-13
      - Buildings and improvements ledger... 25-13(4)
      - Equipment ledger... 25-13(5)
      - Land ledger... 25-13(3)
      - Narcotics and alcohol ledger... 25-13(9)
      - Plant account ledger... 25-13(8)
      - Precious and dental metals... 25-13(5)
      - Provisions ledger... 25-13(7)
      - Supplies ledger... 25-13(6)
      - Storeroom management... 25-14
      - Transfer of custody... 25-17

#### D

- Damage control, afloat... 4-25
- DD forms, list... 23-217
- Dead and wounded, removal... 4-44

### Deaths:

- Certificate of death, NAVMED-N... 17-10—14
- Civil authorities, reporting... 3-12(4)
- Fleet reservists, inactive... 17-17
- Forms for civilian authorities... 23-310—314
- Funeral expenses, burial at sea of inactive personnel or civilian... 17-66
- Military Sea Transportation Service:
  - Civil marine employees... 17-76
  - Civil-service employees, nonmilitary... 17-75
  - Military crewmembers and military or civilian passengers... 17-77
  - Missing personnel instructions... 17-21
  - Occurring away from command... 17-15
  - Post-mortem examinations... 21-23
  - Reporting to civil authorities... 15-12(4)
  - Retired inactive personnel... 17-16
  - St. Elizabeths Hospital... 17-19

---

**Change II**
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decommissioning</td>
<td>25-22</td>
</tr>
<tr>
<td>Decompression sickness and diving accidents report, NAVMED-816</td>
<td>23-30</td>
</tr>
<tr>
<td>Dental:</td>
<td></td>
</tr>
<tr>
<td>Activities, director</td>
<td>6-46-47</td>
</tr>
<tr>
<td>Appointments, Daily, NAVMED-1298</td>
<td>6-153</td>
</tr>
<tr>
<td>Civilian professional activity</td>
<td>6-34</td>
</tr>
<tr>
<td>Classifications</td>
<td>6-101</td>
</tr>
<tr>
<td>Clinics</td>
<td>6-75-81</td>
</tr>
<tr>
<td>Closings</td>
<td>6-15</td>
</tr>
<tr>
<td>Appointments</td>
<td>6-15</td>
</tr>
<tr>
<td>Duty assignments</td>
<td>6-16</td>
</tr>
<tr>
<td>Establishment</td>
<td>6-13</td>
</tr>
<tr>
<td>Grade and strength</td>
<td>6-14</td>
</tr>
<tr>
<td>Promotion</td>
<td>6-17-20</td>
</tr>
<tr>
<td>Division, BUMED</td>
<td>6-3-12</td>
</tr>
<tr>
<td>Examination and Treatment Record, NAVMED-1299</td>
<td>6-154</td>
</tr>
<tr>
<td>Examinations</td>
<td>6-99</td>
</tr>
<tr>
<td>Recording</td>
<td>6-113</td>
</tr>
<tr>
<td>Specifications</td>
<td>6-100</td>
</tr>
<tr>
<td>Types</td>
<td>6-100</td>
</tr>
<tr>
<td>Facilities</td>
<td>6-178-182</td>
</tr>
<tr>
<td>Folder, DD-722-1</td>
<td>6-109, 16-28-29</td>
</tr>
<tr>
<td>Log</td>
<td>6-29</td>
</tr>
<tr>
<td>Material</td>
<td>6-160-174</td>
</tr>
<tr>
<td>Dental officer:</td>
<td></td>
</tr>
<tr>
<td>Aircraft carrier</td>
<td>6-40</td>
</tr>
<tr>
<td>Assistant</td>
<td>6-23</td>
</tr>
<tr>
<td>Aviation unit</td>
<td>6-56</td>
</tr>
<tr>
<td>Designation</td>
<td>6-22</td>
</tr>
<tr>
<td>Dispensary</td>
<td>6-55</td>
</tr>
<tr>
<td>District</td>
<td>6-47</td>
</tr>
<tr>
<td>Duties, general</td>
<td>6-22-36</td>
</tr>
<tr>
<td>Fleet</td>
<td>6-37</td>
</tr>
<tr>
<td>Force</td>
<td>6-38</td>
</tr>
<tr>
<td>Hospital</td>
<td>6-54</td>
</tr>
<tr>
<td>Hospital ship</td>
<td>6-42</td>
</tr>
<tr>
<td>Marine Corps</td>
<td>6-59-60</td>
</tr>
<tr>
<td>Mobile dental unit</td>
<td>6-57</td>
</tr>
<tr>
<td>Naval Reserve</td>
<td>6-198-209</td>
</tr>
<tr>
<td>Recruit depot</td>
<td>6-52</td>
</tr>
<tr>
<td>Repair ship</td>
<td>6-41</td>
</tr>
<tr>
<td>Research</td>
<td>6-68, 6-133-134F</td>
</tr>
<tr>
<td>River command</td>
<td>6-48</td>
</tr>
<tr>
<td>Ship</td>
<td>6-39</td>
</tr>
<tr>
<td>Shipyard</td>
<td>6-53</td>
</tr>
<tr>
<td>Shore station</td>
<td>6-41</td>
</tr>
<tr>
<td>Tender</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>6-122-132</td>
</tr>
<tr>
<td>Center</td>
<td>6-52</td>
</tr>
<tr>
<td>Civilian</td>
<td>6-126</td>
</tr>
<tr>
<td>Correspondence courses</td>
<td>6-131</td>
</tr>
<tr>
<td>Indocurrence, basic course</td>
<td>6-123</td>
</tr>
<tr>
<td>Internships</td>
<td>6-122</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>6-124, 6-126A</td>
</tr>
<tr>
<td>Request form</td>
<td>6-130</td>
</tr>
<tr>
<td>Residency</td>
<td>6-125</td>
</tr>
<tr>
<td>Specialized</td>
<td>6-126</td>
</tr>
<tr>
<td>Staff and administrative schools</td>
<td>6-127</td>
</tr>
<tr>
<td>Transport</td>
<td>6-42-44</td>
</tr>
<tr>
<td>Dental Record, SF-603</td>
<td>6-107-118</td>
</tr>
<tr>
<td>Abbreviations and designations</td>
<td>6-115</td>
</tr>
<tr>
<td>Custody</td>
<td>6-110</td>
</tr>
<tr>
<td>Examinations, recording</td>
<td>6-113</td>
</tr>
<tr>
<td>Instructions, general</td>
<td>6-108</td>
</tr>
<tr>
<td>Markings</td>
<td>6-116-118</td>
</tr>
<tr>
<td>Operations, recording</td>
<td>6-114</td>
</tr>
<tr>
<td>Purpose</td>
<td>6-107</td>
</tr>
<tr>
<td>Recovery</td>
<td>6-111</td>
</tr>
<tr>
<td>Special entries</td>
<td>6-111</td>
</tr>
<tr>
<td>Treatments, recording</td>
<td>6-114</td>
</tr>
<tr>
<td>Dental School</td>
<td>6-135-138, 13-8</td>
</tr>
<tr>
<td>Dental service, chief of:</td>
<td></td>
</tr>
<tr>
<td>Dispensary</td>
<td>6-55</td>
</tr>
<tr>
<td>Hospital</td>
<td>6-54</td>
</tr>
<tr>
<td>Dental Service Reports, DD-477, 477-1</td>
<td>6-150</td>
</tr>
<tr>
<td>Dental service warrant officers</td>
<td>6-69</td>
</tr>
<tr>
<td>Dental Standards:</td>
<td></td>
</tr>
<tr>
<td>Annual physical</td>
<td>6-91</td>
</tr>
<tr>
<td>Appointment</td>
<td>6-38-39</td>
</tr>
<tr>
<td>Aviation duty</td>
<td>6-95-96</td>
</tr>
<tr>
<td>Diving duty</td>
<td>6-93A</td>
</tr>
<tr>
<td>Enlistment and reenlistment</td>
<td>6-87</td>
</tr>
<tr>
<td>Nuclear power surface ship</td>
<td>6-93</td>
</tr>
<tr>
<td>Promotion</td>
<td>6-91</td>
</tr>
<tr>
<td>Purpose</td>
<td>6-99</td>
</tr>
<tr>
<td>Submarine duty</td>
<td>6-93</td>
</tr>
<tr>
<td>Waivers of defects</td>
<td>6-97</td>
</tr>
<tr>
<td>Women</td>
<td>6-94</td>
</tr>
<tr>
<td>Dental technicians</td>
<td>6-83-88</td>
</tr>
<tr>
<td>Schools</td>
<td>6-139-144</td>
</tr>
<tr>
<td>Dental treatment</td>
<td>6-98, 6-102</td>
</tr>
<tr>
<td>Army and Air Force members</td>
<td>6-98(1) (e) (j)</td>
</tr>
<tr>
<td>Before transfer to station without dental officer</td>
<td>6-92</td>
</tr>
<tr>
<td>Canadian Armed Forces personnel</td>
<td>6-98(1) (a) (c)</td>
</tr>
<tr>
<td>Civil personnel injured in a naval station</td>
<td>6-98(1) (b)</td>
</tr>
<tr>
<td>Coast and Geodetic Survey members</td>
<td>6-98(1) (f), (j)</td>
</tr>
<tr>
<td>Coast Guard members</td>
<td>6-98(1) (f), (j)</td>
</tr>
<tr>
<td>Dependents outside U.S.</td>
<td>6-98(1) (h)</td>
</tr>
<tr>
<td>Fleet Naval Reserve and Marine Corps Reserve on active duty</td>
<td>6-98(1) (b)</td>
</tr>
<tr>
<td>Inactive duty Navy and Marine Corps members</td>
<td>6-98(1) (i)</td>
</tr>
<tr>
<td>Medical officer</td>
<td>3-15</td>
</tr>
<tr>
<td>Naval Reserve and Marine Corps Reserve active duty</td>
<td>6-98(1) (d)</td>
</tr>
<tr>
<td>Navy and Marine Corps on active duty</td>
<td>6-98(1) (g)</td>
</tr>
<tr>
<td>Nonnaval</td>
<td>6-105, 11-7(3), 20, 12-16</td>
</tr>
<tr>
<td>Persons hospitalized, accordance with law</td>
<td>6-98(1) (g)</td>
</tr>
<tr>
<td>Priority</td>
<td>6-98(2)</td>
</tr>
<tr>
<td>Prisoners of war</td>
<td>6-98(1) (m)</td>
</tr>
<tr>
<td>Prosthetic</td>
<td>6-103</td>
</tr>
<tr>
<td>Public Health Service members</td>
<td>6-98(1) (f), (j)</td>
</tr>
<tr>
<td>Recording on SF-600</td>
<td>6-119</td>
</tr>
<tr>
<td>Recording on SF-603</td>
<td>6-114-118</td>
</tr>
<tr>
<td>Refusal</td>
<td>6-105, 6-113(1) (m)</td>
</tr>
<tr>
<td>Retired Navy and Marine Corps on active duty</td>
<td>6-98(1) (g)</td>
</tr>
<tr>
<td>Veterans Administration patients</td>
<td>6-98(1) (l)</td>
</tr>
<tr>
<td>Dentures, inscription</td>
<td>6-104</td>
</tr>
<tr>
<td>Department of Defense forms, list</td>
<td>23-217</td>
</tr>
<tr>
<td>Dependents:</td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td>5-9</td>
</tr>
<tr>
<td>Charges, collections, and reports</td>
<td>21-33</td>
</tr>
<tr>
<td>Dental treatment outside U.S.</td>
<td>6-98(1) (h)</td>
</tr>
<tr>
<td>Medical care</td>
<td>21-4-8</td>
</tr>
<tr>
<td>Depth perception, aviation</td>
<td>15-62(12)</td>
</tr>
<tr>
<td>Deserters:</td>
<td></td>
</tr>
<tr>
<td>Health Record</td>
<td>16-11</td>
</tr>
<tr>
<td>Physical examination</td>
<td>16-56</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>22-20</td>
</tr>
<tr>
<td>Schick test and control</td>
<td>22-29(3)</td>
</tr>
<tr>
<td>Tetanus toxoids</td>
<td>23-24</td>
</tr>
<tr>
<td>Disability of medical officer afloat</td>
<td>4-12(4)</td>
</tr>
<tr>
<td>Disbursing division, hospital</td>
<td>11-14</td>
</tr>
<tr>
<td>Discharge, physical examination</td>
<td>15-48</td>
</tr>
<tr>
<td>Disease-bearing insects and pests, control</td>
<td>22-31</td>
</tr>
</tbody>
</table>

Change II
INDEX

Diseases subject to quarantine .................................................. 22-36
Cholera ................................................................. 22-36(1)(a)
Plague ................................................................. 22-36(1)(b)
Smallpox ............................................................... 22-36(1)(d)
Typhoid ................................................................. 22-36(1)(e)
Yellow fever ......................................................... 22-36(1)(e)
Dissection ............................................................... 22-38
Dispensary, definition .................................................. 1-21(1)
Disposition and Expenditures, Remains of the ........... 17-9B
Dead, NAVMED-609 .............................................. 17-9B
Dispotion of records, retirement ........................................... 23-301
District dental officer .............................................. 6-47
District medical officer: .............................................. 5-3
Duties ................................................................. 5-4
Diving accidents and decompression sickness .......... 22-41
Ears—Continued
Ears—Continued
Eyes—Continued
Facilities, dental ...................................................... 6-187–192
Field records retirement schedule ......................... 23-303
Field sanitation ....................................................... 22-41
Field service ......................................................... 22-41
Food handlers ........................................................ 22-41(1)(e)
Galley ................................................................. 22-41(1)(f)
Immunizations ........................................................ 22-41(3)
Induction of personnel ............................................. 22-41(1)(a)
Material and supplies .............................................. 22-41(1)(d)
Medical Department responsibilities .................. 14-2
Nonmedical personnel ............................................ 22-41(1)(e)
Personnel .............................................................. 22-41(1)(b)
Field of vision, aviation ....................................... 15-62(20)
Finance division, hospital ..................................... 11-15
Fire and rescue party afloat .................................. 4-30
Fire quarters afloat ............................................... 4-28
Flights: ............................................................................. 5-2
Doctrines and emergencies:........................................
Abandon ship ........................................................ 4-31
Collision .................................................................... 4-29
Damage control ......................................................... 4-25
Dead and wounded .................................................... 4-44
Defense against special warfare ........................... 4-36
Duty in battle .......................................................... 4-24
Final preparation for battle ........................................ 4-43
Fire and rescue party .............................................. 4-30
Fire fighters .................................................................. 4-28
Plight quarters ........................................................ 4-27
General quarters: .....................................................
Condition I ............................................................ 4-22
Condition II ............................................................. 4-23
Condition III ........................................................... 4-24
Handling rescued personnel ...................................... 4-33
Landing force ................................................................ 4-34
Man overboard .......................................................... 4-32
Preparation for ........................................................ 4-41
Transfer of wounded to hospital ships .................. 4-45
Drugs: .................................................................
Dental ........................................................................ 6-31
Prescribing and dispensing ....................................... 6-31
Record ..................................................................... 23-254
Sale in exchange ........................................................ 3-4(2)
Duties: ............................................................................. 25
Assistant medical officer, general ......................... 2-16, 3-17
Battle stations ............................................................ 4-35
Civilian physician ...................................................... 5-29
Dental service warrant officers ............................... 6-70
Dentist technicians ..................................................... 6-70
District medical officer ............................................. 5-4
Division medical officer ............................................ 4-11(1)
Fleet medical officer .................................................. 4-11(1)
Force medical officer ................................................ 4-11(1)
Group X, medical, Hospital Corps ........................... 4-11(1)
Hospital corpsmen in hospitals ................................ 11-28
Inspector, naval medical activities ........................... 5-2
Medical officer, general ............................................. 3-1–15, 3-18–30
Medical officer of a hospital ...................................... 4-12–19
Medical officer of a shore station ............................. 5-6–17
Medical Service Corps, dental .................................. 6-72
Medical Service Corps, general .............................. 7-27
Medical Service Corps, specific ................................ 7-28
4
Change II
INDEX

Medical treatment—Continued
Other services, retired-with-pay members... 21-15
Registrants, Selective Service... 21-24
Supernumeraries... 21-2
Meetings, medical... 4-10
Misconduct, dental injuries... 6-112(2)
Missing personnel... 17-21
Mobile dental unit officer... 6-37
Morning Report of Sick, NAVMED-T... 23-219
Motor-torpedo-boat training and duty, physical standards... 15-32

Narcotics:
Custody... 2-34
Log... 22-233
Loss... 3-36, 25-13(9)
Prescribing... 3-33
Security... 3-35
Narrative Summary, SF 502... 16-36
Naval Dental Reserve... 6-198-209
NAVMED forms, list... 23-215
Near point of convergence, aviation... 15-62(17)
Neck standards... 15-16
Nervous system:
Aviation personnel... 15-62(10)
Motor-torpedo-boat training and duty... 15-32
 standards... 15-24
Neuropsychiatric Report, NAVMED-102... 23-17
Neuropsychiatric, special hospitals... 12-4
Neck and throat:
Aviation personnel... 15-62(35)
Diving personnel... 15-30(1)(h)
Motor-torpedo-boat training and duty... 15-32
 standards... 15-15
Submarine personnel... 15-29(2)(d)
NROTC physical standards... 15-34A
Nuclear power surface ship training program, physical standards... 15-29A

Nurse Corps:
Appointments... 8-6
Authority for... 8-5
Charge nurse... 8-13
Chief of nursing service... 8-3
Dental facilities... 6-73
Director... 8-14
Duties... 8-10-14
Establishment... 8-1
Grade... 8-3
Hospitals... 11-27
Institution... 8-7(1)
Promotion... 8-8, 8-9
Strength... 8-2
Supervisor... 8-12

Occupational health... 21-1-10
Occupational Health Report, NAVMED-576... 23-21
Ocular motility, aviation... 15-62(13)
Officer in charge, dental... 6-50
Officer of the day... 11-8(6), 11-12(2)
Officer of the deck or day report... 3-9
Oncology, special hospitals... 12-3
Operations, Dental Record... 6-114
Ophthalmoscopie examination, aviation... 15-62(22)
Organization, hospital... 11-4
Orthopedic and prosthetic material... 24-35(3)
Orthopedic examination of major joints... 15-89A

P
Pathogenic cultures and organisms, transfer... 22-39

Patient's:
Air transportation... 11-39
Hospital... 11-7(3), 11-8(2), 11-20, 11-30
Neuropsychiatric... 12-4
Register, DD Form 739... 23-222
Transfer... 3-22, 4-17
From hospital... 11-30
Perineum, penes, sacroiliac, and lumbar sacral joints, examination... 15-31

Personnel:
Complements and allowances:
Medical Department afloat... 4-12(2)
Medical Department ashore... 6-8
Fleet reservists, inactive; death... 17-17
Hospital... 11-7(4), 11-8(4)
Inactive or civilian personnel, burial at sea... 17-66
Inspection, afloat... 4-16(1)
Physically disqualified for reenlistment when separated... 15-41
Retired inactive, death... 17-16
Personnel and records division, hospital... 11-19

Photofluorographic:
Chest Survey Report, NAVMED-618... 15-90(6)/j(4)
Equipment report, NAVMED-1406... 23-44
Log, NAVMED-1161... 15-90(6)/j(1)

Physical defects and waiver:
Definition of organic defects... 15-36
Physical defects... 15-35
Procedure for recommending waiver... 15-38
Relative significance of physical defects... 15-37
Physical examinations:
Annual:
Female enlisted... 15-46A
Midshipmen and NRTOC... 15-46
Officers... 15-45
Applicants, candidates, and reservists... 6-11
Applicants for steward ratings... 15-54
Aviation personnel:
Annual and promotion... 15-71
Board of flight surgeons... 15-72
Candidates for flight training... 15-67-68
Forwarding of flight physicals... 15-73
Reexaminations for physical incapacity... 15-70
Reporting of examinations on class 1 personnel... 15-65
Special reporting, flight training... 15-66
Candidates for commission or warrant... 15-42
Candidates for Naval Academy... 15-43
Candidates for Naval Preparatory School... 15-43
Civil employees... 15-57
Commercial life insurance... 3-21(2)
Deserters... 15-56
Detached to sea duty or duty outside U.S... 15-51
Discharge, transfer to Fleet Reserve, or retirement of enlisted personnel... 15-48
Enlisted personnel selected to attend service schools... 15-53
Enlistment or reenlistment... 15-40
Heart and blood vessels... 15-88
Heterophoria and prism divergence at near... 15-87
Instructions... 15-39
Intoxication evidence... 15-58
Members on temporary disability retired... 15-58A
Orthopedic, major joints... 15-80A
Personnel physically disqualified for reenlistment when separated... 15-41
Prisoners... 15-55
Promotion of officers... 15-47
INDEX

Physical examinations—Continued

Range of motion .......................................... 15-89
Reporting of results ................................. 15-81, 16-37-40
Reserve, Navy and Marine Corps:
Active duty .................................................. 15-76
Actual control of aircraft .......................... 15-79
Appointment, enlistment, promotion ........... 15-75
Physical defects, reporting, disposition ...... 15-86
Quadrennial examination ............................ 15-78
Training duty ............................................... 15-77
Retired members ordered to active duty ...... 15-44
Roentgenographic of chest, ........................ 15-90
Separation of officers ................................ 15-49
Submarine and diving ................................ 14-11(3), 14-15
Transfer of enlisted personnel .................. 3-6, 15-50
Visual acuity .............................................. 15-86

Physical standards, including causes for re-
jection:
Abdomen .................................................. 15-20, 15-20(2), 15-29(2) (i),
15-30(1) (e), 15-32(2) (c), 15-62(19).
Application .............................................. 15-3
Aviation personnel:
Class 1, service group I .................................. 15-62
Class 1, service group II ............................ 15-63
Class 1, service group III .......................... 15-64
Class 2, personnel ..................................... 15-69
Instruction .............................................. 15-69
Policies of service groups .......................... 15-61
Restrictions until physically qualified ..... 15-60
Color perception ......................................... 15-11,
15-29(2) (c), 15-29A(1) (e), 15-30(1) (e),
15-32(2) (c), 15-62(19).
Diving duty .............................................. 15-30
Ears ......................................................... 15-12,
15-12(2), 15-29(2) (e), 15-30(1) (g),
15-32(2) (f), 15-62(23).
Endocrine glands and metabolism .............. 15-9, 15-9(2)
Entrance into service .................................. 15-6
Extremities .............................................. 15-14, 15-23-23(2)
Eyes ......................................................... 15-10,
15-29(1) (e), 15-29A(1) (b), 15-30(1) (d),
15-32(2) (b), 15-34(1)
Genitourinary system .................................. 15-22,
15-23(2), 15-29A(1) (e), 15-30(1) (d),
15-32(2) (d), 15-62(19),
Height ..................................................... 15-3(2)
Inductees ................................................. 15-27
Interpretation ........................................... 15-4
Major joints .............................................. 15-89A
Medical history taking ............................... 15-5,
15-30(1) (c), 15-62(2)
Motor-torpedo-boat training and duty ....... 15-32
Neck ......................................................... 15-16, 15-16(2)
Nervous system ......................................... 15-24,
15-24(2), 15-32(2) (d), 15-62(10),
15-62(12).
Nose and throat ......................................... 15-15,
15-15(2), 15-29(2) (d), 15-30(1) (h),
15-32(2) (e), 15-62(25).
NROTC ...................................................... 15-34A
Nuclear power surface ship training .......... 15-29A
Perineum, pelvis, sacrococcyx, and lumbosacral
Joints ...................................................... 15-21, 15-21(2)
Prescribing ............................................... 15-1
Psychiatric ............................................... 15-7,
15-7(3), 15-29(2) (e), 15-29A(1) (f),
Purpose ................................................... 15-2
Reserve, Navy and Marine Corps .............. 15-74
Skin ......................................................... 15-13,
15-13(2), 15-29(2) (i), 15-30(1) (m),
15-32(2) (b).

Physical standards, including causes for re-
jection—Continued

Spine ..................................................... 15-17, 15-17(2)
Submarine personnel .................................. 15-29
Teeth ..................................................... 6-86-97,
15-25, 15-29(2) (f), 15-29A(1) (d),
15-30(1) (f), 15-32(2) (d), 15-34(4).
Thorax ..................................................... 15-18,
15-18(2), 15-29(2) (p), 15-30(1) (f),
15-62(5).
Underwater demolition teams ................. 15-30
Veneral disease ......................................... 15-22,
15-29(2) (j), 15-30(1) (i), 15-62(3)
Weight and height .................................... 15-8,
15-30(1) (e), 15-34(2), 15-62(4)
Weight tables .......................................... 15-61
Women personnel ....................................... 15-34
Physicians, civilian .................................... 5-24-29
Plague ...................................................... 22-28
Poliomyelitis ............................................. 22-30
Positions, civilian ...................................... 10-5-8
Post mortem examination ......................... 17-24
Poultice brands ........................................... 3-9
Civilian ................................................. 3-33(1), 21-7
Dental ..................................................... 6-31
Form, DD 1289 ............................................. 5-31
Mail ......................................................... 21-7(2)
Preventive medicine:
Communicable diseases ............................ 22-17-19
Field sanitation ......................................... 22-40-41
Food and water supply ................................ 22-13
Garbage, refuse and sewage disposal ......... 22-15-16
Immunization ............................................. 22-21-30
Insect, pest and rodent control .................. 22-31-32
Lighting, heating, and ventilation ............ 22-12
Procedures .............................................. 22-3
Quarantine procedures ............................... 22-23-39
Responsibility ........................................... 22-2
Sanitary standards for living spaces .......... 22-7
Sanitation and industrial hygiene ............. 22-4
Scope ....................................................... 22-1
Prisoners, physical examination ............... 22-11
Prisoners of war, dental treatment .......... 6-98(1) (m)
Prisons, sanitary standards ...................... 22-11
Private practice:
Dentistry ............................................... 6-35
Medicine ............................................... 3-26A
Promotion:
Dental Corps .......................................... 6-17-20
Medical Corps ......................................... 6-17-20
Medical Service Corps ............................... 7-10-21
Nurse Corps ............................................. 8-8
Physical examination of officers .............. 15-47
Property:
Accountability ......................................... 5-12, 25-6
Bureau responsibility ............................... 25-1
Custody ............................................... 25-13-18
Decommissioning of ship or station .......... 25-22
Definition ............................................... 25-2
Dental ..................................................... 6-160-174
Donations ............................................... 25-11
Inventory ............................................... 25-8
Records ................................................... 25-5
Issue of equipment .................................. 25-20
Issue of supplies ...................................... 25-19
Physical classification ............................. 25-5
Buildings and improvements ..................... 25-3(2)
Equipment .............................................. 25-3(3)
Land ....................................................... 25-3(1)
Supplies .................................................. 25-3(4)

Change II
INDEX

Sanitary standards for living spaces—Continued

Berthing spaces affoat:
- Berthing compartments 22-8(2)
- Inspectors 22-8(1)
- Plumbing fixtures 22-8(3)

Brigs 22-10

Hospitals:
- Bed requirements 22-9(2)
- Patients per ward 22-9(1)
- Prisons 22-11

Sanitation:
- Cooperation with civil authorities 22-4(3)
- Indoctination of personnel 24-4(2)
- Industrial hygiene 22-6
- Inspection and investigation 22-4(1)
- Recommendations 24-4(4)
- Records 22-4(6)
- Reports 22-4(6)
- Swimming sites:
  - Bathing loads 22-5(4)
  - Pools 22-5(2)
  - Recommendations 22-5(1)
  - Sanitary control 22-5(3)

Schick test 22-29(3)

School:
- Aviation Medicine 13-18
- Dental 6-135-138, 13-8
- Dental Technician 6-139-144
- Hospital Administration 13-9
- Hospital Corps 9-11
- Medical 13-6
- Security and master at arms division, hospital 11-20
- Selective Service registrants, medical care 21-24
- Self-contained underwater breathing apparatus, diving, physical standards 15-30
- Separation from service, officers 15-49
- SP forms, list 25-216
- Ship dental officer 6-39
- Ship medical officer 4-12-19
- Ships going into commission, inspection 5-17
- Shipyard dental officer 6-53
- Shore station dental officer 6-51
- Shoulder, physical examination 15-99A
- Sick Care Treatment Record, NAVMED 10 16-30
- Sick, morning report, NAVMED-T 23-219
- Sick Slip, Individual, DD 689 16-35, 16-70-73
- Sight conservation program 26-9

Skin:
- Diving personnel 15-30(1)
- Motor-torpedo-boat training and duty 15-32
- (2) (1)
- Standards 15-13
- Submarine personnel 15-29(2)
- Smallpox 22-22
- Special Duty Medical Abstract, NAVMED 1348 16-58-60

Special hospitals:
- Aural rehabilitation 12-2
- Neuropsychiatry 12-4
- Attendants 12-4(2)
- Evaluation, treatment, and transfer 12-4(1)
- Final disposition 12-4(7)
- Notification of next of kin 12-4(5)
- Personal effects 12-4(6)
- Security of patients during transfer 12-4(3)
- Oncology 12-3
- Special services division, hospital 11-21
- Specialists for emergency treatment 20-3-15
- Spine standards 15-17

Standard Federal medical forms, list 23-216
- Standing orders, medical officers 3-7
- Statement and Inventory of Precious and Special Dental Metals, NAVMED-1301 6-156
- Statement in rebuttal, medical survey 18-14
- Sterilizers for battle dressing stations 4-41
- Steward ratings, applicants; physical examination 15-54

Storerooms:
- Management 25-14
- Medical 4-15

Submarine and diving services:
- Duties 14-10
- Illness due to occupational hazards 14-16
- Inspections by medical officer 14-11
- Instruction 14-12
- Physical examinations 14-11(3), 14-15
- Radiation hazards 14-11(4)
- Reexamination 15-29(4)
- Reports 14-14, 14-17
- Venereal disease 14-13

Supernumeraries:
- Ambulance service 21-2(2)
- Charges, collections, and reports 21-33
- Definition 21-1
- Dependents 21-4-8
- Health Record termination 16-17
- Medical care 21-2
- Other than service patients:
  - Beneficiaries 21-30
    - Bureau of Employees Compensation 21-26
    - Public Health Service 21-26
    - Veterans Administration 21-22
    - Civilians under special circumstances 21-28
    - Members of foreign military establishments 21-30
  - Officers and employees of Government and Federal contractors outside U.S.
    - Officers and employees of the State Department Foreign Service 21-29
    - Registrants, Selective Service 21-24
    - Representative, American Red Cross 21-25
    - Release of information from medical records 23-312
- Service patients not on active naval duty:
  - Army and Air Force Reserve 21-17
  - Beneficiaries of the Naval Home 21-19
  - Fleet Reserve and Fleet Marine Corps Reserve 21-14
  - Former members 21-20
  - Naval pensioners 21-13
  - Navy and Marine Corps Reserve 21-16
  - Officer candidates 21-21
  - Other services, active duty 21-12
  - Other services, retired with pay 21-15
  - Retired Navy and Marine Corps 21-13
  - Services other than inpatient care 21-3
- Table of procedures 21-3

Supplies:
- Dental 6-160-174
- Issue 25-19
- Medical 4-14
- Medical, at battle dressings stations 4-58
- Medical, inspection 5-13
- Surface ship nuclear power training program, physical standards 15-29A
- Survey of property 25-21
- Surveys of dental activities and facilities 6-193-197
- Swimming sites 22-5
- Syphilis Record, SP 602 16-52-53

Change II
### INDEX

#### T

<table>
<thead>
<tr>
<th>Tabulation:</th>
<th>23-217</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD forms</td>
<td>23-217</td>
</tr>
<tr>
<td>NAMxK forms</td>
<td>23-215</td>
</tr>
<tr>
<td>Reports</td>
<td>23-2</td>
</tr>
<tr>
<td>Standard forms</td>
<td>23-216</td>
</tr>
<tr>
<td>Teeth, numerical designation</td>
<td>6-115(1)</td>
</tr>
<tr>
<td>Teeth, standards</td>
<td>6-86--97, 15-25</td>
</tr>
<tr>
<td>Annual physical</td>
<td>6-91</td>
</tr>
<tr>
<td>Appointment</td>
<td>6-82--89</td>
</tr>
<tr>
<td>Aviation duty</td>
<td>6-95--96</td>
</tr>
<tr>
<td>Diving duty</td>
<td>6-93A, 15-30(1)</td>
</tr>
<tr>
<td>Enlistment and reenlistment</td>
<td>6-87</td>
</tr>
<tr>
<td>Motor torpedo boat training</td>
<td>15-32(2)</td>
</tr>
<tr>
<td>Nuclear power surface ship training</td>
<td>6-93, 15-30A(1)</td>
</tr>
<tr>
<td>Promotion</td>
<td>6-90</td>
</tr>
<tr>
<td>Submarine duty</td>
<td>6-93, 15-29(2)</td>
</tr>
<tr>
<td>Waivers of defects</td>
<td>6-97</td>
</tr>
<tr>
<td>Women</td>
<td>6-84, 15-34(4)</td>
</tr>
<tr>
<td>Temperament, diving duty</td>
<td>15-30(1)</td>
</tr>
<tr>
<td>Tendere dental officer</td>
<td>6-41</td>
</tr>
<tr>
<td>Test for accommodation aviation</td>
<td>15-62(16)</td>
</tr>
<tr>
<td>Tetanus and diphtheria toxoids</td>
<td>22-24</td>
</tr>
<tr>
<td>Thorax</td>
<td></td>
</tr>
<tr>
<td>Aviation personnel</td>
<td>15-62(5)</td>
</tr>
<tr>
<td>Diving personnel</td>
<td>15-30(1)</td>
</tr>
<tr>
<td>Standards</td>
<td>15-18</td>
</tr>
<tr>
<td>Submarine personnel</td>
<td>15-29(2)</td>
</tr>
<tr>
<td>Toxicology Unit</td>
<td>13-10</td>
</tr>
</tbody>
</table>

#### Transfer—Continued

<table>
<thead>
<tr>
<th>Patients from a naval hospital</th>
<th>11-30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical reasons</td>
<td>11-30(2)</td>
</tr>
<tr>
<td>Orders and travel</td>
<td>11-30(5)</td>
</tr>
<tr>
<td>Personal reasons</td>
<td>11-30(3)</td>
</tr>
<tr>
<td>Retirement, records</td>
<td>23-302</td>
</tr>
<tr>
<td>Sea duty or duty outside U.S., physical examination</td>
<td>15-51</td>
</tr>
<tr>
<td>Wounded</td>
<td>4-45, 14-9</td>
</tr>
<tr>
<td>Transport dental officer</td>
<td>6-43--44</td>
</tr>
<tr>
<td>Transport duty</td>
<td>4-10</td>
</tr>
<tr>
<td>Transportation, sick and wounded</td>
<td>4-8(1)</td>
</tr>
<tr>
<td>Treatment Purnished Pay Patients, Hospitalization Purnished, DD Form 7</td>
<td>21-33(3)</td>
</tr>
<tr>
<td>Treatment, nonnaval</td>
<td>11-7(3), 20-1-16</td>
</tr>
<tr>
<td>Tuberculosis testing, recruits, midshipmen</td>
<td>15-91</td>
</tr>
<tr>
<td>Tuberculosis control</td>
<td>22-19</td>
</tr>
<tr>
<td>Typhoid and paratyphoid</td>
<td>22-23</td>
</tr>
<tr>
<td>Typhus</td>
<td>22-26</td>
</tr>
</tbody>
</table>

#### U

<table>
<thead>
<tr>
<th>Underwater demolition teams, physical standards</th>
<th>15-30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfavorable Inoculant Reactions, report</td>
<td>22-21(4)</td>
</tr>
<tr>
<td>Unit price of medical stores</td>
<td>25-28</td>
</tr>
</tbody>
</table>

#### V

<table>
<thead>
<tr>
<th>Venereal disease: Applicants for naval service</th>
<th>15-22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aviation personnel</td>
<td>15-62(3)</td>
</tr>
<tr>
<td>Control program</td>
<td>22-18</td>
</tr>
<tr>
<td>Diving personnel</td>
<td>15-30(1)</td>
</tr>
<tr>
<td>Instructions</td>
<td>3-10(2)</td>
</tr>
<tr>
<td>Release of personnel</td>
<td>15-48(5)</td>
</tr>
<tr>
<td>Submarine personnel</td>
<td>14-18, 15-29(2)</td>
</tr>
<tr>
<td>Syphilis Record, SP 602</td>
<td>18-52-53</td>
</tr>
<tr>
<td>Veterans Administration patients, dental treatment</td>
<td>6-98(1)</td>
</tr>
<tr>
<td>Visual acuity, aviation</td>
<td>15-62(11)</td>
</tr>
<tr>
<td>Visual acuity, testing</td>
<td>15-86</td>
</tr>
</tbody>
</table>

#### W

| Waiver, procedure                             | 15-38 |
| Waivers of dental defects                     | 6-97 |
| Ward medical and dental officer               | 11-24 |
| Watches, naval hospital                        | 11-12 |
| Water supply                                  | 22-14 |
| Battle dressing stations                       | 4-39 |
| Weight: Aviation personnel                     | 15-62(4) |
| Diving duty                                   | 15-30(1) |
| Standards                                     | 15-8(1) |
| Submarine personnel                            | 15-39(2) |
| Tables                                        | 15-8(1) |
| Women personnel                               | 15-34(2) |
| Weight: Aviation personnel                     | 15-62(4) |
| Diving duty                                   | 15-30(1) |
| Standards                                     | 15-8(1) |
| Submarine personnel                            | 15-39(2) |
| Tables                                        | 15-8(1) |
| Women personnel                               | 15-34(2) |
| Causes for rejection                           | 14-13, 15-34(8) |
| Wrist and hand, physical examination           | 15-89A(5) |

#### X

| X-rays, chest                                 | 15-90 |

#### Y

| Yellow fever                                  | 22-25 |
## INDEX

### A

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandon ship</td>
<td>4-31</td>
</tr>
<tr>
<td>Abdomen:</td>
<td></td>
</tr>
<tr>
<td>Diving duty</td>
<td>15-30(1)(k)</td>
</tr>
<tr>
<td>Motor-torpedo-boat training and duty</td>
<td>15-32</td>
</tr>
<tr>
<td>(h)</td>
<td></td>
</tr>
<tr>
<td>Standards</td>
<td>18-20</td>
</tr>
<tr>
<td>Submarine personnel</td>
<td>15-29(2)(l)</td>
</tr>
<tr>
<td>Absence of medical officer, afloat</td>
<td>4-12(4)</td>
</tr>
<tr>
<td>Abstract of Service and Medical History, Navmed 1406</td>
<td>16-55—57</td>
</tr>
<tr>
<td>Accounting, dental</td>
<td>6-177</td>
</tr>
<tr>
<td>Administrative:</td>
<td></td>
</tr>
<tr>
<td>Divisions, hospital</td>
<td>11-13</td>
</tr>
<tr>
<td>Officer, hospital, duties</td>
<td>11-12A</td>
</tr>
<tr>
<td>Advanced base organizations:</td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>14-18</td>
</tr>
<tr>
<td>G-components</td>
<td>14-19</td>
</tr>
<tr>
<td>Hospitals</td>
<td>14-20</td>
</tr>
<tr>
<td>Staff dental officers</td>
<td>14-22</td>
</tr>
<tr>
<td>Staff medical officers</td>
<td>14-21</td>
</tr>
<tr>
<td>Training</td>
<td>14-23</td>
</tr>
<tr>
<td>Advancement in rating:</td>
<td></td>
</tr>
<tr>
<td>Dental technicians</td>
<td>6-67</td>
</tr>
<tr>
<td>Hospital Corps</td>
<td>9-8</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
</tr>
<tr>
<td>Diving duty</td>
<td>15-30(1)(k)</td>
</tr>
<tr>
<td>Motor-torpedo-boat training and duty</td>
<td>15-32</td>
</tr>
<tr>
<td>Nuclear power surface ship training</td>
<td>15-29A</td>
</tr>
<tr>
<td>Aircraft carrier dental officer</td>
<td>6-40</td>
</tr>
<tr>
<td>Alcohol and alcoholic beverages:</td>
<td></td>
</tr>
<tr>
<td>Custody</td>
<td>3-34</td>
</tr>
<tr>
<td>Prescribing and dispensing</td>
<td>3-33</td>
</tr>
<tr>
<td>Security</td>
<td>3-35</td>
</tr>
<tr>
<td>Allotments:</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>6-176</td>
</tr>
<tr>
<td>Personal services</td>
<td>10-5</td>
</tr>
<tr>
<td>Ambulances:</td>
<td></td>
</tr>
<tr>
<td>Civil authorities liaison and use of</td>
<td>3-29(2)</td>
</tr>
<tr>
<td>Supernumerary use</td>
<td>21-2(2)</td>
</tr>
<tr>
<td>American Red Cross</td>
<td>1-24, 11-10(3)</td>
</tr>
<tr>
<td>Medical treatment</td>
<td>21-23</td>
</tr>
<tr>
<td>Amphibious operations, medical service</td>
<td>14-1</td>
</tr>
<tr>
<td>Annual physical examinations:</td>
<td></td>
</tr>
<tr>
<td>Divers</td>
<td>15-30(2)</td>
</tr>
<tr>
<td>Female enlisted</td>
<td>15-45A</td>
</tr>
<tr>
<td>Midshipmen and NROTC students</td>
<td>15-46</td>
</tr>
<tr>
<td>Officers</td>
<td>15-45</td>
</tr>
<tr>
<td>Appointments:</td>
<td></td>
</tr>
<tr>
<td>Dental Corps</td>
<td>6-15</td>
</tr>
<tr>
<td>Dental service warrant officers</td>
<td>6-69</td>
</tr>
<tr>
<td>Medical Corps</td>
<td>2-3-5</td>
</tr>
<tr>
<td>Medical Service Corps</td>
<td>7-5—8, 9-10</td>
</tr>
<tr>
<td>Nurse Corps</td>
<td>8-6</td>
</tr>
<tr>
<td>Warrant officer, Hospital Corps</td>
<td>9-9</td>
</tr>
<tr>
<td>Aptitude board:</td>
<td></td>
</tr>
<tr>
<td>Data in report</td>
<td>18-5</td>
</tr>
<tr>
<td>Form of report</td>
<td>18-4</td>
</tr>
<tr>
<td>Functions</td>
<td>18-3</td>
</tr>
<tr>
<td>Processing report</td>
<td>18-6</td>
</tr>
<tr>
<td>Articles, professional:</td>
<td></td>
</tr>
<tr>
<td>Dental Corps</td>
<td>6-33</td>
</tr>
<tr>
<td>Medical Corps</td>
<td>3-20</td>
</tr>
<tr>
<td>Medical Service Corps</td>
<td>1-23</td>
</tr>
<tr>
<td>Atomic warfare, defense against</td>
<td>4-26</td>
</tr>
<tr>
<td>Audiolinguistic aids report</td>
<td>22-126</td>
</tr>
<tr>
<td>Audit board for precious and special dental metals</td>
<td>6-157</td>
</tr>
<tr>
<td>Aural rehabilitation, special hospitals</td>
<td>12-2</td>
</tr>
<tr>
<td>Autopsies</td>
<td>17-24</td>
</tr>
<tr>
<td>Aviation medical examiners, assignments and duties</td>
<td>14-3—9</td>
</tr>
<tr>
<td>Aviation Medicine School</td>
<td>13-18</td>
</tr>
<tr>
<td>Aviation personnel:</td>
<td></td>
</tr>
<tr>
<td>Physical examinations</td>
<td>15-59</td>
</tr>
<tr>
<td>Annual and promotion</td>
<td>15-71</td>
</tr>
<tr>
<td>Board of flight surgeons</td>
<td>15-72</td>
</tr>
<tr>
<td>Candidates for flight training</td>
<td>15-67</td>
</tr>
<tr>
<td>Candidates for flight training, reporting</td>
<td>15-68</td>
</tr>
<tr>
<td>Forwarding of flight physicals</td>
<td></td>
</tr>
<tr>
<td>Reexamination for physical incapacity</td>
<td>15-70</td>
</tr>
<tr>
<td>Reporting on class 1 personnel</td>
<td>15-65</td>
</tr>
<tr>
<td>Special reporting on personnel in flight training</td>
<td>15-66</td>
</tr>
<tr>
<td>Physical standards</td>
<td></td>
</tr>
<tr>
<td>Class 1, service group I</td>
<td>15-62</td>
</tr>
<tr>
<td>Class 1, service group II</td>
<td>15-63</td>
</tr>
<tr>
<td>Class 1, service group III</td>
<td>15-64</td>
</tr>
<tr>
<td>Class 2, personnel</td>
<td>7-39</td>
</tr>
<tr>
<td>Color perception</td>
<td>15-62(19)</td>
</tr>
<tr>
<td>Depth perception</td>
<td>15-62(12)</td>
</tr>
<tr>
<td>Ears</td>
<td>15-62(23)</td>
</tr>
<tr>
<td>Equilibrium</td>
<td>15-62(26)</td>
</tr>
<tr>
<td>Eyes</td>
<td>15-62(15)</td>
</tr>
<tr>
<td>Field of vision</td>
<td>15-62(20)</td>
</tr>
<tr>
<td>Interpupillary distance</td>
<td>15-62(18)</td>
</tr>
<tr>
<td>Intraocular distance</td>
<td>15-62(17)</td>
</tr>
<tr>
<td>Near point of convergence</td>
<td>15-62(21)</td>
</tr>
<tr>
<td>Ocular motility</td>
<td>15-62(13)</td>
</tr>
<tr>
<td>Ophthalmoscopic examination</td>
<td>15-62(22)</td>
</tr>
<tr>
<td>Policies on service groups for naval aviators</td>
<td>15-59</td>
</tr>
<tr>
<td>Red lens test</td>
<td>15-62(14)</td>
</tr>
<tr>
<td>Refraction</td>
<td>15-62(21)</td>
</tr>
<tr>
<td>Restrictions until physically qualified</td>
<td>15-60</td>
</tr>
<tr>
<td>Test for accommodation</td>
<td>15-62(18)</td>
</tr>
<tr>
<td>Aviation Physiology Training Report, Navmed—1349</td>
<td>23-18</td>
</tr>
<tr>
<td>Aviation service</td>
<td>14-3—9</td>
</tr>
<tr>
<td>Aviation unit, dental officers</td>
<td>6-56</td>
</tr>
<tr>
<td><strong>Change 9</strong></td>
<td></td>
</tr>
</tbody>
</table>

### B

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back, physical examination</td>
<td>15-89A(2)</td>
</tr>
<tr>
<td>Barracks, sanitary standards</td>
<td>22-7</td>
</tr>
<tr>
<td>Battle casualties, definitions</td>
<td>1-23</td>
</tr>
<tr>
<td>Battle dressing stations:</td>
<td></td>
</tr>
<tr>
<td>Instructions</td>
<td>4-36</td>
</tr>
<tr>
<td>Light</td>
<td>4-40</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>4-38</td>
</tr>
<tr>
<td>Routes to be marked</td>
<td>4-42</td>
</tr>
<tr>
<td>Sterilizers</td>
<td>4-41</td>
</tr>
<tr>
<td>Water supply</td>
<td>4-39</td>
</tr>
</tbody>
</table>
INDEX

Battle, final preparation ............................................. 4-43
Battle plans:
Casualties, reporting ............................................... 4-8(2)
Transportation of sick and wounded ................................ 4-8(1)
Bedding, inspection .................................................... 4-10(3)
Beds nomenclature ..................................................... 1-21-22
Beneficiaries:
Bureau of Employees Compensation ................................ 21-26
Naval Nurse ......................................................... 21-19
Public Health Service ............................................. 21-23
Veterans Administration ........................................... 21-22
Berthing space, afloat, sanitary standards ....................... 23-8
Binnacle List, Navy Medical ......................................... 23-218
Biological warfare, defense against ................................ 4-26
Births, reporting ..................................................... 3-12(4)
Board of Medical Survey Report, Naval Medical Office ....... 18-12
Boards and committees, hospital .................................... 11-11
Boards of investigation, death ....................................... 17-23
Brigs, sanitary standards ............................................ 22-10
Budget estimates, dental ............................................ 6-178
Bureau:
Organization ........................................................... 1-12
Reporting requirements ............................................. 23-1
Burial Record, NAVMED-HP-98 ..................................... 23-221
Burial report:
NAVMED-601 ....................................................... 17-9A
Navy Cemeteries or Plots ........................................... 23-153

C

Canadian Armed Forces personnel, dental treatment ............ 6-98(1)(a)
Candidates, physical examinations:
Commission or warrant ............................................. 15-42
Naval Academy ....................................................... 15-43
Naval Preparatory School .......................................... 15-43
Casualties:
Aviation ............................................................... 14-8
Mass ................................................................. 6-27
Cells, inspection ..................................................... 4-16(3)
Cemeteries .................................................................. 17-78-81
Map or plan ............................................................ 17-81
National ................................................................. 17-79
Naval plots and cemeteries ......................................... 17-80
Certificate of Death, NAVMED-N ................................... 17-10-14
Certificate of physical condition, annual; ...Revue .......................... 15-78(2)
Chaplains, hospital ...................................................... 11-10(2)
Charges, collections, and reports of super-numeraries .......... 21-33
Chemical warfare, defense against .................................. 17
Chiefs of service, hospital ............................................. 11-23
Cholera ................................................................. 22-27
Chronological Record of Medical Care, SP-600 .................... 6-44-48
Dental record ............................................................ 6-119
Civil authorities, cooperation with .................................. 1-7(2)
3-12, 4-29, 11-7(2), 17-7, 17-25
Civil suit ...................................................................... 3-29(1)
Dental officers ............................................................. 6-38
Civilian employees:
Administration at BUMED activities ............................... 10-1-4
Army, Navy, and Air Force; death .................................. 17-5
Dental facilities .......................................................... 6-74
Dental treatment .......................................................... 6-98(1)(k)
Health program .......................................................... 26-1-10
Medical records .......................................................... 26-7
Physical examination .................................................... 15-5-6
Positions .................................................................. 10-5-8

Civilians(s):
Agencies, death forms .................................................. 17-8
Dental professional activity ............................................. 6-34
Medical aid ............................................................... 3-27
Physicians ................................................................. 5-24-29
Claims for emergency medical and dental treatment .......... 20-6, 20-16
Clinical services, hospital ............................................ 11-22
Clinics, dental ........................................................... 6-78-81
Coast and Geodetic Survey members, dental treatment ........ 6-98(1)(f, j)
Coast Guard members, dental treatment ............................ 6-98(1)(f, j)
Collision afloat .......................................................... 4-39
Color perception:
Aviation personnel ....................................................... 15-82(19)
Diving duty ............................................................... 15-30(16-37)
Motor - torpedo - boat training and duty ......................... 15-32(2)(c)
Nuclear power surface ship training ................................ 15-29A(1)(c)
Standards .................................................................. 15-11
Submarine personnel .................................................... 15-29(2)(c)
Commanding officer:
Dental ................................................................. 6-49
Hospital ................................................................. 6-49
Duties ................................................................. 11-7
Delegation ............................................................... 11-7(8)
Communicable disease control:
Reports ................................................................. 3-12, 11-7(2)(b), 22-20
Responsibilities ........................................................ 22-17
Tuberculosis control .................................................... 22-19
Chest X-rays ............................................................. 22-19(2)
Follow-up chest X-rays ............................................... 22-19(2)
Individuals suspected .................................................. 22-19(3)
Precautions ............................................................... 22-19(4)
Venereal disease control .............................................. 22-18
Compartment, inspection .............................................. 4-16(2)
Consultation service:
Bethesda Medical Center .............................................. 13-3
Pensacola Medical Center ............................................. 13-15
Consultation Sheet, SP-513 .......................................... 15-29(2)(c)
Conventions of Geneva ............................................... 3-30
Correspondence:
Courses, dental .......................................................... 6-331
Dental ................................................................. 6-30
Dental personnel ........................................................ 6-30
Courts of inquiry ........................................................ 17-23
Cross-serving Health Record .......................................... 16-19
Individual Sick Slip, DD 689 ......................................... 16-70-73
Custody of property:
Inspection of materials ............................................... 25-16
Inventory adjustment ................................................... 25-18
Inventory procedure .................................................... 25-15
Records .................................................................. 25-13
Buildings and improvements ledger ................................ 25-13(4)
Equipment ledger ....................................................... 25-13(5)
Land ledger ............................................................... 25-13(3)
Narcotics, alcohol, and alcoholic beverages ....................... 25-13(9)
Plant account ledger .................................................... 25-13(8)
Precious and dental metals ............................................ 25-13(9)
Provisions ledger ........................................................ 25-13(7)
Supplies ledger .......................................................... 25-13(8)
Storeroom management ............................................... 25-14
Transfer of custody ..................................................... 25-17

D

Damage control, afloat ................................................. 4-25
DD forms, list ............................................................. 22-2-218A
Dead and wounded, removal ......................................... 4-44
INDEX

Deaths:
Active-duty personnel. 17-2
Army, Air Force, and Coast Guard personnel. 17-3, 17-69
Boards of investigation. 17-9
Certificate of death, NAVMED-N. 17-10-14
Civil authorities, reporting. 17-7
Civilian employees of the Army, Navy, and Air Force. 17-5
Corpsman or crewmembers and military or civilian passengers. 17-75
Merchant seamen. 17-4
Military Sea Transportation Service:
Civilian employees. 17-76
Civil-service employees other than marine personnel. 17-75
Instructions. 17-74
Military and auxiliary. 17-77
Missing personnel instructions. 17-21
Notification of next of kin:
Continental activities having contracts. 17-26
Continental activities not having contracts. 17-27
Extracontinental ships and stations. 17-28
Occurring away from command. 17-15
Other deaths. 17-6
Preparation of remains:
Emailing and inspection. 17-29
In case of violence. 17-22
Post-mortem examinations. 17-24
Relations with civil authorities. 17-25
Reporting to civil authorities. 3-12(4). 17-7
Reports, administrative. 17-28
Reports summary. 17-9
Retired inactive personnel. 17-16
St. Elizabeth's Hospital. 17-19
Transportation of remains:
Arlington Cemetery. 17-41
Arrangements made at transfer points. 17-38
Information for next of kin. 17-40
Method. 17-34
Rules. 17-33
Shipments:
Air. 17-38
Personal effects. 17-39
Rail. 17-35
When accompanied by escort. 17-37
Decommissioning. 23-22
Decompression sickness and diving accidents report, NAVMED-816. 23-30

Dental—Continued

Corps:
Appointments. 6-15
Establishment. 6-15
Grade and strength. 6-14
Promotion. 6-17-20
Division, BMED. 6-4-12
Examination and Treatment Record, NAVMED-199. 6-154
Examinations. 6-99
Recording. 6-113
Specifications. 6-100
Types. 6-130
Facilities. 6-178-182
Folder, DD-722-L. 6-109, 16-28-29
Log. 6-29
Material. 6-100-174

Dental officer:
Aircraft carrier. 6-40
Assistant. 6-53
Aviation unit. 6-53
Designation. 6-41
Dispensary. 6-55
District. 6-47
Duties, general. 6-22-36
Fleet. 6-37
Force. 6-38
Hospital. 6-54
Hospital ship. 6-42
Marine Corps. 6-59-62
Mobile dental unit. 6-57
Naval Reserve. 6-198-210
Recruit depot. 6-52
Repair ship. 6-41
Research. 6-56, 6-133-134F
River command. 6-48
Ship. 6-59
Shipyard. 6-50
Shore station. 6-51
Tender. 6-41
Training. 6-122-132

Center. 6-82
Civilian. 6-128
Correspondence courses. 6-131
Indoctrination, basic course. 6-123
Internships. 6-122
Postgraduate course, general. 6-122
Request form. 6-130
Residency. 6-125
Specialized. 6-126
Staff and administrative schools. 6-120
Transport. 6-43-44

Dental Record, SP-603. 6-107-118
Abbreviations and designations. 6-110
Custody. 6-110
Examinations, recording. 6-113
Instructions, general. 6-108
Markings. 6-116-118
Operations, recording. 6-114
Purpose. 6-107
Recovery. 6-111
Special entries. 6-112
Treatments, recording. 6-114

Dental School. 6-135-139, 13-8
Dental service, chief of:
Dispensary. 6-55
Hospital. 6-54

Dental Service Reports, DD-477, 477-L. 6-150
Dental service warrant officers. 6-69

Dental Standards:
Annual physical. 6-91
Appointment. 6-88-89
Aviation duty. 6-95-96

Change 9
INDEX
Dental Standards--Continued
Div~ dutY----------------------------Enlistment and reenlistment_____________
Motor torpedo boat training and duty_____
Promotion _______ _____ _____________ ---___

6-93
6-87
6-93
6-90

Purpose -------------------------------- 6-86
Submarine dutY------------------------- 6-93
Underwater demolition duty______________ 6-93
Waivers of defects_______________________ 6-97
Women
------------------------------6-94
Dental
technicians
______________________
6-63-68
Schools --------------------------- 6-139-144
Dental treatment__________________________ 6-98
Army and Air Force members __ 6-98(1) <e>, <i>
Before transfer to station without dental
officer -------------------------------- 6-92
Canadian Armed Forces personneL_ 6-98(1) <a>
Civil personnel injured in a naval station _____________________________ 6-98(1) <k>
Coast and Geodetic Survey members ------------------------ 6-98(1) <I>, <1>
Coast Guard members _________ 6-98<1> <1>. <1>
Dependents outside u.s. ___________ 6-98(1) <h>
Fleet Naval Reserve and Marine Corps Reserve on active duty _____________ 6-98(1) <b>
Inactive duty Navy and Marine Corps
members ----------------------- 6-98(1) m
Medical officer------------·--------------- 3-15
Naval Reserve and Marine Corps Reserve
on active dutY------------------- 6-98<1> <d>
NavY and Marine Corps on active
duty --------------------------- 6-98(1) <a>
Nonnaval __________ 6-106, 11-7(3), 20-12, 20-16
Persons hospitalized, accordance with
law ______________________________ 6-98(1) (g)
Priority----- __ ------ - ----------------- 6-98(2)
Prisoners of war ___________________ 6-98(1) <m>
Prosthetic --------------------------- - -- 6-103
Public Health Service members __ 6-98(1) <I>, (j)
Recording on SF-600- - -------- ---------- 6-119
Recording
on SF-603---------------Fte!usal ________________________
6-105,6-114--118
6-112<1>
Retired Navy and Marine Corps on active
dutY--------- --------------------- 6-98(1) <c>
Veterans Administration patients____ 6-980) m
Dentures, inscription __________ __________ ___ 6-104
Department of Defense forms, list ______ 23-216A
Dependents:
Care ---------------- ··. ----------------~9
Charges, collections, and reports__________ 21-33
Dental treatment outside U.s ________6-98U) (h)
Medical care__ ____ _______________ _____ 21-4--8
Depth perception, aviation _____________ 15- 62(12)
Deserters:
Health Record _________________ __________ 16-11
Physical examination __________________ __
Diphtheria.-------------------------------- 22-29
Schick test and controL ______ __ _____ 22-29(3)
Dl.sa.bility of medical officer a.fioat ________ 4-12(4)
Disbursing division, hospitaL ________________ 11-14
Discharge, physical examination ___________ _ 15-48
Disease-bearing insects and pests, controL ___ 22-31
Diseases subject to quarantine ______________ 22-36
Cholera _______________ ____________ 22-36(1)(a)
Plague __________________ __________ 22-36<1><b>
Smallpox __________________________ 22-36<1)(d)
Typhus _____________ _______________ 22-36<1><c>
1rellow fever ____ ________ ___ ________ 22-36<1><e>
Disinsectization --------------------------- 22-38
Dispensary, definition ___________________ _ 1-21<1>
Disposition and Expenditures, Remains of the
Dead, NAVME!Hl09---------- --- ---------- 17-9B
Disposition af records, retirement _________ 21-301
1~56

4
Change 9

District dental officer______________________ 6-47
District medical officer:
Designation----------------------------- ~3
Duties ---------------------------------- 5-4
Diving accidents and decompression sickness
report, NAVMED-816---------------------- 23-30
Diving duty, physical standards_____________ 15-30
Ability to equalize pressure _________ 15-31)(1> <o>
Diving service_________________________ 14-10-17
Division medical officer-------------------- 4-11
Doctor's Progress Notes, SF-509------------- 6-121
Donations of property _____________________
Drills and emergencies:
Abandon shiP---------------------------- 4-31
Collison -------------------------------- 4-29
Damage controL------------------------- 4-25
Dead and wounded______________________ 4-44
Defense against special methods of warfarein---------- ----------------------- 4-35
4-26
Duty
battle___________________________
Final preparation for battle______________ 4-43
Fire and rescue party___________________ 4-30
Fire quarters---------------------------- 4-28
Flight quarters________________________ __ 4-27
General quarters:
Condition L--------------------------- 4-22
Condition rr ____________ --------------- 4-23
Condition III-- ----------------------- 4-24
Handling rescued personneL------------- 4-33
~ding force_________________ ________ __
4-34
Man overboard-------------------------- 4-32
Preparation !or------ ------------------- 4-21
Transfer of wounded to hospital ships_____ 4-45
Drugs:
Dental --------------------------------- 6-31
Prescrib~ and dispensing_______________
3-33
2~11

Record
-------------------- 3-4(2)
23-254
Sale in -----------exchange ______________________
Duties:
Assistant medical officer, generaL ___ 3-16, 3-17
Battle stations__________________________ 4-35
Civlllan physician_______________________ 5-29
Dental service warrant officers_ __________ 6-70
Dental techniCians______________________ 6-68
District medical officer------------------ 5-4
Division medical officer________________ 4-11(1)
Fleet
4-1-10
Force medical
medical officer------------------offtcer __________________ 4-11<1>
Group X, medical rating___ ______________ 9-12
Inspector, naval medical activities________
5- 2
Medical offtcer, generaL _______ 3-1-15, 3-18-30
Medical of.Hcer of a shiP-------------- 4-12-19
Medical of.Hcer of a shore station _______ 5- 6-17
Medical Service Corps, dentaL___________ 6-72
Medical service Corps, general____________ 7-27
Medical Service Corps, specific_____ _______ 7- 28
Warrant and commissioned warrant offtcers, Hospital Corps___________________ 9-13

E
Ears:
Aviation personneL ________________ 15-62(23)
Diving personneL _________________ 15-30(1) (g)
Motor - torpedo - boat t r a i n i n g and
dutY- - --------- ----------------- 1~32<2> <1>
Standards
------------------15-12
Submarine - ---------personneL __
________ ___ 15-29<2>
<e>
Effects of Submarine Duty on Personnel,
report---------------------------------- 14-14
Elbow, physical examination ___________ 1~9A<4>

(

I

I

I

Nl

~I


INDEX

Emergencies: 
   Afloat ........................................ 4-21
   Dental treatment, limitation 20-2
   Medical and dental treatment other than naval 20-1
   Medical Tag, Navy 23-24
   Precautions, hospital 11-7
   Employee health program 26-1-10
   Employment, civilian 10-1-6
   Physician .................................... 5-22-28
Endocrine glands and metabolism 15-9
Enlisted personnel: 
   Hospital Corps ratings 9-3
   Muster and discipline 5-16
   Service school assignments, physical examination 15-53
Enlistments: 
   Hospital Corps 9-4
   Physical examinations 15-40(1)
Epidemic typhus 22-26
Equilibrium, aviation 15-62 (26)
Equipment: 
   Dental ........................................ 6-160-174
   Issue 25-20
   Escort for remains: 
      Authority 17-42
      Selection and detail 17-44
      Travel instructions 17-45
      When furnished 17-43
Establishment: 
   Dental Corps 6-1
   Hospital Corps 9-1
   Medical Service Corps 7-1
   Nurse Corps 8-1
Examination: 
   Dental ........................................ 8-99
   Professional: 
      Medical Corps 2-6-8
      Medical Service Corps 7-10, 7-21
      Recruits, psychiatric 16-1(6)
   Exchange: 
      Division, hospital 11-18
      Sale of drugs and medical items 3-4(2)
   Executive officer, hospital, duties 11-8
   Explosive ordnance disposal, physical standards extremities, examination 15-30
   Eyes 15-23
   Aviation personnel 15-62(15)
   Civilian employees 26-9, 28-10(2)
   Diving personnel 18-30(1)(d)
   Motor-torpedo-boat training and duty 15-32(2)(b)
   Nuclear power surface ship training 15-29A(1)(b)
   Refraction, nonnaval 20-11
   Refractions for employees 26-9, 26-10(2)
   Standards 15-10
   Submarine personnel 15-12(2)(b)
   Women personnel 15-34(3)

F
   Facilities, dental ................................ 6-187-192
   Field records retirement schedule 23-303
   Field sanitation 22-40, 22-41
   Field service ................................ 22-41(1)(e)
   Galley ........................................ 22-41(1)(f)
   Immunizations 22-41(3)
   Induction of personnel 22-41(1)(g)
   Material and supplies 22-41(1)(d)
   Medical Department responsibilities 14-2
   Nonmedical personnel 22-41(1)(c)
   Personnel 22-41(1)(b)

Field of vision, aviation 15-62(30)
Field supply activities 25-32
Finance division, hospital 11-15
Fire and rescue party afloat 4-30
Fire quarters afloat 4-28
Fits and accidents: 
   Boxes and other medical containers 15-66
   Instructions 3-10(3) 4-18
   Mass casualties, by dental officer 6-27
   Fiscal management 24-1-7
   Fiscal matters, dental 6-175-177
   Fitness of recruits, psychiatric 18-2
   Fitness reports on subordinates 5-15
   Fitting out sick bay spaces and equipment 4-13
   Flags, funeral 17-68
   Fleet dental officer 6-37
   Fleet Marine Force dental companies 6-62-85
   Fleet medical officer 4-1-10
   Flight operations, medical attendance 4-27
   Flight surgeons, assignment and duties 14-2-9
   Food and water supply: 
      Food ........................................ 22-13
      Inspection as to quality 22-13(1)
      Inspection of cooking and messing facilities 22-13(2)
      Inspection of food handlers 22-13(4)
      Preparation 22-13(5)
      Inspection afloat 4-16(2)
      Water ........................................ 22-14
      Inspection of water supply systems 22-14(1)
      Potability of water 22-14(2)
      Purification 22-14(3)
      Supply plants 22-14(4)
      Food service division, hospital 11-16
      Force dental officer 6-38
      Force medical officer 4-11
      Forms, lettered and numbered 23-214
(Note. — Forms may also be indexed by title and basic subject.)
   Availability 23-214(5)
   Tabulation of DD Forms 22-216A
   Tabulation of Naval Forms 23-215
   Tabulation of Standard Forms 23-216
   Funeral expenses: 
      Army, Air Force, and Coast Guard personnel ................................ 17-69
      Burial at sea of inactive personnel and civilians ................................ 17-68
      Burial prior to ascertaining wishes of next of kin ................................ 17-61
      Disposition of remains at activities having contracts ................................ 17-55
      Limitations .................................. 17-56
      Transportation to places outside the U.S. ...................................... 17-62
      Funeral flags ................................ 17-68

G
   Garbage, refuse, and sewage disposal: 
      Garbage and refuse disposal 22-15
      Sewage disposal 22-16
   G components ................................ 14-19
   General quarters: 
      Condition I ................................ 4-22
      Condition II ................................ 4-23
      Condition III ................................ 4-24
   Geneva Conventions: ................................ 3-30
   Genito-urinary system: 
      Diving duty ................................ 15-30(1)(l)
      Nuclear power surface ship training 15-29A(1)(e)
   Standards ..................................... 15-22

Change 9
INDEX

H

Head and face standards .................................................. 15-14
Health program for civilian service employees: Authority and regulations ................................................. 26-2
Clinical and medical services ............................................. 26-6
Functions of occupational health division ............................... 26-5-10
Industrial hygiene .......................................................... 26-8, 26-10(3)
Inspections ................................................................. 26-3
Medical records ............................................................ 26-7
Organization .................................................................. 26-1
Scope ........................................................................ 26-1
Sight conservation program ................................................ 26-9
Small activities .............................................................. 26-10
Health Record .................................................................. 16-1-74
Abstract of Service and Medical History, NAVMED 1406 .................. 16-55-57
Adjunct forms .................................................................. 16-65-69
Chronological Record of Medical Care, SF 600 .............................. 16-44-48
Consultation Sheet, SF 513 ................................................ 16-67
Contents ...................................................................... 16-2
Cross-serving .................................................................. 16-18
Custody of bodies ............................................................ 16-19
Death ............................................................................... 16-21
Hospitalization ............................................................... 16-21-25
Transfers to ships or stations .................................................. 16-20
Dental, SF 603 ................................................................ 16-54
Dental folder, DD 722-L .................................................... 16-28-29
Illustrations of forms ........................................................ 16-74
Immunization Record, SF 601 ............................................. 16-49-51
Information, release of ....................................................... 16-310-313
Ionizing Radiation, Record of Exposure, DD 1141 ...................... 16-61-64
Jacket, DD 722 ............................................................... 16-28-29
Medical Examination, Report, SF 88 ..................................... 16-37-40
Medical Folder, Report, SF 89 ............................................ 16-41-43
Medical Survey, Board, NAVMED M ................................... 16-68
Narrative Summary, SF 502 ................................................ 16-66
Opening ....................................................................... 16-5-8
Reception, File Charge-Out and Disposition, Record, NAVMED 1345 ................................. 16-18(4)
Replacement .................................................................. 16-27
Reserve, inactive ................................................................ 16-28
Sick Call Treatment Record, NAVMED 10 .............................. 16-30-36
Special Duty Medical Abstract, NAVMED 1346 ......................... 16-58-60
Syphilis Record, SF 602 .................................................... 16-52-62
Termination .................................................................... 16-9-17
Verification .................................................................... 16-3
Hearing test, aviation .......................................................... 15-62(24)
Hearing and blood vessels ..................................................... 15-37(2)
Aviation personnel .............................................................. 15-62(6)
Diving duty ..................................................................... 15-30(1)(f)
Methods of examination ....................................................... 15-68
Standards ...................................................................... 15-19
Submarine personnel .......................................................... 15-29(2)(h)
Heights: Aviation personnel .................................................... 15-62(4)
Standards ...................................................................... 15-8(2)
Women personnel ............................................................. 15-34(2)
Heterochromia and prism divergence at near .................................. 15-87
Hip, physical examination ..................................................... 15-39A(6)
Hospital Administration School ............................................ 13-9
Hospital Corps: Advancement in rating ................................... 9-8
Appointment to Medical Service Corps .................................... 9-10
Appointment to warrant officer ............................................. 9-9
Change all rating to and from ............................................... 9-12
Duties, group X: medical ratings .......................................... 9-12
Duties of warrant and commissioned warrant officers .................. 9-13
Enlisted ratings and warrant officers ...................................... 9-8

Hospital Corps—Continued
Enlistment ...................................................................... 9-4
Establishment .................................................................. 9-1
Instructions ..................................................................... 3-10(4)
Number .......................................................................... 9-2
Special assignments .......................................................... 9-12(3)
Training, group X: medical ratings ....................................... 9-11
Transfer to Hospital Corps schools ......................................... 9-6
Hospital corpsmen, hospital ................................................ 11-28
Hospital, definition .......................................................... 1-21(1)
Hospital, naval: Administrative divisions .................................. 11-13
Administrative officer, duties ............................................... 11-12A
Atlas .............................................................................. 23-255
Bedsides .......................................................................... 15-5
Boards and Committees ....................................................... 11-11
Chiefs of services ................................................................ 11-23
Clinical services .................................................................. 11-22
Command ......................................................................... 11-3
Commanding officer: Duties ................................................. 11-7
Enlisted ratings and warrant officers ...................................... 9-8

Diplomacy: Standards ........................................................ 9-11
Epidemic typhus .................................................................. 22-26
Immunizing agents ............................................................. 22-21(2)
Plague .............................................................................. 22-28

Immunization: Certificates ..................................................... 16-51
Cholera ............................................................................. 22-27
Definition .......................................................................... 22-21(1)
Diphtheria ........................................................................ 22-29
Schick test and control ........................................................ 22-29(3)
Epidemic typhus .................................................................. 22-26
Immunizing agents ............................................................. 22-21(2)

Identification of bodies ......................................................... 17-22
Identifying body marks ........................................................ 16-39

I

Hypersensitivity to dental drugs ............................................... 6-112(4)
INDEX

Immunization—Continued
Poliomyelitis ........................................... 22-30
Provisions ............................................... 22-21
Record, SF 601 ......................................... 16-49-51
Requirements ......................................... 22-21(3)
Smallpox .................................................. 22-22
Standards and procurement ......................... 22-21(5)
Tetanus .................................................... 22-24
Typhoid and paratyphoid ......................... 22-23
Typhus, epidemic ........................................ 22-28
Unfavorable reactions ................................... 22-21(4)
Yellow fever ................................................ 22-25

Independent duty, Hospital Corps Group X, 9-12(1)
Industrial hygiene ................................... 26-8, 26-10(3)
Individual Sick Slips, DD 688 ...................... 16-70-73
Inoculant reactions, unfavorable report .......... 22-21(4)
Insect, pest, and rodent control .................
Disease-bearing insects, control ................ 22-31
Rodent control ......................................... 22-32

Inspections:
Conferences ........................................... 5-22
Dental activities and facilities .................. 6-193-197
Hospitals ............... 11-7(6), 11-8(6)
Materials ................................................... 25-18
Medical services for employees ................. 26-3
Shore stations ........................................... 5-22
Instructions ............................................. 5-18
Objectives for Bureau activities ............... 5-20
Objectives for non-Bureau activities .......... 5-21
Reporting .................................................. 5-23
Scope ....................................................... 5-19
Ships going into commission ..................... 5-17
Supplies, medical .................................... 5-13

Inspections afloat:
Compartments, cells, and bedding .............. 4-16(3)
Food and water ......................................... 4-16(2)
General outline ....................................... 4-4
Personnel .................................................. 4-16(1)
Scope ....................................................... 4-3
Special ..................................................... 4-5
Submarine and diving ................................ 14-11
When made ............................................ 4-2
Written reports ....................................... 4-6
Inspector General, Dental ......................... 6-45
Inspector, naval dental activities ................ 6-46
Inspector, naval medical activities:
Designation ............................................ 5-1
Duties ...................................................... 5-2
Intelligence officers, cooperation with ....... 3-13
Interns and internships report, NAVMED-1048 23-33
Internships, dental .................................... 6-122
Interpupillary distance, aviation ............... 15-82(18)
Inhalation, evidence; physical examination ... 15-58
Inventory adjustment of property .............. 25-18
Inventory of property ................................ 25-9
Procedure .................................................. 25-16

J
Joints, orthopedic examination ................. 15-89A
Junior medical officers, hospital .............. 11-25

K
Knee, physical examination ....................... 15-89A(3)

L
Landing force ........................................... 4-34
Leave or liberty, emergency medical or dental treatment ........................................ 20-5
Letters of condolence ................................ 17-28-28
Library service, Medical Center ............... 16-11
Light for battle dressing stations .............. 4-40
Lighting, heating, and ventilation:
Heating and ventilation ....................... 22-12(3)
Illumination .............................................. 22-12(2)

M
Maintenance division, hospital ................. 11-17
Man overboard ......................................... 4-32
Marine Corps dental officer ..................... 6-50-62
Marriages, reporting to civil authorities ....... 2-5-2
Material:
Dental ..................................................... 6-160-174
Medical .................................................... 25-1-29
Maternity case dependent ......................... 21-8
Med reports, list ...................................... 23-2
Medical aid for civilians .......................... 3-27
Medical and dental stores:
Instructions ............................................ 25-27
Receipt and issue ..................................... 25-29
Standard unit prices .................................. 25-28
Medical and dental treatment other than
naval ....................................................... 20-1-16
Instructions ............................................ 20-1
Leave or liberty ........................................ 20-5
Limitation of dental treatment ................. 20-2
Preparation of claims ................................ 20-2
Reports required ....................................... 20-7
Retired personnel ..................................... 20-6
Services of specialists:
Eye refractions and procurement of glasses .... 20-11
Request ................................................... 20-10
When permitted ....................................... 20-9
Special dental treatment:
Definition of an emergency ..................... 20-13
Reports and claims ................................... 20-16
Request ................................................... 20-14
Request for prosthetic treatment ............... 20-15
When permitted ....................................... 20-12
Medical Center:
Baltimore ............................................... 13-11
Bermuda .................................................. 13-11
Boston ..................................................... 13-12

Medical Corps:
Advancement in grade ............................. 2-6-8
Appointments .......................................... 2-6-8
Examination for promotion ...................... 2-7-8
Grade ....................................................... 2-2
Number ...................................................... 2-1

Medical Department of the Navy:
Functions ................................................ 1-1-4
Organization .......................................... 1-5-11
Medical examiners ................................... 15-6-6
Medical History, Report, SF 89 ................. 16-41-43
Medical history, taking ......................... 15-6-5
Medical Intelligence Report of Forces and
Adjacent Areas Visited ......................... 23-124
Medical journal ....................................... 3-8
Medical officer personnel, quarterly report,
NAVMED-1341 ....................................... 23-42

Change 9
INDEX

Medical officers afloat ........................................ 4-1-48
Absence of medical officer ................................. 4-12(4)
Designation .................................................. 4-12(1)
Disability of medical officer .......................... 4-12(4)
Head of department ........................................ 4-12(1)

Medical officers ashore:
Designation .................................................. 5-6
Duties ........................................................ 5-6-17
Accountability of property ................................ 5-12
Complement of Medical Department ..................... 5-8
Dependents .................................................. 5-9
Examination of applicants, candidates, and
Reservists .................................................. 5-11
Fitness reports on subordinates .......................... 5-15
Muster and discipline of enlisted personnel ........ 5-16
Physical examination and treatment of civilian
employees ................................................ 5-10
Responsibilities ............................................. 5-7

Medical officers, general:
Assistant, duties .......................................... 3-16, 3-17
Duties ........................................................ 3-1-15, 3-18-30
School ....................................................... 19-7

Medical Service Corps:
Application .................................................. 7-9
Appointments .............................................. 7-5-8
Dental service warrant .................................... 6-71
Articles on professional subjects ....................... 7-20
Distribution ................................................ 7-3
Duties, dental facilities .................................. 6-72
Duties, general ........................................... 7-27
Duties, specific ......................................... 7-2
Establishment ............................................. 7-1
Examination, admission .................................. 7-12
Examination, advancement .............................. 7-19-21
Examination, physical .................................. 7-11
Examination, physical .................................. 7-11
Grade ........................................................ 7-4
Naval Reserve officers .................................... 7-18
Navy .......................................................... 7-2
Postgraduate:
Courses ..................................................... 7-17
Training ..................................................... 7-30

Medical services furnished supernumeraries, table of ................................. 21-3

Medical supply system:
Basic organization of storehouses ...................... 25-26
Basic organization of supply depots ................... 25-25
Field supply activities ................................... 25
Missions of .................................................. 25-24

Medical survey board:
Authority ................................................... 18-7
Composition ................................................ 18-8
Entries in Health Record .................................. 18-16
Procedure ................................................... 18-11
Purpose ....................................................... 18-9
Referral of cases ......................................... 18-10

Discipline cases .......................................... 18-10(2)(b)
Hospital transfer ......................................... 18-10(2)(e)
Members overseas ........................................ 18-10(2)(f)
Military unsuitability cases ............................ 18-10(2)(c)
Officers return to duty .................................. 18-10(2)(a)
Patients refusing treatment ............................ 18-10(2)(b)
Personnel qualified for limited duty ................. 18-10
Persons continuously on the sick list ............... 18-10
(2)(h)
(2)(g)
Recruits disability EPTE .................................. 18-10(2)(d)
Reports, NAVMED-M ..................................... 18-12
Active from and date .................................... 18-13(3)
Aggravation by service .................................. 18-13(5)(d)
Conduct status ........................................... 18-13(5)(a)
Date of survey ........................................... 18-13(1)
Diagnosis ................................................... 18-13(4)

Medical survey board—Continued

Reports, NAVMED-M—Continued
Endorsement statement .................................. 18-13(10)
Enlistment examination date ......................... 18-13(5)(e)
Existed prior to enlistment ............................. 18-13(5)(c)
Health Record ............................................. 18-18
Identification data ....................................... 18-13(2)
Line of duty status ....................................... 18-13(5)(b)
Present condition ........................................ 18-13(7)
Probable future duration .............................. 18-13(8)
Recommendations ........................................ 18-13(9)
Summary of case history ............................... 18-13(6)

Statement in rebuttal .................................... 18-14

Medical treatment:
American Red Cross ...................................... 21-35
Army and Air Force Reserve ......................... 21-17
Beneficiaries of the Bureau of Employees
Compensation ............................................. 21-26
Beneficiaries of the Naval Home ..................... 21-19
Beneficiaries of the Public Health Service ....... 21-23
Beneficiaries of the Veterans’ Administration .... 21-22
Civilian under special circumstances ............... 21-28
Dependants ................................................ 21-4-8
Facilities, definitions .................................... 1-20-22
Fleet Reserve and Fleet Marine Corps Res-
serve ...................................................... 21-14
Former members .......................................... 21-20
Hospitalization, and Allied Services Report .... 20-7
Members of foreign military establish-
ments ....................................................... 21-30
Naval pensioners .......................................... 21-18
Navy and Marine Corps Reserve ..................... 21-16
Navy and Marine Corps retired with pay ......... 21-13
Officer candidates ....................................... 21-21
Officers and employees of the Government
and Federal contractors outside U.S. .......... 21-27
Officers and employees of the State Depart-
ment Foreign Service .................................. 21-29
Other personnel .......................................... 21-31
Other services, active duty members ............... 21-12
Other services, retired-with-pay members ....... 21-24
Supernumeraries ......................................... 21-2
Meetings, medical ......................................... 4-10
Merchant seamen, death .................................. 17-4
Misconduct, dental injuries ......................... 6-112(2)
Missing personnel ........................................ 17-21
Mission of naval hospitals ......................... 11-2
Mission of supply system ............................. 25-34
Mobile dental unit officer ......................... 6-5
Morning Report of Sick, NAVMED-T .............. 23-219
Motor-torpedo-boat training and duty, physical
standards ............................................... 15-32

N

Narcotics:
Custody .................................................... 3-24
Log .......................................................... 23-253
Loss ......................................................... 3-36, 25-18(9)
Prescribing ................................................ 3-32
Security .................................................... 3-35
Narrative Summary, SF 502 ............................ 16-68
Naval Dental Reserve .................................. 6-198-210
NAVMED forms, list .................................. 25-215
Near point of convergence, aviation ............... 15-62(7)
Neck standards .......................................... 15-16
Nervous system:
Aviation personnel ...................................... 15-62(10)
Motor-torpedo-boat training and duty .......... 15-32
(2)(a)
(2)(f)

Standards .................................................. 15-24
INDEX

Neuropsychiatric Report, NAVKZD--102 _______ 23-17
Neuropsychiatry, special hospitals__________ 12-4
Nose and throat:
Aviation personneL _____________ _____ 15-62<25>
Diving personneL ______ ______ _____ 15-30<1> <h>
Motor-torpedo-boat training and duty----- 15-32
<2> <e>
15-15
-------Standards
(d)
15-29(2)
personneL __________ ____
Submarine ---------------------NROTC physical standards ______ __________ 15-34A
Nuclear power surface ship training program,
physical standards ______ ________ ________ 15-29A
Nurse Corps:
8-6
Appointments--- - ----------------------8-5
-- 8-13
Authority !or-------------------------__ _____________________ _____
Chief o! nursing service__________________ 8-11
Dental facillties__________________ _______ 6-73
8-4
Director-- -- - - - ------------- ----- ------Duties- - ------- - ------------- --------- 8-10--14
8-1
Establishment --- ----------------- -----8-3
<lrade ---------------------------- -----11-27
--------------F.lospitals --------------<1)
----- __ 8-7
______
_____________
Indoctrination
Promotion ____ ___ ________ __ ______ ______ S-a, 8-9
~argenurse

Strength --- - - ----- --------------- ----- Supervisor - - --- - - - - -------- --- - --------

8-2
8-12

0
OCCupational health _____________ ________ 26-1-10
Occupational F.lealth Report, NAVMEI>--576 ___ 23-21
Ocular mot111ty, aviation ____ ____ ___ _____ 15-62<13>
Oftl.cer in charge, dentaL___ _______________ 6-50
omcer of the day________________ 11-8<6>, 11-12<2>
3- 9
omcer of the deck or day report__ ___ ___ ____
Oncology, special hospitals______ ___________ 12-3
Operations, Dental Record ____ _______ ____ __ 6-114
Ophthalmoscopic examination, aviation_ 15-62(22)
Organization:
F.lospital -- - ---- ------------------ ------ 11-4
25-26
Storehouses, medicaL-------------------- 25-25
Supply depots, medical _______ ____ ____ ____
Orthopedic and prosthetic material ______ 24-25(3)
Orthopedic examination of major joints ___ 15-89A

p
Pathogenic cultures and organisms, transfer_ 22-39
Patients:
Air transportation____ ____ ____ ___ ________ 14-9
F.lospital____ ______ 11-7(3). 11-8 (2). 11-29, 11-30
12-4
- - ---- 23-222
-----______
- ----- --_____
- ---739
Neuropsychiatric
______
Register, DD Form
Transfer ___ __________________ ___ ____ 3- 22, 4-17
From hospital __ ___ _________________ ___ 11-30
Perineum and the pelvis including the sacroiliac and lumbosacral joints, examination
- 15-21
- - --------------17-39,
- -----------------of
(g)
17-77(4)
________
effects, deaths
Personal
Personnel :
Active duty, d eath_ ____ ____ ___ ___________ 17- 2
Army, Air Force, and Coast Guard; death __ 17-3,
17-69
Complements and allowances:
Medical Department afloat__ ___ _____ _ 4-12(2)
5-8
Medical Department ashore_________ ___
Fleet Reservists, inactive; death ____ 17- 17, 17-18
F.lospitaL _____ ____________ _____ 11-7(4) , 11-8<4>
Inactive or civilian p ersonnel , burial at sea_ 17-66
Inspection, afloat_ _____________________ 4-16(1)
Physically disqualified for reenlistment
when separated--- -------- ------ - - ---- - 15-41
Retired inactive, death _____ __________ ____ 17-16

Personnel and records division, hospital _____ 11-19
Photofluorographic:
Chest Survey Report,
NAVMED-618--- ----- - ------ 15-90 (6)(e) (4)
Equipment report, NAVMED-1405------- ---- 23-44
Log, NAVMED-1161_ ______________ 15-90(6 ) (e) (1 )
Physical defects and waiver :
Definition of organic defects______ ;. ___ __ _ 15-36
Physical defects----- - ------- - -------- ___ 15-35
Procedure for recommending waiver ____ __ 15-38
Relative significance of physical defects __ _ 15-37
Physical examinations :
Annual for female enlisted ___ ___________ 15-45A
stu-_
NROTC
midshipmen and
for________________
Annual
__ ___
_________
dents __
Annual for officers __________ ____________ _ 15-46
15-45
Applicants, Candidates, and Reservists___ 5-11
_
Applicants for steward ratings___________ 15-54
Aviation personnel :
Annual and promotion _______________ __ 15-71
Board of flight surgeons ______________ _ 15-72
Candidates for flight training ___ 15-67, 15-68
Forwarding of flight physicals_________ _ 15-73
Reexaminations for physical incapacity_ 15-70
Reporting of examinations on class 1
personnel ------------ --------------- 15-65
Special reporting on personnel in flight
15-66
- - --- ---- ------------------commission
trainingfor
or warrant_ ___ 15-42
Candidates
Candidates for Naval Academy ___________ 15-43
Candidates for Naval Preparatory SchooL _ 15-43
Civil employees ______________________ ____ 15-5·7
Commercial life insurance __ _______ __ ___ 3-21 (2)
Deserters - - - - - --------- - ----- ----------- 15-56
Detached to sea duty or duty outside the
u.s. ----------------------------- ----- 15-51
Discharge, transfer to F leet Reserve, or
retirement of enlisted personneL _______ _ 15-48
Enlisted personnel selected to attend service schools----- - - --------------------- 15- 53
Enlistment or reenlistment_ ____ __________ 15-40
F.leart and blood vessels-------------- --- - 15-88
F.leterophoria and prism divergence at
near ------------- - ------ --- ---------- 15-87
------Instructions
58
15- 39
_____________ ___ 15____ ---------------evidence
Intoxication ----Members on temporary disability retired
list________ __ ______ ___ _______________ 15-58A
Orthopedic, major joints_______ ____ ____ _ 15-89A
Personnel physically disqualified for r eenlistment when separated_________ ____ __ 15-41
55
--- - --- - - - - - -_ 15------ ------- --oftl.cers
Prisoners
15-47
________________
____
Promotion- of
Range of mot ion ________ ____________ _____ 15-89
Reporting of results ____ ___ 15-81-84, 16-37- 40
Reserve, Navy and Marine Corps:
Active dutY- -------------------- - ----- - 15-76
Actual control of aircraft ______________ 15- 79
Appointment, enlistment, and promotion ----------- ----- - - -------------- 15-75
Physical defects, reporting, and disposi-------- 15-80
- - -----tion ---------------15-78
_____ _________
examination
Quadrennial
Training duty __ ______________ _________ 15- 77
Retired members ordered to active duty ___ 15- 44
Roentgenographic, of chest___ ________ ____ 15-90
Separation of omcers ____________________ 15-49
Submarine and diving ___ __ _____ 14-11(3) , 14-15
Transfer of enlisted personneL ___ ___ 3-6, 15-50
Visual acuitY--- -- - ---------------------- 15-86
Physical standards, including causes for rejection:
Abdomen __________ 15-20, 15-20<2>. 15-29 (2) (i) ,
15-30 (1)(k ), 15- 32 (2)(h )

9
Change 9


### INDEX

**Remains—Continued**
- Escort ........................................ 17-42—50
- Identification ................................ 17-29
- Information for next of kin ............. 17-40
- Preparation and encasement in case of
  violence ..................................... 17-32
- Rules regarding transportation ........ 17-33
- Shipment by air ............................. 17-36
- Shipment by rail ............................ 17-35
- Shipment of personal effects .......... 17-39
- Transportation, method ................ 17-34
- When accompanied by escort .......... 17-37
- Repair ship dental officer ................ 6-41
- Reports required by Bureau, list of ... 23-3
  (Note—Reports may also be indexed by
  title and basic subject.)
- Reports, dental, list of ........................ 6-149
- Recruited personnel, handling ........ 4-33
- Research:
  - Dental ..................................... 6-58, 6-133-134F
  - Experimentation on personnel ....... 1-17, 6-134E
  - Institute, Naval Medical Center .... 13-10
  - Laboratories and facilities .......... 1-18, 6-134A
  - Medical .................................. 1-13—19
  - Policy .................................... 1-13, 6-133
  - Projects .................................. 1-16, 6-134C
  - Report, RDT&E Task, OPNAV Form
    3910-1 ..................................... 22-43
  - Scope ..................................... 1-14, 6-134
  - Technical reports and releases ..... 1-19
  - Trials of commercial items .......... 1-18, 6-134F
- Reserve, Navy and Marine Corps:
  - Annual certificate of physical condition
    15-13(2) .................................. 17-38
  - Dental .................................... 6-98(1)(c), (i)
  - Dental Program Report ................. 23-104
  - Dental treatment ....................... 6-98(1)(c), (i)
  - Health Record ............................ 15-26
  - Medical Program Report ................ 23-105
  - Physical defects, reporting and disposition .... 15-80
  - Physical examination for appointment,
    enlistment, and promotion .......... 15-75
  - Physical examination for training duty .... 15-77
  - Physical examinations for active duty .......... 15-76
  - Physical examinations for actual control
    of aircraft ................................ 15-79
  - Physical standards ...................... 15-74
  - Quadrennial examinations .............. 15-78
  - Residents, hospital .................... 11-26
  - Rearmed personnel, enlisted;
    physical examination ................. 15-48
    - Dental treatment .................... 6-98(1)(c), (i)
    - Emergency medical and dental treatment,
      nonnaval .............................. 20-5
    - Ordered to active duty, physical examination .... 15-44
  - Termination of Health Record ......... 15-15
  - Retirement of personnel, enlisted;
    physical examination ................. 15-48
    - Dental treatment .................... 6-98(1)(c), (i)
    - Emergency medical and dental treatment,
      nonnaval .............................. 20-5
    - Ordered to active duty, physical examination .... 15-44
  - Retirement of records .................. 23-300
  - River command dental officer ........ 6-48
  - River command medical officer ........ 5-5
  - Rodent control .......................... 22-57
  - Ships ...................................... 22-57
  - Certificate of deratization .......... 22-37(1)
  - Fumigation ............................... 22-37(2)
  - Roentgenographic examination of chest .... 15-80

**S**
- St. Elizabeths Hospital, death at ........ 17-19
- Sanitary standards for living spaces:
  - Barracks .................................. 22-7
  - Inspection ............................... 22-7(1)
  - Plumbing, fixture line Corps .......... 22-7(3)
  - Scrub decks for clothing ............. 22-7(6)
  - Sleeping rooms .......................... 22-7(2)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Page</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q</td>
<td>304</td>
<td>Quarantine procedures: Authority according to locality 22-35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Instructions 22-38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarantinable and communicable diseases 22-36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cholera 22-36(1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plague 22-36(1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smallpox 22-36(1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Typhus 22-36(1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yellow fever 22-36(1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Responsibilities 22-34</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rodents and insects aboard ship 22-37</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transfer of pathogenic cultures 22-39</td>
</tr>
<tr>
<td>R</td>
<td>25-29</td>
<td>Receipt and issue of medical and dental stores 25-29</td>
</tr>
</tbody>
</table>
|         |      | Records:
|         |      | Civilian employees 26-7 |
|         |      | Hospital 11-19 |
|         |      | Property 25-13 |
|         |      | Buildings and improvements ledger 25-13(4) |
|         |      | Equipment ledger 25-13(5) |
|         |      | Land ledger 25-13(3) |
|         |      | Narcotics, alcohol, alcoholic beverages 25-13(9) |
|         |      | Plant account ledger 25-13(6) |
|         |      | Precious and dental metals 25-13(8) |
|         |      | Provisions ledger 25-13(7) |
|         |      | Supplies ledger 25-13(6) |
|         |      | Release of information 23-310—313 |
|         |      | Records retirement: Disposition 23-301 |
|         |      | Field records retirement schedule 23-303 |
|         |      | Department of Defense forms 23-303(8) |
|         |      | NAVMED forms 23-303(8) |
|         |      | Other records 23-303(8) |
|         |      | Standard Federal forms 23-303(8) |
|         |      | Information concerning 23-300 |
|         |      | Preparation for transfer 23-302 |
|         |      | Recruit depot dental officer 6-52 |
|         |      | Red Cross, American 1-34, 11-10(5) |
|         |      | Red Cross flag, hospital 11-7(7) |
|         |      | Red lens test, aviation 15-69(14) |
|         |      | Reenlistment, physical examination 15-40(2) |
|         |      | Referral of cases to medical survey board 18-10 |
|         |      | Refractions:
|         |      | Aviation 15-69(21) |
|         |      | Civilian employees 26-9, 26-10(2) |
|         |      | Naval personnel 20-11 |
|         |      | Refusal of treatment 18-10(2)(b) |
|         |      | Register of patients, OD-739 22-92 |
|         |      | Relations with civil authorities, deaths 17-25 |
|         |      | Remains:
|         |      | Arlington Cemetery 17-41 |
|         |      | Arrangements to be made at travel points 17-38 |
|         |      | Embalming and inspection 17-39 |

---

**Publication**

**Disinsection** 22-35

**Publications for dental facilities** 8-145

**Records retirement: Disposition** 23-301

**Range** 6-145

**Range of motion** 6-145

**Red** 6-145

**Red lens test, aviation** 15-7

**Reporting ship dental officer** 15-7

**Reenlistment, physical examination** 15-13

**Records retirement schedule** 23-303

**Records, dental, list of** 6-149

**Records: Civilian employees** 26-7

**Reenlistment, physical examination** 15-40(2)

**Release of information** 23-310—313

**Refractive errors** 15-69(21)

**Remains: Arlington Cemetery** 17-41

**Rheumatic fever** 6-52

**Responsibilities** 22-34

**Rodents and insects aboard ship** 22-37
INDEX

Sanitary standards for living spaces—Con.
Berthing spaces afloat:
Berthing compartments ................................ 22-8(2)
Inspection ............................................. 22-8(1)
Brigs .................................................. 22-8(3)
Hospitals .............................................. 22-10
Bed requirements ...................................... 22-9(2)
Patients per ward ..................................... 22-9(1)
Prisons ................................................ 22-11
Sanitation:
Cooperation with civil authorities .................... 22-4(3)
Indoctrination of personnel .......................... 22-4(2)
Industrial hygiene ................................... 22-4(1)
Inspection and investigation ........................ 22-4(4)
Recommendations .................................... 22-4(5)
Records .............................................. 22-4(6)
Swimming sites:
Bathing loads ........................................ 22-5(4)
Fouls .................................................. 22-5(2)
Recommendations .................................... 22-5(3)
Sanitary control ...................................... 22-5(3)
Schick test .......................................... 22-29(3)
School:
Aviation Medicine .................................. 13-18
Bethesda Medical Center ............................. 13-7
Dental ............................................... 6-135—138, 13-8
Hospital Administration ............................. 13-9
Dental Technician .................................. 6-139—144
Security and master at arms division, hospital .... 11-20
Selective Service registrants, medical care .......... 21-24
Self-contained underwater breathing apparatus, diving, physical standards ........... 15-30
Separation from service, officers ................... 15-49
SF forms, list ........................................ 23-216
Ship dental officer .................................. 6-59
Ship medical officer ................................ 4-1—29
Ships going into commission, inspection ............ 5—17
Shipyard dental officer ............................... 6-53
Shore station dental officer ........................ 6-51
Shoulder, physical examination ...................... 15—89A(1)
Sick Call Treatment Record, NAVMED 10. 16—30—36
Sick, morning report, NAVMED-T .................. 23—219
Sick Slip, Individual, DD 689 16—35, 16-70—73
Sight conservation program ........................ 26—8
Skin:
Diving personnel 15—30(1)(m)
Motor-torpedo-boat training and duty ........... 15—32
(2) .............................................. 15—32
Standards ........................................... 15—33
Submarine personnel 15—39(2)(1) ............... 15—39
Smallpox ............................................. 22-22
Special Duty Medical Abstract, NAVMED 1346 . 16-58—60
Special hospitals:
Aural rehabilitation ................................ 12—2
Neuro psychiatry .................................... 12—4
Attendants .......................................... 12—4(2)
Evaluation, treatment, and transfer ............... 12—4(1)
Final disposition ................................... 12—4(7)
Notification of next of kin ........................ 12—4(5)
Personal effects .................................... 12—4(6)
Security of patients during transfer ............... 12—4(3)
Oncology ........................................... 12—3
Special services division, hospital ................. 11—21
Specialists for emergency treatment .......... 20—9—15
Spine standards ..................................... 15—17
Standard Federal medical forms, list ............... 23—216
Standing orders, medical officers .................. 3—7
Statement and Inventory of Precious and Special Dental Metals, NAVMED-1301 .. 6—156
Statement in rebuttal, medical survey ........... 18—14
Sterilizers for battle dressing stations ........... 4—41
Steward ratings, applicants: physical examination .... 15—54
Store rooms:
Management ....................................... 25—14
Medical ............................................. 4—15
Submarine and diving services:
Duties .............................................. 14—10
Illness due to occupational hazards .............. 14—16
Inspection by medical officer ...................... 14—11
Instruction ........................................ 14—12
Physical examinations 14—11(3) 14—15
Radiation hazards ................................ 14—11(4)
Reexamination ..................................... 15—29(4)
Reports ............................................. 14—14, 14—17
Venerable disease .................................. 14—13
Supernumeraries:
Ambulance service ................................ 21—2(2)
Charges, collections, and reports ................ 21—33
Definition .......................................... 21—1
Dependent .......................................... 21—4—8
Health Record termination ......................... 21—17
Medical care ....................................... 21—2
Other than service patients:
Beneficiaries of the Bureau of Employees Compensation ........... 21—26
Beneficiaries of the Public Health Service ........ 21—23
Beneficiaries of the Veterans’ Administration .... 21—22
Civilians under special circumstances .......... 21—28
Members of foreign military establishments .... 21—30
Officers and employees of Government and Federal contractors outside U.S. .... 21—27
Officers and employees of the State Department Foreign Service ........... 21—29
Registants, Selective Service ....................... 21—24
Representative of the American Red Cross ....... 21—25
Release of information from medical records .... 23—312
Service patients not on active naval duty:
Army and Air Force Reserve ...................... 21—17
Beneficiaries of the Naval Home ................... 21—19
Fleet Reserve and Fleet Marine Corps Reserve .... 21—14
Former members ................................... 21—20
Naval pensioners ................................... 21—18
Navy and Marine Corps Reserve .................. 21—16
Officer candidates ................................ 21—21
Other services, active duty ......................... 21—22
Other services, retired with pay .................... 21—15
Retired Navy and Marine Corps personnel ....... 21—13
Table of procedures ................................ 21—3
Supplies:
Dental .............................................. 6—160—174
Issue ............................................... 25—19
Medical ............................................. 4—41
Medical, at battle dressing stations ............. 4—38
Medical, inspection ................................ 5—13
Surface ship nuclear power training program, physical standards ........... 15—29A
Surgical operations, report, NAVMED-P ........ 23—13
Survey of property ................................ 25—21
Swimming sites .................................... 22—5
Syphilis Record, SP 602 .......................... 16—52—53
INDEX

<table>
<thead>
<tr>
<th>T</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tabulation of DD forms</td>
<td>23-216A</td>
<td>Tabulation of Navy forms</td>
<td>23-215</td>
</tr>
<tr>
<td>Tabulation of reports</td>
<td>23-2</td>
<td>Tabulation of standard forms</td>
<td>23-216</td>
</tr>
<tr>
<td>Teeth, numerical designation</td>
<td>6-115(1)</td>
<td>Teeth, standards</td>
<td>6-86-97, 15-23</td>
</tr>
<tr>
<td>Annual physical</td>
<td>6-91</td>
<td>Appointment</td>
<td>6-88-89</td>
</tr>
<tr>
<td>Aviation duty</td>
<td>6-95-96</td>
<td>Diving duty</td>
<td>6-93, 15-30(1)(f)</td>
</tr>
<tr>
<td>Enlistment and reenlistment</td>
<td>6-87</td>
<td>Motor torpedo boat training and duty</td>
<td>6-93, 15-32(2)(d)</td>
</tr>
<tr>
<td>Nuclear power surface ship training</td>
<td>15-29A</td>
<td>Promotion</td>
<td>6-90</td>
</tr>
<tr>
<td>Submarine duty</td>
<td>6-93, 15-29(2)(f)</td>
<td>Underwater demolition duty</td>
<td>6-93</td>
</tr>
<tr>
<td>Waivers of defects</td>
<td>6-97</td>
<td>Women</td>
<td>6-94, 13-34(4)</td>
</tr>
<tr>
<td>Temperament, diving duty</td>
<td>15-30(1)(e)</td>
<td>Tender dental officer</td>
<td>6-41</td>
</tr>
<tr>
<td>Test for accommodation, aviation</td>
<td>15-62(16)</td>
<td>Tetanus</td>
<td>22-24</td>
</tr>
<tr>
<td>Thorax:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aviation personnel</td>
<td>15-62(5)</td>
<td>Diving personnel</td>
<td>15-30(1)(f)</td>
</tr>
<tr>
<td>Standards</td>
<td>15-18</td>
<td>Submarine personnel</td>
<td>15-29(2)(g)</td>
</tr>
<tr>
<td>Training:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Center dental officer</td>
<td>6-52</td>
<td>Dental aids</td>
<td>6-132</td>
</tr>
<tr>
<td>Dental officer</td>
<td>6-122-132</td>
<td>Civilian</td>
<td>6-128</td>
</tr>
<tr>
<td>Correspondence course</td>
<td>6-131</td>
<td>Indoctrination, basic course</td>
<td>6-123</td>
</tr>
<tr>
<td>Internships</td>
<td>6-122</td>
<td>Postgraduate course, general</td>
<td>6-124</td>
</tr>
<tr>
<td>Request form</td>
<td>6-130</td>
<td>Residency</td>
<td>6-125</td>
</tr>
<tr>
<td>Specialized</td>
<td>6-126</td>
<td>Staff and administrative schools</td>
<td>6-27</td>
</tr>
<tr>
<td>Dental technicians</td>
<td>6-86</td>
<td>First aid instruction</td>
<td>3-10(3)</td>
</tr>
<tr>
<td>Group X, medical ratings</td>
<td>9-11</td>
<td>Health and educational program</td>
<td>3-10(1)</td>
</tr>
<tr>
<td>Hospital corpsmen, instruction</td>
<td>3-10(4)</td>
<td>Indoctrination of personnel</td>
<td>3-10(5)</td>
</tr>
<tr>
<td>Medical officers, residency</td>
<td>11-26</td>
<td>Nurse Corps</td>
<td>8-7</td>
</tr>
<tr>
<td>Postgraduate, Medical Service Corps</td>
<td>7-30</td>
<td>Professional, hospital</td>
<td>11-8(3)</td>
</tr>
<tr>
<td>Venereal disease, instruction</td>
<td>3-10(2)</td>
<td>Transfer—Continued</td>
<td></td>
</tr>
<tr>
<td>Custody of property</td>
<td>25-17</td>
<td>Patients from a naval hospital</td>
<td>11-30</td>
</tr>
<tr>
<td>Dental care, prior to</td>
<td>6-92</td>
<td>Medical reasons</td>
<td>11-30(2)</td>
</tr>
<tr>
<td>Enlisted personnel, physical examinations</td>
<td>3-6, 15-50</td>
<td>Orders and travel</td>
<td>11-30(5)</td>
</tr>
<tr>
<td>Fleet Reserve, physical examination</td>
<td>15-48</td>
<td>Personal reasons</td>
<td>11-30(3)</td>
</tr>
<tr>
<td>Health record:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duty</td>
<td>16-20</td>
<td>Retirement, records</td>
<td>23-302</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>16-21-25</td>
<td>Sea duty or duty outside continental limits, physical examination</td>
<td>15-51</td>
</tr>
<tr>
<td>Hospital Corps school</td>
<td>9-6</td>
<td>Wounded</td>
<td>4-45</td>
</tr>
<tr>
<td>Patients</td>
<td>3-22, 4-17</td>
<td>Transport dental officer</td>
<td>6-43-44</td>
</tr>
<tr>
<td>By air</td>
<td>14-9</td>
<td>Transport duty</td>
<td>4-19</td>
</tr>
<tr>
<td>Transfer—Continued</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td>15-81(2)</td>
<td>Tuberculosis control</td>
<td>22-19</td>
</tr>
<tr>
<td>Tuberculosis, non naval</td>
<td>11-7(3), 20-1-16</td>
<td>Typhoid and paratyphoid</td>
<td>15-22</td>
</tr>
<tr>
<td>Typhus</td>
<td>22-26</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>Underwater demolition teams, physical standards</td>
<td>15-30</td>
<td>Underfavorable Inoculant Reactions, report</td>
<td>22-21(4)</td>
</tr>
<tr>
<td>Unit price of medical stores</td>
<td>25-28</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>Venereal disease:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicants for naval service</td>
<td>15-22</td>
<td>Venereal disease, civilian, testing</td>
<td>15-18</td>
</tr>
<tr>
<td>Aviation personnel</td>
<td>15-62(3)</td>
<td>Visual acuity, aviation</td>
<td>15-82(1)(i)</td>
</tr>
<tr>
<td>Control program</td>
<td>15-62(3)</td>
<td>Visual acuity, testing</td>
<td>15-85</td>
</tr>
<tr>
<td>Diving personnel</td>
<td>15-30(1)(f)</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>Instructions</td>
<td>3-10(2)</td>
<td>Waivers of dental defects</td>
<td>6-97</td>
</tr>
<tr>
<td>Submarine personnel</td>
<td>14-13, 15-29(2)(f)</td>
<td>Watches, naval hospital</td>
<td>11-12</td>
</tr>
<tr>
<td>Veterans Administration:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Examinations report</td>
<td>21-22(4)</td>
<td>Water supply</td>
<td>22-14</td>
</tr>
<tr>
<td>Patients, dental treatment</td>
<td>6-86(1)(i)</td>
<td>Water supply for battle dressing stations</td>
<td>4-39</td>
</tr>
<tr>
<td>Venereal disease, civilian</td>
<td>15-84</td>
<td>Weight:</td>
<td></td>
</tr>
<tr>
<td>Venereal disease, instruction</td>
<td>3-10(2)</td>
<td>Aviation personnel</td>
<td>15-62(4)</td>
</tr>
<tr>
<td>Custody of property</td>
<td>25-17</td>
<td>Diving duty</td>
<td>15-30(1)(c)</td>
</tr>
<tr>
<td>Dental care, prior to</td>
<td>6-92</td>
<td>Standards</td>
<td>15-5-1</td>
</tr>
<tr>
<td>Enlisted personnel, physical examinations</td>
<td>3-6, 15-50</td>
<td>Submarine personnel</td>
<td>15-29(2)(m)</td>
</tr>
<tr>
<td>Fleet Reserve, physical examination</td>
<td>15-48</td>
<td>Tables</td>
<td>15-5-1(1)</td>
</tr>
<tr>
<td>Health record:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duty</td>
<td>16-20</td>
<td>Women personnel</td>
<td>15-34(2)</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>16-21-25</td>
<td>Women personnel, physical standards</td>
<td>15-34</td>
</tr>
<tr>
<td>Hospital Corps school</td>
<td>9-6</td>
<td>Causes for rejection</td>
<td>15-34(6)</td>
</tr>
<tr>
<td>Patients</td>
<td>3-22, 4-17</td>
<td>Wrist and hand, physical examination</td>
<td>15-89A(5)</td>
</tr>
<tr>
<td>By air</td>
<td>14-9</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Yellow fever</td>
<td>22-25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Change 9
INDEX

A
Abandon ship ............................................. 4-31
Abdomen:
   Diving duty........................................... 15-30(1) (e)
   Motor-torpedo-boat training and duty ............. 15-32
   Standards ............................................. 15-20
Submarine personnel ................................... 15-29(2) (f)
Absence of medical officer, afloat ..................... 4-12 (f)
Abstract of Antiluetic Treatment, NAVMED H-7 __________ 16-51
Abstract of Service and Medical History, NAVMED H-9 ... 16-48
Accounting, dental ..................................... 6-177
Administrative:
   Divisions, hospital ................................ 11-13A
   Advanced base organizations:
      Definition ......................................... 14-18
      O-components ..................................... 14-19
      Hospitals ......................................... 15-20
      Staff dental officers ............................. 14-22
      Staff medical officers ............................ 14-21
      Training ............................................ 14-23
   Advancement in grade, Medical Corps ............... 2-6-13
   Advancement in rating:
      Dental technicians ................................ 6-67
      Hospital Corps .................................... 9-8
      Age:
         Diving duty ..................................... 15-30(1) (b)
         Motor-torpedo-boat training and duty .......... 15-32
         Nuclear power surface ship training ............ 15-29A
      Aircraft carrier dental officer ................. 6-40
      Alcohol and alcoholic beverages:
         Custody .......................................... 3-34
         Prescribing and dispensing ..................... 3-33
         Security ........................................... 3-35
      Allotments:
         Dental ............................................. 6-170
         Funds for civilian employees .................... 10-4
      Ambulances:
         Civil authorities liaison and use of .......... 3-29(2)
         Supernumerary use ................................ 21-2 (2)
      American Red Cross................................ 1-24, 11-10 (3)
      Medical treatment ................................ 21-25
      Amphibious operations, medical service ........ 14-1
      Annual physical examinations:
         Divers ............................................. 15-20 (2)
         Female enlisted .................................. 15-46A
         Midshipmen and NROTC students ................. 15-46
         Officers .......................................... 15-45
      Appointments:
         Dental Corps ..................................... 6-15
         Dental service warrant officers ................ 6-69
         Medical Corps .................................... 2-3-5
         Medical Service Corps ............................ 7-5-8, 9-10
         Nurse Corps ....................................... 8-6
         Warrant officer, Hospital Corps .................. 9-9
      Aptitude board:
         Data in report .................................... 18-5
         Exam report ....................................... 18-4
         Functions ......................................... 18-3
         Processing report ................................ 18-6

B
Back, physical examination ............................. 15-89A(2)
Barracks, sanitary standards ........................... 22-7
Battle casualties, definitions ......................... 1-23
Battle dressing stations:
   Instructions ........................................ 4-36
   Light ................................................ 4-40
   Medical supplies .................................... 4-38
   Routes to be marked ................................ 4-42
   Sterilizers ......................................... 4-41
   Water supply ........................................ 4-39
Change 7
INDEX

BATTLE, final preparation.................................. 4-43
Battle plans:.................................................. 4-8(2)
Casualties, reporting........................................ 4-8(2)
Transportation of sick and wounded........................ 4-8(1)
Bedding, inspection.......................................... 4-16(3)
Beds, nomenclature.......................................... 1-21, 1-22
Beneficiaries:................................................ 1-21-22

Bureau of Employees Compensation................................ 21-26
Naval Home.................................................. 21-19
Public Health Service........................................ 21-22
Veterans Administration..................................... 21-22
Berthing space, afloat, sanitary standards.................. 22-8
Binnacle List, NAVMED-S.................................... 23-217
Biological warfare, defense against........................ 4-26
Births, reporting............................................ 3-12(4)
Board of Medical Survey Report, NAVMED-M................. 18-12
Boards and committees, hospital................................ 11-11
Boards of investigation, death............................... 11-11
Brigs, sanitary standards.................................... 22-10
Budget estimates, dental..................................... 6-175
Bureau: Organization......................................... 1-12
Specifications............................................... 23-1
Burial Record, NAVMED-HF-38................................ 23-221
Burial report: NAVMED-601.................................. 17-9A
Navy Cemeteries or plots.................................... 23-153

C

Canadian Armed Forces personnel, dental treatment........ 6-98(1)(a)
Candidates, physical examinations............................. 15-42
Commission or warrant...................................... 15-43
Naval Academy............................................... 15-43
Naval Preparatory School.................................... 15-43
Casualties: Aviation.......................................... 14-8
Mass......................................................... 6-27
Cells, inspection............................................ 4-16(3)
Cemeteries.................................................... 17-78-81
Map or plan.................................................. 17-81
National...................................................... 17-79
Naval plots and cemeteries.................................. 17-80
Certificate of Death, NAVMED-N.............................. 17-10-14
Certificate of physical condition, annual: Reserve......... 15-78(2)
Change in rank or rating on Health Records: Enlisted personnel.......................... 16-28
Midshipmen.................................................... 16-28
NROTC commissioning...................................... 16-27
Officers...................................................... 16-24
Transfer to Regular Navy or Marine Corps...................... 16-25
Chaplains, hospital......................................... 11-10(2)
Charges, collections, and reports of super-numeraries...... 21-33
Chemical warfare, defense against........................... 4-26
Chiefs of services, hospital.................................. 11-23
Cholera....................................................... 22-27
Limitation of immunization.................................. 22-27(4)
Preservation of vaccine...................................... 22-27(3)
Requirements............................................... 22-27(1)

Chronicologic Record of Medical Care, SF-600:................. 6-19
Dental: Recordings......................................... 6-19
Civil authorities, cooperation with........................... 1-7(2)
3-12, 3-29, 11-7(2), 17-7, 17-26
Civil suits.................................................... 3-29(1)
Dental officers............................................. 6-36
Civilian employees: Allotment of funds......................... 10-4
Army, Navy, and Air Force; death............................ 17-5
Classification and wage administration....................... 10-6-8
Dental facilities........................................... 6-74

Civilian employees—Continued
Dental treatment............................................ 6-98(1)(k)
Employment.................................................. 10-9-12
Health program............................................ 21-10-11
Instruction.................................................. 10-17
Medical records............................................ 26-7
Organization............................................... 10-1-3
Physical examination........................................ 19-57
Position, establishment..................................... 10-5
Records...................................................... 10-18
Relations and services...................................... 10-16
Training..................................................... 10-13-15

Civilian(s):
Agenes, death forms......................................... 17-8
Dental professional activity................................. 6-34
Medical aid.................................................. 3-27
Physicians.................................................... 5-24-29
Claims for emergency medical and dental treatment........ 20-5-20-16
Classification and wage administration of civilian employees... 10-6-8

Clinical board:
Action by convening authority.............................. 18-23
Cases involving discipline.................................. 18-23-1(1)(e)
Clinical record, appending.................................. 18-23-1(4)
Orders, distribution......................................... 18-23-1(4)
Orders, issue.................................................. 18-23-1(4)
Orders, receipt................................................ 18-23-1(4)
Composition.................................................. 18-17
Convening authority........................................ 18-16
Disposition of cases......................................... 18-22
Duties......................................................... 18-21
Procedure.................................................... 18-20
Purpose....................................................... 18-18
Referral of cases............................................ 18-19
Clinical services, hospital.................................. 11-22
Clinics, dental.............................................. 6-75-81
Coast and Geodetic Survey members, dental treatment........ 6-98(1)(j), (f)
Coast Guard members, dental treatment....................... 6-98(1)(j), (f)
Collision afloat............................................. 4-29
Color perception:
Aviation personnel.......................................... 15-62(19)
Diving duty................................................... 15-39(2)
Motor torpedo-boat training and duty........................ 15-32(2)(c)
Nuclear power surface ship training........................ 16-293(c)
Standards..................................................... 15-11
Submarine personnel........................................ 15-29(2)(c)
Combined Dental Personnel Report, NAVMED-1323............ 6-159
Combined Report of Enlisted Hospital Corps, NAVMED-590.... 23-24
Commanding officer:
Dental........................................................ 6-49
Hospital: Duties............................................. 11-7
Delegation.................................................... 11-7(8)
Communicable disease control
Reports........................................................ 8-12, 11-7(2)(b), 22-20
Responsibilities............................................. 22-17
Tuberculosis control........................................ 22-19
Chest X-rays.................................................. 22-19(1)
Follow-up chest X-rays..................................... 22-19(2)
Individuals suspected....................................... 22-19(3)
Precautions................................................... 22-19(4)
Venereal disease control.................................... 22-18
Compartment, inspection..................................... 4-16(3)

Consultation service:
Bethesda Medical Center.................................. 13-3
Pensacola Medical Center.................................. 13-15

Change 7
### INDEX

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations Sheet, SF-513</td>
<td>6-120</td>
</tr>
<tr>
<td>Conventions of Geneva</td>
<td>3-30</td>
</tr>
<tr>
<td>Correspondence:</td>
<td></td>
</tr>
<tr>
<td>Courses, dental</td>
<td>6-131</td>
</tr>
<tr>
<td>Dental</td>
<td>6-30</td>
</tr>
<tr>
<td>Courts of inquiry</td>
<td>17-23</td>
</tr>
<tr>
<td>Custody of Health Records:</td>
<td></td>
</tr>
<tr>
<td>Lost, damaged, or destroyed</td>
<td>16-23</td>
</tr>
<tr>
<td>Reserve personnel, inactive</td>
<td>16-22</td>
</tr>
<tr>
<td>Responsibility</td>
<td>4-17</td>
</tr>
<tr>
<td>Transfer of patient to naval hospital</td>
<td>16-19</td>
</tr>
<tr>
<td>Transfer of patient to nonnaval hospital</td>
<td>16-20</td>
</tr>
<tr>
<td>Transfer to Federal penitentiaries</td>
<td>16-21</td>
</tr>
<tr>
<td>Transfer to penitentiary guards</td>
<td>16-18</td>
</tr>
<tr>
<td>Custody of property:</td>
<td></td>
</tr>
<tr>
<td>Inspection of materials</td>
<td>25-16</td>
</tr>
<tr>
<td>Inventory adjustment</td>
<td>25-18</td>
</tr>
<tr>
<td>Inventory procedure</td>
<td>25-15</td>
</tr>
<tr>
<td>Records</td>
<td>25-13</td>
</tr>
<tr>
<td>Buildings and improvements ledger</td>
<td>25-13(4)</td>
</tr>
<tr>
<td>Equipment ledger</td>
<td>25-13(5)</td>
</tr>
<tr>
<td>Land ledger</td>
<td>25-13(3)</td>
</tr>
<tr>
<td>Narcotics, alcohol, and alcoholic beverages</td>
<td>25-13(9)</td>
</tr>
<tr>
<td>Plant account ledger</td>
<td>25-13(8)</td>
</tr>
<tr>
<td>Precious and dental metals</td>
<td>25-13(9)</td>
</tr>
<tr>
<td>Provisions ledger</td>
<td>25-13(6)</td>
</tr>
<tr>
<td>Supplies ledger</td>
<td>25-14</td>
</tr>
<tr>
<td>Store room management</td>
<td>25-14</td>
</tr>
<tr>
<td>Transfer of custody</td>
<td>25-17</td>
</tr>
</tbody>
</table>

**Deaths—Continued**

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of next of kin:</td>
<td></td>
</tr>
<tr>
<td>Continental activities having contracts</td>
<td>17-26</td>
</tr>
<tr>
<td>Continental activities not having contracts</td>
<td>17-27</td>
</tr>
<tr>
<td>Extra continental ships and stations</td>
<td>17-28</td>
</tr>
<tr>
<td>Occurring away from command</td>
<td>17-28</td>
</tr>
<tr>
<td>Other deaths</td>
<td>17-28</td>
</tr>
<tr>
<td>Preparation of remains:</td>
<td></td>
</tr>
<tr>
<td>Embalming and inspection</td>
<td>17-29</td>
</tr>
<tr>
<td>In case of violence</td>
<td>17-32</td>
</tr>
<tr>
<td>Post-mortem examinations</td>
<td>17-34</td>
</tr>
<tr>
<td>Relations with civil authorities</td>
<td>17-25</td>
</tr>
<tr>
<td>Reporting to civil authorities</td>
<td>3-13(4), 17-7</td>
</tr>
<tr>
<td>Reports, administrative</td>
<td>17-23</td>
</tr>
<tr>
<td>Reports summary</td>
<td>17-9</td>
</tr>
<tr>
<td>Retired inactive personnel</td>
<td>17-16</td>
</tr>
<tr>
<td>St. Elizabeths Hospital</td>
<td>17-19</td>
</tr>
<tr>
<td>Transportation of remains</td>
<td></td>
</tr>
<tr>
<td>Arlington Cemetery</td>
<td>17-41</td>
</tr>
<tr>
<td>Arrangements made at transfer points</td>
<td>17-38</td>
</tr>
<tr>
<td>Information for next of kin</td>
<td>17-40</td>
</tr>
<tr>
<td>Method</td>
<td>17-34</td>
</tr>
<tr>
<td>Rules</td>
<td>17-33</td>
</tr>
<tr>
<td>Shipments</td>
<td></td>
</tr>
<tr>
<td>Air</td>
<td>17-36</td>
</tr>
<tr>
<td>Personal effects</td>
<td>17-39</td>
</tr>
<tr>
<td>Rail</td>
<td>17-35</td>
</tr>
<tr>
<td>When accompanied by escort</td>
<td>17-37</td>
</tr>
<tr>
<td>Decommissioning</td>
<td>25-22</td>
</tr>
<tr>
<td>Decompression sickness and diving accidents</td>
<td></td>
</tr>
<tr>
<td>report, NAVMED-816</td>
<td>23-30</td>
</tr>
<tr>
<td>Defective Medical and Dental Material, report</td>
<td>25-121</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Appointments, Daily, NAVMED-1298</td>
<td>6-153</td>
</tr>
<tr>
<td>Civilian professional activity</td>
<td>6-34</td>
</tr>
<tr>
<td>Classifications</td>
<td>6-101</td>
</tr>
<tr>
<td>Clinics</td>
<td>6-75-81</td>
</tr>
<tr>
<td>Corps</td>
<td></td>
</tr>
<tr>
<td>Appointments</td>
<td>6-15</td>
</tr>
<tr>
<td>Establishment</td>
<td>6-13</td>
</tr>
<tr>
<td>Grade and strength</td>
<td>6-14</td>
</tr>
<tr>
<td>Promotion</td>
<td>6-17-20</td>
</tr>
<tr>
<td>Division, BUMED</td>
<td>5-4-12</td>
</tr>
<tr>
<td>Examination and Treatment Record, NAVMED-1299</td>
<td>6-154</td>
</tr>
<tr>
<td>Examinations</td>
<td>6-99</td>
</tr>
<tr>
<td>NAVMED-1299</td>
<td>6-113</td>
</tr>
<tr>
<td>NAVMED-1300</td>
<td>6-100</td>
</tr>
<tr>
<td>NAVMED-1301</td>
<td>6-101</td>
</tr>
<tr>
<td>NAVMED-1302</td>
<td>6-102</td>
</tr>
<tr>
<td>NAVMED-1303</td>
<td>6-103</td>
</tr>
<tr>
<td>NAVMED-1304</td>
<td>6-104</td>
</tr>
<tr>
<td>NAVMED-1305</td>
<td>6-105</td>
</tr>
<tr>
<td>NAVMED-1306</td>
<td>6-106</td>
</tr>
<tr>
<td>NAVMED-1307</td>
<td>6-107</td>
</tr>
<tr>
<td>NAVMED-1308</td>
<td>6-108</td>
</tr>
<tr>
<td>NAVMED-1309</td>
<td>6-109</td>
</tr>
<tr>
<td>NAVMED-1310</td>
<td>6-110</td>
</tr>
<tr>
<td>Log</td>
<td>6-29</td>
</tr>
<tr>
<td>Material</td>
<td>6-139-174</td>
</tr>
<tr>
<td>Personnel report, combined, NAVMED-1299</td>
<td>6-159</td>
</tr>
<tr>
<td>Dental officer</td>
<td></td>
</tr>
<tr>
<td>Aircraft carrier</td>
<td>6-40</td>
</tr>
<tr>
<td>Assistant</td>
<td>6-23</td>
</tr>
<tr>
<td>Aviation unit</td>
<td>6-26</td>
</tr>
<tr>
<td>Designation</td>
<td>6-22</td>
</tr>
<tr>
<td>Dispensary</td>
<td>6-55</td>
</tr>
<tr>
<td>District</td>
<td>6-47</td>
</tr>
<tr>
<td>Duties, general</td>
<td>6-22-36</td>
</tr>
<tr>
<td>Fleet</td>
<td>6-37</td>
</tr>
<tr>
<td>Force</td>
<td>6-38</td>
</tr>
<tr>
<td>Hospital</td>
<td>6-54</td>
</tr>
<tr>
<td>Hospital ship</td>
<td>6-42</td>
</tr>
<tr>
<td>Marine Corps</td>
<td>6-56-62</td>
</tr>
<tr>
<td>Mobile dental unit</td>
<td>6-57</td>
</tr>
<tr>
<td>Naval Reserve</td>
<td>6-198-210</td>
</tr>
<tr>
<td>Recruiting depot</td>
<td>6-32</td>
</tr>
<tr>
<td>Repair ship</td>
<td>6-41</td>
</tr>
</tbody>
</table>

**Change 7**
## INDEX

**Dental Record, SF-603**

<table>
<thead>
<tr>
<th>Page Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-107-118</td>
<td>Abbreviations and designations</td>
</tr>
<tr>
<td>6-115</td>
<td>Custody</td>
</tr>
<tr>
<td>6-116-118</td>
<td>Examinations, recording</td>
</tr>
<tr>
<td>6-119</td>
<td>Instructions, general</td>
</tr>
<tr>
<td>6-130</td>
<td>Markings</td>
</tr>
<tr>
<td>6-132</td>
<td>Operations, recording</td>
</tr>
<tr>
<td>6-133</td>
<td>Purpose</td>
</tr>
<tr>
<td>6-134</td>
<td>Recovery</td>
</tr>
<tr>
<td>6-135</td>
<td>Special entries</td>
</tr>
<tr>
<td>6-136</td>
<td>Treatments, recording</td>
</tr>
<tr>
<td>6-137</td>
<td>Dental School</td>
</tr>
<tr>
<td>6-138</td>
<td>Dental service, chief of</td>
</tr>
<tr>
<td>6-139</td>
<td>Dental service, chief of</td>
</tr>
<tr>
<td>6-140</td>
<td>Dental service, chief of</td>
</tr>
<tr>
<td>6-141</td>
<td>Dental service, chief of</td>
</tr>
<tr>
<td>6-142</td>
<td>Dental standards</td>
</tr>
<tr>
<td>6-143</td>
<td>Annual physical</td>
</tr>
<tr>
<td>6-144</td>
<td>Appointment</td>
</tr>
<tr>
<td>6-145</td>
<td>Aviation duty</td>
</tr>
<tr>
<td>6-146</td>
<td>Divemaster</td>
</tr>
<tr>
<td>6-147</td>
<td>Enlistment and reenlistment</td>
</tr>
<tr>
<td>6-148</td>
<td>Flight duty</td>
</tr>
<tr>
<td>6-149</td>
<td>Submarine duty</td>
</tr>
<tr>
<td>6-150</td>
<td>Underwater demolition duty</td>
</tr>
<tr>
<td>6-151</td>
<td>Waivers of defects</td>
</tr>
<tr>
<td>6-152</td>
<td>Women</td>
</tr>
<tr>
<td>6-153</td>
<td>Dental technicians</td>
</tr>
<tr>
<td>6-154</td>
<td>Schools</td>
</tr>
<tr>
<td>6-155</td>
<td>Dental treatment</td>
</tr>
<tr>
<td>6-156</td>
<td>Armored Air Force personnel</td>
</tr>
<tr>
<td>6-157</td>
<td>Before transfer to station without dental officer</td>
</tr>
<tr>
<td>6-158</td>
<td>Canadian Armed Forces personnel</td>
</tr>
<tr>
<td>6-159</td>
<td>Civilian personnel injured in a naval station</td>
</tr>
<tr>
<td>6-160</td>
<td>Coast and Geodetic Survey members</td>
</tr>
<tr>
<td>6-161</td>
<td>Coast Guard members</td>
</tr>
<tr>
<td>6-162</td>
<td>Fleet Naval Reserve and Marine Corps Reserve</td>
</tr>
<tr>
<td>6-163</td>
<td>Inactive duty Navy and Marine Corps members</td>
</tr>
<tr>
<td>6-164</td>
<td>Medical officer</td>
</tr>
<tr>
<td>6-165</td>
<td>Naval Reserve and Marine Corps Reserve</td>
</tr>
<tr>
<td>6-166</td>
<td>Nonnaval</td>
</tr>
</tbody>
</table>

**Dental treatment—Continued**

<table>
<thead>
<tr>
<th>Page Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-88(1) (g)</td>
<td>Persons hospitalized, accordance with law</td>
</tr>
<tr>
<td>6-88(1) (h)</td>
<td>Priority</td>
</tr>
<tr>
<td>6-88(1) (i)</td>
<td>Prisoners of war</td>
</tr>
<tr>
<td>6-88(1) (k)</td>
<td>Prosthetic public health service members</td>
</tr>
<tr>
<td>6-88(1) (l)</td>
<td>Recording on SF-600</td>
</tr>
<tr>
<td>6-88(1) (m)</td>
<td>Refusal to report, SF-603</td>
</tr>
<tr>
<td>6-88(1) (n)</td>
<td>Retired Navy and Marine Corps on active duty</td>
</tr>
<tr>
<td>6-88(1) (o)</td>
<td>Veterans Administration patients</td>
</tr>
<tr>
<td>6-88(1) (p)</td>
<td>Dentures, inscription</td>
</tr>
<tr>
<td>6-88(1) (q)</td>
<td>Department of Defense forms, list</td>
</tr>
<tr>
<td>6-88(1) (r)</td>
<td>Dependents</td>
</tr>
<tr>
<td>6-88(1) (s)</td>
<td>Deserter</td>
</tr>
<tr>
<td>6-88(1) (t)</td>
<td>Physical examination</td>
</tr>
<tr>
<td>6-88(1) (u)</td>
<td>Termination of Health Records</td>
</tr>
<tr>
<td>6-88(1) (v)</td>
<td>Disease-bearing insects and pests, control</td>
</tr>
<tr>
<td>6-88(1) (w)</td>
<td>Diseases subject to quarantine</td>
</tr>
<tr>
<td>6-88(1) (x)</td>
<td>Cholera</td>
</tr>
<tr>
<td>6-88(1) (y)</td>
<td>Plague</td>
</tr>
<tr>
<td>6-88(1) (z)</td>
<td>Typhus</td>
</tr>
<tr>
<td>6-88(1) (a)</td>
<td>Yellow fever</td>
</tr>
<tr>
<td>6-88(1) (b)</td>
<td>Disinsection</td>
</tr>
<tr>
<td>6-88(1) (c)</td>
<td>Dispensary, definition</td>
</tr>
<tr>
<td>6-88(1) (d)</td>
<td>Disposition and Expenditures, Remains of the Dead, NAVMED-609</td>
</tr>
<tr>
<td>6-88(1) (e)</td>
<td>Disposition of records, retirement</td>
</tr>
<tr>
<td>6-88(1) (f)</td>
<td>District dental officer</td>
</tr>
<tr>
<td>6-88(1) (g)</td>
<td>District medical officer</td>
</tr>
<tr>
<td>6-88(1) (h)</td>
<td>Designation</td>
</tr>
<tr>
<td>6-88(1) (i)</td>
<td>Duties</td>
</tr>
<tr>
<td>6-88(1) (j)</td>
<td>Diving accidents and decompression sickness report, NAVMED-616</td>
</tr>
<tr>
<td>6-88(1) (k)</td>
<td>Diving duty, physical standards</td>
</tr>
<tr>
<td>6-88(1) (l)</td>
<td>Ability to equalize pressure</td>
</tr>
<tr>
<td>6-88(1) (m)</td>
<td>Diving service</td>
</tr>
<tr>
<td>6-88(1) (n)</td>
<td>Division medical officer</td>
</tr>
<tr>
<td>6-88(1) (o)</td>
<td>Doctor's Progress Notes, SF-509</td>
</tr>
<tr>
<td>6-88(1) (p)</td>
<td>Donations of property</td>
</tr>
<tr>
<td>6-88(1) (q)</td>
<td>Drills and emergencies</td>
</tr>
<tr>
<td>6-88(1) (r)</td>
<td>Abandon ship</td>
</tr>
<tr>
<td>6-88(1) (s)</td>
<td>Collision</td>
</tr>
<tr>
<td>6-88(1) (t)</td>
<td>Damage control</td>
</tr>
<tr>
<td>6-88(1) (u)</td>
<td>Dead and wounded</td>
</tr>
<tr>
<td>6-88(1) (v)</td>
<td>Defense against special methods of warfare</td>
</tr>
<tr>
<td>6-88(1) (w)</td>
<td>Duty in battle</td>
</tr>
<tr>
<td>6-88(1) (x)</td>
<td>Final preparation for battle</td>
</tr>
<tr>
<td>6-88(1) (y)</td>
<td>Fire and rescue party</td>
</tr>
<tr>
<td>6-88(1) (z)</td>
<td>Flight quarters</td>
</tr>
<tr>
<td>6-88(1) (a)</td>
<td>Prosthetic general quarters</td>
</tr>
<tr>
<td>6-88(1) (b)</td>
<td>Condition I</td>
</tr>
<tr>
<td>6-88(1) (c)</td>
<td>Condition II</td>
</tr>
</tbody>
</table>
INDEX

Drills and emergencies—Continued
General quarters—Continued
II ........................................ 4-34
Handling rescued personnel .......... 4-33
Landing force ................................ 4-34
Man overboard ................................ 4-32
Preparation for ................................ 4-21
Transfer of wounded to hospital ships 4-45
Drugs:
Dental ........................................ 6-31
Prescribing and dispensing .......... 3-33
Record ........................................ 28-254
Sale in exchange ........................... 3-4(2)
Duties:
Assistant medical officer, general .... 3-16, 3-17
Battle stations ................................ 5-29
Civilian physician ........................... 5-29
Clinical board ................................ 18-20
Dental service warrant officers ....... 6-70
Dental technicians ......................... 6-68
District medical officer ................... 4-11(1)
Division medical officer ................. 5-4
Fleet medical officer ....................... 4-1-10
Force medical officer ...................... 4-11(1)
Group X, medical rating ................. 9-12
Inspection and naval medical activities
Medical officer, general ................. 3-1-15, 3-18-30
Medical officer of a ship ................. 4-12-19
Medical officer of a shore station .... 5-6-17
Medical Service Corps, dental ......... 6-72
Medical Service Corps, general ...... 7-27
Medical Service Corps, specific ....... 7-28
Warrant and commissioned warrant officers, Hospital Corps ... 9-13
Ear:
Aviation personnel ......................... 15-62(23)
Diving personnel ........................... 15-30(1)(g)
Motor - torpedo - boat training and
duty ........................................... 15-32(2)(f)
Standards ................................... 15-12
Submarine personnel ..................... 15-29(2)(e)
Effects of Submarine Duty on Personnel, report ... 14-14
Elbow, physical examination ............ 15-80A(4)
Emergencies:
Afloat .................................... 4-21
Dental treatment, limitation .......... 20-2
Medical and dental treatment other than
naval ......................................... 20-1
Medical Tag, NAVMED-210 ............ 23-224
Precautions, hospital ...................... 11-7(7)
Employee health program ............... 26-1-10
Employment, civilian ..................... 10-9-12
Physician .................................. 5-24-28
Endocrine glands and metabolism .... 15-9
Enlisted personnel:
Change of rating on Health Records .. 16-28
Hospital Corps ratings ................... 9-3
Muster and discipline ..................... 5-16
Opening of Health Records .............. 16-7
Service school assignments, physical examination .... 15-53
Enlistments:
Hospital Corps ............................ 9-4
Physical examinations ................... 15-40(1)
Epidemic typhus ........................... 22-26
Equilibrium, aviation ................. 15-62(26)
Equipment:
Dental ...................................... 6-160-174
Issue ....................................... 25-29
Escort for remains:
Authority .................................. 17-42
Selection and detail ....................... 17-44
Travel instructions ...................... 17-45
When furnished ........................... 17-43
Establishment:
Civilian employees ...................... 10-5
Dental Corps ................................ 6-1
Hospital Corps ............................ 9-1
Medical Service Corps .................. 7-1
Nurse Corps ................................ 8-1
Examination:
Dental ...................................... 6-99
Professional:
Medical Corps .............................. 2-6-13
Medical Service Corps .... 7-10, 7-25
Recruits, psychiatric .................... 18-1(6)
Exchange:
Division, hospital ........................ 11-18
Explosive ordnance disposal, physical standards ........ 15-30
Extremities .................................. 15-23
Eyes ........................................ 15-10
Aviation personnel ......................... 15-62(15)
Civilian employees ...................... 26-9, 26-10(2)
Diving personnel .......................... 15-32(2)(d)
Motor - torpedo - boat training and
duty ........................................... 15-32(2)(b)
Nuclear power surface ship training .... 15-32A(1)(b)
Refractive, nonmilitary ................... 20-11
Refractions for employees ............... 26-9, 26-10(2)
Standards .................................. 15-10
Submarine personnel ..................... 15-39(2)(b)
Women personnel .......................... 15-24(3)
F
Facilities, dental ......................... 6-187-192
Field records retirement schedule ...... 22-303
Field sanitation ......................... 22-40, 22-41
Field service ................................ 22-41
File of drugs and medical items ......... 3-4(2)
Executive officer, hospital, duties .... 11-8
Explosive ordnance disposal, physical standards ........ 15-30
Extremities .................................. 15-23
Eyes ........................................ 15-10
Aviation personnel ......................... 15-62(15)
Civilian employees ...................... 26-9, 26-10(2)
Diving personnel .......................... 15-32(2)(d)
Motor - torpedo - boat training and
duty ........................................... 15-32(2)(b)
Nuclear power surface ship training .... 15-32A(1)(b)
Refractive, nonmilitary ................... 20-11
Refractions for employees ............... 26-9, 26-10(2)
Standards .................................. 15-10
Submarine personnel ..................... 15-39(2)(b)
Women personnel .......................... 15-24(3)

Change 7
INDEX

Food and water supply:
Food ........................................... 22-13
Inspection as to quality ................. 22-13(1)
Inspection of cooking and messing facili-
ties ........................................... 22-13(2)
Inspection of food handlers .............. 22-13(4)
Preparation .................................. 22-13(5)
Inspection afloat .......................... 4-16(2)
Water ........................................ 22-14
Inspection of water supply systems .... 22-14(1)
Potability of water ......................... 22-14(2)
Purification .................................. 22-14(3)
Supply plants ................................ 22-14(4)
Food service division, hospital ......... 11-16
Force dental officer ...................... 6-38
Force medical officer .................... 4-11
Forms, lettered and numbered ........... 23-214
(Note—Forms may also be indexed by title
and subject.)
Availability ................................ 23-214(5)
Tabulation of DD Forms ................. 23-216
Tabulation of Navmed Forms ............ 23-215
Tabulation of Standard Forms .......... 23-216
Funeral expenses:
Army, Air Force, and Coast Guard person-
nel ........................................... 17-69
Burial at sea of inactive personnel and
 civilians ................................. 17-66
Burial prior to ascertaining wishes of next
of kin ....................................... 17-61
Disposition of remains at activities having
contracts ................................. 17-55
Limitations .................................. 17-56
Transportation to places outside the U.S. 17-62
Funeral flags ............................... 17-68

G
Garbage, refuse, and sewage disposal:
Garbage and refuse disposal .......... 22-15
Sewage system ............................. 22-16
General quarters:
Condition I ................................. 4-22
Condition II ............................... 4-23
Condition III .............................. 4-24
Geneva Conventions ...................... 3-30
Genito-urinary system:
Diving duty ................................ 15-30(1)(i)
Nuclear power surface ship train-
ing ......................................... 15-39A(1)(e)
Standards .................................. 15-22

H
Head and face standards ................. 15-14
Health program for civil service employees:
Authority and regulations .............. 26-2
Clinical and medical services .......... 26-6
Functions of occupational health divi-
sion ........................................ 26-5-10
Industrial hygiene ........................ 26-8, 26-10(2)
Inspections ................................ 26-3
Medical records ........................... 26-7
Organization ............................... 26-4
Scope ....................................... 26-1
Sight examination ........................ 26-9
Small activities ........................... 26-10
Health Records:
Abstract of Antiluetic Treatment, Navmed-
H-7 ........................................... 16-51
Abstract of Service and Medical History,
Navmed-H-5 ................................ 16-48
Annual verification ....................... 16-17(1)
Attachments ............................... 16-2
Health Records—Continued
Aviation Medical Abstract, Navmed-H-9 .... 16-60
Change in rank, rating, or status ....... 16-34
Enlisted personnel ....................... 16-30
Midshipmen ............................... 16-26
NROTC, commissioning .................. 16-27
Officers .................................... 16-24
Transfer to Regular Navy or Marine
Corps ...................................... 16-25
Cover, Navmed-H-1 ........................ 16-29
Custody:
Lost, damaged, or destroyed ........... 16-23
Reserve personnel, inactive ............. 16-22
Responsibility ............................ 16-17
Transfer of patients to naval hospitals .. 16-19
Transfer of patients to other than naval
hospitals ............................... 16-20
Transfer to Federal penitentiaries ....... 16-21
Transfer to ship or station .............. 16-18
Dental Record, Navmed-H-4 ............. 16-46
Immunization, Navmed-H-3 ................ 16-43
Medical History, Navmed-H-8 ......... 16-52
Example of entries ....................... 16-59
Opening ................................... 16-6
Enlisted personnel ....................... 16-7
Instruction ................................ 16-3
NROTC .................................... 16-5, 16-6
Other military personnel ............... 16-66
Physical Examination, Navmed-H-2 .... 16-31
Purpose .................................... 16-1
Service .................................... 16-4
Sick Call Treatment Record, Navmed-H-10 16-61
Special Duty Abstracts, Navmed-H-3a .... 16-45
Termination:
Desertion .................................. 16-10
Disappearance of personnel ............. 16-9
Instructions ................................ 16-8
Midshipmen ............................... 16-14
NROTC .................................... 16-15
Personnel convicted by civil authorities 16-11
Prisoners confined in Federal peniten-
tiaries .................................... 16-12
Retired personnel ........................ 16-13
Supernumeraries ........................ 16-24A
Venereal Disease Abstract, Navmed-H-6 .... 16-50
Hearing test, aviation ..................... 15-62(24)
Heart and blood vessels:
Aviation personnel ...................... 15-62(6)
Diving duty ................................ 15-30(1)(f)
Methods of examination ............... 15-88
Standards .................................. 15-19
Submarine personnel .................... 15-29(2)(h)
Height:
Aviation personnel ...................... 15-62(4)
Standards .................................. 15-8(2)
Women personnel ....................... 15-34(2)
Hip, physical examination .............. 15-89A(6)
Hospital Administration School ....... 13-9
Hospital Corps:
Advancement in rating ................... 9-8
Appointment to Medical Service Corps .. 9-10
Appointment to warrant officer ......... 9-9
Change in rating to and from ......... 9-5
Combined report, Navmed-500 ........... 23-24
Duties, group X: medical ratings ....... 9-12
Duties of warrant and commissioned war-
rant officers ............................ 9-13
Enlisted ratings and warrant officers .... 9-3
Enlistment ................................ 8-4
Establishment ............................ 9-1
Instructions .............................. 3-10(4)
Number .................................... 9-2
INDEX

Internships, dental... 6-122
Interpupillary distance, aviation... 15-63(18)
Intoxication, evidence, physical examination... 15-38
Inventory adjustment of property... 25-18
Inventory of property... 25-8, 25-9
Procedure... 25-15
J
Joints, orthopedic examination... 15-89A
Junior medical officers, hospital... 11-25
K
Knee, physical examination... 15-89A(3)
L
Landing force... 4-34
Leave or liberty, emergency medical or dental treatment... 20-5
Letters of condolence... 17-26-28
Library service, Medical Center... 13-11
Light for battle dressing stations... 4-40
Lighting, heating, and ventilation... 22-12(3)
Illumination... 22-12(2)
M
Maintenance division, hospital... 11-17
Man overboard... 4-32
Marine Corps dental officer... 6-59-62
Marriages, reporting to civil authorities... 3-12(4)
Material:
Defective, report... 23-121
Dental... 6-160-174
Medical... 25-1-29
Maternity case dependent... 25-2
Medical aid for civilians... 3-27
Medical and dental stores:
Instructions... 25-27
Receipt and issue... 25-29
Standard unit prices... 25-28
Medical and dental treatment other than naval:
Instructions... 20-1
Leave or liberty... 20-5
Limitation of dental treatment... 20-2
Preparation of claims... 20-8
Reports required... 20-7
Retired personnel... 20-6
Services of specialists:
Eye refractions and procurement of glasses:
Request... 20-10
When permitted... 20-9
Special dental treatment:
Definition of an emergency... 20-13
Reports and claims... 20-16
Request... 20-14
Request for prosthetic treatment... 20-15
When permitted... 20-12
Medical Center:
Baltimore... 13-1-11
Pensacola... 13-12-18
Medical Corps:
Advancement in grade... 2-6-13
Appointments... 2-3-5
Examination for promotion... 2-7-12
Grade... 2-7
Number... 2-1
Medical Department of the Navy:
Functions... 1-1-4
Military examiner... 1-9-11
Medical examiners... 15-6
Medical History, NAVMED H-8... 16-62-59
Medical history, taking... 15-5, 15-20(1)(a), 15-62(2)
Medical Intelligence Report of Ports and Adjacent Areas Visited... 23-124
Medical officer personnel, quarterly report:
NAVmed-1341... 23-42
Medical officers afloat:
Absence of medical officer... 4-1-45
Designation... 4-12(4)
Disability of medical officer... 4-12(1)
Head of department... 4-12(1)
Medical officers ashore:
Designation... 5-6
Duties... 5-6-17
Accountability of property... 5-12
Complement of Medical Department... 5-8
Dependents... 5-9
Examination of applicants, candidates, and Reservists... 5-11
Fitness reports on subordinates... 5-15
Muster and discipline of enlisted personnel... 5-16
Physical examination and treatment of civilian employees... 5-10
Responsibilities... 5-7
Medical officers, general:
Assistant, duties... 3-16, 3-17
Duties... 3-1-15, 3-18-30
Medical Officers Under Instruction, NAVMED-949... 23-31
Medical School... 13-7
Medical Service Corps:
Application... 7-9
Appointments... 7-9-8
Dental service warrant... 7-27
Articles on professional subjects... 7-29
Distribution... 7-3
Duties, dental facilities... 6-72
Duties, general... 7-4
Duties, specific... 7-26
Establishment... 7-1
Examination, admission... 7-12
Examination, advancement... 7-19-26
Examination, authorization... 7-10
Examination, physical... 7-11
Grade... 7-4
Naval Reserve officers... 7-18
Number... 7-2
Postgraduate:
Courses... 7-17
Training... 7-30
Medical services furnished supernumeraries table of... 21-3
Medical supply system:
Basic organization of storehouses... 25-26
Basic organization of supply depots... 25-25
Field supply activities... 25-23
Missions of... 25-24
Medical survey board:
Authority... 18-7
Composition... 18-8
Entries in Health Record... 18-15
Procedure... 18-11
Purpose... 18-9
Recovery of cases... 18-10
Discipline cases... 18-10(2)(b)
Hospital transfer... 18-10(2)(e)
Military overseas... 18-10(2)(f)
Military unsuitability cases... 18-10(2)(c)
INDEX

N

Narcotics:  3-24
Custody:  23-255
Log:  3-36, 25-13(9)
Loss:  3-32
Prescribing:  3-35
Security:  3-35
Naval Dental Reserve:  23-215
NAVMED forms, list:  15-62(17)
Near point of convergence, aviation:  15-62(17)
Neck standards:  15-16
Nervous system:  23-17
Aviation personnel:  15-62(10)
Motor-torpedo-boat training and duty:  15-32
Standards:  15-24
Neuropsychiatric Report, NAVMED-102:  15-32
Neuropsychiatry, special hospitals:  12-4
Nose and throat:  15-62(25)
Aviation personnel:  12-4
Diving personnel:  15-62(10)
Motor-torpedo-boat training and duty:  15-32
Standards:  15-24
Submarine personnel:  15-29(2)(d)
NROTC:
Change in rank or rating on Health Records:  16-27
Opening of Health Records:  16-6, 18-5
Physical standards:  15-34A
Termination of Health Records:  16-15
Nuclear power surface ship training program, physical standards:  15-29A
Nurse Corps:
Appointments:  8-6
Authority for:  8-6
Charge nurse:  8-13
Chief of nursing service:  8-11
Dental facilities:  6-73
Director:  8-4
Duties:  8-10
Establishment:  8-1
Grade:  8-3
Hospitals:  11-27
Indocination:  8-7(1)
Promotion:  8-8, 8-9
Strength:  8-2
Supervisor:  8-12

O

Occupational health:  26-1-10
Occupational Health Report, NAVMED-76:  23-21
Ocular motility, aviation:  15-62(13)
Officer in charge, dental:  6-50
Officer of the day:  11-8(6), 12-5
Officer of the deck or day report:  3-9
Officers:
Change in rank on Health Records:  16-24
Opening of Health Records:  16-4
Oncology, special hospitals:  12-3
Opening of Health Records:
Enlisted personnel:  16-7
Instructions:  16-3
NROTC:  16-15
Officers and midshipmen:  16-4
Operations, Dental Record:  6-114
Ophthalmoscopic examination, aviation:  15-62(22)
Organization:
Civilian employees:  10-1-3
Hospital:  11-4

P

Medical survey board—Continued

Referral of cases—Continued

Officers return to duty  18-10(2)(a)
Patient refusing treatment  18-10(2)(a)
Personnel qualified for limited duty  18-10
Persons continuously on the sick list  18-10
Recreation:  18-10(2)(d)
Reports, NAVMED-M:  18-12
Admitted from and date:  18-13(5)
Aggravation by service:  18-13(5)(d)
Conduct status:  18-13(5)(e)
Date of survey:  18-13(1)
Diagnosis:  18-13(4)
Endorsement statement:  18-13(10)
Enlistment examination data:  18-13(5)(e)
Existing prior to enlistment:  18-13(5)(e)
Identification data:  18-13(2)
Line of duty status:  18-13(5)(b)
Present condition:  18-13(7)
Probable future duration:  18-13(8)
Recommendations:  18-13(9)
Summary of case history:  18-13(6)
Statement in rebuttal:  18-14
Medical treatment:
American Red Cross:  21-25
Army and Air Force Reserve:  21-17
Beneficiaries of the Bureau of Employees Compensation:  21-26
Beneficiaries of the Naval Home:  21-19
Beneficiaries of the Public Health Service:  21-23
Beneficiaries of the Veterans’ Administration:  21-22
Civilians under special circumstances:  21-28
Dependents:  21-4-8
Facilities, definitions:  1-20-22
Fleet and Field Marine Corps Reserve:  21-14
Former members:  21-20
Hospitalization, and Allied Services Report, NAVMED:  20-7
Members of foreign military establishments:  21-30
Naval pensioners:  21-18
Naval and Marine Corps Reserve:  21-18
Naval and Marine Corps retired with pay:  21-13
Officer candidates:  21-21
Officers and employees of the Government and Federal contractors outside U.S.:  21-27
Officers and employees of the State Department Foreign Service:  21-29
Other personnel:  21-31
Other services, retired-with-pay members:  21-15
Registrar, Selective Service:  21-24
Supernumeraries:  21-2
Meetings, medical:  4-10
Merchant seaman, death:  17-4
Midshipmen:
Change in rank or rating on Health Records:  16-26
Opening of Health Records:  16-4
Termination of Health Records:  16-14
Misconduct, dental injuries:  6-112(2)
Missing personnel:  17-21
Mission of naval hospitals:  11-2
Mission of supply system:  25-24
Mobile dental unit officer:  6-57
Morning Report of Sick, NAVMED-T:  23-219
Motor-torpedo-boat training and duty, physical standards:  15-32

Navy and Marine Corps Reserve:  21-18
Naval and Marine Corps retired with pay:  21-13
Officer candidates:  21-21
Officers and employees of the Government and Federal contractors outside U.S.:  21-27
Officers and employees of the State Department Foreign Service:  21-29
Other personnel:  21-31
Other services, active duty members:  21-12
Other services, retired-with-pay members:  21-15
Registrar, Selective Service:  21-24
Supernumeraries:  21-2
Meetings, medical:  4-10
Merchant seaman, death:  17-4
Midshipmen:
Change in rank or rating on Health Records:  16-26
Opening of Health Records:  16-4
Termination of Health Records:  16-14
Misconduct, dental injuries:  6-112(2)
Missing personnel:  17-21
Mission of naval hospitals:  11-2
Mission of supply system:  25-24
Mobile dental unit officer:  6-57
Morning Report of Sick, NAVMED-T:  23-219
Motor-torpedo-boat training and duty, physical standards:  15-32
INDEX

Organization—Continued
Storerooms, medical........................................ 25-26
Supply depots, medical.................................... 25-25
Orthopedic and prosthetic material.................. 24-25(3)
Orthopedic examination of major joints........... 15-89A

P

Pathogenic cultures and organisms, transfer........ 22-39
Patients:
Air transportation. ........................................ 14-9
Hospital. ................................................... 11-7(3), 11-8(2), 11-39, 11-30
Neuropsychiatric. ......................................... 12-4
Register, DD Form 739 ................................... 23-222
Transfer from hospital.................................... 11-30
Perineum and the pelvis including the sacrobe-
iliac and lumbosacral joints, examination of... 15-21
Personal effects, deaths................................. 17-39, 17-77(4)(g)
Personnel:
Active duty, death........................................ 17-3
Army, Air Force, and Coast Guard; death........ 17-3, 17-69
Complements and allowances:
Medical Department afloat............................... 4-12(2)
Medical Department ashore.............................. 5-8
Fleet Reservists, inactive; death ........................ 17-17, 17-18
Hospital..................................................... 11-7(4), 11-8(4)
Inactive or civilian personnel, burial at sea...... 17-65
Inspection, afloat......................................... 4-16(1)
Instruction for civilian employees.................... 10-17
Physically disqualified for reenlistment when
separated................................................... 15-41
Retired inactive, death................................... 17-16
Personnel and records division, hospital........... 11-19
Photofluorographic Chest Survey Report............ NAVMED-618
Photofluorographic Log, NAVMED-1161.............. 15-90
Photofluorographic Log, NAVMED-1161.............. (6)(e)(1)

Physical defects and waiver:
Definition of organic defects............................ 15-38
Physical defects.......................................... 15-38
Proximal relative significance of physical defects 15-37
Physical examinations:
Annual for female enlisted ............................. 15-45A
Annual for midshipmen and NROTC stu-
dents....................................................... 15-46
Annual for officers....................................... 15-45
Applicants, Candidates, and Reservists............. 5-11
Applicants for steward ratings......................... 15-54
Aviation personnel:
Annual and promotion.................................. 15-71
Board of flight surgeons.................................. 15-72
Candidates for flight training......................... 15-67, 15-68
Forwarding of flight physicals......................... 15-73
Reexaminations for physical incapacity.............. 15-70
Reporting of examinations on class 1
personnel................................................. 15-65
Special reporting on personnel in flight
training...................................................... 15-66
Candidates for commission or warrant.............. 15-42
Candidates for Naval Academy.......................... 15-43
Candidates for Naval Preparatory School............ 15-43
Civil employees.......................................... 15-57
Commercial life insurance.............................. 3-21(2)
Deserters.................................................... 15-56
Detached to sea duty or duty outside the
U.S.......................................................... 15-51
Discharge, transfer to Fleet Reserve, or
retirement of enlisted personnel...................... 15-48

Physical examinations—Continued
Enlisted personnel selected to attend serv-
ice schools............................................... 15-53
Enlistment or reenlistment............................. 15-40
Heart and blood vessels................................. 15-88
Heterophoria and prism divergence at
near....................................................... 15-87
Instructions.............................................. 15-39
Intoxication evidence.................................... 15-58
Members on temporary disability retired
list.................................................................. 15-38A
NAVMED H-2 form........................................ 16-31-40
Orthopedic, major joints................................ 15-89A
Personnel physically disqualified for reen-
listment when separated................................. 15-41
Promotion of officers..................................... 15-47
Range of motion............................................ 15-89
Reporting of results...................................... 15-81-84
Reserve, Navy, and Marine Corps..................... 15-76
Active duty............................................... 15-79
Actual control of aircraft............................... 15-79
Appointment, enlistment, and promo-
tion........................................................ 15-75
Physical defects, reporting, and disposi-
tion................................................................ 15-80
Quadrennial examination.................................. 15-77
Training duty............................................... 15-44
Retired members ordered to active duty............ 15-44
Roentgenographic, of chest............................. 15-70
Separation of officers..................................... 15-49
Submarine and diving...................................... 15-15
Transfer of enlisted personnel......................... 2-6, 15-50
Visual acuity............................................... 15-86
Physical standards, including causes for re-
jection:
Abdomen..................................................... 15-11
15-20, 15-20(2), 15-29(2) (f), 15-30(1) (k), 15-32(2) (b)
Abdomen..................................................... 15-3
Application................................................ 15-3
Aviation personnel:
Class 1, service group I.................................. 15-62
Class 1, service group II.................................. 15-63
Class 1, service group III................................ 15-64
Class 2, personnel........................................ 15-69
Instruction.................................................. 15-59
Policies on personnel of service groups............ 15-61
Restrictions until physical qualified................. 15-60
Color perception........................................... 15-11
15-29(2) (e), 15-29A(1) (e), 15-30(1) (e), 15-32(2) (e), 15-62(19)
Diving duty.................................................. 15-30
Ears............................................................. 15-12
15-12(2), 15-29(2) (e), 15-30(1) (g), 15-32(2) (f), 15-62(23)
Endocrine glands and metabolism....................... 15-9
15-9(2)
Entrance into service...................................... 15-6
Extremities................................................... 15-23
15-23(2)
Eyes............................................................ 15-10
15-10(6), 15-29(2) (b), 15-29A(1) (b), 15-30(1) (d), 15-32(2) (b), 15-34(3)
Genitourinary system...................................... 15-32
Head and face.............................................. 15-14
15-14(2)
Height................................................................ 15-8(2)
Inductees...................................................... 15-27
Interpretation............................................... 15-4
Major joints.................................................. 15-89A
Medical history, taking.................................... 15-5
15-30(1) (e), 15-62(2)
Motor-torpedo-boat training and duty.............. 15-32

10

Change 7
INDEX

Physical standards—Continued

Neck ........................................ 15-13, 15-14(2)

Nose and throat ............................... 15-15

NROTC ........................................ 15-34A
Nuclear power surface ship training .... 15-29A

Perineum and pelvis including sacrococcyx
and lumbosacral joints ..................... 15-21, 15-21(2)

Prescribing .................................... 15-1

Psychiatric .................................... 15-7
15-7(3), 15-29(2)(a), 15-29A(1)(f),
15-34(5), 16-62(9).

Purpose ........................................ 15-2

Reserve, Navy and Marine Corps .......... 15-74

Skin ............................................ 15-13
15-13(2), 15-29(2)(l), 15-30(1)(m),
15-22(2)(l).

Spine ........................................... 15-17, 15-17(2)

Submarine personnel ....................... 14-13, 15-29

Teeth .......................................... 6-36-97,
15-25, 15-29(2)(f), 15-29A(1)(d),

Thorax ......................................... 15-18
15-18(2), 15-29(2)(g), 15-30(1)(h),
15-62(5).

Underwater demolition teams ............. 15-30

Venereal disease ............................ 15-22

Weight and height ........................... 15-8.

Weight tables ............................... 15-8(1)
Women personnel ............................ 15-34

Physicians, civilian ....................... 5-24-29

Plague ........................................ 22-26

Preservation of vaccine ................... 22-26(3)

Requirement for immunization ......... 22-26(1)

Post-mortem examination ................. 17-24

Precious Metal Issue Record, NAVMED-1300 . 6-155

Precious metals, dental .................. 6-155-157

Statement and inventory form, NAVMED-1301 . 6-156

Prescription Form, NAVMED-148 ........ 3-31(2)

Nonuse of brand names ................... 3-31(2)

Prescriptions, dental ...................... 6-31

Preventive medicine:
Communicable diseases .................. 22-17-19
Field sanitation ........................... 22-40, 22-41

Food and water supply ................... 22-13

Garbage, refuse and sewage disposal . 22-15, 22-16

Immunization .............................. 22-21-30

Insect, pest, and rodent control ....... 22-31, 22-32

Lighting, heating, and ventilation .... 22-12

Procedures ................................. 22-3

Quarantine procedures .................. 22-23-39

Responsibility ............................ 22-2

Sanitary standards for living spaces ... 22-7

Sanitation and industrial hygiene .... 22-4

Scope ....................................... 22-1

Prisoners:
Confined in Federal penitentiaries, termina-

tion of Health Records ................... 16-12

Convicted by civil authorities, termina-

tion of Health Records ................... 16-11

Physical examination ...................... 15-55

Prisoners of war, dental treatment .... 6-98(1)(m)

Prisons, sanitary standards ............. 22-11

Private practice:
Dentistry ................................... 6-35

Medicine ................................... 3-26A

Promotion:

Dental Corps ................................ 6-17-20

Medical Corps officers .................. 2-7-12

Medical Service Corps officers ......... 7-19-26

Nurse Corps officers ...................... 8-8

Physical examination of officers ....... 15-47

Property:

Accountability ............................ 5-12, 25-6

Bureau responsibility .................... 25-1

Custody ..................................... 25-13-18

Decommissioning of ship or station .... 25-22

Definition .................................. 25-2

Dental ....................................... 6-160-174

Donations .................................... 25-11

Inventory ................................... 25-8

Records ...................................... 25-9

Issue of equipment ....................... 25-20

Issue of supplies ......................... 25-19

Physical classification .................. 25-3

Buildings and improvements ........... 25-8(2)

Equipment .................................. 25-5

Land ......................................... 25-3(1)

Specifications ............................. 25-3(4)

Reclassification ........................... 25-8

Records ...................................... 25-19

Surveys ...................................... 25-4

Transfer and loan ......................... 25-10

Unnecessary expenditures ............... 25-7

Prosthetic appliances .................... 24-25(3)

Prosthetic dental treatment ............ 6-103

Prosthetic Case Record, NAVMED-952 .... 6-152

Psychiatric:

Aviation personnel ....................... 15-62(9)

Causes for rejection ...................... 15-7(3)

Nuclear power surface ship train-

ing .............................................

15-29A(1)(f)

Standards .................................. 15-7

Submarine personnel ...................... 15-29A(2)(a)

Units:

Examination of recruits ................ 18-1(6)

Fitness of recruits ...................... 18-2

Functions of members ................. 18-1(3)

Instructions .............................. 18-1

Report, NAVMED-1317 ................... 23-38

Women personnel ......................... 15-34(5)

Public Health Service Members, dental treat-

ment ...........................................

6-88(1)(j), (k), (l)

Publications for dental facilities .... 6-145

Q

Quarantine procedures:

Authority according to locality .......... 22-35

Disinfection ................................ 22-33

Instructions ................................ 22-33

Quarantinable and communicable diseases .. 22-36

Quarantinable diseases:

Cholera ..................................... 22-36(1)(a)

Plague ....................................... 22-36(1)(b)

Smallpox .................................... 22-36(1)(d)

Typhus ...................................... 22-36(1)(c)

Yellow fever ............................... 22-36(1)(e)

Responsibilities .......................... 22-34

Rodents and insects aboard ship ........ 22-37

Transfer of pathogenic cultures ....... 22-39

R

Radiation:

Exposure recording ...................... 16-56<1>

Hazards, nuclear submarine ............. 14-11<1>

Range of motion .......................... 15-89

Reading aloud test ....................... 15-7

Change 7
INDEX

Reserve, Navy and Marine Corps:
- Annual certificate of physical condition: 15-78(2)
- Dental Corps.................................................. 6-106-210
- Dental Program Report..................................... 23-104
- Dental treatment............................................. 6-98(1)(d)
- Medical Program Report..................................... 23-105
- Personnel, inactive, Health Record....................... 15-44
- Physical defects, reporting and disposition.............. 15-80
- Physical examination for appointment, enlistment, and promotion. 15-75
- Physical examination for training duty.................... 15-77
- Physical examinations for active duty..................... 15-76
- Physical examinations for actual control of aircraft. 15-79
- Physical standards.......................................... 15-74
- Quadrennial examinations.................................. 15-78
- Residents, hospital......................................... 11-26

Retired personnel:
- Dental treatment............................................. 6-98(1)(c),(i)
- Emergency medical and dental treatment.................... nonnaval 20-6
- Ordered to active duty, physical examination............. 15-44
- Termination of Health Records................................... 16-13
- Retirement of personnel, enlisted; physical examination 15-48
- Retirement of records........................................ 23-300
- River command dental officer...................... 6-48
- River command medical officer............................. 6-45
- Rocky Mountain spotted fever immunization........... 22-30
- Rodent control................................................. 22-32
- Ships.......................................................... 22-37
- Certificate of deratization............................. 22-37(1)
- Fumigation.................................................... 22-37(2)
- Roentgenographic examination of chest.................... 15-80

S

St. Elizabeths Hospital, death at.................................. 17-19

Sanitary standards for living spaces:
- Barracks...................................................... 22-7
- Inspection................................................... 22-7(1)
- Plumbing fixtures......................................... 22-7(3)
- Scrub decks for clothing.................................. 22-7(6)
- Sleeping rooms............................................... 22-7(2)
- Berthing spaces afloat:
  - Berthing compartments................................. 22-8(2)
  - Inspection................................................ 22-8(1)
- Plumbing fixtures......................................... 22-8(3)
- Brigs........................................................... 22-10
- Hospitals:
  - Bed requirements......................................... 22-9(2)
  - Patients per ward....................................... 22-9(1)
- Prisons....................................................... 22-11

Sanitation:
- Cooperation with civil authorities....................... 22-4(3)
- Indocination of personnel.................................. 22-4(2)
- Industrial hygiene.......................................... 22-6
- Inspection and investigation................................ 22-4(4)
- Recommendations........................................... 22-4(6)
- Records...................................................... 22-4(5)
- Reports...................................................... 22-4(6)
- Swimming sites:
  - Bathing loads........................................... 22-5(4)
  - Pools...................................................... 22-5(2)
  - Recommendations......................................... 22-5(1)
  - Sanitary control.......................................... 22-5(3)

Schools:
- Aviation Medicine......................................... 13-18
- Bethesda Medical Center.................................. 13-7
- Dental......................................................... 13-8
- Hospital Administration................................... 13-9
- Dental Technician.......................................... 6-130-144
## INDEX

**Termination of Health Records:**  
Desertion .......................... 16-10  
Disappearance of personnel  .......... 16-9  
Instructions ........................ 15-16  
Midshipmen .......................... 16-14  
NROTC ................................ 16-15  
Personnel convicted by civil authorities 16-11  
Prisoners confined to Federal penitentiaries 16-12  
Retired personnel 16-13  
Supernumeraries ........................ 16-16  
Training:  
Termination of Health Records 22-25  
Retirement, records ........................ 22-23  
Patients to naval hospitals, Health Record 16-19  
Venereal disease, instruction ............. 11-18  
First aid ................................ 15-29(2) (g)  
Custody ................................ 15-34  
Group X, medical ratings .................... 15-50  
Indoctrination of personnel ............... 15-11  
Medical officers, residency ................ 15-18  
Staff and administrative schools .......... 15-29(2) (g)  
Dental technicians ...................... 15-29(2) (g)  
Plat and instruction ................... 15-29(2) (g)  
Group X, medical ratings .................. 15-29(2) (g)  
Health and educational program ............. 15-29(2) (g)  
Hospital corpsmen, instruction ........... 15-29(2) (g)  
Indoctrination of personnel ............... 15-29(2) (g)  
Medical officers, residency ................ 15-29(2) (g)  
Nurse Corps ............................ 15-29(2) (g)  
Postgraduate, Medical Service Corps .... 15-29(2) (g)  
Professional, hospital ................... 15-29(2) (g)  
Transfer:  
Custody of property 25-17  
Dental care, prior to .................... 25-17  
Enlisted personnel, physical examinations 25-17  
Federal penitentiaries, Health Record ...... 25-17  
Fleet Reserve, physical examination ...... 25-17  
Hospital Corps schools .................... 25-17  
Patients .............................. 25-17  
By air .................................. 15-47  
Patients from a naval hospital ............. 15-47  
Medical reasons ........................ 15-47  
Orders and travel ....................... 15-47  
Personal reasons ........................ 15-47  
Patients to naval hospitals, Health Record 25-17  
Patients to nonnaval hospitals, Health Records 25-17  
Retirement, records ..................... 25-17  
Sea duty or duty outside continental limits, physical examination 25-17  
Wounded ................................ 25-17  
Transport dental officer ................... 25-17  
Transport duty .......................... 25-17  
Transportation, sick and wounded ............ 25-17  
Treatment, nonnaval ....................... 25-17  
Tuberculosis control ...................... 25-17  
Typhoid and paratyphoid ................... 25-17  
Requirements .......................... 25-17  

**U**  
**V**  
Venereal disease:  
Abstract, NAVMED H-6 16-60  
Applicants for naval service 15-22  
Aviation personnel ................. 15-62(3)  
Control program ....................... 15-62(3)  
Diving personnel 15-62(3)  
Instructions .......................... 15-62(3)  
Reports:  
Epidemiologic .......................... 15-62(3)  
Recruits ............................... 15-62(3)  
Separation Epidemiologic ................. 15-62(3)  
Syphilis, telegraphic ..................... 15-62(3)  
Submarine personnel 15-62(3)  
Veterans Administration:  
Outpatient Examinations report 21-22(4)  
Patients, dental treatment ............... 21-22(4)  
Visual acuity, aviation ................... 21-22(4)  
Visual acuity, testing .................... 21-22(4)  

**W**  
Wage administration 10-6-8  
Waiver, procedure ....................... 10-6-8  
Wavers of dental defects .................. 10-6-8  
Ward medical and dental officer .......... 10-6-8  
Watches, naval hospital .................... 10-6-8  
Water supply .......................... 10-6-8  
Water supply for battle dressing stations 10-6-8  

**Y**  
Yellow fever ............................ 10-6-8  
Health Record entries ..................... 10-6-8  
Precautions ........................... 10-6-8  
Preservation of vaccine .................... 10-6-8  
Requirements .......................... 10-6-8  

**Change 7**