Army Regulation 11–35

Army Programs

Deployment Occupational and Environmental Health Risk Management

Headquarters
Department of the Army
Washington, DC
16 May 2007

UNCLASSIFIED

SUMMARY of CHANGE

AR 11-35
Deployment Occupational and Environmental Health Risk Management

This new Army Regulation dated 16 May 2007--

- Implements the Presidential Review Directive 5 (August, 1998); the Joint Chiefs of Staff capstone document, "Force Health Protection"; and the National Research Council's, "Strategies to Protect the Health of Deployed U.S. Forces" (chap 1).

- Requires the inclusion of occupational and environmental health risks in Army composite risk management processes for military planning and operations (para 1-5).

- Requires commanders to be aware of, consider, and make informed risk management decisions pre-, during, and post-deployments regarding occupational and environmental risks (paras 1-5 and 2-22).

- Establishes and directs the implementation of an Armywide program for deployment occupational and environmental health risk management (chaps 1, 2, and 3).

- Defines responsibilities for the Army Deployment Occupational and Environmental Health Risk Management Program (chap 2).

- Defines the Army Deployment Occupational and Environmental Health Risk Management Program objectives, elements, and procedures (chap 3).

- Requires the implementation of Department of Defense directives and instructions and Joint Staff guidance regarding deployment occupational and environmental health risk management, deployment health surveillance and readiness, and occupational and environmental surveillance (para 3-3).

Headquarters
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Effective 16 June 2007

Army Programs

Deployment Occupational and Environmental Health Risk Management

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:

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

History. This is a new Army Regulation.

Summary. This regulation covers the policies, responsibilities, and procedures for managing risks associated with occupational and environmental health threats during deployments. This regulation implements Chairman, Joint Chiefs of Staff (CJCS) Memorandum MCM–0006–02; Executive Order 12196; DOD Directives 1010.10, 4715.1E, 6200.4, 6205.2E, and 6490.2; DOD Instructions 1322.24, 4150.7, 6050.05, 6055.1, 6055.5, 6055.7, 6055.8, 6055.11, 6055.12, and 6490.03; and Presidential Review Directive 5.

Applicability. This regulation applies to the Active Army; the Army National Guard/Army National Guard of the United States; the Army Reserve; Army civilian personnel; non-appropriated fund personnel; and Army contractors, if within the scope of their contract unless otherwise stated.

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

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms by Army Commands, Army Service Component Commands, and Direct Reporting Units are prohibited without prior approval from Assistant Secretary of the Army (Installations and Environment), ATTN: SAIE–ESOH, 110 Army Pentagon, Washington, DC 20310–0110.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASA–ESOH), Washington, DC 20310–0200.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the United States Army Reserve.

Contents (Listed by paragraph and page number)

Contents—Continued

Chapter 1
Introduction

1–1. Purpose

This regulation—

a. Is based on joint and Department of Defense (DOD) force health protection (FHP) doctrine, linking sustainment activities in garrison to those activities required for deployments (for example, pre-, during, and post-deployment).

b. Describes the commander's responsibility to reduce potential and actual exposures from occupational and environmental hazards encountered during military operations to as low as practicable to minimize acute, chronic, and delayed health effects within the context of mission parameters and Army composite risk management (CRM) (formerly called operational risk management) principles.

c. Establishes policies for managing the balancing of operational risks associated with occupational and environmental health (OEH) threats during military operations within the context of OEH risk management for all activities associated with deployments including pre- and post-deployment.

d. Defines the Army Deployment Occupational and Environmental Health Risk Management (DOEHRM) Program within the DoD context and the policy for FHP (see Department of Defense Directive (DODD) 6200.4).

e. Assigns responsibilities for—

(1) Integrating the management of OEH risks into military operations across the spectrum of military operations, including single Service, joint, and combined operations and training exercises.

(2) Developing, implementing, and overseeing DOEHRM programs and processes.

(3) Identifying DOEHRM requirements.

(4) Defining organizational missions and force structure required for DOEHRM integration and implementation.

(5) Providing DOEHRM strategy, guidance, and oversight.

(6) Integrating DOEHRM into the Army training and education program.

(7) Determining and documenting the locations of units and individuals.

(8) Conducting comprehensive, coordinated health surveillance activities in accordance with DOD and Joint policies and guidance (see DODD 6490.2, Department of Defense Instruction (DODI) 6490.03, and Chairman, Joint Chiefs of Staff (CJCS) Memorandum MCM–0006–02).

(9) Identifying or developing Army-unique OEH standards, criteria, and guidelines.

(10) Coordinating OEH surveillance data with personnel doctrine, reporting requirements, records maintenance, and unit and personnel locations.

(11) Developing consistent guidance allowing commanders at all levels to assess, through their medical or other appropriately qualified and trained assets, the health risks resulting from potential and actual exposures to OEH hazards.

(12) Implementing DODDs and DODIs, including those listed in appendix A.

f. Establishes DOEHRM Program objectives, elements, and prescribed procedures.

1–2. References

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

1–3. Explanation of abbreviations and terms

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

1–4. Responsibilities

Responsibilities are listed in chapter 2.

1–5. Policy

It is Army policy to—

a. Protect Army personnel from potential and actual exposures to chemical, biological, radiological, nuclear, and high-yield explosives (CBRNE) warfare agents; endemic communicable diseases; food-, water-, and vector-borne diseases; ionizing and non-ionizing radiation; combat and operational stress; heat, cold, and altitude extremes; environmental and occupational hazards; toxic industrial chemicals and materials (TICs/TIMs); and other physical agents.

b. Reduce potential and actual exposures from occupational and environmental hazards encountered during military operations to as low as practicable to minimize acute, chronic, and delayed health effects within the context of mission parameters and Army CRM principles.

c. Make informed risk decisions regarding OEH threats during military operations, using the CRM process to manage such threats and minimize total risk to Army personnel.

d. Ensure that commanders are aware of and consider the acute, chronic, and delayed health risks associated with

occupational and environmental potential and actual exposures (see para 1–5*a*) during all phases of military operations and over the broad spectrum of Army activities.

e. While in garrison or during training exercises, comply with Federal, State, local, or host nation statutes and regulations, directives, and guidance governing OEH except for uniquely military equipment, systems, and operations as authorized in Executive Order 12196.

(1) These statutes and regulations will also apply during deployments unless specifically exempted by appropriate authority based on the mission and situation. Garrison/peacetime standards and criteria will serve as the foundation for deployment military operations with command authority to modify as appropriate.

(2) Contractors whose personnel are using Government-furnished facilities will similarly comply with Federal, State, local, or host nation statutes and regulations, directives, and guidance governing OEH.

f. During deployments, comply with United States (U.S.), Army-unique, or host nation OEH standards, whichever are more restrictive.

(1) When the mission parameters or overall health of deployed personnel warrant CRM decisions that may modify the application of peacetime health standards, such decisions will be made by the brigade commander or above, as far as practicable, or as specified in operational plans and orders. The objective is to minimize total risk to deployed personnel.

(2) Such CRM decision making will be deliberate, documented, and archived. Decisions by commanders to modify the application of OEH standards will be reevaluated as mission parameters change.

g. Implement health surveillance and readiness programs during military operations. Such programs will—

(1) Address anticipating, recognizing, evaluating, controlling, and managing health and safety risks encountered during military operations.

(2) Address pre-, during, and post-deployment activities.

(3) Function as integral components of Army comprehensive health surveillance and readiness programs that cover the entire service career of Army personnel from accession to separation/retirement.

h. Collect, document, evaluate, report, and archive OEH sampling data from military operations, integrating all relevant OEH data with potential and actual exposures and exposure scenarios to individual Army personnel, in their electronic health record (EHR).

(1) The EHR of individual Army personnel will include all relevant OEH sampling data, exposure scenarios, actual exposure data, and medical outcomes from the entire time in service of Army personnel, from accession to separation/retirement, including deployments.

(2) The EHR will be accessible to exposed individuals, their civilian or military health care providers, the Military Health System, the Department of Veterans Affairs (VA), and other Federal agencies tasked with responding to the healthcare needs of Servicemembers, civilians, veterans, and their families.

(3) OEH surveillance data from military operations will be evaluated by healthcare providers prior to such data being placed into individual Soldiers' EHR. Such OEH data from military operations will be cross-referenced with data identifying unit and personnel locations.

(4) All health information management will comply with the Health Insurance Portability and Accountability Act, security and privacy rules, as appropriate (AR 40–66).

i. Ensure necessary healthcare intervention and follow-up for potentially exposed Army personnel.

j. Operate in such a way that DOEHRM supports modular and interoperable joint forces capabilities provided by the Services.

(1) DOEHRM must support joint warfighters across the entire range of military operations, consistent with Joint Operating Concepts categories, to include major combat operations, stability operations, homeland security, and strategic deterrence.

(2) DOEHRM enabling concepts must show a direct link of capabilities to military tasks and must support the integrated employment of core joint capabilities and integrated decision making.

(3) DOEHRM must support a strategically responsive, precision maneuver force that is dominant across the full range of military operations envisioned in a future global security environment.

(4) DOEHRM must be flexible and adaptive to the capabilities of all friendly nations.

k. Ensure significant OEH risks associated with military operations are effectively communicated to all personnel using risk communication tools, processes and principles and DOEHRM lessons learned are shared during unit rotations.

l. Provide commanders with the capabilities and tools for conducting CRM assessments and communicating risks.

m. Provide access to all needed intelligence sources and deployable information systems with occupational and environmental exposure data, unit locations, and movement information.

1–6. Background

a. This policy applies to deployments that—

(1) Involve the relocation of forces and materiel to desired operational areas.

(2) Encompass all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

b. This policy includes the following hazards:

(1) Accidental or deliberate release of weaponized or non-weaponized TICs/TIMs, ionizing and non-ionizing radiological hazards, physical hazards (such as noise, heat, cold, and altitude), and the hazards/residue from the use of CBRNE.

(2) Food-, water-, vector-, and arthropod-borne threats, endemic diseases, residues, or agents naturally occurring or resulting from previous activities of U.S. forces or other concerns, such as non-U.S. military forces, local national governments, or local national agricultural, industrial, or commercial activities.

(3) The TICs/TIMs or hazardous physical agents (such as hazardous noise levels and ionizing and non-ionizing radiation) currently being generated as a by-product of the activities of U.S. forces or other concerns (including pre-deployment activities), such as non-U.S. military forces, local national governments, or local national agricultural, industrial, or commercial activities.

(4) Combat and operational stress.

c. Army standard CRM and risk analyses processes to be applied to OEH risk management are defined in Field Manual (FM) 5–19. (For additional information see also FM 3–100.12/MCRP 5–12.1C/NTTP 5–03.5/AFTTP(I) 3–2.34, Joint Publication (JP) 2–01.3, and JP 5–00.2).

d. DOEHRM will conform to the Army's ongoing transformation from a threat-based, requirement driven, force development process to a capabilities-based, concepts driven, force planning process.

e. DOEHRM is a component of comprehensive OEH risk management across all Army activities. DOEHRM policies and tactics, techniques and procedures (TTP) are compatible and consistent with garrison policies and procedures.

Chapter 2
Responsibilities

2–1. Secretariat and Army Staff Principals

The Secretariat and Army Staff (ARSTAF) principals will, as the functional proponents for their respective areas of responsibility, develop, implement, and oversee programs to integrate the DOEHRM policy into their functional areas or readiness domains.

a. Each ARSTAF principal will define the organizational missions, force structure, and resourcing necessary to implement this policy within their functional areas.

b. The Assistant Secretary of the Army (Installations and Environment) (ASA(I&E)), the Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)), and the Assistant Secretary of the Army (Acquisition, Logistics, and Technology) (ASA(ALT))/Army Acquisition Executive (AAE) are the principal advisors and assistants to the Secretary of the Army for DOEHRM matters.

2–2. The Assistant Secretary of the Army (Installations and Environment)

The Assistant Secretary of the Army (Installations and Environment) (ASA(I&E)) will—

a. Serve as the overall proponent for the DOEHRM Program with the assistance of the Deputy Assistant Secretary of the Army for Environment, Safety, and Occupational Health.

b. Establish overall environmental, safety, and occupational health policy and guidance governing the DOEHRM Program.

c. Provide goals, priorities, general oversight of, and advocacy for the Army DOEHRM Program.

d. Support and defend funding for DOEHRM requirements.

e. Provide executive leadership at the Army Secretariat level to ensure timely integration of DOD directives and policies concerning DOEHRM with Army policies, implementing guidance, and funding.

f. Provide Army DOEHRM input to The Army Plan.

2–3. The Assistant Secretary of the Army (Manpower and Reserve Affairs)

The Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)) will—

a. Establish policy and guidance for integrating DOEHRM requirements within the military and civilian personnel and manpower programs.

b. Support and defend funding of DOEHRM requirements in coordination with ASA(I&E).

c. Ensure that DOEHRM requirements are integrated into Army training programs.

d. Ensure DOEHRM requirements regarding personnel doctrine, personnel reporting requirements, and the maintenance of records, to include records on the locations of units and individual personnel, are implemented.

e. Ensure that Soldiers' EHRs, including actual and potential OEH exposure information, are made available for use

by authorized agencies, including the VA, in accordance with Department of the Army (DA) and DOD information sharing agreements.

f. Provide DOEHRM input to The Army Plan in coordination with the ASA(I&E).

2–4. The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/Army Acquisition Executive

The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/Army Acquisition Executive (ASA(ALT)/AAE) will—

a. Establish overall acquisition, logistical, and technological policy and guidance to integrate DOEHRM requirements into materiel acquisition and contracting.

b. Support and defend funding of DOEHRM requirements.

c. Develop non-medical DOEHRM materiel (such as sampling instruments, clothing, and individual equipment).

2–5. The Chief of Staff of the Army

The Chief of Staff of the Army will provide guidance and oversight for the implementation of DOEHRM programs.

2–6. The Deputy Chief of Staff, G–1

The Deputy Chief of Staff (DCS), G–1, will—

a. Develop personnel policies, requirements, and procedures to support the integration of DOEHRM within the Army personnel functional area.

b. Ensure that Army unit and individual personnel data, including daily location data, for designated major joint or Army deployments and exercises are directly accessible and compatible for integration into DOEHRM information systems.

c. Ensure that Army unit and individual personnel data, including daily location data, for deployments are provided to the Defense Manpower Data Center (DMDC) and other Army and DOD agencies with deployment data accountabilities.

d. In coordination with The Surgeon General (TSG), ensure that Army personnel information systems are interoperable and integrated with DOD medical information systems.

2–7. The Deputy Chief of Staff, G–2

The Deputy Chief of Staff, G-2 (DCS, G–2) will—

a. Develop policies, requirements, and procedures to support the integration of DOEHRM within military intelligence and DOD medical intelligence.

b. Retain responsibility for providing staff oversight for intelligence policies affecting the collection, retention, authority, and production of finished intelligence supporting the implementation and goals of this regulation.

c. Serve as Army liaison and advocate with DOD intelligence agencies for DOEHRM intelligence.

2–8. The Deputy Chief of Staff, G–3/5/7

The Deputy Chief of Staff, G-3/5/7 (DCS, G–3/5/7) will—

a. Develop operational policies, requirements, and procedures to support the integration of DOEHRM within military operations.

b. Review/validate requirements for the integration of DOEHRM within the Army.

c. Develop appropriate guidance and strategy for materiel requirements and combat development programs to implement both the medical and non-medical aspects of Army DOEHRM policy. The guidance will—

(1) Address the requirements determination process and the prioritizing, resourcing, and integrating of DOEHRM into materiel warfighting requirements.

(2) Address Doctrine, Organizations, Training, Materiel, Leadership and Education, Personnel and Facilities (DOTMLPF) requirements for DOEHRM mission capabilities for near-, mid-, and far-term operations in accordance with AR 40–5, AR 40–10, and AR 71–9.

(3) Provide for DOEHRM capabilities that are jointly interdependent and derived from, and support joint operating concepts, functional requirements, and approaches to CRM.

d. Ensure oversight of integration and implementation of DOEHRM into military operations to include force structure, training, doctrine, and organizational missions.

e. Identify ARSTAF proponent(s) to coordinate the execution of DOEHRM policy.

2–9. The Deputy Chief of Staff, G–4

The Deputy Chief of Staff, G-4 (DCS, G–4), in addition to the duties and responsibilities cited in AR 40–10, AR 700–48, AR 700–135, and AR 700–136, will—

a. Develop logistics policies, requirements, and procedures to support the integration of DOEHRM.

b. Identify logistical requirements having DOEHRM implications.

2–10. The Deputy Chief of Staff, G–8

The Deputy Chief of Staff, G-8 (DCS, G–8) will—

a. Assist and advise the ARSTAF principals and the proponent for the DOEHRM Program on planning, programming, and budgeting for the Program Executive Group Program that integrates DOEHRM resource requirements of management decision packages.

b. Adjust requirements proposed by the DOEHRM proponent to prepare a balanced functional program that conforms with overall planning, programming, budgetary, and fiscal guidance.

c. Support and defend the funding of DOEHRM requirements to the level necessary to ensure sustainability throughout the Army.

2–11. The Surgeon General

The Surgeon General (TSG) will—

a. Advise the ARSTAF and Army Secretariat on medical aspects of DOEHRM.

b. Provide policy, strategy, guidance, and oversight for integrating DOEHRM within the Army Medical Department (AMEDD).

c. Identify or develop Army-unique OEH standards, criteria, and guidelines.

d. Ensure that deployment OEH sampling data, reports, and assessments are identified, collected, evaluated, documented, reported, archived, interoperably integrated, and shared across multiple medical and nonmedical functional areas.

e. Ensure that the appropriate deployment OEH data, reports, assessments, exposure scenarios, potential and actual exposures, and medical outcomes are integrated into the EHR with the OEH data covering all members' entire Service experience from accession to separation/retirement. The EHR will be available to medical personnel (military, civilian, and VA) subsequent to departure from military service.

f. Ensure the integration of deployment health surveillance with the comprehensive health surveillance conducted for all Army personnel throughout their time in service to include Guard and Reserve in post-deployment.

g. Provide policy and guidance for AMEDD personnel for integrating deployment OEH surveillance data with personnel doctrine; reporting and recordkeeping requirements; and unit and individual personnel location data.

h. Ensure that AMEDD support of the Army DOEHRM Program is consistent with the medical aspects of DOD and joint OEH risk management policies and implementing instructions.

i. Ensure that DOEHRM medical policies and procedures are consistent and compatible with comprehensive OEH risk management across the Army.

j. Define levels of medical authority and responsibility for decisions regarding management of health information for inclusion in individual EHRs.

k. Assist the Director of Army Safety/Combat Readiness Center in providing commanders with the capabilities and tools for conducting CRM assessments and communicating risks.

l. In coordination with the DCS, G–1, ensure that Army personnel information systems are interoperable and integrated with DOD medical information systems.

2–12. Army Commands, Army Service Component Commands, and Direct Reporting Units

Army Commands (ACOMs), Army Service Component Commands (ASCCs), and Direct Reporting Units (DRUs) will provide command emphasis, resources, policy implementation guidance, and oversight to subordinate commands and activities for the integration and implementation of DOEHRM activities, programs, and processes within their respective command, functional, and readiness domains.

2–13. The Commanding General, U.S. Army Training and Doctrine Command

The Commanding General (CG), U.S. Army Training and Doctrine Command (TRADOC), in addition to the responsibilities in paragraph 2–12 above, will—

a. Develop doctrine, TTP, implementation plans, and operational requirements for commanders, leaders, and others to use in assessing, managing, and countering deployment OEH risks.

b. Incorporate training on DOEHRM into TRADOC leadership schools, as appropriate.

c. Ensure that DOEHRM requirements are integrated into proponent combined arms training strategies.

d. Provide DOTMLPF solutions to the deployment OEH risks presented by hazards identified in paragraph 1–6*b*.

e. Ensure that commanders, supervisors, and FHP staff receive DOEHRM training.

2–14. The Commanding General, U.S. Army Forces Command

The CG, U.S. Army Forces Command, in addition to the responsibilities in paragraph 2–12 above, will—

a. Coordinate with TRADOC and U.S. Army Medical Command (MEDCOM) to identify the required force structure and capabilities to implement DOEHRM practices and policies throughout the Army.

b. Coordinate with DCS, G–3/5/7, and MEDCOM in planning, programming, and budgeting for required capabilities to implement DOEHRM aspects of deployment command decision making and OEH support.

c. Coordinate with MEDCOM, TRADOC, and DCS, G–3/5/7, when requested by the Combatant Command, to provide in-theater analytical capability (using organic or augmented medical assets) for theater-level, rapid CBRNE and nonweaponized health hazard identification and assessment to support CRM decision making.

2–15. The Commanding General, U.S. Army Materiel Command

The CG, U.S. Army Materiel Command, in addition to the responsibilities in paragraph 2–12 above, will—

a. Support the AAE in his or her responsibilities for developing and fielding non-medical materiel for DOEHRM implementation throughout the Army.

b. Develop the nonmedical materiel for the rapid identification and assessment of OEH threats for both short- and long-term effects.

c. Analyze all emerging Army systems for OEH hazards, including toxic hazards and hazardous wastes associated with normal system lifecycle testing, operation, use, maintenance, and disposal.

2–16. The Commander, U.S. Army Medical Command

The Commander, MEDCOM, in addition to the responsibilities in paragraph 2–12 above; AR 40–5, paragraph 2–16; and AR 70–1, paragraph 2–34; will—

a. Operate and maintain, through the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM), the Defense Medical Surveillance System (DMSS).

b. Maintain the DoD Serum Repository for the Secretary of the Army as the responsible official.

c. Establish and operate capabilities to—

(1) Identify and assess health threats to support intelligence preparation of the battlespace.

(2) Archive and analyze deployment and OEH data (both unclassified and classified).

(3) Implement DOD and Army OEH policies.

d. Provide occupational and environmental hazards training to medical personnel who are deployable to the field in direct support of combat personnel. Such training will include, but will not be limited to, the identification of OEH hazards and exposures and the prevention and treatment of adverse health effects of such exposures.

e. Through the U.S. Army Medical Research and Materiel Command, develop, test, and field OEH medical materiel solutions leveraging commercial off-the-shelf technologies.

f. Ensure, through the U.S. Army Medical Department Center and School (AMEDD C&S), that AMEDD personnel are trained to support Army commanders in OEH risk assessment, management, and communication.

g. Ensure that FHP personnel receive specialized DOEHRM training.

h. Ensure, through AMEDD C&S, that lessons learned regarding the medical aspects of DOEHRM during military operations are documented, archived, analyzed, and disseminated.

i. Provide reach-back OEH risk management capabilities including risk communication.

2–17. The Director of Army Safety

The Director of Army Safety, as the lead for Army CRM, will—

a. Ensure the integration of the Army DOEHRM Program and policy into the Army CRM process.

b. Ensure that commanders have the training, capabilities, and tools for conducting CRM assessments and communicating risks.

2–18. Chief, Information Officer, G–6

The Chief, Information Officer, G–6, will—

a. Support the AAE in the acquisition and fielding of DOEHRM-related components of Army information systems both unclassified and classified.

b. Provide validation of DOEHRM requirements for warfighting, base operations, and administrative and other mission processes associated with information and effective implementation of the DOEHRM policy.

2–19. Chief of Engineers

The Chief of Engineers will provide policy and guidance for engineering assets to coordinate with medical assets pre-, during, and post-deployment for incorporation of environmental issues and activities into the assessment and management of OEH risks.

2–20. The Director, Army National Guard Bureau

The Director, Army National Guard Bureau, will—

a. Provide emphasis, policy, and implementation guidance on DOEHRM to each State and Territory Adjutant General.

b. Provide a DOEHRM point of contact for coordination with the DCS, G–3/5/7.

2–21. The Chief, Army Reserve

The Chief, Army Reserve, will—

a. Provide DOEHRM policy support and implementation guidance to Army Reserve activities.

b. Provide a DOEHRM point of contact for coordination with the DCS, G–3/5/7.

2–22. Commanders

Commanders will—

a. Use the Army CRM process as part of the commander's FHP Program for the timely assessment of OEH risks to personnel under their command.

b. Minimize risks created by actual and potential OEH exposures during all phases of military operations, balanced with operational requirements.

c. Ensure that contingency and operational plans include the appropriate DOEHRM elements. Based on mission planning, commanders will be responsible for tasking their unit intelligence personnel to gather finished environmental intelligence threat assessments produced by the Armed Forces Medical Intelligence Center, or request through appropriate command intelligence channels their production if nonexistent or out-of-date. Tasking for collection or requesting collection of information will also be a unit commander's responsibility via the unit's intelligence section when information gaps exist.

d. Provide timely OEH risk information to personnel under their command using assistance of supporting medical staff.

e. Comply with Federal, State, local, or host nation statutes and regulations, directives, and guidance governing OEH in garrison and during training exercises. These statutes and regulations will also apply during military operational deployments and war unless specifically exempted by appropriate authority based on theater policy and the tactical situation.

f. Ensure compliance with all statutory labor relations' obligations where the implementation of this program impacts bargaining unit employees' conditions of employment.

Chapter 3
Program Objectives, Elements, and Prescribed Procedures

3–1. Program objectives

a. The overall program objective is to integrate and implement DOEHRM into the Army and military operations such that—

(1) Army personnel are appropriately protected from acute, chronic, and delayed health effects from OEH threats during military operations.

(2) OEH threat potential and actual exposures during military operations are reduced to as low as practicable, within the context of operational mission parameters.

(3) DOEHRM is fully integrated in Army CRM processes.

(4) Army DOEHRM capabilities are decentralized, adaptable, and complete for any modular, tailored (single Service, joint, or allied/coalition) force. Army DOEHRM capabilities will be available for lower echelon commanders distributed across a non-contiguous operational space to make timely and accurate risk management decisions that include OEH risks.

(5) Commanders are aware of and consider OEH risks and recommended countermeasures as part of their CRM process during military operations.

(6) Commanders are able to execute the full spectrum of military operations while minimizing the total risk, including health risks, to Army personnel.

(7) Identification and communication of significant OEH risks is timely and effective.

(8) Individual potential and actual exposures (or exposure scenarios) and relevant OEH sampling data are documented and archived in an EHR, available to medical personnel (military, civilian, and VA) for diagnosis, treatment, and follow-on care during active duty service and after separation or retirement.

(9) Military operations comply with applicable Federal, State, local, or host nation statues, regulations, directives, and guidance.

(10) DOEHRM is integrated into training at all levels throughout the Army.

(11) DOEHRM is a component of comprehensive OEH risk management across all Army activities.

(12) DOEHRM policies and TTP are compatible and consistent with garrison policies and procedures.

b. Specific enabling objectives and activities that must be accomplished in order to fully integrate DOEHRM into the Army will be identified in the Army DOEHRM plan prepared by the Headquarters, Department of the Army (HQDA), DCS, G–3/5/7, and in individual ACOM, ASCC, or DRU implementation plans.

(1) The more specific enabling objectives and activities in individual ACOM, ASCC, or DRUs plans will address policy and doctrine, requirements, resourcing, integration of policies and procedures within the Army, and oversight of DOEHRM implementation and effectiveness.

(2) Technology must be leveraged to develop and improve DOEHRM capabilities for near real-time prediction, detection, identification, risk assessment, and communication and CRM decision making.

3–2. Program elements

a. Protection. Army DOEHRM will allow commanders to enhance total force protection by managing OEH risks to personnel under their command while balancing mission requirements.

(1) Medical indicators of protection include, but are not limited to, vaccination status, fitness, deployment health protection measures, and the entire gamut of preventive medicine and readiness elements.

(2) Interactions with personnel and intelligence assets pre-, during, and post-deployment will assist commanders in analyzing Army personnel location and intelligence data, respectively, cross referenced with real or potential deployment OEH risks and/or potential and actual exposures.

(3) Army-unique OEH risks, exposure standards, criteria, and guidelines are identified or developed.

(4) Personal protective equipment must be designed and used for maximum Soldier protection.

b. Surveillance. Army DOEHRM will help commanders in the analysis and surveillance of those OEH hazards as identified in paragraph 1–6b.

(1) Commanders will also receive recommendations and make decisions and adjustments based on/in response to remote, individual, and other sensor technology data received during deployment.

(2) As a result of surveillance data and related surveillance requirements, medical tests or treatments may be necessary to sustain or enhance protection of personnel and improve mission effectiveness.

c. Databases. Army DOEHRM requires a significant interfacing among personnel, medical, and IM/IT resources.

(1) Automated databases are necessary to record and archive OEH risk exposure data for individual Army personnel.

(2) Location analysis for individual Army personnel will also need to be recorded on the date/time/location continuum, consistent with personnel doctrine, reporting requirements, and records maintenance.

(3) Databases must be compatible to allow consolidation of exposure and date/time/location data. Data must be accessible for lifetime longitudinal use for both operational decision requirements and medical care considerations.

d. Composite risk management. Commanders will use, to the maximum extent possible, the Army DOEHRM decision-making process in accordance with FM 5–19, JP 2–01.3, and JP 5–00.2. OEH considerations will be included in the process.

e. Training. Incorporating DOEHRM training throughout the Army, at all levels, is necessary to create the awareness and understanding of DOEHRM principles and procedures required for such OEH risk management, as part of overall CRM, to be effective.

(1) Army commanders and leaders will require training to use DOEHRM tools and integrate OEH risk management principles and procedures into their CRM techniques.

(2) Army medical personnel will require training in the use of DOEHRM tools and how to support commanders and leaders in CRM decision making.

(3) All Army personnel will require DOEHRM training for awareness of OEH risks during military operations and for the proper use of appropriate countermeasures.

(4) Training must include the management of OEH risks in joint and allied/coalition military operations.

(5) DOEHRM training must be conducted for all components of the Army, not just the active Force.

3–3. Prescribed procedures

a. Use standard Army CRM processes to manage OEH risks and to minimize total risk to Army personnel. Use the risk management procedures, planning, and risk analyses defined in FM 5–19.

(1) Army CRM processes for identifying, assessing, and controlling risks from operational hazards will include OEH health risks.

(2) The OEH risks are determined by estimating the probability and severity of a potential adverse impact that may result from potential and actual exposures to OEH hazards due to the presence of an adversary or some other cause (for example, accidental release or environmental contamination).

(3) Medical personnel will assist commanders in mitigating OEH risks by evaluating the medical severity and probability of OEH hazards, characterizing the OEH risks in the context of the military operation, and recommending OEH risk management options both during planning and upon discovery of the hazard(s).

(4) Commanders will make informed decisions by balancing the OEH risks with other operational risks and mission requirements.

b. Incorporate OEH risk management into deliberate or crisis action plans for contingency and operational planning. Ensure known and suspected OEH risks are reflected in the overall operational risk summary evaluations. Communicate such information to subordinate units for inclusion into their unit level planning.

c. Use standard risk communication procedures to inform personnel during military operations of all known and perceived significant OEH risks associated with the operation. This risk communication will address the hazards defined in paragraph 1–6b. (Reference Department of the Army Pamphlet (DA Pam) 40–11 or contact USACHPPM at http://chppm-www.apgea.army.mil/.)

d. Generate daily unit personnel rosters and location data (expressed in six digit grid coordinates or equivalent latitude and longitude) for each unit down to the derivative unit identification code level for all deployed elements and for deployed Army personnel.

(1) Provide these data through operational channels to the DMDC within 30 days of creation of the location record per DODI 1336.5.

(2) These data are essential for the success of OEH risk management during military operations as well as for retrospective analysis of pre-, during, and post-deployment exposure scenarios, potential and actual exposures, medical outcomes, and other operational and health surveillance information.

e. Conduct research and development programs in such a way as to incrementally improve DOEHRM capabilities, including IM and other technologies.

f. Implement a health surveillance and readiness program that includes OEH surveillance. See AR 40–5, paragraph 1–5, and DA Pam 40–11, chapter 6, for AMEDD implementing instructions for DODD 6490.2, DODI 6055.1, DoDI 6490.03, and CJCS Memorandum MCM–0006–02, to include disease and non-battle injury (DNBI), reportable medical events, and OEH surveillance. All health information will comply with AR 40–66, security and privacy rules, as appropriate.

(1) Implement health surveillance and readiness activities in pre-, during, and post-deployment phases of military operations.

(2) Use the DMSS to document and archive medical encounters and outcomes related to deployment potential and actual OEH hazard exposures.

(3) Use DD Form 2795 (Pre-Deployment Health Assessment) and DD Form 2796 (Post-Deployment Health Assessment) for documenting pre- and post-deployment health assessments, respectively, according to AR 40–66, paragraphs 5–32, 5–35, 5–36, and 7–4; and other assessments in accordance with DoD, Joint Staff, or HQDA directives.

(4) Use DD Form 2900 (Post-Deployment Health Reassessment (PDHRA)) per Office of the Secretary of the Army Memorandum, 23 January 2006, subject: Post-Deployment Health Reassessment.

(5) Use the Tri-Service Reportable Medical Events System to record reportable medical events and forward that information for inclusion into the DMSS.

(6) Forward all deployment OEH sampling data and exposure scenarios to USACHPPM for analysis and archiving per DA Pam 40–11.

(7) Collect, document, evaluate, report, and archive relevant OEH sampling data and individual exposure data in an EHR, accessible to exposed individuals and their health care providers; the Military Health System (MHS); and authorized agencies, including the VA, in accordance with DA and DOD information sharing agreements.

g. Develop materiel and nonmateriel capability improvements in accordance with Chairman, Joint Chiefs of Staff Instruction (CJCSI) 3170.01E, considering the full range of DOTMLPF solutions.

Appendix A
References

Section I
Required Publications

Except as noted below, Army regulations are available online from the U.S. Army Publishing Directorate web site: http://www.usapa.army.mil/. Field manuals are available online from the General Dennis J. Reimer Training and Doctrine Library web site: http://www.adtdl.army.mil/atdls.htm. DOD directives are available online from the Washington Headquarters Services web site: http://www.dtic.mil/whs/directives.

AR 40–5
Preventive Medicine. (Cited in paras 2–8c(2), 2–16, and 3–3f.)

AR 70–1
Army Acquisition Policy. (Cited in para 2–16.)

DODD 6200.4
Force Health Protection (FHP). (Cited in para 1–1d.)

DODD 6490.2
Comprehensive Health Surveillance. (Cited in paras 1–1e(8), and 3–3f.)

FM 5–19
Composite Risk Management. (Cited in paras 1–6c, 3–2d, and 3–3a.)

MCM–0006–02
Memorandum, CJCS, 1 February 2002, subject: Updated Procedures for Deployment Health Surveillance and Readiness. (Cited in paras 1–1e(8), and 3–3f.) (Available at http://www.dtic.mil/cjcs_directives/cjcs/general.htm.)

Section II
Related Publications

A related publication is a source of additional information. The user does not have to read a related reference to understand this publication. DOD directives are available online from the Washington Headquarters Services web site: http://www.dtic.mil/whs/directives. National Research Council information available at The National Academies Press, 500 Fifth Street, Lock Box 285, NW, Washington DC 20055.

AR 10–87
Major Army Commands in the Continental United States

AR 25–30
The Army Publishing Program

AR 40–10
Health Hazard Assessment Program in Support of the Army Materiel Acquisition Decision Process

AR 40–66
Medical Record Administration and Health Care Documentation

AR 70–41
International Cooperative Research, Development, and Acquisition

AR 71–9
Materiel Requirements

AR 200–1
Environmental Protection and Enhancement

AR 200–2
Environmental Effects of Army Actions

AR 700–48
Management of Equipment Contaminated with Depleted Uranium or Radioactive Commodities

AR 700–135
Soldier Support in the Field

AR 700–136
Tactical Land-Based Water Resources Management

CJCSI 3170.01E
Joint Capabilities Integration and Development System. (Available at www.dtic.mil/cjcs_directives/.)

CJSCI 3180.01
Joint Requirements Oversight Council (JROC) Programmatic Processes for Joint Experimentation and Joint Resource Change Recommendations. (Available at www.dtic.mil/cjcs_directives/.)

DA Pam 40–11
Preventive Medicine

DA Pam 40–501
Hearing Conservation Program

DJSM–0613–03
Improved Occupational and Environmental Health Surveillance Reporting and Archiving

DODD 1010.10
Health Promotion and Disease/Injury Prevention

DODD 4715.1E
Environment, Safety, and Occupational Health (ESOH)

DODD 6205.02E
Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries

DODI 1322.24
Medical Readiness Training

DODI 1336.5
Automated Extract of Active Duty Military Personnel Records

DODI 4150.7
DOD Pest Management Program

DODI 6050.05
DOD Hazard Communication (HAZCOM) Program

DODI 6055.1
DOD Safety and Occupational Health (SOH) Program

DODI 6055.5
Industrial Hygiene and Occupational Health

DODI 6055.7
Accident Investigation, Reporting, and Record Keeping

DODI 6055.8
Occupational Radiation Protection Program

DODI 6055.11
Protection of DOD Personnel from Exposure to Radiofrequency Radiation and Military Exempt Lasers

DODI 6055.12
DOD Hearing Conservation Program (HCP)

DODI 6490.03
Deployment Health

Executive Order 12196
Occupational and Safety Health Programs for Federal Employees. (Available at http://www.archives.gov/federal_register/indx.html.)

FM 3–11.21/MCRP 3–37.2C/NTTP 3–11.24/AFTTP(I) 3–2.37
Multi-Service Tactics, Techniques, and Procedures for Nuclear, Biological, and Chemical Aspects of Consequence Management

FM 3–100.4
Environmental Considerations in Military Operations

FM 3–100.12/MCRP 5–12.1C/NTTP 5–03.5/AFTTP(I) 3–2.34
Risk Management: Multi-service Tactics, Techniques, and Procedures for Risk Management

JP 2–01.3
Joint Tactics, Techniques, and Procedures for Joint Intelligence Preparation of the Battlespace

JP 5–00.2
Joint Task Force Planning Guidance and Procedures. (Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp5_00_2.pdf.)

MCM–0026–02
Chemical Warfare (CW) Agent Exposure Planning Guidance. (Restricted by the Joint Staff Office of Primary responsibility.)

MEMORANDUM
Office of Secretary of Army, 23 January 2006, subject: Post-Deployment Health Reassessment. (Available at www.jdhealth.mil/dcs.)

National Research Council (NRC)
2000. Strategies to Protect the Health of Deployed U.S. Forces: Executive Summary

NRC
2000 Appendix B (2000b). Strategies to Protect the Health of Deployed U.S. Forces: Analytical Framework for Assessing Risks

NRC
2000c. Strategies to Protect the Health of Deployed U.S. Forces: Detecting, Characterizing, and Documenting Exposures

NRC
2000d. Strategies to Protect the Health of Deployed U.S. Forces: Force Protection and Decontamination

NRC
2000e. Strategies to Protect the Health of Deployed U.S. Forces: Medical Surveillance, Record Keeping, and Risk Reduction

Presidential Review Directive 5
Planning for Health Preparedness for and Readjustment of the Military, Veterans, and Their Families after Future Deployments. (Available at http://www.fas.org/irp/offdocs/prd-5-report.htm.)

Unnumbered Publication
Joint Chiefs of Staff Capstone Document: Force Health Protection. (Available at http://www.ha.osd.mil/forcehealth/library/main.html.)

Section III
Prescribed Forms

This section contains no entries.

Section IV
Referenced Forms

Except where otherwise indicated below, the following forms are available as follows: DA Forms are available on APD Web site www.apd.army.mil; DD Form are available at the OSD Web site http://www/dtic.mil/directives/infomgt/forms/formsprogram.htm.)

DA Form 11–2–R
Management and Control Evaluation Certification Statement.

DD Form 2795
Pre-deployment Health Assessment.

DD Form 2796
Post-Deployment Health Assessment.

DD Form 2900
Post-Deployment Health Reassessment (PDHRA).

Appendix B
Management Control Evaluation Checklist

B–1. Function
The function covered by this evaluation is DOEHRM.

B–2. Purpose
The purpose of this evaluation is to assist commanders in evaluating the key management controls as outlined below (with medical personnel evaluating these key controls or resulting evaluation certified by some medical officer/official). This evaluation should be used at the following levels: HQDA; Field Operating Agency; ACOM, ASCC, or DRU; Major Subordinate Command; Installation; and Tables of Organization and Equipment. It is not intended to cover all controls, but you must evaluate all of the controls applicable to your activity.

B–3. Instructions
Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that reveal deficiencies must be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2–R (Management Control Evaluation Certification Statement).

B–4. Test questions
a. Are practices and procedures in place and operating to determine compliance with health standards established in applicable Federal, State, local, and host Government statutes and regulations and in Army regulations?

b. Are practices and procedures in place and operating to assess if deployment operational modification to health standards are properly documented, archived, and protective of health?

c. Were sufficient resources requested to accomplish all responsibilities designated in this regulation? Where actual resources received were insufficient, were those resources applied to the highest priority areas? Was the adverse impact of the unfunded requirements communicated to higher headquarters?

d. Is health and OEH surveillance performed as required?

e. Are Army personnel informed of significant deployment health threats, risks, and appropriate countermeasures via risk communications?

f. Are there standard process outcome metrics in place and applied to evaluate DOEHRM activities?

g. Are commanders, supervisors, and preventive medicine staff provided basic, specialized, and sustainment DOEHRM training that will enable them to properly execute their leadership and staff responsibilities?

h. Is DOEHRM addressed throughout the DOTMLPF process?

i. Are DOEHRM principles incorporated into Army officer and enlisted training manuals and Soldier common task training manuals?

j. Are reportable medical events and OEH surveillance information collected, reported, and archived in accordance with DoD requirements and information systems?

k. Are DOEHRM policies and TTP compatible and consistent with comprehensive OEH risk management procedures across the Army to include garrison?

B–5. Supersession
This is the initial management control evaluation checklist for Deployment Occupational and Environmental Health Risk Management.

B–6. Comments
Help make this a better tool for evaluating management controls. Submit comments to HQDA (DACS–SF) Washington, DC 20310–0200.

Glossary

Section I
Abbreviations

AAE
Army Acquisition Executive

ACOM
Army Command

AMEDD
Army Medical Department

AMEDD C&S
Army Medical Department Center and School

ARSTAF
Army Staff

ASA(ALT)
Assistant Secretary of the Army (Acquisition, Logistics, and Technology)

ASA(I&E)
Assistant Secretary of the Army (Installations and Environment)

ASA(M&RA)
Assistant Secretary of the Army (Manpower and Reserve Affairs)

ASCC
Army Service Component Command

CBRNE
chemical, biological, radiological, nuclear, and high-yield explosives

CG
Commanding General

CJCS
Chairman, Joint Chiefs of Staff

CJCSI
Chairman, Joint Chiefs of Staff Instruction

CRM
composite risk management

DA
Department of the Army

DA Pam
Department of the Army Pamphlet

dBA
A-weighted sound pressure level in decibels

dBP
linear peak sound level

DCS, G-1
Deputy Chief of Staff, G-1

DCS, G-3/5/7
Deputy Chief of Staff, G-3/5/7

DCS, G-8
Deputy Chief of Staff, G-8

DMDC
Defense Manpower Data Center

DMSS
Defense Medical Surveillance System

DNBI
disease and non-battle injury

DOD
Department of Defense

DODD
Department of Defense Directive

DODI
Department of Defense Instruction

DOEHRM
Deployment Occupational and Environmental Health Risk Management

DOTMLPF
Doctrine, Organizations, Training, Materiel, Leadership and Education, Personnel and Facilities

DRU
Direct Reporting Unit

EHR
electronic health record

FHP
Force Health Protection

FM
Field Manual

HQDA
Headquarters, Department of the Army

IM/IT
information management/information technology

JP
Joint Publication

MEDCOM
U.S. Army Medical Command

MHS
Military Health System

NRC
National Research Council

OEH
occupational and environmental health

PDHRA
Post-Deployment Health Reassessment

TICs/TIMs
toxic industrial chemicals and materials

TRADOC
U.S. Army Training and Doctrine Command

TSG
The Surgeon General

TTP
tactics, techniques and procedures

USACHPPM
U.S. Army Center for Health Promotion and Preventive Medicine

VA
Department of Veterans Affairs

Section II
Terms

Acute health effect
A health effect, usually adverse, that manifests itself shortly after the causative event (for example, an exposure to a toxic material). The term is also used to describe an adverse health effect that persists for a relatively short period of time before subsiding completely.

Army garrison
The garrison is the basic organizational structure for providing programs, services, and management to an installation and its resident community. An Army garrison is a table of distribution and allowances organization that commands, controls, and manages Army installations. Garrison Command is the execution arm of the Installation Management Command. It delivers the majority of installation management services to both resident and nonresident organizations. The garrison's mission is linked to the installation's purpose. As the execution arm of the Installation Management Command, the garrison's mission is to provide installation management programs and services for mission activity commanders, Soldiers, civilians, family members, and retirees.

Army personnel
Includes Active Army; members and organizations of the Army National Guard of the United States, including periods when operating in their Army National Guard capacity; the U.S. Army Reserve; Department of the Army civilians; and contractor personnel (when authorized by contract), unless otherwise stated.

Biological agent
A microorganism or biological toxin that causes disease in personnel, plants, or animals or causes the deterioration of materiel.

CBRNE hazard
Those chemical, biological, radiological, nuclear, and high-yield explosive elements that pose or could pose a hazard to individuals. Chemical, biological, radiological, nuclear, and high yield explosive hazards include those created from accidental releases, TICs/TIMs (especially air and water poisons), biological pathogens, radioactive matter, and high-yield explosives. Also included are any hazards resulting from the deliberate employment of weapons of mass destruction during military operations.

Chemical warfare agent
Chemical substance that is intended for use in military operations to kill, seriously injure, or incapacitate personnel through its physiological effects. The term excludes riot control agents, herbicides, smoke, and flame.

Chronic health effect
A health effect that persists for a relatively long period of time (such as weeks, months, or years).

Combat and operational stress
The normal and predictable emotional, cognitive, physical, and behavioral responses of Servicemembers who have been exposed to prolonged, intense, and extraordinary events during combat or other military operations. Factors contributing to combat and operational stress may include high intensity combat; added exposure to the dangers, responsibilities, and consequences of battle; sudden exposure to, and first experience with, battle, injuries, death, atrocities, shock, and fear; recent changes at home; and a wide variety of physical stressors, including fatigue and illness.

Communicable disease
Illness due to a specific infectious agent, or its toxic products, that arises through transmission of that agent of its products from an infected person, animal, or inanimate reservoir to a susceptible host; either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment. Synonymous with infectious disease.

Composite risk management
The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risks with mission benefits.

Delayed health effect
A health effect, usually adverse, that manifests itself in a significant period of time (for example, weeks, months, or years) after a causative effect (for example, an exposure to a toxic material).

Deployment
The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

Deployment occupational and environmental health risk management (DOEHRM)
The management of mission and Soldier risks during deployments associated with—

a. The accidental or deliberate release of non-weaponized TICs/TIMs; hazardous physical agents; ionizing or non-ionizing radiation; or residue from CBRNE.

b. Environmental contaminants, to include vector- and arthropod-borne threats, residues, or agents, naturally occurring or resulting from previous activities of U.S. forces or other concerns, such as non-U.S. military forces, local national governments, or local national agricultural, industrial, or commercial activities.

c. The TICs/TIMs or hazardous physical agents currently being generated as a by-product of the activities of U.S. forces or other concerns, such as non-U.S. military forces, local national governments, or local national agricultural, industrial, or commercial activities.

d. Endemic diseases, deployment related stress, and climatic and/or environmental extremes.

e. Noise induced hearing injury as a result of hazardous noise exposure.

Disease and non-battle injury (DNBI)
Preventable diseases and injuries that are not a result of hostile action by or against an organized enemy, but of non-battle conditions that render a Soldier combat-ineffective. These diseases and injuries include infectious diseases, arthropod-borne diseases, food- and water-borne diseases, environmental injury/illness (such as heat, cold, altitude, toxic materials), and occupational injury/illness. Non-battle injuries include self-inflicted wounds and all injuries that occur during peacetime.

Electronic health record (EHR)
The MHS's interoperable, secure, globally accessible, longitudinal, digital, electronic record of comprehensive medical and health information (that is, Geo-Temporal and Real Property data) throughout an individual's period of eligibility for care under the MHS.

Endemic disease
Illnesses within a defined population usually associated within a particular geographic or specific locale.

Force health protection
Measures taken by commanders, individual Servicemembers, and the MHS to promote, improve, conserve, or restore the mental and physical well being of Servicemembers across the range of military activities and operations. These

measures enable the employment of a healthy and fit force, the prevention of disease and injury, and the provision of quality medical and rehabilitative care for those injured or ill anywhere in the world.

Hazard
A condition with the potential to cause injury, illness, or death of personnel; damage to or loss of equipment or property; or mission degradation.

Hazardous noise exposure
Exposure to impulse noise levels greater than or equal to 140 dBP (for example, weapons fire, improvised explosive devices) or steady state noise greater than or equal to 85 dBA time weighted average (for example, helicopters, military vehicles, generators).

Health surveillance
The regular or repeated collection, analysis, archiving, interpretation, and dissemination of health-related data used for monitoring the health of a population or of individuals, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury. It includes such subcomponents as OEH surveillance and medical surveillance. Effective health surveillance requires that all exposure monitoring data be collected and archived so that it can be linked with individuals and health outcome data in order to ascribe specific potential and actual exposures to individuals and to enable the identification of cohorts of similarly exposed personnel.

Health threat
As it relates to the deployed setting, it is a composite of ongoing or potential enemy actions; environmental, occupational, industrial, and meteorological conditions; endemic human and zoonotic diseases and other medical impacts; and employment of CBRNE warfare agents that can reduce the effectiveness of military forces through wounds, injuries, illness, and psychological stressors if not sufficiently countered.

Ionizing radiation
Any radiation capable of displacing electrons from atoms or molecules, thereby producing ions (for example, alpha, beta, gamma, x-rays, neutrons, and ultraviolet light). For the purposes of this regulation, it excludes naturally occurring background radiation. High doses of ionizing radiation may produce severe skin or tissue damage.

Military operation
A military action to carry out a strategic, operational, tactical, or training mission that includes the relocation of forces and materiel to the operational area (home station, continental United States, or outside the continental United States).

Non-ionizing radiation
Electromagnetic radiation that does not have sufficient energy to remove electrons from the outer shells of atoms. Types of non-ionizing radiation include ultraviolet light, visible light, infrared, microwave, radio and television and extremely low frequency. The primary health effect from high exposure levels of non-ionizing radiation arises from heat generation of body tissue.

Occupational and environmental health (OEH) surveillance
The continuous process of assessing potential exposures and health effects, recommending health risk reduction options, and evaluating the effectiveness of health risk reduction methods for chemicals of concern, weapons of mass destruction, pathogens, disease vectors (such as arthropods and rodents), and radioactive materials in air, soil, water, and food. It also includes surveillance of health effects from heat, cold, non-ionizing radiation (such as radio frequency, microwave, and laser), ionizing radiation sources, noise, and psychological stressors. It includes coordination and information transfer with agencies responsible for surveillance of safety hazards (such as ground, vehicle, and aviation) and environmental management actions to comply with U.S. or host nation environmental compliance, cleanup, and pollution prevention laws and regulations.

Potential OEH exposure
An exposure to an individual(s) or group from a hazard that, if not controlled, has a reasonable probability of actually occurring and will present a health risk. Reasonable probability may be determined based on intelligence, ongoing or planned military operations, past surveillance, ongoing surveillance, past activities in an area, present activities in an area, or an accidental or deliberate release.

Risk communication
The timely process of adequately and accurately communicating the nature of actual and potential OEH hazards, risks (probability and severity), countermeasures, health outcomes, and other health-related information associated with pre-, during, and post-deployment operations to all Army personnel (especially commanders) and other individuals/groups

directly affected by, or highly interested in, the health risks. Health risk communication efforts must be understandable and foster trust. They may involve multiple techniques and should allow for timely two-way communications between subject matter experts (medical personnel) and those individuals and groups who have concerns.

Toxic Industrial Chemicals and Materials (TICs/TIMs)
Any chemicals or materials used or produced in an industrial process (raw material, final products, or byproducts, including solid and liquid wastes and air pollutants) that pose a health hazard due to their toxic properties. Exposure may occur due to normal industrial operations of the facility, hazardous waste accumulation, accidental release, or because of conflict or terrorist actions.

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

USAPD

ELECTRONIC PUBLISHING SYSTEM
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TIME: 07:16:04
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DOCUMENT: AR 11–35

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