

**Army Regulation 11–35**

**Army Programs**

# **Occupational and Environmental Health Risk Management**

**Headquarters  
Department of the Army  
Washington, DC  
11 May 2016**

**UNCLASSIFIED**

# ***SUMMARY of CHANGE***

AR 11-35

Occupational and Environmental Health Risk Management

This major revision, dated 11 May 2016---

- o Changes the regulation title from "Deployment Occupational and Environmental Health Risk Management" to "Occupational and Environmental Health Risk Management" (cover).
- o Implements Department of Defense and Presidential directives (title page and throughout).
- o Aligns the occupational and environmental health risk management principles with those described in ATP 5-19 (paras 1-5, 1-6, and 3-3).
- o Mandates using the Defense Occupational and Environmental Health Readiness System for management of all unclassified--and the Military Exposure Surveillance Library's secret internet protocol router network capability, for archiving all classified--occupational and environmental surveillance data and documents (paras 1-5, 3-2, and 3-3).
- o Updates the background section to reflect that occupational and environmental health risk management requirements apply to all phases of Army operations (deployed and non-deployed, to include training and garrison activities) (para 1-6).
- o Requires deployment health assessments for all deployments where Army personnel are expected to be exposed to an occupational and environmental health hazard that could exceed an occupational or permissible exposure limit (paras 1-5 and 3-3).
- o Updates responsibilities to reflect organizations and roles under the current Army force structure (chap 2).
- o Clarifies the requirement for the Deputy Chief of Staff, G-3/5/7 to develop an Occupational and Environmental Health Risk Management Program implementation plan (para 2-11).
- o Establishes minimum Occupational and Environmental Health Risk Management program reporting requirements, to ensure accountability and ownership of the program throughout the Army (para 3-2).
- o Requires the use of DD Form 2977 (Deliberate Risk Assessment Worksheet) to document all deliberate occupational and environmental health risk assessments (para 3-3).
- o Requires occupational and environmental health site assessments to identify potential threats and pathways of exposure, in accordance with ATP 4-02.82 (para 3-3).

- o Requires the completion of periodic occupational and environmental monitoring summaries to support geographic combatant commanders' health risk decision making (para 3-3).



## Army Programs

### Occupational and Environmental Health Risk Management

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By Order of the Secretary of the Army:

**MARK A. MILLEY**  
General, United States Army  
Chief of Staff

Official:



**GERALD B. O'KEEFE**  
Administrative Assistant to the  
Secretary of the Army

**History.** This publication is a major revision.

**Summary.** This publication has been revised to update the policies, responsibilities, and prescribed procedures within the Army to be followed for managing risks associated with occupational and environmental health threats. This regulation implements CJCS Memorandum MCM 0017–12; EO 12196; DODDs 1010.10, 1404.10, 4715.1E, 6200.04, 6205.02E, and 6490.02; DODIs 1322.24, 4150.07, 4715.19 6050.05, 6055.01, 6055.05, 6055.07, 6055.08, 6055.11, 6055.12, 6055.15, 6055.17, 6200.03, and 6490.03; and PRD/NSTC–5.

**Applicability.** This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve. It also

applies to 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, Energy 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 internal control process.** This regulation contains internal controls and provides an Internal Control Evaluation for use in evaluating key internal controls (see appendix B).

**Supplementation.** Supplementation of this regulation and establishment of agency, command, and installation forms are prohibited without prior approval from the

Assistant Secretary of the Army (Installations, Energy and Environment), SAIE–ESOH, 110 Army Pentagon, Washington, DC 20310–0110. Local forms by Army commands, Army service component commands, and direct reporting units to comply with geographic combatant command requirements have been approved by the Assistant Secretary of the Army (Installations, Energy and Environment), 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 U.S. Army Reserve.

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# Chapter 1

## Introduction

### 1–1. Purpose

This regulation sets policies, responsibilities, and procedures for identifying, managing, and controlling occupational and environmental health (OEH) risks, as part of the Army Occupational and Environmental Health Risk Management (OEHRM) Program. This regulation reforms current practices by setting new standards for preparing and managing OEH surveillance data and documents.

### 1–2. References

See appendix A.

### 1–3. Explanation of abbreviations and terms

See glossary.

### 1–4. Responsibilities

Responsibilities are listed in chapter 2.

### 1–5. Army protection overview

It is Army policy to—

*a.* Protect Army personnel from potential and actual exposures to chemical, biological, radiological, nuclear, and high-yield explosive (CBRNE) warfare agents; endemic communicable diseases; food-, water-, and vector-borne diseases; zoonotic diseases; ionizing and non-ionizing radiation; combat and operational stress; heat, cold, and altitude extremes; environmental and occupational hazards; toxic industrial chemicals and toxic industrial materials (TICs/TIMs); nano-engineered materials; hazardous noise; low- to moderate-yield blast effects; embedded metal fragments and other physical, biological, chemical, and radiological agents.

*b.* Reduce potential and actual exposures from occupational and environmental hazards encountered during all military activities to as low as practicable to minimize acute, chronic, and delayed health effects within the context of mission parameters and Army risk management (RM) principles as described in AR 385–10, DA Pam 385–30 and ATP 5–19.

*c.* Make informed risk decisions regarding OEH threats during all phases of military operations, using the RM process to manage such threats and minimize total risk to Army personnel; use DD Form 2977 (Deliberate Risk Assessment Worksheet) to document the deliberate risk assessment process.

*d.* Ensure that commanders are aware of and consider the acute, chronic, and delayed health risks associated with occupational and environmental exposures (see para 1–5*a*) during all phases of military operations and over the broad spectrum of Army activities.

*e.* Comply with Federal, State, local, or host nation statutes and regulations, directives, and guidance governing OEH while in garrison or during training exercises, except for uniquely military equipment, systems, and operations as authorized in EO 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 are required to comply with Federal, State, local, or host-nation statutes and regulations, directives, and guidance governing OEH. In such circumstances, contracts will include the requirement to comply with Federal, State, local, or host-nation statutes and regulations, directives, and guidance governing OEH.

*f.* Conduct deployment health assessments (DHAs) which include a DD Form 2795 (Pre-deployment Health Assessment), DD Form 2796 (Post-Deployment Health Assessment (PDHA)), and DD Form 2900 (Post-Deployment Health Reassessment (PDHRA)) for all deployments where Army personnel are expected to be exposed to an OEH hazard that could exceed an occupational or permissible exposure limit.

*g.* During deployments, comply with U.S., Army-unique, or host-nation OEH standards, whichever are more restrictive.

(1) Perform industrial hygiene surveys of all units and work sites to identify and evaluate any potential occupational exposures at least once during deployment, and annually after that. This is defined in DA Pam 40–503 and TG 141. Surveys should identify, evaluate, and recommend controls for any occupational exposures, to enable the commander to make an informed risk decision.

(2) When the mission parameters or overall health of deployed personnel warrant RM 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 OEH risks expected to be, and actually, encountered during all military activities.

(3) Such RM decision-making will be evidence-based, deliberate, documented (see para 1–5c), and archived. Decisions by commanders to modify the application of OEH standards will be reevaluated, as mission parameters change, and incorporated as an attachment or annex in the operational plans or orders.

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

(1) Address how to anticipate, recognize, evaluate, control, and manage health and safety risks encountered during military operations.

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

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

*i.* Collect, document, evaluate, report, and enter OEH sampling data from military operations in the respective Defense Occupational and Environmental Health Readiness System (DOEHRS) and Military Exposure Surveillance Library (MESL) applications. Integrate 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, to the greatest extent possible for current and emerging technologies, 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 or retirement. The EHR data will also include deployments.

(2) The EHR will be accessible to 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 Service members, civilians, veterans, and their families for the duration of their service.

(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 Public Law 104–191 (The Health Insurance Portability and Accountability Act of 1996 (HIPAA)), security rules, and privacy rules, as appropriate (see AR 40–66).

*j.* Ensure necessary healthcare evaluation, treatment, and follow-up for potentially exposed Army personnel.

*k.* Operate in such a way that OEHRM supports modular and interoperable Joint Forces capabilities provided by the Services.

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

(2) OEHRM-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) OEHRM must support a strategically responsive, precision maneuver force that is dominant across the ROMO envisioned in a future global security environment.

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

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

*m.* Provide commanders with the capabilities and tools to conduct RM assessments and communicate risks.

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

*o.* Record once-daily, locations of all deployed personnel and report the data electronically to the Defense Manpower Data Center (DMDC), at the secret-level of security and below. This is conducted by unit human resources personnel.

## **1–6. Hazards overview**

*a.* This policy applies to all phases of Army operations to include training and garrison activities.

*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, zoonotic 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, blast over pressure, 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.

(5) Non-traditional OEH threats/exposures, such as blast injury and embedded metal fragments; these threats may not be managed through traditional RM activities, but Soldier exposures must be recorded, monitored, reported, and managed.

*c.* Army standard RM and risk analyses processes to be applied to OEH risk management are defined in ATP 5–19. (For additional information see JP 2–01.3, and JP 3–33.)

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

## **Chapter 2 Responsibilities**

### **2-1. Headquarters, Department of the Army principal officials**

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 OEHRM policy into their functional areas or readiness domains. Each ARSTAF principal will define the organizational missions, force structure, and resourcing necessary to implement this policy within their functional areas.

### **2-2. The Chief of Staff of the Army**

The Chief of Staff of the Army will provide guidance and oversight for implementing OEHRM programs.

### **2-3. The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/Army Acquisition Executive**

The ASA(ALT)/AAE will—

- a.* Establish overall acquisition, logistical, and technological policy and guidance to integrate OEHRM requirements into materiel acquisition and contracting.
- b.* Develop non-medical OEHRM materiel (such as sampling instruments, clothing, and individual equipment) in coordination with medical OEHRM material development to ensure items developed are complementary. This will be done with the help of TSG.
- c.* Ensure that OEH exposure data is compatible and comparable between data collection, analysis, and storage systems.

### **2-4. The Assistant Secretary of the Army (Installations, Energy and Environment)**

The ASA(IE&E) will—

- a.* Serve as the overall proponent for the OEHRM 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 OEHRM Program.
- c.* Provide goals, priorities, general oversight of, and advocacy for the Army OEHRM Program.
- d.* Provide executive leadership at the Army Secretariat level to ensure timely integration of DOD directives and policies concerning OEHRM with Army policies, implementing guidance, and funding.
- e.* Provide Army OEHRM input to The Army Plan.

### **2-5. The Assistant Secretary of the Army (Manpower and Reserve Affairs)**

The ASA(M&RA) will—

- a.* Establish policy and guidance for integrating OEHRM requirements within the military and civilian personnel and manpower programs.
- b.* Ensure that OEHRM requirements are integrated within Army training programs.
- c.* Ensure OEHRM 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.
- d.* 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.
- e.* Provide OEHRM input to The Army Plan in coordination with the ASA(IE&E).

### **2-6. Chief, Information Officer, G-6**

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

- a.* Support the AAE in the acquisition and fielding of OEHRM-related components of Army information systems both unclassified and classified.
- b.* Validate organizational compliance with policies identified in AR 25-1, Army Information Technology, and AR 25-2, Information Assurance.

### **2-7. The Chief, National Guard Bureau**

The CNGB, through the Director, Army National Guard Bureau, will—

- a.* Provide emphasis, policy, and implementation guidance on OEHRM to each State and Territory Adjutant General.
- b.* Provide an OEHRM point of contact for coordination with the DCS, G-3/5/7.

## **2-8. The Director of the Army Staff**

The DAS, through the Director of Army Safety (the lead for Army RM), will—

- a.* Provide ARSTAF oversight for risk management
- b.* Promote the use of RM during all phases of Army planning.
- c.* Ensure that Army OEHRM Program and policy is integrated with the Army RM process.
- d.* Develop, establish, coordinate, and disseminate policy, guidance, and procedures for the Army Safety Program, based upon strategic policy developed by ASA (IE&E), statutory requirements, and national standards in support of the Army's mission.
- e.* Advise the ARSTAF, the Chief of Staff, Army; the Secretariat; and the Secretary of the Army on matters relating to the Army Safety Program and its implementation and effectiveness.
- f.* Implement policies and develop procedures to implement Public Law 91-596 (The Occupational Safety and Health Act of 1970, EO 12196, 29 CFR 1910, 29 CFR 1960, 29 CFR 1926, 29 CFR 1904, and DOD Safety and Occupational Health standards.

## **2-9. The Deputy Chief of Staff, G-1**

The DCS, G-1 will—

- a.* Develop personnel policies, requirements, and procedures to support the integration of OEHRM 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 OEHRM information systems.
- c.* Ensure that Army unit and individual personnel data, including daily location data, for deployments are provided to the 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.

## **2-10. The Deputy Chief of Staff, G-2**

The DCS, G-2 will—

- a.* Develop intelligence and security policies and procedures that support the integration of OEHRM within military intelligence and DOD medical intelligence.
- b.* Advise TSG on intelligence and security policy that may impact OEHRM.
- c.* Provide staff oversight for intelligence activities that affect the collecting, retaining, authorizing, and producing finished intelligence to support implementation and goals of this regulation.

## **2-11. The Deputy Chief of Staff, G-3/5/7**

The DCS, G-3/5/7 will—

- a.* Develop an OEHRM implementation plan, as described in paragraph 3-1*b* of this regulation, in coordination with TSG's functional proponent for preventive medicine.
- b.* Develop operational policies, requirements, and procedures to support the integration of OEHRM within military operations.
- c.* Review and validate requirements for the integration of OEHRM within the Army.
- d.* Develop appropriate guidance and strategy for materiel requirements and combat development programs to implement both the medical and non-medical aspects of Army OEHRM policy. The guidance will—
  - (1) Address the requirements determination process and the prioritizing, resourcing, and integrating of OEHRM into materiel warfighting requirements.
  - (2) Address doctrine, organization, training, materiel, leadership and education, personnel and facilities - policy (DOTMLPF-P) requirements for OEHRM mission capabilities. These requirements are for near-, mid-, and far-term operations, in accordance with AR 40-5, AR 40-10, and AR 71-9.
  - (3) Provide for OEHRM capabilities that are jointly interdependent and derived from, and support joint operating concepts, functional requirements, and approaches to RM.
- e.* Ensure oversight of integration and implementation of OEHRM into military operations to include force structure, training, doctrine, and organizational missions.
- f.* Identify ARSTAF proponent(s) to coordinate the execution of OEHRM policy.

## **2-12. The Deputy Chief of Staff, G-4**

The 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 OEHRM.

- b. Identify logistical requirements having OEHRM implications.

### **2-13. The Deputy Chief of Staff, G-8**

The DCS, G-8 will—

- a. Assist and advise the ARSTAF principals and the proponent for the OEHRM Program on planning, programming, and budgeting to ensure integration of OEHRM resource requirements in management decision packages.
- b. Adjust requirements proposed by the OEHRM proponent to prepare a balanced functional program that conforms to overall planning, programming, budgetary, and fiscal guidance.
- c. Support and defend the funding of OEHRM requirements to the level necessary to ensure sustainability throughout the Army.

### **2-14. The Chief, Army Reserve**

The Chief, Army Reserve, will—

- a. Provide OEHRM policy support and implementation guidance to Army Reserve activities.
- b. Provide an OEHRM point of contact for coordination with the DCS, G-3/5/7.

### **2-15. 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.

### **2-16. The Surgeon General**

TSG will—

- a. Advise HQDA principal officials on medical aspects of OEHRM.
- b. Provide policy, strategy, guidance, and oversight for integrating OEHRM within the Army Medical Department (AMEDD).
- c. Identify or develop Army-unique OEH standards, criteria, and guidelines.
- d. Ensure that 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 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 or 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 to integrate 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 OEHRM Program is consistent with the medical aspects of DOD and joint OEH risk management policies and implementing instructions.
- i. Ensure that OEHRM medical policies and procedures are consistent and compatible with comprehensive OEH risk management across the Army.
- j. In coordination with the ASA(ALT)/AAE, ensure that Army non-medical OEHRM material solutions are compatible and complementary to medical OEHRM material solutions.
- k. Define who has the medical authority and responsibility to decide how to include health information in individual EHRs.
- l. Help the Director of Army Safety/Combat Readiness Center provide commanders with the capabilities and tools to conduct RM assessments and communicate risks.
- m. In coordination with the DCS, G-1, ensure that Army personnel information systems are interoperable and integrated with DOD medical information systems.
- n. Help the DCS, G-3/5/7 develop the OEHRM implementation plan and policies, per paragraph 3-1b.
- o. Through the Commander, U.S. Army Medical Command, in addition to the responsibilities in paragraph 2-20, AR 40-5, and AR 70-1, will—
  - (1) Support the AAE in his or her responsibilities to develop and field non-medical materiel for OEHRM implementation throughout the Army.
  - (2) Develop, in consultation with non-medical materiel developers, the medical materiel for the rapid identification and assessment of OEH threats for both short- and long-term effects.
  - (3) 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.

- (4) Operate and maintain, through the Armed Forces Health Surveillance Center, the Disease Reporting System internet (DRSi) and Defense Medical Surveillance System (DMSS).
- (5) Operate and maintain, through the U.S. Army Public Health Center (USAPHC), the MESL.
- (6) Establish and operate capabilities to—
  - (a) Identify and assess health threats to support intelligence preparation of the battlespace.
  - (b) Archive and analyze unclassified and classified OEH data.
  - (c) Implement DOD and Army OEH policies.
- (7) 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, identifying and monitoring OEH hazards and exposures, and preventing and treating adverse health effects of such exposures.
- (8) Through the U.S. Army Medical Research and Materiel Command, develop, test, and field OEH medical materiel solutions leveraging commercial off-the-shelf technologies. Development of OEH medical materiel solutions must be conducted in consultation and coordination with OEH non-medical materiel development.
- (9) 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.
- (10) Ensure that FHP personnel receive specialized OEHRM training.
- (11) Ensure, through AMEDD C&S, that lessons learned regarding the medical aspects of OEHRM during military operations are documented, archived, analyzed, and disseminated.
- (12) Provide reach-back OEH risk management capabilities including health risk communication.
- (13) Provide consultation and technical reach back services to support the public health emergency officer/installation emergency manager.

## **2–17. The Commanding General, U.S. Army Training and Doctrine Command**

The CG, TRADOC, in addition to the responsibilities in paragraph 2–20, 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 OEHRM into TRADOC leadership schools, as appropriate.
- c. Ensure that OEHRM requirements are integrated within proponent combined arms training strategies.
- d. Provide DOTMLPF–P solutions to the deployment OEH risks presented by hazards identified in paragraph 1–6b.
- e. Ensure that commanders, supervisors, and force health protection (FHP) staff receive OEHRM training.

## **2–18. The Commanding General, U.S. Army Forces Command**

The CG, U.S. Army Forces Command, in addition to the responsibilities in paragraph 2–20, will—

- a. Coordinate with TRADOC and U.S. Army Medical Command (MEDCOM) to identify the required force structure and capabilities to implement OEHRM 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 OEHRM 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 non-weaponized health hazard identification and assessment to support RM decision making.

## **2–19. The Commanding General, U.S. Army Materiel Command**

The CG, U.S. Army Materiel Command, in addition to the responsibilities in paragraph 2–20, will—

- a. Support the AAE in his or her responsibilities for developing and fielding non-medical materiel for OEHRM implementation throughout the Army.
- b. Develop, in consultation with medical materiel developers, the non-medical 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.

## **2–20. Commanders, Army commands, Army service component commands, and direct reporting units**

The commanders of ACOMs, ASCCs, and DRUs will—

- a. Provide command emphasis, resources, policy implementation guidance, and oversight to subordinate commands and activities. This will direct integration and implementation of OEHRM activities, programs, and processes within their respective command, functional, and readiness domains.
- b. Provide an annual report to ASA(IE&E) on the following minimum reporting requirements:
  - (1) DD 2977 forms completed.
  - (2) Exposure incidents (real or presumed).

- (3) Occupational and environmental health site assessments (OEHSAs) completed.
- (4) POEMS completed.
- (5) Moderate or higher risks.
- (6) DHA's which include the DD Form 2795 (Pre-deployment Health Assessment), DD Form 2796 (Post-Deployment Health Assessment (PDHA)), and DD Form 2900 (Post-Deployment Health Reassessment (PDHRA)).
- (7) Embedded metal fragment analyses (semi-annual report through ASA(IE&E) to DOD Health Affairs).

## **2–21. Commanders**

Commanders will—

- a.* Use, to the maximum extent possible, the Army RM decision-making process that conforms with DA Pam 385–30, ATP 5–19, JP 2–01.3, and JP 3–33. OEH considerations will be included in the process.
- b.* Use the Army RM process as part of the commander's FHP Program for the timely assessment of OEH risks to personnel under their command.
- c.* Eliminate or minimize to acceptable level risks created by actual and potential OEH exposures during all phases of military operations, balanced with operational requirements.
- d.* Ensure that contingency and operational plans include the appropriate OEHRM 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 National Center for Medical Intelligence or U.S. Intelligence Community, 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.
- e.* Provide timely OEH risk information to personnel under their command using assistance of supporting medical staff.
- f.* 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. Garrison/peacetime standards will serve as the foundation for deployment military operations with command authority to modify as appropriate. During deployments, commanders will comply with United States Army-unique or host nation OEH standards, whichever are more restrictive.
- g.* 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 OEHRM 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) Exposures from actual and potential OEH threats are reduced to as low as practicable, within the context of operational mission parameters.
  - (3) OEHRM is integrated in, and synchronized with, Army RM processes.
  - (4) Army OEHRM capabilities are decentralized, adaptable, and complete for any modular, tailored (single Service, joint, or allied/coalition) force. Army OEHRM 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) Early in the planning process, commanders are aware of and consider OEH risks and recommended counter-measures as part of their RM process during military operations to include identifying the population at risk through personnel unit databases and health assessments.
  - (6) Commanders are able to execute decisive action 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 exposures (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. Periodic occupational and environmental monitoring summaries (POEMS) are a population-based surveillance document which describe the types of exposure hazards (such as airborne pollutants, water pollutants, infectious disease, noise, heat/cold), summarize site data/information collected, and provide

an assessment of the significance of any known or potential short term (during deployment) and long-term (post deployment) health risks to the personnel population deployed to the site.

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

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

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

(12) OEHRM policies and TTP are compatible and consistent with installation policies and procedures.

*b.* Specific enabling objectives and activities that must be accomplished in order to fully integrate OEHRM into the Army will be identified in the Army OEHRM plan prepared by the 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 DRU plans will address policy and doctrine, requirements, resourcing, integrating policies and procedures within the Army, and oversight of OEHRM implementation and effectiveness.

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

### **3-2. Program elements**

*a. Protection.* Army OEHRM 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 help commanders analyze 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 capabilities must be balanced between protective factor and mission performance.

*b. Surveillance.* Army OEHRM will help commanders in the analysis and surveillance of those OEH hazards identified in paragraph 1-6*b*.

(1) Commanders will also receive recommendations and make decisions and adjustments based on—and 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 strengthen personnel protection and improve mission effectiveness.

*c. Databases.* Army OEHRM requires significant interaction among personnel, medical, safety and occupational health, and information management/information technology resources.

(1) All unclassified OEH surveillance data, including but not limited to laboratory data, field test data, surveys, inspections, incident reports, delineation of exposure pathways, and OEH site assessments, will be entered in DOEHRs.

(2) All classified OEH surveillance data, including but not limited to laboratory data, field test data, surveys, inspections, incident reports, delineation of exposure pathways, and OEH site assessments, will be entered in the MESL application through the USAPHC *SIPRNet* Web site (<https://phc.army.smil.mil>). Additional instructions for submitting and accessing classified OEHS data are available on the MESL link.

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

(4) Databases must be compatible to allow consolidation of exposure and date/time/location data. Data must be accessible for lifetime longitudinal use for operational decision requirements, exposure registries, medical care, and medical follow-up considerations.

*d. Risk management.* The Army RM process, as part of the commander's FHP Program, must include the timely assessment of OEH risks to personnel.

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

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

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

(3) All Army personnel will require OEHRM training for awareness of OEH risks during military operations, the proper use of appropriate countermeasures, and the proper reporting of potentially hazardous conditions.

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

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

*f. Reporting.* Incorporating OEHRM reporting requirements is necessary to ensure accountability and ownership of the OEHRM program throughout the Army.

### **3-3. Prescribed procedures**

*a.* Army RM processes are used to manage OEH risks and to minimize total risk to Army personnel. Approved risk management procedures, planning, and risk analyses are defined in DA Pam 385-30 and ATP 5-19. DD Form 2977 is used to document all deliberate risk assessments.

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

(2) During deployments, OEHSAs must be completed to identify potential OEH threats and pathways of exposure, guide OEH data collection and surveillance activities, support risk assessment, summarize immediate risk mitigation actions, and document environmental conditions. The OEHSAs must be completed per ATP 4-02.82, DA Pam 40-503, and USAPHC TG 317, entered in DOEHRS (unclassified) or through the USAPHC *SIPRNet* Web site (<https://phc.army.smil.mil>) (classified), and updated at least annually.

(3) 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).

(4) Several important actions can mitigate OEH risks: 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).

(5) Informed decisions weigh the OEH risks against other operational risks and mission requirements.

*b.* OEH risk management must be woven into deliberate or crisis action plans for contingency and operational planning. Known and suspected OEH risks are strong, valuable elements of overall operational risk summary evaluations. Such information must be provided to subordinate units for unit-level planning.

*c.* Standard risk communication procedures must be used 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 1-6*b*. (Reference DA Pam 40-11 or contact USAPHC at <http://phc.amedd.army.mil/>.)

*d.* Locations of all deployed personnel must be recorded once daily, and reports on the locations must be sent electronically to the DMDC (at the security classification levels of secret and below).

(1) These data must travel through operational channels to the DMDC within 30 days after the location record is created, to comply with DODI 1336.5.

(2) These data are essential for successful OEH risk management during military operations. They also are needed 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.* Research and development programs must incrementally improve OEHRM capabilities, including IM and other technologies.

*f.* A health surveillance and readiness program that includes OEH surveillance must be implemented. AR 40-5 and DA Pam 40-11 contain AMEDD implementing instructions for DODD 6490.02E, DODI 6055.01, DODI 6490.03, and CJCS Memorandum MCM 0017-12, to include disease and injury (DI), reportable medical events, and OEH surveillance. All health information will comply with AR 40-66, security and privacy rules, as appropriate.

(1) Health surveillance and readiness activities must be implemented in pre-, during, and post-deployment phases of military operations.

(2) The DMSS must be used to document and archive medical encounters and outcomes related to actual and potential deployment OEH hazard exposures.

(3) DD Form 2795 (Pre-DHA), DD Form 2796 (PDHA), and DD Form 2900 (PDHRA) are used for documenting DHAs, in accordance with AR 40-66, DODI 6490.03, and other DOD, Joint Staff, and HQDA directives.

(4) The DR*Si* must be used to record reportable medical events and forward that information for inclusion into the DMSS.

(5) All unclassified OEH sampling data and exposure scenarios must be entered into DOEHRS; the USAPHC *SIPRNet* Web site <https://phc.army.smil.mil> must be used for classified data. This will enable analysis and archiving.

(6) DOEHRS must be used to collect, document, evaluate, report, and archive all relevant, unclassified OEH sampling data and individual exposure data. The USAPHC *SIPRNet* Web site (<https://phc.army.smil.mil>) must be used for classified data. The data must be accessible to health care providers; the Military Health System (MHS); and authorized agencies, including the VA, in accordance with DA and DOD policies and information sharing agreements.

(7) USAPHCs provide support to geographic combatant commanders by completing requested POEMS, using the guidance from the DOD Joint Environmental Surveillance Work Group (POEMS Sub Group) and the Defense Health Agency 2014 Memorandum (Standardized Process and Guidance for Completing, Approving, and Posting Periodic Occupational and Environmental Monitoring Summaries). The POEMS will be used as the official summary of

information known about ambient environmental conditions used to characterize population-level health risks at deployed locations.

*g.* Materiel and non-materiel capability improvements must be developed in accordance with CJCSI 3170.01E, considering the full range of DOTMLPF–P solutions.

*h.* OEHRM information and data documented in medical systems of record applications (such as DOEHRs) must be available for use by health care providers for any related current and/or retrospective health study.

## 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.apd.army.mil>. Field manuals are available online from the General Dennis J. Reimer Training and Doctrine Library Web site: <https://atiam.train.army.mil/catalog/#/dashboard>. 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 para 2-11*d*(2).)

#### **AR 40-66**

Medical Record Administration and Health Care Documentation (Cited in para 3-3*f*.)

#### **AR 70-1**

Army Acquisition Policy (Cited in para 2-16*o*.)

#### **AR 385-10**

The Army Safety Program (Cited in para 1-5*b*.)

#### **ATP 4-02.82**

Occupational and Environmental Health Site Assessment (Cited in para 3-3*a*(2).)

#### **ATP 5-19**

Risk Management (Cited in para 1-5*b*.)

#### **DA Pam 40-11**

Preventive Medicine (Cited in para 3-3*c*.)

#### **DA Pam 40-503**

The Army Industrial Hygiene Program (Cited in para 1-5*g*(1).)

#### **DA Pam 385-30**

Risk Management (Cited in para 1-5*b*.)

#### **Defense Health Agency**

Standardized Process Guidance for Completing, Approving, and Posting Periodic Occupational and Environmental Monitoring Summaries (Cited in para 3-3*f*(7).)

#### **DODD 6490.02E**

Comprehensive Health Surveillance (Cited in para 1-1.)

#### **MCM 0017-12**

Procedures for Deployment Health Surveillance (Cited in para 3-3.)

#### **TG 141**

Industrial Hygiene Sampling Guide (Available at <http://phc.amedd.army.mil/>.) (Cited in para 1-5.)

### 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**

Army Commands, Army Service Component Commands, and Direct Reporting Units

**AR 11-2**  
Managers' Internal Control Program

**AR 25-30**  
The Army Publishing Program

**AR 40-10**  
Health Hazard Assessment Program in Support of the Army Acquisition Process

**AR 40-562**  
Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease

**AR 70-41**  
International Cooperative Research, Development, and Acquisition

**AR 71-9**  
Warfighting Capabilities Determination

**AR 70-75**  
Survivability of Army Personnel and Materiel

**AR 200-1**  
Environmental Protection and Enhancement

**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

**29 CFR 1904**  
Recording and Reporting Occupational Injuries and Illness

**29 CFR 1910**  
Occupational Safety and Health Standards

**29 CFR 1926**  
Safety and Health Regulations for Construction

**29 CFR 1960**  
Basic Program Elements for Federal Employee Occupational Safety and Health Programs and Related Matters

**32 CFR Part 651**  
Environmental Effects of Army Actions

**CJCSI 3170.01E**  
Joint Capabilities Integration and Development System (Available at [www.dtic.mil/cjcs\\_directives/](http://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 [http://www.fa50.army.mil/pdfs/CJCSI3180\\_01.pdf](http://www.fa50.army.mil/pdfs/CJCSI3180_01.pdf).)

**DA Pam 40-21**  
Ergonomics Program

**DA Pam 40-501**  
Army Hearing Program

**DA Pam 385-10**

Army Safety Program

**DA Pam 385-40**

Army Accident Investigations and Reporting

**DODD 1404.10**

DOD Civilian Expeditionary Workforce

**DODD 3000.10**

Contingency Basing Outside the United States

**DODD 4715.1E**

Environment, Safety, and Occupational Health (ESOH)

**DODD 6200.04**

Force Health Protection (FHP)

**DODD 6205.02E**

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

**DODI 1010.10**

Health Promotion and Disease/Injury Prevention

**DODI 1322.24**

Medical Readiness Training

**DODI 1336.05**

Automated Extract of Active Duty Military Personnel Records

**DODI 4150.07**

DOD Pest Management Program

**DODI 4715.18P**

Emerging Contaminants

**DODI 4715.19P**

Use of Open Air Burn Pits in Contingency Operations

**DODI 6050.05**

DOD Hazard Communication (HAZCOM) Program

**DODI 6055.01**

DOD Safety and Occupational Health (SOH) Program

**DODI 6055.05**

Occupational and Environmental Health (OEH)

**DODI 6055.07**

Accident Investigation, Reporting, and Record Keeping

**DODI 6055.08**

Occupational Radiation Protection Program

**DODI 6055.11**

Protecting Personnel from Electromagnetic Fields (EMFs)

**DODI 6055.12**

DOD Hearing Conservation Program (HCP)

**DODI 6055.15**

DOD Laser Protection Program

**DODI 6055.17**

DOD Installation Emergency Management (IEM) Program

**DODI 6200.03**

Public Health Emergency Management within the DOD

**DODI 6490.03**

Deployment Health

**DOD Joint Environmental Surveillance Work Group (POEMS Sub Group)**

Available at <https://community.max.gov/display/DoD/POEMS+Subgroup+Collaboration+Page?src=email>

**Executive Order 12196**

Occupational and Safety Health Programs for Federal Employees (Available at [http://www.archives.gov/federal\\_register/indx.html](http://www.archives.gov/federal_register/indx.html).)

**JP 2-01.3**

Joint Tactics, Techniques, and Procedures for Joint Intelligence Preparation of the Battlespace

**JP 3-33**

Joint Task Force Headquarters (Available at [http://www.dtic.mil/doctrine/new\\_pubs/jointpub\\_operations.htm](http://www.dtic.mil/doctrine/new_pubs/jointpub_operations.htm).)

**MEMORANDUM**

Assistant Secretary of Defense/Health Affairs, 18 June 2012, subject: Clarification of the Requirement for Continuation of Semi-Annual Reporting of Results of Embedded Fragment Analyses

**Department of the Army/G-1, 6 May 2010**

Post-Deployment Health Reassessment Compliance (Available at <http://www.armyg1.army.mil/hr/pdhra/docs/G-1%20PDHRA%20Compliance%20Memo%20to%20MACOM%20CDRs.pdf>.)

**U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 14-063, 04 August 2014**

Policy for Use of the Defense Occupational and Environmental Health Readiness System – Industrial Hygiene (DOEHRs-IH) – Environmental Health Module (EHM)

**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

**Public Law 91-596**

The Occupational Safety and Health Act of 1970

**Presidential Review Directive/National Science and Technology Council–5 (PRD/NSTC–5)**

Planning for Health Preparedness for and Readjustment of the Military, Veterans, and Their Families after Future Deployments

**TG 317**

Technical Guide for Collection of Environmental Sampling Data Related to Environmental Health Site Assessments for Military Deployments (Available at <http://phc.amedd.army.mil/>.)

**Section III**

**Prescribed Forms**

This section contains no entries.

**Section IV**

**Referenced Forms**

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site ([www.apd.army.mil](http://www.apd.army.mil)); DD forms are available on the Office of the Secretary of Defense (OSD) Web site ([www.dtic.mil/whs/directives/infomgt/forms.index.htm](http://www.dtic.mil/whs/directives/infomgt/forms.index.htm)).

**DA Form 11–2**

Internal Control Evaluation Certification

**DA Form 2028**

Recommended Changes to Publications and Blank Forms

**DD Form 2795**

Pre-deployment Health Assessment

**DD Form 2796**

Post-Deployment Health Assessment (PDHA)

**DD Form 2900**

Post-Deployment Health Re-assessment (PDHRA)

**DD Form 2977**

Deliberate Risk Assessment Worksheet

## **Appendix B**

### **Internal Control Evaluation Checklist**

#### **B-1. Function**

The function covered by this evaluation is OEHRM.

#### **B-2. Purpose**

The purpose of this evaluation is to assist commanders in evaluating the key internal controls as outlined below (with medical personnel evaluating these key controls or resulting evaluation certified by a 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 internal 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 internal 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 (Internal Control Evaluation Certification).

#### **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 OEHRM activities?
- g.* Are commanders, supervisors, and preventive medicine staff provided basic, specialized, and sustainment OEHRM training that will enable them to properly execute their leadership and staff responsibilities?
- h.* Is OEHRM addressed throughout the DOTMLPF-P process?
- i.* Are OEHRM 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 OEHRM policies and TTP compatible and consistent with comprehensive OEHRM procedures across the Army to include garrison?

#### **B-5. Supersession**

This evaluation replaces the questions previously published for this regulation.

#### **B-6. Comments**

Help make this a better tool for evaluating internal controls. Submit comments to HQDA (DACS-SF) Washington, DC 20310-0200.

## **Glossary**

### **Section I Abbreviations**

**AAE**

Army acquisition executive

**ACOM**

Army Command

**AIPH**

U.S. Army Institute of Public Health

**AMC**

Army Materiel Command

**AMEDD**

Army Medical Department

**AMEDDC&S**

Army Medical Department Center and School

**ARSTAF**

Army Staff

**ASA(ALT)**

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

**ASA(IE&E)**

Assistant Secretary of the Army (Installations, Energy 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

**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

**DHA**

Deployment Health Assessment

**DMDC**

Defense Manpower Data Center

**DMSS**

Defense Medical Surveillance System

**DI**

disease and injury

**DOD**

Department of Defense

**DODD**

Department of Defense Directive

**DODI**

Department of Defense Instruction

**DOEHR**

Defense Occupational and Environmental Health Readiness System

**DOEHR-IH**

Defense Occupational and Environmental Health Readiness System – Industrial Hygiene

**DOTMLPF-P**

Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities and Policy

**DRSi**

Disease Reporting System Internet

**DRU**

direct reporting unit

**EHR**

electronic health record

**ESOH**

environment, safety and occupational health

**FHP**

Force Health Protection

**FORSCOM**

U.S. Army Forces Command

**HQDA**

Headquarters, Department of the Army

**IM/IT**

information management/information technology

**JP**

Joint Publication

**MEDCOM**

U.S. Army Medical Command

**MESL**

Military Exposure Surveillance Library

**MHS**

Military Health System

**NRC**

National Research Council

**OEH**

occupational and environmental health

**OEHRM**

Occupational and Environmental Health Risk Management

**PDHA**

Post-Deployment Health Assessment

**PDHRA**

Post-Deployment Health Reassessment

**PHEO**

public health emergency officer

**RM**

risk management

**ROMO**

range of military operations

**SIPRNet**

Secret Internet Protocol Router Network

**SOH**

safety and occupational health

**TG**

Technical Guide

**TICs/TIMs**

toxic industrial chemicals and toxic industrial materials

**TRADOC**

U.S. Army Training and Doctrine Command

**TSG**

The Surgeon General

**TTP**

tactics, techniques, and procedures

## **USAPHC**

U.S. Army Public Health Center

## **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 Service members 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 or 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.

**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.

**Disease and Injury (DI)**

Injury or degradation of functional capability sustained by personnel and caused by factors other than those directly attributed to enemy action.

**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 Service members, and the MHS to promote, improve, conserve, or restore the mental and physical well-being of Service members 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 sources include the visible portion of 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 risk management (OEHRM)**

The management of mission and Army personnel risks during all phases of Army operations associated with—

*a.* 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.

*b.* 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.

*c.* 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.

*d.* Combat and operational stress

*e.* Non-traditional OEH threats/exposures, such as blast injury and embedded metal fragments; these threats may not be managed through traditional RM activities, but Soldier exposures must be recorded, monitored, reported, and managed.

### **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.

### **Risk management**

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

### **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.

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