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OCCUPATIONAL & ENVIRONMENTAL HEALTH PROGRAM MANAGEMENT

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This manual implements requirements of AFPD 48-1, Aerospace Medicine Enterprise and AFI 48-145, Occupational and Environmental Health Program. It provides guidance on overall Occupational and Environmental Health (OEH) program management and incorporates Risk Management (RM) principles into the OEH program.

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SUMMARY OF CHANGES

This interim change is to clarify conflicting language in AFMAN 48-146 that mandates physicians, nurses and technicians that perform spirometry to have NIOSH certification. Newly published AFMAN 48-146 5.17 "Education and Training of AF HCPs, nurses and technicians" specifically requires physicians, nurses and technicians receive NIOSH certification for interpretation and performance of spirometry. AF Nurses are considered competent to perform spirometry by virtue of their training and certain physician specialties such as pulmonologist are well versed in performance and interpretation of spirometry. The language to this paragraph needs modification to eliminate NIOSH spirometry certification for those who are already proficient by virtue of previous training. Recommended changes to **paragraph 5.17** are as follows.

Chapter 1

OEH PROGRAM MANAGEMENT

1.1. OEH Assessment.

1.1.1. Air Force Instruction 48-145, Occupational and Environmental Health Program, defines routine OEH assessment as "…a qualitative and/or quantitative assessment conducted to identify and scope the processes employed/activities encountered when executing the unit's mission." Special OEH assessment is defined as, "typically a quantitative assessment that focuses resources on OEH-related hazards that require additional evaluation or classification."

1.1.2. The primary purpose of an OEH assessment is to enhance overall mission effectiveness by protecting AF workers from OEH hazards that may be present in home station and deployed environments, whether deliberate or crisis response mode.

1.1.2.1. OEH assessments contribute to how the AF Medical Service incorporates AFI 10-601, Operational Capability Requirements Development and AFI 10-604, Capabilities-based Planning into overall AF required capabilities. Additionally, OEH assessments provide Bioenvironmental Engineering (BE) with an opportunity to update administrative data, review previous OEH assessment information, and document changes to the health risk assessment (HRA).

1.1.2.1.1. OEH assessments rely on firsthand observation, previously collected information/data, and professional judgment (fully qualified Bioenvironmental Engineer (BEE), civilian industrial hygienist, or BE Craftsman (4B071)).

1.1.2.1.2. During routine OEH assessments (deliberate response), BE may verify previous conclusions using point-in-time exposure measurements collected using direct reading instruments and use the information to prioritize and schedule special assessment(s).

1.1.2.1.3. During crisis response assessments BE will follow local written procedures for response to all types of emergencies (fire, chemical spill, accident, terrorist threat, natural disaster, etc.). BE will provide technical expertise to sample, identify, quantify and monitor hazards such as toxic industrial chemicals/toxic industrial materials (TIC/TIM) and chemical, biological, radiological and nuclear (CBRN) material and approve personal protective equipment (PPE) used by AF emergency responders before procurement and use. During emergency (disaster) response assessments refer to AFI 10-2501, Air Force Emergency Management Program Planning and Operations for additional guidance.

1.1.2.2. OEH assessment is accomplished under the direction of a BEE (43E3X/43E4X), civilian industrial hygienist, or BE Craftsman (4B071). BE is encouraged to invite the Installation Occupational & Environmental Medicine Consultant (IOEMC), Public Health (PH) and other OEH-related specialists to participate in the routine OEH assessment process.

1.1.3. OEH assessment is performed IAW requirements specified in AFI 48-145.

1.1.3.1. BE will perform OEH assessments for new process(es) and/or process(es) not previously assessed within 3-months of the process(es) being identified or for before the process has been performed more than three times, whichever is longer. The workplace categories and assessment frequencies established under AFI 48-145 generate minimum requirements for assessment; this does not preclude more frequent assessment activity.

1.1.3.1.1. In a deployed setting, a routine OEH assessment of a Category-1 workplace should be performed during each Air Expeditionary Force (AEF) rotation, Category-2 workplaces should be performed annually or as operational tempo allows.

1.1.3.1.2. During weapon system acquisition the primary purpose is to identify, assess and/or eliminate or control health hazards associated with day-to-day operations across the full life-cycle acquisition, sustainment and support for weapons systems, munitions, and other materiel systems. Aerospace Medical program personnel should work closely with 711th Human Performance Wing and Air Force Human Systems Integration Office subject matter experts to ensure OEH and other related assessments are available to support these critical processes. Refer to AFPD 48-1 and AFI 48-101.

1.2. AF-approved Occupational & Environmental Health (OEH-MIS) Required Use. The Defense Occupational & Environmental Health Readiness System (DOEHRS), which is the DoD software application designed for use by all Services, is the AF-approved OEH-MIS for active duty, Air National Guard (ANG) and AF Reserve Command (AFRC). DOEHRS will be used to archive all OEH exposure data for both garrison and deployed settings (classified areas exempt). Use of other management information systems for OEH assessments in lieu of AF-approved OEH-MIS is strictly prohibited. Other AF-approved management systems are used for documenting and tracking OEH medical exams, injuries and illnesses, and other OEH patient interactions while ensuring protection of personnel health information within the limits of federal laws and regulations. Medical surveillance requirements and official correspondence with workplace supervisors, while created and primarily stored in other systems, could also be uploaded to DOEHRS to maintain continuity.

1.3. Review Process. A qualified reviewer will verify the accuracy and completeness of all exposure assessment data entered in the OEH-MIS (when practicable at deployed locations) according to Flight/Element QC procedures. Arrange a qualified reviewer from another unit if one is not available. A qualified reviewer is a fully qualified BEE (43E3X/43E4X), civilian industrial hygienist (GS-9 or higher), or BE Craftsman (4B071).

1.4. OEH-MIS Training. Department of Occupational and Environmental Health (USAFSAM/OE) provides in-house training to ensure personnel can effectively use the OEH-MIS. Training may include basic data entry and overview training, advanced user training and system administrator training.

1.5. OEH Reports and Surveys. OEH reports and surveys shall be retained IAW AFMAN 33-363, Management of Records. Records and the Occupational Environmental Health Exposure Data (OEHED) for similar exposure groups (SEG) in Category 1 and Category 2 workplaces that identify employees by name must be filed in the employee's medical record IAW AFI 41-210, Patient Administration Functions and AFI 48-145. Employee exposure records are maintained in the OEH-MIS IAW AFI 48-145, and must be preserved, maintained, and readily accessible for data retrieval and analysis for a minimum of 40-years, or 30-years beyond employment,

whichever is greater. DoDI 6055.05, Occupational and Environmental Health, and 29 CFR 1910.1020, Access to Employee Exposure and Medical Records, prescribe procedures for access to employee exposure and medical records. Employee exposure records include the following minimum information according to 29 CFR 1910.1020(c)(5):

1.5.1. Monitoring results, including personal, area, grab, wipe, and/or other samples and related information.

1.5.2. Hazardous Material (HAZMAT) information pertaining to OEH hazards.

1.5.3. Biological monitoring results.

Chapter 2

ROUTINE OEH ASSESSMENT

2.1. General Information. The main objective of a routine OEH assessment is to identify, assess and evaluate process hazards in the industrial workplace and exposure pathways in the non-industrial workplace and areas outside the workplace (ambient environment), and determine if control recommendations are needed and/or adequately implemented. Procedures and guidance for conducting routine OEH assessment activities are outlined in the following paragraphs.

2.1.1. OEH Assessments are divided into two categories: occupational health risk assessment (OHRA) and environmental health risk assessment (EHRA).

2.1.1.1. OHRAs are conducted in workplaces. OHRAs result in representative exposures to a similar exposure group (SEG).

2.1.1.2. EHRAs are conducted in and outside of the workplace and includes ambient environmental conditions. EHRAs result in potential exposures to populations at risk (PARs).

2.1.1.3. The OHRAs and EHRAs are documented in the OEH-MIS, and together support the Longitudinal Exposure Record (LER). Examples of how to document OHRAs and EHRAs in the OEH-MIS are presented in **Table 2.1**.

2.1.2. Multiple workplace OEH assessment techniques exist: routine assessments, special assessments, and Environmental, Safety and Occupational Health Compliance Assessments (ESOH). Accomplishing one type of assessment may satisfy one or both of the others.

2.1.2.1. If accomplishing a routine or special workplace assessment, credit for portions of an ESOH Compliance Assessment and Management Program (ESOHCAMP) assessment may be taken if the assessment meets the intent of AFI 90-803, Environmental, Safety and Occupational Health Compliance Assessment and Management Program.

2.1.2.2. An ESOHCAMP or special assessment(s) can be considered a workplace's routine assessment, if the results/report meet the intent of paragraph 2.1. Additionally, the results of these assessment(s) must be presented to the Occupational & Environmental Health Working Group (OEHWG) so that medical exam impacts can be determined.

2.1.2.3. If accomplishing a special assessment in a workplace, credit for portions of the routine assessment and/or the ESOHCAMP assessment may be taken as long as the results of the assessment meet the intent of paragraph 2.1 for routine assessments (including OEHWG review) and AFI 90-803 for ESOHCAMP assessments.

2.2. Identify and Establish Industrial Workplace. The industrial workplace is typically a physical location, e.g., a specific building, the flight line or the inside of an airplane, where personnel engage in activities associated with actual or potential exposure to OEH hazards. The term "workplace" can encompass the entire occupational and non-occupational environment exposure spectrum; it includes environmental health (EH) hazards in order to effectively use the OEH-MIS to build a comprehensive LER for each military member. At a minimum, specific

OEH hazards must be linked to a workplace or a location. In the OEH-MIS, the term industrial workplace is synonymous to the term "shop".

2.2.1. Occupational Health Risk Assessments (OHRA): The industrial workplace is generally a location where the OHRA is performed. Examples of workplaces where occupational health exposures may occur are provided in the examples below:

2.2.1.1. Aircraft Structural Maintenance: Aircraft Structural Maintenance (ASM) may consist of corrosion control, fiberglass, sheet metal, composite material and welding processes. If the corrosion control process has a dedicated supervisor, office symbol, funding account, etc., and dedicated personnel are assigned, it may be appropriate to establish corrosion control as a separate workplace. However, if personnel assigned to ASM collectively perform corrosion control, fiberglass, sheet metal, composite material and welding processes, ASM should be designated as the workplace.

2.2.1.2. HAZMAT Response Team: A single organization on an installation is typically responsible for overall HAZMAT response; however, personnel from different organizations, e.g., Fire and Emergency Services, Liquid Fuels, Aircraft Maintenance, etc., may be assembled for the HAZMAT Response Team. HAZMAT response comprises a workplace since the team maintains common equipment, stages from a common facility, and has a dedicated supervisor with associated organizational authority/accountability.

2.2.2. Environmental Health Risk Assessments (EHRA): Personnel may encounter the full spectrum of OEH hazards while assigned to a particular duty location; the OEH hazards may be due to ambient environmental conditions or local industrial activities. OEH hazards may present potential exposure risks to a population, and must be linked to a location or subordinate location (sub-location) in the OEH-MIS.

2.2.2.1. Examples of how to link actual or potential OEH exposures as part of the LER in OEH-MIS are shown below in Table 2.1. How to Link Actual or Potential OEH Exposures in OEH-MIS.

2.2.2.2. Refer to AFMAN 48-154 and the Occupational and Environmental Health Site Assessment (OEHSA) TG for additional guidance on identifying and assessing exposure pathways and PARs and linking OEH hazards to locations.

Table 2.1. How to Link Actual or Potential OEH Exposures in OEH-MIS.

OEH Hazard	Source	Type of Hazard/ Assessment	Area of Impact (SEG/PAR)	DOEHRS Details	DOEHRS Module
Chromates	Arcft Sanding Process	OH / OHRA	Structural Maintenance Shop	Shop, Process, SEG	IH Module
Hydrazine	Maintenance Facility	OH / OHRA	F-16 Hydrazine Response Team	Shop, Process, SEG	IH Module
		OH / EHRA	MPF (adjacent to facility)	Subordinate Location – MPF Building	EH Module
Noise	Arcft Riveting from Structural	OH / OHRA	NDI Shop	Shop, Process, SEG	IH Module
		OH / EHRA	Wing Headquarters	Subordinate	EH Module

	Maintenance Shop		Building (Admin)	Location – HDQTRs Building	
Arsenic / various VOC contamination in Drinking Water	Cross-connection failure	EH / EHRA	Entire Installation	Primary Location - Installation	EH Module
Diesel Exhaust	Generator Farm	OH / EHRA	Tent City (Deployed)	Subordinate Location – Sector	EH Module
Fuel Vapor Intrusion	AAFES Gas Station IRP	EH / EHRA	Elementary School	Subordinate Location – School Building	EH Module
		OH/EHRA	Support Group	Subordinate Location – SUPGRP Building	EH Module
PM $_{2.5/10}$	Ambient	EH / EHRA	Entire Installation	Primary Location – Installation	EH Module
Metals in Soil	Historical Trning Site	EH / EHRA	All Central Housing	Subordinate Location – Sector	EH Module
Lead	Ambient	EH / EHRA	Entire Installation	Primary Location – Installation	EH Module
Pesticides and VOCs	Civilian Pesticide Plant	EH / EHRA	Central Housing	Subordinate Location – Sector	EH Module
Trihalomethanes	Water Distribution Lines	EH / EHRA	North Flight line Sector	Subordinate Location – Sector	EH Module
Asbestos	Unauthorized Renovation Project	EH / EHRA	Arts & Crafts Building	Subordinate Location – Arts & Crafts Building	EH Module or IR Module
VOCs	2010 Gulf Oil Spill	EH / EHRA	Entire Installation	Primary Location – Installation	EH Module or IR Module
Forest Fire Contaminates	2008 Summer Event	EH / EHRA	Entire Installation	Primary Location – Installation	EH Module or IR Module

2.3. Basic OEH Hazard Characterization.

2.3.1. Pre-planning Activity.

2.3.1.1. During a deliberate response a qualified reviewer (paragraph 1.3) should audit previous OEH assessment activities to determine a surveillance strategy for the pending OEH assessment (e.g. ventilation, noise and air sampling strategies).

2.3.1.2. During crisis response, the qualified response-lead should focus activities to determine the surveillance strategy.

2.3.1.3. This audit provides foundational knowledge regarding workplace processes, health hazards, health risks, and existing controls. Furthermore, health-based outcome data, e.g., OEH-related illness/injury investigations and/or trends, may provide insight on the adequacy of current OEH hazard characterization and effectiveness of associated

controls. Note: Hazards may be present even in the absence of trends. The OEHWG can provide BE with OEH illness trends related to a specific workplace.

2.3.1.4. Information related to unit mission, operational tempo, and OEH impacts/concerns for assigned personnel is used to determine the scope of required OEH support. This is especially critical when new workplaces/processes are identified. Minimum information that should be collected during pre-planning includes, as applicable: organization name, parent command/headquarters, mission description, description of operations performed, location, and potential exposure locations, e.g. subordinate units, area on installation, name of workplace supervisor (or equivalent) and contact information.

2.3.2. Identify Process(es).

2.3.2.1. Contact the workplace supervisor (or equivalent), as appropriate, to explain the purpose of the OEH risk assessment and identify process(es). Minimum information to be conveyed includes:

2.3.2.1.1. The scope of and schedule for completing routine OEH assessment.

2.3.2.1.2. Status of previously identified findings.

2.3.2.1.3. Adverse trends in clinical surveillance or OEH-related illnesses.

2.3.3. Associate OEH Hazards with Process(es) or Locations.

2.3.3.1. A process is the lowest level of work that may pose a risk, and may require evaluation and control to ensure human health is adequately protected. The terms activity and process are synonymous. Not all processes are associated with a physical location, e.g., working near the flight line may constitute a process. Examples of some OEH processes are provided below:

2.3.3.1.1. Aircraft painting is divided into distinct processes, e.g., primer application, top-coat application, and stenciling operations.

2.3.3.1.2. Multiple plating tanks in a workplace create potential exposures for personnel who move between tanks to accomplish work. This may be defined as a single process, unless there are significant exposure differences or PPE/control requirements among the tanks.

2.3.3.2. Initial and updated OEHSAs conducted IAW AFMAN 48-154, Occupational and Environmental Health Site Assessment, are critical for identifying exposure pathways, generating initial/special assessments, and documenting to a location.

2.3.3.2.1. Potential radon exposure (occupational or non-occupational setting) IAW 48-148, Ionizing Radiation Protection.

2.3.3.2.2. Fugitive emissions, or other OEH hazard, affecting housing or an administrative building from an adjacent industrial operation.

2.3.3.2.3. Force bed-down on a site where hazardous materials may have been buried.

2.3.3.3. Assign an appropriate name to each process or exposure pathway, and provide a clear description. The workplace supervisor (or equivalent) or the OEH hazard source

owner can aid in effectively naming and describing each process or pathway. Guidance for naming a process is provided below. Guidance for naming an exposure pathway can be found in the OEHSA TG.

2.3.3.3.1. A single "painting" process established under ASM is inappropriate due to the unique health hazards and PPE requirements associated with clearly distinct processes, e.g., de-painting, priming, painting, applying top-coat, etc. A better convention would be to name each specific process.

2.3.3.3.2. "Riveting" is too general as a description to identify the scope of this process; "removing and replacing B-52 rivets" is a better and more descriptive choice.

2.3.3.3.3. Weapon system processes and description must be based upon and utilize Technical Order (TO) verbiage.

2.3.4. Establishing Similar Exposure Groups (SEG).

2.3.4.1. SEGs establish a link between a group of individuals and an OEH exposure(s). Representative and/or individual exposure assessment data are applied to personnel assigned to a SEG(s). A SEG can be established by: (1) observing work practices, (2) accomplishing OEH hazard characterization/assessment and using data to define the SEG, or (3) a combination of both activities.

2.3.4.2. A single SEG is adequate if all individuals assigned to a workplace encounter the same OEH hazards and have the same exposure potential. Multiple SEGs are necessary to accurately reflect "representative" exposures for workers assigned to the same workplace, but who are exposed to different hazards and/or exposure potential. Establishing SEGs is a critical step since the SEG reports provide details to define the overall workplace prioritization category.

2.3.4.3. Personnel may be assigned to multiple SEGs and/or assigned to a SEG outside their assigned unit, e.g. an individual may be assigned to a HAZMAT response team, which is composed of individuals from various workplaces.

2.3.4.4. SEG data must be collected and documented for both home station and deployed locations to ensure an accurate LER is maintained for all AF personnel. Upon arrival in theater, the individual must be assigned to the appropriate deployed SEG(s). Home station and deployment exposures will be documented in the OEH-MIS.

2.3.5. Establishing Populations At Risk (PARs)

2.3.5.1. PARs establish a link between a non-industrial group of individuals and an OEH exposure(s) via a common location or sub-location. EHRAs and exposure data are linked to locations. Service members are not directly assigned and managed in PARs like SEGs.

2.3.5.2. A PAR is defined by OEH hazard exposure pathway identified and managed through the OEHSA process. Reference the OEHSA TG for additional details.

2.3.6. Identifying OEH Hazard Controls. BE assesses the adequacy of existing controls and provides OEH hazard control recommendations to workplace supervisors (or equivalent) if required. Control category recommendations will be provided according to the following priority: (1) engineering controls, (2) administrative controls, (3) PPE. (See **Figure 2.1**,

Hierarchy of Controls). A combination of controls may be necessary to reduce exposure to an acceptable level, especially while engineering controls are being designed/installed, or are not feasible.

2.3.6.1. If BE determines technical order control requirements are not adequate or appropriate, BE can submit a change request based on exposure data and recommend appropriate control requirements IAW TO 00-5-1, AF Technical Order System.

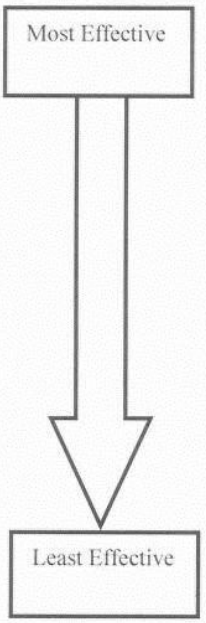
2.3.6.2. BE associates OEH hazard control information to a specific process or location and documents this information in the OEH-MIS.

2.3.6.2.1. Engineering Controls. Engineering controls eliminate or reduce exposure to risk factors and may include, but are not limited to, physical changes to workstations (install local exhaust ventilation), new tools or equipment, materials, processes (wet methods, automation, isolation and enclosure), process elimination or substitution with less hazardous materials. Environmental health hazard controls may include ventilation systems for radon exposure, enclosure for lead-based paint, or an air scrubber for various pollutants. BE must advocate engineering controls to the greatest extent feasible/practical; clearly communicate courses of action to the commanders regarding engineering control solutions and assign risk assessment codes where applicable.

2.3.6.2.2. Administrative Controls. Administrative controls, which manage potential exposure to an acceptable level, include but are not limited to: job rotation, job transfer, limiting exposure time, housekeeping, personal hygiene and education and training. Regulatory requirements prohibit job rotation as a means for controlling exposure to certain contaminants, e.g., asbestos. Administrative controls should be prioritized to maximize effectiveness.

2.3.6.2.3. Personal Protective Equipment. PPE is used when other control options are not feasible or adequate, e.g., during emergency response operations. With the exception of uniquely military situations, PPE requirements will be assessed IAW 29 CFR 1910, Subpart I, Personal Protective Equipment, to ensure appropriate equipment is selected and used.

Figure 2.1. Hierarchy of Controls.



Controls	Examples
Elimination (Engineering Control)	Designed to eliminate hazards such as hazardous materials and noise
Substitution (Engineering Control)	Substitute for less hazardous materials Reduce Energy (e.g. lower speed, force, amperage pressure, temperature, noise)
Other Engineering Controls	Ventilation systems, Process Change, Isolation or Enclosure, Interlocks, Wet Methods, Dilution Systems, Process Automation
Administrative Controls	Safe Job procedures, Rotation of Workers, Adjust Work Schedules Housekeeping and Equipment Maintenance Hazard Communication Training Warning Signs, Backup alarms, Horns, Labels
Personal Protective Equipment	Respirators, Eye, Hand and Foot Protection, Clothing, Barrier Creams Hearing Protection

2.4. OH Exposure Assessment Priority (EAP). If an exposure is unacceptable or uncertain, an EAP must be assigned. EAP indicates the assessor's priority for collecting information. EH does not use the EAP process to assess risk; EH uses the RM process. RM information allows commanders to make informed risk decisions. The RM process does not override or supersede compliance with federally mandated OSHA standards (DoDI 6055.1, DoD Safety and Occupational Health Program, Enclosure 3). If BE has collected sufficient information, then the EAP would indicate a low priority even in situations where the RM would indicate high risk. **Figure 2.2** illustrates the EAP hazard assessment priority process. The OEH-MIS calculates the EAP using a 3-step process:

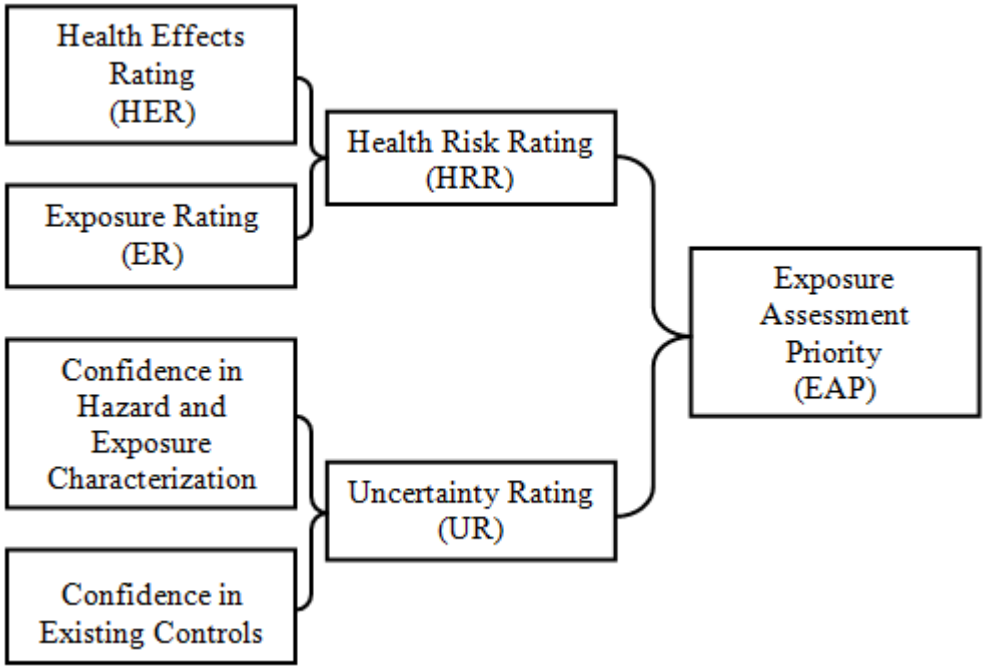
2.4.1. Step 1: Select a Health Effect Rating (HER) (aka Severity). See Section 2.4.5.

2.4.2. Step 2: Select the Exposure Rating (ER) (aka Probability). See Section 2.4.6.

2.4.3. Step 3: Determine the Uncertainty Rating (UR). See Section 2.4.7. The UR is determined by selecting the confidence in hazard and exposure characterization (**Attachment 2**) and confidence in existing controls (**Attachment 3**).

2.4.4. Based on the user selections from the above 3-steps, the OEH-MIS calculates the EAP by multiplying the (HER * ER) * UR. EAP values range from 1 to 125: 1 is the lowest priority and 125 is the highest priority (**Table 2.5**). **NOTE:** The OEH hazard risk determination process follows guidance set forth in AFPAM 90-902, Operational Risk Management (ORM) Guidelines and Tools. The terms, definitions and process may differ slightly but the process is consistent with established guidance.

Figure 2.2. OEH Exposure Assessment Priority (aka Hazard Assessment Process).



2.4.5. Health Effect Rating (HER). The HER is similar to the Severity rating. . For any particular hazard, the HER is a measure/estimate of the health effect related to an individual's exposure without regard to use of administrative controls or PPE (Figure 2.1). The HER is a function of dose (magnitude, frequency and duration of exposure) and response (expected health outcome associated with a particular exposure). The HER is the potential for an exposure to result in an OEH-related illness/injury. Some chemical hazards in the OEH-MIS are pre-loaded with an HER based on an exposure level equal to the Occupational and Environmental Exposure Limit (OEEL).

Table 2.2. Health Effects Rating.

Category	Input Value	Health Effects
Very High	5	Acute life threatening or disabling injury or illness. Immediate hearing loss.
High	4	Chronic irreversible health effects of concern. Noise-induced hearing loss; permanent and temporary threshold shifts, eventually leading to permanent hearing loss.
Moderate	3	Severe, reversible health effects of concern. Irritation of eyes, nose and throat. Acute/short term high risk effects (non-IDLH).
Low	2	Reversible health effects of concern.
Negligible	1	Nuisance/low risk health effects

2.4.6. Exposure Rating (ER). The ER considers the frequency of exposure and the likelihood to exceed the OEEL. The user will make selections based on the values from Table 2.3, Exposure Rating. Contact United States Air Force School of Aerospace Medicine

(USAFSAM) Environmental, Safety and Occupational Health (ESOH) Service Center for assistance selecting the appropriate OEEL and action level if needed.

Table 2.3. Exposure Rating.

Category	Input Value	Description
Very High	5	Continuously experienced; expected to be above the OEEL.
High	4	Likely to be an exposure greater than 50% of OEEL or the action level but less than the OEEL.
Moderate	3	Exposure frequently less than action level or 50% of OEEL and 10% of OEEL.
Low	2	Could occur at some time; exposure infrequent; less than 10% of OEEL.
Negligible	1	Unlikely; can assume will not occur; no detectable exposure

2.4.7. Uncertainty Rating (UR). The UR (Table 2.4) is computed as a function of the confidence in hazard and exposure characterization and the confidence in existing controls as an intermediate value in the calculation of the EAP. For each OEH hazard requiring an EAP determination, assess the confidence in hazard and exposure characterization (Attachment 2) and confidence in existing controls (Attachment 3).

Table 2.4. Uncertainty Rating.

	Confidence in Characterization			
Confidence in Controls		Low	Medium	High
	Low	5	4	3
	Medium	4	3	2
	High	3	2	1

2.4.8. Record the rationale for assigning the HER, ER and UR in the OEH-MIS to establish a historical record of decisions. This is especially important when the decisions are based primarily on qualitative information or professional judgment (fully qualified BEE, civilian industrial hygienist, or BE Craftsman (4B071)).

2.4.9. The EAP can result in a number of priority ratings (Table 2.5) which impact management decisions. Decisions include but are not limited to 1) No action required, 2) Collect additional exposure data (internal/external projects), or 3) Recommend modifying controls or processes. EAP component choices (HER, ER, and UR) also affect management decisions.

Table 2.5. Exposure Assessment Priority.

Priority	EAP Rating	EH RM
Very High	61-125	Very High
High	30-60	High
Medium	16-29	Medium

Low	1-15	Low

2.4.9.1. Workplace Monitoring Plan (Internal) Projects. Internal projects require action/completion by BE within a specified time frame, e.g., sampling. Sampling strategies to complete internal projects should optimize use of resources, e.g., manpower, equipment, in a cost effective manner. The project description should include these minimum elements:

2.4.9.1.1. Specific OEH hazard requiring measurement, e.g., chromates in primer

2.4.9.1.2. Type of sampling or assessment required, i.e., area vs. personal

2.4.9.1.3. Synergistic or additive effects

2.4.9.1.4. Sampling and analytical method used

2.4.9.1.5. Number of required samples to make risk decision (recommend minimum of 3)

2.4.9.1.6. Related SEGs or PARs.

2.4.9.1.7. Start and estimated completion date

2.4.9.2. Discrepancy (External) Projects. External projects are assigned to an organization outside BE for completion. BE will use the OEH-MIS to assign Risk Assessment Codes (RAC) IAW AFI 91-202, The US Air Force Mishap Prevention Program, **paragraph 1.5.17.7.3**.

Chapter 3

SPECIAL OEH ASSESSMENT

3.1. Special OEH Assessment. Special OEH assessments are typically a quantitative assessment of OEH hazards that require additional evaluation based on findings generated during a routine assessment or trigger event. It may include work that is not part of or cannot be completed as part of routine OEH assessment. Examples include, but are not limited to: detailed sampling and analysis of industrial processes or OEHSA exposure pathways, follow-up activity from OEH illness or injury reports, pregnancy evaluations, assessments of abnormal epidemiological trends, lead-based paint HRA, and/or review of engineering/facility modifications.

3.2. Special Assessment. Some special assessments may be required on a recurring basis, e.g., periodic ventilation system evaluations or inspections in a regulated area. All special assessments must be associated with at least one process or exposure pathway documented in the OEH-MIS. Special Assessment. Special assessments will be actively managed, scheduled, completed or deferred using the priority established in **Table 2.5**. In the event special assessments are deferred due to insufficient resources, BE will use the deferred assessment as justification for additional resources. In situations where a special assessment has identified a health hazard that requires action by a "non-BE" entity, a Risk Assessment Code (RAC) should be assigned. RACs are used to assist with prioritizing abatement plans and mitigating hazards, and are the DoD directed tool to communicate hazards to commanders and the AF leadership.

3.3. Exposure Assessment.

3.3.1. A special OEH exposure assessment is accomplished to increase confidence in OEH hazard characterization and/or confidence in hazard control performance. Accurate, valid exposure assessment data form the foundation of an effective OEH program. The American Industrial Hygiene Association publication "A Strategy for Assessing and Managing Occupational Exposures" provides a thorough discussion on numerous tools and methods that can be used to effectively collect OEH exposure data.

3.3.2. Confidence in an OEH hazard characterization may be affected by previous exposure assessments, e.g., quantitative measurement data (obtained locally or consolidated from similar operations from other locations), or estimates of exposure (modeling).

3.3.2.1. Quantitative Measurement Data. Data collected under actual operating conditions for a specific location/process provide an ideal estimate for a given SEG/PAR exposure. Consolidated data for similar operations can be an acceptable substitute with appropriate application of professional judgment by a fully qualified BEE, civilian industrial hygienist, or BE Craftsman (4B071). Detailed information on exposure assessments can be obtained from USAFSAM.

3.3.2.1.1. Screening Assessment. A screening assessment provides an initial estimate of OEH exposure. If one measurement result is far below 10% of an OEEL and variability in the exposure profile is minimal, then one measurement may be all that is needed to have high confidence in exposure characterization. If a measurement is well above the OEEL but variability in the exposure profile is large, the confidence in exposure characterization would be low. However, a minimum of

three samples is recommended to complete a screening assessment. Sampling can be accomplished using a direct-reading instrument or traditional integrated sampling techniques. Screening samples should be random, collected over time, and from different workers within the SEG. If possible, screening samples should be taken on three different days to account for some inter-day process variability. The conditions during each sampling event must be fully documented using a sample narrative. If the 95th percentile of the exposure distribution estimated by the three screening sample results is less than the action level of the OEEL, application of professional judgment by a fully qualified BEE, civilian industrial hygienist, or BE Craftsman (4B071) is required to determine the need for further sampling.

3.3.2.1.2. Detailed Assessment. A detailed assessment is necessary if the results from the screening assessment are inconclusive or indicate further assessment is required. A detailed assessment is conducted to better characterize an exposure. This is done by using all available sample results including past sample results and corresponding narratives. The variance in operations, sampling methods and limitations of analytical methods used must be taken into consideration when performing a detailed assessment.

3.3.2.2. Modeling. Modeling can be used to make a conservative estimate of exposure by demonstrating a worst-case scenario that will result in an exposure well below an established OEEL; however, personnel must understand the limitations of any model before using it to estimate exposures. Modeling is typically an 'order of magnitude' estimate - a qualified reviewer should identify that the model assumptions tend to overestimate exposures. Comparing the OEEL with this exposure overestimate should allow a qualified reviewer to determine if an exposure is 'acceptable' or that more data is needed.

3.3.3. Special assessments may require detailed assessment of existing OEH hazard controls. Confidence in OEH hazard controls is based on an assessment of existing control conditions.

3.3.4. Multiple processes may significantly contribute to the overall exposure during a work shift. Overall exposure may be assessed for a single process or a full work shift (more than one process). Make every attempt to sample as much of the work shift as possible and include segments of greatest exposure during the sampling periods. Cumulative exposure for an 8-hour work shift must be computed prior to comparing sampling results to an 8-hour time weight average (TWA) exposure standard.

3.3.5. A conventional work schedule is five consecutive 8-hour workdays, followed by two days off. Most OEH exposure standards are developed based on application of a conventional work schedule. However, standards based on an 8-hour workday may be inappropriate when applied to unconventional work schedules or extended work shifts, e.g., under deployment conditions. Detailed information on a technique that can be used to adjust for non-standard conditions is provided in **Attachment 4**.

Chapter 4

OEH RISK COMMUNICATION

4.1. OEH Assessment. The OEH assessment process is complete when the risks and results are communicated and the report is sent to the workplace supervisor (or equivalent) via the workplace commander. OEH risk communication is pertinent to SEGs, PARs, OEH hazards outside the workplace as well as industrial and non-industrial workplaces. Supervisors (or equivalents) are expected to address follow-up/corrective actions by the suspense dates provided and reply in writing to BE. All follow-up/corrective actions require BE follow-up until the discrepancy is corrected.

4.2. Immediate Risk Communication. Do not delay in reporting this information under the following conditions.

4.2.1. Immediately Dangerous to Life or Health (IDLH) Environment. When an environment is determined to be IDLH, BE must recommend immediate cessation of process then report condition to workplace supervisor as well as medical treatment facility (MTF) chain of command as soon as possible.

4.2.2. Exposures that exceed OEEL. When an uncontrolled exposure is suspected to be above a relevant OEEL, BE will immediately report that condition to the workplace supervisor, then report through the MDG chain of command as soon as possible.

4.3. OEH Reporting:

4.3.1. Assessment Reporting. The OEH assessment report identifies significant findings, conclusions and recommendations. BE will determine local requirements for including additional information to address base-specific needs. BE will communicate significant findings to the workplace supervisor (or equivalent) at the conclusion of the OEH assessment no more than 60-days after initial contact with workplace supervisor or IAW OSHA standards when applicable.

4.3.1.1. Routine OEH Risk Communication. Attachments to the routine OEH assessment report should be generated directly from information/data archived in the OEH-MIS. Recommended content for routine OEH assessment reports includes:

4.3.1.1.1. Cover letter.

4.3.1.1.2. Summary of health risks and list of current processes which exceed action levels, or exposure pathways with unacceptable exposure.

4.3.1.1.3. Summary of all RACs assigned to the shop/processes

4.3.1.1.4. Recommendations and required follow-up actions, including suspense dates and request to notify BE of completion in writing.

4.3.1.1.5. Direct the workplace supervisor (or equivalent) to make the report and attachments available to all employees IAW AFI 91-202, paragraph 1.5.20.10.

4.3.1.2. Attachments:

4.3.1.2.1. Identified health risk controls linked to specific process(es) and SEG(s), or exposure pathways and PAR(s).

4.3.1.2.2. Certified PPE list (mandatory).

4.3.2. Special OEH Risk Communication

4.3.2.1. The results from the screening and/or detailed assessment will be documented in the OEH-MIS. A special assessment report will be prepared and distributed to the affected commanders, functional managers, or workplace supervisor (or equivalent). For OSHA expanded standard OEH hazards, ensure reporting timelines are IAW OSHA standards. Report format and coordination will be determined by local decision/policy but shall include health risk summary and recommendations/courses of action.

4.3.2.2. BE will establish local procedures to ensure affected individuals receive written notification of special assessment results, e.g., air sampling or noise dosimetry results. Procedures must include requirements for documenting the date sample results are received, for a Quality Assurance/ Quality Control (QA/QC) review and steps for tracking special assessment report completion.

4.3.2.3. Outcomes from special assessments that result in a significant change to the health risk and exposure pathways must be presented to the OEHWG (or equivalent), including plans for additional evaluations and recommendations to reduce risk.

4.4. Occupational and Environmental Health Exposure Data (OEHED). The OEHED is exposure assessment data used to determine the operational risk associated with actual and/or potential OEH exposures and to develop preventive medicine recommendations associated with an individual or SEG.

4.4.1. OEHED is updated as part of the routine OEH and special assessment surveys, or whenever there is a significant change to exposure data, existing controls, or the adequacy of existing controls.

4.4.2. BE will ensure complete OEHED is loaded into the OEH-MIS.

4.4.3. A current OEHED generated from the OEH-MIS will be provided to PH for the OEHWG (as applicable) to determine Medical Surveillance Exam (MSE) requirements.

4.4.4. For Category-1 and Category-2 workplaces, a current copy of the OEHED summary will be filed in the worker's medical record (or uploaded to the electronic medical record if resources allow) at the time of each MSE or departure from the deployed environment.

4.5. OEH Chronological Record. BE will maintain a chronological record of each contact with a workplace in the OEH-MIS. The record must include the date, individual contacted, type of contact (telephone, email, workplace visit, letter sent/received), reason for the contact, and a brief summary of any relevant information discussed/transmitted.

Chapter 5

OCCUPATIONAL AND ENVIRONMENTAL MEDICINE SERVICES: SURVEILLANCE, FITNESS FOR DUTY, CARE AND ADMINISTRATIVE SUPPORT

5.1. General Information. Both Occupational and Environmental Medicine (OEM) are within the scope of Occupational Medicine, a branch of preventive medicine focused on the health and safety of workers in industrial environments and populations exposed to environmental hazards. In the AF, OEM is provided under the oversight and direction of the IOEMC in coordination with PH through Flight Medicine (FM) clinics and, at select bases, by Occupational Medicine Services (OMS) clinics. AF OEM programs, policies and procedures are based on medical science and on agreements, laws, and policies that come from local, state and federal laws and guidelines (e.g. Office of Personnel Management (OPM), Department of Labor (DoL), Office of Workers Compensation Program (OWCP), Division of Longshore and Harbor Workers Compensation (DLHWC), 29 CFR 1910, 5 CFR 339, American College of Governmental Industrial Hygienists, American National Standards Institute, Department of Transportation; union agreements) and on OEM principals. This chapter is primarily a guide to the AF Health Care Provider (HCP) and nurse who may be responsible for supporting OEM at the base level. It also contains sections specifically applicable to PH.

5.2. Eligibility for AF OEM Services (5 CFR 339, AFH 41-114, AFI 41-115, AFI 41-210):

5.2.1. Active Duty (AD) Members. AD members are fully eligible for AF OEM services (typically provided in FM or OMS clinics). They receive care for work related illnesses/injuries in their assigned MTF when the MTF can provide required services or through the TRICARE network as needed.

5.2.2. Air National Guard (ANG) and USAF Reserve (USAFR) Members. ANG members received OEM services through the ANG Medical Group at their assigned wing. USAFR member OEM support is arranged through the Reserve Medical Unit.

5.2.3. DoD Civilian Federal Employees (CFE) Eligibility for OEM services.

5.2.3.1. CFEs receive AF required medical examinations and assessments from AF designated HCP at no cost to the CFE (5 CFR 339.303; 29 CFR 1910). When an MTF lacks the resources to perform a required examination, specialty consult, study or lab, IOEMC may arrange to send the patient to the civilian community (within 25 miles of the base when possible) upon approval of funding from the unit or organization to whom the CFE belongs (see details later in this chapter). The IOEMC is responsible for ensuring results are of adequate quality to protect the CFE and the interests of the USAF.

5.2.3.2. DoD CFEs may elect to seek care for work-related illness and injury within the MTF when and where supported at the discretion of the MTF/CC (See 5 CFR 339, AFH 41-114, AFI 41-115, and AFI 41-210). If a CFE elects care for a work related condition in an MTF that supports provision of care, the CFE must sign a statement designating the AF health care provider as his or her treating physician for the CFEs' Workers' Compensation claimed condition. (See sample form, attachment 5) However, if the CFE previously elected care for the same medical condition through OWCP from a non-AF HCP, the CFE must first obtain a written authorization from OWCP to change providers.

5.2.3.3. DLHWC only applies to NAF employees for whom only one time initial care may be provided (when local policy permits) in an AF MTF prior to being referred by the NAF liaison to care in the civilian community.

5.2.3.4. Some CFEs are covered by insurance other than OWCP and DLHWC (e.g. some DECA members). Specific requirements re: illness and injury treatment may apply. Contact the local base Civilian Personnel Services to learn if any CFEs on base fall into this category.

5.2.3.5. Where resources permit, CFEs can be assessed by an AF HCP to determine fitness to complete a work shift (when requested by the CFE's supervisor) and may be provided with first aid at no expense to the CFE (See Section 37 of AFH 41-114, AFI 41-210).

5.2.3.6. When an AF HCP determines an illness or injury alleged to be work related by the CFE was not caused by factors of AF employment, the AF HCP shall provide no further care or medical work up for the condition.

5.2.3.7. When emergency stabilization prior to transport is indicated for a non-work related condition, this shall be provided and the clinic will notify the MTF resource management office in order to recover expenses.

5.2.3.8. Dual status employees (CFEs who are eligible for TRICARE benefits) may elect medical care for a work related condition through their assigned MTF or TRICARE provider.

5.2.4. Eligibility of OEM Services for Contract workers. Contract workers unless specifically authorized in writing or by official DoD or AF policy are not eligible for care, Fitness For Duty Examinations (FFDEs) or Medical Surveillance Examinations (MSEs) in an MTF and shall obtain OEM services through their employer (AFI 41-210, AFI 41-115, AFH 41-114). If a contract employee presents to an MTF and requires emergency stabilization prior to transport, this shall be provided and the clinic will notify the MTF resource management office in order to recover costs. (Other rules may apply in a deployed setting or if otherwise covered in an AF or DoD contract).

5.2.5. Eligibility of OEM Services for Supervisors, AF Attorneys, Civilian Personnel Services and AF providers: OEM consultative services may be provided to each of these as required for official AF activities.

5.3. Required OEM Examinations and Assessments for CFEs that Exceed Local MTF Capability. Consults, studies, laboratory tests or medical examinations for non-Defense Health Program (DHP) covered medical assessment of CFEs may be ordered when required to support the needs of the AF and when the local Medical Treatment Facility (MTF) has the resources to support the required activity (AFI 41-210). When the MTF does not have resources available, these examinations etc. may also be obtained outside of the MTF at the expense of the CFE's unit or organization per the process described below.

5.3.1. AF HCP Request for Outside Examination or Assessment.

5.3.1.1. Only when doing so is required by or for the AF and the local MTF cannot provide support will the AF HCP order consults, studies, laboratory tests or examinations for a CFE from the civilian medical community. When the purpose of the consult, study,

laboratory test or examination is solely to secure a benefit sought by the CFE and not to meet a need or request of the AF, the CFE is responsible for all costs and should make arrangements. In the absence of written guidance, the AF HCP will first confirm with the CFE's supervisor and CPS that a consult, study, test or examination is required by or for the AF. Prior to contacting the supervisor and CPS, the AF HCP should consider the following three primary reasons for an AF HCP to order an AF funded civilian sector consult, study or test or examination:

5.3.1.1.1. The outside consult, study, laboratory test or examination is required by the AF in order to comply with a law or official policy and the local MTF cannot support internally (e.g. the OSHA Hazardous Noise standard requires interpretation of abnormal audiograms by a qualified HCP but the MTF has no qualified HCP).

5.3.1.1.2. There is evidence to suggest the CFE has a disqualifying medical condition or one that would require work limitations (e.g. post cerebral vascular accident with possible cognitive deficits); the medical information obtainable from the CFE, his or her personal HCP(s) or OWCP treating physician is insufficient to support a defensible medical recommendation to remove or return to extended partial or full duty; and the evaluating AF HCP determines a consult, study, laboratory test or examination is needed to obtain additional information to support a requested medical recommendation to the base Civilian Personnel Services (CPS) or the supervisor.

5.3.1.1.3. The CFE's private physician has provided information in support of a CFE obtaining special treatment or accommodation from a supervisor (e.g. permanently cannot work more than 6-hours a day), but the AF HCP judges the medical assessment or recommendations are inaccurate or inappropriate. However, the AF HCP does not feel he or she can defend a contrasting medical opinion without obtaining a medical consult, study, laboratory test or examination.

5.3.1.2. The AF HCP completes a request for the required examination services on a DD Form 2161 Referral for Civilian Medical Care. When completing this form, the HCP ensures the form and request:

5.3.1.2.1. Meet Referral Management Center (RMC) criteria for a consult or referral.

5.3.1.2.2. Clearly state the request is for assessment only and does not include a request or authorization for actual medical care or treatment.

5.3.1.2.3. The cost estimate for the service requested is included (the ordering clinic will need to verify the cost estimate with an outside service provider).

5.3.1.2.4. Boxes at top of the form and under the patient information section are checked to indicate charges are to be billed to the referring medical treatment facility.

5.3.1.2.5. All portions of the form referring to CHAMPUS are crossed out.

5.3.1.2.6. Under "Information for Civilian Providers of Care" the RMC's office symbol and address are entered along with a note explaining that "Payment will be withheld until receipt of the completed written report."

5.3.1.2.7. Line through "Health Benefits Advisor Signature" and replace with "Referral Management Center Officer Signature." An RMC officer signs in the appropriate space.

5.3.1.3. Tracking the referral process may be facilitated by use of a tracking form (see sample in **Attachment 6**).

5.3.1.4. The acting IOEMC approves or rejects requests for a Line unit or organization funded consult, study, laboratory test or examination. The IOEMC is responsible for ensuring the consult appropriately supports a legitimate AF requirement for clinical assessment and does not authorize medical care or treatment. Unit or organization funding commitment must be obtained prior to sending the consult request.

5.3.2. Obtaining Funding for Outside Examinations and Assessments. Consults, studies and tests that will be done outside the MTF for a CFE must be approved for full payment before they are ordered. If the AF HCP determines a required examination or assessment is appropriate and the local MTF does not have the capability to provide the examination (or a portion of the exam), the MTF may arrange to have the examination (lab tests, etc.) performed in the civilian sector (non-DoD) healthcare community after receiving authorization from the CFE's unit or organization commander guaranteeing payment of the examination. Payment is made from the same appropriation that funds the CFE's salary. The Defense Health Program (DHP) appropriation may not be used for the examination, unless the employee's salary is DHP-funded (e.g., an MTF CFE).

5.3.2.1. The MTF provider's support staff notifies the MTF Resource Management Office (RMO) that a private sector exam is needed for a CFE (the clinic must include the estimated cost of the exam/test).

5.3.2.2. The RMO sends a Request for Commander's Authorization of Payment for Civilian Medical Exam (Attachment 7) packet to the employee's Unit Commander. The packet includes two attachments:

5.3.2.2.1. Commander's Authorization of Payment for Civilian Medical Exam (Attachment 7): This letter serves as the MTF's authorization to schedule the CFE's referral. It also expresses the Commander's acknowledgement that his/her unit's funds will be used for payment of the exam.

5.3.2.2.2. Instructions to the Unit Resource Advisor (Attachment 7): This information sheet explains to the employee's Unit Resource Advisor the steps he/she must take in order for payment to be made to the civilian healthcare provider. Payment will not be made until the exam results are received by the MTF.

5.3.2.3. Once the RMO receives the Commander's Authorization of Payment for Civilian Medical Exam from the CFE's unit, a copy is provided to the MTF clinic. The clinic may then schedule the employee's exam. The clinic coordinates the appointment with the CFE's supervisor, recommending the supervisor direct the CFE to attend the appointment.

5.3.2.4. The MTF clinic that scheduled the CFE's exam must emphasize to the civilian sector provider's office that results of the exam and the associated invoice for full and final payment must be sent to the MTF's Referral Management Center (be sure to provide the address, FAX, point of contact information). The bill is not sent directly to the employee's unit in order to avert Health Insurance Portability and Accountability Act of 1996 (42 USC 1320d-9) (HIPAA) and Privacy Act of 1974, As Amended (5 USC 552a) (Privacy Act) violations, and to ensure the provider receives payment.

5.3.2.5. The RMC will:

5.3.2.5.1. Forward the exam results to the MTF provider that requested the exam.

5.3.2.5.2. Forward the invoice for the exam to RMO.

5.3.2.6. The RMO will:

5.3.2.6.1. Verify that the invoice contains 'Full' or 'Final' payment on the invoice. If the invoice does not state that it is for full/final payment, then RMO must contact the civilian provider's billing office in order to receive a revised bill.

5.3.2.6.2. Process payment according to the option indicated by the employee's unit commander on the bottom of the Commander's Authorization of Payment for Civilian Medical Exam, and the Instructions to the Unit Resource Advisor.

5.3.2.6.3. RMO will not proceed with payment until exam results are received by the MTF.

5.3.2.6.4. Bases with pre-existing agreements between the Line and the MTF that already support execution of required non-DHP consults, studies, laboratory tests and medical examinations for civilian federal employees are not required to replace their agreed to practices in order to comply with this policy.

5.4. Occupational Medicine Examinations. Occupational medicine examinations can be categorized into two main groups: Medical Surveillance Examinations (MSEs) and Fitness for Duty Examinations (FFDEs). The MSE is primarily to determine if similarly exposed CFE and AD workers are adequately protected from exposures of concern. The FFDE is to determine if workers are medically fit to perform in their assigned positions. (DoD 6055.05-M, Occupational Medical Examinations and Surveillance Manual, and AFI 48-145, Occupational and Environmental Health Program; AFI 48-123, Medical Examinations and Standards; 29 CFR 1910; 5 CFR 339)

5.4.1. Medical Surveillance Examinations (MSEs):

5.4.1.1. MSEs protect the health and safety of individual workers and groups of workers with known potential hazardous exposures (e.g. physical, chemical and biological hazards). Individual workers are protected by early detection of abnormalities associated with exposure, subclinical illness or early clinical illness. Early detection enables intervention through control of exposures and, when appropriate, medical management. Trend analysis of exam findings for similar exposure groups is essential for the identification of adverse trends and preventive intervention. As screening tools, MSEs represent an important part of AF medical surveillance.

5.4.1.2. MSE protocols are SEG specific. The Clinical Occupational Health Exam Requirements (COHER) form (previously known as the AF Form 2766 and currently producible in Preventive Health Assessment and Individual Medical Readiness (PIMR) program) is used to identify MSE protocol content by defining examination, education and training requirements for the workers belonging to each SEG.

5.4.1.3. Examination requirements are driven by potential workplace exposures identified on the SEG specific OEHED summary document, the most appropriate action level, AF and DoD policy, official standards (e.g. OSHA standards contained in 29 CFR

1910), accepted references and union agreements (e.g. firefighters). The COHER must clearly identify requirements for baseline, periodic and termination of exposure surveillance exams and all relevant references (e.g. OSHA standards, AF and DoD policy). Certain OSHA expanded standards require a separate termination of employment MSE for employees who remain employed by the AF after previously terminating the potential for further exposure to a covered hazardous exposure (e.g. by transferring out of a particular SEG).

5.4.1.4. The IOEMC determines the MSE requirements contained in the COHER. He or she must be medically credentialed to certify occupational exam requirements. The COHER used to conduct an MSE must be signed and dated by the IOEMC. Guidance for required or recommended immunizations may be included on the COHER.

5.4.1.5. Basis for MSE protocols:

5.4.1.5.1. Preparation of requirements begins with awareness of relevant guidance in OSHA Expanded Standards, DoD 6055.05-M, AFI 48-123, AFI 48-145 and this manual.

5.4.1.5.2. PH assists with creation of COHER protocols by researching requirements and proposing protocol content.

5.4.1.5.3. The IOEMC shall have access to authoritative occupational medicine and toxicology references when reviewing MSE requirements. The Navy "Medical Matrix" program is another potentially useful source. As recommendations may differ by source, careful study, interpretation and medical judgment are needed to ensure appropriate exam protocols. When questions arise, PH and BE OEHWG members can explain the basis for their recommendations. The USAFSAM consultant service provides guidance and maintains a limited number of exposure specific sample COHERs.

5.4.1.6. Special actions required.

5.4.1.6.1. Employees must be notified of the results of their examinations for <u>all</u> MSEs. They shall be advised to seek care from their personal health care provider for any incidental, non-work related conditions detected that require further evaluation or care.

5.4.1.6.2. A number of the OSHA expanded standards (standards containing detailed instruction re: the management and medical management of hazardous materials, contained in 29 CFR 1910) require specific actions (e.g. removal from an exposure, written letter, testing etc.) when certain conditions are observed. Notification letters to the supervisor and employee following routine exams are required for a number of exposures.

5.4.1.6.3. When special requirements exist, the COHER protocol must include an explanation.

5.4.1.6.4. While letters from the AF HCP to both the employee and supervisor do not have to be sent for all MSEs, this is done at the Air Logistics Centers and has the benefits of ensuring compliance with OSHA standards and of providing a consistent means of ensuring both the employee and supervisor know and understand the results

of the MSE. When letters are sent, in addition to any specific OSHA expanded standard requirements, the following content may be appropriate:

5.4.1.6.4.1. Letter to supervisor: the actual results of studies and labs and any medical findings and diagnoses are not included. The supervisor is informed that the CFE or AD member did or did not complete the MSE, does or does not require further work up or return visits, does or does not meet any required certification exam requirements (e.g. Respirator use certification), and may or may not return to full or restricted duty (if returned to restricted duty, limitations and duration are specified).

5.4.1.6.4.2. Letter to the employee: a summary explanation of the results of the examination, studies, labs (when applicable) and of the information sent to the supervisor is included. If the exam revealed a work-related illness for which the CFE or AD member was offered and chose to obtain care at the MTF, the illness is mentioned along with a recommendation to follow up in the appropriate clinic. If a non-work related medical condition requires further work-up and treatment, the AD member is advised to seek care at the MTF and the CFE with his or her private physician. Any relevant lab or study results are provided to the employee to take to his or her provider. If additional work-up or treatment is needed in the AF MTF, the CFE or AD member is informed.

5.4.1.6.5. Worker awareness of the reason for inclusion in the MSE program.

5.4.1.6.5.1. Per 5 CFR 339.205, employees must be notified in writing of the reasons why their work position requires inclusion in the MSE program. This requirement is accomplished by PH when it sends a copy of a new COHER to the SEG supervisor with an explanation of why it applies to the members of the SEG.

5.4.1.6.5.2. PH asks the supervisor to post both the copy of the current COHER and the explanation, to keep copies for employees to access, and to require review by new employees during orientation.

5.4.1.6.6. OSHA has provided mandatory medical monitoring guidance for a number of known exposures (e.g. lead, cadmium, noise, etc.); however, many hazardous chemicals are not specifically addressed by OSHA. OSHA regulates these under the general duty clause (sect 5) of the Occupational Safety and Health Act of 1970 (codified at 29 USC 651-678), which requires employers to provide employees "employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm" (29 USC 654).

5.4.1.6.7. Union agreements may dictate some exam content and services provided. CPS at the base level knows who to contact for copies of existing agreements that may impact MSE content. Union agreements are legally binding but are subject to change through the bargaining process.

5.4.1.6.8. Baseline, periodic and termination MSEs:

5.4.1.6.8.1. Baseline MSEs.

5.4.1.6.8.1.1. Baseline examinations should be performed prior to work in a SEG, but must be performed no later than 60-days after beginning that work

(30 days for baseline audiograms per AFOSHSTD 48-20).

5.4.1.6.8.1.2. Having baseline data can be very useful in determining if (1) the worker can be safely placed in a SEG; (2) pathology not caused by SEG exposures is present; (3) early pathology is beginning to emerge; (4) abnormal findings on later exams represent significant change.

5.4.1.6.8.2. Periodic MSEs.

5.4.1.6.8.2.1. Periodic MSEs are typically annual; however, some exposures may require more frequent monitoring per OSHA standard (e.g. lead, organophosphates). Exam compliance is regularly monitored at the HQ AF Environmental, Safety, and Occupational Health Council (ESOHC).

5.4.1.6.8.2.2. MSEs that are required on an annual basis by OSHA must be completed within 12-months of the last MSE (as specified in multiple but not all OSHA expanded standards). OSHA does not recognize a grace period for these MSEs.

5.4.1.6.8.3. Termination MSEs.

5.4.1.6.8.3.1. Termination MSEs are normally performed when an employee leaves a SEG. Depending on the exposure, there may be allowances for counting the last periodic examination as the termination exam per OSHA, DoD or AF guidance. Where not otherwise required, an MSE accomplished within 180-days of termination may serve as the termination examination.

5.4.1.6.8.3.2. Some OSHA expanded standards require a termination monitoring examination at the time of termination of employment (e.g. asbestos within 30-days of termination). These must be provided even if the employee had an earlier termination exam at the time of leaving a SEG and has worked away from the exposure for months or years prior to terminating employment. These employees shall be tracked to ensure the requirement is met.

5.4.1.6.9. Beryllium workers are those currently or who have previously worked in a SEG with documented exposure to beryllium at or above the AF medical monitoring action level for beryllium of 0.2 $\mu g/m^3$. They receive MSEs annually until termination of employment, regardless of removal from potential beryllium exposure. If at the time of termination of employment the worker is within 90-days of the last MSE for beryllium, that exam will serve as the termination surveillance exam for beryllium. Examinations are performed IAW guidance documents contained in PIMR.

5.4.1.6.10. MSE Scheduling.

5.4.1.6.10.1. MSE scheduling is normally arranged by PH in coordination with the clinic providing the examinations and the IOEMC. PH maintains good communication with the supervisors for each SEG to ensure new and existing workers obtain timely baseline, periodic, termination and when applicable termination of employment MSEs. PH works with workplace supervisors for each SEG with required MSEs to ensure personnel rosters are updated every 6-

months in PIMR.

5.4.1.6.10.2. Final decision authority for establishing a process to schedule MSEs rests with the IOEMC; the local scheduling process will be documented in the OEHWG minutes.

5.4.1.6.10.3. PH tracks MSE completion and maintains records of no show/cancellation rates for clinical surveillance, and coordinates with supervisors to maximize completion rates and to minimize impact on mission where possible.

5.4.1.6.10.4. AF HCPs document all MSE results in the workers' medical records. AF HCPs work with PH to communicate results of MSEs to the individual workers, supervisor and OEHWG within time limits specified by OSHA and/or AFOSHSTDs (e.g. OSHA expanded standard for Lead; AFOSHSTD 48-20 notification requirement for a permanent threshold shift to hearing). AF HCPs ensure scheduling of any required follow-ups and monitoring until completion is accomplished in their respective clinics.

5.4.1.6.10.5. By the fifth work day of each month, AF clinics performing MSEs report to both PH and the IOEMC the number of outstanding MSEs that have not been closed out and completed within 4 weeks of the initial clinic visit.

5.4.1.6.10.6. For AFRC Host Bases:

5.4.1.6.10.6.1. The PH function in the BE/PH office tracks MSE completion rates; conducts trend analysis on OEM data; trains supervisors and shop representatives on OEM programs; provides recommended COHER protocols to a credentialed HCP for review and approval.

5.4.1.6.10.6.2. The Reserve Medical Unit manages the OEM program, schedules MSEs; verifies completeness of MSEs; reports findings of MSEs to members; notifies a member's supervisor of the member's fitness for duty; schedules, coordinates and assesses additional follow up exams, if necessary; identifies and coordinates with PH fitness and risk evaluations; attends the OEHWG; and manages incomplete and overdue MSEs with the Unit Commander, First Sergeant, and Unit Health Monitor.

5.4.1.6.10.7. There are two systems for scheduling exams, by SEG and by MSE anniversary:

5.4.1.6.10.7.1. When practical, exams are arranged to correspond with the annual review of the COHER, which is in turn tied to the BE's periodic surveillance of a SEG. Ideally, the workplace assessment takes place first; followed by the next scheduled OEHWG and then all SEG members have their annual exam the following month. This system minimizes non-compliance and the need for more frequent examinations for a whole SEG when exposure and regulatory changes are identified as requiring a change to a SEG's COHER.

5.4.1.6.10.7.2. At some workplaces and bases, employees are frequently moved between SEGs or deployed. It may be more practical to track employees and their monitoring exams by worker MSE anniversary. When

appropriate, active duty members may be scheduled for both a preventive health assessment and an MSE at the same time. However, the two are distinct exams and the requirements of both must be clearly met and documented in the medical record. While there is a potential for some time savings and some redundancy may be avoided, adequate time and attention must be taken to ensure both assessments are properly completed.

5.4.1.6.10.7.3. Regardless of the scheduling system used for Category 1 and 2 SEGs, the current OEHED summary and the current MSE protocol (COHER) are filed in the worker's medical record at the time of the MSE (or uploaded to the electronic medical record if resources allow). For deployed settings, workers who belong to a SEG with an OEHED should have a copy filed in their medical record (DD Form 2766) prior to departure from the deployed location.

5.4.1.6.11. MSE compliance rates are reviewed at the OEHWG, Aerospace Medicine Council and reported to the installation ESOHC. Any SEG with less than 90% MSE currency is reported by PH or FM/OMS to the Squadron/Directorate CC and SEG leader.

5.4.1.6.12. Failure of an employee to submit to a required MSE represents a risk to the health and safety of the worker. When there is no legitimate reason for failure to comply (e.g. extended deployment or other prolonged absence) and after repeated contacts to request compliance by PH or the clinic scheduler, the HCP may recommend in writing to both the employee and the employee's supervisor removal of the worker from the SEG's hazardous exposures pending examination compliance. This recommendation is included in the employee's medical record with an explanation that the employee's failure to participate in medical monitoring interferes with protection of the employee's health and safety in the presence of the potential hazardous exposures of concern.

5.4.2. Fitness for Duty Examinations (FFDEs): [Except where AD members are specifically identified, this section only applies to CFEs; fitness for duty of AD members is covered in AFI 10-203, Duty Limiting Conditions].

5.4.2.1. Background:

5.4.2.1.1. FFDEs are used to inform supervisors and CPS personnel, enabling them to make and execute appropriate administrative decisions (e.g. actions to hire, deny, accommodate, remove, restrict or return to duty a CFE with a known or alleged potentially work limiting medical condition). Positions requiring an FFDE have essential functions that are safety, security, or both safety and security sensitive. This means that if the worker is unable to perform the assigned tasks properly, safety, security, or both could be compromised. **A FFDE may be required for positions that have specific medical standards, physical requirements, or are covered by a medical evaluation program**

5.4.2.1.2. CPS or a supervisor typically requests an AF HCP perform a FFDE on a CFE either via a formal written request (e.g. a new hire pre-placement examination or a formal fitness for duty request) or through an established policy (e.g. supervisors

are provided an AF HCP recommendation for regular duty or restricted duty following an annual firefighter physical or whenever a new medical condition is identified by the AF HCP). CPS and the supervisor ensure the AF HCP is informed of all functional requirements, environmental factors and any applicable medical standards that pertain to the CFE's current or applied for work position.

5.4.2.1.3. When an AF HCP performs an FFDE, he or she assesses each identified potentially limiting medical condition relative to the functional requirements and environmental factors of the position. He or she determines what, if any, limitations or restrictions to assigned duties are needed to ensure the worker can safely (i.e. without risk of harm to self or others) accomplish assigned job functions in the work environment. The AF HCP does not recommend termination or separation of an employee.

5.4.2.1.4. The supervisor or CPS, not the AF HCP, decides if recommended medical limitations and restrictions can and will be accommodated and whether a worker will be retained or terminated. They determine if a CFE's request for reasonable accommodation will be supported or denied.

5.4.2.1.5. If a CFE attempts to secure a benefit from his or her supervisor or the AF for a medical condition, the CFE should obtain an examination at his or her own expense outside of the AF (5 CFR 339.304).

5.4.2.1.6. An AF HCP must not perform a FFDE on a CFE for the purpose of determining eligibility for coverage under the Family Medical Leave Act.

5.4.2.1.7. In the event of a mishap or security failure, an investigation may be requested to determine the appropriateness of fitness recommendations made by the AF HCP. It is important to have adequately documented in the medical record the rationale for recommended restrictions or return to unrestricted duty.

5.4.2.2. Sources of information required to perform FFDEs:

5.4.2.2.1. CPS or the supervisor is responsible for identifying the functional requirements, environmental factors and any applicable medical standards on the Optional Form 178, "Certificate of Medical Examination" (OF 178) or equivalent form. The form can refer to an attached Position Description or cite a specific medical standard. A full copy of an applicable medical standard does not need to be attached, but the AF HCP must be provided a means of accessing the medical standard (e.g. the clinic would need a copy [electronic or physical] of the currently accepted version of the National Fire Protection Association (NFPA) 1582 "Standard on Comprehensive Occupational Medical Program for Fire Departments, 2007 Edition, Occupational and Environmental Health Site Assessment Technical Guide" for firefighter examinations; and a current and SG approved copy of the AF Technical Instruction Guide (TIG) for the same publication).

5.4.2.2.2. The CFE is asked to provide the AF HCP a relevant medical history appropriate to the requirements of the position. This will often require complete past medical, surgical and social histories. However, a family history is not taken as this would be a violation of the Genetic Information Non-disclosure Act. Additional past medical information may be needed:

5.4.2.2.2.1. When the job involves safety or security sensitive activities, the CFE is asked if he or she has any active Workers' Compensation claims or Veterans Affairs (VA) accepted conditions. If there is an active Workers' Compensation claim, he or she must provide the AF HCP a current summary of covered medical conditions and recommended work restrictions from the treating HCP or clinic and a copy of the most recent Workers' Compensation letter showing the accepted condition(s) and any prescribed work restrictions. If there is an accepted VA medical condition, a copy of the "VA rating decision" document must be provided to the AF HCP for review.

5.4.2.2.2.2. If the applied for position involves a security clearance or requires continuous alertness, physical coordination, and good judgment in the interest of safety, the CFE is asked to report any history of drug or alcohol dependence and any chronic pain conditions treated regularly with controlled substances. If previously in a rehabilitation program, the CFE is asked to release all discharge summaries for review by the AF HCP (review may identify the need for further information release to confirm adequate treatment and compliance). Documentation of the objective portion of the exam includes observed functional abilities and deficits relevant to the CFE's job requirements and work conditions.

5.4.2.2.3. When requesting additional medical documentation from a CFE, it is appropriate to request that the employee arrange to have the information sent directly from the outside clinic, hospital or provider to the AF HCP to ensure the integrity of the information. The CFE is responsible for any costs involved. If a CFE refuses to release requested information that is needed in order to determine if medical restrictions are needed to ensure safety or security, it is appropriate for the AF HCP to write a recommendation to CPS and the supervisor recommending restrictions to work activities in the interest of safety (and security when applicable) pending the CFE's release of the requested medical information.

5.4.2.2.4. The AF HCP's clinical assessment must include review of any information provided by the CFE from his or her personal HCPs.

5.4.2.3. Specific FFDEs and types of FFDEs:

5.4.2.3.1. Formal FFDEs, including New Hire Pre-placement FFDEs:

5.4.2.3.1.1. Requests for Formal FFDEs are made by CPS or the supervisor in writing and are accompanied by an OF 178 or equivalent form. As described previously, the request must include all functional requirements, environmental factors and refer to any applicable written medical standards. If these do not appear to be appropriate to the position, the AF HCP contacts the supervisor or CPS to work a resolution. These requests are made when (unless otherwise stated in DoD or AF policy): 1. A newly hired CFE is assessed to determine if medically qualified for an applied for position; 2. An existing employee applies for a new position; or 3. The supervisor questions the CFE's long term medical capacity to safely perform the essential functions of his or her assigned position. [Note: A formal FFDE is not typically performed on a CFE who is expected to fully recover from a recent illness or injury or who has a condition requiring accommodations that do not significantly impact performance of essential job

functions.]

5.4.2.3.1.2. The primary purpose for performing a Formal FFDE is to ensure the CFE is medically qualified to safely perform the essential functions of the assigned position with or without limitations and without risk to the health and safety of the CFE and others. However, the examination may also later serve as a baseline for assessments of whether or not a claimed injury or illness was caused or aggravated by factors of employment.

5.4.2.3.1.3. Specific recommendations made by the AF HCP to the supervisor or CPS on the SF 78 or its replacement are usually limited to determining whether the individual meets the medical requirements of a specific position and can, from a medical standpoint, perform the job capably and safely. This determination falls into one of the following three categories:

5.4.2.3.1.3.1. Medically Qualified - The AF HCP documents "Medically qualified without limitation." The individual meets all medical requirements for the position and is capable of performing all essential functions without risk to self or others and requires no functional or environmental restriction

5.4.2.3.1.3.2. Medically Qualified with Restriction(s) - The AF HCP documents "Medically qualified with accommodation of the following restrictions:" then specifies the restrictions (and their duration) to work activities that are necessary to allow the CFE to safely perform the functions of the job. For example, a CFE with severe degenerative joint disease of the knee and who is assigned to a position where he is expected to climb stairs or a ladder could have a restriction of "no climbing or descending steep stairs or ladders." A potential accommodation would be the use of a lift or – provided climbing (or reaching an elevated height) is not an essential function of the job – reassignment to work where no climbing is required. The duration of the recommended restrictions should be specified. Before making permanent restriction recommendations, it is important to contact the supervisor to determine if the restrictions can be accommodated and if they would prevent performance of essential functions.

5.4.2.3.1.3.3. Not Medically Qualified – this recommendation is only made when there is very clear evidence the worker has a medical condition that could not be accommodated to allow the worker to perform the essential functions of the job (e.g. severe cognitive disabilities or mental deficits incompatible with essential functions; recurrent non-compliance with medication by a schizophrenic who handles hazardous materials or weapons). Non-44U providers and those who have not previously recommended workers as "not medically qualified" will consult with a senior AF 44U (e.g. the AFMSA OM Consultant or the USAFSAM OM Field Consultant) before making this recommendation.

5.4.2.3.1.4. If permanent restrictions are recommended, the examining HCP prepares a case summary statement in the CFE's medical record. The case summary is confidential medical information and is not routinely provided to the supervisor or CPS (Section 504, Public Law 93-112, Rehabilitation Act of 1973

(29 USC 701 et seq) As Amended, DOD 6055.05 M). The medical record contains protected health information that cannot be disclosed under HIPAA without consent of the CFE.

5.4.2.3.1.4.1. Case summary content: case summaries may later be required to validate a disability retirement application or a CFEs' Compensation claim, or as evidence in a legal hearing. The summary includes a relevant medical history and clinical findings (to include specialty consults, studies, labs etc.), an assessment of the prognosis and whether or not the CFE's medical condition has reached maximal medical improvement, and the rationale for the recommended work limitations and duration. The case summary also contains the recommended limitations to work and their duration. Finally, it explains how specific essential job functions cannot be safely performed if recommended restrictions are or are not accommodated.

5.4.2.3.1.5. As previously mentioned, the supervisor or CPS, not the HCP, makes the decision to accommodate or not accommodate and to hire or terminate a CFE.

5.4.2.3.1.6. Rules regarding the role of occupational medicine in the reasonable accommodation process, as well as for medical documentation and medical confidentiality in the accommodation process, are further addressed in Chapter 6 of AFI 36-2706, Air Force Equal Opportunity Program, Military and Civilian, 5 October 2010].

5.4.2.3.2. Security Clearance FFDEs and Record Reviews

5.4.2.3.2.1. The Personal Security Program requires initial and periodic review of medical records by an AF medical authority to ensure CFEs do not have a medical or mental condition or are taking a medication that would potentially make a CFE unfit to hold an existing or applied for security clearance (AFI 31-501). These reviews may be requested by the employee's servicing security activity.

5.4.2.3.2.2. Disqualifying conditions include those that would be expected to cause defective judgment or reliability (see DoD 5200.2-R for examples). A review may reveal the need for additional information in the form of an AF clinical assessment and/or release of outside clinical information (such information is sent directly from the outside clinical source to the evaluating HCP to prevent potential alteration by the CFE).

5.4.2.3.2.3. Additional reasons for conducting such a review include a direct request from leadership or detection of a potentially disqualifying condition by a HCP during other clinical activities. A recommendation to suspend a CFE's access to classified materials is made to <u>both</u> the CFE's supervisor and commander (or civilian equivalent). Commanders have the authority to suspend access to classified information. Consults for a psychiatric assessment of a CFE must be done IAW the guidance provided elsewhere in this chapter.

5.4.2.3.3. Surety FFDEs. Surety workers (including AD members). Guidance re: medical requirements for Presidential Support Program (PSP) can be found in DoDD 5210.55 Department of Defense Presidential Support Program and DoDI 5210.87 Selection of DoD Military and Civilian Personnel and Contractor Employees for

Assignment to Presidential Support Activities (PSAs). Guidance re: the Personal Reliability Program (PRP) can be found in DoD 5210.42-R/AFMAN 10 – 3902 and AFI 31-501 Personnel Security Program Management. The medical portions of these programs are managed under the direction of the local SGP.

5.4.2.3.4. Medical Standard Based FFDEs

5.4.2.3.4.1. Medical standards and medical guidance.

5.4.2.3.4.1.1. A medical standard is a written description of medical requirements for a particular occupation (e.g. firefighter) based on a determination that a certain level of fitness or health status is required for successful performance (5 CFR 339.104).

5.4.2.3.4.1.2. Medical guidance in the form of potentially disqualifying medical conditions and recommended medical considerations is not a set of "requirements," but rather information to assist the AF HCP in considering those medical conditions that may interfere with the safe performance of assigned functions in the assigned workplace.

5.4.2.3.4.2. When an AF HCP assesses a CFE for medical qualification and applicable medical standards or guidance exist, the AF HCP must individually assess each potentially disqualifying medical condition discovered relative to the functional and environmental requirements of the assigned or proposed position (per 5 CFR 339). This requirement applies regardless of what is written in a published medical standard. It also applies to potentially disqualifying medical and psychiatric conditions for which there may be no medical standard, based on the knowledge and judgment of the AF HCP. In other words, a CFE is not summarily restricted or disqualified based on a diagnosis or medical history.

5.4.2.3.4.2.1. The AF HCP must provide adequate documentation in the medical record to make it clear he or she assessed each potentially disqualifying medical condition and then determined whether that condition is incompatible with job requirements and safety. As explained earlier, the AF HCP recommends work restrictions when appropriate. When restrictions are recommended, medical qualification or disqualification is accomplished when CPS or the supervisor decides to accommodate or not accommodate the recommended restrictions.

5.4.2.3.4.2.2. For example, a firefighter applicant is potentially medically disqualified IAW the NFPA 1582 medical standard because of his history of coronary artery disease. If he has excellent heart function he would not necessarily require a work limitation or be medically disqualified; while a CFE with an ejection fraction of 40% and who can only achieve eight metabolic equivalents on a treadmill test would require specific and probably disqualifying work limitations. In other words, if using the 2007 version of the NFPA 1582, the AF HCP MUST make an exception to the written guidance in order to meet the above requirement to perform an individual assessment. This does not necessarily mean paying for tests and studies, but would require review of relevant medical information from the CFE's private

HCP.

5.4.2.3.4.3. The DoD and AF have published medical standards for various positions and functional requirements. For example, DOD 5200.2-R describes psychiatric conditions that may be disqualifying for activities requiring a security clearance. DoD 6055.05M (2007) provides medical standards and guidance for DoD civilian police. The AF has published "Technical Implementation Guide 1582-07 for NFPA 1582, Standard on Comprehensive Occupational Medical Program for Fire Departments, 2007 Edition."

5.4.2.3.4.4. Medical standards can change on a schedule independent from this publication and can be found on the AF and DoD electronic publication web pages or the Occupational Medicine webpage on the AF Knowledge Exchange. The AF typically adheres to the OSHA expanded standards which may direct questions to ask when assessing a CFE's fitness to participate in certain activities (e.g. OSHA Respirator Medical Evaluation Questionnaire (Mandatory) 29 CFR 1910.134 App C). OSHA standards are updated quarterly and can be found at **http://www.osha.gov**/. In some cases, the AF has more restrictive standards (e.g. Beryllium).

5.4.2.3.4.5. All AF specific medical standards and similar guidance regarding potentially disqualifying medical findings and conditions must be formally approved by the AF/SG, AF/SG2 or AF/SG3.

5.4.2.3.4.6. Published medical standards may have modifications that have been bargained with a labor union. The local CPS normally has a labor relations representative who is aware of local union agreements that may pertain to an AF or DoD medical standard. (For example, medical exam requirements for firefighters have been bargained locally).

5.4.2.3.5. Disability Retirement Package Reviews and FFDEs.

5.4.2.3.5.1. When a CFE applies for disability retirement or when it appears the AF must make the application on behalf of a CFE, CPS may request an AF HCP review application materials and make a written statement back to CPS commenting on whether or not the materials provided support OPM medical requirements for disability retirement. It is the employee's responsibility (when capable) to obtain and submit required medical information in support of his or her application.

5.4.2.3.5.2. The OPM criteria for disability retirement that pertain to the AF HCP review include: sufficient medical documentation to support the conclusions that the employee has a medical condition that precludes useful and efficient service; the condition must be expected to continue for at least 1-year; and the employee cannot be retained through reasonable accommodation and/or reassignment to a vacant position.

5.4.2.3.5.3. The diagnostic or clinical impressions must be justified IAW established diagnostic criteria and the conclusions and recommendations must be consistent with generally accepted medical principles and practice (CRCRS and FERS Handbook).

5.4.2.3.5.4. If the reviewing AF HCP determines he or she needs to perform a direct clinical assessment, he or she may recommend CPS make a written offer to the employee (or the employee's guardian) to have the AF HCP perform that assessment in support of the disability retirement application at no cost to the employee. If the employee accepts, CPS sends a written notification to the AF HCP requesting the examination and explaining the offer was accepted by the employee or guardian.

5.4.2.3.6. Pregnancy and Fetal Protection Assessments.

5.4.2.3.6.1. Fetal Protection/Reproductive Risk Program. All workers, to include CFE, AD, and traditional reservists (TRs), both male and female, are made aware of reproductive risks and protective measures in the workplace through the appropriate occupational health program (e.g. Hazard Communication, Hearing Conservation Program, and Radiation Protection). A pregnant CFE may request an individual workplace reproductive health hazard exposure assessment and, if potential hazards are identified, a medical consultation. Those desiring these services should make an appointment to be seen in PH for assessment. The fact that the AF makes available individual workplace reproductive health hazard exposure assessments and medical consultations does not confer a right on the employee to have assigned duties altered. Such workplace alterations will be made in accordance with the needs of the AF and with legal requirements. Pregnancy is not a disability and, absent complications, does not entitle the employee to a reasonable accommodation. Additionally, HCPs refer all pregnant AD members to PH. (The Pregnancy Discrimination Act of 1978 (Public Law 95-555, 92 Stat. 2076))

5.4.2.3.6.2. Pregnant AD and TR members.

5.4.2.3.6.2.1. AF HCPs managing a pregnancy notify PH at onset and recommend limitations on an AF Form 469 IAW AFI 44-102 (if the pregnancy is being managed by a civilian HCP, the civilian HCP's recommendation is provided to the AF HCP who then completes an AF Form 469. (TR Airmen provide the documentation to their medical unit following a similar process as AD with civilian HCP)

5.4.2.3.6.2.2. In coordination with PH, the AF HCP reviews the BE assessment of workplace exposures of concern relative to the pregnancy and then recommends appropriate work restrictions to the supervisor. The HCP will make the final decision.

5.4.2.3.6.2.3. All pregnancy related AF Form 469's are reviewed by an IOEMC appointed physician prior to release of the profile to the member's commander. The reviewing physician ensures recommendations are made that would adequately protect the worker and fetus from work place exposures and that work restrictions are consistently applied where possible (variations are expected given potential maternal health conditions, different workplace factors and the individual medical recommendations of the obstetrics HCP). See AFI 10-203 and AFI 44-102 for additional guidance.

5.4.2.3.6.3. Pregnant Civilian Federal Employee Voluntary Assessment.

5.4.2.3.6.3.1. Pregnant CFEs who elect to undergo an exposure assessment and medical consultation are interviewed by PH. If they work in an industrial environment, PH sends BE a request for a workplace exposure assessment (the same process as for AD members). PH drafts a letter for the worker setting out any recommended changes to the worker's duties in a potentially hazardous environment and forwards the electronic copy to the IOEMC appointed physician. The CFE is then scheduled to see the same IOEMC appointed physician. (The employee is asked to bring any recommended work limitations previously provided by her obstetrics HCP.)

5.4.2.3.6.3.2. After review of the BE, PH and obstetrics HCP materials and examination of the CFE, the IOEMC appointed HCP makes any necessary changes to the PH draft letter, ensuring it clearly identifies any recommended changes to the worker's duties and their duration.

5.4.2.3.6.3.3. The authoring HCP signs and dates the letter and sends it to the employee only and places a copy in the medical record. The corresponding medical record entry is subject to medical confidentiality rules. Should the employee wish to seek alteration of job duties based on the recommendations, the employee may provide a copy of the letter to the supervisor.

5.4.2.3.6.3.4. The HCP may send work limitation recommendations directly to the pregnant CFE's supervisor only if those recommendations are based on a direct threat to the health or safety of the worker or co-workers (i.e., not based on fetal protection).

5.4.2.3.7. Breast feeding.

5.4.2.3.7.1. A number of industrial chemicals and medications are potentially transmitted in breast milk. A small number of known chemicals are concentrated in breast milk at levels higher than are found in the mother's blood. However, medical literature on the risk to breastfed children of industrial working mothers is very limited.

5.4.2.3.7.2. AD and civilian mothers returning from maternity leave who plan to continue breast feeding and to resume work in a SEG with hazardous chemical exposures are reminded of the option to see PH for an assessment.

5.4.2.3.7.3. After interviewing a breast feeding worker, PH consults with BE and then the IOEMC appointed HCP who will determine what (if any) work limitations are recommended. These recommendations are provided in a written letter to the employee only, and a copy placed in the medical record. These recommendations are subject to medical confidentiality rules. Should the employee wish to seek alteration of job duties based on the recommendations, the worker may provide a copy of the letter to the supervisor.

5.4.2.3.8. Psychiatric FFDEs.

5.4.2.3.8.1. Psychiatric Consults:

5.4.2.3.8.1.1. Before ordering the psychiatric consult, the medical record

entry should clearly show if the consult is being ordered or offered and for what reason.

5.4.2.3.8.1.1.1. Ordered psychiatric assessment. The AF may order a psychiatric consult on a CFE only when (1) the CFE has already undergone a general medical examination and it is found that there is no physical explanation for actions which may affect the safe and efficient performance of work by the CFE or others; or (2) a psychiatric examination is specifically required for medical qualification for a position according to written medical standards.

5.4.2.3.8.1.1.2. Offering a psychiatric assessment. When a CFE does not meet the criteria to order a psychiatric examination, the AF may only offer one to a CFE in order to make an informed management decision. This may be appropriate when a CFE requests a change in duty status, assignment, work conditions or any other benefit or special treatment for an alleged psychiatric condition or when the individual has a performance or conduct problem which may require AF action.

5.4.2.3.8.1.2. The consult may only be used to inquire into a person's mental fitness to successfully and safely perform the duties of his or her position without undue hazard to the CFE or others (5 CFR 339.301).

5.4.2.3.8.1.3. A CFE who claims he or she has a psychiatric condition that caused a behavior at work or necessitates a special accommodation is responsible for providing supportive medical evidence; the CFE is asked to have all relevant medical information sent directly to the AF HCP from the CFE's treating HCP.

5.4.2.3.8.1.4. If, after review of the CFE's outside medical information, the AF HCP determines an additional AF funded consult is needed in order to properly further assess the case and adequately advise the supervisor; or when a CFE is exhibiting behavior that warrants psychiatric assessment, but the CFE is unwilling to pay for an evaluation because he or she thinks there is nothing wrong with him or herself and is willing to submit to a psychiatric evaluation; then the AF HCP may order or offer (see above) a psychiatric consult (see additional criteria below). Psychiatric functional tests alone (without an assessment by a psychologist or psychiatrist) are inadequate evidence upon which to determine fitness for duty.

5.4.2.3.8.1.4.1. Before offering or ordering a psychiatric assessment, the AF HCP must confirm this can be provided in the local MTF or must confirm the CFE's unit or organization will fund sending the CFE to an outside mental health care provider (not telling the unit or organization the diagnosis or type of provider).

5.4.2.3.8.1.4.2. If the assessment is offered, the CFE's choice to submit to or decline the exam is clearly documented in the medical record.

5.4.2.3.8.1.4.3. When applicable, the CFE is asked by the AF HCP ordering the consult to arrange for medical summaries to be sent by their private

psychiatric HCP(s) to the mental health consultant well in advance of the scheduled appointment.

5.4.2.3.8.1.4.4. The AF HCP consult request states very clearly that the consult is for the purpose of assessment only. The consult request does not ask for or authorize treatment.

5.4.2.3.8.1.4.5. The work requirements and environmental factors (e.g. SF 78 and position description) are sent with the request.

5.4.2.3.8.1.4.6. The quality of the evaluation can be greatly enhanced by giving the consulting psychiatric HCP approval to conduct psychological testing if needed.

5.4.2.3.8.1.4.7. The consult request should contain an explanation of precipitating events. (e.g. CFE reports receiving special messages from an inanimate object in the workplace).

5.4.2.3.8.1.4.8. The consulted psychiatric HCP must not be the CFE's treating provider and preferably has no direct ties or obligations to the treating psychiatric HCP.

5.4.2.3.8.1.4.9. The following questions are recommended for inclusion in the consult: Has the CFE been and is he or she responsible for his or her words and deeds? Is the CFE capable of consistently and safely performing assigned duties with or without specific limitations (if limitations, what are these and of what duration)? Has the CFE complied with recommended treatment? Has the CFE adequately cooperated to allow performance of a thorough assessment? Did the CFE release all relevant medical information from personal treating HCPs and programs that was needed for this psychiatric assessment? Did the CFE authorize the evaluating mental health care provider to talk to his or her supervisor? What is the diagnosis and prognosis? If medications have been prescribed, please explain. Has the CFE reached maximal medical improvement? If the CFE has a security clearance, the request asks if the CFE has the judgment and ability to consistently safeguard classified information. If the CFE carries a weapon, works in a hazardous environment, or performs other safety sensitive tasks, the request should include questions re: safety to participate in these activities.

5.4.2.3.8.2. Psychiatric referral.

5.4.2.3.8.2.1. A referral of a CFE within the AFMS for psychiatric care may only be made if endorsed by the IOEMC after confirming a work related condition exists (in consultation with a psychiatrist or psychologist), MTF resources support, AND when managing a Civilian Expeditionary Workforce (CEW) employee who qualifies for care per DoD guidance.

5.4.2.3.8.2.2. Other CFEs with psychiatric illness obtain care in the civilian sector at their own expense and apply for coverage through OWCP, DLHWC, or a supplementary compensation insurance if they believe their condition is

work related.

5.4.2.3.9. Workers' Compensation Case Assessment FFDEs.

5.4.2.3.9.1. The AF can require that a CFE undergo a formal FFDE by an AF HCP for the purpose of determining appropriate work limitations that may affect placement decisions when the employee has applied for OWCP coverage of work related illness or injury. OWCP must be notified when a CFE fails to show for the examination.

5.4.2.3.9.2. When a CFE has an OWCP recognized treating physician for a work related condition other than the AF HCP for an OWCP accepted medical condition, work limitations specified by the treating physician must be adhered to and less restrictive limitations must not be recommended directly by the AF HCP. However, the AF HCP may recommend to the supervisor and to CPS additional or more restrictive work limitations.

5.4.2.3.9.3. In accordance with 20 CFR 10.506, the AF cannot phone the OWCP treating provider to discuss or ask for information re: an OWCP case, but may do so in writing or electronically (ensure the CFE has signed an approved release of information both for the content of the letter written and for the treating physician's reply). The AF has a right to request and obtain copies of the treatment records in a compensation case without a release from the patient (AF HCPs make such requests through the Installation Compensation Program Administrator or through the OWCP district office). Refusal on the part of an employee to release OWCP related information or to submit to an AF ordered examination may adversely impact the CFE's future employment with the AF.

5.4.2.3.9.4. The AF has the right to require a CFE who has an active OWCP/FECA claim to submit to a medical assessment performed by an AF HCP. This request is typically made of the CFE by his or her supervisor in writing. Refusal on the part of an employee to release OWCP related information or to submit to an AF ordered examination may adversely impact the CFE's OWCP/FECA claim and future employment with the AF.

5.4.2.3.9.5. If an AF HCP determines the OWCP treating physician limitations are inappropriately restrictive, he or she can send a written explanation to the treating provider re: the ability of the base to potentially accommodate the worker. He or she can also make a written request to the regional OWCP district office asking for review of the case by the District Medical Advisor. The request would summarize the clinical information and the rationale for calling the treating physician's recommendations into question. These requests should be routed through and approved by the Centralized Injury Compensation Program (AFPC/DPIRPC) who in turn may contact the CFE's supervisor. The local CPS has contact information for the DPIRPC program.

5.4.2.3.9.6. NAF employees fall under the DLHWC at most locations, but at some locations are under a separate insurance arrangement. For NAF employees, seek counsel both from the local CPS authority and the Base Legal Office (JA) and ensure there is a written request from CPS before assessing the legitimacy of

a NAF employee's compensation case restrictions.

5.4.2.3.10. Non-work Related Medical Condition Assessment FFDEs.

5.4.2.3.10.1. A supervisor or CPS may obtain medical advice from the AF HCP to assist in determining what work limitations are needed for a CFE with or returning from an absence due to a non-work related illness, injury or recent surgical procedure. A supervisor or CPS may request an assessment by an AF HCP when either believes the CFE may be medically unfit to safely perform assigned duties and the employee agrees to the assessment.

5.4.2.3.10.1.1. Non-OEM physicians in civilian communities may have a limited understanding of the principals of OEM. Most are not as familiar as the AF HCP with the work requirements and work environment of AF CFEs. Some will not call the CFE's supervisor to ask about work requirements, conditions and accommodation of recommended work limitations. They may not be concerned with expediting the return of the CFE to productivity.

5.4.2.3.10.1.2. When an AF HCP evaluates a CFE's fitness to return to duty, he or she makes an independent medical assessment and provides appropriate recommendations to the CFE and CFE's supervisor. It is not appropriate to simply endorse the outside provider's recommended limitations without making a medical judgment as to whether or not the outside recommendation is appropriate.

5.4.2.3.10.1.3. The AF HCP provides the CFE's supervisor or CPS the information needed to make a well informed decision about a CFE's fitness to safely perform assigned duties with or without accommodation of recommended work restrictions.

5.4.2.3.10.1.4. Returning CFEs safely and expeditiously to productive work not only benefits the AF but protects CFEs. Workers subjected to prolonged sick leave are at risk for developing long lasting illness behaviors.

5.4.2.3.10.1.5. Disagreement with local providers may sometimes be avoided by notifying them early on of the AF's ability to accommodate work limitations and providing copies of documents showing employee functional requirements and environmental factors.

5.4.2.3.10.2. AF HCP requests for medical information from CFEs' private physicians.

5.4.2.3.10.2.1. If a CFE claims to have a medical condition or to have recently undergone a medical procedure, and has been referred by CPS or the supervisor to a AF HCP for assessment of fitness for duty, the CFE is required to provide the AF HCP with a note from the treating HCP containing: the date written, the treating HCP's signature and printed name with contact information, the diagnosis, recommended work limitations and their duration (or a recommendation to return to regular duty).

5.4.2.3.10.2.2. The evaluating AF HCP reviews the private physician's diagnosis and recommended work limitations, performs a focused outpatient

clinical assessment of the CFE's alleged medical condition, reviews the job requirements and conditions, and then determines if the outside HCP's recommended limitation are appropriate or if different recommendations should be made to the supervisor prior to making a recommendation to both the employee and the supervisor.

5.4.2.3.10.2.3. If there is a question regarding the duration of the recommended limitations, the AF HCP may consult an authoritative text that describes the range of time expected following injuries and procedures (at the time of this writing, a DoD wide enterprise contract exists for the use of web-based MDGuidelines®). The AF HCP may need to see additional information in order to determine appropriate work limitations (e.g. a cardiac ultrasound report to determine the ejection fraction and a cardiac stress test report prior to returning a post myocardial infarction case to a heat stress environment or strenuous activity) and may ask a CFE to have the private physician send relevant existing medical information to the AF HCP at the CFE's expense. The AF cannot require medical tests of a CFE unless it pays for those tests (5 CFR 339).

5.4.2.3.10.2.4. The AF HCP may request a written release from the CFE (on a form approved by the MTF consulting JA or a DD Form 2870 "AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION" per local procedure) to allow the AF HCP to send a letter or talk directly to the outside HCP in order to explain work requirements and potential accommodations. The AF HCP does not need a release to have support staff call to confirm a CFE provided note was truly sent from the private physician's office or to send a copy of the work requirements in the SF 78 (or its replacement) and position description or a memo summarizing these requirements. If an AF HCP fills out or AF support staff fill out a records release request for the CFE to sign, the request must specify "A family medical history and other genetic information is not requested."

5.4.2.3.10.3. Supervisor requests for treating physician medical information.

5.4.2.3.10.3.1. A supervisor or CPS may consult with an AF HCP prior to requesting a FFDE when a CFE claims a non-work related medical condition that necessitates reasonable accommodation of specific work limitations (e.g. inability to work night shift, to work in a particular area due to a phobia, etc) for an indefinite or prolonged period.

5.4.2.3.10.3.2. If the AF HCP determines outside medical information is required in order to advise the supervisor or CPS, he or she may ask the supervisor or CPS to inform the employee in writing of the need to have the following information sent directly by the treating HCP to the evaluating AF HCP (with a signed release):

5.4.2.3.10.3.2.1. Copies of relevant medical records (to include summary reports of specialty consultations, studies, labs, and record entries.

5.4.2.3.10.3.2.2. A note identifying the relevant medical diagnosis or

diagnoses, including the current clinical status, the patient's past and present compliance with recommended treatment, the prognosis (including plans for future treatment), an estimate of the expected date of maximal medical improvement, a list of all recommended work limitations and their duration; and a narrative explaining the basis for the conclusion that the accommodations are medically necessary.

5.4.2.3.10.3.2.3. The written request from the supervisor or CPS to the employee must state, "A family medical history and other genetic information are not requested" and a statement explaining that all documentation must be obtained at the CFE's expense.

5.4.2.3.10.4. Upon review of the CFE's medical information, the AF HCP determines if further medical or psychiatric assessment is needed in order to provide the supervisor or CPS adequate information to allow for a well informed decision. If so, the AF HCP may advise the supervisor or CPS to commit unit funds to pay for the assessment. An AF HCP must not order such an evaluation unless he or she has confirmation of unit funding. Psychiatric assessments must only be ordered IAW guidance found elsewhere in this chapter.

5.4.2.3.10.5. A request from a supervisor or CPS for a medical assessment may be inappropriate if the issue is primarily administrative in nature (e.g. a CFE who is angry, argumentative, abusive, bullies others, exhibits a personality disorder, or exhibits other behavior most appropriately managed by administrative action).

5.4.2.3.11. Fitness assessment during other clinic visits. In a broad sense, all employee medical examinations (including MSEs) are fitness for duty assessments: if findings from any clinical examination are incompatible with unrestricted duty performance, the AF HCP recommends appropriate duty restrictions to the worker's supervisor (or commander).

5.5. OEM Medical Care for work related illnesses and injuries:

5.5.1. AD members obtain medical care for occupational injuries and illnesses through their assigned HCPs who take care of their day-to-day health care needs (MSEs for these members are typically accomplished in FM or OMS clinics). An AD member can be referred to or sent for a consult from an AF OEM HCP where this service is available. Industrial illnesses are brought to PH's attention for investigation and reporting.

5.5.2. AF CFE medical care for occupational injuries and illnesses. There are essentially three systems covering work related medical care for CFEs: Office of Workers' Compensation Program (OWCP) under the Federal Employees Compensation Act of 1971 (5 USC Chapter 81) (FECA) which covers the majority of AF CFEs; Division of Longshore and Harbor Workers Compensation (DLHWC) which covers Non-Appropriated Fund (NAF) employees; and those covered by other forms of insurance. As there are differences in eligibility, means of applying for and obtaining reimbursement, and other rules and procedures, knowing the CFE's form of coverage is essential.

5.5.2.1. Injury vs. Illness, OWCP definitions:

5.5.2.1.1. An occupational injury is a medical condition that evolves over the period of no more than a single workday or shift (e.g. a laceration). (CA-810, Injury Compensation for Federal Employees, 2009 Revised)

5.5.2.1.2. An occupational illness is a medical condition that evolves over more than one work shift (e.g. carpal tunnel syndrome).

5.5.3. If an eligible CFE seeks definitive and ongoing care for a work related condition at an AF clinic capable of providing that care, the CFE must make a written, signed and dated decision to either choose the AF clinic or a private HCP as his or her OWCP treating HCP. This statement is placed in the medical record. The CFE has the right under FECA to choose to seek care from a non-AF HCP.

5.5.4. If an employee has elected care for a work related condition through workers' compensation from a private HCP and a claim is pending or accepted, the AF HCP must not treat the CFE for the claimed condition and must not recommend to the employee or employee supervisor work limitations that are less restrictive than those recommended by the treating HCP. The AF HCP must not phone the private HCP to discuss an OWCP case, but may communicate by other means while adhering to appropriate release requirements.

5.5.5. Once the CFE has chosen a treating HCP and has notified OWCP, the CFE cannot change his or her OWCP treating HCP until he or she obtains written approval from OWCP.

5.5.6. While the AF has a right to require a medical assessment of a CFE who has claimed a work related illness or injury, the AF may not delay required care in order to obtain that assessment (i.e. if the CFE has elected to obtain care outside of the AF).

5.5.7. An AF provider must not provide medical care to a CFE for a claimed medical condition when the CFE has chosen a private HCP to treat that condition. An AF HCP may review work limitations recommended by the private HCP, but as discussed earlier in this chapter, must not provide less restrictive limitations than the treating HCP. If the claim is denied by OWCP, the AF HCP is not so restricted.

5.5.8. OWCP Forms. An acutely injured non-NAF CFE requiring emergency care outside the AF MTF obtains an authorization for payment in the form of a CA-16 from his or her supervisor. Application for a claim is made by the CFE on a CA-1 for injuries, on a CA-2 for illnesses, and on a CA-2A for a recurrence of an illness or injury.

5.5.9. An AF HCP who has been chosen by an injured CFE as his or her OWCP treating provider can refer a case to a specialist; relinquishing his or her control as the treating provider (the CFE is provided a choice of specialists who accept OWCP coverage).

5.5.10. Illnesses are not initially covered by OWCP. If a CFE has a potential industrial illness that cannot be worked up or cared for within the MTF, he or she must seek care at his or her own expense. Further assessment at the expense of the employee's unit may be appropriate when conditions described under section 5.2 are met.

5.5.11. For both injuries and illnesses, OWCP determines if the condition is work related or not and decides to accept or to reject the claim (this can take many months for an illness). An AF HCP who determines a condition is or is not work related in opposition to an OWCP determination, may write to the OWCP claims representative who owns the case and request

review of the case by the OWCP District Medical Advisor. This should be coordinated with the Centralized Injury Compensation Program (CPS can assist).

5.5.12. The AF HCP can also request OWCP assign a nurse case manager to a case. AF HCP's are not to counsel CFEs on their rights and coverage under OWCP and shall refer patients to the CPS OWCP representative for assistance and guidance regarding filing a claim, forms completion, and how to work with private insurance companies to obtain care prior to OWCP acceptance or rejection of an illness claim.

5.5.13. Emergency conditions requiring expeditious medical care may require the worker to postpone discussion with CPS until the condition or conditions are stabilized.

5.5.14. Division of Longshore and Harbor Workers Compensation (DLHWC).

5.5.14.1. NAF employees with an initial work related injury or illness typically obtains care in the civilian medical community; they may be seen in an MTF if resources allow for a one time initial evaluation and treatment. A DoL form LS-1 Request for Examination and/or Treatment must be filled out as part of the visit.

5.5.14.2. If seen in the MTF, the NAF employee should be referred to the CPS specialist who will assist in their transition to the care of a civilian provider. NAF employees may receive pre-placement and formal FFDE's from an AF HCP when requested by CPS in writing and the MTF resources are sufficient to support (AFH 41-114).

5.5.15. Other workers' compensation insurance for CFEs. If a CFE requests care for a work related medical condition and is not covered by either OWCP or DLHWC, contact the local CPS for assistance.

5.6. Occupational injury and illness reporting requirements.

5.6.1. Medical record entry.

5.6.1.1. The medical record entry for the initial presentation of an alleged work related illness or injury not only documents assessment of the medical condition and appropriate medical response, but provides information necessary to support both OSHA reporting and OWCP claims determinations.

5.6.1.2. The medical history includes the time of injury or illness detection; location; CFE activity at the time of event; mechanism of injury; use or failure to use PPE and protective measures; contributing factors (e.g. slippery ground); prior health status; earlier evaluation and treatment (if occurred); delays in reporting; current medications; any relevant pre-existing or past injuries, surgeries and illnesses; whether or not the event was witnessed; and duty title.

5.6.1.3. If the CFE reports to the clinic shortly after the incident and appears to be intoxicated, the history and examination attempts to determine the level of intoxication and potential impairment that may have contributed (performance of a toxicology screen may be subject to local policy, (e.g. for cause); or may be necessary in order to determine if it is safe for the employee to drive on base if he or she drove to work or the clinic).

5.6.1.4. The physical exam thoroughly documents objective findings and may include non-physiological findings (e.g. Waddell's Signs), medical treatment provided and planned, further planned investigation (e.g. if an alleged chemical or ergonomic exposure

awaiting PH and BE assessment), and the CFE choice of treating physician for OWCP claim purposes (either AF HCP/Clinic or private provider).

5.6.1.5. When determining causality, the AF HCP must be aware that OSHA and OWCP criteria for determining work relatedness are not equivalent. OSHA criteria for work relatedness are beyond the scope of this publication and can be found in 29 CFR 1904.5 (**http://www.osha.gov**/). These OSHA criteria must be applied when the AF HCP determines work relatedness in the AF Safety Automation System (AFSAS). However, when determining causation in the medical record, the AF HCP uses the criteria outlined in the DoL FECA publication CA-810 Injury Compensation for Federal Employees; 2009 (**http://www.dol.gov**/).

5.6.1.6. If an investigation is still pending and causality is not as yet conclusive, or if there is reason to doubt work relatedness, this is documented in the record entry. As PH (with possible assistance from BE) will investigate illnesses, additional information may be forthcoming that may impact the determination of causality.

5.6.1.7. If a condition is considered or determined to be not work related, the AF HCP documents the determination in the medical record and refers the CFE to his or her private HCP for further care and does not continue to treat the condition.

5.6.1.8. For an illness, if the AF HCP determines it is work related, he or she documents this determination in the medical record and may treat the condition if MTF resources are available to support. Until the case is accepted by OWCP, any outside referral for care is at the patient's expense. If a claim is disallowed by OWCP but the AF HCP is certain the claim should be allowed, the AF HCP may write a letter to the district OWCP office providing an explanation and requesting review by the OWCP physician consultant. Again, this should be coordinated through the Centralized Injury Compensation Program.

5.6.1.9. For an injury, once a CA-16 is completed payment for treatment outside of the MTF is covered by OWCP for up to 60 days pending an OWCP decision re: claim acceptance. If the CFE elects care within the MTF, this coverage would apply to referral out to specialty care. (CA-810)

5.6.2. Occupational Safety and Health Administration (OSHA) Reporting.

5.6.2.1. In accordance with 29 CFR 1960.8(b) and 29 CFR 1904.39, the AF reports all civilian work related illnesses and injuries to the DoL. Base Safety (SE) is the POC for this purpose and is supported by the local MTF.

5.6.2.2. AD members are considered to be on duty 24/7 for the purpose of injury reporting. Unless otherwise specified by local or MAJCOM policy, supervisors are responsible for completing the OSHA 301A or equivalent form for all work related injuries and submitting the completed form through appropriate channels.

5.6.2.3. All work related industrial illnesses presenting to the MTF are entered into the Air Force Safety Automated System (AFSAS) by PH with a workplace evaluation entered by BE, and a final determination of work relatedness entered by the IOEMC designated AF HCP; SE accesses this information from AFSAS to meet the OSHA 300 log requirement. OSHA criteria for work relatedness are beyond the scope of this publication and can be found in 29 CFR 1904.5 (**http://www.osha.gov**/).

5.6.2.4. OSHA does not require the OSHA 301A form or its equivalent to be completed by a medical person (OSHA Recordkeeping Handbook, OSHA 3245-01R, 2005), but this does not relieve the AFMC HCPs of the responsibility to do so when required by their governing policy.

5.6.2.5. When the OSHA 301A form or equivalent is completed in clinic, a copy is placed in the AF medical record.

5.6.2.6. Privacy. Under the below circumstances, the clinic must coordinate with the local Ground Safety office to ensure CFE names are not placed on the OSHA 301A or equivalent form. A separate, confidential list of the case numbers and employee names must be maintained to allow for updating the cases and in order to provide information if necessary and appropriately authorized. The circumstances include:

5.6.2.6.1. An injury or illness to an intimate body part or the reproductive system.

5.6.2.6.2. An injury or illness resulting from a sexual assault.

5.6.2.6.3. Mental illnesses.

5.6.2.6.4. HIV infection, hepatitis, or tuberculosis.

5.6.2.6.5. Needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material (see Section 29 CFR 1904.8 for definitions).

5.6.2.6.6. Other illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the log.

5.7. Investigating alleged workplace illness or injury.

5.7.1. HCPs may consult directly with BE, PH, and SE when investigating an alleged workplace illness or injury. However, PH is notified of all illness investigations and provided copies of any relevant written information to avoid duplication of effort and potential contradiction.

5.7.2. The IOEMC or their appointee has authority to determine what is/is not appropriate to an investigation and is the local medical authority who determines occupational injury and illness causality.

5.8. Causality.

5.8.1. As previously mentioned in this publication, OSHA and OWCP criteria for determining work relatedness are not equivalent. AF HCPs who see CFE's in clinic need to follow OWCP criteria when determining causality as described in CA-810 (**http://www.dol.gov**). Those determining causality in AFSAS must use criteria found in 29 CFR 1904.5 (**http://www.osha.gov**/). Below is a brief description of criteria at the time of this publication, but review and familiarity with the above references is essential for each of the two types of causality determinations:

5.8.1.1. For purposes of OSHA reporting: An injury or illness is work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the

work environment, unless an exception in 29 CFR 1904.5(b)(2) specifically applies (Providers determining work relatedness should periodically review the current version of this reference as CFRs are subject to potential change on a quarterly basis).

5.8.1.2. OWCP makes the final decision to accept or reject a claimed medical condition as work related or not work related. But the provider making a determination of causality must understand that OWCP considers an illness or injury work related for FECA employees if:

5.8.1.2.1. An injury or factors of employment result in a medical condition through a natural and unbroken sequence. This is called "direct causation."

5.8.1.2.2. A pre-existing condition (whether or not previously caused by work) is worsened, either temporarily or permanently, by work-related factors. This is called "aggravation."

5.8.1.2.3. A work-related injury or disease hastens the development of an underlying condition. When the ordinary course of the disease does not account for the faster than expected speed with which a condition develops. This is called "acceleration."

5.8.1.2.4. A latent condition which would not have manifested itself when it did, were it not for conditions of employment (e.g. latent tuberculosis becomes active secondary to an event at work). This is called "precipitation."

5.8.1.2.5. The event took place on the AF base during duty hours (includes an AF parking lot or while eating at work or in AF housing).

5.8.1.2.6. The event took place off the base but when operating a private auto in the course of performing work or when eating off base required as part of performance of duties.

5.8.1.2.7. Exceptions include visiting the base after work hours for non-work related reasons and when engaged in union activities.

5.9. First Aid and Supplemental Care to Allow a CFE to Complete a Shift. As indicated in AFH 41-114, Military Health Services System (MHSS) Matrix, Section 37, the MTF commander can offer first aid services in order to permit a CFE to complete a shift.

5.10. Genetic Information Non-discrimination Act (GINA) of 2008 (42 USC 2000ff – 2000ff-11). It is unlawful for the AF to fail or refuse to refer for employment or otherwise discriminate against an individual (CFE or applicant) based on genetic information (i.e. family medical history (FMH) and genetic test results of the individual or up to fourth degree relatives). AF HCPs must not ask for or take a FMH when performing FFDEs. For CFE, an FMH may only be taken and recorded as per the below exceptions:

5.10.1. Medical care assessment. A focused FMH can be taken when used for the specific purpose of assessing a medical condition for the purpose of determining appropriate medical care and disposition. For example, a patient presenting to the clinic for assessment and treatment of chest pain could be asked if he or she has a family history of heart disease or diabetes but would not be asked if he or she has a family history of cancer or history of "chronic medical conditions." Per GINA, prior to the AF HCP requesting the focused FMH, the CFE must sign a statement for inclusion in the medical record that verifies the CFE knowingly and voluntarily agrees to provide the focused FMH. For example: "I, [John

Doe], knowingly and voluntarily choose to release genetic information for permanent inclusion in my medical record for the purpose of enabling [Dr. XXXX] to assess the medical or potential medical condition(s) for which I am being assessed today. I have not been coerced to provide this release. This information is protected from disclosure to my supervisory chain and may not be used to influence employment related decisions."

5.10.2. Wellness programs: genetic information collection (including FMH) collected in support of wellness programs must meet the same criteria as described for "Medical care assessment" above. This information should be kept separate from the OEM medical record and should not be shared with the AF HCP.

5.10.3. Genetic monitoring of the biological effects of toxic substances in the workplace can be performed only if the following are accomplished.

5.10.3.1. The employer provides written notice of the genetic monitoring to the employee.

5.10.3.2. The employee knowingly and voluntarily provides written authorization for monitoring before it begins.

5.10.3.3. The genetic monitoring is required by Federal or State law and is compliant with Federal and State laws.

5.10.3.4. The employee is informed of individual monitoring results.

5.10.3.5. Only aggregate information that cannot identify specific individuals can be shared with AF leadership.

5.10.4. AF OEM Medical Records:

5.10.4.1. FMH information (1) provided by the patient without solicitation is recorded in the AF OEM medical record; (2) if taken and recorded prior to publication of this AF interpretation may remain in the AF OEM medical record; (3) must not be used to influence employment related decisions.

5.10.4.2. When making an Armed Forces Health Longitudinal Technology Application (AHLTA) clinical encounter entry and when a FMH is not included in order to comply with GINA, the following or similar text is entered in place of a FMH, "No family history taken IAW GINA."

5.10.4.3. Outside medical records released to the AF HCP which contain a family medical history are filed in the AF medical record. AF HCPs requesting a consult in support of an OEM assessment do not ask for genetic information to include FMH; the following text is included on the release form, "A family medical history and other genetic information is not requested."

5.10.4.4. Specimen collection for the purposes of identification by the Armed Forces Repository of Specimen Samples for the Identification of Remains (AFRSSIR) is exempted by GINA. Collection of a tissue or blood sample from a civilian for submission to AFRSSIR is allowed by GINA.

5.11. Rehabilitation Act of 1973 definitions and requirements to consider when making work limitation recommendations:

5.11.1. A "qualified individual with a disability" means a person who satisfies the job-related requirements of the employment position he or she holds or is applying for, and who, with or without reasonable accommodation, can perform the essential job functions of that position.

5.11.2. The AF must make reasonable accommodations for the known physical or mental limitations of employees and applicants for employment with disabilities, unless providing an accommodation would create an undue hardship. (The decision to accommodate AF HCP recommendations/limitation is determined by the supervisor, not the HCP).

5.11.3. Details about medical conditions are not communicated to leadership or CPS. For example, if a CFE is unable to perform essential job functions because of a heart condition, the supervisor may be told the CFE is not fit to perform specific duties, but the actual diagnosis and medications are not disclosed by the AF HCP without consent of and written authorization from the CFE (Reference DoDI 6055.05 M, AFI 48-123, AFI 48-145). Per HIPAA, the minimum amount of protected health information necessary should be disclosed (45 CFR 164.502(b), 164.514(d)).

5.11.3.1. If the CFE wishes to be accommodated in the position, he or she will have to disclose sufficient medical information to establish that he or she has a disability and that the disability necessitates a reasonable accommodation. In most cases, complete medical records cannot be requested because such records may reveal information that is not relevant to determining whether the employee has a disability or needs an accommodation. Requests for medical information should be narrowly tailored to answer specific questions to help determine if the individual has a disability and/or if reasonable accommodation is needed (and if so, what specifically is required as a reasonable accommodation).

5.11.3.2. The CFE must cooperate with the supervisor/manager: (a) providing the specifics of the accommodation requested and how the requested accommodation will allow the individual to perform the essential functions of the job; and (b) providing the requested medical documentation and medical releases. Failure to provide the information necessary to evaluate the validity of the requested accommodation will result in the denial of the request.

5.11.4. Unrelated or incidental medical diagnoses are not disclosed to the CPS or supervisor. However, if a condition is discovered that is expected to prevent a CFE from safely performing the essential functions of his or her job on a permanent basis or for the foreseeable future, the AF HCP makes a recommendation to the supervisor that there is a need for a FFDE (without disclosing the diagnosis).

5.12. Family Medical Leave Act of 1993 (29 USC 2601 – 2619), (FMLA). AF CFE's applying for coverage under the FMLA (or similar local, state or federal law) in order to care for a family member with a serious health condition provide FMH information as part of the application. However, this information is not placed in the AF OEM medical record of the applicant and is not maintained by the MTF. This information must be placed in a separate medical file where it must be treated as a confidential medical record by the appropriate CPS specialist who is responsible for its protected access, maintenance and eventual disposal. The AF HCP is not allowed to serve as a second or third medical opinion in these cases as is explained in 29 CFR 825.307.

5.13. Medical Information Access. Medical information (medical records, forms, letters, diagnoses, medications, etc.) for AF CFEs in general (as per the Rehabilitation Act of 1973 and HIPAA) must be protected and, unless specifically allowed by official policy or a signed CFE release, access denied to CPS, inquiring labor attorneys, supervisors, commanders and leadership.

5.13.1. Medical personnel may release recommended work limitations to supervisors and commanders without permission from the CFE but shall safeguard other information (DODD 1020.1, Nondiscrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense, 1982; Certified Current 2003).

5.13.1.1. First aid and safety personnel may be made aware if a medical condition is known to potentially require emergency treatment, but a HIPAA, compliant release shall be accomplished (29 CFR 1614.203; 29 CFR 1630.14).

5.13.1.2. Application by the CFE for OWCP, LHWA, and disability retirement requires the CFE to sign a medical release.

5.13.1.3. In all consultations, CFE privacy must be maintained IAW the Rehabilitation Act of 1973, As Ammended; the Privacy Act; HIPAA, GINA, FECA/OWCP, DoD and AF policy, OPM policies and the need to know. OWCP and disability retirement applications include signed releases. Legal proceedings may require release documents. Either the CFE signs a release or an official policy must authorize the release.

5.14. Administrative Activities.

5.14.1. OEM Consult Services. AF supervisors, other leaders, and official functions may require OEM consultative services in order to make informed decisions. Support for these services involving CFEs exists at bases with OMS clinics and to the extent resources permit at other base FM clinics. Internal customers include MTF leadership, AF HCPs, PH, and BE. External customers include SE, base leadership, Public Affairs, JA, CPS, base supervisors of civilian employees and others.

5.14.1.1. The IOEMC guides the uniform and consistent application of occupational and environmental medical decisions and policies at the base level.

5.14.1.2. The IOEMC ensures the MTF professional staff are briefed at least annually on the industrial hazards and potential illnesses/injuries experienced by the population that may be seen in the MTF.

5.14.1.3. Where resources permit, the IOEMC can also provide the following advisory and consultative services:

5.14.1.3.1. Current and complete medical and technical information regarding specific medical and physical conditions or medical examination procedures relevant to existing or proposed physical requirements or health-related personnel management programs for base AF employees.

5.14.1.3.2. Technical assistance includes advisory opinions in medical and OEH areas (i.e., ergonomics; risk communication; emergency response/disaster preparedness; workers' compensation; disability retirement; medical standards; Equal Employment Opportunity Commission cases; civil lawsuits, Merit System Protection

Board challenges) to ensure compliance with AF/DoD policy and local/state/federal requirements. The IOEMC participates in base level ESOH council meetings.

5.14.1.3.3. Expert review and analysis of medical documentation and other materials submitted by the AF in support of medical/physical disqualifications of applicants; employees' restoration rights under 5 U.S.C. 8151 following full or partial recovery from compensable on-the-job injuries; and requests for job accommodations or other special benefits related to accommodation of documented health conditions.

5.14.1.3.4. Written reports on medical standards, medical policy issues, or individual medical documentation reviews as requested.

5.14.1.3.5. Guidance for resolving complex medical/personnel management issues where there are no established guidelines or precedents, including, but not limited to the following:

5.14.1.3.5.1. Advisory opinions clarifying medical/psychiatric issues on the continued eligibility for access to classified information of Federal employees who hold top security clearances.

5.14.1.3.5.2. Guidance regarding new and experimental procedures relating to such issues as vision correction procedures, surgical implants, or prosthetic devices, as a means of satisfying medical or physical qualification requirements.

5.14.1.3.5.3. Reports to condense findings, analyses, conclusions and recommendations of AF evaluation and clearance processes.

5.14.1.3.5.4. Research and analysis of complex legal and medical issues in coordination with AF labor attorneys.

5.14.1.3.5.5. Research and analysis of technical, scientific and medical data in support of local policy development and program management.

5.14.1.3.5.6. Research and analysis of materials, devices, tools, systems prior to acquisition in order to advise leadership on compatibility with human systems integration.

5.14.2. Protecting Our Workers and Ensuring Reemployment (POWER) Program (Formerly Safety, Health and Return-to-Employment (SHARE); and before that, the FECA Working Group).

5.14.2.1. The Centralized Injury Compensation Program representative or CPS appointed liaison runs the POWER Working Group and administers the program.

5.14.2.2. The IOEMC or appointed AF HCP prepares to participate in the POWER Working Group by reviewing medical cases at the request of the Centralized Injury Compensation Program Liaison.

5.14.2.3. The IOEMC or AF HCP provides medical advice regarding what the CFE can and cannot do; whether or not the OWCP assessment of causality and recommended work limitations appear appropriate; whether the condition appears to have reached maximal medical improvement, is expected to improve, resolve or deteriorate; whether or not the case should be challenged based on a determination that it is not due to factors of

employment or does not otherwise qualify; and whether or not an OWCP case manager should be requested if not already assigned to move the case forward.

5.14.2.4. If the review reveals the treating physician may be inappropriately limiting work activities, the IOEMC or AF HCP may need to contact OWCP as discussed elsewhere in this chapter (AFI 48-145; DoDI 1400.25-V810).

5.14.3. Case Management.

5.14.3.1. Effective case management of CFEs with work related illnesses and injuries can greatly reduce lost productivity, compensation costs, and patient morbidity by helping the CFE get to appropriate care expeditiously. Where a nurse case manager or Certified Occupational Health Nurse (COHN) is not available, OWCP can be contacted to request assignment of an OWCP nurse case manager (for accepted OWCP claims cases).

5.14.3.2. Communication with OWCP is arranged when performing local case management to avoid conflicts with OWCP nurse case management activities. An AF case manager should not interfere with the activities of the OWCP case manager.

5.14.4. Workplace Visits by AF HCPs. Visits to the workplace are invaluable to AF HCPs to acquaint them with the work demands and hazards of their patient population. All Category-1 workplaces are visited annually by an AF HCP. Knowledge gained visiting the workplace is extremely valuable as it enables appropriate determination of work limitations, surveillance exam protocols and illness/injury mechanism/causality.

5.14.4.1. Workplace Visit Preparation. The HCP contacts the workplace supervisor to schedule the workplace visit. A joint visit with the BE technician is ideal but not mandatory. The HCP visit is best performed soon after the periodic BE assessment. Prior to the visit, the following information is reviewed by the AF HCP:

5.14.4.1.1. The BE SEG summary to identify exposures of concern.

5.14.4.1.2. Past OEM visit reports and any ongoing assessments.

5.14.4.1.3. Toxicology and pathology associated with the exposures of concern (this information can be found in a number of online sources and toxicology texts; many are familiar to BE).

5.14.4.1.4. The most recent surveillance exam protocol (COHER).

5.14.4.1.5. PH trend analysis.

5.14.4.1.5.1. If not readily available, ask PH to look for adverse clinical and surveillance information trends within the SEG.

5.14.4.1.5.2. If adverse trends are identified, medical records may need to be reviewed to better identify what is happening (e.g. elevated liver functions might suggest exposure to solvents, several cumulative trauma illnesses may suggest an ergonomic problem).

5.14.4.2. Conducting the workplace visit.

5.14.4.2.1. The visit begins and ends with the workplace supervisor. Explain to the supervisor the purpose of the visit (to ensure medical monitoring and medical care are

appropriate based on workplace hazards and controls, to assist the supervisor in compliance with OHSA requirements) and to ask the supervisor if he or she has any questions or concerns with exposures in the workplace or services provided by the MTF. Permission is asked to interview CFEs privately about any exposure concerns they may have (Confirm beforehand with CPS if the base has any union agreements that require Union notification prior to talking to civilian workers about their working conditions).

5.14.4.2.2. An essential element of the evaluation is validating identified physical, biological, chemical and/or radiological hazards, effectiveness of OEH controls and assessment of work practices. It is particularly helpful to have a summary of the recommended OEH controls (e.g. PPE, ventilation controls, worker rotation) from the most recent BE HRA to ascertain whether controls are used. Better still is for the AF HCP or nurse to bring a BE technician along who can point out the hazards and the controls and identify potential weaknesses in the controls. If possible, take two or three employees aside individually and ask them if they have any concerns about work place exposures and protective measures (assuming verification of notification requirements has been properly addressed as per the preceding paragraph).

5.14.4.2.3. If the visit is conducted in response to a particular employee complaint, the specific circumstances surrounding that complaint are thoroughly evaluated.

5.14.4.2.4. At the close, the supervisor is informed of any significant findings, recommendations, or the need for additional research or assessment. He or she is reminded that PH depends on the workplace supervisor to notify PH of employees who start or terminate work in the SEG in order to schedule initial and termination MSEs. A copy of the final report is supplied to the supervisor within 5-duty days of the visit.

5.14.4.3. Workplace Visit Documentation.

5.14.4.3.1. Sufficiently, thorough and timely documentation of the visit is important. The HCP creates a written report including the name and phone number of the workplace supervisor, the date and who conducted the visit, the amount of time spent at the workplace, a description of the work operations and work practices, the PPE used, any findings of concern, the number of workers interviewed, what concerns if any were voiced and any required actions.

5.14.4.3.2. Safety concerns are communicated to SE and exposures of concern are shared with BE. Illness and injury clusters or trends are shared with PH. All findings, conclusions and actions are included in the final written report and are presented in the next OEHWG. The original report is sent to the workplace supervisor and a copy attached to the next OEHWG minutes.

5.14.5. Workplace visits by PH. PH will conduct workplace visits as needed to investigate adverse trend results based on OEH surveillance and epidemiological findings and on a routine scheduled basis IAW AFI 48-145.

5.14.5.1. Workplace visits may be done in conjunction with BE and/or the AF HCP or nurse. However, it is often beneficial to accompany the BE personnel on the closing conference with the workplace supervisor.

5.14.5.2. PH personnel conducting the visit. Workplace visits must be led by at least a 5-level PH technician (3-level PH technicians must be accompanied).

5.14.5.3. Workplace visits will primarily be an opportunity for PH personnel to learn processes and hazards in the industrial environment. In addition, these visits are an opportunity to offer assistance to the supervisor in their OEH training/education program, fit personnel for ear plugs, verify compliance with hearing protection devices and other PPE, update workplace rosters, and inform the supervisor and other personnel on their medical surveillance requirements, responsibilities for reporting injuries/illnesses and referring pregnant females to PH.

5.14.5.3.1. Prior to the visit, PH will thoroughly review the BE shop survey, pertinent Material Safety Data Sheets (MSDS), MSE compliance and trend analysis findings (based on a records review and audiogram reports), and occupational illness reports.

5.14.5.3.2. PH will generate a report with MSE compliance and trend analysis findings and provide this report to the supervisor.

5.14.5.4. Workplace visits will be documented in the OEHWG minutes and in the OEH-MIS, when possible.

5.15. Civilian Expeditionary Workforce (CEW).

5.15.1. CEW employees are required to pass a medical examination prior to deployment (see DoDI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees and DoDD 1404.10, DoD Civilian Expeditionary Workforce for guidance and criteria).

5.15.2. Pre- and post-deployment questionnaires and deployment monitoring of CEW civilians is conducted through PH as required in DoDI 6490.03, Deployment Health.

5.15.3. As per DoDD 1404.10, CEW employees who become ill, contract diseases, or who are injured or wounded while deployed in support of U.S. military forces engaged in hostilities are eligible for medical evacuation and health care treatment and services in MTFs at no cost to the civilian employee and at the same level and scope provided to military personnel. Upon return to the home base, CEW CFEs treated in theater continue to be eligible for treatment in an MTF or civilian medical facility for deployment related illnesses, diseases, wounds, or injuries (at no cost to the CFE) pending claim adjudication by OWCP. (See AFI 41-210 for a more detailed explanation of beneficiary status)

5.15.4. CFEs who have returned from deployment and are subsequently determined to have a deployment related compensable illness, disease, wound, or injury are also eligible for treatment in an MTF at no cost to the CFE pending adjudication by OWCP. (See AFI 41-210)

5.15.5. Upon return to the home base, these CFEs are encouraged to meet with the appropriate OWCP representative in CPS as soon as possible to file for OWCP coverage if this has not already been accomplished. As mentioned previously, they must sign a note for the medical record documenting their choice of a treating provider (either the AF HCP or a private civilian provider). They have a right to seek care in the private sector rather than

through the AF, but if they do this they are responsible for arranging for payment to include establishing a claim with OWCP.

5.16. Travel Medicine. AF CFE's scheduled for official TDY to foreign countries with known health hazards necessitating prophylactic vaccination or chemoprophylaxis, medical assessments and education may obtain these free of charge from an AF HCP. PH assists by providing travel medicine information to the HCP.

5.17. Education and Training for AF HCPs, nurses and technicians. The IOEMC and full time OEM HCPs attend CME conferences on a regular basis to maintain currency and appropriate certifications. COHNs have continuing medical education requirements. Physicians, nurses and technicians who perform or interpret spirometry in support of MSEs and FFDEs may be considered qualified to perform these duties by virtue of specialty training or certification by National Institute for Occupational Safety and Health (NIOSH) or equivalent.

5.18. OEH Surveillance and Epidemiology.

5.18.1. PH collects and conducts trend analysis on OEH data to support OEHWG workplace review/worksite visits, and metrics for OEH program effectiveness and compliance (hearing conservation, pregnancy profiles, occupational illnesses), or as need arises.

5.18.2. Trend Analysis should be conducted on:

5.18.2.1. Medical Records (for MSEs). For category 1 workplaces, a medical records review of MSE findings is conducted using the following sampling plan:

Table 5.1. Records Review Matrix.

# Personnel in Workplace	# of Records Reviewed
≤ 100	10
101-200	20
201-300	30
301-400	40
401-500	50
≥501	50

5.18.2.2. Each record should be reviewed for compliance with MSE requirements (frequency, content of MSE) and associated abnormal findings, and occupational injuries and illnesses. In addition, visits to a HCP by workers enrolled in a MSE program should be reviewed for the past year looking for potentially undiagnosed OEH-related illnesses (i.e., unexplained rashes possibly related to chemical solvents/JP-8, nose bleeds possibly related to hexavalent chrome exposure, musculoskeletal injuries possibly related to workplace ergonomic issues, etc.).

5.18.2.3. Trends of MSE completeness (# of records reviewed, % of records with all MSE requirements met) and % of records indicating abnormal findings should be documented.

5.18.2.4. Occupational Illnesses/Injuries (non-Hearing Conservation Program): among assigned workers by workplace, calculate the # and % of workers with occupational illnesses (and injuries if available).

5.18.2.5. Audiograms for the Hearing Conservation Program: By workplace, for # annual audiograms conducted within a one year period (or other specific time period), calculate the # and % of significant and permanent threshold shifts (STS/PTS).

5.18.3. The OEHWG should evaluate findings in the context of known workplace hazards, BE recommendations, PPE, training, and available historic workplace-specific data and trends. Where adverse trends are identified, the OEHWG will identify a plan for further investigation, determine underlying cause(s) (if any), document findings in the OEHWG minutes, and communicate findings and recommendations with the workplace supervisor or SEG leader and the unit commander.

5.18.4. Program effectiveness: Trends should be evaluated for the installation as a whole, as well as by unit and workplace. Analysis might include stratification on other available factors (e.g., AFSC), in order to assist in targeting prevention/education efforts. Historic data, if available, should be used as a comparison when evaluating adverse/advantageous trends.

5.18.5. Compliance metrics for OEH medical data might include MSE compliance rates, audiogram follow-up rates, and average pregnancy profile completion times. At a minimum, MSE compliance should be tracked and reported IAW 48-101, and other AF and DoD guidance.

5.19. Documentation of PH Activities: PH will maintain OH program documentation electronically whenever possible. All interactions with industrial shop/SEG personnel will be noted on a continuous log noting at a minimum: date, who was contacted, what was discussed/accomplished, and any other pertinent information. Pertinent information will also be annotated on the log whenever a shop/SEG is discussed at the OEHWG (e.g., OEHED, MSE approval, trend analysis). Entries will include the signature and signature block of the individual making the entry. All other OH documentation will be maintained in the appropriate electronic database/format. Protected health information will only be maintained if absolutely necessary and will be appropriately protected from inadvertent disclosure. Additional documentation maintained by PH will be up to local discretion.

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Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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SF Form 600, Chronological Record of Medical Care Standard

Abbreviations and Acronyms

ACGIH—American Conference of Governmental Industrial Hygienist

AD—Active Duty

AEF—Air Expeditionary Force

AF—Air Force

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMS—Air Force Medical Service

AFOSH—Air Force Occupational and Environmental Safety, Fire Protection, and Health

AFPAM—Air Force Pamphlet

AFSAS—Air Force Safety Automated System

AFPD—Air Force Policy Document

AFRC—Air Force Reserve Command

AHLTA—Armed Forces Health Longitudinal Technology Application

ANG—Air National Guard

AOC—Area of Concern

ASM—Aircraft Structural Maintenance

BE—Bioenvironmental Engineering

BEE—Bioenvironmental Engineer

CA—Compensation Act

CBRN—Chemical, Biological, Radiological and Nuclear

CEW—Civilian Expeditionary Workforce

CFE—Civilian Federal Employee

CFR—Code of Federal Regulation

COHER—Clinical Occupational Health Exam Requirements

COHN—Certified Occupational Health Nurse

CPS—Civilian Personnel Services

CSRS—Civil Service Retirement System

DLHWC—Division of Longshore and Harbor Workers Compensation

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

DOEHRS—Defense Occupational & Environmental Health Readiness System

DoL—Department of Labor

EH—Environmental Health

EAP—Exposure Assessment Priority

ER—Exposure Rating

ESOH—Environment, Safety and Occupational Health

ESOHC—Environment, Safety and Occupational Health Council

ESOHCAMP—Environmental, Safety and Occupational Health Compliance Assessment and Management Program

FECA—Federal Employee Compensation Act

FERS—Federal Employee Retirement System

FFDE—Fitness for Duty Examination

FM—Flight Medicine

FMH—Family Medical History

FMLA—Family Medical Leave Act

GINA—Genetic Information Non-discrimination Act

HAZMAT—Hazardous Material

HCP—Health Care Provider

HER—Health Effects Rating

HIPAA—Health Insurance Portability and Accountability Act

HRA—Health Risk Assessment

HRR—Health Risk Rating

IAW—In Accordance With

IDLH—Immediately Dangerous to Life or Health

IOEMC—Installation Occupational & Environmental Medicine Consultant

JAG—Judge Advocate General

LER—Longitudinal Exposure Record

MAJCOM—Major Command

MSE—Medical Surveillance Examination

MTF—Medical Treatment Facility

NAF—Non-appropriated Fund

NFPA—National Fire Protection Association

NIOSH—National Institute for Occupational Safety and Health

OEEL—Occupational and Environmental Exposure Limit

OEH—Occupational & Environmental Health

OEHED—Occupational & Environmental Health Exposure Data

OEH-MIS—Occupational & Environmental Health - Management Information System

OEHSA—Occupational & Environmental Health Site Assessment

OEHWG—Occupational & Environmental Health Working Group

OEM—Occupational & Environmental Medicine

OH—Occupational Health

OHCAMP—Occupational Health Compliance Assessment and Management Program

OMS—Occupational Medicine Services

ORM—Operational Risk Management

OSHA—Occupational Safety and Health Administration

OWCP—Office of Workers Compensation Program

PAR—Population at Risk

PH—Public Health

PPE—Personal Protective Equipment

QA—Quality Assurance

QC—Quality Control

RAC—Risk Assessment Code

RMU—Reserve Medical Unit

SEG—Similar Exposure Group

SF—Standard Form

TIC—Toxic Industrial Chemical

TIM—Toxic Industrial Material

TO—Technical Order

TLV—Threshold Limit Value

TR—Traditional Reservist

TWA—Time Weighted Average

UR—Uncertainty Rating

USAF—United States Air Force

USAFSAM—United States Air Force School of Aerospace Medicine

Terms

Action Level (AL)—An exposure level that dictates active air monitoring, medical monitoring, and employee training. The AL for airborne exposures is typically one-half the OEEL for TWA exposures, except where 29 CFR 1910 Subpart Z designates a different concentration or where the statistical variability of sample results indicates that a lower fraction of the OEEL should be used as the AL. (Source: AFMAN 48-155)

Activity—See Process

Administrative Controls—Any procedure that significantly limits exposure by controlling or manipulating the work schedule or manner in which the work is performed. (Source: DoDI 6055.1)

Assessment—Application of professional judgment (fully qualified BEE, civilian industrial hygienist, or BE Craftsman (4B071)) based on qualitative and quantitative information such as exposure measurements and estimates, mathematical modeling, and/or observations of work practices.

Characterization—The collection and organization of information needed to describe the workplace, workforce and OEH hazards.

Confidence in Controls—A qualitative and/or quantitative determination of how well and how consistently an OEH hazard is being controlled. (Source: AFI 48-145)

Confidence in Hazard Characterization—A qualitative and/or quantitative determination of the adequacy of OEH hazard data for reaching sound conclusions regarding exposure (Source: AFI 48-145)

Control—Action taken to eliminate hazards or reduce their risk. (Source: DoDI 6055.1)

Contractor—A non-Federal employer performing work under a DoD contract, whether as prime contractor or subcontractor. (Source: DoDI 6055.1)

Crisis Event—A contingency involving a threat that develops rapidly and creates a condition that commitment of US military forces and resources is contemplated. A crisis event: a) requires time-sensitive development of plans in response to an imminent crisis, b) follows prescribed crisis action procedures to formulate and implement an effective response within the time frame permitted by the crisis and c) requires time-sensitive planning for the deployment, employment, and sustainment of assigned and allocated forces and associated capability in response to a situation based on the circumstances that exist at the time planning occurs.

Deliberate Event— An event for which deliberate planning is accomplished in prescribed cycles. Deliberate events require the deployment/employment of forces and associated capabilities in response to an anticipated or hypothetical event and are reliant on assumptions regarding the circumstances that will exist when the plan is executed. Deliberate events are not normally time sensitive or dynamic.

Department of Defense Personnel Civilian On-Duty—Civil Service employees of the DoD Components (including Reserve Component military Reserve technicians and Reserve technicians, unless in a military duty status); non-appropriated fund (NAF) employees (excluding military personnel working part-time to avoid dual reporting); Corps of Engineers Civil Works employees; Youth or Student Assistance Program employees; foreign nationals employed by the DoD Components; Navy Civil Service Mariners with the Military Sealift Command, and Army-Air Force Exchange Service employees. (Source: DoDI 6055.1)

Department of Defense Personnel: Military— All U.S. military personnel on active duty, Reserve or National Guard personnel on active duty or performing inactive duty training, Service Academy cadets, Officer Candidates in Officer Candidates School and AOCS, Reserve Officer Training Corps cadets when engaged in directed training processes, and foreign national military personnel assigned to the DoD Components. (Source: DoDI 6055.1)

Engineering Controls— Eliminate or reduce exposure: process elimination, substitution of less toxic material, process changes (automation, isolation, and enclosure), design changes (tools, workstations, and equipment), and ventilation (dilution and local exhaust). (Source: DoDI 6055.05)

Environmental Health— Assessing, understanding and controlling the impacts of people on their environment (air, water, soil) and the impacts of the environment on the people.

Evaluation— Process of ascertaining or judging the value or adequacy of an action or an outcome by careful appraisal of previously specified data in light of the particular situation and the goals or objectives previously established. (Source: DoDI 6055.1)

Exposure— Concentration, frequency and duration to which personnel are subjected to a hazard.

Exposure Profile— A representation of how an exposure varies over time. Considered during exposure characterization and takes into account an estimate of the exposure and its variability as well as the accuracy of the estimate.

Exposure to Hazard— Expression of personnel exposure that considers the number of persons exposed and the frequency or duration of the exposure. (Source: DoDI 6055.1)

Force Health Protection (FHP)— All measures taken by commanders, supervisors, individual Service members, and the MHS to promote, protect, improve, conserve, and restore the mental and physical well being of Service members across the range of military activities and operations. These measures enable the fielding of a healthy and fit force, prevention of injuries and illness and protection of the force from health hazards, and provision of medical and rehabilitative care to those who become sick or injured anywhere in the world. (Source: DoDI 6200.05)

Hazard— Real or potential condition or agent (stressor) that can cause injury, illness, or death to personnel or damage to or loss of equipment or property, mission degradation, or damage to the environment. (Source: DoDI 6055.1)

Longitudinal Exposure Record— A comprehensive record of all OEH exposures for a full working lifetime; applies to all DoD personnel. (Source: AFI 48-145)

Occupational and Environmental Exposure Limit (OEEL)— The OEEL is the most appropriate limit adopted from established recognized standards including, but not limited to, those in AFIs and AFOSH Standards, the latest edition of the Threshold Limit Values (TLV) Booklet published annually by the American Conference of Governmental Industrial Hygienists, 29 CFR 1910.1000 Tables Z-1, Z-2, and Z-3 and 40 CFR 141. OEELs are limits of exposure established to protect personnel from hazardous OEH threat exposures. OEELs apply to OEH threat exposures for individuals and/or similarly exposed groups of individuals. (Source: AFMAN 48-155)

OEH Clinical Surveillance— The process by which workers receive MSEs, which are designed and conducted based on an assessment of workers' identified OEH risks. The results of these examinations are analyzed to determine if AF operations adversely affect the health of the workers. OEH clinical surveillance is also required in specific instances to meet OSHA requirements for medical monitoring. Additionally, clinical surveillance can be used to assess the adequacy of protective measures. The process by which workers receive Occupational & Environmental Health Medical Examinations, which are designed and conducted based on an

assessment of workers' identified OEH risks. The results of these examinations are analyzed to determine if Air Force operations are adversely affecting the health of the workers. OEH clinical surveillance is also required in specific instances to meet OSHA requirements for medical monitoring. Additionally, clinical surveillance can be used to assess the adequacy of protective measures.

Occupational Environmental Health (OEH) Hazard Characterization— Process for assessing individual OEH hazards, taking into accounts factors such as route of exposure, severity of OEH-related illness that may result from exposure, length of exposure, or duration of exposure.

Personal Protective Equipment (PPE)— Use of PPE shall be considered last in the control hierarchy unless other methods are not feasible. This may be the case while engineering controls are being designed and installed, or during non-routine operations including maintenance and emergency response. For non-military unique workplaces, PPE requirements shall be assessed IAW 29 CFR 1910.132 to identify tasks where PPE is required and to ensure that the proper equipment is selected and used. (Source: DoDI 6055.05)

Physical Hazards— OEH hazards that may include: noise, vibration, ergonomic (excessive force, excessive repetition, awkward position), ionizing radiation, lasers, radiofrequency radiation, light (infrared, visible, ultraviolet), cold, heat, hyperbaric and hypobaric.

Process— Any item of work or situation that may pose a risk, and may require evaluation and control or the lowest level of work that may require evaluation to assess exposure and associated controls. Not all processes are associated with a physical location, e.g., working near the flight line may constitute a process. The terms activity and process are synonymous.

Risk— Chance of adverse outcome or bad consequence; such as injury, illness, or loss. The risk level is expressed in terms of hazard probability and severity. (Source: DoDI 6055.1)

Risk Assessment— A structured process to identify and assess hazards. An expression of potential harm, described in terms of severity, accident probability, and exposure to hazard. (Source: DoDI 6055.1)

Risk Communication— The process of adequately and accurately communicating the magnitude and nature of potential environmental and occupational health risks to commanders and to Service members. (Source: DoDI 6490.3)

Risk Management— A process that assists organizations and individuals in making informed risk decisions in order to reduce or offset risk; thereby increasing operational effectiveness and the probability of mission success. It is a systematic, cyclical process of identifying hazards and assessing and controlling the associated risks. The process is applicable across the spectrum of operations and tasks, both on and off-duty.

Routine OEH Assessment— A qualitative and/or quantitative assessment conducted to identify and scope the processes employed to execute the unit's mission. (Source: AFI 48-145)

Severity—An assessment of the expected consequence, defined by degree of injury or occupational illness that could occur from exposure to a hazard. (Source: DoDI 6055.1)

Similar Exposure Group (SEG)— A group of individuals for whom representative exposure of any member of the group is predictive of exposures of all members of the group. The term

"SEG" is formally defined in the AIHA publication, "A Strategy for Assessing and Managing Occupational Exposures."

Special OEH Assessment— A quantitative assessment that focuses resources on OEH-related hazards requiring additional evaluation or classification. (Source: AFI 48-145)

Time Weighted Average (TWA)— An average exposure over a defined time period; also referred to as time weighted average concentration.

Unacceptable Exposure— A condition for which the probability of adverse health effects is significant, or there is evidence of adverse health effects associated with a specific OEH hazard. It can drive actions such as product substitution, implementation of new controls or the enhancement of existing controls to attain an acceptable exposure.

Uncertain Exposure— When the exposure level/profile of a hazard is not well characterized and the acceptability or unacceptability of a SEG's exposure assessment cannot be rendered. It may be due to the lack of accurate and/or reliable data as well as an uncontrolled environment. Will typically result in a need to capture more data to better understand an exposure and decide acceptability or unacceptability.

Uniquely Military—Equipment, Systems and Operations unique to the national defense mission, such as military aircraft, ships, submarines, missiles, and missile sites, early warning systems, military space systems, artillery, tanks, and tactical vehicles; and excludes operations that are uniquely military such as field maneuvers, naval operations, military flight operations, associated research test and development activities, and actions required under emergency conditions.

Workplace—Any environment where a potential OEH exposure may occur. A workplace may be administrative, industrial, or all encompassing, e.g., any setting where an OEH exposure may occur while deployed. (Source: AFI 48-145)

Workplace Supervisor—An individual with the authority to implement controls to eliminate, minimize, or reduce OEH-related risk associated with a hazard in a workplace.

Attachment 2

DETERMINING CONFIDENCE IN OEH EXPOSURE CHARACTERIZATION

A2.1. All criteria for a given category must be achieved in order to apply a given level of confidence in hazard characterization. If all criteria do not apply, move to the next lesser degree of confidence.

A2.1.1. HIGH: High confidence means the medium confidence rating supported by sufficient quantitative evaluation, or detailed technical reports where environmental factors do not influence exposure. Further quantification is not required or the source of hazard does not have potential to generate significant exposures. Sufficient quantitative data has been collected to draw a conclusion about exposure acceptability. Conclusions with high confidence based on sampling results should have a sufficient number of random measurements (ideally 6 samples) to use statistics (i.e., 95% confident that the 95^{th} percentile is less than the OEEL).

A2.1.1.1. Valid monitoring, i.e., air sampling, swipe sampling, scatter radiation measurements, has been performed and no additional monitoring is required (other than periodic monitoring). Professional judgment has been correctly applied to associate quantitative monitoring results to fully characterize the hazard being assessed.

A2.1.2. MEDIUM: Medium confidence means potential health outcome based solely upon a detailed administrative and onsite review of activities within the workplace and application of professional judgment supported by application of objective based engineering principles or comparison to similar DoD and or private sector operations (qualitative or quantitative). Qualitative methods were used to characterize a low risk hazard, i.e., infrequent, insignificant contact with a mild skin irritant or low heat stress during mild work.

A2.1.2.1. Screening samples or initial air sampling results are within acceptable limits, but not totally conclusive; additional monitoring is required to increase confidence in the conclusion. Qualitative methods were used to characterize a low risk hazard, i.e., infrequent, insignificant contact with a mild skin irritant or low heat stress during mild work.

A2.1.3. LOW: Low confidence means potential health outcome based solely upon a qualitative review of the workplace. No quantitative data available for this or similar activities. The source of the hazard has the potential to generate exposures above the action level. Quantitative data does not exist, or is insufficient to draw a conclusion regarding exposure.

A2.1.3.1. The hazard has not been fully characterized.

A2.1.3.2. Qualitative assessment alone was used to initially characterize a medium/high risk hazard, i.e., skin absorption, significant ergonomic stress, exposure to carcinogens.

Attachment 3

DETERMINING CONFIDENCE IN CONTROLS

A3.1. All criteria for a given category must be achieved to apply a given level of confidence in controls. If all criteria do not apply, move to the next lesser degree of confidence.

A3.1.1. HIGH: High confidence in controls means that unacceptable exposure is reduced through a combination of effective engineering controls and regulated area enforcement (as applicable). The human element as related to control effectiveness has been almost entirely eliminated. Engineering controls/work practice controls are in place and fully operational. Evaluations have been completed to demonstrate adequate exposure control.

A3.1.1.1. Hazard characterization has led to a high confidence that the exposure is less than the OEEL. Controls are not required.

A3.1.1.2. Chemical Inhalation – Exposure is controlled below the AL by engineering controls that have been proven effective through air sampling of exposure, and that are proven serviceable by periodic evaluation (i.e., quarterly ventilation surveys).

A3.1.1.3. Chemical contact and absorption, and physical hazards – Exposure is controlled below exposure limits by engineering controls that are proven serviceable by periodic evaluation.

A3.1.1.4. Administrative controls are in place to prevent access to regulated areas by unprotected, untrained personnel.

A3.1.1.5. Medical surveillance has identified no unacceptable dose, verifying controls are effective.

A3.1.2. MEDIUM: Medium confidence in controls means that unacceptable exposure potential exists, but is controlled by applicable method, administrative controls or PPE. The human element effects control effectiveness, so unacceptable exposure is possible if appropriate use of controls is not enforced.

A3.1.2.1. Chemical application method controls exposure (e.g., worker uses tongue depressor to apply sealant).

A3.1.2.2. PPE is required to control exposure, and workers have been observed using required PPE effectively.

A3.1.2.3. Medical surveillance has identified no unacceptable dose, verifying controls are effective; or, workers have no medically substantiated complaints of symptoms associated with exposure.

A3.1.3. LOW: Low confidence in controls means that the exposure is not adequately controlled, or a reliable conclusion cannot be made regarding the exposure given the information or data available. Controls are in poor a state of repair/non-operational/not actively used. Chemical inhalation exposure controlled by engineering controls that have not been proven effective through air sampling, or have been proven ineffective by air sampling.

A3.1.3.1. PPE is required to control exposure, but workers have been observed not using required PPE effectively, or using inadequate PPE (e.g., wrong type of glove).

A3.1.3.2. Regulated areas are accessible by untrained, unprotected personnel.

A3.1.3.3. Medical surveillance has identified unacceptable dose, such as temporary threshold shift; or, an occupational illness/injury report has been made; or, workers complain of symptoms associated with exposure, such as skin irritation or ergonomic strain which has been medically substantiated.

Attachment 4

ADJUSTING 8-HOUR TWA EXPOSURE STANDARDS

A4.1. Mathematical models can be used to adjust traditional 8-hour work schedules to non-standard conditions. Adjusting exposure standards to account for non-standard schedules can present challenges and no definitive consensus exists on the best way to adjust standards.

A4.2. Exposure standards do not represent a clear boundary between safe and unhealthy exposure. Typically exposure standards are based on health-related data and established with a conservative margin of safety. Additional information regarding unusual work schedules may be found in American Conference of Governmental Industrial Hygienist (ACGIH) TLV® Booklet.

A4.3. Brief and Scala Model:

A4.3.1. The Brief and Scala Model takes into account the number of hours worked in a 24-hour day and the period of time between exposure events and may not be applicable in all circumstances. This model is designed to ensure the daily dose for the toxicant of concern during the altered work shift is less than the dose for a conventional work shift. This accounts for the decrease in time allowed for biological elimination of the toxicant.

A4.3.2. Information required: hours worked per 24-hour day. The advantages of this method are:

A4.3.2.1. It is a simple calculation.

A4.3.2.2. It generates a conservative estimate of the dose.

A4.3.2.3. It requies no detailed knowledge about the substance being evaluated.

Figure A4.1. Formula:

$$Adjusted\ exposure\ standard\ (TWA) = \frac{8*(24-h)*listed\ exposure\ standard(TWA)}{16*h}$$

where h – hours worked/day

Figure A4.2. Example:

Substance:	Ethyl alcohol
Exposure Standard:	1000 ppm, 8 -hour TWA
Work shift:	12 hours

Solution:

$$Adjusted\ exposure\ standard\ for\ 12-hour\ work\ shift = \frac{8*(24-12)*1000ppm}{16*12}$$

$$Adjusted\ exposure\ standard\ for\ 12-hour\ work\ shift = 500\ ppm\ (12hr\ T$$

Attachment 5

SAMPLE ELECTION OF CARE PROVIDER STATEMENT

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

Patient Election of Care Provider for Work Related Injury or Illness

I have chosen to have the Air Force Medical Service

as my health care provider for the work related medical condition I am being seen for today.

I understand I have the right to refuse care through the Air Force and to seek care through my private medical care provider. However, I decline to exercise that right. I understand that I cannot change my choice of providers for a Workers' Compensation claimed condition without obtaining permission from the Office of Workers' Compensation Program.

_____ _____

(Patient Signature) (Date)

PATIENT'S IDENTIFICATION (Use this space for

RECORDS MAINTAINED		
PATIENT'S NAME (Last, First, Middle initial)		SEX
RELATIONSHIP TO SPONSOR:	STATUS	RANK/ GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART/ SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

Attachment 6

SAMPLE REQUEST TRACKING SHEET

Tracking Worksheet for Civilian Federal Employee Examination Requests Using DD Form 2161
(For internal Medical Treatment Facility Use ONLY)

Disclaimer: This worksheet is used by AF providers when requesting specialty medical consults, studies and laboratory tests for civilian federal employees. It is only used when Unit funding is required to obtain the consult/study/test (AFMAN 48-146) and is not used for medical care. Inappropriate use of this form may lead to criminal prosecution of responsible parties.

☐ Initial Request OR ☐ Request for additional service(s) [attach original worksheet dated _____] (check one)

Employee Name/Phone: Date of Request:_____

Job title/Position Description#: Unit/Shop:

Supervisor Name/Phone/Email/Address:

Purpose of Request (check one): ☐ OSHA required ☐ OWCP Controvert ☐ Formal Fitness for Duty Assessment

Requesting Medical Officer Name/Phone/Email/Address:

Service Requested: (check one)

Medical Specialty Consult:	_ Orthopedics, Hand	Study:
_ Audiology	_ Orthopedics, Spine	_ Magnetic Resonance Imagining
_ Cardiology	_ Otolaryngology	_ Cat Scan
_ Dermatology	_ Physiatry	_ Ultra Sound
_ Gastroenterology	_ Psychiatry	_ X-ray
_ General Surgery	_ Psychology	_ B read of Chest X-ray
_ Immunology	_ Pulmonology	_ Cardio lab
_ Infectious Disease	_ Rheumatology	_ Pulmonary lab
_ Neurology	_ Other:_____	_ Cardiopulmonary lab
_ Neuropsychology/Neuropsychiatry		_ Other_____
_ Oncology	Laboratory (chemistry, culture,	_____
_ Ophthalmology	cell, tissue):	COMMENTS:
_ Optometry	_ Specific Lab required:_____	
_ Orthopedics, General	_____	

==========

Estimate for consult/study/lab obtained $_____ _____ _____(date/initial)

DD 2161 request ☐ approved ☐ rejected by IOEMC _____ _____(date/initial)

DD 2161 request ☐ approved ☐ rejected by Resource Management Office _____ _____(date/initial)

Unit approved payment ☐ Yes ☐ No; Official contacted _____ _____ _____(date/initial)

Appointment arranged for worker by ordering clinic; set for date/time_____ _____ _____ _____(date/initial)

Supervisor letter to employee sent by ☐ Email ☐ Fax ☐Mail _____ _____(date/initial)

Confirmed worker attended appointment: _____ _____(date/initial)

- If worker failed to attend, supervisor/requesting provider notified: _____ _____(date/initial)

- Supervisor approved rescheduling of appointment ☐ Yes ☐ No ☐ n/a _____ _____(date/initial)

Report Requests (1, 2, 3 wks after appt): _____ _____; _____ _____ ; _____ _____(date/initial)

Report received: _____ _____(date/initial)

Invoice paid $_____ to_____ _____ _____(date/initial)

Report sent to requesting provider ☐ Email ☐ Mail ☐ Fax ☐ Hand delivered _____ _____(date/initial)

OSHA—Occupational Safety & Health Administration; OWCP—Office of Workers' Compensation Program; IOEMC—Installation Occupational & Environmental Medicine Consultant; CCA—Civilian Consult Administration

Attachment 7

CONTENT FOR THE ”REQUEST FOR COMMANDER’S AUTHORIZATION OF PAYMENT FOR CIVILIAN MEDICAL EXAM” SAMPLE MEMORANDUM

_____

MEMORANDUM FOR _____/CC

FROM: MDG/CC

SUBJECT: Request for Commander’s Authorization of Payment for Civilian Medical Exam

A civil service employee from your organization, _____, requires an Occupational Health medical exam, consult, study or laboratory test that cannot be provided by the military Medical Treatment Facility (MTF). We will assist the employee in obtaining the required exam in the civilian healthcare sector. Subsequent to receiving the exam results, we will finalize our medical determination. However, we need your assistance to secure payment for the examination prior to appointment scheduling. Please note, payment is for purposes of medical assessment only and does not cover provision of medical care.

Subject to 5 CFR § 339.301, individuals who have applied for or occupy positions which have medical standards or physical requirements, or which are part of an established medical evaluation program, may be required to report for medical examinations. Generally, exams are preventive efforts used to screen and monitor the employee's health for hazardous workplace exposures or for task requirements.

Per 5 CFR § 339.304, the Air Force must pay for all examinations ordered or offered to the employee, unless the purpose of the exam is to secure a benefit sought by the employee. Costs for these exams are borne by the same appropriation that funds the employee’s salary.

a. Attachment 1 contains a Commander’s Authorization of Payment for Civilian Medical Exam letter for your review and approval/signature. The bottom “Payment Information” section should be completed by your unit Resource Advisor (RA).

b. Attachment 2 contains payment instructions for your unit RA, along with an estimate of the cost for the employee’s exam.

The MTF will schedule the exam employee’s exam once your approval and method of payment is received. If you have any questions, please contact the pertinent office listed on the RA instruction sheet. Thank you for your prompt attention to this matter.

MTF Commander’s Signature.

Attachments
1. Commander’s Authorization of Payment for Civilian Medical Exam
2. Instructions to Unit Resource Advisor

Content for the ”Request for Commander’s Authorization of Payment for Civilian Medical Exam” Sample Memorandum

_____

MEMORANDUM FOR MDG/SGSR (ATTN: MTF RMO)

FROM: _____

SUBJECT: Commander's Authorization of Payment for Civilian Medical Exam

You are authorized to schedule _____ for a required medical examination, consult, study, or laboratory test. I authorize my unit's funds be used to pay for the exam; the method of payment is indicated below. This authorization is for purposes of medical assessment only and does not cover provision of medical care.

I understand that in order to avoid unauthorized disclosure of medical information under the Health Insurance Portability and Accountability Act of 1996, the civilian healthcare provider will send the results of the exam and the associated invoice to the military Medical Treatment Facility (MTF). The MTF will forward the invoice to my unit's Resource Advisor (RA). My RA will ensure payment is promptly remitted to the civilian healthcare provider.

Once the results are received by the MTF, I understand that the military MTF provider will complete the employee's examination and notify me/the supervisor of the employee's medical status, if warranted.

UNIT COMMANDER'S SIGNATURE

PAYMENT INFORMATION
(Completed by Unit RA – Please review "Instructions to Unit Resource Advisor")

Method of Payment:

□ Please reference our certified funding MORD. A copy of the MORD is attached.

□ We will pay the invoice using our unit Government Purchase Card (GPC). A copy of the approved GPC purchase request is attached.

NOTE: GPC is the preferred method of payment (most cost-effective to the government).

Sample "Instructions to Unit Resource Advisor"

INSTRUCTIONS TO UNIT RESOURCE ADVISOR

Per the Request for Commander's Authorization of Payment for Civilian Medical Exam to your unit commander, please follow the steps delineated below in order to pay for an examination for a civilian employee assigned to your unit.

Employee's Name: _____

Estimated Cost of the Exam (MORD Amount): $_____

MTF Provider/Clinic Requesting the Exam: _____

Provider/Clinic Contact Info: _____

MTF Payment POC/Resource Management Office (RMO):

RMO POC: _____

E-mail: _____

Duty Phone: _____ FAX: _____

Please review the options for payment from the table on the reverse side of this form, then indicate your selection in the "Payment Information" section of the Commander's Authorization of Payment for Civilian Medical Exam letter.

Reverse Side of Sample "Instructions to Unit Resource Advisor"

Payment via MORD	Payment via unit GPC
STEP 1: Please prepare an AF Form 406, Miscellaneous Obligation/Reimbursement Document (MORD), for the estimated cost provided above. In your Line of Accounting, please cite Element of Expense and Investment Code (EEIC) 572EM (Non-TRICARE Civilian Employee Medical Exams). The funding MORD will be in PC "S" for IAPS input and future payment.	STEP 1: Unit GPC card holder inputs the service (exam) into AXOL.
STEP 2: Please send to the MTF POC above— (1) Signed Commander's Authorization for Payment of Civilian Medical Exam letter, and (2) Copy of certified MORD	STEP 2: Send a copy of the approved GPC purchase request to the MTF POC.
PROCESSING FINAL PAYMENT	
STEP 3: The civilian provider will submit to the MTF the employee's exam results, and the invoice for payment. NOTE: The MTF will verify that the invoice states "Full" or "Final" payment. If the invoice does not state that it is for full/final payment, then the MTF must contact the civilian provider's billing office in order to receive a revised bill.	
STEP 4: The MTF will prepare an SF 1034, Public Voucher for Purchases and Services Other Than Personal, IAW the AFAFO Miscellaneous Payment Guide located on the AFAFO Community of Practice at the following link - https://km.saffm.hq.af.mil/ASPs/docman/DOCMain.asp?Tab=0&FolderID=OO-FM-AF-01-63&Filter=OO-FM-AF-01 to reflect the full/final amount owed to the civilian provider, and (1) Annotate the standard document number (SDN) of MORD on the SF 1034. (2) Attached a copy of the invoice to the SF 1034. (3) Forward all documents to the base-level FMA.	STEP 4: The MTF will provide the unit RA with a copy of the invoice. The Unit GPC card holder makes payment. NOTES: - If the GPC transaction is rejected, the MTF will notify the unit RA immediately. The unit RA will assist the MTF in resolving the GPC payment. STEP 5: In order to capture costs in the proper EEIC, you will need to prepare a Journal Voucher in order to transfer the

(4) Send a copy to the unit RA. NOTES: - If the final cost exceeds the amount of funding on the MORD, the MTF POC will notify you to increase the MORD amount in order to cover full payment. The payment cannot be forwarded to FMA until the additional funds are loaded on the MORD. - If the final cost is less than the amount on the MORD, you may deobligate the balance.	cost of the exam you're your GPC's EEIC to EEIC 572EM (Non-TRICARE Civilian Employee Medical Exams). Using EEIC 572EM enables AF-wide visibility of funds expended on these exams.