18-2 Removal from Duty for Medical Reasons: Sick In Quarters (SIQ), Convalescent Leave, Light Duty, or Limited Duty

(1) ***MTF Responsibilities***. Navy MTFs will recommend Navy and Marine Corps members for periods of medically restricted duty when this is deemed clinically appropriate by properly credentialled Department of Defense (DOD) health care providers. MTF leadership will ensure an appropriate mechanism exists within their respective MTFs to notify the patient, the patient's parent command, and when possible, the patient's personnel support detachment (PSD) or administrative office, of the timeframe of this medically restricted duty period, and of the restrictions from duty recommended for the service member in each case. The following paragraphs present the categories of potential "medically restricted duty" status for Navy and Marine Corps members.

(2) ***Sick In Quarters (SIQ).*** A properly credentialled DOD health care provider may recommend a member for SIQ status following medical treatment or for the purpose of "medically directed self treatment." "SIQ," as implied in the name, is a status in which the military member is relieved of all military duties with the expectation that the member will be in his or her residence recuperating until the expiration of the SIQ period. Providers recommending members for SIQ do so in full anticipation that the member will return to a medically unrestricted duty status at the conclusion of the SIQ period. SIQ status should usually not exceed 72 hours. (MILPERSMAN articles in the 1050 series and MCO P1900.16 series may be consulted for additional information in those rare instances in which extensions of SIQ status (potentially up to 14 days) emerge as medically indicated. Respective Service headquarters instructions on the management of pregnant servicewomen should be consulted for special categories of SIQ, e.g., "OB Quarters," that may be appropriate in caring for these patients.)

(a) Health care providers recommending a service member for SIQ are responsible for ensuring, in concert with the ADSM's parent command, that the facilities to accommodate the patient's condition, and the availability of any necessary auxiliary caregivers at the member's "quarters," are entirely clinically compatible with the condition for which the member is being placed SIQ.

(b) Providers are also responsible for ensuring the patient in an SIQ status fully understands any follow-on evaluation and care requirements during and following the SIQ period.

(c) Appropriate clinical judgment is critical in successfully evaluating a patient for SIQ status, and any doubt as to the appropriateness of an SIQ placement will be resolved by foregoing SIQ status in lieu of a more comprehensive treatment protocol.

(d) The recommendation to place a member on SIQ must be communicated by the senior medical department representative or MTF to the appropriate level of the member's parent command for concurrence. MTF commanders and senior medical department representatives shall ensure an appropriate notification process exists for timely notification to an ADSM's parent command of any SIQ recommendation; a critical component of this process is verifying the timely receipt of information by the parent command. MTF business practices in this regard must carefully balance the undeniable need to provide information to the parent command with the need to protect the patient against further aggravation or discomfort from the condition that has resulted in the SIQ recommendation. In some cases, requiring the patient to physically return to his or her parent command to present an "SIQ chit" for approval may be clinically contraindicated. Here, the provider and MTF leadership need to rely on other appropriate communication methods that satisfy both the health care needs of the patient and the operational and administrative control needs of the parent command (e.g., if the patient's return to the parent command is contraindicated, the provider or another appropriate MTF official might call the patient's division officer for official notification; this would be followed by the patient's delivering the SIQ paperwork to the division officer upon the patient's return to duty).

(1) In the event of a conflict between the MTF's SIQ recommendation and the parent command's willingness to grant SIQ status, the matter should be elevated to such a level in the chain of command of the respective MTF and the parent command that an appropriate compromise is achieved

that preserves both the parent command's mission readiness posture and the patient's well-being. As in all endeavors, the member's CO bears overall and final responsibility for the well-being of the member; Navy Medicine must ensure that appropriate information is conveyed that allows COs to exactingly carry out this responsibility in medical matters.

(2) Placing a member on SIQ does not require the convening of an MEB.

(3) ***Convalescent Leave.*** A properly credentialed DOD health care provider may recommend a member be placed in convalescent leave (often referred to as "con leave") status following significant medical treatment and/or a period of inpatient hospitalization. "Convalescent leave" is a period when the member is relieved of all military duties and is in a leave status until the expiration of the leave period. (Convalescent leave is not charged as regular leave; if given medical clearance members may travel, usually at their own expense, to a location other than their residence during a convalescent leave period. Some convalescent leave travel for members medically evacuated (MEDEVAC'd) from a war zone may qualify for reimbursement.) Every health care provider recommending convalescent leave on any patient will be familiar with the provisions of, and have ready access through their patient administration officer to, MILPERSMAN article 1050-180, MCO P1900.16 series, and NAVMEDCOMINST 6320.3B, section A-4d (as modified by BUMED Notice 1300 of 3 May 1991) which detail convalescent leave policies. Providers must pay particular attention to factors such as length of convalescent leave periods and requirements for medical evaluation during and at the conclusion of convalescent leave.

Note: Convalescent leave periods are not to exceed 30 days (with the exception of post-delivery maternity cases in which 42 days of convalescent leave may be recommended). Questions on any aspect of the convalescent leave program are to be referred to the MTF's patient administration officer.

(a) Health care providers recommending convalescent leave are responsible for ascertaining from the patient that the facilities to accommodate the patient's condition, and the availability of any necessary auxiliary caregivers at the member's proposed convalescent leave site, are entirely clinically compatible with the patient's condition.

(b) Appropriate clinical judgment is critical in successfully evaluating a patient for convalescent leave status, and any doubt as to the appropriateness of a convalescent leave recommendation will be resolved by foregoing the leave in lieu of a more comprehensive treatment protocol.

(c) The decision to place a member on convalescent leave generally requires concurrence of the member's parent command. (In instances where the member's parent command is geographically removed from the MTF recommending convalescent leave, the MTF CO or their designee can approve the convalescent leave without approval of the parent command.) Parent command concurrence on a convalescent leave recommendation is often obtained by having the member deliver the convalescent leave request, after medical endorsement from the provider, to the parent command. There may be cases however, in which directing the patient back to the parent command is logistically difficult or clinically contraindicated based on the condition that resulted in the convalescent leave recommendation. In these instances, MTF business practices must carefully balance the undeniable need to provide information to the parent command with the need to protect the patient against further aggravation or discomfort from the condition that has resulted in the convalescent leave recommendation. In such cases, the provider and MTF leadership need to rely on other appropriate communication methods that satisfy both the health care needs of the patient and the operational and administrative control needs of the parent command (e.g., if the patient's return to the parent command prior to starting convalescent leave is clinically contraindicated, the provider or another appropriate MTF official might call the patient's division officer for official notification; this would be followed by the patient's delivering to the division officer the convalescent leave paperwork upon the patient's return to duty. Moreover, the convalescent leave notification can be conveyed in the message traffic sent by MTFs to parent commands advising them when command members are discharged from an inpatient hospitalization.).

(d) In the event of a conflict between the MTF's convalescent leave recommendation and the parent command's granting convalescent leave, the matter should be elevated to such a level in the chain of command of the respective MTF and parent command that an appropriate compromise is achieved

that preserves both the parent command's mission readiness posture and the patient's well-being. As in all endeavors, the member's CO bears overall and final responsibility for the well-being of the member; Navy Medicine must ensure that appropriate information is conveyed that allows COs to exactingly carry out this responsibility in medical matters.

(e) Placing a member on convalescent leave does not of itself require the convening of an MEB.

(4) ***Light Duty.*** A properly credentialed DOD health care provider may recommend a Navy or Marine Corps member for light duty to evaluate the affect that an illness, injury, or disease process has on the member's ability to be in a medically unrestricted duty status. "Light duty" is a period when the member reports to their work space, but during the period the member is excused from the performance of certain aspects of military duties, as defined in their individual light duty write-up. The goal of light duty is to allow for appropriate clinical evaluation without causing further damage to the patient during the evaluation period. A provider placing a member on light duty does so only with the expectation that the member will be able to return to medically unrestricted duty status at the end of the light duty period; care must be exercised to ensure that light duty is not abused or used as an inappropriate substitute for MEB overview of a case. Accordingly, when a diagnosis is initially made of a new condition for which the provider feels light duty is appropriate, light duty is permitted. (This criterion of a "new condition" does not preclude multiple "light duty" periods over the course of a member's career; it does however preclude excessive periods of light duty consecutively for the same condition.) Light duty presumes frequent provider and patient interaction to determine whether return to medically unrestricted duty status or more intensive therapeutic intervention is appropriate in any given case. Therefore, light duty will be ordered in periods not to exceed 30 days to ensure appropriate patient clinical oversight. Consecutive light duty for any "new condition" up to 90 days may be ordered by the provider (in maximum 30-day periods), but in no case will light duty exceed 90 consecutive days, inclusive of any convalescent leave periods. At the end of the light duty period, the member will either be immediately returned to medically unrestricted duty or will be referred to an MEB.

(a) The MEB will prepare an MEBR for placing the member on temporary LIMDU and/or referring the member to the PEB for DES processing. In no case will a member reach the 90th day of light duty without the MTF having submitted an MEBR either placing the ADSM on LIMDU or referring the patient to the PEB for DES adjudication.

(b) A provider recommending a member for a light duty status will complete NAVMED 6310/1 (11-2004), Individual Sick Slip. The provider will clearly annotate the restrictions and limitations imposed upon the member's duty, as well as the time period required in a light duty status. The provider will ensure that the NAVMED 6310/1 is placed in the member's health record and that copies are provided to the member for the member to deliver to the parent command.

(c) If there is a question that the medical condition necessitating light duty is due to an injury, thereby requiring line of duty/misconduct (LOD/M) determination, the provider will ensure the member is directed to the MTF's patient administration department immediately following the determination that light duty is clinically indicated. The patient administration or medical boards office will launch (via naval message traffic) the request to the parent command for a line of duty determination/investigation (LODD/I). LOD/M determinations are discussed in more detail in article 18-16.

(d) The decision to place a member on light duty requires concurrence of the member's parent command. As light duty placement, by definition, will usually return the patient to the parent command throughout the light duty period, parent command concurrence for a light duty recommendation is most often obtained by having the member deliver the light duty recommendation to the parent command. MTF commanders shall ensure an appropriate notification process exists by which the MTF makes timely notification to the parent command of any Navy or Marine member recommended for light duty; a critical component of this process is a mechanism for positively verifying the timely receipt of information by the parent command.

(e) MTF providers and patient administration officers must maintain close liaison with parent commands of members placed on light duty, and remain mindful of the burdens placed on a command when

its members are medically restricted from performing aspects of their duty. In the event of a conflict between the MTF's light duty recommendation and the parent command's granting light duty, the matter should be elevated to such a level in the chain of command, of the respective MTF and parent command, that an appropriate compromise is achieved that preserves both the parent command's mission readiness posture and the patient's well-being. However, if a parent command indicates that it is incapable of accommodating a proposed light duty placement for a member, and the provider has conclusive clinical indications that denial of light duty will cause further harm to the patient, the provider should immediately initiate MEB proceedings for an MEBR leading to the patient's placement on temporary LIMDU. As in all endeavors, the member's CO bears overall and final responsibility for the well-being of the member; Navy Medicine must ensure that appropriate information is conveyed that allows COs to exactingly carry out this responsibility in medical matters.

(f) Placing a member on light duty does not require the convening of an MEB.

(5) ***Limited Duty.*** A properly convened MEB at an MTF may recommend that a member be placed on a documented period of medically restricted duty as a result of illness, injury, or disease process. LIMDU is a period when the member reports to their work space, but during the period the member is excused from the performance of certain aspects of military duties as defined in their individual LIMDU write-up. For this chapter, and in the actions of all MEBs throughout Navy Medicine, "limited duty" will refer to temporary limited duty (as opposed to permanent limited duty). Temporary limited duty is also known as LIMDU and or TLD; these terms are used interchangeably throughout this chapter.

(a) LIMDU is similar in many respects to light duty; major differences between the two are that, in comparison to light duty, LIMDU periods:

(1) Last longer than light duty periods.

(2) Require notification to not only the parent command, but to respective service headquarters and the servicing PSD of the member's status.

(3) May necessitate the transfer of the member from the parent command if it is a deployable unit.

(4) Do not necessarily require the consent of the member's parent command, or of the respective service headquarters. MTF commanders possessing "Convening Authority" allowing them to empanel MEBs must ensure appropriate business practices to alleviate undue burden on both the patient and the patient's parent command, and must include in all LIMDU cases appropriate notification to the patient's parent command servicing personnel/administrative office, and the respective service headquarters personnel office.

(b) Continuing care, recovery, and rehabilitation are conducted during LIMDU in an effort to return the member to medically unrestricted duty status.

(c) LIMDU may only be provided to a patient as the result of the actions of an MEB. LIMDU MEBs are addressed in detail in article 18-10.

(d) A patient whose case is referred to the PEB for DES adjudication, if the patient is not already in a LIMDU status, will be concurrently placed on LIMDU pending the PEB outcome. The Abbreviated Limited Duty Medical Evaluation Board Report detailed in article 18-17 may be used for this purpose.

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