"THE PRIMER"

Aide Memoire
For
The New
General Duty Medical Officer

v0.99

2013

This is an informal compendium of personal observations and opinions based on CAF Doctrine (Standards and Guidelines) current as of December 1, 2013.

This is in no way intended to be an official, authorized, Canadian Armed Forces Document or Publication. It is an aide memoire intended to help a new GDMO find resources that he/she may commonly use.

It is not intended to be the sole reference used, and information herein should be verified through D Med Pol, or other authorities, whenever there are any concerns.

If you note any errors or recommend any changes, or would like an electronic copy of the original document, please contact Scott MacLean at scott.maclean@ualberta.ca

Acknowledgement should be given to those at D Med Pol who previously prepared "The Pearls" (2008 Edition) on which this document was based.

Definitions and Acronyms

AA	Alcoholics Anonymous
ACLS	Advanced Cardiac Life Support
ACSC	Aeromedical Standards and Clinical Services
ACSO	Air Combat Systems Officer
AEC	Aerospace Control
AESOP	Aerospace Electronic Sensor Operator
AGE	Air-Gas Embolus
AIME	Airway Intervention and Management in Emergencies
AMT	Aeromedical Training NCM
AMTO	Aeromedical Training Officer
AMTRP	Advanced Military Trauma Resuscitation Program
APLS	Advanced Pediatric Life Support
AR(MEL)	Administrative Review (Medical Employment Limitation)
ATLS	Advanced Trauma Life Support
AUMB	Aerospace and Undersea Medical Board
AWACS	Airborne Warning and Control System
BFOR	Bona fide occupational requirement
BFT	Battle Fitness Test
BPSO	Base Personnel Selection Officer
BSurg	Base Surgeon
CAFJOD	Canadian Armed Forces Junior Officer Development
CANSOFCOM	Canadian Special Operations Forces Command
CDU	Care Delivery Unit
CEMS	Common Enrollment Medical Standard
CF	Canadian Forces
CF 2016	Form – Medical Attendance Record (No longer in use)
CF 2017	Form - For release medical, 2017a is now in use for signatures
CF 2033	Form - For regular physical, 2033a is now in use for signatures
CF 2034	Paper Health Record - “The Old Chart”
CF 2088	Form - For permanent MEL recommendations
CF 98	Form - For reporting of training/operation based injury, reporting to CoC
CF H Svcs Gp	Canadian Forces Health Services Group
CF2007	Form - For optometrist/opthalamic vision assessment
CFHIS	Canadian Forces Health Informatics System
CFMS	Canadian Forces Medical Services
CFP 154	Canadian Forces Policy 154 - Medical Standards
CFPC	College of Family Physicians of Canada
CFS	Canadian Forces Station (i.e. CFS Alert)
CIC	Cadet Instructors Cadre
Class A Service	Reserve service, Part time, no more than 12 consecutive days, <180d/year
Class B Service	Reserve service, 13+ Days in a row, >180d/year
Class C Service	Reserve service, Operating as full-time employee

CM	Clinic Manager
CMA	Canadian Medical Association
CMBG	Canadian Mechanized Brigade Group
CMPA	Canadian Medical Protection Agency
CO	Commanding Officer
COATS	Cadet Organizations Administration and Training Service
CoC	Chain of Command
COT	Compulsory Occupation Transfer
CPE	Continuing Professional Education
D Med Pol	Director Medical Policy
DAG	Departure Assistance Group
DART	Disaster Assistance Relief Team
DCS	Decompression Sickness
DMCA	Director Military Careers Administration
DND 2298	Form for Reserve Force Compensation
DRDC(T)	Defense Research Development Canada (Toronto)
EI	Employment Insurance
ER	Emergency Room
EST	Electroshock Therapy
FTE	Full-time Equivalent
G-LOC	Gravity-induced Loss of Consciousness
GDMO	General Duty Medical Officer
HBO	Hyperbaric Oxygen
HCP	Health Care Practitioner
HQ	Headquarters
IBTS	Integrated Battle Task Standard
ICU	Intensive Care Unit
IM	Intramuscular
IV	Intravenous
JPSU	Joint Personnel Support Unit
LFAA	Land Forces Atlantic Area
LFCA	Land Forces Central Area
LFWA	Land Forces Western Area
MCRP	Maintenance of Clinical Readiness Program
MEL	Medical Employment Limitation
MO	Medical Officer
MOSID	Military Occupation Structure Identification
MP	Military Police
NCM	Non-commissioned Member
NDHQ	National Defense Headquarters
NP	Nurse Practitioner
OUTCAN	Outside of Canada
PA	Physician Assistant
PCat	Permanent Medical Category

PCN	Primary Care Nurse
PHA	Periodic Health Assessment
PTSD	Post Traumatic Stress Disorder
QA	Quality Assurance
RCMP	Royal Canadian Mounted Police
RFC	Reserve Force Compensation
RTU	Return to Unit
RTW	Return to Work
RWOR	Retain without Restrictions
RWR	Retain with restrictions
SAR	Search and Rescue
SDA	Special Duty Area
SISIP	Service Income Security Insurance Plan
SQFT	Secteur du Quebec de les Forces Terrestre
TCat	Temporary Medical Category
UMT	Unit Medical Team
VAC	Veteran's Affairs Canada

Introduction

"When I was your age" there was a document called "THE PEARLS" – put together by D Med Pol or its recent staff. This document was last updated in 2008, and a lot had changed. We asked for an update, and were answered with "CFP 154" – which covers a lot about the CAF Medical Standards and the Periodic Health Exam – but does little to enhance the understanding of a new GDMO on how the system works, the "tricks of the trade," and dealing with some of the challenges and questions you might face on a daily basis.

This document was created by a few recently qualifield GDMOs in the spirit of "THE PEARLS," while acknowledging that the document is only as up to date as it can be, and that any information contained herein should be verified at the source (CFP 154 or CFHS Instructions and Directives.) Some of the portions are taken relatively verbatim from CAF Policy, and some are a collection of thoughts and opinions, and should be treated as such.

This document is in no way a substitution for knowledge of up-to-date CAF Policy.

Things to do as soon as you can

There are a few things you should do, or obtain, as soon as you can. They will help your practice, and ensure that your life runs as smoothly as possible. This list is not exhaustive, but a gathering of opinions.

1. A 3- or 4-line stamp from Staples to use as a signature block for yourself. This should include at least name, rank, role (i.e. GDMO) location (i.e. "CDU C") and extension number/phone number. You can get this from your orderly room, and should, however, it takes time. You'll get tired of signing your name AND all this information in short order.
2. Some sort of file system for paper forms. You will come across a lot of forms in your daily work, and having some sort of efficient filing system for blank forms will make your life easier.
3. A coffee maker for your office. (If you're a coffee person). I suggest getting one for your CDU to share and having it in a common location – but that's up to you. I found that as a GDMO, the $25 I spent a week on K-cups for my team was worth the morale benefits.
4. Familiarize yourself with your clinic staff, directed medical services staff, pharmacist, specialist clinic staff, xray staff, etc. The better you know these people, the easier your day will be.
5. Try to keep a smile on your face as much as you can. The days can be long, hard, and frustrating. Keeping a smile on your face, and a positive attitude, rubs off on those around you.
6. Develop a relationship with your Civilian staff, Med Techs, Clerks, and other staff in your CDU. Figure out who will cover your inbox when you are unavailable. At the very least, come up with a plan involving your Base Surgeon or other members at your clinic to sort this out, or email your prof

tech chain when leaving on tasks in order to ensure coverage. THIS IS CRITICAL – YOU CAN BE SUED FOR INAPPROPRIATE FOLLOWUP, AND MAY END UP IN THE FIELD A DAY AFTER ORDERING A LAB TEST.

7. Do your CFHIS Modules as soon as possible. If you can plow through them in 2-3 days (don't see any patients these days) you will get access to CFHIS quicker, and you will save yourself time on BMOC later (assuming they keep time available to complete modules on that course.)
8. Print documents you refer to often, it will make your life easier.(For example, consider printing the CFHIS modules and making a CFHIS reference binder. Put tabs in it for common problems, i.e. repeating a prescription) Be aware that sometimes, references change.
9. Try your best to make an internet bookmark list. There seem to be little internet elves within the mil.ca domain who move pages around randomly – and this means your links will sometimes be out of date – but if you refer to something commonly, you might at least get a warning if it's about to move.
10. Speak with your clerk about scheduling. Set a personal schedule that works for you, including Admin time, PT time, and appropriate time for fast-track appointments. Spend a bit of time in your first few months figuring out where you are under-employed and try to fix that. Consider same-day or within 72 hours bookings for some appointments. (For example, I have set aside several 10 minute appointments at the end of each day for those people who present on sick parade for non-sick parade issues.)
11. This is probably the most important (If cheesy)

    Be the change you want to see in the world.

    (Or in our case – the system.)

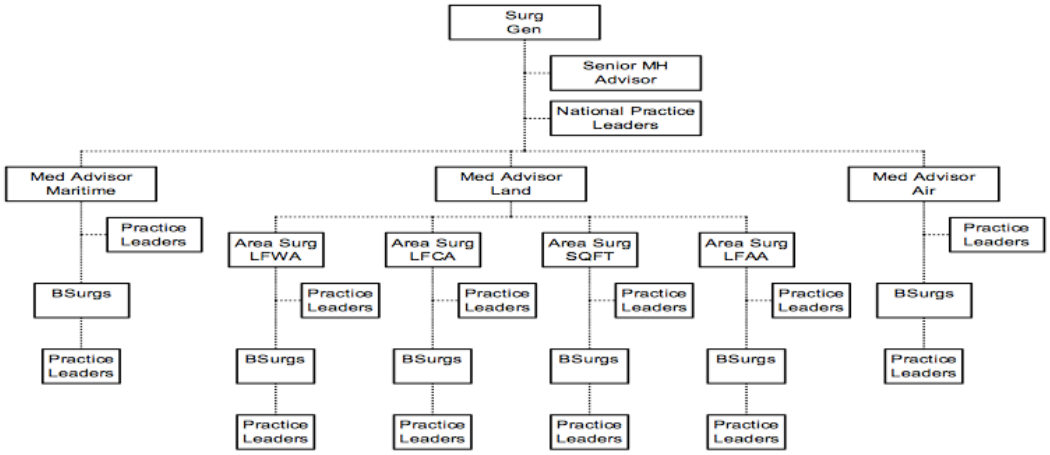
    If there's something you think is wrong, work to improve it. Train your staff. Be a role model and leader. Complaining out loud won't fix it (at least not alone), but hard work will.

Professional Technical Net

The Professional Technical Net (Prof/tech net) is responsible for the medical policy and direction of the Canadian Armed Forces. The Surg Gen exercises prof/tech control over all other medical caregivers via a well- defined responsibility accountability framework referred to as the prof/tech network. This framework extends down to every individual caregiver. It also includes linkages with the Chain of Command (both CF H Svcs Gp and supported Commands) at all levels.

The expanded D Med Pol organization is being adequately resourced to proactively identify and produce policy for pressing health care issues. It is directly responsive both to the Surg Gen and to the Med Advisors. The diagram below outlines the Prof/tech net, but for the most part, your only concerns revolve around the Base/Wing Surgeons and the Area Surgeons.

THE PROFESSIONAL TECHNICAL NET



Role of the Base Surgeon

Relying upon the expertise of clinical professionals and appointed Practice Leaders, the BSurg implements policy and directly oversees all elements of clinical practice at the clinic level. The BSurg provides leadership in numerous patient-focussed activities including patient complaint management, quality assurance and pharmacy and therapeutics committees. As well, the BSurg carries out reviews of population health trends, and provides education and guidance in the important areas of disability management and medical category management.

The expectation is that BSurgs will welcome the opportunity to more fully carry out their professional advisory role and become first-line practitioners in the prof/tech chain since the necessary admin (non-prof/tech) functions are absorbed through the new Clinic Manager appointments at most large clinic sites. At units smaller than Base Clinics, a clear prof/tech reporting relationship will be defined between each CAF health care provider and their next most senior authority.

Role of D Med Pol

Director Medical Policy (D Med Pol) is the corporate authority, on behalf of the Surgeon General, to impartially review the medical files of all Canadian Armed Forces members, and when appropriate, assign permanent medical categories and employment limitations to best preserve the member's health and/or reduce the risk of further deterioration. It is directed at maintaining a consistent and standardized approach to various medical problems and translates your limitations into the operational context that the staff at DMCA will understand.

Medical Administrative Process

The military medical community has the mandate and responsibility to describe, and communicate to the administrative and employment authorities, a clear and concise medical opinion of any employment limitations and the capability of the member to perform the expected duties and tasks safely and effectively. The assignment of the numerical medical category must always follow the definition of employment limitations and serves simply as an indicator to the administrators that there may be medical employment considerations.

Processing Regular Force Medical Files

There are a number of review and approval pathways for processing temporary and permanent changes to medical categories and medical employment limitations. The path taken depends on the nature of the change and the occupation of the member. The table at Annex B summarizes the various approval pathways.

Submission Requirements

With the introduction of the electronic medical record, the submission and review of medical files has become somewhat less paper-intensive. The following is a list of the important items, which will be presented whenever you submit medicals for D Med Pol review.

- CF 2088;
- CF 2033(a) or CF2017(a) as well as associated PHA Part 1 and 2 on CFHIS
- Generic and MOSID Specific Task Statements (Reviewed and signed by the physician)
- Draft Medical Employment Limitations (As part of your 2033/2017 and 2018 on CFHIS)
- Leage G and O factors blank in CF 2088 and CF 2033/2017!
- Make recommendations for G, O factors on CFHIS (plan section) and on CF 2018.

The Paper Trail (Err…CFHIS Trail)

Where is the file?

Files received at D Med Pol are logged into our database and filed by our medical records clerk. The D Med Pol clerk is the point of contact for any inquiries regarding the status of a member's file or for requests for a file to be expedited.

How are the CF 2033 and 2088 processed?

D Med Pol reviews the information provided by the originating medical unit and awards a category and medical employment limitations (MELs). If it is a temporary category, the whole package is sent back to the clinic. If it is a permanent category, we produce a medical statement of limitations (MELs). The original CF2088 and the medical statement is then sent to DMCA for AR (MEL), if required, and a copy is sent to you (the originating medical unit). The member and his unit will officially find out his/her limitations and any possible career action when DMCA is ready to "discuss" the case and sends out the disclosure package. There can be a long delay between the time that D

Med Pol reviews the file and the AR(MEL) begins. It is mandatory that you inform the member of D Med Pol's Medical Statement prior to disclosure, as it may be different from what you had initially recommended.

What if the attending physician disagrees with D Med Pol's decision?

If you feel the member's medical condition has either changed or is not accurately reflected in the MELs prepared by D Med Pol, you can either argue your case directly through the professional technical net or formally resubmit the file with additional information or substantiation.

Administrative Review (MEL)

The AR (MEL) process involves the review of the member's employabilityin light of assigned employment limitation(s) associated with a permanent change in the member's medical condition. The aim of the process is to determine the member's suitability for further service in keeping with Canadian Armed Forces' policies and regulations. The career decisions associated with the AR (MEL) process are the domain of, and rest with, DMCA.

What is the disclosure package?

Once DMCA has completed their review of the MEL's, they will release a disclosure package to the member through his/her unit. The package includes the *original CF 2088*, medical statement, and intended career action. During disclosure, members are free to raise any issues they feel are relevant and can provide evidence in support of their concerns. If these concerns are medical in nature, the member may send them in a sealed envelope to DMCA indicating their confidential nature. DMCA will then forward the member's evidence for review and comments to D Med Pol. The disclosure is the first opportunity for the CO and the member to comment to DMCA on the MELs and their career implications.

D Med Pol vs. DMCA

D Med Pol is responsible for standardization and quality assurance of MELs, G and O factor determination, and developing policy related health care. Career decisions are the domain of DMCA **not** D Med Pol at the CF H Svcs. Once D Med Pol reviews a case and outlines the member's employment limitations in the medical statement, the case is sent to DMCA for administrative review. DMCA reviews the member's employment limitations and, recommends one of the following career dispositions:

- Retain without career restrictions (RWOR);
    - Meets Universality of Service + Bonafide Occupational Requirements

- Retain with/without career restrictions (RWR)- retention normally for the duration of the member's existing TOS. There may be restrictions on things such as career courses, postings and promotions.
    - Meets Universality of Service + Bonafide Occupational Requirements

- Compulsory Occupational Transfer (COT); or

    - Meets Universality of Service but not Bonafide Occupational Requirements

- Release - release may be under any item, not necessarily 3a or 3b. Again, this is DMCA's decision.
    - Members who wish to be released ASAP must fax a signed memo to DMCA and clearly indicate they waive their rights for disclosure and do not want to be retained: their file will become a priority.

The role of CAF medical personnel in this process is to diagnose, treat and assign medical employment limitations. Do not try to become the member's career manager. Remember, only DMCA makes career decisions.

Reserve Medicals

The medical standards process for reserve force personnel is the same as for Regular Force personnel. However, DMCA is not involved in their AR (MEL) process. D Med Pol reviews the submitted files in the same manner but forwards the prepared MELs to various area/formation headquarters based upon the affiliation of the reserve force member. The files are therefore sent to the appropriate authority.

CIC Officers

The Cadet Instructors Cadre (CIC) command structure does not implement a formal AR (MEL) process at present. CIC files are still reviewed by D Med Pol, medical statements prepared, and the CF 2088 completed. The package is forwarded to the appropriate Regional Cadet HQ.

However, no administrative action is taken other than filing the MELs and observing the medical limitations provided. In determining MELs for CIC officers, it is prudent to take into account the CIC employment environment. They do not deploy on operations and most of the Generic Task Statements are never encountered. They are, however, responsible for the safety and well being of young cadets so a careful assessment of their physical and mental fitness to perform this role is essential.

Reservist Entitlement to Care

The concept of Reservist Entitlement to Care is complicated. There is a matrix that shows the process flowchart for determining whether or not reservists are entitled to care at your location at Annex C.

They are always entitled to:

- Occupational assessments for promotion, fitness for deployment/tasking/course, or other CAF purpose

- Immunizations required for deployment/tasking/course or other CAF purpose
- PHA and assignment of appropriate MELs as required
- Care for acute injury related to service

After that, things get more complex, and refer to the flowchart. If in doubt, err on the side of providing care. If you have concerns, seek advice.

With our recent operational tempo and international deployments, we have seen more reserve force members go into theatre, and as a result, some end up ill or injured. There was an Ombudsman's report looking at the care of reserve force ill and injured members – which demonstrates the importance of providing adequate care for our reserve force members through their course of illness.

In particular, the report focused on compensation for those reserve members who were ill or injured, required ongoing care, and were not able to get back to their previous jobs. The Forces has come up with policy related to reserve forces and the concept of RFC – Reserve Force Compensation. You may be asked to complete forms related to this injury or illness. Members become eligble for RFC when their illness results in them being unable to perform duty due to illness or injury attributable to service, and the illness continues beyond the termination of contract during which it occurred.

Your role as an MO would be to assess the patient and their disability, similar to the SISIP process, is to assess the degree of disability of the patient, and whether they would be suitable for duty, suitable for their previous employment in the civilian world, or suitable for any employment or study at all.

The compensation program is complex, and is often considered on a case-by-case basis. Appropriate policy can be found by searching for CBI 210.72 or reserve force compensation on the intranet, the forms you need can be found by searching out DND 2398 on the intranet (although the member should provide this form to you.)

Medical Category System and Periodic Health Assessment

The Medical Category system has become less important than MELs over the past number of years, but provides a rapid and simple way to communicate a members general medical fitness to the chain of command. The Periodic Health Assessment (PHA) is employed to determine a member's medical category and general medical fitness, perform appropriate screening tests, and provide the opportunity for a member to raise any health concerns.

The Screening Questionnaire

Before seeing you, the member will have completed a few things, including a screening questionnaire to provide you with some considerations when seeing them, and saving you some time when it comes to the PHA Part 2 – Encounter. (Members should

generally have also completed their Part 1 (Hearing, vision, height, weight, BMI, and vitals) as well as screening investigations before their Part 2 – but this doesn't always happen.)

Questions from the Screening Questionnaire and guidelines for dealing with answers are included in Annex D.

Frequency of Exam

In general, PHAs are valid for five years for members under 40, and two years for members over 40 for all MOSIDs unless otherwise specified. When a PHA is performed between the ages of 35 and 40, it shall be valid for a maximum period of 5 years, but not beyond age 42. Enrolment medicals are generally only good for 2 years – with few exceptions (Training base (36 mos), Reservist (2-5 years)) with the intent being that "as soon as training is completed, the member should have a PHA if it has taken longer than 2 years. People in Kingston may see this with respect to Cadets at RMC – who may wait even longer than 36 months to get their medical updated.)

Age	Frequency of PHA
<40	Every 5 years
>40	Every 2 years

The period of validity does not apply to aircrew or dive medicals, which have their own periods of validity. During the period of validity, and unless otherwise specified, the results of the PHA can be used to determine occupational fitness for administrative or personnel management purposes provided the HCP has confirmed that no new medical concerns have arisen since the last PHA (normally through a combination of health record review and brief consultation with the member). Examples of these occasions where occupational fitness must be determined include, but are not limited to:

- Component Transfer;
- Pre-deployment screening;
- Promotion screening;
- OUTCAN Screening;
- Screening for Isolated/Semi-Isolated Postings; and
- Screening for CFS Alert.

Health Assessments performed for other reasons may be considered equivalent to a PHA for purposes of confirming occupational fitness. These include:

- Enrolment Medical Examinations;
- Release Medical Examinations;
- A Temporary Medical Category; and,
- A Permanent Change of Medical Category or MELs.

This has a significant implication to the concept of "focused TCATs" – where the PHA for TCAT is performed with focus only on the illness or injury requiring temporary

restrictions and MELs. In general the practice has been discouraged, but still occurs. At a minimum, a complete PHA should be completed for removal of TCAT and restrictions, where the member would then be awarded a new medical category and their PHA would be valid for the designated period of validity.

The Medical Category

The medical category includes the year of birth (YOB) and six factors written in numeric form. It is expressed as:

YOB - Year of Birth
V - Visual Acuity
CV - Color Vision
H - Hearing
G - Geographical Factor
O - Occupational Factor
A - Air Factor

A quick guideline for medical categories (V, H, G, O) is included as Annex E.

YOB – Year of Birth

Disease rather than the normal aging process appears to be a more important factor in the probability of debilitation, as one gets older. At the same time, it is known that many diseases show a prevalence that varies with age. As such, inclusion of the year of birth (YOB) in the medical category is reasonable. It is expressed by the last two digits of the YOB.

Vision Factor

Visual acuity and refractive standards refer to the eye in its normal physiological state and not to situations where visual acuity and refractive status have been artificially altered by orthokeratology or radial keratotomy carried out within the previous twelve months. Visual acuity and refraction measurements resulting from orthokeratology or radial keratotomy within the previous twelve months are not deemed valid for the purpose of recruitment and employment. (Must stabilize before can be considered.) Visual acuity is expressed in grades from V1 to V5 as below.

Grading	Uncorrected Vision		Corrected Vision	
	Better Eye	**Other Eye**	**Better Eye**	**Other Eye**
V1	6/6	Up to 6/9	N/A	N/A
V2*	Up to 6/18 or Up to 6/12	Up to 6/18 Up to 6/30	6/6	6/9
V3*	Up to 6/60	Up to 6/60	6/6	6/9
V4*	Worse than 6/60	Worse than 6/60	6/9	6/60
V5	This grading is assigned to those whose visual acuity is worse than the V4 grading or when the refraction error exceeds plus or minus 7.00 dioptres (+/- 7.00D) spherical equivalent in the better eye regardless or the uncorrected distant vision			

*As long as the refractive error does not exceed plus or minus 7.00 dioptres (+/- 7.00D) spherical equivalent in the better eye

Calculation of Spherical Equivalent

This requires a complete visual exam and CF2007. In order to calculate the spherical equivalent:

1. divide the cylinder power by 2
2. add this value to the sphere power
3. the result is the spherical equivalent

Vision Factor Change

If the member's vision acuity changes (even if still within MOSID minimum medical requirement), a CF 2007 must be obtained from an ophthalmic technician (or if not available from an optometrist). In most cases, the CF 2007 should be considered valid if done in the last 6 months. (This is based on Aircrew standards.) If you have any concerns regarding change in vision, particularly if it is different from the recent CF 2007, send for further assessment.

If **V5** is considered, an ophthalmologist or an optometrist capable of performing a complete fundus examination must examine to rule out any complications. If the above examination is normal, member should have following limitation:

To repeat eye examination every two years

Any member with a **V2** or higher vision factor, should have the following limitation:

To wear corrective lenses as directed

Acquired monocular vision

Patients with acquired monocular vision are normally assigned a 3 month period of no driving before returning to driving vehicles in which depth perception is not critical. This would preclude the operation of such equipment as cranes and dump trucks for example. When establishing a permanent category the following limitations will be given:

> *Member has monocular vision with an associated decrease in peripheral vision and impaired depth perception. Therefore, should avoid tasks where these skills are considered essential.*
>
> *To wear corrective lenses as directed.*

Color Vision Factor

Color vision measurement refers to the eye in its normal state and not to measurement through colored contact lenses designed to "correct" color vision defects. Three grades of color vision are recognized: CV1, CV2 and CV3. Members should be tested at time of recruiting, and generally are not retested at time of PHA unless there are concerns, or if they are referred for a complete visual assessment.

- CV1 – Normal Color Vision – CV Safe
  - Pass Color plates
  - No further testing is required
- CV2 – Abnormal Color Vision (Minor defects) – CV Safe
  - Fail Color plates
  - Pass Farnsworth D-15 Standard test
- CV3 – Abnormal Color Vision (Major defects) – CV Unsafe
  - Fail Color plates
  - Fail Farnsworth D-15 Standard test

Hearing Factors

The ability to hear the spoken voice or audible signals, often against a considerable background of concurrent noise, is of paramount importance in certain trades. Auditory acuity is expressed in grades from H1 to H4. Hearing aids are not to be worn during measurement of auditory acuity.

CATEGORY	EAR	ACUITY	FREQUENCY RANGE
H1	Both ears	≤ 30 dB	500 to 8000 Hz

H2	Both ears	≤ 30 dB	500 to 3000 Hz
H3	Better ear	≤ 50 dB	500 to 3000 Hz
H4	Better ear	> 50 dB	500 to 3000 Hz

Note 1. Following a surgical procedure to improve hearing, an audiometric examination will be done to determine any residual hearing loss. The audiometric examination should be done at a time recommended post-operatively by the surgical specialist and the appropriate H grade assigned.

Dealing with a change in Hearing

Hearing is assessed at Part 1 of the PHA. Our audiogram is a SCREENING exam. If there are any concerns regarding a change in hearing category as a result of the initial screening exam, a referral to Audiology for a complete assessment after which a change in hearing category can be done.

In particular, any threshold shift of 15+ dB requires further examination. Consider re-screening within a couple of weeks (At least 3 days later/3 days after exposure to hazard) at your unit to confirm, and then refer if the change persists.

If this referral is required, MAKE IT, and when completing the CF 2033 – on the right side there is a space for "tests required." Complete that part, and then when the tests are returned, the main part of the CF 2033 can be completed.

Changes to hearing category do not need to be assessed by D Med Pol unless they no longer meet trade standard.

You can argue that all members require an MEL for hearing protection (or that it's common sense) however the recommendation for H2/H3 is that an MEL be applied that states:

> *Maximum hearing protection required.*

With more severe hearing loss (ie H4), consider both applying more restrictive MELs and assessing the suitability of retention in the current occupation. MEL may be worded as:

> *Should not be exposed to loud noise (firing range, heavy machinery, close proximity to aircraft engines) as this may exacerbate a chronic medical condition.*

For members who require hearing aids, note that it typically is assessed G2O3 with MEL (*requires use of hearing aid device*) through D Med Pol.

Dealing with Tinnitus

Tinnitus is a challenge, as often it is a reported symptom with normal hearing exam. As of 1 Dec 2013, there were no easily discoverable guidelines on Tinnitus in CF H Svcs Gp instructions. Tinnitus is generally quite challenging to manage, even if you can firmly determine the diagnose, and, through the CAF Spectrum of Care, there are no funded management options. There are, however, Veteran's Affairs benefits for Tinnitus, and, as a result of this, tinnitus will show up and does warrant futher investigation.

Differential diagnosis is large, including Meniere's disease. A general approach to tinnitus is similar to a change in hearing:

- Refer for formal audiology assessment (with tympanometry);
- Consider ENT referral;
- Consider imaging
    - MRI – R/O Acoustic neuroma, neoplasm
    - CT – R/O otosclerosis, Paget's disease of bone
    - Either – R/O carotid dissection, aneurysm, fibromuscular dysplasia

Again, there is no firm guideline from the CAF on this. In the civilian world, based on most recent evidence, the above workup would certainly be appropriate to rule out any other reversible or more serious disorders. The challenge is management, as there is not much evidence for anything in particular.

A good rule of thumb is to treat tinnitus as a warning sign for future hearing loss. As a GDMO, your job is to focus on prevention – maximum ear protection, and avoiding ototoxic medication.

Geographic Factors

Geographic Factor is intended to provide information on requirements for appropriate medical care (type of care and accessibility to care.) It provides guidance on fitness for extended operations, fitness for certain locations (i.e. isolated postings, non-climate controlled facilities, absence of electricity) or requirement for frequent medical services.

G1 - assigned to the member who has successfully passed the stringent medical requirements for such unique duty as astronaut training; (If you see this on a chart, and the person isn't an astronaut – they should probably be G2.)

G2 - assigned to the member:

- who has no geographical limitations due to a medical condition; and
- who is considered healthy and, at most, requires only routine, periodic or scheduled medical services no more frequently than every twelve (12) months

G3 - assigned to the member:

- who is considered likely fit for field exercises, sea environment, isolated postings and operational taskings for periods up to six (6) months;
- who has a known requirement for scheduled medical service by an MO but no more frequently than every six (6) months;
- whose limitations resulting from a known medical condition do not pose an unacceptable risk to the health and/or safety of the individual or fellow workers in the operational/work environment;
- who may require and take prescription medications, the unexpected unavailability of which will not create an unacceptable risk to the member's health and/or safety;
- who may require a medical evaluation before being sent on the tasking; and/or
- who requires enhanced medical and/or psychiatric screening before a deployment.

G4 - assigned to the member:

- who is considered unfit because of medical limitations inherent to the medical condition itself or because of the unacceptable risk to the health and/or safety of this person or to fellow workers imposed by the operational environment on the medical condition;
- who may be on prescription medications, the unexpected discontinuance of which, for even a few days, is considered likely to create an unacceptable risk to the health and / or safety of this person (or to co-workers);
- who may require close proximity to medical services/ready access to physician-directed medical care; and / or
- who generally requires scheduled medical care by a MO more frequently than every six (6) months.

G5 - assigned to the member:

- who requires scheduled specialist medical care more frequently than every six (6) months; and
- who is considered unfit for duty in an area that does not have ready access to full medical services.

G6 - assigned to the member who is considered unfit for any work environment. (RARE.)

Involvement of Specialist Care

Involvement of ongoing specialist care generally means that a member would have the geographic category G5, unless the requirement is less frequent than every 12 months, then the member could be designated G2.

It is important to note that involvement of psychology is considered specialist care, and should result in G5 designation if actively seeing psychology more frequently than every 12 months.

Involvement of non-physician services (directed medical services)

The involvement of non-physician medical services (physio, counselling, social work, etc) generally requires the geographic category G4.

Occupational Factors

The physical and mental activity and the stress associated with employment within a specific MOSID, although often difficult to describe and measure in an objective and reproducible manner, are important aspects in the grading of the occupational factor. The demands on the member may vary with the MOSID, as well as with the geographical locale.

In general, the associated mental stress is not described in any detail, unless a specific MOSID or medical condition(s) (usually psychiatric) so dictates. In these cases, consultation with a military psychiatrist should describe acceptable levels of mental stress for the particular member.

Members with medical conditions that impose limitations should be assessed against both the Generic and the MOSID Task Statements. In this way, an appropriate O factor can be assigned.

O1 - assigned to those rare members who have successfully completed medical screening for such unique duties as astronaut training. (Not really used anymore. If you see it on a chart, it should probably be changed to O2.)

O2 - assigned to the member who has no employment limitations of a medical nature.

O3 - assigned to the member who has some specific employment limitation(s) which can be clearly and specifically detailed, and which prevent the member from fully meeting the Generic or the MOSID task statements. (ie. “No running” prevents completion of the FORCE test and restricts in the Physical portion of the Generic task statements. Other conditions may restrict the response to stressful environments.)

O4 - assigned to the member:

- who has sufficient limitations such that employment in an operational scenario is, on balance, compromised; (*unfit operational environment*)
- who is generally restricted to light duties only, i.e., general office tasks, including

delivering mail, parcels and supplies and maintaining a stock room (these tasks involve lifting and carrying objects of variable weight and bulk and require the ability to walk and climb stairs while carrying out these duties);
- who is capable of working a full eight (8) hours per day; and / or
- who is considered fit for shift work as long as it is stable (i.e., shifts don't change rapidly).

O5 - assigned to the member:

- who is generally restricted to sedentary duties such as clerical / desk work only, which do not involve lifting and carrying objects or climbing stairs or ladders with these materials (typically these individuals are capable of acting as a receptionist, answering telephones, and doing typing and some light office filing);
- who is capable of working up to eight (8) hours per day but generally at his / her own pace;
- who is not considered fit for shift work; and
- unfit for any military work.

O6 - assigned to the member who is unable to work in any capacity (i.e. needs 24hr care.)

Air Factor

There is a requirement for air operations and transportation to express the functional capacity of the member in terms of his/her ability to perform in an aircraft. The final "A" factor is graded from 1 to 7 and identifies the functional relationships that pertain to aircrew, passengers and those who are unfit to fly.

A1 - assigned to pilots who are medically fit for unrestricted duty in all CAF aircraft;

A2 - assigned to navigators, flight engineers, observers and helicopter reconnaissance observers who are medically fit for unrestricted duty in all CAF aircraft where such positions are required;

A3 - assigned to those aircrew members for whom a medical restriction has been identified. An A3 classification will always clearly stipulate the specific limitations to be imposed;

A4 - assigned to all aircrew who are medically fit for unrestricted airborne duty but whose duties do not entail actual operation of the aircraft to which they are assigned. If such individuals were to become incapacitated they would not create a hazard to aircraft operation nor impede the safe return of the aircraft to the ground. An A4 classification may be annotated "While So Employed" (WSE) when it is assigned to members of MOSIDs which are not normally associated with flying. Air Traffic Control and Air Weapons Control personnel must also maintain an A4 category for unrestricted

employment;

A5 - assigned to all non-aircrew members of the CAF who are medically fit to fly as passengers in CAF aircraft;

A6 - this grade is assigned to all CAF members who are considered medically unfit to fly in any capacity; and

A7 - this grade is assigned to all aircrew personnel who are medically unfit for any flight duty in CAF aircraft but who may still fly as passengers.

Military Operational Considerations

It is critical to consider the impact of the member's condition in the context of a military operational environment. While it is difficult to accurately define an operational environment, we have learned from previous operational experiences that there is a high degree of unpredictability/uncertainty, combined with potentially tremendous levels of mental, physical, and emotional stress. In addition, service members on operations can expect to deploy with little or no access to medical care for protracted periods and may have little or no access to their normal support structure (friends and family). To this end, you should consider the following:

a. What is the risk of a crisis in a given year?

b. In the event of a crisis related to the medical condition, what level of medical care will be required (PA, GDMO, or specialist) and how soon?

c. What are the potential consequences of a delay in medical treatment?

d. Will the potential mental or physical stress of an operational environment place the member or others at risk? This is of particular concern in members who suffer from PTSD, bipolar illness, anxiety or depression; and suicidality.

e. Are there any specific requirements related to medication use (refrigeration, laboratory services, absolute requirement or risk of suffering significant complications)? We no longer include statements regarding medication that the member can easily carry and without which for days to weeks he/she would be unlikely to suffer a crisis.

Medical Employment Limitations vs. Medical Category

The number-coded medical category system (the numeric figure) provides a simple way to communicate a member's general fitness to the chain of command. However, the numeric figures are of little to no use by themselves unless they are accompanied by clearly stated medical employment limitations (MELs). Moreover, the Director Military Careers Administration (DMCA) gives little to no heed to the numeric figures. MELs, on

the other hand, are fundamental and matter most in determining employability and deployability.

The importance of clearly stated MELs cannot be overstated. The permanent MELs represent the central issue around which employment and career decisions are made. Within the process of assigning MELs, any decision to medically restrict the employment and deployment of a member must be based on considerations relating to the member's medical condition, prognosis and recovery, the member's safety, the safety of other CAF members and the public, the operational effectiveness and the member's rights and freedoms. Any MEL should be based on the above-mentioned considerations.

Temporary Category

A temporary medical category may be assigned locally for any period up to a maximum of 12 months, but are typically 6 months at a time (except for aircrew or diving medicals). After 12 months, the member's condition has typically stabilized and a decision regarding permanent medical status should be made at that time. When deemed necessary, an *extension* of the temporary category may be obtained but in all cases the file must be staffed through D Med Pol for approval.

Submissions for T Cat extension should address the member's past medical history, treatment plan, and prognosis (with specialist substantiation if indicated). Above all, there must be a clear expectation of significant improvement. The member should be advised that D Med Pol might not approve the extension when a P Cat is determined to be more suitable.

Permanent Category

A permanent medical category should be initiated once the nature of the member's medical condition has stabilized, treatment maximized, or the condition is unlikely to improve. Important points to remember include:

When to submit to D Med Pol. Whenever the assigned P Cat involves a modification of the "G" or "O" factors or when there is a change to any other factor that violates the member's trade specific MOSID standard then the file must be staffed through D Med Pol for review and eventually AR (MEL);

Leave the "G" and "O" factors blank. Please leave the G and O factors blank on all sections of the CF 2033 and CF 2088. This includes the review blocks (section 3 and 5 of the CF 2033 and Part II and III of the CF 2088). D Med Pol will assign the numbers prior to submission to AR (MEL). This will help reduce the number of administrative inquiries into why the category was changed. You can make recommendations for G and O factors in your note in CFHIS.

Common Enrolment Medical Standard

A Common Enrolment Medical Standard (CEMS) is required for recruit candidates in order to ensure that they remain eligible for assignment to the widest range of

MOSIDs. All applicants, except Canadian Rangers, must initially meet this minimum standard, although they may require a more rigid (higher) standard to enter/be assigned to some MOSIDs. The CEMS is V4 CV3 H2 G2 O2 A5.

Universality of Service

The principle of universality of service or "soldier first" principle holds that CAF members are liable to perform general military duties and common defence and security duties, not just the duties of their military occupation or occupational specification. This may include, but is not limited to, the requirement to be physically fit, employable and deployable for general operational duties.

Generic Task Statements

The generic task statement is a collection of specific physical tasks and stress related performance factors that all members of the CAF must be capable of completing. For your convenience, this list is included at Annex F;

MOSID Considerations

A list of the current MOSID specific minimum medical standards can be found within CFP154, as well as at Annex G. There is a common misconception that as long as your assigned medical category is better than or equal to your trade's minimum acceptable category, you will be considered medically fit. This notion fails to recognise that the critical issue is the member's employment limitations. Thus, when you are assigning employment limitations to someone whose category will remain within his/her MOSID standard, it would be prudent to advise them that there case will likely undergo AR (MEL).

MOSID-Specific Task Statements

The MOSID specific task statements can be found in CFP 154. Unfortunately, they do not exist for officers nor for all NCM MOSIDs. The task statements consist of a collection of tasks that identify the mandatory performance criteria for a given MOSID. Thus, you can recommend limitations that are relevant to what the member is supposed to be fit to do both generically and within his/her trade (BFORs); and

Reassessment of permanent MELs

There are generally two possibilities here:

- Member has gone through the AR(MEL) process for a previous illness or injury, and develops another illness or injury requiring new MELs, or
- Member has been assessed through AR(MEL) and you disagree with the MELs applied.

In the first case, you need to proceed as per normal, with the chit and 2088 indicating the previous MELs (or referring to the previously documented AR(MEL) on CFHIS) as well as the new MELs.

In the second case, the process for reassessment of permanent MELs involves re-submission to D Med Pol with another CF2033a, 2018, and 2088. It is probably not necessary to complete another PHA part 1 and 2; but a note should be included in CFHIS in the appropriate area (most likely as a new PHA part 2 or an addendum to the previous PHA part 2.)

On occasion, you will face a member who may have been complaining of illness resulting in significant employment or posting limitations – and has been recommended for release – at which point they seem to make a recovery from their illness. The Maligerer is a challenge – and you should seek some advice when dealing with their medical categories.

Quality Assurance

Ultimately, the base surgeon is responsible for QA. That being said, medicals generally require a second signature to verify/agree with the recommendations of the medical. You may be asked to review a medical, and should take this role seriously, as it can have serious implications on careers, insurance coverage, and veteran's affairs compensation. Depending on the QA program in place at your unit, you may also occasionally be tasked to do a chart review of someone's charts. (And they may be tasked to review yours.)

At the very least, the mobility of our members and the national EMR that is CFHIS means that your notes will be read by others, and your note should be appropriately written, concise, and clear.

Medical Disposition

The significance of accurate employment limitations cannot be overstated. They are the central issue around which employment and career decisions are made. It is extremely important that you try to be as specific as possible. Confine your statements to the specific limitations related to the medical condition. Do not make recommendations regarding the member's career or other administrative matters.

Possible Dispositions

There are a number of possible variations on disposition – but generally, there are a few important ones to consider, from least to most restrictive:

- Return to duty, fit full duties
    - Generally you don't need to do anything for this. No chit required.
    - Sometimes the CoC will request a fit full duties/"patient attended" note from your Clinic. Try to discourage this practice where you can.
    - You CAN remove MELs early (say at 7 days when your original plan was 14 days) with a Fit Full Duties chit.
- Return to duty with limitations
    - Max 30 days from GDMO level without TCat

    - Occasionally you can have back-to-back 30 days – if you are on a 2nd chit, consider TCAT.
    - You can remove these early, or consider modifying early for graduated return to work.
- Excused Duties
    - Max 2 days, technically a form of Sick Leave.
    - Watch out for frequent fliers
- Sick Leave
    - Max 14 days from GDMO Level
    - Important to remember that this is THERAPY. Sick leave is with the intent to improve a medical condition or illness – not intended for time off/away from a stressful situation/environment, nor is it intended for compassionate reasons.
- Sick in Quarters/Residence
    - Like sick leave – but the member is techinically on-duty, and should have someone provide meals for them, monitor them, etc.
    - This is a helpful disposition for someone you feel needs some observation for deterioration but is not sick enough for hospital
    - Also helpful for the malingerer who you think is looking for a day off
    - This may be challenging to figure out at your base. Spend a bit of time figuring out how this can be arranged, who needs to be contacted, and who is responsible for observing the patient.
- Admission
    - The Hospitalized patient is on-duty, does not require a sick chit for that day. This is an important concept, particularly when related to surgical patients.

These are all of the "types" of disposition – but you can be creative and try to work within this system. For example, Return to duty with limitations could be applied in someone who you feel should work half-days.

Develop a close relationship with your military police/local police as well – if you come across a situation where you feel a patient may be at risk of being suicidal or harming someone else, you should immediately get the MPs involved. They may choose to hold the patient for observation and are able to help you transfer the patient to an appropriate level of care.

Individual Approach

Diseases vary in their impact on individuals and individuals cope differently with the stress that diseases place upon them. As a result, it is possible to have two service members with the same disease and based upon their unique responses, one could have limitations that result in his/her release while the other might have only minor limitations and be retained.

With this in mind, designating MELs for an individual is an art that requires a bit of assessment of the patient, the patient's occupation, and the impact of the illness on the patient and their occupation. Guidelines are not hard and fast for most conditions, and should not be employed universally without taking into consideration the individual.

The Concept of Medical Employment Limitations and Risk

The first-glance idea when thinking about MELs is that they are all about function, what can and can't this person do. A large part of MELs do involve functional capacity – and with that in mind, when there is conflict about MELs, often a functional assessment through physiotherapy is warranted to help determine MELs for a patient. One of the challenges in formulating MELs is the issue of pain ('It hurts when I..') – which is part of your assessment for MELs and determination of fitness. It should be an early part of your discussion with a patient when their MELs for pain become things that are likely to interfere with employability and/or career.

The second, more complex part of MELs involved assessment of risk. It is important to consider a few things:

- If there is an exacerbation of illness, how soon does the member need to be seen/treated?
- If they do have an exacerbation, are they likely to be able to continue to fulfull their duties until treatment?
- What are the chances of an exacerbation in the next 10 years?

The figure below provides an example of how D Med Pol, and AR(MEL) might apply these criteria to cases when determining limitations and career recommendations.

	Level I Reqr med tmt within **72 hrs**	Level II Reqr med tmt within **24 hrs**	Level III Reqr med tmt within **1 hr**
< 10 % / 10 years	**L**	**L**	**M**
10 - 20 % / 10 years	**L**	**L**	**M**
20 - 50 % / 10 years	**L**	**M**	**H**
> 50 % / 10 years	**L**	**H**	**H**

The result of these assessments of risk help D Med Pol assign appropriate MELs, and determine the risk (to the member, and the organization) of retention and employment in an operational environment.

Using CFHIS for a Chit

Since its adoption, CFHIS administration has been striving to improve the system to be responsive to the needs of the users. Initially, users had to "create their own" MELs,

using either freehand or guidelines/MEL Bank (See Annex H.) Since then, CFHIS has created a template for the sick chit with dropdown menus for MELs. This is with the goal of standardizing wording and specific limitations. While not perfect, it does make things a bit easier, and does allow for free-hand text boxes as well, which should be used as necessary.

Things to Avoid - Career Suggestions as a MEL

Often, members will come to you with requests for letters, suggestions on a chit, or other requests to help them transfer units, achieve a certain posting location, or move them to a specific role within their unit.

Do not try to be the member's career manager or the Personnel Selection Officer. Do not make recommendations such as "*should be given an occupation transfer to supply tech"*, "*should be accommodated in his current trade"*, or "*should be posted to the JPSU."* ***These are not medical employment limitation recommendations.***

You can, however, at the request of the member, consider writing a letter of support for the member to use through their Chain of Command and appropriate channels. Be careful with this, as you can get yourself into someone's bad books for overstepping your role.

Should vs. Shall

One of the dilemmas facing military physicians is the issue of how to protect patients who can do certain tasks but may exacerbate their condition if they are required to do the task too often. A good example of this would be a soldier with moderate mechanical lower back pain. In most situations, this individual can perform lifting activities but would be best to avoid repetitive heavy lifting on a regular basis. In this situation, we now use the limitation *"should avoid"* as this best reflects the member's physical capabilities.

When this limitation is awarded, the member is **expected to** perform the activity when instructed to do so by the chain of command but should avoid doing so whenever possible. This means the decision to do the task is not that of the member but rests with his/her chain of command. It is important to articulate these implied interpretations of this limitation to both the member and to their chain of command. If the medical condition changes or the member and their physician decide that the task can no longer be performed under any circumstance, then new employment limitations should be submitted to D Med Pol.

If you feel that the person performing this task at all could exacerbate their condition, then it is more appropriate to use the terms "shall not" or "shall avoid," or alternately "Unfit <text>." In this situation, the person is medically directed to not perform that task.

Informing your Patient

One of the major sources of dissatisfaction for members is not being kept properly informed. In every case, they should be advised regarding the significance of being assigned temporary or permanent limitations. While it is one thing to function as the patient's advocate, it is another to give the member false hope when his/her condition is such that the limitations you assign them will likely result in a recommendation for release.

This becomes more important when dealing with TCAT and PCAT designations. All too often, the first time members are made aware that their careers are in jeopardy is when they are notified by DMCA that their case is being subjected to an AR (MEL) review and they have an opportunity for disclosure. These individuals are often justifiably angry and initiate time consuming redress of grievances, ministerial inquiries, ombudsman inquiries, etc.

The volume of permanent medical category-related inquiries could be substantially reduced if patients were informed from the very beginning that their limitations are such that they will require AR (MEL) review and that one of the possible outcomes of such a review is a recommendation for release from the CAF.

With this in mind, please be extremely careful when advising patients about career implications. Do not try to predict the outcome of the AR (MEL). We strongly recommend that you simply advise the member that his file will be sent for AR (MEL) review and that you are uncertain as to what the career outcome will be.

It would be appropriate when indicated to refer the member to a Case Manager who has the primary responsibility to support and provide the member with transition assistance, informing of services and benefits available to ill and injured members.

Informing Chain of Command

It is the responsibility of the member to inform his/her Chain of Command of their limitations by providing a copy of their sick chit. As a result, it is important that your sick chit provides clear guidance with respect to limitations, what the member is unable to do, and the specific limitations. (IE. Unable to lift >5 kg vs. unable to lift heavy weights)
Also, the concept of shall vs should is an important consideration.

Dealing with Chain of Command Concerns

The member's chain of command has a duty to follow your medical directions (investigations, treatment, disposition, and MELs.) They are also encouraged to clarify MELs and plan where necessary. The commander has also been directed to try to seek advice directly from health services personnel, rather than asking the member to act as intermediary.

All of this means that you will be fielding calls from chain of command. Remember the aspects of privacy that are required – the information on the sick chit is what the CoC is entitled to know. Some members will choose to discuss their health issues with the CoC, but without consent, you are not permitted to discuss.

Your role is to try to clarify MELs and requirements to CoC, and typically if you are clear with these on your initial sick chit, you should be all set. If not, you might get called. At this point, you should consider discussing this with the member as well, to provide them with some opportunity to discuss with CoC and give you some guidance regarding the disclosure of information to CoC.

This becomes more of an issue on field operations – particularly when it comes down to the question "does this person need to be sent home or not" – and you may come into conflict when you suggest that a member needs to be returned to unit(RTU). Be ready for this, and be ready to describe your medical plan, investigations/treatment facilities required, and the applicable MELs requiring the person to be RTU.

Compassionate and Family Concerns

You may have patients who present to your office requesting compassionate leave due to stress at home or in the workplace, the health of a family member, or other reasons. Compassionate leave requests go through the member's own chain of command, and often the Padre/chaplain is the best person to help facilitate this. There is limited role for the GDMO in this process.

Dealing with Mental Health Concerns

A working group was established in September 2007 and research of the literature and up-dated evidence-based medicine were reviewed in order to give the most appropriate MELs in case of mental health diseases. Case diagnosis should be given according to the DSM, including a multiaxial diagnosis. Appropriate MELs will be non-paternalistic and involve the participation of the patient. When submitting cases for DMedPol's review, the following information is essential and if missing could be returned for further info:

- Detailed but concise history which must include the following:
    - documentation of approximate date of onset of episodes
    - details of treatment required for mental health problems to include:
        - name of medication and dosage (s)
        - if medication changed or added specify date
        - if medication d/c specify reason (side effects- d/c by patient etc)
        - identify requirement for EST
        - identify if IV or IM long term (chronic) therapy is required
    - history of hospitalisation
        - was mandatory form required
        - length of stay and reason for extended stay

- history of return to work and if difficulty reason for delay
- Specialists reports (see note 3)

  Each case will be evaluated to identify if the member's health would allow work in a military environment. The well-being of the other members in the mission and the success of the mission itself have also to be taken in consideration.

- Duration of Temporary Category. Recognizing that mental health diseases take many months of follow-up it is often necessary for members to remain on temporary category for extended periods. However, D Med Pol ***will not approve*** an extension of the T Cat if the following conditions are not filled:
  - **has demonstrated signs of improvement**;
  - **is involved in the Return To Work Program**; and
  - **has the support of a specialist**.

- Specialist Involvement. Any member suffering from a mental disorder, who is not responding to therapy, should be referred to a specialist early in their treatment in order to provide the best opportunity for recovery. Submissions to D Med Pol for review of T Cat extension or P Cat must contain a recent specialist consult note that clearly addresses the following issues:
  - The requirement for ongoing follow-up and medication;
  - The risk of exacerbation of the member's condition; and
  - The impact of exposure to a high intensity operational environment on the member and his/her condition.

Operational Stress Injury, PTSD, and Operational Environment

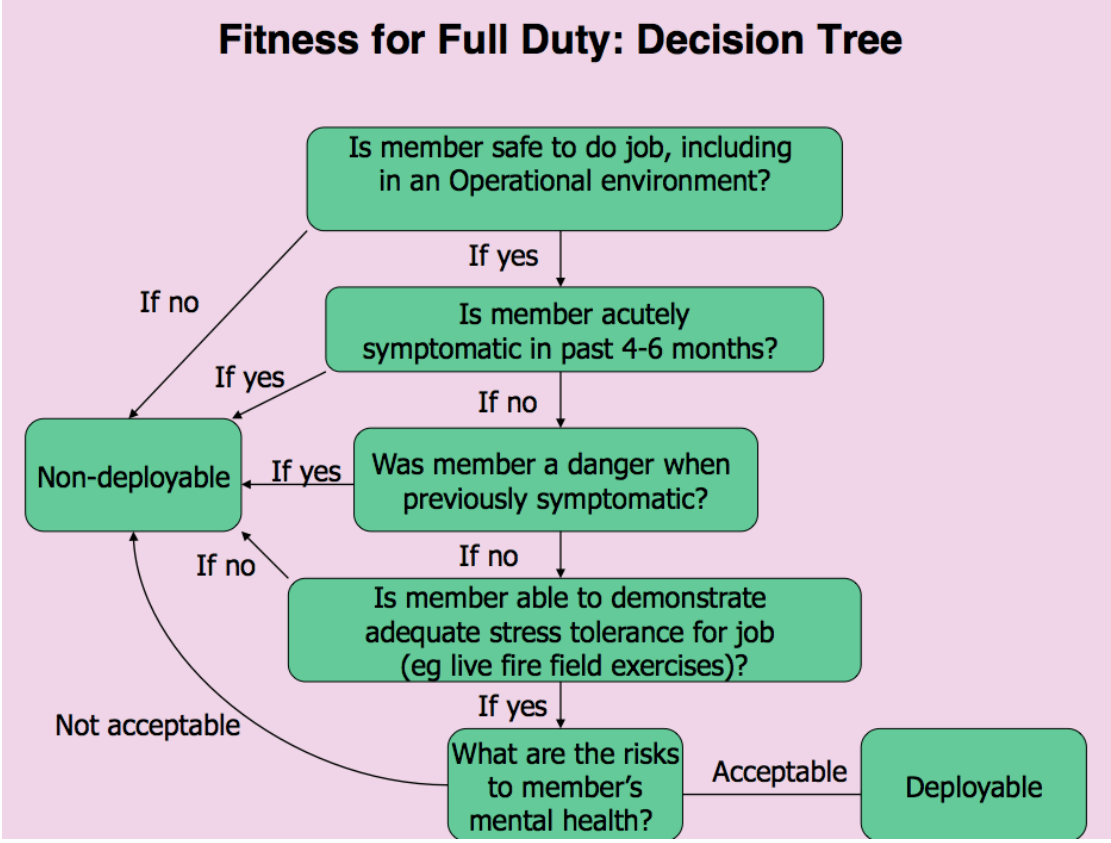
You will see PTSD. You will see members who have been diagnosed with PTSD, and instead have depression, anxiety, or Axis II or IV issues contributing. The challenge with our members is that they often haven't had a complete psychiatric assessment before heading to theatre, and the realities of operational stress unmask issues like poor coping skills, anxiety, depression, addictions, or personality disorders/traits.
The reality is that some of our soldiers will have PTSD and will be ill or injured, and require treatment.

We do have some medical evidence that soldiers with known, untreated PTSD are at increased risk of an exacerbation in the setting of an additional traumatic event. We do not, unfortunately, have much information on recurrence in treated PTSD. There is the suggestion that prior trauma in civilians is somewhat protective to development of PTSD in the setting up another traumatic event. (The concept of having a hard life being protective to developing PTSD when other trauma occurs.) The problem here is that we don't have much evidence that supports sending the injured soldier back into the field after the diagnosis and treatment of PTSD – so do these people end up "unfit operational environment" permanently?

There is no simple answer to this question – and as a result, the GDMO needs to assess a few things:

- Risk of soldier decompensation in theatre
- Risk of post-deployment relapse

When assessing fitness – you need to assess the patient's recovery as well – Consider a discussion with the patient about the previous trauma, what has changed, what have they learned in treatment, and how can they prevent future trauma from having similar effects. There is never a hard-and-fast rule for fitness to deploy. A general guideline for assessing the patient is below.



Workplace Conflict

Perhaps one of the most challenging problems a medical officer must deal with is providing appropriate support to the member who is experiencing significant work related issues or problems with their personal life. Members who are unhappy with their supervisor/co-worker, place of employment, or career in general, often turn to the medical system for professional services/support and for assistance in achieving a short or long-term solution to the underlying problem.

In the same manner, members struggling to cope with significant stressors at home such as marital discord, financial hardship, legal issues, or illness in the family will seek out assistance from the medical community. As care givers, it is our responsibility to

provide our full support and connect them with the appropriate multi-disciplinary services. We need to exercise some caution when, as health professionals, we may be asked to support a treatment strategy that relies too heavily upon avoidance. Sick leave may be used as a short term therapy – but in general, long-term sick leave supports the avoidance mentality, and should be avoided with a graduated return-to-work (or some sort of working environment) strategy as needed.

Medicalization

Problems arise when the well-intentioned efforts of the health care team result in the medicalization of the work or home-related issue. In many cases, the member is inappropriately placed on extended sick leave or awarded sequential T Cats that only serves to reinforce the sick role. In addition, the member's supervisor/command chain typically has not been informed of the nature of the member's problem secondary to "confidentiality" issues and assumes that there is a serious medical condition.

Inevitably, the file arrives at D Med Pol and the expectation of the treating MO, the CO, and the member is that there will be permanent medical limitations and a 3b release. It is at this point that the situation becomes even more complicated. D Med Pol cannot award permanent MELs or a permanent medical category unless there is a permanent underlying medical condition. The initiating MO will often provide a vague or loose diagnosis of stress burnout, adjustment disorder, personality disorder, or even depression. However, the underlying issue described in the clinical notes remains non-medical (job dissatisfaction, harassment issues, legal charges, supervisor disharmony, posting problems, divorce, etc.) and resolution of the offending issue or stressor would likely result in resolution of the symptoms. Therefore, a restrictive P Cat will not be awarded.

Recommended Approach

Members experiencing work and personal related issues need the support of the medical branch. This support may include referral to multi-disciplinary support services, the conflict resolution centre, a brief period of sick leave, or even of a T Cat to protect the member through the assignment of medical employment limitations. The T Cat reflects the time needed to complete the medical assessment, to reach a diagnosis in complex cases, and to allow for appropriate care. In addition, there are two key elements that must be addressed:

a. Inform the Member. It should be made clear to the member that he/she needs help to resolve the work/personal issue before it negatively impacts on continuation of employment. Stating that medical support will be assured to the fullest but that there will not be permanent medicalization (prolonged sick leave, P Cat, 3b release) of their situation should have a major impact on the member's response to their situation. Medical officers need to encourage the CAF member that the root cause or underlying issues must be addressed by the appropriate agency or means. In addition, with the implementation of the RTW programme,

MOs can request a meeting with the member and a trusted workplace supervisor to help develop an approach to addressing the non-medical elements of their current state.

b. Inform the Command Chain. It is critical that the command chain be informed and involved at the earliest opportunity. Either the member can disclose his/her situation with their supervisor or the medical officer/health care provider can brief the command chain once consent has been granted. Obtaining consent should not be difficult, particularly if the problem is work related. Again, failure to adequately inform and involve the chain of command will seriously hinder any back to work plan.

D Med Pol Response to Medicalized Situations

D Med Pol fully realizes that the treating physician may be under significant pressure to contribute to ongoing medicalization of the situation. In most cases, the situation creeps up on both the MO and the member. After several months without the underlying issue being addressed, it can be very difficult to instil hope that alternative approaches (dispute resolution, PSO referral, case conference, etc) can be successful.

However, within D Med Pol, the response to these cases will essentially remain the same. If there is no clear and well-documented underlying permanent medical condition, then the member will not be awarded a permanent medical category. Following review of these files, D Med Pol will award a G2 O2 and return the file to the initiating Base facility advising them that administrative/personal issues must be dealt with locally by the command chain.

Awarding a G2 O2 does not imply that the member does not currently require medical support or temporary employment limitations. Support and local employment limitations should be provided where indicated. We are simply establishing that where there is no permanent underlying medical condition, the final permanent category will be G2 O2.

"Stress Leave"

If you haven't figured this out yet, there is no checkbox for "Stress leave" on the CAF Chit. You WILL have people come to your office saying "I need stress leave," "my counsellor said I needed stress leave," etc. and as a result, you need to develop an approach to this issue. It is important to ensure that you don't simply dismiss it, as there is always something underlying the complaint. This approach often includes a mental status exam, exploration of workplace or home issues, and a discussion with psychosocial services or mental health services.

The big question you need to answer – Is there a condition here that requires intervention, MELs, referral, and what is the plan. A few tips:

- Consider discussing possible disposition with the patient, ie. Half-days, regular followup (q2day followup for a week), or use of annual leave.
- Consider suggesting Chaplain services. Consider suggesting that the patient takes the issue up with CoC if there is a workplace conflict.
- Suggest that the member sees the Personnel Selection Officer (BPSO) in order to consider a transfer to another workplace.
- Try your best to avoid medicalizing non-medical issues.

"Doc, I need a chit because I can't go to the field/sea"

There have been recent concerns with member's chits being re-written in an attempt to avoid field exercises. In some cases there are valid reasons for the members not to attend the field, in others the reasons are not so clear. Our job as GDMOs is not to decide how to employ the member, but to provide clear and concise MELs that the Chain of Command can use to determine employability.

In general a clinician should "never" write unfit field. If you feel there are extenuating non-medical circumstances that would preclude a member from an exercise please bring the case forward to the team lead, or base surgeon.

There are often reasons why a member needs to return to an area for appointments, followup, etc. This should be clearly indicated (ie. Member must return to Base Hospital three times a week for medical assessment) or must have access to facilities due to a medical concern (ie. Member must have access to hot shower on a daily basis) however it is uncommon that the member requires the limitation that they "must remain in garrison setting."

A few examples of possible reasons are:

- Just discharged from Drug/Alcohol rehab and attending AA on a daily basis;
- Returned from surgery-related sick leave and on light duties, wound dressing/packing being changed daily and you have concerns about cleanliness in the field;
- IV therapy required;
- Member attending therapy sessions 3hrs/day three days a week which is only available in one location.

If you choose to go down that path, be prepared to defend your decision to both your ProfTech chain as well as the member's Chain of Command. Unfit field has a way of catching on at units, and before you know it you will have people lined up at the door.

A suggestion for an appropriate wording in this situation would be:

> "*Requires sedentary/ garrison type work environment and hard shelter accommodation*".

Unfit sea is equally as uncommon, however, on occasion a member will have sea sickness or another illness of such severity that it requires ongoing medical care that could not be provided onboard ship.

A suggestion for an appropriate wording in this situation would be:

> "*Unable to tolerate sea environment (ship's motion at sea)*"

Be aware that both of these situations, if ongoing, have significant potential to affect the member's employability and career in the long run.

It is the units responsibility to ensure the members MEL's are respected. It is our responsibility to ensure that the limitations are reasonable, clear, and valid.

"Doc, I need a chit because I can't do my PT test"

The FORCE test is required once per year, and is new in 2013. MELs related to the test should only be awarded when the member is completely unable to attempt all or part of the test or if doing so would cause further damage or further injury. A short-term injury requiring a chit for the FORCE test is often reasonable, but a member coming in stating "I just can't run that fast" or "my back hurts when I do that part of the test" is not a reason for a MEL.

In the event of a permanent injury or illness, permanent MELs should only be applied if the member is permanently unable to perform the tasks as part of the FORCE test – which, by design, is likely to have implications in the area of Universality of Service.

The FORCE test is still in the implementation process, and may change in the future.

The FORCE Evaluation consists of four test components, each designed to measure different physical capabilities:

Sandbag Lift: 30 consecutive lifts of a 20 kilogram sandbag above a height of 1 metre, alternating between left and right sandbags separated by 1.25 metres. Standard: 3 minutes 30 seconds.

Intermittent Loaded Shuttles: Using the 20 metre lines, complete ten 20 metre shuttles alternating between a loaded shuttle with a 20 kilogram sand bag and unloaded shuttles, for a total of 400 metres. Standard: 5 minutes 21 seconds.

20-Metre Rushes: Starting from prone, complete two 20 metre shuttle sprints dropping to a prone position every 10 metres, for a total of 80 metres. Standard: 51 seconds.

Sandbag Drag: Carry one 20 kilogram sandbag and pull four on the floor over 20 metres without stopping. Standard: Complete without stopping.

"Doc, I need a chit because I can't do the Battle Fitness Test"

As with the FORCE test, MELs related to the test should only be awarded when the member is completely unable to attempt all or part of the test or if doing so would cause further damage or predictably exacerbate an injury. A short-term injury being "unfit rucksack" or "unfit forced march" is often reasonable, but a member coming in stating "I just can't march that fast" or "my back hurts when I do that part of the test" is not a reason for a MEL.

In the event of a permanent injury or illness, permanent MELs should only be applied if the member is permanently unable to perform the BFT, and may have implications in the area of Universality of Service if they are unable to meet their employment requirements.

"Doc, I need an extension of my chit, I'm not getting any better!"

There are a few issues here – you need to ask yourself, why isn't this injury behaving the way it should. One of the challenges we will often face is the "slow healer." In our system, there are a couple of issues related to the slow healer – often they are stigmatized and labeled at their unit as weak or broken. This is unfortunate reality, but can real impact on a patient's recovery, particularly with mental health. They may be malingering or hanging on to an injury because they are being posted out, or tasked to an undesirable job/location. It may also be that the patient isn't following the directions, and the return to work program was either too fast or not followed.

It is important to have an idea of recovery periods and graduated return to work guidelines, and have some idea that "something's not right here" when what should be a 3-4 week injury becomes a permanent MEL for some reason.

In the world of occupational medicine Workplace Safety and Insurance Boards and Compensation Boards have dedicated a lot of time and money to developing guidelines and expected recovery periods for many (if not all injuries) out there. The reason for this is money – WSIB/WCB is an insurance company, and they want people to return to work as soon as possible.

For example, WCB PEI suggests a wide range of recovery times and a return to work timeline for rotator cuff tendinopathy:

Rotator Cuff Tendinitis/Strain: 1st to 3rd degree

Job Classification	RTW Minimum/Maximum
Sedentary Work	0 days - 4 days
Light Work	0 days - 1 week
Medium Work	2 weeks - 6 weeks
Heavy Work	4 weeks - 12 weeks
Very Heavy Work	4 weeks- 12 weeks

A few examples of these guidelines are can be found at the below locations, as well as some descriptors of "sedentary, light, medium, heavy, and very heavy work."

Workplace Compensation Board (Prince Edward Island)
http://www.wcb.pe.ca/DocumentManagement/Document/pub_disabilitydurationguidelinesandexpectedhealingtimes.pdf

Official Disability Guidelines (US-Based Site – Good for the "finer details" of recovery and evidence-based MELs.)
http://www.odg-twc.com
Login: forces
Password: 7079

"Doc, I'm pregnant – where's my chit?"

Pregnancy is complicated.

When a member believes that she is pregnant, contact shall be made with a CF Health Care Clinic to make arrangements to be seen by a CAF health care provider (HCP). This should be done as soon as possible through a booked appointment or through sick parade. If the base has a Well Woman Clinic this option may be considered for obtaining a pregnancy confirmation test. Many Well Woman Clinics offer a walk in service as well as booked appointments. An HCP will order the routine laboratory tests to confirm the pregnancy and guide the member through the first steps of her prenatal care. Although prenatal classes are not offered by the CAF, members are encouraged to inquire in their community about locally offered classes. Not only do the classes provide valuable information about prenatal care, but they help the CAF member navigate through the community resources available for the support of new mothers and babies.

Pregnancy is to be recorded on the DND 2268 - Application Form - Maternity/Parental Benefits - by a medical officer. This usually occurs at the same time as the appointment for initiating the temporary medical category for pregnancy, which is about 12 weeks. In some instances, the member may require that a CF 2018 be raised to state medical employment limitations at the time that the pregnancy is confirmed.

Prenatal Medical Care

Once pregnancy is confirmed, the HCP will discuss options for prenatal care. A member may choose to have her pregnancy followed by a clinician at a CAF Clinic, or she may choose to have her pregnancy followed in the civilian community, by a civilian physician, licensed mid-wife or obstetrician, where these services are available. These services will be still be monitored by the CAF clinic. Midwifery services are only licensed and regulated in some provinces and will only be offered in the location in which the member is serving. In all cases, access to any type of medical service varies dependent upon location.

Prenatal care for pregnancies that are considered to be high risk (e.g. twins) is normally managed by a civilian obstetrician throughout the pregnancy.

CF H Svcs Clinic

CAF HCPs normally provide pre-natal care up until the beginning of the third trimester only. CAF members who choose to have their pre-natal care provided by a CAF HCP will, therefore, have their care transferred to a civilian community provider (e.g. physician, obstetrician or licensed midwife) at the beginning of the third trimester. Some bases have the option of having shared care with the civilian community provider. In these instances, the patient will see both providers on a rotating basis until the last trimester when they will be seen primarily by the clinician who will be responsible for the delivery; Where prenatal care is provided by civilian community health care providers, the member will essentially have two Health Care Providers: one at the CAF clinic; and one at the civilian facility.

When prenatal care is provided by civilian community clinicians, all lab tests, ultrasounds etc. must be performed at the CAF Clinic where these services are available. Where they are not available, the member shall check with their CAF HCP to determine where she should go to have these tests done. All tests ordered by a civilian HCP must be approved by a CAF HCP prior to undergoing tests. When these services are not approved in advance, the member may be responsible for associated costs. At the end of the care with the community provider, it is the member's responsibility to fill out a release of information form to ensure all of her civilian medical records are forwarded to the military medical facility. Forms are available at the Medical Records section.

Where services such as dietary counseling, supportive counseling, home care, etc., are recommended by a civilian or CAF HCP, arrangements must be made through the CAF. The CAF HCP will ensure that the member is entitled to these services under the Spectrum of Care and will refer her to the appropriate facility for care.

Where services are not covered under the Spectrum of Care, the Care Provider may seek authorization in advance for special services as needed.

A CAF HCP will guide the member in obtaining such services as prenatal classes, assistance with breast feeding, labor attendants. Costs for such services are generally incurred by the member.

Delivery and Post Partum Care

The civilian HCP will make arrangements for delivery. Many hospitals have programs for expectant mothers that include a tour of the facilities. The CAF Clinic shall be notified by the member, or a representative of the member, when admitted to hospital.

Planned, out-of-hospital deliveries attended by a licensed mid-wife may be an acceptable option for select, low-risk pregnancies. This should be discussed with the CAF HCP who can review existing provincial midwife college guidelines.

Following delivery of the infant(s), the responsibility for the member's care is returned to the CAF Clinic. If a member is under the care of a civilian specialist, such as an obstetrician, she may require additional follow-up; consequently, the CAF Clinic must be kept informed of the situation. Care for the infant(s) falls under the associated provincial medical system.

Geographical (G) Factor Limitation

Upon a diagnosis of pregnancy, the member will be assigned a temporary medical category with a geographical factor of G4 for a period of 12 months and appropriate medical employment limitations are assigned: eg, Requires regular medical follow-up with ready access to physician services. Typically, a short chit is required (30d) in order to bridge the time to TCAT appointment.

Practically speaking, the category is normally assigned at the end of the first trimester (with possible exceptions for high risk pregnancies etc) rather than at the time of diagnosis.

Occupational (O) Factor Limitation

The need for occupational employment limitations may result from either of the following reasons:

- Medical Complications or High Risk Pregnancy - e.g., hypertension, bleeding, or multiple pregnancy; and
- Ergonomics - bodily configuration and lack of mobility may preclude certain activities such as lying in a prone position for weapons qualifications or operating certain equipment.

Occupational factor medical employment limitations may include:

- PT limited in type, duration, intensity, and frequency;
- No contact sports or hand-to-hand combat;
- Lifting as tolerated; Unfit drill, parades, or marching;
- Should not be exposed to known industrial toxins or environmental hazards;
- Unfit gas hut;
- Requires regular sleep and meals and should be allowed to rest at reasonable intervals while on duty; and
- Exempt from routine immunizations

Air (A) Factor Limitation

Aircrew are to be referred immediately to a flight surgeon. The assigning of a temporary downgraded air (A) factor for pregnant aircrew will be based on criteria deemed to be operationally important by the Division Surgeon, 1 Canadian Air Division.

Sick Leave

Sick leave should be recommended at any time during the pregnancy when the member is unfit for any duty or when complications arise. Because a member is almost invariably unfit for any duty immediately post-partum, it is appropriate that sick leave, to a maximum of 14 days, be recommended following uncomplicated delivery. Since caesarean section is a surgical procedure, subsequent sick leave will be recommended as for any other surgical procedure.

A total of four weeks is normally appropriate (with followup in this period with delivering physician and/or GDMO.) Following the completion of the sick leave, a member wishing to terminate her maternity leave early to return to work will be given appropriate MELs as required. Recommendations for sick leave or modification of duties provided by a Civilian Clinician must be authorized by the CAF HCP.

Pregnant Members' Fitness for Promotion

In the case of a temporary medical category assigned solely for reason of pregnancy, the permanent medical category of the individual prior to diagnosis of pregnancy shall be used to determine fitness for promotion.

Physical Fitness Training/ Testing

The HCP for prenatal care will provide guidance for physical activity during pregnancy as well as post delivery guidance on fitness. Generally, a member will not be required to participate in a compulsory fitness program for three months post delivery. Physical fitness testing, during pregnancy and the first three months post partum, shall take place only on medical advice.

The Enigma we call JPSU

Posting to the JPSU provides an ill or injured Canadian Armed Forces (CAF) member with the opportunity to focus on recovery and rehabilitation, with the primary aim of returning to duty. The posting of ill and injured members to the JPSU also allows Commanding Officers to focus on unit operational imperatives, with a secondary possibility that a vacant position may be filled via the posting process by the ill or injured member's career manager.

How does JPSU work?

Ill and injured Regular Force members are eligible for posting to the JPSU. Under certain conditions, Reserve Force members may be eligible for posting to the JPSU. Posting to the JPSU is based on a prognosis of restricted employment due to medical reasons for a period of six months or more.

A CAF member posted to the JPSU is under command and control of the JPSU. The member is assigned to the Support Platoon of the nearest Integrated Personnel Support Centre (IPSC). The Support Platoon will utilize its resources to ensure that the member is provided with every reasonable opportunity to return to active duty. Admittedly, a return to duty may not be possible for everyone, and for those CAF personnel who will eventually be medically released, the efforts of the IPSC team will shift to providing a smooth transition upon release.

How does a JPSU posting affect Medical Care Plan?

In short – it should not affect the medical care plan at all. The daily routine for ill and injured CAF members posted to the JPSU will be guided by the medical employment limitations (MELs) documented by CAF Health Services. Within the guidelines of the MELs, personnel posted to the JPSU will be supported in their treatment and recovery by the leadership of the IPSC Support Platoon, and will be expected to participate in return to work (RTW) and other treatment programs to enhance their return to active duty or to ensure a smooth transition.

How does someone get to JPSU?

A posting to the JPSU must be recommended by the unit Commanding Officer, and supported by the Base/Wing Surgeon or a delegated senior medical officer. The approving authority for posting Regular Force personnel to the JPSU is Director of Military Careers and it is the appropriate Command Headquarters (HQ) for Reserve Force personnel.

Working with a case manager

Much like the physician's role is to advocate for the patient, the case manager is there to advocate for the member, help them negotiate the system, and help guide them through the JPSU/return to work/release process. Often, the case manager has a very good understanding of the patient's situation, the plan, and the goals of the program.

You will occasionally be approached by the case manager to help complete a complexity tool, which helps them determine the benefits and programs the member is eligible for. On occasion, you will be approached my the member to help with navigation of the system – typically, a referral to the case manager will help both the member, and you, understand how things should work.

Best Intentions and Retraining

In general terms, the return to work (RTW) process should proceed as follows, keeping in mind that close liaison between the MO, case manager, CO and member will be required. The first step for an injured or ill member is a visit to the MO. The MO performs an assessment, assigns MEL and determines the most suitable treatment program. It is at this point that the crucial process of education and involvement of the member in the RTW process should begin. If the diagnosis / treatment program indicate a potential benefit from early RTW, the MO advises the member and refers to CO via RTW Referral Form. The referral form includes MELs, duration or term of disability,

maximum number of hours per day or days per week member should be employed on modified duties and a specific statement if member should not be employed at home unit. For complex cases, other health care personnel, as designated by the Base Surgeon, may assist in the process of determining an appropriate set of MELs.

The duties of the GDMO include submitting RTW referral including MELs, duration (term) and maximum number of hours / day or days / week of modified duty availability to CO. For complex cases, other health care personnel designated by the Base Surgeon may assist in the determination of a workable set of MEL. (There may be cases where, in the best interest of a timely recovery, the MO will recommend that modified duties be conducted at other than home unit)

Something to consider – be careful when determining MELs for a RTW program – sometimes you will have a member request a change in MELs to allow for RTW program – ask yourself – does this change mean the member could go back to previous duties?

Release

Release Items

There are a number of release items you should be familiar with. They are listed below.

- 1(a) – Misconduct – sentenced to dismissal
- 1(b) – Misconduct – Service misconduct
- 1(c) – Misconduct – Illegally Absent
- 1(d) – Misconduct – Fraudulent Statement on Enrollment

- 2(a) – Unsatisfactory service – unsatisfactory conduct
- 2(b) – Unsatisfactory service – Unsatisfactory performance

- 3(a) – Medical – on medical grounds, being disabled and unfit to perform duties as a member of the Service
- 3(b) – Medical – on medical grounds, being disabled and unfit to perform duties in present trade and not otherwise advantageously employable under existing service policy.

- 4(a) – Voluntary – On request – when entitled to an immediate annuity
- 4(b) – Voluntary – on completion of a fixed period of service
- 4(c) – Voluntary – on request – other causes

- 5(a) – Service completed – retirement age
- 5(b) – Service completed – reduction in strength
- 5(c) – Service completed – service for which required
- 5(d) – Service completed – not advantageously employable

- 5(e) – Service completed – irregular enrolment
- 5(f) – Service completed – unsuitable for further service.

Although there are numerous Items of Release from the CAF there are really only two types of Release; Voluntary and Compulsory. Generally, Voluntary or Item 4 releases, are authorized by COs for NCMs and NDHQ for Officers. All releases under Items 1, 2 and 3 and 5 are Compulsory in nature and are authorized by NDHQ.

Normally, once the effective date of release has passed, a member's Item of Release cannot be amended. The exception to this is for medical situations.
Should DMCA receive notification from D Med Pol that member should be reviewed for an Item 3 release after the effective date of release has passed, then a change of release Item will be considered, and, if approved by DMCA, the member's file is adjusted accordingly by the DMCA 4-2 Audit section.

The ones which are most relevant to us as Medical Officers are 3a and 3b. It is important to note the paragraph above – at times we will have releases which are initially 4(c) for expediency, but after release medical and D Med Pol review – should have been a 3(a) or 3(b) release.

Release Medical vs. Medical Release

. Prior to release from the CAF, there is a requirement for a release medical as follows:

a. Regular Force. Every regular force member requires a complete medical (CF 2017) prior to his/her release from the CAF.

b. Reserve Force. As per CFAO 34-39, every member of the reserve force who has experienced an injury, disease, or illness during their service with the CAF requires a complete medical prior to his/her release from the CAF.

Given the current environment of injury/disability related benefits, the significance of this examination and report cannot be underestimated. It is important to be as thorough and complete as possible in order to ensure that the member receives the benefits to which he/she is entitled. However, while it is important to be a good patient advocate, you also have a duty to provide only objective and supportable information. You may be tempted or pressured to distort, exaggerate, or overlook findings in order to obtain a secondary objective…see the next paragraph.

Benefits related to Medical Release (3a or 3b)

A range of attractive benefits are associated with a medical release: eligibility for service pension following 2 years of service; indexed for cost of living service pension; SISIP benefits (Voc Rehab); and VAC related disability pensions are the most noteworthy. The details regarding benefit values and eligibility are complicated and

expertise in this area is the purview of the release section and to some extent, the case manager but not necessarily the medical officer.

Members should be directed to the Case Manager who is the appropriate expert at your Medical Clinic to have their questions answered and assist them in accessing the appropriate resources in a timely manner.(eg. Early transition interview with VAC, SISIP LTD application, Vocational Rehabilitation Program Still Serving Member, etc.)

The Release Medical Questionnaire

The Release Medical Questionnaire is much more concise that the Screening Questionnaire (At some locations, members may be completing the PHA screening questionnaire as well as the release medical questionnaire.)

The focus of the release medical questionnaire is to determine if the patient has any medical issues that bother them now, and whether they had them before enrolling in the CAF. Most of the time, patients will have a laundry list of issues (both minor and major) and will attribute some portion of them to their time in the CAF. It is important to discuss these issues, use your judgement to determine whether or not they are realistically related to military duty, and, based on their enrollment medical, whether it was a pre-existing condition. Good luck!

Medical Category on Release

The Medical Category on release should typically be the same as the “current medical category” – however, in some cases, it may not be. This is where the art of prognostication comes into play – you need to use the information at hand to determine how things will settle out in terms of a permanent application of limitations.

Applying a new category on release

If, as a result of your assessment, the member has new limitations that would result in a change of permanent medical category, then a CF 2088 must be prepared and the file sent to D Med Pol for review. *Please leave the "G" and "O" factors blank when you submit the CF 2017 and CF 2088 to D Med Pol*. If the change of category is warranted, then an appropriate category will be assigned and a new statement of limitations prepared by D Med Pol. This file will then be sent for AR (MEL).

This may result in a decision by DMCA to change the member's release item and thus modify their pension or benefit entitlement. The member should be referred to a Case Manager who will provide the SISIP application and assist the member as much as possible considering the limited amount of time before release. ***However, it is never the mandate of the Health Services to adjust the medical category and/or employment limitations with the goal of ensuring benefits.*** For example, release medicals where the member's category is elevated from G2O2 to G4O4 as a result of an injury that occurred in 1992 is a good example of questionable medical reporting.

Temporary Category on Release.

A member **cannot** be assigned a temporary medical category on release even if his/her medical problem is only temporary. During the release medical, the medical officer must assign employment limitations that represent the member's long-term level of functioning and not necessarily their immediate level of disability.

Should a member fail to completely recover, he/she should contact DMCA indicating this fact and request that their case be reviewed. The member should include his/her statement of what the problem is and provide appropriate medical documentation of their chronic condition. DMCA refers all these cases to D Med Pol. D Med Pol reviews the file in light of the new information and determines if a new medical statement is indicated. This medical statement would then be sent to DMCA who then decides whether or not the former member should have been medically released.

Medical Extension of Release Date

The principle behind the medical extension of release date is to provide some flexibility to the release process so that if a member who becomes acutely ill or suffers a serious deterioration, the medical branch can step in, delay the release and stabilize the member prior to release. It should not be used to simply extend the treatment plan for months or years. When considering requesting an extension of release date for medical reasons, please consider discussing with your Prof Tech Net chain.

In the vast majority of cases involving members of the CAF who are to be medically released, the release date will be as soon as possible. Medical extensions of release date are requested by the member's command chain through DMCA with recommendations from D Med Pol. Extensions are normally approved for acute medical problems such as non-elective surgery or admission to hospital for urgent medical care. Extensions to provide ongoing treatment for a chronic medical condition for which the member is being released or for administrative reasons will rarely be supported.

Sick Leave while on Retirement Leave

You may encounter a situation where a member is awaiting their release, or has been awarded a release date, and requests (or requires) sick leave. There are a few guiding principles when in this situation.

a. When to Recommend Sick Leave. The purpose of sick leave is to supplement the medical treatment provided to members of the Canadian Armed Forces and is granted for that period of time during which the member would be unable to perform **any** of their regular duties. That is, for the period of severe illness for which the member would have been sent home from work. It is **not** to be granted when a more appropriate modification of duties, such as light duties, would suffice.

b. Sick Leave on Retirement Leave While awaiting Medical Release. When a member is awaiting a medical release (3a or 3b), the CAF is aware that the member is ill

and has awarded a release date that will normally provide the member with an appropriate period of time to allow for transition of their care. Thus, sick leave will not normally be approved for the ongoing treatment of the illness or condition that resulted in the 3a or 3b release. Otherwise, sick leave could potentially be granted for an indefinite period of time and the member would never be "ready for release".

c. Keeping Track of the Commencement of Retirement Leave. While following-up members who are awaiting an AR(MEL) decision and possible release it is helpful when the member's MO inquires as to the date when retirement leave is to commence as the DMCA message may not always come to the attention of the MO. Sick leave can be provided, where indicated, up to the day before commencement of retirement leave but is not indicated afterwards for that same condition.

Provision of Care

There are numerous CAF traditions, policies and practices that impacted the development of the CAF in-garrison primary health care system. These CAF-unique characteristics present both challenges and opportunities in regard to how services can be structured compared to primary health care models in the civilian environment.

Sick Parade

Sick parade is a predefined period when the CAF Member may present, without appointment, for assessment of health concerns of less than 48 hours duration. However, many CAF members use sick parade for health concerns which have been present for well over 48 hours duration. Such use of sick parade detracts from optimal continuity of care. Nevertheless, there are many historical, cultural, demographic and occupational/operational factors that affect how and when the CAF Member accesses health care. All of these factors need to be taken into account as the CFHS strives to encourage the CAF Member to use scheduled appointments for their health care needs whenever possible.

Requirement for Canadian Armed Forces Personnel to be Deployable

The CAF Member is required to maintain a level of medical, dental and physical fitness consistent with their role on deployed operations. In support of this requirement, regular medical and dental examinations and other occupational health and safety assessments are mandated by policy and are an integral part of the delivery of health services in the CAF. You will hear the term "DAGing" a lot – this is intended to be a regularly scheduled way of ensuring that our members are ready to go on a (usually) annual basis. It typically entails reviewing their medical category and ensuring that their medical will not expire in the next year/during an operation, and following up appropriately.

Dual Role of the Canadian Armed Forces Medical Officer

The CAF Medical Officer (MO) functions as a consultant to the chain of command in regard to matters of occupational health, operational support, public health and health

promotion. This does not preclude the need for the CAF MO to advocate on behalf of their patient.

For health care professionals, the two principal objectives of the CAF Medical Clinic can sometimes be difficult to balance. In the role of a Patient Advocate, health care professionals must directly support the member, and the member must trust that their health care needs are of prime concern to the clinicians. On the other hand, Commanding Officers are tasked to carry out a mission. Health care professionals must support the Commanding Officer by providing appropriate limitations and notifying the chain of command of these limitations. The result is a "dual duty" – to the patient as an advocate, and the Chain of Command as an advisor. This imposes significant obligations upon the CAF physician to ensure that the member is fit for the tasks that they are required to do by their chain of command.

Reliance on Civilian Sector for Most Secondary and Tertiary Care.

For a number of reasons, the CAF does not provide the full range of health services with its own personnel and facilities. Hospital services, most specialist services and many diagnostic and therapeutic services are provided as required off the Base using contractual agreements. Arrangements for third party billings have been made that also apply to the use of off-Base medical clinics and General Practitioner services during evenings and weekends.

The CDU Structure

The core of the CAF Model of Care is the Care Delivery Unit (CDU). The CDU is an interdisciplinary team of Canadian Armed Forces (CAF) and civilian health care providers who work consistently with each other in a collaborative manner. The MO, will normally be the CDU Leader for all administrative, supervisory, occupational health and professional technical (Prof Tech) matters. Ideally, the MO selected to be the Team Leader will have one to two years of experience as an MO, including direct experience with an operational unit, however, this is not always possible.

The CDU PA has the overall supervisory role of the Med Techs in their CDU. The PA or the Sergeant/Master Corporal Med Tech may be called upon to take on additional administrative responsibilities when their CDU team lead or PCN is away.

For the CDU with a rostered population of 1500, the staffing would ideally include the following:

- Two General Duty Medical Officers (GDMOs);
- One civilian MD;
- One PCN;
- One PA;
- One NP; and
- Three Med Techs

For the purposes of workload planning, MOs and PAs are assumed to be available for direct patient care 50% of the time and are thus the equivalent of 0.5 Full Time Equivalent (FTE) of a Civilian MD. NPs typically spend more time with patients than civilian MDs, and so they are also considered the equivalent of 0.5 FTE of a Civilian MD. Using this method, and again recognizing that the staffing mix will vary somewhat from CDU to CDU and from CAF Medical Clinic to CAF Medical Clinic, there should normally be a total of 3.0 FTE Civilian MD-equivalent clinical staff per 1500 rostered patients.

Who are the people in your neighbourhood?

The Clinic Manager

The Clinic Manager(CM) is responsible for the overall delivery of health care and health service programs within the designated geographical area of their Clinic, including detachment sites. The CM is also responsible for their Clinic's efficient and effective day-to-day operation and for maintaining accreditation standards. The responsibility for providing leadership and expertise in the overall planning, coordination, implementation and evaluation of all programs and services provided to the CAF Member in their designated area of responsibility, is within the CM's scope of responsibilities. In addition, the CM is accountable for the successful and fiscally responsible operation of their Clinic.

The Base Surgeon

The Base Surgeon is responsible to ensure high-quality clinical care and services are provided to the CAF Member. To this end, he/she provides Prof Tech oversight of all clinical activities required for efficient and effective delivery of health care services at the Clinic, including its detachments.

The Base Surgeon is also responsible to ensure that the clinical staff maintain the professional standards of clinical practice and approved processes are followed for all clinical programs and services.

Where does a GDMO Fit in?

The GDMO provides comprehensive primary care services to members of the supported population encompassing health promotion, prevention of disease and injury and curative, rehabilitation and support services as well as being an occupational health expert. The GDMO leading a CDU assumes both an administrative and clinical role. The CDU Leader, along with their CDU PA, ensures that their CDU supports training needs of its Med Techs while ensuring a balance between education and training and the patient's rights and privacy.

The Civilian Physician

The clinical role of the CDU Civilian MD is essentially the same as the CDU GDMO, with the exception that MOs are required to be significantly more involved with the activities of operational and training units on the Base.

The Nurse Practitioner

The NP functions as a member of their CDU in the provision of comprehensive primary health care services to their CDU's rostered population, encompassing health promotion, prevention of diseases and injuries and curative, rehabilitation and support services. Within their Scope of Practice, the NP initiates and manages the care of patients with a disease or disorder and/or monitors the ongoing therapy of patients with chronic stable illnesses by providing effective pharmacological, complementary or counselling interventions.

The NP practices as a member of an interdisciplinary team and consults with members of other health professions as appropriate in order to ensure the health care needs of their patients are met.

The CFHS has identified the College of Nurses of Ontario Standards of Practice as the Provisional CAF Scope of Practice for CAF and Public Service NPs hired in CAF Medical Clinics, CAF-wide.

The Physician Assistant

The PA functions as a member of their CDU in the provision of comprehensive primary health care services to their CDU's rostered population. Activities encompass treatment and prevention of diseases and injuries and curative and support services in accordance with the Physician Assistant Scope of Practice.

The CDU PA will divide their time equally between the provision of patient care within their CDU and those administrative duties incumbent in their role. Included in the administrative responsibility are the supervisory and teaching functions for their CDU Med Techs. The patient care component will be focused on attending to Sick Parade, Walk-in and Urgent Care presentations.

The Primary Care Nurse

The PCN serving in the CDU will have a challenging Nursing experience that combines components of patient care and management. The CDU PCN requires an in-depth knowledge of current professional Nursing theory, with an emphasis on primary care, practice and techniques.

Within their scope of practice and under the supervision of the MO, the PCN treats patients with acute or chronic illnesses or injury on an episodic, outpatient basis. Treatment includes screening, triage, patient education, pain management, care planning, discharge planning and other interventions to restore, maintain or promote their patient's health.

The CDU PCN promotes wellness and illness prevention while assisting in the management of acute and chronic diseases so the CAF Member can attain their best possible health outcomes. Primary care Nursing services are provided to the CAF

Member who seeks care and assistance with self-management and/or family- supported health activities and may involve community-based agencies. The CDU PCN may assist with examinations, procedures, minor surgeries, dressing changes, administration of medications, injections, and immunizations. Additionally they may start intravenous therapy, perform phlebotomy, ECGs, and inhalation treatments as required.

The CDU PCN also has an administrative role, coordinating the daily functioning of their CDU's operations through supervision of their CDU administrative support and Health Records staff. (This varies base-to-base.)

In some locations, the PCN acts as a liaison with the unit chain of command, as they often have a close understanding of a patient's situation, and an intimate knowledge of the chain of command of the units that they are supporting, particularly in locations where the PCN is a civilian who maintains an active role in facilitating continuity within the CDU in the setting where military staff are often on operational commitments. They may also facilitate followup with patients for things like normal lab results.

The Med Tech

The Med Tech has significant clinical responsibilities while on deployed CAF operations. For this reason, their employment while in-garrison must serve to ensure that they have the opportunities to train to their full scope of practice, particularly in the areas of assessment and treatment, so that they will be prepared for their role on deployed operations. Additionally, the Med Tech possesses skills and knowledge that are key to the success of the day-to-day operations of the CDU.

The Med Tech will be primarily responsible for screening, assisting with triage, patient preparation and, under supervision, the provision of treatment, in accordance with their scope of practice and under the appropriate level of supervision. They also participate in an administrative role and may facilitate medical testing for PHAs.

The responsibility for teaching and training the Med Tech in clinical practice rests principally with the MO and the PA.

The Admin/Support Staff

Each CDU normally has 2.0 FTE administrative/clerical staff to support the CDU operation. The key functions of this position include CDU reception, patient registration, chart preparation and closure and management of referrals to Specialists and other external resources.

The customer service component of the administrative support role is critical in terms of the effect this front-end process has on how the CAF Member perceives the efficiency, effectiveness and caring elements of their total experience at the CAF Medical Clinic. For this reason, the individuals placed in the administrative/clerical support role should be carefully selected and appropriately trained and supervised.

What can Team Members do?

The CDU Model comprises several different health care practitioners who have different roles and responsbilities. The table below provides a quick reference as to the roles of your team members within their scope of practice.

Profession	PHA	Light Duties	Excused Duty	Sick Leave	Temporary Category	Permanent Category
Medical Officer (MO)	X	X	X	X	X	X
Civilian Physician	X	X	X	X	X	X
Nurse Practitioner (NP)	X	Up to 14 days + one extension.	X	See footnote[1]	See Footnote[2]	
Physiotherapist		Up to 14 days + one extension.	X			
Physician Assistant (PA)	X	Up to 14 days + one extension.	X		See Footnote[2]	
Medical Technician		Up to 5 days.	X			

Figure A-5-1, Authorities to Perform Periodic Health Assessments Grant Medical Employment Limitations and Award Sick Leave

[1] QR & Os state that only a physician, either military or civilian, can grant sick leave. Nevertheless, there are occasions when in the conduct of their normal duties NPs may decide that a period of sick leave should be prescribed for a CF member. Until QR&Os can be amended, Base Surgeons may elect to create a process whereby NP recommendations for up to 14 days sick leave are counter-signed by a physician.

[2] CF members should not normally be booked for a medical appointment with either a PA or an NP where it is anticipated that there will be a requirement for a change of medical category. The only exception to this rule is for specifically identified self-limiting medical conditions, such as pregnancy. The list of conditions for which PAs and NPs may assign a Temporary Category is contained in their respective Scope of Practice Guidelines found on the CFHS website. It is also recognized that during the course of conducting a routine PHA, it may become clear to the PA or NP that a change in category is warranted. In these instances, the PA or NP should complete the Temporary Category Medical documentation, but it must be counter-signed by a physician before being sent to the local approving authority.

Spectrum of Care

The CAF Spectrum of Care refers to the health care benefits and services, both medical and dental, which are available and publicly funded for the CAF Member. The CAF Spectrum of Care includes comprehensive benefits such as physician and hospital services, supplemental benefits such as medications and vision care, occupational health benefits, preventive medicine benefits, health promotion benefits, and dental benefits.

The basis of spectrum of care comes from the following principles when assessing whether or not something should be funded:

- Necessary for health
- Evidence based
- Likely to restore operational effectiveness or deployability
- Not for experiments, research, or cosmetic reasons
- Funded by a single province or federal agency.

A few commonly encountered items that require physician approval or prescription for therapy include out-patient services of the following practitioners, within the limits as follows:

- physiotherapist (20 appointments);
- speech language pathologist (10 appointments);
- psychologist (10 appointments);
- chiropractor (10 appointments);
- osteopath (10 appointments);
- dietary counselor (5 appointments);
- acupuncture, when in conjunction with pain management or when used as an adjunct to treatment of substance dependence (10 appointments); and
- podiatrist or chiropodist (5 appointments).

Assistive Devices and Adaptive Equipment Items required for meeting in a timely manner the medical needs for functional independence of entitled CAF members. The Base Surgeon is given authority to prescribe immediate ADAE requirements and their installation to a maximum of $15 000 per item. This does not include permanent home modification which would be covered under CBI 211.

Bariatric Surgery Bariatric surgery is an effective procedure for the treatment of a bona fide medical condition: morbid obesity. This surgery is recognized as a legitimate surgery and included as an entitled service within the majority of provincial health care plans. Bariatric surgery is included in the SoC as an entitled service for CAF members who meet strict medical criteria: BMI > 35, presence of recognized co-morbid medical conditions (glucose metabolism abnormality, type 2 diabetes, hypertension, dyslipidemia, cardiovascular disease, obstructive sleep apnea) and failure of all other obesity treatment programs; or BMI > 40. Surgery will require an extended period of TCAT as well as likely some resulting PCAT MELs because of the risk of acute complications. Out of country surgery is not supported. Every request for bariatric surgery must be sent to Director Medical Policy (D Med Pol) – Senior Staff Officer Primary Care (SSO Primary Care) for review and approval.

Dealing with Non-Spectrum of Care items

When you are faced with a request for a non-spectrum of care item that you feel meets the criteria for a spectrum of care item, you can ask for it to be funded. In order to do

this, send your request through your base surgeon who evaluates your case, and sends it up for consideration of funding to Area Surgeon and appropriate authorities.

A non-exhaustive list of non-spectrum of care items is below.

- most services provided for purely cosmetic purposes or dictated by other than a medical requirement. Some of the excluded services are:
    - removal of wrinkles;
    - excision or dermabrasion of tattoos and scars, except as a result of injury or surgery;
    - capillary graft to correct hereditary alopecia (hair loss);
    - electrolysis, except for pathological hirsutism or folliculitis;
    - correction of a congenital deformity, except if it causes significant physical symptoms;
    - excision of excess adipose tissue;
    - any type of laser eye therapy: orthokeratology, LASIK, radial keratotomy, or photo refractive keratotomy; and
    - breast implants.
- reversal of tubal ligation or vasectomy;
- massage therapy (except for still serving VAC pensioned members who are entitled to that benefit); and
- homeopathic and unproven herbal remedies.

This list is not exhaustive, and is often under review. At times, the Spectrum of Care committee will meet to discuss issues and determine whether policy should be adjusted or not.

CAF Drug Formulary

The Canadian Armed Forces drug benefit list is quite extensive, but there are many medications which are either accessible only under certain conditions or criteria. Medications undergo review by pharmaceutical and therapeutics committee, and either have one of four dispositions:

- Regular Benefit
    - First Line medication
- Special Authorization
    - Second or Third line meds
    - Specific criteria must be met
- Exception Benefit
    - No evidence for selection over formulary agents
    - Considered on case-by-case basis
- Non-benefit – Not covered

A searchable database can be found at:

http://hrapp.forces.gc.ca/drugbenefitlist-listedemedicaments/index-eng.asp

This database also provides you with the status of the drug, and the criteria that must be met in order for that drug to be covered through the CAF.

Special Authorization Drugs

In many cases, when you prescribe a medication which is an "Special Authorization" medication, you can indicate on the prescription why the patient is eligible. (For example, prenatal vitamin rx → indicate why the patient needs it on prescription.)

You may receive a call from the Drug Exception Centre (toll-free number 1-877-469-1003) or you may be able to phone them directly for approval of some items if there is confusion, and this communication is necessary for exception items. Generally, this process is quite quick (<1day turnaround) and does not particularly delay the patient's treatment unless they do not meet criteria for prescription. Typically, your pharmacist or the drug exception centre can suggest an alternative therapy if the patient is not eligible.

Employment Considerations for Specific Common Conditions

Development of MELs and specific guidelines for certain conditions is a challenge, and was the bulk of the previous "PEARLS." Since then, the CFP 154 has been improved and made more comprehensive in order to allow GDMOs to apply their judgement and other considerations when applying MELs, taking into account risk, occupational environment and requirements, and the individual.

CFP154

CFP 154 is a policy document prepared by D Med Pol, and accessible on the intranet at:
http://cmp-cpm.forces.mil.ca/health-sante/pd/CFP-PFC-154/default-eng.asp

It provides instructions for completing medical exams, as well as some guidelines for consideration when determining MELs for certain specific conditions.

It is intended to act as a guideline in most cases for issues to consider, discuss with your patients or discuss with your consultants in determining risk, prognosis, and MELs for your patients.

Medication Limitations.

For the majority of conditions that require the member to take medication on a regular basis, employment restrictions are not necessary. There are, however, several situations where medication related MELs are indicated:

a. Critical Medications. With certain medical conditions, such as Seizure Disorders, Type 1 DM, and conditions requiring anticoagulation and monitoring, discontinuation of a critical medication may result in a significant and disabling exacerbation of the underlying illness. Appropriate MELs could include:

Requires daily medication. Discontinuation of this medication may result in an exacerbation of a chronic medical condition for which physician services would be required on an urgent basis. During an exacerbation, member may be unable to complete expected duties.

b. Requirement for Laboratory Monitoring. There a number of medications for which regular laboratory monitoring is essential to determine appropriate blood levels or to monitor for medication induced adverse effects. Specific examples include Coumadin, Lithium, and various DMARDs. Appropriate MELs could include:

Requires regular access to physician directed services (laboratory facilities).

c. Requirement for Storage. There are a number of medications that have specific storage requirements. In order to permit employment or deployment, proper storage of the medication must be ensured. For example, various immuno-modulators require refrigerated storage. An appropriate MEL would be:

Requires access to refrigerated storage.

d. Requirement for Medical Services. There are number of medications that are only administered by, or under close supervision from, medical personnel. This could include various IV, IM or SC medications. The key here is that the member requires assistance or supervision with the administration of the medication and that the medication is considered essential. An appropriate MEL would be:

Requires regular access to medical services more frequently than every six months.

Alcohol and Addictions

In the past, the policy regarding alcohol and addictions was that members should not be awarded permanent MELs or modifications to the "G" and "O" factors for alcohol or addictions.

Since then, we have adopted a more active medical management program regarding addictions and alcohol – and, in general, substance use disorders require medical management and MELs, at the very least, for a temporary period, and may lead to permanent medical employment limitations.

A few important points:

a. On return from a residential treatment facility, a TCAT should be seriously considered in order to facilitate a return to the workplace and addictions aftercare program participation.
b. With respect to administrative issues, medical categories and treatment do not preclude administrative/disciplinary proceedings.
c. When considering recommendation of appropriate treatment, you should discuss with member the possibility of disclosing the issues to CoC in order to ensure that the workplace is involved in supportive care.

Surgical Issues

Surgical procedures, and associated MELs and sick leave requirements, are generally flexible and depend on a number of factors. It is suggested that you develop a close relationship with your consultant surgeons, and determine what they would like to recommend for sick leave, associated MELs during recovery, and timelines. Remember, as GDMO you are asking for their advice, but you don't necessarilty have to heed it. (If you don't, you'd better have a good reason, and someone else to refer to next time if things turn our poorly!)

A set of guidelines for a number of procedures that is in use at some CAF units is included in Annex I.

Some things you will come across you should know about

Dr. Stiegelmar's Four Types of Patients

In medicine, the two-by-two table can be incredibly useful. One application is a description that one of our experienced colleagues came up with of the four types of patients you will see in your career:

	Truly Healthy	Truly Sick
Thinks they are healthy	A	B
Thinks they are sick	C	D

The majority of patients in the world fall into the A category – they think they are healthy, and they are truly healthy. There are an unfortunate group who think they are sick, and are truly sick – Group D. Both of these groups, from a physician perspective, are pretty easy to deal with.

The other two groups will provide you with most of your headaches and challenges, both in different ways.

Those in Category C will often be demanding, challenging patients who are convinced they need investigation or medical employment limitations. They are administratively challenging, and often have secondary gain or an underlying agenda. This is where your headache will come – trying to maintain employability and operational requirements with the Category C patient.

Those in Category B are the opposite- They are injured, but think they are quite fine. For example, pilots who minimize injury or illness, or a combat arms soldier who is injured but wants to continue on course to completion. These members are challenging in that they will often minimize injuries or symptoms, and create the potential for further injury or illness, and, more importantly, risk to the patient, their colleagues, and the mission. This is where the art of risk assessment comes into play – and your role as a Medical Officer becomes one of authority.

CANSOFCOM

CANSOFCOM members operate all over the country and on many operations and exercises. Most of them will fit into Category A above, but some of them will fit into the other categories, especially Category B, above. Like pilots, CANSOFCOM members will often present with a well-researched opinion of what they think is wrong, and what they want you to do about it. Be wary of the issues discussed in Category B above – in particular, the risk to the mission, and the operational requirements, when dealing with CANSOFCOM members. These members are sometimes strong personalities, and may be challenging patients – consider this when discussing prognosis and treatment, and often stressing the risks to their colleagues of their condition may make a difference.

Aircrew

Aircrew are an interesting bunch. They generally fall into two groups, as below. (This list is occasionally in flux with new roles and tasks. For the most recent list see Aeromedical Authority Directive 100-1 – Medical Standards for Aircrew.)

Group A	Group B
Pilot	AMT/AMTO (While in hypobaric ops)
ACSO	AirEvac Med Tech
AESOP	Flight Attendant
AEC	Flight Steward
Loadmaster	Flight Surgeon
SAR Tech	Flight Nurse
AMT/AMTO	AWACS

All of the above have air factors that are NOT A5, and cannot be awarded by a GDMO. (Need BAvMed Provider or Flight Surgeon Course.) You can, however, ground aircrew who are in the above categories.

The concept of “grounding” is often thought to only apply to Pilots, but you should think of all of the above members as aircrew, and if they are on active flying duties, or likely to possibly return to active flying duties, you need to consider this when assessing this patient, and provide appropriate MELs, including “grounding” or unfit flying or aircrew duties, as necessary. It is important to note that when this is an MEL, it is not lifted automatically at the end of the period of the chit, but the patient must be seen by a

aviation medicine provider (Flight Surgeon or BAv Med Provider within scope) in order to be pronounced “fit flying duties/fit aircrew duties.”

Another consideration is the PHA on someone who WAS aircrew. For example, a Flight Nurse who is now working in a clinic on the ground, who was previously A4. When this person is due for a PHA, they have two options – one, see an aviation medicine provider, or two, see a non-aviation medicine provider and become A5 (or A7). There is the possibility of completing the PHA, and then forwarding the file (and patient) to an aviation medicine provider to complete the aircrew medical portion.

Air Crew Limitations

There are some “set in stone” conditions where a member must be grounded. Aircrew are aware of these limitations, and there is a “grey area” regarding whether they must be reassessed by a flight surgeon in order to be ungrounded for these conditions. A general guideline is that if there is a new therapy initiated, the aircrew member should be grounded until reassessed by an aviation medicine specialist.

The other part of this is injury – for example, a pilot with neck pain and restricted neck movement – or even one who is just too fatigued – There is policy that states that an aircrew member shall not fly when feeling unusually fatigued or suffering from any physical or psychological illness or injury (except minor cuts, scrapes, etc) without prior approval of an aviation medicine specialist. Aircrew scheduled to fly while affected by an upper respiratory tract disorder such as a common cold should report to an aviation medicine specialist for determination of fitness for flying duties. Grounding will last until medically cleared.

Under no circumstances shall an aircrew member be permitted to fly while under the influence of any drug without aviation medicine specialist approval. All drugs taken with the knowledge of the aviation medicine specialist are considered to be medical treatment.

Annex A
to FSG 300-01
November 2008

QUICK REFERENCE - TEMPORARY FLYING RESTRICTIONS

Visual/Motion Simulator	12 hours for U/T or OTU or aircrew with simulator sickness
Centrifuge Trg	12 hours no G-LOC; min 12 hours including one night's sleep with G-LOC and no driving for 4 hours after G-LOC
Spatial D Trg	Remainder of day or 24 hours if symptoms
Illness/Fatigue	Until medically cleared
Accutane	7 day initial plus G4(T6), pilots A3 (with or as co-pilot)
Antibiotics	4 day initial, 7 days chronic, topical no grounding
Antidepressants	Refer to FSG 1900-01 Medications and Aircrew
Antihypertensives	2–4 wks, Fighter pilots (CF18, Hawk) on ACE inhibitors to DRDC(T), Beta-blockers = A3 (unfit solo fighter and TacHel contour flying)
BPH	Tamsulosin/finasteride 7day initial-pilots tamsulosin A3 (with or as co-pilot)
Botox Inj	7 day initial
Cold FX	7 day initial
Dyslipidemia	7 day initial, high performance pilots on niacin grounded then DRDC(T)
Glaucoma	7 day initial for adrenergic & beta-blockers, Latanoprost no grounding
Gout	14 day initial allopurinol
HSV	7 day initial on first course of treatment
Steroid Inj Joints	48 hours initial
INH	7 days initial plus G4 (T6)
Oral Contraceptives	7 days initial, 3 days change
Minoxidil & finasteride	7 days initial for both but minoxidil not approved for pilots
Smoking Cessation	14 days initial for bupropion, extreme caution in pilots + A3 (with or as copilot); nicotine patch OK
Viagra	48 hours
Anaesthetics	7 days general, spinal, epidural, 12 hours local, 72 hours NO or short term conscious anaesthesia
Blood donations	72 hours for active airborne flight duty only
Desensitization Shots	36 hours initial, 24 hours continuing
Gas-Hut Training	2 hours
Immunizations	36 hours for most except 10 days for Japanese Encephalitis
Malaria	24 hours initial chloroquine, doxycycline, malarone, primaquine
Ophthalmology	24 hours for cycloplegia
Hypoxia demo > 10,000'	18 hours no flying duties if no DCS symptoms
Rapid decompression	18 hours no flying duties if no DCS symptoms
DCS symptoms	Type 1, 72 hour following complete symptom relief, HBO treated or not. Type 2 and AGE, 7 days following symptom relief, HBO treated or not. Type 2 and AGE with residual symptoms or >1 HBO, 10 days
Aircraft Ground Press	30 mins not exceeding 1.6 ATA and not exceeding 5 min peak pressure. 9 hours not exceeding 1.9 ATA and not exceeding 30 min total/24 hours 18 hours not exceeding 1.9 ATA, not exceeding 5 hours total/24 hours 24-48 hours not exceeding 1.9 ATA and exceeding 5 hr total/24 hours
Diving	No-D dive to max 15 msw (50 fsw) for SAR ops or trg can fly with max cabin 2,000' if O_2 available 24 hours before flying after decompression dives and 48 hours before hypobaric chamber duties

What do you need to do as a non-flight physician?

Play it safe – as above, if you have any concerns regarding the fitness of an aircrew member for flight duties, you have two options – immediately have them assessed by an aviation medicine specialist, or ground them until they can be an assessed. Aircrew are generally aware of the restrictions that may be placed on them as a result of illness, injury, or treatment, and for the most part, will understand your decision.

Dive Crew

A general rule when working with dive-eligible units is to ask if the member is a diver. Non-dive medical officers should not see divers unless there is dive medical officer available. If this is the case, an ill or injured divers should be deemed unfit diving until they can be seen by a dive medical officer.

Isolated Posting

Screenings for postings to designated isolated and semi-isolated posts are for locations where medical resources are limited for members and families. Screenings to semi isolated postings are conducted to ensure that sufficient medical resources are available to meet the needs of the member and the family.

Screening includes social work consultation, and assessment of family members that may be accompanying the member to the isolated location. In most cases, family members are screened through social work, as well as by a civilian physician, however, if resources are unavailable, you may be asked to assess the family member. In some isolated locations, CFHS staff provide care for dependents, and it is important to be aware of this .

Post Deployment Screening

Upon leaving theatre, CAF personnel will complete a Declaration of Illness or Injury During Service in a Special Duty Area (SDA) form. This screening form is designed as a triage form in order to identify clinically significant or unresolved issues that may require follow-up based on clinical assessment. It is important to focus on the screening tool as a triage assessment – and followup appropriately in order to ensure continuity of care.

Related post deployment medical activities, such as TB testing at 3 months post-deployment, should be coordinated as much as possible with other post-deployment activities to minimize unnecessary travel. Enhanced post deployment screening will continue to be performed, ideally between 90 and 120 days after return, but may occur up to 180 days after return if operational requirements preclude earlier screening.

SISIP

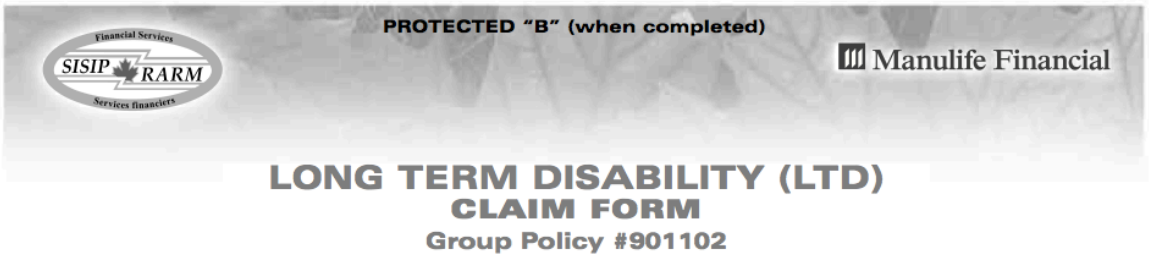
SISIP is the CAF's recommended life/disability insurance program, and when you have members who are applying for insurance, or are ill or injured, you may be approached to complete forms or provide information for their applications.

In terms of providing information for insurance – you need a release from the member, and you could direct them to CAF Health Records – however, in many cases you may save everyone some time by providing info directly from the patients records. (For example, if you have someone who was previously diagnosed with ulcerative colitis – when they apply for SISIP disability they may require some information on their UC – for example, a letter from a specialist detailing prognosis. This may already be in CFHIS.)

You will learn more about the health record on basic medical officer training. In general, unlike the civilian community, the CAF owns the patient's records, which are protected. If you print documents you should ensure that there is no unrelated info in there, and you should note that it is a printed copy, not the original.

When someone is applying for benefits, they will have an extensive form detailing their illness, diagnosis, treatments, disability, and prognosis. According to the forms, you are expected to have the patient complete the release, and then complete the forms and send directly to SISIP administration. By the nature of our organization, we often are seeing patients for the first time when they have this application, and it takes some time to review the chart and complete the forms. Typically, the patient does not need to be present for this, however, there are some components (ie. Assessing the degree of disability, particularly with mental health concerns) that you may wish to discuss with the member before completing the forms.

You can find the forms for SISIP online if you would prefer to do them in typed rather than paper form. Search "SISIP Long Term Disability Claim Form" on any computer – the forms look like this:



Veteran's Affairs Canada

While we know medical documents are primarily tools to facilitate ongoing medical care, it is helpful if CAF physicians record certain important details with respect to injuries/illnesses sustained by members as VAC uses the regular med docs (CF 2016/2034) to determine entitlement for pension purposes. This makes the recording of duty-related injuries/illnesses, permanent disabilities and MELs very important for disability reviews. Causation, MELs, degree of impairment, and diagnosis, as well as key words such as recurrent or chronic can be excellent descriptors and be crucial information for adjudication at these reviews.

a. Determination of duty-related or not.

- While it is not the role of the CFHS to ensure that a CF 98 is completed, care providers can recommend and document the completion of a CF 98.
- Document the conclusion, if known, of the unit's investigation of the CF 98, in the CF 2016 and/or the CF 2034. Even if the final answer is not known, if it is known that the issue has been concluded, this can be cross-referenced.
- If the member feels their illness or injury is duty-related, this may also be annotated, but noted that it is the member's opinion.
- Recording the circumstances of the injury/illness, such as where, when and how the injury occurred can be very helpful.
- Objective measurements can be very useful.
- If the clinician has sufficient information to determine duty-relatedness, it should be documented as this can significantly assist future pension adjudications.

b. Known occupational environment.

- Conditions associated with specific occupational exposures or environments can be identified and recorded as such if this is the clinician's opinion. For instance, repetitive trauma to certain areas of the body, as part of the member's occupation, may be known to contribute to an understood and often seen deterioration. (An example would be vertebral compression fractures in parachutists; or OA of the neck in helicopter aircrew.) This will aid in the determination of causality.

c. Recurrent or chronic conditions.

- If the condition being assessed is recurrent or chronic, using this specific terminology in the documentation is very helpful for the determination of pensions, and for correlation with other investigations and findings within the member's medical document. It should be plainly stated.
- If possible, note particular duties that could contribute to the condition being assessed.
- Note number, frequency and pattern of recurrences, if applicable.
- If it were felt that the condition is not likely to improve appreciably within the next two years, it would be considered to be permanent. VAC usually requires that at least 6 months without change is required before a condition may be considered chronic or when 'Medical Stability'/the plateau of improvement has been attained; if there is an increasing frequency and/or severity of symptoms, this requires documentation.

d. Recognized medical terminology.

- CFHIS has made this easier – All encounters require the use of a diagnostic code (ICD9 or ICD10.) You may have someone come in saying "VAC said I needed a diagnosis" – consider this in your assessment – and consider whether

or not the patient meets diagnostic criteria for the condition they feel they are "diagnosed" with.

How does the CAF, VAC, and SISIP work together?

This is complex, there are many documents on this interaction that are available, but in general, the place you should send your patients (and you should go as well) for answers is generally case management. As you can see by the following diagram, it's pretty complex. It is important to have a general idea of "who looks after what" – but your job isn't to be an expert, that's what case management is for.

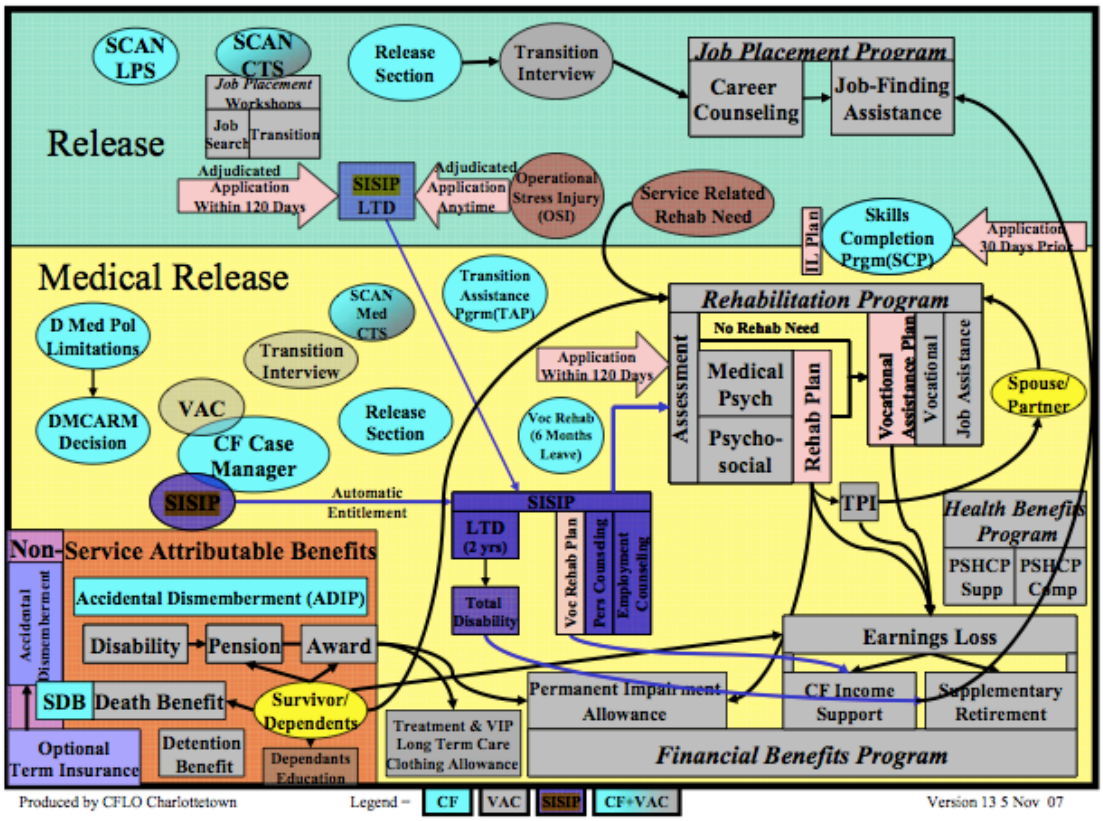


Figure 2. Current CF/VAC Program Relationships. This flowchart highlights the complex inter-relationships of existing programs available to ill and injured CF members and their families, or the CF members' survivors.

Canadian Rangers

There are no minimum medical standards for Canadian Rangers, whether on enrolment or during their service. If required to assess Canadian Rangers, medical personnel should describe the applicable employment limitations and inform appropriate administrative authorities.

Prisoners at Detention Barracks

You may be asked to pronounce someone "fit for cells" if they are picked up by military police or sent to Edmonton for time in our military prison. It is important to be aware of

the nature and intensity of training at the Detention Barracks, and assess the patient accordingly with particular attention paid to general physical fitness and mental health. Generally, prisoners will be accompanied by detention barracks staff, and any questions may be asked of this staff person for clarification.

A general review of the patient's medical file, and a physical exam, is generally appropriate to determine if a patient is "Fit for cells" – if you have any concerns, particularly regarding mental health, use the resources available to you to get help.

Common New GDMO Concerns

You will have LOTS of new things happen once you get to your unit, find an office, and get yourself sorted out. As soon as you feel like you're getting the hand of things, new duties and tasks seem to pop up. Hopefully this section will help you answer some of the questions you might have when they occur. If not – get help. Ask someone with some experience – they will have answers for you too!

So you're going to the field!

Handling this situation depends on a lot of things – have you had military experience before, have you gone on your basic military training course yet, and do you like camping?

The most important things are figuring out what you are going in support of, who is going with you, and what your medical facility (and sleeping facilities) will be like.

As the MO going, you are often the one responsible for the medical facilities, and the medical staff, on the field exercise. OPS will generally provide you with a medical plan, but try your best to be involved in the planning, so you can make sure you are aware of what the plan is, the evacuation chain, and, if for no other reason, you make sure you have a place to eat and sleep. (There are stories of medics showing up at an exercise and not having a place to sleep because they thought the unit they were supporting was providing it.)

YOU WILL HAVE DOWNTIME! Be ready for this. Think books, music, cards, movies, whatever you enjoy to pass the time. But also – consider teaching your medics. Have something prepared. Be practical. Go through your kit and find things that are about to expire, and have practical sessions around them.

Medics often are "taught" how to do something based on powerpoint lectures and non-hands-on learning sessions. Get them in there, show them the kit and how to use it (ie. Pleurevac setup), and they will appreciate it. (Don't overkill it – your medics like downtime too – but 1-2 hours a day or learning makes things go well.)

Liaise with the unit you are supporting and let them know you are training. Ask them for support, for example, an armoured vehicle to practice extractions with, or troops to use as simulated patients. The padre is a great resource, who often has a fair amount of downtime and a good attitude towards participating in your exercises as an unfortunate patient.

Most of all – try your best to enjoy it. Positive attitude and positive leadership rubs off on other people. The same is true of negativity.

So you need to update your Individual Battle Task Standards (IBTS)!

Every year, your unit should make sure you have a bunch of things up to date – FORCE test, immunizations, will, emergency notification form, etc. They also need to ensure that your military skills training is up to date, and this process is typically part of a training period called IBTS at your unit (Or at least at 1 CMBG). IBTS training generally depends on your unit type (Deployable(Field Amb) vs. Non-Depoloyable (Clinics)) and the components of this are below. When you get the opportunity to do these tasks, try to get them done, as it has the potential to affect your possibility to participate in really cool training and operational experiences if you don't have it up to date.

Non-Deployable Units

Annex/Appendix as per Ref B	IBTS	Standard	Notes
A/1	Fire C7 service rifle or C8 carbine	IS 2 Pass C7/C8 PWT 2 test para 29 (60 rds) no night shoot	All personnel assigned the C7 as personal wpn The use of a SAT (Small Arms Training Simulator) may be incorporated for lower level trg. Valid for 12 months
A/4	Fire 9mm Service pistol	Pass PWT 2 test	For personnel assigned the 9mm as personal wpn The use of a SAT may be incorporated for lower level trg. Valid for 12 months
B/12	Apply Media awareness	IS 1	Valid for 12 months
C/1	Maintain deployment administration	IS 1	Annually
C/4	Information security	IS 2	Valid for 24 months
C/5	Conduct after capture	IS 1	Valid for 24 months
C/6	Fitness	IS 2/EXPRES	IAW CF H Svcs Gp policy

Deployable Units

Annex/Appendix as per Ref B	IBTS	Standard	Notes
A/1	Fire C7 service rifle or C8 carbine	IS 2 Pass C7/C8 PWT 2 test para 29 (60 rds) no night shoot	All personnel assigned the C7 as personal wpn The use of a SAT (Small Arms Training Simulator) may be incorporated for lower level trg. Valid for 12 months
A/3	Fire C9 LMG	Pass wpn handling test only	**If wpn avail** Valid for 12 months
A/4	Fire 9mm Service pistol	Pass PWT 2 test	For personnel assigned the 9mm as personal wpn The use of a SAT may be incorporated for lower level trg. Valid for 12 months
A/6	Fire service shotgun	Pass wpn handling test	**If wpn avail** Valid for 12 months
A/7	Throw grenades	IS 1	M2228 Practice grenades Valid for 12 months
A/8	Fire Short Range Anti-armour weapons (SRAAW) (light)	Pass wpn handling test	**If wpn avail** Valid for 12 months
B/1	Perform Individual Field Craft	IS 2	Valid for 36 months
B/2	Navigate	IS 2	Valid for 36 months
B/3	Perform Chemical Biological, Radiological, and Nuclear Defence (CBRN)	IS 1	Gas hut required during IS 2 stage only. Valid for 36 months
B/4	Employ command control, communications, computer, & information requirement systems	IS 2	Valid for 24 months
B/5	Apply Explosive threat and hazard awareness and recognition (ETHAR)	IS 1	Valid for 12 months
B/6	Apply military first aid	IS 1	Medically trained personnel have attained the standard IAW 1 H Svcs Gp Trg Dir 6000-005. Valid for 36 months
B/12	Apply Media awareness	IS 1	Valid for 12 months
B/15	Conduct searches and detain personnel	IS 1	Valid for 24 months
C/1	Maintain deployment administration	IS 1	Annually
C/4	Information security	IS 2	Valid for 24 months
C/5	Conduct after capture	IS 1	Valid for 24 months
C/6	Fitness	IS 2	Valid for 12 months

So you're going to a course!

Much like going to the field, this depends on the course and your experience. Try to find out from people who have been on these courses before what you should expect, and what you should bring with you. Usually there is a set of joining instructions that provides you with an idea of what the course is like and what military kit you should bring with you – but its also good to know things like what the accommodations are like, how long the days are, homework and projects, etc.

Some of the courses you will end up at are incredibly valuable in terms of medical learning, while you will end up on some courses that seem like a waste of your time and skill set. For the most part, this is out of your hands. Use your course critique to influence the direction that the course goes in the future, and hopefully your input can affect change.

So you need a "jump bag!"

The jump bag, go bag, emergency bag, med bag, whatever you choose to call it is a bit of a mystery, and it's often very hard to get someone to help you put one together and not get the "Well, it's very individual, depends on what you're doing" answer.

While this is true, and the items you might choose to put in the bag depend on a number of factors, including medical support, distance from hospital, operational environment, and mounted vs. dismounted operations, it is important to have a starting point. A document has been prepared that includes some suggested kit and medications that would be in a "super jump bag" – The list is extensive but not exhaustive.

It is hoped that this document (attached in Annex J and K, available in E-format as well) will serve as a starting point for you to decide what you'd like to include/exclude, and go from there. The bag may "never be the same" for one exercise to another – but good preparation on day 1 makes modification later on down the road much easier.

In order to obtain medications for the bag/kit, write a prescription "For Emergency Use By Physician" for the medications, take it to pharmacy. They may be reluctant to provide controlled medications until needed for an exercise/operation, which is reasonable.

A few things that will make your life easier – when you make your bag up, **WRITE DOWN EXPIRY DATES**. When you are tasked, run down your list of expiry dates and make sure things are up to date. Take expired meds back to the pharmacy with a new prescription for the meds. When you use a med on a patient, try your best to write a prescription for that person/med, hang on to it, and return it to pharmacy when you get back in order to replace the med. (This isn't essential, but if operations allow for it will make your/your pharmacist's lives easier)

So you're going to be a Unit Medical Team (UMT) doc!

Depending on how your Chain of Command has decided to operate, most UMTs are not operating as they had been previously. It used to be that UMTs ran sick parade and clinics within unit lines (For example, 1 PPCLI would have an office for the Doc at their unit, and the doc/medics would be there for them as needed.) Things have since changed and shifted away from that concept, however, many UMTs exist, at least on paper, to support unit operations and exercises. As a result, you might find that you've been tagged as a "UMT doc" for a unit. You might want to think about how that applies. There should be some sort of instruction at your unit that tells you what is expected of a UMT doc, but a good guideline for things to do up front are:

- Contact the Unit Adjutant – Generally a good starting point
    - The Adjt should be able to help you get an idea of what the Unit would like from you
    - You should AT LEAST meet the CO, DCO, and other important personnel at the unit. The Adjt can help this

- Try to "be present" at the unit for things like O Groups, CO's Coffee Hour, and training activities
- If you have the opportunity, consider providing lectures on health promotion and protection.
- Try to talk to the Unit Operations Officer (Ops O) Training Officer (Trg O) to figure out what the plan is – they might be more up to date on when they need your help than your own unit is.

So you're going to be a team lead!

If you're headed to a team lead role, hopefully you have gained either a bit of military experience, or a bit of experience as GDMO. Essentially, this is an expanded role for one physician in each CDU where the Clinical Team Lead has an expanded awareness of the complex patients in the CDU. The goal of this is to ensure that in the absence of the treating clinician there is a clinician with a basic grounding of the high maintenance cases. Team Lead may also be relied upon by the other staff in the clinic to deal with or advise on "challenging cases."

Clinician team lead will also have a role for the effective running of the CDU when it comes to communicating and ensuring info passage to clinicians, as well as ensuring effective orientation of new clinicians. The intent is to work to resolve challenges at an appropriate lower level, when appropriate, vs BSurg getting involved in the first instance, or only when things have become a significant issue.

So you're going to backfill a base/wing surgeon position!

The role of the Base Surgeon is quite different that that of a GDMO. BSurg has different responsibilities with respect to health and safety on the base, with respect to operational units and JPSU, and completing forms and things like extended sick leave. If you are headed somewhere for backfill (or somehow posted as a Base Surgeon right away – take the time to sit down with your base surgeon, deputy base surgeon, or someone who has done it before, get a contact number for questions, and familiarize yourself with some forms you might come across, including JPSU posting requests, approval forms for non-spectrum of care items, and VAC/non-VAC/Career Transition Services benefit programs, as well as the concept of Seriously Ill/injured and Very Seriously Ill/injured and how Aids to Daily Living programs work.

So you need to prepare a lecture!

Remember your audience – don't teach medical school material to med techs, it may be over their head. Their job is practical. Try to tailor your teaching to the audience, and include practical sessions as much as possible. More often than not, our med techs are suffering the effects of "skill fade" (as are our medical officers) and getting the opportunity to practice skills is incredibly useful.

Try searching google for EMT or paramedic teaching sessions and resources – you will often find helpful material. If you are fortunate enough to be at a unit with a medical simulator, try to get yourself up to speed on it. It can be a useful tool for you to make

theoretical sessions practical, and expand your hands-on teaching to critical care and trauma without extensive simulated patient makeup and moulage work.

So you want to moonlight!

Policies relating to moonlighting are currently in flux – there had previously been some laxity in policy related to working outside the CAF in all trades – but generally, the policy stated that it was not allowed without the approval of the commanding officer.

This was not always enforced, and not a problem until there was some sort of incident that occurred and things became problematic, at which point there was lots of administrative trouble and paperwork.

There are a few things to know, some of which are explicitly stated in policy, and some which are implied and/or in policy that is under development or review.

- You should submit a memo with a declaration of your intent to moonlight and where you plan to do it.
- You need CMPA (malpractice insurance) to moonlight
- Moonlighting cannot interfere with your capacity to do your job as a GDMO
- You can use annual leave to locum (whether this applies to parental leave is unclear based on current policy.)
- If you are on a TCat, sick chit, etc that prohibits moonlighting activity, you can't do it. (IE – 2 days excused duties – you can't go work. 14 days sick leave post-op, can't go work. Unfit stethoscope, can't go work.)
- If you see a DND member, or RCMP member (no provincial health care) – You are not eligible to bill Medavie Blue Cross for this encounter. (This policy is in revision – but Dental branch has come out with a policy stating this quite explicitly.) While unlikely you will get "caught", you might, and may have to repay these funds.
- Moonlighting is intended to be done outside of normal working hours in public or private facilities – you can't bring people to your clinic/CDU.

This all sounds pretty complex – Generally, moonlighting is done, and doesn't interfere with military duties. The opposite is often untrue. You need to find a group/place to moonlight that is open to unexpected changes in schedule or cancellation, and this group needs to be aware that you are in the Canadian Armed Forces and that operational requirements come first. If you are required to sign a contract or agreement – ensure that there is a clause in there related to military service and an "out clause" – you might want to get a lawyer to look it over and ensure it is clear. (Sometimes its enough to have a good relationship with scheduling staff, and a "backup" person you can call in case you need coverage.)

So you want to use your CPE funds!

All CAF clinicians are eligible for $2000/fiscal year for CPE activities. If you are in a role where you have additional responsibilities (ie. BSurg) or have completed postgrad

training in certain areas (aerospace, hyperbaric, occupational, preventive, or emergency medicine) you are eligible for additional funds depending on role and expertise to a max of $3000/year. Specialists are eligible for $5000/year.

You are also eligible for 5 working days of CPE to attend funded activities, which may be combined with annual or other approved leave. The 5 CPE working days are considered duty days, not leave days. Your CO may choose to designate them educational leave days.

CPE activities must meet the following criteria to be eligible for funding:

1. Activities must be directly relevant to the CAF health care provider's clinical scope of practice and thus be applicable to in-garrison and/or operational requirements.
2. Activities must meet the standards for CPE of relevant professional organizations, for example:
    - Accredited group learning activities such as conferences, workshops and seminars;
    - Self-learning tools, such as journals and current textbooks (in paper or electronic format);
    - Medical content or educational software for use with computers and/or personal electronic devices; and
    - Other educational activities that are defined and recognized within a relevant professional organization's CPE program.

The following ARE NOT reimbursed through CPE:

- Computers or electronics
- MCRP programs and designated courses (ie ACLS, ATLS)
- Membership fees for organizations (ie CMA membership.)

Activities outside of Canada may be approved, but the process is more complex.

In order to get approved for CPE activities, there are a few things to do:

- Plan WELL AHEAD – 3-6 months.
- Don’t pay for anything until it is approved.
- Get your ducks in a row – find out what it will cost, including fees and taxes.
- Talk to your training officer and submit a training request form, as well as a memo to your CO requesting CPE time. If you are requesting leave to be added onto your CPE time, submit a leave pass as well.
- The approval for attendance must come from your CO (and be recommended by someone in the prof tech chain) as well as from national health services advisors.
- Once you have been approved and complete the activity, provide proof of completion with your claim when it is being finalized. Don’t forget to submit your certificate for MAINPRO as well!

If you complete an activity on your own, and then try to get it funded – you might be refused. Be aware of this.

If you are unable to find a conference or activity that fits within the above criteria, you can consider submitting a request for funding for an alternative, i.e. textbooks, which will be considered on a case-by-case basis, with the assessment based on relevance to your current role or responsibility.

So you are wondering about getting your license paid for!

In 2012-2013, there were extensive changes to the way that licenses and certification were paid for. As of Dec 1, 2013, the policy on CFPC membership funding was still unclear, but it looks as though it will be approved, as Mainpro CME program participation is a requirement to maintain your certification in most if not all provinces.

Provincial licensing fees are approved.

Talk to your orderly room, and bring in your receipts as well as a copy of your license each year. They will help you get your reimbursement for your license, and, assuming that CFPC membership is approved by the time you are reading this, your CFPC membership fees as well.

Provincial medical association and Canadian Medical Association fees are not reimbursed at the time of writing.

So you're wondering about Maintenance of Clinical Readiness Program!

The maintenance of clinical readiness program underwent a significant overhaul in 2011-2013, and by all accounts the program itself is much improved. Unfortunately, the application of the program across the country is quite variable due to a number of factors, including operational requirements and availability of positions at local hospitals. The Surgeon General has declared that MCRP is a priority, and this declaration should result in MCRP being a priority at individual units in time.

In general, most GDMOs are required to do at least one half-day a week (every week) of MCRP in acute care (ER, anesthesia, ICU), and those tasked with high-readiness jobs or operational tasks have additional requirements. The MCRP program also prescribes a timeline for courses like APLS, ACLS, ATLS, AMTRP, and AIME.

MCRP programming is currently being tracked online with a program, where you are requested to input your MCRP activities in order to ensure you are meeting the program's prescribed mandate.

You may be asked to input your moonlighting work as MCRP time – the choice here is up to you – but the intent of the MCRP is to provide the time during duty hours in order to

allow you to meet criteria. This means that CoC should be providing you with both time, and opportunity to meet these criteria. The choice to input your moonlighting time is up to you – but your CoC has a duty to provide you with this time (and they are assessed on how many members within their unit are meeting MCRP criteria.)

You may also be asked to waive your MCRP requirements in order to be tasked. (You should not be asked to waive it unless it is for a specific reason.) This is again up to you – but consider the risks associated with waiving your requirements. For example, if you are tasked with DART, which requires 10 days of Pediatric acute/emergency medicine time – if you waive this activity – are you competent to treat pediatric emergencies that may present on this tasking.

Finally, for MCRP – while completing MCRP (non-moonlighting) you are considered on-duty – this means a few things:

- You can't get paid for it. (Unless you're moonlighting then counting those hours)
- You should not work more than 40 hours / week. (So if you MCRP "non-moonlighting" an overnight ER shift for 8 hours, you should get 8 "workday hours" off. Note, this is the intent, and remember, operational requirement trumps most rules in most cases. For example, if you were MCRP tasked to ICU for a week, and worked 120 hours, you would be unlikely to get 3 weeks off. ☺)
- You are protected by crown liability for those on-duty hours

So you've heard about CAFJOD and need to get it done!

CAFJOD is the CAF's officer development program, previously called "Opie-Dopies" and OPMEs. The target audience is junior officers (2nd Lieutenant to Captain) who are completed training, with the intent to get these officers "up to speed" on the workings of the CAF to gain promotion to the senior officer ranks.

There are seven CAFJOD Modules which are run through an online learning system, and are generally done one or two at a time. Many Commanders will direct that junior officers complete one CAFJOD per season, and the more you do, the better your score on your performance evaluation. For "completion" of CAFJODs you need to complete all 7 modules:

- Module 1 – Staff Duties
- Module 2 – Enabling the Fighting Force
- Module 3 – Military Justice
- Module 4 – Leadership and Ethics
- Module 5 – Joint Operations
- Module 6 – Canadian Military History
- Module 7 – Support the Institution

There are ways to get credit for previous learning, which will not be covered here. For details on registration, scheduling, and other information on the program, search on the intranet for "CAFJOD." Programs are run online through the DND Self-Learning program.

So you've heard about the Facebook Groups!

There are a few facebook groups floating around – One for CAF Medical Officers, and one for Junior GDMOs. If you are a facebooker, consider joining one (or both) as appropriate. There is a lot of experience on there, some of it helpful, some of it less helpful. But again, sometimes you need to become more informed before making a decision. These people will usually be pretty honest, and you will get multiple opinions on a question, which is great. Sometimes these groups also help you keep up to date on what's going on with the CFMS.

So you're planning for Parental Leave!

All of this information is totally unofficial and my first advice is talk to your Orderly room, talk to your accountant, and talk to your lawyer. After that, here's what has been noted to work if you are hoping to moonlight.

There are a few regulations that may or may not apply related to moonlighting while on leave, moonlighting in general, and parental leave. Then you get into the legalities regarding Employment Insurance. It's not simple, and nothing below is a "guarantee" – but some things to consider.

My first advice is take parental leave. Remember, it "pauses" the return of service clock, so this time doesn't count towards your return of service. (So some people choose not to take it because of this.) If you're choosing not to take it because you "feel bad" you're missing work – you will be tasked, deployed, sent to the field, spend long days at work. You can't get the time with your new child back, and work continues without you. (We are often tasked out for weeks to months at a time – and the unit functions without us then!)

The other advice – Don't overdo it. You are taking parental leave to be a parent. It is risky to take 9-12 months off and not practice your skills, and then assume you're good to go when you finish leave. There's no official "you can work 2 nights a week" statement, or anything like that, but it is frowned upon to leave your full time job, go on leave, and then go to another full time job working 5 days a week. You can get in trouble and create a huge headache for yourself.

If you don't plan on moonlighting, then parental leave is simple. You go to the Orderly room about 3 months prior to leave, tell them you plan on taking parental leave, and they will give you guidance.

If you do plan on moonlighting for maintenance of skills, things get a bit more challenging in terms of EI. Suggestions below are based on individual experience, and accountant and lawyer's interpretations of policy.

Important principles

- In order to qualify for the CAF's Parental Leave Benefits, you need to have an active EI claim.
- In order to activate an EI claim, you need a 14 day period without any income.
- Once you activate your EI claim, you need to do two things : bring your claim form back to the orderly room, and continue to report to EI every few weeks on your income.
- Basically – your goal should be to minimize/eliminate any funds you receive from EI. It is likely that over the course of your parental leave, you will earn more than you would if you claimed EI. Service Canada has complex formulae for determining your eligibility when you are self-employed, and if you don't take any money from them, they tend not to waste your time trying to figure all this out.
- There are two types of income when it comes to EI – Employment income and Self-Employment income.
- For a non-incorporated, non-contracted physician, generally income is self-employment type. This is a bit complex when it comes to EI. You need to declare when you go in the first time that you have a second job on top of your CAF job, and are self employed. You need to declare the hours you have been doing it, when it started, what you estimate to make (or what you made per week/month/year since you started. They will then review your case, and determine if you are eligible for EI. This could potentially shut everything down if (based on discussions with service canada staff):
    - You make too much money such that a normal person would rely on it for their only income
    - You work too many hours in your second job such that a normal person would rely on it for their primary employment
    - You haven't moonlighted before and don't start until after you started your EI claim/Parental leave. (This looks like a "new job" at that point.
    - There may be other reasons, but these are the ones that Service Canada provided.
- For incorporated physicians, things MAY be simpler. From what I can gather, it becomes "employment income" rather than self-employment income. This means online filing, rather than phoning in to Service Canada, and makes your life simpler. I haven't tested this out, but it is worthwhile to consider and discuss with your lawyer, accountant, and phone Service Canada about. There are a number of A few things to note:
    - Don't incorporate after your leave starts. This raises red flags at Service Canada and your file will be extensively reviewed.
    - Talk to your accountant. Talk to your Lawyer. And talk to your accountant again.

        - You need to pay fees (EI, CPP, etc.) when you are paying yourself a salary.
        - Try to incorporate months before your parental leave starts, and establish a set salary for your work. (I would suggest ~$1000/week – this is enough to override the "max per week" you are allowed for EI, and then you don't take any money from Service Canada.)
        - For the 14 days in order to qualify for EI – don't pay your salary. Don't do any work.
        - After that, you should be free to work, send your money into your corporation, tell EI every week that you've worked and earned income ($1000/week) and you should be all set.
    - There have been a number of things people have tried in order to "Get around" the EI rules, collect EI, and collect parental leave. This generally doesn't work, and you get caught. You get charged, go to real court (not DND court), deal with that, and then DND finds out, you go to DND court, and probably lose all of the money you got from both Service Canada, DND, and whatever fines you have to pay. Things that don't work (based on case law):
        - Not paying any salary during your parental leave, then taking a big dividend afterwards.
        - Paying the money into a spouse's corporation then paying the spouse.
- What EI seems to care about is:
    - When the work was done
    - When the pay was received
    - A combination of both.
        - For example, if you worked in week 1, made self-employment income of 2,000$. You don't work in week 2 – make 0$. You do this every 2 weeks for the whole period of leave. You claim this, and get EI funds every 2nd week. They will call you and say you made too much money over the whole of the leave period, because you, on average, made more than the maximum allowed per week. (Again, this is based on case law and changes in the EI regulations in the years 2010-2013.)
- My non-expert advice – find a way to not take any money from EI, work 5-10 days a month for maintenance of skills (and this maintenance of skills is the reason you are doing the work), and maintain your EI claim for the whole period of your leave.

Do I need CMPA malpractice insurance?

If you aren't moonlighting or working outside of the CAF, the short answer is no. The decision you have to make, however, is do you want to rely on the CAF legal system

(which rarely deals with medical liability issues), and the possibility of settling a malpractice suit with a patient rather than litigating, or would you rather pay out-of-pocket for CMPA and have experts that you could consult in case of need.

If you are moonlighting, you do require CMPA of the appropriate category.

Do I need to join my provincial or national medical association?

Simple answer – No (for military work, as far as I can tell, in no province is it necessary.) More complex answer – find out what the benefits of membership are, particularly if you are moonlighting or planning on taking parental leave. For some provinces, if you bill the public, it is mandatory to be a member. Some provinces have CME reimbursement programs, retention benefits, parental leave programs, and CMPA reimbursement programs, as well as peer support programs and opportunities for leadership training and CME training at reduced rates. Become familiar with the programs in your province, and then make the decision. In some provinces, the benefits far outweigh the costs associated with membership due to provincially funded programs.

Annex A. Important Web Links

A disclaimer on the web links below – Things within DND seem to change frequently. As a result, for the most part, only "External links" are included, with a few others within DIN. If you find the link below doesn't work – try searching for the title of the page or descriptors, and update your links within your internet browser.

CFHS Homepage (DIN/DWAN)
http://cmp-cpm.forces.mil.ca/health-sante/default-eng.asp

CAF Drug Formulary
http://hrapp.forces.gc.ca/drugbenefitlist-listedemedicaments/index-eng.asp

CFP 154 – Medical Standards
http://cmp-cpm.forces.mil.ca/health-sante/pd/CFP-PFC-154/default-eng.asp

CFHS Library – Use this to access UPTODATE and other CFHS Library Materials
http://cmp-cpm.forces.mil.ca/health-sante/ps/ml-bm/default-eng.asp

CFHS Policy and Guidance
http://cmp-cpm.forces.mil.ca/health-sante/pd/doc-eng.asp http://cmp-cpm.forces.mil.ca/health-sante/pd/search-recherche-eng.asp

Maintenance of Clinical Readiness Program
http://cmp-cpm.forces.mil.ca/health-sante/hp-ps/mcrp-pmpc/default-eng.asp

Defence Forms Catalogue
http://imgapp.mil.ca/DFC2/DFC_Main.asp?strLang=e

CF Personnel Appraisal System (CFPAS) home page
http://cmp-cpm.forces.mil.ca/dgmc/engraph/CFPAS_Home_e.asp

Strengthening the Forces/Health Promotion and Protection
http://cmp-cpm.forces.mil.ca/health-sante/ps/hpp-pps
Public Health Agency of Canada
www.phac-aspc.gc.ca/tmp-pmv/index-eng.php
www.phac-aspc.gc.ca/tmp-pmv/catmat-ccmtmv/index-eng.php

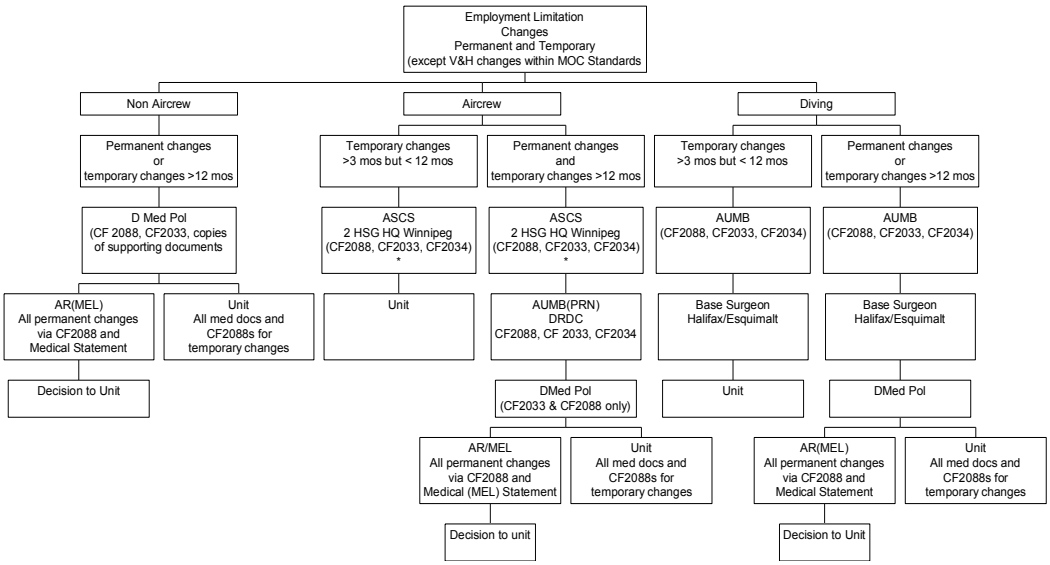
Center for Disease Control and Prevention – Yellow book
www.cdc.gov/travel

WHO International Travel Guidelines
www.who.int/ith/en

International Association for Medical Assistance to Travellers
www.iamat.org

Annex B. Various Approval Pathways for Reg Force Medical Files

Processing Regular Force Medical Files
with Medical Employment Limitations Changes
(or limitations reviewed by D Med Pol prior to 1997)
*** except V&H category changes that are within MOC Standards and A category changes reverting from aircrew back to non-aircrew status*

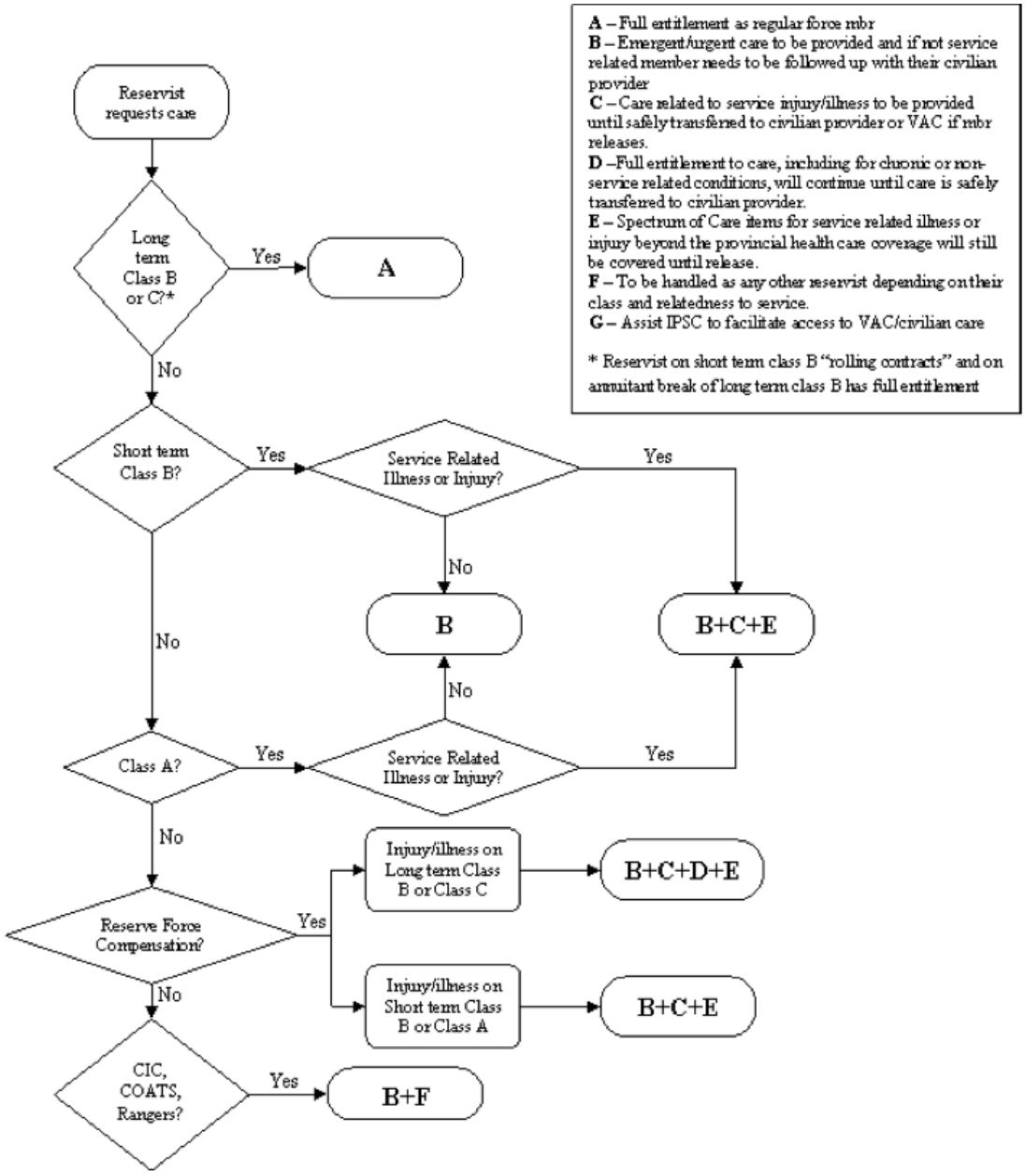


* ACSC may forward aircrew files to AUMB as needed
All Component Transfer aircrew files to be sent to AUMB

**CF 2034 will be returned to unit from DRDC Toronto following AUMB review
CF 2033 & CF 2088 to D Med Pol for review

Notes: ASCS (Aeromedical Standards & Clinical Services)
AUMB (Aerospace & Undersea Medical Board)

Annex C. Reservist Entitlement to Care



Annex D. Screening Questionnaire and Guidelines

Quick Guide for Interpreting the PHA Patient Questionnaire (DND 2552)

Q1. In general, would you say your health is: (Excellent, Very Good, Good, Fair, Poor)
Fair or poor health status – inquire regarding health problems to prioritize care.

Q2. Compared to one year ago, how would you rate your health in general now? (Much better, Somewhat better, the same, somewhat worse, much worse)
If worse – why?

Q3.Marital Status

Q4.How often do you have a drink containing alcohol (Never → 4 times a week)
Q5.How many drinks containing alcohol do you have on a day when you are drinking (1→10+)
Q6.How often do you have six or more drinks on one occasion? (Never → Daily)
Each question scored 0-4, then summed. Score of 5+ for women, 6+ for men indicates hazardous alcohol intake. High scores for Q5 or Q6 are red flags for high-risk drinking.

Q7. In the last year, have you ever drunk or used drugs more than you meant to?
Q8. Have you felt you wanted or needed to cut down on drinking or drug use?
Positive answers to either warrants further investigation

Q9. At the present time, how often do you smoke cigarettes? (And followup questions
   a. *How much do you smoke?*
   b. *Are you interested in quitting?*
   c. *Have you quit before?*
   d. *Are you thinking in stopping in the next month?*

Q10. Do you use any alternative forms of tobacco?
To determine stage of change for smoking cessation intervention

Q11. Consider a 7-day period, how many times on average do you do at least 15 minutes of strenuous, moderate, and mild exercise?
Q12. Which physical fitness test do you routinely perform?
Q13. Did you perform your CAF EXPRES test of BFT in the last year, and were you successful?
To assist with assessing physical fitness and physical activity.
Weekly activity score (METS) = 9x(# strenuous exercise) + 5x (#moderate exercise) + 3x(# mild exercise)
35+ for women, 38+ for men = sufficient activity

Q14. Do you have problems with sexual function?
Q15. Do you have any risk factors for STIs?
Positive responses warrant further investigation, screening, and prevention interventions.

Q16. How often do you have enough fruits and vegetables?

Food guide recommends 7+/day in most of our population.

Q17. How frequently do you use safety precautions such as seatbelts, bike helmets, or life jackets?
Counsel if sometimes or never.

Q18. Over the last 2 weeks, how often have you been bothered by any of the following?
a. *Little interest or pleasure in doing things?*
b. *Feeling down, depressed, or hopeless?*

PHQ2 – Score each question 0-3, sum total. Score 3+ requires further assessment.

Q19. In the past 12 months, have you seriously considered committing suicide or taking your own life?
Positive response should be explored.

Q20. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the last 4 weeks you:
a. *have had nightmares or thought about it when you did not want to?*
b. *Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?*
c. *Were constantly on guard, watchful, or easily startled?*
d. *Felt numb or detached from others, activities, or your surroundings?*

If 3 of 4 are positive, further investigation. If 2+, and symptoms are severe, have some concern and discuss impact on function. If this is questioned shortly after a traumatic event, symptoms may be enhanced.

Q21. At the present time are you concerned, preoccupied, or worried about:
a. *personal/family relationships*
b. *work/professional relationships*
c. *financial problems*
d. *other issues*

Positive responses should be explored.

Q22. Do you want to discuss with your health care provider any concerns regarding exposure in your working or living environments, including on deployment?
To identify areas for discussion and risk communication.

Q23. Have you experienced ringing in your ears or difficulty hearing following a work shift in the last 2 years?
To assist with interpretation of changes in audiogram, whether they are non-occupational or non-occupational in etiology.
Q24. Have you been treated since your last PHA for what you would consider a significant condition?
Q25. Do you have any allergies?
Q26. What medications do you currently take?
To update history and allergies in CFHIS.

Q27. List your most recent operational deployments.
Q28. Are you or have you seen a health professional about your emotional or mental health?
Q29. Do you think any of the concerns mentioned on this form are related to deployment?
Q30. Are you currently or have you received a pension or lump sum payment from Veteran's Affairs Canada?
Q31. Do you plan to apply for a pension from VAC?
Q32. Do you have any concerns or questions you wish to discuss or bring to the attention of your health care provider?
For identification of any possible stressors and discussion during PHA encounter.

Annex E. Quick Guideline for Medical Categories V, H, G, and O

CFP 154
TABLE OF VISION STANDARDS

	Better Eye	Other	Comments
V1	6/6	6/9	Normal vision without glasses
V2	6/18 6/12	6/18 6/30	Corrects to 6/6, 6/9. Can perform without glasses.
V3	6/120	6/120	Corrects to 6/6, 6/9. Needs glasses.
V4	N/A	N/A	Corrects to 6/9, 6/120. Essentially monocular vision. Refractive error does not exceed + or - 7 dioptres SE.
V5	For serving members only. Less than V4. Given by ophthalmologist. Sufficient corrected visual acuity to perform duties. Refractive error exceeds + or - 7 dioptres SE.		
V6	For recruits and serving members. Given by ophthalmologist. 3A medical release.		

CFP 154 ANNEX B
HEARING STANDARDS

H1	Not > 30 dbs in 500 - 8000 cps in both ears (normal hearing).
H2	Not > 30 dbs in 500 - 3000 cps in both ears. Deficit in high frequency range.
H3	Not > 50 dbs in 500 - 3000 cps in better ear. Deficit in speech range. Consider hearing aid.
H4	Loss > 50 dbs in 500 - 3000 cps in better ear. Hearing cannot be improved to H3 with surgery or hearing aid.

GEOGRAPHICAL FACTOR

3 Elements to consider: Climate, Accommodation, Medical Care Available

G1	Assigned where member has successfully completed stringent medical screening for such unique duties as astronaut training.
G2	No climatic or environmental limitation. Minor medical condition. Does not require specific treatment. Enrolment minimum.
G3	Medical condition requiring periodic medical follow-up no more frequently than every six months. May require physician services on a non urgent basis.
G4	Climatic or Isolation limitation, barrack equivalent accommodation. Unfit field, sea, UN or isolated posting. Small risk of suffering a crisis that will require the member to be seen by a physician within 24 hours. During this time, the member will be unable to complete expected duties. Requires physician follow-up every month.
G5	Restriction to large urban centres in Canada. High risk of suffering a crisis that will require specialist medical care in 7 days. During the time the member will be able to perform all expected duties. Requires specialist follow-up every month.
G6	Requires environmental limitations or medical services incompatible with military. Unfit any work environment. Assigned by Surg Gen. 3A release.

OCCUPATIONAL FACTOR

Involves physical and mental stress.

O1	Assigned where member has successfully completed stringent medical screening for such unique duties as astronaut training. Above average fitness, strength, stamina.
O2	Enrolment minimum. No limitation or minor limitation which does not prevent member from meeting the Generic/MOC Task Statements.
O3	Moderate physical disability. Unfit heavy physical work for prolonged periods. Employment limitation(s) can be clearly detailed and prevent member from meeting Generic/MOC Task Statements.
O4	Light duties. Routine adm duties or general office tasks. Unfit sports and parades.
O5	Sedentary duties, desk work only. Set own pace. Unfit shift work. Find the right job.
O6	Medically unfit for any military service or civilian occupation. Assigned by Surg Gen. 3A release.

Annex F. Generic Task Statements

PHYSICAL FACTORS	
1.	Must be able to perform high-crawl over a distance of 45 m and low-crawl over a distance of 30 m.
2.	Must be able to dig a personal trench.
3.	Must be able to carry sandbags weighing 20 kg over a distance of 50 m for a period of 10 min.
4.	Must be able to evacuate a casualty 750 m across country by carrying one end of a stretcher bearing an 80-kg load.
5.	Must be able to evacuate a casualty, during a fire on board ship, by carrying one end of a Stoke's litter bearing an 80-kg load up and down a flight of stairs.
6.	Must be able to undertake the CAF EXPRES program.
7.	Must be able to perform drill for at least 30 minutes.
8.	Must be able to safely handle and effectively operate a personal weapon.
9.	Must be able to safely perform duties in or close to water.
10.	Must be able to communicate via radio.
STRESS FACTORS	
1.	Must be able to perform duties in a military environment, including but not limited to: • frequent movement, relocation, isolation, and temporary duty away from home or unit; and • working over extended periods of time in hostile environments, exposed to life threatening situations.
2.	Must be able to perform duties under extreme climatic conditions.
3.	Must be able to perform duties while wearing protective NBC equipment.
4.	Must be able to perform duties in unpredictable working conditions, which may involve such stresses as: • no advance notice • limited rations • missing meals • irregular or prolonged hours • lack of sleep
5.	Must be able to perform duties with minimal medical support, which may include: • limited frequency of care; • limited access to health care personnel: Med A, nurse, nurse practitioner, physiotherapist, chiropractor, physician, and specialist; • limited proximity to medical services (clinics, hospitals, laboratories), in terms of distance and traveling time; • limited access to medical supplies, electricity, toilet facilities, medical devices, etc.; • unavailability of medications or inability to take them on time; • inability to perform medical procedures (injections, use of CPAP, etc.); • exacerbating effects of a particular climate, physical environment or mental environment on the member's medical condition.
6.	Must be able to travel as a passenger via any mode of transportation.

(Note – These have not been changed since the introduction of the new FORCE test)

Annex G. MOSID Minimum Medical Standards

Non-Commissioned Members

MOSID	OCCUPATION	V	CV	H	G	O	A
5	Crewman	3	3	3	2	2	5
10	Infantryman	3	3	3	2	2	5
17	Naval Weapons Technician	4	2	3	2	2	5
19	Airborne Electronic Sensor operator *	3	2	2	2	2	2
21	Flight Engineer*	3	2	2	2	2	2
99	Intelligence Operator	4	3	3	3	3	5
100	Meteorological Technician	4	2	3	2	2	5
101	Search and Rescue Technician	2	2	2	2	2	4
105	Boatswain	4	2	3	2	2	5
109	Aerospace Telecommunications and Information Systems Technician	4	2	3	3	3	5
114	Naval Combat Information Operator	4	2	2	2	2	5
115	Naval Electronic Sensor Operator	4	2	2	2	2	5
116	Naval Electronics Technician (Acoustic)	4	2	3	2	2	5
117	Naval Electronics Technician (Communications)	4	2	3	2	2	5
118	Naval Electronics Technician (Tactical)	4	3	3	2	2	5
119	Naval Electronics Technician (Manager)	4	3	3	2	2	5
120	Communicator Research	4	3	2	3	3	5
121	Marine Engineering Mechanic	4	2	3	2	2	5
122	Marine Engineering Technician	4	2	3	2	2	5
123	Marine Engineering Artificer	4	2	3	2	2	5
124	Hull Technician	4	2	3	2	2	5
125	Electrical Technician	4	2	3	2	2	5
127	Clearance Diver	3	1	2	2	2	5
129	Vehicle Technician	4	2	3	2	2	5
130	Weapons Technician (Land)	4	2	3	2	2	5
134	Materials Technician	4	2	3	2	2	5
135	Aviation Systems Technician	4	2	3	3	3	5
136	Avionic Systems	4	2	3	3	3	5
137	Imagery Technician	4	1	3	2	2	5
138	Aircraft Structures Technician	4	2	3	3	3	5
149	Fire Fighter	3	2	3	2	2	5
150	Medical Assistant	4	3	3	2	2	5
152	Medical Laboratory Technologist	4	2	3	3	2	5
153	Medical Radiation Technologist	4	3	3	3	2	5
155	Biomedical Electronics Technologist	4	2	3	3	2	5
161	Military Police	3	2	3	3	2	5
164	Cook	4	3	3	3	2	5
165	Steward	4	3	3	3	3	5

166	Musician	4	3	3	3	3	5
167	Postal Clerk	4	3	3	3	2	5
168	Supply Technician	4	3	3	3	2	5
169	Ammunition Technician	4	1	3	2	2	5
170	Traffic Technician	3	2	3	2	2	5
171	Mobile Support Equipment Operator	3	2	3	3	3	5
225	Marine Engineering Systems Operator	4	2	3	2	2	5
226	Port Inspection Diver	3	2	2	2	2	5
230	Canadian Rangers (NCM)						
238	Geomatics Technician	4	2	3	3	2	5
261	Air Weapons System Technician	4	1	3	3	3	5
298	Resource Management Support Clerk	4	3	3	3	3	5
299	Naval Communicator	4	2	2	2	2	5
301	Refrigerator and Mechanical Technician	4	2	3	2	2	5
302	Electrical Distribution Technician	4	2	3	2	2	5
303	Electrical Generating Systems Technician	4	2	3	2	2	5
304	Plumber and Heating Technician	4	3	3	2	2	5
305	Water, Fuels And Environmental Technician	4	3	3	2	2	5
306	Construction Technician	4	3	3	2	2	5
307	Construction Engineering Superintendent	4	3	3	3	3	5
322	Court Reporter	4	3	2	3	3	5
324	Sonar Operator	4	2	2	2	2	5
327	Fire Control Systems Technician	4	2	3	2	2	5
334	Medical Technician	4	3	3	2	2	5
334	Medical Technician – Operating Room Technician	3	3	3	3	2	5
334	Medical Technician – Senior Preventive Medicine Technician	4	2	3	3	2	5
334	Medical Technician – Aero-medical Technician	3	2	3	3	2	4
334	Medical Technician – Physician Assistant	4	3	3	3	2	5
334	Medical Technician – Junior Preventive Medicine	4	2	3	3	2	5
335	Dental Technician	4	3	3	3	2	5
335	Dental Technician - Dental Hygienist	4	3	3	3	2	5
337	Aerospace Control Operator – Aerospace Operator	3	2	2	3	3	4
337	Aerospace Control – Radar Control	3	2	2	3	3	4
339	Combat Engineer	3	2	3	2	2	5
342	Clearance Diver Technician	3	2	2	2	2	5
343	Non-Destructive Testing Technician	4	2	3	3	3	5
357	Chemical, Biological, Radiological and Nuclear Operator	3	1	3	2	2	5
359	COATS GS NCM [2 & 3]	4	3	3	3	3	5
362	Army Communication & Information Systems Specialist	4	2	3	2	2	5
363	Aircraft Maintenance Superintendant	4	2	3	3	3	5
366	Weapons Engineering Technician	4	2	3	2	2	5

368	Artilleryman	3	2	3	2	2	5

Notes:
Rangers, Officer Cadet (TRG) require CEMS.
There is a new MOSID (00369 Operator) which as not yet published standards.
* = May require same cycloplegic standards as for restricted pilots and other aircrew.
1= Except for those in operational role
2=Applies for initial assignment to MOSID, may be considered with MELs on enrollment with lower standard.
3=Higher standard may be applied based on job requirements

Occupational Specialist – NCM

MOSID	OCCUPATION	V	CV	H	G	O	A
	Technical Crewman *	3	2	2	2	2	4
	Flight Attendant	3	3	3	3	3	4
	Mission Specialists	3	2	2	2	2	2
	Parachutist	3	3	3	2	2	5
165	Flight Steward	3	3	3	3	3	4
	Loadmaster	3	2	2	2	2	4
	Submariner	3	2	2	2	2	5
334	Medical Technician (AIREVAC)	3	2	2	2	2	4
339	Combat Diver	2	2	2	2	2	5
	Ships Divers	2	2	2	2	2	5
334	Diving Medicine Technician	3	3	2	2	2	5

Notes:
* = May require same cycloplegic standards as for restricted pilots and other aircrew.
1= Except for those in operational role
2=Applies for initial assignment to MOSID, may be considered with MELs on enrollment with lower standard.
3=Higher standard may be applied based on job requirements

Officers

MOSID	OCCUPATION	V	CV	H	G	O	A
	General Officers (including Specialists) and Colonels	4	3	3	3	3	5/7
178	Armour	3	3	3	2	2	5
179	Artillery	3	3	2	2	2	5
180	Infantry	3	3	3	2	2	5
181	Engineers	3	3	3	2	2	5
182	Air Combat Systems Officer[1]	3	2	2	2	2	2
183	Pilot	2	2	2	2	2	1

184	Aerospace Control	3	2	2	3	3	4
185	Aerospace Engineering	4	2	3	3	3	5
187	Land Electrical and Mechanical Engineering	4	3	3	2	2	5
188	Naval Engineering	3	3	3	2	2	5
189	Airfield Engineering	3	3	3	2	2	5
190	Physiotherapy	4	3	3	3	2	5
191	Dental	4	3	3	3	2	5
191	Dental – Dental Officer Specialist	4	3	3	3	2	5
192	Health Care Administrator	4	3	3	3	2	5
193	Health Services Operations	4	3	3	3	2	5
194	Pharmacy	4	3	3	3	2	5
195	Nursing	4	3	3	3	2	5
196	Medical	4	3	3	3	2	5
196	Medical – Medical Specialist	4	3	3	3	2	5
197	Bioscience Officer	3	3	3	3	2	4
198	Social Work	4	3	3	3	2	5
203	Public Affairs Officer	4	3	3	3	3	5
204	Legal	4	3	3	3	3	5
207	Marine Surface and Sub-Surface	4	2	2	2	2	5
208	Personnel Selection	4	3	3	3	3	5
210	Music	4	3	3	3	3	5
211	Training Development	4	3	3	3	3	5
212	Postal	4	3	3	3	3	5
213	Intelligence Officer	4	3	3	3	3	5
214	Military Police Officer	4	2	3	3	3	5
215	Naval Control of Shipping	3	2	2	2	2	5
228	Canadian Rangers (Officer)						
	Lieutenant-Colonels	4	3	3	3	3	5/7
232	Cadet Instructor Cadre (CIC)	4	3	3	3	3	5
232	CIC – SEA [2 & 3]	4	3	3	3	3	5
232	CIC – LAND [2 & 3]	4	3	3	3	3	5
232	CIC – AIR [2 & 3]	4	3	3	3	3	5
240	Officer Cadets (TRG)						
328	Logistics	4	3	3	3	3	5
340	Communications and Electronics Engineering – Air	4	3	3	3	3	5
341	Signals	4	3	3	3	3	5
344	Naval Combat Systems Engineering	4	3	3	2	2	5
345	Marine Systems Engineering	4	3	3	2	2	5
346	Naval Engineering	4	3	3	2	2	5
349	Chaplain	4	3	3	3	3	5
360	COATS GS OFFR [2 & 3]	4	3	3	3	3	5

Notes
Rangers, Officer Cadet (TRG) require CEMS.
* = May require same cycloplegic standards as for restricted pilots and other aircrew.
1= Except for those in operational role
2=Applies for initial assignment to MOSID, may be considered with MELs on enrollment with lower standard.
3=Higher standard may be applied based on job requirements

Occupational Specialists – Officers

MOSID	OCCUPATION	V	CV	H	G	O	A
181	Combat Diving Officer	2	2	2	2	2	5
195	Flight Nurse	3	2	2	2	2	4
196	Flight Surgeon	4	3	3	3	2	4
196	Submarine Medical Officer	4	3	2	3	2	5
00197-01	Aeromedical Training Officer	4	3	3	3	3	4
00207-03	Ship's Diving Officer	2	2	2	2	2	5
207	Clearance Diving Officer	2	2	2	2	2	5

Notes:
* = May require same cycloplegic standards as for restricted pilots and other aircrew.
1= Except for those in operational role
2=Applies for initial assignment to MOSID, may be considered with MELs on enrollment with lower standard.
3=Higher standard may be applied based on job requirements

Annex H. MEL Bank

Geographic Limitations

- G2 O2 – Requires no further limitation

"Medical Follow-up Frequency"

- requires periodic medical follow-up no more frequently than every six months
- requires periodic medical follow-up more frequently than every six months
- requires annual specialist follow-up
- requires regular specialist follow-up more frequently than every six months
- requires regular access to directed medical services (eg. Physiotherapy, laboratory facilities)

Operational Screening

- requires screening with a medical officer before selection for operational environment to confirm deployability
- requires screening with a specialist before selection for operational environment to confirm deployability

Risk-based MELs

- member has a chronic medical condition with a risk of recurrence of less than 10%, between 10 – 20%, between 20 – 50%, greater than 50% over 10 years.

  LEVEL I
  - In the event of a recurrence, the member will require basic levels of medical attention within 72 hours.

  LEVEL II
  - In the event of a recurrence, the member will require moderate levels of medical attention within 24 hours.

  LEVEL III
  - In the event of a recurrence, the member will require significant levels of medical attention within 60 minutes.

- member is at high risk of requiring medical care within 24 hours due to the combination of; risk of recurrence, treatment-associated risks and the requirement for enhanced medical care for some common complaints; risk believed to increase in operational environment.
- exposure to common operational hazards may cause an exacerbation of a chronic medical condition requiring urgent medical attention
- requires daily medication without which, after discontinuation of medication for XX hours/days, the member is at (high) risk of experiencing a crisis related to the chronic medical condition that may/will require the attention of a physician within XX hours.

Occupational Limitations

"Common Five" Generic Task Statements

- unable to perform a high-crawl over a distance of 45m and low-crawl over a distance of 30m

- unable to tolerate digging a personal trench
- unable to carry sandbags weighing 20kg over a distance of 50 m for a period of 10 minutes
- unable to evacuate a casualty 750m across country by carrying one end of a stretcher bearing an 80kg load
- unable to evacuate a casualty, during a fire on board ship, by carrying one end of a Stoke's litter bearing an 80kg load up and down a flight of stairs

"Physical" Generic Task Statements

- medically unfit CAF EXPRES program
- can perform CAF EXPRES test but step test instead of shuttle run
- unable to perform drill and parades for at least 30 minutes
- unable to safely handle and effectively operate a personal weapon
- unable to safely perform duties in or close to water
- unable to communicate via radio

"Stress" Generic Task Statements

- unable to tolerate the integral requirements of a military environment which requires the member to be able to perform duties while being exposed to frequent movement, relocation and temporary duty away from home
- requires regularly scheduled meals
- cannot tolerate extreme climactic conditions for a prolonged duration
- cannot tolerate wearing protective CBRN equipment

"Minimal" Occupational Limitations

- PT limited in type, duration, intensity or frequency
- unable to tolerate running
- unfit forced/ruck marching

- should avoid rucksack marching beyond what is required to comply with CAF personal and operational fitness policy
- unable to do a forced march for a lengthy period while carrying a rucksack and a personal weapon
- unable to do contact sports and high impact activities (running, jumping, stop and go sports)
- unable to lift overhead, repetitively or forcefully against resistance
- unable to lift more than XX kg repetitively
- unable to lift, push or hold items more than XX kg on any occasion

- unable to work on unstable platforms or at heights
- unable to work in environments (i.e. heights, with hazardous equipment, diving, etc.) where sudden incapacitation may result in a risk of significant injury to self or others
- unable to do tasks which require agility or fine motor skills
- unable to maintain the required steadiness/mobility to work on board HMC ships (because of ladders, stairs, unstable platforms)
- unable to tolerate sea environment (ship's motion at sea)

"Moderate" Occupational Limitations

- clerical type work with light physical tasks as tolerated only
- requires frequent rest and the opportunity to change physical position (every XX minutes)
- unable to walk more than XX minutes without rest

"Severe" Occupational Limitations

- sedentary clerical duties only
- unable to tolerate shift-work

- unable to tolerate working greater than half-days
- work schedule and tasks as tolerated by member only
- unfit work in any military environment
- unable to work in any military or civilian employment in any environment

Vision, Color Vision, Hearing

- to wear prescription lenses as directed
- member suffers from a condition with an associated decrease in peripheral vision and impaired depth perception. Therefore, should avoid all tasks where these skills are considered essential
- visual problem which may make it difficult to distinguish certain colors
- maximum hearing protection required
- should not be exposed to prolonged loud noise (firing range, heavy machinery, close proximity to aircraft engines, etc.) on regular basis as this may exacerbate a chronic medical condition
- requires use of hearing aid device for military duties

AUMB

- as per AUMB – A7 Unfit Aircrew
- as per AUMB – A3
- A7 – unfit airevac duties as per 1 Cdn Air Div

Other Useful MELs

- requires daily medication without which the member is at risk of experiencing a crisis related to the chronic medical condition
- avoid running on a daily basis as this may exacerbate a chronic medical condition
- no sudden or sustained heavy physical exertion
- should avoid sitting for more than 1 hour at a time without the ability to stand/walk around for 5-10 minutes
- no hand to hand combat or contact sports
- unable to tolerate shaving (to follow CAF standards for beard trimming and to shave only when operationally required)
- requires regularly scheduled meals
- requires access to ablution facilities when diet irregular
- to completely avoid specific agents which may provoke a crisis requiring self-administration of medication. Risk of exposure is <10/>10%, and if exposed, failure to respond to self-administered medication is rare but may need emergency medical services
- to carry self-administered medication at all times
- member is at high risk of requiring medical care within 24 hours due to the combination of risk of recurrence, treatment-associated risks and the requirement for enhanced medical care for some common complaints; risk believed to increase in operational environment
- requires medical review before employment in a safety-sensitive position
- requires a prosthetic device without which member's mobility would be impaired; there are no limits for the duration of wear for the device**/**unable to use device for more than XX hours continuously.
- requires access to additional equipment for the maintenance, use, and repair of the device a well as back-up devices to maintain mobility in the event of a breakdown of the device
- is at risk of developing problems related to the use of the device which will require Role 1 care within 48 hours. The risk is believed to be small/moderate/high, but/and may be increased by conditions of deployment. During this time, mobility will be impaired

- requires daily medication without which the member is at risk of sudden, unheralded and complete incapacitation. Even on the medication, the member remains at risk of complete incapacitation
- unable to safely handle explosives, team operated munitions or loading weapons where dropping ammunition could cause an explosion
- fit to drive class C vehicle (Iltis and hard top jeeps) and Class A vehicles (staff car and station wagon) only
- unfit driving military vehicles
- requires access to refrigeration facilities
- may require use of medication prior to physical activities, cold weather or high altitude environment
- requires the use of specialized electrical equipment daily during sleep. Without the use of this equipment for more than 2 days, the member is at risk of having a decreased ability to remain alert
- should use specialized electrical equipment during sleep (AC/DC)

Annex I. Post-Surgical Care and Modified Duties for Selected Procedures

Procedure	Length of Surgery	Length of Sick Leave	Length/Type of Light Duties (See next page for #1/#2 details)
Gallbladder	1.5 hrs	14 days	30 days/#2
Hernia - Ventral	Varies	30 days	14 days/#1
Hernia - Bilateral	1.5 hrs	30 days	14 days/#1
Hernia - Inguinal	1-2.5hrs	30 days	14 days/#1
Hernia - Epigastric	1 hr	14 days	30 days/#1
Hernia - Umbilical	1 hr	14 days	30 days/#1
Laparoscopic hernia	1-2hrs	14 days	30 days/#1
Pilonidal cyst removal	45 min	30 days	14 days/#1
Fistulotomy	45 min	7 days	7 days/#1
Exam under anesthetic	30 min		
Vericose vein stripping	45 min	14 days	14 days/#2
Laparotomy/bowel resection	2-3 hrs	6 wks	Varies
Anal-rectal procedures	45 min - 1 hr	30 days	14 days/#1
Laparoscopic cholecystectomy	1 hr 15 min	14 days	14 days/#1
Vasectomy	30 min	3 days	7 days/#1
Nisssan Fundoplication		14 days	14 days/#1
Laparotomy & orchidectomy		21 days	30 days/#2
Thyroid		2 - 4 wks (hemi vs total)	2 - 4 wks (hemi vs total)
Breast lump		14 days	30 days/#1
Appendectomy		30 days	30 days/#1
Minor hand procedure		7 days	7 days/#1
Pilonidal sinus & flap closure		14 days	30 days/#1
Modified Duties for the above surgeries: * #1 - No lifting greater than 5 kg, no ruck marching, no sit-ups, no push-ups, PT at won pace, type, intensity, frequency and duration			
* #2 - No lifting greater than 5 kg, no ruck marching, no situ-ups, no push-ups, no prolonged standing more than 15 minutes, no running, no cycling, no forced march, no drill, no parade. May walk for long distances. PT at own pace, type, intensity, frequency and duration			

Selected Orthopaedic Procedures Sick Leave

- Achilles repair – 14-30d
- Compartment syndrome – 14d
- Knee Scope – 14d
- Leg Surgery – 14-30d
- Ankle/Toe Surgery – 14d

Generally, all initial SL after surgeries should be 7-14 days and then in for recheck, unless otherwise stated by surgeon. (You can start with

7, and have them in for recheck if you'd like – but some surgeries are relatively disabling in short term, and it might not be worthwhile to have the patient come in. Sometimes a phone call to make sure they are doing ok can save everyone a big headache.)

Annex J. Sample Jump Bag Kit List

Jump Bag Supplies (Non-Pharmaceutical)	Quantity	Expiry Dates
This was based on a bag that was prepared for UMS Support - possible dismounted visits to company-level biv sites.		
General		
Trauma Shears	1	
Nitrile Gloves	10	
Glasses/Goggles	1	
Hand Sanitizer	1	
large ziploc bags	10	
Carabiner	2	
Sharpie marker	2	
Triage cards/tape	Set	
Penlight/Headlamp	1	
Batteries for instruments as needed	PRN	
Alcohol wipes	20	
Chlorhexedine swabs (large q-tip like)	10	
Sharps container (small)	1	
Survival blanket (silver plastic)	2	
Muco/Lube	Lots	
Airway		
Hand suction apparatus	1	
Oropharyngeal Airway	2-3 sets	
Nasopharyngeal Airway	2-3 pairs	
Bag valve mask	1	
CPR Mask /Shield	1-2	
Muco/Lube	3-4 pouches	
ET Tubes - Sizes 6-8 x 2 each	2 each	
King LTS/Combitube	2 each color/size	
LMA size 3, 4, 5	2 each size	
Cricothyroidotomy kit	2	
Intubating LMA if available	2	
Lidocaine Spray*	1	
Magill forceps	1	
Airtraq if available	1	
Bougie	1	
End Tidal CO2 detector	2	
Syringe for inflating cuffs on tubes	PRN	
Laryngoscope + Curved + Straight Blades	1 Set	
Stylet for ET Tubes	1-2	

Trauma Gear		
Hard plastic Adjustable C-collar	1	
Moldable splint	1-2	
Pelvic Binder	1	
Tourniquet	2-4	
Chest Tube Kit		
14 ga needle	4	
Chest Tube	1	
Medium-Large Kelly Forceps	5	
Straight Forceps	4	
Lidocaine *	30mL	
Chlorhexedine/Iodine swabs (large q-tip like)	4	
Sterile towels/Paper Drape	2	
Sterile Gloves	2pr	
4" waterproof tape	1	
Chest tube gauze (fenestrated) dressing	4	
(Vaseline impregnated gauze?)	2	
#11 blade (disposable scalpel)	2	
Suture - 0 silk or ethilon	2	
IV/IO Kit		
IV Catheter - 16 ga	4	
IV Catheter - 18 ga	4	
IV Catheter - 20 ga	4	
IO Kit (Manual or drill style)	1	
IV extension set	2-4	
IV short lock set (5-10cm lock set)	2-4	
10 cc syringe	5	
3 cc syringe	5	
60 cc syringe	2	
25ga needle for injection	10	
18 ga blunt needle	10	
Tegaderm IV site dressings	10	
10cc saline flushes*	10	
Dressings and Sutures		
(Dressing/Suture tray)	1	
Sutures - 3-0 or 4-0 prolene	10	
Suture - 0 silk or ethilon	2	
Needle Driver	2	
Scissors	2	
Adson forceps	2	
4x4 gauze	Lots	

2x2 gauze	Lots	
Burn dressing (saran wrap)	Lots	
OLAES Dressing	2-4	
COBAN tape (3")	2-3 rolls	
HALO chest seal (or similar)	1-2	
Israeli Battle Dressing (or similar)	2-4	
4" gauze roll	4	
Blast Dressing	4	
Rolls of Tape	4	
Tensor bandage (3")	2	
Tensor bandage (4")	2	
Duct tape	1 roll	
Merocel nasal packing	2-4	
Eye cover (metallic)	2	
Bunches of Kids bandaids	100	
Tongue Depressor	10	
Nosebleed Clips	2	
Diagnostic Tools		
Thermometer (Consider the disposable strips)	1	
Pulse Oximeter	1	
Manual BP Cuff	1	
Stethoscope	1	
Otoscope	1	
Ophthalmoscope	1	
Glucose monitor	1	
Glucose test strips	1	

Note: This list is not intended to be complete (in fact, many of these items could or should be omitted because they are a waste of valuable space) but intended to be a starting point for things to think about. Consider talking to your senior MOs, Med Techs, and PA who have experience when selecting what to put in your "Go Bag!"

Ten things to think about

1. Where are you going – how far away from a hospital are you?
2. Who is going with you – do you have medics, ambulances, or other medical support?
3. What clinical skills are you comfortable with?
4. Can you carry something smaller/lighter to accomplish the same thing?
5. Do you NEED to do this intervention right here, right now, or should is be done under more controlled conditions?
6. After the intervention – what is your plan – and do you have what you need to do that?
7. Do you have the tools to diagnose the condition you are planning to treat (ie. No Monitors/EKG – why are you carrying code drugs?)
8. Does anyone else need your help more urgently?
9. Can you get the patient out of here after your intervention?
10. Do you have what you need to deal with potential complications of your management?

When selecting a bag, consider something with lots of compartments, and consider using smaller pouches inside the main bag to separate your kit to allow for easy, quick, organized access. Consider getting hard plastic or foam-lined cases for your medications in glass vials/ampoules.

Some suggested lists based on EMT, SAR, and Wilderness medicine practice
http://www.practicaltrauma.com/trauma.shtml
http://ireca.org/storage/documents_2012/Equipment%20List.pdf
http://www.wemsi.org/teammedkit1.pdf
http://www.wemsi.org
http://www.wemsi.org/medkit_docs.html

Medical Bag/Kit to Purchase
http://www.ctoms.ca
http://www.blackhawk.com/catalog/Medical,1369.htm
http://www.mysteryranch.com/military/military-medical-packs

Drug Pouches/Cases
http://www.pelican.com/canada/
https://www.mooremedical.com/index.cfm?/Bags-Kits-Pharmaceutical-Cases/_/N-jn/No-0/?Nao=0&Ds=0&N=707&No=0&PGC=88&FNC=Catalog_Pharmaceutical%20Cases&Ns=TotalRevenue88%7C0
https://www.boundtree.com/iv-drug-bags-subcategorynode-82-0.aspx
http://www.spservices.co.uk/item/LondonKits_ParabagDrugpakMiniPaddedAmpBag_0_74_503_1.html
http://www.thomasems.com/drug-case-new.html

CAF DWAN Link for some Kit Lists
http://cmed.petawawa.mil.ca/english/camms/KitSearch_e.asp

Annex K. Sample Emergency Kit Medication List

Item	Route	Dose	What for?	Requested
Acetazolamide	PO	125 mg	altitude sickness	100
Acyclovir	IV	500 mg	Antiviral	4 vials
Adenosine Preload 6mg/2mL	IV	6mg	ACLS	3
Adenosine Vials 6mg/2mL	IV	6mg	ACLS	2
Aerochamber			Respiratory Distress	1
Amiodarone	IV	300 mg	ACLS	2 Vials
Ampicillin	IV	2g	Antibiotic	2
Aspirin	PO	81 mg	ACLS	1 bottle x 30 tabs
Aspirin	PO	325 mg	ACLS	1 bottle x 30 tabs
Atropine Preload	IV	1 mg/10 mL	ACLS	3
Azithromycin	PO	250mg	Antibiotic	40
Benztropine	IV	2mg.2mL	Antidote	2
Bronchophan	PO	100mg/5 mL	Cold Pack	10 bottles
Bupivacaine 0.5%		20mL	Local Anesthetic	4
Buscopan	IV	20mg	Antispasmotic	2
Calcium Chloride 10% preload 1g/10mL	IV	1 g	ACLS	2
CapGas II End-Tidal CO2 Detector				1
Captopril	PO	25mg	ACLS	20
Cefazolin	IV	1g	Antibiotic	4
Cefixime	PO	400 mg	Antibiotic	20
Ceftriazone	IV	1g	Antibiotic	2
Cephalexin	PO	500 mg	Antibiotic	100
Ceterizine	PO	10mg	Allergy/Cold Pack	100
Charcoal Activated	PO	50g	Antidote	6 bottles
Cimetidine 150mg/mL, 2mL	IV	300mg	Anaphylaxis	2
Ciprofloxacin	IV	400 mg	Antibiotic	5 bags
Ciprofloxacin	PO	500mg	Antibiotic	1 bottle x 100 tabs
Clindamycin	IV	300 mg	Antibiotic	2
Clindamycin	PO	300 mg	Antibiotic	40
Clopidogrel	PO	75 mg	ACLS	4 tabs
Dexamethasone	PO	4mg	Altitude Sickness	100
Dexamethasone	IV	20 mg/5mL		1
Dextrose Preload	IV	25 g/50mL		1 Preload
Diazepam	IV	10 mg amp	Countermeasure, Seizure	10 amp
Diltiazem 125mg/25 mL	IV	125 mg	ACLS	2
Dimenhydrinate	IV	50 mg/mL	Nausea	10 amp
Diphenhydramine	IV	50 mg/mL	Anaphylaxis	10 amp
Diphenhydramine BENADRYL	IV	50mg/m	Anaphylaxis	4 amp

		L		
Diphenhydramine BENADRYL	PO	50 mg	Anaphylaxis	12 tabs
Dobutamine	IV		ACLS	
Dopamine Premix Bag 400mg in 125mL	IV	125 mL	ACLS	2
Doxycycline	IV	100mg	Antibiotic	4
Doxycycline	PO	100 mg	Antibiotic	28
Enoxaparin	IV/SC	30 mg/0.3mL	ACLS	1
Enoxaparin	IV/SC	300 mg/3 mL	ACLS	1
Epinephrine 1:1000 ampule 1mg	IM	1mg	Anaphylaxis	2
Epinephrine 1:10000 preload 1mg/10mL	IV	1mg	ACLS	3
Epinephrine Autoinjector	IM	0.3mg	Anaphylaxis	4 Autoinjectors
Erythromycin Base	PO	333 mg	Antibiotic	30
Ethanol 10% in D5W	IV	1L	Antidote	1
Famcicovir	PO	500mg	Antiviral	30
Fentanyl for injection	IV/IM/SC	100 mcg	Analgesic	3
Fluconazole	PO	100mg	Antibiotic	16
Flumazenil	IV	0.5mL	Antidote	5 Vials x 0.5mL
Furosemide	IV	20mg	ACLS	4
Gentamicin	IV	80 mg vial	Antibiotic	10
Glucagon Kit	IV	1mg	ACLS	2
Glucose Gel	PO	15g	ACLS	1
Glucose Monitoring Strips	-			10
Glycopyrrolate 0.2 mg/mL	IV	2mL	Antidote	10
Haloperidol for injection	IV	5mg/mL	Antipsychotic	2 Amps x 1mL
Hydralazine	IV	20mg	ACLS	4
Ibuprofen	PO	200 mg	Mild Pain	200
Insulin R 100u/mL x 10mL	IV/SC	10mL	ACLS	2
Ipratropium	MDI	1 unit	Respiratory Distress	1 MDI
Ipratropium 500 mcg/2mL	Nebule	500 mcg	Respiratory Distress	4
KCl 10mmol in 100mL	IV	100mL	ACLS	4
Ketamine 50mg/mL x 10mL	IV/IM	10mL	ACLS	4
Ketorolac	IV	30 mg	Analgesic	10
Labetalol	PO	100mg	ACLS	10
Labetalol 5mg/mL x 20 mL	IV	20mL	ACLS	5
Lidocaine 1% with epi		20mL	Local Anesthetic	1
Lidocaine 2% jelly	Topical	30mL	Local Anesthetic	1
Lidocaine 2% Preload 100mg/5mL	IV	100mg	ACLS	2
Lidocaine 2% with epi		20mL	Local Anesthetic	1
Lidocaine 2% without 10mL		10mL	Local Anesthetic	2
Lidocaine ET Spray	Spray	30mL	ACLS	1
Lorazepam	PO	1mg	Psychiatric	10
Magnesium Sulfate 1000mg/2mL	IV	1000mg	ACLS	4
Mannitol 20% in 100 mL	IV	100mL	ACLS	5
Methylprednisolone	IV	125mg	Anaphylaxis	2
Metoclopramide	PO	10mg	Antiemetic	20

Metoclopramide 10 mg/2mL	IV/IM/SC	10 mg	Antiemetic	2
Metoclopramide 10mg/2mL	IV/IM	10mg	Antiemetic	2
Metoprolol	PO	25 mg	ACLS	20
Metoprolol	IV	5mg	ACLS	5 vials
Metronidazole	PO	500 mg	Antibiotic	30
Metronidazole for IV	IV	500 mg	Antibiotic	4
Midazolam 5mg/mL, 2mL vial	IV	10 mg	ACLS	2
Mometasone (nasonex)	Intranasal	50 mcg	Cold Pack	5
Morphine	IV	15mg	Analgesic	3
Moxifloxacin	PO	400 mg	Antibiotic	10
NaCl 0.9%	Bottle	1L		1
NaCl 0.9% 100 mL Bag	IV	100mL		2
NaCl 0.9% 1L Bag	IV	1L		2
NaCl 0.9% 500mL Bag	IV	500mL		2
Naloxone	IV	0.4mg amp	Antidote	6 vials
Naloxone	IV	0.4mg amp	Antidote	6 vials
Naproxen	PO	500 mg tab	Analgesic	100
Neostigmine	IV	10 mg	Antidote	1 vial
Nifedipine	PO	20mg tab	ACLS	20
Nitroglycerin	IV		ACLS	
Nitroglycerin	SL	0.4mg Spray	ACLS	2 bottles
Olanzapine	PO	5mg	Antipsychotic	4
Ondansetron	IV	4mg/2mL	Antiemetic	4
Ondansetron	PO	4mg	Antiemetic	20
Oseltamivir	PO	75mg	Antiviral	10
Oxygen Tank			RECHECKED 13 Nov 2013	1
Oxymetazoline Spray	Intranasal			5
Pantoloc	IV	40 mg vial	GI Bleed	10
Pantoloc	PO	40 mg	Gi Bleed	10
Penicillin G	IV	600mg	Antibiotic	6
Penicillin V K	PO	300 mg	Antibiotic	80
Percocet 5/325	PO	5/325mg	Moderate-severe pain	20
Phenylephrine	IV	5mg vial	ACLS	4 vials
Phenytoin 250mg/5mL	IV	250mg	Seizure	10
Piperacillin-Tazobactam	IV	3.375g	Antibiotic	4
Prednisone	PO	50 mg	Respiratory Distress	50
Pregnancy Tests	-	-		10
Prochlorperazine (Stemetil)	IV	10mg/2 mL	Antiemetic	2
Promethazine(Phenergan) 25mg/mL	IV	25 mg	Antiemetic	4
Propafol 10mg/mL	IV	20mL	ACLS	4

Pseudoephedrine	PO	60 mg	Cold Pack	200
Ranitidine	PO	150 mg	Anaphylaxis	10
Ranitidine 25 mg/mL x 2mL	IV	50 mg	Anaphylaxis	4
Rifampin	IV	600 mg	Antibiotic	3
Rifampin	PO	300 mg	Antibiotic	30
Rocuronium 10mg/mL in 5mL	IV	5mL	ACLS, Countermeasure	8
Salbutamol	MDI	1 MDI	Respiratory Distress	1
Salbutamol 100 mcg/puff MDI	MDI	1MDI	Respiratory Distress	1
Salbutamol 2.5mg in 2.5mL	Nebule	2.5 mg	Respiratory Distress	4
Saline Nasal Rinse	Intranasal	30mL	Cold Pack	10
Sodium Bicarbonate 8.4% 50mL	IV	50mL	ACLS	4
Sterile water	Bottle	1L		1
Sterile water for injection	IV	20mL		10
Succinylcholine 20mg/mL	IV	20mg/mL	ACLS	10
Sulfamethoxazole/Trimethoprim	PO	800/160 mg	Antibiotic	28
Sumatriptan	SC	12mg	Migraine	1
Tenecteplase	IV	50mg Kit	ACLS	1
Thiamine	IV	100 mg/mL	Antidote	2
Tranexamic acid 100 mg/mL	IV	10mL	ATLS	2
Tylenol #3	PO	325/30	Moderate Pain	100
Tylenol	PO	325 mg	Mild Pain	250
Vancomycin	IV	1g	Antibiotic	4
Vasopressin	IV	40u/2mL	ACLS	2
Verapamil 5mg/2mL	IV	5mg/2mL	ACLS	4
Does not include items from trauma bay crash cart, or from CBRN Resources/Countermeasures bags.				