40-3
C 1
See C1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, C19, 20, 21, 22, 23, 24, 25, 26, 27,
S/S Sep 73

ARMY REGULATIONS AR 40–3

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

THE ARMY LIBRARY
WASHINGTON, D. C.

HEADQUARTERS, DEPARTMENT OF THE ARMY MARCH 1962

CHANGE No. 27

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *18 August 1972*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

Effective 15 October 1972

This change authorizes emergency care in other military, Federal and civilian medical facilities for applicants who suffer injury or acute illness during processing, civilian medical care for Army members without regard to status after 1 July 1971, and MEDDAC commanders as approving authorities for civilian medical care, reduces the outpatient charge for educational representatives overseas to the Special Outpatient Rate, authorizes medical care for Secret Service protectees and protectors, changes the procedure for administrative return of military patients to the US, and changes the inpatient rate for social security beneficiaries to Rate B.

AR 40–3, 26 March 1962, is changed as follows:

1. Changed material is indicated by a star.

2. Remove old pages and insert new pages as indicated below:

Remove pages	*Insert pages*
1 and 2	1 through 2.1
34.1 through 34.5	34.1 through 34.5
35 and 36	35 and 36
61 and 62	61 and 62
65 and 66	65 and 66
69 through 76.3	69 through 76.4
98.13 and 98.14	98.13 and 98.14
98.17 and 98.19	98.17 through 98.19

3. File this change sheet in front of the publication for reference purposes.

The Proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) direct to HQDA (DASG–DDO–AP) Washington, DC 20314.

* This change supersedes DA message DASG–DDO–H 311600Z, Mar 72 (U), subject: Interim Change to AR 40–3 (Change 27); and DA message DASG–DDO–H 291449Z Jun 72 (U), subject: Interim Change to AR 40–3 (Change 27).

By Order of the Secretary of the Army:

BRUCE PALMER, JR.
General, U. S. Army
Acting Chief of Staff

Official:
VERNE L. BOWERS
Major General, United States Army
The Adjutant General

Distribution:

Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12–9 requirements for AR, Medical Service—Applicable to all Army Elements—A (Qty Rqr Block No. 104).

CHANGE No. 26

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *14 February 1972*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

Effective in accordance with DA messages superseded below

This change amends the instructions on obtaining consents for medical care; authorizes care for applicants who suffer injury or acute illness during processing, care for pre-adoptive children, and care at USATGH for Micronesian citizens; and requires a medical board and referral to a PEB on the first periodic medical examination following placement on the TDRL, and referral to a PEB when periodic examination is performed within 1 year of the fifth anniversary of placement on the TDRL. It also provides procedures that furnish special optical prescription for plastic lens on a central worldwide basis; provides for change in the distribution of DD Form 771 in order to fulfill statutory record requirements; and the addition of explosives ordnance detachment (EOD) personnel to those authorized nonstandard spectacle frames.

AR 40–3, 26 March 1962, is changed as follows:

1. Changed material is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

Remove pages	*Insert pages*
1 through 4.1	1 through 4.1
14.3 through 14.5	14.3 through 14.5
27 and 28	27 and 28
34.1 through 34.4	34.1 through 34.5
39 and 40	39 and 40
47 and 48	47 and 48
87 through 90	87 through 90
98.9 and 98.10	98.9 and 98.10
98.13 and 98.14	98.13 and 98.14

3. File this change sheet in front of the publication for reference purposes.

***This change supersedes DA message DCSPER–PS&T 182203Z, Jan 71(U), DA message DASG–DDO–H 291841Z Sep 71(U), and DA message DASG–DDL–P, 29 Dec 71(U), subject: Interim Change to AR 40–3 (Change 26).**

TAGO 462A - February 480-472 -72

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) direct to HQDA(DASG-DDO-H), Washington, DC 20314.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
VERNE L. BOWERS,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service—Applicable to all Army Elements—A (qty rqr block No. 104).

CHANGE No. 25

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *26 July 1971*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

Effective in accordance with DA messages shown in supersession note

This change establishes a policy on contact lens service, establishes an impact-resistant lens program, prescribes the use of a newly-designed spectacle prescription form for plastic lenses, and eliminates "Other Outpatient Rate," and "Medical Examination Rate" from the charges made for care in Army medical facilities.

AR 40-3, 26 March 1962, is changed as follows:

1. Changed material is indicated by a star.

2. Remove old pages and insert new pages as indicated below:

Remove pages	*Insert pages*
3 through 4.1	3 through 4.1
15 and 16	15 and 16
34.1 and 34.2	34.1 and 34.2
85 through 90	85 through 90.3
95 and 96	95 and 96
98.7 through 98.17	98.7 through 98.19

3. File this change sheet in the front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) direct to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, DC 20314.

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*This change supersedes DA Message MEDDD-SR 042141Z Apr 68 (U), subject: Spectacle Insert for Protective Field Masks for National Guard Personnel; DA Message MEDDD-SR 162155Z Apr 68 (U), subject: Spectacle Insert for Protective Field Masks for National Guard Personnel; DA Message MEDDD-SR 112023Z Jul 68 (U), subject: Spectacle Insert for Protective Field Masks for Army Reserve Personnel; DA Message MEDDD-SR 021407Z Feb 70 (U), subject: Single Vision Optical Support for Rodriguez US Army Hospital; DA Message MEDDD-SR 071850Z Apr 70 (U), subject: Peening of Prescription Spectacles; DA Message MEDDD-SR 162050Z Jun 70 (U), subject: Interim Change to AR 40-3; and DA Message MEDDD-CA 282021Z Aug 70 (U), Subject: Interim Change to AR 40-3 (Change 24) Effective 1 September 1970.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
VERNE L. BOWERS,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12–9 requirements for AR, Medical Services—Applicable to all Army Elements—A (Qty Rqr Block No. 104).

CHANGE No. 24

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *27 April 1971*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

Effective 1 July 1971

This change adds instructions on emergency patients, defines sanity boards, changes the definition of dependents, adds several new categories of persons eligible for care, changes the charges for care provided Boy Scouts, dependents of Red Cross personnel, and persons evacuated from one area to another, moves the provisions for supplementation of facilities from Section VIII to Section II, revises the section on dental care, adds a section on special arrangements for use of Veterans Administration facilities, and adds an appendix on BEC district offices.

AR 40–3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added, are indicated by a star.

2. Remove old pages and insert new pages as indicated below:

Remove pages	*Insert pages*
1 through 4.1	1 through 4.1
7 and 8	7 and 8
11 through 14.6	11 through 14.5
15 through 22.1	15 through 22.1
27 through 34.2	27 through 34.4
35 through 54.1	35 through 54
57 through 60	57 through 60
61 through 64	61 through 64
65 and 66	65 and 66
67	67
69 through 75	69 through 76.3
79 through 80.3	79 through 80.3
81 and 82	81 through 82.1
91 through 95	91 through 96
98.1	98.1
98.3 and 98.4	98.3 through 98.4.1
	98.5
98.7 through 98.17	98.7 through 98.17
102.7	102.7 and 102.8

3. This change sheet should be filed in the front of the publication for reference purposes.

* This change supersedes the following DA messages: 772075, 30 June 1966; 774583, 20 July 1966; 858239, 3 April 1968; MEDDD–OP 182121Z Mar 70 (U), Subject: Interim Change to AR 40–3 (Change 24); and MEDDD–C 162108Z Sep 70 (U), Subject: Interim Change to AR 40–3 (Change 24).

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) direct to The Surgeon General, ATTN: MEDDD–C, Department of the Army, Washington, DC 20314.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
VERNE L. BOWERS,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, and USAR: To be distributed in accordance with DA Form 12–9 requirements for Medical Service—Applicable to all Army Elements—A (Qty Rqr Block No. 104).

CHANGE No. 23

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *18 December 1969*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

Effective 7 November 1969 in accordance with DA message MEDOC–S 071922Z Nov 69 except as otherwise indicated

This change provides a current list of approving authorities for civilian medical care.

AR 40–3, 26 March 1962, is changed as follows:

1. Changes are indicated by a star.
2. Remove old pages and insert revised pages as indicated below.

Remove pages	*Insert pages*
71 and 72	71, 72, 72.01
91 through 94	91 through 94

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to The Surgeon General, ATTN: MEDDD–OP, Department of the Army, Washington, DC 20314.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and *USAR:* To be distributed in accordance with DA Form 12–9 requirements for AR, Medical Service—Applicable to all Army Elements—A (qty rqr block No. 104).

***This change supersedes DA message MEDOC–S 071922Z Nov 69 (U), subject: Interim Change to AR 40–3 (Change 23).**

TAGO 432A December 300-470*—69

CHANGE No. 22

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *23 October 1969*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

Effective 1 December 1969

This change includes a complete revision of section XVI on orthopedic footwear. It eliminates local commercial facilities and the Veterans Administration as sources of procurement for orthopedic footwear and requires that they be requisitioned from the Defense Orthopedic Footwear Center. This change also includes a revised section XII, Optical Services, to reflect current practices in the furnishing of spectacles.

AR 40-3, 26 March 1962, is changed as follows:

1. Changed material is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

Remove pages—	*Insert pages—*
3 through 4.1	3, 4, and 4.1
85 through 90.1	85 through ~~90.10~~ 90
98.3 through 98.6	98.3 and 98.4

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, DC 20315.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service Applicable to all Army Elements (quan rqr block No. 104).

*** This change supersedes DA messages 836533, 16 October 1967 and 838311, 31 October 1967.**

TAGO 302A—October 390-468*—69

U.S. GOVERNMENT PRINTING OFFICE: 1969

CHANGE No. 21

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *19 May 1969*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

Effective 15 April 1969 in accordance with DA message 905128

AR 40-3, 26 March 1962, is changed as follows:

1. This change establishes priorities for care in Army facilities.
2. Material changed is indicated by a star.
3. Remove pages and insert new pages 11 through 12.1.
4. File this change in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and *USAR:* To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Services—Applicable to all Army Elements—A (qty rqr block No. 104).

*** This change supersedes DA message 905128, 15 April 1969.**

TAGO 1179A—May 340-475[C15]—69

CHANGE No. 20

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *30 April 1969*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

Effective 1 June 1969

AR 40-3, 26 March 1962, is changed as follows:

1. This change revises approving authority area of responsibility in order to expedite payment of civilian medical bills. The changes stated in items b, e, and i of figure 2-1 are *effective 1 April 1969*. Any claim received after 1 April 1969 which is related to a claim previously processed under provisions of Change 17 will also be processed under provisions of Change 17.

2. Paragraphs which have been changed are indicated by a star.

3. Remove pages 69 through 72.1 and insert new pages 69 through 72.2.

4. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, and *USAR:* To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service Applicable to all Army Elements—A (quan rqr block No. 104).

This change supersedes DA message 903743, 4 April 1969.

CHANGE No. 19

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *10 March 1969*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40-3, 26 March 1962, is changed as follows:

1. Changed material is indicated by a star.

2. Remove pages 81 through 84 and insert revised pages 81 through 83 and new page 102.5.

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, and *USAR:* To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service—Applicable to all Army Elements—A (quan rqr block No. 104).

This change supersedes DA message 897201, 12 February 1969.

CHANGE No. 18

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *7 February 1969*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40-3, 26 March 1962, is changed as follows:

1. Paragraphs which have been changed are indicated by a star.
2. Remove old pages and insert new pages as indicated below.

Remove pages	*Insert pages*
41 and 42	41 and 42
49 and 50	49 and 50

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, and *USAR:* To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service—applicable to all Army Elements—A (quan rqr block No. 104).

*This change supersedes so much of DA message 890080, 10 December 1968, as pertains to AR 40-3.

CHANGE No. 17

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *12 December 1968*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added are indicated by a star.
2. Remove old pages and insert new pages as indicated below:

Remove pages—	*Insert pages—*
3, 4, and 4.1	3, 4, and 4.1
69 through 72.1	69 through 72.2
75	75
80.1 through 80.3	80.1 through 80.3

3. File this change sheet in the front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and *USAR:* To be distributed in accordance with DA Form 12-9 requirements for Medical Service—applicable to all Army elements—A (qty rqr block No. 104).

*This change supersedes DA message 872993, 19 July 1968.

CHANGE No. 16

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *2 August 1968*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added are indicated by a star.
2. Remove old pages 53 and 54 and insert new pages 53, 54 and 54.1.
3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements to The Surgeon General, ATTN: MEDD-OP, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9 (Quan rqr block No. 104) requirements for AR, Medical Service—Applicable to all Army Elements—A.

*This change supersedes DA message 869025, 20 June 1968.

CHANGE No. 15

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *13 September 1967*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added are indicated by a bold star.
2. Remove old pages and insert new pages as indicated below:

Remove pages—	Insert pages—
1 through 5 (C14)	1 through 4.1
9 and 10	9 through 10.1
14.1 through 14.5	14.1 through 14.6
25 through 28	25 through 28.2
35 through 58	35 through 60
69 through 72	69 through 72.1
87 and 88	87 and 88

3. This transmittal sheet should be filed in the front of the publication for reference purposes.

[MEDDD-OP]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

*This change supersedes DA message 800440, February 7 1967, and DA message 810799, 18 April 1967.

CHANGE No. 14

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *3 February 1967*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40–3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added are indicated by a bold star.

2. Remove old pages and insert new pages as indicated below:

Remove pages—	Insert pages—
1 through 4	1 through 5
7 and 8	7 and 8
11 and 12	11 and 12.1
15 through 20	15 through 20.2
26.1	26.1
29 through 36.1	29 through 36.1
39 and 40	39 and 40
47 through 49	47 and 48
53 through 59	53 through 58
61 through 63	61 through 64
65 through 67	65 through 67
69 through 70.1	69 through 70.1
75	75
79 through 80.1	79 through 80.3
91 through 95	91 through 95
97	97
98.7 through 98.16	98.7 through 98.17

3. Delete by pen-and-ink change the term "Coast and Geodetic Survey" wherever it appears in this regulation and substitute therefor "Environmental Science Services Administration."

*** This change supersedes DA message 704017, 17 February 1965; DA message 707560, 17 March 1965; DA message 709410, 31 March 1965; DA message 716333, 19 May 1965; DA message 719560, 11 June 1965; DA message 721403, 25 June 1965; DA message 722761, 7 July 1965; DA message 728338, 16 August 1965; DA message 769699, 15 June 1966; DA message 779902, 26 August 1966; DA message 782814, 19 September 1966; DA message 789403, 4 November 1966.**

4. This transmittal sheet should be filed in the front of the regulation for reference purposes.

[MEDDD–OP]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12–9 requirements for Medical Service–A.

☆ U.S. Government Printing Office: 1967—250-507/6599A

CHANGE No. 13

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *30 December 1966*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40–3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added are indicated by a star.

2. Remove old pages 85 through 90.1 and insert new pages 85 through 90.1.

3. This transmittal sheet should be filed in the front of the publication for reference purposes.

[MEDDD–OP]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:
KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12–9 requirements for Medical Service—A.

*This change supersedes DA messages 719171, 9 June 1965 and 771117, 24 June 1966.

TAGO 989A—Jan. 150-471 O—67

CHANGE No. 12

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *18 March, 1965*

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added are indicated by a bold star.

2. Remove old pages and insert new pages as indicated below:

Remove pages—	Insert pages—
1 through 4, 4.1	1 through 4.
14.1, 14.2	14.1, 14.2.
15 through 18, 18.1	15 through 18, 18.1,
21, 22	21, 22, 22.1.
25, 26, 26.1	25, 26, 26.1.
29, 30, 30.1, 31 through 33	29 through 34.
37, 38	37, 38.
47 through 50	47 through 49.
61, 62	61, 62.
70.1	70.1.
77, 78	77, 78.
80.1	80.1.
85 through 90	85 through 90, 90.1.
98.5, 98.6	98.5, 98.6.
Table I (no folio)	98.7 through 98.16.

3. This transmittal sheet should be filed in the front of the publication for reference purposes.

[MEDDD-OP]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

***This change supersedes DA message 976068, 1 July 1964; DA message 976361, 2 July 1964; and DA message 987525, 25 September 1964; and DA message 988247, 1 October 1964.**

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGE No. 11

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *30 June 1964*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added are indicated by a bold-type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
3 and 4	3 through 4.1
17 through 18.1	17 through 18.1
21 and 22	21 and 22
25 and 26	25 and 26
31 and 32	31 and 32
61, 62, and 63	61, 62, and 63
65 and 66	65 and 66
69 and 70	69, 70, and 70.1
73, 74, and 74.1	73, 74, and 74.1
93 and 94	93 and 94
	98.3 through 98.6

3. This transmittal sheet should be filed in the front of the publication for reference purposes.

[MEDDD]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9, requirements for Medical Services—A.

***This change supersedes AR 32-30, 21 October 1958.**

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGE No. 10

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *20 April 1964*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by this change are indicated by a bold-type star.

2. Remove old pages and insert new pages as indicated below:

3. This transmittal sheet should be filed in the front of the publication for reference purposes.

Remove pages—	Insert pages—
7 through 14	7 through 14.5
17 through 18.1	17 through 18.1
21 and 22	21 and 22
27 through 30.1	27 through 30.1
39 and 40	39 and 40
61 through 74	61 through 74, and 74.1
85 through 90	85 through 90
	98.1

[MEDDD-OP]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 9-12 requirements for DA Regulations, Medical Service—A.

*This change supersedes DA message 945691 20 November 1963; DA message 946280, 26 November 1963; and DA message 949504, 24 December 1963.

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGE No. 9

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *3 December 1963*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by these changes are indicated by a bold-type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
19 and 20	19 and 20
23 and 24	23 and 24
27 and 28	27 and 28
31 and 32	31 and 32
35 and 36	35 and 36
37 through 40	37 through 40
45 through 48	45 through 48
65 and 66	65 and 66
69 and 70	69 and 70
81 and 82	81 and 82

[MEDDD-OP]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGES No. 8

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *25 September 1963*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by these changes are indicated by a bold-type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
85 and 86	85 and 86.

[MEDDD-OP]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGES No. 7

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *31 July 1963*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by these changes are indicated by a bold-type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
1 through 4	1 through 4
9 and 10	9 through 10, 10.1 through 10.5
17 and 18	17 and 18, 18.1
23 and 24	23 and 24,
26.1	26.1
49 through 54	49 through 54
61 through 66	61 through 66
69 through 72	69 through 72, 72.1
85 and 86	85 and 86
93 and 94	93 and 94

3. The following changes will be made in pen and ink to the cover sheet for C 1, AR 40-3, 17 July 1962:

a. So much of paragraph 3*f*(4) as reads "Rept to SG on DD Form 7A" should be changed to read "None."

b. So much of paragraph 3*f*(5) as reads "MR" should be changed to read "Yes (med exams only)."

4. The following changes will be made in pen and ink to table I:

a. Category 7*e*, column 2, change to read "Off and employees of Dept of State, Dept of Agriculture, Agency for International Development, U.S. Information Agency, Federal Aviation Agency, Foreign Claims Settlement Commission (to include applicants for appointment) and depns of such officers and employees."

b. Category 8*j*(2), column 2, change to read "Civ employees of the Defense Establishment (not beneficiaries of the Bureau of Employees Compensation) and their dependents*."

c. Note E.—The category of personnel authorized the protective field mask by TA 77-7 will be furnished, at no expense to the individual, optical inserts, therefor in accordance with the criteria established in paragraph 118*e*(1), AR 40-3.

[MEDDD]

*These changes supersede AR 614-60, 25 July 1956, including C 2, 25 January 1961, and DA message 340999, 13 June 1963.

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

AR 40-3
ch. 6

MEDICAL SERVICE

MEDICAL, DENTAL AND VETERINARY CARE

CHANGES No. 6

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., *3 May 1963*

AR 40-3, 26 March 1962, is changed as follows:

1. Material which has been modified or added by these changes is indicated by a bold type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
69 and 70	69 and 70.

[MEDDD]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and *USAR:* To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Services—A.

U.S. GOVERNMENT PRINTING OFFICE: 1963 O—685857

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGES No. 5

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., *22 April 1963*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by these changes are indicated by a bold type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
7 and 8	7 and 8
15 and 16	15 and 16
27 through 30	27 through 30.1
39 through 44	39 through 44
65 and 66	65 and 66
69 and 70	69 and 70

[MEDDD]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGES No. 4

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., *4 April 1963*

AR 40-3, 26 March 1962, is changed as follows and consists only of this transmittal:

Effective immediately, Army medical treatment facilities will prepare separate Standard Form 1080 billings for each of the Federal agencies participating in Department of State Medical Program. Oversea facilities will submit these billings direct to Department of State authorizing post for payment. Facilities in CONUS will submit billings direct to Medical Division, Department of State. Agencies currently taking part in the program are Agency for International Development (AID), United States Information Agency (USIA), Foreign Agriculture Service (FAS), Agricultural Research Service (ARS), Federal Aviation Agency (FAA), Bureau of Public Roads (BPR), Peace Corps (PC), and Foreign Claims Settlement Commission (FCSC). All authorizations for examination, immunization, outpatient or inpatient care now being issued should show agency affiliation.

[MEDDD]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1963 O—682191

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGES No. 3

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., *22 March 1963*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by these changes are indicated by a bold type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
11 and 12	11, 12, and 12.1
17 and 18	17 and 18
21 and 22	21 and 22
35 and 36	35 and 36
37 and 38	37 and 38
47 through 50	47 through 50
69 and 70	69 and 70
77 and 78	77 and 78
80.1	80.1
89	89 and 90

[MEDDD]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

*These changes supersede DA Circular 310-45, 7 December 1962.

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGES No. 2

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., *13 November 1962*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by these changes are indicated by a bold type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
21 and 22	21 and 22
25 and 26 no page	25, 26, and 26.1
29 through 36.1	29 through 36.1
39 and 40	39 and 40
57 and 58	57 and 58
61 and 62	61 and 62
65 and 66	65 and 66
69 and 70	69 and 70

3. Make the following pen and ink changes:

a. Paragraph 3g. Change "paragraph 24*b*, AR 600-10" to "paragraph 48*b*, AR 600-20."

b. Paragraph 5. Change the title "Special consent requirements" to "Special consent requirements for nonmilitary patients."

c. Paragraph 8a. Change "(See AR 600-140))" to "(see AR 600-140)."

d. Paragraph 50g. Change "relatives" to "relative."

e. Paragraph 52d(11). Change "paragraph 19, AR 624-200" to "paragraph 20, AR 624-200."

f. Paragraph 56b(3). Change "released" to "release."

g. Paragraph 107. Change "20 hours" to "24 hours."

h. Paragraph 118a(1). Change "San Francisco Oversea Supply Agency" to "U.S. Army Oversea Supply Agency, San Francisco, Fort Mason, Calif."

i. Paragraph 133b. Change "734-series" to "735-series".

4. The following changes will be made in pen and ink to table I:

a. Category 1a, column 5, change to read "Coll locally from off; coll locally from Treasurer, USMA for cadets, USMA; and coll locally from QM for enl."

b. Category 2a, column 5, change to read "Rept to SG on DD Form 7—Coll subsistence locally from off; midshipmen, USNA are considered as enlisted pers for payment of subs."

c. Category 3a, column 5, change to read "Rept to SG on DD Form 7—Coll subs locally from off and cadets, USAFA."

d. Category 7e(1), column 5, change to read "collect locally from authorizing office on Standard Form 1080 supported by DD Form 7 and letter of authorization, EXCEPT Army Hospital, Teheran, Iran."

e. Category 7e (1) and (2), column 7, change to read, "Collect locally from authorizing office on Standard Form 1080 supported by DD Form 7A and letter of authorization, EXCEPT Army Hospital, Teheran, Iran."

*These changes rescind DA message 569870, 23 August 1961.

f. Category 7e(3), columns 5 and 7, change to read "Collect locally from individual, EXCEPT Army Hospital, Teheran, Iran."

g. Category 7e(4), column 7, change to read "Collect locally from authorizing office on Standard Form 1080 supported by DD Form 7A and letter of authorization."

h. Category 7i is added as follows:

(1) Column 2—Peace Corps personnel (volunteers, volunteer leaders and employees) and dependents of volunteer leaders and employees including Peace Corps applicants.

(2) Note D—For detailed information as to extent of care, see paragraph 16.1, AR 40-3. For reimbursement procedures for Peace Corps personnel (volunteers, volunteer leaders and employees) and dependents of volunteer leaders and employees, see categories 7e (1), (3), and (4), whichever is applicable in the given case; in the case of Peace Corps applicants, DD Forms 7 or 7A, whichever is applicable, will be forwarded to The Surgeon General.

i. Category 8j(3.1) is added as follows:

(1) Column 2—Civilian employees of contractors of the Department of the Navy and their dependents.
(2) Column 3—Par. 27c.1, AR 40-3.
(3) Column 4—Rate B.
(4) Column 5—Coll locally from employee or dependent.
(5) Column 6—OR.
(6) Column 7—Coll locally from employee or dependent.
(7) Column 8—MR or IMR.
(8) Columns 9 through 11—No.

j. Category 8s, column 2, change to read "Certain pers evacuated from one area to another,"

k. Category 8u is added as follows:

(1) Column 2—Volunteer subjects in approved Department of the Army research projects.
(2) Column 3—Paragraph 37.1, AR 40-3.
(3) Columns 4 through 7—None.
(4) Columns 8 through 11—Yes.

[AG 701 (19 Oct 62) MEDDD]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Services—A.

MEDICAL SERVICE

MEDICAL, DENTAL, AND VETERINARY CARE

CHANGES No. 1

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., *17 July 1962*

AR 40-3, 26 March 1962, is changed as follows:

1. The paragraphs which have been modified or added by these changes are indicated by a bold type star.

2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
25 through 32	25 through 32
35 and 36	35 through 36.1
43 through 46	43 through 46
51 and 52	51 and 52
69 through 72	69 through 72
75	75
79 and 80	79 through 80.1
81 through 84	81 through 84
89	89
	102.1 through 102.3

3. The following changes will be made in pen and ink to table I:

a. Category 1b, column 3, change to read "Pars. 8*a* and *b*, AR 40-3."

b. Category 7c(1), column 9, change to read "See pars. 4*b* and 14*f*."

c. Category 7c(2), column 3, change to read "Par. 14*e*, AR 40-3."

d. Category 7e(1) and (2), columns 5 and 7, change to read "Collect locally from the authorizing office."

e. Category 7e(4), column 7, change to read "Collect locally from the authorizing office."

f. Category 7h is added as follows.

(1) Column 2—Applicants for cadetship at the various service academies.
(2) Column 3—Par. 18.1, AR 40-3.
(3) Columns 4 through 6—NA.
(4) Column 7—Rept to SG on DD Form 7A.
(5) Column 8—MR.
(6) Columns 9 through 11—NA.

g. Category 8*g*(1), columns 4 and 5, change to read "None."

h. Category 8*j*(8) is added as follows.

(1) Column 2—Civ employees of the General Accounting Office and their depns.
(2) Column 3—Par. 27*h*, AR 40-3.
(3) Column 4—Rate C.
(4) Column 5—Coll locally from indiv.
(5) Column 6—SOR.
(6) Column 7—Coll locally from indiv.
(7) Column 8—MR or IMR.
(8) Columns 9 through 11—No.

*These changes rescind DA message 307495, 27 June 1962.

i. Category 8*n*, column 2, change to read "Pers outside the continental U.S. who contribute to accomplishment of a major oversea commander's mission."

4. Page 99, insert "I" after the word appendix.

[AG 701 (26 Jun 62) MEDDD]

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

AR 40-3

JOINT MESSAGEFORM

SECURITY CLASSIFICATION: UNCLASSIFIED

PAGE	DRAFTER OR RELEASER TIME	PRECEDENCE ACT	PRECEDENCE INFO	LMF	CLASS	CIC	FOR MESSAGE CENTER/COMMUNICATIONS CENTER ONLY: DATE – TIME	MONTH	YR
01 OF 01		PP			UUUU				

BOOK NO

MESSAGE HANDLING INSTRUCTIONS

1 Oct 73 14 13Z

FROM: DA (TSG) WASH DC//DASG-HCP//

TO: All Holders of ID Copies of AR 40-3

Rec'd 10/24/73

SUBJECT: Interim Change to AR 40-3 (Change 33)

1. This interim change is being distributed through publications pinpoint distribution system to all holders of AR 40-3.

2. Page 22. Para 12c (para 4-30c of forthcoming revision) is rescinded effective 30 July 1973.

6 5 4 3 2 1 0

DISTR:

DASG-HCP

0

DRAFTER TYPED NAME, TITLE, OFFICE SYMBOL, PHONE & DATE: E. Higginbotham DASG-HCP X31661

SPECIAL INSTRUCTIONS

RELEASER TYPED NAME, TITLE, OFFICE SYMBOL AND PHONE: R. E. ADAMS, Colonel, MSC 36751 DASG-ZX

SIGNATURE

SECURITY CLASSIFICATION: UNCLASSIFIED

DATE TIME GROUP

DD FORM 1 DEC 70 173 REPLACES DD FORM 173, 1 JUL 68, WHICH WILL BE USED.

UNCLASSIFIED

01 02

PP UUUU

28 AUG 73 15 17Z

NO

Rec'd 20 Sep 73

DA//DASG-HCP//

ALL HOLDERS OF ID COPIES OF AR 40-3

SUBJECT : INTERIM CHANGE TO AR 40-3 {CHANGE 32}, EFFECTIVE 30 JULY 1973

1. THIS INTERIM CHANGE IS BEING DISTRIBUTED THROUGH PUBLICATIONS PINPOINT DISTRIBUTION SYSTEM TO ALL HOLDERS OF AR 40-3.

2. PAGE 20. PARA 11 {PARA 4-11 OF FORTHCOMING REVISION} IS SUPERSEDED AS FOLLOWS:

11. RETIRED MEMBERS OF THE UNIFORMED SERVICES {PARA 2P}{PARA 1-2Q OF FORTHCOMING REVISION}

A. RETIRED MEMBERS LISTED BELOW ARE AUTHORIZED THE SAME MEDICAL AND DENTAL CARE AS ACTIVE DUTY MEMBERS, SUBJECT TO THE AVAILABILITY OF SPACE AND FACILITIES AND THE CAPABILITIES OF THE PROFESSIONAL STAFF AND THE PRIORITIES LISTED IN FIGURE 2 {FIGURE 2-1} OF FORTHCOMING REVISION}:

{1} THOSE RETIRED FOR LENGTH OF SERVICE.

{2} THOSE PERMANENTLY OR TEMPORARILY RETIRED FOR PHYSICAL DISABILITY {SEE B BELOW FOR EXCEPTION}.

{3} THOSE ON THE EMERGENCY OFFICERS' RETIRED LIST WHO ARE

DAPE DAAG COPO DACA DAIG DACS-ZC
DAPC DAIO

E. Higginbotham

E HIGGINBOTHAM DASG-HCP X31661

Robert R. Pitchford

UNCLASSIFIED

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02 02

ENTITLED TO RETIRED PAY FOR PHYSICAL DISABILITY.

B. PERIODIC MEDICAL EXAMINATIONS FOR MEMBERS ON THE TDRL, INCLUDING HOSPITALIZATION IN CONNECTION WITH CONDUCT OF THE EXAMINATION WILL BE FURNISHED ON THE SAME PRIORITY BASIS AS ACTIVE DUTY MEMBERS.

JOINT MESSAGEFORM | SECURITY CLASSIFICATION | AR 40-3

PAGE	DRAFTER OR RELEASER TIME	PRECEDENCE ACT	PRECEDENCE INFO	LMF	CLASS	CIC	FOR MESSAGE CENTER/COMMUNICATIONS CENTER ONLY	DATE – TIME	MONTH	YR
1 OF 02								27	FEB	73

BOOK | MESSAGE HANDLING INSTRUCTIONS

Bat 13 26 Mar 73

FROM: DA //DAPE-MPE//

TO: ALL HOLDERS OF ID COPIES OF AR 40-3, MEDICAL SERVICES

Rec'd 20 Mar 73

UNCLAS

SUBJECT: CHANGE TO AR 40-3

1. THIS CHANGE IS BEING DISTRIBUTED THROUGH PUBLICATIONS PINPOINT DISTRIBUTION SYSTEM TO ALL HOLDERS OF AR 40-3.

2. CHANGE TO AR 40-3 IS NOW BEING PROCESSED FOR PUBLICATION IN THE NEAR FUTURE. THE CHANGE REFLECTS NEW AND SIGNIFICANT CHANGES TO THE PRESENT SYSTEM REGARDING DISABILITY SEPARATION AND RETIREMENTS.

3. THIS MESSAGE PROVIDES EARLY INFORMATION FOR USERS OF AR 40-3 REGARDING THE CHANGES WHICH ARE TO BE IMPLEMENTED UPON RECEIPT OF THIS MESSAGE.

4. AR 40-3 IS CHANGED AS FOLLOWS. PARAGRAPHS NOTED TO READ AS FOLLOWS:

A. PARAGRAPH 54G(1) - "ALL MEMBERS WHO DO NOT MEET MEDICAL FITNESS STANDARDS FOR RETENTION OR WHOSE FITNESS IS QUESTIONABLE, INCLUDING MEMBERS WHO HAVE TWO OR MORE IMPAIRMENTS WHICH INDIVIDUALLY ARE NOT UNFITTING, BUT WHICH TOGETHER CAUSE SUFFICIENT DISABILITY

6 5 4 3 2 1 0

DISTR:

0

DRAFTER TYPED NAME, TITLE, OFFICE SYMBOL, PHONE & DATE: TC MCGINN/DAPE-MPE/52225

TYPED NAME, TITLE, OFFICE SYMBOL AND PHONE: WM. WEBER/COL, GS/ DAPE-MPE/72597

RELEASE SIGNATURE

SPECIAL INSTRUCTIONS

SECURITY CLASSIFICATION | DATE TIME GROUP

TO MAKE FITNESS TO PERFORM THE DUTIES OF THEIR OFFICE, GRADE, RANK OR RATING QUESTIONABLE; AND THOSE WITH LATENT IMPAIRMENTS OF SUCH SIGNIFICANCE AS TO RAISE A QUESTION AS TO THEIR MEDICAL FITNESS TO PERFORM THE DUTIES OF THEIR OFFICE, GRADE, RANK OR RATING SHOULD BE CONSIDERED UNDER THE PROVISIONS OF PARAGRAPH 3-3B, AR 40-501, INCLUDING THOSE WHO APPLY FOR CONTINUANCE ON ACTIVE DUTY UNDER THE PROVISIONS OF CHAPTER 10, AR 635-40."

B. PARAGRAPH 62A(2) - "THE ABILITY OF THE MEMBER TO MAINTAIN HIMSELF COMMENSURATE WITH APPROPRIATE ASSIGNMENT LIMITATIONS."

C. PARAGRAPH 62A(3) - "THE PROGNOSIS FOR CONTINUING PRODUCTIVE MILITARY SERVICE, WITHIN APPROPRIATE ASSIGNMENT LIMITATIONS, WITHOUT UNDUE LOSS OF TIME FROM DUTY FOR MEDICAL TREATMENT."

JOINT MESSAGEFORM

SECURITY CLASSIFICATION: UNCLASSIFIED

PAGE	DRAFTER OR RELEASER TIME	PRECEDENCE ACT	PRECEDENCE INFO	LMF	CLASS	CIC	FOR MESSAGE CENTER/COMMUNICATIONS CENTER ONLY	DATE – TIME	MONTH	YR
01 OF 03		PP			EEEE			29	Dec	71

BOOK: NO

MESSAGE HANDLING INSTRUCTIONS

FROM: DA (TSG)

TO:

UNCLAS

DASG-DDL-P

ACTOM all commands for Chief Surgeon or Surgeon as applicable.

MDW for Medical Director.

SUBJECT: Interim Change to AR 40-3 (Change 26)

1. This interim change is being distributed through publications pinpoint distribution system to all holders of AR 40-3.

2. Effective 15 January 1972, paragraph 118.2 is added to Section XII, AR 40-3 as follows:

118.2 Plastic Lenses for Special Prescriptions

a. Notwithstanding provisions of paragraphs 118 and 118.1, clear plastic lenses will be furnished for the following:

(1) Cataract series lenses

(2) Multi-focal lenses where the highest power meridian of the distance portion is plus or minus 8.00 diopters or higher when written in minus cylinder form.

(3) Prescriptions having a power difference between the

DISTR:

HQDA (DASG-DDL-P); (DASG-PSC-O)

DRAFTER TYPED NAMED, TITLE, OFFICE SYMBOL AND PHONE: LEO P. SOLINGER, x35548

RELEASER: TYPED NAME, TITLE, OFFICE SYMBOL AND PHONE: COL WILLIAM C. LUEHRS, x36751

SIGNATURE: William C. Luehrs

SPECIAL INSTRUCTIONS

SECURITY CLASSIFICATION: UNCLASSIFIED

DD FORM 1 JUL 68 173 REPLACES DD FORM 173, 1 NOV 63 AND DD FORM 173-1, 1 NOV 63, WHICH ARE OBSOLETE.

*GPO : 1968 O - 361-369

JOINT MESSAGEFORM

SECURITY CLASSIFICATION: UNCLASSIFIED

PAGE	DRAFTER OR RELEASER TIME	PRECEDENCE ACT	PRECEDENCE INFO	LMF	CLASS	CIC	FOR MESSAGE CENTER/COMMUNICATIONS CENTER ONLY	DATE – TIME	MONTH	YR
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BOOK NO

MESSAGE HANDLING INSTRUCTIONS

right and left lens of 4.00 diopters or more.

(4) Prescriptions which require prism in excess of 3 prism diopters in each lens and where the fresnel press-on prism is not acceptable.

b. Prescriptions for categories of lenses in subparagraph "a" above will be prepared on DD Form 771-1 (Eyewear Prescription-Plastic Lenses).

c. Clinics will forward all special prescriptions as outlined in subparagraph "a" above to the US Army Medical Optical and Maintenance Agency, Denver, Colorado 80240.

3. Page 88, paragraph 119m is changed by substituting the following therefore:

m. DD Form 771 will be prepared in sets of three copies. Copies 1 and 2 will be forwarded daily to the servicing optical laboratory or unit. The laboratory will retain Copy 1 and return Copy 2 with completed spectacles to the clinic. Copy 2 with marking Quote Lenses are Heat Treated and Tested unquote will be inserted in patient's Health Record (DD Form 722) as permanent record of compliance with FDA requirements and Copy 3

6 5 4 3 2 1 0

DISTR:

0

DRAFTER TYPED NAMED, TITLE, OFFICE SYMBOL AND PHONE

SPECIAL INSTRUCTIONS

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SIGNATURE

SECURITY CLASSIFICATION: UNCLASSIFIED

DD FORM JUL 68 173 REPLACES DD FORM 173, 1 NOV 63 AND DD FORM 173-1, 1 NOV 63, WHICH ARE OBSOLETE.

JOINT MESSAGEFORM

SECURITY CLASSIFICATION: UNCLASSIFIED

PAGE	DRAFTER OR RELEASER TIME	PRECEDENCE ACT	PRECEDENCE INFO	LMF	CLASS	CIC	FOR MESSAGE CENTER/COMMUNICATIONS CENTER ONLY	DATE – TIME	MONTH	YR
03 OF 03		PP			EEEE			29	Dec	71

BOOK NO

MESSAGE HANDLING INSTRUCTIONS

will be furnished to the patient with completed spectacles.

4. Page 90, paragraph 121f, change title to read:

Investigative, Intelligence and EOD Personnel.

5. Page 90, paragraph 121f(1) add item (c) as follows:

(c) Explosive ordnance disposal personnel with MOS 9224 and MOS 55D.

6. Page 90, paragraph 121f(2) add the words or explosive ordnance disposal in fourth line following word intelligence.

7. All ophthalmology and optometry clinics will be furnished with information outlined above.

6 5 4 3 2 1 0

DISTR:

0

DRAFTER TYPED NAMED, TITLE, OFFICE SYMBOL AND PHONE

SPECIAL INSTRUCTIONS

RELEASER: TYPED NAME, TITLE, OFFICE SYMBOL AND PHONE

SIGNATURE

SECURITY CLASSIFICATION: UNCLASSIFIED

DD FORM 1 JUL 68 173 REPLACES DD FORM 173, 1 NOV 63 AND DD FORM 173-1, 1 NOV 63, WHICH ARE OBSOLETE.

GPO 1969 O - 361-369

ARMY REGULATION
No. 40-3

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *26 March 1962*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

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LIST OF SUPERSEDED PUBLICATIONS

These regulations supersede the following:

AR 40–101, 30 July 1958, including C 3, 23 March 1960, C 4, 10 January 1961, and C 5, 18 August 1961.

AR 40–103, 6 March 1956, including C 1, 28 May 1957.

AR 40–104, 29 September 1960.

AR 40–106, 14 November 1956.

AR 40–107, 14 November 1956.

AR 40–108, 5 March 1959, including C 1, 16 April 1959, C 5, 15 July 1960, C 7, 20 December 1960, C 8, 21 February 1961, C 9, 13 July 1961, C 10, 27 November 1961 and C 11, 12 January 1962.

AR 40–112, 19 October 1956, including C 2, 23 January 1961, and C 3, 18 April 1961.

AR 40–116, 10 August 1960.

AR 40–117, 30 March 1959, including C 2, 16 August 1961.

AR 40–118, 13 January 1961, including C 1, 28 June 1961.

AR 40–130, 5 November 1958.

AR 40–180, 22 September 1960.

AR 40–212, 18 November 1960, including C 1, 24 April 1961, C 4, 14 August 1961, and C 5, 14 December 1961.

Paragraph 9, AR 40–90, 23 October 1950. (AR 40–90 including C 2, 12 December 1957, and C 3, 19 June 1958 now superseded in their entirety.)

Paragraph 5, AR 40–2, 4 November 1960.

Paragraph 20, AR 40–500, 16 August 1956.

Letter, AGAM–P(M) 701 (16 Nov 60) MEDDD–OP, Department of the Army, 1 December 1960, subject: "Medical Care for Special Foreign Nationals."

Letter, AGTP–P(M) 703 (1 Feb 54), Department of the Army, 19 February 1954, subject: "Dental Treatment for Trainees."

SECTION I

GENERAL

1. Purpose and scope. *a. Purpose.* This regulation—

(1) Prescribes policies regarding medical, dental, and veterinary care, including the manner and conditions under which such care is furnished, and indicates the sources from which it is obtained. See AR 40–121 for—

(*a*) Medical care authorized dependents of active duty and retired members of the uniformed services, including dependents of members who died on active duty or in a retired status.

(*b*) Civilian medical care authorized retired members of the uniformed services.

(2) Prescribes policies concerning the admission and disposition of patients.

b. Scope. Except as indicated in section X this regulation is applicable to all commands of the Army.

2. Definitions. For the purpose of this regulation, the following definitions apply:

a. Civilian employee. Except as indicated in (1) and (2) below, the term "civilian employee" means a person employed by the Federal Government and paid from appropriated or nonappropriated funds.

(1) The term "civilian employee" does not apply to a person so employed who is a beneficiary of the Bureau of Employees' Compensation for purposes of medical care.

(2) Outside the United States this term does not apply to indigenous personnel unless the major oversea commander concerned authorizes their care under the provisions of paragraph 31.

b. Commander of an Army medical treatment facility. This term means the commander or person in charge of a medical treatment facility.

c. Date of initial admission to hospital. The date on which the patient was first admitted to a hospital for his current period of uninterrupted hospitalization. (The transfer of a hospitalized patient between medical treatment facilities is not considered to interrupt his period of hospitalization.)

★*d. Dependents.*

(1) Dependents of members of the uniformed services are defined in AR 40–121.

(2) Dependents of foreign nationals are defined in paragraph 25*a* of this regulation.

(3) The following definition is applicable to dependents authorized care by paragraphs 16, 16.1, 26, 27, and 31 of this regulation, effective 17 August 1970:

(*a*) Spouses.

(*b*) Children as defined in AR 40–121.

(*c*) Dependent parents and parents-in-law as defined in AR 40–121.

e. Disability separation. The term includes temporary or permanent retirement and discharge for physical disability, with or without entitlement to receive severance pay.

f. Elective care. Care that is desired or requested by the patient which, in the opinion of the cognizant medical authority, is not medically indicated.

g. Emergency dental care. Dental treatment for the relief of painful or acute conditions.

h. Foreign military patient. This term applies to a patient who is a member of the armed forces of a foreign government.

i. Major oversea commander. This term means the Commander in Chief, United States Army, Europe; the Commander in Chief, United States Army, Pacific; the Commanding General, United States Army, Alaska; the Commander, United States Army Forces Southern Command; and the Commanding General, United States Army Forces, Strike Command.

j. Maximum hospital benefit. That point during hospitalization when the patient's progress appears to have stabilized and it can be anticipated that additional hospitalization will not directly contribute to any further substantial recovery. A patient who will continue to improve slowly over a long period of time without specific therapy or medical supervision, or with only a moderate amount of treatment on an outpatient basis, may be considered as having attained maximum hospital benefit.

k. Medical care. Medical care includes, but is not limited to, the furnishing of hospitalization, outpatient treatment, dental care unless otherwise specified, nursing service, medical examinations, immunizations, drugs, subsistence, transportation and other adjuncts such as prosthetic devices, spectacles, hearing aids, orthopedic footwear, and appliances, e.g., braces, walking irons, elastic stockings, etc.

l. Member of a uniformed service. A person appointed, enlisted, inducted or called, ordered or conscripted into a uniformed service who is serving on active duty or active duty for training.

m. Nonmilitary patient. The term "nonmilitary patient" applies to all patients exclusive of those in *h* above and *t* below.

n. Optimum hospital improvement for disposition purposes. That point during hospitalization when, after *essential initial* medical treatment, the patient's medical fitness for further active service can be determined, and it is considered probable that further treatment for a reasonable period will not result in any material change in the patient's condition which would alter his ultimate type of disposition or amount of separation benefits.

o. Outside the United States. This term means all areas exclusive of those specified in *s* below.

p. Retired member of a uniformed service.

(1) *Prior to 1 January 1967,* this term means a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, as a result of service in a uniformed service except a member or former member entitled to retired pay under Chapter 67 of Title 10, U.S. Code who has served less than 8 years on active duty (other than for training).

(2) *On and after 1 January 1967,* this term means a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, as a result of service in a uniformed service.

q. Routine dental care. Includes all dental care necessary to maintain dental health and function, other than care of an emergency or elective nature.

r. Uniformed services. The Army, the Navy, the Marine Corps, the Air Force, the Coast Guard, the Commissioned Corps of the Environmental Science Services Administration and the Commissioned Corps of the Public Health Service.

s. United States. This term means the 50 States, and the District of Columbia.

t. U.S. military patient. This term applies to a patient who is a member of the U.S. Armed Forces on active duty or active duty for training.

SECTION II

POLICIES AT ARMY MEDICAL TREATMENT FACILITIES

3. General. The commander of an Army medical treatment facility is responsible for determining which persons within the various categories authorized care in such facilities will receive treatment in, be admitted to, and be discharged from his facility. The commander is also responsible for supervising care and treatment, including the employment of recognized professional procedures, and for providing each patient with the best possible care in keeping with accepted professional standards, and in accordance with the rules of land warfare. See FM 27-10.

3.1. Policies. The following policies will be observed in the treatment, admission, hospitalization, and disposition of patients:

a. Priorities. When a commander must deny care to eligible personnel because of a temporary lack of capability at his facility, consideration must be given to the basis of entitlement to medical care at Army medical treatment facilities applicable to the various categories of personnel as reflected in figure 1. In addition, when it becomes apparent that beds occupied in an Army hospital by persons in a low priority category will be needed for prospective patients in higher priority categories, the commander must arrange, if possible, to dispose of transportable cases in the lower priority categories.

b. Domiciliary care. Such care will not be provided in Army hospitals, except when required for active duty members of the uniformed services.

c. Sick call. The daily assembly of sick and injured military duty personnel for examination is established to provide routine medical care at designated times each day. Military personnel not reporting for treatment at sick call will be seen on an appointment basis only, except for emergencies. Instructions concerning preparation and disposition of the Individual Sick Slip (DD Form 689) are contained in AR 40-207. Subsequent to examination, patients medically unfit for duty will be admitted to a hospital or confined to quarters; patients not so admitted will be given such treatment as is deemed necessary. When excused from duty for medical reasons which do not indicate a need for hospitalization, military personnel may be authorized to occupy a bed in a dispensary or remain in quarters.

d. Attachment to a medical holding unit. Upon admission to an Army hospital a uniformed services patient will be attached to the medical holding unit, except as indicated below:

(1) A patient transferred from one Army hospital to another in an assigned status will be carried in an assigned status by the receiving hospital.

(2) Air Force personnel in Army hospitals where an Air Force medical squadron is stationed will be accounted for and administered by the Air Force medical squadron.

(3) An Army military patient who is medically evacuated from a combat area and is admitted to a hospital maintaining a medical holding unit will be admitted to that hospital in an assigned status.

e. Notification of admission of attached patients.

(1) The commander of a hospital to which a patient is admitted in an attached status will immediately notify the commander of the unit or organization with which the patient is

currently on duty. Normally this notification will be made by use of DD Form 689 (Individual Sick Slip). See AR 40-207 and AR 335-60.

(2) For U.S. Navy and Marine Corps personnel this notification will include in the remarks section of DD Form 689 a statement indicating the probable length of hospitalization.

(3) In addition to the notification required under (1) above, when a patient is admitted while en route overseas, the hospital commander will notify the commander of the appropriate oversea replacement station, Army terminal, or aerial port of embarkation (DAATCO for Army personnel) and will indicate the probable length of hospitalization and whether the patient will be assigned to the medical holding unit in accordance with *g* below. If records available to the hospital commander do not indicate the scheduled or normal shipment date of the patient for the determination required by *g*(6) (*b*) below, a request for this data will accompany the notification.

f. Notification to Department of the Army of the admission and release of general officers of the Army on active duty.

(1) Except as indicated in (2) below, whenever a general officer is hospitalized or released from hospitalization, the commander of the hospital where admitted or released will submit the following information on date of admission or release or as soon thereafter as practicable by electrically transmitted message to the Deputy Chief of Staff for Personnel, Department of the Army, ATTN: General Officer Branch, Washington, D.C.

(*a*) Messages concerning admissions will cite this regulation and contain information corresponding with *1* through *7* below:

1. Last name, first name, and middle initial.
2. Service number.
3. Grade.
4. Hospital to which admitted.
5. Date admitted.
6. Brief medical diagnosis, in nontechnical language.
7. Prognosis and anticipated length of hospitalization.

(*b*) Messages concerning releases will cite this regulation and contain ininformation corresponding with *1* through *6* below:

1. Last name, first name, and middle initial.
2. Service number.
3. Grade.
4. Hospital from which released.
5. Date of release.
6. Disposition, e.g., duty, quarters.

(2) Information is not required when the individual is moved in an attached status from one hospital to another.

(3) Notifications prescribed above are exempt from reports control under paragraph 39*k*, AR 335-15.

g. Assignment to a medical holding unit. Except as indicated in (7) and (8) below, uniformed services patients who are *assigned* to an active Army unit will be reassigned to a medical holding unit under circumstances described below.

(1) Upon evacuation from a combat area to a hospital maintaining a medical holding unit (on the date of admission).

★(2) Except as (4) below applies, when the hospital commander determines that a patient will be hospitalized in excess of 90 days. Assignment will be made as soon as this determination is made. The 90-day period refers to total period of continuous hospitalization and is not limited to a specific hospital.

(3) When it is determined by an oversea hospital commander that a patient

will be evacuated to the continental United States and the patient is not assigned to a unit in the continental United States.

★(4) When the hospital commander determines that an Army patient in an attached status will require processing for relief from active duty, discharge, or retirement under the provisions of AR 635-40, and hospitalization is necessary. A member undergoing disability evaluation will be placed under the administrative control of the commander of the medical treatment facility to whatever degree is necessary to facilitate evaluation processing. The decision as to whether the member will be assigned to the medical holding unit of the medical treatment facility will be made on the basis of whether the individual may render productive service to his parent unit while undergoing disability processing. Members will be processed on an outpatient basis from their parent organization whenever feasible.

(5) When the hospital commander determines that a patient, whose unit or numbered shipment is scheduled for more than a local move, will not be returned to duty prior to the date of departure by his unit or numbered shipment. Within proper security limits, commanders of such units or numbered shipments will keep the hospital commander advised of the expected date of departure.

(6) When the hospital commander determines that—

(*a*) A patient en route overseas will require hospitalization in excess of 30 days beyond his scheduled reporting date.

(*b*) A patient hospitalized at a hospital serving an oversea replacement station, Army terminal, or aerial port of embarkation will require hospitalization in excess of 30 days beyond his normal shipment date.

(7) Notwithstanding the provisions of (1) through (6) above, the following cate-

gories of patients in an attached status to an Active Army unit will not be assigned to medical holding units:

(*a*) Special Reserve components program personnel. See AR 680-1.

(*b*) Personnel assigned to a CONUS organization who become hospitalized while temporarily in an oversea command. If such personnel are to be evacuated to CONUS, they will be evacuated in an attached status. Subsequently action by the CONUS hospital commander will be determined under the provisions of (2) through (6) above.

(8) Notwithstanding the provisions of (1) through (6) above, general officers will not be relieved from duty assignment and assigned to medical holding units without the approval of the Deputy Chief of Staff for Personnel, Department of the Army.

★Except under the conditions listed in (1) above, assignment to a medical holding unit will be effected by issuance of orders. Orders will be issued in accordance with AR 310-10 (TC 216). Reporting date will be computed and established as prescribed by AR 680-1. Distribution of orders will be in accordance with AR 310-10, and care will be exercised that all organizations concerned with accounting for a patient are included.

h. Individual records and clothing.

(1) Personnel records of patients attached to a medical holding unit will be retained in the organization to which the patient is assigned. Records required by the medical treatment facility in conjunction with the study and evaluation of a patient will be furnished the medical treatment facility on a loan basis when requested by the facility commander.

(2) Upon receipt of an order reassigning a member of his organization to a medical holding unit, the organization commander will forward the member's personnel and pay records within 48 hours to the hospital. Individual clothing will be forwarded in accordance with AR 735-5.

i. Grouping of patients. Hospitalized patients will be grouped according to their requirements for housing and medical care, including nursing care, and will be furnished quarters, facilities, and professional supervision on that basis. Patients who must be retained under medical jurisdiction solely for administrative reasons or for medical conditions which can be treated on a clinic basis will be provided quarters and messing facilities, where practicable, separately from other hospital patients. Medical care for such patients will be furnished on a periodic clinic appointment basis. Maximum use will be made of administrative personnel in the supervision of such patients.

j. Evaluation after admission. Each patient will be evaluated as soon as possible after admission and reevaluation will continue until disposition is made. The patient's probable type and date of disposition will be anticipated. Necessary processing by various medical and administrative agencies will take place concurrently with the treatment of the patient. It is especially important that the medical disposition decision be made as early as possible for U.S. military patients who may be separated for physical disability.

k. Admission to closed psychiatric wards. Patients will be admitted to closed psychiatric wards only when they have a mental illness that renders them dangerous to themselves or others, or when a period of careful, close psychiatric observation is necessary to determine whether such a condition may exist. When a patient is admitted to a closed psychiatric ward, the reason for admission must be clearly stated in the patient's clinical record by the admitting physician. Patients should be retained on closed psychiatric wards only as long as is medically required. These same policies apply equally in those rare instances when it is necessary to place a patient on an open ward under constant surveillance.

★*l. Remediable physical defects developed in the military service.*

(1) When a medical examination reveals that an Army military patient has developed a remediable defect, he will be offered the opportunity of operative repair, if it is medically indicated. If an operation, other treatment, or

other diagnostic procedure, which is considered necessary to enable the individual to perform his military duties properly is refused, the provisions of paragraph 48, AR 600-20 apply.

(2) When Navy or Air Force patients are involved in a situation such as that described in (1) above, the matter will be referred to the nearest headquarters of the service concerned.

★*m. Transfer of Patient (DA Form 8-6).* Patients will be treated at the lowest echelon equipped and staffed to provide necessary medical care consistent with evacuation policies. U.S. military patients will not be retained in medical facilities longer than the minimum time necessary to attain the mental and physical state required for duty or for separation from the active service if they do not meet retention medical fitness standards. U.S. military patients normally are transferred to hospitals from other medical facilities. If the treatment required is not available at the facility providing area hospital care, patients will be further transferred to the most readily accessible uniformed services medical treatment facility possessing the required capability and to which they are eligible for admission. Transportation of the patient and an attendant or attendants, if required, is authorized at Government expense. Government transportation will be used when available. (See AR 40-121 for special considerations involving the transfer of dependent patients.)

★*n. Immunization.* Immunizations may be administered forcibly when necessary in accordance with paragraph 48*c*(2), AR 600-20.

o. Return to duty of attached Army military patients.

(1) Army military patients who are in an attached status will be returned to their duty organizations when ready for duty. Organization commanders do not have the option of refusing to accept the return of such personnel.

(2) An attached Army military patient, who at the time of admission was en route overseas, when ready for duty, will—

(*a*) If POR qualified, be furnished a statement covering the period of hospitalization and directed to revert to the status held at the time of admission.

(*b*) If no longer POR qualified, be reported for assignment instructions in accordance with *q* below.

(*c*) In the case of either (*a*) or (*b*) above, the commander of the oversea replacement station, Army terminal, or aerial port of embarkation will be notified of the action taken.

p. Disposition of assigned patients in CONUS.

(1) Except as provided in (2) below, all patients who are medically fit for duty and who are assigned to a medical holding unit will be reported by the hospital commander for assignment instructions in accordance with the procedures in *q* below.

(2) Upon completion of hospitalization, assigned patients in the following categories will be reassigned by the hospital commander without reference to higher authority.

(*a*) Individuals who at the time of hospitalization were undergoing basic combat training or advanced individual training and who are hospitalized in the medical treatment facility serving the installation where training was interrupted will be reassigned to their former training activity.

(*b*) Individuals who are medically fit for duty under AR 40-501 but who are to be returned to duty with a recommendation for separation (para 54*e*(1)) will be reassigned to their former units. Exception to this policy may be made by the hospital commander in individual cases when he determines that other action will better serve the interests of the Government. In such cases, reassignment instructions will be requested as in (1) above, or separation action may be instituted at the hospital.

(*c*) Individuals awaiting trial by courts-martial will be reassigned to their former units or reassigned to the unit or installation where the trial will be held. The advice of the local judge advocate or legal officer will be sought in these cases.

(*d*) Individuals awaiting the results of investigation or clearance will be reassigned to their former units provided a request has been made for such reassignment by the commander concerned.

★(*e*) Individuals who are eligible under existing criteria for relief from active duty or discharge will be processed at the hospital if facilities exist. In the absence of such facilities, the individual will be processed for separation in accordance with the provisions of paragraph 3-1*b*, AR 635-10.

★(3) Officers who are medically fit for duty but who have applied for or are scheduled for retirement (within 60 days) or who have submitted a tender of resignation will remain assigned to the medical holding unit pending receipt of instructions from The Adjutant General. The hospital commander will immediately report such officers to The Adjutant General, ATTN: AGPO, Department of the Army. If the officer appeared before a medical board, a copy of the medical board proceedings will be promptly forwarded to The Adjutant General, ATTN: AGPO. Where practicable, officers awaiting instructions under this paragraph will be placed on duty as prescribed in *r* below.

q. Requests for assignment instructions. When it is anticipated that a patient who is to be returned to duty under *p*(1) above will complete hospitalization within 60 days, a request for assignment instructions will be initiated by the hospital or administrative unit commander and forwarded to Headquarters, Department of the Army not later than 15 days prior to the estimated date of completion of hospitalization. *It is incumbent upon all hospital commanders and commanders of Army administrative units to monitor the progress of assigned patients and assure that every effort is made to forecast the expected date of return to duty accurately so that the administrative procedures involved in returning a patient to duty will not unnecessarily delay a patient's disposition.*

★(1) Requests for assignment instructions for officers, other than general officers, will be addressed to the Chief of Personnel Operations, ATTN: OPDOD. The following information will be included:

★(*a*) Name, grade, and SSN.

(*b*) Control branch.

(*c*) Category and expiration date.

(*d*) Amount of leave desired, if any.

(*e*) Estimated date of completion of hospitalization.

(*f*) Physical profile and assignment limitation, if any.

(2) Enlisted personnel will be reported to the Chief of Personnel Operations in accordance with instructions in AR 614-205. Whenever practicable, reports may be made by phone direct to the Office of Personnel Operations ((3)(*b*) below).

(3) In exceptional cases, it may be impossible to predict the date of return to duty for an assigned patient to meet the 15-day time requirement. In such cases, instructions will be requested by telephone contact with the Chief of Personnel Operations as follows:

★(*a*) For officers and warrant officers, call 202-695-6362 (OXford 56362) or 202-696-8522 (OXford 68522).

★(*b*) For enlisted personnel in grades E-1 through E-6 (except special category personnel), call 202-695-7291 (OXford 5-7291). For enlisted personnel in grades E-7 through E-9 and all special category personnel, call Combined Arms Section (OXford 5-3546); Maintenance and Supply Section (OXford 71490); General Support Section (OXford 5-2602); and Special Category Section (OXford 54038).

(4) When a patient is to be returned to other than full duty, the request for assignment instructions will indicate the type of disposition recommended and the following information, as appropriate:

(*a*) The date on which the individual will revert to full duty or the date the individual is to return to a medical treatment facility for examination, treatment, or reevaluation.

(*b*) The type and degree of functional impairment involved and any control measures which should be considered in a duty assignment.

(*c*) The type or types of duty recommended.

(*d*) Geographic or climatic assignment limitation recommended.

(*e*) Physical limitations to POR qualification.

(*f*) Status of any applications for compassionate reassignment submitted under the provisions of paragraph 22, AR 614–6.

(*g*) Whether current medical condition may result in removal or denial of security clearance.

(*h*) Preference for area of assignment.

★(5) Assignment instructions will be issued by the Chief of Personnel Operations. When it is determined that an individual cannot be assigned as directed within *30 days* after the previously estimated date of completion of hospitalization, this information will be forwarded by electrical message to the Chief of Personnel Operations, ATTN: OPDOD for officers and warrant officers, and for enlisted personnel refer to (3)(*b*) above. The message will include a reference to the initial request for assignment instructions.

r. Duty for assigned patients awaiting orders in CONUS.

(1) In the event assignment instructions have not been received by the time a patient completes hospitalization, the hospital commander will issue orders placing the patient on duty with a unit designated by the CONUS army commander. When this is medically contraindicated, the hospital commander may place the individual on duty with the hospital duty unit. See AR 635–40. Such an individual will not be charged against the hospital's personnel allotment or manning table.

(2) CONUS Army commanders and the Commanding General, Military District of Washington, U.S. Army, will designate for each Army hospital (regardless of command jurisdiction) within their areas a unit with which the hospital commander may place patients on duty ((1) above) so that the patient's abilities can be utilized. Preferably, units so designated will be other than medical treatment facilities and will be located as near to the hospital as possible, preferably at the same installation. A patient placed on duty with an organization will not be charged against that unit's personnel allotment or manning table.

s. Disposition of patients in oversea hospitals. Recovered patients in oversea hospitals will be returned to duty in accordance with instructions issued by the major oversea commander. For patients who will be evacuated from an oversea command, see AR 40–20, AR 310–10, and AR 330–12.

t. Separation of enlisted personnel assigned to medical holding units. See paragraph 5–19, AR 635–200, for special separation provisions for enlisted personnel, other than REP 63 personnel, assigned to medical holding units.

★*u. Flight restrictions—Army aviators.* When an Army aviator is placed in a patient status or it is otherwise determined that he is not physically qualified to engage in aerial flight, the individual's commander will be notified with appropriate recommendation for restriction or suspension of flight status as prescribed in AR 600–107.

★*v. Emergency care.* Patients authorized only emergency care and those admitted as civilian emergencies will be treated only during the period of the emergency. Action will be taken to dispose of such patients as soon as the emergency period ends.

4. Authorization. Medical care is under the control of the commander of the medical treatment facility concerned. Persons requesting care will be required to furnish identification satisfactory to the commander. The following measures and/or restrictions will be observed in furnishing medical care to patients:

a. Extent of care. Eligible persons will be provided medical care to the extent it is authorized, required, and available. When a person is accepted for medical care, all care and adjuncts thereto (including nonstandard supplies) determined by the commander of the medical treatment facility concerned to be necessary will be provided from resources available to the commander, unless specifically prohibited by section III. When care is required which is beyond the capabilities of an Army medical

treatment facility, the commander thereof will arrange for the required care by one of the means shown below. The method of choice will be based upon professional considerations and travel economy.

(1) Transfer the patient in accordance with paragraph 3.1*m*.

(2) Procure from civilian sources the necessary supplemental material and professional and personal services required for the proper care and treatment of the patient. Charges for such material or services will be paid from funds available to operate the army medical treatment facility.

★(3) The supplementation authorized in (2) above will be accomplished normally in the Army medical treatment facility. However, when such action is not feasible, supplementation may be obtained elsewhere. Patients may be sent to other Federal or civilian facilities for specific treatment or services under this paragraph provided they remain under the jurisdiction of the facility commander during the entire period of care.

★(4) The provisions of paragraph 84.1 are applicable to services obtained in civilian facilities under the provisions of this paragraph.

b. Dental care. Dental care for personnel listed in paragraphs 14, 16*a* and *c*, and 24 will be limited to emergency dental care for the relief of pain or acute conditions, or for dental conditions requiring hospitalization. Such dental care will not include the provision of prosthetic dental appliances or permanent restorations.

c. Spectacles. Provisions relative to furnishing of spectacles are set forth in paragraphs 116 and 124.3.

d. Care furnished on an outpatient basis. Whenever possible, diagnostic procedures, preoperative and postoperative care, convalescence, and followup observation and treatment will be accomplished on an outpatient basis.

e. Elimination of duplicate diagnostic procedures. Every attempt will be made to eliminate duplication of diagnostic procedures for patients transferred between medical treatment facilities.

f. Performance of duty while in patient status. U.S. military patients may be assigned duties in and about the medical treatment facility when such duties will be of therapeutic value. Physical condition, past training, and acquired skills must all be considered before assigning any patient a given task. Patients will not be assigned duties which are not within their capabilities or which require more than a very brief period of orientation. No patient will be retained in the facility beyond the individual medical requirements of his case.

g. Facilities disciplinary barracks. Except in an emergency, medical treatment facilities located within the prisoner confinement inclosure will furnish medical care to prisoners only.

★*h. Prolonged definitive medical care for U.S. military patients who are unlikely to return to duty.* Prolonged definitive medical care is not provided for U.S. military patients who are unlikely to return to duty. The time at which a patient should be processed for disability separation must be determined on an individual basis, taking into consideration the interests of the Government as well as those of the patient. A long-term patients roster will be maintained and up-dated at least once a month to enable the hospital commander and appropriate staff elements to monitor the progress of patients undergoing prolonged definitive treatment. This roster will list all patients in a specialized facility with 90 or more continuous days of hospitalization, and in other facilities, it will include such patients with 60 or more days. The roster will include basic patient identification data (ward or absent status, register number, name, grade, clinic service, and whether assigned to the Medical Holding Unit), projected disposition (date, type and profile), diagnosis description and cumulative hospital days (this facility and total); additional items for local use may be included (e.g., ETS date).

★*i. Hospitalization prior to the effective date of separation orders.* When a military patient for whom separation (particularly retirement) orders have been issued is hospitalized prior to

the effective date of the orders, the hospital commander will immediately notify the agency which issued the order so that action may be taken to amend or revoke them, if necessary, prior to the effective date. (See AR 635-100 (officers) and AR 635-200 (enlisted personnel) concerning notification of the Department of the Army on personnel who have a pending retirement.)

j. Use of subsisting elsewhere status. When appropriate, military patients may be authorized to live in buildings not under the administrative control or supervision of a hospital in a "subsisting elsewhere" status, and receive required medical care on an "excused-from-duty" status. The use of subsisting elsewhere status will be reserved for hospital inpatients whose constant presence in the hospital is not essential to treatment, and provided arrangements can be made for suitable subsistence and lodgings acceptable to the medical treatment facility commander. This status will not be used when another means, such as leave, is more appropriate or required or when the needs of a patient can be adequately met as an outpatient. It will in no way delay the final disposition of a patient from the hospital. Military patients in subsisting elsewhere status continue to be carried on the rolls of the hospital's medical holding unit.

k. Psychotic prisoner patients. When a prisoner patient suffering from psychosis is admitted to a medical treatment facility, the commander of such facility will, if the information is not contained in the patient's available records, ascertain whether the issue of insanity was raised at the time of trial or if there is anything in the record of trial upon which may be based a reasonable doubt as to the patient's sanity at the time of offense or trial. Information about the foregoing will be requested as indicated below and the reply will be included with the patient's clinical records.

(1) When the commander of a medical treatment facility is advised through correspondence with the commander of a U.S. disciplinary barracks that a prisoner is carried on the rolls of such organization (a prisoner is not so carried unless he has been physically received there), inquiry will be addressed to The Judge Advocate General, ATTN: Military Justice Division, Department of the Army, Washington, DC 20310.

(2) For all other prisoners, inquiry will be addressed to the commander who convened the court-martial which convicted the prisoner.

l. Special considerations affecting nonmilitary patients.

(1) *Nonmilitary patients other than those covered in (2) below.*

(*a*) Individuals suffering from acute emotional disturbances of sufficient severity to require hospitalization may be admitted. Individuals with neurological conditions who require hospitalization may also be admitted provided the condition is not one of the following:

1. Paraplegia when the basic cause is known and is not amenable to surgical correction.

2. Prolonged crippling residuals of cerebral vascular disease or similar nervous system afflictions.

(*b*) When it is known that a patient has a chronic mental illness, hospitalization will not be authorized unless an acute emergency situation exists.

(*c*) Maximum length of hospitalization for patient with neurological or psychiatric disorders normally is considered to be 90 days. In exceptional cases that 90-day limitation may be extended by the hospital commander concerned but only rarely to exceed 6 months and never more than 1 year. The 90-day limitation is not to be construed by a referring installation or next-of-kin as implying a right of the patient to remain at the Army medical treatment facility for 90 days, if sound judgment indicates that further hospitalization is not necessary or would be prolonged for an unreasonable period past 90 days, or if domiciliary or custodial care only is required. Under these circumstances, disposition is made to the care of the next-of-kin or to appropriate civilian authorities as may be indicated in the manner prescribed in paragraph 70*b*.

(2) *Dependents of active duty, retired, and*

deceased members of the uniformed services. Dependents may be provided hospitalization for chronic conditions and nervous, mental, and emotional disorders when such conditions and disorders require active and definitive treatment. Dependents in this category will not be admitted if they require only domiciliary or nursing-home type care. Admission will be subject to determination by the hospital commander that space and facilities are available and the capability of the professional staff is sufficient to provide care to a particular dependent without interfering with the performance of the primary mission of the facility. The various categories of dependents will be authorized admission in the order of priority listed in AR 40-121. The provisions of (1) above may be used as a guide in determining disposition of dependent patients in this category who require prolonged hospitalization.

m. Length of hospitalization for Army military personnel on active duty or active duty for training.

(1) Army military personnel on active duty or active duty for training who are likely to recover sufficiently to be medically fit to return to duty within 12 to 15 months generally will be afforded maximum hospital benefits.

(2) Army military personnel in this category who are not likely to recover sufficiently to be medically fit for return to duty within 12 to 15 months will be processed for disposition upon attaining optimum hospital benefits.

(3) For personnel in this category who will require hospitalization beyond their term of service, see the following regulations for procedures to continue such personnel on active duty for the purpose of receiving medical care, completing line of duty investigations, or completing physical disability processing:

(*a*) AR 635-200 (Enlisted Personnel on Active Duty).

(*b*) AR 635-100 (Personnel Separations—Officer Personnel).

(*c*) AR 135-200 (Active Duty for Training of Individual Members).

5. Consent by nonmilitary patients to medical care. *a.* A nonmilitary individual may not be furnished medical care in any Army medical treatment facility without either his consent or the consent of a person authorized to consent on his behalf in accordance with the provisions of applicable local laws or the order of a court having jurisdiction over both the individual and the facility concerned. Consent may be either express or implied (*b* and *c* below). This rule applies even though an individual may be entitled by law to medical care in Army medical treatment facilities; it applies worldwide, except as it may be modified by local laws or international agreements.

★*b.* An implied consent is one that may be implied from actions of the patient or other circumstances, even though specific words of consent are not used. For example, a patient's application for admission to a hospital is an implied consent to hospitalization; if a patient is a minor incapable of giving consent, an implied consent of the parent may be found in actions of the parent in requesting or not objecting to medical care for the minor. Moreover, consent to treatment is implied in certain emergency situations where a patient is incapable of giving or denying consent, and his condition represents a serious or imminent threat to his life, health, or well-being.

c. An express consent involves an interchange of language by which the patient or person authorized to act on his behalf specifically states that his consent is given to proposed medical care. An express consent may be valid whether oral or in writing, but a written consent must be recorded on Standard Form 522 (Clinical Record—Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures) in connection with the following when nonmilitary patients (both inpatients and outpatients) are involved:

(1) All major and minor surgery which involves an entry into the body, either through an incision or through one of the natural body openings.

(2) Any procedure or course of treatment in which anesthesia is used, whether or not an entry into the body is involved.

(3) All nonoperative procedures which involve more than a slight risk of harm to the patient, or which involve the risk of a change in the patient's body structure.

(4) All procedures where roentgen ray, radium, or other radioactive substance is used in the treatment of the patient.

(5) All procedures which involve electroshock or insulin coma therapy.

(6) Admission of patients with psychotic disorders.

(7) Admission of patients to closed wards.

(8) All other procedures which, in the opinion of the attending physician or dentist, chief of service, or the commander require a written consent. Any question as to the necessity or advisability of obtaining a written consent from or on behalf of the patient should be resolved in favor of procuring such a consent.

★*d.* In order for a consent to be legally sufficient (whether expressed or implied), it must be given by a person legally capable to give such consent.

(1) Members of the uniformed services who are minors (under the age of 21) are considered to be emancipated and therefore capable of consent as if they were adults.

(2) The sufficiency of a consent by a nonmember minor to any medical examination or treatment will be determined by the statutory and judicial laws of the United States and the State in which the medical facility is located (e.g., many States allow the treatment of venereal disease with the consent of the minor alone and the parents need neither be informed nor their consent obtained). In cases where the consent of the minor alone is legally sufficient, his or her decision authorizing or rejecting the proposed treatment is binding. In the absence of any law on the subject, it should be determined from the maturity of the minor involved whether he or she may give a legally sufficient consent. In these cases particular attention should be paid to the minor's age and level of intelligence and to his understanding of the complicacy and seriousness of the proposed treatment. If there is a question as to the sufficiency of the minor's consent, the advice of a judge advocate or other legal officer should be sought. The consent of the parents will be required only when it is determined that the consent of the minor alone is not legally sufficient. Even in those circumstances where the consent of the minor alone is not legally sufficient, nevertheless the consent of the minor patient will be obtained in addition to the consent of the parents in all instances in which the minor is able to understand and fully comprehend the significance of the procedure contemplated.

(3) If valid under the laws of the State in which the medical treatment facility is located, parents may grant powers of attorney to:

(*a*) Their mature minor children authorizing them to consent to medical care for themselves and other minor children of the family.

(*b*) Individuals standing in a temporary loco parentis status authorizing them to consent to medical care for minor children of the family.

(4) Except in an emergency, when a patient for some reason other than mental incompetency is unable to respond, the consent of the spouse or next of kin must be obtained. In the event the spouse or next of kin cannot be reached, the question of authority or need to consent will be referred to the appropriate judge advocate or legal adviser for advice.

(5) When a judicial interpretation of mental incompetency has been made, consent must be obtained from the individual appointed by the court to act for the incompetent patient.

(6) When the question of mental competency arises and a judicial determination of mental competency has not been made, the question of authority to consent or treat will be referred to the appropriate judge advocate or legal officer for advice.

(7) Without appropriate court order or the consent of the patient or a person authorized to act on his behalf, the commander of an Army medical facility may temporarily detain a nonmilitary individual with a psychiatric disorder which makes him dangerous to himself or to others, when such individual is found on the military reservation where the medical facility is located, or where there is a real emergency requiring that the individual, although off the reservation, be temporarily detained in that facility. In such a case, if proper consent to, or authorization for admission to the facility cannot be obtained, the local civilian authorities should be notified immediately (without regard to "working days"), and the individual should be transferred to those authorities. It is emphasized that the temporary involuntary detention of a nonmilitary individual should conform with local law and statutes governing involuntary detention, particularly where the United States does not possess exclusive jurisdiction. In order to provide for situations herein discussed, arrangements should be made in advance with local civilian authorities

to accept forthwith those nonmilitary psychotic individuals who may not be admitted to or retained in Army medical facilities because of lack of consent or appropriate court order. In making these arrangements, the point should be made, if necessary, that such individuals who are not residents of the locality are entitled to the same care and treatment by local civilian authorities as would be transients or tourists not connected with the Federal Government. See also paragraph 68.

(8) Movement of nonmilitary psychotic individuals without proper consent or court order normally will not be performed under the auspices of an Army medical treatment facility.

(9) The validity of a court order directing involuntary confinement or treatment of a patient in any Army medical treatment facility is a matter for review, in each instance, by the appropriate judge advocate or legal adviser.

(10) When a written consent is required, it will be personally signed by the patient, or the person authorized to act on his behalf.

(11) Consent for dental procedures which come under the provisions of *c*(1) or (2) above may be obtained at the time a course of treatment is started. One SF 522 may be used for a complete course of treatment.

e. One of the elements affecting the validity of a consent, implied or express, is whether the person giving the consent understands that to which consent is being given and, to a sufficient degree, the possible consequences of the procedure for which consent is given. The physician or dentist who is to perform or supervise the performance of a procedure will counsel the patient and/or the consenting individual as to the nature or expected results of the proposed procedure, which fact is attested to by the patient or person authorized to give consent on Standard Form 522.

Priority	*Category*	*Degree of entitlement*
1st	A. Members of the uniformed services on active duty (including ADT) and comparable personnel of the NATO nations who meet the conditions prescribed by the NATO SOFA (para 25*a*(1)).	Complete and unqualified.
	B. Members of the Reserve components of the Armed Forces not on active duty.	Care must be provided when it is required for conditions contracted in line of duty during a period of active duty (including ADT) or while traveling to or from such duty or for injuries suffered while performing inactive duty training.
	C. Members of the Citizens Military Training Corps.	Care must be provided for conditions contracted while traveling to or from or during attendance at CMTC training camps.
2d	Dependents of active duty members of the uniformed services, the dependents of persons who died while in such a status, and the dependents of active duty members of the NATO nations who meet the conditions prescribed by the NATO SOFA (para 25*a*(1)).	Care must be provided when facilities and staffing permit.
3d	Members of the Senior Reserve Officers' Training Corps of the Armed Forces.	Care may be provided when it is required during periods of attendance at training camps.
4th	Retired members of the uniformed services and their dependents and the dependents of deceased retired Members.	Care may be provided when facilities and staffing permit.
5th	Civilian employees of the Federal Government under the limited circumstances covered by the Federal Employees' Health Service Program (AR 40-5).	Care may be provided when facilities and staffing permit.
6th	All others	Care may be provided when facilities and staffing permit.

Figure 1. Degree and basis of entitlement.

SECTION III

PERSONS ELIGIBLE FOR MEDICAL CARE AT ARMY MEDICAL TREATMENT FACILITIES

6. Persons eligible, extent of treatment and charges therefor. *a. Persons eligible.* The personnel enumerated in this section are eligible for medical care under the conditions outlined herein. The commander of the medical treatment facility is responsible for determining the applicable category of this section under which a person is provided medical care. When a person is eligible under more than one of the categories in this section, he will be provided care under whichever category he chooses.

b. Extent of medical care. The extent of medical care authorized such as hospitalization, outpatient treatment immunizations, prosthetic devices, etc., type of reimbursement, and other criteria for medical care for all eligible categories is prescribed in table I, located in back of this regulation. Where prosthetic devices or appliances are not authorized, Army medical treatment facilities may,, in connection therewith as a part of authorized treatment, furnish the following services:

(1) Examination and treatment to include the taking of necessary measurements.

(2) Procurement of the device or appliance concerned for the individual at no expense to Army funds.

(3) Fitting of the device or appliance concerned and training in its use.

c. Rates.

(1) *General.* Rates for medical care are prescribed in AR 40–330.

(2) *Inpatient.* The inpatient rates shown in column 2 of table I for applicable categories of patients are all-inclusive rates prescribed for personnel in an inpatient status. No additional charge will be made.

★(3) *Outpatient.*

(*a*) The categories of personnel listed in table I which have the symbol "OR" or "SOR" in column 4 and who receive outpatient treatment during a visit on a given day to an outpatient facility will be charged the Outpatient Rate or the Special Outpatient Rate, whichever is applicable, for each visit. This will include immunizations and the furnishing of medicine in prescription which is an actual part of outpatient care. Only one visit will be counted for each patient presenting himself or visited on a given day, or the number of conditions for which he is treated on that day.

(*b*) When a beneficiary of the Bureau of Employees' Compensation (para 13), is furnished a prosthetic appliance, spectacles, a hearing aid, or orthopedic footwear on an outpatient basis, a separate charge will be made for the item. DD Form 7A (Report of Treatment Furnished Pay Patients; Outpatient Treatment Furnished (Part B)) submitted to The Surgeon General will show the type of item furnished and the cost. Charges for spectacles will be in accordance with paragraph 124.3.

★(4) *Medical examinations or immunizations.* Categories of personnel listed in table I which have the symbol "OR" or "IMR" in column 4 who are furnished medical examinations or immunizations, other than in connection with inpatient or outpatient care, will be charged the Outpatient Rate or the Immunization Rate, as applicable.

d. Charges. Persons not authorized care in Army medical treatment facilities by law or regulation will be charged the full pay-patient rate for the type of care provided except when charges are waived by the Secretary of the

Army or the appropriate oversea commander or when the commander of a medical treatment facility determines that a particular patient is medically indigent.

7. Members of the Uniformed services on active duty (other than for training). All members of the uniformed services, including members of the Reserve components, who are on active duty (other than for training) are entitled to medical and dental care in facilities of the uniformed services under 10 U.S.C. 1074a while they are on that duty. Members of the National Guard in active Federal service pursuant to a "call" under chapter 15, or sections 3500 or 8500 of title 10, U.S. Code, Cadets of the United States Military, Air Force and Coast Guard Academies, and Midshipmen of the United States Naval Academy are on active duty (other than for training). Care will be provided without regard to whether the condition for which treatment is required was incurred or contracted in line of duty. (See AR 635-100 and AR 635-200 for extensions of periods of active duty for the purpose of continuing medical treatment for in-line-of-duty conditions after expiration of term of service.)

8. Members of the uniformed services Reserves and National Guard personnel. *a. Treatment during and after training duty.* Members of the uniformed services Reserves on active duty for training or inactive duty training and National Guard personnel performing full-time training or inactive duty training are authorized medical and dental care in Army medical treatment facilities as follows:

(1) While on active duty for training or full-time training duty, they are authorized medical care without regard to whether the disease or injury was contracted or incurred in line of duty.

(2) After expiration of the period of active duty for training or full-time training duty specified in their orders, they are authorized medical and dental care only if the injury or disease was incurred or contracted *in line of duty* while on that training or duty, or traveling directly to or from such training or duty. (See paragraph 15, AR 135-200, for administrative procedures to be carried out at the time of expiration of the training or duty.)

(3) While on inactive duty training, they are authorized medical and dental care when required as the result of an injury incurred *in line of duty.* (The term "injury" as used in this subparagraph includes acute poisonings, except those due to contaminated food, resulting from exposure to a toxic or poisonous substance.) Care is not authorized for injuries incurred while en route to or from inactive duty training.

(4) After a period of inactive duty training, they are authorized medical and dental care only if the injury for which treatment is required was incurred *in line of duty* while on inactive duty training.

Note. In appropriate cases, the Veterans Administration may provide care for members injured *in line of duty* while proceeding directly to or from inactive duty training.

(5) Care is not authorized Army and Air Force Reserve and National Guard personnel for disease contracted during inactive duty training. However, a member of the Naval, Marine Corps, or Coast Guard Reserve who becomes ill or contracts a disease *in line of duty* while performing inactive duty training is entitled to care for that illness or disease on the same basis as for an injury incurred while performing such duty.

(6) While not on duty and while voluntarily participating in aerial flights in Government-owned aircraft under proper authority and incident to training, they are authorized medical and dental care required as the result of an injury incurred *in line of duty.*

Upon expiration of the period of active duty for training, full-time training duty or inactive duty training specified in orders, members of the Reserves and National Guard are released from that training or duty. While receiving treatment after expiration of the ordered training period, they are in a patient status but not on active duty.

b. Treatment under other conditions. Upon presentation of a letter of authorization, the following individuals may be hospitalized in or transferred to an Army medical treatment facility for the purpose of appearing before a medical board and a physical evaluation board, if indicated, as provided in AR 635-40:

(1) Individuals undergoing hospitalization in other Federal medical treatment facilities or civilian hospitals.

(2) Individuals not in a hospital status where it appears that they are disqualified for further military service as a result of a condition incurred in line of duty.

c. Authorization for care for personnel on active duty for training or full-time training duty for 30 days or less, and those on inactive duty training.

(1) In cases where the initial admission is accomplished during a period of active duty for training or full-time training duty and medical care is continued after expiration of the duty period, written authorization for care is not required.

(2) In all other cases, the individual will be required to present an official authorization for treatment for initial admission or readmission as follows:

(*a*) Authorization issued by the Chief, National Guard Bureau, or his designee, in the case of a member of the Army or Air Force National Guard who suffered injury or contracted disease while performing training duty in his National Guard status.

(*b*) Orders (TC 401, AR 310-10) issued by the commander of the major command under whose jurisdiction the duty was performed, or his designee, in the case of a member of the Army Reserve who suffered injury or contracted disease while performing active duty for training (to include REP 63 personnel of the Army National Guard).

(*c*) Authorization from the Bureau of Medicine and Surgery, Department of the Navy, for members of the Naval Reserve and Marine Corps Reserve. Authorization from the individual's unit commander for Air Force Reserve personnel. Authorization from an appropriate official of the service concerned for members of the other uniformed services.

(3) Prior written request from the person's unit commander is required for admission of Army and Air Force Reserve and National Guard personnel injured while on inactive duty training and for admission of members of the Naval Reserve, Marine Corps Reserve, and Coast Guard Reserve who suffer injury or contract disease while on inactive duty training.

(4) If medical care is furnished in an emergency without the required authorization, the commander of the medical treatment facility concerned will request such authorization from the appropriate authority indicated above as soon as practicable. Letters of authorization will include the name, SSN, grade, and organization of the patient; the type and period of duty in which engaged; the diagnosis (if known); and will state that the injury suffered or disease contracted was in line of duty and that the patient is entitled to medical care.

d. Line-of-duty determinations. When individuals are admitted to or treated at a medical treatment facility during a period of training duty for doubtful line-of-duty conditions, the commander of the medical treatment facility will initiate action promptly to insure that a line-of-duty determination is made (AR 600-10). A copy of the final determination (to include a report of investigation, when made) will be furnished the commander of the medical treatment facility.

(1) If the investigation results in a not-in-line-of-duty determination prior to the date of expiration of the training period, every effort will be made to dispose of hospitalized individuals by the expiration date or as soon as they become transportable. Such persons are not authorized medical care at Government expense after expiration of their training period. The cost of any care furnished after the expiration date will be collected from the individual by the medical treatment facility concerned.

(2) When a recommended in-line-of-duty

determination is reversed by the final approval authority, the individual will be furnished medical care without charge (except for subsistence in the case of officers) from the date of expiration of the period of training duty to the date of receipt of notification by the medical treatment facility of the final not-in-line-of-duty determination. Medical care is not authorized at Government expense subsequent to the individual's notification and the cost thereof will be collected from the individual by the medical treatment facility. Every effort will be made to dispose of such hospitalized cases at the earliest practicable date.

e. Services authorized for in-line-of-duty conditions. Care for Reserve and National Guard personnel who incur an injury or disease in line of duty while on active duty for training or full-time training duty and those who incur an injury in line of duty while engaged in inactive duty training includes the following services for that injury or disease:

(1) Hospitalization and medical treatment.

(2) Routine dental treatment. Dental treatment for other conditions for personnel on duty for 30 days or less will be limited to emergency care.

(3) Prosthetic devices, prosthetic dental appliances, hearing aids, spectacles, orthopedic footwear, and orthopedic appliances. When these items need repair or replacement and the unit commander determines that the items were not damaged or lost through negligence on the part of the individual concerned, repair or replacement is authorized at Government expense.

f. Spectacle inserts for protective field masks.

(1) Reserve and National Guard personnel whose units have an Active Army mission of manning missile sites are authorized spectacle inserts for protective field masks.

(2) Reserve and National Guard personnel assigned to units designated for control of civil disturbances are authorized spectacle inserts for protective mask M17.

g. Periodic medical examinations. Periodic medical examinations are authorized Reserve and National Guard personnel not on active duty in accordance with NGR 27 and AR 140-120. When hospitalization is necessary to the proper conduct of these examinations, subsistence charges will be collected in the manner prescribed in table I.

h. Temporary members of the Coast Guard Reserve. See paragraph 13*a*(4) for care available to temporary members of the Coast Guard Reserve as beneficiaries of the Bureau of Employees' Compensation.

9. Citizens Military Training Corps. All necessary medical care is authorized for individuals who, in line of duty, suffered personal injury or contracted disease while traveling to or from or while attending a Citizens Military Training Camp. This authorization extends only to those individuals who incurred injury or contracted disease under the above conditions *at a time when they were members of the Citizens Military Training Corps.* Such care will be furnished until the resulting disability cannot be materially improved by further hospitalization or treatment.

10. Members of the Senior Reserve Officers' Training Corps of the Armed Forces. *a. Members of the Army Senior Reserve Officers' Training Corps including students who are enrolled in the 4-year Senior ROTC Program (10 U.S.C. 2107) or the 2-year Advanced Training Senior ROTC Program (10 U.S.C. 2104) and members enrolled as authorized by 10 U.S.C. 2103.* Medical care is authorized these members in Army medical treatment facilities as outlined below:

★(1) Medical care for injury incurred or disease contracted without reference to line-of-duty while attending field training under the provisions of 10 U.S.C. 2109. Field training includes ROTC annual training camps and ROTC training encampments at Army installations. Rifle team and drill team activities and competitive meets do not qualify as field training. (See paragraph 29 for care authorized ROTC members who are injured or become ill while participating in extracurricular activities.)

(*a*) Routine dental treatment will be furnished for conditions which are disabling and the result of injury or disease incurred in line of duty. Dental care for other conditions will be limited to emergency treatment.

(*b*) Prosthetic devices, prosthetic dental appliances, hearing aids, spectacles, orthopedic footwear, and orthopedic appliances will be furnished for conditions which are disabling and the result of injury or disease incurred in line of duty. When the camp commander determines that these items were not damaged or lost through negligence on the part of the individual concerned, repair or replacement is authorized under normal outpatient care at no expense to the individual.

(*c*) If a member of the Senior ROTC is undergoing hospitalization upon termination of camp, or if before his departure from camp he is in need of hospitalization because of a disability *not in line of duty* and is medically unable to withstand transportation to his home for the time being, he may be retained in or admitted to an Army medical treatment facility. Such care is not authorized at Army expense and the cost therefor will be collected at Rate B from the member by the medical treatment facility concerned. Every effort will be made to dispose of hospitalized cases at the earliest practicable date.

★(2) Medical examinations and immunizations (AR 145-1).

(3) Medical care, including hospitalization, for injury incurred or disease contracted in line of duty while at or traveling to or from a military installation for the purpose of undergoing medical or other examinations or for visits of observation under the provision of 10 U.S.C. 2110.

(4) Medical care is not authorized during attendance at a civilian educational institution except as indicated below:

★(*a*) Medical examinations required by chapter 3, AR 145-1, including hospitalization when necessary to the proper conduct of the examination.

★(*b*) Immunizations required by chapter 5, AR 145-1, including hospitalization for any severe reactions resulting therefrom.

b. Members of the Naval and Air Force Senior Reserve Officers' Training Corps. These members are authorized medical treatment, examinations, and immunizations in Army medical treatment facilities to the same extent and under the same circumstances as members of the Army Senior Reserve Officers' Training Corps.

c. Written authorization for treatment. Written authorization for treatment for those ROTC members referred to in *a* and *b* above will be prepared by the camp commander and will be addressed to the commander of the Army medical treatment facility concerned.

d. Beneficiaries of the Bureau of Employees' Compensation. For conditions under which medical care is provided at the expense of the Bureau of Employees' Compensation to those ROTC members referred to in *a* and *b* above, see paragraph 13.

★10.1 Designated applicants for enrollment in the Senior Reserve Officers' Training Program. Designated applicants for enrollment in the Senior ROTC Program are students who have been designated by the Professor of Military Science for enrollment in the 4-year Senior ROTC Program (10 U.S.C. 2107) or the 2-year Advanced Training Senior ROTC Program (10 U.S.C. 2104), including those selected for the 6-week field training or practice cruise to qualify for enrollment therein, and those selected by the PMS for enrollment as authorized by 10 U.S.C. 2103.

a. When properly authorized, designated applicants for enrollment in the Senior Reserve Officers' Training Program (including applicants for enrollment in the 2-year program and MS II enrollees applying for MS III) will be furnished medical examinations at Army medical treatment facilities, including hospitalization, when necessary for the proper conduct of the examination. They are also authorized medical care, including hospitalization, for injury incurred or disease contracted in line of duty while at or traveling to or from a military installation for the purpose of undergoing medical or other examinations or for visits of observation (10 U.S.C. 2110).

b. Designated applicants for membership in the Army, Naval and Air Force Senior ROTC Programs are authorized medical care in Army medical treatment facilities during the initial 6-week training period (field training/practice cruises) authorized by 10 U.S.C. 2104(b)(6) on the same basis as enrolled members of the ROTC Advanced courses.

11. Retired members of a uniformed service (para 2*p*). Medical care is authorized subject to the applicable conditions indicated below:

a. Those retired for other than physical disability.

b. Those retired for physical disability.

(1) *Temporary retirement (periodic medical examinations).* Members temporarily retired who require hospitalization in connection with the conduct of periodic medical examinations.

(2) *Temporary or permanent retirement (less than 20 years of active duty).* Members temporarily or permanently retired for physical disability or receiving disability retirement pay, with less than 20 years of active duty, except hospitalization for the following chronic conditions: chronic arthritis, malignancy, psychiatric or neuropsychiatric disorder, neurological disabilities, poliomyelitis with disability residuals and degenerative disease of the nervous system severe injuries to the nervous system including quadriplegia, hemiplegia, and paraplegia, tuberculosis, blindness and deafness requiring definitive rehabilitation, and major amputees. (Hospitalization for the above conditions is the responsibility of the Veterans Administration.)

(3) *Temporary or permanent retirement (20 years or more of active duty).* Members temporarily or permanently retired for physical disability or receiving disability retirement pay with 20 years or more of active duty, except those with blindness, neuropsychiatric or psychiatric disorders, and tuberculosis. (Hospitalization for the above conditions is the responsibility of the Veterans Administration.)

(4) *Emergency Officers' Retired List.* Members of the Emergency Officers' Retired List who are entitled to retired pay for physical disability.

12. Beneficiaries of the Veterans Administration. *a.* Medical care is authorized subject to the conditions specified below.

(1) *Veterans Administration field stations.* Control of all referrals of veterans to Army medical treatment facilities, except those in foreign countries as stated in (6) below, is vested in the Veterans Administration field station having jurisdiction over the geographic area in which the Army medical treatment facility is located (hereinafter referred to as "field station"). The procedures outlined herein relating to inpatient care apply to routine or emergency admissions to Army medical treatment facilities where beds have been allocated for Veterans Administration patients by prior agreement, as well as to those emergency admissions to Army medical treatment facilities in which bed allocations have not been granted. *Admission to an Army medical treatment facility within the continental United States in which bed allocations have not been made will be authorized only for the purpose of furnishing emergency medical care.*

(2) *Authorization.* Army medical treatment facilities will furnish medical care to a veteran on presentation of a signed authorization for treatment from the field station having jurisdiction. Reimbursement will not be made by the Veterans Administration for medical care furnished prior to the date that the request for authorization of the medical care was made, except as indicated in (3) below.

(3) *Emergency medical care.* A medical treatment facility admitting a veteran for emergency medical care will notify the appropriate field station within 72 hours after the date and hour of admission and request authorization. When the field station authorizes emergency hospitalization, the effective date of the authorization will be the date the patient was admitted to the facility. A medical treatment facility furnishing emergency outpatient care to a veteran will notify the field station having jurisdiction within 72 hours after the care was furnished and request authorization. *Emergency outpatient care will be authorized by the field station when necessary in the treatment of a disease or injury incurred or aggravated in active military service or in those cases in which outpatient treatment is required to prevent interruption of training of a veteran undergoing authorized vocational rehabilitation or education.* When the field station does not authorize the emergency medical care stated herein, or when authorization for such care has not been received from that office by the Army medical treatment facility while the veteran is receiving medical care, charges for medical care will be collected locally from the veteran concerned.

(4) *Outpatient care.* Outpatient care, other than emergency outpatient care, must be authorized in advance. Such care will be furnished on presentation of a signed authorization from the field station having jurisdiction.

(5) *Disposition of emergency cases.* A veteran admitted for emergency medical care will be released from the Army medical treatment facility promptly upon termination of the emergency unless other disposition as indicated in (*a*) and (*b*) below has been arranged with the field station.

(*a*) Transfer to a Veterans Administration hospital if further hospitalization is required.

(*b*) Retention as a Veterans Administration beneficiary chargeable against a bed allocated to that agency.

(6) *Medical care at Army medical treatment facilities in foreign countries.*

(*a*) Care will be authorized by the Veterans Administration for eligible veterans in need of treatment.

(*b*) The responsibility for authorizing medical care in foreign countries is vested in the Manager, Veterans Administration Office for Europe, Rome, Italy, for veterans residing in Western Europe; the Attaché for Veterans Affairs, American Embassy, Mexico City, for veterans in Mexico; and the Veterans Benefit Office, Washington, D.C., 20420, for eligible veterans residing in all other foreign countries. Veterans may be furnished medical care at Army medical treatment facilities in foreign countries on presentation of a signed authorization for treatment. A medical treatment facility furnishing a veteran emergency medical care without proper authorization will notify the responsible Veterans Administration representative, as indicated above, of this fact within 72 hours after the date and hour the initial care was rendered, by the most expeditious means available, stating the diagnosis and extent of treatment required and requesting authorization for the treatment and instructions as to the disposition of the patient upon termination of the emergency. If the approving authority does not issue an authorization for this care, charges for medical care will be collected locally from the veteran concerned.

(7) *Wheelchairs and beds.* These items may be furnished without charge, if locally available from Government stocks, to a Veterans Administration beneficiary upon his discharge from the medical treatment facility provided, in the opinion of the medical treatment facility commander, he requires constant and continuous use of these items after his discharge.

★*b.* The following records which are required by the Veterans Administration are in addition to those required on all patients in Army medical treatment facilities. The VA form, which will be obtained from the field station having jurisdiction, and Standard Form 502 (Clinical Record—Narrative Summary) will be completed as indicated below and forwarded to such station:

(1) *VA Form 10-P-10 (Application for Hospital Treatment or Domiciliary Care).* This form will be completed for those veterans who are admitted to any Army medical treatment facility for emergency medical care without prior authorization. All information required in the medical certificate thereon will be furnished whether the admission is approved or disapproved by the field station. Since completion of the medical certificate will require examination of the patient, those admissions to the hospital which are disapproved by the field station will be reported as medical examinations on DD Form 7A to The Surgeon General.

(2) *Standard Form 502.* This form will be completed when a veteran is discharged or disposed of. When an interim report of hospitalization is requested by the field station, it will be prepared on this form.

★*c.* Those retired members of a uniformed service whose hospitalization for certain chronic conditions is the responsibility of the Veterans Administration will not normally be hospitalized in an Army hospital for treatment of those conditions. When a patient in this category is admitted to an Army hospital for treatment of a selected chronic condition listed in paragraphs 11*b*(2) and (3), he will be transferred to a Veterans Administration hospital as soon as his condition permits. Until transfer can be arranged, the patient will be treated as a retired member since the Veterans Administration will not reimburse the Army for such hospitalization except in Alaska and Hawaii. The provisions of this paragraph do not apply in Alaska and Hawaii where these patients are treated as Veterans Administration beneficiaries and normal reimbursement procedures are in effect.

13. Beneficiaries of the Bureau of Employees' Compensation. *a. For whom authorized.* Persons in the categories listed below are authorized medical care as beneficiaries of the Bureau of Employees' Compensation (hereinafter referred to as the Bureau).

(1) Members of the Reserve Officers Training Corps of the Army, Navy, and Air Force provided the condition necessitating treatment had its inception on or after 1 August 1956 and was incurred in line of duty under one of the following circumstances:

(*a*) While performing travel to or from camps or cruises.

(*b*) While undergoing flight instruction.

(*c*) During attendance at training camps or while on cruises. (The care furnished under this authority relates solely to care furnished after termination of training camps or cruises. For conditions under which care is furnished during the period of attendance at ROTC training camps, see paragraph 10.)

(2) Employees (regardless of nationality) of the Government of the United States for injury or disease which is the proximate result of their employment.

(3) Employees of the Government of the District of Columbia (except members of the Police and Fire Departments) for injury or disease which is the proximate result of their employment.

(4) Temporary members of the Coast Guard Reserve for physical injury incurred incident to service while performing active Coast Guard duty or engaged in authorized travel to or from such duty.

(5) Volunteer civilian members of the Civil Air Patrol (except Civil Air Patrol Cadets) for injury or disease which is the proximate result of active service, and travel to and from such service, rendered in performance or support of operational missions of the Civil Air Patrol under direction and written authorization of the Air Force.

(6) Peace Corps volunteers for injury or disease which is the proximate result of their employment or which was sustained or contracted while located outside the United States and its territories.

★*b. Conditions governing the furnishing of medical care.* Medical care will be furnished to a beneficiary of the Bureau on presentation of Form CA-16 (Request for Examination and/or Treatment) with Part A thereof prepared and signed by the official superior of the beneficiary. If emergency medical care is furnished without presentation of this form, the appropriate official will be notified immediately and requested to submit this form within 48 hours. If that official determines that it is inappropriate to prepare Form CA-16 under the regulations issued by the Bureau and notifies the medical treatment facility to that effect, charges for medical care will be collected locally from the individual concerned. Supplies of this form, if needed, may be obtained from the appropriate Adjutant General Publication Center or the appropriate Bureau of Employees' Compensation Office as shown in appendix IV.

★*c. Hospitalization.*

(1) *Form CA-16.* The beneficiary will present the original and one copy of this form to the Army medical treatment facility in which medical care is desired. As promptly as possible after the beneficiary has been examined at the medical treatment facility, Part B of this form will be completed and signed by the attending medical officer except when Form CA 20 (Attending Physician's Report) is submitted as indicated in (2) below. The original of the completed Form CA-16 will be forwarded immediately to the appropriate office of the Bureau as shown in appendix IV. The other copy of the completed Form CA-16 will be attached to DD Form 7 (Report of Treatment Furnished Pay Patients; Hospitalization Furnished (Part A)) as a substantiating document.

(2) *Form CA-20 (Attending Physician's Report).* If Part B of Form CA-16 is not submitted as indicated in (1) above, the attending medical officer will execute Form CA-20 and forward it immediately to the appropriate office of the Bureau as shown in appendix IV. If extensive hospitalization is required, a narrative report should be submitted on SF 502 in lieu of Form CA-20 showing the history, physical findings, laboratory findings, and including a general abstract of the patient's hospital record. This information should be forwarded to the appropriate office of the Bureau periodically or at the time of discharge if the hospitalization does not exceed one month. The report should also show the diagnosis for conditions due to the injury; conditions not due to the injury; and condition on discharge with the opinion as to the degree of physical inpairment, if any, from conditions due to the injury.

★*d. Outpatient care.* The beneficiary will present the original of Form CA-16 to the Army medical treatment facility in which outpatient medical care is desired. As promptly as possible after the beneficiary is examined at the medical treatment facility, Part B of Form CA-16 will be executed by the attending medical officer. The completed form will be retained in the files of the medical treatment facility as a possible substantiating document for DD Form 7A (Report of Treatment Furnished Pay Patients; Outpatient Treatment Furnished (Part B)). If not requested by The Surgeon General for this purpose, disposal will be as prescribed in AR 340-18-9.

e. Prostheses and appliances.

(1) All necessary prostheses, hearing aids, spectacles, or special orthopedic footwear will be furnished when required in the proper treatment of a case.

(2) All necessary dental care, including prosthetic dental appliances, will be furnished when authorized by the Bureau of Employees' Compensation.

f. Transfer of beneficiaries.

(1) *Transfer of cases requiring prolonged treatment.* A beneficiary of the Bureau requiring prolonged treatment will be reported by the facility to the Bureau for removal from the Army medical treatment facility as soon as the patient's condition permits. Transfer will be at the expense of the Bureau.

(2) *Transfer when necessary for other purposes.* When transfer is necessary for the proper treatment of the patient, a beneficiary of the Bureau may be transferred from one Army medical treatment facility to another. Prior authorization for such transfers will be secured from the Bureau if

time permits. In an emergency, a patient may be transferred without prior authorization, but if such action is taken, the Bureau will be notified immediately. The expense of such transfer will be borne by the Bureau.

g. Disallowances by the Bureau. The Bureau will advise the medical treatment facility of any claim which is not compensable because of a finding that the employee's injury or disease was not incurred in the performance of duty. In that event the charges for medical care become the personal responsibility of the patient *on and after the date of receipt of the notice of disallowance.* The medical treatment facility will notify the patient of the Bureau's ruling and effect collection from him for any period of hospitalization subsequent to the date of receipt of the notice of disallowance.

14. Beneficiaries of the Public Health Service. The following beneficiaries of the Public Health Service are authorized medical care upon presentation of written authorization as indicated in *a* through *e* below. If a beneficiary is furnished emergency medical care without the required written authorization, it is the responsibility of the commander of the Army medical treatment facility to seek written authorization as soon as possible from the appropriate authorities as indicated in *a* through *d* below.

a. Members of crews of vessels of the Coast and Geodetic Survey, other than commissioned officers (par. 7). Authorization for inpatient care and emergency outpatient care in the United States, its territories, possessions, and the Commonwealth of Puerto Rico and authorization for inpatient and outpatient care outside these areas will be prepared on PHS Form 894 (Treatment Authorization), and signed by the officer in charge of a Public Health Service medical care facility. Where it is not possible to obtain this authorization, a letter of authorization signed by the patient's superior officer may be accepted.

b. American seamen aboard privately owned and operated vessels of United States registry and vessels owned and operated by the United States Government; active enrollees in the United States Maritime Service; and members of the Merchant Marine Cadet Corps. Authorization for inpatient care and emergency outpatient care in the United States, its territories, possessions, and the Commonwealth of Puerto Rico will be as indicated in *a* above.

c. Public Health Service civilian employees in the field service when injured or taken sick in line of duty.

(1) *Authorization for inpatient and emergency outpatient care in the United States, its territories, possessions, and the Commonwealth of Puerto Rico.* Authorization for care will be as indicated in *a* above.

(2) *Authorization for inpatient and outpatient care outside the United States, its territories, possessions, and the Commonwealth of Puerto Rico.* Any necessary medical care may be furnished on written authorization of the employee's superior officer. The authorization will show the patient's name, organization, grade, and diagnosis (if known), and will give other identifying data (such as "civilian employee, field service PHS").

d. American Indians, Eskimos, and Aleuts in the United States. Medical care is authorized as follows on presentation of Form PHS-2514:

(1) *American Indians in the continental United States.* Authorization for medical care will be prepared and signed by the medical officer in charge of an Indian Health Area office.

(2) *American Indians, Eskimos, and Aleuts in Alaska.* Authorization for medical care will be prepared and signed by the medical officer in charge of the PHS Alaska Native Health Service Area Office, Anchorage, Alaska.

e. Inactive Reserve Public Health Service commissioned officers. Medical examinations and immunizations may be furnished upon presentation of authorization (PHS Form 894) from the Division of Commissioned Officer Personnel, Public Health Service, Washington, D.C., 20203. The authorization will include the nature of the service desired, the reason therefor and contain the statement that the individual is entitled to these services at Public Health Service expense. Copy in duplicate of

the proper medical examination forms will be inclosed with the authorization showing in detail thereon the exact extent of the medical examination required. When immunizations are requested in addition to medical examinations, the type of each immunization will be stated specifically. The original of the medical examination forms, properly executed, will be forwarded as soon as the examination is completed, to the authorizing office referred to above. The carbon copy of the medical examination forms and the authorization for medical examinations and immunizations will be forwarded to The Surgeon General, ATTN: MEDOC-F together with DD Form 7A. When hospitalization is necessary to the proper conduct of these examinations, DD Form 7 will be forwarded to The Surgeon General.

f. Dental care. In addition to the dental care provided under the conditions outlined in paragraph 4*b*, in oversea areas (other than United States possessions and the Commonwealth of Puerto Rico), dental care is authorized to the extent necessary pending the patient's return to the United States, to a United States possession, or to the Commonwealth of Puerto Rico.

15. Registrants acting under orders of the Selective Service System. Emergency medical care including emergency hospitalization is authorized for registrants who suffer illness or injury while acting under orders issued by or under the authority of the Director of Selective Service.

★16. Officers and/or employees of the Foreign Service of the United States, and the Agency for International Development, Department of State; the Foreign Agricultural Service, and the Agricultural Research Service, Department of Agriculture; the United States Information Agency; the Bureau of Public Roads, Department of Commerce (those connected with aid programs); the Federal Aviation Agency; the Foreign Claims Settlement Commission; the Veterans Administration (those attached to the Rome office); dependents of such officers and/or employees; and applicants for appointment to such agencies. Medical care is authorized as specified below.

a. Officers and employees and their dependents who are beneficiaries of one of the above agencies outside the United States.

(1) *Inpatient care.* Authorization for officers and employees will be prepared by the individual's superior officer, or, if there is no superior officer, by the individual himself. The authorization will show the individual's name, the diagnosis, if known, and will state that the individual is a citizen of the United States on duty abroad in the employment of one of the above agencies, naming the type of service and the place of duty. In the case of dependents, authorization will be prepared by the immediate superior officer of the dependent's sponsor, or, if there is no immediate superior officer, by the sponsor himself. The authorization will show the dependent's name, the diagnosis, if known, and will state that the dependent is residing abroad with his or her sponsor. It will give also the name and relationship of the dependent's sponsor, with the statement that the sponsor is a citizen of the United States on duty abroad in the employment of one of the above agencies, giving the place and type of employment. In either case, the authorization will also state that the individual is entitled to inpatient care at the expense of one of the above agencies.

(2) *Outpatient treatment.* Outpatient treatment at the expense of one of the above agencies is authorized only when treatment is furnished for a condition which results in hospitalization or treatment required for posthospitalization followup.

(3) *Medical examinations and immunizations.* Medical examinations including periodic examinations (usually biennial) and immunizations may be furnished upon presentation of authorization completed as indicated in (1) above. In addition, the authorization will include the nature of the service desired, the reason therefor and contain the statement that the individual is entitled to these services at the expense of one of the above agencies. Copy in triplicate of the proper medical examination form will

★be inclosed with the authorization showing in detail thereon the exact extent of the medical examination required. When immunizations are requested, the type of each immunization will be stated specifically. The original and one carbon copy of the medical examination form will be forwarded, as soon as the examination is completed, to the authorizing office.

b. Applicants for appointment who are beneficiaries of one of the above agencies outside the United States. Medical examinations and immunizations of applicants for appointment as officers or employees in the service of one of the above agencies may be furnished upon presentation of authorization completed as indicated in *a*(1) above. For additional instructions concerning authorization and disposition of forms, the provisions of *a*(3) above apply.

c. Officers and employees and their dependents (not beneficiaries of one of the above agencies) outside the United States.

(1) *Inpatient care.* Authorization for officers and employees and their dependents listed above will be prepared as indicated in *a*(1) above, except it will state that charges for medical care will be collected from the individual.

(2) *Outpatient treatment.* Charges for all outpatient treatment will be collected locally from the individual.

d. Officers and employees and their dependents (to include applicants for appointment) who are beneficiaries of one of the above agencies in the United States.

(1) *Medical examinations and immunizations.* Medical examinations and immunizations of applicants for appointment as officers or employees in the service of one of the above agencies.

(2) *Periodic medical examinations.* Periodic medical examinations (usually biennial) of officers and employees of one of the above agencies who are on duty or leave in the continental United States.

(3) *Medical examinations and immunizations.* Medical examinations and immunizations for dependents of officers and employees of one of the above agencies.

Authorization for any of these services will be prepared by one of the above agencies as indicated in *a*(1) above. For additional instructions concerning authorization and disposition of forms, the provisions of *a*(3) above apply.

e. Evacuation from Army medical treatment facilities outside the United States and extent of medical care in the United States.

(1) *Evacuation.* Those officers and employees and their dependents listed in *a* and *c* above who are hospitalized in Army medical treatment facilities outside the United States and who require prolonged hospitalization may be evacuated to the United States through medical evacuation channels. Such evacuation, in the case of officers and employees, will be coordinated with the nearest office of the agency concerned.

(2) *Medical care.*

(*a*) The extent of medical care furnished at Army medical treatment facilities in the United States and reimbursement criteria prescribed in the case of those officers and employees and their dependents listed in *a* above, who are evacuated to the United States for *medical* reasons will be comparable in all respects to that which is authorized or prescribed outside the United States. Officers and employees listed in *a* above who are returned to the United States for *nonmedical* reasons, e.g., leave or temporary duty, and accompanying dependents may be furnished medical care at the expense of one of the above agencies for treatment of an illness or

injury which was incurred in line of duty while outside the United States.

(*b*) For the extent of medical care authorized in the United States for those officers and employees and their dependents listed in *c* above, who are evacuated to the United States for medical reasons, the provisions of paragraph 36 apply.

16.1. Peace Corps personnel (volunteers, volunteer leaders, and employees), including Peace Corps applicants, and dependents of volunteer leaders and employees. Medical care will be furnished subject to the conditions specified below and on presentation of a signed authorization for treatment from a representative of the Peace Corps in the case of volunteers, volunteer leaders and dependents of volunteer leaders; from a representative of the Department of State (the Principal or Administrative Officer of the Foreign Service Post) in the case of employees and their dependents; or from a representative of Peace Corps Headquarters in Washington, D.C., in the case of Peace Corps applicants.

a. Outside the United States.

(1) *Volunteers, volunteer leaders, and dependents of volunteer leaders.* Medical care is authorized under the same conditions and at the same rate for the same care for which personnel listed in paragraph 16*a* are eligible.

(2) *Employees and their dependents.*

(*a*) Medical care for employees and their dependents who are beneficiaries of the Peace Corps is authorized under the same conditions and at the same rate for the same care for which personnel listed in paragraph 16*a* are eligible.

(*b*) Medical care for employees and their dependents who are not beneficiaries of the Peace Corps is authorized under the same conditions and at the same rate for the same care for which personnel listed in paragraph 16*c* are eligible.

★(3) *Peace Corps applicants.*

(*a*) Except as provided in (*b*) below, medical service for Peace Corps applicants is limited to medical examinations and immunizations. Hospitalization is authorized only when necessary for the proper conduct of examinations. Reports of medical examinations will be forwarded to Director, Medical Programs, Peace Corps, Washington, D.C. 20006.

(*b*) Peace Corps applicants in training status outside CONUS are authorized medical care in Army medical treatment facilities on the same basis as Peace Corps Volunteers.

b. Inside the United States.

★(1) *Peace Corps applicants.* The provisions of *a*(3)(*a*) above, apply.

(2) *Volunteers, volunteer leaders, and dependents of volunteer leaders and employees.* Medical care is authorized to the extent provided by paragraph 36.

c. Records. A complete medical report will be furnished the local Peace Corps physician upon completion of hospitalization or, in the event of a prolonged illness, a medical report will be sent periodically. Similarly, in the case of outpatient treatment, a brief medical report will be forwarded to the local Peace Corps physician upon completion of treatment.

d. Evacuation. Evacuation from Army medical treatment facilities to the continental United States will be coordinated with the local Peace Corps representative.

e. Care as BEC beneficiaries. See paragraph 13*a*(6) for care available to Peace Corps volunteers as beneficiaries of the Bureau of Employees' Compensation.

17. Members of the U.S. Soldiers' Home. *a.* Except as provided by *b* below, such members are authorized all necessary medical care.

b. Members who have a dual status as a member of the U.S. Soldiers' Home or as a member or former member of the Army or

Air Force retired for physical disability are not eligible for admission for the chronic conditions listed in paragraph 11*b*.

18. Beneficiaries of the Department of Justice. *a. Federal Bureau of Investigation.* Upon presentation of written authorization, agents of the Federal Bureau of Investigation may be furnished medical examinations. Charges for medical examinations will be collected by The Surgeon General on receipt of DD Form 7A. When hospitalization is necessary to the proper conduct of these examinations, DD Form 7 will be forwarded to The Surgeon General.

b. Claims administered by the Department of Justice. Upon presentation of written authorization from the Department of Justice or the United States attorney in the case, claimants whose claims are being administered by the Department of Justice may be furnished medical examinations to determine the extent and nature of the injuries or disabilities claimed. Charges for medical examinations will be collected by The Surgeon General on receipt of DD Form 7A. When hospitalization is necessary to the proper conduct to these examinations, DD Form 7 will be forwarded to The Surgeon General.

18.1 Applicants for cadetship at the various service academies. *a. Army, Navy, and Air Force.* Applicants for cadetship at the US Military Academy, the US Naval Academy, and the US Air Force Academy may be furnished medical examinations and hospitalization when necessary to the proper conduct of these examinations without charge.

b. Coast Guard. Upon presentation of written authorization from commanders of US Coast Guard District Offices, applicants for cadetship at the US Coast Guard Academy may be furnished medical examinations. No charge will be made for these examinations when performed on an outpatient basis. When hospitalization is necessary to the proper conduct of these examinations DD Forms 7 will be forwarded to The Surgeon General.

★19. Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve components thereof, and Selective Service registrants. Applicants for enlistment or reenlistment and registrants while under military control will be furnished necessary medical examinations, and hospitalization when their medical fitness for military service cannot be determined without hospital study.

20. Applicants for appointment in the Regular Army and Reserve components, including those members of the Reserve components who apply for active duty. Medical examination may be furnished in accordance with AR 601-100 and AR 140-120. When medical fitness for appointment cannot otherwise be determined hospitalization is authorized.

★20.1. Applicants who suffer injury or acute illness. Applicants listed in paragraphs 18.1, 19, and 20 who suffer injury or acute illness while awaiting or undergoing processing at Army facilities or Armed Forces Examining and Entrance Stations may be furnished emergency medical care, including emergency hospitalization.

21. Persons in military custody and nonmilitary Federal prisoners.

a. Prisoners of war and retained personnel. Such persons are authorized necessary medical care to include prosthetic devices, prosthetic dental appliances, and spectacles. Hearing aids and orthopedic footwear are also authorized when necessary for the individual to carry out his duties or attend to his own needs.

b. Civilian internees. Civilian internees are provided care in Army medical treatment facilities only in the absence of adequate civilian facilities (para 42, AR 633-51). In the event such persons are treated in an Army facility, all necessary care will be provided, including dentures, spectacles, and other required artificial appliances (para 43, AR 633-51).

c. Military prisoners confined in Army facilities.

(1) Military prisoners whose punitive discharges have been executed but whose sentences have not expired are authorized all necessary medical care.

(2) Military prisoners whose punitive discharges have been executed and who require hospitalization beyond expiration of sentences are not eligible for care but may be hospitalized as pay patients until disposition can be made to some other facility.

d. Military prisoners on Commandant's parole or excess leave. The punitive discharges of prisoners in these categories have not been executed. Accordingly, they are still members of the military

services and are authorized medical care to the same extent as other members.

e. Military prisoners on parole under the supervision of the Federal Probation Service. The punitive discharges of prisoners in this category have been executed but their sentences have not expired. Such individuals are not eligible for care in Army medical treatment facilities. However, in exceptional cases, care in Army facilities may be requested under the provisions of paragraph 35.

f. Nonmilitary Federal prisoners. Such persons are authorized only emergency medical care. When such care is furnished, the institution to which the prisoner is sentenced must furnish the necessary guards to control the prisoner and prevent his escape. *Under no circumstances* will military personnel be utilized to guard or control the prisoner. Upon completion of emergency medical care, arrangements for transfer to a nonmilitary medical facility or return of the prisoner will be made with the appropriate official of the institution to which the prisoner is sentenced. Charges for emergency medical care will be collected by The Surgeon General on receipt of DD Form 7 or 7A.

22. Former female members of the Armed Forces and their newborn infants. *a. General.* Former female members of the Armed Forces separated under honorable conditions because of pregnancy, or who, although separated under honorable conditions for reasons other than pregnancy, are shown by a medical examination given at an Armed Forces medical treatment facility to have been pregnant at the time of separation, are authorized medical care in military medical treatment facilities for that pregnancy as specified in *c* and *d* below. Such care is limited to care in military facilities and does not, regardless of the circumstances, include care obtained in civilian facilities.

b. Application. Former female members of the Armed Forces who desire maternity care will apply in writing to the military medical treatment facility nearest their home and present their copy of DD Form 214 (Armed Forces of the United States Report of Transfer or Discharge), or DD Form 256A (Honorable Discharge Certificate) or DD Form 257A (General Discharge Certificate), as appropriate, as proof of their eligibility for medical care.

c. Extent. For the purpose of this paragraph the term "maternity care" includes prenatal care, hospitalization, confinement, and postnatal care either in a hospital or as an outpatient for 6 weeks following delivery.

d. Newborn infants. No charge is made for newborn infant patients while the mother is a patient in the medical treatment facility. In those cases where the mother is discharged from the medical treatment facility and it is necessary for the infant to remain as a patient or where the infant is admitted as an individual patient under the authority of this subparagraph, charges will be made at the rates prescribed for the mother in each case. If newborn infant patients require medical care beyond the postnatal 6 weeks period, disposition will be made to private, welfare, State, or Federal agencies.

23. Individuals whose military records are being considered for correction. Individuals who require medical evaluation in connection with consideration of their case by the Army Board for Correction of Military Records are authorized necessary medical care. (Personnel in this category are advised by The Adjutant General that they may report to a designated Army medical treatment facility for evaluation.)

24. Seamen. *a. General.* Civilian seamen in the service of vessels operated by the Department

of the Army or the Military Sea Transportation Service listed in *b* and *c* below are still in the service of a vessel, although not on board and not engaged in their duties, as long as they are under the power and jurisdiction of competent Department of the Army or Military Sea Transportation Service authorities.

b. Civilian seamen in the service of vessels operated by the Department of the Army. Except in emergencies, such persons will be furnished medical care only when facilities of the Public Health Service are not available. Authorization for such care will be granted upon presentation of written authorization from the master or other appropriate administrative authority which may be dispensed with only in emergencies.

c. Civilian seamen in the service of vessels operated by the Military Sea Transportation Service. Such persons are eligible for care upon presentation of written authorization from the master or other appropriate administrative authority. In cases where immediate treatment is required and the employee concerned does not have the required written authorization, the nearest Military Sea Transportation Service office or representative will be requested to submit such authorization as soon as possible. The authorization will be attached to DD Form 7 or 7A as related papers when submitted to The Surgeon General.

d. Crews of ships of United States registry. Such crews, including ships' officers are eligible for care when outside the United States, its territories, possessions, and the Commonwealth of Puerto Rico. This category includes the crews of ships of United States registry such as those aboard Department of Defense time-chartered vessels of commercial operators; those aboard time-chartered vessels other than time-chartered vessels referred to above for emergency medical care; and those on privately owned and operated vessels. A crewmember who requires prolonged hospitalization may be evacuated to the United States through medical evacuation channels when lack of transportation facilities prevents evacuation through the local ship's agent.

25. Foreign nationals. *a. Inside the United States.*

(1) Military personnel of one of the NATO nations listed below, when in connection with their official duties such personnel are stationed in or passing through the United States, and their dependents *as that term is defined in (10) below.*

(*a*) Belgium.
(*b*) Canada.
(*c*) Denmark.
(*d*) France.
(*e*) Federal Republic of Germany.
(*f*) Greece.
(*g*) Iceland.
(*h*) Italy.
i) Luxembourg.
j) Netherlands.
(*k*) Norway.
(*l*) Portugal.
(*m*) Turkey.
(*n*) United Kingdom.

(2) Civilian personnel who are accompanying the military personnel referred to in (1) above as employees of an armed service of the nation concerned (provided they are neither stateless persons nor nationals of any state which is not a Party to the North Atlantic Treaty, nor nationals of, nor ordinarily resident in the United States), and their dependents as that term is defined in (10) below. (As indicated in *d*(1) below, care for this category is limited to emergency care or care at installations which have been designated remote by the Secretary of the Army for medical care purposes.)

Note. Subparagraphs (1) and (2) above implement the medical portion of the NATO Status of Forces Agreement insofar as care in Army medical treatment facilities is concerned. Care in Air Force and Navy facilities for the persons enumerated in (1) and (2) above is governed by regulations of those services.

(3) Military personnel whose names appear in the *Diplomatic List* (the so-called "Blue List") or the List of Employees of Diplomatic Missions (the so-called "White List") published periodically by the Department of State.

(4) Military personnel assigned or attached to U.S. military units for duty.

★(5) Military personnel assigned or attached to U.S. military units for training.

(6) Military personnel on duty in the United States at the invitation of the Department of Defense or one of the military departments.

(7) Military personnel accredited to joint U.S. defense boards or commissions.

(8) Military and civilian personnel not covered above who are in the United States in a status officially recognized by the Department of the Army. (When doubt exists regarding the eligibility of any person seeking care under this subparagraph, he should be advised to apply for determination of his eligibility to the Assistant Chief of Staff for Intelligence, Department of the Army, Washington, DC 20310, through the military attaché of his country stationed in Washington.) MAP trainees (military or civilian) applying for care under this authority will present a copy of their invitational travel orders to the United States.

★(9) Dependents of military personnel covered in (3) through (8) above when residing with their sponsor.

★(10) As used in this paragraph, the term *dependent* means a person who bears one of the following relationships to his or her sponsor:

(*a*) A wife.

(*b*) A husband if he is dependent on his sponsor for over one-half of his support.

(*c*) An unmarried legitimate child, including an adopted child or stepchild, *who is dependent on the sponsor for over one-half of his support* and who either—

1. Has not passed his 21st birthday;

2. Is incapable of self-support because of a mental or physical incapacity that existed prior to his reaching age 21; or

3. Has not passed his 23d birthday and is enrolled in a fulltime course of study in an accredited institution of higher learning.

★*b. Notification of hospitalization inside the United States.*

(1) When foreign nationals listed in *a* above are hospitalized at Army medical treatment facilities, an immediate notification will be prepared in letter form in quadruplicate. The original and two copies will be submitted by airmail to the Assistant Chief of Staff for Intelligence, Department of the Army, Washington, DC 20310, in order that the country concerned may be advised regarding the status of foreign personnel. The quadruplicate copy will be submitted by airmail to The Surgeon General, ATTN: MEDMI-F. The notification will include the name, grade, service number, and branch of service (where applicable), and country of the foreign national; status (e.g., trainee, visitor, dependent, etc.); date of hospitalization; diagnosis, prognosis, and probable date of release. If the patient's probable date of release cannot be determined during his initial evaluation or the initial notification does not indicate a prolonged period of hospitalization and it subsequently develops that the patient will require prolonged hospitalization, an additional notification similar to that described above will be submitted. In addition, when Canadian military personnel are admitted to or discharged from an Army medical treatment facility in the United States, a copy or extract of the Admission and Disposition Sheet will be forwarded immediately to the Canadian Joint Staff, Washington, DC.

(2) Notifications required by (1) above are exempt from reports control under paragraph 7-2*k*, AR 335-15.

c. Outside the United States.

(1) Those who qualify under paragraph 31*a* or 34.

(2) MAP trainees (military and civilian) and the dependents of MAP military trainees.

★(3) Persons covered by agreements entered into by an agency of the U.S. Government authorized to make such agreements when care in Army medical treatment facilities is a condition of the agreement. (A copy of all such agreements will be submitted to The Surgeon General, ATTN: MEDDD-OP, Department of the Army, Washington, DC 20314.)

(4) Liaison officers from a NATO Army Force or members of a liaison detachment from such a Force.

Note. This subparagraph implements paragraph 8*f* or NATO Standardization Agreement 2101.

★(5) Crew and passengers of visiting military aircraft of NATO nations which land at NATO or U.S. military airfields *within NATO* countries.

Note. This subparagraph implements the medical portion of NATO Standardization Agreement 3113.

★(6) *The transfer of foreign personnel from outside the United States to the United States solely for the purpose of providing medical care in Army medical treatment facilities is not authorized except under unusual circumstances as determined by the Secretary of the Army.* The U.S. Army attaché in the country concerned is responsible for effecting through diplomatic channels such coordination as may be necessary with the local government and interested agencies will request the attaché to render such administrative assistance as may be within his capabilities.

d. Charges for and extent of care.

★(1) Persons referred to in *a*(1), (2), and (5) and *c*(2) and (4) above are eligible under the same conditions and at the same rate for the same care for which U.S. Army personnel (military or civilian, as the case may be) are eligible. Medical care for foreign nationals in the United States on MAP Orientation Tours under the provisions of AR 551-50 or visiting the United States at the invitation of the Department of Defense or one of the military Departments is limited to emergency care to preserve life or health or to prevent undue suffering.

(2) Except as indicated in (3) below, persons, referred to in *a*(3), (4), (6), (7), (8), and (9) above will not be admitted to an Army hospital for chronic conditions or any other condition which would not be benefited by hospitalization for a period of less than 90 days. No such person will be provided care for which he would not be eligible if he were in a comparable U.S. category. Rates for such persons will be the same as those charged comparable U.S. Army personnel (military or civilian, as the case may be) and collection will be made locally from the individual concerned except in the case of foreign enlisted patients. Reimbursement for subsistence for this latter category of personnel will be accomplished in the same manner as for U.S. Army enlisted patients.

(3) Persons being provided care pursuant to a specific agreement entered into by an authorized agency of the U.S. Government will be provided care to the extent specified in the agreement or, if there be no such specification, to the extent indicated in (2) above. Such persons will be charged at the rate specified in the agreement or, if no rate is specified, at the rate charged comparable U.S. Army personnel (military or civilian, as the case may be).

(4) In the case of MAP trainees (military or civilian) furnished care under *a*(8) and *c*(2) above, subsistence charges will be collected locally from officer and civilian trainees. No charges will be collected from enlisted MAP trainees. At the end of each calendar month, all MAP trainees (officer, enlisted and civilian) furnished care (excluding those furnished care in USAREUR) will be reported to The Surgeon General, ATTN: MEDOC-F. Reports will be prepared on DD Form 7 or DD Form 7A, as appropriate, and submitted in triplicate supported by a copy of invitational travel orders to the U.S. installation or activity where training is being received. Dependents of MAP military trainees will be charged Rate D when hospitalized with collection direct from patient or sponsor. No charge will be made for outpatient services furnished dependents of MAP military trainees.

(5) Persons referred to in *c*(5) above normally will be furnished that medical care which is available at the NATO or U.S. military airfield concerned. When hospitalization is furnished, the charges for subsistence will be collected locally from the patient and the charges for hospitalization, computed on the basis of inpatient Rate B or F will be collected from the appropriate NATO nation by Headquarters, USAREUR, on receipt of DD Form 7

from the Army hospital providing the care. No charge will be made for outpatient care.

26. Red Cross personnel and their dependents, other officially recognized welfare workers, non-Red Cross volunteer workers and civilian student employees. Such persons are authorized medical care subject to the applicable conditions indicated below:

★*a. Red Cross personnel.*

(1) Uniformed and nonuniformed, fulltime, paid professional field and headquarters staff when on duty with a uniformed service. (Care for nonuniformed personnel was effective 16 August 1969.)

(2) Uniformed, fulltime, paid secretarial and clerical workers on duty outside the United States.

(3) Nonuniformed, fulltime, paid secretarial and clerical workers on duty in Red Cross offices at installations within the United States, and volunteer workers, uniformed and nonuniformed, both within and outside the continental United States. (Medical care for these categories of personnel will be limited to care for injuries sustained in the course of performance of their duties at uniformed services facilities.)

★*b. Dependents of Red Cross personnel.* Dependents of the Red Cross personnel listed in *a*(1) and (2) above are authorized medical care when accompanying their sponsors outside the United States at the uniformed services dependent rate, effective 16 August 1969.

c. Other officially recognized welfare workers and non-Red Cross volunteer workers. For injury sustained in the course of performance of their duties at Army facilities.

★*d. Civilian student employees.* Civilian student employees in training at an Army Medical Department facility.

27. Civilian employees and their dependents. ★*a. Those authorized occupational health services.*

(1) *Civilian employees of the Army.*

(*a*) Civilian employees of the Army paid from appropriated funds and applicants for such employment by the Army are authorized to receive without charge those occupational health services referred to in AR 40-5. When hospitalization is necessary to the proper conduct of the medical examinations referred to in AR 40-5, a charge for subsistence will be made. Subsistence charges will be collected locally from the individual concerned. (The above authorization includes the furnishing of a medical evaluation for those employees who, prior to their evacuation from overseas, did not receive such an evaluation for the purpose of determining their mental or physical fitness for continued employment.)

(*b*) Civilian employees of the Army paid from appropriated funds are authorized to receive without charge spectacle inserts (including fittings) for protective masks where the masks are issued as protective equipment under the provisions of AR 385-32. The spectacle inserts will be furnished under the criteria of paragraph 118*g*(1).

(*c*) Civilian employees of the Army paid from industrial funds and applicants for such employment by the Army are authorized to receive without charge health services and spectacle inserts at the expense of Army industrial funds under the same conditions as stated in (*a*) and (*b*) above. When such services are provided, arrangements will be made locally at an estimated per capita cost. These costs will be paid by the receiving agency and handled as an automatic reimbursement by the medical treatment facility providing the service.

(*d*) Civilian employees of the Army paid from nonappropriated funds and applicants for employment are authorized to receive without charge those examinations required by AR 40-5.

(*e*) Civilian seamen in the service of vessels operated by the Department of the Army who are paid from appropriated funds are authorized to receive without charge those occupational health services referred to in AR 40-5.

(2) *Civilian employees of Federal departments and agencies other than Army.* Such employees (or prospective employees) who are paid from appropriated or industrial funds are authorized to receive those health services referred to in AR 40-5. Except in the case of civilian employees and prospective employees of the Navy, Marine Corps, and Air Force in the Washington metropolitan area to whom authorized occupational health services are furnished as the financial responsibility of the Department of the Army, arrangements will be made locally at an estimated per capita cost. The costs will be paid by the receiving agency and handled as an automatic reimbursement by the medical treatment facility providing the service. (The above authorization includes the furnishing of a medical evaluation for civilian employees of the Navy, Marine Corps, and Air Force who, prior to their evacuation from overseas, did not receive such an evaluation for the purpose of determining their mental or physical fitness for continued employment.)

Medical care furnished the above categories of personnel for injuries incurred in the performance of duty will be provided in accordance with paragraph 13.

b. Civilian employees of the Defense Establishment (not beneficiaries of the Bureau of Employees' Compensation) and their dependents. This group includes civilian employees of the Defense Establishment, paid from either appropriated or nonappropriated funds, and their dependents outside the United States and at military installations in the United States which have been designated as remote by the Secretary of the Army for the purpose of providing medical care to these individuals. Charges will be collected locally from the individual at the rates indicated below for the applicable fiscal year.

(1) *Inpatient care.* Outside the United States, charges for inpatient care will be at Rate B or F for United States citizens and at Rate C for noncitizens. Charges for inpatient care at designated remote installations in the United States will be at Rate B or F.

(2) *Outpatient care.* Outside the United States, charges for outpatient care will be at the special outpatient rate for both citizens and noncitizens. Charges for outpatient care at designated remote installations in the United States will be at the outpatient rate.

(3) *Immunizations.* No charge will be made for immunizations and reimmunizations required by AR 40-562.

★*Note.* Remote installations in the United States may extend care under the provisions of this paragraph to Federal civilian employees other than those of the Department of Defense when specifically authorized by the Secretary of the Army.

c. Civilian employees of contractors of the Department of the Army. Medical care may be furnished only outside the United States, except that in the case of civilian-contractor flight instructors medical examinations may be furnished in the United States.

c.1. Civilian employees of contractors of the Department of the Navy and their dependents. Medical care may be furnished only outside the United States.

d. Civilian employees (including former and prospective employees) of contractors of the Department of the Army. Medical examinations (to include hospitalization when necessary in connection therewith) may be furnished without charge only within the United States on an individual basis upon authorization by the CONUS army or major oversea commander concerned or the Commanding General, Military District of Washington, U.S. Army. When hospitalization is necessary to the proper conduct of these examinations, a charge for subsistence will be made and collected locally from the individual concerned.

e. Civilian employees of all Federal agencies. Medical examinations in connection with disability retirement may be furnished civilian employees of all Federal agencies without charge when such examinations are requested by authorized representatives of the U.S. Civil Service Commission, except that when hospitalization is necessary to the proper conduct of these examinations subsistence charges will be collected locally from the individual concerned.

f. Civilian employees of the Department of Commerce, except for Bureau of Roads person-

nel connected with aid programs (para 16). Medical care may be furnished only outside the United States.

g. Civilian employees of the Department of Interior and their dependents. Medical care may be furnished Department of Interior employees and their dependents when the employee's place of permanent residence is not the geographical area where he is employed as follows:

(1) Outside the United States.

(2) Upon request of the Governor of American Samoa, in Hawaii for employees and their dependents who are stationed in American Samoa.

h. Civilian employees of the General Accounting Office and their dependents. Medical care may be furnished only outside the continental United States.

★28. Army National Guard Technicians (civilian employees of the Army National Guard) manning missile sites. These technicians were made civilian employees of the Department of the Army and the Department of the Air Force by Public Law 90–486. They are now authorized care under the provisions of paragraph 27.

★29. Civilian participants in Army-sponsored activities. Civilian participants in Army-sponsored sports, recreational or training activities who are injured or become ill while participating in such activities may be furnished inpatient and outpatient medical care without charge except for subsistence when hospitalized, effective 8 November 1969. The commander of a medical treatment facility may also furnish medical examinations and immunizations to these individuals when he considers that such procedures are necessary. Hospitalization will be furnished only on a temporary basis until such time as appropriate disposition can be accomplished. Persons eligible under this paragraph include:

a. Senior ROTC cadets and students participating in extracurricular activities under Army sponsorship.

b. Junior ROTC/NDCC (National Defense Cadet Corps) cadets and students participating in Army-sponsored instructional activities.

c. Boy Scouts and Girl Scouts of America participating in visits, training exercises, and encampments at Army installations.

d. Civilian athletes training and/or competing in sports activities as part of the U.S. Olympic effort.

e. Civilian participants in Army marksmanship and parachute team training and competitive meets.

f. Students and members of sports groups invited to participate in sports activities at Army installations as part of the Army Sports Program.

g. Members of Little League Teams and Youth Conservation Groups participating in sports, recreational or training activities at Army installations. (See paragraph 37.8 for medical support provided underprivileged children participating in the President's Youth Opportunity Programs.)

★30. Claimants whose claims are administered by Federal departments and claimants who are the proposed beneficiaries of private relief bills. *a. Army.* In order to determine the extent and nature of the injuries or disabilities claimed, civilian claimants upon the request of the Army agency responsible for administering the claim may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge being made.

b. Other Federal departments. In order to determine the extent and nature of the injuries or disabilities claimed, civilian claimants upon the request of the Federal department responsible for administering the claim may be furnished outpatient medical examinations without charge. When hospitalization is necessary to the proper conduct of these examinations, DD Form 7 will be forwarded to The Surgeon General.

c. Other claimants. Claimants who are the proposed beneficiaries of private relief bills

based on injuries or disabilities allegedly arising out of the operation of the Defense Establishment may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge being made in order to determine the extent or nature of the injuries or disabilities claimed.

31. Persons outside the continental United States who contribute to accomplishment of a major oversea commander's mission. *a. General.* Persons who contribute to the accomplishment of a major oversea commander's mission and for whom medical care is deemed essential by the major oversea commander concerned may receive medical care in facilities outside the continental United States only in the absence of adequate civilian facilities as determined by the major oversea commander concerned. Rate B or F or the outpatient rate, whichever is applicable, will apply except as indicated in *b, c,* and *d* below.

b. Civilian representatives of religious groups and others. Civilian representatives of religious groups, celebrities and entertainers, athletic clinic instructors, and representatives of the USO, other social agencies, and educational institutions, and persons in similar status providing direct services to the US Armed Forces, who are acting under official invitational orders from the Department of Defense, or from one of the military departments, to visit military commands overseas may be furnished medical care without charge in facilities outside the continental United States. Charges for subsistence will be collected locally from the individual. Dependents of USO oversea area executives, club directors, and associate club directors when accompanying their sponsors outside the United States may be furnished medical care at the uniformed services dependent rate, *effective 4 March 1969.*

★ *c. Educational representatives of recognized educational institutions.* Educational representatives of recognized educational institutions regularly assigned to duty in military commands overseas who are contributing to a major oversea commander's mission, and their dependents when residing with their sponsors, may be furnished medical care in facilities outside the continental United States at Rate B or F or at the special outpatient rate, whichever is applicable.

d. Rates for individuals under hardship circumstances. When a major oversea commander determines that hardship would result if an individual or a category provided care under this paragraph were charged the rates specified in *a* above, he may prescribe Rate D as the charge for hospitalization or waive the charge for outpatient care, or do both, as appropriate.

32. American nationals. American nationals outside the United States covered by agreements entered into between the Department of the Army and other Federal civilian agencies when care in Army medical treatment facilities is a condition of the agreement may be furnished medical care.

33. Joint Civilian Orientation Conference guests. Joint Civilian Orientation Conference guests while attending a Joint Civilian Orientation Conference will be provided medical care. Charges for medical care will be at Rate B or at the outpatient rate, whichever is applicable, and collection will be made locally from the individual.

34. Special foreign nationals. *a. Care authorized.* Medical care may be furnished to such persons outside CONUS when it is determined that this action can be expected to contribute to the advancement of the public interests of the United States.

b. Authority. Authority is granted to major oversea commanders to make the foregoing determination.

c. Delegation of authority. Major oversea commanders may, when the geographical dispersion and varying political conditions of their command warrant such action, delegate the authority in *b* above and *e* below to one or more of their major subordinate commanders. Such authority, however, may not be redelegated.

d. Considerations.

(1) Generally, care under this paragraph

will be afforded only to foreign officials of high national prominence. Care may be afforded under this paragraph, however, to other foreign nationals when, because of unusual circumstances or the extraordinary nature of the case, such action would be in consonance with *a* above.

(2) Normally, care will not be afforded under this paragraph for chronic conditions or any other condition which, if hospitalization is involved, would not be benefited by hospitalization for a period of less than 90 days.

(3) Normally, the recommendations of the Chief of the Diplomatic Mission to the country involved should be sought prior to determining whether care should be afforded under this paragraph.

e. Charges. Charges for medical care provided under this paragraph will be at Rate B or F or the outpatient rate, whichever is applicable, and collection will be made locally, except that in unusual cases the major oversea commander may waive the charges.

f. Evacuation to the United States. Persons being afforded care under this paragraph will not be evacuated to the United States for further care unless they are first made designees of the Secretary of the Army pursuant to paragraph 35.

35. Designees of the Secretary of the Army. Persons not otherwise eligible for medical care may receive such care when they are designated for this purpose by the Secretary of the Army. Such designees will be charged Rate B or F or the outpatient rate, whichever is applicable, unless specifically otherwise authorized by the Secretary. In the event the Secretary authorizes the furnishing of hospitalization with no reimbursement therefor, a charge for subsistence will be collected locally from the individual unless the Secretary also waives these charges.

35.1 Pre-adoptive children. Under the provisions of paragraph 35, the Secretary of the Army has authorized pre-adoptive children of active duty and retired members of the uniformed services to receive medical care in Army medical facilities until the adoption is finalized and they become entitled to care under chapter 55, title 10, US Code. Care will be provided under the same conditions and subject to the same charges as would apply to any dependent entitled to medical care in such facilities.

a. Commanders of Army medical treatment facilities are delegated responsibility for determining whether an individual child falls within this class of Secretarial designees, after approval on an individual basis by the local Staff Judge Advocate.

b. To apply for medical care for a pre-adoptive child as a Secretary of the Army designee, the sponsor must submit a request to the medical facility commander with the following information and documentation:

(1) The name and date of birth of the prospective adoptee.

(2) The sponsor's name, grade, social security number, and organization, or address for retirees.

(3) A notarized, acknowledged, or photostat copy of the legal decree or other instrument issued by a court of law or adoption agency which awarded custody for the purpose of adoption. (Approval will not be granted without such an official document.)

(4) The date of placement and expected date of final adoption.

c. If the medical facility commander determines that the child fits within this class of Secretarial designees, he will forward the application to the local Staff Judge Advocate for verification of the determination. If verified, the application will be so annotated by the Staff Judge Advocate and returned to the medical facility commander. A copy will be provided the sponsor and the original retained by the medical facility until the adoption is final. It may then be destroyed.

d. Responsibility for approval will not be delegated below the medical facility commander.

36. Certain personnel evacuated from one area to another. Personnel who for medical reasons are evacuated from an area in which they are

eligible for medical care to an area where they are not otherwise eligible for such care will be admitted to or furnished treatment at medical treatment facilities to which evacuated or while en route thereto when medical care is deemed necessary. Care should be furnished under this paragraph on a temporary basis only until such time as appropriate disposition can be accomplished.

37. Civilians in emergency. *a.* Any person is authorized care in an emergency in order to prevent undue suffering or loss of life. See paragraph 3.1*v* for extent of care.

b. Charges for medical care under this paragraph will be at Rate B or F or the outpatient rate, which ever is applicable, except when the patient is determined to be medically indigent, the commander may waive the charges. For the purpose of this regulation, a person who has insufficient income to meet the costs of necessary medical care and services is considered to be medically indigent.

37.1 Volunteer subjects in approved Department of the Army research projects. Volunteers under the provisions of AR 70-25 are authorized all necessary medical care for injury or disease which is the proximate result of their participation in such projects. (Medical care for civilian employees who volunteer and who perform duty as a volunteer during their regularly scheduled tour of duty will be provided in accordance with paragraph 13.)

★37.2 Beneficiaries of the US Secret Service. *a. Secret Service Special Agents (examinations).* Upon presentation of written authorization, Secret Service Special Agents may be provided routine annual medical examinations in Army medical treatment facilities on a reimbursable basis. Examinations will be conducted and recorded in the same manner as routine annual medical examinations for Army officers except that they will be conducted on an outpatient basis only. If hospitalization is considered desirable in connection with the examination, a statement to that effect will be entered in item 73 or 75 of the SF 88 (Report of Medical Examination), as appropriate. One copy of the SF 88 and SF 93 (Report of Medical History) for medical examinations provided these agents will be forwarded to the Chief, United States Secret Service, Treasury Department, Washington, DC 20220. Charges for examinations will be collected by The Surgeon General on receipt of DD Form 7A supported by a copy of the authorization for medical examination.

b. Secret Service protectees and protectors. Medical Service authorized by AR 1-4 on a nonreimbursable basis includes care in Army medical facilities for persons being provided protection by the US Secret Service and individuals engaged in providing such protection. When hospitalized, a charge for subsistence will be collected locally from the individual.

37.3 Federal Aviation Agency (FAA) Air Traffic Controllers. *a.* Upon the written request of FAA regional representatives, designated Army hospitals are authorized to provide the following services to Air Traffic Controllers who are undergoing a physical examination by an FAA physician:

(1) Chest X-rays.

(2) Electrocardiographs.

(3) Audiograms.

b. The Army hospital commander will not read or evaluate the results of these tests. Results will be forwarded direct to the FAA Regional Office arranging for the examination.

c. Services provided will be reported to HQDA (DASG-RMF) on DD Form 7A supported by a copy of the request for the services.

37.4 Job Corps and Volunteers in Service to America (VISTA) personnel and applicants. *a. Job Corps.* Upon presentation of Job Corps Form 503 (Authorization for Medical Fitness Examination by a Federal Facility), Job Corps Form 505 (Authorization for Hospitalization by a Federal Facility), or Job Corps Form 507 (Authorization for Outpatient Care and Services by a Federal Facility) signed by an appropriate official of the Job Corps, Job Corps applicants for enrollment and Job Corps enrollees may be provided the following services in

Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Job Corps applicants for enrollment.* Pre-enrollment medical examinations and immunizations.

(2) *Job Corps enrollees.* Hospitalization, outpatient medical treatment, examinations, and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering.

b. VISTA. Applicants for employment by VISTA and VISTA personnel may be provided the following services in Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Applicants for employment by VISTA.* Pre-employment medical examination of VISTA Form 36 (Authorization for Medical Examination and Care by a Federal Facility) signed by an appropriate VISTA official.

(2) *VISTA personnel.* Hospitalization, outpatient medical treatment, examinations, and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering. Hospitalization and outpatient medical treatment may be provided upon presentation of a "Blue Cross and Blue Shield Identification Card." Other authorized services may be provided upon presentation of VISTA Form 36.

c. Services available at Armed Forces Examining and Entrance Stations. Upon presentation of Job Corps Form 503 or VISTA Form 36, male Job Corps applicants and male VISTA applicants may be provided pre-employment medical examinations and immunizations at Armed Forces Examining and Entrance Stations (AFEES) when in the opinion of the AFEES commander the capability exists.

d. Remediable physical defects. Upon presentation of appropriate authorization form signed by a Job Corps or VISTA physician, surgery or other treatment required to correct remediable physical defects of Job Corps enrollees and VISTA personnel may be provided in Army medical treatment facilities if within the professional judgment of the medical officers concerned such treatment is indicated and the required resources are available. The authorization form should contain a statement that in the opinion of the authorizing physician the condition will interfere with or substantially impede the training or future employability of a Job Corpsman or will seriously interfere with a VISTA volunteer's performance of duty.

e. Reports to The Surgeon General. Hospitalization, outpatient care, examinations and immunizations furnished will be reported to The Surgeon General on DD Form 7 or 7A supported by a copy of the Job Corps or VISTA Form authorizing the services. In the case of VISTA personnel provided hospitalization or outpatient treatment on the basis of their Blue Cross and Blue Shield Identification Card, the VISTA identification number of the patient will be shown after the name of the patient in Item 5 of the DD Form 7 or 7A.

f. Beneficiaries of the Bureau of Employees' Compensation. After termination of their duty with the Job Corps or VISTA, these personnel are eligible for Bureau of Employees' Compensation benefits. To establish their eligibility for these benefits, Army medical treatment facilities providing treatment to such personnel will, upon request, complete the medical certificate on BEC Form CA-2.

37.5 US Nationals in foreign penal institutions. US nationals serving with, employed by, or accompanying the Armed Forces outside the United States and its possessions, and their dependents, when confined in foreign penal institutions are authorized medical care of the type and quality furnished prisoners in US military confinement (AR 27-50).

37.6 Social security beneficiaries. Beneficiaries of the Social Security Health Insurance Program for the Aged (Medicare) may be provided hospitalization in Army medical treatment facilities in an emergency to prevent undue suffering or loss of life. The Social Security Administration's local office will be notified as soon as possible after emergency admission of one of their beneficiaries. The Social Security Administration can pay for care furnished its

beneficiaries in a Federal hospital only during the period of the emergency. The patient or responsible family member will be informed of this and will be advised that arrangements should be made with a civilian hospital which participates in the Medicare Program so that the patient can be transferred as soon as his condition has improved to the extent that he can be moved. Collection for the patient's share of the cost of hospitalization under the Medicare Program will be a matter between the patient and the Social Security Administration and no collection will be made from these patients by the Army hospital. Emergency hospitalization of Social Security beneficiaries will be reported to HQDA (DASG-RMF) on DD Form 7. This paragraph does not apply to dependents and retired members who are entitled to care in uniformed services facilities. Such persons are provided care as uniformed services beneficiaries under the provisions of paragraph 11 of this regulation and paragraph 4-6, AR 40-121.

37.7 Domestic servants outside the United States. Army medical treatment facilities located outside the United States are authorized to provide the following health measures without charge for domestic servants employed or to be employed by military and civilian personnel of the Department of Defense:

a. Pre-employment health examinations.

b. Periodic communicable disease detection examinations.

c. Immunizations.

37.8 Underprivileged children participating in the President's Youth Opportunity Programs. When medical support is not available from other sources, certain limited medical services may be provided underprivileged children participating in the President's Youth Opportunity Program in Army facilities on a reimbursable basis in accordance with the provisions of chapter 6, AR 28-19.

37.9 Micronesian citizens. Micronesian citizens referred to US Army Triple General Hospital for specialized treatment by the High Commissioner, Trust Territory of the Pacific Islands, may be provided hospitalization and outpatient treatment as beneficiaries of the Trust Territory of the Pacific Islands (a Federal agency) at the Interdepartmental rate and outpatient rate, respectively. Collection will be made locally.

SECTION IV

DISPOSITON OF PATIENTS FROM ARMY MEDICAL TREATMENT FACILITIES

38. General policies. *a.* Prior to disposition, all Army military patients will be evaluated for retention in the military service. In addition, each member will be evaluated under such special standards as may be applicable in his case (aviation, diving, airborne, special forces, etc.). Dispositions to a duty status will take into consideration the long-range effect, if any, upon the health and well-being of the patient after his return to his regularly assigned job.

b. Medical officers will not designate a particular medical treatment facility for use by patients who require followup examination after their disposition unless unusual professional considerations dictate such action.

c. Except under emergency circumstances a patient will not be granted a pass or leave when absence will in any way delay his disposition.

d. Army military patients who are administratively unfit for retention will be processed in accordance with procedures contained in appropriate administrative regulations such as AR 635-100, AR 635-206, and AR 635-212.

e. Patients who normally would be discharged from the hospital on Sundays or holidays will be discharged on the preceding workday, whenever such earlier discharge is not medically contraindicated.

f. All administrative actions such as requests for duty assignment, medical records, line of duty determinations, and medical board processing will be taken as quickly as possible in order to expedite the eventual disposition of military patients.

g. No patient will be retained in a medical treatment facility solely for the purpose of completing items 35 and 36 of DA Form 8-118 (Medical Board Proceedings) (para 45*o*).

★*h.* When efforts to dispose of a patient are not successful, his case will be brought to the attention of The Surgeon General, HQDA (DASG-DDO-P).

i. Convalescent leave may be granted in accordance with paragraph 8-3, AR 630-5, and Part K, Chapter 5, Volume 1, Joint Travel Regulations.

39. Return of oversea Army military patients to CONUS for medical reasons. Major oversea commanders may return military patients who are members of the Army to CONUS for medical reasons when they determine that such action is in the best interests of the Army and the patient.

a. The major oversea commander concerned will determine whether a patient being returned to CONUS under this paragraph will appear before a medical board prior to evacuation.

b. If hospitalization or active medical supervision is required while in a travel status, the patient will be evacuated through medical channels.

★*c.* If hospitalization or active medical supervision is not required while in a travel status, the patient will be returned to CONUS through regular administrative channels by the most expeditious means.

(1) As soon as it is determined that such a patient is to be returned to CONUS, a request for hospital designation will be submitted by the major oversea commander through normal

medical regulating channels to ASMRO, WASH DC, in accordance with chapter 3, AR 40-350. In addition to reporting patient's name, rank, branch of service, specialty and diagnostic coding (Eighth Rev IDCA, PHS PUO No. 1693), the following special instructions will be included with each entry:

(*a*) Designation symbol "39c".

(*b*) Number of days of leave or delay en route, if any, authorized.

(*c*) Specific medical reason for return to CONUS.

(*d*) A statement whether patient has appeared before a medical board in accordance with paragraph 41.

(*e*) Patient's choice of CONUS residence (town or city and state).

(2) The patient will be transferred as soon as possible after receipt of the hospital designation from ASMRO. Orders issued by the oversea commander will assign the patient to the medical holding unit of the hospital designated by ASMRO. Reporting date will be computed in accordance with AR 680-1.

(3) Commanders returning patients to CONUS under this authority will not grant leave or delay en route when such action is medically contraindicated. The medical treatment facility commander who initiates action to return a patient to CONUS administratively will determine whether leave or delay en route is medically contraindicated.

(4) The major commander will assure that the medical treatment facility in possession of the clinical records (when applicable) and the custodians in possession of the health and personnel records are notified that a CONUS hospital has been designated for the patient. These records will be furnished the individual for hand-carry to the destination hospital when no leave or delay en route is authorized. Individuals authorized leave or delay en route will hand-carry their health and personnel records but their clinical records will be airmailed direct to the destination hospital immediately upon completion of the clinical record. Clinical records will be completed for patients being returned to duty from an inpatient status for administrative return to CONUS. Necessary action will be taken to insure that a copy of the clinical record cover sheet and narrative summary are incorporated into the individual's health record prior to departure from the oversea command. The clinical record cover sheet will contain in Item 29 the name of the destination hospital and the following statement: Returned to CONUS in accordance with paragraph 39*c*.

d. When an Army military patient is hospitalized in an oversea command and his home of record is located within that oversea command, he may be retained in the oversea command for medical treatment and further disposition (including separation), provided the military medical facilities available within the oversea command can adequately meet his needs.

★*e*. Evacuation orders on officer patients should receive distribution shown in paragraph *d*(2) under Special and Letter Orders, Table 1-1, AR 310-10. In the case of Army Medical Service officers, the copies listed in column 4, table 1-1, AR 310-10, should be forwarded to HQDA (DASG-PT) Washington, DC 20314.

★*f*. Members being considered for referral to a physical evaluation board because of physical disability ordinarily will be returned to a CONUS medical treatment facility for medical board and further processing. Members who are authorized separation or retirement in an oversea command (chap. 2, AR 635-100, and chap. 3, AR 635-200) may be processed as described in chapter 4, AR 635-40.

39.1. Evacuation of wives from oversea areas to the United States. When hospitalized wives are evacuated from oversea areas to the United States for further hospitalization and are accompanied by their child or children but not by their sponsors, plans must be made for the care of the children while the mother is hospitalized. Oversea commanders will insure that plans for the child or children are coordinated with the social worker at the receiving hospital prior to departure of the family from the oversea area.

40. Responsibility for dispositions. *a. Commanders of Army medical treatment facilities.* These commanders are responsible for disposition of all personnel under their jurisdiction for medical care. This responsibility is primarily exercised through the attending medical officer and includes the evaluation of medical fitness of military patients for further military duty.

b. Attending medical officers. These officers are responsible to the commander of the medical treatment facility for the proper and timely professional care of the patients assigned to them as well as for the continual evaluation of these patients for an early and appropriate disposition.

c. Medical board. This board assists the commander of a medical treatment facility in determining the medical fitness, mental competence, mental responsibility, and disposition of patients.

d. The Secretary of the Army. The responsibilities of the Secretary of the Army in administering the physical disability program are exercised through the U.S. Army Physical Disability Appeals Board, the U.S. Army Physical Disability Agency, and The Adjutant General. Details of procedures are set forth in AR 635-40. The U.S. Army Physical Disability Agency (USAPDA), through Physical Evaluation Boards (PEB) and the U.S. Army Physical Review Council (USAPRC), evaluates and reviews all cases of individuals referred to PEBs by medical boards when physical fitness for further military service is questionable. When a PEB finds a member physically unfit for further military service, the board then evaluates the nature and degree of the individuals's disability in accordance with the Veterans Administration Schedule for Rating Disabilities (VASRD) and modifying regulations, and recommends either discharge or retirement as appropriate. The U.S. Army Physical Disability Appeal Board (USAPDAB) considers all cases which are properly referred to it through the appeal system established by AR 635-40. The Adjutant General takes necessary action to implement Secretarial decisions by publication of Department of the Army orders or the issuance of appropriate instructions to subordinate headquarters.

41. Medical boards. ★*a. General.* The medical board is an instrumentality of the Army Medical Department appointed by the commander of a medical treatment facility to assist him as indicated in paragraph 40*c* in making disposition of those patients for whom medical board action is required by higher authority, and in other cases when he deems such action advisable. *Recommendation of a disability rating is a prerogative of physical evaluation boards. Medical boards will not express conclusions or recommendations regarding percentages of disability.* Headquarters, Department of the Army will designate the medical facility to conduct medical board evaluations for specific cases when deemed appropriate. When medical or other circumstances preclude medical board evaluation at the hospital where the member is located, a medical board at the nearest Army medical facility properly staffed to do so will be convened to evaluate the member and recommend disposition.

b. Appointing authority. Commanders of all

Army medical treatment facilities are authorized to appoint medical boards.

c. Composition. Except as indicated below, medical boards will be composed of three or more Medical Corps officers, one of whom will be a senior Medical Corps officer with detailed knowledge of the directives pertaining to standards of medical fitness and unfitness, disposition of patients, and disability separation processing. The other members of the board should be familiar with these matters. Doctors of medicine, doctors of osteopathy, and doctors of dentistry who are civilian employees and contract surgeons may be detailed as members of a medical board. A Medical Service Corps officer may be utilized as recorder without vote to assist the medical board when desired by the medical treatment facility commander. When a member of the medical board does not have training in the medical, surgical, neuropsychiatric, or dental specialty of the patient's primary impairment, appropriate specialty consultations will be obtained prior to consideration of the case by the medical board.

★*d. Boards for medical officers.* Commanders who have authority to convene or review the proceedings of a medical board, or their superiors in the chain of command, who require referral to a medical board will be ordered to appear before a board not under their jurisdiction. Medical Corps officers who require referral to a medical board will be ordered to appear before a board other than that which is provided by the facility to which they are assigned for duty. In unusual and compelling circumstances, authority to deviate from this policy may be requested from The Surgeon General, ATTN: MEDDD-OP. A copy of the approved exception will be attached to each copy of the medical board proceedings.

42. Use of medical boards. Generally, only those cases which present aspects of a problematical or controversial nature and those cases in which medical board action is required by regulation should be evaluated by a medical board prior to disposition. Patients who are to be returned to duty without any permanent revision in their profile and those who require transfer to another hospital prior to final disposition should not ordinarily be considered by a medical board prior to such disposition. Situations which require consideration by a medical board are—

a. All cases in which PEB referral is required (para 54*g*).

b. Patients hospitalized over 6 months returning to a duty status in order to insure that the individual has correct physical profile, assignment limitations, and medical followup instructions, as appropriate.

c. Patients with a doubtful prognosis, medical condition, or physical defects which are usually progressive in nature, or cases in which a claim against the Government may be expected. It is intended that such medical board action insure the adequate documentation of the nature, extent, and cause of all the medical conditions or physical defects in question.

d. Patients whose medical fitness for return to duty is problematical or controversial. When a member's fitness for further military duty is questionable, it becomes essential that his condition be thoroughly evaluated with respect to all abnormalities which may be present. Under these conditions, evaluation will be undertaken only in medical treatment facilities which have not only the professional staffing and equipment necessary for examination and medical evaluation, but also possess the administrative competence and experience to document appropriately the case and to initiate the processing of the member. When a medical treatment facility lacks this capability, the member will be transferred to the nearest qualified Army medical treatment facility.

e. Reserve component personnel on active duty for training or participating in Reserve duty training—

(1) Who are medically unfit for further military service upon completion of hospitalization; or

(2) Who require hospitalization beyond the termination of their tour of duty.

f. Reserve component personnel not on active duty who require evaluation for medical fitness as a result of injury incurred or aggravated during employment on active duty or inactive duty training, or as a result of disease incurred or aggravated during employment on active duty in excess of 30 days. Following medical board action in such cases, personnel who are medically unfit will be referred to a physical evaluation board.

g. ROTC members on a training tour (annual training camps and training encampments at military installations)—

(1) Who may be eligible as a result of an injury incurred or a disease contracted during their training tour for benefits administered by the Bureau of Employees' Compensation. See AR 145-1.

(2) Who require hospitalization beyond the termination of their training tour.

★*h.* Members on the TDRL—

(1) On the first periodic medical examination of an individual following placement on the TDRL.

(2) On the subsequent periodic medical examinations when in the opinion of the attending medical officer the status of the member has stabilized or when the disposition is questionable.

(3) The last periodic medical examination of members on the TDRL will, if accomplished at a military medical treatment facility capable of holding a medical board, be supported by a medical board.

i. Cases involving mental competency.

j. Individuals scheduled for separation under AR 635-100 and AR 635-212 when it appears that a mental illness, medical condition, or physical defect is the direct cause of unfitness, unsuitability or homosexuality.

k. Army medical boards will be utilized to determine mental competency of any retired member of the Armed Forces when that retired member is hospitalized in an Army medical treatment facility and for retired Army members hospitalized in a non-Federal facility by the facility designated to have responsibility. (The Departments of the Navy; Air Force; Health, Education, and Welfare; and the Veterans Administration are authorized to determine mental competency of retired Army members when such persons are hospitalized in a facility under its jurisdiction.)

l. Any other case deemed necessary by the appointing authority.

43. Medical board proceedings. Medical boards operate informally. Their members assemble to discuss and evaluate the patient's case. His clinical, health, and other records, as appropriate, are reviewed. When a patient's condition permits, he should be given the apportunity to appear in person and present his views relative to his proposed disposition. Medical fitness or medical unfitness for further duty regardless of motivation is determined on the basis of the medical fitness standards and guidance contained in chapter 3, AR 40-501 for military personnel, and chapter 2, AR 40-501 for ROTC members, except for medical conditions and physical defects which were known at the time of enrollment in the Advanced Course ROTC and which are essentially unchanged. The board will insure that all of the medical and/or physical defects which the individual has are determined and recorded. In cases of patients recommended for duty, the physical profile and appropriate duty assignment limitations or restrictions should be established.

44. Recording proceedings. *a.* Medical board proceedings normally will be recorded on DA Form 8-118. When medical boards are held for the purposes described in paragraphs 42*b*, 42*e*(2), or solely for the purpose of revising the physical profile and the findings do not include medical unfitness, the proceedings will be recorded on DA Form 3349 (Medical Condition—Physical Profile Record). Instructions covering the use of DA Form 3349 are contained in chapter 9, AR 40-501. The following general instructions apply whenever DA Form 8-118 is used to record medical board proceedings. A brief, but complete, clinical history including a summary of available prior medical records (including the Health Record and the SF 88 accomplished at the time of entry into service) prepared by the patient's attending physician on SF 502 will be attached to the board proceedings as inclosure 1.

(1) In cases involving psychiatric illness considered to have existed at the time of entry into the service, a decided effort will be made to include in the narrative summary clinical and social data concerning the conditions of the patient's entry into service—showing significant behavior and attitude toward the Army and toward the act of entry into service—data upon which to base a judgment whether the patient was at the time of his entry into the service mentally competent to understand the nature of the act of entry into service. If the patient is considered to have been incompetent to understand the act of entry into

service at that time, then the clinical data should show the approximate inclusive dates subsequent to entry into service when he did become competent to understand the nature of this act. If he never became so competent, then clinical data should be included to support this opinion.

(2) When a condition which existed prior to entry into service is judged to be aggravated by service, the severity and circumstances of the aggravation will be clearly indicated in the summary.

(3) A complete current report of medical examination will be recorded on SF 88 and attached as inclosure 2 to the board proceedings.

(4) When an enlisted member is being evaluated because of a psychiatric condition, a copy of DA Form 20 (Enlisted Qualification Record) should be reviewed by the medical board and attached to the board proceedings as Inclosure 3.

b. Except as required elsewhere in this regulation, DA Form 8-118 and inclosures will be prepared in the number of copies and distributed as shown in figure 2. For cases involving a finding of mental incompetency, one additional copy will be prepared. All members of the board will sign the original and initial the duplicate of the proceedings, except that for cases in which a finding of mental incompetency is made all copies for use of finance officers must be signed by each member. The copy of SF 502 that becomes part of the clinical record will be annotated by the attending physician to show final disposition of the patient. DA Form 8-118 is designed for use with mechanical reproduction machines using the diazo-type process. When so used, the master copy will be considered the hospital records copy (fig. 2). Reproduced copies are acceptable for physical evaluation boards and other administrative purposes.

Type of Disposition	Health Record	Clinical Record	Hospital File	Other
	Copy No.	Copy No.	Copy No.	Copy No.
1. Returned to duty	1	2	3	
2. Retained under medical jurisdiction for later evaluation	1	2	3	
3. Referred to Physical Evaluation Board	—	7	8	1 through 6 to PEB.
4. Separation—not for disability:				
a. Release from AD (Return to ARNGUS, USAF)	1	2	3	
b. Discharge	1	2	3	
5. EPTS separation—not referred to PEB	1	2	3	4 with cy entry and exit SF 88 and 89 attached to HQDA (DASG-HES-Y) through Surgeon, USAREC, Ft. Monroe, VA 23551. See para 9-8*d* and *e*, AR 635-40.

Notes:

1. See paragraph 10-10, AR 635-40 for disposition of DA Form 8-118 when a disabled individual is continued on active duty.
2. See also paragraphs 48, 56*b*(4), 56*c*, 57, 61*c*, and 70 of this regulation.
3. See AR 40-501 for instructions on use of DA Form 3349 to notify unit commanders of physical profile and assignment limitations on members returned to duty.

Figure 2. Distribution of medical board proceedings.

c. DA Form 8-118 is designed for use primarily in connection with evaluating military patients. When nonmilitary patients appear before a medical board, DA Form 8-118 will be modified by omitting entries which are obviously inappropriate.

★*d.* In PEB cases, care must be exercised in recording medical board proceedings to insure clarity and completeness. Physical evaluation boards, more often than not, evaluate an individual's impairments primarily on the basis of the records. Review and appeal bodies use only the records and never see a member. It is imperative, therefore, that entries be carefully worded so that they are both informative and precise. The entry on SF 502 describing the individual's present condition should include an accurate description of the limitations imposed by each listed impairment and, if applicable, a discussion of the combined effect of all impairments.

45. Preparation of DA Form 8-118. The following instructions for preparing DA Forms 8-118 are furnished:

a. Items 1 through 15. Identifying information in items 1 through 15 will be obtained from personnel or medical records.

b. Items 16, 17, and 18. Check applicable boxes. Where the determination of a patient's medical fitness is questionable, the matter will be resolved in favor of referring the member to the Physical Evaluation Board by checking "medically unfit" and inserting immediately above, the word "questionably."

c. Item 19. Using Department of Defense Disease and Injury Codes listed in AR 40-401 and TB Med 15, list all diagnoses, by nomenclature and code, in descending order of importance, and note paragraph and subparagraph of chapter 3, AR 40-501, as applicable, in each case being referred to a PEB. In addition, the following special instructions apply:

(1) All manifestations which indicate the severity of a diagnosis will be summarized on SF 502.

(2) When necessary, include a statement of the patient's requirements for further hospitalization or treatment, including the condition(s) which necessitates further care and the probable duration of the required care.

(3) For patients with psychiatric conditions, include a statement indicating whether or not the patient is mentally competent for pay purposes; whether or not the patient has the capacity to understand the nature of, and to cooperate in, physical evaluation board proceedings; and whether or not the patient is dangerous to himself or others.

(4) For psychiatric prisoner patients include the following statements:

(*a*) Whether the patient was mentally responsible at the time of the offense in that he could or could not differentiate between right and wrong and could or could not adhere to the right.

(*b*) Whether at the time of the offense the patient was capable of having the degree of knowledge, intent, willfulness, malice, or premeditation required for the offense (if the offense included any of these).

(*c*) Whether at the time of the trial the patient possessed the requisite mental capacity and could or could not reasonably cooperate in his own defense.

(*d*) Whether during the appellate process the patient possessed the requisite mental capacity and could or could not reasonably cooperate in his own defense.

(5) For patients being processed for separation for EPTS conditions, list the name and location of the medical treatment facility where the physical examination incident to entrance on active duty was conducted.

(6) In cases where continuance on active duty under the provisions of AR 635-40 is requested, enter profile on SF 88. See paragraph 62 of this regulation.

(7) For deleterious type cases (those in which disclosure of information to the patient would be detrimental to his physical or mental health) include a statement to this effect.

d. Item 20. Complete all items for each diagnosis listed in item 19.

(1) Members undergoing disability evaluation for conditions involving questionable line-

of-duty status, with respect to misconduct, negligence, or unauthorized absence, should have a copy of approved findings of the line-of-duty determination included in the evaluation records file. When such record of approved determination is not included in the file, the commander of the medical treatment facility concerned will request the appropriate authority to furnish a copy of the approved findings. To avoid undue delay, these cases may be processed as though a favorable determination had been made. See paragraph 1-9, AR 635-40.

(2) Determination of whether the disability was incurred or aggravated while the member was entitled to basic pay will be made by the medical officer concerned, subject to review, change, or modification by the medical board, hospital commander, or adjudicative bodies in the evaluation processing system.

(3) Every member will be presumed to have been in sound condition when examined and accepted for service except as noted at the time of entrance examination and acceptance. Therefore, it will ordinarily be presumed, in the absence of clear and convincing evidence to the contrary, that the disease or injury causing disability was incurred in line-of-duty. However, the fact that a member was accepted for active duty is not, in itself, conclusive that the disability was incurred after such acceptance but must be correlated with all available pertinent medical facts in accordance with accepted medical principles.

e. Item 21. Briefly summarize in nontechnical language the salient incapacitating diagnoses. (Not required for patients found medically fit.)

f. Item 22. Enter a specific recommendation selected from the types of disposition listed in paragraphs 54 and 55.

g. Item 23. Use when recommending return to duty with limitations. Do not use for patients recommended for return to full duty or separation.

h. Item 24. Check applicable box. Patient must initial all copies. Do not use this space when a patient is found medically fit.

★*i. Items 25 and 26.* Check applicable box. Use only when the patient answers item 24 in the affirmative.

j. Item 27. Indicate whether or not the board's findings and recommendations are unanimous. If they are not unanimous, attach as an inclosure a minority report by the dissenting member.

k. Items 28, 29, and 30. When a psychiatrist is a board member, add the letter "P" after branch (para 44). In typed portion, when board members are not officers, indicate status, such as contract surgeon.

l. Items 31 and 32. For use by the approving authority. If the board's proceedings are returned for reconsideration, attach as an inclosure the reason for return.

m. Item 33. For use by the approving authority only when the action of a board which has reconsidered a case is disapproved. Attach as an inclosure the approving authority's reason for disapproval.

n. Item 34. Self-explanatory.

o. Items 35 and 36 (para 38*q*).

(1) When an individual is being retained in a medical treatment facility to receive required treatment, these items will be completed when the approved board's action is made known to the patient. If the patient disagrees with the action, attach a statement of the patient's reason. When the patient does not disagree, line out the second and third sentences in item 35.

(2) When an individual is no longer at a medical treatment facility, a letter will be sent by the medical treatment facility concerned advising him of the medical board's findings and recommendations and requesting that a written reply be made indicating his agreement or disagreement with the action. An indorsement with two blocks will be included with the letter. One block will indicate acknowledgment that he has been informed of the medical board's findings and recommendations, but desires to request reconsideration and is attaching as inclosure 1 a statement setting forth the reasons for his request. He will be requested to check one of the two boxes, attach his request

for reconsideration, if appropriate, and sign and date the indorsement. The letter and the indorsement will be filed as an inclosure to DA Form 8-118. If, after a reasonable period of time the individual fails to respond, the DA Form 8-118 will be closed out without completing items 35 and 36. A statement will be made in the continuation block to the effect that these items could not be completed because of the individual's failure to respond.

p. Items 37 and 38. For use by the approving authority in acting on a patient's request for reconsideration. If the proceedings are returned to the medical board for reconsideration, the board's action resulting from the reconsideration will be attached as an inclosure (if appropriate this may be in statement form, signed by the board members). Any further action by the appointing authority will be entered in continuation.

q. Continuation. For use on continuing entries in other spaces. Identify each such entry by the number of the item being continued. In addition, this space may be used for remarks and as required in *p* above.

46. Requests for reconsideration. A patient who disagrees with the findings or recommendations of a medical board will be afforded an opportunity to submit pertinent statements or evidence for consideration by the approving authority. Any statements or evidence submitted become an integral part of the board proceedings.

★47. Approving authority. *a.* The appointing authority is also the approving authority for medical board proceedings. He does not participate in the medical board's proceedings, either as a member, witness, consultant, or in any other capacity. Medical board proceedings and all addenda thereto will be reviewed by the approving authority and his action entered thereon. If he approves the findings and recommendations or, when reconsideration of previously approved board action is requested, confirms these, the recommended disposition will be effected at the earliest practicable date except as provided in paragraph 57. If the approving authority does not concur with the board's findings or recommendations, he will return the proceedings to the board for further consideration. If the findings or recommendations of a board which has reconsidered a case are not approved by the appointing authority, he will forward the board's proceedings, in duplicate, together with his recommendations, to The Surgeon General, ATTN: MEDPS-S for review.

b. The approving authority may delegate the authority to review and act on medical boards, provided the individual to whom this authority is delegated (e.g., chief of professional services) does not participate in the medical board's proceedings, either as a member, witness, consultant, or in any other capacity.

48. Distribution of medical board proceedings. Distribution of medical board proceedings will be as indicated in figure 2, depending upon the disposition of the patient, and as further prescribed in paragraph 57 for prisoner patients and in paragraph 70 for certain military personnel requiring further hospitalization upon separation. The additional copies prepared for mentally incompetent patients, after approval by the convening authority, will be forwarded direct to Settlement Operations, Finance Center, U.S. Army, Indianapolis, IN 46249.

49. Counseling of member. When the approved recommendation of a medical board is that the member appear before a physical evaluation board, the member will be referred to the Physical Evaluation Board Liaison Officer for counseling as provided in AR 635-40. The member will not be told that he will be discharged or retired from the service or that his disability is a certain percentage.

50. Records sent to a physical evaluation board. When a case is referred to a physical evaluation board, all records pertinent to the case will be forwarded to the board by the most expeditious means available. Among the records to be forwarded are—

★*a.* Approved DA Form 8-118 (Medical Board Proceedings) with inclosure 1, SF 502

(Narrative Summary) and inclosure 2, SF 88 (Report of Medical Examination).

★*b.* Verified statement of service; except for:

(1) Officers serving on initial two-year active duty obligation when MPRJ (Military Personnel Records Jacket, US Army) is available, in which case copy of appointment letter showing acceptance date and copy of active duty orders will be used in lieu of statement of service.

(2) Enlisted members serving on initial period of service when MPRJ is available, in which case a reproduced copy of enlistment or induction record will be used in lieu of statement of service.

c. All clinical records, X-ray film, and other medical records, including those received from The Adjutant General, other service hospitals, and the Veterans Administration.

★*d.* DD Form 722 (Health Record).

e. A copy of instructions when medical board was convened by direction of higher authority.

f. For enlisted personnel, a reproduced copy of DA Form 20, Enlisted Qualification Record. When the member's current grade is Private (E-1), a statement will be included in the extract showing circumstances which preclude advancement to the grade of Private (E-2) under provisions of AR 600-200 and, when sentence of a court-martial is involved, whether remission action is contemplated.

g. A copy of the court-martial order, if the member has been sentenced to dismissal or punitive discharge, which has been suspended.

★*h.* DD Form 261 (Line of Duty and Misconduct Status) or DA Form 2173 (Statement of Medical Examination and Duty Status), if applicable (para 45*d*(1)).

★*i.* A statement indicating whether elimination proceedings are pending or charges are pending for which dismissal or punitive discharge may be adjudged by a court-martial, and describing their current status.

j. Application for expeditious discharge under provisions of chapter 9, AR 635-40, if appropriate.

k. Statement of election relative to request for continuance on active duty under the provisions of chapter 10, AR 635-40, and the member's application for such continuance, if he elected to apply.

★*l.* Affidavit of retention beyond tour of active duty or ADT, if applicable (para 4*m*(3)).

m. In cases where the patient is not on extended active duty, a copy of the orders which ordered him to active duty, active duty for training, or inactive duty training; or a copy of the order rehospitalizing the patient, pursuant to paragraph 15, AR 135-200.

n. In mentally incompetent or deleterious type cases, a statement showing: Name, address, and relationship of next-of-kin (or court appointed guardian); whether he (or she) has been advised that the case is being referred to a PEB. If the next-of-kin is not known or cannot be located and there is no court appointed guardian, a summary of attempts to identify or locate him (or her) will be provided.

o. Copy of request for VA hospital bed designation, if appropriate.

p. Copy of orders moving patient to a VA hospital for continued hospitalization, if appropriate.

q. Copy of letter(s) to appropriate State authorities for disposition of psychotic members who are not eligible for VA hospitalization, as applicable.

★*r.* A copy of the action taken by the appropriate Courts-Martial authority when member's case has been processed in accordance with paragraph 1-4, AR 635-40.

51. Elections concerning physical evaluation board procedures and counsel. Rescinded.

52. Request for previous medical and other essential records. *a. Records in Headquarters, Department of the Army, files.*

(1) DD Form 877 (Request for Medical/Dental Records and Other Information) will be used to obtain medical records when these records are required for any purpose other than processing for appearance before a physical evaluation board.

★(2) DA Form 261 (Request for Records and Official Statement of Service from The Adjutant General) will be submitted as soon as it has been determined that a member may be scheduled for disability evaluation. (For exceptions, see paragraph 50*b*.) The verified copy of statement of service when received will be furnished to the PEB Liaison Officer for use in counseling the member and thereafter included in the records when forwarded to the PEB. Instructions on the initiation of this form are contained in *e* below. Airmail ordinarily will be used to transmit this request, except when circumstances necessitate use of telephonic or electrically transmitted message.

(*a*) Requests for records of commissioned and warrant officers on active duty will be addressed to The Adjutant General, ATTN: AGPF-F, Department of the Army, Washington, DC 20315.

(*b*) Requests for records of enlisted personnel on active duty will be addressed to the Commanding Officer, U.S. Army Enlisted Personnel Support Center, ATTN: AGPE-F, Fort Benjamin Harrison, IN 46249.

(*c*) Requests for records of Reserve component personnel not on active duty, will be addressed to the Commanding General, U.S. Army Administration Center, 9700 Page Boulevard, St. Louis, MO 63132.

★(3) When circumstances necessitate use of telephonic or electrically transmitted messages in the interest of expediting the processing of the case, request for the member's medical records and a verified statement of service will be transmitted to The Adjutant General, ATTN: AGPF-OR, for officers and warrant officers (AUTOVON 22-21849); AGPE-R for enlisted personnel (AUTOVON 239-3481); or to the addressee in (2)(*c*) above for Reserve component personnel (AUTOVON 698-7733 or 7734) stating:

PEB action pending for (Name, Grade, and Social Security number). Lend medical/clinical records. Member claims prior service in Army, Navy, Air Force, Marine Corps, Coast Guard, or _____ National Guard from _____ to _____, under service number (or Social Security number) _____.

(4) The Office of The Adjutant General, or other custodians of records indicated above, will withdraw all available requested records and forward them together with a verified statement of service by airmail to the requesting hospital. All records so obtained will be forwarded with the medical board proceedings when the case is referred to a physical evaluation board. The same records will accompany the proceedings of the physical evaluation board when they are forwarded for review to the Department of the Army.

★*b. Records held by service hospitals.* Request for records will be sent direct to the hospital concerned and will include dates of hospitalization and register numbers if known. Hospitals receiving such requests will expedite forwarding of all available original medical records. If the records requested are no longer on hand, the request will be forwarded to the activity to which the records were forwarded and the requesting activity informed of the referral.

c. Records held by the Veterans Administration.

(1) Requests for medical records from the Veterans Administration will be forwarded direct to the VA Regional Office or field station known to have custody of the veteran's file (claims or insurance).

(2) When only records from a VA hospital are desired, the request may be forwarded direct to the VA hospital concerned, if known.

(3) Requests for records when the location of the VA custodian is not known will be forwarded to: Veterans Administration Central Office, Office Operations Service (034A1), Washington, DC 20420.

(4) All requests for records and/or abstracts of records data will include the name of the member; all available VA file numbers (claims and insurance); service numbers or SSN; the official purpose for which the records are requested; and the complete address of the installation to be furnished the records.

(5) The Veterans Administration will usually furnish original VA clinical records

and/or X-ray film in response to specific requests. If the clinical records or X-ray film cannot be released, however, copies of the final summaries of clinical records and X-ray facsimiles may be made and released instead.

(6) When the requested original records have served their purpose, they will be returned direct to the VA installation which forwarded them. When the patient's case is not considered by a PEB, the records will be returned to the VA by the hospital. When the patient's case is considered by a PEB, the records will be returned to the VA by the hospital after final determination has been made in the case by the Department of the Army. In these cases, any original records received in Headquarters, Department of the Army, with PEB proceedings will be returned to the hospital for disposition. Copies or facsimile reproductions will not be returned unless specifically requested.

d. Action taken by the hospital upon transfer of a patient. If the patient is transferred to another hospital before receipt of requested records, the hospital commander may request that the records be forwarded to the hospital to which the patient has been transferred, or he may await receipt of the records and immediately forward them to the patient's new location. In any event, the commander of the losing hospital will notify the commander of the gaining hospital of the actions taken and the results obtained with respect to the procurement of the records. Copies of negative responses will be forwarded to the gaining hospital for submission to the PEB.

★*e. Completion of DA Form 261.* DA Form 261 must be completed in accordance with the following instructions:

(1) *Item 1.* If the individual has only a middle initial, it will be used. If there is no middle name or initial, no entry will be made under "middle name." If the individual claims prior service in the Army or another service under another name, the other name will be shown in parentheses.

(2) *Item 2a.* Show all service numbers. In the case of members claiming prior service in another service, it is important that the service number be ascertained from the member and shown in item 2a. It may be necessary to procure medical records from the service concerned. Such service will also have to be verified for longevity purposes. Availability of service number will expedite identification of the individual to the service concerned, thereby expediting procurement of medical records and verification of service.

(3) *Item 2b.* Enter Social Security number as recorded on personnel records.

(4) *Item 3.* Enter the member's current grade from the official reports. If current records are not available, explain basis of entry in item 19.

(5) *Item 4.* Enter branch and component of member at the time of request for records.

(6) *Item 5.* Enter designation of organization to which member was assigned immediately prior to hospitalization.

(7) *Item 6.* Include the official name of the medical facility requesting the records and the post office address of such facility.

(8) *Item 7.* Date will be that on which request for records is dispatched from the hospital.

(9) *Items 8 through 12.* Leave blank.

(10) *Items 13 and 13a.* Self-explanatory.

(11) *Item 14.* Enter inclusive dates of time lost during current period of service. If an individual was discharged from a previous enlistment and the service record was continued in his current enlistment, this item, and item 15 will include information regarding all service covered by the service record.

(12) *Item 15.* All grades held by member during his current period of active service, to include dates of promotion and/or reduction, if any. When a reduction in grade has occurred, include a statement giving the specific reason and authority for reduction. In all cases in which the member's current grade is Private (E-1), include a statement showing circumstances which preclude the member's advancement to Private (E-2) under AR 600-200.

(13) *Item 16.* If records are not available, information regarding highest grade may be obtained from the patient.

(14) *Item 17.* This question must be

answered so that reference to any former Army retiring board or physical evaluation board action may be checked against present diagnosis.

(15) *Item 18.* Include names and locations of hospitals and dates of hospitalization during current episode of treatment in order that necessary medical and/or clinical records may be located without delay.

(16) *Item 19.* Enter any remarks pertinent to other items. If additional space is needed, a separate sheet of paper may be attached.

(17) *Item 20.* The officer responsible for preparation of the request for records will sign the original.

53. Veterans Administration Physicians Guide—Disability Evaluation Examinations and Veterans Administration Schedule for Rating Disabilities. Medical officers whose responsibilities include the preparation of cases for eventual presentation to physical evaluation boards will be familiar with the Veterans Administration Physicians Guide—Disability Evaluation Examinations and the Veterans Administration Schedule for Rating Disabilities, and insure that the information and terminology recorded adequately describes severity so as to permit the establishment of disability percentage ratings. Requests for either publication will be forwarded with justification through channels to HQDA (DASG-ASR).

54. Types of disposition for members of the Army. *a. Full duty.* Patients who meet retention medical fitness standards and are medically fit to perform duty without restrictions or assignment limitations will be returned to full duty. This type of disposition may be made by the attending medical officer or upon the approved recommendation of a medical board. Disposition to *full* duty from a duty status involving duty or assignment restrictions can be made only if based on approved medical board recommendations.

b. Temporarily restricted duty. Patients who meet retention medical fitness standards and who are considered medically fit to perform useful duty while recovering from sickness or injury will be placed on temporarily restricted duty. Such patients will be evaluated at least once every 3 months with a view to upgrading their duty status. No individual may be in a temporarily restricted duty status for more than 12 months. This type of disposition involving a total of 3 months or less normally should be made by the attending medical officer. Return to full duty from a temporarily restricted duty status imposed as a result of a medical board can be made only if based on approved medical board recommendations.

c. Trial duty. Patients whose medical fitness for retention and performance of useful duty is problematical may be recommended for trial duty by a medical board. No individual may be on trial duty without being evaluated at least once every 3 months with a view to upgrading his duty status or separating him from the service, if appropriate. Individuals will not be retained on a trial duty status for more than 12 months without prior approval of Headquarters, Department of the Army.

d. Duty with permanent assignment limitations. Patients who meet retention medical fitness standards and who are fit to perform useful duty with specific permanent assignment limitations will be recommended for duty with permanent assignment limitations by a medical board. Individuals who do *not* meet retention medical fitness standards and who are recommended for continuance on active duty as outlined in AR 635-40 will have their permanent assignment limitations identified by the medical board processing the case for continuance on active duty.

e. Duty for separation or separation recommended.

(1) Patients who meet retention medical fitness standards and who are *scheduled* for any administrative separation or retirement, including separation for administrative unfitness, will be returned to duty for separation. This type of disposition may be made by either the attending medical officer or by the commander based on medical board recommendations.

(2) Patients who do not meet retention medical fitness standards, do not require active hospitalization, and who are eligible for and elect separation for a condition existing prior to service which has not been aggravated by such service will be processed as outlined in chapter 9, AR 635-40. This type of disposition can be made only on medical board recommendation.

(3) An enlisted patient who meets retention medical fitness standards (chap. 3, AR 40-501) but did not meet procurement medical fitness standards (chap. 2, AR 40-501) when accepted for

induction or initial enlistment will be processed for separation on the recommendation of an approved medical board if he applies for separation within the time limit prescribed in paragraph 5-9, AR 635-200. If he declines to apply for separation, and his erroneous entry into the service was discovered within the time limit stated in AR 635-200, he must sign a statement acknowledging that he has been informed of his right to apply for such separation but declines to do so, and desires to complete the term of service for which he enlisted or was inducted. The statement will become a permanent part of his personnel records.

(4) Patients who meet retention medical fitness standards but are considered administratively unfit for further military service, will be returned to duty with separation recommended under the appropriate administrative regulation. This type of disposition may be made by either the attending medical officer or by the commander based on medical board recommendations.

f. Transfer to another medical treatment facility (para 3.1*m*). This type of disposition may be made by either the attending medical officer or the commander. (See para 70 for transfer to VA facility.)

g. Referral to a physical evaluation board. The following personnel will be referred to a physical evaluation board:

(1) All members who do not meet medical fitness standards for retention or whose fitness is questionable, including members who have two or more impairments which individually are not unfitting, but which together cause sufficient disability to make fitness for military service questionable; and those with latent impairments of such significance as to raise a question of post-separation or retirement fitness should be considered for separation or retirement under paragraph 3-36*c*, AR 40-501, including those who apply for continuance on active duty under the provisions of chapter 10, AR 635-40.

★(2) Members on the TDRL:

(*a*) Following completion of the first periodic medical examination and medical board after placement on the TDRL.

(*b*) Who have improved so that they may be physically fit, or

(*c*) Who have stabilized so as to permit final disposition, or

(*d*) When periodic examination is performed within 1 year of the fifth anniversary of placement on the TDRL.

(3) Cases where referral is directed by Headquarters, Department of the Army.

h. AWOL. When a patient absents himself without leave and remains in an AWOL status for 10 consecutive days his medical records will be closed. This type of disposition is made by the attending medical officer.

i. Death.

55. Types of disposition for nonmilitary patients. *a.* Discharge from hospital when the patient is released to own custody or custody of the sponsor or next of kin, or other authorized individual. (Appointments or instructions for followup treatment, if required, are initiated by the attending medical officer.)

b. Transfer to another medical treatment facility (para 3.1*m*).

c. Absent without release when the patient departs without proper release or is otherwise unaccounted for.

d. Release against medical advice when the patient and/or his sponsor signs an appropriate release.

e. Death.

56. Members of the Reserve component on active duty for training pursuant to orders which specify a period of 30 days or less, members of the Reserve components participating in Reserve duty training, and members of the ROTC on training tour. *a. Evaluation by medical board.* When an individual in one of these categories is considered medically unfit

for duty upon completion of hospitalization, he will be evaluated by a medical board prior to release from the hospital. Patients requiring hospitalization beyond the termination of their tour of duty will be evaluated for disposition within the following time limits:

(1) *Conditions not in line of duty.* At the earliest practicable time that the patient becomes transportable.

(2) *Conditions in line of duty.* As early as the patient requests release from the hospital or when the patient attains maximum hospital benefits.

b. Procedures following approved medical board action.

(1) Reserve component patients medically unfit for further active duty or training as result of injury incurred or aggravated during a period of active duty for training or Reserve duty training will be referred to a physical evaluation board.

(2) Reserve component/patients who are medically fit for further active duty or training will be released from the hospital.

(3) For special procedures affecting ROTC members, see AR 145-1. Disposition normally will be release from the hospital except as provided in (4) below.

(4) When it is determined that a patient does not require further hospitalization in an Army hospital and does not qualify for physical disability processing by a physical evaluation board, the patient will be released from the hospital or transferred to a nonmilitary medical facility. Arrangements for such transfer will be made by the hospital commander in the case of USAR and ROTC personnel, and with the assistance of the adjutant general of the State concerned in the case of National Guard personnel. When appropriate arrangements cannot be made after reasonable endeavor, the case will be reported through the Army commander, the Commanding Officer, U.S. Army Records Center, St. Louis, Mo., or the Chief, National Guard Bureau, as appropriate, to The Surgeon General, ATTN: MEDDD-OH, for disposition instructions. Cases so reported will include a summary of all actions taken; two copies of the medical board proceedings; a summary of all Federal service claimed by the individual, if any, including the dates of such service; the address of the patient's home of record; line-of-duty status; recommendations of the hospital commander; and copies of any pertinent correspondence.

c. Notification of disposition and separation.

★(1) When a member of the Army Reserve or ADT or Reserve duty training or the Reserve Officers' Training Corps is released from the hospital, the CONUS army commander concerned, or the Commanding General, U.S. Army Administration Center, St. Louis, Mo., as appropriate, will be notified of the date and type of disposition and, in those cases where medical board proceedings are required, will be furnished two copies of the proceedings.

(2) When a member of the National Guard on ADT or Reserve duty training is released from the hospital, the adjutant general of the State concerned will be furnished the information and documents specified in (1) above.

(3) Members of the Reserve components will be separated from their status in their respective component by action of the hospital commander when appropriate. Members of the Reserve Officers' Training Corps will not be separated from their status by action of the hospital commander without approval of higher authority as provided in AR 145-120.

d. Letter of instruction in special cases. In some instances a member of a Reserve component may be returned to his home in a convalescent status pending final determination of medical fitness for military service. Such member, upon release from the hospital, will be provided with a letter of instruction which will reflect—

(1) Diagnosis of disease or injury and line-of-duty determination.

(2) Date, time, place of disease or injury, status of member, and authority for status.

(3) Approximate period of convalescence.

(4) The medical treatment facility or physician to whom to report for—

(*a*) Followup care (e.g., removal of cast).

(*b*) Final determination of medical fitness for military service.

(*c*) Determination of date of return to "full," "temporarily restricted" or "trial" military duty status.

57. Prisoner patients. *a.* One or more of the following recommendations for disposition of prisoner patients whose sentence includes punitive discharge or dismissal will be made.

(1) Return to confinement to serve remainder of sentence. This recommendation is to be made when it is found that the condition for which a prisoner was hospitalized is in a satisfactory state of remission and/or control (whether or not he meets retention standards unless return to confinement will medically compromise his health or well-being or prejudice the interests of the Government). In appropriate instances a medical board will recommend assignment limitations. A copy of the approved board proceedings will be transmitted to the appropriate confinement officer. A covering letter may be sent to clearly identify any aspects of confinement which will medically affect the prisoner.

(2) Transfer to an Army specialized medical treatment facility provided further treatment may result in substantial improvement.

(3) Remission of sentence by the Secretary of the Army, or change in type of discharge, concurrent with transfer to a VA hospital or State institution, or release to care of next of kin or to own care. (Transfer to a VA hospital will be accomplished only when the punitive discharge or dismissal from service is under other than dishonorable conditions.)

(4) Transfer to a VA hospital or State institution upon expiration of sentence. (Transfer to a VA hospital will be accomplished only when the punitive discharge or dismissal from service is under other than dishonorable conditions.)

(5) Transfer under the provisions of AR 633-5 to a Federal confinement facility having medical or psychiatric treatment facilities.

b. When a medical board recommends disposition of a prisoner by action which would require remission of sentence, change of type of discharge or transfer to a Federal confinement facility, the original and duplicate of the medical board proceedings will be forwarded for consideration and necessary action through The Surgeon General, ATTN: MEDPS, to the authority prescribed in (1) or (2) below.

(1) Recommendations affecting prisoners carried on the rolls of a U.S. disciplinary barracks; recommendations for transfer to a Federal confinement facility, irrespective of the prisoner's place of confinement; and recommendations for substitution of an administrative form of discharge for a discharge of dismissal executed in accordance with the sentence of a court-martial, irrespective of the prisoner's place of confinement, will be forwarded to The Provost Marshal General, ATTN: PMGK, Washington, DC 20315.

(2) Recommendations other than those specified in (1) above will be forwarded to the officer exercising general court-martial jurisdiction over the prisoner.

c. A prisoner hospitalized beyond the expiration of his sentence to confinement will be carried by the Army medical treatment facility as an Army patient if his punitive discharge or dismissal has not been accomplished. If discharge or dismissal from the Army has been accomplished and his sentence to confinement has expired, the prisoner will be carried by the Army medical treatment facility as a pay patient until his disposition can be effected (para 21*c*).

d. The commandant of the disciplinary barracks or the installation commander, if the place of confinement is other than a disciplinary barracks, is responsible for administrative control of the prisoner. He may in cases of early expiration of sentence, and upon request of the medical treatment facility commander, administratively forfeit good conduct time pursuant to AR 633-30, to permit final action in the case before the prisoner's sentence to confinement expires.

e. A prisoner will not receive a disposition other than to an Army medical treatment facility if he is eligible to meet a physical evaluation board in accordance with AR 635-40.

f. In the event a prisoner is not eligible for restoration to duty for service because of some mental disability which arose subsequent to his confinement and his service and military record is such that, but for such disability, it appears reasonably certain that he would have been restored to duty by the Secretary of the Army with an opportunity to earn an honorable discharge, the Secretary of the Army may substitute an administrative discharge for a discharge or dismissal executed in accordance with the sentence of a court-martial. Similar action also may be taken where it appears after trial that, at the time of his offense, a prisoner was not mentally responsible for his acts under accepted legal standards. Recommendations for such action will be forwarded as outlined in *b* above.

g. Information copies of correspondence regarding disposition of prisoner patients will be furnished the commandant of the disciplinary barracks or installation commander, as appropriate.

58. Terminal case. Rescinded.

★58.1. Sanity boards. A sanity board is a board of one or more medical officers (preferably three) convened pursuant to paragraph 121, Manual for Courts-Martial, U.S. 1969 (Revised Edition), to inquire into the mental condition of an accused before trial. Findings of the sanity board concerning the sanity of the accused will be submitted to the commander who convened the board in letter form, including specific answers to the three questions set forth in paragraph 121, Manual for Courts-Martial.

59. Psychoneurotic patients. *a.* In general, treatment under hospital conditions is not of benefit to psychoneurotic patients. To the maximum extent possible, neurotic reactions will be diagnosed and treated on an outpatient basis.

b. In a large percentage of cases, treatment or clarification and possibly removal of situational pressures will result in the cessation of neurotic symptomatology, leaving only the basic substrata of a personality or character defect. Since personality and character defects fall within the group of character and behavior disorders, military patients manifesting these conditions are candidates for disposition under the provisions of AR 635-100 or AR 635-212, if separation is indicated. Such cases will be referred to a medical board only when the professional or administrative factors are complex.

60. Psychotic patients. *a.* At facilities not designated as specialized treatment centers for psychiatry, when the preponderance of available clinical evidence indicates the presence of a psychosis in a military patient and treatment, observation, or evaluation for a period in excess of 30 days is indicated, transfer to a facility designated as a specialized treatment center for psychiatry normally will be accomplished within 30 days of the date of admission, except as provided in *c* below.

b. At facilities designated as specialized treatment centers for psychiatry, cases of psychosis ordinarily will not be held for prolonged periods of observation to determine the permanency of the disability. An evaluation of response to treatment will be made as soon as practicable after a definite diagnosis has been established. In those cases where treatment has not resulted in substantial improvement, disposition will be made as expeditiously as practicable. Intensive treatment for a period of under 180 days in the majority of cases will be sufficient to establish the degree of disability and provide optimum hospital benefits.

c. In cases of military prisoners where, as a result of detailed psychiatric evaluation, it is determined that treatment in an Army hospital having specialized neuropsychiatric facilities would not result in substantial improvement, or that further evaluation and observation is not warranted, the prisoner patient will be examined by a medical board convened at the place of confinement for consideration of appropriate disposition.

d. It is a commander's responsibility to exercise all reasonable measures available for the protection of the personal affairs of the psychotic as well as for other members of his command. Legal assistance officers will be

contacted for counsel and advice. A psychotic soldier, despite his mental illness, may be sufficiently competent to execute a legally acceptable power of attorney or other instrument authorizing another person to act in his behalf in the sale or other disposition of personal property, the collection of debts, and the settlement of all legal obligations and claims. Mental incompetency may vary in degree and in relation to specific situations. Opinion as to competency will be obtained from a psychiatrist in regard to specific situations arising in the settlement of personal affairs.

61. Examination of members on the temporary disability retired list (TDRL). *a.* An individual placed on the temporary disability retired list is required by law to undergo a medical examination at least once every 18 months during the 5-year period after the date of placement thereon to determine whether his disability has stabilized. Proceedings of the physical evaluation board and all medical records available in The Adjutant General's Office are forwarded to the medical treatment facility selected to accomplish this examination.

b. Except where hospitalization is essential to the proper conduct of the examination, individuals will be evaluated on an outpatient basis and not admitted to the hospital. One or more medical officers will conduct the examination. The advice of professional consultants will be obtained whenever indicated. This may include the referral of all medical records to a specialized treatment facility for review and recommendations. The findings of the attending medical officer(s) will be considered by a medical board when appropriate (para 42*h*) which may recommend one of the following:

(1) Retention on the temporary disability retired list when the condition of the individual has not stabilized sufficiently to permit final determination. In these cases include the date of the next periodic medical examination.

(2) Reevaluation by a physical evaluation board when—

(*a*) The examination is conducted within 9 months of the fifth anniversary of the individual's placement on the TDRL.

(*b*) The disability has stabilized.

(*c*) The disability has improved to the extent that the member may meet retention medical fitness standards.

c. If the recommendation of the medical board is "retention on the TDRL," the approved medical board proceedings will be forwarded to The Adjutant General, ATTN: AGPO. If reevaluation by a physical evaluation board is recommended, the case will be forwarded to the appropriate physical evaluation board, together with medical records secured from The Adjutant General, the Veterans Administration, and other sources. Physical profile will not be included in examinations of TDRL members.

d. Advice of professional consultants will be obtained in all cases involving members who were placed on the TDRL because of tuberculosis. All medical records and x-rays will be forwarded for review to either Fitzsimons General Hospital or Valley Forge General Hospital. Patients previously treated or who have had their records previously reviewed at either hospital will have their records forwarded to that hospital for review; otherwise these records will be forwarded to the nearer of these hospitals. Records and x-rays concerning the current examination will include the following:

(1) A member's statement concerning date(s) and place(s) of any hospital or outpatient treatment for any cause since his last examination.

(2) Pertinent x-ray examinations, including chest x-rays.

(3) A completed report of medical examination (SF 88).

(4) Laboratory studies and the results of three cultures of sputum or gastric contents for M. tuberculosis (or urine cultures in cases of genitourinary tuberculosis).

(5) A recommendation for disposition of the member.

★*e.* The reviewing facility will report its findings and recommendations to the referring facility except for those instances cited in *b*(2) above. In those instances the Commanding General, Fitzsimons General Hospital or Valley Forge General Hospital, acting for The Surgeon General as prescribed in paragraph 7–4*c*(3), AR 635–40, will prepare his findings and recommendations in the form of an addendum to the medical board proceedings that were part of the PEB action placing the individual on the TDRL. The records will be forwarded through The Adjutant General, ATTN: AGPO–RT, to the physical evaluation board as indicated in table 1, AR 635–40.

62. Continuance on active duty of partially disabled personnel. Individuals (except general officers) who appear to be unfit for retention (chap. 3, AR 40–501) should be informed that they may apply for continuance on active duty under the provisions of chapter 10, AR 635–40. Continuance on active duty under this program is not a right. Each case is individually considered and an application is approved at Headquarters, Department of the Army, if the individual can perform an essential service in spite of his unfitness without further aggravating his condition.

a. A medical board which plans to recommend referral of a member to a physical evaluation board will consider whether the member is medically qualified for continuance on active duty in his current MOS, either primary or a secondary, or in another field for which the member might be readily trainable. The purely medical considerations for continuance on active duty are—

(1) The nature and degree of the medical condition or physical defect in terms of the effect on the individual's health and well-being if he remains on active duty.

(2) The ability of the member to maintain himself in a normal military environment.

(3) The prognosis for completing at least 20 years of useful military service without undue loss of time from duty for hospitalization or medical treatment.

b. If the medical board finds that the member meets the medical criteria stated above, appropriate assignment and duty limitations will be recorded on the DA Form 8–118. (These limitations may preclude the member from performing in his MOS and require later reclassification as provided in administrative regulations.) The medical board will also record a physical profile appropriate to the member's condition on the Standard Form 88 attached to the DA Form 8–118. Rules for profiling are set forth in AR 40–501.

c. After the action of the medical board has been approved, the member will be referred to the Physical Evaluation Board Liaison Officer (PEBLO) for counseling before his case is forwarded to the PEB for action under AR 635–40.

d. When a member who has been continued on active duty as provided in AR 635–40 undergoes his periodic physical examination (AR 40–501) particular consideration will be given to his unfitting defect; whether there has been any change or whether the condition has significantly affected his performance of duty. If his potential for further continuance on active duty appears to have been lowered or is otherwise questionable, a medical board will again consider his medical qualification for continuance.

e. A member who has been continued on active duty under this program must be evaluated by a medical board prior to final separation or retirement from the service. His present condition will be carefully described in complete detail and his case will be referred to a PEB for consideration. Such a member is entitled to evaluation by the medical board and the PEB under the standards in effect when he was originally "continued on active duty" or at time of final evaluation, whichever set is more favorable to him as he elects. Medical board and PEB considerations are necessary even though the member may have been cured. In such a case, the member would not, of course, be considered unfit because of physical disability since no disability exists. The foregoing statement is explanatory and may not be used as a rule to deny consideration of a member's case in the circumstances described.

63. U.S. Navy and U.S. Air Force patients. *a.* When administrative units of the United States Navy or Air Force are stationed at CONUS Army medical treatment facilities, the disposi-

tion of naval or air military personnel is the responsibility of the parent service unit.

b. When no administrative detachments of the other Armed Forces are stationed at a CONUS facility, disposition of naval and air military personnel will be effected as follows:

(1) When the patient is fit for duty he will be returned to his assigned organization and station. If the patient's organization or station is not known, assignment instructions will be requested from the parent service. In addition, for naval personnel, requests will be made if the patient has been hospitalized more than 30 days. Requests will be addressed to—

(*a*) *For Navy and Marine Corps personnel:* The Commandant of the Naval District in which the medical treatment facility is located.

(*b*) *For Air Force personnel:* Chief of Staff, U.S. Air Force, Washington, DC 20310.

(2) When the patient is not fit for duty, he will be reported for transfer to a medical treatment facility having final disposition authority through normal medical regulating channels.

c. Major oversea commanders will prescribe disposition procedures for Navy and Air Force patients hospitalized in oversea medical treatment facilities.

d. Special problems not provided for above will be reported to The Surgeon General, ATTN: MEDDD-OH for necessary instructions.

64. Patients of NATO, SEATO, CENTO, and ABCA nations. *a.* In accordance with ratified agreements with the NATO (STANAG 2061), SEATO (SEASTAG 2061), CENTO (CENTO STANAG 2061), and ABCA (SOLOG 66) nations, patients who are members of the military forces of these nations will be transferred to their own national organization at the earliest practicable opportunity consistent with the observance of the principle that

the medical welfare of the patient is paramount and that arrangements for disposition of such patients should be capable of being implemented within existing organizations and under any of the following conditions:

(1) When a medical facility of their own nation is within reasonable proximity of the facility of the holding nation.

(2) When the patient is determined to require hospitalization in excess of 30 days.

(3) When there is any question as to the ability of the patient to perform duty upon release from the hospital.

b. The decision as to whether a patient, other than those requiring transfer under *a* above, is fit for release from the medical treatment facility is the responsibility of the commander of the medical facility treating the patient.

c. All clinical documents, to include X-rays, relating to the patient will accompany him on transfer to his own national organization.

d. The decision of suitability for transfer and the arrangements for transfer will be the responsibility of the commander of the medical treatment facility. Final transfer channels should be arranged by local liaison before actual movement.

e. Patients not suitable for transfer to their own national organization must be dealt with for treatment and disposition purposes as Army military patients until they are transferred, i.e., they will be dealt with either in military hospitals or in civilian hospitals that are part of the military medical evacuation system of the U.S. Armed Forces.

f. Patients not requiring admission to a medical unit will be returned to their nearest national organization under arrangements to be made locally.

65. Foreign military patients from other nations. Such individuals for whom no specific disposition instructions were furnished at the time of admission will be reported to The Surgeon General, ATTN: MEDMI-F, for disposition instructions.

66. Further disposition policies for certain other nonmilitary patients. *a.* Dispositionn policies pertaining to beneficiaries of the Veterans Administration are contained in paragraph 12.

b. Disposition policies pertaining to beneficiaries of the Bureau of Employees' Compensation are contained in paragraph 13.

67. Recommendation for change of duty or station. United States military patients with physical defects or medical conditions which warrant a change of duty or change of station will be processed by a medical board. It is a medical responsibility either to evacuate or to advise the patient's unit commander of the necessity of change of duty or change of station for medical reasons. Under no circumstances will the patient be given a statement or certificate and told to apply for a transfer or change of assignment by reason of his physical defect or medical condition.

68. Nonmilitary patients mentally ill in a foreign country. *a.* United States military commanders in foreign countries have no authority under either domestic law or rules of customary international law to evacuate nonmilitary patients involuntarily from foreign countries. This lack of authority extends to forcible evacuation in medical emergency cases, e.g., where the patient is mentally ill to an extent that he is dangerous to himself and others. The involuntary evacuation to CONUS or some other country of nonmilitary patients will be effected only when their removal has been authorized by competent authorities of the host government. In cases of persons serving with, employed by, or accompanying the Armed Forces or a Federal agency outside the Department of Defense, the above authorizations should be obtained as a result of a request by or with concurrence of the service or agency concerned.

b. Prior to the evacuation to CONUS of a nonmilitary patient hospitalized for diagnosis or treatment for a mental condition, the oversea commander, if there is a sponsor involved, should determine whether or not the sponsor will depart for CONUS at approximately the departure date of the patient and whether the sponsor intends to proceed immediately to the

hospital receiving the patient. The sponsor will be advised of the provisions of *d* below. On the basis of this information the hospital commander will, prior to the actual departure of the patient, assure that sufficient information is recorded in the medical records so that the receiving hospital may secure the necessary assistance for handling reasonable eventualities. This should include the names, addresses, and telephone numbers of interested responsible relatives or friends who may, in the event of emergency, either assist in locating the sponsor or act in his behalf in accordance with *e*(1) below. The medical evacuation of the patient should be coordinated with the oversea commander in order to expedite the evacuation and avert potential difficulties. A nonmilitary person who has been ordered removed as described in *a* above may not be evacuated involuntarily unless he is delivered to United States control at the port of embarkation by competent authorities. In no event, however, will non-U.S. nationals be involuntarily evacuated between countries pursuant to this paragraph unless such evacuation is required by a treaty or agreement with the host government and the non-military patient to be evacuated is delivered to United States control by the receiving State authorities at the port of embarkation.

c. The Commanders in Chief, U.S. Army, Europe and U.S. Army, Pacific and Commander U.S. Army Forces Southern Command will seek through the appropriate foreign service establishments of the United States to conclude agreements or understandings with appropriate foreign authorities concerning procedures to be followed in connection with the foregoing. Requests for instructions as to exceptional cases should be forwarded to The Surgeon General, ATTN: MEDAS-L.

d. The time of departure of the sponsor from the oversea area is within the jurisdiction of the major oversea commander (AR 614-30). Depending upon whether the sponsor departs at about the time of the patient's departure or at some later date, the major oversea commander will take the following actions:

(1) In those cases where the sponsor departs the oversea command shortly before, with, or shortly after the evacuation of his dependent, he will be advised to report to the CONUS Army hospital with the *least practicable delay after his dependent's arrival at the CONUS Army hospital.* A statement indicating the sponsor's understanding of his responsibilities should be prepared for his signature, indicating his present duty station, his expected leave address upon arrival in CONUS and, in those cases where such information is available, the next duty station of assignment within CONUS. A copy of this statement should also be furnished the commander of the oversea hospital and incorporated in the medical record of the patient.

(2) In the event the determination is made for the military sponsor to proceed to CONUS at a date subsequent to evacuation of his dependent, the major oversea commander will notify the commander of the Returnee Reassignment Station in CONUS of the sponsor's date of departure, mode of travel, port of entry, and expected time of arrival in CONUS and request the appropriate hospital commander in CONUS be so advised. The commander of the Returnee Reassignment Station processing the sponsor upon arrival in CONUS will also be requested to notify the hospital commander in CONUS of the date the sponsor departs the station and the expected time of arrival of the sponsor at the hospital, including information regarding leave or delay en route and the address where the sponsor may be reached prior to arrival at the hospital. The sponsor must be advised to notify promptly the hospital commander by telegram of any change occurring in his leave address or expected time of arrival at the hospital. The sponsor will supply the statement described in (1) above. He will also designate in writing, the name, address, relationship, and, if possible, the telephone number of one responsible, interested relative. He will indicate also that he has made appropriate arrangements with that individual to take necessary actions on behalf of the sponsor. This individual should be willing, if possible, to go to the installation in CONUS at which the patient is finally hospitalized to assist if necessary. A copy of these statements will be provided the commander of the oversea hospital for inclosure in the patient's medical record.

e. Disposition of nonmilitary psychotic.

(1) The patient may, after arrival in CONUS, withdraw the request for hospitalization and demand release from the hospital. Disposition will ordinarily be made to appropriate civilian authorities or, with the approval of such authorities, to the sponsor or next of kin as may be indicated. When a psychotic nonmilitary patient requires further hospitalization, the medical treatment facility commander will communicate with the sponsor or next of kin to ascertain whether the relative wishes to assume the custody and responsibility for the care of the patient. In each case, the relative will be fully advised of the facts which render acceptance of the patient inadvisable and of the difficulty and responsibility in the care of such patient. The relative who elects to receive the patient will be required to produce satisfactory evidence that proper care will be furnished. This evidence should be in the form of an affidavit from the sponsor or next of kin declaring that he or she is willing to assume responsibility for the patient and has the necessary financial means to provide adequate care and treatment.

(2) When transfer to the next of kin is inappropriate, the medical treatment facility commander will communicate with the appropriate civilian authorities of the State of residence for the purpose of obtaining authorization to transfer the patient to their custody. The addressees of the appropriate civilian authorities are listed in appendix I.

(3) In order to aid the civilian agencies in arriving at a decision with the least practicable delay, they should be given information as to the diagnosis, the date of onset of the condition, history of previous hospitalization for mental illness, residence, place and date of birth, race, and name and address of the next of kin.

(4) Inasmuch as commitment proceedings or laws for involuntary hospitalization vary among the States, appropriate personnel of Army medical treatment facilities should be thoroughly familiar with local requirements for emergency involuntary admission to or retention in local civilian facilities designated for the care of the psychotic or mentally ill.

69. Final disposition procedures for military patients. *a. Patients who are fit for duty.* Patients who are fit for duty will be returned to duty as soon as possible. Attached military patients will be returned to their units of assignment. Individuals assigned to medical holding units will be reported for reassignment in accordance with instructions in paragraph 3.1*p* and *q*.

b. Patients who are unfit for duty. Patients who are assigned to medical holding units will be processed for separation as appropriate by the transfer point which supports the medical facility. Patients who are not assigned to the medical holding unit will be returned to their units of assignment for separation action. The following additional instructions apply:

(1) Patients who meet retention medical fitness standards but do not meet procurement medical fitness standards will be disposed of as provided in paragraph 54 of this regulation and paragraph 5-9, AR 635-200.

(2) Patients who have been referred to physical evaluation boards and are approved for continuance on active duty as provided in chapter 10, AR 635-40, will be disposed of in compliance with instructions from Headquarters, Department of the Army.

(3) Patients who are being or have been processed through the physical disability evaluation system and who do not require active medical supervision, will be disposed of as provided in AR 635-40 or in compliance with instructions from Headquarters, Department of the Army.

(4) Patients who are being or have been

processed through the physical disability evaluation system, who require continued active medical supervision, and who are eligible, will be transferred to a Veterans Administration medical facility as soon as possible to await final physical disability processing action (para 70*a*).

(5) Patients who are being or have been processed through the physical disability evaluation system, who require continued active medical supervision, but who are NOT eligible for transfer to a Veterans Administration medical facility will be disposed of as soon as possible in accordance with instructions in paragraph 70*b*. Separation will be accomplished within 72 hours of receipt of instructions from Headquarters, Department of the Army to do so, and will not be delayed pending completion of disposition arrangements.

★*c. Retention of patients beyond tour of active duty or ADT.* Procedures for retention of patients whose period of service will expire while needing medical or dental care are contained in AR 135-200, AR 635-100, and AR 635-200.

70. Military patients requiring continued hospitalization after separation. When it is determined that a patient will require continued hospitalization after separation, the medical treatment facility commander will initiate action to accomplish disposition as follows:

a. Transfer to a Veterans Administration facility. If the patient had other than dishonorable service, an electrically transmitted message will be forwarded to the Armed Services Medical Regulating Office (ASMRO), Main Navy Building, Washington, D.C., for a bed designation in a Veterans Administration facility (AR 40-350).

★(1) A member being transferred from an Army medical treatment facility to a Veterans Administration facility for further hospitalization following physical evaluation board action will be ordered on PCS to such facility as provided in (3) below. The member will remain assigned to the medical holding unit for record purposes only and reports will be completed in accordance with AR 40-400, AR 40-417, AR 40-418, and AR 40-425. Patients transferred on PCS to a VA facility will not be charged leave during the period of such hospitalization, and will be entitled to transfer of dependents and shipment of household goods in accordance with the Joint Travel Regulations. Direct communication between the military medical treatment facility commander and the manager of the VA hospital is authorized in accomplishing the transfer of patients to VA hospitals.

(2) All requests to the VA for a bed designation will be made at the earliest date which will permit completion of processing within the period that the VA bed designation will remain in effect (normally 30 days). On receipt of a VA bed designation, the medical treatment facility commander will promptly forward a copy to the PEB which is processing the member's case. If any condition should arise which will prevent completion of processing or transfer of the patient within this period, immediate action will be taken to cancel or extend the VA bed designation through ASMRO.

(3) Action prior to transfer of patient to VA hospital:

★(*a*) Counseling as prescribed in AR 635-10. In cases of mentally incompetent patients, the individuals acting in their behalf will be counseled.

(*b*) The Adjutant General will furnish the appropriate separation certificates for Regular Army officers and *all* retirement certificates. Discharge certificates or certificates of service (AR 635-5) will be prepared for all other personnel.

(*c*) DD Form 214 will be prepared for all personnel in accordance with AR 635-5. If it is impracticable to secure the member's signature in item 34, the item will be left blank. No notation of any kind will be placed on the No. 1 copy of DD Form 214, or any other separation form which is presented to the member, to indicate that he is mentally or otherwise incompetent to sign.

(4) The patient will be transferred to the designated hospital following receipt of the notification from ASMRO of a bed assignment

in a Veterans Administration hospital. The time of transfer will be determined as follows:

★(*a*) When the findings of the physical evaluation board indicate that the patient will be permanently retired, placed on the TDRL or discharged, the patient will be transferred at the earliest practicable date following the announcement of such findings by the PEB, except that mentally incompetent patients may be transferred after completion of medical board action.

(*b*) When it is anticipated that a patient's hospitalization will be completed prior to the effective date of retirement or separation, the patient will not be processed for transfer to a VA facility.

(5) Due regard will be given to the availability and economical utilization of all Government transportation. Military Airlift Command (MAC) routine air evacuation will be utilized in making transfer whenever feasible. Arrangements for the transportation of patients to the Veterans Administration hospital will be made by the commander of the military hospital from which the patient is transferred.

(6) A request for medical treatment by the Veterans Administration will be completed in accordance with paragraph 76 for each patient who is transferred to a Veterans Administration hospital for treatment pending separation.

(7) In all cases in which the condition of the patient warrants an escort, he will be accompanied by an attendant (or attendants) during the transfer from the military hospital. Attendant, as used herein, includes medical personnel assigned to aeromedical evacuation flights.

(8) When an attendant accompanies a patient, the attendant will carry the records and documents listed below to the hospital to which the patient is transferred. When no attendant is necessary, the patient will carry a properly completed and authenticated copy of VA Form 10-P-10. Other pertinent records and documents listed below will be forwarded by certified mail prior to the departure of the patient.

(*a*) DD Form 675 (Receipt for Records and Patient's Property) in duplicate.

(*b*) VA Form 10-P-10. (Attach a copy of SF 502 to the back of the form and enter "See attached Summary" in item 47, VA Form 10-P-10, instead of completing the medical certificate thereon.)

Note. Only LOD—No cases will be required to complete Items 29 and 30 on page 1, and Items 35 to 44 inclusive on page 2 of VA Form 10-P-10.

(*c*) DA Form 8-267 (Request for Medical Care in a Federal Medical Treatment Facility Outside Department of Defense).

★(*d*) Copy of current clinical records, including Copy No. 7 of medical board proceedings.

(*e*) X-ray films, if any.

(*f*) Duplicate of statement on DA Form 664 (Serviceman's Statement Concerning Application for Compensation from the Veterans Administration (VA Form 21-526e)).

(*g*) VA Form 21-526e (Veterans Application for Compensation or Pension at Separation from Service) if completed.

(9) When the patient is ready for transfer, notification in advance will be made, by the most expeditious means available, to the Hospital Director of the Veterans Administration hospital with information to ASMRO. The notification will include the patient's' name, grade, and Social Security number, together with any applicable information regarding the following:

(*a*) Whether the patient is ambulatory.

(*b*) Identification of train or plane.

(*c*) Scheduled time of arrival.

(*d*) Whether accompanied by an attendant and, if so, the name and grade of the attendant.

A request will be included that prompt notification of the hour and date of the patient's arrival be forwarded to the military hospital. When an unusual delay in travel is experienced during the transfer of a patient accompanied by an attendant, the attendant will advise the losing military hospital and the Hospital Director of the Veterans Administration hospital to which the patient is being transferred, by the most expeditious means available, of the change

in scheduled time of arrival and reasons therefor.

★(10) When final disposition instructions on the patient are received by the Army medical facility, the Veterans Administration hospital to which the patient was transferred will be notified of the type and date of disposition by the most expeditious means available.

b. Patients not eligible for Veterans Administration hospitalization. In cases where the patient is not eligible for Veterans Administration, the commander will initiate action to insure appropriate disposition prior to separation. Disposition of psychotic patients will be made following provisions similar to those contained in paragraph 68*e*. In those cases where the next of kin will not accept the patient or provide the care he requires, the medical facility commander will communicate with the appropriate civil authorities in the patient's State of residence and secure permission to transfer the patient to their custody. If permission is not granted, the commander will repeat the procedure with the civil authorities of the State from which the patient entered the service if that State differs from the State of residence. For other than psychotic patients, where the patient is capable of making his own decisions, he will be provided assistance in making arrangements for his own hospitalization. Where the patient is in such condition that this cannot be accomplished, the next of kin will be requested to make arrangements for and accept the patient.

SECTION V

MEDICAL CARE AT NAVY OR AIR FORCE MEDICAL TREATMENT FACILITIES

71. For whom authorized. Subject to the restrictions referred to below, the personnel listed below will be provided medical care when available at Navy or Air Force medical treatment facilities. Medical care will be provided when such facilities are more readily available than medical treatment facilities of the Army. Determination of availability of facilities will be made, except in emergencies, by the commander or person in charge of the individual requiring care.

a. Members of the Army included in paragraphs 7 and 8 subject to the restrictions contained therein. (Authorization for medical care referred to in paragraph 8*c* will be obtained from the appropriate authority by the Army administrative unit or, where Army administrative units are not established, by the Army medical facility designated to assume administrative responsibility in accordance with paragraph 74*a*.) The term "administrative responsibility" will include, but not be limited to, the following:

(1) Necessary professional medical evaluation and assistance.

(2) Notification to the patient's parent unit and (when applicable) temporary duty organization.

(3) Morning report accounting, pay and allowances, and other personnel functions for patients assigned to a medical holding unit; and these same personnel functions except pay and allowances for patients attached to a medical holding unit.

(4) Arranging transfer to another uniformed services facility in appropriate cases.

(5) Issuance of any necessary orders for further travel upon completion of hospitalization.

b. Members of, and designated applicants for enrollment in, the Army Senior Reserve Officers' Training Corps subject to the restrictions outlined in paragraph 10*a*.

★*c.* Applicants for enlistment or reenlistment in the Army, including applicants for enlistment in the Reserve components thereof, are limited to the following:

(1) Necessary medical and mental examinations.

(2) Hospitalization to determine medical fitness for military service.

(3) Emergency medical care for acute illnesses and injuries suffered while awaiting or undergoing processing at Army recruiting main stations or at Armed Forces Examining and Entrance Stations.

d. Registrants under the Universal Military Training and Service Act limited to the types of care referred to in *c* (1) and (2) above.

★*e.* Applicants for appointment in the Regular Army and in the Reserve components of the Army including those members of the Army Reserve components applying for active duty, and applicants for cadetship at the US Military Academy limited to the types of care referred to in *c* above.

f. Prisoners of war, retained personnel, persons interned by the Army, and other persons in military custody or confinement.

g. Civilian seamen in the service of vessels operated by the Department of the Army.

h. Civilian employees of the Army limited to those occupational health services authorized in AR 40-5.

i. Retired Army members subject to the restrictions outlined in paragraph 11.

j. Civilian employees (including former and prospective employees) of contractors of the Department of the Army limited to the types of care referred to in paragraph 27*d.*

k. Individuals who suffered personal injury or contracted disease in line of duty at a time when they were members of the Citizens Military Training Corps (para 9).

l. **Rescinded.**

m. Army National Guard technicians (civilian employees of the Army National Guard) assigned or to be assigned nuclear weapons duties at missile sites limited to medical examinations required by AR 611-15 when it is considered that a medical evaluation will assist in determining suitability for such assignment or continued assignment.

Note. When a psychiatric evaluation required in connection with the medical examination is made at a naval medical treatment facility, and it is determined that the technician is not mentally or emotionally suitable for assignment or continued assignment to missile site duties, an additional evaluation by an Army psychiatrist will be scheduled to corroborate previous psychiatric findings and to permit the Army psychiatrist to appear at any hearings held in the event a technician appeals the decision made in his case.

n. US nationals confined in foreign penal institutions (para 37.5).

72. General policies. *a.* For the method of assigning or attaching patients to Army administrative units or other designated Army organizations upon admission for, during, and upon completion of hospitalization, and the manner in which they will be carried on administrative records, the pertinent provisions of paragraphs 3.1 and 74 apply.

b. Medical care and adjuncts thereto will be provided in accordance with the instructions of the military service providing the care.

c. Collection of subsistence charges from all Army officer patients will be made locally by the Navy or Air Force hospital.

d. When general officers of the Army on active duty are admitted to or released from Navy or Air Force hospitals, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*)*1* through *5* is required.

73. Army administrative units. When deemed necessary and concurred in by the service concerned, CONUS army commanders will establish Army administrative units at Navy or Air Force hospitals from resources available to them. CONUS army commanders are authorized direct communication with the Navy or Air Force commander concerned for this purpose. An Army administrative unit established at a Navy or Air Force hospital will be assigned to and integrated with the nearest MEDDAC.

a. Assignment. Enlisted duty personnel will be assigned to Army administrative units by the CONUS army commander concerned. Army Medical Department officer duty personnel will be assigned by the Department of the Army.

b. Command.

(1) The commander of an Army administrative unit will be responsible to the appropriate MEDDAC commander for the operational functions of the unit, and will be responsible for compliance by the unit with station orders and/or regulations of the Navy or Air Force hospital.

(2) The commander of the Army administrative unit will act as, or will designate a subordinate officer of his unit as the commander of the medical holding unit.

(3) Army personnel at a Navy or Air Force hospital will be subject to the military authority of the Navy or Air Force commander, but will be assigned or attached to the Army administrative unit for administration. Military control of such personnel normally will be exercised by the Navy or Air Force commander through the commander of the Army administrative unit.

★*c. Supervision and support.* The appropriate MEDDAC commander will be responsible for the supervision of Army administrative units established by him, and for their logistical and administrative support.

d. Medical boards. A report of the proceedings of a Navy clinical or Air Force medical board, based upon Army medical standards, may be used in lieu of a report of proceedings of an Army medical board. Such reports will be accepted by Army physical evaluation boards in lieu of Army medical board reports.

★*e. Medical reports and records.* Army administrative units will submit reports; i.e., DA Form 3604 (Assignment and Utilization of Army Medical Department Personnel) required by AR 40-202, and DA Form 2789 (Beds and Patients Report) required by AR 40-418.

f. Military discipline.

(1) The commander of an Army administrative unit has authority under the Uniform Code of Military Justice, Article 15, to impose nonjudicial punishment upon those Army members of his command who are subject to the provisions of the Uniform Code of Military Justice (UCMJ, Article 2). General court-martial jurisdiction and all matters pertaining to the administration of military justice over personnel of the Army administrative unit are the responsibility of the CONUS army commander concerned.

(2) Army prisoner patients, with the consent of the Navy or Air Force commander may be transferred into and out of Navy or Air Force hospitals under either Army guard or the guard of the military service concerned.

(3) Local confinement facilities of the Navy or Air Force may be used with permission of the Navy or Air Force commander for temporary confinement of Army personnel.

g. Autopsies and professional inspections.

(1) Navy or Air Force medical officers may make professional inspection of deceased Army personnel, as required.

(2) The Navy or Air Force commander may direct that an autopsy be performed upon the bodies of Army military personnel when he deems such procedure necessary in order to determine the true cause of death and to secure information for the completion of military records. Such autopsies, including microscopic examination of tissues may be performed by Navy or Air Force medical officers in accordance with the provisions of TM 8-300. Copies of autopsy protocols will be filed with the permanent records of the Army administrative unit.

h. Funds. Nonappropriated funds and patients' trust funds will not be established. Adequate safeguards for patients' funds and valuables will be provided by Navy or Air Force hospitals.

74. Administration of patients where Army administrative units are not established. *a. Within the continental United States.* The CONUS army commander is responsible for the administration of all Army patients at Navy or Air Force hospitals located in his geographic area where Army administrative units have not been established. The CONUS army commander will be an addressee in each hospital designation message from the Armed Services Medical Regulating Office which will result in the transfer of an Army patient into any Navy or Air Force hospital within his area. Immediately upon receipt of a message which pertains to a hospital where an Army administrative unit has not been established, the CONUS army commander will designate an Army medical treatment facility to be responsible for the administration of all Army patients hospitalized at the Navy or Air Force hospital. The CONUS army commander will forward to all addressees of the above mentioned messages by the same means of communication with the same precedence as the original, the name and location of the designated Army medical treatment facility. In the case of direct admissions, the Navy or Air Force commander will notify the Army patient's organization commander who will request the CONUS army commander in whose area the patient is hospitalized to designate an Army medical treatment facility to be responsible for the administration of the patient.

b. Outside the United States. Responsibility for Army military patients in Navy or Air Force hospitals rests with the major oversea commander in whose area such a facility is located. Ordinarily, the nearest Army medical treatment facility will be designated to assume administrative responsibility for the patient. In areas not under the jurisdiction of a major oversea commander, the military attaché to the country in which the military patient is hospitalized will assume responsibility.

SECTION VI

MEDICAL CARE AT FEDERAL MEDICAL TREATMENT FACILITIES OTHER THAN THOSE OF THE ARMED FORCES

75. For whom authorized. Subject to the restrictions referred to in paragraph 71, the personnel listed below will be provided medical care when available at Federal medical treatment facilities other than those of the Armed Forces (hereinafter referred to as "Federal medical treatment facilities"). Medical care will be provided when such facilities are more readily available than medical treatment facilities of the Armed Forces.

a. Personnel enumerated in paragraph 71*a*.

(1) When general officers of the Army on active duty are admitted to or released from Federal medical treatment facilities, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*) *1* through *5* is required.

(2) Authorization for medical care referred to in paragraph 8*c* will be obtained from the appropriate authority by the Army medical facility designated to assume administrative responsibility in accordance with paragraph 76*a*(2).

b. Personnel enumerated in paragraph 71 *b, c, d, f, h, j, k, l* and *m*.

★*c.* Personnel enumerated in paragraph 71*e* limited to the types of care specified in paragraph 71*c*(2) and (3).

d. Personnel enumerated in paragraph 71*g* limited to care in medical treatment facilities of the Veterans Administration. (Such personnel when furnished care in hospitals and outpatient clinics of the Public Health Service are beneficiaries of that service.)

e. Retired Army members (para 71*i*).

(1) Prior to 1 January 1967, limited to care provided in hospitals and outpatient clincis of the Public Health Service, except that when requested by the Department of the Army, retired Army members placed on the Temporary Disability Retired List may be furnished required medical examinations at medical treatment facilities of the Veterans Administration.

(2) On and after 1 January 1967, retired Army members may be provided inpatient and outpatient medical and dental care for nonservice-connected disabilities in Veterans Administration facilities as Army beneficiaries.

f. Foreign nationals who are members of the Army of one of the NATO nations listed in paragraph 25*a*(1) and who, in connection with their official duties, are stationed in or passing through the United States.

g. The dependents (as defined in para 25*a*(10)) of the individuals described in *f* above (limited to care provided in hospitals and outpatient clinics of the Public Health Service).

76. Manner in which care is provided. *a. Ordinary medical care.*

(1) Except as indicated in paragraph 75*a*, and *e*, and *b, c,* and *d* below, an individual will not obtain care from Federal medical treatment facilities without obtaining prior authorization from his commander. If the commander determines that the individual requires medical care, he will prepare DA Form 8-267, in triplicate. This form will be addressed to the officer in

charge of the Federal medical facility in which medical care is desired. The patient will present the original and one copy of the form to the facility when he applies for treatment. (This requirement does not apply in the case of members of the Army who apply for medical care at medical facilities of the Public Health Service.)

(2) If the officer in charge of a Federal medical treatment facility accepts the Army beneficiary, the commander of the patient will notify the appropriate CONUS army commander or Army oversea commander or the Commanding General, US Army Military District of Washington, within whose territorial limits the facility is located, who will assign an Army medical treatment facility to assume administrative responsibility for the patient and will advise the officer in charge of the Federal medical facility of this assignment. Administrative responsibility will include, but not be limited to, those functions specified in paragraph 71*a* (1), (2), (3), and (5) and the following:

(*a*) Preparation of necessary individual medical records (AR 40-400).

(*b*) Seriously ill and death notifications (AR 40-2).

(*c*) Arranging transfer to another uniformed services facility (or to a uniformed services facility) in appropriate cases.

b. Emergency medical care. In an emergency, when the urgency of the situation does not permit the preparation of DA Form 8-267 by the patient's commander as prescribed in *a* above, authorized personnel may be furnished medical care without such request for treatment at the discretion of the officer in charge of the Federal medical treatment facility. The patient's commander will prepare DA Form 8-267, however, as soon thereafter as possible and forward it to the Federal medical treatment facility. At the same time he will notify the appropriate CONUS army commander or Army oversea commander or the Commanding General, US Army Military District of Washington, as stated in *a* above.

c. Absent from station. Authorized personnel when absent from their duty stations may be furnished medical care at Federal medical treatment facilities without obtaining prior authorization of their commanders and without DA Form 8-267, at the discretion of the officer in charge of such facilities. It is the responsibility of the patient or someone acting in his behalf to notify his commander of this fact so that his commander can comply with the requirements of *b* above. When the officer in charge of the Federal medical treatment facility is unable to obtain the required DA Form 8-267, he will state on the voucher for each such case that he ascertained from the DA identification card in possession of the patient that he was a member of the Army at the time medical care was furnished.

d. Care for retired members in Veterans Administration facilities. DA Form 8-267 is not required for medical care obtained by retired Army members in Veterans Administration facilities. Identification will be by means of DD Form 2A (Ret) (gray).

77. Utilization of Federal medical treatment facilities. If it is necessary to utilize the services of such facilities to supplement Army medical treatment facilities or Armed Forces Examining and Entrance Stations, the commanders thereof may obtain such services on their written request direct to the officer in charge of the facility concerned.

78. Rates of compensation. Payment for inpatient care will be made at the inpatient rate prescribed by the Bureau of the Budget for the applicable fiscal year. Payment for outpatient care will be made at the rates prescribed by the Federal agency furnishing the care except in the case of members and retired

members of the Army who are furnished outpatient care at Public Health Service facilities without charge.

79. Preparation and payment of vouchers. ★*a.* Vouchers for care furnished by Federal medical treatment facilities will be prepared by the agencies concerned and forwarded, supported by copies of the requests for treatment when appropriate, for settlement to The Surgeon General, ATTN: MEDOC-F, with the following exceptions:

(1) Vouchers for services incurred in accordance with paragraph 71*c* (1) and (2), *d*, *e*, *h*, and *m* and quadrennial medical examinations of Army Reserve personnel will be settled by the appropriate CONUS army or oversea commander of the Commanding General, Military District of Washington, U.S. Army, who may delegate the settlement of these vouchers to organizations within their command.

(2) Vouchers for medical examinations performed for members and prospective members of the Army National Guard will be paid by the State concerned.

(3) Vouchers for services incurred under the provisions of paragraph 77 (except those in connection with recruiting and induction activities) will be paid locally from funds made available to operate the installations obtaining the services.

b. The Surgeon General will collect and deposit charges for subsistence from all officer inpatients who were subsisted in Federal medical facilities at Government expense with the following exception. The Public Health Service will collect and deposit these charges from all officers who were subsisted in Public Health Service facilities at Government expense.

★80. Medical records. The Army medical treatment facility designated responsibility for the patient will prepare individual medical records (AR 40-400), health records (AR 40-403), and morbidity reports including morbidity telegraphic reports and special telegraphic reports of selected diseases on Army patients (AR 40-417) who are provided medical care at Federal medical treatment facilities.

SECTION VII

★MEDICAL CARE AT MEDICAL TREATMENT FACILITIES OF THE CANAL ZONE GOVERNMENT

81. **For whom authorized.** *a.* The following persons will be afforded medical care in medical treatment facilities of the Canal Zone Government at Army expense:

(1) Dependents (as defined in AR 40-121) of active duty, retired, and deceased Army personnel.

(2) Department of the Army civilian employees (paid from appropriated funds) with duty station in the Canal Zone and their dependents when living with their sponsors, except when an employee's disease or injury qualifies him for benefits under the Bureau of Employees' Compensation. (The amount paid by the Army is the reimbursement rate established by the Canal Zone Government less the amount payable by such employees and their dependents.)

(3) All categories of personnel eligible to receive medical care at Army medical treatment facilities under the provisions of Section III may be afforded medical care at medical treatment facilities of the Canal Zone Government. (Such categories do not include those who are beneficiaries of other Federal agencies.)

b. The conditions under which care is furnished, the extent of treatment authorized, and rates of charge will be comparable in all respects to those prescribed for such individuals in Army medical treatment facilities outside the United States.

82. **Rates of compensation.** Payment for medical care furnished will be made at rates prescribed by the Canal Zone Government.

SECTION VIII

MEDICAL CARE FROM CIVILIAN SOURCES

83. **For whom authorized.** Subject to the restrictions referred to in paragraph 71, personnel listed below will be provided medical care, when available, from civilian sources at the expense of Army funds. Care by civilian sources is authorized when it cannot be provided by medical treatment facilities of the Armed Forces or by other Federal medical treatment faclities, except as indicated in *h* below which pertains to hospitalization for persons interned by the Army.

Note. Except as provided in *f* below, retired Army members are not provided civilian medical care under the provisions of this section. Such members are authorized civilian medical care under the provisions of AR 40-121.

★*a.* Personnel enumerated in paragraph 71*a*. *Such care will be governed by the provisions of paragraph 85a as applicable.*

b. Personnel enumerated in paragraph 71*b*, *c*, *d*, *g*, *h*, *k*, and *n*. (That portion of this subparagraph which cites paragraph 71*b* is retroactive to 17 April 1962.)

★*c.* Personnel enumerated in paragraph 71*e* limited to the types of care specified in paragraph 71*c*(2) and (3).

d. Foreign nationals who are members of the Army of one of the NATO nations listed in paragraph 25*a*(1) and who, in connection with their official duties, are stationed in or passing through the United States. (*This provision is applicable to authorized civilian medical care obtained on and after 1 July 1963.*).

★*e.* For conditions under which dependents of individuals listed in *d* above are provided civilian medical care, see AR 40-121.

f. Retired Army members on the Temporary Disability Retired List who require periodic medical examinations, to include hospitalization when necessary in connection therewith, retroactive to 14 January 1963. (*The provisions of AR 40-121 are not applicable to examinations authorized by this subparagraph.*)

g. Prisoners of war, retained personnel, and other persons in military custody or confinement.

h. Civilians interned by the Army. These persons will be provided hospitalization at medical treatment facilities of the Armed Forces only in the absence of adequate civilian facilities pursuant to paragraph 42, AR 633-51.

84. **Qualifications of professional personnel engaged to furnish medical care.** *a. Licensing of civilian professional personnel.*

(1) Except as indicated in (2) below, doctors of medicine, doctors of osteopathy, doctors of dentistry (para 134), doctors of veterinary medicine (para 135), and optometrists (para 117*c* and 124) engaged to furnish medical services in accordance with this regulation must have valid licenses to practice their specialties in a State, territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico. Nurses engaged to provide nursing care must be currently registered to practice nursing in a State, territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(2) In the case of such professional personnel when engaged to perform services in oversea areas, except the Commonwealth of Puerto Rico, licensing and registration criteria will be as prescribed by the oversea commander concerned.

b. Restrictions.

(1) Except as indicated in (2) below, only

those licensed or registered professional personnel covered in *a* above can be utilized for medical services if payment is to be made from Army funds.

(2) Practitioners specializing in the sciences allied to the practice of medicine who are licensed to practice in the area concerned may be utilized for medical services under (1) above when such service is provided on the written request of a licensed doctor of medicine, osteopathy or dentistry as part of the medical care required.

(3) Payment for chiropractic services is not authorized.

★**84.1 Exclusion of hospitals which practice discrimination.** *a.* The Department of Defense has determined that certain civilian hospitals practice discrimination in the admission and/or treatment of patients on the basis of race, color or national origin and has declared these hospitals ineligible to receive payment from the Government for inpatient or outpatient care furnished Department of Defense beneficiaries on and after the effective date of ineligibility. The list of ineligible civilian hospitals, together with the effective date of ineligibility, is published in appendix A, AR 40-121. Payment cannot be made for inpatient or outpatient care provided by these hospitals on and after the effective date of ineligibility except in unusual circumstances when approved by the Department of Defense. This applies regardless of whether the hospital seeks payment or the patient pays the hospital and requests reimbursement. Payment to physicians and other professional or paramedical personnel who bill independently of the hospital will not be refused solely because their services were provided in an ineligible hospital.

b. Before payment is denied for care obtained by an Army beneficiary in an ineligible hospital, the approving authority will review the case to determine whether unusual circumstances exist which may justify payment of the bill. Examples of unusual circumstances which may justify payment are a bona fide emergency, absence of an eligible hospital within reasonable distance, and admission of a patient to an ineligible hospital for short-term inpatient care prior to the effective date of ineligibility and treatment continues beyond that date. If it is found that unusual circumstances exist, the bill with a statement of the circumstances will be forwarded to The Surgeon General (HQDA-(DASG-DDO)) for review and forwarding to the Department of Defense for decision.

85. Special considerations for members of the Army. ★*a. Civilian medical care will not be authorized for members who have sought asylum in foreign countries.* Charges incurred for civilian medical care for members absent without authority *on and after 1 July 1971 will be at Army expense.* Charges incurred for civilian medical care for members absent without authority *prior to 1 July 1971 will not be at Army expense.* However, in the latter case, where the absence without authority is terminated by the individual's actual or constructive return to military control, the charges for treatment may be paid in accordance with paragraph 88. For this purpose, constructive return to military control becomes effective for the entire episode of medical care when notification that the AWOL member is undergoing medical treatment is received and acknowledged by military authorities. "Military authorities" in this instance refers to the CONUSAMDW commander or oversea Army commander of the area in which the civilian medical care is obtained, the chief of the military district of the area, the nearest installation commander, the individual's commander, or any other authority authorized to effect return to military control under AR 630-10. The military authority receiving the notification will immediately acknowledge the same orally or in writing, verify the individual's status in the manner prescribed by chapter 4, AR 630-10, and take appropriate action with a view to the member's eventual return to actual military control. When an individual has been unable to return or report because of legitimate circumstances beyond his control, or has otherwise been erroneously reported AWOL or in desertion the responsible officer will take the action described in section V, chapter 4, AR 630-10.

b. When general officers of the Army on active duty are admitted to or released from civilian medical treatment facilities, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*) *1* through *5* is required.

c. Authorization for medical care referred to in paragraph 8*c* will be obtained from the appropriate authority by the Army medical treatment facility designated to assume administrative responsibility in accordance with paragraph 88*a*(1).

86. Elective care. Elective care in civilian medical treatment facilities or by civilian physicians is not authorized at Army expense.

87. Approving authorities. Approving authorities for civilian medical care are shown in figure 2.1.

88. Manner in which care is provided. *a. Ordinary medical care.* Except as indicated in (2) below, personnel entitled to medical care at Army expense will not obtain such care from civilian agencies at Army expense without obtaining prior authorization from the designated approving authority. All documents authorizing civilian care will include the following statement: "Payment will not be made by the Government for any nonemergency care obtained pursuant to this authority in hospitals which discriminate in the admission or treatment of patients on the basis of race, color or national origin."

★(1) *Prior authorization by designated approving authority.* Requests for prior authorization normally will be submitted in writing as outlined in paragraph 89 and transmitted through channels to the designated approving authority; except in unusual circumstances, in which case, requests will be transmitted by the most expeditious means available direct to the approving authority. If the requested medical care is authorized by a MEDDAC commander in CONUS, he will maintain administrative responsibility of the patient. If the medical care is authorized by a CONUS or oversea Army commander, he will designate an Army medical treatment facility which will assume administrative responsibility of the patient. If the civilian medical care is authorized by another approving authority, he will request the appropriate Army commander to designate such an Army medical facility. Facilities will be advised of these designations immediately, and the individual requiring medical care will be instructed through his commander to inform the civilian agency that medical records in the case will be requested by the designated Army facility. Administrative responsibility will include, but not be limited to, those functions specified in paragraph 71*a*(1), (2), (3), and (5) and the following:

(*a*) Preparation of necessary individual medical records (AR 40-400).

(*b*) Seriously ill and death notifications (AR 40-2).

(*c*) Arranging transfer to a uniformed services facility in appropriate cases.

(2) *Without prior authorization by designated approving authority.* Individuals may obtain civilian medical care without prior authorization of the designated approving authority when any of the following circumstances exist:

(*a*) In emergencies when the urgency of the situation does not permit the obtaining of such prior authorization.

(*b*) When the individual is serving outside continental United States and is not under the jurisdiction of any approving authority listed in figure 2.1.

(*c*) When authorized by the immediate commanding officer after a determination that the total cost of medical treatment will not exceed $150. (See para 134*d*(2) for dental treatment.)

(*d*) When an individual who is absent without authority is undergoing civilian care and such absence is terminated by the individual's actual or constructive return to military control as specified in paragraph 85.

When civilian medical care is obtained without prior authorization, it is the responsibility of

the patient's immediate commander to advise the appropriate approving authority without delay that such care is being or has been obtained, so that the approving authority may designate (or, if the approving authority is not a CONUS or oversea Army commander, secure designation of) an Army facility which will assume administrative responsibility as set forth in (1) above. When civilian medical care is obtained by an individual while on leave or pass or temporary duty from his duty station, it is his responsibility to notify, or to have someone acting in his behalf notify, the Army commander of the area where care is being provided of this fact. When a member, while on leave or temporary duty in continental United States from an oversea station or while awaiting reassignment from or to an oversea station, obtains civilian medical care, he, or someone acting in his behalf, will notify the Army commander in whose geographic area the care is being provided of this fact.

b. Specialist service. The engagement of a civilian specialist (as distinguished from an appointed civilian professional consultant) is subject to prior authorization of the designated approving authority, except when the urgency of the situation is such that the services of a civilian specialist are immediately necessary to furnish emergency medical care.

c. Consultation service. The engagement of a civilian consultant (as distinguished from an appointed civilian professional consultant) will be authorized only in unusual cases.

89. Requests for authority to engage care. Letter requests for authority to engage care will include the following information:

a. For ordinary care.

(1) Character and extent of condition requiring treatment.

(2) Statement whether or not condition requiring treatment is chronic.

(3) Place of duty and duties of the individual.

(4) Status—duty, leave, or pass. If not on duty, the exact period of leave or pass.

b. For specialist service.

(1) Diagnosis.

(2) Professional procedure considered necessary and estimate of time required for treatment.

(3) Statement of condition of patient and the practicability of his transfer to a Uniformed Service or other Federal hospital for the necessary treatment.

(4) Place of duty and duties of the individual.

(5) Status—duty, leave, or pass. If not on duty, the exact period of leave or pass.

90. Autopsies. The commander or the surgeon of an installation or command may authorize autopsies to be performed by civilian physicians, civilian laboratories, or at civilian medical treatment facilities in order to determine the true cause of death and to secure information for the completion of military records.

91. Rates of compensation. The rates of compensation allowed for civilian medical care are contained in AR 40-330.

92. Preparation and payment of vouchers. ★*a.* Ordinarily, vouchers will be prepared as soon as practicable after completion of the services by the commander of the Army medical treatment facility assigned administrative responsibility of the patient pursuant to paragraph 88 and forwarded for settlement to the appropriate approving authority, *except that those vouchers for services authorized by the MEDDAC commander in CONUS (para a, fig. 2.1) will be forwarded for settlement to the appropriate CONUS Army commander or to the Commanding General, US Army Military District of Washington, in whose geographic area the medical care was furnished. In the latter case, these vouchers will be supported by information showing the approval of the appropriate MEDDAC commander.* When civilian medical care is obtained but administrative responsiblity of the patient is not assigned to any Army medical treatment facility, the appropriate CONUSAMDW or oversea Army commander may designate the patient's commander

to prepare the vouchers and related medical records and reports. When civilian medical care is furnished to an Army member at the request of a troop train commander or group leader, the bills for such services, together with information supporting the services, will be forwarded for vouchering and preparation of the necessary medical records and reports to the appropriate CONUSAMDW or oversea Army commander.

b. **Rescinded.**

★*c.* The approving authorities shown in figure 2.1 are responsible for the approval and payment of vouchers for civilian medical care obtained within the territorial limits of their commands *regardless of the location of the patient's assigned duty station* except as stated in *a* above (pertaining to vouchers for services authorized by MEDDAC commanders) and in *d* and *e* below. The CONUSAMDW and major Army oversea commanders at their discretion may delegate the authority to pay civilian medical vouchers to organizations within their commands, or may request another command and/or approving authority to pay such vouchers if circumstances justify such action. Such delegation of authority normally will be given in writing but telephonic authorization may be granted when the urgency of the situation warrants it. In the latter event, such telephonic delegation of authority will be confirmed by letter.

d. During emergencies, when large numbers of troops are moved to concentrated areas within continental United States, the Department of the Army may direct the Commanding General, US Continental Army Command, to designate a CONUS Army commander to approve and pay civilian medical vouchers for all military personnel assigned or attached to units within the concentrated area.

★*e.* In cases which present unusual or difficult aspects, the approving authority will request advice from The Surgeon General (HQDA (DASG-RMF)). Where considered appropriate, such cases may be retained by The Surgeon General for adjudication.

f. Except as provided in *h* below, DA Form 8-9 (Public Voucher for Medical Services) will be used to present charges for payment of services by civilian physicians, hospitals, clinics, special nurses, dentists, druggists, veterinarians, practitioners (para 84*b*(2)), blood donors, ambulance companies and makers of prosthetic devices (any one of which will hereinafter be referred to as an "agency"). The original DA Form 8-9 and three copies will be forwarded to the approving authority. Vouchers marked "copy," "duplicate," or "corrected copy" will not be acceptable. The instructions stated herein will be followed when completing DA Form 8-9 (see exception in (3) below).

(1) Information as follows will be entered in the appropriate spaces and columns on the form:

(*a*) *Voucher prepared at.* Enter place and date.

(*b*) *To (payee).* Enter legal name and address of agency furnishing services.

(*c*) *Name of patient or brand number of Government-owned animal, etc., (information indicated in heading).*

1. Enter organization of patient or animal at time of treatment and branch of service.

2. Station will include name and location.

3. If patient is treated while on TDY away from parent station, this fact will be included.

4. Vouchers covering services furnished to personnel of the Reserve components on active duty or not on active duty will include such facts.

5. Vouchers covering services for station sick call do not require a listing of patients' names or brand number of Government-owned animals. Instead, show the number of patients or animals seen opposite the date of the visit.

(*d*) *Disease or disability and nature of services.* Enter as appropriate:

1. Diagnosis.

2. Description of services.

3. Type of surgical operation.

4. Routine laboratory tests (aggregate).

5. Special laboratory tests by name.

6. X-rays (aggregate).

7. Use of operating room.

8. Anesthetic.

9. Routine medicines (aggregate).

10. Medicines on prescription—with number of each prescription.

11. Dental services—indicate nomenclature of each tooth or tooth surface, restored, extracted, or treated. Do not use numerical designation.

12. Special nurses—the inclusive hours of tours of duty.

13. Ambulance service—mileage involved.

14. Description of other services received which are not specified herein.

(*e*) *Period of service.*

1. Enter the inclusive dates of hospitalization.

2. The dates of each tour for special nursing service.

3. Dates of surgical operations and dental procedures and dates of subsequent attendance included in the charge.

4. The date of each visit by the physician to the patient or by the patient to physician's office.

5. Dates for each prescription.

(*f*) *Number of days or treatments.* Enter total number of days of hospitalization or nursing service or total number of treatments.

(*g*) *Rate per day or per treatment.* Enter daily rate for hospitalization or nursing service or rate for treatment. For ambulance service, enter rate for mileage and the notation "flat rate," if appropriate.

(*h*) *Total amount.* Enter the total for hospitalization, treatments, or nursing services which is computed by multiplying the rate by the number of days or treatments. The total charges for other items as indicated under (*d*) above will be entered separately.

(*i*) *Total.* Enter the total amount of all charges listed on the voucher.

(*j*) *Payee's certificate.* The certificate will be signed by the agency in whose name the voucher is stated. The signature will agree exactly with the name of the agency as shown in the "To (payee)" space in the heading of the voucher. When a voucher is authenticated in the name of a hospital, clinic, corporation, or company, the individual signing for the hospital, clinic, etc., will include his business title or designation. When a certified invoice is attached to the voucher, enter "See certified invoice attached" in lieu of signature by the agency.

(*k*) *Certifying officer's statement.* The blank space in the statement will be completed to show the status of the patient or animal as duty, pass, leave, absent without leave, or delay en route. Delay en route status must be amplified to show the authority therefor, number of days delay and travel authorized, the stations involved, the departure date from the losing unit and the reporting date to the gaining unit. Following the word "because" the statement will show "none available" or will state the reason care could not be obtained from Department of Defense or other Government medical facilities. If a Federal medical treatment facility is in the vicinity of the place of treatment, explanation must be made indicating why the patient did not obtain treatment and/or prescriptions thereat. After completion of the statement, it will be signed by the patient's commander or some other commissioned officer of the Army on active duty having cognizance of the case.

(2) Any unusual charges or any civilian medical care furnished under unusual circumstances must be fully explained in accompanying correspondence. Charges for services performed by those practitioners stated in paragraph 84*b*(2) will be supported by the authorization (or copy thereof) of the licensed doctor of medicine, osteopathy, or dentistry requesting the services. When additional visits on the same date are made by civilian physicians, the necessity therefor will be indicated. When more than one physician cares for a patient, the necessity therefor will be reported. *Charges for personal items for patients, such as cigarettes, personal telephone calls, meals for visitors, are not payable from Army funds.*

(3) If certified invoices, itemized and signed as required by (1) (*d*) through (*j*) above are submitted by the agency, the body of the voucher will not be completed in the detail shown under (1) above. Instead, show only the information required by (1) (*a*), (*b*), (*c*), (*d*) *1*, (*e*), (*i*), and (*k*). When additional copies of invoices are desired, they will be reproduced by the installation or activity requiring the invoices.

(4) Charges for professional services by physicians or nurses who are not members of the hospital or clinic staff *will not* be included in a voucher in the name of the hospital or clinic but *will be vouchered separately in the name of each individual, except where the hospital or clinic has already paid for the services.* If a hospital or clinic has paid a physician or nurse who is not a member of its staff, an itemized, certified bill from the doctor or nurse stating the payment has been received from the hospital or clinic, will be attached to the hospital or clinic voucher to substantiate the charges. Hospital vouchers containing charges for professional services by physicians or nurses who are members of the hospital staff will bear the notation that the doctor or nurse was a "salaried member of the hospital staff."

(5) Vouchers covering charges for nursing services will contain the following additional certificate to be entered in the body of the voucher and signed by the attending physician:

I certify that the services of a nurse were indispensable to the proper care of the patient named.

(6) Official telegraph charges and telephone tolls incurred by civilian agencies in connection with medical care of authorized personnel will be included on their vouchers as part of the necessary expense, provided a statement is furnished showing the points between which the service was rendered, the date, the amount paid for each service, and that the telegrams or calls were on official business. For local telephone calls, the voucher will show the number of such calls, rates for a call, the total amount expended each day and that the calls were on official business.

(7) The spaces provided on DA Form 8–9 for "Approved for, date, place, signature, and accounting classification" will be left blank for use by the authorized approving officer.

(8) When it is necessary to use two or more sheets of DA Form 8–9 to complete the itemization of charges, the footing of the first sheet should be carried forward to the top of the second and continued thus until the itemization is complete. The certificate and statement should be cut off all sheets except the last. All originals in proper sequence should be fastened securely together and all memorandum copies should be fastened securely together.

g. Charges for services by civilian agencies should not be paid by other than finance and accounting officers, disbursing officers, or class B agent officers *except when absolutely necessary.* When such payments are made by other than these officers, claims for reimbursement will be presented on DA Form 8–17 (Public Voucher—Reimbursement of Medical Services). The original DA Form 8–17 and three copies will be forwarded to the approving authority. Vouchers marked "copy," "duplicate," or "corrected copy" will not be aceptable. The instructions stated herein will be followed when completing DA Form 8–17.

(1) Information as follows will be entered in the appropriate spaces and columns on the form:

(*a*) *Voucher prepared at.* Enter place and date.

(*b*) *To (Payee).* Enter legal name and address of individual claiming reimbursement. the address shown should be reasonably permanent to insure delivery of check payment.

(*c*) *Subvoucher No.* Each subvoucher will be numbered depending on the number of subvouchers included in the reimbursement claim and those numbers listed in this column in numerical sequence.

(*d*) *Name of agency paid.* Enter in line with the appropriate subvoucher number, the name of the doctor, hospital, nurse, etc., to whom payment was made.

(*e*) *Serivces as shown on attached subvouchers.* Enter in line with the appropriate subvoucher number, "medical services," "hospital services," "ambulance services," "medicines on prescription," etc., as the case may be.

(*f*) *Amount.* Enter the total amount of each subvoucher.

(*g*) *Total.* Enter the total amount of all subvouchers listed on the voucher for which reimbursement is being claimed.

(*h*) *Payee's statement.* The statement must be completed to show why it was necessary to pay the charges and signed by the individual claiming reimbursement. The signature will agree exactly with the name of the claimant as shown in the "To (Payee)" space in the heading of the voucher.

(2) DA Form 8-17 (Public Voucher—Reimbursement of Medical Services) must be accompanied by appropriate subvoucher. Separate subvouchers will be completed for each agency paid by the person claiming reimbursement. The subvouchers will be prepared on DA Form 8-9 in accordance with instructions prescribed in *f* above, with the exception that the payee's certificate thereon will be amended by adding a statement that payment has been received from the individual claiming reimbursement naming him, and signed by the agency rendering the service. In lieu of the signature to this certificate, receipted bills of the agency rendering the services, showing the full name of the person signing, including his business title or designation, and acknowledging payment from the person claiming reimbursement, may be attached to the subvoucher. When this is done, the payee's certificate on the subvoucher will contain the notation, "See receipted bill attached."

(3) The spaces provided on DA Form 8-17 for "Approved for, date, place, signature, and accounting classification" will be left blank for use by the authorized approving officer.

(4) When it is necessary to use two or more sheets of DA Form 8-17 to complete the listing of the subvouchers, the procedure prescribed in *f*(8) above will apply.

h. Charges for medical examinations of applicants for enlistment, registrants and other authorized personnel will be presented for payment on DA Form 8-11 (Public Voucher for Medical Examinations). The original DA Form 8-11 and three copies will be forwarded to the approving authority for payment. Items on the form are self-explanatory.

93. Medical records. *a* Except as provided in *b* below, the Army medical treatment facility having responsibility for the patient will prepare those medical records and reports referred to in paragraph 80 on Army patients who receive civilian medical care.

b. When an Army medical treatment facility has not been designated to administer the patient and the vouchers for civilian medical care are prepared by another station as provided in paragraph 92, the commanding officer of that station will prepare the medical records and reports referred to in paragraph 80.

c. Reasonable charges of civilian physicians or civilian medical treatment facilities for the furnishing of medical records and reports will be allowed when such services have been requested by competent military authority.

94. Utilization of civilian medical services. Rescinded.

Categories	*Approving authorities*
a. Members of the Army, to include members of the Army Reserve on active duty (other than for training), who are patients or who are on duty at installations and activities within the continental United States other than those referred to in b, e, f, g and m below.	a. The commanding officer of the medical department activity (MEDDAC) for his geographic area of responsibility.
b. Members of the Army Reserve while on active duty for training or inactive duty training.	b. The appropriate CONUS Army commander, the Commanding General, US Army Military District of Washington, or the appropriate Army major oversea commander under whose jurisdiction the training was performed.
c. Members of the Army who are patients or who are on duty at installations and activities outside the continental United States.	c. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagasy Republic and Ceylon—United States Army, Europe; and (2) Countries in the Pacific, Alaskan and Southern Commands—respective Army major oversea commanders except as indicated in h and i below.
d. Members of the Army National Guard of the several States, Commonwealth of Puerto Rico, the District of Columbia, and the Army National Guard of the United States while on active duty for periods of 30 days or less or not on active duty (except REP 63 personnel. See e below.)	d. Chief, National Guard Bureau, Washington, DC 20310.
e. REP 63 personnel who incurred an injury or disease in line of duty while on their initial tour of ADT and have completed ADT	e. Same as b above.

★*Figure 2.1. Approving authorities.*

Categories	*Approving authorities*
and returned to Army National Guard.	
f. Members of the Army in continental United States who are on leave or temporary duty from oversea stations or who are awaiting reassignment from or to oversea stations.	f. The appropriate CONUS Army commander or the Commanding General, US Army Military District of Washington, in whose geographic area the medical care is furnished.
g. Members of Army Student Detachments.	g. The appropriate CONUS Army commander, the Commanding General, US Army Military District of Washington, or the appropriate Army major oversea commander in whose area the school, college or university is located.
h. Members of the Army assigned to Army Military Missions and MAAG's.	h. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagasy Republic and Ceylon—United States Army, Europe; and (2) All other countries—the mission or MAAG chief.
i. Members of the Army assigned to Defense Attaché offices.	i. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagasy Republic and Ceylon—United States Army, Europe; and (2) All other countries—the appropriate Defense Attaché.
j. Members of the Army outside the continental United States who are on leave or temporary duty from CONUS stations or	j. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) West Indies and

Figure 2.1—Continued.

Categories	*Approving authorities*
who are on temporary or special duty assignment.	Bermuda—Third United States Army; (2) Canada and Mexico—Fifth United States Army; (3) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagasy Republic, Ceylon and the islands in the Atlantic Ocean north of Tropic of Cancer except the Bahama Islands and Bermuda—United States Army, Europe; and (4) Countries in the Pacific, Alaskan and Southern Commands—respective Army major oversea commanders.
k. Foreign Nationals who are members of the Army of one of the NATO nations and who, in connection with their official duties, are stationed in or passing through the United States.	k. Same as f above.
l. Retired Army members on the Temporary Disability Retired List.	l. The Surgeon General, Department of the Army, Washington, DC 20314.
m. Nonunit Reserve personnel under centralized management jurisdiction of CG RCPAC, who are required to undergo medical examinations or hospitalization in connection therewith.	m. The Commanding General, US Army Reserve Components Personnel and Administration Center, 9700 Page Blvd, St. Louis, MO 63132.
n. Civilian employees of the Army for occupational health services.	n. Same as l above.
o. US Nationals in foreign penal institutions.	o. Same as j above.
p. Members of the Army Senior ROTC and designated applicants for enrollment in the Army Senior ROTC Program.	p. Same as c and f above.
q. Applicants for enlistment or reenlistment in the Army including applicants for enlistment in the Reserve components thereof.	q. The appropriate commander of the Armed Forces Examining and Entrance Station for examinations; same as c and f above

Figure 2.1—Continued.

Categories	*Approving authorities*
	for hospitalization to determine medical fitness for military service or for emergency medical care.
r. Registrants under the Universal Military Training and Service Act.	r. The appropriate commander of the Armed Forces Examining and Entrance Station for examinations; same as c and f above for hospitalization to determine medical fitness for military service.
s. Applicants for appointment in the Regular Army and in the Reserve components of the Army including those members of the Army Reserve components applying for active duty; and applicants for cadetship at the US Military Academy.	s. Same as q above.
t. Prisoners of war, retained personnel and other persons in military custody or confinement.	t. Same as c and f above.
u. Civilians interned by the Army.	u. Same as c and f above.
v. Civilian seamen in the service of vessels operated by the Department of the Army.	v. Same as c and f above.
w. Members of the Civilian Military Training Corps.	w. Same as f above.

Figure 2.1—Continued.

SECTION IX

EMERGENCY MEDICAL CARE PROGRAM

95. Objective. The primary objective of this program is to develop the military medical resources required for the essential medical support of the Armed Forces during—

★*a.* The emergency-disaster phase following a thermonuclear, chemical, or biological attack.

b. The post-attack rehabilitation period until procurement sources adequate to meet essential minimum military requirements are established.

96. Policy. This program provides medical support required to maintain the greatest number of military personnel on duty under conditions imposed by a major attack. This support consists of—

a. Treatment which is directed primarily toward those casualties who can be returned to duty most promptly.

b. Post-attack medical support of the surviving military population which consists primarily of general medical and surgical care of both casualties and noncasualties, and preventive medicine and public health measures for reduction and control of disease and injuries.

97. Phases. This program is a continuation of military medical support during and following a major disaster period, and as such is not in itself a distinct entity. For administrative purposes, however, the program is divided into four phases. This phasing, defined below, is based on consideration of assumed circumstances and situations during and following a major disaster. It does not represent time phasing. In an actual disaster situation all phases would run concurrently.

a. Phase I—Self-aid or buddy aid. Treatment during this phase will be given primarily by other than Medical Service personnel and, in most instances, will be given without medical supervision. Casualties will either treat themselves or be treated by other nonmedical personnel. Phase I care will consist of those first aid procedures which are required to sustain life and minimize injury until the casualty enters medical channels. Proper performance of Phase I care will require a thorough knowledge of first aid treatment procedures.

b. Phase II—Emergency medical care and treatment. Treatment during this phase will be more extensive than that given in Phase I and will be given primarily by nonprofessional medical personnel under professional supervision. Phase II care will consist of those emergency treatment procedures which are required to save life, to minimize further injury, and to provide initial definitive care. Proper performance of Phase II care will require a thorough knowledge of emergency medical care and treatment procedures on the part of nonprofessional medical personnel and a thorough understanding of medical techniques and administrative procedures for mass casualty care on the part of professional medical personnel.

c. Phase III—Post-attack medical support. This support will be given by professional medical personnel and ancillary medical personnel under professional supervision. It will consist of preventive medicine procedures and patient care. The latter will include both inpatient and outpatient care and will be conducted under conditions of severe shortages of materiel, in improvised facilities, and with limited professional and technical staffs. Primary emphasis will be placed on prevention of disease and injury and on restoring the greatest number of individuals to duty as quickly as possible. Hospital-type care will be provided within the means available only to those individuals who require constant medical supervision.

d. Phase IV—Post-attack resupply of medical resources. This phase includes the determination of military medical requirements (manpower, facilities, materiel, and services) which must be obtained from the surviving national economy, and the requisitioning, procurement, distribution, and use of these resources.

98. Acquisition, distribution, storage, and control of medical materiel for Phases I and II. See AR 40-58.

98.1 NATO Handbook of Emergency War Surgery. *a.* In implementation of international

standardization agreements (NATO STANAG 2068 and ABC SOLOG 70), the Department of Defense has published the U.S. edition of the NATO Handbook of Emergency War Surgery.

b. The basis of issue of the handbook is as follows:

(1) Commanders will issue one copy to each Medical, Dental, and Veterinary Corps officer upon first coming on active duty. The handbook becomes the personal property of the officer.

(2) Each medical librarian (sec. VI, AR 40-2) will obtain as many copies as the size, purpose, and use of the library may require.

c. Commanders will requisition handbooks necessary to meet the requirements in *b* above through normal publication channels.

d. For purposes other than those stated in *b* above, the handbook is available at a nominal cost from the Superintendent of Public Documents, Washington, D.C.

★**98.2 Training.** Department of Army Pamphlet 350-9 outlines responsibilities and provides guidance for the training of Army personnel in survival care, emergency medical care, and in the management of mass casualties. Department of Army Pamphlet 350-8 provides information on similar training for military dependents and Department of Army civilian employees.

SECTION X

BLOOD PROGRAMS

99. General. This section deals with the Department of Defense Blood Program, the Military Blood Program Agency, the Army Blood Program and command blood programs. It also contains general information concerning blood grouping and recording, procurement of blood, and the method of payment therefor. It is applicable to all commands of the Army in the continental United States. Major oversea commanders will adopt such portions of this section as are applicable and may establish appropriate procedure and controls in connection therewith.

99.1 Department of Defense Blood Program and the Military Blood Program Agency. The Department of Defense Blood Program and the functions and responsibilities of the Military Blood Program Agency are described in DOD Directive 6480.5, "Department of Defense Blood Program," 15 May 1962 (app. II).

99.2 Administration and operation of the Military Blood Program Agency. *a.* The Surgeon General is responsible for discharging the responsibilities assigned to the Secretary of the Army by Sections V.A. 1., 2. and 3. and V.B., appendix II.

b. The Surgeon General shall establish and maintain the Military Blood Program Agency from resources available to him and shall exercise command jurisdiction over it.

c. The Director, Military Blood Program Agency shall carry out the functions and responsibilities specified in Section V.A.3. a. through j., appendix II.

d. The Director, Military Blood Program Agency is authorized to communicate directly with appropriate agencies and departments on matters within the purview of that Agency. He may also communicate directly with appropriate commanders, except that direct communication with the commanders of specified and unified commands will be subject to the requirements of Section V.A.d., appendix II.

99.3 Responsibilities of the The Surgeon General. The Surgeon General will—

a. Select a qualified officer, in consultation with The Surgeon General of the Navy and the Surgeon General of the Air Force, to serve as Director of the Military Blood Program Agency.

b. Participate in determining the number and types of personnel to be provided the Military Blood Program Agency.

c. Submit requirements and report capabilities, as requested, to the Director, Military Blood Program Agency.

99.4 Army blood program. The Army blood program encompasses all aspects of command blood programs referred to in paragraph 100. It also includes the following:

a. The distribution of whole blood and its fractions to Army hospitals on a local or regional basis.

b. A research and development program devoted to progress and improvement in the areas of blood, blood derivatives, and plasma volume expanders and the techniques, facilities and materiel related thereto.

100. Command blood program. A command blood program will be established by the commander of each installation at which blood

is procured and used, and by all other commanders having jurisdiction over such installations. Such a program will place particular emphasis on the interchange of blood between installations.

★*a.* Blood donor centers will be operated at those installations required to collect blood in support of the appropriate schedule to the current Mobilization Manpower Program of the Army. Blood donor centers are listed in the Mobilization Medical Department Program. The operation of blood donor centers, which is prescribed in TM 8-255, will serve the threefold purpose of—

(1) Training medical personnel in the various aspects of blood donor center operations.

(2) Providing blood for routine requirements.

(3) Serving as a nucleus for rapid expansion during mobilization.

b. The functions of a blood donor center include the following:

(1) Selection of qualified donors and their care.

(2) Withdrawal and collection of blood.

(3) Laboratory procedures including determination of ABO groups, anti-A and anti-B agglutinum titers in Group O serum, Rh type, and serological test for syphilis.

(4) Refrigerated storage of blood and preparation of blood for shipment.

★*c.* Those Army installations not listed in the Mobilization Medical Department Program at which blood donor centers are in existence or planned for activation will submit written notification to The Surgeon General, ATTN: MEDD-OH, of the capabilities of the blood donor center in terms of units of whole blood.

101. Determining and recording of blood groups. *a.* All individuals on active duty in the Army will have their ABO blood group determined by both the cell and serum grouping tests and their Rh type determined by the use of Anti Rho (D) serum. The results of the grouping tests will be recorded as "A", or "B", "AB" or "O" followed by "Pos" or "Neg" for the blood type. The accomplishment of blood grouping and typing in each organization is the responsibility of the commander. The surgeon is responsible for the proper performance of the test and he will insure that personnel performing this test are properly trained and supervised. Blood group and type determinations will be made for all individuals processed through reception stations, training divisions, or similar organizations before transfer to other organizations. Blood group and type determinations for individuals not processed through such organizations ordinarily will be made at the initial Army installation or organization where they report for duty provided facilities for performing the test are available.

b. The commander of the medical facility performing blood grouping of an individual will be responsible that the organization issuing the identification tag and identification card (DD Form 2A) is informed of the correct blood group and type of the individual so that they may be properly recorded on the identification tag and card.

**Note.* This subparagraph, together with subparagraph 81*c*, AR 606-5, implements CENTO Standardization Agreement 2199.

c. The blood group and type of an individual will be entered on the following medical records in the spaces as noted.

(1) DD Form 722, Health Record (Extreme right of index tab).

(2) SF Form 88, Report of Medical Examination (Item 49).

(3) SF Form 601, Health Record/Immunization Record (Reverse side in spaces provided).

★(4) PHS Form 731, Immunization Certificate (Remarks Section).

102. Procurement of blood. Blood will be procured in the manner prescribed below.

a. By donation from military personnel, civilian personnel employed at installations, and the dependents of both.

b. By interchange of blood between installations when it is economically advantageous to the Government.

c. By request to the Red Cross Regional Blood Center serving the area in which the installation is located.

d. By arrangements made with civilian blood banks licensed by the National Institutes of Health, Department of Health, Education and Welfare to furnish donors in exchange for blood.

e. When blood cannot be obtained from the above sources, it may be purchased from civilian blood banks licensed by the National Institutes of Health, Department of Health, Education and Welfare or by payment of donors, whichever is more economical to the Government.

f. Payment of donors is authorized at the local prevailing rate, provided that in no case will the amount paid any donor for a single donation exceed $50.

g. Under exceptional circumstances the amount paid for blood withdrawals may exceed the local prevailing rate, provided such rate is not in excess of $50. Examples of exceptional circumstances are—

(1) Donors who because of previous attacks of the disease possess certain antibodies against eastern equine encephalitis, St. Louis encephalitis, etc., and who because of their particular blood qualities might justifiably demand a fee in excess of the local prevailing rate.

(2) Blood withdrawals at remote installations where donors may be scarce.

(3) Donors with Rh negative blood when such blood is being obtained because of the Rh negative quality.

102.1 Nourishment for blood donors following blood withdrawals. *a.* Except as indicated in *b* below, nourishments for blood donors following blood withdrawals at Army medical treatment facilities are authorized at Army expense from funds available locally.

b. Nourishments in connection with blood donor activities at Army medical treatment facilities which are under the auspices of the American National Red Cross will be furnished by that agency.

103. Method of payment. ★*a.* When blood is obtained from and delivered by American National Red Cross sources, a service charge will be made by the Red Cross for each unit (approximately 450ml) of whole blood delivered and not returned. Red Cross whole blood not transfused will be returned to the blood center at the expense of the hospital. The hospital will be given a partial credit for each unit of blood returned provided it is suitable for fractionation. For whole blood returned at the request of the Red Cross blood center, the hospital will receive full credit for each unit provided it is suitable for transfusion purposes. Dollar amounts of charges and credits are set forth in section V, AR 40-330. At the end of the month, the local Red Cross Chapter will bill the using installation for all blood retained during the month at the rates set forth in section V, AR 40-330. The bill will be vouchered on SF 1034 (Public Voucher for Purchases and Services Other Than Personal) and paid from funds made available to operate the using installation. Checks will be drawn in favor of the American National Red Cross and forwarded to the Red Cross Regional Blood Center that furnished the blood together with a copy of the bill.

b. Charges for services by blood donors for blood withdrawals made in accordance with paragraph 102*e* may be paid from the Imprest Fund in accordance with AR 37-103-1, or presented on DA Form 8-9 and forwarded for payment as indicated in (1) or (2) below. Instructions for preparation of DA Form 8-9 are contained in section VIII.

(1) Vouchers for blood withdrawals at Army installations will be paid from Army funds available locally.

(2) Vouchers for blood withdrawals in civilian hospitals will be transmitted with the other accounts for the treatment of the patient concerned to the appropriate authority listed in section VIII.

103.1 Utilization of outdated blood. *a.* The following statement constitutes Department of Defense policy regarding utilization of outdated blood in the Department of Defense Blood Program:

Military blood banking operations will result in the accumulation of varying amounts of whole blood which is not used prior to its expiration date. The constituents of this outdated blood remain as a source of valuable biologic products. As a matter of policy all appropriate and practicable means will be employed to insure optimum conservation and utilization of these constituents.

b. Feasible courses of action to implement this policy are listed below:

(1) A plasma storage program maintained at the local blood bank level consisting of single or double units of group specific plasma.

(2) A plasma exchange program between individual blood banks and plasma fractionating laboratories.

c. Commanders of Army medical treatment facilities are furnished the following guidance:

(1) Participation in a blood exchange program with a commercial firm is authorized provided that all the requirements set forth in APP 13–1403 are complied with.

(2) The organization or installation entering into the blood exchange contract must have procurement authority for the items being purchased.

(3) The property turned in must be similar to the property being acquired under the standards outlined in APP 13–1403(b), e.g., polio immune globulin, normal serum albumin, irradiated normal human plasma, and other blood products.

(4) The property being exchanged must be exempt from screening under the provisions of APP 13–1405.

d. The determination whether the items are similar and whether the property being exchanged is exempt from screening must be made by the person or organization possessing the technical knowledge sufficient to classify the property.

★**103.2 Blood products available from the Defense Personnel Support Center.** Normal source of supply for blood products listed in the Federal Supply Catalog, DOD Section, Medical Materiel, is the Defense Personnel Support Center. Procurement from other sources is not authorized except as outlined in paragraph 103.4 and in chapter 4, AR 40–61.

★**103.3. Blood products available from the American National Red Cross.** *a.* Blood components and derivatives which may be ordered from Red Cross Regional Blood Centers are—

(1) Red Blood Cells (approximately 250 ml)

(2) Plasma—fresh frozen (approximately 200-ml)

(3) Plasma Protein Fraction, 5 percent 250 ml

(4) Serum Albumin, 25 percent 50 ml

(5) Serum Albumin, 25 percent 100 ml

(6) Fibrinogen, 2gms

(7) Immune Serum Globulin, 2 ml 10 ml

(8) Other Blood Components As Available

Orders from Army hospitals located outside the continental United States should be forwarded to Headquarters, American National Red Cross, Washington, DC 20006. Platelet concentrates can be obtained from the American Red Cross only from a blood center located within the same State as the hospital.

b. Serum albumin, fibrinogen, and immune serum globulin are generally not stocked locally and should be ordered separately from other blood products. CONUS Army medical treatment facilities located near a Red Cross blood center should send their orders for these products to that center. Other CONUS Army medical treatment facilities should send their orders for these products to the medical director of the Red Cross area in which they are located. The Red Cross area medical directors and the States covered by each are shown in figure 2.2.

103.4 No-charge Immune Serum Globulin for certain patients. Immune Serum Globulin may be obtained from the Red Cross without charge for any person being provided out-patient treatment at an Army medical treatment facility for chronic agammaglobulinemia or dysgammaglobulinemia. Separate requests for such no-charge Immune Serum Globulin should be addressed to the area medical director listed in figure 2.2. The request should be signed by a physician and should be on an individual patient basis. Additional information concerning the patient will be furnished the Red Cross area medical director upon request.

103.5 Return of empty blood containers. Hospitals may make arrangements with the Red Cross blood centers for return of empty containers at the expense of the American Red Cross.

Area	*States covered*
Medical Director Eastern Area American Red Cross 615 No. St. Asaph Street Alexandria, VA 22314	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia.
Medical Director Midwestern Area American Red Cross 4050 Lindall Blvd. St. Louis, MO 63108	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, Texas, Wisconsin.
Medical Director Western Area American Red Cross 1550 Sutter Street San Francisco CA 94109	Alaska, Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming.
Medical Director Southeastern Area American Red Cross 1955 Monroe Drive, NE Atlanta, GA 30324	Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee.
Medical Director Hawaiian Area American Red Cross Post Office Box 3948 Honolulu, HI 96812	Hawaii.

Figure 2.2

SECTION XI

AUDITORY EVALUATION AND HEARING AIDS

104. For whom authorized. The categories of personnel who are authorized auditory evaluation, hearing aids, and aural rehabilitation are listed in table 1.

105. Auditory evaluation and treatment facilities. Patients requiring the above services will be referred through the facilities listed in *a* through *c* below. The choice of a particular facility will be based on professional considerations, travel economy, and the length of time required to obtain evaluation and/or treatment.

a. Auditory Screening Clinics.

(1) *Designation.* Any military facility with the capability to administer pure-tone audiometry may be considered an Auditory Screening Clinic.

(2) *Services provided.* These clinics will conduct screening pure-tone audiometry for military personnel. Individuals who demonstrate hearing levels below H-1 standards as defined in appendix VIII, AR 40-501, will be tested at least twice more to substantiate the hearing loss. Individuals with confirmed or suspected hearing loss compatible with H-4 profile will be referred by the Auditory Screening Clinic to the nearest Auditory Evaluation and Treatment Clinic or a Veterans Administration audiology clinic for further evaluation and/or treatment. Individuals with confirmed or suspected hearing loss compatible with H-2 or H-3 profile will be referred to a medical facility where auditory examination and profiling can be accomplished. This may be done at the Auditory Screening Clinic if appropriate Medical Corps personnel are available.

★*b. Auditory Evaluation and Treatment Clinics.*

(1) *Designated clinics.* Clinics at Brooke, Fitzsimons and Letterman General Hospitals and the U.S. Army Hospital, Landstuhl, Germany, are designated as Auditory Evaluation and Treatment Clinics. The Army Audiology and Speech Center, Walter Reed General Hospital, also serves as an Auditory Evaluation and Treatment Clinic.

(2) *Designation of additional clinics.* Additional clinics will be designated by The Surgeon General at medical facilities where audiologic activities will be under the supervision of a medical officer either certified or qualified in otorhinolaryngology. Requests for designation will be submitted to The Surgeon General, Department of the Army, ATTN: MEDPS-C, Washington, DC 20315, describing in detail physical facilities and equipment, qualifications of the responsible professional personnel, and the procedures to be followed for selection and issue of hearing aids.

(3) *Services provided.* These clinics will conduct auditory examinations for profiles, separation or retirement, special auditory tests, hearing aid evaluations, and provide for procurement and issuances of hearing aids and ear molds.

c. Army Audiology and Speech Center (AASC). The Army Audiology and Speech Center represents the highest echelon of auditory evaluation and treatment in the Army Medical Department. The Center serves as the coordinating facility for all Auditory Evaluation and Treatment Clinics. It conducts basic and applied research, provides consultation service, maintains a stock of hearing aids and accessories, issues and fits hearing aids and provides hearing aid repair service to Army medical treatment facilities worldwide. In addi-

tion, patients may be referred from Auditory Evaluation and Treatment Clinics or by Veterans Administration audiology clinics to the Army Audiology and Speech Center for aural rehabilitation.

106. Disposition of patients with hearing impairment. *a.* Active duty personnel who are examined for separation or retirement and found to have hearing compatible with H-4 profile may be processed at an Auditory Evaluation and Treatment Clinic or at the Army Audiology and Speech Center in accordance with AR 40-501 and AR 635-40.

b. Active duty personnel whose hearing does not meet retention standards will be processed at an Auditory Evaluation and Treatment Clinic, the Army Audiology and Speech Center, or at an audiology clinic of the Veterans Administration.

c. Retired personnel with hearing loss who require further auditory evaluation may be referred to an Auditory Evaluation and Treatment Clinic, the Army Audiology and Speech Center, or to an audiology clinic of the Veterans Administration.

d. Patients with temporary hearing loss or middle ear disease will be treated in accordance with local policy. These cases will not be transferred to one of the facilities listed in paragraph 105 unless the hearing remains below retention standards following medical or surgical treatment.

e. Patients who were initially classified as having inappropriate hearing levels, but who are later determined to have H-3 hearing levels or better, will be returned to duty with appropriate profiling. If nonorganic hearing loss is diagnosed, a notation will be made in the health record.

107. Veterans Administration audiology clinics. A patient may be referred to a Veterans Administration audiology clinic by the Auditory Screening Clinic for confirmation of the degree of hearing loss or for a hearing aid evaluation. Veterans Administration audiology clinics are listed in appendix III.

a. When referral is to be made to a Veterans Administration audiology clinic, the referring medical officer will obtain an appointment for the individual concerned. The individual will take with him to the Veterans Administration audiology clinic a completed SF 513 (Clinical Record—Consultation Sheet) and a record of his audiologic evaluation.

b. The Veterans Administration audiology clinic will determine the need for a hearing aid and, where indicated, issue a hearing aid in accordance with their standard policies. After fitting and issue of the hearing aid, the patient will return to the referring Army facility for followup and profiling.

c. Upon request by the referring medical facility, the Veterans Administration will furnish two hearing aids to personnel under the conditions listed in paragraph 109.

d. Charges for hearing aids obtained from the Veterans Administration will be paid locally from funds available to the referring installation.

108. Procurement of earing aids. In order to properly utilize hearing aid repair facilities at the Army Audiology and Speech Center, the selection of hearing aids for issue by Auditory Evaluation and Treatment Clinics will be limited to those instruments included on a list provided annually by the Army Audiology and Speech Center. Procurement of these aids will be through established Army medical supply channels to Assistant Director, Supply Service for Marketing (134J), Veterans Administration Marketing Center, P.O. Box 76, Hines, IL 60141.

109. Number of hearing aids to be furnished. All authorized individuals will be furnished one hearing aid except individuals in receipt of change of orders for movement overseas, assigned to STRAC units, or who are frequently assigned overseas on temporary duty. Binaural hearing aid sets and Contralateral Routing of Signals (CROS) instruments will be considered single items.

110. Records. When a hearing aid is issued by the Army Audiology and Speech Center, an

Auditory Evaluation and Treatment Clinic, or a Veterans Administration audiology clinic, the following information will be entered in the health record of a patient:

a. Make and model of the hearing aid, with quantity.

b. Date of issue.

c. Type of battery and number of batteries included in initial issue.

111. Replacement and repair of hearing aids. *a.* Replacement and repair of defective hearing aids will be provided worldwide through the nearest Army medical facility. The medical supply officer will check the batteries, receiver cord, electrical and mechanical contacts. Defective batteries and receiver cords will be replaced and the contacts cleaned. If the hearing aid still fails to operate, the complete hearing aid, less batteries, will be shipped by the medical supply officer by registered air mail to the Army Audiology and Speech Center, together with DA Form 2407 (Maintenance Request). The name, grade, and Social Security number of the hearing aid user will be placed in section 16 of the form, with comment on the nature of the defect or complaint. A copy of the DA Form 2407 will be provided the user as a receipt for the hearing aid.

b. Upon receipt by the Army Audiology and Speech Center, the hearing aid will be examined, repaired, tested, and returned to the medical supply officer of the installation from which it was received. If the hearing aid is unrepairable, the Army Audiology and Speech Center will replace the hearing aid with a new instrument.

112. Parts and accessories. Receivers, receiver cords, and hearing aid garment bags will be requisitioned by the installation medical supply officer from the Army Audiology and Speech Center.

113. Batteries. *a.* A 3-month supply of batteries will be provided with the issue of the hearing aid and will be indicated on the issue voucher when the instrument is issued. This information will be recorded by the issuing facility in the individual's health record (para 110).

b. As batteries require replacement, they will be obtained locally from the installation medical supply officer. Medical supply officers normally will obtain hearing aid batteries from the installation consolidated supply officer for stock and issue to hearing aid users.

c. Local procurement of batteries may be accomplished under the conditions specified in (1) and (2) below.

(1) If batteries required are not immediately available from the installation consolidated supply officer at the installation where application for replacement is made and purchase will not exceed $200 for each purchase order, the installation medical supply officer may procure batteries from commercial sources. Payment for such purchases will be accomplished from funds available locally.

(2) When application of (1) above is impracticable, the installation medical supply officer may authorize the user of the hearing aid to procure the batteries (not to exceed a 3-month supply) through commercial channels. Payment for these batteries will be made by the individual who will be reimbursed on presentation of the following documents to the Army installation authorizing the purchase:

(*a*) A statement from the individual in triplicate showing his full name, grade, service number, Social Security account number, the place and date of the purchase, and charges. The statement will contain adequate identification of the hearing aid and will show the name of the agency from which it was obtained. It will also contain a statement signed by the individual that the charges are correct, that payment therefor has not been received, and that the batteries were necessary for the operation of the hearing aid.

(*b*) The signed receipted bill of the vendor itemized to show the date of purchase, battery numbers, and charges.

(*c*) A signed statement from the medical supply officer of the Army installation normally furnishing the batteries to the individual that the necessary batteries were not available locally and that the charges do not exceed those customary in the vicinity.

114. Accountability and responsibility. Each individual will acknowledge receipt in writing to the installation medical supply officer when he receives his hearing aid. When the loss, damage, or destruction of a hearing aid is believed attributable to the misconduct of the individual, the commander of such individual will initiate the necessary administrative action to determine the circumstances and, if indicated, secure reimbursement to the Government for such loss, damage, or destruction. The commanding officer will initiate action through the medical treatment facility having responsibility for the medical care of the individual to replace the hearing aid.

SECTION XII

OPTICAL SERVICES

116. For whom authorized. *a.* The categories of individuals who are authorized the issue and repair of spectacles are shown in table I.

b. Spectacles may be furnished to the following categories of individuals on a reimbursable basis at rates computed as outlined in paragraph 124.3:

(1) Dependents of members of the uniformed services outside the United States or at Army installations within the United States which have been designated as remote for the purpose of providing spectacle service to dependents.

(2) Dependents of foreign military personnel of the NATO nations and of other officially recognized foreign military personnel at Army installations within the United States which have been designated as remote for the purpose of providing spectacle service to dependents of members of the US uniformed services.

(3) Civilian employees of the Department of the Army (and their dependents) employed at Army installations within the United States which have been designated as remote for the purpose of providing medical care to civilian employees.

(4) Foreign civilian personnel accompanying foreign military personnel of the NATO nations (and their dependents) and other officially recognized foreign civilian personnel at Army installations within the United States which have been designated as remote for the purpose of providing medical care to US Army civilian employees.

(5) Nonmilitary personnel authorized medical care at Army medical treatment facilities outside the United States.

c. Notwithstanding the provisions of paragraph 121*a*, nonstandard spectacles may be fabricated and issued on a reimbursable basis to authorized individuals as outlined in this paragraph where authorized by the Department of the Army as a measure to lessen expenditures on the local economy in oversea commands.

117. Examination of eyes. *a.* The eyes of all military personnel will be examined, when indicated, as soon as possible after entering service. Spectacles, if required, will be ordered promptly. This procedure will reduce to a minimum the number of spectacle orders for POR and POM alerted personnel.

b. When medical treatment facilities of the Department of Defense are not available, refraction will be obtained from medical treatment facilities of Federal agencies outside the Department of Defense in accordance with section VI. When refraction cannot be provided by medical treatment facilities of Federal agencies outside the Department of Defense, a civilian physician or optometrist may be employed in accordance with section VIII. Such refraction will include fitting and adjusting of spectacles. All prescriptions will be entered in DD Form 771 (Eyewear Prescription).

118. Issue of spectacles. *a. General.* Spectacles will not be obtained from sources other than military optical laboratories or units, except as provided in paragraph 124.

b. CONUS. Spectacle prescriptions prepared by military eye clinics in accordance with paragraph 119 will be submitted to optical laboratories as follows:

★(1) First, Third, and Fifth US Armies and US Army Military District of Washington: to US Army Medical Optical and Maintenance Agency, Denver, CO 80240, except that single vision spectacles (white, tinted and case hard-

ened lenses) in standard gray frame and inserts for protective masks will be submitted to the laboratories indicated below:

(*a*) Fort Dix: to the Optical Laboratory, Supply and Servic s Division, Walson Army Hospital, Fort Dix, NJ 08640.

★(*b*) Stations in the states of Alabama, Florida, Georgia, North Carolina, and South Carolina and in Puerto Rico: to the Optical Laboratory, Supply and Services Division, US Army Hospital, Fort Jackson, SC 29207.

(*c*) Stations in the states of Illinois, Indiana, Kentucky, Michigan, Ohio, and Tennessee: to the Optical Laboratory, Supply and Services Division, Ireland Army Hospital, Fort Knox, KY 40120.

(*d*) Stations in the states of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas: to the Opitcal Laboratory, Logistics Division, Brooke Army Medical Center, Fort Sam Houston, TX 78234.

(2) Sixth US Army area to: US Army Medical Optical Laboratory, Tracy, CA 95376.

c. Oversea commands. Medical facilities and units will transmit spectacle prescriptions to the US Army optical laboratories or units designated by the major oversea commander. Where US Army optical laboratories or units are not available or where prescriptions are beyond the fabricating capability of optical laboratories or units in the command, the medical facility will forward DD Form 771 to—

(1) US Army Medical Optical Laboratory, Tracy, CA 95376 by medical facilities and units located in the Pacific area and Alaska.

★(2) US Army Medical Optical and Maintenance Agency, Denver, CO 80240 by medical facilities and units located in all oversea commands and areas other than the Pacific area and Alaska.

d. Certain spectacle prescriptions for Navy and Marine Corps personnel. Spectacle prescriptions for aviation sunglasses, aviation clear coated lenses, and nonstandard spectacles for Navy and Marine Corps personnel will be forwarded by medical treatment facilities to the Navy Ophthalmic Lens Laboratory, US Navy Supply Center, Cheatham Annex, Williamsburg, VA 23185.

e. Individual's personal property. Spectacles, including spectacle inserts for protective masks, are custom-made for the individual. As such, they are considered the individual's personal property and will accompany him upon transfer.

f. Number of standard spectacles to be furnished.

★(1) Military personnel who require spectacles will have two pairs in serviceable condition. Where individual personnel do not require the constant utilization of spectacles, the examiner may prescribe a single pair of spectacles.

★(2) A pair of civilian type plastic spectacles with proper lens correction which are similar in design and color to military standard issue spectacles may be considered in fulfilling the two pair standard spectacle requirement.

(3) A replacement pair of spectacles will be ordered whenever a pair of spectacles becomes unserviceable.

(4) The provisions of (1) above and *g* below will be fulfilled in preparing and processing personnel for oversea movement as outlined in AR 612-2.

g. Special types of spectacles. Special types of spectacles will be prescribed in the number of pairs indicated under the conditions specified below:

★(1) Spectacle inserts for protective masks (one pair) will be furnished—

(*a*) To personnel—

1. Assigned to STRAF units.

2. Identified by DA for oversea assignments.

3. Assigned to Army Air Defense units, including National Guard assigned thereto.

4. Assigned to National Guard or Army Reserve units designated for control of civil disturbances as provided in paragraph 121.1.

(*b*) Under the following criteria—

1. The binocular visual acuity is poorer than 20/70 (poorer than 20/40 in the case of Army aviators, aircraft crewmembers and military vehicle operators); or

2. Bifocal correction is required (this correction will be furnished in standard lenses only); or

3. Medical or employment requirements necessitate wearing of spectacle inserts although the binocular visual acuity is greater than prescribed in *1* above. When prescribed under this provision, DD Form 771 will include a statement of the condition requiring the inserts and will be approved by the commander of the medical treatment facility.

(2) Military personnel requiring prescription spectacles will be prescribed one pair of prescription sunglasses when—

(*a*) Individual is being assigned on PCS orders to USARPAC or is being assigned to a unit which is subject to a movement directive stipulating transfer to USARPAC; or

(*b*) PCS orders indicate that unit to which individual is being assigned is subject to movement directive as outlined in (*a*) above; and

(*c*) Movement directive or PCS orders indicate the personnel will be furnished items authorized by CTA 50-901 for Zone 1. Spectacle orders on DD Form 771 will cite movement directive or PCS orders in remarks section with destination being USARPAC.

(3) Aviation sunglasses (two pairs) for those personnel who require corrective lenses and are on flight status or perform control tower or drone control duties.

(4) Aviation clear coated spectacles (two pairs) to personnel on flight status who require corrective lenses to perform aircrew duties.

(5) Plano clear lenses in standard gray frames (one pair) for practicing dental offices, hygienists, and technicians as a protective device against hazards of debris and mouth contaminants when using high-speed dental equipment.

(6) Shooting glasses (one pair amber lenses and one pair gray lenses in aviation spectacle frames) for personnel of the US Army Advanced Marksmanship Unit, and members of the pistol and rifle teams representing CONUS armies and MDW, ARADCOM, USMA, and major oversea commands.

h. Delivery of spectacles. The prompt delivery of spectacles to the individual concerned requires that prescribing clinics forward spectacle prescriptions daily to optical laboratories or units and that airmail service be utilized where it will reduce the transmission time. Optical laboratories or units will utilize airmail service or other means where feasible to reduce delivery time of spectacles to clinics. Clinics will—

(1) Dispense completed spectacles promptly upon receipt.

(2) Forward undelivered spectacles immediately to the new address in the event of transfer of the individual to another station.

(3) Return to the servicing optical laboratory or unit those spectacles which cannot be delivered or forwarded to the individual concerned. A statement explaining the reason for the return of spectacles will accompany the spectacles and DD Form 771.

118.1 Impact resistant lenses. Spectacles furnished to personnel authorized in paragraph 116 will contain impact resistant lenses as indicated below:

a. Cellulose Acetate Frame Spectacles

(1) Personnel requiring a single vision correction of plus or minus 3.00 diopters or greater in the spherical portion of the lens when written in minus cylinder form will be furnished with clear plastic lenses.

(2) Personnel with corrections of less than the power indicated above (in either eye) and those requiring multi-focal lenses will be furnished with crown glass heat-treated lenses.

(3) Tinted lenses (all colors and light transmissions) will be furnished with crown glass heat-treated lenses.

b. Aviation spectacles (sunglasses and magnesium fluoride coated glasses) will be furnished with crown glass heat-treated lenses.

c. Spectacle inserts for protective masks will be furnished with crown glass heat-treated lenses.

d. Plano clear lenses for dental officers and allied personnel will be provided with crown glass heat-treated lenses.

e. Shooting glasses will be furnished with glass heat-treated lenses.

f. Personnel employed in industrial occupations or subject to eye hazardous conditions will be provided with glass industrial safety thickness lenses, a minimum of 3mm thickness.

★118.2 Plastic lenses for special prescriptions. *a.* Notwithstanding provisions of paragraphs 118 and 118.1, clear plastic lenses will be furnished for the following:

(1) Cataract series lenses.

(2) Multi-focal lenses where the highest power meridian of the distance portion is plus or minus 8.00 diopters or higher when written in minus cylinder form.

(3) Prescriptions having a power difference between the right and left lens of 4.00 diopters or more.

(4) Prescriptions which require prism in excess of 3 prism diopters in each lens and where the fresnel press-on prism is not acceptable.

b. Prescriptions for categories of lenses in *a* above will be prepared on DD Form 771-1 (Eyewear Prescription—Plastic Lenses).

c. Clinics will forward all special prescriptions as outlined in *a* above to the US Army Medical Optical and Maintenance Agency, Denver, CO 80240.

119. Preparation of DD Form 771 (Eyewear Prescription). This form will be used for all prescriptions providing for glass lenses (see para 119.1 for prescriptions with plastic lenses).

a. Date. Enter date that prescription is prepared.

b. Order Number. Enter station number, followed by prescription number assigned serially within fiscal year, and last two digits of fiscal year, with the three groupings separated by hyphens.

c. To. Enter title and address, including ZIP Code of servicing optical laboratory.

d. From. Enter complete designation and location, including ZIP Code, of prescribing unit.

e. Name, grade, social security number/service number, and age. Enter identifying data on patient.

f. Unit and address. Enter complete information on patient's unit and location.

g. Status information. Check status of patient as authority for furnishing spectacles and check box showing uniformed service of which he is a member.

h. Spectacles.

(1) Check appropriate box for type of eyewear being prescribed.

(2) When protective mask inserts are prescribed, it is necessary to designate the appropriate mask and position as follows:

(*a*) M-9 masks—indicate insert position A, B, C, D, E, W, or X.

(*b*) M-17 masks—indicate the position (lower, central, or upper) with the bridge width (wide or narrow).

(*c*) M-14A2, M-17A1 and M-25—a single size insert will fit each of these masks. Indicate mask type to identify type of spectacle insert. As an interim measure, the same insert may be prescribed for the M-24 (aviator's mask) pending development of a new item.

i. Fabrication data. Enter interpupillary distance for distant and near vision, eye size, bridge size, temple length and style, number of pairs, and cases. The frame size will be prescribed to fit the patient and not to serve any other purpose.

j. Single-vision and multivision data. Enter correction required for each eye, including applicable information for each of the columnar headings. The prescribing officer will prepare the prescription in terms of "plus cylinder" for single-vision prescriptions and in terms of "minus cylinders" for bifocal prescriptions.

k. Special lenses or frame. Enter details as required by prescription form, including basis and/or justification for a special item; full description of any unusual prescription; and additional information that will assist the laboratory in fabricating the prescription.

l. Signatures. Enter name, grade, and title of prescribing officer (medical officer or optometrist). If an approving officer's signature is required, the medical facility commander may designate a senior officer to perform this function. DD Form 577 (Signature Cards) will be furnished to the servicing optical laboratory or unit for each prescribing officer and designated approving authority.

★*m.* DD Form 771 will be prepared in sets of three copies. Copies 1 and 2 will be forwarded daily to the servicing optical laboratory or unit. The laboratory will retain copy 1 and return copy 2 with completed spectacles to the clinic. Copy 2 with marking "Lenses are Heat-Treated and Tested" will be inserted in patient's Health Record (DD Form 722) as permanent record of compliance with FDA requirements and copy 3 will be furnished to the patient with completed spectacles.

119.1 Preparation of DD Form 771-1 (Eyewear Prescription—Plastic Lenses). This form will be prepared for all prescriptions requesting plastic lens components as authorized by paragraph 118.1.

The date, order number, to, from, name, grade, social security number, age, unit and address, and status information will be completed in accordance with the provisions in paragraph 119.

a. Spectacles. Check appropriate box for type of eyewear being described. The spaces for "aviation spectacles" and "protective mask insert" will not be utilized.

b. Fabrication data. Enter interpupillary distance for distant or near vision, eye size, bridge size, temple length and style, number of pairs, and cases. The frame size will be prescribed to fit the patient and not serve any other purpose.

c. Single-vision data. Enter correction required for each eye including applicable information for each of the columnar headings. The prescribing officer will prepare the prescription in terms of *minus cylinder* for single-vision plastic lens spectacles.

d. Information for compilation of statistical data. The appropriate boxes will be indicated with an "X" for initial issues and replacement issues. Careful consideration should be given to each entry so that the information can be recorded at a data center. Information should be secured from the patient and the patient's health record in order that appropriate boxes are checked.

e. Special lenses, frames, and signature. Provisions of paragraph 119 are applicable for these items.

f. Distribution of copies. DD Form 771-1 will be prepared in sets of five copies. The prescribing clinic will retain copy 5 for its records and copy 3 will be inserted in the patient's Health Record (DD Form 722). Copies 1, 2, and 4 together with interleaved carbons will be forwarded to the designated optical laboratory. The laboratory will retain copy 1, return copy 2 with completed spectacles to the clinic, and transmit copy 4 to designated data center. The clinic will furnish copy 2 to the patient with the completed spectacles.

120. Spectacle priority system. Medical treatment facilities will use the following priority system in the order of the listing below for designating and processing spectacle orders:

a. POR and POM orders. These orders will be identified by typing or stamping the words POR or POM in the Special Lenses or Frame section or DD Form 771.

Note. POR and POM orders will be kept to an absolute minimum by insuring that the eyes of all personnel are examined as early as possible during the training period. Spectacles, when indicated, will be ordered immediately.

b. Trainee orders submitted for enlisted personnel undergoing training. This class of orders will be identified by typing the word TRAINEE in the Special Lenses or Frame section of DD Form 771.

c. All other orders. All spectacle orders not identified in *a* or *b* above.

121. Types of spectacles available. Requests for each of the following types of spectacles will be submitted separately on DD Form 771.

a. Spectacles—standard issue. Prescription spectacles will be furnished in standard gray spectacle frames. Prescription spectacles in frames other than the standard issue type will not be furnished for cosmetic appearance or personal preference purposes. They may be furnished, however, in those cases where a facial deformity or abnormality precludes the use of the standard spectacle frame. The standard frame with or without adjustable pads has been designed to fit most facial characteristics. Request for prescription spectacles in special frames will state in detail the purpose necessitating such frames.

b. Spectacle inserts for protective masks. Fitting sets listed below will be utilized for protective masks authorized in paragraph 118*g*(1). The sets contain an Instruction Manual which will be utilized in prescribing, fitting, and adjusting the spectacles.

(1) *M-9-series.* Mask, Protective. Use Fitting Set, Field Protective Mask Eyewire, and Support.

(2) *M-17.* Mask, Protective. Fitting Set CBR Mask Optical Insert, FSN 6540-656-1252.

(3) *M-14A2, M-17A1, M-25, and M-24 masks.* A fitting set is not required. The single size spectacle insert (PD 66) FSN 6540-935-6573, can be adjusted to the appropriate height by inserting the retention struts at the proper level within the rubber blocks in the masks. Vertex distance will be accomplished by regulating the distance that struts are inserted in rubber blocks. The struts are a malleable material which permits required adjustment of the positioning angle of insert.

c. Aviation sunglasses. Neutral 15 percent (N-15) transmittance gray lenses in the standard

aviation frame will be the prescription sunglass for personnel on flying status in the performance of aircrew duties and for control tower and drone-control operators. Where the correction exceeds 2.75 diopters of myopia or 1.50 diopters of hyperopia in any meridian, the servicing optical laboratory will furnish clear glass lenses coated in a gray tint in lieu of the standard N-15 tinted lenses, except that any correction in excess of 5.50 diopters of myopia or hyperopia in any meridian will be furnished in a standard S-7 frame. The furnishing of coated lens in lieu of tinted glass is necessary because of undesirable light transmittance changes occurring in tinted lens of foci greater than those specified. When ordering aviation sunglasses, a statement is required that the individual is on flying status or in a control-tower or drone-control operator.

d. Aviation low reflectance coated spectacles. Magnesium fluoride coated lenses in standard aviation spectacle frame will be the clear glass prescription spectacles for personnel in flying status in the performance of aircrew duties. Magnesium fluoride coated lens will not be provided when the correction exceeds 5.50 diopters of myopia or hyperopia in any meridian. When ordering aviation coated spectacles, a statement is required that the individual is on flying status.

e. Shooting glasses. Prescription shooting glasses for members of pistol and rifle teams will be prescribed only where the officer in charge of the team certifies that the individual requiring the glasses is a member of a team listed in paragraph 118*g*(6) and the spectacle order includes a statement that the individual has been certified as a member of an authorized pistol and rifle team.

★*f. Investigative, intelligence, and EOD personnel.*

(1) Issue of two pairs of spectacles with nonstandard frames is authorized for the following personnel:

(*a*) Criminal investigation personnel with MOS 951 and 95D and to officers serving in MOS 9100 and 9110 who are actually supervising CID activities.

(*b*) Intelligence enlisted personnel with MOS 97B40, 97B50, 97C40, 97C50, 97D20, 97D40, and 97Z50, warrant officers in MOS 971A and 972A, and officers serving in MOS 9666 and 9668.

(*c*) Explosive ordnance disposal personnel with MOS 9224 and MOS 55D.

★(2) Requests for nonstandard frames will be initiated by commanding officers of units with assigned criminal investigative, intelligence or explosive ordnance disposal personnel and will indicate that the individual designated therein is engaged in investigation or security tasks and is assigned to a controlled DA MOS position which is authorized nonstandard spectacles in (1) above. The military grade of the individual will not be used in requests or on spectacle prescriptions. Prescribing officers will indicate on DD Form 771 that appropriate authority has been furnished. Recommended frame style will also be indicated where practicable. In CONUS and all oversea commands, except USAREUR, prescriptions will be forwarded to the US Army Medical Optical and Maintenance Agency, Denver, CO 80240, or the US Army Medical Optical Laboratory, Tracy, CA 95376, as appropriate. In USAREUR prescriptions will be forwarded to servicing optical laboratory.

(3) Nonstandard frames to be selected and authorized by eye clinics will have the same basic measurements as the standard military spectacle frames and will be measured and dispensed by utilizing standard spectacle fitting set. Detailed information relative to size, colors, and types of available nonstandard frames will be furnished by servicing optical laboratories.

121.1 Furnishing spectacle inserts to National Guard and Army Reserve. *a.* Spectacle inserts for protective mask M-17 only may be prescribed for National Guardsmen and Army Reservists assigned to units designated for control of civil disturbances. The following procedures will be applicable to refraction, prescribing, fabrication, and fitting of inserts:

(1) The Chief, National Guard Bureau, and Chief, Army Reserve will designate types of personnel in appropriate units to be examined for need of spectacle inserts. The listing of troop units will be furnished to CONUS Army surgeons.

(2) CONUS Army surgeons will provide optometric service from Class I medical facilities for refraction, prescribing, and fitting of spectacle inserts into M-17 protective masks. Where AMEDD Class II medical facilities are in proximity to appropriate units, the CONUS Army surgeon will arrange for such services with the Class II facility. CONUS Army surgeons will also notify appropriate CONUS optical laboratories listed in paragraph 118*b* of units authorized spectacle inserts.

(3) Where optometric services by personnel from Class I or II medical facilities are provided at unit armories or other sites, the National Guard or Army Reserve will be responsible for payment of TDY costs incident thereto.

(4) Prescribing of spectacle inserts will be subject to provisions of paragraph 118*g*(1).

(5) Prescriptions will indicate that recipient is a National Guardsman or Army Reservist, unit to which assigned, and state in which unit is located.

b. Fabrication, accounting, and reimbursement for spectacle inserts will be as follows:

(1) Prescriptions will be forwarded to optical laboratory providing area support service as outlined in paragraph 118*b*.

(2) Charges for spectacle inserts will be $3.50 per pair.

(3) Optical laboratories will provide their servicing finance and accounting offices with—

(*a*) Periodic reports on number of prescriptions received from National Guard and Army Reserve for establishing orders received —automatic.

(*b*) Periodic reports by state and separately for National Guard and Army Reserve of individuals and their unit designations for whom inserts have been fabricated.

(4) Servicing finance and accounting offices will prepare and process Standard Form 1080 (Voucher Transfers Between Appropriations and/or Funds) for reimbursement to applicable National Guard and Army Reserve disbursing activities.

(5) Optical laboratories will report number of inserts fabricated for National Guard and Army Reserve personnel separately as memorandum items in Remarks Section, Optical Laboratory Report, RCS MED-199(R1), DA Form 2717.

122. Limitations on issue of lenses. *a.* The furnishing of uncut lenses is not authorized.

b. Lenses of ⅛ diopter variations will not be furnished.

c. Bifocal adds of less than 0.75 diopters will not be furnished.

d. Optical laboratories or units are authorized to substitute spherical or cylindrical power when filing a prescription for lenses not carried in stock, provided the sphere or cylinder component is not changed more than 0.25 diopter.

e. The types of lenses in (1) through (8) below will be prescribed only for special purposes which preclude the use of standard clear spectacle lenses. Prescriptions on DD Form 771 will indicate in special lenses or frame section the purpose necessitating such lenses and will be approved by the commander of the medical treatment facility. The issue of these lenses for cosmetic appearance or personal preference is not authorized.

(1) *Tinted lenses.* When required, the standard gray tint lenses will be prescribed, except that other shades or a different percent of light transmission may be prescribed where necessary. Plano tinted lenses are not corrective lenses and will not be furnished by optical laboratories or units.

(2) *Lenses with special base curves.* State base curve desired. Substitutions within accepted commercial designations will be made, if practical. When duplicating lenses with special base curves, the curves of the old lenses will be indicated.

(3) *Prism segment focals.* State amount of prism, axis of base, segment location, and inset

with relation to optical center of distance portion.

(4) *Trifocals.* State power and size of intermediate segment and the near vision segment. State segment location and inset with relation to optical center of distant portion. Normal power of intermediate segment is 50 percent of addition, and the size is usually 7 mm. Total and overall segment height should be specified.

(5) *Myodisc and lenticular lenses.* These lenses are available on special order.

(6) *Heat-treated lenses for protection of the eyes.* These lenses are available when so indicated on DD Form 771. Plano safety spectacles will be obtained in accordance with AR 385-32.

(7) *Coated lenses except for aviation coated spectacles.*

(8) *Bifocals other than straight top, 25 mm.* State power, segment location, and inset with relation to optical center of distance portion.

★*f.* Requirements for iseikonic and telescopic lenses will be determined, funded, and procured by the prescribing facility.

★*g.* Rescinded.

★**122.1 Contact lens service.** *a.* The prescription and fitting of contact lenses is authorized only at those Army medical facilities which meet the following criteria:

(1) An optometrist or ophthalmologist competent in contact lens fitting must be available.

(2) Adequate diagnostic, inspection, and modification equipment must be available to assure success in the fitting.

b. General guidelines for approval or issuance of contact lenses are summarized as follows:

(1) Monocular aphakia or an extremely high degree of anisemetropia.

(2) Other monocular conditions such as keratoconus and severe cases of irregular astigmatism.

(3) High degrees of refractive error in which ordinary spectacles cause discomfort by reasons of ghost images, prismatic displacements, etc.

(4) Specialized types of duty in a physical environment which precludes satisfactory performance of duty with ordinary spectacles (exposure to sea spray, smoke, water vapors, extreme cold). Use of contact lenses is contraindicated in environments where exposure to toxic chemical vapors or dust occurs.

(5) In special instances for members of recognized athletic teams whose participation constitutes a morale factor for the service at large. However, it must be clearly established that ordinary lenses would be a hazard to the eyes under the prevailing conditions.

c. When contact lenses are provided to eligible persons under the provisions of *b* above, or paragraph 4-6*p*, AR 40-121, requirements will be determined by the prescribing facility. Funding and procurement will be through local medical supply channels. Contact lenses approved for purchase by the Government should be constructed so as to permit free circulation of the natural tear film over the cornea.

d. The commander of the medical facility is responsible for determining whether a limited elective contact lens service will be provided for persons not meeting the criteria of *b* above or paragraph 4-6*p*, AR 40-121. Such a service is highly desirable to develop and preserve competency and proficiency among the professional personnel involved. However, such service, if provided, will not be permitted to interfere with basic vision care. Contact lenses prescribed under such a program will be procured at the expense of the individual and it is advised they are available through the facilities of the Army and Air Force Exchange Service. The collection or acceptance of fees for prescription and fitting services provided by an Army medical facility is prohibited (para 1-5*b*, AR 40-1).

★**122.2 Laboratory responsibilities for spectacles.** Optical laboratories and units will—

a. Inspect each pair of completed spectacles for compliance with prescription. Where any deviation is made which is not authorized by these regulations, the prescription form will be noted accordingly for information of the prescribing clinic.

b. Peen or stake screws which attach temples to spectacle fronts or close eyewires prior to shipment of spectacles to ordering clinics. Optometry clinics will peen temple screws after replacement repair of spectacles front or temple.

c. Remove all lens markings used in the fabrication process prior to inspection of spectacles.

d. Subject all heat-treated lenses to appropriate impact test by use of steel drop ball. The prescription form will be annotated that impact test has been accomplished.

123. Permanent record of prescription. In order to facilitate the replacement or repair of lost or broken lenses or frames and to preclude unnecessary eye examinations and the issuance of more than the prescribed number of pairs of spectacles, copy 3 of DD Form 771 will be filed with the individual's permanent health records.

124. Repair or replacement of spectacles. *a. General.* For the purpose of this paragraph the term "repair" will be construed as the replacement of either lens or both and/or any integral part of the frame. Normally, spectacles are repaired either at medical treatment facilities or sent to a military optical laboratory or unit depending upon the complexity of the repair. However, the personnel listed in column 1 of figure 3 whose spectacles were lost, damaged, or destroyed may have such spectacles repaired or replaced from civilian sources when the appropriate authority shown in column 2 of figure 3 determines that the following conditions exist:

(1) The member has no other serviceable spectacles.

(2) He is far removed from a military medical treatment facility.

(3) Lack of a suitable pair of spectacles would interfere with his performance of duty.

b. Payment of charges. The charges for civilian repair or replacement will be paid by the appropriate authority authorizing the repair or replacement from the appropriate open allotment for civilian medical care at rates stated in AR 40-330.

124.1 Clinic requirements for spectacles. Chiefs of ophthalmology services are authorized to submit spectacles orders to optical laboratories or units for prescription spectacles for use in the postoperative care of cataract patients. These spectacles will remain the property of the eye clinic.

124.2 Optical Laboratory Report. DA Form 2717 (Optical Laboratory Report) will be prepared by all optical laboratories or units in accordance with chapter 11, AR 40-61.

124.3 Charges for spectacles. Spectacles furnished to authorized individuals under the provisions of paragraphs 116*b* and *c* will be issued on a reimbursable basis. Charges for spectacles issued under this authority will be based on the cost of component parts and a nominal amount to cover breakage incurred in the fabrication process. Charges will be collected locally from the individual except in the case of beneficiaries of the Bureau of Employees' Compensation (para 6*c*(3)(*b*)).

Category	*Appropriate authority*
Members of the Army on active duty	Immediate commander.
Members of the Army Reserve components on active duty for periods of 30 days or less, and those who are not on active duty.	Commander of the major command under whose jurisdiction the duty was performed, or his designee, in the case of a member of the Army Reserve or of a member of the Army National Guard (Federal status); or upon determination by the Chief, National Guard Bureau, or his designee, in the case of a member of the Army National Guard (National Guard status).

Figure 3. Persons authorized repair or replacement of spectacles from civilian sources.

★SECTION XIII

DENTAL CARE

125. General. Prevalence and incidence of oral disease are so great that for the foreseeable future a discrepancy will exist between need for dental care and professional resources available for providing care. The Commanding Officer of each dental activity or Chief, Department of Dentistry of a hospital is responsible for determining how available resources can most effectively be employed in support of the Army mission. Included in this responsibility is the determination of:

a. Which types of disease conditions will receive earliest treatment.

b. The extent of care that can be given patients within the various categories of personnel authorized care. Terminology for specifying extent of care is as follows:

(1) *Emergency care* consists of measures provided for conditions of trauma or disease requiring prompt attention because of their severity, acuteness, or the degree of pain they cause.

(2) *Interceptive care* consists of measures undertaken to control existing disease *lesions.* Restoration of function and/or esthetics may occur incidentally but are not specific objectives of the treatment.

(3) *Preventive care* consists of measures undertaken to prevent the occurrence of disease or to control disease *processes.*

(4) *Corrective care* consists of measures undertaken to attain or restore an optimum* state of function and esthetics.

(5) *Definitive care* consists of measures undertaken to attain and maintain an optimum* state of oral health. Definitive care may consist only of preventive care or it may include both preventive and corrective care.

126. For whom authorized. Dental care is authorized for the same persons provided medical care. Limitations on extent of care are found in sections II through VIII, this regulation, AR 40-30, and AR 40-121.

127. Policy. In determining how best to employ available resources, Commanders of Dental Activities or Chiefs of Departments of Dentistry, will take into consideration the following factors: the degree of entitlement to dental care at Army medical and dental facilities; the degree of acuteness of the condition for which treatment is sought or provided; the probable degree of impact on the Army's mission effectiveness; and age-related disease susceptibility.

a. Entitlement to care. Priorities reflecting the basis for degree of entitlement to care at Army medical and dental treatment facilities are shown in figure 1, section II.

b. The degree of acuteness of the condition for which treatment is sought or provided. Dental emergency conditions have highest priority for care. Otherwise the relevance of degree of acuteness to priority of care must be judged in relationship to other criteria for determining how best to invest treatment resources.

c. Impact on the Army's mission effectiveness. The major effect of oral disease on mission effectiveness occurs when military personnel develop acute, painful oral conditions. The seriousness of the impact depends on the degree of effect on persons having the conditions, the types of duties to which they are assigned, and

*The best possible under existing circumstances.

how readily accessible dental care is. Even though it is not possible within presently available resources to prevent all dental emergencies, judicious use of these resources can significantly reduce the impact of dental emergencies on the Army's mission effectiveness.

(1) Army personnel being assigned to or likely to be assigned to areas of active combat or to other areas of critical importance, especially those having MOS which would indicate duty to be performed in forward areas removed from readily available dental support, will as a minimum be given interceptive care for conditions having a high probability of developing into dental emergencies during the expected tour of duty. To the extent possible such persons also will receive preventive care to include the learning of dental plaque control measures. Interceptive and preventive care will be provided both before departure for the critical assignment, and to the extent possible, during the assignment. Specific instructions as to geographical areas considered to be of critical importance, which MOS's and types of conditions are to receive priority care, and any special types of treatment to be given will be furnished by OTSG.

(2) Normally basic combat and advanced individual trainees will receive only emergency care and those preventive and/or interceptive services OTSG designates to be given such personnel. This approach minimizes interference with essential training yet takes advantage of the mental flexibility and reorientation which accompanies the civilian-military transition period to develop desirable oral health habits. Specific instructions regarding preventive and interceptive dentistry programs for trainees will be provided by OTSG.

(3) Army personnel being assigned to isolated areas where dentistry is not available from uniformed services facilities will report to the nearest Army dental treatment activity as early as possible prior to departure for such an assignment to be examined and receive any indicated treatment. Army personnel serving in isolated areas who periodically travel to areas where dental treatment is available from uniformed services facilities will apply for any needed treatment during visits to such areas, and will be given priority consideration for care over all others but those going to combat areas.

d. Age-related disease susceptibility. Reducing the incidence of oral disease is the only way dental treatment requirements can be reduced to a manageable level. Further, with oral disease prevention measures becoming increasingly effective and efficient, the benefits derived from preventive programs fully justify a reasonable investment of professional resources in carrying out such programs. When allocating resources either to preventive care, or other tpes of care, age-related differences in oral disease susceptibility must be considered because of differences in probable effectiveness of various measures taken among different age groups in the patient population. Designation of age criteria for segmenting the active duty military population into groupings for various types of programs will be made by OTSG which will provide guidance to treatment activities. General guidelines for segmenting the Active Army population are as follows:

(1) *Caries susceptible groups.* Emphasis on treatment of population groups showing high rates of caries susceptibility will be towards the prevention and control of caries through application of caries inhibiting agents. These groups, in general, will be of a younger age. To the extent possible, consistent with program areas having a high priority, persons in these groups will be given interceptive or corrective care as appropriate (para 128 and 129).

(2) *Periodontal disease susceptible groups.* Groups most susceptible will, in general, be the older age groups; and, in addition to their susceptibility to periodontal disease, such groups will often show accumulated ravages of earlier periods of high caries susceptibility. For these groups, the following mandatory procedures will be carried out annually during their month of birth or as close as possible thereto.

(*a*) A complete dental examination.

(*b*) Evaluation of status of oral self-care and provision of any indicated counseling.

(*c*) Prophylaxis and calculus removal and appointments for any needed interceptive or corrective care, whichever is appropriate (para 128 and 129).

Specific instructions on age grouping to be included in the periodontal disease susceptible category will be furnished by OTSG.

128. Definitive Dental Care. Basic to the provision of definitive dental care is control of dental plaque. Otherwise it is not possible either to attain or maintain an optimum state of oral health. As previously noted under the definition of "definitive care," definitive care may consist only of preventive care or may include both preventive and corrective care. The major objective of the preventive phase of definitive care is attaining and maintaining an effective level of plaque control. Patients for whom definitive care is planned and whose treatment will include corrective care will be evaluated both before and during the corrective care phase of treatment for ability and willingness to perform effective plaque control. Should lack of ability or willingness to control plaque be found, treatment planning will be modified to provide needed instruction and counseling in oral self-care before initiating or continuing corrective care.

129. Interceptive Dental Care. Interceptive care may be provided in specified situations such as during preparation for critical assignments (para 127*c*(1)); or when insufficient time precludes the provision of definitive care; or, a patient's unwillingness or inability to control plaque makes inadvisable the investing of scarce resources in definitive care.

130. Dental examinations and dental inspections. *a. Dental examinations.* A dental examination must be performed by a dental officer and consists of a thorough inspection and evaluation of oral and adjacent structures and tissues.

(1) A dental examination for personnel entering initially on active duty is not required except when it is not possible to take a panograph during initial dental processing. For individuals who have had a panograph taken during initial dental processing, a dental examination as described above is not required until such time as complete definitive care is contemplated. Personnel who present themselves with specific complaints may have these complaints recorded singly in item 16, SF 603 (Health Record—Dental).

(2) A dental examination is required annually for active duty Army personnel who fall within the provisions of paragraph 127*d*(2).

(3) Dental examinations for individuals evaluated under various medical fitness standards will be conducted in compliance with the provisions of AR 40-501. A type B medical examination, as described in that regulation requires that bite-wing x-rays be taken as a minimum supplemental diagnostic aid.

(4) Any additional supplemental diagnostic procedures required for admission to any of the service academies will be honored.

(5) The findings of dental examinations will be recorded in item 16, Subsequent Diseases and Abnormalities, on Standard Form 603, except as noted below.

(*a*) When panographic equipment is not available during initial dental processing, Charts 4 and 5, Section I, Standard Form 603 will be utilized to establish a record for identification purposes.

(*b*) The findings of dental examinations in connection with medical fitness standards will be recorded in compliance with AR 40-501.

b. Dental inspections. A dental inspection consists of a screening or survey of the oral cavity to detect gross pathology or to identify patients requiring early treatment of potential emergency conditions. Dental inspections will not be recorded in dental health records or reported on DD Form 477, Dental Service Report.

131. Dental classification. Recording of dental classifications in dental health records, or on other records or forms used in patient scheduling or management is optional at the discretion of the senior dental officer at an installation or activity. If dental classification is used, designations of classifications will be as follows:

a. Class 1. Individuals requiring no dental treatment.

b. Class 2. Individuals requiring routine but not early treatment.

c. Class 3. Individuals requiring early treatment to prevent the development of more serious conditions.

d. Class 4. Individuals requiring essential prosthodontic appliances, including persons with insufficient teeth to masticate the basic Army ration or in need of appliances essential to the performance of their duties.

e. Class 5. Individuals requiring emergency dental treatment.

f. If desired, the following letters may be used in combination with the above numbers to indicate the treatment categories in which the problem exists:

C—Cleaning
G—Gingival or periodontal treatment
O—Operative treatment
S—Surgical treatment
P—Prosthodontic treatment
E—Endodontic treatment

For example, an individual with an acute necrotizing ulcerative gingivitis and extensive caries might be classified 5G30.

131.1 Dental appointments. *a.* Army facilities providing dental care will schedule appointments to interfere as little as possible with essential duties of the patients, and will immediately notify patients and/or unit commanders when scheduled appointments must be changed or canceled.

b. Unit commanders are responsible for having patients report for appointments promptly, and for immediately notifying the appropriate dental facility or activity when appointments cannot be kept.

c. Flexible appointment scheduling, in which the time scheduled for an appointment is determined by the type and extent of treatment planned, is essential for efficient operation.

132. Preventive dentistry. A preventive dentistry program will be organized at each installation to which a dental officer is assigned (TB MED 5).

a. Objective. The objective is the prevention and control of oral disease as a priority aspect of dental care programs. Continuing emphasis will be placed on the patient's role in and responsibility for oral disease prevention and control.

b. Scope. The program will encompass both community and clinical measures, as applicable to the local situation. To the extent possible auxiliaries will be used in carrying out the program.

(1) *Community measures.*

(*a*) Community measures will include programs to educate and motivate the patient population to the observance of good oral health practices. Orientation and motivation of military members of the Army community is a command responsibility (para 1-3*a*(11) and (12), AR 40-5). Specific instructions on methodologies for certain community programs such as self-application of anticariogenic materials will be provided by OTSG.

(*b*) Fluoridation of installation water supplies is advocated where the natural fluoridation content of the water supply is below protective levels, where an appreciable number of children reside, and where the fluoridation process is otherwise considered practical and feasible. See chapter 7, AR 40-5, and TB MED 271 for procedure to be followed in applying for approval of water fluoridation rogram.

(2) *Clinical measures.*

(*a*) Clinical measures include evaluation of and needed instruction in oral self-care measures, diet counseling, oral prophylaxis, and the provision of specific preventive therapy. Persons showing evidence of active caries will be given anticariogenic therapy. For patients participating in a self-application anticariogenic therapy program, clinical application to provide incresed protection is recommended.

(*b*) Establishment of Oral Health Centers for providing preventive and control measures is advocated (para 1-3*a*(12), AR 40-5). The primary purpose of an oral health center is to provide education, instruction, and

counseling to patients on oral diseases, their prevention, and control. Additionally, the center can be used for examinations and/or self-application of caries inhibiting agents. Preferably, for psychological impact, an oral health center should be separate from any dental facility devoted to emergency, interceptive or corrective care.

c. Preventive dentistry officers.

(1) *Appointment.* A dental officer will be appointed as the preventive dentistry officer at each command or installation to which more than one Dental Corps officer is assigned. Where only one Dental Corps officer is assigned, that officer will, in addition to other duties, serve as the preventive dentistry officer. At larger installations, clinic preventive dentistry officers may be appointed to coordinate preventive dentistry activities of the various sections of the clinic and to coordinate clinic activities with community activities and with oral health center activities.

(2) *Duties.* Duties of the command or installation preventive dentistry officer will include formulation, supervision, and execution of any or all aspects of the command or installation preventive dentistry program in accordance with Department of Army regulations, OTSG guidance, and directions of the Commander of the Dental Activity or Chief, Department of Dentistry as appropriate. A major duty of the command or installation preventive dentistry officer is to correlate and integrate community oral health programs with clinical programs so that the two are mutually supporting.

133. Removable dental prosthesis identification. Every removable dental prosthesis completed by an Army Dental activity will carry the SSN of the patient when physiological, esthetic and space considerations permit. If limited by these considerations, as many as possible of the terminal digits of the SSN will be used. The identification must be legible and will be placed in or on a material which optimizes durability and technical feasibility for use. Guidance on suitable materials will be provided by OTSG.

133.1 Dental gold and platinum. *a. General.* Although items of dental gold, dental alloy, and platinum are classified as expendable, they will be securely stored when not in use.

b. Accounting. Following receipt of items of dental gold, gold alloys, and platinum from the officer having formal accountability, no special accounting controls are required. The general provisions of Army regulations in the 735 series are applicable as they pertain to expendable items.

★*c. Scrap.* Scrap dental metals and alloys will be disposed of as provided in DOD 4160.21-M and AR 755-2.

134. Dental care in civilian facilities for active-duty personnel. *a. Approving authorities.* The approving authorities for civilian dental care are the same as the approving authorities for civilian medical care.

b. Elective care. Elective care in civilian facilities will not be provided at Army expense.

c. Emergency dental care. Prior approval of the designated approving authority is not required for utilization of a civilian dentist for emergency dental care. Emergency dental care normally will be confined to the relief of the immediate emergency. The placing of a permanent restoration in a tooth being treated as an emergency may be considered as part of the emergency care.

d. Routine or extensive dental care.

(1) Except as provided in (2) below, personnel entitled to receive dental care from civilian sources will not obtain routine or extensive dental treatment until prior authorization from the designated approving authority has been received.

(2) The immediate commanding officer, after determining that the total cost of treatment will not exceed $150, may authorize routine civilian dental care without prior authorization by the designated approving authority.

e. Request for authorization.

(1) Letters of request for authority to obtain routine or extensive dental care, when the

total cost exceeds $150, will be forwarded through channels to the designated approving authority and will contain the following information:

(*a*) Character and extent of disability.

(*b*) Professional procedures necessary.

(*c*) Estimate of time required for correction and probable cost.

(*d*) When and where the patient was last on duty at a station or summer camp where dental service was available.

(*e*) Probable length of tour of duty at the patient's present station.

(*f*) Present status; whether duty, leave, or pass. If on leave or pass, the date of termination should be stated.

(*g*) Statement as to availability or nonavailability or requested dental care from uniformed services dental facilities or those of other Federal agencies.

(2) Statemens required by (1)(*a*), (*b*), and (*c*) above will be prepared by the civilian dentist and will contain a diagnosis, treatment plan, and itemized estimated cost of treatment. The diagnosis and treatment plan will indicate nomenclature of teeth and tooth surfaces rather than numerical designation.

(3) The approving authority may grant or deny the request for civilian dental care or recommend that the patient be ordered to a military installation where he can receive dental care. If request is denied, the dental examination required by (2) above is a proper charge to Army funds.

f. Preparation and payment of vouchers. Instructions for the preparation and submission of vouchers are contained in section VIII.

g. Record of treatment. The approving authority will require a record of civilian dental treatment to be placed in the DD Form 722-1 (Health Record, Dental Folder) of the individual concerned so that treatment rendered may be transcribed to the SF 603 (Health Record, Dental) by the next dental custodian (para 26, AR 40-403).

SECTION XIV

VETERINARY CARE

135. Employment of civilian veterinarians. ★*a. General.* When veterinary treatment, including medicine, nursing, and hospital care is required for Army-owned animals and such care and treatment is not otherwise available from Government sources, the commander, on recommendation of the surgeon, may employ the necessary civilian veterinary service at Army expense. Accounts for consultation will not be allowed except in extraordinary cases as determined by the commander of the major command concerned. Surgical appliances will be paid for only upon satisfactory evidence of their necessity and such evidence, except in cases of emergency, will be submitted to the commander of the major command concerned for approval before purchase. Physical examinations of public animals and prospective public animals are authorized to determine their fitness for military service.

b. Preparation and payment of vouchers. Instructions for the preparation and submission of vouchers are contained in section VIII.

136. Rates of compensation. The rates of compensation allowed for civilian veterinary care are contained in AR 40-330.

SECTION XV

MEDICAL SUPPLY SUPPORT TO ARMY ATTACHÉS

137. General. Medical supply support will be provided by Army attachés through the following means in order of the priority listed:

a. Army attachés will make maximum use of local supply sources or U.S. military medical treatment facilities located within a reasonable distance.

b. Major oversea commanders will provide medical supply support upon request by Army attachés stationed within the perimeter of the major oversea command whenever communications and transportation, including State Department pouch, APO, or FPO, permit.

★*c.* The Commanding General, Walter Reed Army Medical Center, will be responsible for providing medical supply support to Army attachés where other supply sources are not available or where difficulties exist in communications. The Commanding General, Walter Reed Army Medical Center, will designate the U.S. Army Dispensary, Pentagon, as a supply source for this medical support. Requests for medical supplies will be forwarded through the Assistant Chief of Staff for Intelligence, Department of the Army, to the U.S. Army Dispensary, Pentagon, for filling.

138. Procedure. Requests for prescription-type items will be accompanied by a doctor's prescription.

139. Funding. Medical supplies issued to Army attachés by the Army command will be financed from medical funds available to the command.

SECTION XVI

ORTHOPEDIC FOOTWEAR

140. General. Orthopedic footwear will be medically prescribed in all cases where disabled or deformed feet cannot be fitted satisfactorily with a size and type of footwear available in regular supply channels modified by orthopedic adjustments. Orthopedic footwear supplied under the provisions of this section are considered medical appliances and will be furnished without charge to the individual except when furnished to dependents in accordance with AR 40-121.

141. Definitions. *a. Orthopedic footwear.* Corrective, compensating, or remedial boots or shoes manufactured on a special orthopedic last for individuals with foot injuries or deformities. Orthopedic footwear is designed to conform to the contour of abnormal feet which have been disabled or distorted and may contain specially molded innersoles or built-in appliances.

b. Orthopedic adjustments to standard footwear. Devices such as Thomas heels, metatarsal bars, heel wedges, or similar adjustments that are used to modify standard boots or shoes.

142. For whom authorized and manner provided. *a.* The categories of personnel who are authorized initial issue, replacement, and repair of orthopedic footwear are listed in table I. These individuals are also authorized orthopedic adjustments to standard footwear.

b. Orthopedic footwear will be requisitioned from the Defense Orthopedic Footwear Clinic (DOFC), Boston Army Base, Boston, MA 02110.

143. Number of pairs of orthopedic footwear furnished. *a.* A minimum of two pairs of orthopedic footwear will be furnished each member of the uniformed services on active duty requiring such footwear. Additional footwear may be furnished based on the nature and type of duty the member may be called upon to perform and the basic issue requirements of the applicable uniformed service.

b. Other categories of authorized personnel requiring orthopedic footwear will be furnished two pairs.

144. Procedure for obtaining orthopedic footwear. When an individual requires orthopedic footwear, DD Form 150 (Special Measurement Blank for Special Measurement/Orthopedic Boots and Shoes) will be prepared by the prescribing medical officer and forwarded to the installation medical supply officer. The medical supply officer will prepare a requisition on DD Form 1348 (DOD Single Line Item Requisition System Document (Manual)) or DD Form 1348-M (Single Line Item Requisitioning System Document (Mechanical)), leaving Block 17 blank and entering in the Remarks block: "Orthopedic Initial Requirement for a trial pair of orthopedic footwear," the patient's name, rank, Social Security Number, size, and type of footwear for each foot. The installation medical supply officer will then forward the requisition with two copies of the completed DD Form 150 to the DOFC. The DOFC will return the footwear for a trial with a DOFC Form 10 (Fitting Report—Special Footwear).

a. When the individual's foot cannot be clearly and fully described, it may be necessary to prepare a cast for one or both of the feet to enable the DOFC to construct the proper footwear last. At installations where facilities for the fabrication of plaster casts are not availa-

ble, casts may be obtained locally from Veterans Administration or commercial sources at the expense of funds available to the installation. The cast or casts will be properly packaged and forwarded to the DOFC with the DD Form 150 and DD Form 1348.

b. The trial pair of orthopedic footwear will be test-fitted by a medical officer before issue to the individual to make sure they correct the disability. At the same time, the fitting report (DOFC Form 10) will be completed and returned to the installation medical supply officer. When the orthopedic footwear is issued, entry will be made on SF 600 (Health Record —Chronological Record of Medical Care) in accordance with AR 40-403 or, in the case of personnel for whom health records are not maintained, entry will be made in clinical or outpatient medical records. For enlisted personnel, entry will be made in the Individual/Organizational Clothing and Equipment Record (DA Form 3326 (Female) and DA Form 3327 (Male)) in accordance with AR 700-84 (personal footwear) or AR 735-35 (organizational footwear) depending on the type of issue.

c. If minor adjustments are required in the trial pair of orthopedic footwear, they will be made locally in accordance with paragraph 147. In such cases, the medical officer will note the adjustment on the fitting report so that the DOFC may make them before shipping additional footwear. If major adjustments are required, the footwear and annotated fitting report will be returned to the DOFC for modification by the installation medical supply officer.

d. If the trial pair of orthopedic footwear does not require any adjustments, the installation medical supply officer will return the fitting report to the DOFC with a new requisition on DD Form 1348 or DD Form 1348—M, leaving Block 17 blank, for the balance of the authorized footwear. When the additional orthopedic footwear is received, the installation medical supply officer will issue them to the individual.

e. Retired members of the uniformed services who are in need of orthopedic footwear should apply to the nearest uniformed services medical facility for a medical examination to establish the need for orthopedic footwear. If the examination confirms the need for such footwear, they will be requisitioned by the installation medical supply officer as outlined above.

145. Replacement orders. Before ordering replacement footwear, a medical examination should establish that previously prescribed orthopedic footwear remains satisfactory. If no changes are required, DD Form 150 will be marked "Orthopedic Replacement Requirement." If changes are required, the prescribing medical officer will indicate the changes on a new DD Form 150, conspicuously marked "Revised." The installation medical supply officer will then prepare a requisition for the replacement footwear in accordance with paragraph 144 and forward it to the DOFC. When an Army member is located in an area where a medical officer is not available and the previously prescribed orthopedic footwear is satisfactory, replacement action will be initiated without a medical examination by sending a request direct to the DOFC.

146. Delivery of footwear after patient transfer. When orthopedic footwear is delivered for a patient who has been transferred, the footwear will be shipped to the medical supply officer at his current duty station. The supporting medical facility will provide assistance in fitting the footwear. If the individual has been transferred to a Veterans Administration facility, the footwear will be forwarded to the facility director, together with the fitting report and any other pertinent data received with the footwear. If the patient has been discharged, the footwear with all pertinent data will be forwarded to the Director of the Veterans Administration Regional Office which exercises jurisdiction over the area where the veteran is residing.

147. Orthopedic adjustments to standard footwear. *a.* Orthopedic adjustments to standard footwear may be furnished without charge to the individual when prescribed by a medical officer. In such cases, however, the patient will procure the standard footwear to which the orthopedic adjustment is made.

b. Orthopedic adjustment to standard footwear may be made by Army shoe repair shops or obtained from commercial shoe repair shops using funds available to the installation.

148. Repair of orthopedic footwear. *a.* Orthopedic footwear which requires more than minor repairs will be sent to the DOFC. Based on information furnished by the medical officer, the installation medical supply officer will prepare a requisition in accordance with paragraph 144 indicating the required repairs, and forward it with the footwear to the DOFC.

b. Minor repairs of orthopedic footwear (excluding maintenance repair such as normal soling and heeling) are authorized without charge to the individual. Repairs may be made by Army shoe repair shops or obtained from commercial shoe repair shops using funds available to the installation.

149. Orthopedic lasts and patterns. Special lasts and patterns required in the fabrication of orthopedic footwear for supply to authorized personnel will be kept on file at the DOFC.

★SECTION XVII

SPECIAL ARRANGEMENTS FOR HOSPITALIZATION OF ACTIVE DUTY PATIENTS IN VETERANS ADMINISTRATION FACILITIES

150. Hospitalization of active duty Army patients in Veterans Administration facilities. During periods of heavy patient workloads which may in part exceed the staff and/or space capabilities of Army hospitals in the CONUS, it may be necessary to direct the transfer of active duty Army patients who are expected to return to duty, but who require prolonged hospitalization, to Veterans Administration hospitals. This procedure will be initiated only after The Surgeon General has obtained approval for its implementation from the Secretary of the Army and has appropriately notified the Chief Medical Director of the Veterans Administration. When this measure is directed, the Army hospital commander will take the following actions to accomplish such transfers:

a. Transmit a message in the format specified in paragraph 4-2, AR 40-350, to the Armed Services Medical Regulating Office (ASMRO) requesting a bed designation in a Veterans Administration hospital.

b. Transfer the patient to the designated Veterans Administration hospital at the earliest possible time following receipt of bed-designation notification from ASMRO. If the patient cannot be moved within the time limits specified by ASMRO, the notification procedure prescribed by paragraph 4-3, AR 40-350, will be followed.

c. Carry out the procedures prescribed by paragraphs 70*a*(5), (6), (7), (8)(*a*) through (*e*), and (9).

d. Upon designation of a medical facility or administrative unit to assume administrative responsibility for the patient (para 151), make an administrative transfer of the patient and expeditiously forward his financial and personnel records to the gaining facility or unit.

151. Administration of Army patients in Veterans Administration facilities. *a.* The CONUS Army commander will be an addressee in each hospital designation message from ASMRO which will result in the transfer of an Army patient into a Veterans Administration hospital within his area.

b. The CONUS Army commander will designate an Army medical treatment facility or Army administrative unit (*c* below) to provide administrative support (para 76*a*(2) and 80) to Army patients in Veterans Administration hospitals. Such support will be provided from available resources or additional personnel may be requested from higher headquarters.

c. When the number of Army patients in one Veterans Administration hospital or in a group of Veterans Administration hospitals in the same general area exceeds 50 or more, CONUS Army commanders may establish Army administrative units at the Veterans Administration hospital. Such units will be assigned and integrated with the nearest MEDDAC.

Note. The Commanding General, Walter Reed Army Medical Center, will be an addressee in hospital designation messages for patients transferred to the Veterans Administration Hospital, Washington, D. C., and will provide administrative support to patients in that hospital.

152. Reimbursement. The Veterans Administration will be reimbursed for hospitalization of Army patients by The Surgeon General in accordance with paragraphs 78 and 79.

Table I

PERSONS AUTHORIZED CARE AT ARMY MEDICAL TREATMENT FACILITIES

See AR 40-330 for explanation of rates

★Rate abbreviations used in this table: OR—outpatient rate; SOR—special outpatient rate; IMR—immunization rate

Section A. Members and Former Members of the Uniformed Services and Their Dependents

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
★ARMY					
a. Members of the Army serving on AD (para 7).	Subsistence only	Coll locally from off; coll locally from Treasurer, USMA, for USMA cadets; coll locally from MPA appropriation for enl.	None	None	Yes.
b. Members of the Reserve & Nat Guard on AD, ADT, & inactive duty training (para 8).	Subsistence only	Coll locally from off; coll locally RPA or NGPA appropriation for enl.	None	None	Yes (incl spectacle inserts for protective field masks) subject to limitations in para 8.
c. Members of Army Senior ROTC (para 10*a*).	Subsistence only except Rate B appl for those in para 10*a*(1)(*c*).	Coll subs locally from RPA appropriation; coll locally from those listed in para 10*a*(1)(*c*).	None	None	Yes, subject to the limitations in para 10*a*(1)(*b*).
NAVY AND MARINE CORPS					
a. Members of the Navy and Marine Corps serving on AD, ADT, & inactive duty training (para 7 & 8).	Subsistence only	Coll subs locally from off; coll locally from C of Naval personnel, Code (PERS-H3) Dept of Navy, Wash, DC 20370, for USNA midshipmen; coll locally from MPA or RPA appropriation for enlisted.	None	None	Yes for those on AD. Yes for those not on AD subject to the limitations in para 8.

Table I—Continued

Section A. Members and Former Members of the Uniformed Services and Their Dependents—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
b. Members of Naval Senior ROTC (para 10*b*).	Subsistence only except Rate B applies when member is responsible for payment.	Coll subs locally from RPA appropriation; coll locally when member is responsible for payment.	None	None	Yes, subject to the limitations in para 10*b*.
AIR FORCE					
a. Members of the Air Force serving on AD, ADT, & inactive duty training (para 7 & 8).	Subsistence only	Coll subs locally from off; coll locally from USAF Academy for USAFA cadets; coll locally from MPA, RPA or NGPA appropriation for enlisted.	None	None	Yes for those on AD. Yes for those not on AD subject to the limitations in para 8.
b. Members of Air Force Senior ROTC (para 10*b*).	Subs only except Rate B applies when member is responsible for payment.	Coll subs locally from RPA appropriation; coll locally when member is responsible for payment.	None	None	Yes, subject to the limitations in para 10*b*.
COAST GUARD AND COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICES AND ENVIRONMENTAL SCIENCE SERVICES ADMINISTRATION. Members of the above svc on AD, ADT, and inactive duty training (para 7 and 8).	Rate A	Rept to SG on DD Form 7; coll subs locally from off and cadets, USCGA; coll locally from MPA or RPA appropriation for enlisted.	None	None	Yes for those on AD. Yes for those not on AD subject to the limitations in para 8.
RETIRED PERSONNEL					
a. Retired officers of the uniformed services (para 11).	Subs only for Army, Navy, Marine Corps, and Air Force; for others, Rate A.	Coll subs locally from all off; for other than Army, Navy, Marine Corps, and Air Force, rept to SG on DD Form 7.	None	None	Yes.
b. Retired enl pers of the uniformed services (para 11).	None for enl of Army, Navy, Marine Corps, and Air Force; for others, Rate A.	None for enl of Army, Navy, Marine Corps, and Air Force; for others, rept to SG on DD Form 7.	None	None	Yes.
APPLICANTS					
★a. Applicants for cadetship at the various service academies (para 18.1 & 20.1).	Subs only for USMA, USNA and USAFA; Rate A for all others.	Coll subs locally from MPA appropriation for USMA, USNA, and USAFA; rept to SG on DD Form 7 for all others.	None	None	NA.
★b. Applicants for enlistment or reenlistment in the Armed Forces including applicants for enlistment in the Res components thereof, and Selective Service registrants (para 19 & 20.1).	Subsistence only	Coll locally from MPA appropriation.	None	None	No.
★c. Applicants for appointment in the Regular Army and Res components, including members of Res components applying for AD (para 20 & 20.1).	Subsistence only	Coll locally from indiv.	None	None	NA.
d. Designated applicants for enrollment in the Senior Reserve Officers' Training Program (para 10.1).	Subsistence only	Coll locally from RPA appropriation.	None	None	No.
FORMER MILITARY PRISONERS					
a. Mil prisoners whose punitive discharge has been executed but whose sentence has not expired (para 21*c* (1)).	Subsistence only	Coll locally from MPA appropriation.	None	None	Yes.
b. Mil prisoners hospitalized beyond expiration of sentence (para 21*c*(2)).	Rate B	Coll locally from indiv.	NA	NA	No.

Table I—Continued

Section A. Members and Former Members of the Uniformed Services and Their Dependents—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
FORMER FEMALE PERSONNEL OF THE ARMED FORCES AND THEIR NEWBORN INFANTS (para 22).	Subsistence only	Coll locally from indiv.	None	None	No.
INDIVIDUALS WHOSE MILITARY RECORDS ARE BEING CONSIDERED FOR CORRECTION (para 23).	Subsistence only	Coll locally from indiv.	None	None	No.
★DEPENDENTS OF ACTIVE DUTY AND RETIRED MEMBERS OF THE UNIFORMED SERVICES, INCLUDING DEPENDENTS OF PERSONS WHO DIED WHILE ON AD OR IN RETIRED STATUS (AR 40-121, AR 40-122, AR 40-123, and AR 40-124). [1]	Rate D for Army, Navy, Marine Corps, and Air Force; for others, Rate B or F.	Coll Rate D locally from all dependents; for other than Army, Navy Marine Corps, and Air Force dependents, rept to SG on DD Form 7.	None	None	Artificial limbs and artificial eyes only.[2]

[1] For detailed information on care of dependents, see AR 40-121.

[2] Items other than artificial limbs and artificial eyes may be sold to dependents outside the United States and at designated stations within the United States (see AR 40-121). Special or contact lense may be purchased from funds available to the medical facility for those dependents requiring these items for complete medical or surgical management of eye conditions, as authorized by paragraph 4-6p, AR 40-121.

Table I—Continued

Section B. Beneficiaries and Employees of Other Federal Agencies

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
★BENEFICIARIES OF THE VETERANS ADMINISTRATION (para 12).	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	Yes.
★BENEFICIARIES OF THE BUREAU OF EMPLOYEES COMPENSATION (para 13; CPR C1).	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	Yes.
★BENEFICIARIES OF THE PUBLIC HEALTH SERVICE.					
a. Members of the crews of vessels of Environmental Science Services Administration (other than commissioned officers), certain American seamen, enrollees in the US Maritime Svc, members of the Merchant Marine Cadet Corps, civ employees in the field svc, and American Indians, Eskimos, and Aleuts (para 14*a* through *d*).	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	No.[1]
b. Inactive Reserve Public Health Service Commissioned officers (para 14*e*).	NA	NA	OR or IMR	Rept to SG on DD Form 7A.	NA.
REGISTRANTS ACTING UNDER ORDERS of the SELECTIVE SERVICE SYSTEM (para 15).	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	No.
OFFICERS AND EMPLOYEES OF THE FOREIGN SVC AND AID, DEPT OF STATE; FAS AND ARS, DEPT OF AGRICULTURE; USIA; BPR, DEPT OF COMMERCE (THOSE CONNECTED WITH AID PROGRAM); FAA; FCSC; VA (THOSE ATTACHED TO ROME OFFICE); DEPENDENTS OF SUCH OFFICERS AND EMPLOYEES; AND APPLICANTS FOR APPOINTMENT TO SUCH AGENCIES.					

See footnote at end of table.

Table I—Continued

Section B. Beneficiaries and Employees of Other Federal Agencies—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
★a. Officers and employees and their dependents who are beneficiaries of one of above agencies outside the US (para 16*a*) and after med evac to the US (para 16*e*).	Rate A or F for off and employees; rate B or F for depns.	Coll locally from authorizing office on SF 1080 supported by DD Form 7 and ltr of auth.	OR (para 16*a*(2)) or IMR.	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	No.[1]
★b. Applicants for appointment who are beneficiaries of one of above agencies outside US (para 16*b*).	NA	NA	OR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	NA.
c. Officers and employees and their dependents who are not beneficiaries of one of above agencies outside US (para 16*c*).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
★d. Officers and employees and their dependents (incl applicants for appointment) who are beneficiaries of one of above agencies in US (para 16*d*).	NA	NA	OR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	NA.
PEACE CORPS PERSONNEL					
★a. Peace Corps volunteers, volunteer leaders and their dependents; and employees and their dependents who are beneficiaries of the Peace Corps outside US (para 16.1*a* (1) and (2) (*a*)).	Rate A or F for vols, vol leaders and employees; rate B or F for dependents.	Coll locally from authorizing office on SF 1080 supported by DD Form 7 and ltr of auth.	OR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	No.[1]
★b. Peace Corps applicants (para 16.1*a*(3) and *b*(1)).[2]	Rate A	Coll locally from authorizing office on SF 1080 supported by DD Form 7 and ltr of auth.	OR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	NA.

See footnotes at end of table.

c. Peace Corps employees and their dependents who are not beneficiaries of the Peace Corps outside US (para 16.1*a*(2)(*b*)).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
MEMBERS OF THE US SOLDIERS' HOME (para 17).	Rate E	Rept to SG on DD Form 7.	None	None	No.
BENEFICIARIES OF THE DEPARTMENT OF JUSTICE.					
a. Federal Bureau of Investigation agents (para 18*a*).[2]	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	NA.
b. Claimants whose claims are administered by the Department of Justice (para 18*b*).[2]	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	NA.
SECRET SERVICE SPECIAL AGENTS (para 37.2).	NA	NA	OR (Med exam only).	Rept to SG on DD Form 7A.	NA.
CIVILIAN EMPLOYEES OF ALL FEDERAL AGENCIES (LIMITED TO DISABILITY RETIREMENT MEDICAL EXAMINATIONS) (para 27*e*).[2]	Subsistence only	Coll locally from indiv.	None	None	NA.
CIVILIAN EMPLOYEES OF THE DEPARTMENT OF COMMERCE (para 27*f*).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	NO.[1]
CIVILIAN EMPLOYEES OF THE DEPARTMENT OF INTERIOR AND THEIR DEPENDENTS (para 27*g*).	Outside US, rate B or F for citizens and rate C for noncitizens; inside US, rate B or F.	Coll locally from indiv.	Outside US, SOR or IMR; inside US, OR, or IMR.	Coll locally from indiv.	No.[1]
CIVILIAN EMPLOYEES OF THE GENERAL ACCOUTING OFFICE AND THEIR DEPENDENTS (para 27*h*).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
FEDERAL AVIATION AGENCY AIR TRAFFIC CONTROLLERS (para 37.3).	NA	NA	OR	Rept to SG on DD Form 7A.	NA.
JOB CORPS AND VOLUNTEERS IN SERVICE TO AMERICA (VISTA) PERSONNEL AND APPLICANTS (para 37.4).					
a. Job Corps applicants for enrollment and VISTA applicants for employment.	NA	NA	OR or IMR	Rept to SG on DD Form 7A.	NA.

See footnotes at end of table.

Table I—Continued.

Section B. Beneficiaries and Employees of Other Federal Agencies—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
b. Job Corps enrollees and VISTA personnel.	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	NA.
★SOCIAL SECURITY BENEFICIARIES (para 37.6).	Rate B	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	NA.
MICRONESIAN CITIZENS (para 37.9)	Rate A	Collect locally from TTPI on SF 1080 supported by DD Form 7 and ltr of auth.	OR	Collect locally from TTPI on SF 1080 supported by DD Form 7A and ltr of auth.	NA.

[1] Outside the United States, spectacles may be furnished these individuals on a reimbursable basis (para 116b(5)).
[2] Hospitalization authorized only when required in connection with conduct of medical examinations.

Table I—Continued

Section C. Miscellaneous Categories of Persons Authorized Care

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
CITIZENS MILITARY TRAINING CORPS (para 9).	Subsistence only	Coll locally from indiv.	None	None	Yes (para 9).
PERSONS IN MILITARY CUSTODY AND NONMILITARY FEDERAL PRISONERS.					
a. POW's, retained personnel and internees (para 21*a* and *b*).	Subsistence only	Coll locally from MPA appropriation.	None	None	Yes (para 21*a*).
b. Nonmilitary Federal prisoners (para 21*f*).	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	No.
SEAMEN					
a. Civilian seamen in svc of vessels operated by Army (para 24*b*).	None	None	None	None	No.[1]
★b. Civilian seamen in svc of vessels operated by MSTS (para 24*c*).	Rate A	Rpt to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	No.[1]
★c. Crews of ships of US registry (para 24*d*).	Rate B	Coll locally from local ship's agent or from indiv.	OR or IMR	Coll locally from local ship's agent or from indiv.	No.[1]
FOREIGN NATIONALS					
a. Foreign mil pers of NATO nations in US foreign mil pers in US under DOD sponsorship, and other foreign mil pers in US in a status officially recognized by DA (para 25*a*(1) and (3) through (8)).	Subsistence only	Coll locally from off; coll locally from MPA appropriation.	None	None	Yes.
b. Dependents of above foreign mil pers in US (para 25*a*(1), (5) and (9)).	Rate D	Coll locally from indiv.	None	None	No.[2]
★c. Foreign civ pers accompanying foreign mil pers of NATO nations in US and their depns; and other officially recognized foreign civ pers in US (para 25*a*(2) and (8)).	Rate B or F	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No.[2]

See footnotes at end of table.

Table I—Continued

Section C. Miscellaneous Categories of Persons Authorized Care—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices spectacles, hearing aids, and orthopedic footwear authorized
★d. MAP trainees (military and civilian) (para 25a(8), c(2) and d(4)).	Rate B	Coll subs locally from off and civ; coll subs locally from MPA appropriation. Rpt to SG on DD Form 7 except in USAREUR.	OR or IMR	Rept to SG on DD Form 7A except in USAREUR.	Yes.
e. Dependents of MAP military trainees (para 25a(9) and c(2)).	Rate D	Coll locally from indiv.	None	None	No.[4]
★f. Special foreign nationals outside US (para 25c(1) and (34)).	Rate B, F or none	Coll locally from indiv when applicable.	OR, IMR or none	Coll locally from indiv when applicable.	Yes.
★g. Foreign nationals who contribute to accomplishment of mission of oversea commander (para 25c(1)).	Rate B, D, F or none.	Coll locally from indiv when applicable.	OR, IMR or none	Coll locally from indiv when applicable.	No.[1]
h. Liaison personnel from a NATO Army Force outside US (para 25c(4)).	Subsistence only	Coll locally from off; coll subs locally from indiv.	None	None	Yes.
i. Crews and passengers of NATO aircraft which land at NATO or US military airfields in NATO countries (para 25c(6) and d(5)).	Rate B or F	Coll subs locally; report to HQ USAREUR on DD Form 7.	None	None	NA.
RED CROSS PERSONNEL					
a. Red Cross pers, other officially recognized welfare workers, non-Red Cross volunteer workers, and civ student-employees (para 26a, c and d).	Subsistence only	Coll locally from indiv.	None	None	No.[1]
b. Dependents of full-time paid Red Cross professional staff and of uniformed fulltime paid secretarial and clerical workers accompanying their sponsors outside the US (para 26b).	Rate D	Coll locally from indiv or sponsor.	None	None	No.[1]

See footnotes at end of table.

CIVILIAN EMPLOYEES AND THEIR DEPENDENTS.					
a. Civilian employees authorized Occupational Health Services (para 27a). [5, 6]	Subsistence only	Coll locally from indiv.	None	None	No, except spectacle inserts for protective masks.
b. Civilian employees of the Defense Establishment (not beneficiaries of BEC) paid from appropriated or nonappropriated funds and their dependents (para 27b).	Outside US, rate B or F for citizens and rate C for noncitizens; inside US, rate B or F.	Coll locally from indiv.	Outside US, SOR; inside US, OR, or IMR except as provided in para 27b.	Coll locally from indiv.	No. [7]
CONTRACTOR EMPLOYEES					
a. Civilian employees of contractors of Dept of the Army outside US (para 27c).	Rate B or F	Coll locally from contractor.	OR or IMR	Coll locally from contractor.	No. [1]
b. Civilian employees (incl former and prospective employees) of contractors of Dept of the Army in US (para 27d). [6]	Subsistence only	Coll locally from indiv.	None (med exams only).	None	No.
c. Civilian employees of contractors of Dept of Navy and their dependents outside US (para 27c.1).	Rate B or F	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No. [1]
ARMY NATIONAL GUARD TECHNICIANS (CIV EMPLOYEES OF ARNG) MANNING MISSILE SITES (para 28). [6]	Subsistence only	Coll locally from indiv.	None	None	No, except gas mask spectacles.
CIVILIAN PARTICIPANTS IN ARMY-SPONSORED ACTIVITIES	Subsistence only	Coll locally from indiv or sponsor.	None	None	No.
CLAIMANTS WHOSE CLAIMS ARE ADMINISTERED BY FEDERAL DEPARTMENTS AND BENEFICIARIES OF PRIVATE RELIEF BILLS (para 30). [6]					
a. Claimants whose claims are administered by Army.	None	None	None	None	NA.
b. Claimants whose claims are administered by other Federal Departments.	Rate A	Rept to SG or DD Form 7.	None	None	NA.
c. Beneficiaries of private relief bills	None	None	None	None	NA.

See footnotes at end of table.

Table 1—Continued.

Section C. Miscellaneous Categories of Persons Authorized Care—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
PERSONS OUTSIDE CONUS WHO CONTRIBUTE TO ACCOMPLISHMENT OF A MAJOR OVERSEA COMMANDER'S MISSION.					
a. Civilian representatives of religious groups and others (para 31b).	Subsistence only	Coll locally from indiv.	None	None	No. [1]
★b. Educational representatives of recognized educational institutions (para 31c).	Rate B or F	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No. [1]
c. Dependents of USO professional personnel outside US (para 31b).	Rate D	Coll locally from indiv or sponsor.	None	None	No. [1]
d. All others (para 31a and d)	Rate B, F or D	Coll locally from indiv.	OR, IMR, or none	Coll locally from indiv made applicable.	No. [1]
AMERICAN NATIONALS COVERED BY AGREEMENTS (para 32).	Rate B or F	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No. [1]
JOINT CIVILIAN ORIENTATION CONFERENCE GUESTS (para 33).	Rate B	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No.
DESIGNEES OF THE SECRETARY OF THE ARMY (para 35).	Rate B or F, subs only or none.	Coll locally from indiv where applicable.	OR, IMR, or none	Coll locally from indiv where applicable.	No.
CERTAIN PERSONS EVACUATED FROM ONE AREA TO ANOTHER (para 36).	Same as in original area.	Coll locally from indiv.	Same as in original area.	Coll locally from indiv.	No.
CIVILIANS IN EMERGENCY (para 37).					
a. Indigents	None	None	None	None	NA.
b. Nonindigents	Rate B or F	Coll locally from indiv.	Coll locally from indiv.	OR	NA.
VOLUNTEER SUBJECTS IN APPROVED DEPT OF THE ARMY RESEARCH PROJECTS (para 37.1).	None	None	None	None	Yes.
US NATIONALS IN FOREIGN PENAL INSTITUTIONS AND THEIR DEPENDENTS (para 37.5).	None	None	None	None	Yes.
DOMESTIC SERVANTS OUTSIDE THE US (para 37.7).	NA	NA	None	None	No.

See footnotes at end of table.

[1] Outside the United States spectacles may be furnished these individuals on a reimbursable basis (para 116b(5)).

[2] These items may be furnished these individuals on a reimbursable basis at stations within the United States which have been designated remote for the purpose of furnishing such items to dependents of US uniformed services personnel (para 25d(1) and 116b(2)); and para 4-7b, AR 40-121.

[3] Spectacles may be furnished these individuals on a reimbursable basis at stations within the United States which have been designated remote for the purpose of furnishing medical care to US civilian employees (para 116b(4)).

[4] These items may be furnished these individuals on a reimbursable basis outside the United States and at stations within the United States which have been designated remote for the purpose of furnishing such items to dependents of US uniformed services personnel (para 25d(1) and 116b(1)); and para 4-7b, AR 40-121.

[5] Reimbursement is made to Army on a per capita cost basis for health services provided civilian employees (or prospective employees) of the Army paid from industrial funds and civilian employees (or prospective employees) of Federal departments and agencies other than Army, except employees (or prospective employees) of Navy, Marine Corps, and Air Force in the Washington area.

[6] Hospitalization authorized only when required with conduct of medical examinations.

[7] Spectacles may be furnished these individuals on a reimbursable basis outside the United States and at stations within the United States which have been designated remote for the purpose of furnishing medical care to civilian employees (para 116b(3) and (5)).

☆ U. S. GOVERNMENT PRINTING OFFICE: 1978 510-452/3048

APPENDIX

ADDRESSES OF APPROPRIATE CIVILIAN AUTHORITIES TO FACILITATE DISPOSITION OF PSYCHOTIC NONMILITARY PATIENTS

Alabama:
The Judge of Probate
.....County (of residence)
.....Ala.

Alaska:
Medical Officer
Morningside Hospital
Portland, Oreg.

Arizona:
Superintendent
Arizona State Hospital
2500 East Van Buren
Phoenix, Ariz.

Arkansas:
Superintendent
State Hospital for Nervous Diseases
Little Rock, Ark.

California:
Director
Department of Mental Hygiene
Sacramento 14, Calif.

Colorado:
City Attorney's Office
Mental Hygiene Division
City and County Building
Denver, Colo.

Connecticut:
Supervisor of Settlements
Office of Commissioner of Welfare
Room 252, State Office Building
Hartford 15, Conn.

Delaware:
Superintendent
Delaware State Hospital
Farnhurst, Del.

District of Columbia:
Supervisor
Interstate Services
815 Rhode Island Avenue, NW.
Washington 1, D.C.

Florida:
Superintendent
Florida State Hospital
Chattahoochee, Fla.

Georgia:
Department of Public Welfare
.....County (of residence)
.....Ga.

Hawaii:
Medical Director
State Hospital
Kaneoho, Oahu

Idaho:
Executive Secretary
State Hospital Board
Capitol Building
Boise, Idaho

Illinois:
Deportation Officer
Department of Public Welfare
2436 West Warren Boulevard
Chicago, Ill.

Indiana:
Interstate Correspondence
Department of Public Welfare
141 South Meridian Street
Indianapolis, Ind.

Iowa:
Parole and Deportation Clerk
Board of Control of State Institutions
Des Moines, Iowa

Kansas:
State Department of Social Welfare
Division of Institutional Management
801 Harrison Street
Topeka, Kans.

Kentucky:
Director
Division of Hospitals and Mental Hygiene
Department of Welfare
Frankfort, Ky.

Louisiana:
State Hospital Director
State Hospital Board
20th Floor, Capitol Building
Baton Rouge, La.

Maine:
Commissioner
Department of Institutional Service
State House
Augusta, Maine

Maryland:
Deportation Agent
Department of Mental Hygiene
506 Park Avenue
Baltimore 1, Md.

Massachusetts:
Commissioner
Department of Mental Health
15 Ashburton Place
Boston, Mass.

Michigan:
Director
Department of Mental Health
403 Bank of Lansing Building
Lansing 16, Mich.

Minnesota:
Deportation Officer
Division of Public Institutions
Globe Building
St. Paul. Minn.

Mississippi:
Supervisor of Policies and Procedures
State Department of Public Welfare
Jackson, Miss.

Missouri:
Director
Division of Mental Diseases
Department of Public Health and Welfare
Jefferson City, Mo.

Montana:
Consolidated Boards
Board of Commissioners for the Insane
State Capitol Building
Helena, Mont.

Nebraska:
Chairman
Board of Control
State House
Lincoln, Nebr.

Nevada:
Superintendent
Nevada State Hospital for Mental Diseases
Post Office Box 2460
Reno, Nev.

New Hampshire:
Superintendent
New Hampshire State Hospital
Concord, N.H.

New Jersey:
Deportation Agent
Department of Institutions and Agencies
State Office Building
135 West Hanover Street
Trenton, N.J.

New Mexico:
Superintendent
New Mexico State Hospital
Box 1181
Las Vegas, N. Mex.

New York:
Assistant Commissioner
New York State Department of Mental Hygiene
217 Broadway
New York 7, N.Y.

North Carolina:
Director
Division of Psychiatric and Psychological Services

State Department of Public Welfare
Raleigh, N.C.

North Dakota:
Director
Division of Field Services
Public Welfare Board of North Dakota
Bismarck, N. Dak.

Ohio:
Division of Mental Hygiene
Department of Public Welfare
1210 State Office Building
Columbus 16, Ohio

Oklahoma:
Medical Director
Department of Mental Health
306 State Capitol
Oklahoma City, Okla.

Oregon:
Secretary
Oregon State Board of Control
Salem, Oreg.

Pennsylvania:
Deportation Agent
Bureau of Mental Health
Department of Welfare
Harrisburg, Pa.

Rhode Island:
Fiscal Agent
Department of Social Welfare
40 Fountain Street
Providence, R.I.

South Carolina:
Superintendent
South Carolina State Hospital
Columbia, S.C.

South Dakota:
Superintendent
Yankton State Hospital
Yankton, S. Dak.

Tennessee:
Department of Public Welfare
Bureau of Field Service
603 Cotton States Building
Nashville, Tenn.

Texas:
Executive Director
Texas State Board of Hospitals and Special Schools
45th and Lamar Streets
Austin, Tex.

Utah:
Superintendent
Utah State Hospital
Provo, Utah

Vermont:
Secretary
State Board of Mental Health
Waterbury, Vt.

Virginia:
Commissioner
Virginia Department of Mental Hygiene
9 North 12th Street
Richmond, Va.

Washington:
Administrative Assistant
Department of Public Institutions
Olympia, Wash.

West Virginia:
Member-Secretary
West Virginia Board of Control
Room 103, Capitol Building
Charleston, W. Va.

Wisconsin:
Collection and Deportation Counsel
State Department of Public Welfare
State Capitol
Madison 2, Wis.

Wyoming:
Board of Charities and Reform
State Capitol Building
Cheyenne, Wyo.

Canal Zone:
Corozal Hospital
C.Z.

Puerto Rico:
Commissioner of Health
San Juan, P.R.

APPENDIX II

May 15, 1962
NUMBER 6480.5
ASD(M)

DEPARTMENT OF DEFENSE DIRECTIVE

Subject Department of Defense Blood Program

References: (a) DoD Directive 6480.1, "National Blood Program, August 20, 1953 (hereby cancelled)
(b) "National Blood Program, Statement of Basic Principles," issued by the Office of Civil and Defense Mobilization (now, Office of Emergency Planning), November 9, 1960

I. PURPOSE

This Directive (1) defines the Department of Defense Blood Program and assigns responsibilities for carrying out its provisions; (2) assigns to the Secretary of the Army certain responsibilities for joint aspects of the Department of Defense Blood Program, to be executed on a joint staff basis, under the direction and control of the Secretary of Defense.

II. APPLICABILITY AND SCOPE

The provisions of this Directive apply to the military departments and the unified and specified commands, and cover the collection, processing and distribution of whole blood and its fractions, under all degrees of emergency conditions.

III. CANCELLATION

Reference (a) is hereby superseded and cancelled.

IV. DEFINITIONS

As used in this Directive, Department of Defense Blood Program means the blood programs of the military departments and of the unified and specified commands, and the structure necessary to integrate these programs in time of national emergency. It includes the following functions:

1. The collection at military installations, the processing, and the distribution of whole blood and its fractions to military hospitals on a local or regional basis.
2. The procurement of whole blood, for military use, from sources outside the Department of Defense.
3. The maintenance and implementation of plans to provide for the collection, processing, and distribution of whole blood and its fractions to the Armed Forces, world-wide, under all degrees of emergency conditions.
4. The provision and maintenance of a source of trained personnel, facilities, and supplies and equipment, adequate to meet initial emergency requirements.
5. A research and development program devoted to progress and improvement in the areas of blood, blood derivatives, and plasma volume expanders, and the techniques, facilities and materiel related thereto.

V. RESPONSIBILITIES

A. The Secretary of the Army is responsible for:

1. Assigning to a specific, identifiable organizational activity within his department the responsibilities and functions listed in subparagraphs a. through j., below.

2. Providing for joint staffing of the designated activity by medical service representatives of the Army, Navy, and Air Force who shall be selected by and have direct access to their respective Surgeons General.

3. Providing adequate administrative support for the designated activity.

The following responsibilities and functions are to be executed by the designated activity:

a. Implementing the DoD Blood Program policy guidance established by the Assistant Secretary of Defense (Manpower).

b. Maintaining and disseminating plans for coordinating the collection, processing and distribution of blood and blood products necessary to meet requirements beyond the capability of the military department or command concerned, and directing the implementation of such plans.

c. Coordinating and integrating the plans, policies, and procedures of the military departments, and unified and specified commands under the DoD Blood Program, to the extent necessary to assure the effectiveness of the plans referred to in b., above.

d. Coordinating DoD Blood Program plans and actions which have military operational implications with the Joint Chiefs of Staff.

e. Providing the Defense Supply Agency with technical and professional operational guidance on the procurement of whole blood and fractions, when required, and on mobilization and industrial mobilization requirements for plasma expanders, both natural and synthetic.

f. Providing direct DoD liaison with other Government agencies having an interest in blood and related items.

g. Developing and promulgating policies (fully coordinated with the military departments) on:
(1) The collection, procurement, processing, storage, distribution, and use of whole blood.
(2) The acceptability, distribution, and use of blood fractions and synthetic or other non-human plasma volume expanders.

h. Obtaining and maintaining, on a continuing basis, emergency and mobilization military requirements of whole blood from the military departments and commands, as appropriate; and determining net DoD requirements.

i. Receiving all requisitions for emergency quantities of whole blood from overseas, and from Continental United States, when quantities required exceed local resources.

j. Establishing on behalf of the Director of Defense Research and Engineering a central register of military department research and development projects on blood, blood derivatives, and plasma volume expanders to prevent unnecessary duplication and overlapping of effort.

B. The Secretaries of the Army, Navy, and Air Force, and the Commanders of unified and specified commands, are responsible for:

1. Maintaining internal departmental and command Blood Programs. These Programs shall provide for the collection, or other means of procurement, of whole blood and its fractions at military installations; and for processing and distributing these products to meet (a) normal departmental or command requirements, and (b) within their capabilities, requirements generated by military operations as well as local, regional, or national emergencies.

2. Insuring that their respective Blood Programs reflect the policies established herein, and the guidance to be developed by the designated activity referred to in V.A.1.

3. Insuring that the organizational structure of their blood programs can be readily expanded and integrated with the joint program when necessary.

4. Submitting requirements and reporting capabilities, as requested, to the designated activity referred to in V.A.1.

C. The Assistant Secretary of Defense (Manpower) is responsible for providing overall policy guidance on the DoD Blood Program, and for coordinating it with the National Blood Program, when required.

D. The Director, Defense Research and Engineering is responsible for coordinating and issuing policy guidance on military department research and development projects related to the DoD Blood Program.

VI. GENERAL

In carrying out the responsibilities set forth above, the Secretary of the Army is authorized to communicate directly with commanders of unified and specified commands, subject to the requirements of V.A. d, above.

VII. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective June 1, 1962. Within thirty (30) days of receipt of this Directive (1) The Secretaries of the Army, Navy and Air Force shall develop such implementing instructions as are appropriate to their departments and (2) the Secretary of the Army shall develop, in collaboration with the Secretaries of the Navy and Air Force, implementing instructions for the joint aspects of the Directive. All implementing instructions will be submitted to the Assistant Secretary of Defense (Manpower) for approval. After approval and publication, two copies of the implementing regulations shall be submitted to the Assistant Secretary of Defense (Manpower).

ROSWELL GILPATRIC,
Deputy Secretary of Defense

U.S. GOVERNMENT PRINTING OFFICE : 1962 O—649153

APPENDIX III

VETERANS ADMINISTRATION AUDIOLOGY CLINICS

Arizona
Tucson
Arkansas
Little Rock
California
Los Angeles
San Francisco
Colorado
Denver
District of Columbia
Washington, D.C.
Florida
Bay Pines
Miami
Georgia
Atlanta
Illinois
Chicago
Iowa
Iowa City
Kansas
Kansas City
Kentucky
Louisville
Louisiana
New Orleans
Massachusetts
Boston
Michigan
Allen Park
Ann Arbor
Minnesota
Minneapolis
St. Paul
Montana
Fort Harrison
New Jersey
Newark
New Mexico
Albuquerque
New York
New York
Syracuse
North Carolina
Durham
Ohio
Cleveland
Oklahoma
Oklahoma City
Pennsylvania
Philadelphia
Pittsburgh
Puerto Rico
San Juan
Texas
Dallas
Houston
Virginia
Richmond
Washington
Seattle

★APPENDIX IV

BUREAU OF EMPLOYEES' COMPENSATION DISTRICT OFFICES

Districts	*Area of jurisdiction*
District No. 1—Boston, Massachusetts Deputy Commissioner 125 Lincoln Street Boston, Massachusetts 02111	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.
District No. 2—New York, New York Deputy Commissioner 321 West 44th Street New York, New York 10036	Delaware, New Jersey, New York and Pennsylvania.
District No. 6—Jacksonville, Florida Deputy Commissioner 400 West Bay Street Box 35049 Jacksonville, Florida 32202	Florida, Georgia and South Carolina
District No. 7—New Orleans, Louisiana Deputy Commissioner Federal Office Building, South 600 South Street New Orleans, Louisiana 70130	Alabama, Arkansas, Louisiana, Mississippi and Texas
District No. 9—Cleveland, Ohio Deputy Commissioner 1240 East 9th Street Room 879 Cleveland, Ohio, 44199	Indiana, Kentucky, Michigan, Ohio, Tennessee, and West Virginia
District No. 10—Chicago, Illinois Deputy Commissioner 536 South Clark Street Chicago, Illinois 60605	Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, and Wisconsin
District No. 13—San Francisco, California Deputy Commissioner 450 Golden Gate Avenue Box 36022 San Francisco, California 94102	Arizona, California, Colorado, Nevada, New Mexico, and Utah

District No. 14—Seattle, Washington Deputy Commissioner Smith Tower Building 506 Second Avenue Room 2008 Seattle, Washington 98104	Alaska, Idaho, Montana, Oregon, Washington, and Wyoming
District No. 15—Honolulu, Hawaii Deputy Commissioner 1833 Kalakaua Avenue Room 610 Honolulu, Hawaii 96815	All land and water areas west of the continents of North and South America to the 60th degree east longitude (except for Iran)
District No. 25—Washington, D.C. Deputy Commissioner 1111 20th Street, N.W. Room 812 Washington, D. C. 20211	District of Columbia, Maryland, North Carolina, Virginia, Canada, Mexico, Central and South America, and all land and water areas east of the continents of North and South America to the 60th degree east longitude (including all of Iran)

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[AG 701 (1 Dec 61) MEDDD]

ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirequirements for DA Regulations—Medical Service—A

☆ U. S. GOVERNMENT PRINTING OFFICE: 1962—610809

14 February 1972

C 26, AR 40-3
*AR 40-3

ARMY REGULATION

No. 40-3

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *26 March 1962*

MEDICAL SERVICES
MEDICAL, DENTAL, AND VETERINARY CARE

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based on injuries or disabilities allegedly arising out of the operation of the Defense Establishment may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge being made in order to determine the extent or nature of the injuries or disabilities claimed.

31. Persons outside the continental United States who contribute to accomplishment of a major oversea commander's mission. *a. General.* Persons who contribute to the accomplishment of a major oversea commander's mission and for whom medical care is deemed essential by the major oversea commander concerned may receive medical care in facilities outside the continental United States only in the absence of adequate civilian facilities as determined by the major oversea commander concerned. Rate B or F or the outpatient rate, whichever is applicable, will apply except as indicated in *b*, *c*, and *d* below.

b. Civilian representatives of religious groups and others. Civilian representatives of religious groups, celebrities and entertainers, athletic clinic instructors, and representatives of the USO, other social agencies, and educational institutions, and persons in similar status providing direct services to the US Armed Forces, who are acting under official invitational orders from the Department of Defense, or from one of the military departments, to visit military commands overseas may be furnished medical care without charge in facilities outside the continental United States. Charges for subsistence will be collected locally from the individual. Dependents of USO oversea area executives, club directors, and associate club directors when accompanying their sponsors outside the United States may be furnished medical care at the uniformed services dependent rate, effective 4 March 1969.

c. Educational representatives of recognized educational institutions. Educational representatives of recognized educational institutions regularly assigned to duty in military commands overseas who are contributing to a major oversea commander's mission, and their dependents when residing with their sponsors, may be furnished medical care in facilities outside the continental United States at Rate B or F or at the outpatient rate, whichever is applicable.

d. Rates for individuals under hardship circumstances. When a major oversea commander determines that hardship would result if an individual or a category provided care under this paragraph were charged the rates specified in *a* above, he may prescribe Rate D as the charge for hospitalization or waive the charge for outpatient care, or do both, as appropriate.

32. American nationals. American nationals outside the United States covered by agreements entered into between the Department of the Army and other Federal civilian agencies when care in Army medical treatment facilities is a condition of the agreement may be furnished medical care.

33. Joint Civilian Orientation Conference guests. Joint Civilian Orientation Conference guests while attending a Joint Civilian Orientation Conference will be provided medical care. Charges for medical care will be at Rate B or at the outpatient rate, whichever is applicable, and collection will be made locally from the individual.

34. Special foreign nationals. *a. Care authorized.* Medical care may be furnished to such persons outside CONUS when it is determined that this action can be expected to contribute to the advancement of the public interests of the United States.

b. Authority. Authority is granted to major oversea commanders to make the foregoing determination.

c. Delegation of authority. Major oversea commanders may, when the geographical dispersion and varying political conditions of their command warrant such action, delegate the authority in *b* above and *e* below to one or more of their major subordinate commanders. Such authority, however, may not be redelegated.

d. Considerations.

(1) Generally, care under this paragraph will be afforded only to foreign officials of high national prominence. Care may be afforded under this paragraph, however, to other foreign nationals when, because of unusual circumstances or the extraordinary nature of the case, such action would be in consonance with *a* above.

(2) Normally, care will not be afforded under this paragraph for chronic conditions or any other condition which, if hospitalization is in-

volved, would not be benefited by hospitalization for a period of less than 90 days.

(3) Normally, the recommendations of the Chief of the Diplomatic Mission to the country involved should be sought prior to determining whether care should be afforded under this paragraph.

e. Charges. Charges for medical care provided under this paragraph will be at Rate B or F or the outpatient rate, whichever is applicable, and collection will be made locally, except that in unusual cases the major oversea commander may waive the charges.

f. Evacuation to the United States. Persons being afforded care under this paragraph will not be evacuated to the United States for further care unless they are first made designees of the Secretary of the Army pursuant to paragraph 35.

35. Designees of the Secretary of the Army. Persons not otherwise eligible for medical care may receive such care when they are designated for this purpose by the Secretary of the Army. Such designees will be charged Rate B or F or the outpatient rate, whichever is applicable, unless specifically otherwise authorized by the Secretary. In the event the Secretary authorizes the furnishing of hospitalization with no reimbursement therefor, a charge for subsistence will be collected locally from the individual unless the Secretary also waives these charges.

★35.1 Pre-adoptive children. Under the provisions of paragraph 35, the Secretary of the Army has authorized pre-adoptive children of active duty and retired members of the uniformed services to receive medical care in Army medical facilities until the adoption is finalized and they become entitled to care under chapter 55, title 10, US Code. Care will be provided under the same conditions and subject to the same charges as would apply to any dependent entitled to medical care in such facilities.

a. Commanders of Army medical treatment facilities are delegated responsibility for determining whether an individual child falls within this class of Secretarial designees, after approval on an individual basis by the local Staff Judge Advocate.

b. To apply for medical care for a pre-adoptive child as a Secretary of the Army designee, the sponsor must submit a request to the medical facility commander with the following information and documentation:

(1) The name and date of birth of the prospective adoptee.

(2) The sponsor's name, grade, social security number, and organization, or address for retirees.

(3) A notarized, acknowledged, or photostat copy of the legal decree or other instrument issued by a court of law or adoption agency which awarded custody for the purpose of adoption. (Approval will not be granted without such an official document.)

(4) The date of placement and expected date of final adoption.

c. If the medical facility commander determines that the child fits within this class of Secretarial designees, he will forward the application to the local Staff Judge Advocate for verification of the determination. If verified, the application will be so annotated by the Staff Judge Advocate and returned to the medical facility commander. A copy will be provided the sponsor and the original retained by the medical facility until the adoption is final. It may then be destroyed.

d. Responsibility for approval will not be delegated below the medical facility commander.

36. Certain personnel evacuated from one area to another. Personnel who for medical reasons are evacuated from an area in which they are eligible for medical care to an area where they are not otherwise eligible for such care will be admitted to or furnished treatment at medical treatment facilities to which evacuated or while en route thereto when medical care is deemed necessary. Care should be furnished under this paragraph on a temporary basis only until such time as appropriate disposition can be accomplished.

37. Civilians in emergency. *a.* Any person is authorized care in an emergency in order to prevent undue suffering or loss of life. See paragraph 3.1*e* for extent of care.

b. Charges for medical care under this paragraph will be at Rate B or F or the outpatient rate, which ever is applicable, except when the patient is determined to be medically indigent, the commander may waive the charges. For the purpose of this regulation, a person who has insufficient income to meet the costs of necessary medical care and services is considered to be medically indigent.

37.1 Volunteer subjects in approved Department of the Army research projects. Volunteers under the provisions of AR 70 25 are authorized all necessary medical care for injury or disease which is the proximate result of their participation in such projects. (Medical care for civilian employees who volunteer and who perform duty as a volunteer during their regularly scheduled tour of duty will be provided in accordance with paragraph 13.)

37.2 Secret Service Special Agents (examinations). Upon presentation of written authorization, Secret Service Special Agents may be provided routine annual medical examinations in Army medical treatment facilities on a reimbursable basis. Examinations will be conducted and recorded in the same manner as routine annual medical examinations for Army officers except that they will be conducted on an outpatient basis only. If hospitalization is considered desirable in connection with the examination, a statement to that effect will be entered in item 73 or 75 of the SF 88 (Report of Medical Examination), as appropriate. One copy of SF 88 and SF 93 (Report of Medical History) for medical examinations provided these agents will be forwarded to the Chief, United States Secret Service, Treasury Department, Washington, DC 20220. Charges for examinations will be collected by The Surgeon General on receipt of DD Form 7A supported by a copy of the authorization for medical examination.

Note. See AR 1-4 for nonreimbursable medical support provided the US Secret Service in the performance of its protective responsibility for the President.

37.3 Federal Aviation Agency (FAA) Air Traffic Controllers. *a.* Upon the written request of FAA regional representatives, designated Army hospitals are authorized to provide the following services to Air Traffic Controllers who are undergoing a physical examination by an FAA physician:

(1) Chest X-rays.

(2) Electrocardiographs.

(3) Audiograms.

b. The Army hospital commander will not read or evaluate the results of these tests. Results will be forwarded direct to the FAA Regional Office arranging for the examination.

★*c.* Services provided will be reported to HQDA (DASG-RMF) on DD Form 7A supported by a copy of the request for the services.

37.4 Job Corps and Volunteers in Service to America (VISTA) personnel and applicants. *a. Job Corps.* Upon presentation of Job Corps Form 503 (Authorization for Medical Fitness Examination by a Federal Facility), Job Corps Form 505 (Authorization for Hospitalization by a Federal Facility), or Job Corps Form 507 (Authorization for Outpatient Care and Services by a Federal Facility) signed by an appropriate official of the Job Corps, Job Corps applicants for enrollment and Job Corps enrollees may be provided the following services in Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Job Corps applicants for enrollment.* Pre-enrollment medical examinations and immunizations.

(2) *Job Corps enrollees.* Hospitalization, outpatient medical treatment, examinations, and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering.

b. VISTA. Applicants for employment by VISTA and VISTA personnel may be provided the following services in Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Applicants for employment by VISTA.* Pre-employment medical examination of VISTA Form 36 (Authorization for Medical Examination and Care by a Federal Facility) signed by an appropriate VISTA official.

(2) *VISTA personnel.* Hospitalization, outpatient medical treatment, examinations, and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering. Hospitalization and outpatient medical treatment may be provided upon presentation of a "Blue Cross and Blue Shield Identification Card." Other authorized services may be provided upon presentation of VISTA Form 36.

c. Services available at Armed Forces Examining and Entrance Stations. Upon presentation of Job Corps Form 503 or VISTA Form 36, male Job Corps applicants and male VISTA applicants may be provided pre-employment medical examinations and immunizations at Armed Forces Ex-

amining and Entrance Stations (AFEES) when in the opinion of the AFEES commander the capability exists.

d. Remediable physical defects. Upon presentation of appropriate authorization form signed by a Job Corps or VISTA physician, surgery or other treatment required to correct remediable physical defects of Job Corps enrollees and VISTA personnel may be provided in Army medical treatment facilities if within the professional judgment of the medical officers concerned such treatment is indicated and the required resources are available. The authorization form should contain a statement that in the opinion of the authorizing physician the condition will interfere with or substantially impede the training or future employability of a Job Corpsman or will seriously interfere with a VISTA volunteer's performance of duty.

e. Reports to The Surgeon General. Hospitalization, outpatient care, examinations and immunizations furnished will be reported to The Surgeon General on DD Form 7 or 7A supported by a copy of the Job Corps or VISTA form authorizing the services. In the case of VISTA personnel provided hospitalization or outpatient treatment on the basis of their Blue Cross and Blue Shield Identification Card, the VISTA identification number of the patient will be shown after the name of the patient in Item 5 of the DD Form 7 or 7A.

f. Beneficiaries of the Bureau of Employees' Compensation. After termination of their duty with the Job Corps or VISTA, these personnel are eligible for Bureau of Employees' Compensation benefits. To establish their eligibility for these benefits, Army medical treatment facilities providing treatment to such personnel will, upon request, complete the medical certificate on BEC Form CA-2.

37.5 US Nationals in foreign penal institutions. US nationals serving with, employed by, or accompanying the Armed Forces outside the United States and its possessions, and their dependents, when confined in foreign penal institutions are authorized medical care of the type and quantity furnished prisoners in US military confinement (AR 27-50).

★37.6 Social Security beneficiaries. Beneficiaries of the Social Security Health Insurance Program for the Aged (Medicare) may be provided hospitalization in Army medical treatment facilities in an emergency to prevent undue suffering or loss of life. The Social Security Administration's local office will be notified as soon as possible after emergency admission of one of their beneficiaries. The Social Security Administration can pay for care furnished its beneficiaries in a Federal hospital only during the period of the emergency. The patient or responsible family member will be informed of this and will be advised that arrangements should be made with a civilian hospital which participates in the Medicare Program so that the patient can be transferred as soon as his condition has improved to the extent that he can be moved. Collection for the patient's share of the cost of hospitalization under the Medicare Program will be a matter between the patient and the Social Security Administration and no collection will be made from these patients by the Army hospital. Emergency hospitalization of Social Security beneficiaries will be reported to HQDA (DASG-RMF) on DD Form 7. This paragraph does not apply to dependents and retired members who are entitled to care in uniformed services facilities. Such persons are provided care as uniformed services beneficiaries under the provisions of paragraph 11 of this regulation and paragraph 4-6, AR 40-121.

37.7 Domestic servants outside the United States. Army medical treatment facilities located outside the United States are authorized to provide the following health measures without charge for domestic servants employed or to be employed by military and civilian personnel of the Department of Defense:

a. Pre-employment health examinations.

b. Periodic communicable disease detection examinations.

c. Immunizations.

37.8 Underprivileged children participating in the President's Youth Opportunity Programs. When medical support is not available from other sources, certain limited medical services may be provided underprivileged children participating

in the President's Youth Opportunity Program in Army facilities on a reimbursable basis in accordance with the provisions of chapter 6, AR 28-19.

★37.9 Micronesian citizens. Micronesian citizens referred to US Army Tripler General Hospital for specialized treatment by the High Commissioner, Trust Territory of the Pacific Islands, may be provided hospitalization and outpatient treatment as beneficiaries of the Trust Territory of the Pacific Islands (a Federal agency) at the Interdepartmental rate and outpatient rate, respectively. Collection will be made locally.

SECTION IV

DISPOSITION OF PATIENTS FROM ARMY MEDICAL TREATMENT FACILITIES

38. General policies. *a.* Prior to disposition, all Army military patients will be evaluated for retention in the military service. In addition, each member will be evaluated under such special standards as may be applicable in his case (aviation, diving, airborne, special forces, etc.). Dispositions to a duty status will take into consideration the long-range effect, if any, upon the health and well-being of the patient after his return to his regularly assigned job.

b. Medical officers will not designate a particular medical treatment facility for use by patients who require followup examination after their disposition unless unusual professional considerations dictate such action.

c. Except under emergency circumstances a patient will not be granted a pass or leave when absence will in any way delay his disposition.

★*d.* Army military patients who are administratively unfit for retention will be processed in accordance with procedures contained in appropriate administrative regulations such as AR 635-100, AR 635-206, and AR 635-212.

e. Patients who normally would be discharged from the hospital on Sundays or holidays will be discharged on the preceding workday, whenever such earlier discharge is not medically contraindicated.

f. All administrative actions such as requests for duty assignment, medical records, line of duty determinations, and medical board processing will be taken as quickly as possible in order to expedite the eventual disposition of military patients.

g. No patient will be retained in a medical treatment facility solely for the purpose of completing items 35 and 36 of DA Form 8-118 (Medical Board Proceedings) (para 45*o*).

h. When efforts to dispose of a patient are not successful, his case will be brought to the attention of The Surgeon General, ATTN: MEDDD-OH.

★*i.* Convalescent leave may be granted in accordance with paragraph 8-3, AR 630-5, and Part K, Chapter 5, Volume 1, Joint Travel Regulations.

39. Return of oversea Army military patients to CONUS for medical reasons. Major oversea commanders may return military patients who are members of the Army to CONUS for medical reasons when they determine that such action is in the best interests of the Army and the patient.

a. The major oversea commander concerned will determine whether a patient being returned to CONUS under this paragraph will appear before a medical board prior to evacuation.

b. If hospitalization or active medical supervision is required while in a travel status, the patient will be evacuated through medical channels.

c. If hospitalization or active medical supervision is not required while in a travel status, the patient will be returned to CONUS through regular administrative channels by the most expeditious means.

★(1) As soon as it is determined that such a patient is to be returned to CONUS, a request for hospital designation will be submitted as

prescribed by the major oversea commander concerned to The Surgeon General, ATTN: MEDDD-OH, Department of the Army, Washington, D.C. by electrically transmitted message. The following information concerning the patient will be included in the message:

(*a*) Name.

(*b*) Grade.

(*c*) Social Security number.

(*d*) General area where the patient prefers to be hospitalized. (In putting this question to the patient, it should be emphasized that his transfer to a specific hospital cannot be guaranteed.)

(*e*) Diagnosis.

(*f*) A statement indicating whether the patient has appeared before a medical board convened in accordance with paragraph 41.

(2) The Surgeon General in responding to requests received under the provisions of (1) above will use the following codes for the purpose of designating the CONUS destination hospital:

Code	*Hospital*
Reed	Walter Reed General Hospital (3401.01), Walter Reed Army Medical Center, Washington, DC 20012.
Forge	Valley Forge General Hospital (3416), Phoenixville, PA 19460.
Brooke	Brooke General Hospital (3410.01), Brooke Army Medical Center, Fort Sam Houston, TX 78234.
Bmont	William Beaumont General Hospital (3414), Fort Bliss, TX 79920.
Fitz	Fitzsimons General Hospital (3412), Denver, CO 80240.
Lman	Letterman General Hospital (3415), Presidio of San Francisco, CA 94129.
Madigan	Madigan General Hospital (3411), Tacoma, WA 98431.
Womack	Womack Army Hospital (3155-01), Fort Bragg, NC 28307.
Martin	Martin Army Hospital (3150-01), Fort Benning, GA 31905.

★When hospitals other than the ones listed above are designated by The Surgeon General, the name of the hospital and the installation will be used. In cases where a hospital is not a named hospital, USAH (name of installation) will be used. The CONUS destination hospital will be listed as an information addressee on the message.

★(3) The patient will be transferred as soon as possible after receipt of the hospital designation from The Surgeon General. Orders issued by the oversea commander will assign the patient to the medical holding unit of the hospital designated by The Surgeon General and will cite ACPATT. Reporting date will be computed in accordance with AR 680-1.

(4) Commanders returning patients to CONUS under this authority will not grant delay en route or leave when such action is medically contraindicated. The medical treatment facility commander who initiates action to return administratively a patient to CONUS will determine whether leave or delay en route is medically contraindicated.

(5) The major commander will assure that the medical treatment facility in possession of the clinical records and the unit in possession of the health and personnel records are notified of the CONUS hospital designation. These records will be forwarded by the appropriate custodian to the designated hospital by airmail and, in addition, in the case of individuals returning by MSTS, a copy of Standard Form 502 (Clinical Record—Narrative Summary) will accompany the individual for use by MSTS medical officers. The clinical record cover sheet will include the name of the designated hospital in item 28 and will contain in item 25 the following statement:

Returned to CONUS under provisions of paragraph 39*c*, AR 40-3, with ..... days delay en route or leave authorized.

d. When an Army military patient is hospitalized in an oversea command and his home of record is located within that oversea command, he may be retained in the oversea command for medical treatment and further disposition (including separation), provided the military medical facilities available within the oversea command can adequately meet his needs.

★*e*. Evacuation orders on officer patients should receive distribution shown in paragraph *d*(2) under Special and Letter Orders, Table 1-1, AR 310-10. In the case of Army Medical Service officers, the copies listed in column 4, table 1-1, AR 310-10, should be forwarded to The Surgeon General, ATTN: MEDPT, Department of the Army, Washington, DC 20314.

SECTION V

MEDICAL CARE AT NAVY OR AIR FORCE MEDICAL TREATMENT FACILITIES

71. For whom authorized. Subject to the restrictions referred to below, the personnel listed below will be provided medical care when available at Navy or Air Force medical treatment facilities. Medical care will be provided when such facilities are more readily available than medical treatment facilities of the Army. Determination of availability of facilities will be made, except in emergencies, by the commander or person in charge of the individual requiring care.

a. Members of the Army included in paragraphs 7 and 8 subject to the restrictions contained therein. (Authorization for medical care referred to in paragraph 8*c* will be obtained from the appropriate authority by the Army administrative unit or, where Army administrative units are not established, by the Army medical facility designated to assume administrative responsibility in accordance with paragraph 74*a*.) The term "administrative responsibility" will include, but not be limited to, the following:

(1) Necessary professional medical evaluation and assistance.

(2) Notification to the patient's parent unit and (when applicable) temporary duty organization.

(3) Morning report accounting, pay and allowances, and other personnel functions for patients assigned to a medical holding unit; and these same personnel functions except pay and allowances for patients attached to a medical holding unit.

(4) Arranging transfer to another uniformed services facility in appropriate cases.

(5) Issuance of any necessary orders for further travel upon completion of hospitalization.

b. Members of, and designated applicants for enrollment in, the Army Senior Reserve Officers' Training Corps subject to the restrictions outlined in paragraph 10*a*.

c. Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve components thereof, limited to the following:

(1) Necessary medical and mental examinations.

(2) Hospitalization to determine medical fitness for military service.

(3) Emergency medical care for acute illnesses and injuries suffered while awaiting or undergoing processing at recruiting main stations or at Armed Forces Examining and Entrance Stations.

d. Registrants under the Universal Military Training and Service Act limited to the types of care referred to in *c* (1) and (2) above.

e. Applicants for appointment in the Regular Army, and Reserve components including those members of the Reserve components applying for active duty subject to the restrictions contained in paragraph 20.

f. Prisoners of war, retained personnel, persons interned by the Army, and other persons in military custody or confinement.

g. Civilian seamen in the service of vessels operated by the Department of the Army.

h. Civilian employees of the Army limited to those occupational health services authorized in AR 40-5.

i. Retired Army members subject to the restrictions outlined in paragraph 11.

j. Civilian employees (including former and prospective employees) of contractors of the Department of the Army limited to the types of care referred to in paragraph 27*d*.

k. Individuals who suffered personal injury or contracted disease in line of duty at a time when they were members of the Citizens Military Training Corps (para 9).

l. **Rescinded.**

★*m.* Army National Guard technicians (civilian employees of the Army National Guard) assigned or to be assigned nuclear weapons duties at missile sites limited to medical examinations required by AR 611-15 when it is considered that a medical evaluation will assist in determining suitability for such assignment or continued assignment.

Note. When a psychiatric evaluation required in connection with the medical examination is made at a naval medical treatment facility, and it is determined that the technician is not mentally or emotionally suitable for assignment or continued assignment to missile site duties, an additional evaluation by an Army psychiatrist will be scheduled to corroborate previous psychiatric findings and to permit the Army psychiatrist to appear at any hearings held in the event a technician appeals the decision made in his case.

★*n.* U.S. nationals confined in foreign penal institutions (para 37.5).

72. General policies. *a.* For the method of assigning or attaching patients to Army administrative units or other designated Army organizations upon admission for, during, and upon completion of hospitalization, and the manner in which they will be carried on administrative records, the pertinent provisions of paragraphs 3.1 and 74 apply.

b. Medical care and adjuncts thereto will be provided in accordance with the instructions of the military service providing the care.

c. Collection of subsistence charges from all Army officer patients will be made locally by the Navy or Air Force hospital.

d. When general officers of the Army on active duty are admitted to or released from Navy or Air Force hospitals, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*) *1* through *5* is required.

73. **Army administrative units.** ★When deemed necessary and concurred in by the service concerned, CONUS army commanders will establish Army administrative units at Navy or Air Force hospitals from resources available to them. CONUS army commanders are authorized direct communication with the Navy or Air Force commander concerned for this purpose. An Army administrative unit established at a Navy or Air Force hospital will be assigned to and integrated with the nearest MEDDAC.

★*a. Assignment.* Enlisted duty personnel will be assigned to Army administrative units by the CONUS army commander concerned. Army Medical Department officer duty personnel will be assigned by the Department of the Army.

★*b. Command.*

(1) The commander of an Army administrative unit will be responsible to the appropriate MEDDAC commander for the operational functions of the unit, and will be responsible for compliance by the unit with station orders and/or regulations of the Navy or Air Force hospital.

(2) The commander of the Army administrative unit will act as, or will designate a subordinate officer of his unit as the commander of the medical holding unit.

(3) Army personnel at a Navy or Air Force hospital will be subject to the military authority of the Navy or Air Force commander, but will be assigned or attached to the Army administrative unit for administration. Military control of such personnel normally will be exercised by the Navy or Air Force commander through the commander of the Army administrative unit.

SECTION VI

MEDICAL CARE AT FEDERAL MEDICAL TREATMENT FACILITIES OTHER THAN THOSE OF THE ARMED FORCES

75. For whom authorized. Subject to the restrictions referred to in paragraph 71, the personnel listed below will be provided medical care when available at Federal medical treatment facilities other than those of the Armed Forces (hereinafter referred to as "Federal medical treatment facilities"). Medical care will be provided when such facilities are more readily available than medical treatment facilities of the Armed Forces.

a. Personnel enumerated in paragraph 71*a*.

(1) When general officers of the Army on active duty are admitted to or released from Federal medical treatment facilities, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*) *1* through *5* is required.

★(2) Authorization for medical care referred to in paragraph 8*e* will be obtained from the appropriate authority by the Army medical facility designated to assume administrative responsibility in accordance with paragraph 76*a*(2).

★*b.* Personnel enumerated in paragraph 71 *b, c, d, f, h, j, k, l* and *m*.

c. Personnel enumerated in paragraph 71*e* who require hospitalization to determine medical fitness for appointment.

d. Personnel enumerated in paragraph 71*g* limited to care in medical treatment facilities of the Veterans Administration. (Such personnel when furnished care in hospitals and outpatient clinics of the Public Health Serivce are beneficiaries of that service.)

e. Retired Army members (para 71*i*).

(1) Prior to 1 January 1967, limited to care provided in hospitals and outpatient clinics of the Public Health Service, except that when requested by the Department of the Army, retired Army members placed on the Temporary Disability Retired List may be furnished required medical examinations at medical treatment facilities of the Veterans Administration.

(2) On and after 1 January 1967, retired Army members may be provided inpatient and outpatient medical and dental care for non-service-connected disabilities in Veterans Administration facilities as Army beneficiaries.

f. Foreign nationals who are members of the Army of one of the NATO nations listed in paragraph 25*a*(1) and who, in connection with their official duties, are stationed in or passing through the United States.

g. The dependents (as defined in para 25*a*(10)) of the individuals described in *f* above (limited to care provided in hospitals and outpatient clinics of the Public Health Service).

76. Manner in which care is provided. *a. Ordinary medical care.*

(1) Except as indicated in paragraph 75*a* and *e*, and *b*, *c*, and *d* below, an individual will not obtain care from Federal medical treatment facilities without obtaining prior authorization from his commander. If the commander deter-

mines that the individual requires medical care, he will prepare DA Form 8-267, in triplicate. This form will be addressed to the officer in charge of the Federal medical facility in which medical care is desired. The patient will present the original and one copy of the form to the facility when he applies for treatment. (This requirement does not apply in the case of members of the Army who apply for medical care at medical facilities of the Public Health Service.)

(2) If the officer in charge of a Federal medical treatment facility accepts the Army beneficiary, the commander of the patient will notify the appropriate CONUS army commander or Army oversea commander or the Commanding General, Military District of Washington, U.S. Army, within whose territorial limits the facility is located, who will assign an Army medical treatment facility to assume administrative responsibility for the patient and will advise the officer in charge of the Federal medical facility of this assignment. Administrative responsibility will include, but not be limited to, those functions specified in paragraph 71*a* (1), (2), (3), and (5) and the following:

(*a*) Preparation of necessary individual medical records (AR 40-400).

(*b*) Seriously ill and death notifications (AR 40-2).

(*c*) Arranging transfer to another uniformed services facility (or to a uniformed services facility) in appropriate cases.

b. Emergency medical care. In an emergency, when the urgency of the situation does not permit the preparation of DA Form 8-267 by the patient's commander as prescribed in *a* above, authorized personnel may be furnished medical care without such request for treatment at the discretion of the officer in charge of the Federal medical treatment facility. The patient's commander will prepare DA Form 8-267, however, as soon thereafter as possible and forward it to the Federal medical treatment facility. At the same time he will notify the appropriate CONUS army commander or Army oversea commander or the Commanding General, Military District of Washington, U.S. Army, as stated in *a* above.

c. Absent from station. Authorized personnel when absent from their duty stations may be furnished medical care at Federal medical treatment facilities without obtaining prior authorization of their commanders and without DA Form 8-267, at the discretion of the officer in charge of such facilities. It is the responsibility of the patient or someone acting in his behalf to notify his commander of this fact so that his commander can comply with the requirements of *b* above. When the officer in charge of the Federal medical treatment facility is unable to obtain the required DA Form 8-267, he will state on the voucher for each such case that he ascertained from the DA identification card in possession of the patient that he was a member of the Army at the time medical care was furnished.

d. Care for retired members in Veterans Administration facilities. DA Form 8-267 is not required for medical care obtained by retired Army members in Veterans Administration facilities. Identification will be by means of DD Form 2A (Ret) (gray).

77. Utilization of Federal medical treatment facilities. If it is necessary to utilize the services of such facilities to supplement Army medical treatment facilities or Armed Forces Examining and Entrance Stations, the commanders thereof may obtain such services on their written request direct to the officer in charge of the facility concerned.

78. Rates of compensation. Payment for inpatient care will be made at the inpatient rate prescribed by the Bureau of the Budget for the applicable fiscal year. Payment for outpatient care will be made at the rates prescribed by the Federal agency furnishing the care except in the case of members and retired

SECTION VIII

MEDICAL CARE FROM CIVILIAN SOURCES

83. For whom authorized. Subject to the restrictions referred to in paragraph 71, personnel listed below will be provided medical care, when available, from civilian sources at the expense of Army funds. Care by civilian sources is authorized when it cannot be provided by medical treatment facilities of the Armed Forces or by other Federal medical treatment facilities, except as indicated in *h* below which pertains to hospitalization for persons interned by the Army.

Note. Except as provided in *f* below, retired Army members are not provided civilian nmedical care under the provisions of this section. Such members are authorized civilian medical care under the provisions of AR 40-121.

a. Personnel enumerated in paragraph 71*a*. *Such care will not be authorized for persons who are absent without authority.*

★*b.* Personnel enumerated in paragraph 71*b*, *c*, *d*, *g*, *h*, *k*, and *n*. (That portion of this subparagraph which cites paragraph 71*b* is retroactive to 17 April 1962.)

c. Personnel enumerated in paragraph 71*e* who require hospitalization to determine medical fitness for appointment.

d. Foreign nationals who are members of the Army of one of the NATO nations listed in paragraph 25*a*(1) and who, in connection with their official duties, are stationed in or passing through the United States. (*This provision is applicable to authorized civilian medical care obtained on and after 1 July 1963.*)

e. For conditions under which dependents of individuals listed in *d* above are provided civilian medical care, see AR 40-125.

f. Retired Army members on the Temporary Disability Retired List who require periodic medical examinations, to include hospitalization when necessary in connection therewith, retroactive to 14 January 1963. (*The provisions of AR 40-121 are not applicable to examinations authorized by this subparagraph.*)

g. Prisoners of war, retained personnel, and other persons in military custody or confinement.

h. Civilians interned by the Army. These persons will be provided hospitalization at medical treatment facilities of the Armed Forces only in the absence of adequate civilian facilities pursuant to paragraph 42, AR 633-51.

84. Qualifications of professional personnel engaged to furnish medical care. *a. Licensing of civilian professional personnel.*

(1) Except as indicated in (2) below, doctors of medicine, doctors of osteopathy, doctors of dentistry (para 134), doctors of veterinary medicine (para 135), and optometrists (para 117*c* and 124) engaged to furnish medical services in accordance with this regulation must have valid licenses to practice their specialties in a State, territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico. Nurses engaged to provide nursing care must be currently registered to practice nursing in a State, territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(2) In the case of such professional personnel when engaged to perform services in oversea areas, except the Commonwealth of Puerto Rico, licensing and registration criteria will be as prescribed by the oversea commander concerned.

b. Restrictions.

(1) Except as indicated in (2) below, only

those licensed or registered professional personnel covered in *a* above can be utilized for medical services if payment is to be made from Army funds.

(2) Practitioners specializing in the sciences allied to the practice of medicine who are licensed to practice in the area concerned may be utilized for medical services under (1) above when such service is provided on the written request of a licensed doctor of medicine, osteopathy or dentistry as part of the medical care required.

★(3) Payment for chiropractic services is not authorized.

84.1 Exclusion of hospitals which practice discrimination. *a.* The Department of Defense has determined that certain civilian hospitals practice discrimination in the admission and/or treatment of patients on the basis of race, color or national origin and has declared these hospitals ineligible to receive payment from the Government for inpatient or outpatient care furnished Department of Defense beneficiaries on and after the effective date of ineligibility. The list of ineligible civilian hospitals, together with the effective date of ineligibility, is published in appendix B, AR 40–121. Payment cannot be made for inpatient or outpatient care provided by these hospitals on and after the effective date of ineligibility except in unusual circumstances when approved by the Department of Defense. This applies regardless of whether the hospital seeks payment or the patient pays the hospital and requests reimbursement. Payment to physicians and other professional or paramedical personnel who bill independently of the hospital will not be refused solely because their services were provided in an ineligible hospital.

★*b.* Before payment is denied for care obtained by an Army beneficiary in an ineligible hospital, the approving authority will review the case to determine whether unusual circumstances exist which may justify payment of the bill. Examples of unusual circumstances which may justify payment are a bona fide emergency, absence of an eligible hospital within reasonable distance, and admission of a patient to an ineligible hospital for short-term inpatient care prior to the effective date of ineligibility and treatment continues beyond that date. If it is found that unusual circumstances exist, the bill with a statement of the circumstances will be forwarded to The Surgeon General, ATTN: MEDDD–C, for review and forwarding to the Department of Defense for decision.

85. Special considerations for members of the Army. ★*a.* Charges incurred for civilian medical care for persons absent without authority will not be at Army expense. Where the absence without authority is terminated by the individual's actual or constructive return to military control, the charges for treatment may be paid in accordance with paragraph 88. For this purpose, constructive return to military control becomes effective for the entire episode of medical care when notification that the AWOL member is undergoing medical treatment is received and acknowledged by military authorities. "Military authorities" in this instance refers to the CONUS Army commander or oversea Army commander of the area in which the civilian medical care is obtained, the chief of the military district of the area, the nearest installation commander, the individual's commander, or any other authority authorized to effect return to military control under AR 630–10. The military authority receiving the notification will immediately acknowledge the same orally or in writing, verify the individual's status in the manner prescribed by section X, AR 630–10, and take appropriate action with a view to the member's eventual return to actual military control. When an individual has been unable to return or report because of legitimate circumstances beyond his control, or has otherwise been erroneously reported AWOL or in desertion the responsible officer will take the action described in section XII, AR 630–10.

b. When general officers of the Army on active duty are admitted to or released from civilian medical treatment facilities, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*) *1* through *5* is required.

★*c.* Authorization for medical care referred to in paragraph 8*c* will be obtained from the appropriate authority by the Army medical treatment facility designated to assume administrative responsibility in accordance with paragraph 88*a*(1).

86. Elective care. Elective care in civilian medical treatment facilities or by civilian physicians is not authorized at Army expense.

87. Approving authorities. Approving authorities for civilian medical care are shown in figure 2.1.

Categories	*Approving authorities*
a. Members of the Army who are patients or who are on duty at hospitals, medical centers, and at those other medical activities located thereat under the command jurisdiction of The Surgeon General.	a. The commander of the appropriate hospital or medical center.
b. Members of the Army who are patients or who are on duty at installations and activities within the continental United States other than those referred to in a[1] above and l below.[1]	b. The appropriate CONUS Army commander or the Commanding General, Military District of Washington, U.S. Army, in whose geographic area the medical care is furnished.
c. Members of the Army who are patients or who are on duty at installations and activities outside the continental United States.[2]	c. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagsy Republic and Ceylon—United States Army, Europe; and (2) Countries in the Pacific, Alaskan, and Southern Commands—respective Army major oversea commanders except as indicated in g and h below.
d. Members of the Army National Guard of the several States, Commonwealth of Puerto Rico, the District of Columbia, and the Army National Guard of the United States while on active duty for periods of 30 days or less or not on active duty (except REP 63 personnel. See e below.)	d. Chief, National Guard Bureau, Washington, DC 20310.

Figure 2.–1

See footnotes at end of list.

88. Manner in which care is provided. *a. Ordinary medical care.* Except as indicated in (2) below, personnel entitled to medical care at Army expense will not obtain such care from civilian agencies at Army expense without obtaining prior authorization from the designated approving authority. All documents authorizing civilian care will include the following statement: "Payment will not be made by the Government for any non-emergency care obtained pursuant to this authority in hospitals which discriminate in the admission or treatment of patients on the basis of race, color or national origin."

Categories	*Approving authorities*
e. REP 63 personnel who incurred an injury or disease in line of duty while on their initial tour of ADT and have completed ADT and returned to Army National Guard.[1]	e. The appropriate CONUS army, commander, the Commanding General, Military District of Washington, U.S. Army, or the appropriate Army major oversea commander under whose jurisdiction the ADT was performed.
f. Members of the Army in continental United States who are on leave or temporary duty from oversea stations or who are awaiting reassignment from or to oversea stations.	f. Same as b above.
g. Members of the Army assigned to Army Military Missions and MAAG's.[2]	g. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagsy Republic and Ceylon—United States Army, Europe; and (2) All other countries—the mission or MAAG chief.
h. Members of the Army assigned to Defense Attaché offices.[2]	h. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagsy Republic and Ceylon—United States Army, Europe; and (2) All other countries—the appropriate Defense Attaché.
i. Members of the Army outside the continental United States who are on leave or temporary duty from CONUS stations or who are on temporary or special duty assignment.[2]	★i. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) West Indes and Bermuda—Third United States Army; (2) Canada and Mexico—Fourth United States Army; (3) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagsy Republic, Ceylon and the islands in the Atlantic Ocean north of Tropic of Cancer except the Bahama Islands and Bermuda—United States Army, Europe; and (4) Countries in the Pacific, Alaskan and Southern Commands—respective Army major oversea commanders.

Figure 2.1—Continued.

See footnotes at end of list.

Categories	*Approving authorities*
j. Foreign Nationals who are members of the Army of one of the NATO nations and who, in connection with their official duties, are stationed in or passing through the United States.	j. Same as b above.
k. Retired Army members on the Temporary Disability Retired List.	k. The Surgeon General, Department of the Army, Washington, DC 20314.
l. Nonunit Reserve personnel under centralized management jurisdiction of CG, USAAC who are required to undergo medical examinations or hospitalization in connection therewith.	l. The Commanding General, U.S. Army Administration Center, St. Louis, MO 63132.
m. Civilian employees of the Army for occupational health services.	m. Same as k above.
n. U.S. Nationals in foreign penal institutions.[2]	n. Same as i above.
o. Members of the Army Senior ROTC and designated applicants for enrollment in the Army Senior ROTC Program.[2]	o. Same as b and c above.
p. Applicants for enlistment or reenlistment in the Armed Forces including applicants for enlistment in the Reserve components thereof.[2]	p. The appropriate commander of the Armed Forces Examining and Entrance Station for examinations; same as b and c above for hospitalization to determine medical fitness for military service or for emergency medical care.
q. Registrants under the Universal Military Training and Service Act.[2]	q. The appropriate commander of the Armed Forces Examining and Entrance Station for examinations; same as b and c above for hospitalization to determine medical fitness for military service.
r. Applicants for appointment in the Regular Army and in the Reserve components including those members of the Reserve components applying for active duty.[2]	r. Same as q above.
s. Prisoners of war, retained personnel and other persons in military custody or confinement.[2]	s. Same as b and c above.
t. Civilians interned by the Army.[2]	t. Same as b and c above.
u. Civilian seamen in the service of vessels operated by the Department of the Army.[2]	u. Same as b and c above.
v. Members of the Civilian Military Training Corps.	v. Same as b above.

Figure 2.1—Continued.

[1] The changes stated in b and e are *effective 1 April 1969*. Any claim received after 1 April 1969 which is related to a claim previously processed under provisions of Change 17 will also be processed under provisions of Change 17.

[2] The changes stated in c, g, h, i, n, o, p, q, r, s, t, and u are effective for medical care obtained on and after 1 July 1969.

(1) *Authorization by designated approving authority.* Requests for prior authorization normally will be submitted in writing as outlined in paragraph 89 and transmitted through channels to the designated approving authority, except in unusual circumstances in which case requests will be transmitted by the most expeditious means available direct to the approving authority. If the requested medical care is authorized by a CONUS or oversea Army commander, he will designate an Army medical treatment facility which will assume administrative responsibility. If the civilian medical care is authorized by another approving authority, he will request the appropriate Army commander to designate such an Army Medical facility. This facility will be advised of this designation immediately, and the individual requiring medical care will be instructed through his commander to inform the civilian agency that medical records in the case will be requested by the designated Army facility. Administrative responsibility will include, but not be limited to, those functions specified in paragraph 71*a*(1), (2), (3), and (5) and the following:

(*a*) Preparation of necessary individual medical records (AR 40-400).

(*b*) Seriously ill and death notifications (AR 40-2).

(*c*) Arranging transfer to a uniformed services facility in appropriate cases.

(2) *Without prior authorization by designated approving authority.* Individuals may obtain civilian medical care without prior authorization of the designated approving authority when any of the following circumstances exist:

(*a*) In emergencies when the urgency of the situation does not permit the obtaining of such prior authorization.

(*b*) When the individual is serving outside continental United States and is not under the jurisdiction of any approving authority listed in figure 2.1.

(*c*) When authorized by the immediate commanding officer after a determination that the total cost of medical treatment will not exceed $150. (See para 134*d*(2) for dental treatment.)

(*d*) When an individual who is absent without authority is undergoing civilian care and such absence is terminated by the individual's actual or constructive return to military control as specified in paragraph 85.

When civilian medical care is obtained without prior authorization, it is the responsibility of the patient's immediate commander to advise the appropriate approving authority without delay that such care is being or has been obtained, so that the approving authority may designate (or, if the approving authority is not a CONUS or oversea Army commander, secure designation of) an Army facility which will assume administrative responsibility as set forth in (1) above. When civilian medical care is obtained by an individual while on leave or pass or temporary duty from his duty station, it is his responsibility to notify, or to have someone acting in his behalf notify, the Army commander of the area where care is being provided of this fact. When a member, while on leave or temporary duty in continental United States from an oversea station or while awaiting reassignment from or to an oversea station, obtains civilian medical care, he, or someone acting in his behalf, will notify the Army commander in whose geographic area the care is being provided of this fact.

b. Specialist service. The engagement of a civilian specialist (as distinguished from an appointed civilian professional consultant) is subject to prior authorization of the designated approving authority, except when the urgency of the situation is such that the services of a civilian specialist are immediately necessary to furnish emergency medical care.

c. Consultation service. The engagement of a civilian consultant (as distinguished from an appointed civilian professional consultant) will be authorized only in unusual cases.

89. Requests for authority to engage care. Letter requests for authority to engage care will include the following information:

a. For ordinary care.

(1) Character and extent of condition requiring treatment.

(2) Statement whether or not condition requiring treatment is chronic.

(3) Place of duty and duties of the individual.

(4) Status—duty, leave, or pass. If not on duty, the exact period of leave or pass.

b. For specialist service.

(1) Diagnosis.

(2) Professional procedure considered necessary and estimate of time required for treatment.

(3) Statement of condition of patient and the practicability of his transfer to a Uniformed Service or other Federal hospital for the necessary treatment.

(4) Place of duty and duties of the individual.

(5) Status—duty, leave, or pass. If not on duty, the exact period of leave or pass.

90. Autopsies. The commander or the surgeon of an installation or command may authorize autopsies to be performed by civilian physicians, civilian laboratories, or at civilian medical treatment facilities in order to determine the true cause of death and to secure information for the completion of military records.

91. Rates of compensation. The rates of compensation allowed for civilian medical care are contained in AR 40-330.

92. Preparation and payment of vouchers. ★*a.* Ordinarily, vouchers will be prepared as soon as practicable after completion of the services by the commander of the Army medical treatment facility assigned administrative responsibility of the patient pursuant to paragraph 88 and forwarded for settlement to the appropriate approving authority. However, when civilian medical care is obtained but administrative responsibility of the patient is not assigned to any Army medical treatment facility, the appropriate approving authority may designate the patient's commander to prepare the vouchers and related medical records and reports. When civilian medical care is furnished to an Army member at the request of a troop train commander or group leader, the bills for such services, together with information supporting the services, will be forwarded for vouchering and preparation of the necessary medical records and reports to the appropriate approving authority.

b. **Rescinded.**

★*c.* Except as stated in *d* and *e* below, the approving authorities shown in figure 2.1 are responsible for the approval and payment of vouchers for civilian medical care obtained within the territorial limits of their commands regardless of the location of the patient's assigned duty station. An approving authority at his discretion may delegate the authority to pay civilian medical vouchers to organizations within his command, or he may request another command and/or approving authority to pay such vouchers if circumstances justify such action. Such delegation of authority normally will be given in writing but telephonic authorization may be granted when the urgency of the situation warrants it. In the latter event, such telephonic delegation of authority will be confirmed by letter.

★*d.* During emergencies, when large numbers of troops are moved to concentrated areas within continental United States, the Department of the Army may direct the Commanding General, U. S. Continental Army Command, to designate a CONUS Army commander to approve and pay civilian medical vouchers for all military personnel assigned or attached to units within the concentrated area.

★*e.* In cases which present unusual or difficult aspects, the approving authority will request advice from The Surgeon General, ATTN: MEDOC-F. Where considered appropriate, such cases may be retained by The Surgeon General for adjudication.

★*f.* Except as provided in *h* below, DA Form 8-9 (Public Voucher for Medical Services) will be used to present charges for payment of services by civilian physicians, hospitals, clinics, special nurses, dentists, druggists, veterinarians, practitioners (para 84*b*(2)), blood donors, ambulance companies and makers of prosthetic devices (any one of which will hereinafter be referred to as an "agency"). The original DA

Form 8-9 and three copies will be forwarded to the approving authority. Vouchers marked "copy," "duplicate," or "corrected copy" will not be acceptable. The instructions stated herein will be followed when completing DA Form 8-9 (see exception in (3) below).

(1) Information as follows will be entered in the appropriate spaces and columns on the form:

(*a*) *Voucher prepared at.* Enter place and date.

(*b*) *To (payee).* Enter legal name and address of agency furnishing services.

(*c*) *Name of patient or brand number of Government-owned animal, etc., (information indicated in heading).*

1. Enter organization of patient or animal at time of treatment and branch of service.

2. Station will include name and location.

3. If patient is treated while on TDY away from parent station, this fact will be included.

4. Vouchers covering services furnished to personnel of the Reserve components on active duty or not on active duty will include such facts.

5. Vouchers covering services for station sick call do not require a listing of patients' names or brand number of Government-owned animals. Instead, show the number of patients or animals seen opposite the date of the visit.

(*d*) *Disease or disability and nature of services.* Enter as appropriate:

1. Diagnosis.

2. Description of services.

3. Type of surgical operation.

4. Routine laboratory tests (aggregate).

5. Special laboratory tests by name.

6. X-rays (aggregate).

7. Use of operating room.

8. Anesthetic.

9. Routine medicines (aggregate).

10. Medicines on prescription—with number of each prescription.

11. Dental services—indicate nomenclature of each tooth or tooth surface, restored, extracted, or treated. Do not use numerical designation.

12. Special nurses—the inclusive hours of tours of duty.

13. Ambulance service—mileage involved.

14. Description of other services received which are not specified herein.

(*e*) *Period of service.*

1. Enter the inclusive dates of hospitalization.

2. The dates of each tour for special nursing service.

3. Dates of surgical operations and dental procedures and dates of subsequent attendance included in the charge.

4. The date of each visit by the physician to the patient or by the patient to physician's office.

5. Dates for each prescription.

(*f*) *Number of days or treatments.* Enter total number of days of hospitalization or nursing service or total number of treatments.

(*g*) *Rate per day or per treatment.* Enter daily rate for hospitalization or nursing service or rate for treatment. For ambulance service, enter rate for mileage and the notation "flat rate," if appropriate.

(*h*) *Total amount.* Enter the total for hospitalization, treatments, or nursing services which is computed by multiplying the rate by the number of days or treatments. The total charges for other items as indicated under (*d*) above will be entered separately.

(*i*) *Total.* Enter the total amount of all charges listed on the voucher.

(*j*) *Payee's certificate.* The certificate will be signed by the agency in whose name the voucher is stated. The signature will agree exactly with the name of the agency as shown in the "To (payee)" space in the heading of the voucher. When a voucher is authenticated in the name of a hospital, clinic, corporation, or company, the individual signing for the hospital, clinic, etc., will include his business title or designation. When a certified invoice is attached to the voucher, enter "See certified invoice attached" in lieu of signature by the agency.

★(*k*) *Certifying officer's statement.* The blank space in the statement will be completed to show the status of the patient or animal as duty, pass, leave, absent without leave, or delay en route. Delay en route status must be amplified to show the authority therefor, number of days delay and travel authorized, the stations involved, the departure date from the losing unit and the reporting date to the gaining unit. Following the word "because" the statement will show "none available" or will state the reason care could not be obtained from Department of Defense or other Government medical facilities. If a Federal medical treatment facility is in the vicinity of the place of treatment, explanation must be made indicating why the patient did not obtain treatment and/or prescriptions thereat. After completion of the statement, it will be signed by the patient's commander or some other commissioned officer of the Army on active duty having cognizance of the case.

★(2) Any unusual charges or any civilian medical care furnished under unusual circumstances must be fully explained in accompanying correspondence. Charges for services performed by those practitioners stated in paragraph 84*b*(2) will be supported by the authorization (or copy thereof) of the licensed doctor of medicine, osteopathy, or dentistry requesting the services. When additional visits on the same date are made by civilian physicians, the necessity therefor will be indicated. When more than one physician cares for a patient, the necessity therefor will be reported. *Charges for personal items for patients, such as cigarettes, personal telephone calls, meals for visitors, are not payable from Army funds.*

(3) If certified invoices, itemized and signed as required by (1) (*d*) through (*j*) above are submitted by the agency, the body of the voucher will not be completed in the detail shown under (1) above. Instead, show only the information required by (1) (*a*), (*b*), (*c*), (*d*)*1*, (*e*), (*i*), and (*k*). When additional copies of invoices are desired, they will be reproduced by the installation or activity requiring the invoices.

(4) Charges for professional services by physicians or nurses who are not members of the hospital or clinic staff *will not* be included in a voucher in the name of the hospital or clinic but *will be vouchered separately in the name of each individual, except where the hospital or clinic has already paid for the services.* If a hospital or clinic has paid a physician or nurse who is not a member of its staff, an itemized, certified bill from the doctor or nurse stating the payment has been received from the hospital or clinic, will be attached to the hospital or clinic voucher to substantiate the charges. Hospital vouchers containing charges for professional services by physicians or nurses who are members of the hospital staff will bear the notation that the doctor or nurse was a "salaried member of the hospital staff."

(5) Vouchers covering charges for nursing services will contain the following additional certificate to be entered in the body of the voucher and signed by the attending physician:

> I certify that the services of a nurse were indispensable to the proper care of the patient named.

(6) Official telegraph charges and telephone tolls incurred by civilian agencies in connection with medical care of authorized personnel will be included on their vouchers as part of the necessary expense, provided a statement is furnished showing the points between which the service was rendered, the date, the amount paid for each service, and that the telegrams or calls were on official business. For local telephone calls, the voucher will show the number of such calls, rates for a call, the total amount expended each day and that the calls were on official business.

(7) The spaces provided on DA Form 8-9 for "Approved for, date, place, signature, and accounting classification" will be left blank for use by the authorized approving officer.

(8) When it is necessary to use two or more sheets of DA Form 8-9 to complete the itemization of charges, the footing of the first sheet should be carried forward to the top of the second and continued thus until the itemization is complete. The certificate and statement should be cut off all sheets except the last. All originals in proper sequence should be fastened securely together and all memorandum copies should be fastened securely together.

g. Charges for services by civilian agencies should not be paid by other than finance and accounting officers, disbursing officers, or class B agent officers *except when absolutely necessary*. When such payments are made by other than these officers, claims for reimbursement will be presented on DA Form 8-17 (Public Voucher—Reimbursement of Medical Services). The original DA Form 8-17 and three copies will be forwarded to the approving authority. Vouchers marked "copy," "duplicate," or "corrected copy" will not be acceptable. The instructions stated herein will be followed when completing DA Form 8-17.

(1) Information as follows will be entered in the appropriate spaces and columns on the form:

(*a*) *Voucher prepared at*. Enter place and date.

(*b*) *To (Payee)*. Enter legal name and address of individual claiming reimbursement. The address shown should be reasonably permanent to insure delivery of check payment.

(*c*) *Subvoucher No*. Each subvoucher will be numbered depending on the number of subvouchers included in the reimbursement claim and those numbers listed in this column in numerical sequence.

(*d*) *Name of agency paid*. Enter in line with the appropriate subvoucher number, the name of the doctor, hospital, nurse, etc., to whom payment was made.

(*e*) *Services as shown on attached subvouchers*. Enter in line with the appropriate subvoucher number, "medical services," "hospital services," "ambulance services," "medicines on prescription," etc., as the case may be.

(*f*) *Amount*. Enter the total amount of each subvoucher.

(*g*) *Total*. Enter the total amount of all subvouchers listed on the voucher for which reimbursement is being claimed.

(*h*) *Payee's statement*. The statement must be completed to show why it was necessary to pay the charges and signed by the individual claiming reimbursement. The signature will agree exactly with the name of the claimant as shown in the "To(Payee)" space in the heading of the voucher.

(2) DA Form 8-17 (Public Voucher—Reimbursement of Medical Services) must be accompanied by appropriate subvoucher. Separate subvouchers will be completed for each agency paid by the person claiming reimbursement. The subvouchers will be prepared on DA Form 8-9 in accordance with instructions prescribed in *f* above, with the exception that the payee's certificate thereon will be amended by adding a statement that payment has been received from the individual claiming reimbursement naming him, and signed by the agency rendering the service. In lieu of the signature to this certificate, receipted bills of the agency rendering the services, showing the full name of the person signing, including his business title or designation, and acknowledging payment from the person claiming reimbursement, may be attached to the subvoucher. When this is done, the payee's certificate on the subvoucher will contain the notation, "See receipted bill attached."

(3) The spaces provided on DA Form 8-17 for "Approved for, date, place, signature, and accounting classification" will be left blank for use by the authorized approving officer.

(4) When it is necessary to use two or more sheets of DA Form 8-17 to complete the listing of the subvouchers, the procedure prescribed in *f*(8) above will apply.

h. Charges for medical examinations of applicants for enlistment, registrants and other authorized personnel will be presented for payment on DA Form 8-11 (Public Voucher for Medical Examinations). The original DA Form 8-11 and three copies will be forwarded to the approving authority for payment. Items on the form are self-explanatory.

★93. Medical records. *a*. Except as provided in *b* below, the Army medical treatment facility having responsibility for the patient will prepare those medical records and reports referred to in paragraph 80 on Army patients who receive civilian medical care.

b. When an Army medical treatment facility has not been designated to administer the patient and the vouchers for civilian medical care are prepared by another station as provided in paragraph 92, the commanding officer of that station will prepare the medical records and reports referred to in paragraph 80.

c. Reasonable charges of civilian physicians or civilian medical treatment facilities for the furnishing of medical records and reports will be allowed when such services have been requested by competent military authority.

★94. Utilization of civilian medical services. Rescinded.

e. Peace Corps employees and their dependents who are not beneficiaries of the Peace Corps outside US (para 16.1a(2)(b)).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
MEMBERS OF THE US SOLDIERS' HOME (para 17).	Rate E	Rept to SG on DD Form 7.	None	None	No.
BENEFICIARIES OF THE DEPARTMENT OF JUSTICE.					
a. Federal Bureau of Investigation agents (para 18a).[2]	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	NA.
b. Claimants whose claims are administered by the Department of Justice (para 18b).[2]	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	NA.
SECRET SERVICE SPECIAL AGENTS (para 37.2).	NA	NA	OR (Med exam only).	Rept to SG on DD Form 7A.	NA.
CIVILIAN EMPLOYEES OF ALL FEDERAL AGENCIES (LIMITED TO DISABILITY RETIREMENT MEDICAL EXAMINATIONS) (para 27e).[2]	Subsistence only	Coll locally from indiv.	None	None	NA.
CIVILIAN EMPLOYEES OF THE DEPARTMENT OF COMMERCE (para 27f).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
CIVILIAN EMPLOYEES OF THE DEPARTMENT OF INTERIOR AND THEIR DEPENDENTS (para 27g).	Outside US, rate B or F for citizens and rate C for noncitizens; inside US, rate B or F.	Coll locally from indiv.	Outside US, SOR or IMR; inside US, OR, or IMR.	Coll locally from indiv.	No.[1]
CIVILIAN EMPLOYEES OF THE GENERAL ACCOUNTING OFFICE AND THEIR DEPENDENTS (para 27h).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
FEDERAL AVIATION AGENCY AIR TRAFFIC CONTROLLERS (para 37.5).	NA	NA	OR	Rept to SG on DD Form 7A.	NA
JOB CORPS AND VOLUNTEERS IN SERVICE TO AMERICA (VISTA) PERSONNEL AND APPLICANTS (para 37.4).					
a. Job Corps applicants for enrollment and VISTA applicants for employment.	NA	NA	OR or IMR	Rept to SG on DD Form 7A.	NA.

See footnotes at end of table.

Table I—Continued

Section B. Beneficiaries and Employees of Other Federal Agencies—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
b. Job Corps enrollees and VISTA personnel.	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	NA.
SOCIAL SECURITY BENEFICIARIES (para 37.6).	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	NA.
★MICRONESIAN CITIZENS (para 37.9)	Rate A	Collect locally from TTPI on SF 1080 supported by DD Form 7 and ltr of auth.	OR	Collect locally from TTPI on SF 1080 supported by DD Form 7A and ltr of auth.	NA.

[1] Outside the United States, spectacles may be furnished these individuals on a reimbursable basis (para 16-5).
[2] Hospitalization authorized only when required in connection with conduct of medical examinations.

CIVILIAN EMPLOYEES AND THEIR DEPENDENTS					
a. Civilian employees authorized Occupational Health Services (para 27a).[5, 6]	Subsistence only	Coll locally from indiv.	None	None	No, except spectacle inserts for protective masks.
★b. Civilian employees of the Defense Establishment (not beneficiaries of BEC) paid from appropriated or nonappropriated funds and their dependents (para 27b).	Outside US, rate B or F for citizens and rate C for noncitizens; inside US, rate B or F.	Coll locally from indiv.	Outside US, SOR; inside US, OR, or IMR except as provided in para 27b.	Coll locally from indiv.	No.[7]
CONTRACTOR EMPLOYEES					
★a. Civilian employees of contractors of Dept of the Army outside US (para 27c).	Rate B or F	Coll locally from contractor.	OR or IMR	Coll locally from contractor.	No.[1]
b. Civilian employees (incl former and prospective employees) of contractors of Dept of the Army in US (para 27d).[6]	Subsistence only	Coll locally from indiv.	None (med exams only).	None	No.
★c. Civilian employees of contractors of Dept of Navy and their dependents outside US (para 27c.1).	Rate B or F	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No.[1]
ARMY NATIONAL GUARD TECHNICIANS (CIV EMPLOYEES OF ARNG) MANNING MISSILE SITES (para 28).[6]	Subsistence only	Coll locally from indiv.	None	None	No, except gas mask spectacles.
CIVILIAN PARTICIPANTS IN ARMY-SPONSORED ACTIVITIES	Subsistence only	Coll locally from indiv or sponsor.	None	None	No.
CLAIMANTS WHOSE CLAIMS ARE ADMINISTERED BY FEDERAL DEPARTMENTS AND BENEFICIARIES OF PRIVATE RELIEF BILLS (para 30).[6]					
a. Claimants whose claims are administered by Army.	None	None	None	None	NA.
b. Claimants whose claims are administered by other Federal Departments.	Rate A	Rept to SG or DD Form 7.	None	None	NA.
c. Beneficiaries of private relief bills	None	None	None	None	NA.

See footnotes at end of table.

Table I—Continued

Section C. Miscellaneous Categories of Persons Authorized Care—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices spectacles, hearing aids, and orthopedic footwear authorized
PERSONS OUTSIDE CONUS WHO CONTRIBUTE TO ACCOMPLISHMENT OF A MAJOR OVERSEA COMMANDER'S MISSION.					
a. Civilian representatives of religious groups and others (para 31*b*).	Subsistence only	Coll locally from indiv.	None	None	No.[1]
★b. Educational representatives of recognized educational institutions (para 31*c*).	Rate B or F	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No.[1]
c. Dependents of USO professional personnel outside US (para 31*b*).	Rate D	Coll locally from indiv or sponsor.	None	None	No.[1]
★d. All others (para 31*a* and *d*)	Rate B, F or D	Coll locally from indiv.	OR, IMR, or none	Coll locally from indiv made applicable.	No.[1]
★AMERICAN NATIONALS COVERED BY AGREEMENTS (para 32).	Rate B or F	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No.[1]
★JOINT CIVILIAN ORIENTATION CONFERENCE GUESTS (para 33).	Rate B	Coll locally from indiv.	OR or IMR	Coll locally from indiv.	No.
★DESIGNEES OF THE SECRETARY OF THE ARMY (para 35).	Rate B or F, subs only or none.	Coll locally from indiv where applicable.	OR, IMR, or none	Coll locally from indiv where applicable.	No.
CERTAIN PERSONS EVACUATED FROM ONE AREA TO ANOTHER (para 36).	Same as in original area.	Coll locally from indiv.	Same as in original area.	Coll locally from indiv.	No.
CIVILIANS IN EMERGENCY (para 37).					
a. Indigents	None	None	None	None	NA.
★b. Nonindigents	Rate B or F	Coll locally from indiv.	Coll locally from indiv.	OR	NA.
VOLUNTEER SUBJECTS IN APPROVED DEPT OF THE ARMY RESEARCH PROJECTS (para 37.1).	None	None	None	None	Yes.
US NATIONALS IN FOREIGN PENAL INSTITUTIONS & THEIR DEPENDENTS (para 37.5).	None	None	None	None	Yes.
DOMESTIC SERVANTS OUTSIDE THE US (para 37.7).	N/A	N/A	None	None	No.

See footnotes at end of table.

[1] Outside the United States spectacles may be furnished these individuals on a reimbursable basis (para 116*b*(5)).

[2] These items may be furnished these individuals on a reimbursable basis at stations within the United States which have been designated remote for the purpose of furnishing such items to dependents of US uniformed services personnel (para 25*d*(1) and 116*b*(2)); and para 16*b*, AR 40-121.

[3] Spectacles may be furnished these individuals on a reimbursable basis at stations within the United States which have been designated remote for the purposes of furnishing medical care to US civilian employees (para 116*b*(4)).

[4] These items may be furnished these individuals on a reimbursable basis outside the United States and at stations within the United States which have been designated remote for the purpose of furnishing such items to dependents of US uniformed services personnel (para 25*d*(1) and 116*b*(1)); and para 16*b*, AR 40-121.

[5] Reimbursement is made to Army on a per capita cost basis for health services provided civilian employees (or prospective employees) of the Army paid from industrial funds and civilian employees (or prospective employees) of Federal departments and agencies other than Army, except employees (or prospective employees) of Navy, Marine Corps, and Air Force in the Washington area.

[6] Hospitalization authorized only when required with conduct of medical examinations.

[7] Spectacles may be furnished these individuals on a reimbursable basis outside the United States and at stations within the United States which have been designated remote for the purpose of furnishing medical care to civilian employees (para 116*b*(3) and (5)).

S/S C26, dated 14 February 1972

27 April 1971

C 24, AR 40-3
*AR 40-3

ARMY REGULATION
No. 40-3

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, *26 March 1962*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

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deceased members of the uniformed services. Dependents may be provided hospitalization for chronic conditions and nervous, mental, and emotional disorders when such conditions and disorders require active and definitive treatment. Dependents in this category will not be admitted if they require only domiciliary or nursing-home type care. Admission will be subject to determination by the hospital commander that space and facilities are available and the capability of the professional staff is sufficient to provide care to a particular dependent without interfering with the performance of the primary mission of the facility. The various categories of dependents will be authorized admission in the order of priority listed in AR 40–121. The provisions of (1) above may be used as a guide in determining disposition of dependent patients in this category who require prolonged hospitalization.

m. Length of hospitalization for Army military personnel on active duty or active duty for training.

(1) Army military personnel on active duty or active duty for training who are likely to recover sufficiently to be medically fit to return to duty within 12 to 15 months generally will be afforded maximum hospital benefits.

(2) Army military personnel in this category who are not likely to recover sufficiently to be medically fit for return to duty within 12 to 15 months will be processed for disposition upon attaining optimum hospital benefits.

(3) For personnel in this category who will require hospitalization beyond their term of service, see the following regulations for procedures to continue such personnel on active duty for the purpose of receiving medical care, completing line of duty investigations, or completing physical disability processing:

(*a*) AR 635–200 (enlisted personnel on active duty).

★(*b*) AR 635–100 (Personnel Separations—Officer Personnel).

(*c*) AR 135–200 (Active Duty for Training of Individual Members).

5. Consent by nonmilitary patients to medical care. *a.* A nonmilitary individual may not be furnished medical care in any Army medical treatment facility without either his consent or the consent of a person authorized to consent on his behalf in accordance with the provisions of applicable local laws or the order of a court having jurisdiction over both the individual and the facility concerned. Consent may be either express or implied (*b* and *c* below). This rule applies even though an individual may be entitled by law to medical care in Army medical treatment facilities; it applies worldwide, except as it may be modified by local laws or international agreements.

b. An implied consent is one that may be implied from actions of the patient or other circumstances, even though specific words of consent are not used. For example, a patient's application for admission to a hospital is an implied consent to hospitalization; if a patient is a minor incapable of giving consent, an implied consent of the parent may be found in actions of the parent in requesting or not objecting to medical care for the minor. Moreover, consent to treatment is implied in certain emergency situations where a patient is incapable of giving or denying consent, and his condition represents a serious or imminent threat to his life, health, or well-being. Despite the fact that an implied consent is usually found in emergency situations. medical care will not be given even in an emergency to a nonmilitary minor where the parent or guardian expressly or impliedly objects.

c. An express consent involves an interchange of language by which the patient or person authorized to act on his behalf specifically states that his consent is given to proposed medical care. An express consent may be valid whether oral or in writing, but a written consent must be recorded on Standard Form 522 (Clinical Record—Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures) in connection with the following when nonmilitary patients (both inpatients and outpatients) are involved:

(1) All major and minor surgery which involves an entry into the body, either through

an incision or through one of the natural body openings.

(2) Any procedure or course of treatment in which anesthesia is used, whether or not an entry into the body is involved.

(3) All nonoperative procedures which involve more than a slight risk of harm to the patient, or which involve the risk of a change in the patient's body structure.

(4) All procedures where roentgen ray, radium, or other radioactive substance is used in the treatment of the patient.

(5) All procedures which involve electroshock or insulin coma therapy.

(6) Admission of patients with psychotic disorders.

(7) Admission of patients to closed wards.

(8) All other procedures which, in the opinion of the attending physician or dentist, chief of service, or the commander require a written consent. Any question as to the necessity or advisability of obtaining a written consent from or on behalf of the patient should be resolved in favor of procuring such a consent.

d. In order for a consent to be valid (whether implied or express) it must be given by a person legally capable of giving such consent, except in an emergency.

(1) If a nonmilitary patient is unmarried and under the age of 21, consent will ordinarily be obtained from the patient's parent or guardian. In addition, a minor unmarried patient's consent will also be obtained if the patient is able to understand and fully comprehend the significance of the procedures contemplated. If there is a question whether consent of a parent is required in view of the age, mental condition or emancipated status of the patient, or because of nonavailability of the parents or similar factors, the advice of the local staff judge advocate or other legal officer should be sought.

(2) Except in an emergency, when a patient for some reason other than mental incompetency is unable to respond, the consent of the spouse or next of kin must be obtained. In the event the spouse or next of kin cannot be reached, the question of authority or need to consent will be referred to the appropriate judge advocate or legal adviser for advice.

(3) When a judicial interpretation of mental incompetency has been made, consent must be obtained from the individual appointed by the court to act for the incompetent patient.

(4) When the question of mental competency arises and a judicial determination of mental competency has not been made, the question of authority to consent or treat will be referred to the appropriate judge advocate or legal officer for advice.

(5) Without appropriate court order or the consent of the patient or a person authorized to act on his behalf, the commander of an Army medical facility may temporarily detain a nonmilitary individual with a psychiatric disorder which makes him dangerous to himself or to others, when such individual is found on the military reservation where the medical facility is located, or where there is a real emergency requiring that the individual, although off the reservation, be temporarily detained in that facility. In such a case, if proper consent to, or authorization for admission to the facility cannot be obtained, the local civilian authorities should be notified immediately (without regard to "working days"), and the individual should be transferred to those authorities. It is emphasized that the temporary involuntary detention of a nonmilitary individual should conform with local law and statutes governing involuntary detention, particularly where the United States does not possess exclusive jurisdiction. In order to provide for situations herein discussed, arrangements should be made in advance with local civilian authorities to accept forthwith those nonmilitary psychotic individuals who may not be admitted to or retained in Army medical facilities because of lack of consent or appropriate court order. In making these arrangements, the point should be made, if necessary, that such individuals who are not residents of the locality are entitled to the same care and treatment by local civilian authorities as would be transients or tourists not connected with the Federal Government. See also paragraph 68.

(6) Movement of nonmilitary psychotic individuals without proper consent or court order normally will not be performed under the auspices of an Army medical treatment facility.

(7) The validity of a court order directing involuntary confinement or treatment of a patient in any Army medical treatment facility is a matter for review, in each instance, by the appropriate judge advocate or legal adviser.

(8) When a written consent is required, it will be personally signed by the patient, or the person authorized to act on his behalf.

(9) Consent for dental procedures which come under the provisions of *c*(1) or (2) above may be obtained at the time a course of treatment is started. One SF 522 may be used for a complete course of treatment.

e. One of the elements affecting the validity of a consent, implied or express, is whether the person giving the consent understands that to which consent is being given and, to a sufficient degree, the possible consequences of the procedure for which consent is given. The physician or dentist who is to perform or supervise the performance of a procedure will counsel the patient and/or the consenting individual as to the nature or expected results of the proposed procedure, which fact is attested to by the patient or person authorized to give consent on Standard Form 522.

Priority	*Category*	*Degrees of entitlement*
1st	A. Members of the uniformed services on active duty (including ADT) and comparable personnel of the NATO nations who meet the conditions prescribed by the NATO SOFA (para 25*a*(1)).	Complete and unqualified.
	B. Members of the Reserve components of the Armed Forces not on active duty.	Care must be provided when it is required for conditions contracted in line of duty during a period of active duty (including ADT) or while traveling to or from such duty or for injuries suffered while performing inactive duty training.
	C. Members of the Citizens Military Training Corps.	Care must be provided for conditions contracted while traveling to or from or during attendance at CMTC training camps.
2d	Dependents of active duty members of the uniformed services, the dependents of persons who died while in such a status, and the dependents of active duty members of the NATO nations who meet the conditions prescribed by the NATO SOFA (para 25*a*(1)).	Care must be provided when facilities and staffing permit.
3d	Members of the Senior Reserve Officers Training Corps of the Armed Forces.	Care may be provided when it is required during periods of attendance at training camps.
4th	Retired members of the uniformed services and their dependents and the dependents of deceased retired members.	Care may be provided when facilities and staffing permit.
5th	Civilian employees of the Federal Government under the limited circumstances covered by the Federal Employees' Health Service Program (AR 40-5).	Care may be provided when facilities and staffing permit.
6th	All others	Care may be provided when facilities and staffing permit.

Figure 1. Degree and basis of entitlement.

Air Force retired for physical disability are not eligible for admission for the chronic conditions listed in paragraph 11*b*.

18. Beneficiaries of the Department of Justice. *a. Federal Bureau of Investigation.* Upon presentation of written authorization, agents of the Federal Bureau of Investigation may be furnished medical examinations. Charges for medical examinations will be collected by The Surgeon General on receipt of DD Form 7A. When hospitalization is necessary to the proper conduct of these examinations, DD Form 7 will be forwarded to The Surgeon General.

b. Claims administered by the Department of Justice. Upon presentation of written authorization from the Department of Justice or the United States attorney in the case, claimants whose claims are being administered by the Department of Justice may be furnished medical examinations to determine the extent and nature of the injuries or disabilities claimed. Charges for medical examinations will be collected by The Surgeon General on receipt of DD Form 7A. When hospitalization is necessary to the proper conduct to these examinations, DD Form 7 will be forwarded to The Surgeon General.

18.1 Applicants for cadetship at the various service academies. *a. Army, Navy, and Air Force.* Applicants for cadetship at the U.S. Military Academy, the U.S. Naval Academy, and the U.S. Air Force Academy may be furnished medical examinations and hospitalization when necessary to the proper conduct of these examinations without charge.

b. Coast Guard. Upon presentation of written authorization from commanders of U.S. Coast Guard District Offices, applicants for cadetship at the U.S. Coast Guard Academy may be furnished medical examinations. No charge will be made for these examinations when performed on an outpatient basis. When hospitalization is necessary to the proper conduct of these examinations DD Forms 7 will be forwarded to The Surgeon General.

19. Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve components thereof, and Selective Service registrants. Applicants for enlistment or reenlistment and registrants while under military control will be furnished necessary medical examinations, and hospitalization when their medical fitness for military service cannot be determined without hospital study. In addition, applicants for enlistment or reenlistment who suffer acute illnesses and injuries while awaiting or undergoing enlistment processing at recruiting main stations or at Armed Forces Examining and Entrance Stations may be furnished emergency medical care including emergency hospitalization.

20. Applicants for appointment in the Regular Army and Reserve components, including those members of the Reserve components who apply for active duty. Medical examination may be furnished in accordance with AR 601-100 and AR 140-120. When medical fitness for appointment cannot otherwise be determined, hospitalization is authorized.

★21. Persons on military custody and nonmilitary Federal prisoners.

a. Prisoners of war and retained personnel. Such persons are authorized necessary medical care to include prosthetic devices, prosthetic dental appliances, and spectacles. Hearing aids and orthopedic footwear are also authorized when necessary for the individual to carry out his duties or attend to his own needs.

b. Civilian internees. Civilian internees are provided care in Army medical treatment facilities only in the absence of adequate civilian facilities (para 42, AR 633-51). In the event such persons are treated in an Army facility, all necessary care will be provided, including dentures, spectacles and other required artificial appliances (para 43, AR 633-51).

c. Military prisoners confined in Army facilities.

(1) Military prisoners whose punitive discharges have been executed but whose sentences have not expired are authorized all necessary medical care.

(2) Military prisoners whose punitive discharges have been executed and who require hospitalization beyond expiration of sentences are not eligible for care but may be hospitalized as pay patients until disposition can be made to some other facility.

d. Military prisoners on Commandant's parole or excess leave. The punitive discharges of prisoners in these categories have not been executed. Accordingly, they are still members of the military services and are authorized medical care to the same extent as other members.

e. Military prisoners on parole under the supervision of the Federal Probation Service. The punitive discharges of prisoners in this category have been executed but their sentences have not expired. Such individuals are not eligible for care in Army medical treatment facilities. However, in exceptional cases, care in Army facilities may be requested under the provisions of paragraph 35.

f. Nonmilitary Federal prisoners. Such persons are authorized only emergency medical care. When such care is furnished, the institution to which the prisoner is sentenced must furnish the necessary guards to control the prisoner and prevent his escape. *Under no circumstances* will military personnel be utilized to guard or control the prisoner. Upon completion of emergency medical care, arrangements for transfer to a nonmilitary medical facility or return of the prisoner will be made with the appropriate official of the institution to which the prisoner is sentenced. Charges for emergency medical care will be collected by The Surgeon General on receipt of DD Form 7 or 7A.

22. Former female members of the Armed Forces and their newborn infants. *a. General.* Former female members of the Armed Forces separated under honorable conditions because of pregnancy, or who, although separated under honorable conditions for reasons other than pregnancy, are shown by a medical examination given at an Armed Forces medical treatment facility to have been pregnant at the time of separation, are authorized medical care in military medical treatment facilities for that pregnancy as specified in *c* and *d* below. Such care is limited to care in military facilities and does not, regardless of the circumstances, include care obtained in civilian facilities.

b. Application. Former female members of the Armed Forces who desire maternity care will apply in writing to the military medical treatment facility nearest their home and present their copy of DD Form 214 (Armed Forces of the United States Report of Transfer or Discharge), or DD Form 256A (Honorable Discharge Certificate) or DD Form 257A (General Discharge Certificate), as appropriate, as proof of their eligibility for medical care.

c. Extent. For the purpose of this paragraph the term "maternity care" includes prenatal care, hospitalization, confinement, and postnatal care either in a hospital or as an outpatient for 6 weeks following delivery.

d. Newborn infants. No charge is made for newborn infant patients while the mother is a patient in the medical treatment facility. In those cases where the mother is discharged from the medical treatment facility and it is necessary for the infant to remain as a patient or where the infant is admitted as an individual patient under the authority of this subparagraph, charges will be made at the rates prescribed for the mother in each case. If newborn infant patients require medical care beyond the postnatal 6 weeks' period, disposition will be made to private, welfare, State, or Federal agencies.

23. Individuals whose military records are being considered for correction. Individuals who require medical evaluation in connection with consideration of their case by the Army Board for Correction of Military Records are authorized necessary medical care. (Personnel in this category are advised by The Adjutant General that they may report to a designated Army medical treatment facility for evaluation.)

24. Seamen. *a. General.* Civilian seamen in the service of vessels operated by the Department

based on injuries or disabilities allegedly arising out of the operation of the Defense Establishment may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge being made in order to determine the extent or nature of the injuries or disabilities claimed.

31. Persons outside the continental United States who contribute to accomplishment of a major oversea commander's mission. *a. General.* Persons who contribute to the accomplishment of a major oversea commander's mission and for whom medical care is deemed essential by the major oversea commander concerned may receive medical care in facilities outside the continental United States only in the absence of adequate civilian facilities as determined by the major oversea commander concerned. Rate B or F or the outpatient rate, whichever is applicable, will apply except as indicated in *b, c,* and *d* below.

b. Civilian representatives of religious groups and others. Civilian representatives of religious groups, celebrities and entertainers, athletic clinic instructors, and representatives of the USO, other social agencies, and educational institutions, and persons in similar status providing direct services to the US Armed Forces, who are acting under official invitational orders from the Department of Defense, or from one of the military departments, to visit military commands overseas may be furnished medical care without charge in facilities outside the continental United States. Charges for subsistence will be collected locally from the individual. Dependents of USO oversea area executives, club directors, and associate club directors when accompanying their sponsors outside the United States may be furnished medical care at the uniformed services dependent rate, effective 4 March 1969.

c. Educational representatives of recognized educational institutions. Educational representatives of recognized educational institutions regularly assigned to duty in military commands overseas who are contributing to a major oversea commander's mission, and their dependents when residing with their sponsors, may be furnished medical care in facilities outside the continental United States at Rate B or F or at the outpatient rate, whichever is applicable.

d. Rates for Individuals under hardship circumstances. When a major oversea commander determines that hardship would result if an individual or a category provided care under this paragraph were charged the rates specified in *a* above, he may prescribe Rate D as the charge for hospitalization or waive the charge for outpatient care, or do both, as appropriate.

32. American nationals. American nationals outside the United States covered by agreements entered into between the Department of the Army and other Federal civilian agencies when care in Army medical treatment facilities is a condition of the agreement may be furnished medical care.

33. Joint Civilian Orientation Conference guests. Joint Civilian Orientation Conference guests while attending a Joint Civilian Orientation Conference will be provided medical care. Charges for medical care will be at Rate B or at the outpatient rate, whichever is applicable, and collection will be made locally from the individual.

34. Special foreign nationals. *a Care authorized.* Medical care may be furnished to such persons outside CONUS when it is determined that this action can be expected to contribute to the advancement of the public interests of the United States.

b. Authority. Authority is granted to major oversea commanders to make the foregoing determination.

c. Delegation of authority. Major oversea commanders may, when the geographical dispersion and varying political conditions of their command warrant such action, delegate the authority in *b* above and *e* below to one or more of their major subordinate commanders. Such authority, however, may not be redelegated.

d. Considerations.

(1) Generally, care under this paragraph will be afforded only to foreign officials of high

national prominence. Care may be afforded under this paragraph, however, to other foreign nationals when, because of unusual circumstances or the extraordinary nature of the case, such action would be in consonance with *a* above.

(2) Normally, care will not be afforded under this paragraph for chronic conditions or any other condition which, if hospitalization is involved, would not be benefited by hospitalization for a period of less than 90 days.

(3) Normally, the recommendations of the Chief of the Diplomatic Mission to the country involved should be sought prior to determining whether care should be afforded under this paragraph.

e. Charges. Charges for medical care provided under this paragraph will be at Rate B or F or the outpatient rate, whichever is applicable, and collection will be made locally, except that in unusual cases the major oversea commander may waive the charges.

f. Evacuation to the United States. Persons being afforded care under this paragraph will not be evacuated to the United States for further care unless they are first made designees of the Secretary of the Army pursuant to paragraph 35.

35. Designees of the Secretary of the Army. Persons not otherwise eligible for medical care may receive such care when they are designated for this purpose by the Secretary of the Army. Such designees will be charged Rate B or F or the outpatient rate, whichever is applicable, unless specifically otherwise authorized by the Secretary. In the event the Secretary authorizes the furnishing of hospitalization with no reimbursement therefor, a charge for subsistence will be collected locally from the individual unless the Secretary also waives these charges.

36. Certain personnel evacuated from one area to another. Personnel who for medical reasons are evacuated from an area in which they are eligible for medical care to an area where they are not otherwise eligible for such care will be admitted to or furnished treatment at medical treatment facilities to which evacuated or while en route thereto when medical care is deemed necessary. Care should be furnished under this paragraph on a temporary basis only until such time as appropriate disposition can be accomplished.

37. Civilians in emergency. *a.* Any person is authorized care in an emergency in order to prevent undue suffering or loss of life. See paragraph 3.1*v* for extent of care.

★*b.* Charges for medical care under this paragraph will be at Rate B or F or the outpatient rate, whichever is applicable, except when the patient is determined to be medically indigent, the commander may waive the charges. For the purpose of this regulation, a person who has insufficient income to meet the costs of necessary medical care and services is considered to be medically indigent.

37.1 Volunteer subjects in approved Department of the Army research projects. Volunteers under the provisions of AR 70-25 are authorized all necessary medical care for injury or disease which is the proximate result of their participation in such projects. (Medical care for civilian employees who volunteer and who perform duty as a volunteer during their regularly scheduled tour of duty will be provided in accordance with paragraph 13.)

37.2 Secret Service Special Agents (examinations). Upon presentation of written authorization, Secret Service Special Agents may be provided routine annual medical examinations in Army medical treatment facilities on a reimbursable basis. Examinations will be conducted and recorded in the same manner as routine annual medical examinations for Army officers except that they will be conducted on an outpatient basis only. If hospitalization is considered desirable in connection with the examination, a statement to that effect will be entered in item 73 or 75 of the SF 88 (Report of Medical Examination), as appropriate. One copy of SF 88 and SF 93 (Report of Medical History) for medical examinations provided these agents

will be forwarded to the Chief, United States Secret Service, Treasury Department, Washington, DC, 20220. Charges for examinations will be collected by The Surgeon General on receipt of DD Form 7A supported by a copy of the authorization for medical examination.

**Note.* See AR 1-4 for nonreimbursable medical support provided the U. S. Secret Service in the performance of its protective responsibility for the President.

37.3 Federal Aviation Agency (FAA) Air Traffic Controllers. *a.* Upon the written request of FAA regional representatives, designated Army hospitals are authorized to provide the following services to Air Traffic Controllers who are undergoing a physical examination by an FAA physician:

(1) Chest X-rays.

(2) Electrocardiographs.

(3) Audiograms.

b. The Army hospital commander will not read or evaluate the results of these tests. Results will be forwarded direct to the FAA Regional Office arranging for the examination.

c. Services provided will be reported to The Surgeon General, ATTN: MEDOC-F, on DD Form 7A supported by a copy of the request for the services.

37.4 Job Corps and Volunteers in Service to America (VISTA) personnel and applicants. *a. Job Corps.* Upon presentation of Job Corps Form 503 (Authorization for Medical Fitness Examination by a Federal Facility), Job Corps Form 505 (Authorization for Hospitalization by a Federal Facility), or Job Corps Form 507 (Authorization for Outpatient Care and Services by a Federal Facility) signed by an appropriate official of the Job Corps, Job Corps applicants for enrollment and Job Corps enrollees may be provided the following services in Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Job Corps applicants for enrollment.* Pre-enrollment medical examinations and immunizations.

(2) *Job Corps enrollees.* Hospitalization, outpatient medical treatment, examinations and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering.

b. VISTA. Applicants for employment by VISTA and VISTA personnel may be provided the following services in Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Applicants for employment by VISTA.* Pre-employment medical examination of VISTA Form 36 (Authorization for Medical Examination and Care by a Federal Facility) signed by an appropriate VISTA official.

(2) *VISTA personnel.* Hospitalization, outpatient medical treatment, examinations, and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering. Hospitalization and outpatient medical treatment may be provided upon presentation of a "Blue Cross and Blue Shield Identification Card." Other authorized services may be provided upon presentation of VISTA Form 36.

c. Services available at Armed Forces Examining and Entrance Stations. Upon presentation of Job Corps Form 503 or VISTA Form 36, male Job Corps applicants and male VISTA applicants may be provided pre-employment medical examinations and immunizations at Armed Forces Examining and Entrance Stations (AFEES) when in the opinion of the AFEES commander the capability exists.

d. Remediable physical defects. Upon presentation of appropriate authorization form signed by a Job Corps or VISTA physician, surgery or other treatment required to correct remediable physical defects of Job Corps enrollees and VISTA personnel may be provided in Army medical treatment facilities if within the professional judgment of the medical officers concerned such treatment is indicated and the required resources are available. The authorization form should contain a statement that in the opinion of the authorizing physician the condition will interfere with or substantially impede the training or future employability of a Job Corpsman or will seriously interfere with a VISTA volunteer's performance of duty.

e. Reports to The Surgeon General. Hospitalization, outpatient care, examinations and immunizations furnished will be reported to The Surgeon General on DD Form 7 or 7A supported by a copy of the Job Corps or VISTA form authorizing the services. In the case of VISTA personnel provided hospitalization or outpatient treatment on the basis of their Blue Cross and Blue Shield Identification Card, the VISTA identification number of the patient will be shown after the name of the patient in Item 5 of the DD Form 7 or 7A.

f. Beneficiaries of the Bureau of Employees' Compensation. After termination of their duty with the Job Corps or VISTA, these personnel are eligible for Bureau of Employees' Compensation benefits. To establish their eligibility for these benefits, Army medical treatment facilities providing treatment to such personnel will, upon request, complete the medical certificate on BEC Form CA-2.

37.5 U.S. Nationals in foreign penal institutions. U.S. nationals serving with, employed by, or accompanying the Armed Forces outside the United States and its possessions, and their dependents, when confined in foreign penal institutions are authorized medical care of the type and quantity furnished prisoners in U.S. military confinement (AR 27-50).

★37.6 Social Security beneficiaries. Beneficiaries of the Social Security Health Insurance Program for the Aged (Medicare) may be provided hospitalization in Army medical treatment facilities in an emergency to prevent undue suffering or loss of life. The Social Security Administration's local office will be notified as soon as possible after emergency admission of one of their beneficiaries. The Social Security Administration can pay for care furnished its beneficiaries in a Federal hospital only during the period of the emergency. The patient or responsible family member will be informed of this and will be advised that arrangements should be made with a civilian hospital which participates in the Medicare Program so that the patient can be transferred as soon as his condition has improved to the extent that he can be moved. Collection for the patient's share of the cost of hospitalization under the Medicare Program will be a matter between the patient and the Social Security Administration and no collection will be made from these patients by the Army hospital. Emergency hospitalization of Social Security beneficiaries will be reported to The Surgeon General, ATTN: MEDOC-F, on DD Form 7. This paragraph does not apply to dependents and retired members who are entitled to care in uniformed services facilities. Such persons are provided care as uniformed services beneficiaries under the provisions of paragraph 11 of this regulation and paragraph 4-6, AR 40-121.

★37.7 Domestic servants outside the United States. Army medical treatment facilities located outside the United States are authorized to provide the following health measures without charge for domestic servants employed or to be employed by military and civilian personnel of the Department of Defense:

a. Pre-employment health examinations.

b. Periodic communicable disease detection examinations.

c. Immunizations.

★37.8 Underprivileged children participating in the President's Youth Opportunity Programs. When medical support is not available from other sources, certain limited medical services may be provided underprivileged children participating in the President's Youth Opportunity Program in Army facilities on a reimbursable basis in accordance with the provisions of chapter 6, AR 28-19.

or aggravated during employment on active duty in excess of 30 days. Following medical board action in such cases, personnel who are medically unfit will be referred to a physical evaluation board.

★*g.* ROTC members on a training tour (annual training camps and training encampments at military installations)—

(1) Who may be eligible as a result of an injury incurred or a disease contracted during their training tour for benefits administered by the Bureau of Employees' Compensation. See AR 145-1.

(2) Who require hospitalization beyond the termination of their training tour.

★*h.* TDRL periodic medical examinations when in the opinion of the attending medical officer the status of the member has stabilized or when the disposition is questionable. The last periodic medical examination of members on the TDRL will, if accomplished at a military medical treatment facility capable of holding a medical board, be supported by a medical board.

i. Cases involving mental competency.

★*j.* Individuals scheduled for separation under AR 635-100 and AR 635-212 when it appears that a mental illness, medical condition, or physical defect is the direct cause of unfitness, unsuitability, or homosexuality.

k. Army medical boards will be utilized to determine mental competency of any retired member of the Armed Forces when that retired member is hospitalized in an Army medical treatment facility and for retired Army members hospitalized in a non-Federal facility by the facility designated to have responsibility. (The Departments of the Navy; Air Force; Health, Education, and Welfare; and the Veterans Administration are authorized to determine mental competency of retired Army members when such persons are hospitalized in a facility under its jurisdiction.)

l. Any other case deemed necessary by the appointing authority.

43. Medical board proceedings. Medical boards operate informally. Their members assemble to discuss and evaluate the patient's case. His clinical, health, and other records, as appropriate, are reviewed. When a patient's condition permits, he should be given the opportunity to appear in person and present his views relative to his proposed disposition. Medical fitness or medical unfitness for further duty regardless of motivation is determined on the basis of the medical fitness standards and guidance contained in chapter 3, AR 40-501 for military personnel, and chapter 2, AR 40-501 for ROTC members, except for medical conditions and physical defects which were known at the time of enrollment in the Advanced Course ROTC and which are essentially unchanged. The board will insure that all of the medical and/or physical defects which the individual has are determined and recorded. In cases of patients recommended for duty, the physical profile and appropriate duty assignment limitations or restrictions should be established.

44. Recording proceedings. ★*a.* Medical board proceedings normally will be recorded on DA Form 8-118. When medical boards are held for the purposes described in paragraphs 42*b*, 42*e*(2), or solely for the purpose of revising the physical profile and the findings do not include medical unfitness, the proceedings will be recorded on DA Form 3349 (Medical Condition —Physical Profile Record). Instructions covering the use of DA Form 3349 are contained in chapter 9, AR 40-501. The following general instructions apply whenever DA Form 8-118 is used to record medical board proceedings. A brief, but complete, clinical history including a summary of available prior medical records (including the Health Record and the SF 88 accomplished at the time of entry into service) prepared by the patient's attending physician on SF 502 will be attached to the board proceedings as inclosure 1.

(1) In cases involving psychiatric illness considered to have existed at the time of entry into the service, a decided effort will be made to include in the narrative summary clinical and social data concerning the conditions of the patient's entry into service—showing significant behavior and attitude toward the Army and toward the act of entry into service—data

upon which to base a judgment whether the patient was at the time of his entry into the service mentally competent to understand the nature of the act of entry into service. If the patient is considered to have been incompetent to understand the act of entry into service at that time, then the clinical data should show the approximate inclusive dates subsequent to entry into service when he did become competent to understand the nature of this act. If he never became so competent, then clinical data should be included to support this opinion.

(2) When a condition which existed prior to entry into service is judged to be aggravated by service, the severity and circumstances of the aggravation will be clearly indicated in the summary.

(3) A complete current report of medical examination will be recorded on SF 88 and attached as inclosure 2 to the board proceedings.

★(4) When an enlisted member is being evaluated because of a psychiatric condition, a copy of DA Form 20 (Enlisted Qualification Record) should be reviewed by the medical board and attached to the board proceedings as Inclosure 3.

★*b.* Except as required elsewhere in this regulation, DA Form 8–118 and inclosures will be prepared in the number of copies and distributed as shown in figure 2. For cases involving a finding of mental incompetency, one additional copy will be prepared. All members of the board will sign the original and initial the duplicate of the proceedings, except that for cases in which a finding of mental incompetency is made all copies for use of finance officers must be signed by each member. The copy of SF 502 that becomes part of the clinical record will be annotated by the attending physician to show final disposition of the patient. DA Form 8–118 is designed for use with mechanical reproduction machines using the diazo-type process. When so used, the master copy will be considered the hospital records copy (fig. 2). Reproduced copies are acceptable for physical evaluation boards and other administrative purposes.

Type of Disposition	Health Record	Clinical Record	Hospital File	Other
	Copy No.	Copy No.	Copy No.	Copy No.
1. Returned to duty	1	2	3	
2. Retained under medical jurisdiction for later evaluation	1	2	3	
★3. Referred to Physical Evaluation Board	—	7	8	1 through 6 to PEB.
★4. Separation—not for disability:				
a. Release from AD (Return to ARNGUS, USAF)	1	2	3	
b. Discharge	1	2	3	
★5. EPTS separation—not referred to PEB	1	2	3	4 with cy entry and exit SF 88 and 89 attached to TSG, ATTN: MEDPS–SX, through Surgeon, USAREC, Ft. Monroe, VA 23551. See para 9–8*d* and *e*, AR 635–40.

Notes:

1. See paragraph 10–10, AR 635–40 for disposition of DA Form 8–118 when a disabled individual is continued on active duty.

2. See also paragraphs 48, 56*b*(4), 56*c*, 57, 61*c*, and 70 of this regulation.

★3. See AR 40–501 for instructions on use of DA Form 3349 to notify unit commanders of physical profile and assignment limitations on members returned to duty.

★*Figure 2. Distribution of medical board proceedings.*

answered so that reference to any former Army retiring board or physical evaluation board action may be checked against present diagnosis.

(15) *Item 18.* Include names and locations of hospitals and dates of hospitalization during current episode of treatment in order that necessary medical and/or clinical records may be located without delay.

(16) *Item 19.* Enter any remarks pertinent to other items. If additional space is needed, a separate sheet of paper may be attached.

(17) *Item 20.* The officer responsible for preparation of the request for records will sign the original.

53. Veterans Administration Physicians Guide—Disability Evaluation Examinations and Veterans Administration Schedule for Rating Disabilities. Medical officers whose responsibilities include the preparation of cases for eventual presentation to physical evaluation boards will be familiar with the Veterans Administration Physicians Guide—Disability Evaluation Examinations and the Veterans Administration Schedule for Rating Disabilities, and insure that the information and terminology recorded adequately describes severity so as to permit the establishment of disability percentage ratings. Requests for either publication will be forwarded with justification through channels to The Surgeon General, ATTN: MEDAS–A.

54. Types of disposition for members of the Army. *a. Full duty.* Patients who meet retention medical fitness standards and are medically fit to perform duty without restrictions or assignment limitations will be returned to full duty. This type of disposition may be made by the attending medical officer or upon the approved recommendation of a medical board. Disposition to *full* duty from a duty status involving duty or assignment restrictions can be made only if based on approved medical board recommendations.

b. Temporarily restricted duty. Patients who meet retention medical fitness standards and who are considered medically fit to perform useful duty while recovering from sickness or injury will be placed on temporarily restricted duty. Such patients will be evaluated at least once every 3 months with a view to upgrading their duty status. No individual may be in a temporarily restricted duty status for more than 12 months. This type of disposition involving a total of 3 months or less normally should be made by the attending medical officer. Return to full duty from a temporarily restricted duty status imposed as a result of a medical board can be made only if based on approved medical board recommendations.

c. Trial duty. Patients whose medical fitness for retention and performance of useful duty is problematical may be recommended for trial duty by a medical board. No individual may be on trial duty without being evaluated at least once every 3 months with a view to upgrading his duty status or separating him from the service, if appropriate. Individuals will not be retained on a trial duty status for more than 12 months without prior approval of Headquarters, Department of the Army.

d. Duty with permanent assignment limitations. Patients who meet retention medical fitness standards and who are fit to perform useful duty with specific permanent assignment limitations will be recommended for duty with permanent assignment limitations by a medical board. Individuals who do *not* meet retention medical fitness standards and who are recommended for continuance on active duty as outlined in AR 635–40 will have their permanent assignment limitations identified by the medical board processing the case for continuance on active duty.

e. Duty for separation or separation recommended.

(1) Patients who meet retention medical fitness standards and who are *scheduled* for any administrative separation or retirement, including separation for administrative unfitness, will be returned to duty for separation. This type of disposition may be made by either the attending medical officer or by the commander based on medical board recommendations.

★(2) Patients who do not meet retention medical fitness standards, do not require active hospitalization, and who are eligible for and elect separation for a condition existing prior

to service which has not been aggravated by such service will be processed as outlined in chapter 9, AR 635-40. This type of disposition can be made only on medical board recommendation.

★(3) An enlisted patient who meets retention medical fitness standards (chap. 3, AR 40-501) but did not meet procurement medical fitness standards (chap. 2, AR 40-501) when accepted for induction or initial enlistment will be processed for separation on the recommendation of an approved medical board if he applies for separation within the time limit prescribed in paragraph 5-9, AR 635-200. If he declines to apply for separation, and his erroneous entry into the service was discovered within the time limit stated in AR 635-200, he must sign a statement acknowledging that he has been informed of his right to apply for such separation but declines to do so, and desires to complete the term of service for which he enlisted or was inducted. The statement will become a permanent part of his personnel records.

(4) Patients who meet retention medical fitness standards but are considered administratively unfit for further military service, will be returned to duty with separation recommended under the appropriate administrative regulation. This type of disposition may be made by either the attending medical officer or by the commander based on medical board recommendations.

★*f. Transfer to another medical treatment facility* (para 3.1*m*). This type of disposition may be made by either the attending medical officer or the commander. (See paragraph 70 for transfer to VA facility.)

★*g. Referral to a physical evaluation board.* The following personnel will be referred to a physical evaluation board:

(1) All members who do not meet medical fitness standards for retention or whose fitness is questionable, including members who have two or more impairments which individually are not unfitting, but which together cause sufficient disability to make fitness for military service questionable; and those with latent impairments of such significance as to raise a question of post-separation or retirement fitness should be considered for separation or retirement under paragraph 3-36*c*, AR 40-501, including those who apply for continuance on active duty under the provisions of chapter 10, AR 635-40.

(2) Members on the TDRL:

(*a*) Who have improved so that they may be physically fit, or

(*b*) Who have stabilized so as to permit final disposition, or

(*c*) When periodic examination is performed within nine months of the fifth anniversary of placement on the TDRL.

(3) Cases where referral is directed by Headquarters, Department of the Army.

h. AWOL. When a patient absents himself without leave and remains in an AWOL status for 10 consecutive days his medical records will be closed. This type of disposition is made by the attending medical officer.

i. Death.

55. Types of disposition for nonmilitary patients. *a.* Discharge from hospital when the patient is released to own custody or custody of the sponsor or next of kin, or other authorized individual. (Appointments or instructions or followup treatment, if required, are initiated by the attending medical officer.)

b. Transfer to another medical treatment facility (para 3.1*m*).

c. Absent without release when the patient departs without proper release or is otherwise unaccounted for.

d. Release against medical advice when the patient and/or his sponsor signs an appropriate release.

e. Death.

56. Members of the Reserve component on active duty for training pursuant to orders which specify a period of 30 days or less, members of the Reserve components participating in Reserve duty training, and members of the ROTC on training tour. *a. Evaluation by medical board.* When an individual in one of these categories is considered medically unfit

3. Medical or employment requirements necessitate wearing of spectacle inserts although the binocular visual acuity is greater than prescribed in *1* above. When prescribed under this provision, DD Form 771 will include a statement of the condition requiring the inserts and will be approved by the commander of the medical treatment facility.

(2) Military personnel requiring prescription spectacles will be prescribed one pair of prescription sunglasses when—

(*a*) Individual is being assigned on PCS orders to USARPAC or is being assigned to a unit which is subject to a movement directive stipulating transfer to USARPAC; or

(*b*) PCS orders indicate that unit to which individual is being assigned is subject to movement directive as outlined in (*a*) above; and

(*c*) Movement directive or PCS orders indicate the personnel will be furnished items authorized by CTA 50-901 for Zone 1. Spectacle orders on DD Form 771 will cite movement directive or PCS orders in remarks section with destination being USARPAC.

(3) Aviation sunglasses (two pairs) for those personnel who require corrective lenses and are on flight status or perform control-tower or drone control duties.

(4) Aviation clear coated spectacles (two pairs) to personnel on flight status who require corrective lenses to perform aircrew duties.

★(5) Plano clear lenses in standard gray frames (one pair) for practicing dental officers, hygienists, and technicians as a protective device against hazards of debris and mouth contaminants when using high-speed dental equipment.

(6) Shooting glasses (one pair amber lenses and one pair gray lenses in aviation spectacle frames) for personnel of the US Army Advanced Marksmanship Unit, and members of the pistol and rifle teams representing CONUS armies and MDW, ARADCOM, USMA, and major oversea commands.

h. Delivery of spectacles. The prompt delivery of spectacles to the individual concerned requires that prescribing clinics forward spectacle prescriptions daily to optical laboratories or units and that airmail service be utilized where it will reduce the transmission time. Optical laboratories or units will utilize airmail service or other means where feasible to reduce delivery time of spectacles to clinics. Clinics will—

(1) Dispense completed spectacles promptly upon receipt.

(2) Forward undelivered spectacles immediately to the new address in the event of transfer of the individual to another station.

(3) Return to the servicing optical laboratory or unit those spectacles which cannot be delivered or forwarded to the individual concerned. A statement explaining the reason for the return of spectacles will accompany the spectacles and DD Form 771.

★**118.1 Impact resistant lenses.** Spectacles furnished to personnel authorized in paragraph 116 will contain impact resistant lenses as indicated below:

a. Cellulose Acetate Frame Spectacles—

(1) Personnel requiring a single vision correction of plus or minus 3.00 diopters or greater in the spherical portion of the lens when written in minus cylinder form will be furnished with clear plastic lenses.

(2) Personnel with corrections of less than the power indicated above (in either eye) and those requiring multi-focal lenses will be furnished with crown glass heat-treated lenses.

(3) Tinted lenses (all colors and light transmissions) will be furnished with crown glass heat-treated lenses.

b. Aviation spectacles (sunglasses and magnesium fluoride coated glasses) will be furnished with crown glass heat-treated lenses.

c. Spectacle inserts for protective masks will be furnished with crown glass heat-treated lenses.

d. Plano clear lenses for dental officers and allied personnel will be provided with crown glass heat-treated lenses.

e. Shooting glasses will be furnished with glass heat-treated lenses.

f. Personnel employed in industrial occupations or subject to eye hazardous conditions will be provided with glass industrial safety thickness lenses, a minimum of 3mm thickness.

★119. Preparation of DD Form 771 (Eyewear Prescription). This form will be used for all prescriptions providing for glass lenses (see para 119.1 for prescriptions with plastic lenses).

a. Date. Enter date that prescription is prepared.

b. Order Number. Enter station number, followed by prescription number assigned serially within fiscal year, and last two digits of fiscal year, with the three groupings separated by hyphens.

c. To. Enter title and address, including ZIP Code. of servicing optical laboratory.

d. From. Enter complete designation and location, including ZIP Code, of prescribing unit.

e. Name, grade, social security number/service number, and age. Enter identifying data on patient.

f. Unit and address. Enter complete information on patient's unit and location.

g. Status information. Check status of patient as authority for furnishing spectacles and check box showing uniformed service of which he is a member.

h. Spectacles.

(1) Check appropriate box for type of eyewear being prescribed.

(2) When protective mask inserts are prescribed, it is necessary to designate the appropriate mask and position as follows:

(*a*) M-9 masks—indicate insert position A, B, C, D, E, W, or X.

(*b*) M-17 masks—indicate the position (lower, central, or upper) with the bridge width (wide or narrow).

(*c*) M-14A2, M-17A1 and M-25—a single size insert will fit each of these masks. Indicate mask type to identify type of spectacle insert. As an interim measure, the same insert may be prescribed for the M-24 (aviator's mask) pending development of a new item.

i. Fabrication data. Enter interpupillary distance for distant and near vision, eye size, bridge size, temple length and style, number of pairs, and cases. The frame size will be prescribed to fit the patient and not to serve any other purpose.

j. Single-vision and multivision data. Enter correction required for each eye, including applicable information for each of the columnar headings. The prescribing officer will prepare the prescription in terms of "plus cylinder" for single-vision prescriptions and in terms of "minus cylinders" for bifocal prescriptions.

k. Special lenses or frame. Enter details as required by prescription form, including basis and/or justification for a special item; full description of any unusual prescription; and additional information that will assist the laboratory in fabricating the prescription.

l. Signatures. Enter name, grade, and title of prescribing officer (medical officer or optometrist). If an approving officer's signature is required, the medical facility commander may designate a senior officer to perform this function. DD Form 577 (Signature Cards) will be furnished to the servicing optical laboratory or unit for each prescribing officer and designated approving authority.

m. Distribution of copies. DD From 771 will be prepared in sets of three copies. Copies 1 and 2 will be forwarded daily to the servicing optical laboratory or unit. Copy 3 will be inserted in the patient's Health Record (DD Form 722).

★119.1 Preparation of DD Form 771-1 (Eyewear Prescription—Plastic Lenses). This form will be prepared for all prescriptions requesting plastic lens components as authorized by paragraph 118.1. The date, order number, to, from, name, grade, social security number, age, unit and address, and status information will be completed in accordance with the provisions in paragraph 119.

a. Spectacles. Check appropriate box for type of eyewear being described. The spaces for "aviation spectacles" and "protective mask insert" will not be utilized.

b. Fabrication data. Enter interpupillary distance for distant or near vision, eye size, bridge size, temple length and style, number of pairs, and cases. The frame size will be prescribed to fit the patient and not serve any other purpose.

c. Single-vision data. Enter correction required for each eye including applicable information for each of the columnar headings. The prescribing officer will prepare the prescription in terms of *minus cylinder* for single-vision plastic lens spectacles.

d. Information for compilation of statistical data. The appropriate boxes will be indicated with an "X" for initial issues and replacement issues. Careful consideration should be given to each entry so that the information can be recorded at a data center. Information should be secured from the patient and the patient's health record in order that appropriate boxes are checked.

e. Special lenses, frames, and signature. Provisions of paragraph 119 are applicable for these items.

f. Distribution of copies. DD Form 771-1 will be prepared in sets of five copies. The prescribing clinic will retain Copy 5 for its records and Copy 3 will be inserted in the patient's Health Record (DD Form 722). Copies 1, 2, and 4 together with interleaved carbons will be forwarded to the designated optical laboratory. The laboratory will retain Copy 1, return Copy 2 with completed spectacles to the clinic, and transmit Copy 4 to designated data center. The clinic will furnish Copy 2 to the patient with the completed spectacles.

120. Spectacle priority system. Medical treatment facilities will use the following priority system in the order of the listing below for designating and processing spectacle orders:

a. POR and POM orders. These orders will be identified by typing or stamping the words POR or POM in the Special Lenses or Frame section of DD Form 771.

Note. POR and POM orders will be kept to an absolute minimum by insuring that the eyes of all personnel are examined as early as possible during the training period. Spectacles, when indicated, will be ordered immediately.

b. Trainee orders submitted for enlisted personnel undergoing training. This class of orders will be identified by typing the word TRAINEE in the Special Lenses or Frame section of DD Form 771.

c. All other orders. All spectacle orders not identified in *a* or *b* above.

121. Types of spectacles available. Requests for each of the following types of spectacles will be submitted separately on DD Form 771.

a. Spectacles—standard issue. Prescription spectacles will be furnished in standard gray spectacle frames. Prescription spectacles in frames other than the standard issue type will not be furnished for cosmetic appearance or personal preference purposes. They may be furnished, however, in those cases where a facial deformity or abnormality precludes the use of the standard spectacle frame. The standard frame with or without adjustable pads has been designed to fit most facial characteristics. Request for prescription spectacles in special frames will state in detail the purpose necessitating such frames.

b. Spectacle inserts for protective masks. Fitting sets listed below will be utilized for protective masks authorized in paragraph 118*g*(1). The sets contain an Instruction Manual which will be utilized in prescribing, fitting, and adjusting the spectacles.

(1) *M-9-series.* Mask, Protective. Use Fitting Set, Field Protective Mask Eyewire, and Support.

(2) *M-17.* Mask, Protective. Fitting Set CBR Mask Optical Insert, FSN 6540-656-1252.

(3) *M-14A2, M-17A1, M-25, and M-24 masks.* A fitting set is not required. The single size spectacle insert (PD 66) FSN 6540-935-6573, can be adjusted to the appropriate height by inserting the retention struts at the proper level within the rubber blocks in the masks. Vertex distance will be accomplished by regulating the distance that struts

are inserted in rubber blocks. The struts are a malleable material which permits required adjustment of the positioning angle of insert.

c. Aviation sunglasses. Neutral 15 percent (N-15) transmittance gray lenses in the standard aviation frame will be the prescription sunglass for personnel on flying status in the performance of aircrew duties and for control tower and drone-control operators. Where the correction exceeds 2.75 diopters of myopia or 1.50 diopters of hyperopia in any meridian, the servicing optical laboratory will furnish clear glass lenses coated in a gray tint in lieu of the standard N-15 tinted lenses, except that any correction in excess of 5.50 diopters of myopia or hyperopia in any meridian will be furnished in a standard S-7 frame. The furnishing of coated lens in lieu of tinted glass is necessary because of undersirable light transmittance changes occurring in tinted lens of foci greater than those specified. When ordering aviation sunglasses, a statement is required that the individual is on flying status or in a control-tower or drone-control operator.

d. Aviation low reflectance coated spectacles. Magnesium fluoride coated lenses in standard aviation spectacle frame will be the clear glass prescription spectacles for personnel in flying status in the performance of aircrew duties. Magnesium fluoride coated lens will not be provided when the correction exceeds 5.50 diopters of myopia or hyperopia in any meridian. When ordering aviation coated spectacles, a statement is required that the individual is on flying status.

e. Shooting glasses. Prescription shooting glasses for members of the pistol and rifle teams set forth in paragraph 118*g*(6) will be prescribed only where the officer in charge of the team certifies that the individual requiring the glasses is a member of a team listed in paragraph 118*g*(6) and the spectacle order includes a statement that the individual has been certified as a member of an authorized pistol and rifle team.

f. Investigative and intelligence personnel.

(1) Issue of two pairs of spectacles with nonstandard frames is authorized for the following personnel:

(*a*) Criminal investigation personnel with MOS 951 and 95D and to officers serving in MOS 9100 and 9110 who are actually supervising CID activities.

(*b*) Intelligence enlisted personnel with MOS 97B40, 97B50, 97C40, 97C50, 97D20, 97D40, and 97Z50, warrant officers in MOS 971A and 972A, and officers serving in MOS 9666 and 9668.

★(2) Requests for nonstandard frames will be initiated by commanding officers of units with assigned criminal investigative or intelligence personnel and will indicate that the individual designated therein is engaged in investigation or security tasks and is assigned to a controlled DA MOS position which is authorized nonstandard spectacles in (1) above. The military grade of the individual will not be used in requests or on spectacle prescriptions. Prescribing officers will indicate on DD Form 771 that appropriate authority has been furnished. Recommended frame style will also be indicated where practicable. In CONUS and all oversea commands, except USAREUR, prescriptions will be forwarded to the US Army Medical Optical and Maintenance Agency, Denver, CO 80240, or the US Army Medical Optical Laboratory, Tracy, CA 95376, as appropriate. In USAREUR prescriptions will be forwarded to servicing optical laboratory.

(3) Nonstandard frames to be selected and authorized by eye clinics will have the same basic measurements as the standard military spectacle frames and will be measured and dispensed by utilizing standard spectacle fitting set. Detailed information relative to size, colors, and types of available nonstandard frames will be furnished by servicing optical laboratories.

★121.1 Furnishing spectacle inserts to National Guard and Army Reserve. *a.* Spectacle inserts for protective mask M-17 only may be prescribed for National Guardsmen and Army Reservists assigned to units designated for control of civil disturbances. The following procedures will be applicable to refraction, prescribing, fabrication, and fitting of inserts:

	Corps, and Air Force; for others, Rate A.	other than Army, Navy, Marine Corps, and Air Force, rept to SG on DD Form 7.	None	None	Yes.
b. Retired enl pers of the uniformed services (para 11).	None for enl of Army, Navy, Marine Corps, and Air Force; for others, Rate A.	None for enl of Army, Navy, Marine Corps, and Air Force; for others, rept to SG on DD Form 7.	None	None	
APPLICANTS					
a. Applicants for cadetship at the various service academies[1] (para 18.1).	Subs only for USMA, USNA and USAFA; Rate A for all others.	Coll subs locally from MPA appropriation for USMA, USNA, and USAFA; rept to SG on DD Form 7 for all others.	None (exams only)	None	NA.
b. Applicants for enlistment or reenlistment in the Armed Forces including applicants for enlistment in the Res components thereof, and Selective Service registrants (para 19).	Subsistence only	Coll locally from MPA appropriation.	None	None	No.
c. Applicants for appointment in the Regular Army and Res components, including members of Res components applying for AD (para 20).[1]	Subsistence only	Coll locally from indiv.	None (exams only)	None	NA.
d. Designated applicants for enrollement in the Senior Reserve Officers' Training Program (para 10.1).	Subsistence only	Coll locally from RPA appropriation.	None	None	No.
FORMER MILITARY PRISONERS					
a. Mil prisoners whose punitive discharge has been executed but whose sentence has not expired (para 21*c*(1)).	Subsistence only	Coll locally from MPA appropriation.	None	None	Yes.
b. Mil prisoners hospitalized beyond expiration of sentence (para 21*c*(2)).	Rate B	Coll locally from indiv.	NA	NA	No.

See footnotes at end of table.

Table I—Continued

Section A. Members and Former Members of the Uniformed Services and Their Dependents—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
FORMER FEMALE PERSONNEL OF THE ARMED FORCES AND THEIR NEWBORN INFANTS (para 22).	Subsistence only	Coll locally from indiv.	None	None	No.
INDIVIDUALS WHOSE MILITARY RECORDS ARE BEING CONSIDERED FOR CORRECTION (para 23).	Subsistence only	Coll locally from indiv.	None	None	No.
DEPENDENTS OF ACTIVE DUTY AND RETIRED MEMBERS OF THE UNIFORMED SERVICES, INCLUDING DEPENDENTS OF PERSONS WHO DIED WHILE ON AD OR IN RETIRED STATUS (AR 40-121, AR 40-122, AR 40-123, and AR 40-124.)[2]	Rate D for Army, Navy, Marine Corps, and Air Force; for others, Rate B or F.	Coll Rate D locally from all dependents; for other than Army, Navy, Marine Corps, and Air Force dependents, rept to SG on DD Form 7.	None	None	Artificial limbs and artificial eyes only.[3]

[1] Hospitalization authorized only when required in connection with the conduct of medical examinations.
[2] For detailed information on care of dependents, see AR 40-121.
[3] Items other than artificial limbs and artificial eyes may be sold to dependents outside the United States and at designated stations within the United States (see AR 40-121). Special or contact lenses may be purchased from funds available to the medical facility for those dependents requiring these items for complete medical or surgical management of eye conditions, as authorized by paragraph 4-6p, AR 40-121.

c. Peace Corps employees and their dependents who are not beneficiaries of the Peace Corps outside US (para 16.1a(2)(b)).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
MEMBERS OF THE U.S. SOLDIERS' HOME (para 17).	Rate E	Rept to SG on DD Form 7.	None	None	No.
BENEFICIARIES OF THE DEPARTMENT OF JUSTICE					
★a. Federal Bureau of Investigation agents (para 18a).[2]	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	NA.
★b. Claimants whose claims are administered by the Department of Justice (para 18b).[2]	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	NA.
★SECRET SERVICE SPECIAL AGENTS (para 37.2).	NA	NA	OR (Med exam only).	Rept to SG on DD Form 7A.	NA.
CIVILIAN EMPLOYEES OF ALL FEDERAL AGENCIES (LIMITED TO DISABILITY RETIREMENT MEDICAL EXAMINATIONS) (para 27e).[2]	Subsistence only	Coll locally from indiv.	None	None	NA.
CIVILIAN EMPLOYEES OF THE DEPARTMENT OF COMMERCE (para 27f).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
★CIVILIAN EMPLOYEES OF THE DEPARTMENT OF INTERIOR AND THEIR DEPENDENTS (para 27g).	Outside US, rate B or F for citizens and rate C for noncitizens; inside US, rate B or F.	Coll locally from indiv.	Outside US, SOR or IMR; inside US, OR, or IMR.	Coll locally from indiv.	No.[1]
CIVILIAN EMPLOYEES OF THE GENERAL ACCOUNTING OFFICE AND THEIR DEPENDENTS (para 27h).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
★FEDERAL AVIATION AGENCY AIR TRAFFIC CONTROLLERS (para 37.3).	NA	NA	OR	Rept to SG on DD Form 7A.	NA.
JOB CORPS AND VOLUNTEERS IN SERVICE TO AMERICA (VISTA) PERSONNEL AND APPLICANTS (para 37.4).					
★a. Job Corps applicants for enrollment and VISTA applicants for employment.	NA	NA	OR or IMR	Rept to SG on DD Form 7A.	NA.

See footnotes at end of table.

Table I—Continued

Section B. Beneficiaries and Employees of Other Federal Agencies—Continued

Categories of persons authorized care (references are Hospitalization charge to AR 40-3 unless otherwise specified)		Collection action	★Outpatient or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids, and orthopedic footwear authorized
★b. Job Corps enrollees and VISTA personnel.	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	NA.
★SOCIAL SECURITY BENEFICIARIES (para 37.6).	Rate A	Rept to SG on DD Form 7.	OR or IMR	Rept to SG on DD Form 7A.	NA.

[1] Outside the United States, spectacles may be furnished these individuals on a reimbursable basis (para 116b(5)).
[2] Hospitalization authorized only when required in connection with conduct of medical examinations.

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SECTION III

PERSONS ELIGIBLE FOR MEDICAL CARE AT ARMY MEDICAL TREATMENT FACILITIES

6. Persons eligible, extent of treatment and charges therefor. ★*a. Persons eligible.* The personnel enumerated in this section are eligible for medical care under the conditions outlined herein. The commander of the medical treatment facility is responsible for determining the applicable category of this section under which a person is provided medical care. When a person is eligible under more than one of the categories in this section, he will be provided care under whichever category he chooses.

b. Extent of medical care. The extent of medical care authorized such as hospitalization, outpatient treatment immunizations, prosthetic devices, etc., type of reimbursement and other criteria for medical care for all eligible categories is prescribed in table I, located in back of this regulation. Where prosthetic devices or appliances are not authorized, Army medical treatment facilities may, in connection therewith as a part of authorized treatment, furnish the following services:

(1) Examination and treatment to include the taking of necessary measurements.

(2) Procurement of the device or appliance concerned for the individual at no expense to Army funds.

(3) Fitting of the device or appliance concerned and training in its use.

c. Rates.

(1) *General.* Rates for medical care are prescribed in AR 40–330.

(2) *Inpatient.* The inpatient rates shown in column 2 of table I for applicable categories of patients are all-inclusive rates prescribed for personnel in an inpatient status. No additional charge will be made.

(3) *Outpatient.*

(*a*) The categories of personnel listed in table I which have the symbol "OR," "SOR," or "OOR" in column 4 and who receive outpatient treatment during a visit on a given day to an outpatient facility will be charged the Outpatient Rate, the Special Outpatient Rate, or the Other Outpatient Rate, whichever is applicable, for each visit. This will include immunizations and the furnishing of medicine on prescription which is an actual part of outpatient care. Only one visit will be counted for each patient presenting himself or visited on a given day, regardless of the number of times the patient may be seen during the day, or the number of conditions for which he is treated on that day.

(*b*) When a beneficiary of the Bureau of Employees' Compensation (para 13), is furnished a prosthetic appliance, spectacles, a hearing aid, or orthopedic footwear on an outpatient basis, a separate charge will be made for the item. DD Form 7A (Report of Treatment Furnished Pay Patients; Outpatient Treatment Furnished (Part B)) submitted to The Surgeon General will show the type of item furnished and the cost. Charges for spectacles will be in accordance with paragraph 124.3.

(4) *Medical examinations or immunizations.* Categories of personnel listed in table I which have the symbol "MR" or "IMR" in column 4 who are furnished medical examinations or immunizations, other than in connection with inpatient or outpatient care, will be charged the medical examination rate or the immunization rate, as applicable.

★*d. Charges.* Persons not authorized care in Army medical treatment facilities by law or regulation will be charged the full pay-patient rate for the type of care provided except when charges are waived by the Secretary of the Army or the appropriate oversea commander or when the commander of a medical treatment facility determines that a particular patient is medically indigent.

★**7. Members of the uniformed services on active duty (other than for training).** All members of the uniformed services, including members of the Reserve components, who are on active duty (other than for training) are entitled to medical and dental care in facilities of the uniformed services under 10 U.S.C. 1074a while they are on that duty. Members of the National Guard in active Federal service pursuant to a "call" under chapter 15, or sections 3500 or 8500 of title 10, U.S. Code, Cadets of the United States Military, Air Force and Coast Guard Academies, and Midshipmen of the United States Naval Academy are on active duty (other than for training). Care will be provided without regard to whether the condition for which treatment is required was incurred or contracted in line of duty. (See AR 635-100 and AR 635-200 for extensions of periods of active duty for the purpose of continuing medical treatment for in-line-of-duty conditions after expiration of term of service.)

★**8. Members of the uniformed services Reserves and National Guard personnel.** *a. Treatment during and after training duty.* Members of the uniformed services Reserves on active duty for training or inactive duty training and National Guard personnel performing full-time training or inactive duty training are authorized medical and dental care in Army medical treatment facilities as follows:

(1) While on active duty for training or full-time training duty, they are authorized medical care without regard to whether the disease or injury was contracted or incurred in line of duty.

(2) After expiration of the period of active duty for training or full-time training duty specified in their orders, they are authorized medical and dental care only if the injury or disease was incurred or contracted *in line of duty* while on that training or duty, or traveling directly to or from such training or duty. (See paragraph 15, AR 135-200, for administrative procedures to be carried out at the time of expiration of the training or duty.)

(3) While on inactive duty training, they are authorized medical and dental care when required as the result of an injury incurred *in line of duty.* (The term "injury" as used in this subparagraph includes acute poisonings, except those due to contaminated food, resulting from exposure to a toxic or poisonous substance.) Care is not authorized for injuries incurred while en route to or from inactive duty training.

(4) After a period of inactive duty training, they are authorized medical and dental care only if the injury for which treatment is required was incurred *in line of duty* while on inactive duty training.

Note. In appropriate cases, the Veterans Administration may provide care for members injured *in line of duty* while proceeding directly to or from inactive duty training.

(5) Care is not authorized Army and Air Force Reserve and National Guard personnel for disease contracted during inactive duty training. However, a member of the Naval, Marine Corps, or Coast Guard Reserve who becomes ill or contracts a disease *in line of duty* while performing inactive duty training is entitled to care for that illness or disease on the same basis as for an injury incurred while performing such duty.

(6) While not on duty and while voluntarily participating in aerial flights in Government-owned aircraft under proper authority and incident to training, they are authorized medical and dental care required as the result of an injury incurred *in line of duty.*

Upon expiration of the period of active duty for training, full-time training duty or inactive duty training specified in orders, members of the Reserves and National Guard are released from that training or duty. While receiving treatment after expiration of the ordered train-

based on injuries or disabilities allegedly arising out of the operation of the Defense Establishment may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge being made in order to determine the extent or nature of the injuries or disabilities claimed.

31. Persons outside the continental United States who contribute to accomplishment of a major oversea commander's mission. *a. General.* Persons who contribute to the accomplishment of a major oversea commander's mission and for whom medical care is deemed essential by the major oversea commander concerned may receive medical care in facilities outside the continental United States only in the absence of adequate civilian facilities as determined by the major oversea commander concerned. Rate B or F or the outpatient rate, whichever is applicable, will apply except as indicated in *b, c,* and *d* below.

★*b. Civilian representatives of religious groups and others.* Civilian representatives of religious groups, celebrities and entertainers, athletic clinic instructors, and representatives of the USO, other social agencies, and educational institutions, and persons in similar status providing direct services to the U.S. Armed Forces, who are acting under official invitational orders from the Department of Defense, or from one of the military departments, to visit military commands overseas may be furnished medical care without charge in facilities outside the continental United States. Charges for subsistence will be collected locally from the individual. Dependents of USO oversea area executives, club directors, and associate club directors when accompanying their sponsors outside the United States may be furnished medical care at the uniformed services dependent rate, effective 4 March 1969.

c. Educational representatives of recognized educational institutions. Educational representatives of recognized educational institutions regularly assigned to duty in military commands overseas who are contributing to a major oversea commander's mission, and their dependents when residing with their sponsors, may be furnished medical care in facilities outside the continental United States at Rate B or F or at the outpatient rate, whichever is applicable.

d. Rates for individuals under hardship circumstances. When a major oversea commander determines that hardship would result if an individual or a category provided care under this paragraph were charged the rates specified in *a* above, he may prescribe Rate D as the charge for hospitalization or waive the charge for outpatient care, or do both, as appropriate.

32. American nationals. American nationals outside the United States covered by agreements entered into between the Department of the Army and other Federal civilian agencies when care in Army medical treatment facilities is a condition of the agreement may be furnished medical care.

33. Joint Civilian Orientation Conference guests. Joint Civilian Orientation Conference guests while attending a Joint Civilian Orientation Conference will be provided medical care. Charges for medical care will be at Rate B or at the outpatient rate, whichever is applicable, and collection will be made locally from the individual.

34. Special foreign nationals. *a. Care authorized.* Medical care may be furnished to such persons outside CONUS when it is determined that this action can be expected to contribute to the advancement of the public interests of the United States.

b. Authority. Authority is granted to major oversea commanders to make the foregoing determination.

c. Delegation of authority. Major oversea commanders may, when the geographical dispersion and varying political conditions of their command warrant such action, delegate the authority in *b* above and *e* below to one or more of their major subordinate commanders. Such authority, however, may not be redelegated.

d. Considerations.

(1) Generally, care under this paragraph will be afforded only to foreign officials of high national prominence. Care may be afforded under this paragraph, however, to other foreign nationals when, because of unusual circumstances or the extraordinary nature of the case, such action would be in consonance with *a* above.

(2) Normally, care will not be afforded under this paragraph for chronic conditions or any other condition which, if hospitalization is involved, would not be benefited by hospitalization for a period of less than 90 days.

(3) Normally, the recommendations of the Chief of the Diplomatic Mission to the country involved should be sought prior to determining whether care should be afforded under this paragraph.

e. Charges. Charges for medical care provided under this paragraph will be at Rate B or F or the outpatient rate, whichever is applicable, and collection will be made locally, except that in unusual cases the major oversea commander may waive the charges.

f. Evacuation to the United States. Persons being afforded care under this paragraph will not be evacuated to the United States for further care unless they are first made designees of the Secretary of the Army pursuant to paragraph 35.

35. Designees of the Secretary of the Army. Persons not otherwise eligible for medical care may receive such care when they are designated for this purpose by the Secretary of the Army. Such designees will be charged Rate B or F or the outpatient rate, whichever is applicable, unless specifically otherwise authorized by the Secretary. In the event the Secretary authorizes the furnishing of hospitalization with no reimbursement therefor, a charge for subsistence will be collected locally from the individual unless the Secretary also waives these charges.

36. Certain personnel evacuated from one area to another. Personnel who for medical reasons are evacuated from an area in which they are eligible for medical care to an area where they are not otherwise eligible for such care will be admitted to or furnished treatment at medical treatment facilities to which evacuated or while en route thereto when medical care is deemed necessary. Care should be furnished under this paragraph on a temporary basis only until such time as appropriate disposition can be accomplished.

★37. Civilians in emergency. *a.* Any person is authorized care in an emergency in order to prevent undue suffering or loss of life. See paragraph 3.1*v* for extent of care.

b. Charges for medical care under this paragraph will be at Rate B or F or the Other Outpatient Rate, whichever is applicable, except when the patient is determined to be medically indigent, the commander may waive the charges. For the purpose of this regulation, a person who has insufficient income to meet the costs of necessary medical care and services is considered to be medically indigent.

37.1 Volunteer subjects in approved Department of the Army research projects. Volunteers under the provisions of AR 70-25 are authorized all necessary medical care for injury or disease which is the proximate result of their participation in such projects. (Medical care for civilian employees who volunteer and who perform duty as a volunteer during their regularly scheduled tour of duty will be provided in accordance with paragraph 13.)

37.2 Secret Service Special Agents (examinations). Upon presentation of written authorization, Secret Service Special Agents may be provided routine annual medical examinations in Army medical treatment facilities on a reimbursable basis. Examinations will be conducted and recorded in the same manner as routine annual medical examinations for Army officers except that they will be conducted on an outpatient basis only. If hospitalization is considered desirable in connection with the examination, a statement to that effect will be entered in item 73 or 75 of the SF 88 (Report of Medical Examination), as appropriate. One copy of SF 88 and SF 89 (Report of Medical History) for medical examinations provided these agents

★SECTION XII

OPTICAL SERVICES

116. For whom authorized. *a.* The categories of individuals who are authorized the issue and repair of spectacles are shown in table I.

b. Spectacles may be furnished to the following categories of individuals on a reimbursable basis at rates computed as outlined in paragraph 124.3:

(1) Dependents of members of the uniformed services outside the United States or at Army installations within the United States which have been designated as remote for the purpose of providing spectacle service to dependents.

(2) Dependents of foreign military personnel of the NATO nations and of other officially recognized foreign military personnel at Army installations within the United States which have been designated as remote for the purpose of providing spectacle service to dependents of members of the U.S. uniformed services.

(3) Civilian employees of the Department of the Army (and their dependents) employed at Army installations within the United States which have been designated as remote for the purpose of providing medical care to civilian employees.

(4) Foreign civilian personnel accompanying foreign military personnel of the NATO nations (and their dependents) and other officially recognized foreign civilian personnel at Army installations within the United States which have been designated as remote for the purpose of providing medical care to U.S. Army civilian employees.

(5) Nonmilitary personnel authorized medical care at Army medical treatment facilities outside the United States.

c. Notwithstanding the provisions of paragraph 121*a*, nonstandard spectacles may be fabricated and issued on a reimbursable basis to authorized individuals as outlined in this paragraph where authorized by the Department of the Army as a measure to lessen expenditures on the local economy in oversea commands.

117. Examination of eyes. *a.* The eyes of all military personnel will be examined, when indicated, as soon as possible after entering service. Spectacles, if required, will be ordered promptly. This procedure will reduce to a minimum the number of spectacle orders for POR and POM alerted personnel.

b. When medical treatment facilities of the Department of Defense are not available, refraction will be obtained from medical treatment facilities of Federal agencies outside the Department of Defense in accordance with section VI. When refraction cannot be provided by medical treatment facilities of Federal agencies outside the Department of Defense, a civilian physician or optometrist may be employed in accordance with section VIII. Such refraction will include fitting and adjusting of spectacles. All prescriptions will be entered in DD Form 771 (Eyewear Prescription).

118. Issue of spectacles. *a. General.* Spectacles will not be obtained from sources other than military optical laboratories or units, except as provided in paragraph 124.

b. CONUS. Spectacle prescriptions prepared by military eye clinics in accordance with paragraph 119 will be submitted to optical laboratories as follows:

(1) First, Third, Fourth, and Fifth U.S. Armies and the Military District of Washington: to Medical Optical Activities Branch, Fitzsimons General Hospital, Denver, CO 80240, except that single vision spectacles (white, tinted and case hardened lenses) in standard gray frame and inserts for protective masks will be submitted to the laboratories indicated below:

(*a*) Fort Dix: to the Optical Laboratory, Supply and Services Division, Walson Army Hospital, Fort Dix, NJ 08640.

(*b*) Stations in the states of Alabama, Florida, Georgia, North Carolina, and South Carolina: to the Optical Laboratory, Supply and Services Division, U.S. Army Hospital, Fort Jackson, SC 29207.

(*c*) Stations in the states of Illinois, Indiana, Kentucky, Michigan, Ohio, and Tennessee: to the Optical Laboratory, Supply and Services Division, Ireland Army Hospital, Fort Knox, KY 40120.

(*d*) Stations in the states of Arkansas,

Louisiana, New Mexico, Oklahoma, and Texas: to the Optical Laboratory, Logistics Division, Brooke Army Medical Center, Fort Sam Houston, TX 78234.

(2) Sixth U.S. Army area to: U.S. Army Medical Optical Laboratory, Tracy, CA 95376.

c. Oversea commands. Medical facilities and units will transmit spectacle prescriptions to the U.S. Army optical laboratories or units designated by the major oversea commander. Where U.S. Army optical laboratories or units are not available or where prescriptions are beyond the fabricating capability of optical laboratories or units in the command, the medical facility will forward DD Form 771 to—

(1) U.S. Army Medical Optical Laboratory, Tracy, CA 95376 by medical facilities and units located in the Pacific area and Alaska.

(2) Medical Optical Activities Branch, Fitzsimons General Hospital, Denver, CO 80240 by medical facilities and units located in all oversea commands and areas other than the Pacific area and Alaska.

d. Certain spectacle prescriptions for Navy and Marine Corps personnel. Spectacle prescriptions for aviation sunglasses, aviation clear coated lenses, and nonstandard spectacles for Navy and Marine Corps personnel will be forwarded by medical treatment facilities to the Navy Ophthalmic Lens Laboratory, U.S. Navy Supply Center, Cheatham Annex, Williamsburg, VA 23185.

e. Individual's personal property. Spectacles, including spectacle inserts for protective masks, are custom-made for the individual. As such, they are considered the individual's personal property and will accompany him upon transfer.

f. Number of standard spectacles to be furnished.

(1) Military personnel who require spectacles will have two pairs in serviceable condition.

(2) A pair of civilian type spectacles with the proper correction will be considered in fulfilling the two-pair standard spectacle requirement.

(3) A replacement pair of spectacles will be ordered whenever a pair of spectacles becomes unserviceable.

(4) The provisions of (1) above and *g* below will be fulfilled in preparing and processing personnel for oversea movement as outlined in AR 612-2.

g. Special types of spectacles. Special types of spectacles will be prescribed in the number of pairs indicated under the conditions specified below:

(1) Spectacle inserts for protective masks (one pair) will be furnished to personnel when—

(*a*) The binocular visual acuity is poorer than 20/70 (poorer than 20/40 in the case of Army aviators, aircraft crew members and military vehicle operators); or

(*b*) Bifocal correction is required (this correction will be furnished in standard lenses only); or

(*c*) Medical or employment requirements necessitate wearing of spectacle inserts although the binocular visual acuity is greater than prescribed in (*a*) above. When prescribed under this provision, DD Form 771 will include a statement on the condition requiring the inserts and will be approved by the commander of the medical treatment facility.

(2) Military personnel requiring prescription spectacles will be prescribed one pair of prescription sunglasses when—

(*a*) Individual is being assigned on PCS orders to USARPAC or is being assigned to a unit which is subject to a movement directive stipulating transfer to USARPAC; or

(*b*) PCS orders indicate that unit to which individual is being assigned is subject to movement directive as outlined in (*a*) above; and

(*c*) Movement directive or PCS orders indicate the personnel will be furnished items authorized by TA 50-901 for Zone 1. Spectacle orders on DD Form 771 will cite movement directive or PCS orders in remarks section with destination being USARPAC.

(3) Aviation sunglasses (two pairs) for those personnel who require corrective lenses and are on flight status or perform control-tower or drone control duties.

(4) Aviation clear coated spectacles (two pairs) to personnel on flight status who require corrective lenses to perform aircrew duties.

(5) Plano clear noncasehardened lenses in standard gray frames (one pair) for practicing dental officers, hygienists, and technicians as a protective device against hazards of debris and mouth contaminants when using high-speed dental equipment.

(6) Shooting glasses (one pair amber lenses

and one pair gray lenses in aviation spectacle frames) for personnel of the U.S. Army Advanced Marksmanship Unit, and members of the pistol and rifle teams representing CONUS armies and MDW, ARADCOM, USMA, and major oversea commands.

h. Delivery of spectacles. The prompt delivery of spectacles to the individual concerned requires that prescribing clinics forward spectacle prescriptions daily to optical laboratories or units and that airmail service be utilized where it will reduce the transmission time. Optical laboratories or units will utilize airmail service or other means where feasible to reduce delivery time of spectacles to clinics. Clinics will—

(1) Dispense completed spectacles promptly upon receipt.

(2) Forward undelivered spectacles immediately to the new address in the event of transfer of the individual to another station.

(3) Return to the servicing optical laboratory or unit those spectacles which cannot be delivered or forwarded to the individual concerned. A statement explaining the reason for the return of spectacles will accompany the spectacles and DD Form 771.

119. Preparation of DD Form 771. *a. Date.* Enter date that prescription is prepared.

b. Order number. Enter station number, followed by prescription number assigned serially within fiscal year, and last two digits of fiscal year, with the three groupings separated by hyphens.

c. To. Enter title and address, including ZIP Code, of servicing optical laboratory.

d. From. Enter complete designation and location, including ZIP Code, of prescribing unit.

e. Name, grade, service number, and age. Enter identifying data on patient.

f. Unit and address. Enter complete information on patient's unit and location.

g. Status information. Check status of patient as authority for furnishing spectacles and check box showing uniformed service of which he is a member.

h. Spectacles.

(1) Check appropriate box for type of eyewear being prescribed.

(2) When protective mask inserts are prescribed, it is necessary to designate the appropriate mask and position as follows:

(*a*) M-9 masks—indicate insert position A, B, C, D, E, W, or X.

(*b*) M-17 masks—indicate the position (lower, central, or upper) with the bridge width (wide or narrow).

(*c*) M-14A2, M-17A1 and M-25—a single size insert will fit each of these masks. Indicate mask type to identify type of spectacle insert. As an interim measure, the same insert may be prescribed for the M-24 (aviator's mask) pending development of a new item.

i. Fabrication data. Enter interpupillary distance for distant and near vision, eye size, bridge size, temple length and style, number of pairs and cases. The frame size will be prescribed to fit the patient and not to serve any other purpose.

j. Single-vision and multivision data. Enter correction required for each eye, including applicable information for each of the columnar headings. The prescribing officer will prepare the prescription in terms of "plus cylinders" for single-vision prescriptions and in terms of "minus cylinders" for bifocal prescriptions.

k. Special lenses or frame. Enter details as required by prescription form, including basis and/or justification for a special item; full description of any unusual prescription; and additional information that will assist the laboratory in fabricating the prescription.

l. Signatures. Enter name, grade, and title of prescribing officer (medical officer or optometrist). If an approving officer's signature is required, the medical facility commander may designate a senior officer to perform this function. DD Form 577 (Signature Cards) will be furnished to the servicing optical laboratory or unit for each prescribing officer and designated approving authority.

m. Distribution of copies. DD Form 771 will be prepared in sets of three copies. Copies 1 and 2 will be forwarded daily to the servicing optical laboratory or unit. Copy 3 will be inserted in the patient's Health Record, DD Form 722.

120. Spectacle priority system. Medical treatment facilities will use the following priority system in the order of the listing below for designating and processing spectacle orders:

a. POR and POM orders. These orders will be identified by typing or stamping the words POR or POM in the Special Lenses or Frame section of DD Form 771.

Note. POR and POM orders will be kept to an absolute minimum by insuring that the eyes of all personnel are examined as early as possible during the training period. Spectacles, when indicated, will be ordered immediately.

b. Trainee orders submitted for enlisted personnel undergoing training. This class of orders will be identified by typing the word TRAINEE in the Special Lenses or Frame section of DD Form 771.

c. All other orders. All spectacle orders not identified in *a* or *b* above.

121. Types of spectacles available. Requests for each of the following types of spectacles will be submitted separately on DD Form 771.

a. Spectacles—standard issue. Prescription spectacles will be furnished in standard gray spectacle frames. Prescription spectacles in frames other than the standard issue type will not be furnished for cosmetic appearance or personal preference purposes. They may be furnished, however, in those cases where a facial deformity or abnormality precludes the use of the standard spectacle frame. The standard frame with or without adjustable pads has been designed to fit most facial characteristics. Request for prescription spectacles in special frames will state in detail the purpose necessitating such frames.

b. Spectacle inserts for protective masks. Fitting sets listed below will be utilized for protective masks authorized in paragraph 118*g*(1). The sets contain an Instruction Manual which will be utilized in prescribing, fitting, and adjusting the spectacles.

(1) *M-9-series.* Mask, Protective. Use Fitting Set, Field Protective Mask Eyewire and Support.

(2) *M-17.* Mask, Protective. Fitting Set CBR Mask Optical Insert, FSN 6540-656-1252.

(3) *M-14A2, M-17A1, M-25, and M-24 masks.* A fitting set is not required. The single size spectacle insert (PD 66) FSN 6540-935-6573, can be adjusted to the appropriate height by inserting the retention struts at the proper level within the rubber blocks in the masks. Vertex distance will be accomplished by regulating the distance that struts are inserted in rubber blocks. The struts are a malleable material which permits required adjustment of the positioning angle of insert.

c. Aviation sunglasses. Neutral 15 percent (N-15) transmittance gray lenses in the standard aviation frame will be the prescription sunglass for personnel on flying status in the performance of aircrew duties and for control tower and drone-control operators. Where the correction exceeds 2.75 diopters of myopia or 1.50 diopters of hyperopia in any meridian, the servicing optical laboratory will furnish clear glass lenses coated in a gray tint in lieu of the standard N-15 tinted lenses, except that any correction in excess of 5.50 diopters of myopia or hyperopia in any meridian will be furnished in a standard S-7 frame. The furnishing of coated lens in lieu of tinted glass is necessary because of undesirable light transmittance changes occurring in tinted lens of foci greater than those specified. When ordering aviation sunglasses, a statement is required that the individual is on flying status or is a control-tower or drone-control operator.

d. Aviation low reflectance coated spectacles. Magnesium fluoride coated lenses in standard aviation spectacle frame will be the clear glass prescription spectacles for personnel in flying status in the performance of aircrew duties. Magnesium fluoride coated lens will not be provided when the correction exceeds 5.50 diopeters of myophia or hyperopia in any meridian. When ordering aviation coated spectacles, a statement is required that the individual is on flying status.

e. Shooting glasses. Prescription shooting glasses for members of the pistol and rifle teams set forth in paragraph 118*g*(6) will be prescribed only where the officer in charge of the team certifies that the individual requiring the glasses is a member of a team listed in paragraph 118*g*(6) and the spectacle order includes a statement that the individual has been certified as a member of an authorized pistol and rifle team.

f. Investigative and intelligence personnel.

(1) Issue of two pairs of spectacles with nonstandard frames is authorized for the following personnel:

(*a*) Criminal investigation personnel with MOS 951 and 95D and to officers serving in MOS 9100 and 9110 who are actually supervising CID activities.

(*b*) Intelligence enlisted personnel with MOS 97B40, 97B50, 97C40, 97C50, 97D20, 97D40, and 97Z50, warrant officers in MOS 971A and 972A, and officers serving in MOS 9666 and 9668.

(2) Requests for nonstandard frames will be initiated by commanding officers of units with assigned criminal investigative or intelligence personnel and will indicate that the individual designated therein is engaged in investigative or security tasks and is assigned to a controlled DA MOS position which is authorized nonstandard spectacles in (1) above. The military grade of the individual will not be used in requests or on spectacle prescriptions. Prescribing officers will indicate on DD Form 771 that appropriate authority has been furnished. Recommended frame style will also be indicated where practicable. In CONUS and all oversea commands, except USAREUR, prescriptions will be forwarded to Fitzsimons General Hospital, Denver, Colo., or U.S. Army Medical Optical Laboratory, Tracy, Calif., as appropriate. In USAREUR prescriptions will be forwarded to servicing optical laboratory.

(3) Nonstandard frames to be selected and authorized by eye clinics will have the same basic measurements as the standard military spectacle frames and will be measured and dispensed by utilizing standard spectacle fitting set. Detailed information relative to size, colors, and types of available nonstandard frames will be furnished by servicing optical laboratories.

122. Limitations on issue of lenses. *a.* The furnishing of uncut lenses is not authorized.

b. Lenses of 1/8 diopter variations will not be furnished.

c. Bifocal adds of less than 0.75 diopters will not be furnished.

d. Optical laboratories or units are authorized to substitute spherical or cylindrical power when filling a prescription for lenses not carried in stock, provided the sphere or cylinder component is not changed more than 0.25 diopter.

e. The types of lenses in (1) through (8) below will be prescribed only for special purposes which preclude the use of standard clear spectacle lenses. Prescriptions on DD Form 771 will indicate in special lenses or frame section the purpose necessitating such lenses and will be approved by the commander of the medical treatment facility. The issue of these lenses for cosmetic appearance or personal preference is not authorized.

(1) *Tinted lenses.* When required, the standard gray tint lenses will be prescribed, except that other shades or a different percent of light transmission may be prescribed where necessary. Plano tinted lenses are not corrective lenses and will not be furnished by optical laboratories or units.

(2) *Lenses with special base curves.* State base curve desired. Substitutions within accepted commercial designations will be made, if practical. When duplicating lenses with special base curves, the curves of the old lenses will be indicated.

(3) *Prism segment focals.* State amount of prism, axis of base, segment location and inset with relation to optical center of distance portion.

(4) *Trifocals.* State power and size of intermediate segment and the near vision segment. State segment location and inset with relation to optical center of distant portion. Normal power of intermediate segment is 50 percent of addition, and the size is usually 7 mm. Total and overall segment height should be specified.

(5) *Myodisc and lenticular lenses.* These lenses are available on special order.

(6) *Heat-treated lenses for protection of the eyes.* These lenses are available when so indicated on DD Form 771. Plano safety spectacles will be obtained in accordance with AR 385-32.

(7) *Coated lenses except for aviation coated spectacles.*

(8) *Bifocals other than straight top, 25 mm.* State power, segment location, and inset with relation to optical center of distance portion.

f. Contact lenses are a nonstandard item of issue and will not be furnished at Government expense purely for cosmetic reasons, or to satisfy a personal preference.

(1) General guidelines for approval of issuances of contact lenses are summarized as follows:

(*a*) Monocular aphakia or an extremely high degree of anisemetropia.

(*b*) Other monocular conditions such as keratoconus and severe cases of irregular astigmatism.

(*c*) High degrees of refractive error in which ordinary spectacles cause discomfort by reasons of ghost images, prismatic displacement, etc.

(*d*) Specialized types of duty in a physical environment which precludes satisfactory performance of duty with ordinary spectacles (exposure to sea spray, smoke, water vapors, extreme cold). Use of contact lenses is contraindicated in environments where exposure to toxic chemical vapors or dust occurs.

(*e*) In special instances for members of recognized athletic teams whose participation constitutes a morale factor for the service at large. However, it must be clearly established that ordi-

nary lenses would be a hazard to the eyes under the prevailing conditions.

(2) Contact lenses approved for purchase by the Government should meet the following criteria:

(*a*) Be capable of being safely inserted and worn without the use of an artificial fluid.

(*b*) Be constructed so as to permit free circulation of the natural tear film over the cornea.

g. Requirements for iseikonic and telescopic lenses will be determined, funded and procured by the prescribing facility.

123. Permanent record of prescription. In order to facilitate the replacement or repair of lost or broken lenses or frames and to preclude unnecessary eye examinations and the issuance of more than the prescribed number of pairs of spectacles, copy 3 of DD Form 771 will be filed with the individual's permanent health records.

124. Repair or replacement of spectacles. *a. General.* For the purpose of this paragraph the term "repair" will be construed as the replacement of either lens or both and/or any integral part of the frame. Normally, spectacles are repaired either at medical treatment facilities or sent to a military optical laboratory or unit depending upon the complexity of the repair. However, the personnel listed in column 1 of figure 3 whose spectacles were lost, damaged, or destroyed may have such spectacles repaired or replaced from civilian sources when the appropriate authority shown in column 2 of figure 3 determines that the following conditions exist:

(1) The member has no other serviceable spectacles.

(2) He is far removed from a military medical treatment facility.

(3) Lack of a suitable pair of spectacles would interfere with his performance of duty.

b. Payment of charges. The charges for civilian repair or replacement will be paid by the appropriate authority authorizing the repair or replacement from the appropriate open allotment for civilian medical care at rates stated in AR 40-330.

124.1. Clinic requirements for spectacles. Chiefs of ophthalmology services are authorized to submit spectacles orders to optical laboratories or units for prescription spectacles for use in the postoperative care of cataract patients. These spectacles will remain the property of the eye clinic.

124.2. Optical Laboratory Report. DA Form 2717 (Optical Laboratory Report) will be prepared by all optical laboratories or units in accordance with chapter 11, AR 40-61.

124.3. Charges for spectacles. Spectacles furnished to authorized individuals under the provisions of paragraphs 116*b* and *c* will be issued on a reimbursable basis. Charges for spectacles issued under this authority will be based on the cost of component parts and a nominal amount to cover breakage incurred in the fabrication process. Charges will be collected locally from the individual except in the case of beneficiaries of the Bureau of Employees' Compensation (para 6*e*(3)(*b*)).

Category	*Appropriate authority*
Members of the Army on active duty	Immediate commander.
Members of the Army Reserve components on active duty for periods of 30 days or less, and those who are not on active duty.	Commander of the major command under whose jurisdiction the duty was performed, or his designee, in the case of a member of the Army Reserve or of a member of the Army National Guard (Federal status); or upon determination by the Chief, National Guard Bureau, or his designee, in the case of a member of the Army National Guard (National Guard status).

Figure 3. Persons authorized repair or replacement of spectacles from civilian sources.

counseling to patients on oral diseases, their prevention, and control. Additionally, the center can be used for examinations and/or self-application of caries inhibiting agents. Preferably, for psychological impact, an oral health center should be separate from any dental facility devoted to emergency, interceptive or corrective care.

c. Preventive dentistry officers.

(1) *Appointment.* A dental officer will be appointed as the preventive dentistry officer at each command or installation to which more than one Dental Corps officer is assigned. Where only one Dental Corps officer is assigned, that officer will, in addition to other duties, serve as the preventive dentistry officer. At larger installations, clinic preventive dentistry officers may be appointed to coordinate preventive dentistry activities of the various sections of the clinic and to coordinate clinic activities with community activities and with oral health center activities.

(2) *Duties.* Duties of the command or installation preventive dentistry officer will include formulation, supervision, and execution of any or all aspects of the command or installation preventive dentistry program in accordance with Department of Army regulations, OTSG guidance, and directions of the Commander of the Dental Activity or Chief, Department of Dentistry as appropriate. A major duty of the command or installation preventive dentistry officer is to correlate and integrate community oral health programs with clinical programs so that the two are mutually supporting.

133. Removable dental prosthesis identification. Every removable dental prosthesis completed by an Army Dental activity will carry the SSN of the patient when physiological, esthetic and space considerations permit. If limited by these considerations, as many as possible of the terminal digits of the SSN will be used. The identification must be legible and will be placed in or on a material which optimizes durability and technical feasibility for use. Guidance on suitable materials will be provided by OTSG.

133.1 Dental gold and platinum. *a. General.* Although items of dental gold, dental alloys, and platinum are classified as expendable, they will be securely stored when not in use.

b. Accounting. Following receipt of items of dental gold, gold alloys, and platinum from the officer having formal accountability, no special accounting controls are required. The general provisions of Army regulations in the 735 series are applicable as they pertain to expendable items.

c. Scrap. Scrap dental metals and alloys will be disposed.

134. Dental care in civilian facilities for active-duty personnel. *a. Approving authorities.* The approving authorities for civilian dental care are the same as the approving authorities for civilian medical care.

b. Elective care. Elective care in civilian facilities will not be provided at Army expense.

c. Emergency dental care. Prior approval of the designated approving authority is not required for utilization of a civilian dentist for emergency dental care. Emergency dental care normally will be confined to the relief of the immediate emergency. The placing of a permanent restoration in a tooth being treated as an emergency may be considered as part of the emergency care.

d. Routine or extensive dental care.

(1) Except as provided in (2) below, personnel entitled to receive dental care from civilian sources will not obtain routine or extensive dental treatment until prior authorization from the designated approving authority has been received.

(2) The immediate commanding officer, after determining that the total cost of treatment will not exceed $150, may authorize routine civilian dental care without prior authorization by the designated approving authority.

e. Request for authorization.

(1) Letters of request for authority to obtain routine or extensive dental care, when the total cost exceeds $150, will be forwarded through channels to the designated approving authority and will contain the following information:

(*a*) Character and extent of disability.

(*b*) Professional procedures necessary.

(*c*) Estimate of time required for correction and probable cost.

(*d*) When and where the patient was last on duty at a station or summer camp where dental service was available.

(*e*) Probable length of tour of duty at the patient's present station.

(*f*) Present status; whether duty, leave, or pass. If on leave or pass, the date of termination should be stated.

(*g*) Statement as to availability or nonavailability or requested dental care from uniformed services dental facilities or those of other Federal agencies.

(2) Statements required by (1)(*a*), (*b*), and (*c*) above will be prepared by the civilian dentist and will contain a diagnosis, treatment plan, and itemized estimated cost of treatment. The diagnosis and treatment plan will indicate nomenclature of teeth and tooth surfaces rather than numerical designation.

(3) The approving authority may grant or deny the request for civilian dental care or recommend that the patient be ordered to a military installation where he can receive dental care. If request is denied, the dental examination required by (2) above is a proper charge to Army funds.

f. Preparation and payment of vouchers. Instructions for the preparation and submission of vouchers are contained in Section VIII.

g. Record of treatment. The approving authority will require a record of civilian dental treatment to be placed in the DD Form 722-1 (Health Record, Dental Folder) of the individual concerned so that treatment rendered may be transcribed to the SF 603 (Health Record, Dental) by the next dental custodian (para 26, AR 40-403).

Table I

PERSONS AUTHORIZED CARE AT ARMY MEDICAL TREATMENT FACILITIES

See AR 40-330 for explanation of rates

Rate abbreviations used in this table: OR—outpatient rate; SOR—special outpatient rate; OOR—other outpatient rate; MR—medical examination rate IMR—immunization rate

Section A. Members and Former Members of the Uniformed Services and Their Dependents

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient, medical exam, or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids and orthopedic footwear authorized
ARMY					
★a. Members of the Army serving on AD (para 7).	Subsistence only	Coll locally from off; coll locally from Treasurer, USMA, for USMA cadets; coll locally from MPA appropriation for enl. tion for enl.	None	None	Yes.
★b. Members of the Reserve & Nat Guard on AD, ADT, & inactive duty training (para 8).	Subsistence only	Coll locally from off; coll locally RPA or NGPA appropriation for enl.	None	None	Yes (incl spectacle inserts for protective field masks) subject to to limitations in para 8.
c. Members of Army Senior ROTC (para 10a.).	Subsistence only except Rate B appl for those in para 10a(1)(c).	Coll subs locally from RPA appropriation; coll locally from those listed in para 10a(1)(c).	None	None	Yes, subject to the limitations in para 10a(1)(b).
NAVY AND MARINE CORPS					
★a. Members of the Navy and Marine Corps serving on AD, ADT, & inactive duty training (para 7 & 8).	Subsistence only	Coll subs locally from off; coll locally from C of Naval personnel, Code (PERS-H3) Dept of Navy, Wash, DC 20370, for USNA midshipmen; coll locally from MPA	None	None	Yes for those on AD. Yes for those not on AD subject to the limitations in para 8.

Table I—Continued

Section A. Members and Former Members of the Uniformed Services and Their Dependents—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient, medical exam, or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids and orthopedic footwear authorized
		or RPA appropriation for enlisted.			
b. Members of Naval Senior ROTC (para 10*b*).	Subsistence only except Rate B applies when member is responsible for payment.	Coll subs locally from RPA appropriation; coll locally when member is responsible for payment.	None	None	Yes, subject to the limitations in para 10*b*.
AIR FORCE					
★a. Members of the Air Force serving on AD, ADT, & inactive duty training (para 7 & 8).	Subsistence only	Coll subs locally from off; coll locally from USAF Academy for USAFA cadets; coll locally from MPA, RPA or NGPA appropriation for enlisted.	None	None	Yes for those on AD. Yes for those not on AD subject to the limitations in in para 8.
b. Members of Air Force Senior ROTC (para 10*b*).	Subs only except Rate B applies when member is responsible for payment.	Coll subs locally from RPA appropriation; coll locally when member is responsible for payment.	None	None	Yes, subject to the limitations in para 10*b*.
★COAST GUARD AND COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICE AND ENVIRONMENTAL SCIENCE SERVICES ADMINISTRATION. Members of the above svc on AD, ADT, and inactive duty training (para 7 and 8).	Rate A	Rept to SG on DD Form 7; coll subs locally from off and cadets, USCGA; coll locally from MPA or RPA appropriation for enlisted.	None	None	Yes for those on AD. Yes for those not on AD subject to the limitations in para 8.
RETIRED PERSONNEL					
a. Retired officers of the uniformed services (para 11).	Subs only for Army, Navy, Marine	Coll subs locally from all off; for	None	None	Yes.

	Corps and Air Force; for others, Rate A.	other than Army, Navy, Marine Corps and Air Force, rept to SG on DD Form 7.			
b. Retired enl pers of the uniformed services (para 11).	None for enl of Army, Navy, Marine Corps and Air Force; for others, Rate A.	None for enl of Army, Navy, Marine Corps and Air Force; for others, rept to SG on DD Form 7.	None	None	Yes.
APPLICANTS					
a. Applicants for cadetship at the various service academies [1] (para 18.1).	Subs only for USMA, USNA and USAFA; Rate A for all others.	Coll subs locally from MPA appropriation for USMA, USNA, and USAFA; rept to SG on DD Form 7 for all others.	None (exams only)	None	NA.
b. Applicants for enlistment or reenlistment in the Armed Forces including applicants for enlistment in the Res components thereof, and Selective Service registrants (para 19).	Subsistence only	Coll locally from MPA appropriation.	None	None	No.
c. Applicants for appointment in the Regular Army and Res components, including members of Res components applying for AD (para 20).[1]	Subsistence only	Coll locally from indiv.	None (exams only)	None	NA.
d. Designated applicants for enrollement in the Senior Reserve Officers' Training Program (para 10.1).	Subsistence only	Coll locally from RPA appropriation.	None	None	No.
FORMER MILITARY PRISONERS					
a. Mil prisoners whose punitive discharge has been executed but whose sentence has not expired (para 21c(1)).	Subsistence only	Coll locally from MPA appropriation.	None	None	Yes.
b. Mil prisoners hospitalized beyond expiration of sentence (para 21c(2)).	Rate B	Coll locally from indiv.	NA	NA	No.
FORMER FEMALE PERSONNEL OF THE ARMED FORCES AND THEIR NEWBORN INFANTS (para 22).	Subsistence only	Coll locally from indiv.	None	None	No.

See footnotes at end of table.

Table I—Continued

Section A. Members and Former Members of the Uniformed Services and Their Dependents—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient, medical exam, or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids and orthopedic footwear authorized
INIVIDUALS WHOSE MILITARY RECORDS ARE BEING CONSIDERED FOR CORRECTION (para 23).	Subsistence only	Coll locally from indiv.	None	None	No.
DEPENDENTS OF ACTIVE DUTY AND RETIRED MEMBERS OF THE UNIFORMED SERVICES, INCLUDING DEPENDENTS OF PERSONS WHO DIED WHILE ON AD OR IN RETIRED STATUS (AR 40-121, AR 40-122, AR 40-123, and AR 40-124.)[2]	Rate D for Army, Navy, Marine Corps and Air Force; for others, Rate B or F.	Coll Rate D locally from all dependents; for other than Army, Navy, Marine Corps and Air Force dependents, rept to SG on DD Form 7.	None	None	Artificial limbs and artificial eyes only.[3]

[1] Hospitalization authorized only when required in connection with the conduct of medical examinations.

[2] For detailed information on care for dependents, see AR 40-121.

★[3] Items other than artificial limbs and artificial eyes may be sold to dependents outside the United States and at designated stations within the United States (see AR 40-121). Special or contact lenses may be purchased from funds available to the medical facility for those dependents requiring these items for complete medical or surgical management of eye conditions, as authorized by paragraph 4-6*p*, AR 40-121.

Table I—Continued

Section B. Beneficiaries and Employees of Other Federal Agencies

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient, medical exam, or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids and orthopedic footwear authorized
BENEFICIARIES OF THE VETERANS ADMINISTRATION (para 12).	Rate A	Rept to SG on DD Form 7.	OOR or IMR	Rept to SG on DD Form 7A.	Yes.
BENEFICIARIES OF THE BUREAU OF EMPLOYEES COMPENSATION (para 13; CPR C1).	Rate A	Rept to SG on DD Form 7.	OR, MR, or IMR	Rept to SG on DD Form 7A.	Yes.
BENEFICIARIES OF THE PUBLIC HEALTH SERVICE.					
a. Members of the crews of vessels of Environmental Science Services Administration (other than commissioned officers), certain American seamen, enrollees in the U.S. Maritime Svc, members of the Merchant Marine Cadet Corps, civ employees in the field svc, and American Indians, Eskimos, and Aleuts (para 14*a* through *d*).	Rate A	Rept to SG on DD Form 7.	OOR, MR, or IMR	Rept to SG on DD Form 7A.	No.[1]
b. Inactive Reserve Public Health Service Commissioned officers (para 14*e*).	NA	NA	MR or IMR	Rept to SG on DD Form 7A.	NA.
REGISTRANTS ACTING UNDER ORDERS of the SELECTIVE SERVICE SYSTEM (para 15).	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	No.
OFFICERS AND EMPLOYEES OF THE FOREIGN SVC AND AID, DEPT OF STATE; FAS AND ARS, DEPT OF AGRICULTURE; USIA; BPR, DEPT OF COMMERCE (THOSE CONNECTED WITH AID PROGRAM); FAA; FCSC; VA (THOSE ATTACHED TO ROME OFFICE); DEPENDENTS OF SUCH OFFICERS AND EMPLOYEES; AND APPLICANTS FOR APPOINTMENT TO SUCH AGENCIES.					
★a. Officers and employees and their dependents who are beneficiaries of one of above agencies outside the U.S. (para 16*a*) and after med evac to the U.S. (para 16*e*).	Rate A or F for off and employees; rate B or F for depns.	Coll locally from authorizing office on SF 1080 supported by DD Form 7 and ltr of auth.	OR (para 16*a*(2)), MR or IMR.	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	No.[1]

See footnote at end of table.

Table I—Continued

Section B. Beneficiaries and Employees of Other Federal Agencies—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient, medical exam, or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids and orthopedic footwear authorized
b. Applicants for appointment who are beneficiaries of one of above agencies outside U.S. (para 16*b*).	NA	NA	MR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	NA.
c. Officers and employees and their dependents who are not beneficiaries of one of above agencies outside U.S. (para 16*c*).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
d. Officers and employees and their dependents (incl applicants for appointment) who are beneficiaries of one of above agencies in U.S. (Para 16*d*).	NA	NA	MR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	NA.
PEACE CORPS PERSONNEL					
a. Peace Corps volunteers, volunteer leaders and their dependents; and employees and their dependents who are beneficiaries of the Peace Corps outside U.S. (para 16.1*a* (1) and (2)(*a*)).	Rate A or F for vols, vol leaders and employees; rate B or F for dependents.	Coll locally from authorizing office on SF 1080 supported by DD Form 7 and ltr of auth.	OR, MR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	No.[1]
b. Peace Corps applicants (para 16.1*a*(3) and *b*(1)).[2]	Rate A	Coll locally from authorizing office on SF 1080 supported by DD Form 7 and ltr of auth.	MR or IMR	Coll locally from authorizing office on SF 1080 supported by DD Form 7A and ltr of auth.	NA.
c. Peace Corps employees and their dependents who are not beneficiaries of the Peace Corps outside U.S. (para 16.1*a*(2)(*b*)).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
MEMBERS OF THE U.S. SOLDIERS' HOME (para 17).	Rate E	Rept to SG on DD Form 7.	None	None	No.
BENEFICIARIES OF THE DEPARTMENT OF JUSTICE					
a. Federal Bureau of Investigation agents (para 18*a*).[2]	Rate A	Rept to SG on DD Form 7.	MR	Rept to SG on DD Form 7A.	NA.
b. Claimants whose claims are administered by the Department of Justice (para 18*b*).[2]	Rate A	Rept to SG on DD Form 7.	MR	Rept to SG on DD Form 7A.	NA.
SECRET SERVICE SPECIAL AGENTS (para 37.2).	NA	NA	MR (Med exam only).	Rept to SG on DD Form 7A.	NA.
CIVILIAN EMPLOYEES OF ALL FEDERAL AGENCIES (LIMITED TO DISABILITY RETIREMENT MEDICAL EXAMINATIONS) (para 27*e*).[2]	Subsistence only	Coll locally from indiv.	None	None	NA.
CIVILIAN EMPLOYEES OF THE DEPARTMENT OF COMMERCE (para 27*f*).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
CIVILIAN EMPLOYEES OF THE DEPARTMENT OF INTERIOR AND THEIR DEPENDENTS (para 27*g*).	Outside U.S., rate B or F for citizens and rate C for noncitizens; inside U.S., rate B or F.	Coll locally from indiv.	Outside U.S., SOR or IMR; inside U.S., OR, MR or IMR.	Coll locally from indiv.	No.[1]
CIVILIAN EMPLOYEES OF THE GENERAL ACCOUNTING OFFICE AND THEIR DEPENDENTS (para 27*h*).	Rate B or F for citizens; rate C for noncitizens.	Coll locally from indiv.	SOR or IMR	Coll locally from indiv.	No.[1]
FEDERAL AVIATION AGENCY AIR TRAFFIC CONTROLLERS (para 37.3).	NA	NA	OOR	Rept to SG on DD Form 7A.	NA.
JOB CORPS AND VOLUNTEERS IN SERVICE TO AMERICA (VISTA) PERSONNEL AND APPLICANTS (para 37.4).					
a. Job Corps applicants for enrollment and VISTA applicants for employment.	NA	NA	OOR or IMR	Rept to SG on DD Form 7A.	NA.
b. Job Corps enrollees and VISTA personnel	Rate A	Rept to SG on DD Form 7.	OOR or IMR	Rept to SG on DD Form 7A.	NA.
★SOCIAL SECURITY BENEFICIARIES (para 37.6).	Rate A	Rept to SG on DD Form 7.	OR, MR or IMR	Rept to SG on DD Form 7A.	NA.

[1] Outside the United States, spectacles may be furnished these individuals on a reimbursable basis (para 116*b*(5)).
[2] Hospitalization authorized only when required in connection with the conduct of medical examinations.

Table I—Continued

Section C. Miscellaneous Categories of Persons Authorized Care

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient, medical exam, or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids and orthopedic footwear authorized
CITIZENS MILITARY TRAINING CORPS (para 9).	Subsistence only	Coll locally from indiv.	None	None	Yes (para 9).
PERSONS IN MILITARY CUSTODY AND NONMILITARY FEDERAL PRISONERS.					
a. POW's, retained personnel and internees (para 21*a* and *b*).	Subsistence only	Coll locally from MPA appropriation.	None	None	Yes (para 21*a*).
b. Nonmilitary Federal prisoners (para 21*f*)	Rate A	Rept to SG on DD Form 7.	OR	Rept to SG on DD Form 7A.	No.
SEAMEN					
a. Civilian seamen in svc of vessels operated by Army (para 24*b*).	None	None	None	None	No.[1]
b. Civilian seamen in svc of vessels operated by MSTS (para 24*c*).	Rate A	Rpt to SG on DD Form 7.	OR, MR or IMR	Rept to SG on DD Form 7A.	No.[1]
c. Crews of ships of U.S. registry (para 24*d*)	Rate B	Coll locally from local ship's agent or from indiv.	OR, MR or IMR	Coll locally from local ship's agent or from indiv.	No.[1]
FOREIGN NATIONALS					
a. Foreign mil pers of NATO nations in U.S., foreign mil pers in U.S. under DOD sponsorship, and other foreign mil pers in U.S. in a status officially recognized by DA (para 25*a*(1) and (3) through (8)).	Subsistence only	Coll locally from off; coll locally from MPA appropriation.	None	None	Yes.
b. Dependents of above foreign mil pers in U.S. (para 25*a*(1), (5) and (9)).	Rate D	Coll locally from indiv.	None	None	No.[2]
c. Foreign civ pers accompanying foreign mil pers of NATO nations in U.S. and their depns; and other officially recognized foreign civ pers in U.S. (para 25*a*(2) and (8)).	Rate B or F	Coll locally from indiv.	OR, MR or IMR	Coll locally from indiv.	No.[3]
d. MAP trainees (military and civilian) (para 25*a*(8), *c*(2) and *d*(4)).	Rate B	Coll subs locally from off and civ; coll subs locally from MPA appropriation. Rpt to SG on DD Form 7 except in USAREUR.	OR, MR or IMR	Rept to SG on DD Form 7A except in USAREUR.	Yes.

e. Dependents of MAP military trainees (para 25*a*(9) and *c*(2)).	Rate D	Coll locally from indiv.	None	None	No.[4]
f. Special foreign nationals outside U.S. (para 25*c*(1) and (34)).	Rate B, F or none	Coll locally from indiv when applicable.	OR, MR, IMR or none.	Coll locally from indiv when applicable.	Yes.
g. Foreign nationals who contribute to accomplishment of mission of oversea commander (para 25*c*(1)).	Rate B, D, F or none.	Coll locally from indiv when applicable.	OR, MR, IMR or none.	Coll locally from indiv when applicable.	No.[1]
h. Liaison personnel from a NATO Army Force outside U.S. (para 25*c*(4)).	Subsistence only	Coll locally from off; coll subs locally from indiv.	None	None	Yes.
i. Crews and passengers of NATO aircraft which land at NATO or U.S. military airfields in NATO countries (para 25*c*(6) and *d*(5)).	Rate B or F	Coll subs locally; report to HQ USAREUR on DD Form 7.	None	None	NA.
RED CROSS PERSONNEL					
a. Red Cross pers, other officially recognized welfare workers, non-Red Cross volunteer workers and civ student-employees (para 26*a*, *c* and *d*).	Subsistence only	Coll locally from indiv.	None	None	No.[1]
★b. Dependents of full-time paid Red Cross professional staff and of uniformed full-time paid secretarial and clerical workers accompanying their sponsors outside the U.S. (para 26*b*).	Rate D	Coll locally from indiv or sponsor.	None	None	No.[1]
CIVILIAN EMPLOYEES AND THEIR DEPENDENTS					
a. Civilian employees authorized Occupational Health Services (para 27*a*).[5 6]	Subsistence only	Coll locally from indiv.	None	None	No, except spectacle inserts for protective masks.
b. Civilian employees of the Defense Establishment (not beneficiaries of BEC) paid from appropriated or nonappropriated funds and their dependents (para 27*b*).	Outside U.S., rate B or F for citizens and rate C for noncitizens; inside U.S., rate B or F.	Coll locally from indiv.	Outside U.S., SOR; inside U.S., OR, MR, or IMR except as provided in para 27*b*.	Coll locally from indiv.	No.[7]
CONTRACTOR EMPLOYEES					
a. Civilian employees of contractors of Dept of the Army outside U.S. (para 27*c*).	Rate B or F	Coll locally from contractor.	OOR or IMR	Coll locally from contractor.	No.[1]
b. Civilian employees (incl former and prospective employees) of contractors of Dept of the Army in U.S. (para 27*d*).[6]	Subsistence only	Coll locally from indiv.	None (med exams only).	None	No.
c. Civilian employees of contractors of Dept of Navy and their dependents outside U.S. (para 27*c*.1).	Rate B or F	Coll localy from indiv.	OOR or IMR	Coll locally from indiv.	No.[1]

See footnotes at end of table.

Table I—Continued

Section C. Miscellaneous Categories of Persons Authorized Care—Continued

Categories of persons authorized care (references are to AR 40-3 unless otherwise specified)	Hospitalization charge	Collection action	Outpatient, medical exam, or immunization charge	Collection action	Prosthetic devices, spectacles, hearing aids and orthopedic footwear authorized
ARMY NATIONAL GUARD TECHNICIANS (CIV EMPLOYEES OF ARNG) MANNING MISSILE SITES (para 28).[5]	Subsistence only	Coll locally from indiv.	None	None	No, except gas mask spectacles.
★CIVILIAN PARTICIPANTS IN ARMY-SPONSORED ACTIVITIES	Subsistence only	Coll locally from indiv or sponsor.	None	None	No.
★CLAIMANTS WHOSE CLAIMS ARE ADMINISTERED BY FEDERAL DEPARTMENTS AND BENEFICIARIES OF PRIVATE RELIEF BILLS (para 30).[6]					
a. Claimants whose claims are administered by Army.	None	None	None	None	NA.
★b. Claimants whose claims are administered by other Federal Departments.	Rate A	Rept to SG on DD Form 7.	None	None	NA.
c. Beneficiaries of private relief bills	None	None	None	None	NA.
PERSONS OUTSIDE CONUS WHO CONTRIBUTE TO ACCOMPLISHMENT OF A MAJOR OVERSEA COMMANDER'S MISSION.					
a. Civilian representatives of religious groups and others (para 31*b*).	Subsistence only	Coll locally from indiv.	None	None	No.[1]
b. Educational representatives of recognized educational institutions (para 31*c*).	Rate B or F	Coll locally from indiv.	OR, MR or IMR	Coll locally from indiv.	No.[1]
★c. Dependents of USO professional personnel outside U.S. (para 31*b*).	Rate D	Coll locally from indiv or sponsor.	None	None	No.[1]
★d. All others (para 31*a* and *d*)	Rate B, F or D	Coll locally from indiv.	OR, MR, IMR or none.	Coll locally from indiv where applicable.	No.[1]
AMERICAN NATIONALS COVERED BY AGREEMENTS (para 32).	Rate B or F	Coll locally from indiv.	OR, MR or IMR	Coll locally from indiv.	No.[1]
JOINT CIVILIAN ORIENTATION CONFERENCE GUESTS (para 33).	Rate B	Coll locally from indiv.	OR, MR or IMR	Coll locally from indiv.	No.
DESIGNEES OF THE SECRETARY OF THE ARMY (para 35).	Rate B or F, subs only or none.	Coll locally from indiv where applicable.	OR, MR, IMR or none.	Coll locally from indiv where applicable.	No.
★CERTAIN PERSONS EVACUATED FROM ONE AREA TO ANOTHER (para 36).	Same as in original area.	Coll locally from indiv.	Same as in original area.	Coll locally from indiv.	No.
★CIVILIANS IN EMERGENCY (para 37).					
a. Indigents	None	None	None	None	NA.
b. Nonindigents	Rate B or F.	Coll locally from indiv.	OOR	Coll locally from indiv.	NA.
VOLUNTEER SUBJECTS IN APPROVED DEPT OF THE ARMY RESEARCH PROJECTS (para 37.1).	None	None	None	None	Yes.
U.S. NATIONALS IN FOREIGN PENAL INSTITUTIONS & THEIR DEPENDENTS (para 37.5).	None	None	None	None	Yes.
★DOMESTIC SERVANTS OUTSIDE THE U.S. (para 37.7).	N/A	N/A	None	None	No.

[1] Outside the United States spectacles may be furnished these individuals on a reimbursable basis (para 116*b*(5)).

[2] These items may be furnished these individuals on a reimbursable basis at stations within the United States which have been designated remote for the purpose of furnishing such items to dependents of U.S. uniformed services personnel (para 25*d*(1) and 116*b*(2)); and para 16*b*, AR 40-121.

[3] Spectacles may be furnished these individuals on a reimbursable basis at stations within the United States which have been designated remote for the purpose of furnishing medical care to U.S. civilian employees (para 116*b*(4)).

[4] These items may be furnished these individuals on a reimbursable basis outside the United States and at stations within the United States which have been designated remote for the purpose of furnishing such items to dependents of U.S. uniformed services personnel (para 25*d*(1) and 116*b*(1)); and para 16*b*, AR 40-121.

★[5] Reimbursement is made to Army on a per capita cost basis for health services provided civilian employees (or prospective employees) of the Army paid from industrial funds and civilian employees (or prospective employees) of Federal departments and agencies other than Army, except employees (or prospective employees) of Navy, Marine Corps and Air Force in the Washington area.

[6] Hospitalization authorized only when required with conduct of medical examinations.

[7] Spectacles may be furnished these individuals on a reimbursable basis outside the United States and at stations within the United States which have been designated remote for the purpose of furnishing medical care to civilian employees (para 116*b*(3) and (5)).

S/S C 24, dated 27 April 1971 *AR 40-3

ARMY REGULATION

No. 40-3

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., *26 March 1962*

MEDICAL SERVICES

MEDICAL, DENTAL, AND VETERINARY CARE

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SECTION I

GENERAL

1. Purpose and scope. *a. Purpose.* This regulation—

★(1) Prescribes policies regarding medical, dental, and veterinary care, including the manner and conditions under which such care is furnished, and indicates the sources from which it is obtained. See AR 40-121 for—

(*a*) Medical care authorized dependents of active duty and retired members of the uniformed services, including dependents of members who died on active duty or in a retired status.

(*b*) Civilian medical care authorized retired members of the uniformed services.

(2) Prescribes policies concerning the admission and disposition of patients.

b. Scope. Except as indicated in section X this regulation is applicable to all commands of the Army.

2. Definitions. For the purpose of this regulation, the following definitions apply:

a. Civilian employee. Except as indicated in (1) and (2) below, the term "civilian employee" means a person employed by the Federal Government and paid from appropriated or nonappropriated funds.

(1) The term "civilian employee" does not apply to a person so employed who is a beneficiary of the Bureau of Employees' Compensation for purposes of medical care.

(2) Outside the United States this term does not apply to indigenous personnel unless the major oversea commander concerned authorizes their care under the provisions of paragraph 31.

b. Commander of an Army medical treatment facility. This term means the commander or person in charge of a medical treatment facility.

c. Date of initial admission to hospital. The date on which the patient was first admitted to a hospital for his current period of uninterrupted hospitalization. (The transfer of a hospitalized patient between medical treatment facilities is not considered to interrupt his period of hospitalization.)

★*d. Dependents.* Except as indicated in paragraph 25*a*, this term refers to individuals who bear to a person who is authorized medical care any of the relationships specified in AR 40-121.

e. Disability separation. The term includes temporary or permanent retirement and discharge for physical disability, with or without entitlement to receive severance pay.

f. Elective care. Care that is desired or requested by the patient which, in the opinion of the cognizant medical authority, is not medically indicated.

g. Emergency dental care. Dental treatment for the relief of painful or acute conditions.

h. Foreign military patient. This term applies to a patient who is a member of the armed forces of a foreign government.

i. Major oversea commander. This term means the Commander in Chief, United States Army, Europe; the Commander in Chief, United States Army, Pacific; the Commanding General, United States Army, Alaska; the Commander, United States Army Forces Southern Command; and the Commanding General, United States Army Forces, Strike Command.

j. Maximum hospital benefit. That point during hospitalization when the patient's progress appears to have stabilized and it can be antici-

pated that additional hospitalization will not directly contribute to any further substantial recovery. A patient who will continue to improve slowly over a long period of time without specific therapy or medical supervision, or with only a moderate amount of treatment on an outpatient basis, may be considered as having attained maximum hospital benefit.

★*k. Medical care.* Medical care includes, but is not limited to, the furnishing of hospitalization, outpatient treatment, dental care unless otherwise specified, nursing service, medical examinations, immunizations, drugs, subsistence, transportation and other adjuncts such as prosthetic devices, spectacles, hearing aids, orthopedic footwear, and appliances, e.g., braces, walking irons, elastic stockings, etc.

★*l. Member of a uniformed service.* A person appointed, enlisted, inducted or called, ordered or conscripted into a uniformed service who is serving on active duty or active duty for training.

m. Nonmilitary patient. The term "nonmilitary patient" applies to all patients exclusive of those in *h* above and *t* below.

n. Optimum hospital improvement for disposition purposes. That point during hospitalization when, after *essential initial* medical treatment, the patient's medical fitness for further active service can be determined, and it is considered probable that further treatment for a reasonable period will not result in any material change in the patient's condition which would alter his ultimate type of disposition or amount of separation benefits.

o. Outside the United States. This term means all areas exclusive of those specified in *s* below.

★*p. Retired member of a uniformed service.*

(1) *Prior to 1 January 1967,* this term means a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, as a result of service in a uniformed service except a member or former member entitled to retired pay under Chapter 67 of Title 10, U.S. Code who has served less than 8 years on active duty (other than for training).

(2) *On and after 1 January 1967,* this term means a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, as a result of service in a uniformed service.

q. Routine dental care. Includes all dental care necessary to maintain dental health and function, other than care of an emergency or elective nature.

★*r. Uniformed services.* The Army, the Navy, the Marine Corps, the Air Force, the Coast Guard, the Commissioned Corps of the Environmental Science Services Administration and the Commissioned Corps of the Public Health Service.

s. United States. This term means the 50 States, and the District of Columbia.

t. U.S. military patient. This term applies to a patient who is a member of the U.S. Armed Forces on active duty or active duty for training.

gories of patients in an attached status to an Active Army unit will not be assigned to medical holding units:

(*a*) Special Reserve components program personnel. See AR 335-60.

(*b*) Personnel assigned to a CONUS organization who become hospitalized while temporarily in an oversea command. If such personnel are to be evacuated to CONUS, they will be evacuated in an attached status. Subsequently action by the CONUS hospital commander will be determined under the provisions of (2) through (6) above.

★(8) Notwithstanding the provisions of (1) through (6) above, general officers will not be relieved from duty assignment and assigned to medical holding units without the approval of the Deputy Chief of Staff for Personnel, Department of the Army.

Except under the conditions listed in (1) above, assignment to a medical holding unit will be effected by issuance of orders. Orders will be issued in accordance with AR 310-10 (TC258). EDCSA will be computed and established as prescribed by AR 680-8. Distribution of orders will be in accordance with AR 310-10, and care will be exercised that all organizations concerned with accounting for a patient are included.

h. Individual records and clothing.

(1) Personnel records of patients attached to a medical holding unit will be retained in the organization to which the patient is assigned. Records required by the medical treatment facility in conjunction with the study and evaluation of a patient will be furnished the medical treatment facility on a loan basis when requested by the facility commander.

(2) Upon receipt of an order reassigning a member of his organization to a medical holding unit, the organization commander will forward the member's personnel and pay records within 48 hours to the hospital. Individual clothing will be forwarded in accordance with AR 735-5.

i. Grouping of patients. Hospitalized patients will be grouped according to their requirements for housing and medical care, including nursing care, and will be furnished quarters, facilities, and professional supervision on that basis. Patients who must be retained under medical jurisdiction solely for administrative reasons or for medical conditions which can be treated on a clinic basis will be provided quarters and messing facilities, where practicable, separately from other hospital patients. Medical care for such patients will be furnished on a periodic clinic appointment basis. Maximum use will be made of administrative personnel in the supervision of such patients.

j. Evaluation after admission. Each patient will be evaluated as soon as possible after admission and reevaluation will continue until disposition is made. The patient's probable type and date of disposition will be anticipated. Necessary processing by various medical and administrative agencies will take place concurrently with the treatment of the patient. It is especially important that the medical disposition decision be made as early as possible for U.S. military patients who may be separated for physical disability.

k. Admission to closed psychiatric wards. Patients will be admitted to closed psychiatric wards only when they have a mental illness that renders them dangerous to themselves or others, or when a period of careful, close psychiatric observation is necessary to determine whether such a condition may exist. When a patient is admitted to a closed psychiatric ward, the reason for admission must be clearly stated in the patient's clinical record by the admitting physician. Patients should be retained on closed psychiatric wards only as long as is medically required. These same policies apply equally in those rare instances when it is necessary to place a patient on an open ward under constant surveillance.

l. Remedial physical defects developed in the military service.

(1) When a medical examination reveals that an Army military patient has developed a remedial defect, he will be offered the opportunity of operative repair, if it is medically indicated. If an operation, other treatment, or other diagnostic procedure, which is considered necessary to enable the individual to perform his military duties properly is refused, the provisions of paragraph 48, AR 600-20 apply.

(2) When Navy or Air Force patients are involved in a situation such as that described in (1) above, the matter will be referred to the nearest headquarters of the service concerned.

m. Transfer of Patient (DA Form 8-6). Patients will be treated at the lowest echelon equipped and staffed to provide necessary medical care consistent with evacuation policies. U.S. military patients will not be retained in medical facilities longer than the minimum time necessary to attain the mental and physical state required for duty or for separation from the active service if they do not meet retention medical fitness standards. U.S. military patients normally are transferred from dispensaries to hospitals. If the treatment required is not available at the facility providing area hospital care, patients will be further transferred to the most readily accessible uniformed Services medical treatment facility possessing the required capability and to which they are eligible for admission. Transportation is authorized at Government expense. (See AR 40-121 for special considerations involving the transfer of dependent patients.) Government transportation will be used when available.

n. Immunization. Immunizations may be administered forcibly when necessary in accordance with paragraph 48*b*, AR 600-20.

o. Return to duty of attached Army military patients.

(1) Army military patients who are in an attached status will be returned to their duty organization when ready for duty. Organization commanders do not have the

Priority	*Category*	*Degree of entitlement*
1st	A. Members of the uniformed services on active duty (including ACDUTRA) and comparable personnel of the NATO nations who meet the conditions prescribed by the NATO SOFA (para 25*a*(1)).	Complete and unqualified.
	B. Members of the Reserve components of the Armed Forces not on active duty.	Care must be provided when it is required for conditions contracted in line of duty during a period of active duty (including ACDUTRA) or while traveling to or from such duty or for injuries suffered while performing inactive duty training.
	C. Members of the Citizens Military Training Corps.	Care must be provided for conditions contracted while traveling to or from or during attendance at CMTC training camps.
2d	Dependents of active duty members of the uniformed services, the dependents of persons who died while in such a status, and the dependents of active duty members of the NATO nations who meet the conditions prescribed by the NATO SOFA (para 25*a*(1)).	Care must be provided when facilities and staffing permit.
3d	Members of the Senior Reserve Officers Training Corps of the Armed Forces.	Care may be provided when it is required during periods of attendance at training camps.
4th	Retired members of the uniformed services and their dependents and the dependents of deceased retired members.	Care may be provided when facilities and staffing permit.
5th	Civilian employees of the Federal Government under the limited circumstances covered by the Federal Employees' Health Service Program (AR 40-5).	Care may be provided when facilities and staffing permit.
6th	All others	Care may be provided when facilities and staffing permit.

★*Figure 1. Degree and basis of entitlement.*

option of refusing to accept the return of such personnel.

(2) An attached Army military patient, who at the time of admission was en route overseas, when ready for duty, will—

(*a*) If POR qualified, be furnished a statement covering the period of hospitalization and directed to revert to the status held at the time of admission.

(*b*) If no longer POR qualified, be reported for assignment instructions in accordance with *q* below.

(*c*) In the case of either (*a*) or (*b*) above, the commander of the oversea replacement station, Army terminal, or aerial port of embarkation will be notified of the action taken.

p. Disposition of assigned patients in CONUS.

(1) Except as provided in (2) below, all patients who are medically fit for duty and who are assigned to a medical holding unit will be reported by the hospital commander for assignment instructions in accordance with the procedures in *q* below.

(2) Upon completion of hospitalization, assigned patients in the following categories will be reassigned by the hospital commander without reference to higher authority.

(*a*) Individuals who at the time of hospitalization were undergoing basic combat training or advanced individual training and who are hospitalized in the medical treatment facility serving the installation where training was interrupted will be reassigned to their former training activity.

(*b*) Individuals who are medically fit for duty under AR 40-501 but who are to be returned to duty with a recommendation for separation (par. 54*e*(1)) will be reassigned to their former units. Exception to this policy may be made by the hospital commander in individual cases when he determines that other action will better serve the interests of the Government. In such cases, reassignment instructions will be requested as in (1) above, or separation action may be instituted at the hospital.

(*c*) Individuals awaiting trial by courts-martial will be reassigned to their former units or reassigned to the unit or installation where the trial will be held. The advice of the local judge advocate or legal officer will be sought in these cases.

(*d*) Individuals awaiting the results of investigation or clearance will be reassigned to their former units provided a request has been made for such reassignment by the commander concerned.

(*e*) Individuals who are eligible under existing criteria for relief from active duty or discharge will be processed at the hospital if facilities exist. In the absence of such facilities, the individual will be processed for separation in accordance with the provisions of paragraph 3, AR 612-22.

(3) Officers who are medically fit for duty but who have applied for or are scheduled for retirement (within 60 days) or who have submitted a tender of resignation will remain assigned to the medical holding unit pending receipt of instructions from The Adjutant General. The hospital commander will immediately report such officers to The Adjutant General, ATTN: AGPO-S-R, Department of the Army. If the officer appeared before a medical board, a copy of the medical board proceedings will be promptly forwarded to The Adjutant General, ATTN: AGPO-S-R. Where practicable, officers awaiting instructions under this paragraph will be placed on duty as prescribed in *r* below.

q. Requests for assignment instructions. When it is anticipated that a patient who is to be returned to duty under *p*(1) above will complete hospitalization within 60 days, a request for assignment instructions will be initiated by the hospital or administrative unit commander and forwarded to Headquarters, Department of the Army not later than 15 days prior to the estimated date of completion of hospitalization. *It is incumbent upon all hospital commanders and com-*

manders of Army administrative units to monitor the progress of assigned patients and assure that every effort is made to forecast the expected date of return to duty accurately so that the administrative procedures involved in returning a patient to duty will not unnecessarily delay a patient's disposition.

(1) Requests for assignment instructions for officers, other than general officers, will be addressed to the Chief of Personnel Operations, ATTN: OPXR. The following information will be included:

(*a*) Name, grade, and service number.

(*b*) Control branch.

(*c*) Category and expiration date.

(*d*) Amount of leave desired, if any.

(*e*) Estimated date of completion of hospitalization.

(*f*) Physical profile and assignment limitation, if any.

(2) Enlisted personnel will be reported to the Chief of Personnel Operations in accordance with instructions in AR 614-205. Whenever practicable, reports may be made by phone direct to the Office of Personnel Operations ((3) (*b*) below).

(3) In exceptional cases, it may be impossible to predict the date of return to duty for an assigned patient to meet the 15-day time requirement. In such cases, instructions will be requested by telephone contact with the Chief of Personnel Operations as follows:

★(*a*) For officers and warrant officers, call 202-695-6362 (OXford 56362) or 202-695-4457 (OXford 54457).

★(*b*) For enlisted personnel in grades E-1 through E-6 (except special category personnel), call 202-695-7291 (OXford 5-7291). For enlisted personnel in grades E-7 through E-9 and all special category personnel (par. 11 and app., AR 614-210), call Combined Army Branch (OXford 5-3546); Maintenance and Supply Branch (OXford 5-3670); General Support Branch (OXford 5-2602); and Special Categories Branch (OXford 5-3408).

(4) When a patient is to be returned to other than full duty, the request for assignment instructions will indicate the type of disposition recommended and the following information, as appropriate:

(*a*) The date on which the individual will revert to full duty or the date the individual is to return to a medical treatment facility for examination, treatment, or reevaluation.

(*b*) The type and degree of functional impairment involved and any control measures which should be considered in a duty assignment.

(*c*) The type or types of duty recommended.

(*d*) Geographic or climatic assignment limitation recommended.

(*e*) Physical limitations to POR qualification.

(*f*) Status of any applications for compassionate reassignment submitted under the provisions of paragraph 22, AR 614-6.

(*g*) Whether current medical condition may result in removal or denial of security clearance.

(*h*) Preference for area of assignment.

(5) Assignment instructions will be issued by the Chief of Personnel Operations. When it is determined that an individual cannot be assigned as directed within *60 days* after the previously estimated date of completion of hosptialization, this information will be forwarded by electrical message to the Chief of Personnel Operations, ATTN: OPXR for officers and warrant officers, and for enlisted personnel refer to (3) (*b*) above. The message will include a reference to the initial request for assignment instructions.

r. Duty for assigned patients awaiting orders in CONUS.

(1) In the event assignment instructions have not been received by the time a patient completes hospitalization, the hospital commander will issue orders placing the patient on duty with a unit designated by the ZI army commander. When this is medically contraindicated, the hospital commander may place the individual on duty with the hospital duty unit. See AR ★635-40. Such an individual will not be charged against the hospital's personnel allotment or manning table.

(2) CONUS army commanders and the Commanding General, Military District of Washington, U.S. Army, will designate for each Army hospital (regardless of command jurisdiction) within their areas a unit with which the hospital commander may place patients on duty ((1) above) so that the patient's abilities can be utilized Preferably, units so designated will be other than medical treatment facilities and will be located as near to the hospital as possible, preferably at the same installation. A patient placed on duty with an organization will not be charged against that unit's personnel allotment or manning table.

s. Disposition of patients in oversea hospitals. Recovered patients in oversea hospitals will be returned to duty in accordance with instructions issued by the major oversea commander. For patients who will be evacuated from an oversea command, see AR 40-20, AR 310-10, and AR 330-12.

★*t. Separation of enlisted personnel assigned to medical holding units.* See paragraph 5-19, AR 635-200, for special separation provisions for enlisted personnel, other than REP 63 personnel, assigned to medical holding units.

4. Authorization. Medical care is under the control of the commander of the medical treatment facility concerned. Persons requesting care will be required to furnish identification satisfactory to the commander. The following measures and/or restrictions will be observed in furnishing medical care to patients:

a. Extent of care. Eligible persons will be provided medical care to the extent it is authorized, required, and available. When a person is accepted for medical care, all care and adjuncts thereto (including nonstandard supplies) determined by the commander of the medical treatment facility concerned to be necessary will be provided from resources available to the commander, unless specifically prohibited by section III. When care is required which is beyond the capabilities of an Army medical treatment facility, the commander thereof will arrange for the required care by one of the means shown below. The method of choice will be based upon professional considerations and travel economy.

(1) Transfer the patient in accordance with paragraph 3.1*m*.

(2) Procure from civilian sources the necessary supplemental material and professional and personal services required for the proper care and treatment of the patient. Charges for such material or services will be paid from funds available to operate the Army medical treatment facility.

b. Dental care. Dental care for personnel listed in paragraphs 14, 16*a*, and *c*, and 24 will be limited to emergency dental care for the relief of pain or acute conditions, or for dental conditions requiring hospitalization. Such dental care will not include the provision of prosthetic dental appliances or permanent restorations.

c. Spectacles. Provisions relative to furnishing of spectacles are set forth in paragraphs 116 and 124.3.

d. Care furnished on an outpatient basis. Whenever possible, diagnostic procedures, preoperative and postoperative care, convalescence, and followup observation and treatment will be accomplished on an outpatient basis.

e. Elimination of duplicate diagnostic procedures. Every attempt will be made to eliminate duplication of diagnostic procedures for patients transferred between medical treatment facilities.

f. Performance of duty while in patient status. U.S. military patients may be assigned duties in and about the medical treatment facility when such duties will be of therapeutic value. Physical condition, past training, and acquired skills must all be considered before assigning any patient a given task. Patients

will not be assigned duties which are not within their capabilities or which require more than a very brief period of orientation. No patient will be retained in the facility beyond the individual medical requirements of his case.

g. Facilities disciplinary barracks. Except in an emergency, medical treatment facilities located within the prisoner confinement inclosure will furnish medical care to prisoners only.

h. Prolonged definitive medical care for U.S. military patients who are unlikely to return to duty. Prolonged definitive medical care is not provided for U.S. military patients who are unlikely to return to duty. The time at which a patient should be processed for disability separation must be determined on an individual basis, taking into consideration the interests of the Government as well as those of the patient. Such patients will neither be retained nor separated, however, solely for the purpose of increasing their retirement or separation benefits. A record of the name, probable date and type of disposition for each patient in a specialized medical treatment facility who has been continuously hospitalized for 90 days, and for each patient in other facilities who has been hospitalized continuously for more than 60 days, will be maintained in the hospital headquarters as an aid in controlling length of patient stay.

i. Hospitalization prior to the effective date of separation orders. When a military patient for whom separation (particularly retirement) orders have been issued is hospitalized prior to the effective date of the orders, the hospital commander will immediately notify the agency which issued the order so that action may be taken to amend or revoke them, if necessary, prior to the effective date.

j. Use of subsisting elsewhere status. When appropriate, military patients may be authorized to live in buildings not under the administrative control or supervision of a hospital in a "subsisting elsewhere" status, and receive required medical care on an "excused-from-duty" status. The use of subsisting elsewhere status will be reserved for hospital inpatients whose constant presence in the hospital is not essential to treatment, and provided arrangements can be made for suitable subsistence and lodgings acceptable to the medical treatment facility commander. This status will not be used when another means, such as leave, is more appropriate or required or when the needs of a patient can be adequately met as an outpatient. It will in no way delay the final disposition of a patient from the hospital. Military patients in subsisting elsewhere status continue to be carried on the rolls of the hospital's medical holding unit.

★*k. Psychotic prisoner patients.* When a prisoner patient suffering from psychosis is admitted to a medical treatment facility, the commander of such facility will, if the information is not contained in the patient's available records, ascertain whether the issue of insanity was raised at the time of trial or if there is anything in the record of trial upon which may be based a reasonable doubt as to the patient's sanity at the time of offense or trial. Information about the foregoing will be requested as indicated below and the reply will be included with the patient's clinical records.

(1) When the commander of a medical treatment facility is advised through correspondence with the commander of a U.S. disciplinary barracks that a prisoner is carried on the rolls of such organization (a prisoner is not so carried unless he has been physically received there), inquiry will be addressed to The Judge Advocate General, ATTN: Military Justice Division, Department of the Army, Washington, D.C. 20310.

(2) For all other prisoners, inquiry will be addressed to the commander who convened the court-martial which convicted the prisoner.

★*l. Special considerations affecting nonmilitary patients.*

(1) *Nonmilitary patients other than those covered in (2) below.*

(*a*) Individuals suffering from acute emotional disturbances of sufficient severity to require hospitalization may be admitted. Individuals with neurological conditions who require hospitalization may also be admitted provided the condition is not one of the following:

1. Paraplegia when the basic cause is known and is not amenable to surgical correction.

2. Prolonged crippling residuals of cerebral vascular disease or similar nervous system afflictions.

(*b*) When it is known that a patient has a chronic mental illness, hospitalization will not be authorized unless an acute emergency situation exists.

(*c*) Maximum length of hospitalization for patient with neurological or psychiatric disorders normally is considered to be 90 days. In exceptional cases this 90-day limitation may be extended by the hospital commander concerned but only rarely to exceed 6 months and never more than 1 year. The 90-day limitation is not to be construed by a referring installation or next-of-kin as implying a right of the patient to remain at the Army medical treatment facility for 90 days, if sound judgment indicates that further hospitalization is not necessary or would be prolonged for an unreasonable period past 90 days, or if domiciliary or custodial care only is required. Under these circumstances, disposition is made to the care of the next-of-kin or to appropriate civilian authorities as may be indicated in the manner prescribed in paragraph 70*b*.

(2) *Dependents of active duty, retired, and deceased members of the uniformed services.* Dependents may be provided hospitalization for chronic conditions and nervous, mental, and emotional disorders when such conditions and disorders require active and definitive treatment. Dependents in this category will not be admitted if they require only domiciliary or nursing-home type care. Admission will be subject to determination by the hospital commander that space and facilities are available and the capability of the professional staff is sufficient to provide care to a particular dependent without interfering with the performance of the primary mission of the facility. The various categories of dependents will be authorized admission in the order of priority listed in AR 40-121. The provisions of (1) above may be used as a guide in determining disposition of dependent patients in this category who require prolonged hospitalization.

★*m. Length of hospitalization for Army military personnel on active duty or active duty for training.*

★(1) Army military personnel on active duty or active duty for training who are likely to recover sufficiently to be medically fit to return to duty within 12 to 15 months generally will be afforded maximum hospital benefits.

(2) Army military personnel in this category who are not likely to recover sufficiently to be medically fit for return to duty within 12 to 15 months will be processed for disposition upon attaining optimum hospital benefits.

(3) For personnel in this category who will require hospitalization beyond their term of service, see the following regulations for procedures to continue such personnel on active duty for the purpose of receiving medical care, completing line of duty investigations, or completing physical disability processing:

(*a*) AR 635-200 (enlisted personnel on active duty).

(*b*) AR 135–173 (Reserve component officers and warrant officers on active duty).

★(*c*) AR 135–200 (Active Duty for Training of Individual Members).

5. Consent by nonmilitary patients to medical care. *a.* A nonmilitary individual may not be furnished medical care in any Army medical treatment facility without either his consent or the consent of a person authorized to consent on his behalf in accordance with the provisions of applicable local laws or the order of a court having jurisdiction over both the individual and the facility concerned. Consent may be either express or implied (*b* and *c* below). This rule applies even though an individual may be entitled by law to medical care in Army medical treatment facilities; it applies worldwide, except as it may be modified by local laws or international agreements.

b. An implied consent is one that may be implied from actions of the patient or other circumstances, even though specific words of consent are not used. For example, a patient's application for admission to a hospital is an implied consent to hospitalization; if a patient is a minor incapable of giving consent, an implied consent of the parent may be found in actions of the parent in requesting or not objecting to medical care for the minor. Moreover, consent to treatment is implied in certain emergency situations where a patient is incapable of giving or denying consent, and his condition represents a serious or imminent threat to his life, health, or well-being. Despite the fact that an implied consent is usually found in emergency situations, medical care will not be given even in an emergency to a nonmilitary minor where the parent or guardian expressly or impliedly objects.

c. An express consent involves an interchange of language by which the patient or person authorized to act on his behalf specifically states that his consent is given to proposed medical care. An express consent may be valid whether oral or in writing, but a written consent must be recorded on Standard Form 522 (Clinical Record—Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures) in connection with the following when nonmilitary patients (both inpatients and outpatients) are involved:

(1) All major and minor surgery which involves an entry into the body, either through an incision or through one of the natural body openings.

(2) Any procedure or course of treatment in which anesthesia is used, whether or not an entry into the body is involved.

(3) All nonoperative procedures which involve more than a slight risk of harm to the patient, or which involve the risk of a change in the patient's body structure.

(4) All procedures where roentgen ray, radium, or other radioactive substance is used in the treatment of the patient.

(5) All procedures which involve electroshock or insulin coma therapy.

(6) Admission of patients with psychotic disorders.

(7) Admission of patients to closed wards.

(8) All other procedures which, in the opinion of the attending physician or dentist, chief of service, or the commander require a written consent. Any question as to the necessity or advisability of obtaining a written consent from or on behalf of the patient should be resolved in favor of procuring such a consent.

d. In order for a consent to be valid (whether implied or express) it must be given by a person legally capable of giving such consent, except in an emergency.

(1) If a nonmilitary patient is unmarried and under the age of 21, consent will ordinarily be obtained from the patient's parent or guardian. In addition, a minor unmarried patient's consent will also be obtained if the patient is able to understand and fully comprehend the significance of the procedures contemplated. If there is a question whether consent of a parent is required in view of the age, mental condition or emancipated status of the patient, or because of nonavailability of the parents or similar factors, the advice of the local staff judge advocate or other legal officer should be sought.

(2) Except in an emergency, when a patient for some reason other than mental incompetency is unable to respond, the consent of the spouse or next of kin must be obtained. In the event the spouse or next of kin cannot be reached, the question of authority or need to consent will be referred to the appropriate judge advocate or legal adviser for advice.

(3) When a judicial interpretation of mental incompetency has been made, consent must be obtained from the individual appointed by the court to act for the incompetent patient.

(4) When the question of mental competency arises and a judicial determination of mental competency has not been made, the question of authority to consent or treat will be referred to the appropriate judge advocate or legal officer for advice.

(5) Without appropriate court order or the consent of the patient or a person authorized to act on his behalf, the commander of an Army medical facility may temporarily detain a nonmilitary individual with a psychiatric disorder which makes him dangerous to himself or to others, when such individual is found on the military reservation where the medical facility is located, or where there is a real emergency requiring that the individual, although off the reservation, be temporarily detained in that facility. In such a case, if proper consent to, or authorization for admission to the facility cannot be obtained, the local civilian authorities should be notified immediately (without regard to "working days"), and the individual should be transferred to those authorities. It is emphasized that the temporary involuntary detention of a nonmilitary individual should conform with local law and statutes governing involuntary detention, particularly where the United States does not possess exclusive jurisdiction. In order to provide for situations herein discussed, arrangements should be made in advance with local civilian authorities to accept forthwith those nonmilitary psychotic individuals who may not be admitted to or retained in Army medical facilities because of lack of consent or appropriate court order. In making these arrangements, the point should be made, if necessary, that such individuals who are not residents of the locality are entitled to the same care and treatment by local civilian authorities as would be transients or tourists not connected with the Federal Government. See also paragraph 68.

(6) Movement of nonmilitary psychotic individuals without proper consent or court order normally will not be performed under the auspices of an Army medical treatment facility.

(7) The validity of a court order directing involuntary confinement or treatment of a patient in any Army medical treatment facility is a matter for review, in each instance, by the appropriate judge advocate or legal adviser.

(8) When a written consent is required, it will be personally signed by the patient, or the person authorized to act on his behalf.

(9) Consent for dental procedures which come under the provisions of *c* (1) or (2) above may be obtained at the time a course of treatment is started. One SF 522 may be used for a complete course of treatment.

★*e.* One of the elements affecting the valid-

ity of a consent, implied or express, is whether the person giving the consent understands that to which consent is being given and, to a sufficient degree, the possible consequences of the procedure for which consent is given. The physician or dentist who is to perform or supervise the performance of a procedure will counsel the patient and/or the consenting individual as to the nature or expected results of the proposed procedure, which fact is attested to by the patient or person authorized to give consent on Standard Form 522.

SECTION III

PERSONS ELIGIBLE FOR MEDICAL CARE AT ARMY MEDICAL TREATMENT FACILITIES

6. Persons eligible, extent of treatment and charges therefor. *a. Persons eligible.* The personnel enumerated in this section are eligible for medical care under the conditions outlined herein. When a person is covered by more than one of the paragraphs in this section, he will be provided care under whichever such paragraph he chooses.

b. Extent of medical care. The extent of medical care authorized such as hospitalization, outpatient treatment immunizations, prosthetic devices, etc., type of reimbursement and other criteria for medical care for all eligible categories is prescribed in table I, located in back of this regulation. Where prosthetic devices or appliances are not authorized, Army medical treatment facilities may, in connection therewith as a part of authorized treatment, furnish the following services:

(1) Examination and treatment to include the taking of necessary measurements.

(2) Procurement of the device or appliance concerned for the individual at no expense to Army funds.

(3) Fitting of the device or appliance concerned and training in its use.

c. Rates.

(1) *General.* Rates for medical care are prescribed in AR 40-330.

(2) *Inpatient.* The inpatient rates shown in column 2 of table I for applicable categories of patients are all inclusive rates prescribed for personnel in an inpatient status. No additional charge will be made.

(3) *Outpatient.*

(*a*) The categories of personnel listed in table I which have the symbol "OR," "SOR," or "OOR" in column 4 and who receive outpatient treatment during a visit on a given day to an outpatient facility will be charged the Outpatient Rate, the Special Outpatient Rate, or the Other Outpatient Rate, whichever is applicable, for each visit. This will include immunizations and the furnishing of medicine on prescription which is an actual part of outpatient care. Only one visit will be counted for each patient presenting himself or visited on a given day, regardless of the number of times the patient may be seen during the day, or the number of conditions for which he is treated on that day.

★(*b*) When a beneficiary of the Bureau of Employees' Compensation (para 13) is furnished a prosthetic appliance, spectacles, a hearing aid, or orthopedic footwear on an outpatient basis, a separate charge will be made for the item. DD Form 7A (Report of Treatment Furnished Pay Patients; Outpatient Treatment Furnished (Part B)) submitted to The Surgeon General will show the type of item furnished and the cost. Charges for spectacles will be in accordance with paragraph 124.3.

★(4) *Medical examinations or immunizations.* Categories of personnel listed in table I which have the symbol "MR" or "IMR" in column 4 who are furnished medical examinations or immunizations, other than in connection with inpatient or outpatient care, will be charged the medical examination rate or the immunization rate, as applicable.

7. **Members of a uniformed service.** Such persons are entitled to medical care. Line of duty determinations do not affect this entitlement.

8. **Members of the Reserve components of the uniformed services who are on active duty for periods of 30 days or less, and those who are not on active duty.** For medical board evaluation for physical disability processing, see paragraphs 42*d* and *e* and 56*b*.

a. Those on active duty. Medical care is authorized for conditions necessitating medical care during the period of active duty without reference to line of duty. When individuals are admitted to or treated at a medical treatment facility during a period of duty for doubtful line-of-duty conditions, the commander of the medical treatment facility concerned will request the appropriate authority (see AR 600-10) to appoint an investigating officer to conduct a line-of-duty investigation. A copy of the investigating officer's approved findings will be furnished the medical treatment facility concerned. If these findings result in a not-in-line-of duty determination prior to the date of expiration of active duty, every effort should be made to dispose of these individuals who are hospitalized by the date of expiration of active duty or as soon as they become transportable.

b. Those not on active duty (Army.)

(1) *For personal injury or disease contracted during a period of active duty.*

(*a*) *For in-line-of-duty conditions.* Medical care is authorized after termination of active duty for personal injury suffered or disease contracted in line of duty. Except in an emergency, prior to admission or readmission to, or treatment at an Army medical treatment facility, the individual will be required to present an official authorization for treatment as follows:

1. Orders (TC 275, AR 310-10) or similar authorization issued by the Chief, National Guard Bureau, or his designee, in the case of a member of the Army National Guard who suffered such injury or contracted such disease while performing active duty in his Army National Guard status.

2. Orders (TC 275, AR 310-10) issued by the commander of the major command under whose jurisdiction the duty was performed, or his designee, in the case of a member of the Army Reserve who suffered such injury or contracted such disease while performing active duty.

3. Letter of authorization issued by the commander of the major command under whose jurisdiction the duty was performed, or his designee; or orders (TC 275, AR 310-10) or similar authorization issued by the Chief, National Guard Bureau, or his designee, after verification of the individual's eligibility for treatment by the commander of the major command under whose jurisdiction the duty was performed, or his designee, in the case of a member of the Army National Guard of the United States who suffered such injury or contracted such disease while performing active duty in the U.S. Army.

If medical care is furnished in an emergency without the required authorization or orders, the commander of the medical treatment facility concerned will request such authorization or orders from the appropriate authority indicated above as soon as practicable. Letters of authorization will include the name, service number, grade, and organization of the patient; the type and period of duty in which engaged; the diagnosis (if known); and will state that the personal injury suffered or disease contracted was in line of duty while on duty and that the patient is entitled to medical care. *In cases where the initial admission is accomplished during a period of duty and medical care is continued upon expiration of active duty, the above requirement for authorization or orders does not apply.*

(*b*) *For doubtful line-of-duty conditions.* Individuals with doubtful line-of-duty conditions whose line-of-duty investigation results in a not-in-line-of-duty determination are not authorized medical care at Army expense after date of expiration of active duty. The cost of any such care furnished will be collected from the individual by the medical treatment facility concerned. Should a recommended in-line-of-duty determination be made at the local level, medical care will continue to be furnished after date of expiration of active duty under (*a*) above. If this recommended in-line-of-duty determination should be reversed by the final approval authority, the individual will be furnished medical care without charge, except for subsistence in the case of officers in a pay status, regardless of line-of-duty status, from the date of expiration of active duty to the date of receipt of notification to the medical treatment facility concerned of the final approved line-of-duty determination. Medical care received subsequent to the individual's notification is not authorized at Army expense and the cost thereof will be collected from the individual by the medical treatment facility concerned. Every effort will be made to dispose of hospitalized cases at the earliest practicable date.

(*c*) *For cases where no recommended line-of-duty determination has been made.* If a recommended line-of-duty determination, as requested by the hospital commander, has not been made by the date of expiration of active duty, every effort will be made to effect disposition of hospitalized cases at the earliest practicable date. Exceptions may be made in those cases where individuals are admitted to the medical treatment facility concerned toward the end of the duty period and an insufficient amount of time is available to make the recommended line-of-duty determinations. The individual in a hospitalized status may be furnished medical care without charge, except for subsistence in the case of officers in a pay status, regardless of line-of-duty status, from the date of expiration of active duty to the date of discharge from the hospital or the date of receipt of notification to the medical treatment facility concerned as to either the recommended or final line-of-duty findings, whichever is earlier. If the individual has not been disposed of by the time the recommended line-of-duty finding is received, the individual will be processed in accordance with (*a*) or (*b*) above, as applicable.

(2) *Members engaged in inactive duty training under competent authority with or without pay.* The term "injury" as used in this subparagraph includes acute poisonings, except those due to contaminated food, resulting from exposure to a toxic or poisonous substance.

(*a*) *For personal injury while participating in such training.* Medical care is authorized for personal injury suffered while participating in inactive duty training such as training assemblies or aerial flights in Government-owned aircraft provided the participation in such flights is under proper authority and incident to training.

(*b*) *Procedure to be followed after termination of such training.* With regard to medical care after termination of the period of inactive duty training for personal injury suffered

while participating in inactive duty training, the applicable provisions of (1)(*a*) above will be followed.

(*c*) *Restrictions. Medical care is not authorized for disease contracted during inactive duty training nor for disease contracted or injuries incurred while proceeding directly to or directly from inactive duty training.*

(3) *Periodic medical examinations.* These examinations are authorized in accordance with NGR 27 and AR 140–120. When hospitalization is necessary to the proper conduct of these examinations, subsistence charges will be collected in the manner prescribed in table I for members of the Reserve components of the Army who, for periods of 30 days or less, are on active duty, and those not on active duty.

★(4) *Furnishing of certain adjuncts.* Prosthetic devices, prosthetic dental appliances, hearing aids, spectacles, orthopedic footwear, orthopedic appliances and routine dental treatment will be furnished the personnel listed above for conditions which are disabling and the result of personal injury suffered or disease contracted in line of duty; dental care for other conditions will be limited to emergency care. When the unit commanders of the personnel listed above determine that these items were not damaged or lost through negligence on the part of the individual concerned, repair or replacement is authorized under normal outpatient care at no expense to the individual.

(5) *Spectacle inserts for protective field masks.* In addition to the adjuncts enumerated in (4) above, those Army Reserve component personnel whose units have an Active Army mission of manning missile sites are authorized spectacle inserts for protective field masks.

★*c. Those not on active duty (other than Army).* Medical care is authorized under the corresponding provisions applicable for members of Army Reserve components (*b* above). *A member of the Naval Reserve or Marine Corps Reserve who becomes ill or contracts a disease in line of duty while performing inactive duty training in entitled to medical care for that illness or disease on the same basis as for an injury incurred while performing such duty.*

d. Temporary members of the Coast Guard Reserve. See paragraph 13*a*(4) for care available to temporary members of the Coast Guard Reserve as beneficiaries of the Bureau of Employees' Compensation.

9. Citizens Military Training Corps. All necessary medical care is authorized for individuals who, in line of duty, suffered personal injury or contracted disease while traveling to or from or while attending a Citizens Military Training Camp. This authorization extends only to those individuals who incurred injury or contracted disease under the above conditions *at a time when they were members of the Citizens Military Training Corps.* Such care will be furnished until the resulting disability cannot be materially inproved by further hospitalization or treatment.

★10. Members of the Senior Reserve Officers' Training Corps of the Armed Forces. *a. Members of the Army Senior Reserve Officers' Training Corps including students who are enrolled in the 4-year Senior ROTC Program (10 U.S.C. 2107) or the 2-year Advanced Training Senior ROTC Program (10 U.S.C. 2104) and members enrolled as authorized by 10 U.S.C. 2103.* Medical care is authorized these members in Army medical treatment facilities as outlined below:

(1) Medical care for injury incurred or disease contracted without reference to line-of-duty while attending field training under the provisions of 10 U.S.C. 2109. Field training includes ROTC annual training camps and ROTC training encampments at Army instllations. Rifle team and drill team activities and competitive meets do not qualify as field training.

(*a*) Routine dental treatment will be furnished for conditions which are disabling and the result of injury or disease incurred in line of duty. Dental care for other conditions will be limited to emergency treatment.

(*b*) Prosthetic devices, prosthetic dental appliances, hearing aids, spectacles, orthopedic footwear, and orthopedic appliances will be furnished for conditions which are disabling and the result of injury or disease incurred in line of duty. When the camp commander determines that these items were not damaged or lost through negligence on the part of the individual concerned, repair or replacement is authorized under normal outpatient care at no expense to the individual.

(*c*) If a member of the Senior ROTC is undergoing hospitalization upon termination of camp, or if before his departure from camp he is in need of hospitalization because of a disability *not in line of duty* and is medically unable to withstand transportation to his home for the time being, he may be retained in or admitted to an Army medical treatment facility. Such care is not authorized at Army expense and and the cost therefor will be collected at Rate B from the member by the medical treatment facility concerned. Every effort will be made to dispose of hospitalized cases at the earliest practicable date.

(2) Medical examinations (AR 145–120 and AR 145–355) and immunizations (AR 145–30).

(3) Medical care, including hospitalization, for injury incurred or disease contracted in line of duty while at or traveling to or from a military installation for the purpose of undergoing medical or other examinations or for visits of observation under the provision of 10 U.S.C. 2110.

(4) Medical care is not authorized during attendance at a civilian educational institution except as indicated below:

(*a*) Medical examinations required by required by paragraph 5*c*(2), AR 145–120, including hospitalization when necessary to the proper conduct of the examination.

(*b*) Immunizations required by paragraph 27*a*, AR 145–30, including hospitalization for any severe reactions resulting therefrom.

b. Members of the Naval and Air Force Senior Reserve Officers' Training Corps. These members are authorized medical treatment, examinations, and immunizations in Army medical treatment facilities to the same extent and under the same circumstances as members of the Army Senior Reserve Officers' Training Corps.

c. Written authorization for treatment. Written authorization for treatment for those ROTC members referred to in *a* and *b* above will be prepared by the camp commander and will be addressed to the commander of the Army medical treatment facility concerned.

d. Beneficiaries of the Bureau of Employees' Compensation. For conditions under which medical care is provided at the expense of the Bureau of Employees' Compensation to those ROTC members referred to in *a* and *b* above, see paragraph 13.

★10.1 Designated applicants for enrollment in the Senior Reserve Officer's Training Program. Designated applicants for enrollment in the Senior ROTC Program are students who have been selected by the Professor of Military Science for enrollment in the 4-year Senior ROTC Program (10 U.S.C. 2107) or the 2-year Advanced Training Senior ROTC Program (10 U.S.C. 2104), including those selected for the 6-week field training or practice cruise to qualify for enrollment therein, and those selected by the PMS for enrollment as authorized by 10 U.S.C. 2103.

a. When properly authorized, designated applicants for enrollment in the Senior Reserve Officers' Training Program (including applicants for enrollment in the 2-year program and MS II enrollees applying for MS III) will be furnished medical examinations at Army medical treatment facilities, including hospitalization, when necessary for the proper conduct of the examination. They are also authorized medical care, including hospitalization, for injury incurred or disease contracted in line of duty while at or traveling to or from a military installation for the purpose of undergoing medical or other examinations or for visits of observation (10 U.S.C. 2110).

b. Designated applicants for membership in the Army, Naval and Air Force Senior ROTC Programs are authorized medical care in Army medical treatment facilities during the initial 6-week training period (field training/practice cruises) authorized by 10 U.S.C. 2104(b)(6) on the same basis as enrolled members of the ROTC Advanced courses.

★11. Retired members of a uniformed service (para 2*p*). Medical care is authorized subject to the applicable conditions indicated below:

a. Those retired for other than physical disability.

b. Those retired for physical disability.

(1) *Temporary retirement (periodic medical examinations).* Members temporarily retired who require hospitalization in connection with the conduct of periodic medical examinations.

(2) *Temporary or permanent retirement (less than 20 years of active duty).* Members temporarily or permanently retired for physical disability or receiving disability retirement pay, with less than 20 years of active duty, except hospitalization for the following chronic conditions: chronic arthritis, malignancy, psychiatric or neuropsychiatric disorder, neurological disabilities, poliomyelitis with disability residuals and degenerative disease of the nervous system, severe injuries to the nervous system including quadriplegia, heimpligia, and paraplegia, tuberculosis, blindness and deafness requiring definitive rehabilitation, and major amputees. (Hospitalization for the above conditions is the responsibility of the Veterans Administration.)

(3) *Temporary or permanent retirement (20 years or more of active duty).* Members temporarily or permanently retired for physical disability or receiving disability retirement pay with 20 years or more of active duty, except those with blindness, neuropsychiatric or psychiatric disorders, and tuberculosis. (Hospitalization for the above conditions is the responsibility of the Veterans Administration.)

(4) *Emergency Officers' Retired List.* Members of the Emergency Officers' Retired List who are entitled to retired pay for physical disability.

12. Beneficiaries of the Veterans Administration. *a.* Medical care is authorized subject to the conditions specified below.

(1) *Veterans Administration field stations.* Control of all referrals of veterans to Army medical treatment facilities, except those in foreign countries as stated in (6) below, is vested in the Veterans Administration field station having jurisdiction over the geographic area in which the Army medical treatment facility is located (hereinafter referred to as "field station"). The procedures outlined herein relating to inpatient care apply to routine or emergency admissions to Army medical treatment facilities where beds have been allocated for Veterans Administration patients by prior agreement, as well as to those emergency admissions to Army medical treatment facilities in which bed allocations have not been granted. *Admission to an Army medical treatment facility within the continental United States in which bed allocations have not been made will be authorized only for the purpose of furnishing emergency medical care.*

(2) *Authorization.* Army medical treatment facilities will furnish medical care to a veteran on presentation of a signed authorization for treatment from the field station having jurisdiction. Reimbursement will not be made by the Veterans Administration for medical care furnished prior to the date that the request for authorization of the medical care was made, except as indicated in (3) below.

(3) *Emergency medical care.* A medical treatment facility admitting a veteran for emergency medical care will notify the appropriate field station within 72 hours after the date and hour of admission and request authorization. When the field station authorizes emergency hospitalization, the effective date of the authorization will be the date the patient was admitted to the facility. A medical treatment facility furnishing emergency outpatient care to a veteran will notify the field station having jurisdiction within 72 hours after the care was furnished and request authorization. *Emergency outpatient care will be authorized by the field station when necessary in the treatment of a disease or injury incurred or aggravated in active military service or in those cases in which outpatient treatment is required to prevent interruption of training of a veteran undergoing authorized vocational rehabilitation or education.* When the field station does not authorize the emergency medical care stated herein, or when authorization for such care has not been received from that office by the Army medical treatment facility while the veteran is receiving medical care, charges for medical care will be collected locally from the veteran concerned.

(4) *Outpatient care.* Outpatient care, other than emergency outpatient care, must be authorized in advance. Such care will be furnished on presentation of a signed authorization from the field station having jurisdiction.

(5) *Disposition of emergency cases.* A veteran admitted for emergency medical care will be released from the Army medical treatment facility promptly upon termination of the emergency unless other disposition as indicated in (*a*) and (*b*) below has been arranged with the field station.

(*a*) Transfers to a Veterans Administration hospital if further hospitalization is required.

(*b*) Retention as a Veterans Administration beneficiary chargeable against a bed allocated to that agency.

(6) *Medical care at Army medical treatment facilities in foreign countries.*

(*a*) Care will be authorized by the Veterans Administration for eligible veterans in need of treatment.

(*b*) The responsibility for authorizing medical care in foreign countries is vested in the Manager, Veterans Administration Office for Europe, Rome, Italy, for veterans residing in Western Europe; the Attaché for Veterans Affairs, American Embassy, Mexico City, for veterans in Mexico; and the Veterans Benefit Office, Washington, D.C., 20420, for eligible veterans residing in all other foreign countries. Veterans may be furnished medical care at Army medical treatment facilities in foreign countries on presentation of a signed authorization for treatment. A medical treatment facility furnishing a veteran emergency medical care without proper authorization will notify the responsible Veterans Administration representative, as indicated above, of this

fact within 72 hours after the date and hour the initial care was rendered, by the most expeditious means available, stating the diagnosis and extent of treatment required and requesting authorization for the treatment and instructions as to the disposition of the patient upon termination of the emergency. If the approving authority does not issue an authorization for this care, charges for medical care will be collected locally from the veteran concerned.

(7) *Wheelchairs and beds.* These items may be furnished without charge, if locally available from Government stocks, to a Veterans Administration beneficiary upon his discharge from the medical treatment facility provided, in the opinion of the medical treatment facility commander, he requires constant and continuous use of these items after his discharge.

b. The following records which are required by the Veterans Administration are in addition to those required on all patients in Army medical treatment facilities. The VA forms, which will be obtained from the the field station having jurisdiction, and Standard Form 502 (Clinical Record—Narrative Summary) will be completed as indicated below and forwarded to such station:

(1) *VA Form 10-P-10 (Application for Hospital Treatment or Domiciliary Care).* This form will be completed for those veterans who are admitted to an Army medical treatment facility for emergency medical care without prior authorization. All information required in the medical certificate thereon will be furnished whether the admission is approved or disapproved by the field station. Since completion of the medical certificate will require examination of the patient, those admissions to the hospital which are disapproved by the field station will be reported as medical examinations on DD Form 7A to The Surgeon General.

(2) *VA Form 10-2593 (Record of Hospitalization).* Two sets of this form, one marked "Admission" and one marked "Discharge," will be presented by the veteran upon referral to an Army medical treatment facility. The facility should enter the date of admission and diagnosis on the set marked "Admission" and return it at once to the field station. When the patient is discharged from the hospital, the set marked "Discharge" should be completed to show pertinent medical data, such as change of diagnosis, operations performed, prosthetic appliances or sensory aids furnished and date of discharge.

(3) *Standard Form 502.* This form will be completed when a veteran is discharged or disposed of. When an interim report of hospitalization is requested by the field station, it will be prepared on this form.

(4) *VA Form 10-7081 (Report of Out-Patient Treatment.)* This form will be completed on a monthly basis for each beneficiary furnished authorized emergency outpatient care. The instructions contained in (3) above are applicable to outpatient care, other than emergency outpatient care, when required in connection with post-hospitalization followup.

★*c.* Those retired members of a uniformed service listed in paragraph 11*b* (2) through (4) whose hospitalization for certain chronic conditions is the responsibility of the Veterans Administration may not be hospitalized at Army medical treatment facilities as beneficiaries of the Veterans Administration.

13. Beneficiaries of the Bureau of Employees' Compensation. *a. For whom authorized.* Persons in the categories listed below are authorized medical care as beneficiaries of the Bureau of Employees' Compensation (hereinafter referred to as the Bureau).

(1) Members of the Reserve Officers Training Corps of the Army, Navy, and Air Force provided the condition necessitating treatment had its inception on or after 1 August 1956 and was incurred in line of duty under one of the following circumstances:

(*a*) While performing travel to or from camps or cruises.

(*b*) While undergoing flight instruction.

(*c*) During attendance at training camps or while on cruises. (The care furnished under this authority relates solely to care furnished after termination of training camps or cruises. For conditions under which care is furnished during the period of attendance at ROTC training camps, see para.10.)

(2) Employees (regardless of nationality) of the Government of the United States for injury or disease which is the proximate result of their employment.

(3) Employees of the Government of the District of Columbia (except members of the Police and Fire Departments) for injury or disease which is the proximate result of their employment.

★(4) Temporary members of the Coast Guard Reserve for physical injury incurred incident to service while performing active Coast Guard duty or engaged in authorized travel to or from such duty.

★(5) Volunteer civilian members of the Civil Air Patrol (except Civil Air Patrol Cadets) for injury or disease which is the proximate result of active service, and travel to and from such service, rendered in performance or support of operational missions of the Civil Air Patrol under direction and written authorization of the Air Force.

★(6) Peace Corps volunteers for injury or disease which is the proximate result of their employment or which was sustained or contracted while located outside the United States and its territories.

★*b. Conditions governing the furnishing of medical care.* Medical care will be furnished to beneficiaries of the Bureau on presentation of a CA Form 16 (Request for Treatment of Injury Under the United States Employees' Compensation Act) or CA Form 17 (Request for Treatment of Injury Under the United States Employees' Compensation Act When Cause of Injury Is in Doubt) from the employee's supervisor, or from the appropriate commander, as applicable. If emergency medical care is furnished without presentation of one of these forms, the employee's supervisor or the appropriate commander, as applicable, will be notified immediately and requested to submit a CA Form 16 or CA Form 17 within 48 hours. If that official determines that it is inappropriate to prepare CA Form 16 or CA Form 17 under the regulations issued by the Bureau and notifies the medical treatment facility to that effect, charges for medical care will be collected locally from the individual concerned. Supplies of these forms, if needed, may be obtained from the Bureau of Employees' Compensation District Office of jurisdiction.

c. Hospitalization.

(1) *CA Form 16 or CA Form 17.* The beneficiary will present the original of one of these forms or if forms are not available, a letter request, to the Army medical treatment facility in which medical care is desired. The medical treatment facility will attach the original of one of these forms or the letter request to DD Form 7 (Report of Treatment Furnished Pay Patients; Hospitalization Furnished (Part A)) as a substantiating document.

(2) *CA Form 20 (Attending Physician's Report).* This form will be executed by the attending medical officer and forwarded direct to the Bureau by the Army medical treatment facility. If extensive hospitalization is required, a narrative report should be submitted on SF 502 in lieu of CA Form 20 showing the history, physical findings, laboratory findings, and including a general abstract of the patient's hospital record. This information should be forwarded to the Bureau periodically or at the time of discharge if the hospitalization does not exceed 1 month. The report should show also the diagnosis for conditions due to the injury; conditions not due to the injury; and condition on discharge with the opinion as to the degree of physical impairment, if any, from conditions due to the injury.

d. Outpatient care. The beneficiary will present the original of CA Form 16 or CA Form 17 or, if forms are not available, a letter request, to the Army medical treatment facility in which outpatient medical care is desired. The medical treatment facility will retain this form in its files as a possible substantiating document for DD Form 7A. If not requested by The Surgeon General for this purpose, disposal will be as prescribed in AR 345-210.

★*e. Prostheses and appliances.*

(1) All necessary prostheses, hearing aids, spectacles or special orthopedic footwear will be furnished when required in the proper treatment of a case.

(2) All necessary dental care, including prosthetic dental appliances, will be furnished when authorized by the Bureau of Employees' Compensation.

f. Transfer of beneficiaries.

(1) *Transfer of cases requiring prolonged treatment.* A beneficiary of the Bureau requiring prolonged treatment will be reported by the facility to the Bureau for removal from the Army medical treatment facility as soon as the patient's condition permits. Transfer will be at the expense of the Bureau.

(2) *Transfer when necessary for other purposes.* When transfer is necessary for the proper treatment of the patient, a beneficiary of the Bureau may be transferred from one Army medical treatment facility to another. Prior authorization for such transfers will be secured from the Bureau if

Air Force retired for physical disability are not eligible for admission for the chronic conditions listed in paragraph 11*b*.

18. Beneficiaries of the Department of Justice. *a. Federal Bureau of Investigation.* Upon presentation of written authorization, agents of the Federal Bureau of Investigation may be furnished medical examinations. Charges for medical examinations will be collected by The Surgeon General on receipt of DD Form 7A. When hospitalization is necessary to the proper conduct of these examinations, DD Form 7 will be forwarded to The Surgeon General.

b. Claims administered by the Department of Justice. Upon presentation of written authorization from the Department of Justice or the United States attorney in the case, claimants whose claims are being administered by the Department of Justice may be furnished medical examinations to determine the extent and nature of the injuries or disabilities claimed. Charges for medical examinations will be collected by The Surgeon General on receipt of DD Form 7A. When hospitalization is necessary to the proper conduct to these examinations, DD Form 7 will be forwarded to The Surgeon General.

18.1. Applicants for cadetship at the various service academies. *a. Army, Navy, and Air Force.* Applicants for cadetship at the U.S. Military Academy, the U.S. Naval Academy, and the U.S. Air Force Academy may be furnished medical examinations and hospitalization when necessary to the proper conduct of these examinations without charge.

b. Coast Guard. Upon presentation of written authorization from commanders of U.S. Coast Guard District Offices, applicants for cadetship at the U.S. Coast Guard Academy may be furnished medical examinations. No charge will be made for these examinations when performed on an outpatient basis. When hospitalization is necessary to the proper conduct of these examinations DD Forms 7 will be forwarded to The Surgeon General.

19. Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve components thereof, and Selective Service registrants. Applicants for enlistment or reenlistment and registrants while under military control will be furnished necessary medical examinations, and hospitalization when their medical fitness for military service cannot be determined without hospital study. In addition, applicants for enlistment or reenlistment who suffer acute illnesses and injuries while awaiting or undergoing enlistment processing at recruiting main stations or at Armed Forces Examining and Entrance Stations may be furnished emergency medical care including emergency hospitalization.

20. Applicants for appointment in the Regular Army and Reserve components, including those members of the Reserve components apply for active duty. Medical examination may be furnished in accordance with AR 601-100 and AR 140-120. When medical fitness for appointment cannot otherwise be determined, hospitalization is authorized.

21. Persons in military custody and nonmilitary Federal prisoners. *a. Prisoners of war, retained personnel, and internees.* Such persons are authorized necessary medical care to include prosthetic devices, prosthetic dental appliances, and spectacles. Hearing aids and orthopedic footwear are also authorized when necessary for the individual to carry out his duties or attend to his own needs.

b. Military prisoners whose punitive discharge has been executed but whose sentence has not expired. Such persons are authorized all necessary medical care.

c. Military prisoners who require hospitalization beyond expiration of sentence. Military prisoners whose punitive discharge has been executed may be hospitalized beyond expiration date of their sentence as pay patients until disposition can be made to some other facility.

d. Nonmilitary Federal prisoners. Such persons are authorized only emergency medical care. When such care is furnished, the institution to which the prisoner is sentenced must furnish the necessary guards to control the

prisoner and prevent his escape. *Under no circumstances* will military personnel be utilized to guard or control the prisoner. Upon completion of emergency medical care, arrangements for transfer to a nonmilitary medical facility or return of the prisoner will be made with the appropriate official of the institution to which the prisoner is sentenced. Charges for emergency medical care will be collected by The Surgeon General on receipt of DD Form 7 or 7A.

22. Former female members of the Armed Forces and their newborn infants. ★*a. General.* Former female members of the Armed Forces separated under honorable conditions because of pregnancy, or who, although separated under honorable conditions for reasons other than pregnancy, are shown by a medical examination given at an Armed Forces medical treatment facility to have been pregnant at the time of separation, are authorized medical care in military medical treatment facilities for that pregnancy as specified in *c* and *d* below. Such care is limited to care in military facilities and does not, regardless of the circumstances, include care obtained in civilian facilities.

★*b. Application.* Former female members of the Armed Forces who desire maternity care will apply in writing to the military medical treatment facility nearest their home and present their copy of DD Form 214 (Armed Forces of the United States Report of Transfer or Discharge), or DD Form 256A (Honorable Discharge Certificate) or DD Form 257A (General Discharge Certificate), as appropriate, as proof of their eligibility for medical care.

c. Extent. For the purpose of this paragraph the term "maternity care" includes prenatal care, hospitalization, confinement, and postnatal care either in a hospital or as an outpatient for 6 weeks following delivery.

d. Newborn infants. No charge is made for newborn infant patients while the mother is a patient in the medical treatment facility. In those cases where the mother is discharged from the medical treatment facility and it is necessary for the infant to remain as a patient or where the infant is admitted as an individual patient under the authority of this subparagraph, charges will be made at the rates prescribed for the mother in each case. If newborn infant patients require medical care beyond the postnatal 6 weeks' period, disposition will be made to private, welfare, State, or Federal agencies.

23. Individuals whose military records are being considered for correction. Individuals who require medical evaluation in connection with consideration of their case by the Army Board for Correction of Military Records are authorized necessary medical care. (Personnel in this category are advised by The Adjutant General that they may report to a designated Army medical treatment facility for evaluation.)

24. Seamen. *a. General.* Civilian seamen in the service of vessels operated by the Department of the Army or the Military Sea Transportation Service listed in *b* and *c* below, are still in the service of a vessel, although not on board and not engaged in their duties, as long as they are under the power and jurisdiction of competent Department of the Army or Military Sea Transportation Service authorities.

b. Civilian seamen in the service of vessels operated by the Department of the Army. Except in emergencies, such persons will be furnished medical care only when facilities of the Public Health Service are not available. Authorization for such care will be granted upon presentation of written authorization from the master or other appropriate administrative authority which may be dispensed with only in emergencies.

c. Civilian seamen in the service of vessels operated by the Military Sea Transportation Service. Such persons are eligible for care upon presentation of written authorization from the master or other appropriate administrative authority. In cases where immediate treatment is required and the employee concerned does not have the required written authorization, the nearest Military Sea Transportation Service office or representative will be requested to submit such authorization as soon as possible. The authorization will be attached to DD Form 7 or 7A as related papers when submitted to The Surgeon General.

d. Crews of ships of United States registry. Such crews, including ships' officers are eligible for care when outside the United States, its territories, possessions, and the Commonwealth of Puerto Rico. This category includes the crews of ships of United States registry such as those aboard Department of Defense time-chartered vessels of commercial operators; those aboard time-chartered vessels other than time-chartered vessels referred to above for emergency medical care; and those on privately owned and operated vessels. A crew member who requires prolonged hospitalization may be evacuated to the United States through medical evacuation channels when lack of transportation facilities prevents evacuation through the local ship's agent.

25. Foreign nationals. *a. Inside the United States.*

(1) Military personnel of one of the NATO nations listed below, when in connection with their official duties such personnel are stationed in or passing through the United States, and their dependents *as that term is defined in (10) below.*

(*a*) Belgium.
(*b*) Canada.
(*c*) Denmark.
(*d*) France.
(*e*) Federal Republic of Germany.
(*f*) Greece.
(*g*) Iceland.
(*h*) Italy.
(*i*) Luxembourg.
(*j*) Netherlands.
(*k*) Norway.
(*l*) Portugal.
(*m*) Turkey.
(*n*) United Kingdom.

(2) Civilian personnel who are accompanying the military personnel referred to in (1) above as employees of an armed service of the nation concerned (provided they are neither stateless persons nor nationals of any state which is not a Party to the North Atlantic Treaty, nor nationals of, nor ordinarily resident in the United States), and their dependents as that term is defined in (10) below. (As indicated in *d*(1) below, care for this category is limited to emergency care or care at installations which have been designated remote by the Secretary of the Army for medical care purposes.)

Note. Subparagraphs (1) and (2) above implement the medical portion of the NATO Status of Forces Agreement insofar as care in Army medical treatment facilities is concerned. Care in Air Force and Navy facilities for the persons enumerated in (1) and (2) above is governed by regulations of those services.

(3) Military personnel whose names appear in the *Diplomatic List* (the so-called "Blue List") or the List of Employees of Diplomatic Missions (the so-called "White List") published periodically by the Department of State.

(4) Military personnel assigned or attached to U.S. military units for duty.

(5) Military personnel assigned or attached to U.S. military units for training, and their dependents as that term is defined in (10) below.

(6) Military personnel on duty in the United States at the invitation of the Department of Defense or one of the military departments.

(7) Military personnel accredited to joint U.S. defense boards or commissions.

(8) Military and civilian personnel not covered above who are in the United States in a status officially recognized by the Department of the Army. (When doubt exists regarding the eligibility of any person seeking care under this subparagraph, he should

be advised to apply for determination of his eligibility to the Assistant Chief of Staff for Intelligence, Department of the Army, Washington, D.C. 20310, through the military attaché of his country stationed in Washington.) MAP trainees (military or civilian) applying for care under this authority will present a copy of their invitational travel orders to the United States.

(9) Dependents (as that term is defined in para 2*d*) of military personnel covered in (3), (4), (6), (7), and (8) above when residing with their sponsor.

(10) The term *dependent* in (1), (2), and (5) above means a person who bears one of the following relationships to his or her sponsor:

(*a*) A wife.

(*b*) A husband if he is dependent on his sponsor for over one-half of his support.

(*c*) An unmarried legitimate child, including an adopted child or stepchild, *who is dependent on the sponsor for over one-half of his support* and who either—

1. Has not passed his 21st birthday;

2. Is incapable of self-support because of a mental or physical incapacity that existed prior to his reaching age 21; or

3. Has not passed his 23d birthday and is enrolled in a full-time course of study in an accredited institution of higher learning.

b. Notification of hospitalization inside the United States.

(1) When foreign nationals listed in *a* above are hospitalized at Army medical treatment facilities, an immediate notification will be prepared in letter form in quadruplicate. The original and two copies will be submitted by airmail to the Assistance Chief of Staff for Intelligence, Department of the Army, Washington, D.C., 20310, in order that the country concerned may be advised regarding the status of foreign personnel. The quadruplicate copy will be submitted by airmail to The Surgeon General, ATTN: MEDII–FL. The notification will include the name, grade, service number, and branch of service (where applicable), and country of the foreign national; status (e.g., trainee, visitor, dependent, etc.); date of hospitalization; diagnosis, prognosis, and probable date of release. If the patient's probable date of release cannot be determined during his initial evaluation or the initial notification does not indicate a prolonged period of hospitalization and it subsequently develops that the patient will require prolonged hospitalization, an additional notification similar to that described above will be submitted. In addition, when Canadian military personnel are admitted to or discharged from an Army medical treatment facility in the United States, a copy or extract of the Admission and Disposition Sheet will be forwarded immediately to the Canadian Joint Staff, Washington, D.C.

(2) Notifications required by (1) above are exempt from reports control under paragraph 39*k*, AR 335–15.

c. Outside the United States.

(1) Those who qualify under paragraph 31*a* or 34.

(2) MAP trainees (military and civilian) and the dependents of MAP military trainees.

(3) Persons covered by agreements entered into by an agency of the U.S. Government authorized to make such agreements when care in Army medical treatment facilities is a condition of the agreement. (A copy of all such agreements will be submitted to The Surgeon General, ATTN: MEDDD–OP, Department of the Army, Washington, D.C., 20315.)

(4) Liaison officers from a NATO Army Force or members of a liaison detachment from such a Force.

Note. This subparagraph implements paragraph 8*f* of NATO Standardization Agreement 2101.

(5) Labor Service personnel in France.

(6) Crew and passengers of visiting military aircraft of NATO nations which land at NATO or U.S. military airfields *within NATO* countries.

Note. This subparagraph implements the medical portion of NATO Standardization Agreement 3113.

(7) *The transfer of foreign personnel from outside the United States to the United States solely for the purpose of providing medical care in Army medical treatment facilities is not authorized except under unusual circumstances as determined by the Secretary of the Army.* The U.S. Army attaché in the country concerned is responsible for effecting through diplomatic channels

such coordination as may be necessary with the local government and interested agencies will request the attaché to render such administrative assistance as may be within his capabilities.

d. Charges for an extent of care.

(1) Persons referred to in *a*(1), (2), and (5) and *c*(2) and (4) above are eligible under the same conditions and at the same rate for the same care for which U.S. Army personnel (military or civilian, as the case may be) are eligible. Labor service personnel in France (*c*(5) above) are furnished care comparable to that provided U.S. Army military personnel without charge under an agreement between France and the United States. In addition, Labor Service personnel who are authorized the protective field mask by TA 77-7 will be furnished, at no expense to themselves, optical inserts therefor in accordance with the criteria established in paragraph 118*g* (1).

(2) Except as indicated in (3) below, persons referred to in *a*(3), (4), (6), (7), (8), and (9) above will not be admitted to an Army hospital for chronic conditions or any other condition which would not be benefited by hospitalization for a period of less than 90 days. No such person will be provided care for which he would not be eligible if he were in a comparable U.S. category. Rates for such persons will be the same as those charged comparable U.S. Army personnel (military or civilian, as the case may be) and collection will be made locally from the individual concerned except in the case of foreign enlisted patients. Reimbursement for subsistence for this latter category of personnel will be accomplished in the same manner as for U.S. Army enlisted patients.

(3) Persons being provided care pursuant to a specific agreement entered into by an authorized agency of the U.S. Government will be provided care to the extent specified in the agreement or, if there be no such specification, to the extent indicated in (2) above. Such persons will be charged at the rate specified in the agreement or, if no rate is specified, at the rate charged comparable U.S. Army personnel (military or civilian, as the case may be).

(4) In the case of MAP trainees (military or civilian) furnished care under *a*(8) and *c*(2) above, subsistence charges will be collected locally from officer and civilian trainees. No charges will be collected from enlisted MAP trainees. At the end of each calendar month, all MAP trainees (officer, enlisted and civilian) furnished care (excluding those furnished care in USAREUR) will be reported to The Surgeon General, ATTN: MEDOC-F. Reports will be prepared on DD Form 7 or DD Form 7A, as appropriate, and submitted in triplicate supported by a copy of invitational travel orders to the U.S. installation or activity where training is being received. Dependents of MAP military trainees will be charged Rate D when hospitalized with collection direct from patient or sponsor. No charge will be made for outpatient services furnished dependents of MAP military trainees.

★(5) Persons referred to in *c*(6) above normally will be furnished that medical care which is available at the NATO or U.S. military airfield concerned. When hospitalization is furnished, the charges for subsistence will be collected locally from the patient and the charges for hospitalization, computed on the basis of inpatient Rate B or F will be collected from the appropriate NATO nation by Headquarters, USAREUR, on receipt of DD Form 7 from the Army hospital providing the care. No charge will be made for outpatient care.

26. Red Cross personnel and their dependents, other officially recognized welfare workers, non-Red Cross volunteer workers and civilian student employees. Such persons are authorized medical care subject to the applicable conditions indicated below:

a. Red Cross.

(1) Uniformed, full-time, paid professional staff when on duty with a uniformed service.

(2) Uniformed, full-time, paid secretarial and clerical workers on duty outside the United States.

(3) Nonuniformed, full-time, paid secretarial and clerical workers on duty in Red Cross offices at installations within the United States, and volunteer workers, uniformed and nonuniformed, both within and outside the continental United States. (Medical care for these categories of personnel will be limited to care for injuries sustained in the course of performance of their duties at uniformed services facilities.)

b. Dependents of personnel in a(1) and (2) above.

(1) Except as indicated in (2) below, such persons are authorized medical care outside the continental United States if actually residing with their sponsors.

(2) In Alaska and Hawaii such persons are authorized medical care only in the absence of adequate civilian facilities as determined by the major oversea commander concerned.

c. Other officially recognized welfare workers and non-Red Cross volunteer workers. For injury sustained in the course of performance of their duties at Army facilities.

d. Civilian student employees. Civilian student employees in training at an Army Medical Service facility.

27. Civilian employees and their dependents.

a. Those authorized occupational health services.

(1) *Civilian employees of the Army.*

(*a*) Civilian employees of the Army paid from appropriated or industrial funds are authorized to receive without charge those occupational health services referred to in AR 40-5. When hospitalization is necessary to the proper conduct of the medical examinations referred to in AR 40-5, a charge for subsistence will be made. Subsistence charges will be collected locally from the individual concerned. (The above authorization includes the furnishing of a medical evaluation for those employees who, prior to their evacuation from overseas, did not receive such an evaluation for the purpose of determining their mental or physical fitness for continued employment.)

(*b*) Civilian employees of the Army paid from appropriated or industrial funds are authorized to receive without charge spectacle inserts (including fittings) for protective masks where the masks are issued as protective equipment under the provisions of AR 385-32. The spectacle inserts will be furnished under the criteria of paragraph 118*g*(1).

(*c*) Civilian employees of the Army paid from nonappropriated funds and applicants for employment are authorized to receive without charge those examinations required by AR 40-5.

(*d*) Civilian seamen in the service of vessels operated by the Department of the Army who are paid from appropriated funds are authorized to receive without charge those occupational health services referred to in AR 40-5.

(2) *Civilian employees of Federal departments and agencies other than Army.*

Such employees who are paid from appropriated or industrial funds are authorized to receive those health services referred to in AR 40-5. Arrangements will be made locally at a per capita cost based on local estimates of such cost and paid for by the receiving agency as an automatic reimbursement except in the case of civilian employees of the Navy, Marine Corps, and Air Force in the Washington metropolitan area to whom authorized occupational health services are furnished as the financial responsibility of the Department of the Army. (The above authorization includes the furnishing of a medical evaluation for civilian employees of the Navy, Marine Corps, and Air Force who, prior to their evacuation from overseas, did not receive such an evaluation for the purpose of determining their mental or physical fitness for continued employment.)

Medical care furnished the above categories of personnel for injuries incurred in the performance of duty will be provided in accordance with paragraph 13.

★*b. Civilian employees of the Defense Establishment (not beneficiaries of the Bureau of Employees' Compensation) and their dependents.* Civilian employees of the Defense Establishment, paid from either appropriated or nonappropriated funds, and their dependents outside the United States and at military installations in the United States which have been designated as remote by the Secretary of the Army for the purpose of providing medical care to these individuals. Charges will be collected locally from the individual at the rates indicated below for the applicable fiscal year.

★(1) *Inpatient care.* Outside the United States, charges for inpatient care will be at Rate B or F for United States citizens and at Rate C for noncitizens. Charges for inpatient care at designated remote installations in the United States will be at Rate B or F.

(2) *Outpatient care.* Outside the United States, charges for outpatient care will be at the special outpatient rate for both citizens and noncitizens. Charges for outpatient care at designated remote installations in the United States will be at the outpatient rate.

(3) *Immunizations.* No charge will be made for immunizations and reimmunizations required by AR 40-562.

c. Civilian employees of contractors of the Department of the Army. Medical care may be furnished only outside the United States, except that in the case of civilian-contractor flight instructors medical examinations may be furnished in the United States.

c.1. Civilian employees of contractors of the Department of the Navy and their dependents. Medical care may be furnished only outside the United States.

d. Civilian employees (including former and prospective employees) of contractors of the Department of the Army. Medical examinations (to include hospitalization when necessary in connection therewith) may be furnished without charge only within the United States on an individual basis upon authorization by the CONUS army or major oversea commander concerned or the Commanding General, Military District of Washington, U.S. Army. When hospitalization is necessary to the proper conduct of these examinations, a charge for subsistence will be made and collected locally from the individual concerned.

e. Civilian employees of all Federal agencies. Medical examinations in connection with disability retirement may be furnished civilian employees of all Federal agencies without charge when such examinations are requested by authorized representatives of the U.S. Civil Service Commission, except that when hospitalization is necessary to the proper conduct of these examinations subsistence charges will be collected locally from the individual concerned.

f. Civilian employees of the Department of Commerce, except for Bureau of Roads personnel connected with aid programs (para 16). Medical care may be furnished only outside the United States.

g. Civilian employees of the Department of Interior and their dependents. Medical care may be furnished Department of Interior employees and their dependents when the employee's place of permanent residence is not the geographical area where he is employed as follows:

(1) Outside the United States.

(2) Upon request of the Governor of American Samoa, in Hawaii for employees and their dependents who are stationed in American Samoa.

h. Civilian employees of the General Accounting Office and their dependents. Medical care may be furnished only outside the continental United States.

28. Army National Guard technicians (civilian employees of the Army National Guard) manning missile sites. These technicians may receive without charge occupational health services to include gas mask spectacles required due to potential health hazards involved in their duty assignment. When hospitalization is necessary to the proper conduct of medical examinations for these technicians, charges for subsistence will be collected locally from the technician concerned. Hospitalization for injuries incurred in the performance of duty will be provided in accordance with paragraph 13.

29. Boy Scouts of America. Members of the Boy Scouts of America who suffer illness or injury while participating in visits, training exercises, and encampments at Army installations are authorized medical care.

30. Claimants whose claims are administered by the military departments, and claimants who are the proposed beneficiaries of private relief bills. *a. Army.* In order to determine the extent and nature of the injuries or disabilities claimed, civilian claimants upon the request of the Army agency responsible for administering the claim may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge being made.

b. Navy and Air Force. In order to determine the extent and nature of the injuries or disabilities claimed, civilian claimants upon the request of the Navy or Air Force agency responsible for administering the claim may be furnished medical examinations without charge. When hospitalization is necessary to the proper conduct of these examinations, DD Form 7 will be forwarded to The Surgeon General.

c. Other claimants. Claimants who are the proposed beneficiaries of private relief bills based on injuries or disabilities allegedly arising out of the operation of the Defense Establishment may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge being made in order to determine the extent or nature of the injuries or disabilities claimed.

31. Persons outside the continental United States who contribute to accomplishment of a major oversea commander's mission. ★*a. General.* Persons who contribute to the accomplishment of a major oversea commander's mission and for whom medical care is deemed essential by the major oversea commander concerned may receive medical care in facilities outside the continental United States only in the absence of adequate civilian facilities as determined by the major oversea commander concerned. Rate B or F or the outpatient rate, whichever is applicable, will apply except as indicated in *b, c,* and *d* below.

b. Civilian representatives of religious groups and others. Civilian representatives of religious groups, celebrities and entertainers, athletic clinic instructors, and representative of the USO, other social agencies, and educational institutions, and persons in similar status providing direct services to the U.S. Armed Forces, who are acting under official invitational orders from the Department of Defense, or from one of the military departments, to visit military commands overseas may be furnished medical care without charge in facilities outside the continental United States. Charges for subsistence will be collected locally from the individual.

c. Educational representatives of recognized educational institutions. Educational representatives of recognized educational institutions

regularly assigned to duty in military commands overseas who are contributing to a major oversea commander's mission, and their dependents when residing with their sponsors, may be furnished medical care in facilities outside the continental United States at Rate B or F or at the outpatient rate, whichever is applicable.

d. Rates for individuals under hardship circumstances. When a major oversea commander determines that hardship would result if an individual or a category provided care under this paragraph were charged the rates specified in *a* above, he may prescribe Rate D as the charge for hospitalization or waive the charge for outpatient care, or do both, as appropriate.

32. American nationals. American nationals outside the United States covered by agreements entered between the Department of the Army and other Federal civilian agencies when care in Army medical treatment facilities is a condition of the agreement may be furnished medical care.

33. Joint Civilian Orientation Conference guests. Joint Civilian Orientation Conference guests while attending a Joint Civilian Orientation Conference will be provided medical care. Charges for medical care will be at Rate B or at the outpatient rate, whichever is applicable, and collection will be made locally from the individual.

34. Special foreign nationals. ★*a. Care authorized.* Medical care may be furnished to such persons outside CONUS when it is determined that this action can be expected to contribute to the advancement of the public interests of the United States.

b. Authority. Authority is granted to major oversea commanders to make the foregoing determination.

c. Delegation of authority. Major oversea commanders may, when the geographical dispersion and varying political conditions of their command warrant such action, delegate the authority in *b* above and *e* below to one or more of their major subordinate commanders. Such authority, however, may not be redelegated.

d. Considerations.

(1) Generally, care under this paragraph will be afforded only to foreign officials of high national prominence. Care may be afforded under this paragraph, however, to other foreign nationals when, because of unusual circumstances or the extraordinary nature of the case, such action would be in consonance with *a* above.

(2) Normally, care will not be afforded under this paragraph for chronic conditions or any other condition which, if hospitalization is involved, would not be benefited by hospitalization for a period of less than 90 days.

(3) Normally, the recommendations of the Chief of the Diplomatic Mission to the country involved should be sought prior to determining whether care should be afforded under this paragraph.

★*e. Charges.* Charges for medical care provided under this paragraph will be at Rate B or F or the outpatient rate, whichever is applicable, and collection will be made locally, except that in unusual cases the major oversea commander may waive the charges.

f. Evacuation to the United States. Persons being afforded care under this paragraph will not be evacuated to the United States for further care unless they are first made designees of the Secretary of the Army pursuant to paragraph 35.

★**35. Designees of the Secretary of the Army.** Persons not otherwise eligible for medical care may receive such care when they are designated for this purpose by the Secretary of the Army. Such designees will be charged Rate B or F or the outpatient rate, whichever is applicable, unless specifically otherwise authorized by the Secretary. In the event the Secretary authorizes the furnishing of hospitalization with no reimbursement therefor, a

charge for subsistence will be collected locally from the individual unless the Secretary also waives these charges.

36. Certain personnel evacuated from one area to another. Personnel who for medical reasons are evacuated from an area in which they are eligible for medical care to an area where they are not otherwise eligible for such care will be admitted to or furnished treatment at medical treatment facilities to which evacuated or while en route thereto when medical care is deemed necessary. Care should be furnished under this paragraph on a temporary basis only until such time as appropriate disposition can be accomplished.

37. Persons eligible for emergency care. Any person is authorized care in order to prevent undue suffering or loss of life.

37.1 Volunteer subjects in approved Department of the Army research projects. Volunteers under the provisions of AR 70-25 are authorized all necessary medical care for injury or disease which is the proximate result of their participation in such projects. (Medical care for civilian employees who volunteer and who perform duty as a volunteer during their regularly scheduled tour of duty will be provided in accordance with paragraph 13.)

37.2 Secret Service Special Agents (examinations). Upon presentation of written authorization, Secret Service Special Agents may be provided routine annual medical examinations in Army medical treatment facilities on a reimbursable basis. Examinations will be conducted and recorded in the same manner as routine annual medical examinations for Army officers except that they will be conducted on an outpatient basis only. If hospitalization is considered desirable in connection with the examination, a statement to that effect will be entered in item 73 or 75 of the SF 88 (Report of Medical Examination), as appropriate. One copy of SF 88 and SF 89 (Report of Medical History) for medical examinations provided these agents will be forwarded to the Chief, United States Secret Service, Treasury Department, Washington, D.C., 20220. Charges for examinations will be collected by The Surgeon General on receipt of DD Form 7A supported by a copy of the authorization for medical examination.

★**37.3 Federal Aviation Agency (FAA) Air Traffic Controllers.** *a.* Upon the written request of FAA regional representatives, designated Army hospitals are authorized to provide the following services to Air Traffic Controllers who are undergoing a physical examination by an FAA physician:

(1) Chest X-rays.

(2) Electrocardiographs.

(3) Audiograms.

b. The Army hospital commander will not read or evaluate the results of these tests. Results will be forwarded direct to the FAA Regional Office arranging for the examination.

c. Services provided will be reported to The Surgeon General, ATTN: MEDOC-F, on DD Form 7A supported by a copy of the request for the services.

★**37.4 Job Corps and Volunteers in Service to America (VISTA) personnel and applicants.** *a. Job Corps.* Upon presentation of Job Corps Form 503 (Authorization for Medical Fitness Examination by a Federal Facility), Job Corps Form 505 (Authorization for Hospitalization by a Federal Facility), or Job Corps Form 507 (Authorization for Outpatient Care and Services by a Federal Facility) signed by an appropriate official of the Job Corps, Job Corps applicants for enrollment and Job Corps enrollees may be provided the following services in Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Job Corps applicants for enrollment.* Pre-enrollment medical examinations and immunizations.

(2) *Job Corps enrollees.* Hospitalization, outpatient medical treatment, examinations and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering.

b. VISTA. Applicants for employment by

VISTA and VISTA personnel may be provided the following services in Army medical treatment facilities as beneficiaries of the Office of Economic Opportunity:

(1) *Applicants for employment by VISTA.* Pre-employment medical examinasentation of VISTA Form 36 (Authorization for Medical Examination and Care by a Federal Facility) signed by an appropriate VISTA official.

(2) *VISTA personnel.* Hospitalization, outpatient medical treatment, examinations, and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering. Hospitalization and outpatient medical treatment may be provided upon presentation of a "Blue Cross and Blue Shield Identification Card." Other authorized services may be provided upon presentation of VISTA Form 36.

c. Services available at Armed Forces Examining and Entrance Stations. Upon presentation of Job Corps Form 503 or VISTA Form 36, male Job Corps applicants and male VISTA applicants may be provided pre-employment medical examinations and immunizations at Armed Forces Examining and Entrance Stations (AFEES) when in the opinion of the AFEES commander the capability exists.

d. Remediable physical defects. Upon presentation of appropriate authorization form signed by a Job Corps or VISTA physician, surgery or other treatment required to correct remediable physical defects of Job Corps enrollees and VISTA personnel may be provided in Army medical treatment facilities if within the professional judgment of the medical officers concerned such treatment is indicated and the required resources are available. The authorization form should contain a statement that in the opinion of the authorizing physician the condition will interfere with or substantially impede the training or future employability of a Job Corpsman or will seriously interfere with a VISTA volunteer's performance of duty.

e. Reports to The Surgeon General. Hospitalization, outpatient care, examinations and immunizations furnished will be reported to The Surgeon General on DD Form 7 or 7A supported by a copy of the Job Corps or VISTA form authorizing the services. In the case of VISTA personnel provided hospitalization or outpatient treatment on the basis of their Blue Cross and Blue Shield Identification Card, the VISTA identification number of the patient will be shown after the name of the patient in Item 5 of the DD Form 7 or 7A.

f. Beneficiaries of the Bureau of Employees' Compensation. After termination of their duty with the Job Corps or VISTA, these personnel are eligible for Bureau of Employees' Compensation benefits. To establish their eligibility for these benefits, Army medical treatment facilities providing treatment to such personnel will, upon request, complete the medical certificate on BEC Form CA-2.

★**37.5 U.S. Nationals in foreign penal institutions.** U.S. nationals serving with, employed by, or accompanying the Armed Forces outside the United States and its possessions, and their dependents, when confined in foreign penal institutions are authorized medical care of the type and quantity furnished prisoners in U.S. military confinement (AR 27-50).

SECTION IV

DISPOSITION OF PATIENTS FROM ARMY MEDICAL TREATMENT FACILITIES

38. General policies *a.* Prior to disposition, all Army military patients will be evaluated for retention in the military service. In addition, each member will be evaluated under such special standards as may be applicable in his case (aviation, diving, airborne, special forces, etc.). Dispositions to a duty status will take into consideration the long-range effect, if any, upon the health and well-being of the patient after his return to his regularly assigned job.

b. Medical officers will not designate a particular medical treatment facility for use by patients who require followup examination after their disposition unless unusual professional considerations dictate such action.

c. Except under emergency circumstances a patient will not be granted a pass or leave when absence will in any way delay his disposition.

★*d.* Army military patients who are administratively unfit for retention will be processed in accordance with procedures contained in appropriate administrative regulations such as AR 635-89, AR 635-105, AR 635-206, and AR 635-212.

e. Patients who normally would be discharged from the hospital on Sundays or holidays will be discharged on the preceding workday, whenever such earlier discharge is not medically contraindicated.

f. All administrative actions, such as requests for duty assignment, medical records, line of duty determinations, and medical board processing, will be taken as quickly as possible in order to expedite the eventual disposition of military patients.

g. No patient will be retained in a medical treatment facility solely for the purpose of completing items 35 and 36 of DA Form 8-118 (Medical Board Proceedings) (para 45*o*).

h. When efforts to dispose of a patient are not successful, his case will be brought to the attention of The Surgeon General, ATTN: MEDDD-OH.

39. Return of oversea Army military patients to CONUS for medical reasons. Major oversea commanders may return military patients who are members of the Army to CONUS for medical reasons when they determine that such action is in the best interests of the Army and the patient.

a. The major oversea commander concerned will determine whether a patient being returned to CONUS under this paragraph will appear before a medical board prior to evacuation.

b. If hospitalization or active medical supervision is required while in a travel status, the patient will be evacuated through medical channels.

c. If hospitalization or active medical supervision is not required while in a travel status, the patient will be returned to CONUS through regular administrative channels by the most expeditious means.

(1) As soon as it is determined that such a patient is to be returned to CONUS, a request for hospital designation will be submitted as prescribed by the major oversea commander concerned to The Surgeon General, ATTN: MEDDD-OH, Department of the Army, Washington, D.C. 20315, by electrically transmitted message. The following information concerning the patient will be included in the message:

(*a*) Name.

(*b*) Grade.

(*c*) Service number.

(*d*) General area where the patient prefers to be hospitalized. (In putting this question to the patient, it should be emphasized that his transfer to a specific hospital cannot be guaranteed.)

(*e*) Diagnosis.

(*f*) A statement indicating whether the patient has appeared before a medical board convened in accordance with paragraph 41.

(2) The Surgeon General in responding to requests received under the provisions of (1) above will use the following codes for the purpose of designating the CONUS destination hospital:

Code	*Hospital*
Reed	Walter Reed General Hospital (3401.01), Walter Reed Army Medical Center, Washington, D.C. 20315
Forge	Valley Forge General Hospital (3416), Phoenixville, Pa.
Brooke	Brooke General Hospital (3410.01), Brooke Army Medical Center, Fort Sam Houston, Tex.
Bmont	William Beaumont General Hospital (3414), Fort Bliss, Tex.
Fitz	Fitzsimons General Hospital (3412), Denver, Colo. 80240
Lman	Letterman General Hospital (3415), Presidio of San Francisco, Calif.
Madigan	Madigan General Hospital (3411), Tacoma, Wash. 98499
Womack	Womack Army Hospital (3155-01), Fort Bragg, N.C.
Martin	Martin Army Hospital (3150-01), Fort Benning, Ga.

(3) The patient will be transferred as soon as possible after receipt of the hospital designation from The Surgeon General. Orders issued by the oversea commander will assign the patient to the medical holding unit of the hospital designated by The Surgeon General and will cite ACPATT. EDCSA will be computed in accordance with paragraph 19, AR 330-12.

(4) Commanders returning patients to CONUS under this authority will not grant delay en route or leave when such action is medically contraindicated. The medical treatment facility commander who initiates action to return administratively a patient to CONUS will determine whether leave or delay en route is medically contraindicated.

(5) The major commander will assure that the medical treatment facility in possession of the clinical records and the unit in possession of the health and personnel records are notified of the CONUS hospital designation. These records will be forwarded by the appropriate custodian to the designated hospital by airmail and, in addition, in the case of individuals returning by MSTS, a copy of Standard Form 502 (Clinical Record—Narrative Summary) will accompany the individual for use by MSTS medical officers. The clinical record cover sheet will include the name of the designated hospital in item 28 and will contain in item 25 the following statement:

> Returned to CONUS under provisions of paragraph 39*c*, AR 40-3, with ..... days delay en route or leave authorized.

d. When an Army military patient is hospitalized in an oversea command and his home of record is located within that oversea command, he may be retained in the oversea command for medical treatment and further disposition (including separation), provided the military medical facilities available within the oversea command can adequately meet his needs.

e. Evacuation orders on officer patients should receive distribution shown in paragraph *d*(2) under Special and Letter Orders, Table I, Section I of AR 310-10. In the case of Army Medical Service officers, the copies listed in column 4, Table I, AR 310-10, should be forwarded to The Surgeon General, ATTN: MEDPT, Department of the Army, Washington, D.C. 20315.

★**39.1. Evacuation of wives from oversea areas to the United States.** When hospitalized wives are evacuated from oversea areas to the United States for further hospitalization and are accompanied by their child or children but not by their sponsors, plans must be made for the care of the children while the mother is hospitalized. Oversea commanders will insure that plans for the child or children are coordinated with the social worker at the receiving hospital prior to departure of the family from the oversea area.

40. Responsibility for dispositions. *a. Commanders of Army medical treatment facilities.* These commanders are responsible for disposition of all personnel under their jurisdiction for medical care. This responsibility is primarily exercised through the attending medical officer and includes the evaluation of medical fitness of military patients for further military duty.

b. Attending medical officers. These officers are responsible to the commander of the medical treatment facility for the proper and timely professional care of the patients assigned to them as well as for the continual evaluation of these patients for an early and appropriate disposition.

c. Medical board. This board assists the commander of a medical treatment facility in determining the medical fitness, mental competence, mental responsibility, and disposition of patients.

★*d. The Secretary of the Army.* The responsibilities of the Secretary of the Army in administering the physical disability program are exercised through the U.S. Army Physical Disability Appeals Board, the U.S. Army Physical Disability Agency, and The Adjutant General. Details of procedures are set forth in AR 635-40. The U.S. Army Physical Disability Agency (USAPDA), through Physical Evaluation Boards (PEB) and the U.S. Army Physical Review Council (USAPRC), evaluates and reviews all cases of individuals referred to PEBs by medical boards when physical fitness for further military service is questionable. When a PEB finds a member physically unfit for further military service, the board then evaluates the nature and degree of the individual's disability in accordance with the Veterans Administration Schedule for Rating Disabilities (VASRD) and modifying regulations, and recommends either discharge or retirement as appropriate. The U.S. Army Physical Disability Appeal Board (USAPDAB) considers all cases which are properly referred to it through the appeal system established by AR 635-40. The Adjutant General takes necessary action to implement Secretarial decisions by publication of Department of the Army orders or the issuance of appropriate instructions to subordinate headquarters.

★**41. Medical boards.** *a. General.* The medical board is an instrumentality of the Army Medical Service appointed by the commander of a medical treatment facility to assist him as indicated in paragraph 40*c* in making disposition of those patients for whom medical board action is required by higher authority, and in other cases when he deems such action advisable. Commanders who have authority to convene or review the proceedings of a medical board, or their superiors in the chain of command, who require referral to a medical board will be ordered to appear before a board not under their jurisdiction. Medical Corps officers who require referral to a medical board will be ordered to appear before a board other than that which is provided by the facility to which they are assigned for duty. *Recommendation of a disability rating is a prerogative of physical evaluation boards. Medical boards will not express conclusions or recommendations regarding percentages of disability.* Headquarters, Department of the Army will designate the medical facility to conduct medical board evaluations for specific cases when deemed appropriate. When medical or other circumstances preclude medical board evaluation at the hospital where the member is located, a medical board at the nearest Army medical facility properly staffed to do so will be convened to evaluate the member and recommend disposition.

b. Appointing authority. Commanders of all Army medical treatment facilities are authorized to appoint medical boards.

★*c. Composition.* Except as indicated below, medical boards will be composed of three or more Medical Corps officers, one of whom will be a senior Medical Corps officer with detailed knowledge of the directives pertaining to standards of medical fitness and unfitness, disposition of patients, and disability separation processing. The other members of the board should be familiar with these matters. Doctors of medicine, doctors of osteopathy, and doctors of dentistry who are civilian employees and contract surgeons may be detailed as members of a medical board. A Medical Service Corps officer may be utilized as recorder without vote to assist the medical board when desired by the medical treatment facility commander. When a member of the medical board does not have training in the medical, surgical, neuropsychiatric, or dental specialty of the patient's primary impairment, appropriate specialty consultations will be obtained prior to consideration of the case by the medical board.

★**42. Use of medical boards.** Generally, only those cases which present aspects of a problematical or controversial nature and those cases in which medical board action is required by regulation should be evaluated by a medical board prior to disposition. Patients who are to be returned to duty without any permanent revision in their profile and those who require transfer to another hospital prior to final disposition should not ordinarily be considered by a medical board prior to such disposition. Situations which require consideration by a medical board are—

a. All cases in which PEB referral is required (para 54*g*).

b. Patients hospitalized over 6 months returning to a duty status in order to insure that the individual has correct physical profile, assignment limitations, and medical followup instructions, as appropriate.

c. Patients with a doubtful prognosis, medical condition, or physical defects which are usually progressive in nature, or cases in which a claim against the Government may be expected. It is intended that such medical board action insure the adequate documentation of the nature, extent, and cause of all the medical conditions or physical defects in question.

d. Patients whose medical fitness for return to duty is problematical or controversial. When a member's fitness for further military duty is questionable, it becomes essential that his condition be thoroughly evaluated with respect to all abnormalities which may be present. Under these conditions, evaluation will be undertaken only in medical treatment facilities which have not only the professional staffing and equipment necessary for examination and medical evaluation, but also possess the administrative competence and experience to document appropriately the case and to initiate the processing of the member. When a medical treatment facility lacks this capability, the member will be transferred to the nearest qualified Army medical treatment facility.

e. Reserve component personnel on active duty for training or participating in Reserve duty training—

(1) Who are medically unfit for further military service upon completion of hospitalization; or

(2) Who require hospitalization beyond the termination of their tour of duty.

f. Reserve component personnel not on active duty who require evaluation for medical fitness as a result of injury incurred or aggravated during employment on active duty or inactive duty training, or as a result of disease incurred or aggravated during employment on active duty in excess of 30 days. Following medical board action in such cases, personnel who are medically unfit will be referred to a physical evaluation board.

g. ROTC members on a training tour (annual training camps and training encampments at military installations)—

(1) Who may be eligible as a result of an injury incurred or a disease contracted during their training tour for benefits administered by the Bureau of Employees' Compensation. See AR 145-124.

(2) Who require hospitalization beyond the termination of their training tour.

h. TDRL periodic medical examinations when in the opinion of the attending medical officer the status of the member has stabilized or when the disposition is questionable. The last periodic medical examination of members on the TDRL will in each case be supported by a medical board.

i. Cases involving mental competency.

j. Individuals scheduled for separation under AR 635-89 and AR 635-212 when it appears that a mental illness, medical condition, or physical defect is the direct cause of unfitness, unsuitability, or homosexuality.

k. Army medical boards will be utilized to determine mental competency of any retired member of the Armed Forces when that retired member is hospitalized in an Army medical treatment facility and for retired Army members hospitalized in a non-Federal facility by the facility designated to have responsibility. (The Departments of the Navy; Air Force; Health, Education, and Welfare; and the Veterans Administration are authorized to determine mental competency of retired Army members when such persons are hospitalized in a facility under its jurisdiction.)

l. Any other case deemed necessary by the appointing authority.

43. Medical board proceedings. Medical boards operate informally. Their members assemble to discuss and evaluate the patient's case. His clinical, health, and other records, as appropriate, are reviewed. When a patient's condition permits, he should be given the opportunity to appear in person and present his views relative to his proposed disposition. Medical fitness or medical unfitness for further duty regardless of motivation is determined on the basis of the medical fitness standards and guidance contained in chapter 3, AR 40-501 for military personnel, and chapter 2, AR 40-501 for ROTC members, except for medical conditions and physical defects which were known at the time of enrollment in the Advanced Course ROTC and which are essentially unchanged. The board will insure that all of the medical and/or physical defects which the individual has are determined and recorded. In cases of patients recommended for duty, the physical profile and appropriate duty assignment limitations or restrictions should be established.

44. Recording proceedings. *a.* Medical board proceedings will be recorded on DA Form 8-118 except when medical boards are held for the purposes described in paragraph 42*a* or solely for the purpose of revising the physical profile and the findings do not include medical unfitness, the proceedings will be recorded on DA Form 8-274 (Medical Condition—Physical Profile Record). Instructions covering the use of DA Form 8-274 are contained in chapter 9, AR 40-501. The following general instructions apply whenever DA Form 8-118 is used to record medical board proceedings. A brief, but complete, clinical history including a summary of available prior medical records (including the Health Record and the SF 88 accomplished at the time of entry into service) prepared by the patient's attending physician on SF 502 will be attached to the board proceedings as inclosure 1.

★(1) In cases involving psychiatric illness considered to have existed at the time of entry into the service, a decided effort will be made to include in the narrative summary clinical and social data concerning the conditions of the patient's entry into service—showing significant behavior and attitude toward the Army and toward the act of entry into service—data upon which to base a judgment whether the patient was at the time of his entry into the service mentally competent to understand the nature of the act of entry into service. If the patient is considered to have been incompetent to understand the act of entry into service at that time, then the clinical data should show the approximate inclusive dates subsequent

to entry into service when he did become competent to understand the nature of this act. If he never became so competent, then clinical data should be included to support this opinion.

(2) When a condition which existed prior to entry into service is judged to be aggravated by service, the severity and circumstances of the aggravation will be clearly indicated in the summary.

(3) A complete current report of medical examination will be recorded on SF 88 and attached as inclosure 2 to the board proceedings.

b. Except as required elsewhere in this regulation, DA Form 8-118 and inclosures will be prepared in the number of copies and distributed as shown in figure 2. For cases involving a finding of mental incompetency, one additional copy will be prepared. All members of the board will sign the original and initial the duplicate of the proceedings, except that

Type of disposition	Health record	Clinical record	Hospital file	Other
	Copy No.	Copy No.	Copy No.	Copy No.
1. Returned to duty	1	2	3	
2. Retained under medical jurisdiction for later reevaluation	1	2	3	
3. Transferred to another hospital	1	2	3	4 Receiving hospital for PEB if held.
4. Referred to Physical Evaluation Board:				
a. EPTS cases		7	8	1 through 6 to PEB.
b. All other cases		6	7	1 through 5 to PEB.
5. Separation—not for disability:				
a. Release from AD (Return to ARNGUS, USAR, or transfer to Army Reserve)	1	2	3	
b. Discharge	1	2	3	

Notes:

1. See paragraph 10-10, AR 635-40 for disposition of DA Form 8-118 when a disabled individual is continued on active duty.

2. See also paragraphs 48, 56*b*(4), 56*c*, 57, 61*c*, and 70 of this regulation.

3. See AR 40-501 for instructions on use of DA Form 8-274 to notify unit commanders of the physical profile and assignment limitations of members returned to duty.

★*Figure 2. Distribution of medical board proceedings.*

for cases in which a finding of mental incompetency is made all copies for use of finance officers must be signed by each member. When a psychiatrist is a member of the medical board, he will be identified by adding the letter "P" in parentheses after the branch in item 28, 29, or 30. The copy of SF 502 that becomes part of the clinical record will be annotated by the attending physician to show final disposition of the patient. DA Form 8-118 is designed for use with mechanical reproduction machines using the diazo-type process. When so used, the master copy will be considered the hospital records copy (fig. 2). Reproduced copies are acceptable for physical evaluation boards and other administrative purposes.

c. DA Form 8-118 is designed for use primarily in connection with evaluating military patients. When nonmilitary patients appear before a medical board, DA Form 8-118 will be modified by omitting entries which are obviously inappropriate.

★*d.* In PEB cases, care must be exercised in recording medical board proceedings to insure clarity and completeness. Physical evaluation boards, more often than not, evaluate an individual's impairments primarily on the basis of the records. Review and appeal bodies use only the records and never see a member. It is imperative, therefore, that entries be carefully worded so that they are both informative and precise.

45. Preparation of DA Form 8-118. The following instructions for preparing DA Forms 8-118 are furnished:

a. Items 1 through 15. Identifying information in items 1 through 15 will be obtained from personnel or medical records.

★*b. Items 16, 17, and 18.* Check applicable boxes. Where the determination of a patient's medical fitness is questionable, the matter will be resolved in favor of referring the member to the Physical Evaluation Board by checking "medically unfit" and inserting immediately above, the word "questionably."

c. Item 19. Using Department of Defense Disease and Injury Codes listed in AR 40-401 and TB Med 15, list all diagnoses, by nomenclature and code, in descending order of importance and note paragraph and subparagraph of chapter 3, AR 40-501, as applicable, in each case being referred to a PEB. In addition, the following special instructions apply:

(1) All manifestations which indicate the severity of a diagnosis will be summarized on SF 502.

(2) When necessary, include a statement of the patient's requirements for further hospitalization or treatment, including the condition(s) which necessitates further care and the probable duration of the required care.

(3) For patients with psychiatric conditions, include a statement indicating whether or not the patient is mentally competent for pay purposes; whether or not the patient has the capacity to understand the nature of, and to cooperate in, physical evaluation board proceedings; and whether or not the patient is dangerous to himself or others.

(4) For psychiatric prisoner patients include statements:

(*a*) Whether the patient was mentally responsible at the time of the offense in that he could or could not differentiate between right and wrong and could or could not adhere to the right.

(*b*) Whether at the time of the offense the patient was capable of having the degree of knowledge, intent, willfulness, malice, or premeditation required for the offense (if the offense included any of these).

(*c*) Whether at the time of the trial the patient possessed the requisite mental capacity and could or could not reasonably cooperate in his own defense.

(*d*) Whether during the appellate process the patient possessed the requisite mental capacity and could or could not reasonably cooperate in his own defense.

(5) For patients being processed for separation for EPTS conditions, list the name and location of the medical treatment facility where the physical examination incident to entrance on active duty was conducted.

(6) In cases where continuance on active duty under the provisions of AR 635-40 is requested, enter profile on SF 88. See paragraph 62 of this regulation.

(7) For deleterious type cases (those in which disclosure of information to the patient would be detrimental to his physical or mental health) include a statement to this effect.

d. Item 20. Complete all items for each diagnosis listed in item 19.

(1) Members undergoing disability evaluation for conditions involving questionable line-of-duty status, with respect to misconduct, negligence, or unauthorized absence, should have a copy of approved findings of the line-of-duty determination included in the evaluation records file. When such record of approved determination is not included in the file, the commander of the medical treatment facility concerned will request the appropriate authority to furnish a copy of the approved findings. To avoid undue delay, these cases may be processed as though a favorable determination had been made. See paragraph 1-9, AR 635-40.

(2) Determination of whether the disability was incurred or aggravated while the member was entitled to basic pay will be made by the medical officer concerned, subject to review, change, or modification by the medical board, hospital commander, or adjudicative bodies in the evaluation processing system.

(3) Every member will be presumed to have been in sound condition when examined and ac-

cepted for service except as noted at the time of entrance examination and acceptance. Therefore, it will ordinarily be presumed, in the absence of clear and convincing evidence to the contrary, that the disease or injury causing disability was incurred in line-of-duty. However, the fact that a member was accepted for active duty is not, in itself, conclusive that the disability was incurred after such acceptance but must be correlated with all available pertinent medical facts in accordance with accepted medical principles.

e. Item 21. Briefly summarize in nontechnical language the salient incapacitating diagnoses. (Not required for patients found medically fit.)

f. Item 22. Enter a specific recommendation selected from the types of disposition listed in paragraphs 54 and 55.

g. Item 23. Use when recommending return to duty with limitations. Do not use for patients recommended for return to full duty or separation.

h. Item 24. Check applicable box. Patient must initial all copies. Do not use this space when a patient is found medically fit.

i. Items 25 and 26. Do not complete.

j. Item 27. Indicate whether or not the board's findings and recommendations are unanimous. If they are not unanimous, attach as an inclosure a minority report by the dissenting member.

k. Items 28, 29, and 30. When a psychiatrist is a board member, add the letter "P" after branch (para 44). In typed portion, when board members are not officers, indicate status, such as contract surgeon.

l. Items 31 and 32. For use by the approving authority. If the board's proceedings are returned for reconsideration, attach as an inclosure the reason for return.

m. Item 33. For use by the approving authority only when the action of a board which has reconsidered a case is disapproved. Attach as an inclosure the approving authority's reason for disapproval.

n. Item 34. Self-explanatory.

o. Items 35 and 36 (para 38*g*).

(1) When an individual is being retained in a medical treatment facility to receive required treatment, these items will be completed when the approved board's action is made known to the patient. If the patient disagrees with the action, attach a statement of the patient's reason. When the patient does not disagree, line out the second and third sentences in item 35.

(2) When an individual is no longer at a medical treatment facility a letter will be sent by the medical treatment facility concerned advising him of the medical board's findings and recommendations and requesting that a written reply be made indicating his agreement or disagreement with the action. An indorsement with two blocks will be included with the letter. One block will indicate acknowledgment that he has been informed of the medical board's findings and recommendations, but desires to request reconsideration and is attaching as inclosure 1 a statement setting forth the reasons for his request. He will be requested to check one of the two boxes, attach his request for reconsideration, if appropriate, and sign and date the indorsement. The letter and the indorsement will be filed as an inclosure to DA Form 8-118. If, after a reasonable period of time the individual fails to respond, the DA Form 8-118 will be closed out without completing items 35 and 36. A statement will be made in the continuation block to the effect that these items could not be completed because of the individual's failure to respond.

p. Items 37 and 38. For use by the approving authority in acting on a patient's request for reconsideration. If the proceedings are returned to the medical board for reconsideration, the board's action resulting from the reconsideration will be attached as an inclosure (if appropriate this may be in statement form, signed by the board members). Any further action by the appointing authority will be entered in continuation.

q. Continuation. For use on continuing entries in other spaces. Identify each such entry by the number of the item being continued. In addition, this space may be used for remarks and as required in *p* above.

46. Requests for reconsideration. A patient who disagrees with the findings or recommendations of a medical board will be afforded an opportunity to submit pertinent statements or evidence for consideration by the approving authority. Any statements or evidence submitted become an integral part of the board proceedings.

★47. Approving authority. *a.* The appointing authority is also the approving authority for medical board proceedings. He does not participate in the medical board's proceedings, either as a member, witness, consultant, or in any other capacity. Medical board proceedings will be reviewed by the approving authority and his action entered thereon. If he approves the findings and recommendations or, when reconsideration of previously approved board action is requested, confirms these, the recommended disposition will be effected at the earliest practicable date except as provided in paragraph 57. If the approving authority does not concur with the board's findings or recommendations, he will return the proceedings to the board for further consideration. If the findings or recommendations of a board which has reconsidered a case are not approved by the appointing authority, he will forward the board's proceedings, in duplicate, together with his recommendations, to The Surgeon General, ATTN: MEDPS-S for review.

b. The approving authority may delegate the authority to review and act on medical boards, provided the individual to whom this authority is delegated (e.g., chief of professional services) does not participate in the medical board's proceedings, either as a member, witness, consultant, or in any other capacity.

★48. Distribution of medical board proceedings. Distribution of medical board proceedings will be as indicated in figure 2, depending upon the disposition of the patient, and as further prescribed in paragraph 57 for prisoner patients and in paragraph 70 for certain military personnel requiring further hospitalization upon separation. The additional copies prepared for mentally incompetent patients, after approval by the convening authority, will be forwarded direct to Settlement Operations, Finance Center, U.S. Army, Indianapolis, Ind. 46249.

★49. Counseling of member. When the approved recommendation of a medical board is that the member appear before a physical evaluation board, the member will be referred to the Physical Evaluation Board Liaison Officer for counseling as provided in AR 635-40. The member will not be told that he will be discharged or retired from the service or that his disability is a certain percentage.

★50. Records sent to a physical evaluation board. When a case is referred to a physical

evaluation board, all records pertinent to the case will be forwarded to the board by the most expeditious means available. Among the records to be forwarded are—

a. Approved Medical Board Proceedings (DA Form 8–118), with inclosure 1, Narrative Summary (SF 502) and inclosure 2, Report of Medical Examination (SF 88).

b. Verified statement of service.

c. All clinical records, X-ray film, and other medical records, including those received from The Adjutant General, other service hospitals, and the Veterans Administration.

d. Health Records (DD Form 722).

e. A copy of instructions when medical board was convened by direction of higher authority.

f. For enlisted personnel, a reproduced copy of DA Form 20, Enlisted Qualification Record. When the member's current grade is Private (E–1), a statement will be included in the extract showing circumstances which preclude advancement to the grade of Private (E–2) under provisions of AR 600–200 and, when sentence of a court-martial is involved, whether remission action is contemplated.

g. A copy of the court-martial order, if the member has been sentenced to dismissal or punitive discharge, which has been suspended.

h. Report of Investigation—Line of Duty and Misconduct Status (DD Form 261), or Statement of Medical Examination and Duty Status (DA Form 2173), if applicable (para 45*d*(1)).

i. A statement indicating whether elimination proceedings are pending against any commissioned or warrant officer, and describing the current status of those proceedings.

j. Application for expeditious discharge under provisions of chapter 9, AR 635–40, if appropriate.

k. Statement of election relative to request for continuance on active duty under the provisions of chapter 10, AR 635–40, and the member's application for such continuance, if he elected to apply.

l. Statement of extension of enlistment, if applicable. See AR 635–200.

m. In cases where the patient is not on extended active duty, a copy of the orders which ordered him to active duty, active duty for training, or inactive duty training; or a copy of the order rehospitalizing the patient, pursuant to paragraph 15, AR 135–200.

n. In mentally incompetent or deleterious type cases, a statement showing: Name, address, and relationship of next-of-kin (or court appointed guardian); whether he (or she) has been advised that the case is being referred to a PEB. If the next-of-kin is not known or cannot be located and there is no court appointed guardian, a summary of attempts to identify or locate him (or her) will be provided.

o. Copy of request for VA hospital bed designation, if appropriate.

p. Copy of orders moving patient to a VA hospital for continued hospitalization, if appropriate.

q. Copy of letter(s) to appropriate State authorities for disposition of psychotic members who are not eligible for VA hospitalization, as applicable.

★51. Elections concerning physical evaluation board procedures and counsel. Rescinded.

★52. Request for previous medical and other essential records. *a. Records in Headquarters, Department of the Army, files.*

(1) DD Form 877 (Request for Medical/Dental Records and Other Information) will be used to obtain medical records when these records are required for any purpose other than processing for appearance before a physical evaluation board.

(2) DA Form 261 (Request for Records and Official Statement of Service from The Adjutant General) will be used to request medical records and a statement of service for members who may be scheduled for disability evaluation. The verified copy of statement of service when received will be furnished to the PEB Liaison Officer for use in counseling the member and thereafter included in the records when forwarded to the PEB. Instructions on the initiation of this form are contained in *f* below. Air mail ordinarily will be used to transmit this request, except when circumstances necessitate use of telephonic or electrically transmitted message.

(*a*) Requests for records of commissioned and warrant officers on active duty will be addressed to The Adjutant General, ATTN: AGPS–FC, Department of the Army, Washington, D.C. 20310.

(*b*) Requests for records of enlisted personnel on active duty will be addressed to the Commanding Officer, U.S. Army Personnel Service Support Center, ATTN: AGPE–V, Fort Benjamin Harrison, Indianapolis, Ind. 46249.

(*c*) Requests for records of Reserve component personnel, not on active duty, will be addressed to the Commanding Officer, U.S. Army Administrative Center, 9700 Page Boulevard, St. Louis, Mo. 63132.

(3) When circumstances necessitate use of telephonic or electrically transmitted messages in the interest of expediting the processing of the case, request for the member's medical records and a verified statement of service will be transmitted to The Adjutant General, ATTN: AGPO, for officers and warrant officers (AUTOVON 22–54077); AGPF for enlisted personnel (AUTOVON 923–3111); or to the addressee in (2) (*c*) above, for Reserve component personnel (AUTOVON 631–1600 X770) stating:

PEB action pending for (Name, Grade, and Service Numbers). Lend medical clinical records. Member claims prior service in Army, Navy, Air Force, Marine Corps, Coast Guard, or _____ National Guard from _____ to _____, under service number _____.

(4) The Office of The Adjutant General, or other custodians of records indicated above, will withdraw all available requested records and forward them together with a verified statement of service by air mail to the requesting hospital. All records so obtained will be forwarded with the medical board proceedings when the case is referred to a physical evaluation board. The same records will accompany the proceedings of the physical evaluation board when they are forwarded for review to the Department of the Army.

b. Records held by service hospitals. Request for records will be sent directly to the hospital concerned and will include dates of hospitalization and register numbers if known. Hospitals receiving such requests will expedite forwarding of all available original medical records.

c. Records held by the Veterans Administration.

(1) Requests for medical records from the Veterans Administration will be forwarded directly to the VA Regional Office or field station known to have custody of the veteran's file (claims or insurance).

(2) When only records from a VA hospital are desired, the request may be forwarded directly to the VA hospital concerned, if known.

(3) Requests for records when the location of the VA custodian is not known will be forwarded to: Veterans Administration Central Office; Office Operations Service (034A1); Washington, D.C. 20420.

(4) All requests for records and/or abstracts of records data will include the name of the member; all available VA file numbers (claims and insurance); service numbers; the official purpose

for which the records are requested; and the complete address of the installation to be furnished the records.

(5) The Veterans Administration will usually furnish original VA clinical records and/or X-ray film in response to specific requests. If the clinical records or X-ray film cannot be released, however, copies of the final summaries of clinical records and X-ray facsimiles may be made and released instead.

(6) When the requested original records have served their purpose, they will be returned directly to the VA installation which forwarded them. When the patient's case is not considered by a PEB, the records will be returned to the VA by the hospital. When the patient's case is considered by a PEB, the records will be returned to the VA by the hospital after final determination has been made in the case by the Department of the Army. In these cases, any original records received in Headquarters, Department of the Army, with PEB proceedings will be returned to the hospital for disposition. Copies or facsimile reproductions will not be returned unless specifically requested.

d. Action taken by the hospital upon transfer of a patient. If the patient is transferred to another hospital before receipt of requested records, the hospital commander may request that the records be forwarded to the hospital to which the patient has been transferred, or he may await receipt of the records and immediately forward them to the patient's new location. In any event, the commander of the losing hospital will notify the commander of the gaining hospital of the actions taken and the results obtained with respect to the procurement of the records. Copies of negative responses will be forwarded to the gaining hospital for submission to the PEB.

e. Negative replies to requests for records. If the records requested are no longer on hand, negative replies will include information, when available, on the addresses to which the records were forwarded and the date forwarded.

f. Completion of DA Form 261. DA Form 261 must be completed in accordance with the following instructions:

(1) *Item 1.* If the individual has only a middle initial, it will be used. If there is no middle name or initial, no entry will be made under "middle name." If the individual claims prior service in the Army or another service under another name, the other name will be shown in parentheses.

(2) *Item 2.* Show all service numbers. Service numbers other than the one in current use will be shown in parentheses. In the case of members claiming prior service in another service, it is important that the service number be ascertained from the member and shown in item 2. It may be necessary to procure medical records from the service concerned. Such service will also have to be verified for longevity purposes. Availability of service number will expedite identification of the individual to the service concerned, thereby expediting procurement of medical records and verification of service.

(3) *Item 3.* Enter the member's current grade from the official reports. If current records are not available, explain basis of entry in item 15.

(4) *Item 4.* Enter branch and component of member at time of request for records.

(5) *Item 5.* Enter designation or organization to which member was assigned immediately prior to hospitalization.

(6) *Item 6.* Include the official name of the medical facility requesting the records and the post office address of such facility.

(7) *Item 7.* Date will be that on which request for records is dispatched from the hospital.

(8) *Item 8.* Extreme care in this item is of paramount importance. First column: Listing of each individual assignment is not desired. When applicable, enter enlisted service first, specifying it as such, using a separate line for each type, such as Army Reserve, National Guard, or Regular Army. Inactive Federal service and active Federal service will be set forth separately as will each separate period of enlistment. Second, show warrant officer service. Third, show commissioned service, again using a separate line for each type, making separate entries for active and inactive Federal service. Show the date the officer accepted his commission. Enter active or inactive to indicate type of service for each entry in this column. Enter other service (such as Naval, Coast Guard) on succeeding lines. Second column: Care in designation of type of service is essential for ease in verification. Third column: Dates must be accurate. Fourth column: Service credited. *Leave blank.*

(9) *Item 9 and 9a.* Self-explanatory.

(10) *Item 10.* Enter inclusive dates of time lost during current period of service. If an individual was discharged from a previous enlistment and the service record was continued in his current enlistment, this item, and item 11 will include information regarding all service covered by the service record.

(11) *Item 11.* All grades held by member during his current period of active service, to include dates of promotion and/or reduction, if any. When a reduction in grade has occurred, include a statement giving the specific reason and authority for reduction. In all cases in which the member's current grade is Private (E-1), include a statement showing circumstances which preclude the member's advancement to Private (E-2) under AR 600-200.

(12) *Item 12.* If records are not available, information regarding highest grade may be obtained from the patient.

(13) *Item 13.* This question must be answered so that reference to any former Army retiring board or physical evaluation board action may be checked against present diagnosis.

(14) *Item 14.* Include names and locations of hospitals and date of hospitalization during current episode of treatment in order that necessary medical and/or clinical records may be located without delay.

(15) *Item 15.* Enter any remarks pertinent to other items. If additional space is needed, a separate sheet of paper may be attached.

(16) *Item 16.* The member will sign the original, using his normal signature.

(17) *Item 17.* The officer responsible for preparation of the request for records will sign the original.

★53. Veterans Administration Physicians Guide-Disability Evaluation Examinations and Veterans Administration Schedule for Rating Disabilities. Medical officers whose responsibilities include the preparation of cases for eventual presentation to physical evaluation boards will be familiar with the Veterans Administration Physicians Guide-Disability Evaluation Examinations and the Veterans Administration Schedule for Rating Disabilities, and insure that the information and terminology recorded adequately describes severity so as to permit the establishment of disability percentage ratings. Requests for either publication will be forwarded with justification through channels to The Surgeon General, ATTN: MEDAS-A.

54. Types of disposition for members of the Army. *a. Full duty.* Patients who meet retention medical fitness standards and are med-

ically fit to perform duty without restrictions or assignment limitations will be returned to full duty. This type of disposition may be made by the attending medical officer or upon the approved recommendation of a medical board. Disposition to *full* duty from a duty status involving duty or assignment restrictions can only be made based on approved medical board recommendations.

b. Temporarily restricted duty. Patients who meet retention medical fitness standards and who are considered medically fit to perform useful duty while recovering from sickness or injury will be placed on temporarily restricted duty. Such patients will be evaluated at least once every 3 months with a view to upgrading their duty status. No individual may be in a temporarily restricted duty status for more than 12 months. This type of disposition involving a total of 3 months or less normally should be made by the attending medical officer. Return to full duty from a temporarily restricted duty status imposed as a result of a medical board can only be made based on approved medical board recommendations.

c. Trial duty. Patients whose medical fitness for retention and performance of useful duty is problematical may be recommended for trial duty by a medical board. No individual may be on trial duty without being evaluated at least once every 3 months with a view to upgrading his duty status or separating him from the service, if appropriate. Individuals will not be retained on a trial duty status for more than 12 months without prior approval of Headquarters, Department of the Army.

★*d. Duty with permanent assignment limitations.* Patients who meet retention medical fitness standards and who are fit to perform useful duty with specific permanent assignment limitations will be recommended for duty with permanent assignment limitations by a medical board. Individuals who do *not* meet retention medical fitness standards and who are recommended for continuance on active duty as outlined in AR 635-40 will have their permanent assignment limitations identified by the medical board processing the case for continuance on active duty.

e. Duty for separation or separation recommended.

(1) Patients who meet retention medical fitness standards and who are *scheduled* for any administrative separation or retirement, including separation for administrative unfitness, will be returned to duty for separation. This type of disposition may be made by either the attending medical officer or by the commander based on medical board recommendations.

★(2) Patients who do not meet retention medical fitness standards, do not require active hospitalization, and who are eligible for and elect separation for a condition existing prior to service which has not been aggravated by such service will be processed as outlined in chapter 9, AR 635-40. This type of disposition can be made only on medical board recommendation as confirmed by a physical evaluation board.

★(3) A patient who meets retention medical fitness standards (chap. 3, AR 40-501) but does not meet procurement medical fitness standards (chap. 2, AR 40-501) will be processed for separation on the recommendation of an approved medical board only if he applies for separation within the time limit and as prescribed in paragraph 5-9, AR 635-200. If he declines to apply for separation, and his erroneous entry into the service was discovered within the time limit stated in AR 635-200, he must sign a statement acknowledging that he has been informed of his right to apply for such separation but declines to do so, and desires to complete the term of service for which he enlisted or was inducted. The statement will become

a permanent part of his personnel records.

(4) Patients who meet retention medical fitness standards but are considered administratively unfit for further military service, will be returned to duty with separation recommended under the appropriate administrative regulation. This type of disposition may be made by either the attending medical officer or by the commander based on medical board recommendations.

f. Transfer to another medical treatment facility (para 3.1*m*). This type of disposition may be made by either the attending medical officer or by the commander based on medical board recommendations.

g. Referral to a physical evaluation board.

★(1) All members who do not meet medical fitness standards for retention or whose fitness is questionable, including members who have two or more impairments which individually are not unfitting, but which together cause sufficient disability to make fitness for military service questionable; and those with latent impairments of such significance as to raise a question of post-separation or retirement fitness should be considered for separation or retirement under paragraph 3-36*e*, AR 40-501. This applies whether expeditious discharge has been recommended under provisions of chapter 9, AR 635-40 or application for continuance on active duty has been made under provisions of chapter 10, AR 635-40.

(2) Cases where referral is directed by Headquarters, Department of the Army.

h. AWOL. When a patient absents himself without leave and remains in an AWOL status for 10 consecutive days his medical records will be closed. This type of disposition is made by the attending medical officer.

i. Death.

55. Types of disposition for nonmilitary patients. *a.* Discharge from hospital when the patient is released to own custody or custody of the sponsor or next of kin, or other authorized individual. (Appointments or instructions for followup treatment, if required, are initiated by the attending medical officer.)

b. Transfer to another medical treatment facility (para 3.1*m*).

c. Absent without release when the patient departs without proper release or is otherwise unaccounted for.

d. Release against medical advice when the patient and/or his sponsor signs an appropriate release.

e. Death.

56. Members of the Reserve component on active duty for training pursuant to orders which specify a period of 30 days or less, members of the Reserve components participating in Reserve duty training, and members of the ROTC on training tour. *a. Evaluation by medical board.* When an individual in one of these categories is considered medically unfit for duty upon completion of hospitalization, he will be evaluated by a medical board prior to release from the hospital. Patients requiring hospitalization beyond the termination of their tour of duty will be evaluated for disposition within the following time limits:

(1) *Conditions not in line of duty.* At the earliest practicable time that the patient becomes transportable.

(2) *Conditions in line of duty.* As early as the patient requests release from the hospital or when the patient attains maximum hospital benefits.

b. Procedures following approved medical board action.

(1) Reserve component patients medically unfit for further active duty or training as result of injury incurred or aggravated during a period of active duty for training or Reserve duty training will be referred to a physical evaluation board.

(2) Reserve component patients who are medically fit for further active duty or training will be released from the hospital.

(3) For special procedures affecting ROTC members, see AR 145-1. Disposition normally will be release from the hospital except as provided in (4) below.

(4) When it is determined that a patient does not require further hospitalization in an Army hospital and does not qualify for physical disability processing by a physical evaluation board, the patient will be released from the hospital or transferred to a nonmilitary medical facility. Arrangements for such transfer will be made by the hospital commander in the case of USAR and ROTC personnel, and with the assistance of the adjutant general of the State concerned in the case of National Guard personnel. When appropriate

arrangements cannot be made after reasonable endeavor, the case will be reported through the Army commander, the Commanding Officer, U.S. Army Records Center, St. Louis, Mo., or the Chief, National Guard Bureau, as appropriate, to The Surgeon General, ATTN: MEDDD-OH, for disposition instructions. Cases so reported will include a summary of all actions taken; two copies of the medical board proceedings; a summary of all Federal service claimed by the individual, if any, including the dates of such service; the address of the patient's home of record; line-of-duty status; recommendations of the hospital commander and copies of any pertinent correspondence.

e. Notification of disposition and separation:

(1) When a member of the Army Reserve or ACDUTRA or Reserve duty training or the Reserve Officers' Training Corps is released from the hospital, the CONUS army commander concerned, or the Commanding Officer, U.S. Army Administration Center, St. Louis, Mo., as appropriate, will be notified of the date and type of disposition and, in those cases where medical board proceedings are required, will be furnished two copies of the proceedings.

(2) When a member of the National Guard on ACDUTRA or Reserve duty training is released from the hospital, the adjutant general of the State concerned will be furnished the information and documents specified in (1) above.

(3) Members of the Reserve components will be separated from their status in their respective component by action of the hospital commander when appropriate. Members of the Reserve Officers' Training Corps will not be separated from their status by action of the hospital commander without approval of higher authority as provided in AR 145-120.

d. Letter of instruction in special cases. In some instances a member of a Reserve component may be returned to his home in a convalescent status pending final determination of medical fitness for military service. Such member, upon release from the hospital, will be provided with a letter of instruction which will reflect—

(1) Diagnosis of disease or injury and line-of-duty determination.

(2) Date, time, place of disease or injury, status of member, and authority for status.

(3) Approximate period of convalescence.

(4) The medical treatment facility or physician to whom to report for—

(*a*) Followup care (e.g., removal of cast).

(*b*) Final determination of medical fitness for military service.

(*c*) Determination of date of return to "full," "temporarily restricted" or "trial" military duty status.

57. Prisoner patients. *a.* One or more of the following recommendations for disposition of prisoner patients whose sentence includes punitive discharge or dismissal will be made:

(1) Return to confinement to serve remainder of sentence. This recommendation is to be made when it is found that the condition for which a prisoner was hospitalized is in a satisfactory state of remission and/or control (whether or not he meets retention standards unless return to confinement will medically compromise his health or well-being or prejudice the interests of the Government). In appropriate instances a medical board will recommend assignment limitations. A copy of the approved board proceedings will be transmitted to the appropriate confinement officer. A covering letter may be sent to clearly identify any aspects of confinement which will medically affect the prisoner.

(2) Transfer to an Army specialized medical treatment facility provided further treatment may result in substantial improvement.

(3) Remission of sentence by the Secretary of the Army, or change in type of discharge, concurrent with transfer to a VA hospital or State institution, or release to care of next of kin or to own care. (Transfer to a VA hospital will be accomplished only when the punitive discharge or dismissal from service is under other than dishonorable conditions.)

(4) Transfer to a VA hospital or State institution upon expiration of sentence. (Transfer to a VA hospital will be accomplished only when the punitive discharge or dismissal from service is under other than dishonorable conditions.)

(5) Transfer under the provisions of AR 633-5 to a Federal confinement facility having medical or psychiatric treatment facilities.

b. When a medical board recommends disposition of a prisoner by action which would require remission of sentence, change of type of discharge or transfer to a Federal confinement facility, the original and duplicate of the medical board proceedings will be forwarded for consideration and necessary action through The Surgeon General, ATTN: MEDPS, to the authority prescribed in (1) or (2) below.

(1) Recommendations affecting prisoners carried on the rolls of a U.S. disciplinary barracks; recommendations for transfer to a Federal confinement facility, irrespective of the prisoner's place of confinement; and recommendations for substitution of an administrative form of discharge for a discharge of dismissal executed in accordance with the sentence of a court-martial, irrespective of the prisoner's place of confinement, will be forwarded to The Provost Marshal General, ATTN: PMGK, Washington, D.C. 20315.

(2) Recommendations other than those specified in (1) above will be forwarded to the officer exercising general court-martial jurisdiction over the prisoner.

c. A prisoner hospitalized beyond the expiration of his sentence to confinement will be carried by the Army medical treatment facility as an Army patient if his punitive discharge or dismissal has not been accomplished. If discharge or dismissal from the Army has been accomplished and his sentence to confinement has expired, the prisoner will be carried by the Army medical treatment facility as a pay patient until his disposition can be effected (para 21*c*).

d. The commandant of the disciplinary barracks or the installation commander, if the place of confinement is other than a disciplinary barracks, is responsible for administrative control of the prisoner. He may in cases of early expiration of sentence, and upon request of the medical treatment facility commander administratively forfeit good conduct time pursuant to AR 633-30, to permit final

action in the case before the prisoner's sentence to confinement expires.

e. A prisoner will not receive a disposition other than to an Army medical treatment facility if he is eligible to meet a physical evaluation board in accordance with AR 635-40.

f. In the event a prisoner is not eligible for restoration to duty for service because of some mental disability which arose subsequent to his confinement and his service and military record is such that, but for such disability, it appears reasonably certain that he would have been restored to duty by the Secretary of the Army with an opportunity to earn an honorable discharge, the Secretary of the Army may substitute an administrative discharge for a discharge or dismissal executed in accordance with the sentence of a court-martial. Similar action also may be taken where it appears after trial that, at the time of his offense, a prisoner was not mentally responsible for his acts under accepted legal standards. Recommendations for such action will be forwarded as outlined in *b* above.

g. Information copies of correspondence regarding disposition of prisoner patients will be furnished the commandant of the disciplinary barracks or installation commander, as appropriate.

58. Terminal cases. Rescinded.

59. Psychoneurotic patients. *a.* In general, treatment under hospital conditions is not of benefit to psychoneurotic patients. To the maximum extent possible, neurotic reactions will be diagnosed and treated on an outpatient basis.

★*b.* In a large percentage of cases, treatment or clarification and possibly removal of situational pressures will result in the cessation of neurotic symptomatology, leaving only the basic substrata of a personality or character defect. Since personality and character defects fall within the group of character and behavior disorders, military patients manifesting these conditions are candidates for disposition under the provisions of AR 635-105 or AR 635-212, if separation is indicated. Such cases will be referred to a medical board only when the professional or administrative factors are complex.

60. Psychotic patients. *a.* At facilities not designated as specialized treatment centers for psychiatry, when the preponderance of available clinical evidence indicates the presence of a psychosis in a military patient and treatment, observation, or evaluation for a period in excess of 30 days is indicated, transfer to a facility designated as a specialized treatment center for psychiatry normally will be accomplished within 30 days of the date of admission, except as provided in *c* below.

b. At facilities designated as specialized treatment centers for psychiatry, cases of psychosis ordinarily will not be held for prolonged periods of observation to determine the permanency of the disability. An evaluation of response to treatment will be made as soon as practicable after a definite diagnosis has been established. In those cases where treatment has not resulted in substantial improvement, disposition will be made as expeditiously as practicable. Intensive treatment for a period of under 180 days in the majority of cases will be sufficient to establish the degree of disability and provide optimum hospital benefits.

c. In cases of military prisoners where, as a result of detailed psychiatric evaluation, it is determined that treatment in an Army hospital having specialized neuropsychiatric facilities would not result in substantial improvement, or that further evaluation and observation is not warranted, the prisoner patient will be examined by a medical board convened at the place of confinement for consideration of appropriate disposition.

d. It is a commander's responsibility to exercise all reasonable measures available for the protection of the personal affairs of the psychotic as well as for other members of his command. Legal assistance officers will be contacted for counsel and advice. A psychotic soldier, despite his mental illness, may be sufficiently competent to execute a legally acceptable power of attorney or other instrument authorizing another person to act in his behalf in the sale or other disposition of personal property, the collection of debts, and the settlement of all legal obligations and claims. Mental

incompetency may vary in degree and in relation to specific situations. Opinion as to competency will be obtained from a psychiatrist in regard to specific situations arising in the settlement of personal affairs.

61. Examination of members on the temporary disability retired list (TDRL). *a.* An individual placed on the temporary disability retired list is required by law to undergo a medical examination at least once every 18 months during the 5-year period after the date of placement thereon to determine whether his disability has stabilized. Proceedings of the physical evaluation board and all medical records available in The Adjutant General's Office are forwarded to the medical treatment facility selected to accomplish this examination.

b. Except where hospitalization is essential to the proper conduct of the examination, individuals will be evaluated on an outpatient basis and not admitted to the hospital. One or more medical officers will conduct the examination. The advice of professional consultants will be obtained whenever indicated. This may include the referral of all medical records to a specialized treatment facility for review and recommendations. The findings of the attending medical officer(s) will be considered by a medical board when appropriate (para 42*h*) which may recommend one of the following:

(1) Retention on the temporary disability retired list when the condition of the individual has not stabilized sufficiently to permit final determination. In these cases include the date of the next periodic medical examination.

(2) Reevaluation by a physical evaluation board when—

(*a*) The examination is conducted within 9 months of the fifth anniversary of the individual's placement on the TDRL.

(*b*) The disability has stabilized.

(*c*) The disability has improved to the extent that the member may meet retention medical fitness standards.

c. If the recommendation of the medical board is "retention on the TDRL," the approved medical board proceedings will be forwarded to The Adjutant General, ATTN: AGPO. If reevaluation by a physical evaluation board is recommended, the case will be forwarded to the appropriate physical evaluation board, together with medical records secured from The Adjutant General, the Veterans Administration, and other sources. Physical profile will not be included in examinations of TDRL members.

★*d.* Advice of professional consultants will be obtained in all cases involving members who were placed on the TDRL because of tuberculosis. All medical records and x-rays will be forwarded for review to either Fitzsimons General Hospital or Valley Forge General Hospital. Patients previously treated or who have had their records previously reviewed at either hospital will have their records forwarded to that hospital for review; otherwise these records will be forwarded to the nearer of these hospitals. Records and x-rays concerning the current examination will include the following:

(1) A member's statement concerning date(s) and place(s) of any hospital or outpatient treatment for any cause since his last examination.

(2) Pertinent x-ray examinations, including chest x-rays.

(3) A completed report of medical examination (SF 88).

(4) Laboratory studies and the results of three cultures of sputum or gastric contents for M. tuberculosis (or urine cultures in cases of genitourinary tuberculosis).

(5) A recommendation for disposition of the member.

★*e.* The reviewing facility will report its findings and recommendations to the referring facility except for those instances cited in *b*(2), above. In those instances the Commanding General, Fitzsimons General Hospital or Valley Forge General Hospital, acting for The Surgeon General as prescribed in paragraph 7-4*c*(3), AR 635-40, will prepare his findings and recommendations in the form of an addendum to the medical board proceedings that were part of the PEB action placing the individual on the TDRL. The records will be forwarded through The Adjutant General, ATTN: AGPO, to the Central Physical Evaluation Board, Walter Reed Army Medical Center, Washington, D.C. 20012.

62. Continuance on active duty of partially disabled personnel. Individuals (except general officers) who appear to be unfit for retention (chap. 3, AR 40-501) should be informed that they may apply for continuance on active duty

under the provisions of chapter 10, AR 635-40. Continuance on active duty under this program is not a right. Each case is individually considered and an application is approved at Headquarters, Department of the Army, if the individual can perform an essential service in spite of his unfitness without further aggravating his condition.

a. A medical board which plans to recommend referral of a member to a physical evaluation board will consider whether the member is medically qualified for continuance on active duty in his current MOS, either primary or a secondary, or in another field for which the member might be readily trainable. The purely medical considerations for continuance on active duty are—

(1) The nature and degree of the medical condition or physical defect in terms of the effect on the individual's health and well-being if he remains on active duty.

(2) The ability of the member to maintain himself in a normal military environment.

(3) The prognosis for completing at least 20 years of useful military service without undue loss of time from duty for hospitalization or medical treatment.

b. If the medical board finds that the member meets the medical criteria stated above, appropriate assignment and duty limitations will be recorded on the DA Form 8-118. (These limitations may preclude the member from performing in his MOS and require later reclassification as provided in administrative regulations.) The medical board will also record a physical profile appropriate to the member's condition on the Standard Form 88 attached to the DA Form 8-118. Rules for profiling are set forth in AR 40-501.

c. After the action of the medical board has been approved, the member will be referred to the Physical Evaluation Board Liaison Officer (PEBLO) for counseling before his case is forwarded to the PEB for action under AR 635-40.

d. When a member who has been continued on active duty as provided in AR 635-40 undergoes his periodic physical examination (AR 40-501) particular consideration will be given to his unfitting defect; whether there has been any change or whether the condition has significantly affected his performance of duty. If his potential for further continuance on active duty appears to have been lowered or is otherwise questionable, a medical board will again consider his medical qualification for continuance.

e. A member who has been continued on active duty under this program must be evaluated by a medical board prior to final separation or retirement from the service. His present condition will be carefully described in complete detail and his case will be referred to a PEB for consideration. Such a member is entitled to evaluation by the medical board and the PEB under the standards in effect when he was originally "continued on active duty" or at time of final evaluation, whichever set is more favorable to him as he elects. Medical board and PEB considerations are necessary even though the member may have been cured. In such a case, the member would not, of course, be considered unfit because of physical disability since no disability exists. The foregoing statement is explanatory and may not be used as a rule to deny consideration of a member's case in the circumstances described.

63. U.S. Navy and U.S. Air Force patients. *a.* When administrative units of the United States Navy or Air Force are stationed at CONUS Army medical treatment facilities, the disposition of naval or air military personnel is the responsibility of the parent service unit

b. When no administrative detachments of the other Armed Forces are stationed at a CONUS facility, disposition of naval and air military personnel will be effected as follows:

(1) When the patient is fit for duty he will be returned to his assigned organization and station. If the patient's organization or station is not known, assignment instructions will be requested from the parent service. In addition, for naval personnel, requests will be made if the patient has been hospitalized more than 30 days. Requests will be addressed to—

(*a*) *For Navy and Marine Corps personnel.* The Commandant of the Naval District in which the medical treatment facility is located.

(*b*) *For Air Force personnel.* Chief of Staff, U.S. Air Force, Washington, D.C. 20310.

(2) When the patient is not fit for duty, he will be reported for transfer to a medical treatment facility having final disposition authority through normal medical regulating channels.

c. Major oversea commanders will prescribe disposition procedures for Navy and Air Force patients hospitalized in oversea medical treatment facilities.

d. Special problems not provided for above will be reported to The Surgeon General, ATTN: MEDDD-OH for necessary instructions.

64. Patients of NATO, SEATO, CENTO, and ABCA nations. *a.* In accordance with ratified agreements with the NATO (STANAG 2061), SEATO (SEASTAG 2061), CENTO (CENTO STANAG 2061), and ABCA (SOLOG 66) nations, patients who are members of the military forces of these nations will be transferred to their own national organization at the earliest practicable opportunity consistent with the observance of the principle that

ing, the name, address, relationship, and, if possible, the telephone number of one responsible, interested relative. He will indicate also that he has made appropriate arrangements with that individual to take necessary actions on behalf of the sponsor. This individual should be willing, if possible, to go to the installation in CONUS at which the patient is finally hospitalized to assist if necessary. A copy of these statements will be provided the commander of the oversea hospital for inclosure in the patient's medical record.

e. Disposition of nonmilitary psychotic.

(1) The patient may, after arrival in CONUS, withdraw the request for hospitalization and demand release from the hospital. Disposition will ordinarily be made to appropriate civilian authorities or, with the approval of such authorities, to the sponsor or next of kin as may be indicated. When a psychotic nonmilitary patient requires further hospitalization, the medical treatment facility commander will communicate with the sponsor or next of kin to ascertain whether the relative wishes to assume the custody and responsibility for the care of the patient. In each case, the relative will be fully advised of the facts which render acceptance of the patient inadvisable and of the difficulty and responsibility in the care of such patient. The relative who elects to receive the patient will be required to produce satisfactory evidence that proper care will be furnished. This evidence should be in the form of an affidavit from the sponsor or next of kin declaring that he or she is willing to assume responsibility for the patient and has the necessary financial means to provide adequate care and treatment.

(2) When transfer to the next of kin is inappropriate, the medical treatment facility commander will communicate with the appropriate civilian authorities of the State of residence for the purpose of obtaining authorization to transfer the patient to their custody. The addressees of the appropriate civilian authorities are listed in the appendix.

(3) In order to aid the civilian agencies in arriving at a decision with the least practicable delay, they should be given information as to the diagnosis, the date of onset of the condition, history of previous hospitalization for mental illness, residence, place and date of birth, race, and name and address of the next of kin.

(4) Inasmuch as commitment proceedings or laws for involuntary hospitalization vary among the States, appropriate personnel of Army medical treatment facilities should be thoroughly familiar with local requirements for emergency involuntary admission to or retention in local civilian facilities designated for the care of the psychotic or mentally ill.

★**69. Final disposition procedures for military patients.** *a. Patients who are fit for duty.* Patients who are fit for duty will be returned to duty as soon as possible. Attached military patients will be returned to their units of assignment. Individuals assigned to medical holding units will be reported for reassignment in accordance with instructions in paragraph 3.1*p* and *q*.

b. Patients who are unfit for duty. Patients who are assigned to medical holding units will be processed for separation as appropriate by the transfer point which supports the medical facility. Patients show are not assigned to the medical holding unit will be returned to their units of assignment for separation action. The following additional instructions apply:

(1) Patients who meet retention medical fitness standards but do not meet procurement medical fitness standards will be disposed of as provided in

paragraph 54 of this regulation and paragraph 5-9, AR 635-200.

(2) Patients who have been referred to physical evaluation boards and are approved for continuance on active duty as provided in chapter 10, AR 635-40, will be disposed of in compliance with instructions from Headquarters, Department of the Army.

(3) Patients who are being or have been processed through the physical disability evaluation system and who do not require active medical supervision, will be disposed of as provided in AR 635-40 or in compliance with instructions from Headquarters, Department of the Army.

(4) Patients who are being or have been processed through the physical disability evaluation system, who require continued active medical supervision, and who are eligible, will be transferred to a Veterans Administration medical facility as soon as possible to await final physical disability processing action (para 70*a*).

(5) Patients who are being or have been processed through the physical disability evaluation system, who require continued active medical supervision, but who are NOT eligible for transfer to a Veterans Administration medical facility will be disposed of as soon as possible in accordance with instructions in paragraph 70*b*. Separation will be accomplished within 72 hours of receipt of instructions from Headquarters, Department of the Army to do so, and will not be delayed pending completion of disposition arrangements.

c. Retention of patients beyond tour of active duty or ACDUTRA. Procedures for retention of patients whose period of service will expire while needing medical or dental care are contained in AR 135-173, AR 135-200, and AR 635-200.

★70. Military patients requiring continued hospitalization after separation. When it is determined that a patient will require continued hospitalization after separation, the medical treatment facility commander will initiate action to accomplish disposition as follows:

a. Transfer to a Veterans Administration facility. If the patient had other than dishonorable service, an electrically transmitted message will be forwarded to the Armed Services Medical Regulating Office (ASMRO), Main Navy Building, Washington, D.C., for a bed designation in a Veterans Administration facility (AR 40-350).

(1) A member being transferred from an Army medical treatment facility to a Veterans Administration facility for further hospitalization following physical evaluation board action will be ordered on PCS to such facility as provided in (3) below. The member will remain assigned to the medical holding unit for record purposes only and reports will be completed in accordance with AR 40-400, AR 40-417, AR 40-418, AR 40-422, AR 40-424, and AR 40-425. Patients transferred on PCS to a VA facility will not be charged leave during the period of such hospitalization, and will be entitled to transfer of dependents and shipment of household goods in accordance with the Joint Travel Regulations. Direct communication between the military medical treatment facility commander and the manager of the VA hospital is authorized in accomplishing the transfer of patients to VA hospitals.

(2) All requests to the VA for a bed designation will be made at the earliest date which will permit completion of processing within the period that the VA bed designation will remain in effect (normally 30 days). On receipt of a VA bed designation, the medical treatment facility commander will promptly forward a copy to the PEB which is processing the member's case. If any condition should arise which will prevent completion of processing or transfer of the patient within this period, immediate action will be taken to cancel or extend the VA bed designation through ASMRO.

(3) Action prior to transfer of patient to VA hospital:

(*a*) Counseling as prescribed in AR 635-15. In cases of mentally incompetent patients, the individuals acting in their behalf will be counseled.

(*b*) Separation certificates. The Adjutant General will furnish the appropriate separation certificates for Regular Army officers and *all* retirement certificates. Discharge certificates or certificates of service (AR 635-5) will be prepared for all other personnel.

(*c*) DD Form 214 will be prepared for all personnel in accordance with AR 635-5. If it is impracticable to secure the member's signature in item 34, the item will be left blank. No notation of any kind will be placed on the No. 1 copy of DD Form 214, or any other separation form which is presented to the member, to indicate that he is mentally or otherwise incompetent to sign.

(4) The patient will be transferred to the designated hospital following receipt of the notification from ASMRO of a bed assignment in a Veterans Administration hospital. The time of transfer will be determined as follows:

(*a*) When the findings of the physical evaluation board indicate that the patient will be permanently retired, placed on the TDRL or discharged, the patient will be transferred at the earliest practicable date following the announcement of such findings by the PEB.

(*b*) When it is anticipated that a patient's hospitalization will be completed prior to the effective date of retirement or separation, the patient will not be processed for transfer to a VA facility.

(5) Due regard will be given to the availability and economical utilization of all Government transportation. Military Airlift Command (MAC) routine air evacuation will be utilized in making transfer whenever feasible. Arrangements for the transportation of patients to the Veterans Administration hospital will be made by the commander of the military hospital from which the patient is transferred.

(6) A request for medical treatment by the Veterans Administration will be completed in accordance with paragraph 76 for each patient who is transferred to a Veterans Administration hospital for treatment pending separation.

(7) In all cases in which the condition of the patient warrants an escort, he will be accompanied by an attendant (or attendants) during the transfer from the military hospital. Attendant, as used herein, includes medical personnel assigned to aeromedical evacuation flights.

(8) When an attendant accompanies a patient, the attendant will carry the records and documents listed below to the hospital to which the patient is transferred. When no attendant is necessary, the patient will carry a properly completed and authenticated copy of VA Form 10-P-10. Other pertinent records and documents listed below will be forwarded by certified mail prior to the departure of the patient.

(*a*) DD Form 675 (Receipt for Records and Patient's Property) in duplicate.

(*b*) VA Form 10-P-10. (Attach a copy of SF 502 to the back of the form and enter "See attached Summary" in item 47, VA Form 10-P-10, in-

stead of completing the medical certificate thereon.)

Note. Only LOD-No cases will be required to complete Items 29 and 30 on page 1, and Items 35 to 44 inclusive on page 2 of VA Form 10-P-10.

(*c*) DA Form 8-267 (Request for Medical Care in a Federal Medical Treatment Facility Outside Department of Defense).

(*d*) Copy of current clinical records.

(*e*) X-ray films, if any.

(*f*) Duplicate of statement on DA Form 664 (Serviceman's Statement Concerning Application for Compensation from the Veterans Administration (VA Form 21-526e)).

(*g*) VA Form 21-526e (Veterans Application for Compensation or Pension at Separation from Service) if completed.

(9) When the patient is ready for transfer, notification in advance will be made, by the most expeditious means available, to the Hospital Director of the Veterans Administration hospital with information to ASMRO. The notification will include the patient's name, grade, and service number, together with any applicable information regarding the following:

(*a*) Whether the patient is ambulatory.

(*b*) Identification of train or plane.

(*c*) Scheduled time of arrival.

(*d*) Whether accompanied by an attendant and, if so, the name and grade of the attendant.

A request will be included that prompt notification of the hour and date of the patient's arrival be forwarded to the military hospital. When an unusual delay in travel is experienced during the transfer of a patient accompanied by an attendant, the attendant will advise the losing military hospital and the Hospital Director of the Veterans Administration hospital to which the patient is being transferred, by the most expeditious means available, of the change in scheduled time of arrival and reasons therefor.

b. Patients not eligible for Veterans Administration hospitalization. In cases where the patient is not eligible for Veterans Administration, the commander will initiate action to insure appropriate disposition prior to separation. Disposition of psychotic patients will be made following provisions similar to those contained in paragraph 68*e*. In those cases where the next of kin will not accept the patient or provide the care he requires, the medical facility commander will communicate with the appropriate civil authorities in the patient's State of residence and secure permission to transfer the patient to their custody. If permission is not granted, the commander will repeat the procedure with the civil authorities of the State from which the patient entered the service if that State differs from the State of residence. For other than psychotic patients, where the patient is capable of making his own decisions, he will be provided assistance in making arrangements for his own hospitalization. Where the patient is in such condition that this cannot be accomplished, the next of kin will be requested to make arrangements for and accept the patient.

SECTION V

MEDICAL CARE AT NAVY OR AIR FORCE MEDICAL TREATMENT FACILITIES

71. For whom authorized. Subject to the restrictions referred to below, the personnel listed below will be provided medical care when available at Navy or Air Force medical treatment facilities. Medical care will be provided when such facilities are more readily available than medical treatment facilities of the Army. Determination of availability of facilities will be made, except in emergencies, by the commander or person in charge of the individual requiring care.

★*a.* Members of the Army included in paragraphs 7 and 8 subject to the restrictions contained therein. (Authorization for medical care referred to in para 8*b* will be obtained from the appropriate authority by the Army administrative unit or, where Army administrative units are not established, by the Army medical facility designated to assume administrative responsibility in accordance with para 74*a*). The term "administrative responsibility" will include, but not be limited to, the following:

(1) Necessary professional medical evaluation and assistance.

(2) Notification to the patient's parent unit and (when applicable) temporary duty organization.

(3) Morning report accounting, pay and allowances, and other personnel functions for patients assigned to a medical holding unit; and these same personnel function except pay and allowances for patients attached to a medical holding unit.

(4) Arranging transfer to another uniformed services facility in appropriate cases.

(5) Issuance of any necessary orders for further travel upon completion of hospitalization.

★*b.* Members of, and designated applicants for enrollment in, the Army Senior Reserve Officers' Training Corps subject to the restrictions outlined in paragraph 10*a*.

c. Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve components thereof, limited to the following:

(1) Necessary medical and mental examinations.

(2) Hospitalization to determine medical fitness for military service.

★(3) Emergency medical care for acute illnesses and injuries suffered while awaiting or undergoing processing at recruiting main stations or at Armed Forces Examining and Entrance Stations.

d. Registrants under the Universal Military Training and Service Act limited to the types of care referred to in *c* (1) and (2) above.

e. Applicants for appointment in the Regular Army, and Reserve components including those members of the Reserve components applying for active duty subject to the restrictions contained in paragraph 20.

f. Prisoners of war, retained personnel, persons interned by the Army, and other persons in military custody or confinement.

g. Civilian seamen in the service of vessels operated by the Department of the Army.

h. Civilian employees of the Army limited to those occupational health services authorized in AR 40-5.

i. Retired Army members subject to the restrictions outlined in paragraph 11.

j. Civilian employees (including former and prospective employees) of contractors of the Department of the Army limited to the types of care referred to in paragraph 27*d*.

k. Individuals who suffered personal injury or contracted disease in line of duty at a time when they were members of the Citizens Military Training Corps (para 9).

l. Labor Service personnel in France under the conditions specified in paragraph 25*d*(1).

m. Army National Guard technicians (civilian employees of the Army National Guard) assigned or to be assigned nuclear weapons duties at missile sites limited to medical examinations required by AR 611–15 when it is considered that a medical evaluation will assist in determining suitability for such assignment or continued assignment.

Note. When a psychiatric evaluation required in connection with the medical examination is made at a naval medical treatment facility, and it is determined that the technician is not mentally or emotionally suitable for assignment or continued assignment to missile site duties, an additional evaluation by an Army psychiatrist will be scheduled to corroborate previous psychiatric findings and to permit the Army psychiatrist to appear at any hearings held in the event a technician appeals the decision made in his case.

★*n.* U.S. nationals confined in foreign penal institutions (para 37.5).

72. General policies. *a.* For the method of assigning or attaching patients to Army administrative units or other designated Army organizations upon admission for, during and upon completion of hospitalization, and the manner in which they will be carried on administrative records, the pertinent provisions of paragraphs 3.1 and 74 apply.

b. Medical care and adjuncts thereto will be provided in accordance with the instructions of the military service providing the care.

c. Collection of subsistence charges from all Army officer patients will be made locally by the Navy or Air Force hospital.

d. When general officers of the Army on active duty are admitted to or released from Navy or Air Force hospitals, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*) *1* through *5* is required.

73. Army administrative units. When deemed necessary and concurred in by the service concerned, CONUS army commanders will establish Army administrative units at Navy or Air Force hospitals from resources available to them. CONUS army commanders are authorized direct communication with the Navy or Air Force commander concerned for this purpose. When an Army administrative unit is established at a Navy or Air Force hospital, administration of duty personnel and patients assigned or attached to such administrative unit will be accomplished in accordance with the instructions of the appropriate CONUS Army commander.

a. Assignment. Enlisted duty personnel will be assigned to Army administrative units by the CONUS army commander concerned. Army Medical Service officer duty personnel will be assigned by the Department of the Army.

b. Command.

(1) The commander of an Army administrative unit will be responsible to the appropriate CONUS army commander for the operational functions of the unit, and will be responsible for compliance by the unit with station orders and/or regulations of the Navy or Air Force hospital.

(2) The commander of the Army admintrative unit will act as, or will designate a subordinate officer of his unit as the commander of the medical holding unit.

(3) Army personnel at a Navy or Air Force hospital will be subject to the military authority of the Navy or Air Force commander, but will be assigned or attached to the Army administrative unit for administration. Military control of such personnel normally will be exercised by the Navy or Air Force commander through the commander of the Army administrative unit.

c. Supervision and support. The appropriate CONUS army commander will be responsible for the supervision of Army administrative units established by him, and for their logistical and administrative support.

d. Medical boards. A report of the proceedings of a Navy clinical or Air Force medical board, based upon Army medical standards, may be used in lieu of a report of proceedings of an Army medical board. Such reports will be accepted by Army physical evaluation boards in lieu of Army medical board reports.

e. Medical reports and records. Army administrative units will submit reports; i.e., DA Form 8–187 (Utilization of Army Medical Service Personnel) required by AR 40–202, and DA Form 2789 (Beds and Patients Report) required by AR 40–418.

f. Military discipline.

(1) The commander of an Army administrative unit has authority under the Uniform Code of Military Justice, Article 15, to impose nonjudicial punishment upon those Army members of his command who are subject to the provisions of the Uniform Code of Military Justice (UCMJ, Article 2). General court-martial jurisdiction and all matters pertaining to the administration of military justice over personnel of the Army administrative unit are the responsibility of the CONUS army commander concerned.

(2) Army prisoner patients, with the consent of the Navy or Air Force commander may be transferred into and out of Navy or Air Force hospitals under either Army guard or the guard of the military service concerned.

(3) Local confinement facilities of the Navy or Air Force may be used with permission of the Navy or Air Force commander for temporary confinement of Army personnel.

g. Autopsies and professional inspections.

(1) Navy or Air Force medical officers may make professional inspection of deceased Army personnel, as required.

(2) The Navy or Air Force commander may direct that an autopsy be performed upon the bodies of Army military personnel when he deems such procedure necessary in order to determine the true cause of death and to secure information for the completion of military records. Such autopsies, including microscopic examination of tissues may be performed by Navy or Air Force medical officers in accordance with the provisions of TM 8–300. Copies of autopsy protocols will be filed with the permanent records of the Army administrative unit.

h. Funds. Nonappropriated funds and patients' trust funds will not be established. Adequate safeguards for patients' funds and valuables will be provided by Navy or Air Force hospitals.

74. Administration of patients where Army administrative units are not established. ★*a. Within the continental United States.* The CONUS army commander is responsible for the administration of all Army patients at Navy or Air Force hospitals located in his geographic area where Army administrative units have not been established. The CONUS army commander will be an addressee in each hospital designation message from the Armed Services Medical Regulating Office which will result in the transfer of an Army patient into any Navy or Air Force hospital within his area. Immediately upon receipt of a message which pertains to a hospital where an Army administrative unit has not been established, the CONUS army commander will designate an Army medical treatment facility to be responsible for the administration of all Army patients hospitalized at the Navy or Air Force hospital. The CONUS army commander will forward to all addressees of the above mentioned messages by the same means of communication with the same precedence as the original, the name and location of the designated Army medical treatment facility. In the case of direct admissions, the Navy or Air Force commander will notify the Army patient's organization commander who will request the

CONUS army commander in whose area the patient is hospitalized to designate an Army medical treatment facility to be responsible for the administration of the patient.

b. Outside the United States. Responsibility for Army military patients in Navy or Air Force hospitals rests with the major oversea commander in whose area such a facility is located. Ordinarily, the nearest Army medical treatment facility will be designated to assume administrative responsibility for the patient. In areas not under the jurisdiction of a major oversea commander, the military attaché to the country in which the military patient is hospitalized will assume responsibility.

SECTION VI

MEDICAL CARE AT FEDERAL MEDICAL TREATMENT FACILITIES OTHER THAN THOSE OF THE ARMED FORCES

75. For whom authorized. Subject to the restrictions referred to in paragraph 71, the personnel listed below will be provided medical care when available at Federal medical treatment facilities other than those of the Armed Forces (hereinafter referred to as "Federal medical treatment facilities"). Medical care will be provided when such facilities are more readily available than medical treatment facilities of the Armed Forces.

a. Personnel enumerated in paragraph 71*a*.

(1) When general officers of the Army on active duty are admitted to or released from Federal medical treatment facilities, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information in dicated in paragraph 3.1*f* (1)(*a*) *1* through *5* is required.

★(2) Authorization for medical care referred to in paragraph 8*b* will be obtained from the appropriate authority by the Army medical facility designated to assume administrative responsibility in accordance with paragraph 76*a*(2).

★*b.* Personnel enumerated in paragraph 71 *b, c, d, f, h, j, k, m* and *n*.

c. Personnel enumerated in paragraph 71*e* who require hospitalization to determine medical fitness for appointment.

d. Personnel enumerated in paragraph 71*g* limited to care in medical treatment facilities of the Veterans Administration. (Such personnel when furnished care in hospitals and outpatient clinics of the Public Health Service are beneficiaries of that service.)

★*e.* Retired Army members (para 71*i*).

(1) Prior to 1 January 1967, limited to care provide in hospitals and outpatient clinics of the Public Health Service, except that when requested by the Department of the Army, retired Army members placed on the Temporary Disability Retired List may be furnished required medical examinations at medical treatment facilities of the Veterans Administration.

(2) On and after 1 January 1967, retired Army members may be provided inpatient and outpatient medical and dental care for non-service connected disabilities in Veterans Administration facilities as Army beneficiaries.

f. Foreign nationals who are members of the Army of one of the NATO nations listed in paragraph 25*a*(1) and who, in connection with their official duties, are stationed in or passing through the United States.

g. The dependents (as defined in para 25*a* (10)) of the individuals described in *f* above (limited to care provided in hospitals and outpatient clinics of the Public Health Service).

76. Manner in which care is provided. *a. Ordinary medical care.*

★(1) Except as indicated in paragraph 75*a* and *e*, and paragraph *b, c,* and *d* below, an individual will not obtain care from Federal medical treatment facilities without obtaining prior authorization from his commander. If the commander determines that the individual requires medical care, he will

prepare DA Form 8-267, in triplicate. This form will be addressed to the officer in charge of the Federal medical facility in which medical care is desired. The patient will present the original and one copy of the form to the facility when he applies for treatment. (This requirement does not apply in the case of members of the Army who apply for medical care at medical facilities of the Public Health Service.)

★(2) If the officer in charge of a Federal medical treatment facility accepts the Army beneficiary, the commander of the patient will notify the appropriate CONUS Army Commander or Army oversea commander or the Commanding General, Military District of Washington, U.S. Army, within whose territorial limits the facility is located, who will assign an Army medical treatment facility to assume administrative responsibility for the patient and will advise the officer in charge of the Federal medical facility of this assignment. Administrative responsibility will include, but not be limited to, those functions specified in paragraph 71*a* (1), (2), (3), and (5) and the following:

(*a*) Preparation of necessary individual medical records (AR 40-400).

(*b*) Seriously ill and death notifications (AR 40-2).

(*c*) Arranging transfer to another uniformed services facility (or to a uniformed services facility) in appropriate cases.

b. Emergency medical care. In an emergency, when the urgency of the situation does not permit the preparation of DA Form 8-267 by the patient's commander as prescribed in *a* above, authorized personnel may be furnished medical care without such request for treatment at the discretion of the officer in charge of the Federal medical treatment facility. The patient's commander will prepare DA Form 8-267, however, as soon thereafter as possible and forward it to the Federal medical treatment facility. At the same time he will notify the appropriate CONUS army commander or Army oversea commander or the Commanding General, Military District of Washington, U.S. Army, as stated in *a* above.

c. Absent from station. Authorized personnel when absent from their duty stations may be furnished medical care at Federal medical treatment facilities without obtaining prior authorization of their commanders and without DA Form 8-267 at the discretion of the officer in charge of such facilities. It is the responsibility of the patient or someone acting in his behalf to notify his commander of this fact so that his commander can comply with the requirements of *b* above. When the officer in charge of the Federal medical treatment facility is unable to obtain the required DA Form 8-267, he will state on the voucher for each such case that he ascertained from the DA identification card in possession of the patient that he was a member of the Army at the time medical care was furnished.

★*d. Care for retired members in Veterans Administration facilities.* DA Form 8-267 is not required for medical care obtained by retired Army members in Veterans Administration facilities. Identification will be by means of DD Form 2A(Ret) (gray).

★**77. Utilization of Federal medical treatment facilities.** If it is necessary to utilize the services of such facilities to supplement Army medical treatment facilities or Armed Forces Examining and Entrance Stations, the commanders thereof may obtain such services on their written request direct to the officer in charge of the facility concerned.

★**78. Rates of compensation.** Payment for inpatient care will be made at the inpatient rate prescribed by the Bureau of the Budget for the applicable fiscal year. Payment for outpatient care will be made at the rates prescribed by the Federal agency furnishing the care except in the case of members and retired

SECTION VII

MEDICAL CARE AT MEDICAL TREATMENT FACILITIES OF THE PANAMA CANAL COMPANY

81. For whom authorized. *a.* The following persons will be afforded medical care in medical treatment facilities of the Panama Canal Company at Army expense:

★(1) Personnel enumerated in paragraph 71 *a, b, c, d, f, g, h, k* and *n.*

(2) Personnel enumerated in paragraph 71*e*, who require hospitalization to determine medical fitness for appointment.

(3) Dependents of active duty Army personnel.

(4) Department of the Army civilian employees (paid from appropriated funds) who are not beneficiaries of the Bureau of Employees' Compensation with duty station in the Canal Zone, and their dependents when living with their sponsors. (The amount paid by the Army is the reimbursement rate established by the Panama Canal Company less the amount payable by such employees and their dependents.)

(5) Retired Army military personnel (para 2*p*) and their dependents.

b. All categories of personnel eligible to receive medical care at Army medical treatment facilities under the provisions of section III, other than those referred to in *a* above, may be afforded medical care at medical treatment facilities of the Panama Canal Company. (Such categories do not include those who are beneficiaries of other Federal agencies.)

c. The conditions under which care is furnished, the extent of treatment authorized, and rates of charge will be comparable to the restrictions and rates of charge prescribed in section III and table I.

82. Rates of compensation. Payment for medical care furnished will be made at rates prescribed by the Panama Canal Company.

SECTION VIII

MEDICAL CARE FROM CIVILIAN SOURCES

83. For whom authorized. ★Subject to the restrictions referred to in paragraph 71, personnel listed below will be provided medical care when available from civilian sources at the expense of Army funds. Care by civilian sources is authorized when it cannot be provided by medical treatment facilities of the Armed Forces or by other Federal medical treatment facilities, except as indicated in *h* below which pertains to hospitalization for persons interned by the Army.

Note. Except as provided in *f* below, retired Army members are not provided civilian medical care under the provisions of this section. Such members are authorized civilian medical care under the provisions of AR 40-121.

a. Personnel enumerated in paragraph 71*a*. *Such care will not be authorized for persons who are absent without authority.*

b. Personnel enumerated in paragraph 71*b*, *c*, *d*, *g*, *h*, *k*, and *n*. (That portion of this subparagraph which cites paragraph 71*b* is retroactive to 17 April 1962.)

c. Personnel enumerated in paragraph 71*e* who require hospitalization to determine medical fitness for appointment.

d. Foreign nationals who are members of the Army of one of the NATO nations listed in paragraph 25*a*(1) and who, in connection with their official duties, are stationed in or passing through the United States. (*This provision is applicable to authorized civilian medical care obtained on and after 1 July 1963.*)

e. For conditions under which dependents of individuals listed in *d* above are provided civilian medical care, see AR 40-125.

f. Retired Army members on the Temporary Disability Retired List who require periodic medical examinations, to include hospitalization when necessary in connection therewith, retroactive to 14 January 1963. (*The provisions of AR 40-121 are not applicable to examinations authorized by this subparagraph.*)

★*g.* Prisoners of war, retained personnel, and other persons in military custody or confinement.

★*h.* Civilians interned by the Army. These persons will be provided hospitalization at medical treatment facilities of the Armed Forces only in the absence of adequate civilian facilities pursuant to paragraph 42, AR 633-51.

84. Qualifications of professional personnel engaged to furnish medical care. *a. Licensing of civilian professional personnel.*

(1) Except as indicated in (2) below, doctors of medicine, doctors of osteopathy, doctors of dentistry (para 134), doctors of veterinary medicine (para 135), and optometrists (para 117*c* and 124) engaged to furnish medical services in accordance with this regulation must have valid licenses to practice their specialties in a State, territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico. Nurses engaged to provide nursing care must be currently registered to practice nursing in a State, territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(2) In the case of such professional personnel when engaged to perform services in oversea areas, except the Commonwealth of Puerto Rico, licensing and registration criteria will be as prescribed by the oversea commander concerned.

b. Restrictions.

(1) Except as indicated in (2) below, only those licensed or registered professional personnel covered in *a* above can be utilized for medical services if payment is to be made from Army funds.

(2) Practitioners specializing in the sciences allied to the practice of medicine who are licensed to practice in the area concerned may be utilized for medical services under (1) above when such service is provided on the written request of a licensed doctor of medicine, osteopathy or dentistry as part of the medical care required.

84.1 Exclusion of hospitals which practice discrimination. *a.* The Department of Defense has determined that certain civilian hospitals practice discrimination in the admission and/or treatment of patients on the basis of race, color or national origin and has declared these hospitals ineligible to receive payment from the Government for inpatient or outpatient care furnished Department of Defense beneficiaries on and after the effective date of ineligibility. The list of ineligible civilian

hospitals, together with the effective date of ineligibility, is published in appendix B, AR 40-121. Payment cannot be made for inpatient or outpatient care provided by these hospitals on and after the effective date of ineligibility except in unusual circumstances when approved by the Department of Defense. This applies regardless of whether the hospital seeks payment or the patient pays the hospital and requests reimbursement. Payment to physicians and other professional or paramedical personnel who bill independently of the hospital will not be refused solely because their services were provided in an ineligible hospital.

b. Before payment is denied for care obtained by an Army beneficiary in an ineligible hospital, the approving authority will review the case to determine whether unusual circumstances exist which may justify payment of the bill. Examples of unusual circumstances which may justify payment are a bona fide emergency, absence of an eligible hospital within reasonable distance, and admission of a patient to an ineligible hospital for short-term inpatient care prior to the effective date of ineligibility and treatment continues beyond that date. If it is found that unusual circumstances exist, the bill with a statement of the circumstances will be forwarded to The Surgeon General, ATTN: MEDDD-OP, for review and forwarding to the Department of Defense for decision.

★85. Special considerations for members of the Army. *a.* Charges incurred for civilian medical care for persons absent without authority will not be at Army expense. Where the absence without authority is terminated by the individual's actual or constructive return to military control, the charges for treatment may be paid in accordance with paragraph 88. For this purpose, constructive return to military control becomes effective for the entire episode of medical care when notification by civilian medical agencies that the AWOL member is undergoing medical treatment is acknowledged by military authorities. "Military authorities" in this instance refers to the CONUS Army commander or oversea Army commander of the area in which the civilian medical care is obtained, the chief of the military district of the area, the nearest installation commander, the individual's commander, or any other authority authorized to effect return to military control under AR 630-10. The military authority receiving the notification will immediately acknowledge the same orally or in writing, verify the individual's status in the manner prescribed by section X, AR 630-10, and take appropriate action with a view to the member's eventual return to actual military control. When an individual has been unable to return or report because of legitimate circumstances beyond his control, or has otherwise been erroneously reported AWOL or in desertion the responsible officer will take the action described in section XII, AR 630-10.

b. When general officers of the Army on active duty are admitted to or released from civilian medical treatment facilities, the commander of the general officer's assigned organization will be responsible for submission of as much of the information prescribed in paragraph 3.1*f* as is available. For admission to such hospitals, only the information indicated in paragraph 3.1*f*(1)(*a*) *1* through *5* is required.

c. Authorization for medical care referred to in paragraph 8*b* will be obtained from the appropriate authority by the Army medical treatment facility designated to assume administrative responsibility in accordance with paragraph 88*a*(1).

86. Elective care. Elective care in civilian medical treatment facilities or by civilian physicians is not authorized at Army expense.

87. Approving authorities. Approving authorities for civilian medical care are shown in figure 2.1.

88. Manner in which care is provided. *a. Ordinary medical care.* Except as indicated in (2) below, personnel entitled to medical care at Army expense will not obtain such care from civilian agencies at Army expense without obtaining prior authorization from the designated approving authority. All documents authorizing civilian care will include the following statement: "Payment will not be made by the Government for any nonemergency care obtained pursuant to this authority in hospitals which discriminate in the admission or treatment of patients on the basis of race, color or national origin."

Categories	*Approving authorities*
a. Members of the Army who are patients or who are on duty at hospitals, medical centers, and at those other medical activities located thereat under the command jurisdiction of The Surgeon General.	a. The commander of the appropriate hospital or medical center.
b. Members of the Army who are patients or who are on duty at installations and activities within the continental United States other than those referred to in a [1] above l below.[1]	b. The appropriate CONUS Army commander or the Commanding General, Military District of Washington, U.S. Army, in whose geographic area the medical care is furnished.
c. Members of the Army who are patients or who are on duty at installations and activities outside the continental United States.[2]	c. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Paksitan, India, Nepal, Afghanistan, the Malagsy Republic and Ceylon-United States Army, Europe; and (2) Countries in the Pacific, Alaskan, and Southern Commands—respective Army major oversea commanders except as indicated in g and h below.
d. Members of the Army National Guard of the several States, Commonwealth of Puerto Rico, the District of Columbia, and the Army National Guard of the United States while on active duty for periods of 30 days or less or not on active duty (except REP 63 personnel. See e below.)	d. Chief, National Guard Bureau, Washington, DC 20310.
e. REP 63 personnel who incurred an injury or disease in line of duty while on their initial tour of ACDUTRA and have completed ACDUTRA and returned to Army National Guard.[1]	e. The appropriate CONUS army, commander, the Commanding General, Military District of Washington, U.S. Army, or the appropriate Army major oversea commander under whose jurisdiction the ACDUTRA was performed.
f. Members of the Army in continental United States who are on leave or temporary duty from oversea stations or who are awaiting reassignment from or to oversea stations.	f. Same as b above.
g. Members of the Army assigned to Army Military Missions and MAAG's.[2]	g. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagsy Republic and Ceylon—United States Army, Europe; and (2) All other countries—The mission or MAAG chief.

Figure 2-1

See footnotes at end of list.

Categories	*Approving authorities*
h. Members of the Army assigned to Defense Attaché offices.[2]	h. The designated Army commander for civilian medical care obtained in the specified areas as follows: (1) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal Afghanistan, the Malagsy Republic and Ceylon-United States Army, Europe; and (2) All other countries—The appropriate Defense Attaché.
i. Members of the Army outside the continental United States who are on leave or temporary duty from CONUS Stations or who are on temporary or special duty assignment.[2]	i. The designated Army Commander for civilian medical care obtained in the specified areas as follows: (1) West Indies and Bermuda—Third United States Army; (2) Mexico—Fourth United States Army; (3) Canada—Fifth United States Army; (4) Countries in the United States European Command, countries in Africa, the Middle East, Pakistan, India, Nepal, Afghanistan, the Malagsy Republic, Ceylon and the islands in the Atlantic Ocean north of Tropic of Cancer except the Bahama Islands and Bermuda—United States Army, Europe; and (5) Countries in the Pacific, Alaskan and Southern Commands—respective Army major oversea commanders.
j. Foreign Nationals who are members of the Army of one of the NATO nations and who, in connection with their official duties, are stationed in or passing through the United States.	j. Same as b above.
k. Retired Army members on the Temporary Disability Retired List.	k. The Surgeon General, Department of the Army, Washington, DC 20314.
l. Nonunit Reserve personnel under centralized management jurisdiction of COUSAAC who are required to undergo medical examinations or hospitalization in connection therewith.	l. The Commanding Officer, U.S. Army Administration Center, St. Louis, MO 63132.
m. Civilian employees of the Army for occupational health services.	m. Same as k above.
n. U.S. Nationals in foreign penal institutions.[2]	n. Same as i above.
o. Members of the Army Senior ROTC and designated applicants for enrollment in the Army Senior ROTC Program.[2]	o. Same as b and c above.

Figure 2-1—Continued

See footnotes at end of list.

Categories	*Approving authorities*
p. Applicants for enlistment or reenlistment in the Armed Forces including applicants for enlistment in the Reserve components thereof.[2]	p. The appropriate commander of the Armed Forces Examining and Entrance Station for examinations; same as b and c above for hospitalization to determine medical fitness for military service or for emergency medical care.
q. Registrants under the Universal Military Training and Service Act.[2]	q. The appropriate commander of the Armed Forces Examining and Entrance Station for examinations; same as b and c above for hospitalization to determine medical fitness for military service.
r. Applicants for appointment in the Regular Army and in the Reserve components including those members of the Reserve components applying for active duty.[2]	r. Same as q above.
s. Prisoners of war, retained personnel and other persons in military custody or confinement.[2]	s. Same as b and c above.
t. Civilians interned by the Army.[2]	t. Same as b and c above.
u. Civilian seamen in the service of vessels operated by the Department of the Army.[2]	u. Same as b and c above.
v. Members of the Civilian Military Training Corps.	v. Same as b above.

Figure 2-1—Continued

[1] The changes stated in b and c are *effective 1 April 1969*. Any claim received after 1 April 1969 which is related to a claim previously process under provisions of Change 17 will also be processed under provisions of Change 17.

[2] The changes stated in c, g, h, i, n, o, p, q, r, s, t, and u are effective for medical care obtained on and after 1 July 1969.

(1) *Authorization by designated approving authority.* Requests for prior authorization normally will be submitted in writing as outlined in paragraph 89 and transmitted through channels to the designated approving authority, except in unusual circumstances in which case requests will be transmitted by the most expeditious means available direct to the approving authority. If the requested medical care is authorized by a CONUS or oversea army commander, he will designate an Army medical treatment facility which will assume administrative responsibility. If the civilian medical care is authorized by another approving authority, he will request the appropriate Army commander to designate such an Army Medical facility. This facility will be advised of this designation immediately, and the individual requiring medical care will be instructed through his commander to inform the civilian agency that medical records in the case will be requested by the designated Army facility. Administrative responsibility will include, but not be limited to, those functions specified in paragraph 71*a*(1), (2), (3), and (5) and the following:

(*a*) Preparation of necessary individual medical records (AR 40-400).