

**Army Regulation 600-110**

**Personnel-General**

**Identification,  
Surveillance, and  
Administration of  
Personnel Infected  
with Human  
Immunodeficiency  
Virus**

**Headquarters  
Department of the Army  
Washington, DC  
22 April 2014**

**UNCLASSIFIED**

# ***SUMMARY of CHANGE***

AR 600-110

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

This rapid action revision, dated 22 April 2014--

- o Changes Human Immunodeficiency Virus testing time requirements for Reserve Component Selected Reserve personnel from every 5 years to every 2 years (paras 3-2k(1), 3-2k(2), 7-4a(3), 7-4a(5), 7-4b(1), and 7-4b(2)).
- o Makes administrative changes (throughout).

Effective 22 May 2014

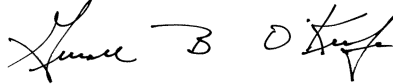
Personnel-General

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

By Order of the Secretary of the Army:

RAYMOND T. ODIERNO  
General, United States Army  
Chief of Staff

Official:



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

**History.** This publication is a rapid action revision. The portions affected by this rapid action revision are listed in the summary of change.

**Summary.** This regulation implements the Office of the Assistant Secretary of Defense, Health Affairs Policy Memorandum-Human Immunodeficiency Virus Interval Testing, dated March 29, 2004 and Department of Defense Instructions 6485.01 and prescribes Army policy and responsibilities on human immunodeficiency virus testing and surveillance requirements; procedures for identification, surveillance, and administration of personnel infected with human immunodeficiency virus; testing and counseling procedures for Soldiers and other military health care beneficiaries for human immunodeficiency virus infection; requirements for testing military applicants; conditions under which civilian employees may be tested; procedures for administration of human immunodeficiency virus infected Active Army, Army National Guard/Army National Guard of the United States, and U.S. Army Reserve Soldiers; guidance on the

limitations on the use of testing information; information and education requirements of the human immunodeficiency virus testing program; and guidance to law enforcement and corrections personnel in handling known or suspected human immunodeficiency virus infected personnel.

**Applicability.** This regulation applies to the Active Army, the Army National Guard/the Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. It also applies to candidates and applicants for accession; Department of the Army civilian employees; nonappropriated fund employees; and military health care beneficiaries. If the provisions of this regulation conflict with existing negotiated labor agreements, the terms of those agreements will be controlling until renegotiated. In any activity where a union has been granted exclusive recognition to represent civilian employees, no new conditions of employment should be implemented without prior discussion with the servicing civilian personnel officer regarding the obligation to negotiate. During mobilization, the proponent may modify chapters and policies contained in this regulation.

**Proponent and exception authority.** The proponent of this regulation is the Deputy Chief of Staff, G-1. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of

the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

**Army internal control process.** This regulation contains internal control provisions in accordance with AR 11-2 and identifies key internal controls that must be evaluated (see appendix B).

**Supplementation.** Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from Deputy Chief of Staff, G-1 (DAPE-HR-PR), 300 Army Pentagon, Washington, DC 20310-0300.

**Suggested improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of Staff, G-1 (DAPE-HR-PR), 300 Army Pentagon, Washington, DC 20310-0300.

**Distribution.** This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

\*This regulation supersedes AR 600-110, dated 17 August 2012.

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### Glossary





# Chapter 1 Introduction

## Section I General

### 1–1. Purpose

This regulation prescribes policy, procedures, responsibilities, and standards concerning identification, surveillance, and administration of personnel infected with human immunodeficiency virus (HIV).

### 1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

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

Abbreviations and special terms used in this regulation are explained in the glossary.

## Section II Responsibilities

### 1–4. Deputy Chief of Staff, G–1

The DCS, G–1 will—

- a. Serve as lead agent for all HIV policies.
- b. Provide Army staff supervision for the HIV program.
- c. Coordinate with U.S. Military Entrance Processing Command policies pertaining to preaccession HIV testing conducted at military entrance processing stations (MEPSs).
- d. Ensure that HIV policies and programs are effectively implemented consistent with Department of Defense (DOD) guidance and current medical knowledge.

### 1–5. The Surgeon General

The Surgeon General will—

- a. Program and manage funds and resources for the support of laboratory, research, education, prevention strategies, and contractor activities for medical aspects of the overall HIV program.
- b. Provide up-to-date clinical and epidemiological information to the Army staff and Secretariat on HIV and Acquired Immune Deficiency Syndrome (AIDS).
- c. Develop procedures for notification and counseling of HIV infected Soldiers and other health care beneficiaries (HCBs).
- d. Through the proponent office for preventive medicine, provide oversight for the identification, surveillance, and management of HIV infected Soldiers.
- e. Ensure responsive laboratory support to the Active Army and reserve components (RC) and to other testing programs for authorized HCBs.
- f. Advise the Office of the DCS, G–1 and the Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs) of Department of the Army (DA) and DOD epidemiological information and trends.
- g. Through the U.S. Army Medical Research and Materiel Command—
  - (1) Provide input concerning the medical administration of the HIV testing program for publication in this regulation.
  - (2) Provide technical oversight in support of the Army's HIV testing program, to include guidance on the most current and appropriate laboratory tests to be used for screening and confirmation.
  - (3) Prescribe the methodology to be used by the laboratories supporting HIV testing.
  - (4) Provide technical guidance for the collection and shipment of specimens.
  - (5) Plan, program, and manage epidemiology and research initiatives.
- h. Release HIV testing statistics only in response to specific queries. Such inquiries must be processed under the provisions of the Privacy Act (Title 5, United States Code, Section 552a (5 USC 552a)) and the Freedom of Information Act (FOIA) (5 USC 552) and should be handled in accordance with the procedures of AR 25–55 and AR 340–21. Generally, HIV information about specific individuals will not be released under the FOIA, but may be released under limited circumstances pursuant to the Privacy Act or DOD 6025.18–R, Chapter 7.
- i. Through the U.S. Army Public Health Command (USAPHC) formerly known as U.S. Army Center for Health Promotion and Preventive Medicine—
  - (1) Serve as the technical lead for the public health aspects of installation HIV programs. The USAPHC functions include program development, written program guidance, automated tools, technical assistance, local HIV program

capacity building and maintenance, and continuing education for HIV program directors/coordinators (Public Health Nurses (PHNs)).

(2) Provide central tracking for HIV infected Soldiers in order to ensure timely notification, medical evaluation, and verification.

(3) Develop commander's guidance to assist the commanders of Soldiers infected with HIV.

(4) Develop programs for health education and primary and secondary HIV prevention education for individual HCBs, especially those who are HIV infected, or at high risk.

(5) Develop community health education materials in collaboration with the Chief Nurse, USAPHC, and the public affairs community (see chap 10).

(6) Assist Army commands (ACOMs), Army service component commands (ASCCs), or direct reporting units (DRUs) in the development and implementation of community health education programs regarding HIV infection and AIDS.

#### **1-6. Chief of Chaplains**

The Chief of Chaplains will provide pastoral care by ensuring that chaplain counseling and religious support is available to Soldiers and Family members who are infected with HIV and the uninfected members of those Families.

#### **1-7. Chief of Public Affairs**

The Chief of Public Affairs will—

*a.* In coordination with The Surgeon General and DCS, G-1, support a command information program that informs audiences about current information pertaining to HIV infection and the AIDS epidemic.

*b.* Help publicize the Army's testing, research, and education efforts for prevention strategies related to HIV and AIDS.

#### **1-8. Chief, National Guard Bureau**

The Chief, NGB will—

*a.* Budget money and resources to provide administrative support for oversight of the HIV testing program in the Army National Guard (ARNG).

*b.* Provide and coordinate medical support for the notification and counseling of HIV infected ARNG Soldiers and their spouses.

*c.* Provide oversight and quality assurance for managing and centrally tracking HIV infected ARNG Soldiers.

*d.* Ensure ARNG units comply with the Army's HIV policy.

*e.* Advise the DCS, G-1 regarding the impact of HIV programs on ARNG personnel and units.

#### **1-9. Commanding General, U.S. Army Human Resources Command**

The CG, HRC will—

*a.* Function as liaison between testing sites.

*b.* Provide timely notification of initial HIV positive test results to the U.S. Army Reserve (USAR).

*c.* Provide and coordinate administrative support for the notification and counseling which is inclusive of verification blood tests and completion of annual medical evaluation which determines fitness for duty.

*d.* Serve as the technical lead for transfer of all confirmed HIV infected individual ready reserve (IRR) Soldiers to the USAR Standby Reserve Active.

*e.* Develop and implement education program for USAR Soldiers.

*f.* Provide oversight and quality assurance for centrally tracking career management activities of HIV infected Soldiers including nondeployable assignments, long-term schooling, request for reassignment orders, and exception to policy.

*g.* Serve as primary point of contact (POC) for active component (AC) issues and inquiries.

*h.* Code administrative records to restrict permanent change of station (PCS) movement of enrollees.

*i.* Coordinate and advise command, assignment, and branch management staff on program provisions.

*j.* Maintain data on current enrollees and reconcile data furnished by medical lab processing element.

#### **1-10. Commanding General, U.S. Army Reserve Command**

The CG, USARC will—

*a.* Submit to HRC money and other resource requirements to provide administrative support for oversight of the HIV testing program in the USAR.

*b.* Provide and coordinate medical support for the notification and counseling of HIV infected USAR Soldiers and their spouses.

*c.* Provide oversight and quality assurance for managing and centrally tracking HIV infected USAR Soldiers.

*d.* Develop and coordinate USAR HIV policy for specified and unified commands, ACOMs, ASCCs, and DRUs.

- e. Advise the DCS, G-1 regarding the impact of HIV programs on USAR personnel and units.

### **1-11. U.S. Army Medical Command commanders**

The USAMEDCOM commanders will—

- a. Identify appropriate resources and locations to collect and ship specimens to the servicing laboratories.
- b. Ensure that information regarding HIV test results is appropriately safeguarded according to the policies in this regulation.
- c. Coordinate testing, notification, counseling, and education procedures with Office of the Surgeon General (OTSG). Provide medical support for these functions per guidance from OTSG.
- d. Ensure that epidemiologic assessment interviews and counseling are performed and that all medical requirements are accomplished according to the policies in this regulation, or request exceptions to policy when appropriate.
- e. Ensure that guidance published by OTSG regarding the Blood Donor and Transfusion Recipient Look Back Program is followed within their command. For more guidance see Policy on the Use of Non-U.S. Food and Drug Administration Compliant Blood Products, March 19, 2010; Blood Program Letters (BPL) 09-01, DOD Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Using Licensed Nucleic Acid Tests (NAT) With Approved Mini-Pool Strategies; and BPL 10-01, Department of Defense (DOD) Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Updated Multiplex HIV/HCV/HBV Nucleic Acid Testing Algorithm.
- f. Designate the medical positions outlined in chapter 2.

### **1-12. Army command, Army service component command, or direct reporting unit commanders**

The ACOM, ASCC, or DRU commanders will—

- a. Budget money and resources to provide administrative support for oversight of the HIV testing program in their command.
- b. Designate a centralized POC in their headquarters to coordinate all administrative and medical aspects and educational preventive strategies, of the HIV testing program.
- c. Ensure compliance with all aspects of the HIV testing program outlined in this regulation at their various installations and activities.
- d. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.
- e. Ensure that their Public Affairs Office conducts an aggressive command information program per chapter 10.

### **1-13. Installation and community commanders**

These commanders will—

- a. Coordinate with the servicing medical department activity (MEDDAC) or medical center (MEDCEN) to accomplish scheduling, education, prevention strategies, and testing of personnel assigned to or supported by their installation or community.
- b. Assist servicing MEDDAC or MEDCEN in implementing HIV education programs for Soldiers, commanders, health care workers, civilian employees, and other HCBs, as needed.
- c. Establish a support network of professional personnel (chaplain, psychologist, psychiatrist, social worker, and a PHN) trained to provide assistance to HIV infected Soldiers and their uninfected Family members in such areas as Family support and suicide prevention.
- d. Use local assets to support command and public information efforts.
- e. Consult, as appropriate, with the servicing staff judge advocate on the limited use provisions of this policy and other restrictions on the use of HIV information.
- f. Ensure that military and civilian personnel receive training and education on HIV and Army policies. Soldier and health care worker HIV prevention training is coordinated by a PHN. Commanders should ensure that all nonsupervisory civilian employees are given sufficient training regarding HIV and/or AIDS in the workplace so that employees understand—
  - (1) The medical ramifications of HIV and/or AIDS as they relate to communicability, and as they affect an employee's ability to perform official duties; and workplace rights of employees who are HIV positive or have AIDS.
  - (2) Civilian employees may be excused from HIV or AIDS training in the workplace if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse civilian employees from scheduled training will offer those employees an appropriate alternative to the training, such as written materials on HIV and/or AIDS in the workplace.
- g. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.

## 1–14. Unit commanders

The unit commanders will—

- a. Be knowledgeable of the provisions of this regulation.
- b. Ensure that HIV information and education is included in unit training programs, with emphasis on the prevention of infection. See chapter 7 for RC personnel policy.
- c. Ensure that their assigned or attached personnel comply with the HIV testing requirements.
- d. Accompany Soldiers identified as HIV infected to the medical treatment facility (MTF) for notification of the (first) initial positive test as soon as possible after contact by preventive medicine, and no later than 4 days after contact by preventive medicine for Soldiers on leave or not on active duty (AD) status. (Unit commanders who are general officers may designate a subordinate officer to perform this function.) Upon learning of the Soldier's HIV status, commanders will not inform the Soldier nor be present in the room during the notification or the epidemiological assessment interview.
- e. Provide support and facilitate the support network for the HIV infected Soldier from the point of initial notification.
- f. Protect the confidentiality of HIV infected Soldiers from unwarranted invasions of their privacy. This responsibility includes strictly limiting knowledge of a Soldier's HIV status to individuals who have a "need to know" about the medical condition in the performance of their duties as defined by the Uniform Code of Military Justice (UCMJ). Commanders and legitimate administrative, legal, and medical authorities must ensure that the recipient of the information understands his or her obligation to protect the confidentiality of that information (see para 5–4).
- g. Consult, as appropriate, with the servicing staff judge advocate on the limited use provisions of this policy and other restrictions on the use of HIV test results and epidemiological information.
- h. Counsel HIV infected Soldiers per the policies in section III (DA Form 4856 (Developmental Counseling Form)) following formal counseling by the installation HIV program director (DA Form 5669 (Preventive Medicine Counseling Record)), with every change of command, and within 30 days of PCS and provide a copy to the HIV program coordinator (PHN).
- i. Ensure that HIV infected AD Soldiers (including Active Guard Reserve (AGR)) report, at a minimum, every 6 months for their infectious disease medical evaluation visit and comply with medical management as directed by their infectious disease physician at military MTFs that have infectious disease providers.
- j. Ensure that copies of HIV infected Soldier's PCS orders are provided to the HIV PHN to communicate to the gaining HIV PHN.

## Section III Policies

### 1–15. General

Headquarters, Department of the Army (HQDA) medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection, the risks to the infected individual incident to military service, the risk of transmission of the disease to non-infected personnel, the overall impact of infected personnel in Army units and on readiness posture, and the safety of military blood supplies.

### 1–16. Human immunodeficiency virus policies

The following are established policies on HIV:

- a. HIV infected personnel are not eligible for appointment or enlistment into the Active Army, the ARNG, or the USAR (see chap 5).
- b. All AD and RC personnel designated in chapters 3, 6, and 7 will be tested periodically for evidence of HIV infection. Frequency of testing will be jointly determined by the DCS, G–1 and OTSG based on available medical and epidemiological evidence.
- c. All procedures involving HIV testing results will comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law (PL) 104–191) regulations and will be handled in a confidential manner to prevent unauthorized access to the information. Access will be strictly limited to individuals who have a legitimate medical, administrative, or legal need to know that information in the performance of their duties. Current HIPAA privacy and security training is required.
- d. Medical follow-up and evaluation will be conducted every 6 months and as directed by the infectious disease physician for all HIV infected Soldiers (see chaps 4 and 8).
- e. Except for those identified during the accession testing program (chap 5), HIV infected AD Soldiers who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations will not be involuntarily separated solely because they are HIV infected (see chaps 3, 6, and 9).
- f. HIV infected AD Soldiers, including AGR, will be limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). Soldiers identified as HIV positive while assigned outside the continental United States (OCONUS) will be reassigned to the United States per AR 614–30, and this regulation.

Direct coordination with Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC-SGD-H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122-5303; Commander, National Guard Personnel Center (NGB-ARP-CT), 4501 Ford Avenue, Alexandria, VA 22302-1450 (for ARNG AGR Title 10 personnel); or Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC-SGD-H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122-5303 (for USAR AGR personnel), will be made to ensure expeditious reassignment of HIV infected Soldiers (see chap 6).

(1) The duty limitation discussed above does not apply to RC personnel who reside overseas, or to AD Soldiers who are permanent residents of, and are currently stationed in Guam, the Virgin Islands, or American Samoa. It does, however, apply to all AD Soldiers not currently assigned to these locations, regardless of permanent residence.

(2) HIV infected Soldiers outside these areas who desire compassionate reassignment to these areas may apply per existing policy for compassionate reassignments. Requests will be considered on a case-by-case basis.

*g.* Conditions of national emergency and/or mobilization and deployment overseas may require reordering of priorities for screening and assignment of HIV infected Soldiers, but will not affect overseas assignment limitations. The Personnel Policy Guidance will contain HIV policy for particular wars, conflicts, or mobilization situations.

*h.* Unless modified by a combatant command (COCOM), AD Soldiers are considered available for deployment if they have a negative serum screening collected within 1 year of deployment.

*i.* RC Soldiers are considered deployable if they have a negative HIV test recorded within 5 years of scheduled deployment (or date of unit status report). However, upon mobilization, all Soldiers being ordered or called to AD will be tested for HIV within 24 hours of reporting to their mobilization station if there is no record of a negative HIV test within the previous 24 months.

*j.* Initial screening HIV test results will normally be available within 48 hours, but may be delayed due to logistical limitations. Soldiers will not be deployed until test results are known. If the test results are negative, the Soldier is considered available for deployment. If the initial test results are positive, the Soldier will be removed from further processing until independent verification tests are conducted and results are known.

*k.* HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40-501, and will be evaluated for physical disability processing under AR 635-40. (See paras 6-13 for officers and 6-14 for enlisted personnel.)

*l.* It is essential that HIV infected Soldiers provide accurate information during the epidemiological assessment process conducted confidentially by the HIV program director or coordinator (PHN). Accordingly, the mere presence of the HIV antibody or other medical evidence of HIV infection alone will not be used as the basis for adverse action against a Soldier (see chap 9).

*m.* Soldiers found to be HIV infected will have HIV listed on the medical problem list. As part of the commander's counseling, they will be counseled and ordered not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs due to the risk of HIV transmission to recipients (see chap 4).

*n.* Mandatory testing of civilians (to include Family members) is not authorized, with the exception of those specific situations that may be defined and approved by DOD. Those situations will be published by HQDA (DAPE-CP or DAPE-HR) as they occur. Voluntary testing will be made available to all HCBs and civilian health care providers per chapter 8.

*o.* Except as stated below, civilian employees who have been diagnosed with HIV or AIDS must be permitted to continue to work so long as their performance is acceptable and they do not pose a significant risk of substantial harm to the health or safety of themselves or others that cannot be eliminated or reduced by reasonable accommodation. If serious performance or safety problems arise, managers and supervisors should address them by applying existing Federal and Army civilian personnel policies and practices. Further guidance is available in chapter 8.

*p.* There is no basis for civilian employees to refuse to work with fellow employees, Soldiers, or agency clients who have, or are suspected of having HIV or AIDS. The concerns of such employees will be addressed with education and counseling as appropriate. If an employee's continued refusal to work with a person with HIV or AIDS results in disruption in the workplace, appropriate disciplinary action may be taken against the employee. Further guidance is available in chapter 8.

*q.* Civilian employees with HIV or AIDS usually are considered "individuals with disabilities" within the meaning of the Rehabilitation Act of 1973, as amended (29 USC 701), the Americans with Disabilities Act (ADA) of 1990, as amended (42 USC 12101), and the Americans with Disabilities Act Amendments Act (ADAAA) PL 110-325), and, if otherwise qualified, are entitled to reasonable accommodation.

*r.* News media inquiries concerning HIV and/or AIDS policies, testing, or issues will be handled as follows:

(1) Routine news media queries on a local level will be directed to the appropriate Public Affairs Office. Media queries concerning Army HIV and/or AIDS policies should be referred to the Office of the Chief of Public Affairs, Media Relations Division.

(2) HIV testing statistics will be released only in response to specific queries. Such inquiries must be processed under the provisions of the Privacy Act (5 USC 552a) and the FOIA (5 USC 552) and should be handled in accordance with the procedures of AR 25-55 and AR 340-21. Generally, HIV information about specific individuals will not be released under the FOIA, but may be released under limited circumstances pursuant to the Privacy Act and DOD 6025.

18–R. In order to prevent accidental disclosure of HIV information that may be attributable to specific individuals, statistics may only be released for major installations or major commands.

s. Policies contained in this regulation will be reviewed as developments occur in scientific and/or medical knowledge, or issuances of revised DOD policies dictates.

## **Chapter 2**

### **Installation Level Human Immunodeficiency Virus Program Management**

#### **2–1. General**

a. The HIV program elements include the following:

- (1) Prevention and education.
- (2) Initial and verification HIV testing.
- (3) Patient notification.
- (4) Counseling.
- (5) Contact tracing.
- (6) Reporting.
- (7) Medical evaluation and management.
- (8) Profiling, fitness for duty evaluations, and medical boards.
- (9) Medical record keeping.
- (10) Personnel actions.
- (11) Case management.
- (12) Program oversight and quality assurance.
- (13) Training and education.

b. The MTF commanders will assign appropriately trained individuals to the roles outlined in paragraph 2–2. Because of variations in medical staffing levels and expertise at different installations, MTF commanders may organize the local program as appropriate and within the general guidelines.

#### **2–2. Human immunodeficiency virus program medical personnel**

The functions delineated below may be reallocated with concurrence of USAMEDCOM commanders specified in paragraph 1–11.

a. *Installation human immunodeficiency virus program director.* This is a preventive medicine physician or other physician designated by the deputy commander for clinical services. The installation HIV program director—

- (1) Monitors and ensures implementation of the program as outlined in this regulation.
- (2) Supervises the installation HIV PHN.
- (3) Serves as POC to the MTF laboratory for HIV testing and shall be the ordering provider for the routine HIV tests (medical readiness force testing, physical exams).
- (4) Notifies the Soldier, in a face-to-face encounter, of a positive HIV test result in the absence of the provider ordering the test for clinical reasons, obtains a (second) verification test, and initiates referral to the servicing MEDCEN infectious disease service.
- (5) Completes the initial DA Form 5669.

b. *Installation human immunodeficiency virus program coordinator (PHN or designee).* The PHN—

- (1) Receives results from the clinical laboratory manager identifying new HIV infections.
- (a) AD Soldiers are managed by the HIV program coordinator (PHN).
- (b) Reserve and Guard Soldiers are referred to the appropriate Reserve or Guard HIV POC.
- (c) AGR Soldiers are referred to the appropriate Reserve or Guard HIV POC and jointly managed with active HIV PHN.

(d) AD Navy, Marine Corps, Coast Guard, and Air Force Servicemembers are referred to the appropriate Service HIV POC.

(e) Retirees and Family members are referred to the servicing MEDCEN infectious disease service after a face-to-face notification of the initial and verification HIV positive test results. The notification procedures are the same as an AD Servicemember except commanders are not informed. The confidential epidemiological assessment is completed by the HIV PHN or referred to local public health officials.

(2) Informs the ordering provider of a new positive HIV test result if performed for clinical reasons, and the need for a face-to-face notification, second verification test, and referral to the servicing MEDCEN infectious disease service. If the test was performed for routine screening (medical readiness force testing, physical exam), inform the HIV program director.

- (3) Confirms the identities of the commander and the Soldier with two unique identifiers before the commander is notified of the positive test result.
- (4) Provides training on this regulation for the commander before initial commander's counseling.
- (5) Coordinates notification of the Soldier, in a face-to-face encounter, of new positive HIV test result by the ordering provider or HIV program director, and obtains a second verification test.
- (6) Coordinates the DA Form 5669 after notification of the (first) positive HIV test.
- (7) Coordinates completion of the commander's counseling (DA Form 4856) on the same day and immediately following the DA Form 5669 counseling.
- (8) Contacts installation HRC HIV POC and central AC or RC HRC HIV POC for assignment-limiting actions.  
*Note.* For Reserve and Guard assignment-limiting actions see chap 7.  
Sends memorandum with following information to central AC or RC HRC HIV POC by encrypted email or confidential fax:
  - (a) Subject: Medically Nondeployable.
  - (b) Reference: AR 40–501, Standards of Medical Fitness.
  - (c) Statement: For Official Use Only (FOUO) in accordance with the above reference, (person's rank, name, and last four digits of the social security number) is assessed as medically nondeployable effective (date of the first positive HIV test).
  - (d) Statement: Further information is available upon request. POC is (name, phone, and DOD email address of the HIV PHN).
  - (e) Signature block: HIV program director.
- (9) Coordinates appointments for the initial medical evaluation with the servicing MEDCEN infectious disease service after notification of the (first) positive test.
- (10) Coordinates a psychosocial evaluation and behavioral health appointment(s) following the initial notification or during the first infectious disease clinic medical evaluation visit and, as needed, for depression screening and suicide prevention.
- (11) Provides HIV counseling and education, including community resources.
- (12) Assesses for latent tuberculosis infection and counsels those who have opted out of latent tuberculosis infection treatment in the past to reconsider given their increased risk of active disease.
- (13) Conducts initial confidential epidemiological assessment for the period from 3 months prior to last negative HIV test or 12 months in absence of a prior test to notification of the first positive test, and completes contact interview(s) in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. Additional epidemiology assessment may be needed for public health purposes.
- (14) Completes Federal, State, local, or host nation public health reporting.
- (15) Locates, notifies, and counsels all military HCBs named as contacts of the HIV infected Soldier. If named contacts reside outside the catchment area, contacts the appropriate military HIV program coordinator (PHN) or other appropriate public health officials for notification and testing of contacts.
- (16) Reviews Soldier responsibilities as reflected in the preventive medicine counseling (DA Form 5669) and commander's counseling (DA Form 4856) statements.
- (17) Completes DA Form 7303 (Donor/Recipient History Interview) during the contact interview and submits to the local Army Blood Donor Center or, if there is no donor center on the installation, submits the completed form to the MTF's laboratory manager who, in turn, will submit it to the Army Blood Program Office (see fig 2–1 for a sample of completed DA Form 7303).
- (18) Assures HIV infected Soldier's Medical Protection System (MEDPROS) documentation reflects a profile deployment restriction code (V) and medical nondeployment module "Yes" following notification of the confirmatory test from the first specimen. Coordinates periodic health assessment (PHA) at diagnosis and annually for AC, as required.
- (19) Maintains, in a locked cabinet, a registry of all known HIV infected Soldiers within the catchment area per OTSG preventive medicine policy and in accordance with HIPAA, and maintains a duplicate file that includes DA Forms 5669, 4856, and 7303, public health forms, and demographic data. DA Forms 5669 and 4856 will not be scanned into the electronic medical record. Upon PCS the duplicate file contents are sent to the gaining HIV program coordinator (PHN). Upon the expiration term of service or retirement, the duplicate file will be destroyed.
- (20) Meets with the HIV infected Soldier annually to complete a new DA Form 5669, update demographics, review safer sex counseling, and coordinate medical readiness. If the Soldier has not completed a medical evaluation every 6 months with the infectious disease physician he or she is out of compliance with this regulation, prompting commander notification.
- (21) Coordinates Soldier transfer out of catchment area within 30 days of PCS to a new duty station and sends preventive medicine and commander's counseling statements encrypted or by confidential fax to gaining HIV program coordinator (PHN).
- (22) Receives Soldier transfer into catchment area within 30 days of Soldier PCS, reviews Soldier responsibilities,

updates the preventive medicine counseling, coordinates commander's counseling, provides infectious disease clinic appointment information, coordinates medical readiness PHA, completes local health department reporting, and provides community resources.

(23) Coordinates HIV education programs for health care workers and unit-level training, as requested.

(24) Reviews HIV test results with MTF or MEDCEN laboratory HIV POC daily to weekly if not performed by the HIV program director.

*c. Notifying individual.* This is the ordering provider in a face-to-face appointment. For all other situations, this is a preventive medicine physician or other trained health care provider (skill level 2 or licensed independent provider). The notifying individual—

(1) Completes a psychosocial assessment and, as needed, referral to behavioral health.

(2) For Army medical and infectious disease staff, informs the MTF preventive medicine HIV director or coordinator (PHN) of AD Navy, Marine Corps, Coast Guard, and Air Force Servicemembers with a suspected or confirmed HIV infection.

*d. Medical evaluation.* This is completed by the regional MEDCEN infectious disease clinic after positive HIV verification. Initial appointments are scheduled by the HIV PHN. This includes—

(1) Conduction a medical reevaluation every 6 months and as directed by the infectious disease physician.

(2) Documenting safer sex education and nondeployable status in medical assessments.

(3) Ensuring HIV PHN is aware of known HIV positive Soldiers and beneficiaries, to include knowledge of impending PCS.

(4) Advising UCMJ commander of noncompliance with medical management of HIV infection pursuant to involuntary separation (see paras 6–13 and 6–14).

*e. Psychosocial evaluation.* This is completed by behavioral health or infectious disease clinic social work or psychiatry staff. This includes—

(1) Documenting evaluation in the electronic medical record.

(2) For communities with limited resources, pastoral care and chaplains providing support until medical evaluation appointments at the regional MEDCEN.

*f. Clinical laboratory manager or blood bank officer.* This function will—

(1) Coordinate obtaining unit-level and individual blood specimens for testing required by this regulation and other references.

(2) Maintain data concerning force testing and clinical screening, including the number of specimens drawn, the number submitted, results of initial testing, and results of confirmatory testing.

(3) Ensure compliance with guidelines for obtaining, processing, labeling, packaging, shipping, and storing specimens.

(4) Serve as local POC for matters pertaining to contracted laboratory support.

(5) Initiate look back investigation on any previous blood donations.



<b>DONOR/RECIPIENT HISTORY INTERVIEW</b>			
<small>For use of this form, see AR 600-110; the proponent agency is the DCS, G-1.</small>			
<b>DATA REQUIRED BY THE PRIVACY ACT OF 1974.</b>			
<b>AUTHORITY:</b>	Title 5, United States Code (USC), Section 301; Title 44, USC, Section 3101; and Title 10 USC, Section 1071.		
<b>PRINCIPAL PURPOSE:</b>	To collect information from confirmed HIV infected individuals who indicate a past history of donating or receiving blood, blood products, organ (s), tissue or sperm since 1977.		
<b>ROUTINE USES:</b>	Information collected may be released to appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded on this form.		
<b>DISCLOSURE:</b>	Disclosure of information requested is voluntary. However, failure to provide the required information may hinder lookback procedures.		
1. NAME OF INDIVIDUAL (Last, First, Middle Initial)		2. CURRENT ADDRESS (Number, Street, City, State)	
Doe, John Q.		111 First Street Ft. Knox, KY 40121	
3. SOCIAL SECURITY NUMBER	4. TELEPHONE NUMBER (Include area code)	5. DATE OF BIRTH (Mo. Day, Yr)	6. SEX
000-00-0000	WORK: (111) 000-0000 HOME: (000) 111-1111	19890101	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
7. I acknowledge that it may be necessary to release information to my confirmed HIV status by representatives of the Medical Advisory Committee of <u>Any Army Community Hospital</u> to the appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded below. I hereby give permission for the release of this information.			
<u>John Q. Doe</u> (signed)		<u>20120505</u>	
<small>(Signature)</small>		<small>(Date)</small>	
<u>Jane Smith</u>		<u>Jane Smith</u> (signed)	
<small>WITNESS (Print/Type Name)</small>		<small>(Signature)</small>	
<u>COL John Q. Smith</u>		<u>20120505</u>	
<small>Medical Advisory, Point of Contact: (Name)</small>		<small>(111) 111-0000 (Telephone Number (DSN))</small>	
<small>(Commercial)</small>			
8. Military Beneficiary Status (Please Check appropriate category):			
Active <input checked="" type="checkbox"/>	Dependent of Active Duty <input type="checkbox"/>	Sponsor's Name _____	
Retired <input type="checkbox"/>	Dependent of Retired <input type="checkbox"/>	Sponsor's SSAN _____	
Civilian <input type="checkbox"/>	Service Army <input type="checkbox"/> Navy <input type="checkbox"/>		
	Air Force <input type="checkbox"/> Marine <input type="checkbox"/> Other <input type="checkbox"/>	<small>(Identify) _____</small>	
9. Have you donated any blood, blood product, organ (s), tissue or sperm since 1977? (Please check appropriate response.)		10. If the answer to question #9 is YES, please indicate below the type and number of times you have donated. (Please circle appropriate response and indicate the number of times below.)	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Blood / Blood Products      Number <u>Blood/2</u>	
		Organ (s) / Tissues      Number _____	
		Sperm      Number _____	
11. For each donation indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available, then please provide the information that is available.			
Donation #1	Type <u>Blood</u>	Date (Month, Day, Yr)	<u>20070110</u>
Name or Organization <u>Any Army Community Hospital</u>			
Location <u>Ft. Knox, KY 40121</u> <small>(Street Address, City, State, Zip Code)</small>			
Donation #2	Type <u>Blood</u>	Date (Month, Day, Yr)	<u>20101022</u>
Name or Organization <u>Any Army Community Hospital</u>			
Location <u>Ft. Knox, KY 40121</u> <small>(Street Address, City, State, Zip Code)</small>			

DA FORM 7303, JAN 1994

APD LF v1.01

Figure 2-1. Sample of completed DA Form 7303

Donation date and location continues. *(Please use additional sheets, if necessary.)*

Donation #3    Type \_\_\_\_\_    Date (Month, Day, Yr) \_\_\_\_\_

Name or Organization \_\_\_\_\_

Location \_\_\_\_\_  
*(Street Address, City, State, Zip Code)*

<p>12. Have you been the recipient of any blood, blood product, organ (s), tissue or sperm since 1977? <i>(Please check appropriate response.)</i></p> <p>YES   <input checked="" type="checkbox"/>    NO   <input type="checkbox"/></p>	<p>13. If the answer to question #12 is YES, please indicate below the type and number of times you have been a recipient. <i>(Please circle appropriate response and indicate the number of times below.)</i></p> <p>Blood / Blood Products    Number <u>1</u></p> <p>Products    Number _____</p> <p>Organ (s) / Tissues    Number _____</p> <p>Sperm    Number _____</p>
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14. For each receipt indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available, then please provide the information that is available. *(Please use additional sheets, if necessary.)*

Receipt #1    Type Blood    Date (Month, Day, Yr) June 9, 1977

Name or Organization Ft. Knox, KY 40121

Location Any Army Community Hospital  
*(Street Address, City, State, Zip Code)*

Receipt #2    Type \_\_\_\_\_    Date (Month, Day, Yr) \_\_\_\_\_

Name or Organization \_\_\_\_\_

Location \_\_\_\_\_  
*(Street Address, City, State, Zip Code)*

Receipt #3    Type \_\_\_\_\_    Date (Month, Day, Yr) \_\_\_\_\_

Name or Organization \_\_\_\_\_

Location \_\_\_\_\_  
*(Street Address, City, State, Zip Code)*

15. REMARKS

SAMPLE

Figure 2-1. Sample of completed DA Form 7303-Continued

## Chapter 3 Human Immunodeficiency Virus Testing

### Section I Introduction

#### 3-1. General

*a.* Soldiers may not refuse mandatory HIV testing of the force, and will be informed of the pending procedure and referred to the HIV PHN for current CDC written patient education and counseling, as needed.

*b.* A testing, counseling, and surveillance program for HIV infection is necessary to—

- (1) Assist in ensuring the continued readiness and deployability of the total force.
- (2) Preserve the health of DA personnel and their Families by identifying HIV infected HCBs and providing appropriate counseling and medical treatment.
- (3) Determine fitness for military duty.
- (4) Permit commanders to assess the readiness, security, military fitness, good order, and discipline of their commands, and to take appropriate action based upon such assessment.
- (5) Avoid potential complications of, and adverse reactions to, immunizations among HIV infected individuals, particularly new accessions to AD Army.
- (6) Develop scientifically based information on the natural history and transmission pattern of HIV.

#### 3-2. Testing categories

HIV testing will be performed in the following situations:

*a. Accessions testing.* See chapter 5.

*b. Active force surveillance testing.* See chapter 6.

*c. Army National Guard and United States Army Reserve surveillance testing.* See chapter 7.

*d. Blood donor testing.* All military blood donors will be screened for HIV using industry standards, ensuring compliance with Food and Drug Administration (FDA) requirements. AD HIV infected Soldiers will be referred to the HIV PHN. HIV infected Soldiers (both AD and RC) identified during civilian blood drives on military installations will be reported to the HIV PHN.

*e. Clinical indications.* All AD Soldiers with signs and/or symptoms compatible with or suggesting HIV infection, such as lymphadenopathy (enlarged lymph nodes), unexplained lymphopenia or leukopenia (depressed white cell count), thrombocytopenia (depressed platelet count), neurological disease, adult oral candidiasis (thrush), or evidence of opportunistic infections (such as pneumocystis pneumonia, candida esophagitis, or mononucleosis syndrome), will be tested in either the outpatient or inpatient setting as part of the medical evaluation.

*f. Patients with sexually transmitted infections.* These patients are seen mainly in primary care, sexually transmitted disease (STD), obstetrics and gynecology, urology, or dermatology clinics, but also may be seen in any MTF clinic or ward. Per CDC STD treatment guidelines, HIV testing is indicated with each new infection to include chlamydia, gonorrhea, nonspecific urethritis, syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, genital herpes, hepatitis, or other sexually transmitted infections (STIs). Such procedures are necessary to detect seroconversion in latent infections. HIV testing of AD Soldiers with a new STI is mandatory, and is the responsibility of the provider who ordered the initial test or made the clinical diagnosis. Patients found to be HIV infected will be evaluated per paragraph 4-11.

*g. Blood transfusion or blood product recipients.* The policies of the Armed Services Blood Program and guidelines of the FDA will be followed in the DA Blood Program and by civilian blood agencies collecting blood on Army installations.

(1) Blood or blood product donors whose donation tests positive for HIV will be notified, counseled, and evaluated, as required by this regulation.

(2) Recipients of blood products obtained from donors who are later determined to be HIV infected will be located, notified of the potential risk, and tested and evaluated.

(3) Donors of blood or blood products whose donations were transfused to recipients who were later determined to be HIV infected will be located, notified of their potential infection, and tested.

*h. Sexual partners.*

(1) Soldiers and other HCBs who are, or have been, sexual partners of HIV infected individuals will be tested. Although there are no documented cases of casual nonsexual transmission of infection, Soldiers who are household members with HIV infected individuals and are not sexual partners will be offered testing if there is any anxiety over the potential for household or casual nonsexual transmission.

(2) RC medical authorities will report information pertaining to HIV infected RC Soldiers and their identified sexual partners, including spouses, through designated channels to the RC HIV PHN or designee. That information will, in turn, be provided to State or local jurisdiction public health authorities in accordance with laws or reporting requirements. Specific guidance for reporting is included in detailed implementing instructions published by the NGB or Office of the Chief, Army Reserve (OCAR).

*i. Intravenous drug use.* Soldiers known to have used drugs intravenously will be routinely screened for HIV.

*j. Voluntary screening.* Individuals who engage in high risk behavior, such as having sex with known HIV infected persons or having multiple sexual partners, will be encouraged to be tested. HIV counseling and testing is available from the preventive medicine department PHN for any Servicemember or eligible beneficiary. See chapter 7 for Army RC personnel policies and procedures.

*k. Overseas assignments.* Unless modified by a COCOM, host nation, or other policy that requires earlier testing, personnel who are awaiting a PCS overseas or are scheduled for overseas deployments or temporary duty (TDY) must be screened and receive a negative HIV test result if they have not been tested within the 6 months preceding their departure. Individuals alerted for overseas assignments will be instructed, as part of their Soldier reassignment processing requirements, to report to the appropriate physical examination clinic or laboratory for a blood sample. For routine HIV testing requirements see paragraph 6–2 for Active Army and paragraphs 7–2 and 7–5 for ARNG and USAR. The following policy applies unless COCOM or host nation’s policies require earlier testing:

(1) RC Personnel called to AD or scheduled for overseas deployments or TDY assignment require a negative HIV test within 2 years of the date they are called to AD regardless of whether the duty is overseas or in the United States (unless the host nation’s policies require testing closer in time to arrival in the host nation).

(2) RC personnel located outside the United States scheduled for training either in the United States or overseas who do not meet the testing windows stated above will be tested immediately upon arrival at the training duty station when testing prior to departure is impractical.

*l. Restricted assignments.* Soldiers on orders for assignment to one of the units or programs identified in paragraph 6–3b must be screened and test negative for HIV infection if they have not been tested within the previous 6 months in accordance with AR 614–30. Individuals alerted for these assignments will be instructed to report to the appropriate physical examination clinic or laboratory for drawing of blood. Soldiers testing positive for HIV will not be assigned to a restricted unit or program.

## **Section II**

### **Human Immunodeficiency Virus Testing Procedures**

#### **3–3. General human immunodeficiency virus testing procedures**

HIV testing will include screening of all personnel designated in this regulation and verification of those who test positive by initial HIV screening tests.

*a.* The screening and verification for HIV will be an FDA-approved test and will be in accordance with Public Health Service or CDC guidelines.

*b.* Testing will be as follows, but may be modified by USAMEDCOM to reflect current best practice:

(1) Initial testing (first specimen).

(a) Personnel will receive an initial screening test performed by a designated facility in accordance with paragraphs 3–4 and 5–3.

(b) If the initial screen is HIV nonreactive, the Soldier is negative for HIV.

(c) If the initial screen is HIV reactive, the specimen will be retested in duplicate to ensure accuracy.

(d) If either of the duplicate tests is reactive, the specimen will be forwarded for confirmatory testing.

(2) Confirmatory testing (first specimen).

(a) If the specimen is repeatedly reactive (two of three tests are reactive), the specimen will reflex to supplemental confirmatory testing using a comparable FDA-approved antibody or nucleic acid test.

(b) If the confirmatory test fails to detect HIV antibody, antigen, and/or nucleic acid then the specimen is considered negative.

(c) If the confirmatory test detects either HIV antibody, antigen, and/or nucleic acid, then a second independent verification specimen will be collected from the individual as soon as possible and sent for identical testing.

(d) If the confirmatory test is indeterminate (detection of antibodies significant in the detection of HIV, but not confirmatory), the sample will be reflexed to qualitative nucleic acid testing for resolution of infection status.

(3) Second independent verification specimen (second specimen).

(a) If the second independent verification specimen result is concordant with the initial positive result, the individual will be medically evaluated for HIV infection at a designated Army MEDCEN.

(b) If the second independent verification specimen result is discordant with the initial positive, then a third specimen will be collected for definitive HIV testing and coordinated through the USAMEDCOM designated laboratory.

(4) Definitive HIV testing (third specimen).

(a) The USAMEDCOM designated laboratory will use the most current, FDA-approved laboratory techniques available for detection of HIV antibody and viral nucleic acid.

(b) If positive, the individual will be medically evaluated for HIV infection at a designated Army MEDCEN.

(c) If negative, the individual is not infected.

### **3–4. Medical and laboratory support for testing**

a. Blood drawing and initial processing of samples from AD Soldiers being tested under the force surveillance program, RC personnel upon prior arrangement, or patients participating in routine adjunct testing will be accomplished by existing medical resources, under the direction of the clinical laboratory manager or other qualified official.

(1) USAMEDCOM will provide and/or coordinate necessary resources for testing support in the United States (including Alaska and Hawaii).

(2) In Europe, the Landstuhl Army Regional Medical Center, under guidance of USAMEDCOM and OTSG, will support all Army personnel in the European Command and Central Command by coordinating collection, processing, and shipment of specimens to USAMEDCOM identified testing facilities.

(3) Army personnel stationed in Korea, Japan, and the Pacific area will be supported as in paragraph (2), above by Tripler Army Medical Center, under guidance of USAMEDCOM and OTSG.

(4) Army personnel in Central and South America will be supported by the Southern Regional Medical Command, under guidance of USAMEDCOM and OTSG.

b. Civilian contract support will be used as discussed below.

(1) Central contracting for HIV screening and verification is the responsibility of OTSG, with support from USAMEDCOM and the U.S. Army Medical Research and Materiel Command.

(2) Contract testing may be used for accession, force surveillance, and routine adjunct testing.

(3) For RC surveillance testing, contracts will require the contractor to perform transportation and testing of blood.

(4) HIV screening capability may be maintained at MTFs to meet in-house requirements for patient HIV testing in time-sensitive patient care activities. These in-house testing procedures may be used to establish suspicion of infection, but screening, verification, and follow-up testing will be performed at USAMEDCOM designated laboratories.

(5) HIV screening or verification tests by other than USAMEDCOM designated laboratory or contract sources are not acceptable to meet any testing requirement established in this regulation.

## **Chapter 4**

### **Notification, Counseling, Clinical Care, and Medical Records**

#### **Section I**

##### **Introduction**

#### **4–1. General**

a. Patient notification, counseling, verification, contact tracing, clinical evaluations, and personnel actions will be completed as rapidly and professionally as possible. HIV PHN will be integral to the coordination and tracking of all aspects of this process.

b. Directors of health services, MEDDAC/MEDCEN commanders, command surgeons, unit surgeons, and clinic commanders will coordinate efforts in notifying individuals, commanders, and units.

#### **4–2. Sensitive information**

Information on HIV infected Soldiers will be handled in a sensitive manner and will comply with HIPAA standards.

#### **Section II**

##### **Notification Procedures**

#### **4–3. Laboratory and provider notification**

a. At USAMEDCOM, the HIV testing contractor or USAMEDCOM designated laboratory will notify the laboratory officer or POC designated at each MTF of the identity (by two unique identifiers, one of which must be the assigned laboratory specimen number) of specimens that test positive or negative for HIV by FDA-approved test (see chap 7 for USAR policy).

b. As an adjunct to routine laboratory notification of the ordering physician, the installation HIV PHN will regularly review new HIV test results with the MTF laboratory, preferably each work day. The HIV PHN will contact the ordering provider as soon as a positive test is identified.

#### **4-4. Notification of the Soldier's Uniform Code of Military Justice commander**

*a.* The HIV PHN will contact the commander in person or by telephone. The identities of the commander and the Soldier will be confirmed with two unique identifiers before the commander is notified of the positive test result. This should occur as soon as possible after receiving the results from the first positive sample, but no longer than 4 days after receipt of results for Soldiers on leave or not on AD status.

*b.* The HIV PHN will instruct the commander not to notify the Soldier about the test result. The HIV PHN will review commander's responsibilities in paragraph 1-14.

*c.* The commander will accompany the Soldier to the MTF, but will not be present in the room when the Soldier is notified about the (first) initial positive test by the medical provider.

*d.* The commander will accompany the Soldier to the MTF, but will not be present in the room when the Soldier is notified about the (second) positive verification test by the medical provider.

*e.* The commander will complete DA Form 4856 immediately after completion of DA Form 5669 (fig 4-1) (completed by the HIV program director) and provide a copy to the HIV PHN and Soldier. The HIV PHN will serve as a resource for the commander.

#### **4-5. Soldier notification**

*a.* All Soldiers will be individually and privately notified of all positive HIV test results in a face-to-face interview with the ordering provider or HIV program director.

*b.* After the first positive sample—

(1) The face-to-face notification must occur as soon as possible after the commander is contacted by preventive medicine and no later than 4 days after contact by preventive medicine for Soldiers on leave or not on AD status.

(2) The Soldier will be informed that he or she has a positive western blot or other FDA-approved test, which indicates HIV infection, and that a second blood sample will be drawn and sent for second independent verification.

(3) The Soldier will be advised not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs and to refrain from sex until evaluated by the MEDCEN infectious disease service. The ordering provider will ensure the Soldier is informed that continuing to have sex without CDC recommended condoms or barriers may place sexual partners at risk of infection.

(4) The Soldier will be advised to immediately notify his or her spouse and/or sexual partner(s) of his or her infection. The Soldier will be advised that the HIV program director or coordinator (PHN) will verify that the spouse was informed and offer counseling and testing services.

(5) The Soldier will be asked if he or she has ever donated blood, and a DA Form 7303 (fig 2-1) will be completed on every Soldier, regardless of donation history, by the HIV PHN and forwarded to the Army Blood Program.

(6) The Soldier will be assessed for the need of an immediate evaluation by behavioral health.

(7) The Soldier will be referred to the regional MEDCEN infectious disease service after the first positive western blot or other FDA-approved test which indicates HIV infection.

(8) The HIV program director will complete DA Form 5669 (fig 4-1) after notification of the first positive test and provide the original to the commander and copies to the Soldier and the HIV PHN.

(9) The UCMJ commander will complete DA Form 4856 after completion of DA Form 5669 and provide copies to the Soldier and the HIV PHN.

#### **4-6. Notification of contacts of human immunodeficiency virus infected personnel**

*a.* The HIV PHN will locate, notify, and counsel all military HCBs named as contacts to the HIV infected Soldier. The HIV PHN will verify the spouse of the newly infected Soldier was informed. If named contacts reside outside the catchment area, contact the appropriate military HIV PHN or other appropriate public health officials for notification and testing of contacts.

*b.* Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating individuals who—

(1) Are not military personnel or military HCBs who are/were sexual partners of known HIV infected individuals.

(2) Were transfusion or blood product recipients from HIV infected donors.

#### **4-7. Notification of the U.S. Army Human Resources Command**

*a.* The Armed Forces Health Surveillance Center, designated central HIV program official, and the local HIV PHN will notify the officer and enlisted HIV POCs at HRC (AC or USAR HIV POC, as appropriate) after the first positive sample (see para 2-2b(8)).

*b.* HRC will place a formal nondeployable flag on the Soldier's record after the first positive sample. This will help ensure completion of the second independent verification test and will help prevent HIV infected Soldiers from deploying. The flag will be removed if the second and/or third independent verification tests are negative.

## Section III Counseling Procedures

### 4–8. Preventive medicine counseling

After the Soldier is notified about the first HIV positive test result (see para 4–5), the HIV program director will verbally counsel the Soldier on the relationship between HIV, the blood tests, and AIDS; the risks of disease transmission to close personal contacts and Family members; methods of prevention; and the fact that HIV infected individuals are not eligible to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, and organs. Verbal preventive medicine counseling will occur after the first positive HIV test. The initial counseling will be recorded using DA Form 5669 (fig 4–1). Copies will be given to the Soldier and his or her commander.

### 4–9. Commander's counseling

a. Commanders will formally counsel Soldiers face-to-face after notification of their (first) positive HIV test and completion of the DA Form 5669. For AD and RC personnel, command counseling will be performed after the preventive medicine counseling. Commanders will use DA Form 4856, maintain the completed counseling forms in a locked filing cabinet or other storage unit to protect the confidentiality of the information, and provide a copy to the HIV PHN.

(1) When the commander counsels the HIV exposed Soldier, the following should be entered verbatim on DA Form 4856 in part III—Summary of Counseling (see [http://www.armyg1.army.mil/hr/hivdna/ref\\_hiv.asp](http://www.armyg1.army.mil/hr/hivdna/ref_hiv.asp) for a word document of the content):

*I have been advised that you were counseled by the preventive medicine personnel concerning your positive HIV test, the risk HIV infection poses to your health, and the potential for transmitting HIV to others. You were advised by the preventive medicine personnel of the necessary precautions you must take to minimize the health risk to others as a result of your HIV infection. While I have great concern for your situation, in my capacity as your commander I must also be concerned with, and ensure the health, welfare, and morale of the other Soldiers in my command. Therefore, I am imposing the following restrictions:*

*(a) You will verbally advise all prospective sexual partners of your HIV infection prior to engaging in any sexual activity. You are ordered to use condoms should you engage in oral, vaginal, penile, or anal sexual activity with a partner.*

*(b) You will not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, and organs, and will report previous donations to the HIV PHN.*

*(c) You will notify medical, dental, and emergency health care workers of your HIV infection.*

*(d) You will comply with the medical management of HIV infection directed by your infectious disease physician, to include medical evaluations every 6 months and as needed.*

*(e) You are nondeployable and may not go TDY OCONUS.*

*(f) You will obtain a PHA facilitated by the HIV PHN as soon as possible and annually.*

*(g) You will out-process and in-process with your preventive medicine HIV PHN as part of every PCS move.*

(2) The following should be entered verbatim on DA Form 4856 in part III—Plan of Action (see [http://www.armyg1.army.mil/hr/hivdna/ref\\_hiv.asp](http://www.armyg1.army.mil/hr/hivdna/ref_hiv.asp) for a word document of the content):

*(a) Cooperate fully with my HIV program coordinator to confidentially reveal the identity of all persons with whom I have had sex or shared needles for the period starting 3 months prior to my last negative HIV test so contacts may receive counseling and testing to break the chain of transmission. In addition to revealing their identities, I will personally inform my contacts, including my spouse, and recommend they seek medical consultation.*

*(b) Understand my status is nondeployable and I may not go TDY OCONUS.*

*(c) Do not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs.*

*(d) Follow my UCMJ commander's order by informing all potential sexual partners of my HIV positive status before engaging in intimate sexual contact. My partner will not be under the influence of alcohol, drugs, or prescription medications that could potentially alter his or her judgment during this discussion.*

*(e) Practice safer sex using a condom or other barrier method recommended by the CDC with every vaginal, penile, anal, and oral sexual encounter. Safer sex practice will not only protect my partners but will also protect me from exposure to other drug-resistant HIV strains.*

*(f) Notify medical, dental, and emergency health care workers of my HIV infection by stating, "I am blood donor ineligible" or "I have HIV."*

*(g) Schedule and attend infectious disease clinic appointments every 6 months and more often, as directed by my infectious disease clinic physician.*

Note.

ARNG and Reserve Soldiers, unless activated, will have annual fit for duty (FFD) medical evaluations.

*(h) Complete DA Form 5669 at diagnosis and annually with my HIV PHN.*

(i) Complete the DA Form 4856 at diagnosis, within 30 days of a unit change of command, and within 30 days of every PCS move.

(j) Complete a PHA at diagnosis and annually as coordinated by my HIV PHN.

(k) Contact my current HIV PHN 1 month before PCS for coordination of medical appointments and command requirements with the gaining HIV PHN and in-process with my new HIV PHN at expiration term of service or retirement.

(l) Report all previous donations of blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs to my HIV Program coordinator (PHN).

(m) Understand the health risk and will avoid live attenuated viral immunizations such as intranasal influenza, chicken pox, smallpox, measles, mumps, rubella, yellow fever, and oral typhoid.

b. The commander's copies of the DA Form 5669 and the DA Form 4856 will be maintained in a locked cabinet or storage unit and designated as "Eyes Only" for the commanding officer as long as the Soldier is assigned to that unit. The commanding officer, in situations of Soldier noncompliance, may disclose this information to designated unit senior leadership on a case-by-case basis to support the Soldier toward compliance. For Soldiers PCSing, the HIV PHN will transfer DA Form 5669 and DA Form 4856 by confidential mail or scanned encrypted email to the gaining HIV PHN. The new HIV PHN will complete a new DA Form 5669 and coordinate with the new unit commander to complete DA Form 4856. For unit commanders PCSing, a commander's copy of DA Form 5669 and DA Form 4856 will be provided to the new unit commander and a new DA Form 4856 will be completed.

#### **4-10. Psychosocial counseling**

a. HIV infected Soldiers will be referred for a psychosocial assessment and counseling as part of their initial medical evaluation. The purpose of this counseling is to provide an initial assessment of the Soldier's mental state and coping skills.

b. Behavioral health resources may include MTF behavioral health department, pastoral chaplain services, Family life chaplain, Military OneSource, MEDCEN infectious disease social work, and psychiatry.

c. The behavioral health provider and/or Family life chaplain should be skilled at counseling personnel dealing with trauma, depression, and rejection. They should be specifically trained in identifying and dealing with potential suicides and personal grief.

d. HIV infected Soldiers may be referred to psychosocial counseling, as needed.

### **Section IV**

#### **Clinical Evaluations and Recording of Medical Information**

#### **4-11. Clinical evaluation, medical profiles, and medical readiness**

a. HIV infected Soldiers will be medically evaluated by infectious disease specialists at a participating MEDCEN supporting the health service region to determine the status of their infection.

b. HIV infected RC Soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40-501 and be found FFD. RC Soldiers are required to obtain the FFD medical examination from the civilian medical community at no expense to the Government. The required medical procedures will be provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation (see chap 7 for additional guidance regarding HIV infected RC Soldiers).

c. The CDC classification system for HIV infection will be used for medical classification purposes.

d. Soldiers determined HIV positive by confirmatory test on the first specimen will be noted in MEDPROS as follows: initial physical, upper, lower, hearing, eyes, psychiatric (PULHES) will remain the same, the V code for deployment restrictions will be added to the profile, and medical nondeployment module changed to "YES" by the HIV program coordinator (PHN).

e. Soldiers who are confirmed as HIV infected do not require a change in the PULHES on their physical profile solely because they are HIV infected. If the Soldier's physical or medical condition warrants a change in physical profile, a DA Form 3349 (Physical Profile) will be issued by the MEDDAC/MEDCEN commander or other profiling authority. Copies of the DA Form 3349 will be sent to the unit commander and the servicing personnel service center. Documents will be sealed in an envelope marked "To Be Opened By Addressee Only" and addressed, by name, to the appropriate unit commander and adjutant general or personnel officer. Procedures will be established by the appropriate medical authority to confirm that unit commanders and adjutants general or personnel officers have received proper notification of HIV infected Soldiers. If a change in physical profile is warranted, the following minimum entries will be made on the DA Form 3349:

(1) Item 1 of the DA Form 3349 will indicate the specific medical condition causing the change in physical profile. The profiling authority should avoid referring to HIV infection or retrovirus infection since these terms describe the disease process rather than the specific medical condition resulting in the profile.

(2) Item 2 will contain a V code denoting deployment restrictions and additional codes may be entered as necessary.



(3) Item 3 PULHES, will be adjusted per AR 40–501.

#### **4–12. Blood donation**

*a.* Preventive medicine will report confirmed HIV infected Soldiers to the Army Blood Program look back coordinator, USAMEDCOM for entry into the donor deferral registry.

*b.* Army blood donor centers will notify local preventive medicine officials about Soldiers who have positive HIV test results identified during blood donation. Test results will include initial reactive or repeat reactive and confirmatory test results.

#### **4–13. Medical records and databases**

Information on, and results of, HIV testing will be entered in individual medical records as follows:

*a.* HIV test dates from the DOD lab contractor go directly to the Armed Forces Health Surveillance Center and are then forwarded to the MEDPROS individual medical readiness.

*b.* Soldiers with a confirmed positive HIV test (first specimen) will be entered by the installation HIV program coordinator (PHN) until such time that a direct electronic feed is available from the confirmatory lab to MEDPROS. The entry is “initial PULHES will remain the same, the V code will be added to the profile, and medical nondeployment module changed to YES.” In the case of a verification test revealing previous erroneous positive result, the HIV coordinator (PHN) will directly coordinate with the regional medical readiness coordinator to correct the MEDPROS database. This allows commanders and medical personnel to track these individuals over time and ensure their continental United States (CONUS) only duty status is not violated.

*c.* Records pertaining to evaluation and reevaluation of HIV infected Soldiers will be filed per AR 40–66.

*d.* Soldiers with confirmed positive HIV test (first specimen) will be entered by the installation HIV program coordinator (PHN) in the Armed Services Blood Program Blood Establishment Computer System, a DOD blood management system for tracking donations, testing, and shipping of products and transfusion of blood products.

<b>PREVENTIVE MEDICINE COUNSELING RECORD</b>			
For use of this form, see AR 600-110; the proponent agency is DCS, G-1.			
<b>DATA REQUIRED BY THE PRIVACY ACT OF 1974</b>			
<b>Authority:</b> 5 USC 301, 10 USC 3012(G). <b>Principal Purpose:</b> To record preventive medicine counseling of Servicemembers testing positive for exposure to HIV. <b>Routine uses:</b> Prerequisite counseling under AR 600-110, paragraph 2-16. <b>Disclosure:</b> Disclosure is voluntary. However, failure to provide the information may result in incorrect identification.			
<b>INSTRUCTIONS</b>			
The counselor will obtain and record the administrative information required in Part I from official military records or from the Soldier's identification card. The HIV program coordinator public health nurse (PHN) will maintain this document in accordance with AR 600-110 in a locked cabinet. Upon PCS, this form will be sent to the gaining HIV program coordinator (PHN). Upon ETS or retirement, this form will be destroyed.			
<b>PART I - PATIENT INFORMATION</b>			
A. NAME OF PATIENT (Last, First, MI) Smith, John Q.	B. DOB 19880101	C. GRADE E6	D. NAME OF SPONSOR Same
E. UNIT HHQ, 1st Training BDE	F. LOCATION Ft. Knox, KY		
G. DATE OF DIAGNOSIS (YYYYMMDD) 20120501	H. DATE AND TIME OF COUNSELING 20120503/1330hrs	I. LOCATION OF COUNSELING Ireland ACH, Ft. Knox, KY	
<b>J. Counselor:</b>			
1. NAME Doe, Jane A.	2. GRADE/CORPS 04/MC	4. UNIT A Company IACH Ft. Knox, KY	
3. TITLE Chief, Preventive Medicine			
<b>PART II - PATIENT COUNSELING ACKNOWLEDGMENT</b>			
<p>I have been informed of my positive HIV test result. I understand as a member of the Active Army, Reserve, or Army National Guard, I have specific responsibilities to prevent transmission of the infection to others, specifically:</p> <p>A. My confirmed positive HIV test means I have been infected with HIV.</p> <p>B. I understand my UCMJ commander is informed of this positive result and is my advocate in accordance with AR 600-110. I have reviewed and understand my Soldier responsibilities.</p> <p>C. There is no cure for HIV infection. My blood, semen, vaginal fluids, and breast milk may potentially transmit HIV infections to others. Even if my viral load is undetectable, my blood, semen, vaginal fluids, and breast milk may transmit HIV infection to others.</p> <p>D. I will not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs.</p> <p>E. I am nondeployable, may not go TDY, OCONUS, and my career occupational specialty may be affected. My UCMJ commander will contact the HRC HIV POC for guidance.</p> <p>F. I realize I may have infected others with HIV before I knew I was infected. For this reason, I am obliged to confidentially reveal the identity of all persons with whom I have had sex or shared needles for the period starting 3 months prior to my last negative HIV test, so that contacts may receive counseling and testing to break the chain of transmission. In addition to revealing their identities, I will personally inform my contacts, including my spouse, and recommend they seek medical consultation.</p> <p>G. Intimate sexual contact includes oral, vaginal, penile, and anal sex with any partner potentially at risk of HIV transmission and infection. The use of condoms may reduce but does not eliminate the risk of HIV infection. I must follow safer sex practices using barriers such as condoms with every sexual act or insist my partners use condoms. Other barriers include female condoms and dental dams. I will not share razors or toothbrushes, and will cover wounds to prevent transmission.</p> <p>H. Condom use does not remove my obligation to inform partners of my HIV infection before engaging in intimate sexual contact. When discussing this, my partner must not be under the influence of any potentially mind-altering substances (alcohol, illegal drugs, prescription medications, and so forth) that could potentially impair his or her judgment.</p> <p>I. I understand I must notify medical, dental, and emergency health care workers potentially exposed to HIV infection through contact with my blood and/or body fluids. I understand the need to clarify which vaccines I am receiving and will avoid live attenuated viral immunizations such as intranasal flu, chicken pox, smallpox, measles, mumps, rubella, yellow fever, and oral typhoid vaccines.</p> <p>J. HIV can be transmitted from an HIV positive mother to her baby; therefore, Family planning issues will be discussed with my infectious disease physician.</p> <p>K. I will comply with the medical management of HIV infection directed by the infectious disease physician, to include attend medical evaluations every 6 months and as needed (active duty HIV-infected Soldiers only). Note: Army National Guard and Reserve Soldiers, unless activated will have annual fit for duty medical evaluations.</p> <p>L. I must complete a DA Form 5669 (Preventive Medicine Counseling Record) and DA Form 4856 (Developmental Counseling Form) at diagnosis and as directed by my HIV program director/coordinator (PHN).</p> <p>M. As a member of the Active Army, Reserve, or Army National Guard, I must complete a periodic health assessment (PHA) at diagnosis, and then annually.</p> <p>N. To maintain my confidentiality and military requirements, I will contact my HIV program coordinator (PHN) 1 month before PCS, planned expiration term of service, or retirement.</p> <p>I acknowledge that I, <u>John Q. Smith</u>, have been counseled and understand that the preventive medicine measures listed in paragraph A through I, above, which were explained to me, are necessary to preclude transmission of HIV infections.</p>			
O. SIGNATURE OF PATIENT	DATE (YYYYMMDD) 20120503	P. SIGNATURE OF COUNSELOR	DATE (YYYYMMDD) 20120503

DA FORM 5669, JUL 2012

PREVIOUS EDITIONS ARE OBSOLETE.

APD LF v1.00ES

Figure 4-1. Sample for DA Form 5669

## **Chapter 5**

### **Accession Testing Program**

#### **5-1. General**

This chapter prescribes the DA policy for accession testing and nonaccession of individuals who are confirmed HIV positive by appropriate confirmatory test.

#### **5-2. Accessions and probationary officers**

- a.* For purposes of this chapter, accessions are—
- (1) First enlistments in the AC or RC.
  - (2) Subsequent enlistments in the AC or RC other than immediate reenlistments in the same component.
  - (3) Original appointments as a commissioned or warrant officers in the AC (except for officer appointments in the AC under the provisions of AR 601-100, chap 2).
  - (4) Appointments as cadets at the United States Military Academy (USMA).
  - (5) First original appointments as commissioned or warrant officers in a RC (to include both qualifications for Federal recognition and for original appointment as a Reserve of the Army in the ARNG following Federal recognition).
  - (6) Original appointments as warrant officers in the Army of the United States.
  - (7) Peacetime orders of a member of a RC to AD, active duty for training (ADT), or full-time National Guard duty (FTNGD) for the purpose of attending initial entry training, regardless of whether the RC member is programmed at the conclusion of training for release from active duty (REFRAD), or is programmed to continue on active duty for operational support (ADOS) or FTNGD. This specifically includes the order to ADOS of Reserve commissioned officers commissioned through the Reserve Officers' Training Corps (ROTC) program where the officer's initial duty assignment is to an officer basic course.
  - (8) Enrollments as an ROTC scholarship cadet or as a nonscholarship cadet in military science III.
  - (9) Enrollments as an officer candidate (Active Army, ARNG, or USAR) in Officer Candidate School (OCS).
- b.* Probationary officers are—
- (1) AC commissioned officers on the AD list with less than 5 years active commissioned service.
  - (2) RC commissioned officers who have less than 5 years commissioned service. Both AD and non-AD commissioned service counts.
  - (3) Warrant officers who have less than 3 years service (AD or non-AD) since original appointment in their present component.
  - (4) Officers who have less than 3 years service in the Army of the United States without component.

#### **5-3. Human immunodeficiency virus testing policies**

- a.* All applicants for accession (officer, warrant officer, and enlisted for AC and RC) will be screened for HIV using FDA-approved tests.
- b.* HIV testing of applicants for enlistment will be accomplished during the initial physical examination at the MEPS. Blood samples will be drawn by medical personnel at the MEPS. Testing from any source except MEPS, other DOD military treatment facilities, or DOD contract facilities is not acceptable for accession testing requirements (see AR 601-270).
- c.* Applicants for accession who have no military status of any kind at the time of testing and who are confirmed HIV infected will not be enlisted or appointed in any component of the Army.
- d.* Individuals who test HIV positive will be provided a list of civilian treatment facilities by the chief medical officer at the MEPS. The chief medical officer will recommend the individual seek further medical evaluation at one of the listed facilities and complete local health department reporting requirements.
- e.* Accession testing will be conducted within the first 29 days of AD at training centers, schools, or units (whichever provides the earliest opportunity) for all personnel who have not been previously screened at a MEPS or other authorized location, or for whom 6 months have elapsed from the initial pre-accession screening (such as personnel entering from the delayed entry program or a pre-commissioning program). For accession purposes, the pre-accession HIV test is valid until the Soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the Soldier will be retested within the first 29 days at the initial AD installation. Those confirmed to be HIV infected will be processed for separation for failure to meet procurement medical fitness standards.
- f.* Accessions processed by other than MEPS or an initial training center will follow a similar process as outlined above at the military point of entry. Vaccination with live virus vaccines may be administered provided there is a record of a previous negative HIV test no older than 24 months.
- g.* Prior service personnel required to meet accession medical fitness standards (AR 40-501) must be tested and found to be HIV negative no more than 6 months before enlistment in the Selected Reserve. Prior service applicants, who are not processed through MEPS, may conditionally enlist without an HIV test, or with a test result older than 6

months. Testing is required within the first 30 days after enlistment through the force surveillance testing program. A one-time 30-day extension may be granted by the State Adjutant General or by a commander of one of the numbered armies in CONUS. Soldiers testing HIV positive will be discharged for an existed prior to service medical condition. AD Soldiers transferring to or enlisting in a Selected Reserve unit at the end of their current contractual or statutory obligation without a break in service are required to meet retention medical fitness standards (AR 40–501). These Soldiers must have a negative HIV test no older than 24 months prior to the date of transfer or enlistment.

*h.* Candidates for active or reserve officer service will be tested during the pre-appointment physical examinations. This applies to any individual pending appointment as an officer in any officer procurement program, to include ROTC, direct commissioning, and OCS (ARNG, Reserve, or Active Army) programs. For accession purposes, the pre-accession HIV test is valid until the Soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the Soldier will be retested within the first 29 days at the initial AD installation. USMA cadets will be tested within 72 hours of reporting to the USMA on reception day.

(1) USMA cadets who are confirmed HIV positive will be separated from the academy and discharged under USMA regulations. The Superintendent, USMA, may delay separation until the end of the current academic year. If the cadet is in his or her final academic year and is otherwise qualified, the cadet may be graduated without commission and discharged. An honorable discharge will be issued if HIV infection is the sole basis for discharge.

(2) ROTC cadets who are confirmed HIV infected will be disenrolled from the program at the end of the current academic term (semester, quarter, or similar period). Cadets who are disenrolled due to HIV infection will be permitted to retain any financial support received through the end of the current academic term and such support is not subject to recoupment.

(3) Enlisted Soldiers who are officer candidates through OCS and are confirmed HIV infected will be immediately disenrolled from the program. If OCS is the Soldier's initial entry training, the Soldier will be discharged under the provisions of AR 635–200. If OCS is not the Soldier's initial entry training, the Soldier will be removed from the program under the provisions of AR 350–51, AR 140–50, or NGR 351–5, as appropriate, and will be reassigned in his or her original military occupational specialty (MOS) in accordance with assignment policies of chapters 6 or 7. Reassignment will be without regard to PCS restrictions.

#### **5–4. Confidentiality**

The provisions of chapters 3, 4, and 9, with regard to confidentiality and use of information, apply to this chapter, except that HIV infection may be used as the basis for separation under the accession testing program. Care will be taken that no one without a “need to know” in the performance of his or her duties is given any information about an applicant's HIV status. “Need to know” individuals are defined as the Soldier's commanding officer, designated laboratory, preventive medicine, behavioral health, pastoral care, pharmacy, wellness, primary care, and specialty medical personnel, Reserve and Guard HIV program directors or coordinators, and designated HRC personnel. In situations of Soldier noncompliance, the commanding officer may disclose this information to the designated unit senior leadership on a case-by-case basis to support the Soldier toward compliance. Current HIPAA privacy and security training is required for all “need to know” individuals.

## **Chapter 6 Active Duty Personnel Policies and Procedures**

### **Section I Assignment Policies and Procedures**

#### **6–1. General**

- a.* The policies and procedures in this chapter apply to all AD Soldiers, including AGR personnel.
- b.* Individuals who are confirmed to be HIV infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains.
- c.* Every effort will be made to ensure that, except for their assignment limitations, HIV infected personnel are treated no differently than other Soldiers. Commanders must ensure that information about the HIV infected Soldier's medical condition is provided only to those whose duties require knowledge of that information (see para 5–4).

#### **6–2. Active force surveillance testing**

- a.* All Soldiers are required to be tested for HIV at least biennially (once every 2 years). Upon confirmation of a positive HIV infection status (after verification specimen) Soldiers are exempt from this requirement.
- b.* Unit commanders are notified of all personnel requiring biennial HIV testing via MEDPROS.
- c.* Unless modified by a COCOM, host nation, or other policy that requires earlier testing, personnel who are awaiting a PCS overseas or are scheduled for overseas deployments or TDY must be screened and receive a negative HIV test result if they have not been tested within the 6 months preceding their departure date. Individuals alerted for

overseas assignments will be instructed, as part of their Soldier reassignment processing requirements, to report to the appropriate physical examination clinic or laboratory for a blood sample. For routine HIV testing requirements for RC personnel, see paragraphs 7-2 through 7-6. The following policy applies unless COCOM or host nation's policies require earlier testing (see AR 614-30).

*d.* In the event that prioritization of testing is required due to resource constraints, screening will be accomplished in the following priority:

(1) Soldiers and military units assigned or pending assignment to areas of the world where a moderate to high risk exists of contracting serious tropical infections, such as yellow fever, malaria, and dengue. Such areas include Central America, South America, the Caribbean, the Philippines, Southeast Asia, Thailand, Malaysia, Central Africa, East Africa, and Southwest Asia.

(2) Soldiers or units pending assignment or deployment to areas of the world where medical support will be limited. Included are assignments to remote areas where periodic evaluation of personnel and monitoring of health will be difficult, such as Korea and the Far East.

(3) Units with contingency plans to deploy on short notice to areas of the world described in paragraphs (1) and (2), above. Included are alerted forces who must be deployed in 30 days or less and all personnel scheduled to participate in overseas exercises that have not been screened within 24 months of the projected deployment date.

(4) Other military units that could be deployed overseas and OCONUS Army Forces in Europe, Korea, and Japan.

(5) All other units.

(6) All Soldiers in conjunction with routine, periodic physical examinations for any purpose, or any other scheduled medical examinations.

### **6-3. Assignment limitations**

*a.* HIV infected Soldiers will not be deployed or assigned overseas. HIV infected Soldiers will not perform official duties overseas for any duration of time. Soldiers confirmed to be HIV infected while stationed overseas will be reassigned to the United States per paragraph 6-8.

*b.* In the United States (including Alaska, Hawaii, Guam, Puerto Rico and the U.S. Virgin Islands), HIV infected Soldiers will not be assigned to—

(1) Any table of organization and equipment or modified table of organization and equipment unit. Installation commanders may reassign any HIV infected Soldier in such units to table of distribution and allowances (TDA) units on their installation provided the Soldier has completed a normal tour in that unit (a normal tour for these purposes is 3 years from reporting date to the unit). After completion of a normal tour, reassignment to TDA units may be made provided assignment can be made according to normal personnel management and assignment criteria in AR 614-100 and AR 614-200. Reassignment must be to an authorized position for the Soldier's grade and primary MOS or secondary MOS. Installation commanders unable to make appropriate reassignments will report the names of HIV infected Soldiers to the Commander, HRC, AHRC-EPD-I (enlisted) or TAPC-OPD-M (officer).

(2) Military-sponsored educational programs, regardless of length but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV infected Soldiers assigned to these programs will be disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to PCS restrictions. Any financial support received by the Soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military sponsored educational programs will be waived. Not included in this restriction are military schools required for career progression in a Soldier's MOS, branch, or functional area (such as, Noncommissioned Officer Education System schools, Captains Career Course, or intermediate level education).

(3) U.S. Army Recruiting Command, Cadet Command, U.S. Military Entrance Processing Command, ARNG full time recruiting force, or ARNG full time attrition/retention force if a Soldier's medical condition requires frequent medical follow-up (medical authorities will determine if follow-up is frequent) and the Soldier's projected duty station is geographically isolated from an Army MTF capable of providing that follow-up. These organizations will report HIV infected Soldiers who cannot be assigned per this policy to the Commander, HRC, AHRC-EPD-I (enlisted) or TAPC-OPD-M (officer), for assignment instructions (AI). For special branch officers, forward assignment requests to HQDA (DAJA-PT) for Judge Advocate General's Corps (JAGC) officers or HQDA (DACH-PEA) for chaplains. For ARNG AGR Title 10 personnel, all requests should be sent to Commander, National Guard Personnel Center (NGB-ARP-CT), 4501 Ford Avenue, Alexandria, VA 22302-1450; for ARNG FTNGD Title 32 personnel, requests should be sent to the applicable State Adjutant General. Requests for AI for USAR AGR personnel should be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC-SGD-H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122-5303.

*c.* Assignment preclusion from units, organizations, schools, or programs other than those listed above must be approved by HQDA (DAPE-HR).

*d.* Commanders may not change the assignment or utilization of HIV infected Soldiers solely because of their

infection unless required by this regulation or the Soldier's medical condition (as reflected on DA Form 3349 or other pertinent medical records). Grouping all HIV infected Soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available.

*e.* HIV infected Servicemembers may transfer to the Active Army from another Armed Force (inter-Service transfer) if they meet medical retention standards (AR 40-501). However, Servicemembers who are HIV infected may not be transferred to the Army from another Armed Force if they are required to meet accession medical standards (AR 40-501), except as specifically permitted in chapter 5.

*f.* HIV infected Soldiers who demonstrate progressive clinical illness or immunological deficiency will be processed per section III of this chapter. (See the glossary for definitions of progressive clinical illness and immunological deficiency.)

#### **6-4. Accompanied tours**

*a.* Family members who are HIV infected may accompany their sponsor overseas. Paragraph 8-6 provides guidance for processing HIV infected Family members.

*b.* When a Family member is HIV infected, the sponsor may request deletion from an overseas assignment alert based on compassionate reasons, or request an "all others" tour. Deletion of the sponsor from overseas AI is not mandated solely based on a Family member's HIV status. If assigned overseas at the time the Family member is diagnosed as HIV infected, the sponsor may apply for a curtailment of foreign service tour (FST) for compassionate reasons per AR 614-30. A mandatory PCS or curtailment of FST of the sponsor will not occur solely because a Family member is determined to be HIV infected.

#### **6-5. Military schooling**

Soldiers who are HIV infected and are determined to meet retention standards are eligible for all military professional development schools (such as Noncommissioned Officer Education System, Captains Career Course, and intermediate level education). HIV infected Soldiers may also attend formal military training required to qualify them for reclassification to a new MOS or award a skill qualification identifier, additional skill identifier, or functional area.

#### **6-6. Reenlistment**

*a.* HIV infected enlisted Soldiers who meet medical retention standards of AR 40-501, chapter 3 are eligible to reenlist, if otherwise qualified.

*b.* There is no requirement to have an HIV test as part of reenlistment qualification unless the Soldier desires to reenlist for an overseas duty assignment or for an organization cited in paragraph 6-3*b*. Soldiers will not be permitted to reenlist for an overseas duty assignment or an organization cited in paragraph 6-3*b*, unless they have tested negative for HIV within the 6-month period preceding the desired date of reenlistment. If HIV infected, they may reenlist for any option in AR 601-280 except overseas or restricted units.

*c.* Enlisted Soldiers who enlisted or reenlisted for a unit or organization cited in paragraph 6-3*b* and who subsequently are confirmed as HIV infected will be processed as follows:

(1) If otherwise eligible, Soldiers will be advised of the procedures of AR 635-200, concerning requests for separation due to unfulfilled enlistment commitments.

(2) Soldiers who are not eligible for separation due to unfulfilled enlistment commitments under AR 635-200 and who are not under a suspension of favorable personnel actions may request separation for the convenience of the Government under AR 635-200, secretarial plenary authority. These procedures are outlined in paragraph 6-14.

(3) Enlistment contracts may be renegotiated where appropriate and Soldiers, if otherwise eligible, may be given other options commensurate with the established assignment limitations for HIV infected Soldiers.

#### **6-7. Utilization**

*a.* There is no medical reason for HIV infected Soldiers' duties to be changed solely because of their infection (except in certain instances for health care providers). In instances where a Soldier performs duties as a member of a flight crew, or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination will be made by a medical evaluation board as to the Soldier's fitness to perform his or her duties.

*b.* In the case of HIV infected health care providers, their duties may be restricted when performing those duties that present a risk of transmitting HIV to their patient. This determination will be made by an expert medical review committee as designated by the deputy commander for clinical services. This committee will make recommendations on a case-by-case basis to the MEDDAC/MEDCEN/Dental Activity commander per AR 40-68 as to the restriction of duties of HIV infected health care providers. The restriction may only be to the extent that the risk is eliminated. In all other instances, HIV infected Soldiers will be utilized in their primary MOS per normal utilization criteria contained in Army personnel regulations and the assignment limitations in paragraphs 6-3*b* and 6-3*d*.

## **6–8. Assignment/reassignment policies and procedures**

### *a. Overseas policies.*

(1) Soldiers serving overseas who are identified as HIV infected will have their FSTs curtailed and will be expeditiously reassigned to the United States. This paragraph does not apply to Soldiers who are permanent residents of and are currently stationed in Guam, the Virgin Islands, or American Samoa. HIV infected Soldiers who are assigned outside these areas and who desire compassionate reassignment to these areas may apply per existing policies for compassionate reassignments. Requests will be considered on a case-by-case basis.

(2) Soldiers who are returned to the United States will have their FST curtailed and will be given credit for a completed tour as prescribed in AR 614–30.

(3) Overseas ACOM, ASCC, or DRU commanders are authorized to approve a second PCS in the same fiscal year for HIV infected Soldiers returning to the United States under this program. AR 614–30 prescribes authorities for approval of PCS and time on station waivers and tour curtailments.

### *b. Overseas procedures.*

(1) Overseas adjutants general or personnel officers will, upon receipt of formal notification of Soldiers who are HIV infected, request immediate FST curtailment per AR 614–30. Curtailments of FST will be coordinated by priority message, “FOR OFFICIAL USE ONLY” with Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer) for AI. For special branch-managed officers, forward assignment requests to HQDA (DAJA–PT) for JAGC officers or HQDA (DACH–PEA) for chaplains. (For ARNG AGR Title 10 personnel, all requests should be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for USAR AGR personnel, all requests should be sent to Commander, U.S. Army Human Resources Command (AHRC–SG), Building 6434–6, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303). Requests will include the following:

(a) Name, grade, social security number, primary MOS or control branch, and unit of assignment.

(b) Include the statement: “This curtailment request is submitted per AR 600–110, paragraph 6–8b.”

(c) Desired report date.

(d) Three assignment preferences in the United States (including Alaska, Hawaii, Guam, Puerto Rico and the U.S. Virgin Islands) with rationale from the Soldier as to the three choices (for example, to be near Family).

(e) Known assignment limitations or special considerations that should be considered in making the assignment.

(f) Tour type: accompanied, unaccompanied (Family members in the United States), unaccompanied (Family members in-country at sponsor’s personal expense).

(2) The Commander, HRC (Commander, National Guard Personnel Center (NGB–ARP–CT), for ARNG Title 10 AGR personnel, or Commander, HRC (AHRC–SGD–H), for USAR AGR personnel) will issue AI expeditiously.

(3) Soldiers overseas identified for referral into the physical disability system will be expeditiously processed per AR 635–40.

(4) Nothing in the procedures discussed above should be interpreted as prohibiting a Soldier from taking leave overseas solely because of HIV infection. Current Army and DOD policy does not restrict a Soldier from any travel in a leave status based on the results of an HIV test. However, HIV infected Soldiers must meet entrance requirements for countries they intend to visit. Countries may require evidence of HIV testing and may require negative test results as part of those entrance requirements.

### *c. Continental United States policies.*

(1) Soldiers identified as HIV infected and who are assigned to organizations cited in paragraph 6–3b will be transferred within their current installations. If local reassignment is not possible, HIV infected Soldiers will be reported to the Commander, HRC for AI. These Soldiers are eligible for other assignments in the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands) according to the needs of the Army and existing PCS policies.

(2) Soldiers who receive overseas AI will require an HIV test as part of their Soldier reassignment processing requirements if they have not been tested in the 6 months prior to their port calls. Those who are HIV infected will be deleted from AI. Soldiers with Family members who are HIV infected will follow the policies and procedures in paragraphs 6–4b and 8–6.

*d. Continental United States procedures.* Adjutants general/personnel officers in the United States will, upon receipt of formal notification from the commander of the local MTF of Soldiers who are HIV infected, take the following actions:

(1) Soldiers who are HIV infected will be deleted from overseas AI. For enlisted personnel, requests for deletions will be submitted to the Commander, HRC (AHRC–EPD–I). Approval will be automatic and confirmed through the Enlisted Distribution and Assignment System by HRC. For officer personnel, requests for deletions will be forwarded to the Commander, HRC (TAPC–OPD–M) for officers managed by Officer Personnel Management Directorate; HQDA (DAJA–PT) for JAGC officers; or HQDA (DACH–PEA) for chaplains. For ARNG Title 10 AGR personnel, all requests for deletion will be forwarded to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 AGR personnel, all requests for deletion will be forwarded to the State Adjutant General, Support Personnel Management Office, of the particular State/territory to which the

AGR Soldier is assigned for duty. For USAR AGR personnel, all requests for deletion will be forwarded to the Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC-SGD-H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122-5303.

(2) Other than accession testing per chapter 5, enlisted Soldiers undergoing initial entry training (to include prior service Soldiers) with AI to an overseas location and who are confirmed as HIV infected will be reported to the Commander, HRC (AHRC-EPD-I) under provisions of AR 635-200 (see separation for convenience of the Government) for separation if less than 180 days of service or for issuance of AI to an installation in the United States or Puerto Rico if over 180 days of service.

### **6-9. Transfer of personnel and medical records**

The procedures below apply to the transfer of personnel and medical records of all Soldiers identified as HIV infected. These procedures apply to moves within the United States as well as from overseas locations to the United States, excluding those conducted through medical evacuation channels.

*a.* When AI on an HIV infected Soldier are received, the HIV infected Soldier will inform his or her HIV program coordinator (PHN) and out-process within 30 days of PCS. The losing HIV program coordinator (PHN) will contact the gaining HIV program coordinator (PHN) and provide the expected date of departure, the new assignment location or unit (if known), and the anticipated arrival date, and send the contents of the duplicate file, including all preventive medicine and commander's counseling statements encrypted or by confidential fax to the gaining HIV program coordinator (PHN).

*b.* The Soldier will in-process with the gaining HIV program coordinator (PHN) immediately upon arrival.

*c.* The gaining HIV program coordinator (PHN) will ensure that any immediately necessary medical care, to include medical evaluation and reevaluation, is fully coordinated.

*d.* The HIV program coordinator (PHN) will notify the gaining unit commander of the Soldier's medical condition as soon after his or her arrival as possible.

*e.* HIV infected Soldiers transferred into a unit will be provided preventive medicine counseling and commander's counseling in the same manner as that prescribed for newly identified HIV infected Soldiers (see paras 4-8 and 4-9).

*f.* Soldiers who are returning to the United States from overseas for initial medical evaluation at the regional infectious disease service will be ordered, as part of HRC (AHRC-SG) for USAR AGR Soldiers' AI, to report TDY en route to the regional Army MEDCEN for the new assignment location for a period not to exceed 10 days. HRC will ensure that the AI includes instructions to provide a copy of the PCS orders to the designated MEDCEN. Soldiers who will be accompanied by Family members will be counseled that housing for the Family at the TDY location will be at the Soldier's own expense and that Government transient quarters may not be available. Soldiers referred to medical or physical evaluation boards immediately following medical evaluation will be handled per normal medical or physical evaluation boards procedures and will be deleted from their original orders. The MEDCEN HIV program coordinator (PHN) will notify the gaining installation HIV program coordinator (PHN) of pertinent medical information telephonically or by encrypted email.

### **6-10. Monitoring patient health**

*a.* Long-term monitoring of the HIV infected individual's health is essential. Clinical evaluation will be accomplished at least twice a year by an infectious disease specialist at a participating MEDCEN. Commanders should be advised if AD Soldiers fail to comply with treatment instructions, preventive medicine counseling, or orders given during the commander's counseling.

*b.* The attending physicians or medical POCs must inform the Soldier's commander when a significant change in immunological status or clinical disease status is identified. Likewise, commanders must consult the attending physician or medical POC if the Soldier's FFD becomes suspect. Soldiers thought to be unfit for duty will be processed through normal medical or physical evaluation boards for determinations.

*c.* When HIV infected Soldiers are attached to another unit for a period in excess of 15 days, their commanders will personally notify the gaining unit commander of the Soldier's medical condition. The gaining commander will maintain this information confidentially and will release that information only to those with an established "need to know" of the medical condition.

## **Section II Procedures**

### **6-11. Overseas**

*a.* The medical activity commander and/or division surgeon—

(1) Provides formal notification to the unit commander and the adjutant general or personnel officer having custody of an HIV infected Soldier's Army Military Human Resource Record (AMHRR).

(2) Expeditiously schedules HIV infected Soldier for a second verification HIV test, medical evaluation at the designated regional MEDCEN, and referral to the HIV program coordinator (PHN) at the gaining CONUS installation.



- b.* The adjutant general or personnel officer having custody of the AMHRR of HIV infected Soldiers—
- (1) Requests FST curtailment per AR 614–30.
  - (2) Expeditiously processes AI issued by HRC (National Guard Personnel Center for ARNG personnel or HRC for USAR AGR personnel) and issues necessary orders.
  - (3) Follows procedures prescribed in paragraph 6–8*b*.
- c.* The CG, HRC—
- (1) Issues AI for Soldiers identified as HIV infected.
  - (2) Directs award of tour credit in the special instructions of the AI.
- d.* For ARNG AGR personnel, the Commander, National Guard Personnel Center, will use the procedures described for CG, HRC, in paragraph *c*, above.

## **6–12. Continental United States**

- a.* The HIV program director—
- (1) Provides formal notification to the unit commander and the adjutant general or personnel officer having custody of the AMHRR of HIV infected Soldiers.
  - (2) Ensures that Soldiers are referred into the physical disability system in coordination with the infectious disease physician, as appropriate.
- b.* Adjutants general or personnel officers having custody of the AMHRR of HIV infected Soldiers—
- (1) Request deletion of those Soldiers who are on overseas AI.
  - (2) Reassign locally those Soldiers who are infected and are assigned to organizations cited in paragraph 6–3*b*. Request AI in those cases where on-post transfer cannot be accomplished to satisfy assignment policy limitations.
  - (3) Follow the procedures described in paragraph 6–8*d*.
- c.* The CG, HRC—
- (1) Approves deletion requests for HIV infected Soldiers who are on overseas AI.
  - (2) Upon request, issues AI for those Soldiers in organizations cited in paragraph 6–3*b* who cannot be reassigned locally.
- d.* For AGR personnel, the following individuals will perform those procedures described for the CG, HRC, in paragraph *c*, above.
- (1) The Commander, National Guard Personnel Center for ARNG personnel on NGB-controlled Title 10 tours.
  - (2) The State Adjutants General for ARNG personnel on Title 32 tours.
  - (3) The Commander, HRC (AHRC–SGD–H) for all USAR personnel.

## **Section III Administrative Separations**

### **6–13. Administrative separation of officers**

- a.* Officers who are HIV infected and no longer desire to remain on AD may submit an unqualified resignation under the provisions of AR 600–8–24 or request voluntary REFRAD under the provisions of AR 600–8–24, as appropriate. Probationary officers (as defined in AR 600–8–24) who have tested positive for HIV infection and who were infected prior to acceptance of appointment may request resignation under the provisions of AR 600–8–24.
- b.* Officers submitting voluntary applications for resignation or REFRAD should use the formats indicated in AR 600–8–24, as appropriate. The officer will execute the following statement and include it in his or her application: “I have been counseled by a member of The Judge Advocate General’s Corps regarding the consequences of my request and I certify that this request is voluntary. I understand that if my request is accepted, I will be granted an honorable discharge (if requesting resignation) or honorable characterization of service (if requesting REFRAD).” Officers who are HIV infected but still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General’s Corps, who will explain the impact of the officer’s request. As a minimum, specific information regarding the officer’s post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum: “Officer was advised that disability benefits under provisions of 10 USC 61 may be available in the event that he or she remains in the Army until the U.S. Army Physical Disability Agency determines the officer is no longer fit to perform assigned military duties.”
- c.* Requests for resignation or REFRAD will be submitted through command channels to the appropriate career manager indicated below:
- (1) Maneuver, fires, and effects (formerly combat arms)—Commander, U.S. Army Human Resources Command (HRC–OPA), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.
  - (2) Operation support division (formerly combat support arms)—Commander, U.S. Army Human Resources Command (HRC–OPB), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(3) Field services division (formerly combat service support)—Commander, U.S. Army Human Resources Command (HRC–OPC), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(4) Health services to health services division—Commander, U.S. Army Human Resources Command (HRC–OPH), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(5) Colonels to senior leader division—Commander, Headquarters, Department of the Army (DACS–CMO), 200 Army Pentagon, Washington, DC VA 20310–0200.

(6) Chaplains—Headquarters, Department of the Army (DACH–PER), 2700 Army Pentagon, Washington, DC 20310–2700.

(7) JAGC officers—Headquarters, Department of the Army (DAJA–PT), 200 Army Pentagon, Washington, DC 20310–2200.

(8) AGR Officers—For ARNG Title 10 AGR officers, Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 AGR officers, State Adjutant General, Support Personnel Management Office; and for USAR AGR officers, Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.

*d.* AC commissioned and warrant probationary officers entering AD who are identified as HIV infected within 180 days of their original appointment, or USAR and ARNG commissioned and warrant probationary officers who report for initial entry training in an AD (other than ADT) status and are identified as HIV infected within 180 days of reporting to AD, will be processed for discharge under the provisions of AR 600–8–24.

*e.* Officers who are HIV infected and have been found not to have complied with preventive medicine counseling prescribed in paragraph 4–8 may be involuntarily discharged. Commanders may recommend that such officers be eliminated under the provisions of AR 600–8–24. Recommendations for separation must be based upon information obtained independently from interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that an officer is HIV infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

*f.* Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the Alcohol Substance Abuse Program (ASAP), noncompliance with the medical management of HIV infection as determined by an infectious disease physician, or the routine diagnosis of STIs other than HIV.

*g.* HIV infected officers remain subject to involuntary separation under any provision of AR 600–8–24, as appropriate. The policies described in chapter 9 apply. Officers who no longer meet medical retention standards will be processed per AR 635–40.

#### **6–14. Administrative separation of enlisted personnel**

*a.* Enlisted Soldiers who are HIV infected may submit a voluntary request for discharge under the provisions of AR 635–200, secretarial plenary authority. Voluntary requests for separation will be submitted through command channels to Commander, U.S. Army Human Resources Command (AHRC–EPF–M), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450. The National Guard Personnel Center will forward these requests to HRC for decision. Requests from ARNG Title 32 enlisted AGR personnel will be sent to the State Adjutant General, Support Personnel Management Office, of the particular State/territory in which the Soldier is assigned for duty. For USAR AGR enlisted personnel, requests will be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.) Requests for voluntary separation will not be accepted from Soldiers who no longer meet medical retention standards of AR 40–501. Such Soldiers will be processed for medical separation under the provisions of AR 635–40.

(1) HIV infected Soldiers who still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General’s Corps, who will explain the impact of the Soldier’s request. As a minimum, specific information regarding the Soldier’s post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum: “Soldier was advised that disability benefits under provisions of 10 USC 61 may be available in the event that he or she remains in the Army until the U.S. Army Physical Disability Agency determines the Soldier is no longer fit to perform assigned military duties.”

(2) Soldiers desiring discharge will complete a DA Form 4187 (Personnel Action) and execute the following statement: “I request discharge from the Army under the provisions of AR 635–200, secretarial plenary authority, for my own convenience. I have been counseled by a member of The Judge Advocate General’s Corps regarding the consequences of my request, and I certify that this request is voluntary. I understand that, if my request is accepted, I will be granted an honorable discharge.”

(3) Requests for separation must include certification that the Soldier is HIV infected but meets medical retention

standards. Commanders endorsing requests for separation under the provisions of paragraph *a*, above, will verify the Soldier's medical condition and that the Soldier still meets medical retention standards.

*b*. Soldiers identified as HIV infected within 180 days of initial entry on AD will be separated under the provisions of AR 635–200 for failure to meet procurement medical fitness standards.

*c*. HIV infected enlisted Soldiers found not to have complied with preventive medicine counseling prescribed in paragraph 4–8 may be involuntarily separated. Commanders may recommend that such enlisted Soldiers be separated under the provisions of AR 635–200, under either secretarial plenary authority, or for acts or patterns of misconduct, as the unit commander deems appropriate. The following procedures apply:

(1) If the Soldier is processed for separation under the provisions of AR 635–200, secretarial plenary authority, the notification procedure (AR 635–200) will be used to notify the Soldier that his or her discharge is being recommended. Soldiers processed for separation under the provisions of AR 635–200 for acts or patterns of misconduct, will be notified of the recommendation for discharge under administrative board procedures (AR 635–200) or the notification procedure (AR 635–200), as appropriate.

(2) Recommendations for involuntary separation must be based upon information that is not obtained through interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that a Soldier is HIV infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

(3) Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the ASAP, noncompliance with the medical management of HIV infection as determined by an infectious disease physician, or the routine diagnosis of STIs other than HIV.

(4) Recommendations for involuntary separation under the provisions of AR 635–200 and recommendations for involuntary separation of Soldiers with 18 or more years of service will be forwarded to Commander, HRC (AHRC–EPF–M), for processing. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 enlisted AGR personnel, requests will be sent to the State Adjutant General, Support Personnel Management Office, of the particular State/territory in which the Soldier is assigned for duty. For USAR enlisted AGR personnel, requests will be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.) As a minimum, recommendations for separation must include documentation of the notification process (to include the Soldier's acknowledgement of notification), statements submitted by the Soldier and/or his or her counsel, certification that the Soldier has been counseled regarding preventive medicine measures, and details/evidence of the Soldier's failure to comply with those measures.

*d*. HIV infected enlisted Soldiers remain subject to involuntary administrative separation under any provision of AR 635–200; however, Soldiers who no longer meet medical retention standards will not be involuntarily separated except under AR 635–200 (see misconduct; in lieu of trial by court-martial; dishonorable and bad conduct discharges; limitations on referral to the Physical Disability Evaluation System; and administrative separations).

## **6–15. Disability separation**

*a*. HIV infected military personnel who demonstrate progressive clinical illness or immunological deficiency as determined by medical authorities, do not meet medical retention standards of AR 40–501 and may be processed for separation per AR 40–501 and AR 635–40.

*b*. While infectious disease medical evaluation will not serve as the sole criteria for determining medical fitness or a disability rating, the clinical manifestations that determine a stage of the disease's severity may, in fact, contribute to determining a Soldier's fitness for duty. All HIV infected Soldiers who show signs of immunological deficiency or a progressive illness must be referred to medical evaluation boards regardless of the clinical stage of the disease. This should result in a more expeditious status determination that will benefit both the Soldier and the Government.

## **Chapter 7 Reserve Components Personnel Policies and Procedures**

### **Section I Introduction**

#### **7–1. General**

This chapter prescribes policies and procedures for HIV testing pertaining to ARNG and USAR personnel performing duty under USC Title 10 and USC Title 32, to include Active Guard and USAR (AGR refer to chap 6). These policies and procedures are intended primarily to apply to troop program units (TPUs); however, the policies and procedures

also pertain to the USAR Standby Reserve (active and inactive) and individual mobilization augmentee (IMA). Current HIPAA security and privacy training is required for “need to know” individuals (see para 5-4).

## **7-2. Testing requirement for National Guard and Reserve Soldiers applying for tours of active duty**

a. Personnel ordered to AD for more than 30 days including travel time (for example, ADT, AGR, initial AD for training, and ADOS) must have been tested for HIV with negative results no more than 2 years prior to the report date and prior to issuance of orders. In rare situations where this requirement cannot be met, orders will include the following statement: “You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate.”

b. Under mobilization conditions (as declared by Congress or executive order and implemented by DOD), the Assistant Secretary of the Army (Manpower and Reserve Affairs) may authorize HIV infected RC Soldiers to be ordered to ADOS. If ordered to ADOS, RC Soldiers known to be HIV infected will be assigned and utilized within the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands). RC Soldiers identified as HIV positive during mobilization station testing will be immediately REFRAD. Specific guidance will be provided in the Personnel Policy Guidance.

c. Personnel ordered to AD with duty overseas for more than 30 days including travel time (for example, ADT, AGR, initial AD for training, and AD for special work) must have been tested for HIV antibodies with negative results 180 days prior to the report date and prior to issuance of orders. In rare situations where this requirement cannot be met, orders will include the following statement: “You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate.” Soldiers identified at power projection platform or during deployment and mobilization as HIV infected after verification test validates will be REFRAD.

## **Section II Policies and Procedures**

### **7-3. General**

- a. HIV testing and retention policies will be consistent with all DOD and DA policies and regulations.
- b. HIV testing should remain available for all Soldiers upon their request without inquiring as to the reason for the test. However, testing for USAR Soldiers will be at no additional cost to the Government if not event driven. Reserve Soldiers can request HIV testing at an MTF by contacting the HIV program coordinator at HRC.
- c. The HIV testing program is accomplished primarily during periodic physical examinations, physical health assessment, or periodic Soldier readiness processing.

### **7-4. Testing timeline requirements**

- a. *General.*
  - (1) Testing of all nonprior service Soldiers will be accomplished upon appointment, enlistment, or induction.
  - (2) Testing of all AD Title 10 and Title 32 USC Soldiers will be accomplished every 2 years. Upon confirmation of HIV infection status (after verification specimen) Soldiers are exempt from this requirement.
  - (3) RC personnel not on AD are required to have current HIV test every 2 years. Upon confirmation of HIV infection status (after verification specimen) Soldiers are exempt from this requirement.
  - (4) HIV testing for ARNG personnel during State emergency duty will be accomplished in conjunction with post deployment health assessment before ARNG personnel are de-mobilized from State emergency duty.
  - (5) RC personnel performing AD Title 10 or Title 32 USC for 30 days or less are required to have a current HIV test, unless HIV infection has previously been confirmed.
  - (6) RC personnel will be screened when called to a period of AD greater than 30 days if they have not received an HIV test within the last 2 years.
  - (7) HIV infected Soldiers will not be permitted to serve in the IRR. Those in the USAR, when so identified, will be processed per paragraph 7-12. HIV infected AD Soldiers leaving AD who have a contractual or statutory obligation remaining will be transferred to the USAR control group (Standby).
  - (8) Personnel located OCONUS scheduled for training either in the United States or overseas who do not meet the testing windows stated above will be tested immediately upon arrival at the training duty station when testing prior to departure is impractical.

- b. *Transferring components.*

- (1) HIV testing of all ARNG Soldiers transferring from one RC to another, or to the IRR, will have a HIV negative test within 2 years. This does not apply to HIV infected Soldiers exercising their option to voluntarily transfer to the Standby or Retired Reserve.

(2) HIV testing of all personnel who transfer from another Service or USAR control group into the ARNG, including members of the Inactive National Guard, will have a HIV negative test within 2 years.

#### **7-5. Reserve component surveillance testing**

- a. ARNG and USAR Selected Reserve screening will be conducted every 2 years.
- b. ARNG and USAR Soldiers will also undergo HIV screening as part of their periodic physical examinations or physical health assessment. AD Soldiers may not refuse screening, but should be informed of the pending procedure. Soldier privacy will be maintained in the same manner as required in AC MTF procedures.
- c. If prioritization of testing is necessary, screening will be accomplished in the same order as in paragraph 6-2d. RC Soldiers ordered to AD for more than 30 days will be considered priority 4 if they do not meet the criteria of priorities 1 to 3.
- d. ARNG and USAR TPU surveillance testing will normally be accomplished as part of the periodic physical examination or physical health assessment.
- e. Soldiers assigned to the IRR and IMA programs will be tested during annual training (AT) or ADT if their last HIV test is older than 2 years, and during periodic physical examinations or physical health assessment, including flight physicals. IRR and IMA Soldiers' physical examinations or physical health assessments that are performed by civilian contract will be considered "interim complete" if the Soldier has a documented HIV test no older than 2 years. Under this circumstance, an HIV test will be required within 48 hours of reporting for any AD period to ensure the physical examination is updated.
- f. IRR and IMA Soldiers not on AD who require testing or are participating in overseas deployment for training will be tested in MTF facilities or by the Reserve Health Readiness Program contracted authorized providers. Those IRR and IMA Soldiers who require periodic medical examinations or PHAs will be tested in MTF facilities or by authorized contract providers.
- g. For USAR Soldiers, HIV test results will be annotated on DD Form 2808 (Report of Medical Examination), item 49, if testing occurred as part of a physical exam. If testing occurred separately from a physical exam, results will be annotated on Standard Form (SF) 600 (Medical Record - Chronological Record of Medical Care). DD Form 2808 and SF 600 will be posted in the Soldiers' medical records. Compliance with HIV testing is in the MEDPROS individual medical readiness record.
- h. HIV test dates are electronically transferred into the MEDPROS individual medical readiness record.

#### **7-6. Human immunodeficiency virus testing for reserve component on active duty**

- a. All RC personnel ordered to AD for more than 30 days under Title 10 or Title 32 USC programs, to include AGR, will be required to have a current HIV test with negative results. Testing will occur within 2 years of a CONUS assignment or within 180 days for an OCONUS assignment. Testing must occur prior to the report date and issuance of orders, including travel time. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate."
- b. According to Department of Defense Instruction (DODI) 6490.03, every deployed Soldier will have a baseline blood serum drawn and placed in the DOD Serum Repository, Armed Forces Health Surveillance Center, within 12 months before the Soldier actually deploys. The Soldier must be informed that this serum will be tested for HIV en route to the repository. This is a separate requirement from the HIV test required within 2 years before deployment (or closer to deployment if mandated by COCOM or other appropriate policies).

#### **7-7. Priority for testing**

- a. Soldiers who are scheduled for overseas PCS will be tested prior to PCS.
- b. Testing will be based on the priorities listed in paragraph 6-2d.
- c. For RC Soldiers mobilized on short notice, the guidance in paragraph 7-6 will be followed. If a Soldier does not have a negative HIV test within the required period of time prior to mobilization, then an HIV specimen will be drawn immediately upon issuance of orders. Specimens should be processed and shipped to the DOD designated laboratory overnight by the collection site for processing. Routinely, the designated laboratory will process the specimens with 24 to 48 hours of receipt and results will return to the RC usually with 7 to 10 days. If a State is mobilizing troops and needs the results back immediately, the State HIV POC can mark the shipment "PROCESS IMMEDIATELY, need for MOBILIZATION." Screening HIV test results will normally be available within 48 hours, but may be delayed due to logistical limitations. Soldiers will not be mobilized until test results are known. If the test results are negative, the Soldier is considered available for mobilization. If the initial test results are positive, the Soldier will be removed from further processing until independent verification tests are conducted and results are known. HIV positive test results generally are available within 72 hours.

## **7–8. Roles and responsibilities**

*a.* The Chief, NGB; CG, HRC; and CG, USARC are responsible for implementation of HIV testing of RC Soldiers in accordance with this regulation.

*b.* The State Adjutants General of each ARNG State and territory and USARC will—

(1) Appoint an HIV program director/manager to develop State (HRC) testing plans for notification and counseling procedures, reporting and recording of test data, and procedures for periodic follow-up.

(2) Ensure that medical patient confidentiality is maintained per laws and regulations and specifically ensure that there are no unwarranted disclosures of information concerning an individual's medical condition.

*c.* The ARNG and HRC HIV program director will—

(1) Perform the duties of a contract officer technical representative for the RC centrally funded HIV testing contract. Ensure that HIV testing services and funding are appropriated in accordance with the HIV contract.

(2) Produce and distribute specific HIV testing information to the HIV program manager or deputy State surgeon for State distribution.

(3) Track and report the number of HIV infected Soldiers in the ARNG to the Chief National Guard surgeon and in the USAR to the CG, USARC on a monthly basis.

(4) Serve as designated backup at the headquarters level for the NGB in the event the State POC cannot be reached during the notification phase of a positive HIV test result from the laboratory or AC HIV program director or coordinator.

*d.* The State (AHRC–SG) HIV program manager will—

(1) Be responsible for coordination and notification of Soldier HIV testing results with the individual, the unit commanders, the State surgeon, regional support command, operational and functional commands, the HIV program director, and the local health department.

(2) Coordinate to obtain the second independent verification specimen to be tested for HIV in a USAMEDCOM designated laboratory. A second specimen is required through the USAMEDCOM designated laboratory even if the Servicemember self identifies after testing positive in a civilian setting.

(3) Track, update, and protect the annual FFD status of all HIV infected Soldiers in the State and USAR on a monthly basis.

(4) Ensure that all HIV testing on Soldiers assigned to the State and USAR is conducted in accordance with this regulation.

(5) Ensure maximum participation with minimal interruption of mission training. The State HIV program manager will identify testing locations by month, date, and quantities of blood samples to be submitted according to the testing contract. The minimum number of testing sites necessary to accomplish the mission will be utilized in order to reduce the overall cost of the centrally funded contract. Order, maintain, and distribute HIV testing supplies for all HIV testing requirements, in accordance with this regulation, within the State and State emergency duty locations.

(6) Maintain transmittal sheets matching names, social security numbers, and units with laboratory numbers. Ensure that the transmittal sheets will be confidentially handled as medical records.

(7) Coordinate the notification of all State and USAR HIV infected personnel in accordance with this regulation and the positive HIV test notification checklist.

(8) Order, manage, and maintain HIV testing supplies for all Soldiers and State Home Land Defense and Home Land Security missions.

*e.* Unit commanders will—

(1) Ensure that all personnel in their units are tested in accordance with this policy.

(2) Ensure that the HIV infection and/or AIDS information and education requirements in chapter 10 are included in unit training programs. This training will be conducted annually and will be documented in command training records. Commanders are encouraged to use TDA Army Medical Department (AMEDD) officers, mission and funds permitting. If AMEDD officers cannot be used, trainers may be members of the chain of command, assigned officers or enlisted Soldiers, or nonmilitary personnel from outside sources.

## **7–9. Army National Guard notification and counseling procedures**

*a.* The results from testing will be returned by the designated HIV testing laboratory to the State designated HIV program director and/or coordinator. All positive HIV tests will be verified by a second independent blood draw. However, the Soldiers must be notified and counseled in accordance with this regulation upon the first positive HIV test.

*b.* ARNG Soldiers who are HIV infected will be notified and counseled in accordance with chapter 4. All HIV infected ARNG Soldiers and their spouses will be individually and privately notified of all positive HIV test results in a face-to-face interview by a designated and qualified AMEDD officer within the State, in accordance with chapter 8. All HIV infected ARNG Soldiers and their spouses will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. HIV infected ARNG Soldiers will be referred to civilian physicians for medical care and further counseling. The telephone number of local

civilian health authorities will be given to Soldiers if information on local physicians or facilities is requested (for notification and testing of ARNG HIV infected Soldiers' spouses see chap 8).

c. Individuals tested at MEPS for accession purposes or component transfers will be notified of HIV positive test results by the examining physician or other appointed, qualified counselor. Soldiers tested at MEPSs as part of a periodic physical examination (space available basis) will be notified of HIV positive test results through the Soldier's unit physician or chain of command.

d. The Soldier, commander, and medical corps officer will be in official status (inactive duty training, Reserve special training, ADT, AT, or ADOS) at the time of notification(s), counseling, and blood drawing.

e. ARNG positive HIV test notification checklist must include the following:

- (1) Has the State HIV program manager been notified?
- (2) Has the State HIV program manager reviewed this regulation?
- (3) Before the Soldier is contacted, has the Soldier's original HIV test sample been tested and clinically indicated using an approved FDA test?
- (4) Has the Soldier been notified in a face-to-face interview, by a physician or designated health care provider, and counseled via the DA Form 5669 and DA Form 4856 and chapter 4?
- (5) Once the Soldier has been notified about the clinical indication of a HIV positive test results, has the Soldier's blood been re-drawn for a second independent verification specimen, using an approved FDA test method?
- (6) Was a copy of the test result given to the Soldier during the face-to-face notification?
- (7) Has the State HIV program manager reported to the local public health authorities?
- (8) Has the Soldier been medically evaluated to determine the status of his or her infection and FFD?
- (9) Has the Soldier been informed that he or she must provide a valid copy of an annual FFD examination performed by a qualified physician to the State HIV program director and/or coordinator?

#### **7-10. U.S. Army Reserve notification and counseling**

a. The results from testing will be returned by the designated HIV testing laboratory to the HRC Surgeon's Directorate HIV program manager. All positive HIV tests will be verified by a second independent blood draw. However, the Soldiers must be notified and counseled in accordance with this regulation upon the first positive HIV test.

b. USAR Soldiers who are HIV positive will be notified and counseled in accordance with chapter 4, as applicable. All HIV positive USAR Soldiers and their spouses will be individually and privately notified of all positive HIV test results in a face-to-face interview by their unit commander and telephonically counseled by a qualified AMEDD officer in accordance with chapter 8. All HIV infected USAR Soldiers and their spouses will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. HIV infected USAR Soldiers will be referred to civilian physicians for medical care and further counseling. The telephone number of local civilian health authorities will be given to Soldiers, if information on local physicians or facilities is requested. For notification and testing of USAR HIV infected Soldiers' spouses see chapter 8.

c. All Soldiers, including IRR, whose initial HIV test is positive, will be notified of the results in a face-to-face interview, by a physician or designated health care provider and counseled via the DA Form 5669 and DA Form 4856 and chapter 4.

d. The HRC HIV program manager will coordinate with the USARC G-1 HIV program manager for a physician or designated health care provider, if necessary, to notify IRR or IMA initial HIV positive Soldiers.

e. Training and information packets will be provided by the USARC POC G-1 HIV program director. Spouses of confirmed HIV infected USAR Soldiers will be notified of the positive test results. The USAR will issue the spouse invitational orders to accompany the Soldier to notification.

f. Physicians or designated health care providers supporting notification to Soldiers with HIV positive test results will refer information provided about spouses or partners with whom the Soldier may have had at-risk contact to the HRC program manager for notification to local public health officials, as prescribed by State and local laws, for further notification and management.

g. HIV infected USAR Soldiers not on ADOS will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. They will be referred to civilian health care providers for medical care and further counseling. Chapter 8 provides guidance for offering HIV testing and counseling to spouses of HIV infected USAR Soldiers.

h. All of the information contained in paragraph 4-8 and on DA Form 5669 will be covered and copies of the record will be provided to the individual Soldier and commander (or designated commander's representative, if the commander is a general officer) at the time of notification. The counselor's copy will be forwarded through the HIV program POC (regional support command or operational and functional command) channels through the USARC POC to the HRC program manager. Notification to public health authorities will be per procedures published by USARC and per State and local law. All records will be forwarded in a sealed envelope marked "To Be Opened By Addressee Only" via command channels and addressed specifically to the USARC HIV program manager by name. Physicians

performing notification and Soldiers notified of an initial or subsequent positive HIV test will be in an official status (inactive duty training, rescheduled training, ADT, AT, ADOS) at the time of notification.

*i.* The unit commander of the initial HIV positive USAR TPU Soldier will be immediately available at the time the Soldier is notified by the physician or designated health care provider. Immediately following the preventive medicine counseling, the commander will counsel the Soldier per paragraph 4–9 and complete DA Form 4856. The counseling statement will be destroyed if the Soldier is determined to be uninfected by verification tests.

#### **7–11. Reporting and recording of information**

- a.* Recording of the results of HIV testing will be per chapter 4.
- b.* Collection procedures and reporting of information for inclusion in the DOD data base will be per chapter 4, section IV.
- c.* Notification to commanders of results of an FDA-approved testing will be per paragraph 4–3.
- d.* Notification to public health authorities will be per procedures published by NGB, USAR, and per State and local law.

#### **7–12. Assignment and personnel actions**

*a.* Soldiers confirmed to be HIV infected, but who manifest no evidence of progressive clinical illness or immunological deficiency, will not be separated solely on the basis of their HIV infection. HIV infected Soldiers, not AGR or ADOS may prove fitness for service. HIV infected AGR personnel will complete a medical evaluation to determine if they are FFD. ADOS Soldiers will be processed for involuntary REFRAD upon confirmation of HIV infection. During the REFRAD processing the Soldier may initiate the FFD requirement. HIV infected Soldiers will have 120 days from the date they are notified of their infection to complete a medical evaluation to determine fitness per the established DOD protocol for HIV or other guidance published by OTSG or OCAR. HIV infected Soldiers found to be medically unfit for duty will be separated per paragraph 7–13. Soldiers found fit will be permitted to serve in the Selected Reserve in a nondeployed billet, if available. Grade, MOS, and commuting constraints are applicable per existing regulations. Soldiers meeting fitness standards and placed in nondeployable billets must be re-evaluated at least annually. Initial and subsequent evaluations will be at the Soldier's expense and will be provided by the Soldier to the State or HRC HIV program manager for recording in the individual medical record. Soldiers may request transfer to the Standby Reserve, Retired Reserve (if eligible), or Honorable Discharge under the plenary authority of the Secretary of the Army in lieu of continued service. (See AR 135–175 for resignation of officers and warrant officers who do not meet the medical fitness standards at time of appointment, or AR 135–178 for voluntary separation of enlisted Soldiers on indefinite reenlistments.)

*b.* HIV infected Soldiers will be involuntarily transferred to the inactive Standby Reserve, following a case-by-case assessment, if they—

- (1) Fail to complete the initial or annual medical evaluation in the prescribed period.
- (2) Are found fit, but cannot be placed in a Selected Reserve nondeployable billet per grade or MOS.
- (3) Are in a Selected Reserve nondeployable billet and do not complete the annual medical evaluation for fitness for duty.

*c.* The mere fact of HIV infection, in and of itself, will not be used as the basis for—

- (1) Disciplinary action against the individual under the UCMJ or State code.
- (2) Adverse characterization of service.
- (3) Nonselection for a vacant nondeployable billet.

*d.* Unit commanders who initiate action to transfer HIV infected Soldiers to the USAR control group (Standby) will do so under the provisions of AR 140–10.

*e.* Assignment and retention policies for ARNG Soldiers who are AGR or on ADOS and are HIV infected will be carried out per chapter 6.

*f.* HIV infected RC Soldiers will not be ordered to a tour of duty for more than 30 days, nor extended on a tour of duty if the extension will cause the total length to exceed 30 days except under mobilization conditions and as authorized by the Assistant Secretary of the Army (Manpower and Reserve Affairs) (see para 7–2*b*).

*g.* HIV infected USAR Soldiers who are ordered to AD for over 30 days and identified as positive after verification will be REFRAD.

#### **7–13. Separation procedures**

*a.* HIV infected ARNG Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards will be processed under AR 40–501 and NGR 600–200 or NGR 635–101, as appropriate.

*b.* HIV infected USAR Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards under AR 40–501 will be processed per AR 135–178 (enlisted) or AR 135–175 (officer).



## **7-14. Education**

*a. Training.* Unit commanders will ensure that the HIV and/or AIDS information and education requirements in chapter 10 are included in unit training programs. This training will be conducted annually and will be documented in command training records. Commanders are encouraged to use TDA AMEDD officers, mission, and funds permitting. If AMEDD officers cannot be used, trainers may be members of the chain of command, assigned officers or enlisted Soldiers, or nonmilitary personnel from outside sources.

*b. Individuals seeking additional information may refer to the following resources:*

(1) DCS, G-1 HIV policy and deoxyribonucleic acid (DNA) registration at <http://www.armyg1.army.mil/hr/hivdna/>.

(2) The USAPHC Health Promotion and Wellness Portfolio has HIV and STI prevention information resources found at <http://phc.amedd.army.mil/Pages/default.aspx>. The CDC divisions of HIV and/or AIDS prevention, National Center for HIV/AIDS, Viral Hepatitis, STI, and tuberculosis prevention Web site has information resources at <http://phc.amedd.army.mil/topics/healthyliving/rsbwh/Pages/HIVandSTDPvention.aspx>.

## **Chapter 8**

### **Family Member and Civilian Personnel Policies and Procedures**

#### **Section I**

#### **Human Immunodeficiency Virus Testing for Family Members and Other Health Care Beneficiaries**

##### **8-1. Testing of Family members and other health care beneficiaries**

Family members and other HCBs may not be compelled to have an HIV test. However, an HIV test may be ordered by a physician or designated health care provider as part one of the clinically indicated laboratory tests required to adequately treat the patient. Patients should be routinely informed that the physician or designated health care provider will order any clinically indicated laboratory tests necessary to include testing for HIV infection unless the patient specifically declines such tests.

##### **8-2. Human immunodeficiency virus testing program components**

An HIV test may be clinically indicated for Family members and other nonmilitary HCBs seeking medical care under the circumstances listed below. Those who test HIV positive will be offered medical evaluation and counseling per paragraphs 4-8 and 4-10.

##### **8-3. Consent requirements**

HCBs not on AD will be verbally informed by their health care provider of clinically indicated laboratory tests, including HIV testing, required in the course of their medical evaluation. After discussion, HCBs may opt-out of HIV testing. The HCB will not be denied care as a result of refusing HIV testing. However, the HCB will be advised that an assessment of the medical condition for which care is sought may be incomplete.

#### **Section II**

#### **Family Member and Other Health Care Beneficiaries Policies and Procedures**

##### **8-4. Notification procedures**

*a.* All HCBs and spouses of HIV infected Soldiers will be individually and privately notified of any positive HIV test result in a face-to-face interview with their ordering physician or designated health care provider.

*b.* The designated physician or health care provider will notify HCBs of the initial positive HIV test. The individual will be informed that he or she has a positive HIV test, that it may mean he or she is infected by HIV and, if confirmed to be infected by a second or subsequent test, he or she will be referred for further medical evaluation. Individuals will be advised not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs and to refrain from sexual relations until the results of the verification tests are available. Test results of Family members will not be reported to the sponsor's command authorities. The Family member and the sponsor will be advised of the results and counseled per paragraph 4-8 by medical personnel.

*c.* Notification of contacts of HIV infected personnel will be as follows:

(1) HCBs who are sexual partners of individuals who are HIV infected, or individuals who were transfusion or blood product recipients from HIV infected donors will be advised by medical authorities to seek medical evaluation as soon as possible.

(2) Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating individuals who—

(a) Are not military personnel or military HCBs who are/were sexual partners of known HIV infected individuals.

(b) Were transfusion or blood product recipients from HIV infected donors.

d. Information pertaining to HIV infected spouses will be reported through designated channels to local public health authorities. For spouses of AD Soldiers, the HIV program coordinator (PHN) will report that information to local public health authorities per local jurisdiction reporting requirements. OTSG will publish guidance for reporting this information. For spouses of RC Soldiers, information will be provided to the State or to the numbered armies in CONUS HIV program POC. That information will, in turn, be provided to the State or local jurisdiction public health authority dealing with HIV and/or AIDS per State or local law or reporting requirements. The NGB and OCAR will publish guidance for reporting this information.

#### **8-5. Testing of spouses of human immunodeficiency virus infected Soldiers**

a. Spouses of Active Army Soldiers will be notified of their sponsor's HIV infection by the Soldier and notification confirmed by the preventive medicine HIV program coordinator (PHN). The HIV program coordinator (PHN) will recommend that the spouse be tested for HIV. However, such testing is voluntary. If the spouse chooses to be tested, the HIV program coordinator (PHN) will ensure that appropriate preventive medicine counseling is conducted. DA Form 5669 is not used for Family member counseling.

b. Spouses of RC Soldiers are normally not HCBs. However, spouses of HIV infected RC Soldiers may be designated by the Secretary of the Army as limited HCBs for purposes of receiving HIV testing and counseling, if approved. The NGB and USARC will publish procedures for informing spouses of HIV infected RC Soldiers of the sponsor's infection and for offering voluntary HIV testing and counseling. See chapter 7 for RC personnel policy.

#### **8-6. Accompanied tours**

Family members who are HIV infected are not restricted by this policy from accompanying their sponsor overseas; however, host nation rules apply. If initial diagnosis of a Family member occurs while at an overseas location, the Family member will be encouraged to undergo immediate detailed medical evaluation. Test results of Family members will not be reported to the sponsor's command authorities. The Family member concerned will be advised of the results. Notification of Family member's test results to anyone other than the Family member will be provided only in accordance with local jurisdiction reporting and notification requirements. If clinical illness is present or evaluation is desired, the Family member will be processed for medical evacuation to the Army MEDCEN designated and will ordinarily be returned to the overseas location on completion of evaluation.

#### **8-7. Exceptional Family Member Program**

When a Family member of an AD Soldier is confirmed as HIV infected or diagnosed with AIDS, either by testing through the MTF or by a civilian practitioner, the primary physician or a member of the HIV clinical staff will notify the Exceptional Family Member Program (EFMP) POC case coordinator for initiation of enrollment in the EFMP per AR 608-75. The primary physician or a member of the HIV clinical staff will counsel the Family member and the sponsor concerning the requirement for mandatory enrollment in the EFMP. The EFMP POC case coordinator, in coordination with the HIV clinical staff, will process the Family member to ensure confidentiality.

#### **8-8. Child, Youth and School Services**

a. Placement of an HIV infected child into Army-sponsored Child, Youth and School Services programs will be determined on a case-by-case basis. The goal of the placement decision is to provide the optimal setting for care based on the overall health status of the child. Factors which will be considered in the decision include neurological development, behavior, and immune system status. Consideration will also be given to special circumstances in which the protective environment of a special purpose Family child care home would be more appropriate (that is, need for stringent infection control procedures to protect an HIV infected child from communicable disease).

b. The placement decision will be made by the installation Special Needs Accommodation Program team consisting of the child's parents; PHN; Child, Youth and School Services coordinator; EFMP coordinator; and the Army Community Services director. The PHN will contact the child's physician prior to the Special Needs Accommodation Program team meeting to ensure the child's safety and medical concerns are adequately addressed and to meet the child's safety needs in the least restrictive environment. If this team is unsure of the appropriate placement decision, additional personnel at the MEDCEN servicing that installation's health service region or the installation's management agency region ACOM, ASCC, or DRU headquarters may be consulted. Confidentiality of the information regarding the child and his or her parents will be maintained by all personnel involved in the decision.

c. Knowledge of the child's HIV status will be limited to those who have a legitimate need for that confidential information per HIPAA and taking into account the following:

- (1) Specific infection control procedures needed to protect the child or the child's care givers.
- (2) Home health procedures dictated by the child's medical treatment plan.
- (3) The need for a supportive environment due to developmental, neurological, or behavioral deficiencies.

## Section III Civilian Employees Policies and Procedures

### 8–9. Testing of civilian employees

*a.* Normally, neither applicants for employment nor current employees may be required to be tested for the presence of HIV and, if no such host nation requirement exists, care should be taken to ensure that DA civilians' pre- and post-deployment serum specimens are not tested for HIV. However, pursuant to DOD guidance, HIV testing may be authorized when it is required by a host country. Determination of host nation HIV testing requirements will be the responsibility of the employer. Any such testing will be at no cost to the employee. Assignment or employment may be denied to employees who refuse to comply with this testing requirement, or who have a positive HIV test result. Prior approval to require a civilian employee to be tested for HIV must be obtained from Headquarters, Department of the Army (DAPE–CPE), 300 Army Pentagon, Washington, DC 20310–0300, when it is determined that a host country requires proof of negative HIV test results. Requests for approval to require an employee to be tested to meet host country requirements must include documentation of the testing requirement. Requests for exception to the testing policy may not be approved by DA. All requests for exceptions to the testing policy will be forwarded through command channels to Headquarters, Department of the Army (DAPE–CPE), 300 Army Pentagon, Washington, DC 20310–0300 for review and staffing. DA will forward to DOD and request approval of all justified host nation civilian testing requirements and will provide notification of the results of the request to the requesting activity.

*b.* DA will provide civilian employees who are overseas and authorized medical care at Army MTFs the opportunity to be tested for the presence of HIV on an elective, space-available basis. Positive HIV test results will be confidential information and will not be the basis of any adverse actions concerning the individual's employment (see para *c*, below). Employees and their Family members will be encouraged to obtain further diagnosis or treatment.

*c.* The presence of HIV and/or AIDS will not, by itself, be the basis of any adverse personnel action against an employee. Existing civilian employment policy provides guidance relating to appropriate action when employees are not physically able to carry out the duties of their job.

*d.* In the case of HIV infected health care providers, their duties may be restricted when performing those duties that present a risk of transmitting HIV to their patient. This determination will be made by an expert medical review committee as designated by the deputy commander for clinical services. This committee will make recommendations on a case-by-case basis to the MEDDAC/MEDCEN/Dental Activity commander, per AR 40–68, as to the restriction of duties of HIV infected health care providers. The restriction may only be to the extent that the risk is eliminated.

*e.* Because of the small, but important, risk of health care providers contracting blood-borne infections, such as HIV, all civilian health care workers will be encouraged to be tested periodically, particularly those employees exposed frequently to blood or body fluids from patients.

*f.* Civilian health care providers sustaining a laceration or needlestick injury with possible transmission of disease will be advised to be tested following injury and at periodic intervals and to be followed medically. Of particular concern are instances where blood or body fluids from an HIV infected patient may be accidentally introduced into the employee. Such employees should be immediately referred to the emergency department for HIV post-exposure prophylaxis evaluation per CDC guidelines. They should be tested at the time of the incident, at 3 months, and again at 6 months after exposure to detect seroconversion in latent infections resulting from the accidental exposure. Employees tested outside the MTF should provide follow-up test results to the MTF occupational medicine provider.

### 8–10. Guidelines for handling issues related to human immunodeficiency virus infection and Acquired Immune Deficiency Syndrome

*a.* These guidelines are intended to assist managers and supervisors of civilian employees in dealing with HIV and/or AIDS related personnel issues arising in the workplace. They provide managers and supervisors of civilian employees a basic framework on how to approach and resolve such issues. Specific technical advice and assistance should be obtained from the servicing civilian personnel advisory center (CPAC), MTF, and legal office in resolving individual cases.

*b.* Guidelines issued by the Public Health Service's CDC dealing with HIV and/or AIDS in the workplace state that "the kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HIV and/or AIDS." Therefore, employees in the workplace who have been diagnosed as, or suspected of being, HIV infected must be allowed to continue working as long as they are able to maintain acceptable performance and do not pose a risk of substantial harm to the health or safety of themselves or others that cannot be eliminated or reduced by reasonable accommodation. If serious performance or safety problems arise, supervisors and managers should address them by applying existing Federal and Army civilian personnel policies and practices.

*c.* There is no medical basis for employees refusing to work with fellow employees or agency clients who are, or are suspected of being, HIV infected. Nevertheless, the concerns of employees who fear working with HIV infected co-workers should be taken seriously and should be addressed with appropriate information and counseling. In addition, employees, such as health care providers, who may come into direct contact with HIV infected persons, or with their body fluids, should be provided appropriate information and equipment to minimize the risks of such contact.

*d.* Managers and supervisors should treat HIV infected employees in the same manner as employees who suffer from other serious illnesses. This means, for example, that employees may be granted sick leave or leave without pay when they are incapable of performing their duties or when they have medical appointments. An employee with HIV and/or AIDS-related conditions may be an “individual with a disability “ under the Rehabilitation Act of 1973, as amended, (29 USC 701), the Americans with Disabilities Act, as amended (42 USC 12101), the Americans with Disabilities Act Amendments Act (PL 110–325), and Equal Employment Opportunity Commission regulations and may be entitled to “reasonable accommodation.“ Managers and supervisors are encouraged to consult with their local legal offices to determine their rights and obligations in any specific cases.

*e.* Consistent with DA’s concern for employees with HIV and/or AIDS infection, the following resources are available:

(1) Management and employee education and information on specific life-threatening illnesses through the activity MTF.

(2) Referral to agencies and organizations which offer support services for personnel with HIV and/or AIDS through the ASAP civilian counseling services, MTF, or the ASAP civilian services employee assistance program screening counseling and referral services.

(3) Benefits consultation from the civilian personnel office to assist employees in effectively managing health benefits, leave, insurance, and other benefits.

*f.* When dealing with situations involving an employee with HIV and/or AIDS, managers and supervisors should—

(1) Understand that HIV and/or AIDS will not, absent other considerations, be the basis for taking any adverse personnel action against an employee.

(2) Remember that information concerning an employee’s health is personal and confidential, and it is covered by the Privacy Act. Accordingly, such information can be released only to agency officials who have a need to know. Further, supervisors and management officials should ensure that precautions are taken to protect all information regarding an employee’s health. All information concerning an employee’s health must be kept separate from the employee’s personnel file and treated as a confidential medical record. (See AR 40–66 and AR 340–21.) Any questions concerning disclosure of such information should be directed to the local staff judge advocate.

(3) Contact the MTF HIV program coordinator (PHN) for information about a specific life-threatening illness or the contagious nature of an illness. The servicing CPAC also should be contacted regarding additional guidance in providing reasonable accommodations for an employee with HIV and/or AIDS.

(4) Contact the MTF program coordinator (PHN) if it is determined additional information should be obtained from the employee’s physician to assist in determining if the employee’s presence at work will pose any threat to the employee or co-workers.

(5) Be understanding, compassionate, and sensitive to the fact that continued employment for an employee with a life-threatening illness may sometimes be therapeutically important in the remission or recovery process, or may help to prolong the employee’s life.

(6) Encourage employees with HIV and/or AIDS to seek assistance from established community support groups for medical treatment and counseling services. Information on these services can be requested through the ASAP, HIV program coordinator (PHN), and/or employee assistance programs.

(7) Be sensitive and responsive to co-workers’ concerns, and emphasize employee education available through CPAC and MTF. Give no special consideration beyond supplying appropriate information, counseling, or training to employees who feel threatened by an HIV infected co-worker. Disciplinary action may be taken against any employee whose refusal to work with an HIV infected employee causes disruption in the workplace.

## **Chapter 9 Limited Use Policy**

### **9–1. Purpose**

The purpose of this chapter is to specify limitations on the use of information regarding HIV testing results and medical evaluation.

### **9–2. Limitations on the use of laboratory test results**

*a.* Test results confirming that a Soldier is HIV infected may not be used against the Soldier—

(1) As the basis for any disciplinary or adverse administrative action, except for the following:

(a) Separation for physical disability. However, Soldiers who are HIV infected but are determined by medical authorities to show no sign of progressive clinical illness or immunological deficiency will not be separated for physical disability solely because of HIV infection.

(b) Separation under the accession testing program of Soldiers meeting the definition of accession (chap 5).

(c) Separation as specifically authorized by paragraphs 6–13 through 6–15.

(2) As a basis for an unfavorable entry in a personnel record (see para 9–5).

(3) To characterize service.

*b.* This policy does not impose any other restrictions on the use of test results within DOD. Nothing in the restrictions in paragraph *a*, above, precludes the use of such laboratory test results in any other manner consistent with law or regulation including—

(1) To establish the HIV infection status of a Soldier who disobeys the preventive medicine counseling, the commander's counseling, or both, in an administrative or disciplinary action based on such disobedience.

(2) To establish the HIV infection status of a Soldier as an element of any other permissible administrative or disciplinary action (for example, as an element of proof of an offense charged under the UCMJ).

(3) To establish the HIV infection status of a Soldier as a proper ancillary matter in an administrative or disciplinary action (for example, as a matter in aggravation in a court-martial in which the HIV infected Soldier is convicted of an act of rape committed after he is informed that he is HIV infected).

*c.* Laboratory test results will receive the same protection as any other medical information per AR 40–66. Medical authorities are required to report test results indicating that a Soldier is HIV infected to the Soldier's chain of command. Although the use of this information by commanders is not limited except as described above, commanders will treat the information with due regard for the privacy of the Soldier concerned.

### **9–3. Limitations on the use of certain other information**

*a.* As part of the effort to control the spread of HIV infection and to develop medical and scientific information concerning the infection, AD Soldiers (including AGR and other Reservists who, because of their status, are entitled to military medical care) who are identified as HIV infected will be questioned by medical authorities concerning possible sources of their exposure to the virus. This medical evaluation process is called an epidemiological assessment. Information that a Soldier may provide to medical authorities during this assessment may not be used against the Soldier or other named third parties except as authorized by this paragraph. Such protected information includes, for example—

(1) Information concerning a Soldier's personal use of drugs.

(2) Information concerning consensual homosexual or heterosexual activity, even if that sexual activity is prohibited by law or regulation.

*b.* Information obtained during, or as a result of, an HIV epidemiological assessment may not be used against the Soldier or other named third parties—

(1) In a court-martial.

(2) In a nonjudicial punishment action (Article 15, UCMJ).

(3) In a line of duty determination.

(4) As a basis, alone or in conjunction with other information, for the involuntary separation of a Soldier, except a separation for physical disability. If the information is used in a physical disability separation procedure, the information may not be used on the issue of whether the disability was due to the Soldier's own misconduct.

(5) In an administrative or punitive reduction in grade.

(6) For denial of a promotion.

(7) In a bar to reenlistment.

(8) As the basis for an unfavorable entry in a personnel record.

(9) As a basis, in whole or in part, to characterize service or to assign a separation program designator.

(10) In any other action considered to be an adverse personnel action (for example, comment in DA Form 67–9 (Officer Evaluation Report) or DA Form 2166–8 (NCO Evaluation Report)).

### **9–4. Exclusions**

The limitations in paragraph 9–3 on the use of information do not apply to the following:

*a.* The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the Soldier.

*b.* Disciplinary or other action based on independently derived evidence.

*c.* Nonadverse personnel actions such as—

(1) Reassignment.

(2) Disqualification (temporary or permanent) from a Personnel Reliability Program.

(3) Denial, suspension, or revocation of a security clearance.

(4) Suspension or termination of access to classified information.

(5) Removal (permanent or temporary) from flight status or other duties requiring a high degree of alertness or stability (for example, explosive ordnance disposal) or restricting the duties of HIV infected health care providers.

*d.* Any evidence or information derived from sources independent of an epidemiological assessment. For example,

admissions of drug abuse or sexual misconduct by an HIV infected Soldier, not made in the context of an epidemiological assessment, may be used as evidence in an administrative or disciplinary action against the Soldier.

### **9–5. Entries in personnel records**

In the event that personnel actions are taken as a result of, or are supported by, evidence of HIV infection, or information described in paragraph 9–3, care will be taken to ensure that no unfavorable entry is placed in a personnel record in connection with the action. Recording a personnel action in a personnel record is not itself an unfavorable entry in such a record. Also, information that reflects an individual has serologic or other evidence of HIV infection is not an unfavorable entry in a personnel record.

## **Chapter 10 Human Immunodeficiency Virus Information and Education Plan**

### **10–1. General**

This chapter establishes—

- a.* The minimum requirements for providing information and education about HIV to the Total Army Family.
- b.* Responsibilities to ensure that the HIV information and education program is successful.
- c.* Resources available to the Army community in carrying out this information and education plan.
- d.* See chapter 7 for RC policy.

### **10–2. Plan components**

The HIV information and education plan consists of the following five components:

- a.* Prevention of HIV, STIs, and unintended pregnancies for Soldiers.
- b.* Training for UCMJ commanders.
- c.* Awareness training about Army HIV policies and bloodborne pathogen prevention for health care workers.
- d.* Training of HIV program directors, coordinators (PHN), and staff.
- e.* Army Family member education, as needed, based on resources.

### **10–3. U.S. Army Public Health Command**

The USAPHC will develop standardized training and education programs for Soldiers, commanders, health care workers, HIV program directors/coordinators and staff, and community groups using current CDC guidelines and adult learning principles. The Chief Nurse, USAPHC is designated as the HIV and/or AIDS education program coordinator to facilitate implementation of the HIV education program.

### **10–4. Human immunodeficiency virus education plan for the military community**

*a.* In collaboration with commanders, MTF staff, the public affairs officer, civilian personnel representatives, and other interested installation agencies, the HIV program coordinator (PHN) will implement the standardized training and education programs developed by USAPHC.

*b.* To execute the HIV education plan for the military community, the following responsibilities are assigned:

(1) The CG, U.S. Army Training and Doctrine Command will ensure that existing health awareness/education blocks of instruction in all Army schoolhouse and initial entry training courses incorporate basic HIV and/or AIDS instruction. This instruction should focus on prevention of HIV, STIs, and unintended pregnancies for Soldiers which place an individual at high risk of exposure to HIV, methods of transmission, measures to protect against exposure, and Army requirements for HIV testing.

(2) Installation commanders will ensure implementation of training for UCMJ commanders, and ensure Soldiers receive AT on prevention of HIV, STIs, and unintended pregnancy. To ensure HIV education programs reach all targeted personnel, classes will be included in the installation's master training calendar.

*c.* Supervisors of civilian employees will ensure that all civilian employees receive training on HIV infection and AIDS in the workplace, so that employees understand—

(1) The medical ramifications of HIV and/or AIDS as they relate to communicability, and as they affect an employee's ability to perform official duties.

(2) Workplace rights of employees who are HIV positive or have AIDS.

(3) Civilian employees may be excused from HIV and/or AIDS in the workplace training if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse civilian employees from scheduled training will offer those employees appropriate alternatives to the training, such as written materials on HIV and/or AIDS in the workplace. (Chap 8 provides guidance for handling HIV and/or AIDS in the workplace issues.)

(*a*) For Family members, HIV education should include an emphasis on high risk behaviors and methods of

preventing infection, including safer sex instruction. Family member education may be accomplished in conjunction with a variety of other installation activities to include—

- (b) Community counseling centers.
- (c) Health care facilities caring for Family members.
- (d) Recreation centers.
- (e) Libraries.
- (f) Chapel or religious education activities.
- (g) Chaplain Family Life Centers.
- (h) Youth activity programs.

(4) Unit commanders will ensure that their Soldiers attend at least one HIV education class annually. They will request assistance from their servicing medical facilities, as needed, to comply with this requirement. (See chap 7 for RC policy.)

(a) Because of individual rotation and to provide flexibility in scheduling, commanders will ensure that HIV education is offered at least quarterly. The education plan will be incorporated into the unit's quarterly training schedule.

(b) RC units may conduct this training annually prior to unit testing.

(5) Commanders at all levels will make HIV education a matter of special interest within their organizational inspection programs. The goal of the review should be to assess the existence and effectiveness of installation and unit education programs.

### **10–5. Educating and training health care providers**

OTSG is responsible for ensuring that education and training programs are implemented for health care providers. Included in this group are health educators, primary care providers, STD interviewers and counselors, drug and alcohol counselors, and occupational safety and health personnel. Education for these individuals should focus on enabling them to perform their duties following the guidelines published by the CDC and the Occupational Safety and Health Administration. Their training should also equip them to provide counseling to at-risk patients as a normal part of their duties. MTF commanders are responsible for implementing HIV education and training for health care personnel at their installations per the education plan developed by OTSG.

### **10–6. Resources**

CDC and USAPHC have additional information on their Web sites on HIV and STD prevention.

a. CDC divisions of HIV/AIDS prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and tuberculosis prevention Web site at <http://www.cdc.gov/std/>.

b. The USAPHC Health Promotion and Wellness Portfolio has HIV and STD prevention information resources available at the following Web site <http://phc.amedd.army.mil/topics/healthyliving/rsbwh/Pages/HIVandSTDPrevention.aspx>.

## **Chapter 11**

### **Law Enforcement and Corrections Policies and Procedures**

#### **Section I**

#### **Army Law Enforcement and Security Personnel**

##### **11–1. Purpose**

This section provides policies and procedures for Army law enforcement and security personnel to prevent duty-related exposure to HIV infection. The information contained herein is consistent with model HIV policies published by the CDC.

##### **11–2. Precautionary measures against duty-related exposure**

As first responders, Army law enforcement and security personnel will frequently encounter situations in which they come in contact with body fluids or objects contaminated with HIV. Examples include serious traffic accidents, injuries, and crimes of violence (murder, rape, robbery, aggravated assault). In situations where exposure to body fluids is likely or possible personnel will take the following precautions:

- a. Wear impermeable gloves (rubber or latex).
- b. Wear eye protection.
- c. Exercise caution to avoid punctures or cuts.
- d. Wear protective over garments to include footwear and head gear.
- e. Use caution when searching and wear heavy-duty gloves to avoid puncture wounds.

- f.* Cover and protect open wounds, cuts, and irritations from possible contamination.
- g.* Use one-way airway devices when administering mouth-to-mouth resuscitation.
- h.* Use sealable plastic bags to collect soiled and stained items consistent with established crime scene processing procedures (AR 195–5).
- i.* Avoid or minimize direct contact with body fluid spills or potentially contaminated objects. Should contact with body fluids occur, wash exposed areas with soap and hot water as soon as possible and seek medical evaluation.

### **11–3. Clean-up and disinfecting procedures**

- a.* Personnel will follow these procedures when cleaning potentially HIV infected items and areas:
  - (1) Avoid direct contact with soiled or stained items.
  - (2) Clean spills and stains with approved solutions (1:10 bleach to water mix).
- b.* In addition, the personal hygiene measures outlined below should be applied after potential exposure:
  - (1) Avoid eating, drinking, or smoking until after cleaning up.
  - (2) Shower the entire body with soap and hot water as soon as possible after exposure.
  - (3) Launder or dry clean soiled clothing before wearing them again.

### **11–4. Availability of equipment and supplies**

- a.* Installation Directors of Emergency Services and commanders must ensure that all personnel have ready access to protective and decontamination equipment and supplies including—
  - (1) Impermeable gloves (rubber or latex).
  - (2) One-way airway devices (adult and pediatric sizes).
  - (3) Sealable plastic bags.
  - (4) Suitable protective over garments.
  - (5) Heavy-duty gloves (for conducting searches).
  - (6) Decontamination solution (household bleach).
- b.* The use of disposable items is recommended.

### **11–5. Actions following possible direct exposure**

Installation Directors of Emergency Services and commanders must immediately refer potentially exposed personnel for medical examination and evaluation. They will also ensure exposed personnel comply with follow-up medical evaluations and ensure proper documentation of event and follow-up. Commanders will develop and implement a post exposure prophylaxis plan in consultation with supporting infectious disease and preventive medicine physicians.

### **11–6. Orientation and training**

Army law enforcement and security personnel will attend awareness training on the causes, methods of transmission, and prevention of duty-related HIV infection at least annually. This requirement does not exempt military personnel from the HIV education requirements of chapter 10. Training will be developed in concert with the local MTF and must reflect the basic tenets of DA policy on HIV as outlined in this regulation. (Special attention will be directed toward ensuring law enforcement and security personnel are properly trained on the use of one-way airway devices.) This training will include realistic demonstrations and hands-on practical exercises. Newly assigned personnel will attend training prior to being utilized for operational law enforcement or security duties.

### **11–7. Policy implementation**

Installation Directors of Emergency Services and commanders will develop and implement standard operating procedures necessary to implement the requirements of this regulation. However, in clearly life-threatening situations, the inability to comply with the foregoing policies and procedures, or the lack of prescribed equipment or supplies, is insufficient justification to either delay or deny emergency aid or assistance. First responders are expected to use sound judgment and good common sense in applying these policies.

## **Section II**

### **Army Corrections System Policies and Procedures**

#### **11–8. Human immunodeficiency virus in correctional facilities**

HIV has become a major policy and management issue for correctional administrators. Correctional institutions have become a focus of concern for this infection.

#### **11–9. Purpose and applicability**

The information and guidelines contained in this section have been developed for correctional staff to assist in the identification and management of prisoners infected with HIV. The policies presented are intended to provide overall guidance in preventing the transmission of HIV within the Army Corrections System as well as protecting the



confidentiality of HIV infected prisoners and reducing the anxiety and misunderstanding about the disease within the Army Corrections System.

#### **11-10. Prisoner testing program**

*a.* All prisoners will be tested for HIV within 24 hours of entering confinement. Prisoners at low risk for HIV infection may be placed in general population while waiting results of tests through routine DOD channels. Prisoners who are determined to be HIV negative will be retested at least annually as part of a program to monitor and detect any transmission of HIV in the facility.

*b.* Should incidents which could result in the transmission of HIV (for example, sexual contact, tattooing, intravenous drug use, or body fluid transfer) occur in confinement or correctional facilities within the Army Corrections System facilities, the participants will be immediately tested for HIV. If all of the participants are known to be HIV infected, testing is unnecessary. In incidents where at least one of the participants is found to be, or is known to be, HIV infected, all HIV negative prisoners involved in the incident will be retested for HIV at 3 months and 6 months from the date of the incident.

*c.* Any prisoner who, at any time, shows clinical signs or symptoms of HIV infection as determined by medical authorities will be tested for HIV.

*d.* Any prisoner who has, or acquires, an STI will be tested for HIV unless medical authority determines testing is unnecessary.

*e.* Except in cases where HIV testing has been done for other reasons within 90 days of their release dates, all prisoners will be retested for HIV within 30 days of their scheduled date of release from confinement.

*f.* HIV testing of any inmate may be considered any time the confinement or correctional facility commander, in coordination with the MEDDAC commander, deems it necessary for the safe operation of the facility or health and welfare of the personnel (prisoners and staff) in his or her command.

#### **11-11. Confidentiality**

Results of all HIV tests must be kept confidential. Personnel who have access to medical, dental, and correctional records will have current HIPAA privacy and security training. Only those personnel, designated by the facility commander, with a legitimate need to know which prisoners are HIV infected will be informed. Correctional treatment files and other correctional records will not be annotated to reflect the inmate's HIV infection. The electronic medical record will document the Soldier's HIV infection. Prisoners who are HIV infected will be discouraged from telling anyone other than medical, psychological, and dental personnel. Any statements made by prisoners in military and/or correctional records to the effect that they are HIV infected will remain in such records and will not be expunged. Normally, only medical records may contain indications that an inmate is HIV infected.

#### **11-12. Prisoner transfers**

All prisoners who are transferred from one Army or Sister Service correctional facility to another will be accompanied by a letter of transmittal from the losing facility commander to the gaining facility commander. The letter of transmittal will inform the gaining facility commander of the prisoner's medical condition. Paragraph 6-9 provides additional guidance for the facility commanders. If a prisoner is transferred with HIV test results pending, those results will be forwarded to the gaining facility commander by preventive medicine personnel as soon as possible per paragraph 4-4.

#### **11-13. Prisoners returning to confinement**

All prisoners who return to confinement after having been absent from the facility (temporary home parole, parole revocation, trial by or otherwise in the custody of civil authorities) will be considered for retesting. Factors to be considered include whether the inmate was in a geographic area with a high incidence rate of HIV infection or other high risk situation.

#### **11-14. Prisoner requested testing**

Prisoners who voluntarily request HIV testing will be medically evaluated and counseled by appropriate medical staff prior to, and after, being tested.

#### **11-15. Medical center evaluation**

*a.* Within 7 calendar days after receiving results that an inmate is HIV infected, the commander will schedule the prisoner for evacuation to a MEDCEN for initial medical evaluation, counseling, treatment, and other medical attention, as necessary. Immediately following such evaluation and appropriate treatment, the prisoner will be returned to the designated confinement or correctional facility.

*b.* All HIV infected prisoners will be reexamined and reevaluated by an infectious disease specialist from a participating MEDCEN at least twice per year, or as determined necessary by local medical authorities. The examination will be accomplished at a MEDCEN or the correctional facility, as appropriate.

### **11–16. Medical management in confinement**

- a.* All HIV infected prisoners will be evaluated and managed on a case-by-case basis per CDC guidelines.
- b.* The medical condition of HIV infected prisoners will be monitored by the local MEDDAC. Frequency of medical visits will be every 4 to 6 weeks, or as deemed appropriate by medical authorities.
- c.* All HIV infected prisoners will be provided emotional and psychosocial support by counselors trained in working with HIV infected individuals.
- d.* Immediately prior to any HIV infected prisoner's release from confinement, military preventive medicine authorities will report applicable information to civilian public health authorities for the State into which the prisoner will be released. Reporting will be per applicable statutes of that State.

### **11–17. Routine confinement practices**

- a.* HIV infected prisoners will not be segregated from the general inmate population based solely on the fact they are HIV infected.
- b.* Normally, the handling of laundry and linen of HIV infected prisoners will be no different than for other prisoners. In certain cases, determined by medical authorities, special handling of contaminated laundry or linen may be necessary.
- c.* Toilet and shower facilities for HIV infected prisoners will not be separate or different from those used by other prisoners in the same custody grades.
- d.* Food service sanitation provisions for HIV infected prisoners will be no different or separate from that of other prisoners, to include dishwashing and garbage handling procedures.

### **11–18. Work, training, restoration, parole, and clemency**

- a.* HIV infected prisoners will be assigned to work and training programs per AR 190–47 and this regulation.
- b.* Recommendations for clemency and parole should not be made based solely upon HIV seropositivity.

### **11–19. Segregation of human immunodeficiency virus infected prisoners**

- a.* HIV infected prisoners who fear being with the general inmate population will be considered for, and may be placed in, administrative segregation. Upon their request, and as deemed necessary by the facility commander, they may be placed in protective custody.
- b.* All HIV infected prisoners who are (beyond mere suspicion) sexually active, sexually aggressive, or otherwise physically aggressive, may be placed in administrative segregation in single cells. They should not be permitted to eat, work, train, or have recreation with any other inmate.

### **11–20. Transfer of human immunodeficiency virus infected prisoners**

- a.* HIV infected prisoners in the Army Corrections System will not be transferred to other confinement or correctional facilities, or centrally confined at any one facility, based solely on their HIV infection status, unless deemed necessary by medical authorities.
- b.* HIV infected prisoners who medical authorities deem in need of special medical attention will be transferred to the U.S. Disciplinary Barracks. They will be maintained in administratively segregated, special quarters inside the U.S. Disciplinary Barracks. HIV infected prisoners within 90 days of release from confinement will normally not be transferred to the U.S. Disciplinary Barracks. HIV infected prisoners who medical authorities deem in need of special medical attention may be transferred to Federal Bureau of Prisons upon approval by the Office of the Provost Marshal General. HIV infected prisoners within 90 days of release from confinement will normally not be transferred to the Federal Bureau of Prisons.

### **11–21. Use of force against human immunodeficiency virus infected prisoners**

In those circumstances requiring the application of force against an HIV infected prisoner, the force will be applied in a manner consistent with that for force applied to other prisoners.

### **11–22. Protection of staff**

Army Corrections System facility staff should have protective clothing and equipment available to them when there is potential for exposure to the blood or body fluids of any prisoner. One-way airways should be used for all cardiopulmonary resuscitation situations. Additionally, the following protective items should be immediately accessible: impermeable disposable gloves, heavy gloves, coveralls, overshoes or plastic bags to cover shoes, sealable plastic bags, and cleaning solution (household bleach).

### **11–23. Counseling**

- a.* HIV infected prisoners will be briefed and counseled per paragraphs 4–8 and 4–9. The commander's copy of the counseling should not be kept in the correctional treatment files but, rather, in a separate file. Access to this file will be

limited to use as determined by the installation commander and will be handled per the guidance in paragraph 4–9. Any Family members of HIV infected prisoners who are HCBs will also be counseled per chapter 8.

*b.* Prior to release from confinement, HIV infected prisoners will again be counseled. During this session, they will be asked if there is any physician to whom a copy of their medical records can be sent to ensure appropriate continuity of health care. After discharge, the Army will honor a request for medical records when properly submitted per AR 40–66.

#### **11–24. Training**

Each Army Corrections System facility confinement or correctional facility will have a comprehensive education and training program for all prisoners and staff. This training and education will be conducted per chapter 10 and may be tailored to accommodate concerns of HIV transmission in a confinement or correctional setting.

#### **11–25. Requests for information**

Release of HIV infected prisoner population statistics for the U.S. Disciplinary Barracks and regional correctional facilities will be included in statistical data for the installation releasable under existing DOD and DA policy. However, these statistics will not be identified with the confinement or correctional facility; they will merely be included in installation totals. Any request for prisoner population data and statistics will be forwarded to Headquarters, Department of the Army (DAPM–ACC), U.S. Army Corrections Command, 150 Army Pentagon, Washington, DC 20310–0150.

## **Appendix A References**

### **Section I Required Publications**

#### **AR 25–55**

The Department of the Army Freedom of Information Act Program (Cited in paras 1–5*h*, 1–16*r*(2).)

#### **AR 40–66**

Medical Record Administration and Health Care Documentation (Cited in paras 4–13*c*, 8–10*f*(2), 9–2*c*, 11–23*b*.)

#### **AR 40–68**

Clinical Quality Management (Cited in paras 6–7*b*, 8–9*d*.)

#### **AR 40–501**

Standards of Medical Fitness (Cited in paras 1–16*k*, 2–2*b*(8), 4–110*b*, 4–11*e*(3), 5–3*g*, 6–3*e*, 6–6*a*, 6–14*a*, 6–15*a*, 7–13*a*, 7–13*b*.)

#### **AR 135–175**

Separation of Officers (Cited in paras 7–12*a*, 7–13*b*.)

#### **AR 135–178**

Enlisted Administrative Separations (Cited in paras 7–12*a*, 7–13*b*.)

#### **AR 140–10**

Assignments, Attachments, Details, and Transfers (Cited in para 7–12*d*.)

#### **AR 140–50**

Officer Candidate School, Army Reserve (Cited in para 5–3*h*(3).)

#### **AR 190–47**

The Army Corrections System (Cited in para 11–18*a*.)

#### **AR 195–5**

Evidence Procedures (Cited in para 11–2*h*.)

#### **AR 340–21**

The Army Privacy Program (Cited in paras 1–5*h*, 1–16*r*(2), 8–10*f*(2).)

#### **AR 350–51**

United States Army Officer Candidate School (Cited in para 5–3*h*(3).)

#### **AR 600–8–24**

Officer Transfers and Discharges (Cited in para 6–13.)

#### **AR 601–100**

Appointment of Commissioned and Warrant Officers in the Regular Army (Cited in para 5–2*a*(3).)

#### **AR 601–270**

Military Entrance Processing Station (MEPS) (Cited in para 5–3*b*.)

#### **AR 601–280**

Army Retention Program (Cited in para 6–6*b*.)

#### **AR 608–75**

Exceptional Family Member Program (Cited in para 8–7.)

#### **AR 614–30**

Overseas Service (Cited in paras 1–16*f*, 3–2*l*, 6–2*c*, 6–4*b*, 6–8*a*(2), 6–8*a*(3), 6–8*b*(1), 6–11*b*(1).)

**AR 614-100**

Officers Assignment Policies, Details, and Transfers (Cited in para 6-3b(1).)

**AR 614-200**

Enlisted Assignments and Utilization Management (Cited in para 6-3b(1).)

**AR 635-40**

Physical Evaluation for Retention, Retirement, or Separation (Cited in paras 1-16k, 6-8b(3), 6-13g, 6-14a, 6-15a.)

**AR 635-200**

Active Duty Enlisted Administrative Separations (Cited in paras 5-3h(3), 6-6c(1), 6-6c(2), 6-8d(2), 6-14.)

**DOD 6025.18-R**

DOD Health Information Privacy Regulation (Cited in paras 1-5h, 1-16r(2).)

**DODI 6485.01**

Human Immunodeficiency Virus (Cited in title page.)

**DODI 6490.03**

Deployment Health (Cited in para 7-6b.)

**NGR 351-5**

State Military Academies (Available at <http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arnseries.htm>.) (Cited in para 5-3h(3).)

**NGR 600-200**

Enlisted Personnel Management (Available at <http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arnseries.htm>.) (Cited in para 7-13a.)

**NGR 635-101**

Efficiency and Physical Fitness Boards (Available at <http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arnseries.htm>.) (Cited in para 7-13a.)

**Personnel Policy Guidance**

Army G-1 Personnel Policy Guidance (PPG) (Cited in paras 1-16g, 7-2b.)

**PL 110-325**

ADA Amendments Act of 2008 (Cited in paras 1-16q, 8-10d.)

**Policy Memorandum, March 29, 2004**

Human Immunodeficiency Virus Interval Testing (Available at [http://mhs.osd.mil/About\\_MHS/HA\\_Policies\\_Guidelines.aspx](http://mhs.osd.mil/About_MHS/HA_Policies_Guidelines.aspx).)

**5 USC 552**

Public information; agency rules, opinions, orders, records, and proceedings (Cited in paras 1-5h, 1-16r(2).)

**10 USC Chapter 61**

Retirement or Separation for Physical Disability (Cited in paras 6-13b, 6-14a(1), 7-1.)

**29 USC 701**

Findings; purpose; policy (Cited in paras 1-16q, 8-10d.)

**32 USC**

National Guard (Cited in para 7-1.)

**42 USC 12101**

Findings and purpose (Cited in paras 1-16q, 8-10d.)

**Section II**

**Related Publications**

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

**AR 5-9**

Area Support Responsibilities

**AR 40-5**

Preventive Medicine

**AR 40-400**

Patient Administration

**AR 135-18**

The Active Guard Reserve (AGR) Program

**AR 135-133**

Ready Reserve Screening, Qualification Records System, and Change of Address Reports

**AR 135-200**

Active Duty for Missions, Projects, and Training for Reserve Component Soldiers

**AR 600-8-4**

Line of Duty Policy, Procedures, and Investigations

**AR 600-63**

Army Health Promotion

**AR 600-85**

Army Substance Abuse Program (ASAP)

**AR 601-210**

Active and Reserve Components Enlistment Program

**AR 608-10**

Child Development Services

**DODI 6130.03**

Medical Standards for Appointment, Enlistment, or Induction in the Military Service (Available at <http://www.dtic.mil/whs/directives/index.html>.)

**BPL 09-01**

DOD Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Using Licensed Nucleic Acid Tests (NAT) With Approved Mini-Pool Strategies (Available at <http://www.militaryblood.dod.mil/Staff/bpl.aspx>.)

**BPL 10-01**

Department of Defense (DOD) Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Updated Multiplex HIV/HCV/HBV Nucleic Acid Testing Algorithm (Available at <http://www.militaryblood.dod.mil/Staff/bpl.aspx>.)

**NGR 40-3**

Medical Care for Army National Guard Members (Available at <http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm>.)

**NGR 635-100**

Termination of Appointment and Withdrawal of Federal Recognition (Available at <http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm>.)

**PL 104-191**

Health Insurance Portability and Accountability Act of 1996

**Policy Memorandum, March 19, 2010**

Policy on the Use of Non-U.S. Food and Drug Administration Compliant Blood Products

**Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, dated November 15, 1985**

(Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00033093.htm>.)

**Section III**

**Prescribed Forms**

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site (<http://www.apd.army.mil>).

**DA Form 5669**

Preventive Medicine Counseling Record (Prescribed in paras 1-14*h*, 2-2, 4-4*e*, 4-5*b*(8) and (9), 4-8, 4-9, 7-9*e*(4), 7-10*c* and *h*, 8-5*a*, B-4*g*.)

**DA Form 7303**

Donor/Recipient History Interview Form (Prescribed in paras 2-2*b*(17) and (19), 4-5*b*(5), B-4*g*.)

**Section IV**

**Referenced Forms**

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site (<http://www.apd.army.mil>); DD forms are available on the Office of the Secretary of Defense (OSD) Web site (<http://www.dtic.mil/whs/directives/infontg/forms/formsprogram.htm>); and Standard Forms (SF) are available on the U.S. General Services Administration (GSA) Web site (<http://www.gsa.gov>).

**DA Form 11-2**

Internal Control Evaluation Certification

**DA Form 67-9**

Officer Evaluation Report

**DA Form 2028**

Recommended Changes to Publications and Blank Forms

**DA Form 2166-8**

NCO Evaluation Report

**DA Form 3349**

Physical Profile

**DA Form 4187**

Personnel Action

**DA Form 4856**

Developmental Counseling Form

**DD Form 2808**

Report of Medical Examination

**SF 600**

Medical Record - Chronological Record of Medical Care

**Appendix B**

**Internal Control Evaluation**

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

The function covered by this evaluation is the Identification, Surveillance, and Administration of Personnel Infected with HIV Program.

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

The purpose of this evaluation is to assist assessable unit managers and internal control administrators in evaluating key internal controls. It is not intended to cover all controls.

### **B-3. Instructions**

These key internal controls must be formally evaluated at least once every 5 years or whenever the internal control administrator changes. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2 (Internal Control Evaluation Certification). Evaluation test questions are outlined in paragraph B-4, below, and are intended as a starting point for each applicable level of internal control evaluation. Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation.

### **B-4. Test questions**

- a. Are all files kept locked in appropriate containers with access by only those with a need to know?
- b. Is there a method in place to ensure Soldiers covered by this regulation are not placed on orders for overseas (for example, TDY or PCS) assignments?
- c. Is there a policy and/or plan established and maintained to describe how key internal controls will be evaluated over a 5-year period?
- d. Is the commander informed by the HIV program coordinator if his or her Soldier is identified as HIV infected within 4 days?
- e. Is there verification of a completed epidemiological assessment or public health department referral for HCBs with a new HIV infection?
- f. Are local public health reporting requirements completed for all new diagnosed HIV infections and when a Soldier is in-processing into a new catchment area?
- g. Does the duplicate file kept by the HIV program coordinator for Soldiers contain copies of current DA Form 5669, DA Form 4856, DA Form 7303, public health report, and demographics?
- h. Is there verification that the AD Soldier is attending infectious disease medical evaluation visits every 6 months and following the medical management plan of his or her physician?
- i. Is there verification that the ARNG and Reserve Soldier has completed a FFD physical?
- j. Is the commander informed if the Soldier is out of compliance?
- k. Does MEDPROS confirm nondeployable status and is there a current PHA?
- l. Is HIPAA training current for medical, administrative, and unit staff who, in the performance of their duties, “need to know” a Soldier’s HIV positive status?
- m. Have all placement personnel been familiarized with the parameters of AR 600-110 relative to military and civilian school assignments?

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

This evaluation is new and does not replace a previous evaluation.

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

Help to make this a better tool for evaluating internal controls. Submit comments to Deputy Chief of Staff, G-1 (DAPE-HR), 300 Army Pentagon, Washington, DC 20310-0300.



## **Glossary**

### **Section I Abbreviations**

#### **AC**

active component

#### **ACOM**

Army command

#### **AD**

active duty

#### **ADOS**

active duty for operational support

#### **ADT**

active duty for training

#### **AGR**

Active Guard Reserve

#### **AI**

assignment instructions

#### **AIDS**

Acquired Immune Deficiency Syndrome

#### **AMEDD**

Army Medical Department

#### **AMHRR**

Army Military Human Resource Record

#### **AR**

Army regulation

#### **ARNG**

Army National Guard

#### **ASAP**

Alcohol Substance Abuse Program

#### **ASCC**

Army service component command

#### **AT**

annual training

#### **BPL**

Blood Program Letters

#### **CDC**

Centers for Disease Control and Prevention

#### **CG**

commanding general

#### **COCOM**

combatant command

**CONUS**

continental United States

**CPAC**

civilian personnel advisory center

**DA**

Department of the Army

**DCS**

Deputy Chief of Staff

**DD**

Department of Defense (forms)

**DOD**

Department of Defense

**DODD**

Department of Defense directive

**DODI**

Department of Defense instruction

**DRU**

direct reporting unit

**EFMP**

Exceptional Family Member Program

**FDA**

Food and Drug Administration

**FOIA**

Freedom of Information Act

**FOUO**

for official use only

**FST**

foreign service tour

**FTNGD**

full-time National Guard duty

**GSA**

General Services Administration

**HIPAA**

Health Insurance Portability and Accountability Act

**HIV**

human immunodeficiency virus

**HQDA**

Headquarters, Department of the Army

**HRC**

Human Resources Command

**IMA**  
individual mobilization augmentee

**IRR**  
individual ready reserve

**JAGC**  
Judge Advocate General's Corps

**MEDCEN**  
medical center

**MEDDAC**  
medical department activity

**MEDPROS**  
Medical Protection System

**MEPS**  
military entrance processing station

**MOS**  
military occupational specialty

**MTF**  
medical treatment facility

**NGB**  
National Guard Bureau

**NGR**  
National Guard regulation

**OCAR**  
Office of the Chief, Army Reserve

**OCONUS**  
outside the continental United States

**OCS**  
Officer Candidate School

**OTSG**  
Office of The Surgeon General

**PCS**  
permanent change of station

**PHA**  
periodic health assessment

**PHN**  
public health nurse

**PL**  
public law

**POC**  
point of contact

**PULHES**

physical, upper, lower, hearing, eyes, psychiatric

**RC**

reserve component

**REFRAD**

release from active duty

**ROTC**

Reserve Officer Training Corps

**SF**

standard form

**STD**

sexually transmitted disease

**TDA**

table of distribution and allowances

**TDY**

temporary duty

**TPU**

troop program unit

**U.S.**

United States

**UCMJ**

Uniform Code of Military Justice

**USAMEDCOM**

U.S. Army Medical Command

**USAPHC**

U.S. Army Public Health Command

**USAR**

U.S. Army Reserve

**USARC**

U.S. Army Reserve Command

**USC**

United States Code

**USMA**

U.S. Military Academy

**Section II****Terms****ADOS**

The Active Duty Operational Support-Reserve Component Program is an authorized tour of active duty performed pursuant to 10 USC 12301(d) and it includes: active duty for training performed at the request of an organizational or operational commander; active duty or ADT performed as a result of reimbursable funding; funeral honors duty performed not in an inactive duty status; and active duty performed by members of the Retired Reserve not receiving regular retired pay. Most tours are only 14 days in length but can go to 2 years depending upon the position filled and additional military requirements. This term replaced extended active duty (EAD) and temporary tour of active duty

(TTAD). The term contingency ADOS (CO-ADOS) replaced voluntary active duty formerly known as contingency EAD (CO-EAD) and contingency TTAD (CO-TTAD). The term ADOS Reserve Component (ADOS-RC) replaced RC-funded, voluntary active duty formerly known as active duty for special work (ADSW).

**Biennial**

Every 2 years.

**Catchment area**

Area and population from which an MTF gets its patients/enrollees.

**Enzyme linked immunosorbent assay**

A commonly used screening test to detect antibodies to HIV.

**Designated medical treatment facility**

Servicing medical treatment facility.

**Epidemiological assessment**

Medical evaluation process used by medical personnel/HIV PHN to determine possible sources of exposure to HIV.

**Exudative**

A discharge of certain elements of the blood into the tissues.

**Health care beneficiary**

A person who, because of military status, employment, or by legal relationship to a person so entitled, is eligible to receive medical care in military medical treatment facilities.

**Human immunodeficiency virus infected**

An individual who has been confirmed to be infected with HIV by a positive HIV screening test and at least two separate confirmatory tests.

**Human immunodeficiency virus negative**

A screening specimen that was not reactive or, if reactive, has been determined not to have HIV antibodies or virus present after confirmatory testing.

**Immunological deficiency**

Persistent reduction in the level of T-helper lymphocytes below 300 cells per cubic millimeter for greater than one month without other demonstrable cause; reduced or absent delayed hypersensitivity, as measured by the standardized battery of skin tests (in association with other significant clinical findings); development of thrush; increased susceptibility to either common or uncommon infections; and more severe episodes of infection than usually seen with a given organism.

**Initial test cycle**

A series of HIV tests which includes an initial screening test at a minimum. If the initial test is reactive (positive), the test cycle includes duplicate initial testing and confirmatory tests necessary to determine an individual's HIV status.

**Longitudinal**

A study conducted from initial diagnosis through termination of the condition.

**Major installation**

Any installation with a military population of 5000 or more.

**Overseas**

Outside the 50 States of the United States, the District of Columbia, and Puerto Rico.

**Progressive clinical illness**

Development of neurological manifestations; Kaposi's sarcoma; other lymphoreticular malignancies; thrombocytopenia; diffuse, persistent lymphadenopathy; or unexplained weight loss, diarrhea, anorexia, fever, malaise, or fatigue.

**Reflex**

Testing performed when an initial test result is outside of the expected normal range (for example, result is reactive and thus a second test(s) is medically indicated). The primary or initial test result is enhanced by the second test(s) as it

provides diagnostic, prognostic, and/or therapeutic information. (This process is done automatically in order to clarify results.)

**Unit commander**

Company, troop, battery, or detachment commander.

**Western Blot**

Laboratory test that detects specific antibodies to components of a virus. Chiefly used to confirm HIV antibodies in specimens found repeatedly reactive using enzyme linked immunosobent assay.

**Section III**

**Special Abbreviations and Terms**

**DNA**

deoxyribo nucleic acid

**FFD**

fit for duty

**HBV**

hepatitis B virus

**HCB**

health care beneficiary

**HCV**

hepatitis C virus

**NAT**

nucleic acid test

**STI**

sexually transmitted infection

**UNCLASSIFIED**

**PIN 063580-000**