DEPARTMENT OF THE NAVY
UNITED STATES NAVAL ACADEMY
121 BLAKE ROAD
ANNAPOLIS, MARYLAND 21402-1300

USNAINST 6260.2
25/NHC
NOV 2 0 2008

USNA INSTRUCTION 6260.2

From: Superintendent, United States Naval Academy

Subj: PHYSICAL EXAMINATION AND MEDICAL TREATMENT OF CIVILIAN EMPLOYEES

Ref: (a) SECNAVIST 5100.10J
(b) BUMED NOTE 6120
(c) OPNAVINST 5100.23G
(d) USNAINST 12630.1J
(e) BUMEDINST 6320.3B
(f) Office of Personnel Management Operating Manual, Chapter 7
(g) Manual of the Medical Department, Chapter 22

Encl: (1) Competence for Duty Examination (NAVMED 6120/1 (Rev. 1-82))
(2) Medical Referral Form (OPNAV 5100/9)

1. Purpose. To promulgate procedures for the medical examination and treatment of civilian personnel employed by activities under the Superintendent, U.S. Naval Academy.

2. Cancellation. USNA/AAC Instruction 6260.2C

3. Background. References (a) through (g) set policy relating to the medical examination and treatment of civilian employees to the federal government.

4. Discussion. Reference (a) requires the establishment of comprehensive and effective occupational medicine (OM) programs. Elements of the OM program at the Occupational Health Clinic (OHC), Naval Health Clinic (NHC) Annapolis include:

a. Diagnosis, treatment, and referral for acute and chronic occupational illnesses and injuries, and limited care of non-occupational, non-urgent conditions to allow a worker to complete his/her shift.

b. Medical surveillance program management.

c. Medical certification examinations per reference (b).

d. Work area consultation.

e. Fitness for duty medical evaluations. These evaluations can be requested by the civilian or his/her supervisors if he/she presumes the existence of a deficit in the employee's on-the-job performance.

f. Competence for duty examinations can be requested by a supervisor who suspects an employee is under the influence of alcohol or other drugs per reference (b). The supervisor must fill out NAVMED 6120/1, enclosure (1). The provider at the OHC performs competence for duty examinations during normal clinic working hours. Competence for duty examinations after hours is performed by the duty health care provider at Brigade Medical.

g. Epidemiological assessment of injury and illness data to focus prevention efforts.

h. Occupational audiology services in support of the hearing conservation program.

i. Prevention services offered by the OHC include verification of immunizations, (Hearing Conservation Program), education, and workplace visits to prevent disease due to occupational exposure.

5. Coordination. The OHC will coordinate appropriate scheduling of the requisite medical examinations and tests to fulfill the elements of the OM program.

6. Action. Treatment will be rendered to civilian personnel as follows:

a. Occupational Injury. All occupational injuries can be evaluated and treated at the OHC during normal working hours. A traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain. When an employee sustains a traumatic injury in the performance of duty, he or she should file a written report on Form CA-1. The form should be given to the supervisor as soon as possible, but not later than 10 days from the date of injury. If the employee is incapacitated, this action may be taken by someone acting on his/her behalf, including a family member, union official, or representative. The form must contain the original signature of the person giving notice. A Medical Referral Form, enclosure (2), must also be completed by the supervisor and accompany the employee to Occupational Health. Please note if the injury is life threatening, contact Fed Fire at x33333 for immediate care.

b. Occupational Illness. An occupational illness is defined as a condition produced in the work environment over a longer period of time than one workday or shift. It may result from systemic infections, repeated stress or strain, exposure to toxins, poisons, or fumes, or other continuing conditions of the work environment. The employee has the right to elect sick or annual leave or leave without pay, pending adjudication of the claim by the Department of Labor. The supervisor should submit a completed Form CA-2 to the Naval Academy Safety Office within 10 working days of receipt from the employee. It should not be held for receipt of supporting information. A Medical Referral Form, enclosure (2), must also be completed by the supervisor and accompany the employee to Occupational Health.

c. Sick Leave (brief). When an employee is incapacitated or providing family care for a period of absence not in excess of three work days, a medical certificate will not normally be required except in those instances when the supervisor has some reason to believe that there may have been an abuse of leave, reference (d).

d. Sick Leave (extended). When an employee is incapacitated or providing family care for a period of absence in excess of three work days, a medical certificate must be filed after return to duty and must be supported by a doctor's signature. The employee's signed statement explaining the nature of the illness may be accepted when it is unreasonable to require a medical certificate because of a shortage of physicians, remoteness of locality, or the illness does not require the services of a physician, reference (d). A Medical Referral Form, enclosure (2), must be completed by the supervisor and accompany the employee to Occupational Health.

e. Return to Work. Employees returning to duty from sick leave more than 7 consecutive calendar days or more than 3 scheduled work days should report to their supervisor and obtain a Medical Referral Form, enclosure (2). Enclosure (2) must be completed by their supervisor. The employee must bring the completed form to the Occupational Health Clinic at the Naval Health Clinic for clearance prior to reporting to work with a note from their private physician certifying capability to perform their duties, reference (d).

f. Dispensary Checkout. Employees who become incapacitated for duty after reporting for work may be required to checkout through the OHC before leaving the Naval Academy. The supervisor will complete a Medical Referral Form, enclosure (2), for employees who need treatment for either on-the-job injuries or occupational diseases or non-occupational illness. All cases of injury while at work shall be treated and recorded at the OHC.

g. Clinic Hours. The OHC is open from 0700-1200 and 1300-1530 Monday through Friday.

h. Hospitalization of Civilian Employees. If immediate hospitalization is required for an occupational injury, the facilities of the nearest available hospital will be utilized. Authorization shall be in the form of a Request for Examination and/or Treatment under the Federal Employees Compensation Act (CA-16). The Office of Worker's Compensation Programs (OWCP), who will determine authorization for medical treatment, must approve claims for hospitalization, and if approved by the OWCP, the employee will be reimbursed. Bills for treatment for non-occupational injuries and/or illnesses will not be paid for by the OWCP.

/S/
J. L. FOWLER

Distribution
All Non Mids (electronically)

COMPETENCE FOR DUTY EXAMINATION
NAVMED 6120/1 (REV. 1-82) S/N 0105-LF-206-1206

INSTRUCTIONS FOR THE USE AND PURPOSE OF THIS FORM ARE CONTAINED IN BUMEDINST 6120.20 SERIES.
THIS FORM SHALL NOT BE USED FOR PROCEDURES PERFORMED FOR CLINICAL OR THERAPY PURPOSES.

DEFINITION OF COMPETENCE FOR DUTY

FOR PERSONS IN THE NAVAL SERVICE: The ability to perform fully the naval duties to which the individual normally would be assigned. (Note: A person who has indulged in intoxicating beverages, narcotics or dangerous drugs to such an extent as to impair sensibly the rational and full exercise of his mental and physical faculties cannot be entrusted with the duties incident to naval service. The fact that the person is in a patient, leave, or liberty status is immaterial to the determination of his competence to perform his naval duties.)

FOR ALL OTHERS: The mental and physical ability to perform fully any task or service which the individual may normally be expected to perform.

INSTRUCTIONS

1. Items 1-12 shall be completed in duplicate by the commanding officer or other proper authority requesting examination.
2. Items 13-48 shall be completed by medical officer conducting examination. Under item 13, History, included information provided by examinee as to ingestion and quantity of alcoholic beverage, narcotic, drug substance, or food, and time taken. Note any evidence of disease or injury (other than the condition promoting this examination) in item 16.
3. When conducting an examination for competence for duty and individual is accused or suspected of an offense, comply with BuMedInst 6120.20 series.
4. All treatment provided at the time of examination shall be entered on form NAVMED 6150/3, Sick Call Treatment Record.

A. REQUEST FOR EXAMINATION

1. TO:	2. DATE	3. TIME *(Hours)*

It is requested that a physical examination be given the following individual to determine competence for duty.

4. NAME *(Last, first, middle)*	5. GRADE OR RATE	6. DUTY STATION

7. REASON FOR REFERRAL

☐ Check here if laboratory analysis is desired.

8. SIGNATURE *(Requester)*	9. GRADE OR RATE	10. TITLE
11. NAME OF REQUESTER *(Typewrite or print in ink)*		12. DUTY STATION

B. CLINICAL EXAMINATION

13. HISTORY

14. GENERAL APPEARANCE *(Include appearance of clothing)*	15. MENTAL STATE

16. DISEASES OR INJURIES *(Other than the condition prompting this examination, per inst. 2 above)*

17. TEMPERATURE	18. PULSE *(Rate and character)*
19. BLOOD PRESSURE	
20. FACE *(Flushed, pallid, cyanotic)*	21. TONGUE
	22. BREATH
23. SKIN *(Warm, cool, moist, dry, pale)*	24. SPEECH *(Thick, slurred, ability to report words such as Mercifid, Pedestrain, Peter Piper)*
25. EYES *(Size of pupils, reaction to light, conjunctiva, etc.)*	

26. OTHER CONDITIONS		27. SAMPLE OF HANDWRITING
	VOMITING	
	INCONTINENCE OF URINE	
	INCONTINENCE OF FECES	

C. NEUROLOGICAL EXAMINATION

28. REFLEXES		29. COORDINATION	
	HYPERACTIVE	FINGER TO NOSE	ROMBERG TEST
	HYPOACTIVE	HEEL TO KNEE	
	TREMOR	ABILITY TO APPROACH AND PICK UP OBJECT FROM THE FLOOR	GAIT

D. LABORATORY EXAMINATIONS *(if requested in Part A):*

30. BLOOD ANALYSIS *(Name of test and results expressed as mgm per ml or in other standard units)*	31. TIME TAKEN (HOUR)	33. OTHER TESTS *(Gastric contents, urine, etc.)*	34. TIME TAKEN (HOUR)
	32. DATE		35. DATE
36. SPECIMEN OBTAINED BY *(Name of person)*		37. RESULTS VERIFIED BY *(Name of person)*	

E. CONCLUSIONS AS TO COMPETENCE FOR DUTY

Check the applicable "YES" or "NO" box to indicate answer.	YES	NO
38. Is examinee competent to perform duty?		
39. Is examinee' condition due to disease or injury?		
40. Is examinee' condition due to the use of drugs or alcohol?		

If the answer to item 38 is NO, also answer items 39 and 40 and indicate in block 43 the approximate time examinee is expected to become competent to return to duty. If the answer to item 39 is YES, describe in block 16 DISEASES or INJURIES. If answer to item 40 is YES describe under block 42.

41. DISPOSITION:

☐ RETURNED TO FULL DUTY ☐ ADMITTED TO SICKLIST ☐ RELEASE TO CUSTODY OF (Specify to whom)

42. REMARKS *(All answers should be as brief as possible. Items requiring more space should be continued in this "Remarks" block. Specify item continued.)*

F. RESPONSE TO REQUESTER

In accordance with the request in Section A, the individual has been examined as set forth above to determine competence for duty.

A signed copy of this report is being inserted in the Health Record of the individual.

43. THE INDIVIDUAL

☐ HAS ☐ HAS NOT RECEIVED A COPY OF THIS REPORT.

44. SIGNATURE *(Examiner)*	45. GRADE OR RATE	46. DUTY STATION	47.
48. NAME *(Typewritten)*			TIME DATE

Medical Referral Form
FOR OFFICIAL USE ONLY (WHEN FILLED IN)

Supervisor's Report	To Medical (Location)	Date of Report	
Employee's Name	Time & Date of Injury	Time Left Job	Time Returned
Social Security Number	Grade, Rate, Job Title	Occupational ☐ Yes ☐ No ☐ Questionable	
Reason for Referral: ☐ Injury ☐ Illness ☐ Return to Work ☐ Employee's Request ☐ Other (Specify)			
Remarks:			
Supervisor's Signature:	Shop/Office:	Telephone #	Email:
Medical Report	Time Reported:	Time Released:	
Occupational ☐ Yes ☐ No ☐Questionable	Degree of Injury ☐ First Aid ☐ Medical Treatment ☐ Other (Explain)		
Recommended Disposition of Employee: ☐ Return to Perm. Job _____ ☐ Restrict Activity Until _____ ☐ Employee to Seek Care from Private Physician ☐ Referred to Private Physician/Hospital ☐ Temporary Transfer to Another Job ☐ Other (Explain)			
Remarks:			
Provider Signature: _____ Phone: _____	☐ Evaluation Completed ☐ Follow-up On or Before (date) _____		