III MARINE EXPEDITIONARY FORCE (MEF) FORCE HEALTH PROTECTION (FHP) GUIDANCE AND REQUIREMENTS 2024

FM CG III MEF G THREE
TO CG III MEF
CG THIRD MARDIV
CG THIRD MARDIV G THREE
CG FIRST MAW G THREE
CG FIRST MAW MED
CG THIRD MEB
CG THIRD MLG G THREE
CG THIRD MLG HSSE CG I MEF
CG I MEF
CG I MEF G THREE
CG II MEF
CG II MEF G THREE
INFO CG III MEF G ONE
CG III MEF MED
COMMARFORPAC G THREE
HQ USPACOM J3
HQ USPACOM J07

UNCLAS
SUBJ/III MARINE EXPEDITIONARY FORCE (MEF) FORCE HEALTH PROTECTION (FHP) GUIDANCE AND REQUIREMENTS 2024//

REF/A/DOC/SECNAVINST 5300.39B/26FEB20//
REF/B/DOC/BUMEDINST 1300.2B/27JUL16//
REF/C/DOC/DODI 6025.19/13JUL22//
REF/D/DOC/DODI 6130.03V2/6JUN22//
REF/E/DOC/DODI 6490.07/5FEB10//
REF/F/DOC/OASD MEMO/7OCT13//
REF/G/DOC/IIIMEFO 6490.1/18FEB22//
REF/H/DOC/DODI 6485.01/6JUN22//
REF/I/DOC/SECNAVINST 6120.3A/14JUN19//
REF/J/DOC/ALNAV 015/23//
REF/K/DOC/BUMEDINST 6110.14/7MAR22//
REF/L/DOC/MCO 6600.3B/30JUL20//
REF/M/DOC/DODI 6200.06/8SEP16//
REF/N/DOC/USINDOPACOM MSG/01MAR23//
REF/O/DOC/DHA-PI 6200.06/9MAY17//
REF/P/DOC/DODI 6465.01/17JUL15//
REF/Q/WEB/CDC VAERS//
REF/R/DOC/BUMEDINST 6230.15B/7OCT13//
REF/S/DOC/USFK REG.40-9/20OCT21//
REF/T/DOC/ODSD MEMO/12NOV15//
REF/U/DOC/OUSD MEMO/29APR05//

REF/V/DOC/OUSD MEMO/16AUG05//
REF/W/DOC/MARADMIN 452/11//
REF/X/DOC/DHA-IHD IP/30AUG19//
REF/Y/DOC/DHA-PI 6025.34/21AUG20//
REF/Z/DOC/BUMED MEMO 6000/23JUN17//
REF/AA/DOC/OUSD MEMO/30JAN23//
REF/AB/DOC/MARADMIN 025/23//
REF/AC/DOC/MARADMIN 109/23//
REF/AD/DOC/ALNAV 009/23/20JAN23//
REF/AE/DOC/CDC YELLOW BOOK 2020//
REF/AF/DOC/IIIMEFO 6220.3A/12APR21//
REF/AG/DOC/BUMEDINST 6224.8C/25APR18//
REF/AH/DOC/DODI 6490.03/19JUN19//
REF/AI/DOC/DHA-PI 6490.03/17DEC19//
REF/AJ/WEB/FCG//
REF/AK/WEB/NCMI//
REF/AL/WEB/TRAVAX//
REF/AM/DOC/DODI 1332.45/27APR21//
REF/AN/DOC/MARADMIN 633/08//
REF/AO/DOC/MARADMIN 294/12//
REF/AP/DOC/BUMEDINST 6310.13/21FEB14//
REF/AQ/DOC/DODI 6490.13/31MAR17//
REF/AR/DOC/DODI 6490.11/1OCT21//
REF/AS/DOC/MARADMIN 133/05//
REF/AT/DOC/MARADMIN 111/23//
REF/AU/DOC/MCO 5000.12F/10MAR21//
REF/AV/DOC/ALNAV 017/23//
REF/AW/DOC/DHA-PI 6200.02/13MAY19//
REF/AX/DOC/DODD 6490.02E/28AUG17//
REF/AY/DOC/BUMEDINST 6220.13B/22MAY18//
REF/AZ/DOC/DHA AFRME 2022//
REF/BA/DOC/BUMEDINST 6220.12C/27SEP11//
REF/BB/DOC/ NMCPHC-TM 6220.12/SEP13//
REF/BC/DOC/MANMED CH2/8JUN12//
REF/BD/WEB/DSRI//

NARR/REF A is SECNAV Instruction 5300.39B, Department of the Navy Overseas Screening Program, 26 Feb 2020//
REF B is BUMED Instruction 1300.2B, Suitability Screening, Medical Assignment Screening, and Exceptional Family Member Program Identification and Enrollment, 27 Jul 2016//
REF C is DoD Instruction 6025.19, Individual Medical Readiness (IMR), 13 Jul 2022//
REF D is DoD Instruction 6130.03, Volume 2, Change 1, Medical Standards for Military Service: Retention, 6 June 2022//
REF E is DoD Instruction 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees, 5 Feb

2010//
REF F is Assistant Secretary of Defense for Health Affairs Memorandum, Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications, 7 Oct 2013.
REF G is III Marine Expeditionary Force Order 6490.1, Pre-deployment Medical Requirements for Units and Individuals Deploying to the III Marine Expeditionary Force Area of Responsibility, 18 Feb 2022//
REF H is DoD Instruction 6485.01, Change 2, Human Immunodeficiency Virus (HIV) in Military Service Members, 6 Jun 2022//
REF I is SECNAV Instruction 6120.3A, Periodic Health Assessment for Individual Medical Readiness, 14 Jun 2019//
REF J is ALNAV 015/23, Individual Medical Readiness Elements, Goals, and Metrics Policy Update, 22 Feb 2023//
REF K is BUMED Instruction 6110.14, with Changes 1-3, and Interim Message Change, Documenting and Reporting Individual Medical Readiness Data, 7 Mar 2022//
REF L is Marine Corps Order 6600.3B, Dental Health Care Program, 30 Jul 2020//
REF M is DoD Instruction 6200.06, Periodic Health Assessment (PHA) Program, 8 Sep 2016//
REF N is USINDOPACOM FY 2023 Force Health Protection Guidance for USINDOPACOM AOR, DTG 011025Z Mar 23//
REF O is Defense Health Agency Procedural Instruction 6200.06, Periodic Health Assessment (PHA) Program, 9 May 2017//
REF P is DoD Instruction 6465.01, Erythrocyte Glucose-6-Phosphate Dehydrogenase Deficiency (G6PD) and Sickle Cell Trait Screening Programs, 17 Jul 2015//
REF Q is U.S. Centers for Disease Control and Prevention (CDC), Vaccine Adverse Event Reporting System (VAERS), https:[slashslash]vaers.hhs.gov/reportevent.html//
REF R is BUMED Instruction 6230.15B, Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases, 7 Oct 2013//
REF S is United States Forces Korea, Regulation 40-9, Force Health Protection (FHP) Requirements for the Korean Peninsula, 20 Oct 21//
REF T is Deputy Secretary of Defense Memorandum, Clarifying Guidance for Smallpox and Anthrax Vaccine Immunization Programs, 12 Nov 2015//
REF U is Under Secretary of Defense for Personnel and Readiness Memorandum, Implementation of Resumption of the Anthrax Vaccine Immunization Program (AVIP) under Emergency Use Authorization (EUA), 29 Apr 2005//
REF V is Under Secretary of Defense for Health Affairs Memorandum, Exception to Policy for Anthrax Vaccination of

Forwarded Deployed Naval Forces (FDNF) and III Marine Expeditionary Force (III MEF) in the Resumption of the Anthrax Vaccination Program (AVIP) under the Emergency Use Authorization (EUA), 16 Aug 2005//
REF W is MARADMIN 452/11, Anthrax Vaccine Immunization Program (AVIP) Update, 10 Aug 2011//
REF X is Defense Health Agency Immunization Healthcare Division Information Paper, Counting Doses in Combined Regimens of Monovalent and Bivalent Hepatitis A and Hepatitis B Vaccines, 30 Aug 2019//
REF Y is Defense Health Agency Procedural Instruction 6025.34, Guidance for the DoD Influenza Vaccination Program (IVP), 21 Aug 2020//
REF Z is BUMED Memorandum 6000, Japanese Encephalitis Vaccine, 23 Jun 2017//
REF AA is Under Secretary of Defense for Personnel and Readiness, DoD Consolidated COVID-19 Force Health Protection Guidance Revision 4, 30 Jan 2023//
REF AB is MARADMIN 025/23, Rescission of COVID-19 Vaccination Requirement, 18 Jan 2023//
REF AC is MARADMIN 109/23, Update to Mandatory COVID-19 Vaccination Requirement of Marine Corps Active and Reserve Components, 28 Feb 2023//
REF AD is ALNAV 009/23, Rescission of COVID-19 Vaccination Requirement for Members of the Armed Forces, 20 Jan 2023.
REF AE is U.S. CDC, Yellow Book: Health Information for International Travel, 2020//
REF AF is III Marine Expeditionary Force Order 6220.3A, Leptospirosis Force Health Protection for Okinawa, 12 Apr 2021//
REF AG is BUMED Instruction 6224.8C, Tuberculosis Surveillance and Control Program, 25 Apr 2018//
REF AG is DoD Instruction 6490.03, Deployment Health, 19 Jun 2019//
REF AI is Defense Health Agency Procedural Instruction 6490.03, Deployment Health Procedures, 17 Dec 2019//
REF AJ is Department of Defense, Foreign Clearance Guide, https:[slashslash]www.fcg.pentagon.mil/fcg.cfm//
REF AK is National Center for Medical Intelligence, https:[slashslash]www.ncmi.dodiis.mil//
REF AL is Shoreland Travax, https:[slashslash]www.travax.com//
REF AM is DoD Instruction 1332.45, Change 1, Retention Determinations for Non-Deployable Service Members, 27 Apr 2021//
REF AN is MARADMIN 633/08, Baseline Pre-Deployment Neurocognitive Assessments, 14 Nov 2008//
REF AO is MARADMIN 294/12, US Marine Corps Traumatic Brain Injury Program, 31 May 2012//
REF AP is BUMED Instruction 6310.13, Guidance for Conducting

Baseline Pre-Deployment Neurocognitive Functional Assessments, 21 Feb 2014//
REF AQ is DoD Instruction 6490.13, Change 1, Comprehensive Policy on Traumatic Brain Injury-Related Neurocognitive Assessments by the Military Services, 31 Mar 2017//
REF AR is DoD Instruction 6490.11, Change 3, DoD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting, 1 Oct 2021//
REF AS is MARADMIN 133/05, Pregnancy and Parenting Policy Tasks and Responsibilities, 18 Mar 2005//
REF AT is MARADMIN 111/23, Update to Pregnancy Notification, 28 Feb 2023//
REF AU is Marine Corps Order 5000.12F, Change 1, Marine Corps Policy Concerning Pregnancy and Parenthood, 10 Mar 2021.
REF AV is ALNAV 017/23, Pregnancy Notification Policy, 27 Feb 2023//
REF AW is Defense Health Agency Procedural Instruction 6200.02, Comprehensive Contraceptive Counseling and Access to the Full Range of Methods of Contraception, 13 May 2019//
REF AX is DoD Directive 6490.02E, Change 2, Comprehensive Health Surveillance, 28 Aug 2017//
REF AY is BUMED Instruction 6220.13B, Rabies Prevention and Control, 22 May 2018//
REF AZ is Defense Health Agency, Armed Forces Reportable Medical Events Guidelines and Case Definitions, 2022//
REF BA is BUMED Instruction 6220.12C, Medical Surveillance and Medical Event Reporting, 27 Sep 2011//
REF BB is Navy and Marine Corps Public Health Center Technical Manual 6220.12, Medical Surveillance and Reporting, Sep 2013//
REF BC is BUMED, Manual of the Medical Department, Chapter 22, Preventive Medicine and Occupational Health, 8 Jun 2012//
REF BD is Defense Health Agency, Disease Reporting System internet, https:[slashslash]drsi.health.mil/NDRSi//
POC/III MEF Preventive Medicine/iiimefprevmed@usmc.mil
POC/LCDR Kachur, R./III MEF Preventive Medicine Officer/DSN 315-622-4665/ryan.kachur@usmc.mil//
POC/LCDR Mansfield, L./III MEF Force Health Protection Officer/DSN 315-622-7865/luke.a.mansfield@usmc.mil//

RMKS//
1. Purpose. To disseminate III MEF requirements and guidance for force health protection (FHP), including those for individual medical readiness (IMR), communicable disease prevention, preventive medicine, deployments, health surveillance, and medical event reporting in support of deployment to and throughout the III MEF area of operations (AO).

2. Applicability. All personnel within III MEF, including those assigned, attached, or reporting to III MEF elements and subordinate commands.

3. Responsibilities.
3.a. Commanders will implement effective FHP programs and should utilize their health services (HS) personnel in fulfilling FHP requirements, both in garrison and during operations, including having them engage early in and throughout operational planning.
3.b. HS personnel responsible for medical readiness and provision of health services within III MEF shall become familiar with the requirements herein and support their supported personnel in completing all that are applicable. Additionally, HS personnel responsible for operational planning shall become familiar with the guidance relevant to deployments. HS personnel are also responsible for identifying and informing their commanders of potential health threats and providing guidance on appropriate countermeasures. Select HS personnel at each command shall obtain and maintain access to the Navy Medical Readiness Reporting System (MRRS). They shall evaluate completion of IMR requirements among their supported personnel via MRRS every month, at a minimum, and support their commander in ensuring timely completion of all applicable requirements by their personnel and the achievement and maintenance of required unit IMR percentage goals.
3.c. III MEF elements and subordinate commands will monitor medical readiness via MRRS reports for unit IMR, projected unit IMR requirements, and immunization scheduling reports. Units without MRRS access should contact their local MRRS Field Maintenance Manager through the respective Major Subordinate Command (MSC) Surgeon Cell.
3.d. Personnel inbound to III MEF. Upon notice of assignment, members shall initiate and complete the overseas screening process for themselves and their dependents via their supporting HS personnel or Medical Treatment Facility (MTF) per refs (a, b). All individual medical readiness requirements and health assessments and exams must be current and meet standards and any indicated approval or waiver for transfer or entry must have been granted. All personnel deploying to the III MEF AO must meet medical, including psychological, and dental fitness requirements for deployment per refs (c, d, e, f, g) and as confirmed by a competent medical authority (CMA).
3.e. Any unit rotating to the III MEF AO, including those under the Unit Deployment Program (UDP), shall follow ref (g) in completing all FHP and IMR requirements, including submission of progress reports, prior to their rotation to the III MEF AO.

4. Individual Medical Readiness. IMR is a central component of FHP. It is the responsibility of every service member to ensure they maintain the maximal medical readiness possible. To that end, HS personnel, under the direction and authority of their commander, shall facilitate completion of all IMR requirements by their supported personnel.
4.a. IMR Categories. Fully medically ready (FMR), Partially medically ready (PMR), and Not medically ready (NMR).
4.b. Determination of service member's IMR category is based upon their status within six elements: (1) periodic health assessment (PHA), (2) deployment-limiting medical conditions, (3) dental readiness, (4) immunizations, (5) medical readiness laboratory studies, and (6) individual medical equipment. Standard procedures for evaluating the six elements to determine the readiness category are contained in refs (c, h, i).
4.c. Partially Medically Ready (PMR). Service members are classified as PMR due to an overdue PHA, dental readiness category 4, or by lacking one or more required immunization, medical readiness laboratory study, or individual medical equipment, per ref (c). Completion of requirements by service members falling into this category should remain a focus of commanders and their HS personnel and will facilitate reaching and maintaining the highest achievable FMR percentage.
4.d. IMR Goals. It should be the goal of every unit to achieve the highest possible Total Force Medical Readiness (TFMR), with the largest attainable FMR percentage. Current goals are delineated in refs (c, j, k, l) and include PMR of 15 percent or lower, and NMR less than 5 percent.
4.e. IMR Requirements.
4.e.1. Periodic Health Assessment (PHA). All personnel shall complete their PHA annually, or within the 90-day grace period of their annual completion date if needed to support operational requirements, IAW refs (m, o, i).
4.e.2. Deployment-Limiting Medical Conditions (DLMC). Health services personnel shall assess for the presence of DLMC, as defined by refs (c, d, e, f), during each review of or encounter with their supported personnel to ensure for their appropriate health fitness for deployment.
4.e.3. Dental Readiness. Dental exam frequency and classifications per refs (c, k, l).
4.e.4. Immunizations. Requirements are detailed in section 5 of this message.
4.e.5. Medical Readiness Laboratory Studies.
4.e.5.a. Blood Type and Rhesus (Rh) factor. One-time screening and on file at Armed Forces Repository of Specimen Samples.

4.e.5.b. Deoxyribonucleic Acid (DNA). One-time screening completed and registered at Armed Forces Medical Examiner System's (AFMES) Repository of Specimen Samples. Verification of AFMES registration is done via MRRS in the "DNA" section of the "Blood" tab of the "Comprehensive Medical Entry" for each service member.
4.e.5.c. Erythrocyte glucose-6-phosphate dehydrogenase (G6PD). One-time screening required per ref (p).
4.e.5.d. Human Immunodeficiency Virus (HIV). Screening frequency per ref (h). At minimum, every 24 months.
4.e.5.e. Sickle Cell (SC). One-time screening required for SC and SC Trait per ref (p).
4.e.6. Individual Medical Equipment.
4.e.6.a. Hearing aids. Required for all personnel needing hearing support.
4.e.6.b. Vision correction devices. Personnel needing vision correction to meet standards are required to have gas mask and ballistic corrective lens inserts and two appropriately functioning pairs of framed corrective lenses (eyeglasses) per ref (i).
4.e.6.c. Warning Tags. Required to be issued to and worn by service members for allergies, G6PD Deficiency, Sickle Cell Trait, and other applicable permanent health conditions per ref (i).
4.e.7. Hearing Readiness. All personnel shall have a baseline audiogram in their record and undergo annual surveillance audiometric testing.
4.e.8. Vision Readiness. The visual ability of all personnel shall be evaluated within the 12 months prior of entry into the MEF AO. Personnel with class 1 and 2 may deploy. Personnel in class 3 (corrected vision worse than 20/40 or uncorrected vision worse than 20/400, or who do not possess required optical devices) or class 4 (most recent vision screening or eye exam greater than within the preceding 12 months or vision classification is unknown) are not deployable. Personnel in class 3 or 4 at the time of screening will be reclassified as deployable upon their meeting corrected or uncorrected vision standards. Personnel requiring visual correction shall possess the appropriate vision correction individual medical equipment.

5. Vaccine Preventable Infectious Disease. Numerous infectious agents are present throughout the AO and pose a risk to individual health and operational capability. Immunizations provide a vital means of protection. This section provides general immunization guidance and requirements as well as information on all required and recommended routine and situationally determined immunizations for personnel within the

III MEF AO. Completion of any single or multi-dose vaccine series at least 14 days prior of travel to potential exposure area is strongly recommended.

5.a. All III MEF assigned or attached personnel will have the following immunizations marked as required in MRRS: Anthrax; Hepatitis A and B (or TwinRix may be substituted); Influenza, Northern Hemisphere; JE-VC ("JEV" in MRRS); MMR; Polio; Tetanus/Diphtheria; Typhoid; and Varicella; at a minimum, per refs (n, r). Other immunizations will be marked required based upon risk due to travel or assignment location.

5.b. Record of previous vaccination or immunity. Proof may be provided via SF 601, immunization record; Form CDC 731, International Certificate of Vaccination or Prophylaxis; DD Form 2766, Adult Preventive and Chronic Care Flow Sheet; or service immunization database record. Alternatively, proofs of immunity may satisfy applicable requirements and must be in the form of lab test results documented by an authorized laboratory. Proof of immunity alleviates the need for vaccination to meet the equivalent requirement.

5.c. Recording of immunization. Documentation of the administration of immunizations shall occur primarily in the electronic health record (EHR). If EHR documentation cannot be completed immediately or soon after vaccination, data may be entered in the applicable service medical readiness system, or on hardcopy forms referenced above when electronic resources are not available. EHR documentation shall occur at the soonest possible point thereafter.

5.d. Immunization exemptions. Health services personnel will adhere to policies and procedures relevant to exemptions, including their appropriate coding, that are contained in ref (r). III MEF HS personnel are prohibited from using exemption codes unless specifically justified per tables C-1 and C-2 of ref (r).

5.e. Medical, permanent (MP) exemptions. All MP exemptions must be supported by documentation from a credentialed healthcare provider and should be entered into the EHR for applicable members.

5.f. Medical, temporary (MT) exemptions. Medical staff must document reasons for MT exemptions in the EHR. Service members should be vaccinated at the earliest opportunity upon resolution of the issue resulting in their temporary exemption.

5.g. Mass exemptions. Entering exemptions for groups of personnel is prohibited. Notably, HS personnel are not to input MS (Medical, supply) exemptions for one or more of their supported personnel if vaccine is temporarily unavailable unless authorized by the III MEF Surgeon.

5.h. Vaccine titers. Results of positive serological lab tests will be documented in MRRS under "Tests" tab of the "Comprehensive Medical Entry" for each member. Lab tests evaluating for antibody titers against Hepatitis A and B, Measles, Mumps, Rubella, and Varicella should be completed prior to potential revaccination whenever feasible. Individuals with positive titers should not be vaccinated with the respective vaccine, and their MRRS record shall be updated to reflect the test result and the immunization exemption code Medical, immune (MI).

5.i. Immunization related adverse events. CMAs are responsible for assessing symptoms experienced by recipients during the applicable time after immunization and differentiating adverse events (AEs) from expected side effects. After identification and treatment of an AE, immunization staff shall report all applicable events via the CDC's Vaccine Adverse Event Reporting System (VAERS) per ref (q). Applicable events and their respective timelines are listed in the VAERS Table of Reportable Events Following Vaccination and on the VAERS website.

5.j. Required training for immunization staff. All staff must complete the training requirements and personnel qualification standard (PQS) of the immunization administration site with which they are associated and for all immunizations that they will be administering. Staff training shall meet standards in Appendix B of ref (r), at a minimum.

5.k. Specific vaccine requirements and recommendations. The following subsections provide guidance on individual vaccines. Full vaccination and corroborating documentation are required prior to arrival in the AO unless stated otherwise. For multi-dose immunization series, the first dose, at a minimum, should be administered prior to arrival in the AO if predeployment time is insufficient to complete series. Full vaccination must be achieved and maintained for the entire duration in the AO.

5.l. Required Immunizations.

5.l.1. Anthrax. Required for all personnel permanently assigned to III MEF. All other personnel assigned/attached to III MEF shall be immunized if assigned to the Korean peninsula for 30 or more consecutive days per refs (s, t, u, v, w). If assigned to other areas within the III MEF AO, personnel or their supporting HS staff shall seek guidance on immunization from MEF or local FHP/Preventive Medicine authorities and complete vaccination as indicated based upon assessed risk. Potential environmental exposure to naturally occurring bacterial agent exists in multiple areas throughout the AO. Additionally, exposure to weaponized bacteria remains a risk. For pre-exposure prophylaxis (PrEP), vaccine is administered in a 3-dose primary and initial

2-dose booster series at 0, 1, 6, 12, and 18 months, and subsequent boosters at 12-month intervals thereafter.
5.1.2. Hepatitis A and B. Documentation of immunization or serologic immunity required. If vaccination is completed with a combination of monovalent and bivalent vaccines, refer to ref (x) to ensure necessary doses have been received.
5.1.3. Influenza, Northern Hemisphere (NH) and Southern Hemisphere (SH). Required for all personnel projected to be present in the respective influenza zone (NH or SH) for 14 or more consecutive days between 1 October and 30 March for the NH and between 1 April and 30 September in the SH. Immunization should occur at least 2 weeks prior to entering each influenza zone delineated in ref (y). Administration of both NH and SH influenza vaccines to the same recipient should be separated by at least 28 days.
5.1.4. Japanese Encephalitis (JE). Required for all personnel permanently assigned to III MEF. All other personnel assigned/attached to III MEF shall be vaccinated if assigned to Japan or Korea for 30 or more days per ref (z) or shall seek guidance on immunization from MEF or local FHP/Preventive Medicine authorities and complete vaccination as indicated based upon assessed risk if assigned to other areas within the AO. Personnel are considered fully immunized after completing Ixiaro JE-VC two-dose series, administered at least 7 days apart, with a preference for 28-day separation. In addition, a one-time booster is required for ongoing risk and is to be administered at least 12 months after completion of the primary series. All personnel who were vaccinated prior to 2011 with a non-Ixiaro JE-VAX brand vaccine are considered insufficiently vaccinated and must complete the two-dose Ixiaro series.
5.1.5. Measles, Mumps, Rubella (MMR). Documentation of immunization or serologic immunity is required. Series completion requires 2 doses separated by 28 days.
5.1.6. Meningococcal. Primary 2-dose series required. Per ref (r), booster dose recommended for personnel deploying to endemic or hyperendemic regions as defined by the CDC or World Health Organization (WHO).
5.1.7. Polio. Completion of series is required. May be 4-dose pediatric series or 3-doses for adults not previously vaccinated. Adult series schedule is second dose 1-2 months after first dose, and third dose 6-12 months after second dose. Completion of the primary series may be assumed for all persons except as dictated in para 4-13c of ref (r).
5.1.8. Polio Booster. Per ref (n), single lifetime booster dose of inactivated polio vaccine (IPV) is required for personnel deploying to regions with polio transmission, as designated by the CDC or WHO.

5.l.9. Smallpox. Required for deployment to the Korean peninsula per ref (s). However, this immunization program remains paused until formal policy guidance is issued by DoD and Department of the Navy.
5.l.10. Tetanus, Diphtheria, and Pertussis. Applicable adult vaccine formulations are Tetanus-diphtheria (Td) and Tetanus-diphtheria-acellular pertussis (Tdap). Td or Tdap is required every 10 years. Also administer in the setting of unclean significant wounds if vaccination occurred more than 5 years prior to injury. For personnel who have never received a dose of Tdap, one dose shall be given regardless of interval since last tetanus-containing vaccination, followed by Td or Tdap boosters every 10 years.
5.l.11. Typhoid. Required. High prevalence of disease throughout the AO. Injectable and oral vaccines are both acceptable. Current if injectable received within two years or oral received within five years.
5.l.12. Varicella. Required for personnel without evidence of immunity provided via any of the following: documented two doses of varicella-containing vaccine received at least four weeks apart; U.S.-born before 1980 (not applicable for healthcare workers); laboratory evidence of immunity (positive antibody titer); history of varicella or herpes zoster diagnosed or verified by healthcare provider.
5.m. Situationally indicated immunizations.
5.m.1. Cholera. Indicated for deployments into regions with an ongoing cholera outbreak, certain humanitarian, and disaster relief operations, and other high risk situations.
5.m.2. Pneumococcal. Recommended for persons over 65 years of age and those older than 18 years of age with high risk underlying conditions and risk factors per the U.S. CDC’s Advisory Committee on Immunization Practices (ACIP).
5.m.3. Rabies. Pre-exposure prophylaxis (PrEP) immunization is indicated for at-risk personnel, including special operations personnel and specific occupational work groups, e.g., veterinary workers, animal controllers and handlers, specific laboratory workers, and those with potential contact with wildlife. Post-exposure prophylaxis (PEP) should be given, under the guidance of a CMA, to all personnel at risk. Administration of PEP should occur immediately upon identification of and preferably no later than 72 hours after at-risk contact. Delay in PEP may result in significant morbidity and mortality for those exposed and infected.
5.m.4. SARS-CoV-2 (COVID-19). Being up to date with primary series and booster immunizations is highly recommended. Personnel must comply with foreign host nation vaccination or

testing entry requirements per refs (aa, n). No longer a current requirement IAW refs (ab, ac, ad).
5.m.5. Tickborne Encephalitis (TBE). May be indicated for travel to risk areas as designated by the CDC or by FHP guidance for individual operational activities.
5.m.6. Yellow Fever. Yellow Fever vaccine (YF-VAX) is required for entry into multiple countries within the USINDOPACOM AOR when traveling from, or transiting through, endemic areas. Review refs (ae, aj) for guidance on immunization requirement and verifying documentation.
5.n. Other Immunizations. Information and guidance governing additional immunizations (e.g., those against Ebola, Haemophilus influenzae serotype b, Human papillomavirus, Zoster) are contained in ref (r) and ACIP recommendations. Every opportunity should be taken to encourage and ensure receipt of the most appropriate immunization coverage among personnel.

6. Infectious disease prevention through the use of prescription medication (Chemoprophylaxis).
6.a. Multiple diseases, none of which have an authorized or approved vaccine, may be mitigated by prescription medication. Chemoprophylaxis may take the form of pre-exposure or post-exposure prescribed medication. Prior to provision of chemoprophylaxis, characteristics of each potential recipient's health status and the potential for medication related adverse effects must be evaluated by a CMA.
6.b. Malaria. Risk varies significantly throughout the AO. There is no known indigenous risk in Japan and Hawaii. Units deploying to other areas must review current risk assessments and should seek guidance from a competent FHP or preventive medicine authority. MEF Surgeon will determine levels of risk for areas throughout the AO and will make the information available through exercise messages and deployment briefs. Component surgeons should consider seeking input on malaria chemoprophylaxis for their units from III MEF Preventive Medicine/FHP. Requests to review chemoprophylaxis plans submitted to the MEF Surgeon should include the deployment duration, location, billeting, type of activities expected, and anticipated exposure to mosquitoes from dusk through dawn, at a minimum.
6.b.1. Malaria chemoprophylaxis is not completely fail proof. Personal protective measures include minimizing exposed skin by wearing sleeves and pant legs down, using effective repellent, and appropriate use of an insecticide treated bed net.
6.b.2. Malaria chemoprophylaxis medication options and method of administration. Malarone and doxycycline are the primary medications of choice throughout the AO. Mefloquine may be used

for personnel with contraindications to Malarone and doxycycline. Due to widely distributed resistant throughout the AO, mefloquine should be avoided in all other cases. Malarone is started 2 days before going into an area with malaria, taken daily while in the risk area, and for 7 days after leaving. Doxycycline is started 2 days prior to arrival in risk area, continued throughout deployment and for an additional 28 days after return. Personnel on flight status must adhere to a 48-hour initial grounding period after starting/restarting doxycycline and a 24-hour period for Malarone, after which they may continue active flight status unless directly differently by their aerospace medicine provider. Other special duty personnel, including those on dive status, must consult their respective supporting operational medical provider for guidance. Directly observed ingestion of chemoprophylactic medication is strongly recommended whenever feasible.

6.b.3. Presumptive anti-relapse therapy (PART). Forces deploying to areas associated with elevated risk of malaria due to Plasmodium vivax and ovale species should receive and complete PART. Prior to prescribing any medication for PART, potential recipients must be screened by laboratory study for G6PD enzyme deficiency. PART should not be prescribed to individuals found to have G6PD deficiency. Upon identification of normal G6PD activity, Primaquine or Tafenoquine may be considered for chemoprophylaxis against relapsing malaria. Choice of medication should be based upon recipient health status and likelihood of adherence. The CDC recommends primaquine be dosed at 30mg base daily for 14 days for maximum effectiveness, starting the day of departure from malaria risk area. The CDC recommendation for tafenoquine is to be dosed at 300 mg and taken one time with food on same day of the last dose of malaria prophylaxis. For deployments and exercises that do not meet this risk threshold, consult local or MEF FHP/Preventive Medicine.

6.c. Human Immunodeficiency Virus (HIV). Pre-Exposure Prophylaxis (PrEP) should be considered and recommended for all personnel at increased risk based upon routes of potential exposure and individual risk factors.

6.d. Leptospirosis. If contact with potentially contaminated water is unavoidable due to training or operational requirements, prophylaxis must be considered per ref (af). Prophylaxis must be considered for risk areas throughout the entire AO.

6.e. Traveler’s Diarrhea. Routine chemoprophylaxis for this illness is not recommended. May be indicated based upon risk and potential impact of illness upon operational capability or completion of travel objectives.

6.f. Information on chemoprophylaxis for other diseases, including anthrax, group a streptococcus, influenza, meningococcal, plague, scrub typhus, and smallpox, may be found in ref (r) and as published by the CDC.

7. Prevention of communicable diseases for which no vaccine or chemoprophylaxis is available [or is not approved, authorized, or available in the U.S.].
7.a. Numerous diseases that deployers are at risk of acquiring throughout the AO are not preventable by vaccine or prophylactic medication. Given this risk, it is essential for HS personnel to educate and train their supported personnel on personal protective measures. Leaders are encouraged to incorporate FHP education and training on a routine as well as a specific basis. It should address risk associated with recreational activities in addition to that inherent in occupational and operational activities. It should avoid complicated medical jargon and be easily understood by personnel of all educational backgrounds and occupational specialties.
7.b. Tuberculosis (Tb). Service members are screened annually via questions contained within the electronic PHA (ePHA). If the ePHA is unavailable and health assessment is completed via hardcopy, then NAVMED 6224/8 Tuberculosis Exposure Risk Assessment must be included in the PHA process per ref (ag). Providers are required to evaluate all members with elevated risk of having become infected. When deciding upon initial testing via a tuberculin skin test (TST) or interferon-gamma release assay (IGRA), probable or known history of Bacille Calmette-Guérin (BCG) immunization should be considered. If personnel with elevated Tb risk are known to be BCG vaccinated, or to have likely been vaccinated based upon vaccination coverage in their country of birth or youth, IGRA should be the screening test of choice to avoid a potentially false-positive TST result. If IGRA is unavailable, then TST should be done, and the result interpreted per CDC guidelines.
7.b.1. Tb converters (TST or IGRA positive) and latent Tb. Converters should be evaluated by a CMA and cleared of active Tb disease. Those cleared of active disease are considered to have latent Tb infection and should be treated per CDC guidelines. Latent Tb is not a communicable infection but is associated with potential transition to active disease. Personnel with latent Tb are deployable if medically cleared and able to adhere to and, when applicable, complete the required medication regimen during deployment.

8. Womens Health Protection. Female service members are vital to force strength and capability. Preventive health screenings

for this portion of the force are important components of FHP. Health services personnel should prioritize facilitation of these tasks to ensure their timely completion.
8.a. Cervical cancer screening. All service members between the ages of 21 and 65 with a cervix should undergo screening at the clinically indicated frequency per U.S. Preventive Services Task Force (USPSTF) guidelines. Most recent screening date and frequency to next exam should be tracked and documented/updated in the "Pap/Mammogram" portion of the "Exams" tab of the "Comprehensive Medical Entry" in MRRS. Health services personnel are strongly encouraged to evaluate completion of cervical cancer screening among their supported personnel on at least a quarterly basis, and to contact those delinquent to encourage completion.
8.b. Breast cancer screening. Female service members between age 50 and 74 should be screened biennially, per USPSTF guidelines. Date of most recent mammogram and frequency to next indicated exam should be tracked and documented in the same manner as for cervical cancer screening.

9. Deployments. The following subsections provide additional guidance and requirements for FHP activities centered on deployments, from predeployment through postdeployment. The full range of predeployment activities to be completed by HS personnel and/or their supported personnel are listed in tables 1, 2, and 3 of ref (ai) and should be referred to in planning and execution. The full range of applicable predeployment activities are required to be completed by personnel deploying for more than 30 consecutive days outside the United States. OCONUS deployments of shorter duration require a subset of these requirements at the commander's discretion. Select FHP requirements are outlined below.
9.a. Predeployment.
9.a.1. FHP planning. Commanders should integrate FHP into the operational planning process early. Health services personnel should conduct comprehensive research to inform FHP planning, including health threat assessment and identification of countermeasures. Information should be collected on communicable diseases, vector behavior and geographic distribution, environmental hazards, and occupational and recreational exposures in all potential operating areas and situations. Occupational groups with unique health requirements, for example, aviation and undersea personnel, should be accounted for. Health services personnel should utilize all applicable informational sources in developing their planning input and guidance. Relevant sources may include web-based informational products (e.g., refs ak, al), peer-reviewed research, DoD Food

Water Risk Assessments (FWRA), Occupational and Environmental Site Health Assessments (OEHSA), and After-Action Reports (AAR), among others.

9.a.2. Foreign Entry Requirements. Deploying units should assess and mitigate the entry requirements, including immunization status, for personnel deploying or redeploying to all areas within the AO. DoD foreign clearance guidance may be currently found at ref (aj) and on the websites of respective U.S. Embassies.

9.a.3. FHP education and training. Deploying personnel are required to be informed and instructed in relevant force health protection topics and procedures per refs (ah, ai). FHP briefs should cover risk level, avoidance techniques, and countermeasures for communicable infections, environmental hazards, occupational and recreational injuries, operational stress control methods, use of personal protective equipment, and guidance against self-medicating with medications that may exacerbate the potential complications associated with certain illnesses. Personnel should be briefed on not self-treating with aspirin, ibuprofen, or aspirin/ibuprofen-containing products, which increase the risk of bleeding complications associated with some viral infections acquired via mosquito bites. Training and education for non-medical personnel should be provided in the most accessible format and technique, and formal medical language should be avoided unless necessary for clarity.

9.a.4. Medical and dental readiness. All personnel must meet IMR standards for deployment and, at a minimum, be fully or partially medically ready and dental readiness category 1 or 2. No personnel with an overdue PHA should deploy per ref (am). Personnel in PMR status must not deploy if their missing requirements are associated with high risk based upon their deployment location and/or projected activities. Required immunizations should be up to date and personnel should have been given the opportunity to receive recommended situational immunizations appropriate for their deployment. All individual medical equipment should be on hand and in good working condition.

9.a.5. Deployment-limiting conditions (DLMC). Per refs (e, f, n), any unresolved health problems that warrant significant duty or mobility limitations disqualify personnel from deployment. Additionally, any health condition that falls into the below subcategories is disqualifying.

9.a.5.a. Unresolved acute illnesses and injuries that may impair duty performance during a significant portion of deployment.

9.a.5.b. Prevents the appropriate wear of personal protective equipment and products to include insect repellent, permethrin

treated uniforms, and Chemical Biological Radiological Nuclear Defense (CBRN-D) Individual Protective Equipment (IPE).
9.a.5.c. Precludes immunization with required vaccines.
9.a.5.d. Requires continued medical specialty care.
9.a.5.e. Necessitates specialty medications or durable medical equipment that are not provided prior to or will not last throughout the entire deployment period.
9.a.5.f. Mental health conditions and/or their treatment, including medications and their dosage, that are not stable for 90 or more days prior to deployment.
9.a.6. Waivers for non-deployable members.
9.a.6.a. Waiver routing. Requests to deploy members who do not meet deployment health suitability standards shall be routed by their command through the respective III MEF element or subordinate command to the MEF Surgeon as soon as personnel are identified. Personnel for whom waivers are requested shall not deploy unless waiver is granted.
a.5.5. Waiver requests must be submitted for:
9.a.5.5.1. All personnel taking psychotropic medication, including antidepressants, whose condition has been stable for 90 days on their current dose.
9.a.5.5.2. History of inpatient psychiatric hospitalization.
9.a.5.5.3. Use of psychotropic medications for non-psychiatric conditions.
a.5.6. Waivers will be considered for:
9.a.5.6.1. Personnel with psychiatric conditions and who have residual symptoms if discharged from psychiatric care and stable on any non-disqualifying pharmacologic therapy for 90 days.
9.a.5.6.2. Off-label prescription and use of anti-psychotic and anti-seizure medications for pain management, sleep issues, PTSD, or other conditions.
a.5.7. d. Waivers shall not be grated for psychotic, bipolar, or seizure disorders.
9.a.6. Pre-Deployment Health Assessment (PDHA). Required to be completed within 120 days of deployment date for deployments of 30 or more consecutive days to locations without access to a DoD-funded Medical Treatment Facility (MTF) per refs (ah, ai).
9.a.7. Baseline neurocognitive assessment. Required within 12 months, and preferably 4-6 months, prior to deployment to all OCONUS locations where or operations during which traumatic brain injury (TBI) is an increased risk and that is without short interval access to a DoD-funded Medical Treatment Facility (MTF) per refs (an, ao, ap, ah, ai, ar, aq). 31st MEU, 3d MEB, and any other forces that serve as the Alert Contingency MAGTF (ACM), will maintain neurocognitive assessment currency by completing annual testing to support of comprehensive medical readiness for rapid deployment.

9.a.8. Tuberculosis screening, pre-deployment. All deployers should be evaluated, either through the ePHA or dedicated screening, for latent and active tuberculosis infection within the 12 months prior to deployment as outlined in section 7.b. Personnel deploying to a high risk area or who will potentially have routine contact with a high risk population (prisons, healthcare facilities, homeless or displaced persons) should be tested via TST or IGRA. For rapid deployments, IGRA should be the test of choice. Tb converters are deployable if satisfying the conditions in section 7.b.1.

9.a.9. Laboratory Studies.

9.a.9.a. Pregnancy screening, by urine or blood lab test, is required no earlier than 14 days and no later than 10 days prior to deployment date for all personnel with the anatomic capability of becoming pregnant per refs (as, au). Testing will be conduct by the supporting medical department via the supporting laboratory. Personnel identified as pregnant shall not deploy and command notification and final deployability determination shall follow refs (at, av).

9.a.9.b. Serum specimen, that is contained within the DoD Serum Repository (DoDSR), is required within 12 months of deployment. HIV lab may serve as the serum specimen if completed and contained in the DoDSR within 12 months of deployment date.

9.a.9.c. HIV screening is required within 24 months of deployment per refs (h, ah, ai).

9.a.10. Prescription medication. All personnel requiring long-term use of prescription medication will deploy with at minimum a 90-day supply of all medications per ref (n). For all deployments, personnel using prescribed medication for contraception shall be prescribed a supply to cover the entire deployment period per ref (aw). For deployments to areas without a local medical treatment center from which FDA-approved medication may be obtained, deploying personnel must deploy with a supply to cover the entire deployment period. Commanders, with guidance from their HS personnel, should consider the medication needs of identified deployers and the impact of lost or unviable medication upon those personnel when re-supply on deployment is improbable.

9.a.11. Medical equipment. Personnel who must wear contact lenses to achieve vision standards, who cannot satisfactorily perform their occupational specialty with their best corrected vision using eyeglasses or fall below vision retention standards with their most appropriate eyeglass prescription should not deploy. Contact lens wear is not authorized in field environments or while deployed with the exception of aviators/air crew. All personnel will deploy with 2 pairs of eyeglasses per ref (i).

9.b. Deployment and Postdeployment. While deployed and after redeployment, it is essential for HS personnel to continue to surveil for health threats relevant to and among their supported personnel. At a minimum, HS personnel should conduct the broadest range of health services and support functions applicable from those listed in the tables 2 and 3 of ref (ai) and detailed in refs (ah, ai, ax).
9.b.1. Animal Bites. Timely identification and treatment of applicable contact with wildlife is essential to early, potentially lifesaving treatment of rabies infections. Health services personnel will evaluate all wildlife encounters by their supported personnel and initiate treatment and reporting when appropriate per ref (ay).
9.b.2. Tuberculosis screening, post-deployment. Tb is endemic in many areas throughout the AO and remains a risk for deployers. Personnel with high risk travel and/or exposures while deployed must be appropriately screened per ref (ag).

10. Health Surveillance and Reporting of Reportable Medical Events (RME). Health services personnel shall familiarize themselves with ref (az), the Armed Forces Reportable Medical Events Guidelines and Case Definitions. These RMEs represent the communicable and environmental disease non-battle injury (DNBI) threats of broadest risk to personnel health and potential disruptive impact to operations. Per refs (ba, bb, bc), it is required that HS personnel surveil for and report all RMEs. RMEs shall be reported via ref (bd), the Disease System Reporting internet (DSRi), and to MEF FHP/Preventive Medicine (iiimefprevmed@usmc.mil). For units without DSRi access, guidance on obtaining an account is currently found at https:[slashslash]www.med.navy.mil/Navy-Marine-Corps-Public-Health-Center/Preventive-Medicine/Program-and-Policy-Support/Disease-Surveillance/DRSI and may also be obtained through MEF FHP/PM or the regional Navy Environmental and Preventive Medicine Unit (NEPMU), e.g., NEPMU-6 in Hawaii.

11. Additional FHP resources. Health services personnel are strongly encouraged to familiarize themselves with the references to this message. For detailed information concerning specific operations, refer to the most current country and/or exercise FHP messages, Annex Qs, and higher echelon command directives. Guidance may be sought from III MEF Health Services Support (HSS) POCs listed above.