

**BY ORDER OF THE  
SECRETARY OF THE AIR FORCE**



**AIR FORCE INSTRUCTION 48-135**

**12 MAY 2004**

Incorporating Change 1, 7 August 2006

***Aerospace Medicine***

**HUMAN IMMUNODEFICIENCY  
VIRUS PROGRAM**

**COMPLIANCE WITH THIS PUBLICATION IS MANDATORY**

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This instruction implements AFPD 48-1, *Aerospace Medical Program*, and Department of Defense (DoD) Directive 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)*, March 19, 1991, with Change 1. It outlines the Air Force Human Immunodeficiency Virus (HIV) program and updates responsibilities and procedures for identification, surveillance, and administration of Active Duty Air Force personnel. The Air National Guard (ANG) and Headquarters Air Force Reserve Command (HQ AFRC) utilize this instruction along with supplements to provide specific guidelines for the administration of Air Reserve Component (ARC) personnel infected with HIV. Headquarters Air Reserve Personnel Center (HQ ARPC) utilizes AFI 48-135 as guidance for Individual Mobilization Augmentees (IMA), with local MTF's as the notifying agent. This instruction requires collecting and maintaining information protected by the Privacy Act of 1974. This is authorized by 10 U.S.C., Chapter 55, *Medical and Dental Care*, 10 U.S.C., Sec. 8013, *Power and Duties of the Secretary of the Air Force*, and Executive Order 9397. Systems Record Notices F044 AF SG E, *Medical Records System*, and R, *Reporting of Medical Conditions of Public Health and Military Significance*, apply. Maintain and dispose of records created as a result of prescribed processes in accordance with AFMAN 37-139, *Records Disposition Schedule*. Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels, to AFMOA/SGOP, 110 Luke Avenue, Room 405, Bolling AFB DC 20332-7050. See [Attachment 1](#) for a glossary of references, abbreviations, acronyms, and terms.

**SUMMARY OF CHANGES**

This interim change implements new guidelines that update requirements for TB tests and the HIV-1 disease classification system found in [Attachment 9](#). A bar ( | ) indicates a revision from the previous edition.

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## 1. Responsibilities:

- 1.1. HQ USAF/SG provides facilities, manpower, and funds to collect HIV testing specimens of Air Force (AF) personnel, to medically evaluate all HIV positive active duty (AD) members, and to ensure spouses and contacts of HIV infected AD members are notified, counseled, and tested appropriately.
- 1.2. HQ AFRC/SG ensures reserve personnel are HIV tested and spouses and contacts of HIV infected reserve personnel are notified appropriately.
- 1.3. HQ ANG/SG ensures ANG personnel are HIV tested and spouses and contacts of HIV infected ANG personnel are notified appropriately.
- 1.4. HQARPC/SG ensures IMA personnel are HIV tested and spouses and contacts of HIV infected IMA personnel are notified appropriately.
- 1.5. HQ AFMC/SG provides facilities, funds, and manpower to the Institute for Environment, Safety and Occupational Health Risk Analysis, (referred to here as USAF HIV Testing Services), to perform HIV testing, epidemiological analysis of HIV tests done on all ADAF personnel and their dependents that are tested and support the DoD Serum Repository.
- 1.6. HQ AETC/SG provides facilities, funds, and manpower to medically evaluate all ADAF HIV positive members.
- 1.7. Wilford Hall Medical Center (WHMC) medically evaluates all ADAF HIV positive members initially and every six months while on active duty.

**2. HIV Program.** The AF tests all members for antibodies to the human immunodeficiency virus, medically evaluates all AD infected members, and educates members on means of prevention.

## 3. Program Elements:

- 3.1. All applicants for enlistment or appointment to the AF or ARC are screened for evidence of HIV infection (**Attachment 3**). Applicants infected with HIV are ineligible for enlistment or appointment to the AF and the ARC. Waiver for HIV infection is not authorized.
- 3.2. All ADAF personnel are screened for serological evidence of HIV infection every two years, preferably during their Preventive Health Assessment (PHA); for clinically indicated reasons; with newly diagnosed active tuberculosis; during pregnancy; when diagnosed with a sexually transmitted disease (STD); upon entry to drug or alcohol treatment programs (**Attachment 4**), or prior to incarceration. HIV testing is conducted IAW **Attachment 4**, recorded IAW **Attachment 5**, and interpreted IAW **Attachment 6**.
- 3.3. ARC personnel are screened for serological evidence of HIV infection at an interval not to exceed five years, preferably during their PHA (Reserve Component PHA or ARCPHA). ARC members will have a current HIV test within two years of the date called to active duty for 30 days or more. HIV testing is conducted IAW **Attachment 4**, recorded IAW **Attachment 5**, and interpreted IAW **Attachment 6**.
- 3.4. Civilian employees are tested for serological evidence of HIV to comply with host nation requirements for screening of DoD employees (**Attachment 7**) and in occupationally related exposures.

3.5. All ADAF personnel testing positive are counseled by a physician, preferably the MTF designated HIV physician, regarding the significance of a positive test. They are given information on modes of transmission, appropriate precautions, and future risks. ADAF members are administered an order to follow preventive medicine requirements as described in [Attachment 8](#). ARC members will be administered this order after their unit commander has determined they can be utilized in the Selected Reserve, and have been found medically qualified for nondeployed military duty by the appropriate ARC SG. All eligible beneficiaries are offered counseling. IAW DoDD 6485.1 *Human Immunodeficiency Virus-1 (HIV-1)*, spouses and contacts of HIV infected ARC members are notified of potential exposure to HIV infection when permitted by state or local law and offered the opportunity for HIV screening and counseling at the supporting ARC or AD MTF. Secretarial designee procedures IAW AFI 41-115 are used to provide this service to spouses of HIV infected ARC members in AD and ARC medical facilities.

3.6. All ADAF members, and ARC members on extended active duty testing positive for HIV, are referred to WHMC for medical evaluation and medical evaluation board (MEB) to determine fitness for duty. ARC members not on extended duty are evaluated to determine their fitness for duty only after their immediate commander has determined whether or not the member may be utilized in the selected reserve. In the case of an ANG member, it is only required if the state identifies a nonmobility, nondeployable position in which the member can be retained. The medical evaluation follows the standard clinical protocol outlined in [Attachment 9](#) and utilizes procedures for evaluating T-helper cell counts described in [Attachment 13](#). ARC members not on extended active duty must obtain a medical evaluation that meets the requirements of [Attachment 9](#) from their civilian healthcare provider (in the case of the ANG, only if the state identifies a nonmobility, nondeployable position in which the member can be retained). An epidemiological assessment (including sexual contacts and history of blood transfusions or donations) is conducted to determine potential risk of HIV transmission (see [Attachment 12](#)).

3.7. ADAF members found fit for duty are not separated solely for HIV seropositivity. HIV infected ARC members not on extended active duty or full-time ANG duty shall be transferred to the Standby Reserve only if their immediate commander determines the member cannot be utilized in the Selected Reserve. Members shall be retained or separated as outlined in [Attachment 10](#).

3.8. HIV infected ADAF members retained on active duty and ARC members retained in the Selected Reserve must be medically evaluated semiannually, and assigned within the continental United States (CONUS), and Alaska, Hawaii, or Puerto Rico. ARC HIV infected members may not be deployed outside of CONUS (except for Alaska, Hawaii, and Puerto Rico) or perform tours of active duty for more than 30 days duration. HIV-infected members shall not be assigned to mobility positions, and those on flying status must be placed on Duty Not Including Flying (DNIF) status pending medical evaluation. Waivers are considered using normal procedures established for chronic diseases. Members on the Personnel Reliability Program (PRP) or other security sensitive positions shall be removed pending medical evaluation. Unit commanders, with medical advice from the Medical Facility Commander (MFC), evaluate each individual on a case-by-case basis for return to PRP or other security sensitive positions. The Secretary of the Air Force may, on a case-by-case basis, further limit duties and assignment of members to protect the health and safety of the HIV-infected member or other members. Submit such request to Office of the Secretary of the Air Force, Air Force Pentagon, Washington, DC 20330-1670.

3.9. Commanders and other personnel comply with limitations on the use of information obtained during the epidemiological assessment of HIV-infected members as outlined in [Attachment 11](#).

3.10. Public Health (PH) provides HIV education to all ADAF members, offers education to other eligible beneficiaries, maintains list of gaining HIV positive personnel, reports to gaining bases their HIV positive personnel, and educates HIV positive members and their dependents.

3.11. The USAF HIV Testing Branch, a branch of the Air Force Institute for Environment, Safety and Occupational Health Risk Analysis (AFIERA), performs HIV testing of submitted specimens. The Risk Analysis Directorate (RS) conducts epidemiological surveillance for HIV infection in Air Force members and dependents.

3.12. AF blood centers follow policies of the Armed Services Blood Program Office, Food and Drug Administration (FDA), and the accreditation requirements of the American Association of Blood Banks (AABB).

3.13. Routine HIV testing is suspended in declared combat zones, defined as those areas where hostile pay is authorized.

3.14. Force-wide, HIV-infected employees are allowed to continue working as long as they are able to maintain acceptable performance and do not pose a safety or health threat to themselves or others in the workplace. If performance or safety problems arise, managers and supervisors address them using existing personnel policies and instructions. HIV-infected healthcare workers, however, should be relieved from patient care responsibilities until counsel from an expert review panel has been sought. In accordance with the most recent guidelines from the Centers for Disease Control and Prevention Guideline for Infection Control in Healthcare Personnel, an expert panel will advise the healthcare worker on work restrictions. For active duty personnel, this expert panel will be convened at Wilford Hall Medical Center during the individual's initial HIV evaluation. For non-active duty healthcare workers, the expert panel will be convened at the local facility and should include participation from two members from the WHMC expert panel (via telephone conference call) to ensure organizational consistency.

3.15. Each MAJCOM will provide the HIV unit at WHMC with an up-to date list of their MTF-designated physicians.

**4. HIV Testing Measurement.** The Air Force goal is to reduce the incidence of HIV infection in personnel. AFIERA tracks trends of HIV incidence in AF members. Air Force labs that do their own HIV testing must communicate test results and ship corresponding serum specimens to USAF HIV Testing Services so they may update the Reportable Disease Data Base (RDDDB), ship samples to the DoD serum repository, and track trends.

**5. Forms.** AF Form 1762, *HIV Log/Specimen Transmittal*, will be used for requesting HIV testing and specimen transmittal (see [Attachment 5](#)). AF Form 3844, *HIV Testing Notification Form*, will be used to notify personnel of required HIV testing (see [Attachment 14](#)). AF Form 3845, *Preventive Medicine Counseling Record*, will be used to record counseling provided for HIV positive individuals (see Atch 16).

**6. Forms Prescribed:** AF Form 1762, *HIV Log/Specimen Transmittal*.

AF Form 3844, *HIV Testing Notification Form*.

AF Form 3845, *Preventive Medicine Counseling Record*.

CHARLES B. GREEN, Major General, USAF, MC, CFS  
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**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

Title 29, United States Code, Section 794, *Non-Discrimination Under Federal Grants and Programs*, current edition

DoD Directive 1332.18, *Separation From the Military Service by Reason of Physical Disability*, November 4, 1996

DoD Instruction 1332.38, *Physical Disability Evaluation*, November 14, 1996

DoD Directive 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)*, March 19, 1991, Change 1

AFPD 48-1, *Aerospace Medical Program*

AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*

AFI 41-115, *Authorized HealthCare and HealthCare Benefits in the Military Health Services System (MHSS)*

AFI 48-123, *Medical Examination and Standards*

AFI 44-108, *Infection Control Program*

CDC. *1998 Guidelines for treatment of sexually transmitted diseases*. MMWR 1998;47(No. RR-1):1-111.

CDC. *HIV Prevention through Early Detection and Treatment of Other Sexually Transmitted Diseases--United States Recommendation of the Advisory Committee for HIV and STD Prevention*. MMWR 1998;47(No. RR-12):1-24.

CDC. *Public Health Service guidelines for counseling and antibody testing to prevent HIV infection and AIDS*. MMWR 1987;36:509-15.

CDC. *Public Health Service Guidelines for the Management of Health-Care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis*. MMWR 1998;47(RR-7);1-28.

CDC. *Recommendations of the U.S. Public Health Service Task Force on the use of zidovudine to reduce perinatal transmission of human immunodeficiency virus*. MMWR 1994;43(No. RR-11):1-20.

CDC. *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*. MMWR July 12, 1991;40(No. RR-08).

***Abbreviations and Acronyms***

**AABB**—American Association of Blood Banks

**ADAF**—Active Duty Air Force

**AETC**—Air Education and Training Command

**AFMC**—Air Force Materiel Command

**AFMOA**—Air Force Medical Operations Agency

**AFMOA/SGOC**—Air Force Medical Operations Agency, Surgeon General's Office of Consultants

**AFPC**—Air Force Personnel Center  
**AFPC/DPAMM**—Air Force Personnel Center/Medical Standards Branch  
**AFPD**—Air Force Policy Directive  
**AFRC**—Air Force Reserve Command  
**AIDS**—Acquired Immunodeficiency Syndrome  
**ANGB**—Air National Guard Bureau  
**ARC**—Air Reserve Component (Air Force Reserve and Air National Guard)  
**ASD**—Assistant Secretary of Defense  
**CDC**—Centers for Disease Control and Prevention  
**CFU**—Colony Forming Units  
**CHCS**—Composite Healthcare System  
**CNS**—Central Nervous System  
**CONUS**—Continental United States  
**COT**—Consecutive Overseas Tour  
**CPF**—Civilian Personnel Flight  
**DAF**—Department of the Air Force  
**DBMS**—Director, Base Medical Services  
**DoD**—Department of Defense  
**DoDSR**—Department of Defense Serum Repository  
**DNIF**—Duty Not Including Flying  
**DSN**—Defense Switched Network  
**ELISA**—Enzyme Linked Immunosorbent Assay  
**FDA**—Food and Drug Administration  
**FM**—Flight Medicine  
**FM & P**—Force Management and Personnel  
**FMP**—Family Member Prefix  
**HBV**—Hepatitis B virus  
**HIV**—Human Immunodeficiency Virus (the virus that causes AIDS)  
**HQ AETC**—Headquarters Air Education and Training Command  
**HQ AFRC/SG**—Headquarters Air Force Reserve Command Surgeon  
**HQ ANG/SG**—Headquarters Air National Guard Command Surgeon  
**HQ USAF**—Headquarters US Air Force

**ICD-9**—International Classification of Diseases, Revision 9

**IMA**—Individual Mobilization Augmentee

**AFIERA**—Air Force Institute for Environment, Safety, & Occupational Health (ESOH) Risk Analysis (IERA)

**IFA**—Immunofluorescent Antibody test

**MAJCOM**—Major Command

**MEB**—Medical Evaluation Board

**MFC**—Medical Facility Commander

**MI**—Milliliter

**MPF**—Military Personnel Flight

**MTF**—Medical Treatment Facility

**NAT**—Nucleic Acid Testing

**NGB**—National Guard Bureau

**OB**—Obstetrics

**OI**—Opportunistic Infection

**OS**—Overseas

**OSHA**—Occupational Safety and Health Association

**OTS**—Officer Training School

**PCS**—Permanent Change of Station

**PE**—Physical Examination

**PES**—Physical Examination Section

**PH**—Public Health

**PPD**—Purified Protein Derivative

**PQAM**—Program Quality Assurance Monitor

**PRP**—Personnel Reliability Program

**RDDDB**—Reportable Disease Data Base

**ROTC**—Reserve Officer Training Corps

**SAF**—Secretary of the Air Force

**SF**—Standard Form

**SG**—Surgeon General

**SSN**—Social Security Number

**STD**—Sexually Transmitted Disease

**TDY**—Temporary Duty

**USA**—United States Army

**USCG**—United States Coast Guard

**USMC**—United States Marine Corps

**USN**—United States Navy

**UCMJ**—Uniform Code of Military Justice

**USUHS**—Uniformed Services University of the Health Sciences

**WB**—Western Blot

**WHMC**—Wilford Hall Medical Center

**WNL**—Within Normal Limits

### *Terms*

**Air Reserve Component** —Air Force Reserve and Air National Guard components of the Air Force

**Department of Defense Civilian Employees** —Current and prospective DoD US civilian employees. Does not include members of the family of DoD civilian employees, employees of, or applicants for, positions with contractors performing work for DoD, or their families.

**Enzyme Linked Immunosorbent Assay** —A screening test read as ‘reactive’ if the results are above a calculated cutoff.

**Epidemiological Assessment** —The process by which personal and confidential information on the possible modes of transmission of HIV are obtained from an HIV-infected person. This information is used to determine if previous, present, or future contacts of the infected individual are at risk for infection with HIV and to prevent further transmission of HIV.

**Host Nation** —A foreign nation to which DoD US civilian employees are assigned to perform their official duties.

**Human Immunodeficiency Virus** —The virus resulting in AIDS.

**Positive** —True positive test is an indicator of a condition being present

**Reserve Component** —Components of the Air Force Reserve and Air National Guard.

**Reactive** —Reacts with the reagent antibody test that produces a visible result

**Serologic Evidence of HIV Infection** —A reactive result given by a FDA approved enzyme-linked immunosorbent assay (ELISA) serologic test that is confirmed by a reactive and diagnostic immunoelectrophoresis test (Western Blot [WB]) test on two separate samples.

**Western Blot Test** —A qualitative assay for the detection and identification of antibodies of HIV-1 contained in human serum. It is intended for use with persons of unknown risk as an additional more specific test on human serum specimens found to be repeatedly reactive using a screening procedure such as ELISA.

**Attachment 2****PREVENTION THROUGH EDUCATION AND TRAINING**

**A2.1.** USAF HIV Prevention Course. The USAF HIV Train the Trainer Prevention Course is currently a formal AETC 5 day interactive academic course designed to instruct the base HIV Resource Team about HIV/AIDS and its prevention. The recommended HIV Resource Team consists of the HIV designated physician, dentist, Infection Control Officer (ICO), and Public Health. Other interested personnel working with HIV patients and/or prevention programs may be assigned to the resource team. In ANG units, the HIV Resource Team is headed by the best-qualified person and consists of the ICO, a physician, and any other members who are qualified and interested in serving. This course is updated according to current medical information and supports Tri-Service prevention activity.

**A2.2.** The HIV Resource Team educates the beneficiary population on an ongoing basis, using various effective strategies.

**A2.3.** HIV prevention activities are integrated into other base programs and MTF prevention programs. A member of the HIV Resource Team is a participant in the Base Health Promotion Working Group and MTF Prevention Committee.

**A2.4.** Education on sexually transmitted diseases (STDs) is tailored to the recipient and routinely integrated in the Preventive Health Assessment (PHA), Put Prevention Into Practice (PPIP), and Health and Wellness Center (HAWC) services; during pertinent clinical encounters; and in threat briefings (i.e. pre/during/post deployment).

### Attachment 3

#### PROCEDURES FOR SCREENING APPLICANTS

**A3.1.** Screen applicants to the USAF or ARC for serologic evidence of HIV infection. Test and interpret results, using the procedures in **Attachment 4**. Report test results to the Reportable Disease DataBase (RDDDB). Counsel applicants on the significance of test results and the need to seek treatment from a civilian physician.

**A3.2.** Screen applicants for enlisted service at the Military Entrance Processing Stations (MEPS) or the initial point of entry to military service. Applicants who enlist under a delayed enlistment program who exhibit serologic evidence of HIV infection before entry on active duty may be discharged due to erroneous enlistment.

**A3.3.** Screen applicants accepted for the Air Force Academy as part of the processing for entry into the Academy and again as part of their medical screening prior to appointment as officers. Screen other officer candidates during their preappointment or precontracting physical examination.

**A3.4.** Screen applicants for ARC during the normal entry physical examinations or in the preappointment programs established for officers. Those individuals with serologic evidence of HIV infection, who must meet accession medical fitness standards to enlist or be appointed, are not eligible for service with the ARC.

**A3.5.** Take the following actions on officer applicants who are ineligible for appointment due to serologic evidence of HIV infection:

A3.5.1. Disenroll enlisted members who are candidates for appointment through Officer Training School (OTS) programs immediately from the program. If OTS is the individual's initial entry training, discharge the individual. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable or entry-level discharge, as appropriate. A candidate who has completed initial entry training during the current period of service before entry into candidate status shall be administered in accordance with Service directives for enlisted personnel.

A3.5.2. Disenroll individuals in preappointment programs, such as Reserve Officer Training Corps (ROTC) and Health Professions Scholarship Program (HPSP) participants. The head of the Military Service concerned, or the designated representative, may delay disenrollment until the end of the academic term in which serologic evidence of HIV infection is confirmed. Disenrolled participants retain any financial support through the end of the academic term in which the disenrollment takes place. Financial assistance received in these programs is not subject to recoupment, if the sole basis for disenrollment is serologic evidence of HIV infection.

A3.5.3. Separate Air Force Academy cadets and personnel attending the Uniformed Services University of the Health Sciences (USUHS) from the Academy or USUHS and discharge them. The superintendent of the Academy may delay separation to the end of the current academic year. A cadet granted such a delay in the final academic year, who is otherwise qualified, may graduate without commission and then is discharged. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable discharge.

A3.5.4. Disenroll commissioned officers in DoD-sponsored professional education programs leading to appointment in a professional military specialty (including medical, dental, chaplain, and legal or judge advocate) from the program at the end of the academic term in which serologic evidence of HIV infection is confirmed. Except when laws specifically prohibit it, waive any additional service obligation incurred by participation in such programs; do not recoup any financial assistance received in these programs. Apply the time spent by the officers in these programs towards satisfaction of any preexisting service obligation.

A3.5.5. Counsel people disenrolled from officer programs who are to be separated; include preventive medicine counseling and advise the individual to seek treatment from a civilian physician.

## Attachment 4

### AIR FORCE HIV TESTING PROCEDURES

#### A4.1. Responsibilities:

A4.1.1. **Medical Facility Commander (MFC).** Is responsible for the HIV testing program. Appoints an HIV designated physician; ensures HIV positive individuals are notified and counseled as soon as possible following receipt of the positive test result; and ensures AD members are referred to WHMC within 60 days of receipt of the HIV positive results notification from the USAF HIV Testing Services to the base. Reserve medical unit commanders will immediately notify wing/unit commanders of any positive HIV test results.

A4.1.2. **Clinical Laboratory Manager.** Draws, processes, and ships specimens for HIV testing. All specimens for HIV testing should be sent to USAF HIV Testing Services, AFIERA/SDET, 2601 West Gate Road, Suite 114, Brooks AFB TX 78235-5241 (DSN 240-8934; formerly Armstrong Lab). If, because of time considerations, local contract HIV testing is done for needlestick exposure, the laboratory manager must ship corresponding split of serum specimen, with HIV test request, to USAF HIV Testing Services. If testing is done by an approved USAF laboratory, the laboratory manager must ship corresponding split of serum specimen and results to USAF HIV Testing Services. AFIERA/SDET will ship AD, Guard and Reserve samples to the Department of Defense Serum Repository (DoDSR). This requirement also applies to HIV blood donor unit screening.

A4.1.3. **Primary Care Management Team.** Ensures HIV testing is accomplished in conjunction with appropriate Preventive Health Assessment or physical examinations (as described in paragraph [A4.2.](#)).

A4.1.4. **Public Health (PH).** Coordinates with Medical Facility Commander's designee to ensure proper notification of the individual member. Is responsible for monitoring HIV positive ADAF members. Receives and reports to gaining public health personnel when HIV positive personnel are transferred. Informs the requesting laboratory of positive results so they can close out the test status in the computer system. The WHMC HIV PH Counselor ensures appropriate case contact interviews, epidemiological follow-ups, and disease reporting procedures are accomplished promptly.

A4.1.5. **HIV Testing Point of Contact.** MTF shipping and receiving technician who is responsible for shipping specimens; identifying supply deficiencies; maintaining results; and acting as the liaison with USAF HIV Testing Services.

A4.1.6. **Civilian Personnel Flight (CPF).** Notifies by letter the clinical laboratory manager of any Department of the Air Force civilian employee requiring HIV testing.

A4.1.7. **Major Commands (MAJCOM).** Deputy Command Surgeon (MAJCOM/SGP) or designee acts as liaison between USAF HIV Testing Services and MTFs within the command.

A4.1.8. **AFIERA/SDET.** Monitors and ensures that all positive HIV tests are reported by local MTFs into the Air Force Reportable Events DataBase.

A4.1.9. **AFIERA Risk Analysis Directorate (AFIERA/RS)** ensures that DoD mandated epidemiological studies are accomplished on a periodic basis.

A4.1.10. **Commander, WHMC.** Ensures AD HIV positive members are scheduled for evaluation within 60 days of receipt of the HIV positive results notification from the USAF HIV Testing Services to the base.

A4.1.11. **Reserve Medical Unit.** Contacts the epidemiology lab to confirm positive test results before release of information, conducting counseling, or determining need for spousal or contact notification.

**A4.2. Physical Examination (PE) Testing:** Primary Care Manager ensures HIV testing is accomplished per the clinical testing requirements in the PHA for AD members or RCPHA for ARC members.

**A4.3. Permanent Change of Station to Overseas (PCS Overseas) Testing.** HIV testing prior to PCS assignment overseas or current HIV test within 12 months of consecutive overseas tours is no longer required (this entire section is rescinded).

A4.3.1. The MPF and CPF (as appropriate) notify all members selected for a PCS OS assignment of the HIV testing requirement, and provide the member with a copy of AF Form 3844, **HIV Testing Notification Form**.

A4.3.2. Members report to the MTF laboratory for HIV testing within two weeks of notification with a copy of AF Form 3844.

A4.3.3. MTF Laboratory personnel obtain an HIV specimen and complete Part 2 of AF Form 3844.

A4.3.3.1. Test routine specimens locally or ship to USAF HIV Testing Services.

A4.3.3.2. Test specimens for "short notice" PCS moves, send to USAF HIV Testing Services, mark "Expedite for PCS Overseas Testing," or send to an approved commercial reference laboratory. If sent to an approved commercial reference lab, a split sample must be sent to USAF HIV TESTING SVS, AFIERA/SDET, 2601 West Gate Road, Suite 114, Brooks AFB Texas, 78235-5241. Address direct shipping inquiries to USAF HIV Testing Services, DSN 240-8934.

A4.3.3.3. The clinical laboratory manager forwards completed AF Form 3844 to MPF personnel.

A4.3.4. MPF ensures a completed AF Form 3844 is returned, prior to clearing the member for travel. Once cleared, the form is destroyed.

A4.3.5. Test results are placed in the medical record, using codes in [Attachment 9](#).

A4.3.6. USAF HIV Testing Services notifies the MFC or designee of positive HIV test results. The MFC or designee immediately notifies AFPC/DPAMM of the positive test results. The MFC or designee schedules the HIV positive member for an appointment for notification, counseling, administration of the preventive medicine order, and referral to WHMC for clinical evaluation.

A4.3.6.1. AFPC/DAMM ensures PCS OS and COT assignments for HIV positive members are evaluated and approved or disapproved.

A4.3.7. The MFC and MTF designated HIV physician in conjunction with Public Health Personnel ensure HIV positive members are counseled and AD members are referred to WHMC for medical evaluation within 60 days of receipt of the HIV positive results notification from the USAF HIV Testing Services to the base. Public Health Personnel will provide results to the requesting laboratory so they can close out test status.

**A4.4. Sexually Transmitted Disease (STD) Clinic Testing:**

A4.4.1. Providers counsel all STD patients regarding the need for HIV testing. Immediate HIV testing and follow-up testing at 6 months is recommended or IAW the most recent CDC recommendations. Informed consent laws are followed for dependents and civilians.

A4.4.2. Providers refer all STD patients to PH for case contact interviews as soon as identified.

A4.4.3. Test specimens IAW [A4.1.2](#).

A4.4.4. MFC or designee ensures all HIV positive individuals are properly notified and counseled, and all ADAF members are referred to WHMC for medical evaluation.

**A4.5. Drug and/or Alcohol Treatment Testing:**

A4.5.1. The Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program Manager (AFMOA/SGOC) or designee notifies all AD members entering treatment programs of required HIV testing and provides the member with AF Form 3844. Local and state laws dictate availability of testing for family members and use of informed consent. Their testing is not mandatory. Individuals who are not DoD military health care beneficiaries (for example, civilian employees) are not HIV tested.

A4.5.2. The treatment entrant reports to the MTF laboratory with AF Form 3844.

A4.5.3. Laboratory personnel obtain an HIV specimen and complete Part 2 of AF Form 3844.

A4.5.4. Accomplish the HIV testing IAW [A4.1.2](#).

A4.5.5. The clinical laboratory manager forwards the completed AF Form 3844 to the ADAPT Program Manager or designee who ensures all AD members entering treatment have been HIV tested.

A4.5.6. MFC or designee ensures all HIV positive individuals are properly notified and counseled, and all AD members are referred to WHMC for medical evaluation.

**A4.6. Clinical Testing:**

A4.6.1. All health care providers order HIV testing for those patients with clinical indications of HIV related diseases (e.g. active tuberculosis, HBV) and for patients with potential exposure to the virus. A confirmed positive result on a urinalysis drug test is a clinical indication for HIV testing. Providers inform patients of HIV testing for clinical indications. Local state informed consent laws are followed for family members and other beneficiaries (for example, retirees). Informed consent is not required for AD members.

A4.6.2. Providers ordering HIV testing ensure test results are reviewed, HIV positive patients are counseled, and HIV positive AD members are referred to WHMC for medical evaluation. Normally, the HIV designated physician in conjunction with public health personnel, provide counseling and referral services.

A4.6.3. Providers will not routinely order HIV testing on all patients.

A4.6.4. Clinical testing is accomplished IAW [A4.1.2](#).

**A4.7. Occupational Exposure Testing.**

A4.7.1. Employees report to PH for occupational exposure testing and follow up IAW OSHA Bloodborne Pathogen Final Rule as implemented in the facility Infection Control Program/Employee Health Program.

A4.7.2. Follow the latest Centers for Disease Control and Prevention (CDC) guidelines for blood and body fluid exposures to bloodborne pathogens as stated in the facility Infection Control Program/Employee Health Program/Bloodborne Pathogen Program. Refer to AFI 44-108, *Infection Control Program*.

A4.7.3. Personnel who perform exposure-prone procedures (to include, but not limited to, surgeons, pathologists, dentists, dental technicians, phlebotomists, emergency medical technicians, and physicians, nurses and technicians working in the emergency room, intensive care, surgery, and labor/delivery) should know their HIV antibody status.

A4.7.4. Follow local state laws on HIV testing and informed consent for non-active duty individuals, including employees and patients. Informed consent is not required for active duty personnel.

A4.7.5. Personnel testing is accomplished IAW [A4.1.2](#).

#### **A4.8. Department of the Air Force (DAF) Civilian Employees:**

A4.8.1. Screen DAF civilian employees (appropriated or nonappropriated) selected for sponsorship, employment, or assignment OS for serological evidence of HIV infection only pursuant to valid requirements imposed by the host country. This mandatory screening does not apply to contractor personnel, family members, or foreign nationals. Refer to DoDD 6485.1, enclosure 8, for HIV testing of civilian personnel.

A4.8.2. Accomplish testing of DAF employees only upon written request by the Civilian Personnel Officer. Volunteers for HIV testing are allowed only where authorized by the MTF commander as being in the best interest of the service.

A4.8.3. Follow local state laws concerning informed consent for HIV testing. If informed consent is required and not obtained, notify CPF in writing that the individual refused testing.

A4.8.4. Report negative HIV test results directly to the CPF by sealed envelope addressed to the individual authorizing the testing.

A4.8.5. The designated HIV physician reports positive HIV results to the individual in person.

A4.8.5.1. Provide initial counseling and refer to a private physician or clinic. DAF civilian employees who are also DoD military beneficiaries may be referred to appropriate military providers.

A4.8.5.2. The designated HIV physician informs the individual that the results are reported to the CPF.

A4.8.5.3. Report to the CPF by sealed envelope addressed to individual authorizing testing after the individual has been notified and counseled; envelope should be labeled as time sensitive and to be opened by addressee only.

A4.8.5.4. If the designated HIV physician is unable to contact the individual for notification or counseling, inform the CPF that contact with the individual is required to discuss HIV test results.

Results will not be discussed with CPF personnel. CPF personnel assists in contacting the individual and refers him or her to the designated HIV physician.

A4.8.6. Accomplish testing IAW [A4.1.2](#).

#### **A4.9. Prenatal Testing:**

A4.9.1. Screen all AD obstetrics (OB) patients for evidence of HIV infection regardless of previous testing.

A4.9.2. Encourage nonactive duty OB patients to be tested. Follow local state laws on informed consent for nonactive duty patients.

A4.9.3. Submit additional specimens as clinical specimens, not as OB specimens.

A4.9.4. Accomplish testing IAW [A4.1.2](#).

#### **A4.10. Results Reporting:**

A4.10.1. **Active Duty** . The USAF HIV Testing Services reports negative test results usually electronically to the submitting MTF within three workdays. Positive notification letters are sent to the MFC and base PH. Enclosed in the notification letters is AF Form 74s. The MFC and PH write on their respective cards the date results were received, complete blocks (phone number, date and sign/organization/installation) and return to USAF HIV Testing Services.

A4.10.2. **Air National Guard and Air Force Reserve** . USAF HIV Testing Services provide a test result to the requesting organization within 7 workdays of receipt. Positive notification letters are sent First Class to Unit's Medical Commander and seven days later a follow-up letter to Public Health to ensure results were received. Enclosed in both notification letters are AF Form 74s. The cards are to be filled in with date results were received, phone number, date and signature/organization/installation of person receiving the results and sent back to USAF HIV Testing Services.

A4.10.3. **Clinical and Civilian Employee Samples** . The USAF HIV Testing Services report negative test results to the submitting MTF Laboratory Services. If positive, a notification letter is sent within seven workdays to PH. Both letters have AF Form 74s enclosed. The MFC and PH write on their respective cards the date results were received, complete blocks (phone number, date and sign/organization/installation) and return to USAF HIV Testing Services.

**A4.11. Blood Bank Testing.** If a military member is identified as HIV positive through blood donation or other blood bank or outside laboratory testing, a specimen still needs to be sent to USAF HIV Testing Services for confirmation and to be entered into the RDDB.

A4.11.1. All military members with a positive NAT/HIV test should be referred to military public health for appropriate counseling and follow-up instructions regarding further testing.

#### **A4.12. Problem Resolution:**

A4.12.1. Inform USAF HIV Testing Services of difficulties obtaining supplies or test results.

A4.12.2. The USAF HIV Testing Services handles all test inquiries.

**NOTE:** Assess HIV risk at every preventive health assessment (PHA) and screen for serologic evidence of HIV infection during their physical exam every 5 years per the clinical testing requirements in the

PHA, or if at increased risk based on risk assessment. ARC personnel are screened during their periodic long flying physical every three years or nonflying physical every five years or as per the RCPHA clinical testing requirements. Civilians who receive OS assignments where the host nation requires HIV testing will be tested according to Department of Defense Directive 6485.1, Enclosure 8 (DoDD 6485.1, Enclosure 8). DoD mandated testing continues to include sexually transmitted disease (STD) clinic patients, drug and alcohol treatment entrants, prior to PCS OS assignments, prenatal patients, and host country requirements before deployment.

## Attachment 5

### COMPLETION OF FORMS FOR REQUESTING HIV TESTING AND SPECIMEN TRANSMITTAL

#### A5.1. AF FORM 1762 Completion:

A5.1.1. AF Form 1762 is used to request HIV Screen Testing and the following information is mandatory: the facility/organization and address at the top of each form sent. If not, specimens will be processed as NBI (no base identification) which will delay results until submitting activity can be ascertained.

A5.1.2. For each request, the Full Name (last name, first name, middle initial) not nick-names, Full SSN (not last 4) with an FMP, Date of Birth (dates are to be entered as DD-MMM-YY, e.g., October 19, 1948 = 19 Oct 48), Duty Code (see [A5.3.](#)) and Source Code (see [A5.4.](#)). [Force Testing no longer exists. All periodic testing is done in conjunction with "P" (physicals) unless meeting one of the other source codes. See [A5.4.](#) Source Codes.]

A5.1.3. Testing will not proceed until all information is provided. Additionally, the individual being tested will not receive a test date in the master AFPC records if the name, FMP/SSN, or date of birth do not match.

A5.1.4. Fill out forms LEGIBLY. If entered by hand, the individual responsible for verifying the identity of personnel being screened, not the person being drawn, will print the information. Typewritten or computer generated forms are preferred. If you have computer support, call USAF HIV Testing Services for available software programs to help produce a computer generated AF Form 1762. The AF Form 1762 is available through DELRINA FormFlow.

A5.1.5. At the bottom of the form, fill in date shipped, name of shipping person, or someone USAF HIV Testing Services can contact if there are problems, and a DSN phone number or commercial number only if DSN is unavailable.

A5.1.6. MTF's that use the Composite Healthcare System (CHCS), refer to ADHOC A98 1011, Automated HIV Shipping Form, which can be downloaded from the Brooks web site: <http://www.tmssc.brooks.af.mil>.

A5.1.7. Guard and Reserve bases not utilizing CHCS can use developed software from US AFI HIV Testing Service (phone number DSN 240-8934).

#### A5.1.8. Common Errors in filing out AF Form 1762:

A5.1.8.1. Not putting Base ID/Submitting Activity at the top of each form

A5.1.8.2. Name - incomplete or not legible. Has name recently changed or is there a suffix (e.g. "Jr." or "III") after the name?

A5.1.8.3. SSN - more or less than 9 digits; not legible. Failure to include FMP with SSN.

A5.1.8.4. No Duty Code, no Source Code, or entry of unauthorized code.

A5.1.8.5. No Date or Shipping official to contact in case of problems.

A5.1.8.6. No DSN phone or commercial number if DSN unavailable.

A5.1.8.7. Failure to retain copy of AF Form 1762.

A5.1.9. Forward the first two copies of the AF Form 1762 to USAF HIV Testing Services along with the specimens. Keep the third copy in the laboratory for MTF record keeping purposes to track timely return of results. If test results have not been received contact USAF HIV Testing Services for assistance.

A5.1.10. The MFC reviews the reports and provides copies of positive results to the physician designated to advise and counsel HIV antibody positive individuals. Follow procedures in section **A4.3.** for civilian employees who require HIV test for OS assignment where the host nation mandates HIV testing. (See **A7.2.** for prospective civilian employees and DoDD 6485.1 for civilian medical personnel.) Prospective civilian employees must identify a private physician or clinic that should be notified in the event of an abnormal laboratory result including HIV seropositivity. The designated HIV physician contacts the prospective employee's private physician or clinic with notification of the positive HIV results. The private physician or clinic notifies the prospective employee of the HIV results and provides counseling and medical follow-up. Notification of the prospective employee's private physician or clinic is accomplished prior to forwarding the positive HIV results to the Chief of Civilian Personnel. The MFC forwards the original of all reports to the laboratory. The laboratory maintains all HIV reports for five years.

A5.1.11. DoD laboratories authorized to perform HIV antibody clinical screening in-house use AF Form 1762 as a log for all HIV antibody ELISA screenings performed. All five items of information are to be completed. By the fifth working day of the month, forward all results from the previous month electronically or by floppy disc to USAF HIV Testing Services. Forward specimens tested negative to USAF HIV Testing Services marked "DoDSR" for placement in the DoDSR. Forward a specimen from each individual who screens positive for HIV in local testing to USAF HIV Testing Services for confirmatory testing.

**A5.2. AF Form 4 is used only to request Western Blot Confirmation Testing.** Do not use this form for HIV screening requests; use an AF Form 1762 as required in section **A5.1.1.** For bases who perform local clinical testing and MTF Blood Banks that screen donors, all specimens that screen positive must be sent to the HIV Testing Services for FDA confirmation algorithm testing. Complete the form as follows: Fill out the top of the form with **all** required information. Blocks 13 and 14 must be completed with Duty Code and Source Code or testing will be delayed until information is obtained.

**A5.3. Duty Codes:** To obtain the most accurate information possible, submitting laboratories must use the patient category code (pat cat code) from CHCS for duty codes on the AF Form 1762 to identify the status of the individual being tested. This is an Alpha, two numeric code which is a mandatory field when registering members into CHCS. Therefore, this information should be available to download to an ADHOC report when computer generating the CHCS AF Form 1762. These codes closely emulate the DEERS codes for status of individual member being tested. For submitting activities not on CHCS, use the Pat Cat that closely defines the status of the individual. The following are the most commonly used:

<b>PAT CATs</b>	<b>DEFINITION</b>
A11	Army, Active Duty
A12	Army, Reserve
A13	Army, Recruits
A14	Army, Academy Cadet
A15	Army, National Guard

<b>PAT CATs</b>	<b>DEFINITION</b>
A21	Army, ROTC
A23	Army National Guard
A26	Army, Applicants-Enlistment's
A31	Army, Retired
A41	Army, Dependent of Active Duty
A43	Army, Dependent of Retiree
A45	Army, Dependent of Deceased Active Duty
A47	Army, Dependent of Deceased Retiree
A48	Army, Unmarried former Spouse
F11	Air Force, Active Duty
F12	Air Force, Reserve
F13	Air Force, Recruits
F14	Air Force, Academy Cadet
F15	Air Force, National Guard
F21	Air Force, ROTC
F23	Air Force National Guard
F26	Air Force, Applicants-Enlistment's
F31	Air Force, Retired
F41	Air Force, Dependent of Active Duty
F43	Air Force, Dependent of Retiree
F45	Air Force, Dependent of Deceased Active Duty
F47	Air Force, Dependent of Deceased Retiree
F48	Air Force, Unmarried former Spouse
M11	Marine Corps, Active Duty
M12	Marine Corps, Reserve
M13	Marine Corps, Recruits
M14	Marine Corps, Academy-midshipmen
M21	Marine Corps, ROTC
M26	Marine Corps, Applicants-Enlistment's
M31	Marine Corps, Retired
M41	Marine Corps, Dependent of Active Duty
M43	Marine Corps, Dependent of Retiree
M45	Marine Corps, Dependent of Deceased Active Duty
M47	Marine Corps, Dependent of Deceased Retiree
M48	Marine Corps, Unmarried former Spouse
N11	Navy, Active Duty
N12	Navy, Reserve
N13	Navy, Recruits
N14	Navy, Academy-Midshipmen
N21	Navy, ROTC
N26	Navy, Applicants-Enlistment's
N31	Navy, Retired
N41	Navy, Dependent of Active Duty
N43	Navy, Dependent of Retiree
N45	Navy, Dependent of Deceased Active Duty
N47	Navy, Dependent of Deceased Retiree
N48	Navy, Unmarried former Spouse
C11	Coast Guard, Active Duty
C12	Coast Guard, Reserve

PAT CATs	DEFINITION
C31	Coast Guard, Retired
C41	Coast Guard, Dependent of Active Duty
C43	Coast Guard, Dependent of Retiree
P11	Public Health Svs, Active Duty
P12	Public Health Svs, Reserve
P31	Public Health Svs, Retired
P41	Public Health Svs, Dependent of Active Duty
P43	Public Health Svs, Dependent of Retiree
K53	Civil Service Employee/Other Federal Agencies
K57	Civilian Employee, Occupational Health
K59	Federal Government Employees, Overseas
K61	VA Sharing Agreement/VA beneficiary
K64	Other Federal Agency (DAF employee)
K66	Federal Prisoners

**A5.4. Source Code.** The only authorized codes used in the appropriate block on the AF Form 1762 are listed below. These codes identify the reason that the individual is being screened. They were adopted for use throughout DoD by the Reportable Disease Data Base (RDDB) Working Group. A single code is entered on the AF Form 1762. Multiple codes for an individual are not authorized:

- A -- Alcohol and Drug Treatment
- B -- Blood Donor (Authorized for use on specimens or confirmation specimens)
- C -- Contact Testing (Referral)
- F -- Force Screening (routine screening of personnel)
- I -- Indicated for Clinical Reasons
- J -- Prisoners or Detained Persons
- N -- Pre-deployment
- O -- OB Clinic/Pregnancy Related
- P -- Physical Examinations
- R -- Requested by Individual
- T -- Post-deployment
- V -- STD Clinic Visit
- X -- Any Other Source (used only in extremely rare cases)

#### **A5.5. Shipment of Specimen Requirements.**

A5.5.1. Ship specimens using instructions provided by USAF HIV Testing Services. It is very important that the MTFs follow these instructions. Deviation could cause rejection of a shipment and necessitate redrawing each individual.

A5.5.2. USAF HIV Testing Services will only accept 12x75 mm polypropylene tubes. If the whole shipment arrives in anything other than these type tubes, the shipment will be returned to the submitting MTF at their expense to process in the correct tubes. Single specimens will have to be redrawn. Tubes and caps can be ordered from most laboratory supply catalogues (see below) or can be obtained by calling the Epidemiology Laboratory Services at DSN 240-8751 or 8378. If the submitting MTF's stock runs out, it will have to hold specimens until a supply of the correct tubes are received.

Test Tubes, 12x75 mm, polypropylene, round bottom

FSN 6640-01-264-2362

Curtin-Matheseon Scientific (CMS) #289-657

S/P-Baxter T-1226-12

Plug Cap for 12x75 test tubes

FSN 6640-01-222-2963

CMS #148-346

S/P-Baxter T1226-32

Tubes and caps in one order

S/P-Baxter T1226-42

Double sided Plastic Bags

Fisher Cat #01-824

Lab Safety Supply Cat #TL-23805

VWR Cat #11216-783

A5.5.3. Write FULL NAME (Last name, first name, middle initial) and the FULL SSN with FMP on label, then place label long-wise without covering the bottom of tube. (Pre/Post deployment specimens need draw date). Secure with a plastic plug cap. DO NOT USE PARAFILM.

A5.5.4. Place patient samples (amount for 1 AF Form 1762/no more than 22) with absorbent material in large portion of plastic shipping bag. Place original and one copy of AF Form 1762 in side pouch corresponding to samples and tear off plastic strip covering the adhesive and SEAL THE BAG. In shipping HIVs with other EPI specimens place in a separate ziplock bag marked: HIV

A5.5.5. The following common errors could be avoided if a quality control program exists.

**A5.5.6. Common errors in Specimen Preparation:**

A5.5.6.1. Not spinning specimen down causing hemolyzed specimens

A5.5.6.2. Putting specimens in the wrong tubes; only polypropylene 12x75 mm will be accepted.

A5.5.6.3. Over-filling tubes, causing tube cap to come off when the specimen is frozen.

A5.5.6.4. Not putting tube caps on tightly.

A5.5.6.5. Tape or parafilm around the cap of the tube.

A5.5.6.6. Omitting the individual's full name/full SSN on tube

A5.5.6.7. Only last four of SSN on the transport tube.

A5.5.6.8. Name on tube does not match name on paperwork.

A5.5.6.9. No AF Form 1762 accompanying the tube.

**A5.5.7. Common Errors in Specimen Packaging:**

A5.5.7.1. Not wrapping tubes with absorbent paper.

A5.5.7.2. Not maintaining a cold environment (use ice, cold packs, or dry ice as appropriate).

A5.5.7.3. Not separating AF Forms 1762 from specimens, causing forms to get wet if leakage occurs.

## Attachment 6

### HIV TESTING AND INTERPRETATION OF RESULTS

#### A6.1. Laboratories:

A6.1.1. Use only approved MTF laboratories or the USAF HIV Testing Services to perform the initial screening test on specimens collected from Service members.

A6.1.2. All approved Air Force MTF laboratories that perform in-house HIV screening must report all HIV results monthly to USAF HIV Testing Services so they can be recorded in RDDDB IAW [A4.1.2](#). Call USAF HIV Testing Services for assistance in generating a computer flat file/email report for these results.

A6.1.3. All approved Air Force MTF laboratories that perform in-house HIV screening must send a specimen for all Active Duty, Guard and Reserve to USAF HIV Testing Services at Brooks AFB for the DoD serum repository. Specimens must be sent as outlined in [A5.5](#).

A6.1.4. All approved Air Force MTF laboratories that perform in-house HIV screening must send all repeatedly reactive specimens to USAF HIV Testing Services for supplemental/confirmatory testing.

A6.1.5. All approved MTF laboratories must subscribe to a Clinical Laboratory Improvement Program (CLIP) proficiency testing program (i.e. CAP, AABB, etc), as well as meet all appropriate CLIP quality standards to maintain approval for in-house testing.

A6.1.6. Failure of approved Air Force MTF laboratories to meet any of the criteria in [A6.1.1.-A6.1.5](#). may result in loss of approved status, as determined by the Associate Chief, Biomedical Service Corps, Laboratory Services.

A6.1.7. The USAF HIV Testing Services, Brooks Air Force Base, maintains positive specimens.

#### A6.2. Specimen Collection and Handling:

A6.2.1. Collect blood samples with appropriate vacutainer tubes.

A6.2.2. As a minimum, each sample is labeled with the individual's full name, FMP/SSN, the date and time of collection, and a laboratory assigned number.

A6.2.3. Samples are centrifuged and serum separated within six hours of collection.

A6.2.4. Specimens are refrigerated before the initial test. If the initial test is not conducted within seven days, or the date at which the sample was collected is unknown, the specimen will be frozen.

A6.2.5. Use cold packs to keep specimens at refrigerated temperatures during transit between laboratories.

A6.2.6. Ship specimens according to US (or foreign) biological agent shipping requirements.

#### A6.3. Initial Test:

A6.3.1. Conduct the initial test using a FDA-approved ELISA test kit. Interpret results according to the manufacturer's package insert.

A6.3.2. The laboratory establishes an internal quality control program that includes a minimum total of 10 percent quality control samples per batch (e.g., standards, negatives, positive controls, and blind samples).

A6.3.3. All controls and blinds will be 100 percent correct before the entire batch results are considered acceptable.

#### **A6.4. Supplemental/Confirmatory Tests:**

A6.4.1. All HIV testing will follow FDA-approved algorithm

A6.4.2. Perform a FDA-approved Western Blot (WB) test.

A6.4.3. The laboratory validates its procedure using a protocol that establishes accuracy, precision, and reproducibility.

A6.4.4. WB test results:

A6.4.4.1. Negative - no bands present.

A6.4.4.2. Positive - any two or more of the following bands present: p24, gp41, and gp 120/160, other viral bands may or may not be present.

A6.4.4.3. Indeterminate - any bands present but pattern does not meet criteria for POSITIVE. Nondiagnostic tests of a different technologies will be used to try to resolve results. For indeterminate results, notify WHMC/MMII at DSN 554-7653 for consultation.

A6.4.5. IFA test results:

A6.4.5.1. Negative - no specific fluorescent staining of the infected cells and no significant difference in the intensity of fluorescent staining and pattern between HIV-1 infected and uninfected cells.

A6.4.5.1.1. Positive - specific cytoplasmic staining in HIV-1 infected cells and significant difference in intensity between HIV-1 infected and uninfected cells.

A6.4.5.1.2. Indeterminate - presence of non-specific staining in both the infected and uninfected cells. This result is regarded as inconclusive and follow up testing should be carried out.

The following scheme (**Table A6.1.**) is used to report results when supplemental testing is conducted to resolve nondiagnostic WB results:



Interpretation: Negative for HIV

The ELISA screening test may produce false positive results when used to screen low risk populations. In this instance, the WB was indeterminate, which can be seen when cross-reacting antibodies are present. The IFA test was performed as a supplemental test and was negative. A False negative IFA is rare. If the clinical suspicion for HIV is high, the test should be repeated in 4-6 weeks.

A6.5.5. The screen ELISA is REACTIVE on at least two of three runs, and the Western Blot is INDETERMINATE (as per CDC guidelines), and the IFA is INDETERMINATE, the report would read:

ELISA	REACTIVE
Western Blot	Indeterminate (bands present)
IFA	Indeterminate
Interpretation:	Indeterminate for HIV

The ELISA screen may produce false positive results when used to screen low risk populations. Because both Western Blot and IFA were Indeterminate, possibility of infection cannot be excluded. The patient should be counseled that the test was indeterminate and repeat testing should be done in 4-6 weeks. In this case, Infectious Disease consultation is recommended.

## Attachment 7

### HIV TESTING OF DOD CIVILIAN EMPLOYEES

**A7.1.** Direct requests for authority to screen DoD civilian employees for HIV to the Assistant Secretary of Defense (ASD)/Force Management and Personnel (FM&P). Only requests that are based on a host nation HIV screening requirement are accepted. Requests based on other concerns, such as sensitive foreign policy or medical health care issues, are not considered under this instruction. Approvals are provided in writing by the ASD/FM&P and apply to all the DoD Components that may have activities located in the host nation.

**A7.2.** Specific HIV screening requirements may apply to DoD civilian employees currently assigned to positions in the host nation and to prospective employees. When applied to prospective employees, HIV screening is considered a requirement imposed by another nation, that must be met before the final decision to select the individual for a position, or before approving temporary duty or detail to the host nation. Individuals who refuse to cooperate with HIV screening requirements or those who cooperate and are diagnosed as HIV seropositive, may not be considered further for employment in host nations with HIV screening requirements.

**A7.3.** DoD civilian employees who refuse to cooperate with the screening requirements are treated, as follows:

A7.3.1. Those who volunteered for the assignment, whether permanent or temporary, are retained in their official position without further action and without prejudice to employee benefits, career progression opportunities, or other personnel actions to which those employees are entitled under applicable law or instruction.

A7.3.2. Those who are obligated to accept assignment to the host nation under the terms of an employment agreement, regularly scheduled tour of duty, or similar and/or prior obligation may be subjected to an appropriate adverse personnel action under the specific terms of the employment agreement or other authorities that may apply.

A7.3.3. Host nation screening requirements, which apply to DoD civilian employees currently located in that country, must be observed. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges to comply with the requirements.

**A7.4.** Individuals who are not employed in the host nation, who accept the screening, and who are evaluated as HIV seropositive shall be denied the assignment on the basis that evidence of seronegativity is required by the host nation. If denied the assignment, such DoD employees shall be retained in their current positions without prejudice. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges, on DoD civilian employees currently located in the host nation. In all cases, employees shall be given proper counseling and shall retain all the rights and benefits to which they are entitled, including accommodations for the handicapped as in the applicable ASD/FM&P Memorandum, and for employees in the United States (29 U.S.C. 794). Non-DoD employees are referred to appropriate support service organizations.

**A7.5.** Some host nations may not bar entry to HIV seropositive DoD civilian employees, but may require reporting of such individuals to host nation authorities. In such cases, DoD civilian employees who are

evaluated as HIV seropositive shall be informed of the reporting requirements. They shall be counseled and given the option of declining the assignment and retaining their official positions without prejudice or notification to the host nation. If assignment is accepted, the requesting authority shall release the HIV seropositive result, as required. Employees currently located in the host nation may also decline to have seropositive results released. In such cases, they may request and shall be granted early return at government expense or other appropriate personnel action without prejudice to employee rights and privileges.

**A7.6.** A positive confirmatory test by WB must be accomplished on an individual if the screening test (ELISA) is positive. A civilian employee may not be identified as HIV antibody positive, unless the confirmatory test (WB) is positive. The clinical standards in this instruction shall be observed during initial and confirmatory testing.

**A7.7.** Provide tests at no cost to the DoD civilian employees, including applicants.

**A7.8.** Counsel DoD civilian employees infected with HIV.

## Attachment 8

### **GUIDELINES FOR ADMINISTERING THE ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS TO INDIVIDUALS INFECTED WITH HIV**

**A8.1.** After the member is notified by a health care provider that he or she has tested positive for HIV infection, and the significance of such a test, the MFC expeditiously notifies the member's unit commander of the positive test results. For active duty members, the member's unit commander issues an order to follow preventive medicine requirements. For unit assigned reservists, this order is issued only after their immediate commander determines the member will be retained in the Selected Reserve. When the order is given, a credentialed provider is present to answer any medical concerns of the member. Use the order at [Attachment 14](#). It is signed and dated by the commander and member. If the member refuses to sign, the commander notes that the member refused to sign in the acknowledgment section. The order is securely stored to protect the member's privacy and confidentiality. A copy of the order is provided to the member. Upon the individual's reassignment, the unit commander forwards the order in a sealed envelope to the gaining commander. The envelope is marked "To Be Opened By Addressee Only." Upon the individual's separation from the Air Force, the order is destroyed.

**A8.2.** AD members testing positive for HIV infection undergo a complete medical evaluation at WHMC. Upon arrival, all HIV positive members are counseled by a health care provider or by the WHMC HIV Public Health Counselor. Use AF Form 3845, **Preventive Medicine Counseling Record**, or similar form. The counselor signs the form. The member signs the counseling record acknowledging receipt of the counseling. One copy of the record is given the member and one copy filed in the records of the HIV Public Health Counselor at WHMC.

**A8.3.** If the member is returned to duty and to a different unit from which he or she came, the gaining unit commander issues an additional order to follow preventive medicine requirements to the member. A copy of this order is given to the member. Use the order at [Attachment 14](#). The commander may request the MFC or other health care provider is present when the order is administered to answer any medical concerns of the member. The commander and member sign and date the order. If the member refuses to sign, the commander notes the member refused to sign in the acknowledgment section. Securely store the order to protect the member's privacy and confidentiality.

**A8.4.** It is unnecessary to recall members issued orders under former procedures. HIV seropositive members, who have not been previously issued preventive medicine requirement orders, must be counseled by a health care provider assigned to the local medical facility on AF Form 3845 and issued an order ([Attachment 14](#)) by his or her unit commander.

**NOTE:** DoD requested the Military Departments standardize the administration of the order to follow preventive medicine requirements to individuals infected with HIV. The guidelines above standardize and simplify procedures.

**Attachment 9****WHMC STANDARD CLINICAL PROTOCOL****A9.1. Medical Evaluation:**

A9.1.1. Accomplish a complete medical evaluation on AF personnel with HIV infection at least every six months. For active duty and ARC members on extended active duty, this evaluation is documented, using the Medical Evaluation Board (MEB) requirements. For unit assigned reservists not on extended active duty, this evaluation is not accomplished until after the commander's decision to retain the member. If the member is retained, the evaluation must be accomplished and documented IAW AFI 48-123 and AFRC medical guidance on nonduty related medical conditions.

A9.1.2. As a minimum, the initial medical workup includes:

A9.1.2.1. An initial epidemiological/clinical assessment.

A9.1.2.2. Complete history and physical examination and neuropsychiatric evaluation.

A9.1.2.3. Complete blood count with differential, platelet count, and red blood cell indices.

A9.1.2.4. Basic chemistry tests to include electrolytes, BUN, creatinine, glucose, AST, alkaline phosphatase, bilirubin, CPK, amylase, lipid panel, and urinalysis.

A9.1.2.5. Total lymphocyte count, total T-lymphocyte cell count, absolute CD4 and CD8 levels, and absolute and percent positive CD3 positive and CD4 positive T cells and CD56 and/or CD56/16 natural killer cells, and B lymphocyte markers.

A9.1.2.6. Tuberculin test

A9.1.2.7. HIV ELISA and confirmation test; viral load x 2 as baseline.

A9.1.2.8. Chest X-ray (posterior/anterior and lateral).

A9.1.2.9. Serologic testing for Toxoplasma titer, G6PD test, CMV IgG, EBV IgG, hepatitis B, hepatitis C.

A9.1.2.10. Evaluative STD tests for syphilis (treponemal and non-treponemal) and evaluative tests for urethritis, cervicitis, or proctitis when clinically indicated.

A9.1.3. Subsequent epidemiological assessments include:

A9.1.3.1. Subsequent chest X-rays when clinically indicated.

A9.1.3.2. A non-treponemal test for syphilis with treponemal test if newly positive

A9.1.3.3. CBC, chemistry tests, and urinalysis

A9.1.3.4. Enumeration of CD4 positive T cells and HIV RNA quantification

A9.1.3.5. Tuberculin test yearly and as required for clinical indications

A9.1.4. Maintain a frozen serum specimen on all HIV positive individuals at a central serum bank for at least three years at -70 degrees Celsius.

A9.1.5. Seek psychiatric consultation if there are concerns about fitness for duty or if the screening evaluation suggests more detailed psychiatric evaluation is needed. If the patient has persistent evi-

dence of diminished intellectual skills, personality changes, and motor impairment, more specialized studies (neurologic studies, computed tomography or magnetic resonance imaging, lumbar puncture, psychiatric examination, and neuropsychiatric testing) may be required to evaluate the possible presence of a HIV-related mental or neurological syndrome.

A9.1.6. Perform additional testing in both initial and follow-up epidemiologic/clinical assessments as indicated to maintain compliance with changes in accepted standards of care for management of HIV infection.

## A9.2. Armed Forces HIV-1 Disease Classification:

A9.2.1. Stage all patients with either serologic evidence of HIV infection or a positive virus isolation or positive polymerase chain reaction (PCR). Use [Table A9.1](#).

**Table A9.1. HIV-1 Disease Classification System**

Stage	HIV Antibody and /or Virus Isolation	Chronic Lymphadenopathy	T-Helper Cells per Cubic Millimeter (mm <sup>3</sup> )	Thrush	Opportunistic Infection
0	-	-	GT400	-	-
1	+	-	GT400	-	-
2	+	+	GT400	-	-
3	+	+/-	LT400	-	-
4	+	+/-	LT400	-	-
5	+	+/-	LT400	+	-
6	+	+/-	LT400	+/-	+

(GT = greater than, LT = less than)

A9.2.2. Because of the natural variability of the number of T-helper cells, do not base classification of HIV infections on a single T-helper cell determination. A second count at an interval of at least one month is required if the initial CD4 absolute number is less than 400 cells per mm<sup>3</sup>. Use the average of the recent counts for staging. Monitor all HIV-1 infected personnel's CD4 lymphocyte percentages or counts at least every six months.

A9.2.3. There are a small number of patients who cannot be readily staged using the scheme in [A9.2.1](#). Use the lower stage when a patient falls between two stages; e.g., select stage 4, if patient falls between stages 4 and 5.

A9.2.4. Stages 1 through 6 require demonstration of the presence of HIV antibody to structural proteins and/or HIV virus isolation or positive polymerase chain reaction (PCR).

A9.2.5. An individual will occasionally be found with at least 400 T-helper cells per  $\text{mm}^3$  who demonstrates partial or complete cutaneous anergy. In staging, if the CD4 number is 400 cells per  $\text{mm}^3$  or greater, place the individual in stage 1 or 2.

A9.2.6. Stage 5 is defined by the occurrence of complete anergy and/or thrush in a patient with less than 400 CD4 cells per  $\text{mm}^3$ .

A9.2.7. Denote the presence of the following symptoms by adding the letter B after the stage; e.g., stage 5B: fever greater than 100.5 degrees Fahrenheit for three weeks, unexplained weight loss of greater than 10 percent of body weight over three months, night sweats for at least three weeks, or chronic diarrhea for at least one month. Many of these patients are found to have an opportunistic infection (OI) when more comprehensive evaluation tests are performed.

A9.2.8. Designate Kaposi's sarcoma by adding the letter K after the appropriate class; e.g., stage 4K.

A9.2.9. Designate the occurrence of other neoplasms by adding the letter N after the appropriate class; e.g., stage 4N.

A9.2.10. Designate central nervous system (CNS) HIV, (neurologic disease as a result of infection of the nervous system by HIV), by adding CNS after the appropriate stage; e.g., stage 4CNS. An abnormal cerebrospinal fluid (e.g., pleocytosis, increased cerebrospinal fluid protein, increased cerebrospinal fluid IgG, viral isolation, or oligoclonal bands) alone does not warrant this designation.

A9.2.11. Define HIV antibody as the presence of antibody to the structural proteins of HIV, as determined by ELISA or WB techniques or supplemental tests. HIV virus isolation or presence of a positive PCR for HIV fulfill criteria to document infection.

A9.2.12. Define chronic lymphadenopathy as two or more extralingual sites with lymph nodes greater than, or equal to, one centimeter in diameter that persist for more than one month.

A9.2.13. T-helper cells are expressed as cells per  $\text{mm}^3$ . Quantitative depletion must be persistent for at least one month before placing in stage 3 or a higher.

A9.2.14. DELETED.

A9.2.15. Define thrush as clinical oral candidiasis or a positive potassium hydroxide (KOH) preparation or yeast seen on gram stain.

A9.2.16. Opportunistic Infection (OI) is defined according to current operative CDC definitions of opportunistic infections.

**A9.3. Medical Record Coding of HIV-1 Infections.** The MTFs use both the 042-044 and 795.8 codes from the International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM). The code extenders 795.8-1 to 795.8-9 were developed to support the DoD classification system to indicate staging. Use the appropriate 795.8 code when a MTF evaluates an individual. Follow DoD disease and procedure classification ICD-9-CM coding guidelines. Use alone, following the initial screening process or in conjunction with the 042-044 codes. The 042-044 codes below describe the site of infection and are compatible with civilian practice:

A9.3.1. Use these codes only on medical records:

<b>CODE</b>	<b>DESCRIPTION</b>
042.0	HIV-1 Infection with Specified Infections
042.1	HIV-1 Infection Causing Other Specified Infections
042.2	HIV-1 Infection with Specified Malignant Neoplasms
042.9	AIDS Unspecified
043.0	HIV-1 Infection Causing Lymphadenopathy
043.1	HIV-1 Infection Causing Specified Diseases of CNS
043.2	HIV-1 Infection Causing Other Disorders of Immune Mechanism
043.3	HIV-1 Infection Causing Other Specified Conditions
043.9	AIDS-Related Complex with or without Other Conditions
044.0	HIV-1 Infection Causing Specific Acute Infections
044.9	HIV-1 Infection Unspecified
795.8-1	HIV-1 (HIV Antibody Positive Stage 1 of Infection)
795.8-2	As Above, Stage 2 of Infection
795.8-3	As Above, Stage 3 of Infection
795.8-4	As Above, Stage 4 of Infection
795.8-5	As Above, Stage 5 of Infection
795.8-6	As Above, Stage 6 of Infection
795.8-9	HIV-1 Antibody Positive, Stage of Infection Unspecified
V72.60	Serologic test only - HIV-1 antibody negative (ELISA or comparable screening test negative), a single positive ELISA that is negative and on repeat ELISA testing that is negative
V72.61	Serologic test only - HIV-1 antibody unconfirmed (repeatedly reactive ELISA with negative WB)
V72.62	Serologic test only - HIV-1 antibody positive (WB or comparable antibody assay positive)
V72.69	Other laboratory examination

#### **A9.4. Disposition of Members Infected:**

A9.4.1. DoD Directive 1332.18, Separation From the Military Service by Reason of Physical Disability, November 4, 1996, and AFI 44-157, Medical Evaluations Boards (MEB) and Continued Military Service, provides guidelines for fitness for duty determinations.

A9.4.2. Refer AD members infected with HIV to a MEB during their initial evaluations and thereafter when dictated by the presence of clinical symptoms of immune deterioration. Reservists will be evaluated by their civilian healthcare provider using the Standard Clinical Protocol at [Attachment 9](#). Patients experiencing an opportunistic infection as defined above or HIV associated malignancies, such as Kaposi's sarcoma; other lymphoreticular malignancies; thrombocytopenia; or systemic problems, such as unexplained weight loss greater than 10 percent of their body weight, severe chronic diarrhea or fever are referred to MEB.

## Attachment 10

### RETENTION AND SEPARATION

#### A10.1. Retention:

A10.1.1. Refer AD members with laboratory evidence of HIV infection for a medical evaluation to document fitness for continued service in the same manner as personnel with other progressive illnesses. Use the standard clinical protocol to conduct the evaluation (**Attachment 9**). Members with laboratory evidence of HIV infection who are evaluated as physically fit for duty may not be separated solely on the basis of laboratory evidence of HIV infection.

A10.1.2. ARC members with laboratory evidence of HIV infection are ineligible for extended active duty for a period of more than 30 days. ARC members who are not on extended active guard and reserve tour, and who show serologic evidence of HIV infection, may be transferred involuntarily to the Standby Reserve only if they cannot be utilized in the Selected Reserve in a nonmobility position.

A10.1.3. ADAF waivers to Assignment Limitation and OCONUS travel for personnel testing positive for HIV infection who are evaluated as physically fit for duty, may be requested through HQ AFPC/DPAMM. Requests for exception to policy are reviewed on an individual basis, keeping the individual's well-being in mind. The request must be from a general officer or theater commander, and state the individual is essential for mission accomplishment. Also, the request will indicate the member will not be going to a mobility position, and adequate medical care will be available to meet the member's needs. HQ AFPC/DPAMM is the final approval authority for exception to policy for Assignment Limitation to Code C. Waivers will be issued provided there are no restrictions with the host country through the Status of Forces Agreement or other international regulation.

#### A10.2. Separation:

A10.2.1. Use AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*, to separate or retire AD members who are infected with HIV and are determined to be physically unfit for further duty.

A10.2.2. AD members with laboratory evidence of HIV infection found not to have complied with lawfully ordered preventive medicine procedures are subject to administrative and disciplinary action, which may include separation.

A10.2.3. Separation of AD members with laboratory evidence of HIV infection under the plenary authority of the Secretary of the Air Force, if requested by the member, is permitted.

A10.2.4. The immediate commander of ARC members not on extended active duty who show serologic evidence of HIV infection will determine if the member can be utilized in the Selected Reserve. If the member cannot be utilized, he/she may be transferred involuntarily to the Standby Reserve or separated. If separated, the characterization of service shall never be less than that warranted by the member's service record.

A10.2.5. Air Force members determined to have been infected with HIV at the time of enlistment or appointment are subject to discharge for erroneous enlistment or appointment.

## Attachment 11

### LIMITATIONS ON THE USE OF INFORMATION FROM EPIDEMIOLOGICAL ASSESSMENTS

#### **A11.1. Limitations of Results:**

A11.1.1. Laboratory tests results performed under this instruction may not be used as the sole basis for separation of a member. The results may be used to support a separation based on physical disability or as specifically authorized by any section in this instruction. This instruction shall not preclude use of laboratory test results in any other manner consistent with law or instruction.

A11.1.2. Laboratory test results confirming evidence of HIV infection may not be used as an independent basis for any adverse administrative action or any disciplinary action, including punitive actions under the Uniform Code of Military Justice (UCMJ) (10 U.S.C. 47, reference [j]). However, such results may be used for other purposes including, but not limited to, the following:

A11.1.2.1. Separation under the accession testing program.

A11.1.2.2. Voluntary separation for the convenience of the Government.

A11.1.2.3. Other administrative separation action authorized by Air Force policy.

A11.1.2.4. In conducting authorized Armed Services Blood Program Look Back activities.

A11.1.2.5. Other purposes (such as rebuttal or impeachment) consistent with law or instruction (e.g., the Federal or Military Rules of Evidence or the Rules of Evidence of a State), including to establish the HIV seropositivity of a member when the member disregards the preventive medicine counseling or the preventive medicine order or both in an administrative or disciplinary action based on such disregard or disobedience.

A11.1.3. HIV infection is an element in any permissible administrative or disciplinary action, including any criminal prosecution (e.g., as an element of proof of an offense charged under the UCMJ or under the code of a State or the United States).

A11.1.4. HIV infection is a proper ancillary matter in an administrative or disciplinary action, including any criminal prosecution (e.g., as a matter in aggravation in a court-martial in which the HIV positive member is convicted of an act of rape committed after being informed that he or she is HIV positive).

#### **A11.2. Limitations on the Use of Information Obtained in the Epidemiological Assessment Interview:**

A11.2.1. Information obtained from a member during, or as a result of, an epidemiological assessment interview may not be used against the member in the following situations:

A11.2.1.1. A court-martial.

A11.2.1.2. Line of duty determination.

A11.2.1.3. Nonjudicial punishment.

A11.2.1.4. Involuntary separation (other than for medical reasons).

A11.2.1.5. Administrative or punitive reduction-in-grade.

A11.2.1.6. Denial of promotion.

A11.2.1.7. An unfavorable entry in a personnel record.

A11.2.1.8. A denial to reenlistment.

A11.2.1.9. Any other action considered by the Secretary of the Air Force concerned to be an adverse personnel action.

A11.2.2. The limitations in paragraph [A11.2.1.](#) do not apply to the introduction of evidence for appropriate impeachment or rebuttal purposes in any proceeding, such as one in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the member or to disciplinary or other action based on independently derived evidence.

A11.2.3. The limitations in paragraph [A11.2.1.](#) do not apply to nonadverse personnel actions on a case-by-case basis, such as:

A11.2.3.1. Reassignment.

A11.2.3.2. Disqualification (temporary or permanent) from a personnel reliability program.

A11.2.3.3. Denial, suspension, or revocation of a security clearance.

A11.2.3.4. Suspension or termination of access to classified information.

A11.2.3.5. Removal (temporary or permanent) from flight status or other duties requiring a high degree of stability or alertness, including explosive ordnance disposal or deep-sea diving.

**A11.3. Entries in Personnel Records:** Except as authorized by this instruction, if any such personnel actions are taken because of, or are supported by, serologic evidence of HIV infection or information described in paragraph [A11.1.2.](#), no unfavorable entry may be placed in a personnel record for such actions. Recording a personnel action is not an unfavorable entry in a personnel record. Additionally, information reflecting an individual's serologic or other evidence of infection with HIV is not grounds for an unfavorable entry in a personnel record.

## Attachment 12

### PERSONNEL NOTIFICATION, MEDICAL EVALUATION, AND EPIDEMIOLOGICAL INVESTIGATION

#### **A12.1. Personnel Notification:**

A12.1.1. Once a health care authority has been notified of an individual with serologic or other laboratory/clinical evidence of HIV infection, public health and or the HIV designated physician shall undertake preventive medicine intervention. The WHMC HIV Public Health Counselor or the HIV designated physician shall coordinate with the military and civilian blood bank organizations and preventive medicine authorities to trace back possible exposure through blood transfusion or donation of infected blood and refer appropriate case-contact information to the appropriate military or civilian health authority.

A12.1.2. All individuals with serologic evidence of HIV infection who are military healthcare beneficiaries, shall be counseled by a physician or a designated healthcare provider on the significance of a positive antibody test. They shall be advised as to the mode of transmission, the appropriate precautions and personal hygiene measures required to minimize transmission through sexual activities and/or intimate contact with blood or blood products, and of the need to advise any past or future sexual partners of their infection. Women shall be advised of the risk of perinatal transmission during past, current, and future pregnancies. The individuals shall be informed that they are ineligible to donate blood, sperm, organs or tissues and shall be placed on a permanent donor deferral list.

A12.1.3. Service members identified to be at risk shall be counseled and tested for serologic evidence of HIV infection. Other DoD beneficiaries, such as retirees and family members, identified to be at risk, shall be informed of their risk and offered serologic testing, clinical evaluation, and counseling. The names of individuals identified to be at risk who are not eligible for military healthcare shall be referred to civilian health authorities in the local area where the index case is identified, unless prohibited by the appropriate State or host-nation civilian authority (See DoD 6485.1). Anonymity of the HIV index case shall be maintained, unless reporting is required by civil authorities.

A12.1.4. Blood donors who demonstrate repeatedly reactive ELISA tests for HIV, but for whom Western Blot or other confirmatory test is negative or indeterminate are not eligible for blood donor pool, shall be appropriately counseled.

#### **A12.2. Medical Evaluation:**

A12.2.1. Active duty personnel and ARC members on extended active duty who have tested positive for the HIV virus, shall be sent to Wilford Hall Medical Center for medical evaluation. All DoD directed evaluations will be completed as an outpatient, coordinated by the HIV Evaluation Unit staff. All Active Duty HIV patients undertaking their initial evaluation will undergo mental health status screening by a WHMC mental health provider.

A12.2.2. Unstable HIV patients or those patients exhibiting an active process requiring physician attention during non-duty hours will be admitted to the appropriate inpatient service.

A12.2.3. WHMC staff will conduct a confidential patient epidemiologic interview, and initiate the contact notification process. This includes a blood donation "lookback" process. A counselor will provide the disease education and risk reduction counseling during the patient interview, and complete

two copies of the standardized medical counseling form (“Prevention Medicine Counseling Record”). One copy is given to the patient, and the other copy maintained in the counselor’s confidential patient files at WHMC. If the patient refuses to sign, WHMC Directorate of Medical Law will be notified. The “Order to Follow Preventive Medicine Requirements” is issued by the unit commander of an HIV infected person prior to the patient’s initial evaluation by the HIV unit.

A12.2.4. All HIV infected active duty and and TDRL personnel arriving at Wilford Hall will receive medical evaluation and staging of their HIV disease by the HIV unit physician. The unit physician will also provide disease specific patient education and appropriate treatment recommendations, and serve as liaison with consulting or inpatient services when necessary. The HIV unit physician will also coordinate with the patient’s primary provider for ongoing patient management and any issues concerning scheduled reevaluations.

### **A12.3. Epidemiological Investigation:**

A12.3.1. Epidemiological investigation shall attempt to determine potential contacts of patients who have serologic or other laboratory or clinical evidence of HIV infection. The patient shall be informed of the importance of case-contact notification to interrupt disease transmission and shall be informed that contacts shall be advised of their potential exposure to HIV. Individuals at risk of infection include sexual contacts (male or female); children born to infected mothers; recipients of blood, blood products, organs, tissues, or sperm; and users of contaminated intravenous drug paraphernalia. At risk individuals who are eligible for healthcare in the military medical system shall be notified. Additionally, per DoD directive, Military Departments provide for the notification, either through local public health authorities or by DoD healthcare professionals, of the spouses of Reserve component members found to be HIV infected. Such notifications shall comply with the “Privacy Act of 1974” (See DoD 6485.1). The Secretaries of the Military Departments shall designate all spouses (regardless of the Service affiliation of the HIV infected Reservist) who are notified under this provision to receive serologic testing and counseling on a voluntary basis from MTF’s under the Secretaries’ of the Military Departments jurisdiction.

A12.3.2. Communicable disease reporting procedures shall be followed consistent with this Directive through liaison between the military public health authorities and the appropriate local, State, Territorial, Federal, or host-nation health jurisdiction.

## Attachment 13

### PROCEDURE FOR EVALUATING T-HELPER CELL COUNT

#### A13.1. Analytical Procedure:

A13.1.1. Determine the percentage of CD4+&CD3+ positive lymphocytes by immunophenotyping blood cells using flow-cytometry instrumentation. Each laboratory performing T-helper cell counts maintains a current and complete standard operating procedure manual. The absolute T-helper cell count is a product of the percentage of T-helper cells (defined as CD4+&CD3+ positive lymphocytes) and the absolute lymphocyte level.

A13.1.2. Equip flow-cytometry instruments for two, three, or four-color fluorochrome analysis. Additionally, equipment will have logarithmic scale capability with a minimum measure output of three decades and provide simultaneous 4-parameter analysis including right-angle light scatter, forward-angle light scatter and at least 2-color simultaneous color fluorescence measurement.

A13.1.3. Flow cytometry analysis must distinguish between the following cell surface phenotypic expressions using in vitro diagnostic approved monoclonal antibodies when possible: CD3, CD4, CD8, CD14, CD45, CD56 and/or CD56/16, and a B lymphocyte marker of either CD19 or CD20. Due to the ready availability of directly conjugated monoclonal reagents, no indirect staining procedures are used for the above lymphocyte markers. A monoclonal antibody that does not universally identify CD4 cells in all specimens shall not be used for the determination of CD4 lymphocytes. Only reagents with specificity to CD3, CD4, CD8, CD14, CD19, CD20, and CD45, CD56 and/or CD56/16 are acceptable under this procedure.

A13.1.4. Draw blood specimens for the absolute lymphocyte count and lymphocyte immunophenotype during the same venipuncture between 0600 and 0900 hours. The absolute lymphocyte count is performed on an ethylenediamine tetra-acetate (EDTA) anticoagulated whole blood specimen within four hours of specimen collection. Heparinized whole blood can be used for immunophenotyping, but not for absolute lymphocyte counts. For shipped samples, the absolute lymphocyte count must be performed locally, within this time limit, and results forwarded with the sample submitted for flow-cytometry. Determine the absolute lymphocyte count on an automated hematology instrument with a locally verified interrun and intrarun coefficient of variation of less than five percent. Use the whole blood lysate procedure for flow-cytometry cell preparations. Stain and lyse flow-cytometry specimens within a time period that has been locally demonstrated to yield an overall cell viability greater than 90 percent. Stain and lyse blood specimens by a standard method detailed in the laboratory director's operating procedure manual. All blood specimens for 2 or 3-color cell surface phenotyping shall be analyzed for nonspecific binding with vendor-matched, isotype-matched, and conjugate-matched control antibody reagents for each test antibody used. As this standard applies to lymphocyte immunophenotyping, lymphocyte populations shall be defined by those cells gated on forward- and right-angle light scatter that are at least 95 percent positive for CD45 (the brightest CD45 population that is specific for lymphocytes) and no more than five percent positive for CD14. Gating and use of isotype controls for color flow-cytometry should comply with guidelines from the Public Health Service and/or the AIDS Clinical Trial Group as they are developed. Analysis should be performed on cells suspended in a fixative, such as buffered paraformaldehyde.

#### A13.2. Internal Quality Control Program:

A13.2.1. Each laboratory maintains a comprehensive internal quality control program. Minimally, on each day of operation monitor the following flow-cytometry procedures or reagents:

A13.2.1.1. Optical focusing and alignment of all lenses and light paths for forward-angle light scatter, right-angle light scatter, red fluorescence, and green fluorescence if these functions are adjustable on the instrument.

A13.2.1.2. Standardize fluorescent intensity beads, particles, or cells with fluorescence in the range of biological samples.

A13.2.1.3. Verify fluorescent compensation beads, particles, or cells with fluorescence in the range of biological samples.

A13.2.1.4. A human blood control sample or equivalent.

A13.2.2. Each laboratory establishes tolerance limits for each of the procedures or reagents in paragraph [A13.1](#). Take corrective action and document when any quality control reagent exceeds established tolerance limits. Accomplish routine maintenance and function verification checks. The laboratory director regularly reviews corrective and quality control records.

**A13.3. External Quality Control Program:** The Army establishes and operates an external quality control program to evaluate the results reported by the flow-cytometry laboratories. The external quality control program includes a hematology survey to monitor the performance of the absolute lymphocyte count and a flow-cytometry survey to monitor the performance of each immunophenotyping procedure.

**A13.4. Recording and Reporting Data:** The laboratory director reviews and verifies the reported results. The laboratory report contains data from which absolute and relative values may be calculated for each lymphocyte subpopulation along with locally derived normal ranges inclusive of the fifth and ninety-fifth percentiles. The laboratory maintains permanent files of patient reports, internal and external quality control records, and instrument maintenance and performance verification checks.

**A13.5. Personnel Qualifications:**

A13.5.1. Properly train all personnel involved with the flow-cytometry instrumentation.

A13.5.2. Director of the flow-cytometry laboratory holds a doctoral degree in a biologic science or is a physician and possesses experience in immunology or cell biology.

A13.5.3. Technical supervisor holds a bachelor's degree in a biological science and has at least two years of experience in flow-cytometry.

**A13.6. Safety:** All laboratories comply with the CDC biosafety level 2 standards. All procedures having the potential to create infectious aerosols shall be conducted within the confines of a Class II biological safety cabinet. Although certain specimen processing procedures may inactivate infectious agents, all material is treated as infectious throughout all procedures. Decontaminate all material generated in the processing and evaluation of blood specimens and dispose of using established hazardous waste disposal policies.

**Attachment 14****ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS**

Because of the necessity to safeguard the overall health, welfare, safety, and reputation of this command and to ensure unit readiness and the ability of the unit to accomplish its mission, certain behavior and unsafe health procedures must be proscribed for members who are diagnosed as positive for HIV infection.

As a military member who has been diagnosed as positive for HIV infection, you are hereby ordered: (1) to verbally inform sexual partners that you are HIV positive prior to engaging in sexual relations. This order extends to sexual relations with other military members, military dependents, civilian employees of DoD components or any other persons; (2) to use proper methods to prevent the transfer of body fluids during sexual relations, including the use of condoms providing an adequate barrier for HIV (e.g. latex); (3) in the event that you require emergency care, to inform personnel responding to your emergency that you are HIV positive as soon as you are physically able to do so.

(4) when seeking medical care, you may wish to inform the provider that you have HIV so that the provider can use that information to optimize your evaluation and treatment; (5) not to donate blood, sperm, tissues, or other organs.

Violating the terms of this order may result in adverse administrative action or punishment under the Uniform Code of Military Justice for violation of a lawful order.

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Signature of Commander and Date

### ACKNOWLEDGMENT

I have read and understand the terms of this order and acknowledge that I have a duty to obey this order. I understand that I must inform sexual partners, including other military members, military dependents, civilian employees of DoD components, or any other persons, that I am HIV positive prior to sexual relations; that I must use proper methods to prevent the transfer of body fluids while engaging in sexual relations, including the use of condoms providing an adequate barrier for HIV; that if I need emergency care I will inform personnel responding to my emergency that I am HIV positive as soon as I am physically able to do so; that when I seek medical or dental care I may wish to inform the provider that I have HIV in order to optimize my evaluation and treatment;

and that I must not donate blood, sperm, tissues, or other organs. I understand that violations of this order may result in adverse administrative actions or punishment under the Uniform Code of Military Justice for violation of a lawful order.

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Signature of Member and Date

**Attachment 15****IC 2004-1 TO AFI 48-135, HUMAN IMMUNODEFICIENCY VIRUS****12 MAY 2004*****SUMMARY OF REVISIONS***

This interim change implements new policy establishing a maximum two-year interval between routine Human Immunodeficiency Virus (HIV) testing for active duty members and establishes requirement for Air Reserve Component (ARC) personnel to have a current HIV test within two years of the date called to active duty for 30 days or more. The interim change also rescinds the requirements for HIV testing prior to overseas assignment, current HIV test within 12 months of continuous overseas tours, and annual HIV testing of personnel who perform exposure-prone procedures.

3.2. All ADAF personnel are screened for serological evidence of HIV infection every two years, preferably during their Preventive Health Assessment (PHA); for clinically indicated reasons; with newly diagnosed active tuberculosis; during pregnancy; when diagnosed with a sexually transmitted disease (STD); upon entry to drug or alcohol treatment programs (**Attachment 4**), or prior to incarceration. HIV testing is conducted IAW **Attachment 4**, recorded IAW **Attachment 5**, and interpreted IAW **Attachment 6**.

3.3. ARC personnel are screened for serological evidence of HIV infection at an interval not to exceed five years, preferably during their PHA (Reserve Component PHA or ARCPHA). ARC members will have a current HIV test within two years of the date called to active duty for 30 days or more. HIV testing is conducted IAW **Attachment 4**, recorded IAW **Attachment 5**, and interpreted IAW **Attachment 6**.

A4.3. Permanent Change of Station to Overseas (PCS Overseas) Testing. HIV testing prior to PCS assignment overseas or current HIV test within 12 months of consecutive overseas tours is no longer required (this entire section is rescinded).

A4.7.3. Personnel who perform exposure-prone procedures (to include, but not limited to, surgeons, pathologists, dentists, dental technicians, phlebotomists, emergency medical technicians, and physicians, nurses and technicians working in the emergency room, intensive care, surgery, and labor/delivery) should know their HIV antibody status.

A5.4. **Source Code.** The only authorized codes used in the appropriate block on the AF Form 1762 are listed below. These codes identify the reason that the individual is being screened. They were adopted for use throughout DoD by the Reportable Disease Data Base (RDDB) Working Group. A single code is entered on the AF Form 1762. Multiple codes for an individual are not authorized:

A -- Alcohol and Drug Treatment

B -- Blood Donor (Authorized for use on specimens or confirmation specimens)

C -- Contact Testing (Referral)

F -- Force Screening (routine screening of personnel)

I -- Indicated for Clinical Reasons

J -- Prisoners or Detained Persons

N -- Pre-deployment

O -- OB Clinic/Pregnancy Related

P -- Physical Examinations

R -- Requested by Individual

T -- Post-deployment

V -- STD Clinic Visit

X -- Any Other Source (used only in extremely rare cases)