Commissioned Corps BULLETIN

Division of Commissioned Personnel • Program Support Center, DHHS

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Surgeon General's Column

Nearly 2 years after the tragic event that took place at Columbine High School in April 1999, we can almost recall the details just as if it were yesterday. The final death toll rang at 14 dead—12 victims and 2 perpetrators—not to mention the millions of American parents and youth who were left bewildered and stunned at seeing so many young lives taken in one place in one day.

It was that catalyzing event that caused Americans to stand up and take notice of our children's behaviors and ability—or inability—to cope with the day-to-day stresses that so many of them face. But what may have gone unnoticed until then was the fact that everyday in America, 13 children die as a result of gun violence—maybe not in a single schoolyard event, but in individual communities all across this country. The problem of youth violence was and still is real. And it was that event that led to the first-ever *Surgeon General's Report on Youth Violence*, summarizing what research has taught us about youth violence.

This report's messages can be summed up in three main messages: *Word of Caution*, *Note of Optimism*, and *Major Challenge* for the Nation—not only at the Federal level, but also for every family, school, and community.

Word of Caution

The Word of Caution is that the youth violence epidemic is not over. There was a dramatic increase in violence between 1983 and 1993. Declines in key markers of youth violence are real and substantial. Youth homicide, robbery, and rape arrest rates in 1999 were actually lower than they were in 1983, prior to the violence epidemic. Weapons carrying and use in violent crimes have declined.

At the same time, however, rates of arrest for aggravated assault remain nearly 70 percent higher than in 1983, and self-report studies indicate that the proportion of youth involved in violent behavior and the rates of violent offending have not declined since the peak years in the mid-1990s. There is considerable evidence from the Youth Risk Behavior Surveys that youth involvement in serious forms of violent behavior is quite stable over time and remains a serious national problem.

This is no time to become complacent. If youths in this country should start carrying and using weapons as they did a decade ago, this country could see a resurgence of the lethal violence we saw at the peak of this epidemic.

Note of Optimism

The Note of Optimism is that the problem of youth violence is not intractable. Research evaluations have clearly shown that specific intervention programs are highly effective in preventing serious violent behavior and/or eliminating major risk factors for violence. Because these studies have met rigorous scientific standards, we can implement these selected intervention programs on a national scale with a high degree of confidence.

Major Challenge

The Major Challenge is to direct and redirect resources toward effective, research-based prevention strategies and programs. Most of the violence prevention strategies and interventions currently employed at both the national and local levels either have not been evaluated with rigor or have been evaluated and found to be ineffective. The Nation cannot afford to waste resources on ineffective or harmful interventions and strategies—or to further jeopardize the well-being of youth who may be assigned to ineffective programs.

It is essential to disseminate scientifically validated studies, to provide resources and incentives for their implementation, and to provide schools and communities the resources needed to evaluate programs that appear promising. In general, risk factors for youth violence include drugs, guns, involvement in serious criminal behavior, precocious sex, and other risky behaviors that often lead to serious violence. But the level of influence various risk factors have on a person varies depending on where they are in their development.

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Published as part of the Commissioned Corps Personnel Manual for Public Health Service Commissioned Corps officers. Forward news of Service-wide or special interest to Division of Commissioned Personnel/HRS/PSC, Room 4A-15, 5600 Fishers Lane, Rockville, MD 20857-0001, Phone: 301-594-3462.

Director, DCP/HRS/PSC RADM R. Michael Davidson

Editor Mrs. Virginia Kapusnick

Surgeon General's Column

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The report found that there are two "onset trajectories" for youth violence—an early one, where violence begins before puberty, and a late one, in which violence begins in adolescence. Youths who become violent before about age 13 generally commit more crimes—and more serious crimes—for a longer time.

During childhood, the strongest risk factors are involvement in serious criminal behavior, substance abuse, being male, physical aggression, poverty, and antisocial behavior. But during adolescence, family influence is supplanted by peer influences. Involvement with delinquent peers and gang membership, and involvement in criminal acts are also major risk factors for youth violence. That includes illicit drug use.

The most critical risk factor for violence for children is the behavior of their peers. That is why gang membership is such a serious risk. This means parents need to know who their children's friends are and they need to encourage healthy peer relationships.

A wide variety of school-based programs are very effective in dealing with problems including drug use, bullying and peer relations, and competence/skill building. According to kids' own reports, bullying and drugs are the major problems they have to deal with at school, but these are often not acknowledged by the adults in the school system.

We found that the most effective programs involve a comprehensive approach and do not focus simply on one factor. But, to be successful, these programs must take into account individual risks and the environment, as well as involve parent training, the family, schools, peer groups, and the community.

Considerable concern has been expressed about the effects of media violence on young people. This report found evidence that exposure to violence in the media can increase children's "aggressive behavior" in the short-term. However, it found that it was extremely difficult to separate out the relatively small long-term effects of exposure to media violence and those of other influences. More research is needed in this area and more research is recommended.

The report also challenges the notion that getting tough with juvenile offenders by trying them in adult criminal courts will reduce the likelihood of their committing more crimes. The fact is that youths transferred to adult criminal court have much higher rates of re-offending and a greater likelihood of committing subsequent felonies than youths who remain in the juvenile justice system. They are also more likely to be victimized, physically and sexually.

The Vision for the Future

This report identifies several possible courses of action that should become the basis for our efforts to preventing violence among youth in the future.

- We must accelerate the decline in gun use by youths in violent encounters, which we have experienced in the last 8 years.
- We must continue to build the science base.
- We must facilitate youth entry into effective intervention programs, where possible, rather than just incarcerating them. This is not just smart, it's also cost-effective.
- We must share model programs throughout the country and offer incentives to ensure that they are held to the program's original design in order to maintain their effectiveness. Strategies must be tailored to the needs of youth at every stage of development, from young childhood to adolescence and beyond.
- We must continue to train and offer certification programs for intervention personnel.
- We must improve strategies at the Federal, State, and local levels for reporting crime information and violent deaths.

Let me leave you with this quote by Plutarch, the ancient philosopher, who once said: "Perseverance is more prevailing than violence; and many things which cannot be overcome when they are together, yield themselves up when taken little by little."

VADM David Satcher
Surgeon General

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SECOND NOTICE! DCP Vacancy Announcement Database

As announced in the February issue, vacancy announcements will no longer be included in the *Commissioned Corps Bulletin*. Those monthly listings have been replaced with a vacancy database that contains hundreds of vacancies and is maintained by the Division of Commissioned Personnel (DCP) on a daily basis.

To get to the system, do the following:

- Go to the DCP web site—http://dcp.psc.gov
- Click on "Jobs"
- Click on "Commissioned Corps Jobs Vacancies Database"

Agencies/Operating Divisions/Programs that would like to have a vacancy included in DCP's database, or anyone who has questions or comments, should contact:

LCDR Kellie Clelland
Recruitment and Assignment Branch
Division of Commissioned Personnel
5600 Fishers Lane, Room 4A-18
Rockville, MD 20857-0001
Phone: 301-594-3484 (or toll-free at 1-877-INFO-DCP, listen to the prompts, select option #1, dial 43484)
E-mail: kclelland@psc.gov

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Reminder!

Update Your Contact Information on the DCP Web Site

Whenever your home address, telephone number(s), fax number, or e-mail address changes, please remember to update your contact information on the Division of Commissioned Personnel's (DCP) web site—http://dcp.psc.gov Select the "Secure Area" option from the menu and then select "Officer and Liaison Activities." Enter your ID and password and follow the link to "Update Your Contact Information."

If you do not know your access information, contact the DCP Help Desk at 301-594-0961.

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IMPORTANT INFORMATION! Servicemembers' Group Life Insurance Benefit Increases to $250,000

As required by law, effective April 1, 2001, all active-duty officers will become insured for the maximum Servicemembers' Group Life Insurance (SGLI) coverage of $250,000, even if they previously declined coverage or elected reduced coverage. The monthly premium for SGLI will remain at $.80 per $10,000 of coverage. Therefore, $20 will become the monthly premium for full coverage.

Should an officer desire less than the automatic maximum coverage or no coverage, he or she must complete form SGLV-8286 (April 2001 version) indicating the amount of coverage desired (including no coverage) and forward it to the Compensation Branch (CB), Division of Commissioned Personnel (DCP), as expeditiously as possible. On or after April 1, 2001, an officer may (1) decline coverage, or (2) elect a reduced level of insurance in a multiple of $10,000. New SGLI elections become effective the first day of the month after an election is received by CB. Thus, all officers will be fully insured for $250,000 throughout the month of April 2001 regardless of any election filed during the month.

All requests for reduced (or no) coverage must be received by CB no later than **April 13, 2001** to ensure proper premium deductions in the April payroll. Any officer who does not make a reduced or declined election by this date will be charged for the full $250,000 of coverage for April as well as for any other month in which the level of coverage remains in effect. If a properly completed form is received in CB between April 14, 2001 and April 30, 2001, there will be a $20 April payroll premium deduction, with an appropriate premium adjustment in the May payroll.

The revised form SGLV-8286 will be available on the Department of Veterans Affairs web site (www. insurance.va.gov/forms/8286.pdf) on **April 1, 2001**. There will be a link from the DCP web site—http://dcp.psc.gov. This is a legal document, therefore, form SGLV-8286 with an **original signature** is required. Fax or electronic documents will *not* be accepted. **NOTE:** Contrary to the instructions on SGLV-8286, Public Health Service (PHS) Commissioned Corps officers ***do not*** need to have form SGLV-8286 witnessed prior to sending to CB.

It is important to note that no election made before April 1, 2001, will apply in regard to a member's level of coverage. Existing beneficiary designations will remain effective until a new form SGLV-8286 is properly completed. SGLI beneficiary payments for deaths on or after the effective date of the new coverage and before completion of a new form SGLV-8286 (April 2001 version) will be allocated in the same proportions as the last valid SGLV-8286 completed by the member.

While the completion of a new SGLV-8286 is not necessary if full coverage is desired, this is a good time to review existing beneficiary elections to ensure they remain appropriate. You may check beneficiary designations in your Official Personnel File (OPF) at the DCP web site—http://dcp.psc.gov. Once at the web site, select the "Secure Area" pull down menu, followed by the "Officer and Liaison Activities". Once your login is complete, select "Access Personnel Record", then select "View OPF" followed by "Subset of OPF". Select "Insurance Forms" and enter your PHS number before selecting "Search". If you wish to make new beneficiary designations, a new form SGLV-8286 should be submitted.

Mail or deliver the completed form SGLV-8286 (with original signature) to:

Division of Commissioned Personnel
ATTN: Compensation Branch
5600 Fishers Lane, Room 4-50
Rockville, MD 20857-0001

Do not route these forms through your Agency/Operating Division/ Program Liaison. Officers are encouraged to **keep a copy** of the signed form SGLV-8286 with their important personal papers.

If you have questions about the SGLI program, you are encouraged to visit—www.insurance.va.gov/sglivgli/sglivgli.htm—to view frequently asked questions and the *SGLI Handbook*.

The following examples may be helpful to you:

1. An officer previously declined SGLI coverage and still wishes to decline coverage. The officer must so designate by completing a form SGLV-8286 on or after April 1, 2001 and submitting it to CB. A form signed and dated prior to April 1 will have no effect on the level of coverage after April 1 (as required by law).
2. An officer chooses to be insured for $100,000 and completes a form SGLV-8286. CB receives the form on April 13, 2001. There will be an April payroll premium deduction for $8. This officer will be covered at the $250,000 level for the month of April, but coverage will be reduced to $100,000 on May 1.
3. An officer chooses to be insured for $100,000 and completes a form SGLV-8286. CB receives the form on April 25, 2001. There will be an April payroll premium deduction for $20 and there will be an premium adjustment in the May payroll. This officer will be covered at the $250,000 level for the month of April, but coverage will be reduced to $100,000 on May 1.
4. An officer chooses to be insured for $100,000 and completes a form SGLV-8286. CB receives the form on May 15, 2001. The officer will be charged the full maximum coverage for the months of April and May 2001, and coverage will be lowered effective June 1, 2001.

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RETIREMENT NEWS

TRICARE Enhancements for Retired Officers

Attention Retired Officers—
To be eligible for the new TRICARE For Life (TFL) program, retired officers must be Medicare-eligible, enrolled in Medicare Part B, and the Defense Enrollment Eligibility Reporting System (DEERS) must be updated to reflect their Part B eligibility.

To enroll in Part B you should contact your local Social Security Administration office during the General Enrollment Period (GEP) which starts January 1 and ends **March 31** each year. If you enroll during the 2001 GEP, your Part B coverage will start on July 1, and you will get TFL when it starts on October 1. If you do not enroll in Part B by the end of the GEP, you will not be eligible for TFL when it starts on October 1.

Current plans call for the Department of Defense to implement an automated process for obtaining Medicare information from the Health Care Financing Administration and entering this information into DEERS. **Therefore, if you have enrolled in Medicare Part B, no further action is required of you at this time.**

For services payable by both Medicare and TRICARE (TRICARE is always second payer to Medicare), TRICARE will pay the Medicare Part A inpatient deductible ($800) plus all Medicare copayments through the Medicare 150-day maximum stay (i.e., 90 days plus 60-day lifetime reserve). TRICARE will also pay the Medicare Part B annual deductible plus Medicare copayments up to 115 percent of the Medicare Maximum Allowable Charge (the legal maximum). Providers charging more are subject to civil penalties.

For services covered by Medicare but not TRICARE, no payment will be made by TRICARE. In this case, the beneficiary pays any applicable Medicare deductible and cost share. For services covered by TRICARE but not Medicare, the primary payer would be TRICARE. The beneficiary pays any applicable TRICARE deductible and cost shares. Unless it is the first claim of the year, the deductible probably would have been satisfied through previous Medicare payments, and the beneficiary would pay only the cost shares.

To be eligible for the TRICARE Senior Pharmacy Program, which goes into effect April 1, 2001, you must be: (1) 65 or older; (2) entitled to Medicare Part A; and (3) enrolled in Medicare Part B (unless you attained age 65 prior to April 1, 2001).

For questions on DEERS eligibility, you may call the Public Health Service DEERS office in the Division of Commissioned Personnel (DCP), at 301-594-3384 (or toll-free at 1-877-INFO DCP, listen to the prompts, select option #1 and dial 43384). For questions on TRICARE For Life you should call the Medical Affairs Branch, DCP, at 1-800-368-2777. □

PHS-1 DMAT Deployed for the Presidential Inauguration

Twenty-four members of the Public Health Service (PHS) Disaster Medical Assistance Team (PHS-1 DMAT) were deployed from Rockville, Maryland, to downtown Washington, D.C. at 4 a.m. on January 20, 2001, to provide medical support for the Presidential Inauguration. The team remained about three blocks from the Capitol throughout the inaugural ceremony and the inaugural parade. The team returned to Rockville about 7 p.m.

If a mass-casualty event had occurred, the PHS-1 DMAT would have provided a casualty collection point where patients would have been triaged, stabilized, and monitored until they could be transported to area medical facilities. The DMAT was well prepared, with assistance of numerous other DMAT members who prepared supplies prior to the deployment, and represented the PHS in an exemplary manner.

Thanks go to the members of the PHS-1 DMAT for their dedication to protecting public health by providing medical support for this important National event. □

Commissioned Officer Leave Tracking System Update

The Division of Commissioned Personnel (DCP) has developed an automated Commissioned Officer Leave Tracking System (COLTS). COLTS provides an enhanced, web-based version of form PHS-31, "Officer's Leave Record," thereby providing leave maintenance clerks an automated tool to accurately record commissioned corps officers' annual leave via the Internet.

DCP's long-term objective to is provide an enhanced, online version of form PHS-1345, "Request and Authority for Leave," but DCP's immediate objective is to replace form PHS-31 with this automated system that provides a centralized record of leave data. This data provides immediate information not only to all leave maintenance clerks and officers, but also to budgetary personnel for the purpose of establishing leave liability. This information will eliminate the process of leave reconciliation required at the time of separation.

Due to the large number of leave maintenance clerks, COLTS is being phased in over a period of several months, with complete deployment planned by the end of Fiscal Year 2001. Deployment of the following Operating Divisions/Programs is as follows: Food and Drug Administration - March; Centers for Disease Control and Prevention *and* Agency for Toxic Substances and Disease Registry - April; National Institutes of Health - May; and Bureau of Prisons - June.

If your Operating Division/Program's leave maintenance clerks have initialized your leave record, you can view your annual leave balance and leave history by logging onto the DCP web site—http://dcp.psc.gov. Select the "Secure Area" option from the menu and then select COLTS. The User ID and Password issued to you to view your Official Personnel File is also used to access COLTS.

If you have any questions or difficulty accessing COLTS, please contact the DCP Help Desk at 301-594-0961. □

Office of the Surgeon General

Oral Health in America: A Report of the Surgeon General

On May 25, 2000, Surgeon General David Satcher released *Oral Health in America: A Report of the Surgeon General*, the first such report dedicated to this topic. The major message of the report is that oral health means much more than healthy teeth—it is integral to the general health and well-being of all Americans. The report reminds us that the mouth reflects general health and identifies the association between oral health problems and other health problems. Oral health must be included in the provision of healthcare and design of community programs.

Safe and effective means of maintaining oral health that everyone can adopt to improve oral health and prevent disease, have benefitted the majority of Americans over the past half century. However, the report also identifies population groups that have yet to benefit. Despite more than $60 billion in annual expenditures, studies indicate an alarming incidence of poor oral health in this country. Many experience needless pain and suffering, complications that can devastate overall health and well-being, and financial and social costs that significantly diminish the quality of life.

Tooth decay remains the most common chronic childhood disease, and about 30 percent of the people in each age group have untreated dental decay, increasing their risk of symptoms and tooth loss. Nearly one in seven Americans has severe periodontal disease by the time they are 54 years old, half of which is attributable to smoking cigarettes. In addition, oral and pharyngeal cancers are diagnosed in about 30,000 Americans each year, with 8,000 people dying annually from these diseases.

For every person without medical insurance there are almost three without dental insurance; making access to dental care a problem for low-income and minority families. Children from these families have a much higher rate of untreated dental decay compared to children in the general population. With these daunting statistics, healthcare providers need to emphasize the importance of dental health to patients of all ages, and address lifestyle behaviors that directly affect oral health. They need to educate their patients and communities as to the value of proper oral hygiene, including daily use of fluoride toothpaste, limiting between-meal snacks, and regular professional care.

This must begin early in life, and children should have their first dental assessment by a health professional at age 1, with examination by a dentist no later than age 3. This exam is not just to look for tooth decay, but to assess the child's oral health and the lifestyles and behaviors being promoted by his or her parents.

It is very important that healthcare providers understand that "baby teeth" are essential for nutrition, speech, and psycho-social development. Young children suffering with a toothache may be unable to verbalize the discomfort or recognize the source, which may lead to failure to thrive or adverse behavior patterns, such as loss of concentration, frustration, anger, sleep disruption, or low school performance.

Use of fluoridated drinking water, daily use of fluoride toothpaste, attention to between-meal dietary practices, and placement of dental sealants on chewing surfaces of permanent molars at age 6 and 12 years can virtually eliminate tooth decay. Yet 100 million Americans do not have fluoridated water and less than one in ten poor children have sealants.

Among adults, effective oral hygiene and tobacco cessation and regular dental care should reduce the risk of losing teeth due to periodontal disease, and control the inflammatory processes that may influence the association of periodontal disease with cardiovascular disease, diabetic complications, and pre-term low birth-weight children. Also, oral cancer screening by either a dentist or physician should be accomplished regularly, especially for people who smoke or chew tobacco and use alcohol, who have a significantly higher rate of oral cancer. For adolescents and adults, we must expand initiatives to prevent tobacco use, improve diet, and encourage the use of protective mouth gear to prevent sports injuries.

This is a report about oral health, not dentistry. Consequently, every category in the Public Health Service Commissioned Corps has a role contributing to the balanced community health system that supports oral health improvement. Action at all levels of society, from individuals to communities and the Nation as a whole, are needed to maintain the health and well-being of Americans already enjoying good oral health and to address the disparities in oral health status. A coordinated effort can overcome the educational, environmental, social, health systems, and financial barriers that have created vulnerable populations whose oral health is at risk.

Perceptions must be changed among the general public, among policymakers, and among healthcare providers as to the importance oral health. The role of the health professions in promoting oral health should include encouraging routine dental exams, increasing public understanding and awareness of the importance of oral health, and recognizing the additional stumbling blocks in the quest to maintain good oral health that people with low income or minority status face. Barriers to seeking and obtaining professional help must be removed. It is also important that we continue further research to build the science base on oral health and apply the findings in practice. We also need to build an effective infrastructure that meets the needs of all Americans and integrates oral health effectively into overall health. We must develop more public-private partnerships to provide opportunities for individuals, communities, and health professionals to work together to maintain and improve the Nation's oral health.

Over the next several months, Operating Divisions of the Department will be outlining a national oral health plan that responds to the issues identified in the *Oral Health in America: A Report of the Surgeon General*. To learn more, follow the links from the Surgeon General's web site, or go directly to http://www.nidr.nih.gov/sgr/sgr.htm

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Commissioned Corps Readiness Force

Programmatic Changes

In the last 2 years, the Commissioned Corps Readiness Force (CCRF) has become an important operating unit of the commissioned corps, deploying eight times in 1999 and nine times in 2000. As with any new, organic organization, several adjustments and additions need to be implemented. The CCRF Policy Advisory Group and the Surgeon General have recently approved several significant changes in the CCRF program, all of which are targeted at deploying trained, competent, physically fit, immunized officers who, as representatives of the finest health service in the world, will always put our best foot forward.

Training—CCRF officers will be required to complete web-based training modules that are now available on the CCRF web site. These modules were developed in cooperation with the National Disaster Medical System (NDMS) through an agreement with the University of Maryland, Baltimore County, and will provide instruction in areas related to disaster management and emergency response. When the entire training program is completed, officers will receive continuing professional education credit for the course work at no cost to the individual. Access to the modules is restricted to *current* CCRF members. For more information, please access the CCRF web site—http://oep.osophs.dhhs.gov/ccrf

Immunizations—CCRF officers will be required to obtain vaccinations for many vaccine-preventable illnesses that may place them at risk in a disaster setting. Specific information is available on the CCRF web site.

Currency/Competency—Because of the high visibility of deploying officers, it is an absolute necessity that they be competent and current in their role as a healthcare provider. By January 2002, CCRF officers must provide evidence that they have worked a minimum of 112 hours annually in the clinical role in which they have chosen to deploy. Officers who normally work in an administrative environment will be asked to work in a community healthcare setting or in a temporary duty (TDY) assignment with one of several Agencies/Operating Divisions (OPDIVs)/Programs which have indicated a willingness to support this activity. The CCRF web site will soon contain information on TDY assignments that officers can utilize to satisfy this requirement.

Physical Fitness—Disaster settings often require that officers work 12-hour days, endure prolonged standing, walking significant distances, unloading and carrying equipment, pitching tents, and lifting stretchers. These activities are sometimes in a less than temperate environment, wherein individuals are placed at additional stress. Unprepared deployed officers could actually become liabilities when required to physically exert themselves. Additionally, the Surgeon General's *Healthy Lifestyles* initiative is something that should be followed by all commissioned officers. The new requirements for the Field Medical Readiness Badge contain a physical fitness component. For these reasons, by January 1, 2002, CCRF officers will annually be required to successfully complete a CCRF Physical Fitness Evaluation. This evaluation can be accessed on the CCRF web site.

Note: LT Stephen Spaulding at St. Elizabeths Hospital heard about this program change and challenged the officers and civil servants on the campus to complete the CCRF Physical Fitness Evaluation. Nineteen officers and several civilians turned out to attempt to complete the evaluation. Most were successful. As a result, the campus now has a significant number of employees engaged in an ongoing physical fitness program. CAPT Jeanette Wick, Commissioned Corps Liaison, reports that the program has been an excellent morale booster for the staff.

Height/Weight Standards—Again drawing on the high visibility of deploying officers in uniform, the CCRF wishes to maximize the benefit of their efforts rather than risk focusing negative attention on an officer's appearance. CCRF officers will be required to meet the commissioned corps Height/Weight Standards employed by the Medical Affairs Branch, Division of Commissioned Personnel, in determining who is eligible for a commission. These standards are available on the CCRF web site.

Increase the Ready Rosters—There are currently four Ready Rosters, containing approximately 80 officers from various Agencies/OPDIVs/Programs, geographic areas, and professional categories. In the last 6 months, more than 250 officers have become roster qualified, and are awaiting assignment. In March, CCRF will add Rosters Five, Six, and Seven. Starting in March, officers on a roster will be eligible to deploy every 7 months. By increasing the number of rosters, this will allow: (1) CCRF to request release of an officer from Agencies/OPDIVs/Programs twice yearly rather than three times a year; (2) it will accommodate new CCRF candidates; and (3) it will allow officers to deploy in different months in succeeding years. Officers who become roster-eligible will be added to existing rosters quarterly.

Update on Awards

For a synopsis of recent changes in the commissioned corps awards that are associated with the CCRF and NDMS—Field Medical Readiness Badge, Crisis Response Service Award, National Emergency Preparedness Award— please refer to the CCRF web site.

Officers on a variety of deployments (listed below) have recently received recognition for their activities. The names of the officers receiving the awards are on the CCRF web site.

Crisis Response Service Award—Nine nurse officers who deployed to the Maniilaq Health Center in Kotzebue, Alaska, received this award for assisting in delivering healthcare to the native Alaskan people. (See story on page 2 of the January 2001 issue of the *Commissioned Corps Bulletin*.)

NOAA Corps International Service Award—Ten medical providers who deployed on National Oceanic and Atmospheric Administration (NOAA) ships for

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Commissioned Corps Readiness Force

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14 to 31 days were awarded the NOAA Corps International Service Award in appreciation for their service to the officers, crew, and scientists onboard the *MacArthur* and the *Starr Jordan*, during the 5-month long Marine Mammal Study this past summer.

Field Medical Readiness Badge (FMRB)—The names of 20 officers who are the last group to earn the FMRB under the original award requirements are listed on the CCRF web site. All future awardees of the FMRB will qualify for the badge under the new requirements, which are also available on the CCRF web site.

Recent Activities

Presidential Inauguration

Several CCRF officers deployed in a variety of roles to support the Office of the U.S. Capitol Attending Physician during the events surrounding the Presidential Inauguration. Six CCRF officers supplemented NDMS as members of Advanced Cardiac Life Support (ACLS) teams that were stationed in the crowd at the foot of the Capitol and in the Sam Rayburn House of Representatives Office Building. The ACLS teams saw a total of 109 patients during a 3-hour period with a variety of complaints, from hypothermia to cardiac events, to eminent childbirth. Additionally, CCRF personnel performed liaison roles with the Federal Bureau of Investigation's Strategic Information and Operations Center, the Federal Emergency Management Agency's Emergency Support Team, and the Office of Emergency Preparedness' Management Support Team. Eighteen officers were involved and their names are listed on the CCRF web site.

Future Training

The National Pharmaceutical Stockpile/Centers for Disease Control and Prevention and the CCRF have agreed to establish a training program for CCRF and NDMS pharmacists regarding chemical and biological terrorism as well as familiarity with the Stockpile. This training will be held at the U.S. Public Health Service Noble Training Center in Anniston, Alabama, April 8-12, 2001. This 3-day training program is seeking pharmacists who are committed to deploying in the event that the Stockpile is utilized by a State or local government that has been subjected to a weapons of mass destruction event. See the CCRF web site for current information.

CCRF Web Site

Due to the significant number of changes in CCRF programs that must be reflected in our database and web site, CCRF has been fortunate to reactivate LCDR William Rowell from the Inactive Reserve to supplement the efforts of LCDR Dan Beck, as they accomplish a large amount of work in a short period of time. The original Information Systems Manager of the CCRF program, LCDR Rowell brings significant historical program knowledge to this position.

CCRF members are responsible for keeping their data current. All CCRF members should visit the CCRF web site frequently to check for news, upcoming events, training opportunities, and to update any changes to their personal information. See *http://oep.osophs.dhhs.gov/ccrf*

Any commissioned officer interested in applying for CCRF membership may apply online at the above web site by simply clicking on "Apply" and following the instructions. All members should also subscribe to the CCRF Listserv in order to receive the most up-to-date CCRF news messages via e-mail. To do so, click on "Listserv" on the web site. The CCRF staff may be reached by e-mail at—ccrf@osophs.dhhs.gov.

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Retirement Seminar to be Held at COA Annual Meeting

The Division of Commissioned Personnel (DCP) will offer a Public Health Service Retirement Seminar at the 2001 Public Health Professional Conference sponsored by the Commissioned Officers Association. The Retirement Seminar is scheduled for Friday, June 1, and Saturday, June 2, and will be held at the Marriott Wardman Park Hotel, 2660 Woodley Road, NW, Washington, D.C.

This seminar is open to all officers no matter how many years of service. Registration for the seminar must be received by **May 1, 2001.** Please request that a blank retirement seminar registration form be faxed to you by using the Faxback feature of *CorpsLine*. You can reach *CorpsLine* at 301-443-6843. Listen to the menu and choose the second option, "To retrieve documents through Faxback," and request document number **6536**. After completing the form, follow the instructions on the form and submit it to the Retirement Seminar Coordinator in DCP.

If you need more information, contact the DCP Retirement Seminar Coordinator at 301-594-3108 (or toll-free at 1-877-INFO-DCP, listen to the prompts, select option #1, dial 43108).

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Commissioned Officer Training Academy

For information about the Commissioned Officer Training Academy, please visit the Division of Commissioned Personnel's web site—*http://dcp.psc.gov*—and select the option *Training*.

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PHS Rank Course 101

The following is an excerpt from a letter the Division of Commissioned Personnel (DCP) recently received. It was written by an active-duty officer. DCP would like to share this insightful and informative letter with our readers.

PHS Rank Course 101

I am often asked by Public Health Service Commissioned Corps officers why civilians and other Uniformed Service members do not know who we are. One of the reasons is that many officers have an identity crisis. I see so many documents written by our officers in which the officer refers to himself as LtCdr or LTCdr or LTCDR or Ltcdr or LtComdr or . . . and it goes on and on. There is also uncertainty on the part of many officers whether the above, even when done correctly, is a grade or a rank. We had an officer introduced at a ceremonial program as "a zero 8 officer." I don't think any of us want to be referred to as "zeros," so I think it is time we cleared the air so at least we know who we are, even if nobody else does. Eventually, others may learn too. Please follow closely:

First, regarding the grade or, more specifically, the pay grade. Our grades are designated as the letter "O" (signifying 'Officer') followed by a digit in the range of 1-10, which corresponds with the pay grade. *Note*: these are *not zeros*, but the letter "O." Thus, a Commander is an O-5, not a 0-5. Grades above O-6 are referred to as flag grades.

The rank of the officer comports with the corresponding Navy rank, namely Ensign through Admiral. It is appropriate to refer to an officer in the pay grade of O-4 as Lieutenant Commander Jones. The appropriate abbreviation is LCDR. *Note:* there are no small letters nor periods. A complete list of the pay grades, ranks, and their appropriate abbreviations is as follows:

Pay Grade Abbreviation	Rank	Rank Abbreviation
O-1	Ensign	ENS
O-2	Lieutenant Junior Grade	LTJG
O-3	Lieutenant	LT
O-4	Lieutenant Commander	LCDR
O-5	Commander	CDR
O-6	Captain	CAPT
O-7	Rear Admiral (lower half)	RADM
O-8	Rear Admiral (upper half)	RADM
O-9	Vice Admiral	VADM
O-10	Admiral	ADM

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Call for Nominations for the Jack D. Robertson and Ernest Eugene Buell Awards for PHS Dental Officers

The Dental Professional Advisory Committee is accepting nominations for the *Jack D. Robertson* and the *Ernest Eugene Buell Awards*. The awards are to be presented on Wednesday, May 30, at the 2001 Public Health Professional Conference in Washington, D.C. The awards will honor dental officers/dentists who are either commissioned officers or civil service employees. Please visit the PHS dental category web site for details on the selection criteria – *http://www.ihs.gov/NonMedicalPrograms/PHS/PHSDental/newsinfo.htm*

Nominations can originate at any level, but must go through appropriate Agency/Operating Division/Program channels prior to submission. Nominations for both awards must consist of: (1) transmittal memorandum; (2) current curriculum vitae; (3) brief citation, suitable for use on public occasions; and (4) written justification for the award, based on the past activities of the individual nominated. The justification should be one to three pages in length and must contain sufficient information to enable a judgment to be made about the individual's level of professional contributions, dedication, demonstrated adherence to principles, and pursuit of excellence. All nominations should be submitted by **March 31, 2001** to:

CAPT Robert W. Hendricks
USCG Air Station Traverse City
1175 Airport Access Road
Traverse City, MI 49686-3586
Phone: 231-922-8285/8284
Fax: 231-922-8292
E-mail: rhendricks@astraversecity.uscg.mil

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Call for Nominations for Pharmacy PAC Membership

The Pharmacy Professional Advisory Committee (PharmPAC) is seeking new members. The PharmPAC is composed of both commissioned corps and civil service pharmacists, and serves as an active link between the Office of the Surgeon General and pharmacists working in the Department of Health and Human Services Operating Divisions (OPDIVs) or in other major Programs where Public Health Service Commissioned Corps pharmacists serve. The PharmPAC meets six times annually and utilizes teleconferencing. To be eligible for membership, you must be a pharmacist and a full-time OPDIV or other major Program employee. In particular, there are openings for three new members for the Indian Health Service and one opening for the Health Resources and Services Administration.

All new appointments will be made for a 3-year term and self-nominations are encouraged. A letter of interest, a supervisor's endorsement, and a resume or curriculum vitae are to be submitted. Please include in the letter the date of your first licensure as a Registered Pharmacist. The deadline for submission of these items is **April 30, 2001**. All submissions should be mailed as follows:

CAPT Frank J. Nice
Chairman, PharmPAC
Membership Subcommittee
National Institutes of Health
NINDS/DIR/CNP
Building 10, Room 5N226
10 Center Drive (MSC 1428)
Bethesda, MD 20892-1428
Phone: 301-496-1561
Fax: 301-402-1007
E-mail: fn1n@nih.gov

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Medical Affairs Branch

Public Health Service Commissioned Corps Disability System

It is important that officers and their supervisors understand the Public Health Service (PHS) Disability System. Otherwise, misunderstandings may occur if an officer becomes disabled.

Prolonged sick leave—greater than 30 days—should not be taken by an officer, nor granted by a supervisor, *without* notifying the Medical Affairs Branch of the Division of Commissioned Personnel (DCP). Leave request forms for sick leave (form PHS-1345, "Request and Authority for Leave of Absence") should be managed just as carefully as for annual leave. All absences from duty for sick leave for a full day or more require a leave request form which must be forwarded, following approval, to the Medical Affairs Branch, DCP, by the leave-granting authority. The address and phone number for the Medical Affairs Branch is:

Division of Commissioned Personnel
ATTN: Medical Affairs Branch
5600 Fishers Lane, Room 4C-06
Rockville, MD 20857-0001
Phone: 301-594-6330 (or toll-free at 1-800-368-2777, option #3)

If an officer will require extensive sick leave, usually greater than 90 days consecutively or 120 aggregatively in any 12-month calender period, or has a disease with a poor prognosis for return to full duty, the Medical Affairs Branch will activate the PHS Disability System as soon as possible.

The Medical Affairs Branch assembles all available medical documentation from the officer and his or her physicians. A fitness-for-duty evaluation at a Military Treatment Facility might be necessary to complete the medical documentation. If the Medical Affairs Branch determines that a prompt return to duty is questionable, it will then convene a Medical Review Board (MRB).

The MRB consists of three senior officers (one physician and two non-physicians) and can recommend any of the following dispositions to the Surgeon General (SG):

1. The officer is fit-for-duty.
2. The officer be placed on limited duty for a fixed period (usually 6 to 12 months) with a reevaluation at the end of that time.
3. The officer is not fit-for-duty and should be placed on the Temporary Disability Retired List (TDRL). The officer must have a disability rating greater than 30 percent.
4. The officer is not fit-for-duty and should be placed on the Permanent Disability Retired List (PDRL).
5. The officer is not fit-for-duty with a disability of less than 30 percent.
6. The officer is not fit-for-duty, but the condition was due to willful misconduct (usually alcohol or drug abuse). In this case, the officer many not be eligible for disability benefits.

Before the recommendation of the MRB is forwarded to the SG, the officer has an opportunity to contest the findings if he or she disagrees with them. In that case, a new Board is convened which conducts a full and fair hearing with the officer and his or her counsel present. The new board presents its finding and forwards the record to the SG for a final decision.

If an officer is placed on TDRL or PDRL with less than 20 years of service, he or she has all the benefits of a retired officer and receives 50 to 75 percent of his or her base pay, depending upon the extent of his or her disability.

If an officer is placed on TDRL or PDRL with more than 20 years of service, he or she receives 50 to 75 percent of his or her base pay based on the degree of disability, or years of service, whichever is greater.

The officer on TDRL must be reevaluated *at least* every 18 months and can be recalled to active duty if his or her medical condition improves. When the officer returns to duty, he or she retains his or her rank, but the period for which he or she was TDRL does not count as service creditable towards retirement. If an assignment cannot be identified, a reserve officer will be placed in the inactive reserve at his or her permanent grade. If a regular corps officer is returned from TDRL and an assignment cannot be secured, the officer's case is referred to an administrative board to determine whether the officer should be retained on active duty or separated from the PHS Commissioned Corps.

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2001 Public Health Professional Conference to be Held May 28-June 2, 2001, in Washington, D.C.

The Commissioned Officers Association (COA) of the U.S. Public Health Service (PHS) is sponsoring the 2001 Public Health Professional Conference, May 28 through June 2, at the Marriott Wardman Park Hotel in Washington, D.C. The Indian Health Service Clinical Support Center is the accredited sponsor of this meeting.

Health professionals from all categories are invited to participate. The meeting will address topics of current concern to all public health professionals and will be presented in General, Mini-General, and Paper Sessions as well as discipline-specific tracks. This Conference also provides sessions addressing personnel issues that you cannot find at other professional conferences

The agenda has been planned based on the theme, *Public Health in the 21st Century: Expanding Our Mission*. Sessions are scheduled from Monday, May 28 through Friday, June 1. Personnel tracks on Monday and Friday have been planned by the Division of Commissioned Personnel. Sessions scheduled Tuesday through Thursday have been coordinated by the Scientific Program Planning Committee and Category Coordinators. Sessions on Wednesday, May 30, are planned as part of the Discipline Specific Day.

A PHS Retirement Seminar has been scheduled in conjunction with this Conference for Friday, June 1 and Saturday, June 2. (See page 7 of this issue of the *Commissioned Corps Bulletin* for additional information regarding the PHS Retirement Seminar.)

Additional information about the Conference can be found on COA's web site—http://www.coausphs.org—or through COA's Conference Coordinator, Ms. Laurie Johnson, at phone number 252-726-9202, or e-mail, lauriej@ec.rr.com. COA's web site includes all the information you need about this Conference, including a full agenda, online abstract submission, online registration, travel information, and more. Click on the "professional conference" button.

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Commissioned Corps Personnel Manual INSTRUCTIONs

The following INSTRUCTIONs and Manual Circulars have been distributed and can be accessed on the Division of Commissioned Personnel's web site—*http://dcp.psc.gov* —under 'Commissioned Corps Personnel Manual.'

Transmittal Sheet 652 dated September 12, 2000–

INSTRUCTION 1 of Subchapter CC27.1, "Commissioned Officers' Awards." This INSTRUCTION consolidated INSTRUCTIONs 1, 2, 3, and 4 of Subchapter CC27.1 and was revised to prescribe policy and procedures for awards established under the Commissioned Officers' Awards Program. In addition, this INSTRUCTION provides guidance on giving formal recognition to officers whose accomplishments or achievements are of outstanding or unique significance to the missions of the Public Health Service.

Manual Circular No. 365 dated November 6, 2000–

The purpose of this Manual Circular is to rescind Section D(1)(e), "Minimum Nomination Criteria," of INSTRUCTION 6, "Chief Professional Officer (CPO) Nomination Criteria and Selection Process," Subchapter CC23.4. The rescission will eliminate the CPO nomination criterion which restricts nominees to having no more than 26 years of service creditable for purposes of determining eligibility to retire.

Manual Circular No. 366 dated January 29, 2001–

The purpose of this Manual Circular is to revise Exhibit XI(4)(b)(1), "Health Services Appointment Standards," of INSTRUCTION 4, "Appointment Standards and Appointment Boards," Subchapter CC23.3. The revision authorizes the appointment of applicants with information technology related degrees (e.g., computer science, computer and information science, computer and information systems management) from accredited schools. In addition, any reference to computer science in INSTRUCTION 4, will be applicable to information technology related disciplines.

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Commissioned Officer Roster and Promotion Seniority Pamphlet on DCP Web Site

The most recent version of Commissioned Corps Personnel Manual Pamphlet No. 1, "Commissioned Officer Roster and Promotion Seniority," (also known as the "Blue Book") dated October 2000, is available on the Division of Commissioned Personnel's (DCP) web site— http://dcp.psc.gov.

The pamphlet contains personal information concerning an officer's career status. As such, it is subject to the provisions of the Privacy Act of 1974. The pamphlet itself must be maintained and stored in such a way as to prevent disclosure to unauthorized persons. Therefore, authorized persons are required to use the user ID and password DCP provided to them to access the pamphlet on DCP's web site. The pamphlet can be found under "Publications" and officers should download a current version of the Adobe Acrobat reader with a search function. If you do not know your ID and password, contact the DCP Help Desk at 301-594-0961.

Note: The Blue Book is not printed and distributed; it is only available in electronic form on DCP's web site. Those requiring a printed copy of the "Blue Book" are advised to print the appropriate sections or pages directly from the web site.

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HEALTHY LIFESTYLES

Get Active—Your Own Way, Every Day, for Life

The best available science continues to reveal the full value that regular physical activity brings to our lives. All physical activities have associated potential risks for injuries. To help reduce the odds of suffering an injury while enjoying the benefits of physical activity, click on the Commissioned Corps Healthy Lifestyles link at—http://www.cdc.gov/nccdphp/dnpa—and go to the U. S. Army War College Guide to Executive Health and Fitness. Chapter Seven titled, "Injury Control for Physically Active Men and Women," provides practical suggestions on avoiding injuries while pursuing an active lifestyle.

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Retirements - February

Title / Name	*OPDIV / Program*
MEDICAL	
CAPTAIN	
Bienvenido E. De La Paz	IHS
George H. Maxted	IHS
Wallace J. Mulligan	IHS
Marc D. Reynolds	IHS
Raymond W. Shields	IHS
Michelle A. Broadnax	SAMHSA
James E. Gaffney	SAMHSA
Thomas A. Fleisher	NIH
Eddie Reed	NIH
COMMANDER	
Darrel W. Killebrew	IHS
DENTAL	
CAPTAIN	
James O. Neally	IHS
NURSE	
CAPTAIN	
Irene R. Buskin	HRSA
Regan L. Crump	HRSA
David L. Griffith	SAMHSA
SCIENTIST	
CAPTAIN	
David G. Taylor	CDC
Walter T. Schaffer	NIH
Paul Seder	NIH
ENVIRONMENTAL HEALTH	
CAPTAIN	
Theodore J. Meinhardt	CDC
Douglas R. Jackson	IHS
Gailen R. Luce	IHS
PHARMACY	
CAPTAIN	
Steven R. Moore	HRSA
Robert E. Staley, Jr.	HRSA
Craig R. McCormack	EPA
DIETETICS	
CAPTAIN	
Patsy R. Henderson	SAMHSA
HEALTH SERVICES	
CAPTAIN	
Robert G. Falter	BOP
Paul R. Henderson	PSC

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Montgomery GI Bill Changes

New legislation made significant changes to the Montgomery GI Bill (MGIB). Although the legislation has been passed, the Public Health Service (PHS) Commissioned Corps and the other Services are in the process of developing procedures for implementing these changes. The following is a brief description of some of the changes:

- Increase in benefits for full-time status from $522 to $650 for 3-year obligations and from $449 to $528 for 2-year obligations. *Individuals who elect a 2-year obligation but remain on active duty for more than 3 years, become eligible for the higher benefit after completion of the third year.*
- Allows Service members eligible for Veterans Educational Assistance Program (VEAP) benefits to enroll in MGIB if they:
  a. enrolled in VEAP on or before October 9, 1996;
  b. served continuously on active duty from October 9, 1996 through April 1, 2000;
  c. make a payment of $2,700;
  d. make an irrevocable election to enroll in MGIB by November 1, 2001; and
  e. meet other VEAP eligibility requirements (which were not changed by this law).
- Members who used 36 months of benefits under VEAP and satisfy the MGIB enrollment requirements listed above can still receive up to 12 months of benefits under MGIB.

  Note: DCP will be contacting officers eligible for VEAP to MGIB enrollment and will be providing them with the necessary forms and instructions. Officers who enrolled in VEAP while serving in another Service need to contact the Officer Support Branch, Division of Commissioned Personnel (DCP), at the number below to ensure that they are placed on the list of eligibles. PHS only has records for officers who enrolled in VEAP while initially serving with PHS.
- Offers an increase in MGIB benefits by allowing participants on active duty to make additional contributions up to a maximum of $600. The monthly full-time benefit will be increased by an additional $1 per month for each $4 contributed.
  a. This change is effective May 1, 2001.
  b. Participants discharged between November 1, 2000 and April 30, 2001, must elect to make additional contributions by **July 31, 2001**.
  c. These additional benefits are not available to members originally eligible for benefits under VEAP.

If you have any questions about VA benefits, please call the Officer Support Branch, DCP, at 301-594-3384 (or toll-free at 1-877-INFO DCP, listen to the prompts, select option #1, dial 43384).

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Professional License / Registration / Certification

If policy requires that you maintain a current, valid, unrestricted license / registration / certification as a Public Health Service (PHS) Commissioned Corps healthcare provider, you are requested to do the following when your license / registration / certification renewal arrives:

(1) Make a photocopy of your license / registration / certification renewal (usually a wallet-sized card which shows a future expiration date) upon receipt from the issuing authority;

(2) Write your PHS Commissioned Corps serial number in the lower right-hand corner of the photocopy (do not submit the original); and

(3) Fax the copy to 301-594-2711, ATTN: Licensure Technician/OSB

- or -

Mail the copy to:
Division of Commissioned Personnel
ATTN: Licensure Technician/OSB
5600 Fishers Lane, Room 4-36
Rockville, MD 20857-0001

(4) To verify receipt and data entry, call *CorpsLine* at 301-443-6843. (Please allow a minimum of 7 to 10 days for processing.)

For additional information, contact the Licensure Technician at 301-594-3108 (or toll-free at 1-877-INFO-DCP, listen to the prompts, select option #1, dial 43108).

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National Public Health Week —2001

"Healthy People in Healthy Communities" is the 2001 theme for National Public Health Week, which will be celebrated April 2 through 8, 2001.

This national celebration provides an opportunity to recognize the contributions of public health to the Nation's well-being as well as help focus public attention on major health issues in the communities. National Public Health Week is celebrated in communities in 46 States and by 60 percent of local health departments.

For more information, visit the American Public Health Association's web site— http://www.apha.org

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NEW! Travel and Transportation Information Center

The Division of Commissioned Personnel (DCP) is pleased to announce the new "Travel and Transportation Information Center" located on DCP's web site—http://dcp.psc.gov. This information center provides answers to many travel and transportation questions. It is our hope that officers will find this site very informative and will visit often.

Recent Changes

The Joint Federal Travel Regulations (JFTR) are accessible online at the following address—http://www.dtic.mil/perdiem/ For a definitive explanation of the changes listed below, please visit the JFTR web site.

New Mileage Rate

Effective January 22, 2001, the mileage reimbursement rate for Federal employees who use privately owned vehicles for temporary duty (TDY) rose from 32.5 cents to 34.5 cents. The reimbursement rates for using personal motorcycles and airplanes when performing TDY have also increased to 27.5 cents and 96.5 cents per mile respectively

Lodging Taxes

Separate reimbursement was authorized for lodging taxes while traveling in the Continental United States (CONUS), effective January 1, 1999. Effective January 1, 2000, separate reimbursement was authorized for lodging taxes while traveling in Alaska, Hawaii, and U.S. Territories and Possessions (includes the Commonwealth of Puerto Rico and the Northern Mariana Islands). For further information, see Appendix A of the JFTR for a listing of Territories and Possessions.

Pet Quarantine Fee Reimbursement

For Permanent Change of Station (PCS) moves with a personnel order effective date on or after December 4, 2000, reimbursement for actual mandatory quarantine fees for household pets is authorized not to exceed $275 per PCS move.

Laundry / Dry Cleaning

Expenses for laundry, dry cleaning, and pressing of clothing are reimbursable as actual expense allowable incidental expense only when incurred with traveling CONUS. Effective for all TDY travel performed on or after January 1, 2001, the cost for laundry, dry cleaning, and pressing of clothing is a separately reimbursable travel expense *in some situations*. Please visit the JFTR web site for a complete explanation.

Allowance for Telephone Calls for Personal Reasons

In accordance with the JFTR, reimbursement may be authorized/approved by the order-issuing official (see the JFTR web site).

Defense Table of Official Distance

The Defense Table of Official Distance (DTOD) is the standard source for worldwide distance information and it *replaces all other sources* used for computing distance (except for airplanes). Please access the DTOD on the JFTR web site.

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Recent Deaths

The deaths of the following retired officers were reported to the Division of Commissioned Personnel:

Title / Name	*Date*
NURSE	
CAPT Jane A. Birch	04/15/00
CAPT Margaret K. Schafer	12/13/00
ENGINEER	
CAPT Herbert H. Jones	12/15/00
ENVIRONMENTAL HEALTH	
CAPT Safety E. Reynolds	02/01/01
VETERINARY	
CAPT Willard H. Eyestone	02/03/01

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**DEPARTMENT OF
HEALTH & HUMAN SERVICES**

Program Support Center
Human Resources Service
Division of Commissioned Personnel, Room 4-04
Rockville MD 20857-0001

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