- 2 -

If at any time during the life of this agreement you should be appointed to a regular position in the service of the Government of the United States of America, this agreement will automatically terminate.

If the terms of this agreement are acceptable to you, kindly indicate your acceptance by signing all copies of this agreement and returning them to_____.

THE UNITED STATES OF AMERICA

_____
(Signature of Physician)

BY: _____
(Signature and Title of Contracting Officer)

_____
(Date)

_____
(Date)

UNIFORM STATE/AID/USIA REGULATIONS

LETTER OF AUTHORITY (U.S. GOVERNMENT FACILITIES)

EMBASSY
OF THE
UNITED STATES OF AMERICA

American Consulate General
Frankfurt, Germany
January 15, *1968*

Officer in Charge,
97th U.S. Army General Hospital
Frankfurt, Germany

Sir:

It is requested that Mr. Robert P. Weaver, an employee of the United States Information Agency, and/or his dependent(s) _____ be furnished the medical services indicated below on or about January 18, *1968*

☐ 1. Immunizations for:

☒ 2. Medical examination as indicated on the attached Form FS-436, Guide for the Examining Physician. The completed report of the examination should be forwarded to the officer shown below in a sealed envelope marked: "MEDICALLY PRIVILEGED INFORMATION - FORWARD TO THE MEDICAL DIRECTOR, DEPARTMENT OF STATE".

Upon submission of an appropriate SF-1080 billing, accompanied by this letter of authorization, signed by the above named employee/dependent, a check will be drawn payable to your Agency and transmitted to you in payment for the medical services furnished.

Very truly yours,

Dorothy P. Welch
Dorothy P. Welch
Personnel Officer

_____
Signature of Employee/
Dependent

Agency Accounting Data:

(*) Revision

UNIFORM STATE/AID/USIA REGULATIONS

684.6 Scope of Examinations

684.6-1 General

Candidates for overseas employment, their dependents, and employees and their dependents taking in-service examinations, are examined in accordance with instructions given on Form FS-436, Guidelines for the Examining Physician.

684.6-2 Special Diagnostic Services

a. Intestinal Parasitism--Stool Examination

When local facilities are inadequate to examine stool specimens for ova and parasites, to diagnose the scope and significance of intestinal parasitism, stool specimens may be sent to the Medical Division (PER/MED) for examination.

Stool specimens should be collected and preserved by using the containers and collection bottles and solutions provided in MIF (merthiolate-iodine-formalin) kits which can be requisitioned from the U.S. Public Health Supply Service Center (see 6 FAH H-213.4-2). These kits should be sent via air pouch to the Department marked for the Medical Division. As many specimens as are necessary to obtain an accurate diagnosis may be submitted at any time.

The diagnosis of each "positive" laboratory finding will be telegraphed to the post. All "negative" findings will be reported by airmail. Unless requested, no advice on a recommended course of treatment will be given the attending physician.

In every instance the stool specimen must be accompanied by the questionnaire enclosed in the kit. For dependents, also report the name of the sponsoring employee and his agency.

Posts which do not have adequate facilities to make stool examinations in connection with predeparture physical examinations should send the stool specimen by MIF to the Department for analysis.

b. Cytologic Examination

When local facilities are inadequate to perform cytologic examination of cervical and vaginal slide smears prepared by the physician, dried smears may be sent to the Medical Division for examination.

Dried or fixed slide smears, prepared by the physician, should be sent via air pouch to the Department marked for the Medical Division. The slides must be protected by one of the standard types of cardboard or plastic slide mailers. Plain paper wrapping in an envelope is unsatisfactory.

In every instance the slide smear should be accompanied by the cytology request, Form DS-1661, Cytology Request, filled out in duplicate. The physician should furnish all information requested on the form. This should include the patient's name, address, and for dependents, the name of the sponsoring employee.

The findings for each abnormal smear will be telegraphed to the post. All "negative" findings will be reported by airmail.

Posts which do not have adequate facilities to perform cytologic examinations in connection with predeparture physical examinations should send the slides to the Department for reading.

684.7 Medical Clearance of Employees and Dependents

684.7-1 Requirements

All employees and their dependents are required to obtain a medical clearance from the Medical Director (see section 684.1). In certain circumstances, after consultation with the Medical Director, a waiver of medical clearance may be granted by the appropriate administrative authority of the employing agency as prescribed in section 684.7-5, or when a dependent declines in-service medical examination on the grounds of religious convictions. (See section 684.1.) Such clearance or waiver must be obtained prior to assignment or location abroad, upon direct transfer to another overseas post if required by appropriate agency authority (see section 684.7-2b) and upon return to the United States for assignment, separation, or home leave.

Employees and/or their dependents who are in the United States for medical treatment or hospitalization shall obtain medical clearance from the Medical Director of the Department of State prior to return to a post abroad. Employees and their dependents who are either stationed in or in the United States on home leave are similarly required to have a valid (section 684.7-2) medical clearance prior to departure from the United States.

684.7-2 Validity of Clearance or Waiver

a. Preemployment

A preemployment full medical clearance is valid for 2 years for persons under 40 years of age, or 1 year for those over 40 years old. Upon expiration of the valid period, a new medical clearance is required prior to entrance on duty.

When appointment is delayed beyond 6 months after the date of clearance, the applicant and each dependent must obtain a review of his medical eligibility by submitting a Form DS-1635, Personal Health Certificate, prepared in accordance with Exhibit 684.7-2a, to the personnel office of the agency concerned.

When an illness or injury is reported on DS-1635, the appropriate personnel office shall submit the certificate to the Medical Division under a transmittal memorandum which contains a request for revalidation of the medical clearance. After review, the Medical Division will return the transmittal memorandum with a statement that the initial clearance is still valid for appointment action, or that clearance is annulled pending further medical information or examination. When the pending status is resolved, a new medical clearance shall be issued which supersedes all previous clearances or waivers.

When the individual reports no illness or injury since his previous examination, no review of the Personal Health Certificate is required by the Medical Division. Form DS-1635 may be retained by the appropriate personnel office, and appointment action completed.

b. In-service

An in-service medical clearance or a waiver is valid for 2 years or a tour of duty, whichever is longer, except:

(1) When an examination becomes necessary under these regulations, or when the individual is medically evacuated to the United States, a new medical clearance or waiver is required and shall supersede all previous clearances or waivers.

(2) When the medical clearance or waiver for an employee and his dependents in, or stationed in, the United States, was issued more than 1 year prior to the date of departure for a tour of duty abroad, a new medical * examination and clearance are required if the individual is age 40 or over, or if his last medical clearance was administratively waived or was less than a full worldwide clearance.

If the employee or dependent is less than age 40, he must obtain a determination from the Medical Director of the continued validity of his last clearance or waiver by submitting a Form DS-1635, Personal Health Certificate, prepared in accordance with Exhibit 684.7-2a, to the personnel office of the agency concerned.*

(3) The reassignment or direct transfer to another post abroad of an individual who has a medical clearance with limitations, or a waiver, requires the prior determination by the Medical Director that the individual's clearance or waiver is valid for such reassignment or transfer.

(*) Revision

UNIFORM STATE/AID/USIA REGULATIONS

FORM DS-1635
2-66

PERSONAL HEALTH CERTIFICATE

NAME	DATE OF BIRTH
Richard Alexander Roe	4-7-62
DEPENDENT OF: Henry P. Roe	AGENCY: A.I.D.
PRESENT MAILING ADDRESS (include ZIP code): 917 East Reardon Street, Silver Spring, Maryland 20901	PROPOSED POST (if known): Kabul
	DATE PREPARED: July 1, 1968

Since the date of my medical examination for the Foreign Service on or about 9-15-67 ; I have had the following illnesses or injuries. I have received professional medical advice or treatment as described below. If none, so state.

ILLNESS/INJURY: (show dates of treatment, by whom, and address)

Treated November 22, 1967 for head injury after a fall by

Dr. William A Doe
2020 40th Street
Silver Spring, Maryland 20901

WARNING: *A false or dishonest answer to the above may be grounds for voting you ineligible for Federal employment, or for dismissing you after appointment (U.S. Code, Title 18, Sec. 1001).*

DATE OF AND MEDICAL REVIEW REPORT (for Medical Division use only)

☐ Clearance still valid.
☐ Additional information/examination required:

I authorize any of the Doctors, Hospitals or Clinics mentioned above to furnish the Department of State, Medical Division a complete transcript of my medical records regarding myself or any member of my family.

NAME OF PATIENT (or indicate self)	Richard Alexander Roe
DATE: 7-1-68	TYPED OR PRINTED NAME AND SIGNATURE: Henry P. Roe, Henry P. Roe, father
SEND TO:	Department of State, Medical Division, Washington, D.C. 20520

684.7-3 Responsibility of Employees

*a. It is the responsibility of each employee to obtain the required medical clearance or waiver of medical clearance for himself and each of his dependents prior to proceeding abroad. While abroad the employee is also responsible for avoiding any personal or official activities which would violate the medical limitation imposed upon himself and his dependents by a valid medical clearance or waiver.

b. It is recommended that, when possible, all employees stationed abroad on tours of more than 2 years obtain medical examinations at Government expense for themselves and eligible dependents every 18 months. Travel is not authorized for routine examinations. (See 684.4-1c.)

c. Employees stationed in the United States should obtain a medical examination for self and eligible dependents every 2 years to keep medical clearances current for possible reassignment. (Immunizations should also be kept current.) *

684.7-4 Penalty for Failure to Obtain Clearance or Waiver

Failure by employees and dependents to obtain medical clearance or waiver may result in forfeiture of medical benefits under the Medical and Health Program set forth in these regulations.

(*) Revision

684.7-5 Waiver of Medical Clearance

a. Employees

The medical clearance requirement may be administratively waived for an employee who is under consideration for an overseas assignment, or is in the United States on home leave or for medical care, if after a discussion with the appropriate medical officer of the Department of State, the responsible personnel officer of the employee's agency determines that:

(1) Overseas duty will not involve undue personal risk to the employee.

(2) Adequate medical skills and/or facilities exist and are available at the post.

(3) The medical problem does not indicate the likelihood of substantial interruption to duty by excessive use of sick leave and/or undue cost for medical treatment/evacuation.

(4) The assignment abroad is in the interest of the Government.

Such an administrative waiver will have no adverse effect on the employee's medical benefits under the regulations prescribed in section 680 and the Foreign Service Act of 1946, as amended.

A copy of the waiver of medical clearance must be forwarded to the Medical Director and to the administrative officer at the post of assignment.

b. Dependents

The medical clearance requirement may also be administratively waived for a dependent of an employee assigned or located abroad under the circumstances set forth in section 684.7-5a, * or in-service medical clearance may be waived on the grounds of religious convictions as prescribed in section 684.1. *

* c. Applicants and Their Dependents

The medical clearance requirement may also be administratively waived for an applicant who is being considered for assignment abroad and/or his dependents, under the circumstances set forth in section 684.7-5a. *

684.8 Reports of Medical Examinations

684.8-1 Submission to Department

Principal and administrative officers should advise examining facilities to render their medical reports on Form DS-1686, Medical History and Examination for Foreign Service, in the English language and to make certain that all medical reports are checked for accuracy and completeness prior to submission to the post. X-rays, electrocardiograms, and all accompanying documents should be identified by date, full name of the patient, applicable agency, post, and the name of the employee if the patient is a dependent.

The medical report, which is received at the post in a sealed envelope, is forwarded UNOPENED to the Deputy Assistant Secretary for Medical Services (DG/MED), Department of State, as soon as possible after completion of the examination. ✻ Before transmitting the documents, the following information should be typed or printed in the upper left-hand corner of the X-ray envelope:

Name: _____
(Last) (First) (Initial)
Date of Birth: _____
Dependent of: _____
(First Name Only)
Post: _____ Agency: _____
Date of X-ray: _____

The envelope containing the DS-1686 and other related medical information should be placed inside the X-ray envelope. The full name of the examinee/patient and the date of birth should be indicated on the inner envelope. Do not include letters or information not related to the examinee's physical or medical report. ✻ It is incumbent upon the handling officer at the post to ensure the confidentiality of these personnel records.

The examining physician should discuss the results of the examination with the examinees and advise them of any conditions which are significant or require attention. However, a medical clearance can be determined and issued only by the Office of Medical Services (DG/MED).

684.8-2 Review by the Office of Medical Services (DG/MED)

Medical examination reports are reviewed by the Office of Medical Services (DG/MED) of the Department of State. Significant medical findings may indicate the need for further examinations or consultations and when deemed necessary are ordered by the Deputy Assistant Secretary for Medical Services (DG/MED).

DG/MED will inform the employee or dependent and the personnel office of the agency concerned of the clearance in each case by providing Form DS-823, Abstract of Medical Report.

a. Preemployment

For applicants and/or their dependents, their copy of form DS-823 is provided the interested personnel office for transmittal to the applicant or dependent.

b. In-Service

For a limited clearance or disqualification, an additional copy of form DS-823 is provided the personnel office of the agency concerned for transmittal to the post pursuant to section 684.8-3.

The medical examination shall not be considered officially completed until the examinee and interested personnel office have received form DS-823 from the Office of Medical Services (DG/MED) indicating the granting or withholding of medical clearance, and any medical limitation to be observed in connection with assignment abroad.

684.8-3 Submission to Post

The post is not provided a copy of Form DS-823, Abstract of Medical Report, for those individuals medically cleared for worldwide service. An information copy of form DS-823 for employees or dependents who have been issued a clearance limiting them to service at a post with adequate medical facilities, low altitude, or both is forwarded to the post by the personnel office of the agency concerned (section 684.8-2), as well as a copy of an administrative waiver of the medical clearance requirement when issued by such office. (See section 684.7-5.)

The post may assume that every employee and dependent traveling on official orders has been properly medically cleared, unless a specific notice to the contrary is received. However, not every individual will have a medical clearance for worldwide assignment

685 Medical Treatment of Employees and Dependents

685.1 Eligibility

Payment for the cost of treatment of an illness or injury of an employee or dependent shall be based on the following conditions of eligibility (see also section 681.6):

a. The individual must be an American citizen employee of the U.S. Government, or an eligible dependent thereof. (See section 681.1.)

b. An employee or dependent shall have completed the prescribed medical examination and have received a medical clearance or waiver. (See section 684.1.)

Each newly acquired dependent, whether acquired through birth, adoption, marriage, or otherwise, initially becomes eligible for benefits under this program upon becoming a dependent. Continuation of these benefits beyond 90 days is subject to each such new dependent's taking the prescribed medical examination and receiving a medical clearance or waiver of clearance within that period of time. Failure to undergo this examination may disqualify the dependent for further medical benefits until the examination has been completed and a medical clearance or waiver has been issued.

c. The illness or injury incurred is sufficiently serious to require hospitalization as judged by standards generally observed in entering a hospital in the United States as an inpatient, or similar treatment outside a hospital, as determined by the principal or administrative officer on the advice of the regional medical officer or the medical adviser, or a listed Christian Science practitioner (see section 681.6ℓ) in the event the patient is a recognized Christian Scientist. (See section 684.1.)

d. The illness or injury was incurred while the patient was located abroad, as defined in section 681.6.

e. The illness or injury is not the result of vicious habits, intemperance, or misconduct on the part of the patient.

685.2 Payment of Expenses

a. Payment shall be made for Inpatient Care (hospital or sanitarium) and/or Outpatient Treatment. If outpatient treatment is authorized, it must be in connection with an illness or injury requiring hospitalization or similar treatment.

Payment of expenses for each separate illness or injury is subject to the following conditions and limitations:

(1) The expenses incurred, including expenses for outpatient care incurred prior or subsequent to hospitalization, must be directly related to the treatment of the illness or injury requiring hospitalization or similar treatment;

(2) The expenses must not be excessive in relation to local prevailing prices for medical services and supplies, or to the rates charged by a locally available U.S. Government hospital; and

(3) The type of treatment rendered must be considered suitable by the principal or administrative officer on the advice of competent medical authority, or by a listed Christian Science practitioner. (See section 681.6, paragraphs k and ℓ.)

(4) For an employee, there is no time limitation on hospital care. Payment of any portion of expenses for outpatient treatment is limited to a maximum of 12 months (1 year) from the date an expense was initially incurred by the Government, unless a waiver is granted as provided by paragraph d of this section.

(5) For a dependent, payment of expenses for institution care or outpatient treatment or combined institution-outpatient treatment is limited to a maximum of 120 treatment days. Any portion of expenses for outpatient treatment must be incurred within 12 months (1 year) of the date an expense was initially incurred by the Government. The 120 days shall be days for which actual expense for treatment is incurred, and such days need not necessarily be consecutive.

For example, a dependent is hospitalized on January 15, 1971, for a period of 60 days. After discharge from the hospital, the dependent's condition requires monthly outpatient visits to the doctor's office. By January 15, 1972, the dependent will have utilized 70 of the allowable 120 days' treatment (60 inpatient treatment days plus 10 outpatient treatment days). The 50 remaining treatment days (as of January 15, 1972) can only be used for inpatient services for the same illness or injury, unless a waiver is granted as provided by the second paragraph of paragraph c of this section.

b. Payment shall not be made for expenses incurred for the personal convenience of the patient, such as private room, telephone, television, extra services, or other accommodations superior to what are normally required, considering the nature and severity of the illness or injury.

If the patient is a dependent, payment shall not be made for the initial $35.00 cost of treatment, as specified by section 941(b) of the Foreign Service Act of 1946, as amended.

c. If the patient is a dependent and if the *Deputy Assistant Secretary for Medical Services (O/MED)* determines, in writing, that the illness or injury is clearly caused or materially aggravated by the fact that the patient is or has been located abroad, O/MED may extend treatment at Government expense beyond 120 days until maximum benefit of treatment has been obtained. Such determination shall be made on the basis of whether it may be reasonably assumed that the patient would not have so incurred or materially aggravated the illness or injury (see section 681.6d) had he or she remained in the United States. (See 4 FAM 437.)

O/MED may waive the 12-month limitation within which outpatient treatment may be authorized for a dependent, if to not do so would result in serious inequity or hardship, and except as provided above, such treatment is within the over-all limitation of 120 days of treatment.

(*) Revision
(**) New Material

d. If the patient is an employee, and if O/MED determines that to withhold authorization for payment of the cost of outpatient treatment beyond the 12-month limitation would result in serious inequity or hardship, O/MED may extend treatment until maximum benefit of treatment has been obtained.

e. Payment for obstetrical care is authorized only in cases where complications have resulted because the treatment received is below the standard available in the United States or if the principal or administrative officer determines, on the advice of competent medical authority, that complications are clearly caused by the fact that the patient is or has been located abroad.

f. Payment for cosmetic or prosthetic care is not authorized, except that in cases where the initial need for cosmetic or prosthetic care results from medical treatment authorized under this section, the cost of the cosmetic treatment and the initial prosthetic appliance may be authorized.

g. Payment for dental care is authorized only in cases where the employee or dependent is hospitalized on an inpatient basis on the advice of competent medical authority or when specially authorized by O/MED.

h. Accounting and vouchering procedures for the payment of medical expenses are contained in 4 FAM 437 and M.O. 758.2 for A.I.D.

685.3 Limitations on Medical Coverage

Medical coverage provided eligible American employees and their dependents overseas does not apply to employees and dependents while they are in the United States on assignment, home leave, or for any other reason, unless an illness or injury is connected with overseas service and the employee or dependent is otherwise eligible for treatment in accordance with section 685.1. Personnel should be advised to provide adequate medical insurance protection for themselves and their dependents while in the United States.

685.4 Authorization for Medical Treatment

685.4-1 Medical Facilities Abroad

When, after consultation with competent medical authority, the principal or administrative officer (see section 681.4) determines that an illness or injury of an employee or dependent meets the conditions of eligibility for medical treatment, he shall arrange for and authorize the treatment on Form FS-569, Authorization for Medical Services for Employees and/or Dependents. In emergency cases, formal authorization shall be requested and issued as soon as possible after hospitalization or treatment is initiated. Form FS-569 is prepared in accordance with Exhibit 685.4 (pp. 1 and 2) and distributed as indicated on the form. Whenever an employee or dependent is authorized hospitalization or medical treatment of any kind at Government expense, principal or administrative officers assure that the employee indicates whether he or his dependent is covered by medical insurance and executes the certificate on form FS-569. Some of the principal insurance carriers are Aetna Indemnity Benefits Plan, Blue Cross/Blue Shield Service Benefit Plan, AFGA Health Benefit Plan, Group Health Association (benefits applicable only if in Washington, D.C., area), as well as other private and Government plans, but excluding the Foreign Service Benefit Plan (AFSPA).

The advice of a Department of State medical officer or the ✻Office of Medical Services (O/MED)✻ may be requested at any time. It should be obtained in all cases where there is doubt as to the need for the treatment recommended by another physician, and should be obobtained from the ✻Deputy Assistant Secretary for Medical Services (O/MED)✻ when treatment by a Christian Science practitioner (section 681.62) has been requested by an employee or dependent.

685.4-2 Medical Facilities in the United States

Eligible American employees or dependents who are unable to obtain suitable medical care abroad for an overseas-incurred illness or injury may be authorized by the post to travel to the United States to receive medical care in U.S. facilities. (See section 686.1.) In such cases, the post shall telegraph in advance via "MED CHANNEL" (see 5 FAM 212.3e) to give the diagnosis and to request instructions from the ✻Deputy Assistant Secretary for Medical Services (O/MED).✻ In emergency situations where the well-being of the employee precludes prior consultation with ✻O/MED✻, the delegated officer at post (section 681.4) may authorize travel to Washington, D.C., but shall immediately inform ✻O/MED✻ the reason for the evacuation, give the date and mode of arrival, and request that arrangements for hospitalization be made. All decisions concerning the U.S. facility to be used, all arrangements for admission, and all action relating to the issuance of a covering authorization for hospitalization and related treatment shall be made by ✻O/MED,✻ except in those instances where this authority is specifically subdelegated by the ✻Deputy Assistant Secretary for Medical Services.✻

(✻) Revision

UNIFORM STATE/AID/USIA REGULATIONS

✻685.4-3 Psychiatric Care

a. Evaluation

Employees and dependents in need of psychiatric evaluation should be referred to a U.S. military medical facility overseas if reasonably accessible. When a U.S. Government medical facility is not accessible, a psychiatric evaluation may be undertaken at posts where competent psychiatrists are available who have been approved as provided by section 682.2-4a. In extreme emergency situations, however, any available physician may be used to establish an initial evaluation and to provide interim care pending evacuation by the first *feasible means.*

b. Treatment

Employees shall receive continuing *psychiatric treatment in the United States* only. There may be instances, however, where it would be more advantageous to the dependent to receive psychiatric treatment abroad. Maximum medical benefit is assured, however, when the psychiatrist and patient share a common language and have a similar cultural and institutional heritage, and the security risk is minimized when U.S.-trained American psychiatrists are relied upon. For this reason, employees and dependents in need of psychiatric treatment must be referred to a U.S. military overseas medical facility if possible. If such facility is not readily accessible or feasible, local psychiatric treatment may be utilized *for the dependents only if:*

(1) A Foreign Service Medical Officer has determined that the psychiatrist is competent, has had thorough Western-oriented training and experience in psychiatry, and is of impeccable reputation in the community;

(2) A local security investigation of the psychiatrist has been made by the post and a suitability determination has been obtained by the medical officer.

(3) Prior authorization for treatment has been received from the Medical Director (evaluation only does not require this prior authorization). When a dependent is being considered for local non-U.S. psychiatric treatment abroad, the Medical Director, prior to authorizing treatment in each individual case, will obtain concurrence from the Office of Security of the agency involved. A summary of each case should accompany the request for authorization.

(4) In no case will treatment be authorized for a dependent by a local psychiatrist who owes allegiance to any Communist-controlled country.

c. Return of Patient to the United States

If, following evaluation and/or initial treatment overseas under the above criteria, it is considered by the principal officer of the post in consultation with the post Medical Adviser or Foreign Service Medical Officer to be more desireable to return the patient to the United States, the Medical Director may authorize return to the United States for continued evaluation and treatment.

685.5 Medical Reports on Treatment of Employees and Dependents

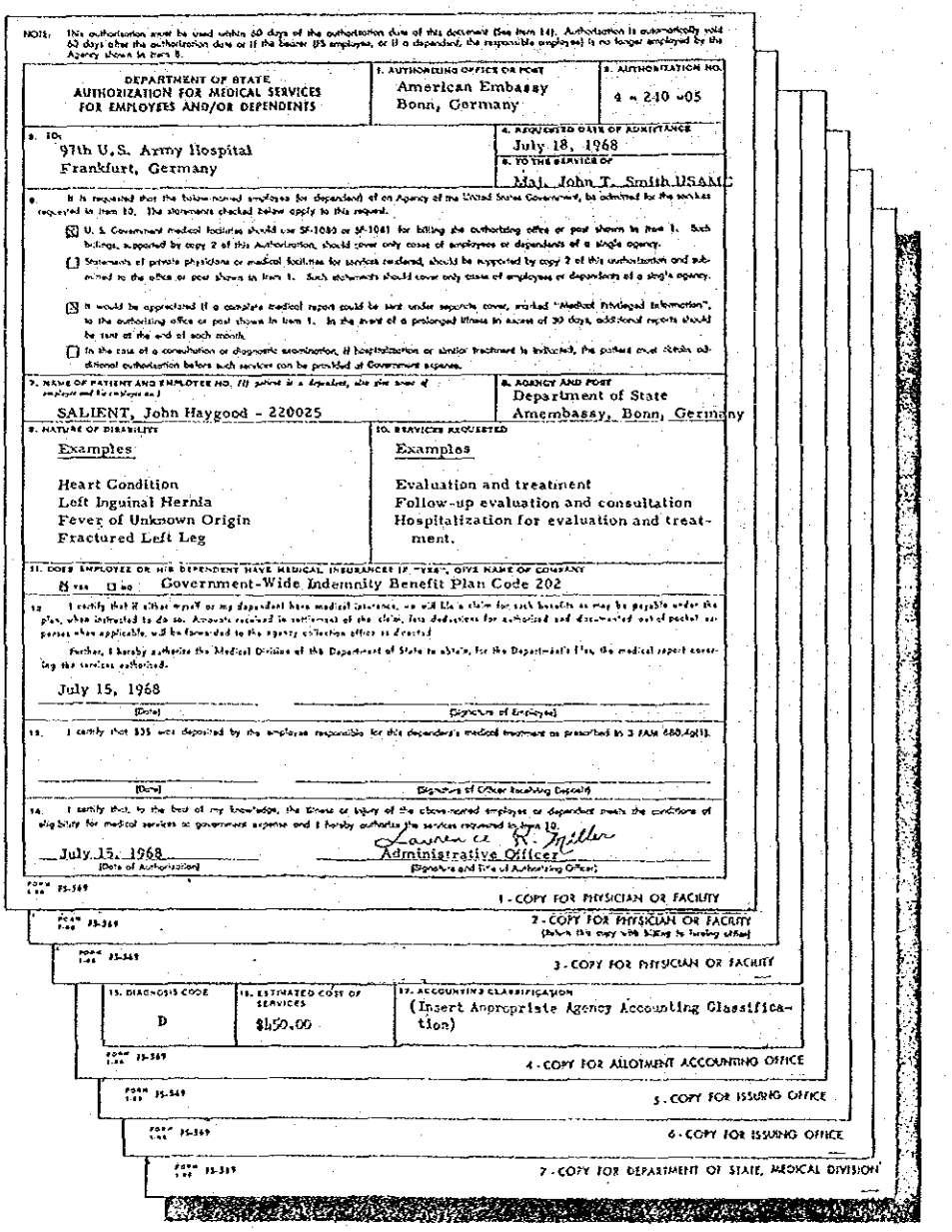
In each instance where treatment of an illness or injury of an employee or dependent is authorized at U.S. Government expense, the authorizing official shall obtain a written report in which the attending physician or listed Christian Science practitioner (section 681.6) summarizes examination findings, records laboratory and X-ray reports, and indicates the course of treatment followed and any significant recommendations or prognosis. Routine medical reports should be forwarded to the Department in a sealed envelope marked "ATTENTION: Office of Medical Services (DG/MED)." Medical reports which relate to medically sensitive problems should be forwarded in a double envelope *with the inner envelope marked* "TO BE OPENED ONLY BY THE MEDICAL DIRECTOR, OFFICE OF MEDICAL SERVICES (DG/MED)." ✻

(✻) Revision

(Exhibit 685.4 (p.1))

UNIFORM STATE/AID/USIA REGULATIONS

FS-569, AUTHORIZATION FOR MEDICAL SERVICES FOR EMPLOYEES AND/OR DEPENDENTS



NOTE: This authorization must be used within 60 days of the authorization date of this document (See Item 14). Authorization is automatically void 60 days after the authorization date or if the bearer (if employee, or if a dependent, the responsible employee) is no longer employed by the Agency shown in Item 8.

DEPARTMENT OF STATE
AUTHORIZATION FOR MEDICAL SERVICES
FOR EMPLOYEES AND/OR DEPENDENTS

1. AUTHORIZING OFFICE OR POST: American Embassy, Bonn, Germany
2. AUTHORIZATION NO.: 4 - 240 -05
3. TO: 97th U.S. Army Hospital, Frankfurt, Germany
4. REQUESTED DATE OF ADMITTANCE: July 18, 1968
5. TO THE SERVICE OF: Maj. John T. Smith USAMC

6. It is requested that the following-named employee (or dependent) of an Agency of the United States Government, be admitted for the services requested in Item 10. The statements checked below apply to this request.

☒ U. S. Government medical facilities should use SF-1080 or SF-1081 for billing the authorizing office or post shown in Item 1. Such billings, supported by copy 2 of this Authorization, should cover only cases of employees or dependents of a single agency.

☐ Statements of private physicians or medical facilities for services rendered, should be supported by copy 2 of this authorization and submitted to the office or post shown in Item 1. Such statements should cover only cases of employees or dependents of a single agency.

☒ It would be appreciated if a complete medical report could be sent under separate cover, marked "Medical Privileged Information", to the authorizing office or post shown in Item 1. In the event of a prolonged illness in excess of 30 days, additional reports should be sent at the end of each month.

☐ In the case of a consultation or diagnostic examination, if hospitalization or similar treatment is indicated, the patient must obtain additional authorization before such services can be provided at Government expense.

7. NAME OF PATIENT AND EMPLOYEE NO. (If patient is a dependent, also give name of employee and his employee no.): SALIENT, John Haygood - 220025
8. AGENCY AND POST: Department of State, Amembassy, Bonn, Germany

9. NATURE OF DISABILITY: Examples
Heart Condition
Left Inguinal Hernia
Fever of Unknown Origin
Fractured Left Leg

10. SERVICES REQUESTED: Examples
Evaluation and treatment
Follow-up evaluation and consultation
Hospitalization for evaluation and treatment.

11. DOES EMPLOYEE OR HIS DEPENDENT HAVE MEDICAL INSURANCE? (If "YES", GIVE NAME OF COMPANY): ☒ YES ☐ NO Government-Wide Indemnity Benefit Plan Code 202

12. I certify that if either myself or my dependent have medical insurance, we will file a claim for such benefits as may be payable under the plan, when instructed to do so. Amounts received in settlement of the claim, less deductions for authorized and documented out-of-pocket expenses when applicable, will be forwarded to the agency collection office as directed.

Further, I hereby authorize the Medical Division of the Department of State to obtain, for the Department's files, the medical report covering the services authorized.

July 15, 1968 [Date] _____ [Signature of Employee]

13. I certify that $35 was deposited by the employee responsible for this dependent's medical treatment as prescribed in 3 FAM 680.4(g)(1).

[Date] _____ [Signature of Officer Receiving Deposit]

14. I certify that, to the best of my knowledge, the illness or injury of the above-named employee or dependent meets the conditions of eligibility for medical services at government expense and I hereby authorize the services requested in Item 10.

July 15, 1968 [Date of Authorization] — Lawrence R. Miller, Administrative Officer [Signature and Title of Authorizing Officer]

FORM FS-569 — 1 - COPY FOR PHYSICIAN OR FACILITY
FORM FS-569 — 2 - COPY FOR PHYSICIAN OR FACILITY (Return this copy with billing to issuing office)
FORM FS-569 — 3 - COPY FOR PHYSICIAN OR FACILITY

15. DIAGNOSIS CODE	16. ESTIMATED COST OF SERVICES	17. ACCOUNTING CLASSIFICATION
D	$150.00	(Insert Appropriate Agency Accounting Classification)

FORM FS-569 — 4 - COPY FOR ALLOTMENT ACCOUNTING OFFICE
FORM FS-569 — 5 - COPY FOR ISSUING OFFICE
FORM FS-569 — 6 - COPY FOR ISSUING OFFICE
FORM FS-569 — 7 - COPY FOR DEPARTMENT OF STATE, MEDICAL DIVISION

UNIFORM STATE/AID/USIA REGULATIONS

AUTHORIZATION FOR MEDICAL SERVICES FOR EMPLOYEES AND/OR DEPENDENTS

(Reverse Side of Form FS-569)

INSTRUCTIONS FOR PREPARATION

Item 1 - Name and location of issuing office or post

2 - Authorizing posts enter the fiscal year digit followed by the second, third and fourth digits of the issuing post code, followed by a two digit serial number assigned by the post and beginning each fiscal year with 01. The Medical Division enter the fiscal year followed by the digit 9 and a four digit serial number beginning each fiscal year with 0001. All Forms FS-569 issued as amendments should show the original authorization numbered followed by the letters A, B, C, etc as applicable.

3 - Name and address of physician or medical facility requested to provide the services authorized.

4 - Approximate date services should begin.

5 - Name of physician concerned with the case, if known; otherwise, name of specialty service (surgery, medicine, psychiatry, etc.).

6 - Enter an X in box opposite statements which apply to the case.

7 - Enter the surname, first and middle names of the patient. If the patient is a dependent, also enter the same information for the responsible employee. In either case show the employee number as shown in item 2 on the Form DS-1032, Notification of Personnel Action.

8 - Enter employee's agency initials and post of assignment. In the case of employees (or their dependents) assigned to an AID project, enter the parent agency, AID and post of assignment, e.g., FAA/AID/Karachi.

9 - General description of nature of disability.

10 - Specify the medical services desired for the patient

11 - Enter an X in the appropriate box. If yes, enter name of company (insuror) and plan.

12 - Date and signature of the employee.

13 - Date and signature of officer who receives the deposit for the $35 of medical expenses for care of dependent. As a last resort, if it is not practicable to collect the deposit before this form is prepared, the following instruction is entered in block 13: "Collect the first $35 (or equivalent in local currency) from the patient and refer thereto on your billing."

14 - Give date of authorization and name and title of officer authorizing services. When an employee desires medical treatment at a U. S. Government facility, for himself or a dependent, which is not authorized at Government expense, a letter may be issued to the facility for purposes of identification and authorizing the treatment at the expense of the employee.

15 - Enter the appropriate diagnosis code (may be omitted) *

16 - Enter the best possible estimate (in U. S. dollars) of the cost of services to be rendered without fail. This is an obligation document. Copy 4 should be forwarded to the responsible agency allotment accounting office immediately. Copy 7 should be forwarded to the Department of State Medical Division. For Department of State personnel, Foreign Service posts forward copies 4 and 7 to the Medical Division.

17 - Enter the accounting classification coding in the sequence prescribed by the Agency shown in item 8. For Department of State cases, codes and the coding sequence are prescribed in the FM-1 Handbook, as revised. For other agency cases issuing offices should consult with the appropriate agency officials.

685.6 Use of Government Medical Facilities Abroad at Employee's Expense
(See section 686.)

685.6-1 Eligibility

Eligible American employees and their dependents stationed or traveling outside the United States may use, at the employee's expense, available U.S. Government medical facilities outside the United States on either an inpatient or outpatient basis.

685.6-2 Procedure for Arranging Admission

In the event of an illness or injury of an employee or a dependent which the principal or administrative officer determines does not meet the conditions of eligibility for medical treatment at Government expense, but nevertheless requires medical care, the principal or administrative officer should forward a letter to the manager or officer in charge of the facility, requesting medical care at the employee's expense. In requesting medical care at Gorgas Hospital, Canal Zone, the salary of the employee must be stated in the letter after the employee's name.

685.6-3 Responsibility of Employee

All hospitalization and medical treatment expenses incurred under section 685.7 are the responsibility of the employee.

685.6-4 Unpaid Bills

Hospital authorities should be advised that if payment is not received within the prescribed period, they should notify the post which requested medical care. The post administrative officer shall take immediate steps to ensure that the hospital is reimbursed by the employee.

685.7 Medical Reports on Treatment at Employee's Expense

When an employee or a dependent undergoes treatment or surgery at his own expense to resolve a significant illness or injury, a medical report should be forwarded to the Medical Director. Illnesses and injuries so treated would routinely be reported on form DS-1686 at the time of the next physical examination. The information is most helpful, however, when reported at the time of the illness and is of value in safeguarding the individual's good health and in protecting rights in Bureau of Employee's Compensation or disability retirement deliberations.

686 Medical Travel

686.1 Authorization for Travel of Employee or Dependent

a. Any American Foreign Service employee or any of his dependents as defined in section 681.6a who require medical care for illness or injury not the result of vicious habits, intemperance, or misconduct, while located or stationed abroad in a locality where there is no qualified person or facility to provide such care, and except as provided in section 684.7-4, shall be eligible to travel at Government expense to the nearest facility where suitable medical care can be obtained, whether or not the medical care is at Government expense.

b. The principal or administrative officer (see section 681.4) may authorize travel, with the concurrence of the responsible officer of the respective agency, of any such employee or dependent to the nearest locality abroad where there can be provided suitable medical care, such as diagnosis, specialized examination, special inoculations, emergency dental care, hospitalization, or obstetrical care which, in his judgment, is inadequate or unavailable at the post, and which cannot or should not be delayed until the employee is eligible for home leave, transfer, or other official travel. The principal or administrative officer, drawing upon competent medical advice, shall determine: (1) the medical need for travel, (2) the nearest locality where suitable medical care can be obtained, and (3) the medical need for one or more attendants (see section 686.2).

c. An employee or a dependent may elect to travel for medical care to a locality other than the nearest authorized locality but he will be required to pay any travel cost and, if medical care is at Government expense, any cost of such medical care which exceeds, respectively, the cost of travel to or cost of medical care at the nearest authorized locality.

d. Travel shall not be authorized for employees or dependents to take routine medical examinations or to receive routine immunizations except when local medical facilities are inadequate and (1) direct transfer to another overseas post is scheduled and the Medical Director specifically requests a predeparture medical examination pursuant to section 684.7-2b(3) or (2) a special examination pursuant to section 684.2d is specifically ordered by appropriate officials designated in section 684.3-3.

686.2 Authorization for Travel of Attendants

The services of an attendant or attendants to accompany an employee or a dependent to a locality where suitable medical care can be obtained may be authorized by the principal or administrative officer (see section 681.4) when it is determined on the advice of competent medical authority that the patient is too ill to travel unattended or is too young to travel alone. When the Military Air Command (MAC) is utilized to evacuate a patient, adequate medical attention en route is normally provided by MAC. Some indication of the reason for evacuation should be given to the patient and, in every instance, the basic problem and possible reactions of the patient should be discussed with the attendant. When in the judgment of the principal or administrative officer the services of a nonemployee medical attendant are warranted, such services may be contracted for as indicated in section 686.2b.

UNIFORM STATE/AID/USIA REGULATIONS

FORMAT FOR MEDICAL ATTENDANT AGREEMENT

MEDICAL ATTENDANT AGREEMENT

American Embassy
New Delhi, India
May 15, 1979

To:_____

_____

_____

It is understood that your services as an attendant will be available to the United States Government for a period of approximately_____days. Accordingly, you are hereby requested to report on_____to accompany_____ _____from_____to_____ and return.

Transportation will be furnished by the United States Government. You will be paid for other authorized incidental expenses related to transportation (exclusive of subsistence), and will receive compensation for your services at the rate of _____per day.

You will be compensated in accordance with the terms of this agreement upon submission of your claim together with a copy of this agreement.

If at any time during the life of this contract you should be appointed to a regular position in the service of the United States Government, this agreement will automatically terminate.

If the terms of this agreement are acceptable to you, kindly indicate your acceptance by signing and returning the original and all copies of the agreement to the _____ _____.

THE UNITED STATES OF AMERICA

_____
(Signature of Attendant)

By_____
(Signature and Title of Contracting Officer)

Date_____

Date_____

Agency Accounting Data:

a. When a nonemployee (nonmember of a family) medical attendant is authorized to accompany a patient, the contracting officer at the post enters into an agreement (see format illustrated in Exhibit 686.2) and provides for the furnishing of transportation, the payment of authorized incidental expenses related to transportation (exclusive of subsistence), and compensation. The amount of compensation for nonemployee medical attendants does not exceed the prevailing rate in the locality for the type of service rendered plus the equivalent of the amount of per diem which would be paid if the medical attendant were an employee. The signed original of the agreement is attached to the original copy of the first voucher paid under the agreement and is submitted to the applicable agency with the USDO's monthly accounts. One copy of the agreement is furnished to the local fiscal office of the applicable employee's agency.

b. A nonemployee member of family may be authorized to accompany a patient as medical attendant, and shall be included in the medical travel order.

686.3 Authorization for Travel of Doctors and Nurses

A chief of mission may, if such travel is warranted, authorize or approve the travel of doctors and nurses to provide medical services to an employee or dependent under the Department's medical program at a post in the host country. The chief of mission may authorize or approve similar travel to a neighboring country when so requested by the chief of mission assigned to that country.

686.4 Performance of Medical Travel

686.4-1 Applicable Regulations

All medical travel, other than medical travel of Marine security guards (see section 149), is performed in accordance with the *Uniform State/AID/USICA*Foreign Service Travel Regulations and Procedures and the provisions prescribed herein. OF-144 (formerly) JF-46, Temporary Duty (TDY) Official Travel Authorization, is utilized to authorize travel of employees, dependents, and employee attendants. The original and one copy of the authorization is furnished to the traveler and a copy is furnished to the local fiscal office of the agency concerned for obligation purposes. Additional copies may be prepared to meet specific agency requirements.

686.4-2 Travel Via Military Air Command (MAC)

Military Air Command (MAC) facilities, which include the services of a medical attendant, will be used for medical travel when available.

686.4-3 Allowable Per Diem for Patients and Attendants

a. Patients Medically Evacuated to Areas Outside the United States

Per diem allowed employees or qualified dependents under the Federal travel regulations will be paid at the full rate for the first 21 days, and at one-half the regular rate for each additional day up to a total of 120 days under the following circumstances:

(1) During the course of travel to and from the nearest locality where suitable medical care can be obtained if such travel is authorized under section 686.1a and b even though payment for treatment is not authorized at Government expense;

(2) During necessary delays prior to admission to the facility for treatment, and delays after discharge while awaiting return travel to post, if payment for such treatment is authorized under section 685.1;

(3) During periods of necessary out-patient treatment.

b. Patients Medically Evacuated to the United States

The employee or qualified dependent medically evacuated to the United States under the circumstances described above, will be paid per diem at the maximum per diem rate until the

(*) Revision

* evacuee receives medical clearance to return to post, or, for a period not to exceed a maximum of 120 days, exclusive of any period of hospitalization.

c. Periods of Hospitalization *

Payment of per diem shall not be made to a patient during a period of hospitalization.

* d. * Employee Attendants

A Foreign Service employee serving as an attendant will be paid per diem while necessarily absent from the employee's official station. An adult parent (employee) serving as an attendant for a dependent minor child shall be entitled to per diem for such periods as the adult parent's presence is required to resolve medical legal problems, to render psychological support during inpatient confinement, and to provide parental care during delays awaiting admission to adequate facilities or during periods of prehospitalization and posthospitalization care related to the hospitalization authorized at Government expense.

* e. * Nonemployee Attendants

Per diem for nonemployee attendants is included in the compensation payable under the terms of the agreement with the attendant as provided in section * 686.2a. *

A nonemployee parent serving as an attendant for a dependent minor child shall be included in the medical travel order and shall be entitled to per diem on the same basis as that of an employee parent.

686.4-4 Separation Maintenance Allowance in Connection With Medical Travel

a. An employee may be eligible for separate maintenance allowance if it can be assumed or established that a dependent, while undergoing treatment away from the post of assignment, will be delayed for a period of 90 consecutive calendar days or more before the dependent will arrive at the post. (See section 260, Standardized Regulations (Government Civilians, Foreign Areas).) The 90-day rule may be reduced to 30 days when an eligible dependent in the United States is detained for medical clearance under the provisions of section 262.32-2, Standardized Regulations (Government Civilians, Foreign Areas) and approval is obtained pursuant to section 315.6-3.

b. An employee may be eligible for separate maintenance allowance if a dependent is authorized to travel and is required to live away from post in order to obtain suitable obstetrical care, if it is assumed or established that there will be a delay of 30 consecutive calendar days or more before the dependent will arrive at the post and approval is obtained pursuant to section 315.6-3. (See section 262.32-1, Standardized Regulations (Government Civilians, Foreign Areas).)

c. Separate maintenance allowance and per diem cannot be paid for the same period.

d. Separate maintenance allowance cannot be paid on behalf of a dependent for any period during which that dependent is hospitalized at Government expense.

686.4-5 Excess Baggage

Excess baggage may be authorized or approved by the principal or administrative officer when the officer deems it necessary because of the climate factor, medical necessity, or other adequate reason. For a nonemployee attendant, specific authorization for the payment of excess baggage should be contained in the agreement with the attendant.

686.4-6 Notification of Patient's Arrival

a. Notification to Posts Abroad

Upon authorization of medical travel, the principal or administrative officer sends a telegram to the post nearest to the locality where medical care is to be obtained, giving the name of the patient, agency, age if a minor, name of the attendant (if applicable), method of transportation, nature of illness, destination, and

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expected time of arrival, and stating whether treatment will be at Government expense. Whenever possible, the telegram also states whether or not the patient has been informed regarding the diagnosis and, if not, the reason. If it is necessary that the patient be met or that ambulance service be provided, the telegram should so state. In each instance, the telegram is repeated to the Department of State, using ✻TAGS: AMED. ✻

b. Notification to the Department of State

When medical travel to the United States is authorized, the telegram is addressed to the Department of State, using ✻TAGS: AMED,✻ and includes the same information required under section 686.4-6a. The Office of Medical Services has no staff at ports of entry and is not staffed at Washington to meet patients except in emergencies. When medical assistance is not required on arrival, arrangements must be made by the travelers; fees for limousine or similar service are reimbursable. If an ambulance is required, the Office of Medical Services will make the necessary arrangements if notified in advance.

687 Medical Supplies and Equipment

687.1 Responsibilities

At posts with organized Health Units, the medical officer or nurse in charge originates requests for and dispenses medication, and maintains and issues medical supplies and equipment. At other posts, the accountable property officer is responsible for these duties except the dispensing of medications. In the absence of a medical officer or nurse, medications will be dispensed by the administrative officer. (See section 687.7-4b.)

687.2 Requisitioning of Medical Supplies and Equipment

For Requisitioning procedures, see 6 FAH H-213.4. Guidance should be sought from the Regional Medical Officer or the Office of Medical Services concerning the appropriateness and quantity of medical supplies, equipment, and medications.

687.3 Record Maintenance

All expendable medical supplies and nonexpendable medical equipment should be subject to the controls prescribed in 6 FAM 220 including periodic verifications of the records. In addition, principal officers shall insure that adequate records and files of filled prescriptions are maintained by the post.

687.4 Storage of Medical Supplies

Medical supplies shall be kept in locked cabinets and, as necessary, items requiring refrigeration or cool storage shall be kept under refrigeration or cool at all times. Only authorized personnel shall have access to medical supplies.

687.5 First Aid Kits

All posts should have an adequate number of small first aid kits on hand at all times for emergency use. All official vehicles should contain first aid kits.

687.6 Disposal of Perishable Items

Perishable items must be disposed of on the expiration date, if one is shown on the package, or when the item is no longer serviceable. Such action is charged off the inventory record as an issuance.

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UNIFORM STATE/AID/USIA REGULATIONS

687.7 Dispensing of Medications

687.7-1 Eligibility

Medications may be dispensed for the treatment of American employees and dependents, local staff employees, A.I.D. contract personnel and dependents and personnel under administrative support agreements.

687.7-2 Emergency Medications

In emergencies, prescription drugs may be dispensed to others when the drug is prescribed by a physician and is unavailable locally. In such cases the person receiving the drug is required to pay for it at cost, including direct and indirect expenses. The proceeds of the sale shall be turned over to the disbursing officer for inclusion in his accounts as a credit to "General Fund Account Symbol 192649-Proceeds from Sales of Government Property - Not Otherwise Classified."

687.7-3 Drugs Requiring a Prescription

Any drug of the following types requires a prescription from a reputable doctor:

Antibiotics (e.g., tetracycline and derivatives, chloramphenicol, erythromycin etc.)
Sulfonamides (e.g., sulfisoxazole or "Gantrisin," succinylsulfathiazole or "Sulfasuxidine," etc.)
Amebicides (e.g., diiodohydroxyquin or "Diodoquin," etc.)
Narcotics (e.g., demerol, morphine, codeine, etc.)
Sedatives (e.g., seconal, phenobarbital, etc.)
Tranquilizers (e.g., "Equinil," "Miltown," etc.)
Steroids (cortisone, predmisolone, etc.)

687.7-4 Authority to Dispense Prescription Drugs

Drugs requiring a prescription may only be dispensed as follows:

a. Doctors in Charge of Health Units

Doctors in charge of Health Units may prescribe and dispense any available medical supplies.

b. Nurses and Administrative Officers

Nurses and administrative officers may dispense prescription drugs only upon receipt of a prescription from a reputable doctor.

687.8 Procurement of Medical Supplies and Equipment for Non-Americans

Requests for medical supplies and equipment from non-Americans shall be directed to American commercial outlets or appropriate foreign diplomatic missions at Washington and not to the Department of State. Posts may, however, render assistance by obtaining and furnishing non-Americans with the names and addresses of medical suppliers.

(*) Revision

688 Postemployment Medical Services

Effective December 23, 1967, and subject to the eligibility requirements of section 684.2c, the Medical Director is authorized to approve payment for the cost of examination and/or treatment otherwise payable under section 685 for an employee after his separation, and for a dependent after the employee's separation or death. Medical services for former employees and their dependents are limited to the following:

(1) Medical treatment for an illness or injury discovered in the course of examination at the time of separation or death;

(2) Treatment for an illness or injury where treatment has begun or is urgently needed on or before the date of separation or death;

(3) Examination and treatment for a latent illness not discovered at the time of separation and which in the opinion of the Medical Director was clearly caused by the individual's presence abroad as an employee or a dependent, where failure to approve payment would result in inequity and acute hardship.

Payment of postemployment expenses will be made in accordance with section 685.2.

UNIFORM STATE/AID/USIA REGULATIONS

POLICIES AND PROCEDURES FOR IMMUNIZATIONS

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POLICIES AND PROCEDURES FOR IMMUNIZATIONS

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III. Facilities to Be Used for Obtaining Immunizations

a. Immunization Clinic, * (O/MED) Office of Medical Services, * Department of State,

b. Department of State Dispensaries or Health Units established abroad.

c. U.S. Government medical facilities throughout the world.

d. *Private physicians in the U.S.* when Government facilities not available.

e. Local physicians abroad when a procedure has been established by the post.

IV. Persons Eligible to Receive Immunizations

The immunization policies and procedures appearing in this appendix are an integral part of the Department of State medical and health program set forth in 3 FAM 680, and are applicable to the U.S. Government personnel identified in section 681.1 and to their eligible dependents.

In addition, American military personnel and dependents outside the United States, regardless of *post of assignment*, are eligible for immunizations where military facilities are not available. * Immunization policies and procedures for military personnel and dependents are governed by military regulations. *

V. Immunization

The immunizations recommended herein, their type, dosage, series schedules, frequency of boosters, and related instructions are based on the best current available medical information. These recommendations should be considered as guidelines and not as rigid instructions. They should be followed in normal situations. Changes in types, frequency, and amounts may be made as local health conditions warrant and in keeping with the advice of competent medical authority.

a. Basic immunizations to be given to all *American employees and dependents before* departure for overseas:

(1) Smallpox
(2) Typhoid
(3) *Poliomyelitis (It is recommended* that all individuals receive the oral vaccine. Salk should only be used if the oral vaccine is unavailable.)
(4) Tetanus, Diphtheria, and Pertussis (under 7 years)
Tetanus, Diphtheria (adult type) 7 years and over
(5) Measles (children 12 months and older and nonimmune adults)
(6) Yellow fever (6 months and older)

b. Immunization against other diseases is *dependent upon the* requirements of the country and recommendation of * O/MED * or the local medical adviser.

c. Immunizations given to military personnel and dependents will be *according to military* regulations.

d. Foreign Service dependents who are Christian Scientists are required to receive only those immunizations mandatory for international travel.

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VI. Documenting Immunization Services

International Certificate of Vaccination

All vaccinations and inoculations shall be recorded on the International Certificate of Vaccination, Form PHS-731, which has been approved by the World Health Organization and is the only acceptable document for international travel, and shall be authenticated by signatures, dates, and stamps as follows:

a. Signature

The written signature of the physician responsible for administering the vaccine is required for each vaccination or inoculation. Signatures to be used by Department of State Medical Units are:

(1) *Office of Medical Services* Immunization Clinic--signature of the *Deputy Assistant Secretary for Medical Services.

(2) Posts abroad:

(a) Units with Foreign Service Medical Officers--signature of the Medical Officer in charge.

(b) Units with a Foreign Service Nurse--signature of the* Deputy Assistant Secretary for Medical Services* .

(c) Units without a Foreign Service Medical Officer or Nurse--the signature of the physician responsible for administering the vaccination.

b. Date

The date on which each immunization is rendered shall be recorded by showing the day, month, and year--in that order--with the month to be written in letters.

c. Stamps

Smallpox, cholera, and yellow fever vaccination certificates shall, in addition to the signature and date, bear a stamp approved or recognized by the health administration of the country in which the vaccination is performed. Medical Units staffed by American-citizen Medical Officers or Nurses may as a rule use the posts' official rubber-stamp seal (see 2 FAM 151.3b). Posts which use foreign-national contract physicians should request the contract physician to authenticate his immunization certificates with the stamp specified or recognized by the health authorities of the country in which the vaccination is administered.

The *Office of Medical Services* Immunization Clinic is the only Department of State Medical Unit authorized to vaccinate against * ellow fever and shall authenticate such immunizations with the special stamp provided for that purpose by the U. S. Public Health Service.

VII. Sterilization of Equipment

A separate sterilized needle and syringe shall be used for each immunization. Disposable syringes and needles or the regular reusable syringes and needles may be used; however, the latter should be sterilized by autoclaving, not by boiling.

VIII. Care of Vaccines

Smallpox (except the dried product), oral polio vaccine, and yellow fever vaccine shall be kept below freezing, preferably between 0 and 5 degrees F., until used. (Freeze compartment of a standard refrigerator.)

An unentered container of oral polio vaccine may be used after as many as 10 thaw-freeze cycles, provided the temperature during the thaw period did not exceed 45 degrees F., and the total cumulative thaw time does not exceed 24 hours. If the 24-hour period is exceeded, the vaccine must be used within 30 days (stored at a temparature no higher than 45 degrees F.). An entered bottle of vaccine must be used within 7 days after thawing, and should not be refrozen.

Dryvax (dried Smallpox) and all other biologicals shall be refrigerated between the temparatures of 35 and 45 degrees F. (i.e., standard refrigerator temperature).

(*) Revision

IX. Disposing of Biologicals

Biologicals should be disposed of on the stipulated expiration date. Caps should be opened and the biologicals removed from the vial.

Any biological which, upon receipt, has a great amount of precipitation or where there is a noticeable change in consistency or color shall be disposed of as above.

X. Intervals Between Inoculations

The prescribed time element between individual doses of a basic inoculation series for immunization is to be regarded as optimum and adhered to as closely as possible. If a delay should occur in the completion of a series, the next dose or doses will be administered at the earliest opportunity. A new series need not be started.

XI. Sensitivity of Patient

Before inoculations are administered, inquiry should be made whether the individual has previously shown any unusual degree of sensitivity to a foreign protein or inoculation. If the person has known allergy or sensitivity to a biological, the nurse shall seek medical advice before proceeding with an immunization. Persons with significant allergy to eggs or fowl should not be given vaccine prepared by cultivation in eggs, i.e., typhus, influenza, yellow fever, measles, * rabies, * etc.

XII. Need for Booster Immunizations

Normally the schedule as advised in the following tables will be used for administering boosters. The responsible physician will determine the need for changing the schedule depending on the area of assignment or the prevalence of disease.

XIII. Repeating Series

Regardless of the length of time since the last primary or booster immunization, a primary series need never be repeated for booster doses to be effective.

XIV. Infants

Intramuscular injections in infants under 6 months of age or extremely small infants over 6 months of age should not be given in the buttock as damage to the sciatic nerve has been reported. Preferred site is the deltoid or the anterior surface of the thigh.

Except in the presence of an epidemic it is probably inadvisable to give *the *live virus vaccines *of* *smallpox or yellow fever to infants under 6 months of age, or to give measles *(rubeola) or rubella* to children under 12 months of age.

XV. Biologicals Available

Rabies Hyper-immune serum - 1,000 unit
Cholera Vaccine - 20 cc vial
Diphtheria-Pertussis-Tetanus vaccine (DPT) - 7.5 cc vial
Gamma globulin (immune serum) - 10 cc vial
Influenza vaccine (polyvalent) - 10 cc vial
Plague vaccine - 20 cc vial
Poliomyelitis vaccine (Salk) - 9 cc vial
Poliomyelitis vaccine (oral) - 10-dose vial
Rabies vaccine 7-dose unit - seven 0.5 cc vials - duck embryo (rabbit type by special order only)
* Rubella virus vaccine, live - single dose vials*
Smallpox (Dryvax) - 10 doses per unit
Tetanus-Diphtheria vaccine (adult) - 5 cc vial
Tetanus toxoid (aluminum phosphate adsorbed) - 5 cc vial
Typhoid vaccine - 15 cc vial
Typhus vaccine (epidemic type) - 20 cc vial
Measles - single dose units, requires diluent and gamma gee (Schwarz Strain does not require gamma gee).
Vaccinia immune globulin - human (VIG) 5 cc vial

These biologicals shall be procured in accordance with the provisions of 3 FAM 687.

Vaccinia immune globulin - human (VIG) - 5 cc vial - shall be procured in accordance with instructions contained in section on smallpox, item i (p. 18).

XVI. Live Virus Vaccines

Oral polio, smallpox, measles, ✲(rubeola), rubella, and yellow fever are live virus vaccines. It is generally recommended that live virus vaccines be given at least 1 month apart whenever possible. If the theoretically desirable 1-month interval is not feasible, as with the threat of concurrent exposures or disruption of immunization programs, the vaccines should preferably be given on the same day--at different sites for parenteral products. An interval of 2 days to 2 weeks should be avoided because interference between the vaccine viruses is most likely then.

Simultaneous administration of live rubella virus vaccine and other live vaccines should be avoided until results of controlled clinical investigations are available. Until then, it is recommended that rubella vaccination be separated by at least one month from the administration of other live virus vaccines. ✲

Gamma globulin, in doses used for hepatitis prophylaxis, may interfere with the development of immunity to live virus vaccines. There is less interference with oral polio. Therefore, whenever possible immunizations should be planned so that gamma globulin will be the final injection in a series. After smallpox, measles ✲(rubeola), rubella, ✲ or yellow fever immunization, delay gamma globulin for at least 3 weeks. After oral polio, wait 1 week before giving gamma globulin.

The prior administration of gamma globulin will necessitate a delay of 2 to 3 months before measles ✲(rubeola) or rubella ✲ immunization, a delay of 3 to 4 weeks before smallpox or yellow fever immunization, and a delay of 1 week before oral polio immunization, except during an epidemic or when required for international travel.

Live virus vaccines should not be given to individuals who have a disease which might affect their immune mechanisms. Examples of such disorders are the lymphomas, agammaglobulinemia, hypogammaglobulinemia, the dysproteinemias (macroglobulinemia, cryoglobulinemia, etc.), persons on long-term steroid maintenance therapy (exception: oral polio), and those receiving antimetabolites, alkylating agents, or irradiation therapy.

XVII. Refrigerated Shipping Standards for Medical Vaccines and Serums

In judging whether the potency of vaccines and serums has been impaired because of inadequate refrigeration during shipment, all posts should be guided by the Department of Defense Medical Supply Center refrigeration shipping standards.

Provided the out-of-refrigeration temparature neither exceeds 95 degrees F. nor falls below freezing, the listed vaccines and serums may be safely unrefrigerated for shipping purposes for the number of days shown:

Item	Permissible Number Unrefrigerated Shipping Days
Antirabies serum	7
Cholera vaccine	7
Diphtheria antitoxin	10
Diphtheria-Tetanus-Pertussis vaccine	7
Globulin, immune serum (human)	10
Measles virus vaccine, live, attenuated	Ship and keep frozen.
Plague vaccine, USP	7
Poliomyelitis vaccine, Salk	7
Poliomyelitis vaccine, live oral Sabin monovalent strains I, II, and III or trivalent	Ship and keep frozen.
Rabies vaccine USP, duck embryo	30
✲Rubella virus vaccine, live, attenuated	7 ✲
Smallpox, dryvax	Refrigeration not required.
Smallpox vaccine, freeze dried	14
Smallpox vaccine, USP	Ship and keep frozen.
Tetanus and diphtheria toxoids combined	10
Tetanus toxoid, USP	7
Typhoid vaccine, USP	7
Typhus vaccine, USP	7
Yellow fever vaccine, USP	Ship and keep frozen.

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Most but not all vaccines are sent via air pouch in packages containing dry ice. These packages bear a white label which has the words "Removed from Refrigeration" printed at the top and the words "Refrigerate upon Arrival" printed at the bottom. Between these lines will appear the pouch room time and date-stamp impression showing the exact time the vaccine was taken from refrigeration in the Department to begin the trip to the addressee post. Some private manufacturers follow this same procedure. When this is the case, the post can tell when the package was or was not refrigerated from the original point of shipment to the time it reaches the final destination.

UNIFORM STATE/AID/USIA REGULATIONS

SCHEDULE OF IMMUNIZATIONS

CHOLERA

a. Age

Infants should not be immunized until 6 months of age.

b. Children's Dosage

Six months through 4 years of age should receive*two*doses subcutaneously 7-*30* days apart.
First dose 0.1 cc
Second dose 0.3 cc

Five years through 9 years of age should receive*two*doses subcutaneously 7-*30* days apart.
First dose 0.3 cc
Second dose 0.5 cc

Ten years and over, adult dosage.

c. Adult Dosage

Two doses subcutaneously 7-*30*days apart:
First dose 0.5 cc
Second dose 1.0 cc

d. Administration

Should be subcutaneous or by intramuscular injection.

e. Booster

It should be given every 6 months while in an area where danger of infection exists. The recall dose*for children under 5 years should be 0.3 cc, for all others it should be 0.5 cc.*

f. Special Information

The series need not be repeated regardless of length of time since last dose. This immunization must be authenticated by a stamp approved by the health administration of the country in which the vaccination is performed.

It is important to give the booster dose on time. *If more than 6 months have elapsed* since the last booster, reimmunization is not valid for international travel until 6 days after reimmunization.

DIPHTHERIA-TETANUS-PERTUSSIS

a. Age

Six weeks* through 6* years. Not to be used on children 7 years of age and older. (See Tetanus-Diphtheria (adult).)

b. Children's Dosage

Three doses of 0.5 cc intramuscularly, 4 to 6 weeks apart. Different sites being used for each injection.

c. Administration

Should always be given intramuscularly. The injection should be terminated by the administration of a small air bubble which helps prevent the deposition of vaccine along the needle tract and lessens the possibility of local reactions.

d. Booster

0.5 cc intramuscularly should be given a year after the third dose and again on entering school, kindergarten, or nursery school.

(*) Revision

GAMMA GLOBULIN

1. Use for Long-Term Prophylaxis of Infectious Hepatitis

a. Age

*Gamma globulin is required for all employees and dependents 12 years of age and older assigned to countries other than the following: United States, * Austria,* Bahamas, Barbados, Belgium, Bermuda, Canada, Denmark, Finland, France (except port cities along the Mediterranean), Germany, Great Britain, Iceland, Ireland and Northern Ireland, Jamaica, Luxembourg, Nassau, Netherlands, New Zealand, Norway, the Republic of South Africa, Sweden, Switzerland, and Trinidad and Tobago.

Gamma globulin for individuals at exempted posts and for dependents under 12 years of age is optional. Individuals with a history of infectious hepatitis do not require gamma globulin. *

b. Dosage

1.0 cc for individuals weighing from 20 to 49 pounds, 2.5 cc for individuals weighing from 50 to 99 pounds, and 5.0 cc for individuals weighing 100 pounds or over. The maximum dose should not exceed 5.0 cc regardless of weight. * Repeat every 4 to 6 months during residence in endemic area. The exact frequency of administration should be at the discretion of the post physician or medical adviser, in relation to the specific local hepatitis situation.*

c. Administration

*Should be given intramuscularly in *gluteal muscles.

d. Contraindications

History of allergy to gamma globulin.

Gamma globulin, in doses used for hepatitis prophylaxis, may interfere with the development of immunity to live virus vaccines. There is less interference with oral polio. Therefore, whenever possible, immunizations should be planned so that gamma globulin will be the final injection of a series. After smallpox, measles*(rubeola), rubella,* or yellow fever immunizations, delay gamma globulin for at least 3 weeks. After oral polio, wait 1 week before giving gamma globulin.

The prior administration of gamma globulin will necessitate a delay of 2 or 3 months before measles*(rubeola) or rubella* immunization, a delay of 3 to 4 weeks before smallpox or yellow fever immunization, and a delay of 1 week before oral polio immunization, except during an epidemic or when required for international travel.

2. Use for Passive Prohylaxis or Attenuation of Measles (Rubeola),* Rubella,* or Infectious Hepatitis in Nonimmune Contacts

Gamma globulin may be administered to close family contacts of patients with measles (rubeola), rubella, or infectious hepatitis upon the recommendation of a physician. No benefit may be expected if administered after onset of clinical symptoms of measles (rubeola), rubella, or infectious hepatitis.

a. Age

Any age.

b. Dosage

(1) For Measles *(Rubeola)*

Preventive dose - 0.1 cc per pound of body weight.

Modifying dose - 0.02 cc per pound of body weight. Increase dosage if given later than 6 days after initial exposure, as advised by attending physician.

(*) Revision

GAMMA GLOBULIN--Continued

(2) For Infectious Hepatitis

In general, should be used for all household contacts. At least 0.01 cc per pound of body weight as soon as possible after exposure. Individuals who have had infectious hepatitis do not need to receive gamma globulin.

*(3) For Rubella

Should be used only for exposed females with no history of rubella who are in the first 4 months of pregnacy.

Dose - 20.0 cc intramuscularly. Larger doses are feasible upon direction of a physician.

It should be kept in mind that the degree of protection obtained is irregular. Recent experimental studies suggest that gamma globulin may prevent the clinical manifestations of rubella in the mother, but not prevent infection and congenital malformation in the fetus.*

c. Administration

Should always be administered intramuscularly* and in divided doses. No more than 5.0 cc should be administered in any one site.*

3. Special Information

There is no conclusive evidence that gamma globulin is effective in preventing transfusion hepatitis and thus there is no adequate basis for recommending that it be given routinely to recipients of blood transfusion.

There is little scientific evidence that gamma globulin is of any value in the prophylaxis of mumps, chicken pox, or other contagious diseases of this nature. There is not scientific evidence that gamma globulin provides a nonspecific protection or aid to those individuals suffering from a severe or chronic infictious process.

INFLUENZA

1. Recommendations for Influenza Immunization and Control in the Civilian Population

Long experience with influenza strongly emphasizes that certain groups of the population are at greatest risk of death or severe morbidity should they acquire the disease. Since polyvalent influenza virus vaccine has been repeatedly shown to be of definite value in preventing influenza, annual immunization of these groups is again stressed.

2. High Risk Groups

Immunization should be considered and generally recommended for persons in groups who experience high mortality from epidemic influenza. Such groups include:

a. Persons at all ages who suffer from chronic debilitating disease, e.g., chronic cardiovascular, pulmonary, renal, or metabolic disorders, in particular:

(1) Patients with rheumatic heart disease, especially those with mitral stenosis.

(2) Patients with other cardiovascular disorders such as arteriosclerotic heart disease and hypertension, especially those with evidence of frank or incipient cardiac insufficiency.

(3) Patients with chronic bronchopulmonary disease, for example, chronic asthma, chronic bronchitis, bronchietasis, pulmonary fibrosis, pulmonary emphysema, pulmonary tuberculosis.

(4) Patients with diabetes mellitus and Addison's disease.

(*) Revision

INFLUENZA--Continued

b. Persons in older age groups. During three successive recent epidemics a moderate increase in mortality has been demonstrated among persons over 45 years and a marked increase among those over 65 years of age.

3. Special Precautions

Serious consideration should also be given to immunizing those in medical and health services, public safety, public utilities, education, transportation, and communications fields. In industries and large institutions where absenteeism is of particular concern, large-scale immunization programs are to be encouraged.

4. *Programs in the Northern Hemisphere*

Immunization in the Northern Hemisphere should begin as soon as practicable after September 1 and should be completed by mid-December. Since a 2-week delay in the development of antibodies may be expected, it is important that immunization be carried out before an epidemic occurs in the immediate area.

5. Dose and Schedule of Vaccination by Age (for those for whom immunization is recommended)

a. Primary Series. Those not vaccinated since July 1963 should receive a subcutaneous dose of polyvalent vaccine followed by a second dose about 2 months later. It is to be pointed out, however, that even a single dose can afford significant protection: a second dose given as early as 2 weeks following the first will enhance the protection.

b. Revaccination. Those revaccinated since July 1963 need receive but a single dose of the vaccine.

c. Dosage

✲Dose volume for adults and children is specified in the manufacturers' labeling.✲

d. Special Information

This vaccine should never be given to anyone who has sensitivity to eggs, chicken, or chicken feathers. Skin testing in such persons is also contraindicated. All persons who are to receive this vaccine are to be questioned regarding egg or chicken allergy prior to immunization.

Since febrile reactions are common following influenza vaccination, an antipyretic may be indicated.

(✲) Revision

MEASLES (RUBEOLA)

It is recommended that the live attenuated measles virus vaccine plus measles immune globulin be used as the preferred method of vaccination.

Measles immune globulin is unnecessary if the Schwarz Strain of measles virus is used.

a. Age

Should be administered to those without a history of measles, at 12 months of age or as soon thereafter as possible.

b. Dosage and Administration

*For both child and adult, administer*0.5 cc of reconstituted vaccine subcutaneously into upper arm.* Immediately thereafter, inject 0.01 cc of measles immune globulin per pound of body weight in the deltoid muscle of the opposite arm, unless the Schwarz Strain of virus is used. * Use separate needles and syringes.

c. Special Information

Exacerbations of tuberculosis known to follow natural measles infection might, by analogy, be associated with measles vaccination. In children, a tuberculin test should be done prior to measles vaccination and positive reactors placed on antituberculous therapy before giving live measles vaccine.

Reactions of fever may occur 7 to 8 days after injection but have been accompanied by few clinical symptoms. Contraindications are marked egg sensitivity, severe febrile illness, and if more than 0.01 cc per pound of body weight of gamma globulin has been administered in the previous months. One must wait at least 2 to 3 months after a hepatitis-prophylactic dose of gamma globulin has been administered.

See section XVI on live virus vaccines (p. 5).

PLAGUE

At present, plague innoculations are recommended for Viet-Nam, Laos, and Cambodia (Khmer Republic), rural areas of the eastern part of the Democratic Republic of the Congo, and rural areas of Burundi and Rwanda. Also, for all persons whose vocation or field work brings them into frequent and regular contact with wild rodents in plague enzootic areas of the western United States, South America, Africa, or Asia.

a. Age

*Six*months and older.

b. Dosage and Administration

*Primary immunization consists of two intramuscular injections 90 days apart.

6 months through 5 years
First injection - 0.3 cc
Second injection - 0.2 cc

6 through 9 years
First injection - 0.5 cc
Second injection - 0.2 cc

10 years and older
First injection - 1.0 cc
Second injection - 0.2 cc*

c. Booster Dosage

*For all ages, the booster dose is 0.2 cc (IM) given at 6-month intervals. The first such booster will be given no sooner than 6 months following the second injection of basic series.

Repeat of basic immunization series is not required regardless of the length of time since the last injection.

Boosters are only given to individuals residing in known plague endemic areas and to those in frequent contact with wild rodents in plague enzootic areas.*

(*) Revision

PLAGUE--Continued

d. Special Information

Repeated injections result in increasing reactivity of body tissues, and hence the incidence and severity of reactions increase with the number of injections received. This is particularly true of local reactions. This is, of course, also true of most other vaccines, and is not a peculiarity of plague vaccine.

e. Contraindications

There are no real contraindications. It is advisable, however, not to give injections during upper respiratory infections because more severe reactions may follow.

POLIOMYELITIS

1. Oral, trivalent (U.S. Trade Name "Orimune")

a. Age

May be given all individuals over 6 weeks of age. Give to infants under (✻ weeks ✻ of age only in the presence of an epidemic.

b. Dosage

Two drops each dose of Orimune (for other brands follow directions on the label).✻ The basic series for all ages is 3 doses. The first two doses are given 8 weeks apart; the third dose is administered 8 to 12 months after the second.✻

c. Administration

Never injected. From dropper by mouth; by teaspoon mixed with distilled water, simple syrup, ✻ or ✻ milk; or absorbed on any number of substances, such as a cube of bread or sugar or cake.✻ Do not precede with, give in, or follow with (within 1/2 hour) water or other beverage containing free chlorine or other halogen.✻ (Avoid contact between dropper and mouth to prevent cross-infection.)

d. Booster

At the time of an epidemic all individuals should receive one dose. Children receive booster on entering school.

e. Contraindications

See section XVI on live virus vaccines (p. 5).

Immunization with oral polio vaccine should not be given during an illness or to a person having diarrhea or vomiting.

f. Special Information

Color variation from yellow to red may occur but has no significance. Store in freezer compartment. Agitate after thawing. Once ready for use, must be used within 7 days. During this period store at temperature no higher than ✻ 8° C. (46° F.).✻

✻Uncutered bottles which have thawed accidentally may be refrozen under certain conditions. (See section VIII on care of vaccines (p. 3).✻

Individuals using U.S. military medical facilities for their immunizations should follow the prescribed military recommendations for their oral poliomyelitis immunization programs.

Individuals having access to foreign national or U.S. community-sponsored oral poliomyelitis programs may utilize this source for their immunization.

Oral trivalent poliomyelitis vaccine should be taken by those who have had only the Salk vaccine.✻ Past history of clinical poliomyelitis is not a contraindication to the administration of live polio vaccine.✻

Whenever possible, the basic series should be given during winter or cooler months of the year.

✻Gamma globulin should not be given within 1 week of oral poliomyelitis vaccine.✻

(✻) Revision

POLIOMYELITIS--Continued

2. Salk

It is recommended that all individuals receive the oral vaccine. Salk should only be used if the oral vaccine is unavailable.

a. Age

May be given at 1 month of age and over.

b. Dosage--All Ages

Three doses of 1.0 cc given at 1-month intervals, and a fourth dose 6 to 12 months after the third. This schedule can be integrated with D. T. P. immunization, beginning at 6 to 12 weeks of age. (See Diphtheria-Tetanus-Pertussis.)

c. Administration

This vaccine should always be given deep subcutaneously or intramuscularly.

d. Booster

A booster dose of 1.0 cc should be given 6 to 12 months after the third dose and then every 2 years if in an area where the incidence of the disease is high and at the time of an epidemic.

e. Special Information

The color of the vaccine may vary from orange to deep red, which are normal colors. If a precipitate develops or the vaccine turns hazy, it should be discarded.

For practical purposes the vaccine contains no penicillin, as the production processes so dilute or destroy penicillin that the final product is penicillin-free even if penicillin was used in the original inoculum.

Poliomyelitis vaccine is now also manufactured using the aluminum phosphate adsorption technique. The dose of this preparation is 0.5 cc rather than 1.0 cc of the original fluid Salk vaccine.

(*) Revision

UNIFORM STATE/AID/USIA REGULATIONS

RABIES

The preferred post-exposure course of treatment for rabies, as recommended by the World Health Organization Expert Committee on Rabies, is as follows:

POST-EXPOSURE TREATMENT

A. Local Treatment of Wounds Involving Possible Exposure to Rabies

(1) Recommended in all exposures

(a) First-aid treatment

Immediate washing and flushing with soap and water, detergent, or water alone (recommended procedure in all bite wounds including those unrelated to possible exposure to rabies).

(b) Treatment by or under direction of a physician

(I) Adequate cleansing of the wound.

(II) Thorough treatment with 20% soap solution and/or the application of a quaternary ammonium compound or other substance of proven lethal effect on the rabies virus.

(III) Topical application of antirabies serum or its liquid or powdered globulin preparation (optional).

(IV) Administration, where indicated, of antitetanus procedures and of antibiotics and drugs to control infections other than rabies.

(V) Suturing of wound not advised.

(2) Additional local treatment for severe exposures only

(a)' Topical application of antirabies serum or its liquid or powdered globulin preparation

(b) Infiltration of antirabies serum around the wound

(1) Where soap has been used to clean wounds, all traces of it should be removed before the application of quaternary ammonium compounds because soap neutralizes the activity of such compounds.

Benzalkonium chloride, in a 1% concentration, has been demonstrated to be effective in the local treatment of wounds in guinea pigs infected with rabies virus. It should be noted that at this concentration quaternary ammonium compounds may exert a deleterious effect on tissues.

Compounds that have been demonstrated to have a specific lethal effect on rabies virus in vitro (different assay systems in mice) include the following:

Quaternary ammonium compounds
0.1% (1:1000) benzalkonium chloride
0.1% (1:1000) centrimonium bromide
1.0% (1:100) Hyamine 2389
1.0% (1:100) methyl benzethonium chloride
1.0% (1:100) benzethonium chloride
1.0% (1:100) S K F ✻1183✻

Other substances:
43 - 70% ethanol; tincture of thiomersal; tincture of iodine and up to 0.01% (1:10,000) aqueous solutions of iodine; 1% to 2% soap solutions.

(✻) Revision

RABIES--Continued

B. Specific Systemic Treatment (from the Fifth Report of the WHO Expert Committee on Rabies):

Nature of Exposure	Status of biting animal (irrespective of whether vaccinated or not)		Recommended Treatment
	At time of exposure	During observation period of 10 days	
I. No lesions; indirect contact	Rabid	-	None
II. Licks: (1) unabraded skin	Rabid	-	None
(2) abraded skin, scratches and unabraded or abraded mucosa	(a) healthy	Clinical signs of rabies or proven rabid *(laboratory).*	Start vaccine at first signs of rabies in the biting animal.
	(b) signs suggestive of rabies	Healthy	Start vaccine immediately; stop treatment if animal is normal on fifth day after exposure.
	(c) rabid, escaped, killed, or unknown	-	Start vaccine immediately.
III Bites: (1) mild exposure	(a) healthy	Clinical signs of rabies or proven rabid (laboratory).	Start vaccine at first signs of rabies in the biting animal.
	(b) signs suggestive of rabies	Healthy	Start vaccine immediately; stop *treatment* if animal is normal on fifth day after exposure.
	(c) rabid, escaped, killed, or unknown	-	Start vaccine immediately.
	(d) wild (wolf, *stray dog, *jackel, fox, bat, etc.)	-	Serum immediately followed by a course of vaccine.
(2) severe exposure (multiple, or face, head, finger, or neck bites)	(a) healthy	Clinical signs of rabies or proven rabid (laboratory).	Serum immediately; start vaccine at first sign of rabies in the biting animal.
	(b) signs suggestive of, rabies	Healthy	Serum immediately followed by vaccine. Vaccine may be stopped if an animal is normal on fifth day after exposure.
	(c) rabid, escaped, killed, or unknown	-	Serum immediately followed by vaccine.
	(d) wild (wolf, jackel, *stray *dog, fox, bat, etc.)	-	Serum immediately followed by vaccine.

(*) Revision

RABIES--Continued

1. Practice varies concerning the volume of vaccine per dose and the number of doses recommended in a given situation. In general, the equivalent of at least 2 ml of a 5% tissue emulsion should be given subcutaneously daily for 14 consecutive days. Many laboratories use 20 to 30 doses in severe exposures. To insure the production and maintenance of high levels of serum-neutralizing antibodies, booster doses should be given at 10 days and at 20 or more days following the last daily dose of vaccine in all cases. This is especially important if antirabies serum has been used, in order to overcome the interference effect.

2. In all severe exposures and in all cases of unprovoked wild animal bites, antirabies serum or its globulin fractions together with vaccine should be employed. This is considered by the Committee as the best specific treatment available for the post-exposure prophylaxis of rabies in man. Although experience indicates that vaccine alone is sufficient for mild exposures, there is no doubt that here also the combined serum-vaccine treatment will give the best protection. However, both the serum and the vaccine can cause deleterious reactions. Moreover, the combined therapy is more expensive; *its use in mild exposures is therefore considered optional. *

   As with vaccine alone, it is important to start combined serum and vaccine treatment as early as possible after exposure, but serum should still be used no matter what the time interval. Serum should be given in a single dose (40 IU per kg. of body weight) and the first dose of vaccine inoculated at the same time. Sensitivity to the serum must be determined before its administration.

   Immunization Before Exposure

   Rabies prophylaxis, before exposure, is indicated for individuals with an unusual risk of repeated exposure, such as veterinarians, dog handlers, field naturalists, laboratory workers, or Foreign Service personnel having a high risk of exposure.

   a. Age: One year of age and older.

   b. Dosage and Administration: Duck embryo vaccine. Three doses each of *1.0* cc subcutaneously. First and second dose one (1) month apart. Third dose 6 to 7 months after second dose. May be given in arm.

   c. Booster: *1.0* cc subcutaneously every 2 years as long as high-risk exposure exists.

   d. Special Information: Important--in case of exposure of an individual who has received this pre-exposure immunization; the usual post-exposure (see paragraph B above) should be given.

   e. Contraindications: Do not give to individuals known to be duck sensitive.

(*) Revision

**RUBELLA LIVE VIRUS VACCINE

a. Age

Boys and girls between the age of 1 year and puberty.

b. Dosage and Administration

A single injection of 0.5 cc subcutaneously.

c. Contraindications

Pregnant women should not be given live rubella virus vaccine. If it is not known to what extent infection of the fetus with attenuated virus might take place following vaccination, or whether damage to the fetus could result. Therefore, routine immunization of adolescent girls and adult women should not be undertaken because of the danger of inadvertently administering vaccine before pregnacy becomes evident.

Rubella vaccine is produced in cell culture. Vaccination is contraindicated in persons with known hypersensitivity to the species from which the cells were derived (indicated in the labeling). The vaccine should also not be given to individuals known to be sensitive to neomycin.

See section XVI on live virus vaccines (p. 5).

d. Special Information

Rubella is generally a mild illness, but if the infection is acquired by a woman in the early months of pregnancy, it poses a direct hazard to the fetus. Preventing infection of the fetus is the principle objective of rubella control. This can best be achieved by eliminating the transmission of the virus among children, who are the major source of infection for susceptible pregnant women.

A history of rubella illness is usually not reliable enough to exclude children from immunization.**

SMALLPOX (Dryvax or Regular)

a. Age

Six months and older unless in presence of epidemic or if required for entry in country.

b. Children's Dosage

One drop.

c. Adult Dosage

One drop.

d. Administration

The upper left arm is the preferred site and the multiple pressure technic should be used for scarification.

e. Booster

Smallpox vaccination should be repeated every 3 years unless in endemic area. It may be repeated as frequently as the medical advisor recommends in these areas, but it is not considered necessary more often than annually. It may be necessary to have vaccination at more frequent intervals* than the usual 3 years* in order to comply with local government travel and quarantine regulations.

f. Special Information

Every vaccination should have some type of reaction and if necessary should be repeated until a reaction occurs. All repeat vaccinations should be checked in 48 hours and primary vaccinations checked in 1 week.

No person should be vaccinated who has a skin rash or atopic eczema. In the presence of an acute threat of smallpox, vaccination is permitted if the skin lesion is not denuded or weeping.

Some authorities recommend that no person on long-term steroid (cortisone or cortisone-like compounds) therapy receive smallpox vaccination.

*See section XVI on live virus vaccines (p. 5) for additional contraindications and other information on smallpox vaccine.

At present, yearly vaccination is given in Indonesia and in the Democratic Republic of the Congo, and under epidemic conditions in other areas as required.*

(*) Revision
(**) New Material

SMALLPOX (Dryvax or Regular)--Continued

g. Contraindications

Do not vaccinate against smallpox if the individual or a member of his household has eczema or dermatitis.

Vaccination during pregnancy entails some risk of producing a fatal transplacental infection of the fetus. Pregnant women anticipating international travel should be given a certificate of contraindication to vaccination. If vaccination during pregnancy is indicated because of exposure to the disease, vaccinia immune globulin (VIG) in dose of 0.3 cc/KG (intramuscularly) should be given at the time of vaccination. VIG will not prevent a take.

h. Passive Immunization

Vaccinia immune globulin (human) injected intramuscularly will prevent or modify smallpox if given within 24 hours after known exposure. It is also used in the treatment of eczema vaccinatum, severe generalized vaccina, or vaccina necrosum. Other indications may be accidental exposure to vaccina virus of a patient with extensive skin lesions such as eczema, burns, or impetigo.
Vaccinia immune globulin should not be given for accidental vaccinia of the eye. These patients generally have good levels of antibody and more may result in corneal precipitates and opacities.

i. Supply Sources

The provisions of 3 FAM 687 do not apply to the procurement of vaccinia immune globulin (human). Instead, the supply sources with cable addresses listed below are to be used for procurement of VIG, and posts may contact the one most convenient:

1) Amembassy BANGKOK; for U.S. Diplomatic Mission Medical Center.
2) Amembassy TOKYO; Pass to C.O., 406th Medical General Lab, Camp Zama.
3) Amembassy FRANKFURT; Pass to C.O., 10th Medical Lab, Landstuhl.
4) Secstate WASHDC; Pass to WRAIR, Walter Reed Army Medical Center, Attention: Deputy Director.
5) Secstate WASHDC; For O/MED: Medical Supplies; VIG Vaccine.*

(*) Revision

TETANUS-DIPHTHERIA (Adult)

a. Age

Only persons 7 years of age and older (see Diphtheria-Pertussis-Tetanus for younger children).

b. * Dosage for Both Children Above Age 7 and Adults

Three injections of 0.5 cc, intramuscularly or subcutaneously. The first two injections are given 4 to 6 weeks apart. The third injection is given 1 year after the second.*

*c. * Administration

*Use * a different site for each injection. A small air bubble should be injected following the vaccine to prevent leakage along the path of the needle. Shake the vial to insure even suspension of toxoid before withdrawing solution.

*d. * Booster

A booster * dose of 0.5 cc intramuscularly or subcutaneously should be given routinely every 10 years following completion of the initial series.

An emergency booster ("wound booster") injection of 0.5 cc should be given to individuals with tetanus-prone wounds who have not received a booster within the preceding 12 months. Also give booster dose for exposure to case of diphtheria.*

*e. * Special Information

Immunity to diphtheria appears to last as long as immunity to tetanus. Therefore, a booster of tetanus-diphtheria every 10 years covers both.

TETANUS TOXOID
(Aluminum Phosphate Adsorbed)

This product is not to be used routinely in immunization against tetanus, as it has been replaced by the combined tetanus-diphtheria vaccine (precipitated, adsorbed, for adult use). It has been used extensively in the past for emergency booster injections in patients who, it was thought, could not tolerate the combined product, presumably because of sensitivity to diphtheria toxoid. However, many reactors to the combined product proved to be hyperreactive to the tetanus component; their situation is best handled by administering a small dose (0.05 cc to 0.1 cc) of the combined product.

UNIFORM STATE/AID/USIA REGULATIONS

TETANUS ANTITOXIN

The development of an effective tetanus antitoxin from human serum (Tetanus Immune Globulin (Human) - Cutter; Hyland) represents an important advance in the prevention of *tetanus*. Unlike equine and bovine antitoxin, human antitoxin does not cause anaphylatic reactions or serum sickness. Although it is made from human serum, it does not transmit viral hepatitis. The half-life of human antitoxin is about 4 weeks as compared with about 10 days for animal antitoxin.

Human antitoxin appears to be protective in the recommended intramuscular dose of 250 units for adults and 4 units per kg. for children. If antitoxin is needed, human antitoxin (when available) should be used in place of the equine product. In previously immunized patients, however, antitoxin will seldom be needed; adequate prophylaxis can be achieved by proper surgical care (including meticulous debridement) and by a booster dose of fluid toxoid.

Human antitoxin should be substituted whenever possible for TAT when it is recommended in the plan below.

SUGGESTED PLAN OF IMMUNOLOGIC TREATMENT FOR PATIENTS WITH TETANUS-PRONE WOUNDS[1]

(Prepared by Norman A. Christensen,[2] M.D., Section of Medicine)

Type of wound (judged after local treatment)*	Patient unimmunized	Patient partially immunized with tetanus toxoid				Patient completely immunized with tetanus toxoid				
		One previous injection of ppfd. or 1 or 2 of plain toxoid within:		Two previous injections of ppfd or 3 of plain toxoid. Last injection:		Three previous injections of ppfd, or four of plain toxoid (basic immunologic series); or subsequent intervals; or wound boosters within:				
	No previous toxoid	1 Mo. of injury	1-12 Mo. prior to injury	Within 1 yr. of injury	1 Mo. or more prior to injury	0-6 Mo.	6-12 Mo.	1-5 Yr.	5-20 Yr.	20+ Yr.
I. Clean	(1) Give first injection of toxoid. Arrange to complete basic immunization†	(1) None	(1) Second injection of ppfd. or 2nd or 3rd of plain toxoid and complete basic series	(1) None	(1) Third injection of ppfd. or 4th of plain toxoid to complete basic series	(1) None	(1) None	(1) None	(1) Interval toxoid booster (2) Can give 2nd injection of toxoid in 4-6 wk. if 10+ yr., then interval booster q. 5 yr.	(1) Two injections of toxoid at 4-6 wk. intervals, then once q. 5 yr.
II. Contaminated, potentially infected	(1) After skin test,‡ give 3000 U. TAT IM (2) Start basic series of toxoid in opposite arm and arrange to complete	(1) 3000 U. TAT IM	(1) 3000 U. TAT IM (2) Second injection of ppfd or 2nd or 3rd of plain toxoid in opposite arm and complete basic series	(1) 3000 U. TAT IM	(1) Same as above	(1) None	(1) None	(1) Wound booster, then interval booster§ of toxoid q. 5 yr.	(1) Wound booster (2) Same as 2 above	(1) Same as above (2) Can give 3000 U. TAT IM in opposite arm if treatment delayed and type of wound warrants
III. Infected	(1) 3000-30,000 U. TAT IM‖ (2) First injection of toxoid in *opposite arm* if 3000 U. TAT; if more, best wait 4 wk. and arrange for basic series	(1) 3000-30,000 U. TAT IM	(1) 3000-30,000 U. TAT IM (2) Second injection of ppfd. or 2nd or 3rd of plain toxoid in opposite arm if 3000 U. TAT; wait 4 wk. if more, and complete basic series	(1) 3000-30,000 U. TAT IM	(1) Same as above	(1) None	(1) Can give wound boosters§ of toxoid	(1) Same as above	(1) Wound booster (2) Same as 2 above (3) Can give 3000 U. TAT IM in opposite arm expec. if more than 10 yr. and if wound seriously infected	(1) Same as (1) above, plus: (2) 3000 U. TAT IM in opposite arm

Definitions

*Local treatment — thorough cleansing and débridement of wound. If it remains potentially or definitely infected, give antibiotic therapy and delay closure until infection is under control.

‡*Skin test with equine (or bovine)-serum tetanus antitoxin (TAT)* — follow prescribed recommendations enclosed in each package, this procedure should *always* precede use of these sera. When the test is positive and indication warrants, give human-serum antitoxin if available, or desensitize patient with available animal-serum antitoxin in prescribed manner (Proc. Staff Meet., Mayo Clin. 32:100-106, April 3, 1957).

‖3000-30,000 U. TAT IM — *amount dependent on nature and character of wound.* Dose is amount considered necessary to protect the patient against tetanus during period of wound healing; e.g., minor infected wounds 3000-5000 U., major infected wounds 10,000-30,000 U.

1. The plan is presented as an aid to the physician in the emergency treatment of wounds, but it is recognized that the ultimate solution of the problem of tetanus is universal immunization with tetanus toxoid.

2. Assisted by members of Mayo Clinic Tetanus Team.

TYPHOID

a. Primary Immunization

Adults and children over 10 years of age

0.5 cc subcutaneously on two occasions, separated by 4 or more weeks.

Children 6 months to 10 years

0.25 cc subcutaneously on two occasions, separated by 4 or more weeks.

In instances where there is insufficient time for the two doses to be administered at the time intervals specified, three doses of the same volume listed may be given at weekly intervals.

*Children 1 through 5 months

Not recommended unless in hyperendemic area. If necessary to administer this vaccine, use the following dosage:

0.1 cc subcutaneously on three occasions, separated by 4 weeks.*

b. Booster

The following alternative routes and dosages of booster immunizations will give comparable protection. Generally less reaction follows the intradermal route. *(Only heat-phenol killed vaccine may be given intradermally. Acetone-killed and dried vaccine (AKD) must be given either intramuscularly or subcutaneously.)*

Adults and children over 10 years of age

0.5 cc subcutaneously or 0.1 cc intradermally every 3 years or at the time of an epidemic.

Children 6 months to 10 years of age

0.25 cc subcutaneously or 0.1 cc intradermally every 3 years or at the time of an epidemic.

It is not necessary to repeat the primary immunization schedule if there has been an interval of any length of time since the initial inoculations were received. A booster is all that is needed.

*TYPHUS (Epidemic Type)

Typhus immunization is recommended only for persons who live in or visit areas where the disease actually occurs and who will be in close contact with the indigenous population in such areas.

It is only in mountainous, highland, or areas where a cold climate and other local conditions favor louse infestation that a potential threat exists. Vaccination may be indicated for travelers to rural or remote highland areas of Ethiopia, Rwanda, Burundi, South Africa, Mexico, Ecuador, Bolivia, or Peru, and mountainous areas of Asia (northern India, Pakistan, Nepal, and Afghanistan).*

a. Children Dosage (6 months*through 9* years)

One-half adult dosage.

b. Adult Dosage*(over 10 years)*

Basic series: two subcutaneous injections of 0.5 cc each, with a 4 week interval between injections.

c. Booster Dosage

Individuals having close contact with the indigenous population in endemic areas receive annual boosters as long as exposure continues. The adult booster is 0.5 cc given subcutaneously. Children under 10 years of age receive one-half the adult dose.

SPECIAL INFORMATION:

Persons with known egg alergy should not receive typhus vaccine except in the presence of an outbreak, and then only under the supervision of a physician, both for skin testing and administration of the vaccine.

(*) Revision

YELLOW FEVER

a. Age

Six months and older.

b. Children's Dosage

0.5 cc subcutaneously.

c. Adult Dosage

0.5 cc subcutaneously.

d. Booster Dosage

0.5 cc subcutaneously.

e. Time Element for Boosters

Every 10 years.

*Approximately 2% of vaccinated individuals will not develop adequate immunity from the initial injection. It is recommended, therefore, that in an epidemic situation all individuals ages 1 year and older who have received only one previous yellow fever injection, be given a booster. Individuals who have received more than one dose in their lifetime do not require a booster if their last injection was within 10 years. *

(NOTE: The World Health Organization Assembly has extended the validity of International Certificates of Vaccination or Revaccination against Yellow Fever from 6 to 10 years as of May 12, 1965. Certificates already issued are automatically extended 10 years from the date of vaccination or revaccination.)

f. Contraindications

The administering physician should determine whether persons who manifest signs of egg allergy should receive the vaccine, since persons sensitive to egg, *chicken, or chicken feathers* may have an allergic reaction. If a history of allergy to *the above* is apparent, it is best to administer the vaccine by scarification. Two scratches *should be* made about one centimeter in length and a drop of vaccine * rubbed into * each.

Also see section XVI on live virus vaccines (p. 5).

(*) Revision

g. Special Information

Yellow fever vaccinations can only be given at Yellow Fever Vaccination Centers specifically designated by the health authorities of the country in which the vaccination is being performed. The physician vaccinator must sign and date the vaccination certificate and indicate thereon the manufacturer, batch, and lot number of the vaccine used. He must also authenticate the vaccination with a stamp approved by the health administration of the country in which the vaccination is performed.

Because of the difficulty in shipping yellow fever vaccine and maintaining its efficacy, and the nonavailability outside the United States of approved vaccine, the Department of State has added yellow fever to its required list of immunizations. Yellow fever immunization should be completed before foreign travel.