DOES THE "TOTAL FORCE" ADD UP? THE IMPACT OF HEALTH PROTECTION PROGRAMS ON GUARD AND RESERVE UNITS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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DOES THE "TOTAL FORCE" ADD UP? THE IMPACT OF HEALTH PROTECTION PROGRAMS ON GUARD AND RESERVE UNITS

TUESDAY, MARCH 30, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING
THREATS AND INTERNATIONAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Schrock, Kucinich, Turner, Maloney, Ruppersberger, Tierney, and Jo Ann Davis of Virginia.

Staff present: Lawrence Halloran, staff director and counsel; Kristine McElroy, professional staff member; Robert Briggs, clerk; Jean Gosa, minority assistant clerk; and Andrew Su, minority professional staff member.

Mr. SHAYS. A quorum being present, the Subcommittee on National Security, Emerging Threats and International Relations hearing entitled, "Does the 'Total Force' Add Up: The Impact of Health Protection Programs on Guard and Reserve Units," is called to order.

When Reservists and National Guard members join their active duty counterparts to form what is called the total force, they bring unique health needs to the battlefield. Long deployments and separation from family can have an especially negative impact on Guard and Reserve morale and performance. Cursory pre-deployment physical and mental health assessments might miss ailments and conditions that would be diagnosed and treated in the more closely monitored regular forces.

Accessing care during and after mobilization is too often a dispiriting struggle against a bureaucracy prone to minimize or disparage their wounds, literally adding insult to injury. So today we ask, do current deployment health programs meet the specific health care needs of the citizen soldiers who make up a vital and growing part of the force structure?

In the course of our oversight of 1991 Gulf war veterans' illnesses, we learned that weaknesses in force health protections exposed U.S. forces to avoidable risks. Pesticides were widely dispersed without adequate warning or safeguards. Use of experimental drugs was not properly monitored. Poor medical recordkeeping shifted the burden of proof to the service members to prove

the source and extent of their exposures and injuries. A macho warrior culture tended to punish or stigmatize health complaints.

After the first Gulf war, Congress mandated improvements to force health protections, including pre and post deployment medical examinations, mental health assessments and serum samples to better establish baseline health data. Recordkeeping was to be centralized, more accurate and more timely. The Department of Defense [DOD], has incorporated these requirements into a broader force health protection strategy that has enhanced both the quality and quantity of health care for service members and their families.

But recent reports suggest that for some, military medicine is still a contradiction in terms, an oxymoron describing the victory of quantity over quality in the rush to front. Processing and treatment facilities have been overwhelmed by patients with conditions that should have prevented their being deployed at all. Injured Guardsmen and Reservists have languished in medical limbo, awaiting care only to be told they are suddenly ineligible because the paperwork extending their active duty status took too long. Recordkeeping is still inconsistent or lacking altogether.

A recent survey of troops in Iraq found sufficient incidence of mental health stressors, anxiety, depression and traumatic stress, and that suicide prevention efforts are being strengthened. Our first panel of witnesses will describe their personal experiences with the deployment health system. We are grateful for their service, their continued courage, and their willingness to be here today.

DOD witnesses will then describe their ongoing efforts to improve health protections and the standard of care for deployed forces. We look forward to their testimony as well.

This hearing is part of a sustained examination of issues affecting Reserve and National Guard units. Last year, with Government Reform Committee Chairman Tom Davis, we exposed serious problems in Army Guard pay systems. Next month, the full committee will convene a hearing on National Guard transformation. Finally in May, this subcommittee will hear testimony on equipment and training shortfalls.

At this time, the Chair would recognize Mr. Tierney for an opening statement.

Mr. TIERNEY. I have no opening statement, Mr. Chairman. I'd like to get to the testimony as soon as we can.

Mr. SHAYS. I thank the gentleman. Mr. Schrock.

Mr. SCHROCK. Ditto.

Mr. SHAYS. We have Mr. Turner.

Mr. TURNER. In the spirit of the proceeding, then, I'll pass also, thank you, Mr. Chairman.

Mr. SHAYS. Ms. Jo Ann Davis, any statement you'd like to make?

Mrs. DAVIS. Mr. Chairman, thank you very much.

Mr. Chairman, I want to thank you for letting me be a part of the discussion this morning, and thank you for holding this important hearing. I especially want to thank Sergeant First Class Scott Emde and his wife Lisa for being here to testify. Scott and Lisa live in the First District in Yorktown, VA, and I'm proud to represent them.

I want you to know how much I thank you for your service to our country. You and your family have made great sacrifices, all

because of your loyalty and your dedication to our Nation. Thank you for all that you have done, and I look forward to hearing your testimony.

Mr. Chairman, as we continue to fight the war against terrorism, the Reserve component, including the Army National Guard, Army Reserve, Naval Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve and the Coast Guard Reserve has been increasingly called upon to go to active duty. Out of the 1.8 million members of the Reserve component, over 300,000 have been called to active duty since September 11, 2001.

As more and more Guard and Reserve members are deployed, we have to make sure that they are getting the health care and the attention that they need. The issue of health protection programs for members of the Reserve component is extremely important. We don't want to have a repeat of Operation Desert Shield and Desert Storm, when more than 125,000 veterans of the Gulf war came back and experienced health problems because of their military service. And there were probably thousands more, but because of lack of health and deployment data, we're just not exactly sure.

The Department of Defense's force health protection strategy was developed as a result of the lessons we learned from the Gulf war. Its purpose is to track service members, diseases and injuries and to provide followup treatment for deployment related health conditions. I look forward to hearing more about how the force health protection is working.

Mr. Chairman, I serve on the Armed Services Committee and I feel very strongly about our Nation's military. These people give more than most Americans will ever be asked to give. And there is no comparison to the dedication and commitment that they have for our country. It's the least we can do to make sure that their health needs are taken care of.

I thank you again, Mr. Chairman, for holding this hearing, and for allowing me to join you. I look froward to hearing the testimony of the witnesses. Thank you, Mr. Chairman.

Mr. SHAYS. I thank you very much, Mrs. Davis.

Let me first take care of some housekeeping. I ask unanimous consent that all members of the subcommittee be permitted to place an opening statement in the record, and that the record remain open for 3 days for that purpose. Without objection, so ordered.

I ask further unanimous consent that all Members be permitted to include their written statements in the record, and without objection, so ordered.

I ask even further unanimous consent that a March 29, 2004 letter from Congressman Ric Keller to the subcommittee be entered into the record. The letter describes efforts to solve health care access problems on behalf of his constituent, Army Specialist John Ramsey, who will testify this morning. Without objection, so ordered.

And also to welcome Mrs. Davis, she is a member of the full committee, she chairs the Subcommittee on Civil Service and Agency Organization, and without objection, she will be allowed to participate in this hearing as well.

At this time, let me recognize the witnesses and then I will swear them in. Before recognizing witnesses, I thank the second panel, Dr. William Winkenwerder, for his acknowledgement that it is valuable to have this panel go first, and thank Lieutenant General James B. Peake as well for that. They are extending their courtesy and respect to this first panel, which this committee deeply appreciates.

This first panel is First Sergeant Gerry L. Mosley, 296th Transportation Co., Brookhaven, MS, U.S. Army Reserves; Specialist John A. Ramsey, 32nd Army Air Missile Defense Command, Florida National Guard; Mrs. Laura Ramsey, spouse of Specialist John A. Ramsey; Sergeant First Class Scott Emde, 20th Special Forces Group, B Co., 3rd Battalion, Virginia National Guard; Mrs. Lisa Emde, spouse of Sergeant First Class Scott Emde; and Specialist Timothi McMichael, U.S. Army Reserves, Medical Hold Unit, Fort Knox, KY.

As is the practice, we swear in all our witnesses, and invite you all to stand and then we'll swear you in. Raise your right hands, please.

[Witnesses sworn.]

Mr. SHAYS. Thank you all very much. We'll note for the record that all have responded in the affirmative. We'll do it as we called you, and I think you're sitting in that same order, so that's how we'll start. Sergeant, we'll start with you. Thank you and welcome.

STATEMENTS OF FIRST SERGEANT GERRY L. MOSLEY, 296TH TRANSPORTATION CO., BROOKHAVEN, MS, U.S. ARMY RESERVES; SPECIALIST JOHN A. RAMSEY, 32ND ARMY AIR MISSILE DEFENSE COMMAND, FLORIDA NATIONAL GUARD; LAURA RAMSEY; SERGEANT FIRST CLASS SCOTT EMDE, 20TH SPECIAL FORCES GROUP, B CO., 3RD BATTALION, VIRGINIA NATIONAL GUARD; LISA EMDE; AND SPECIALIST TIMOTHI MCMICHAEL, U.S. ARMY RESERVES, A CO., MEDICAL HOLD UNIT, FORT KNOX, KY

Sergeant MOSLEY. Mr. Chairman and distinguished members of the committee, on behalf of myself and hundreds of other mobilized soldiers in the U.S. Army Reserve and National Guard, I am honored and pleased to have the opportunity to address the issues this committee has been charged to investigate.

Pre-deployment health assessment forms are grossly inadequate for use as medical screenings to determine if soldiers were medically capable in a duty combat setting. Soldiers with medical conditions that would be adversely affected by deployment were rubber stamped as if fit for duty. Medical profiles were ignored.

I personally know of soldiers with profound hearing loss, insulin dependent diabetes, a soldier with Tourette's syndrome who would not have access to proper medications, serious allergies requiring refrigerated medications, cardiac disease, and unrepaired inguinal hernias. I'm sure that this esteemed committee can appreciate the significance and validity of my conclusions and recognize that these cases are not isolated or infrequent in nature.

The process was a numbers game where the Army justified deploying troops. It was not about quality, healthy troops, it was about the quantity of troops. It was only after the October 2003 re-

port published by Mark Benjamin with UPI and the interventions by Mr. Steve Robinson of National Guard Resource Center that more emphasis was placed on better screening procedures. Those individuals who are responsible for screening soldiers do not listen or validate solider's accounts of the physical and mental health problems they are experiencing. The great motto, blow them off, get them through, hey, let's go to lunch.

The most telling incident of in-theater medical care was the experience of one of my own soldiers. He continually went to sick call in Iraq complaining of painful urination, only to have my commander summoned to sick call. My commander was told this soldier was malingering and should be court martialed. That solider has just returned from Walter Reed Army Medical Center, having a cancerous bladder and prostate gland removed.

What justification is given to a member of the U.S. Army to assume a man with cancer is malingering? What justification is given to this man to have him threatened to be thrown in jail? I ask you to ponder for one moment, if it was you, your father, your mother, brother, sister, son or daughter, how would you feel in a situation like this?

Upon return to American soil, most soldiers have one thing in mind, just as I did, getting home to the family. But upon return from war with injuries or illness that causes a soldier to be unfit for future military service, the inefficient, uncaring, progressively escalating campaign by the U.S. Army of inflicting mental duress called the Medical Evaluation Board proceeding, is started. The U.S. Army must be proud of the bureaucracy at Fort Stewart that is capable of driving a soldier to the brink of insanity while flippantly turning its back on the physical and mental health needs of men and women who are just returning from war.

After the press coverage, it seemed things were improving. However, it didn't take long for things to cool off, and we were still in the same old holding pattern. You do see care providers more than before, but it's just more or less a how are you doing process. Instead of receiving specialty consults or aggressive treatments, soldiers get a prescription for a new pill, all we want is a fix me, don't pill me. I hold up today, before I mobilized in January 2003, an empty bag of the medications that I took. If I took every pill prescribed to me on a daily basis, I would be taking 56 pills a day. I would be taking pills, I couldn't even get out of bed this morning.

MEB cases were dictated, having a soldier sign, concurring, thinking that they would be rated on whatever was wrong with them. That's not the truth. Many times during our required meeting with our case managers, I would complain of both my arms being numb, my neck hurting, stiff, and the shaking. It was only after my Board that I was finally sent to a civilian neurologist, an MRI was done, I have severe, inoperable cervical spondylosis and also Parkinson's disease. That was after many complaints, e-mails to Brigadier General Farrissee at Medical Command asking her to have someone call me, all this communication again. We were talking, no one was listening.

Medical recordkeeping is a simple statement, haphazard and inconsistent. There was no medical recordkeeping for Reserve soldiers in Iraq. Records for our company were not even brought.

I want to make these comments, but I'll address the family support program. Each Reserve and National Guard unit has a family readiness group. There are some that are strong and some that are basically non-functioning. Most of our spouses are at home taking care of our children or they're working their own jobs.

I have served my country faithfully for 31 years. The feeling of inequality between the Reserve and the active component is still there. I can assure you that each time I was fired at by an Iraqi soldier, I never heard the first one of them say, First Sergeant Mosley, I'm sorry, we didn't know you were a Reservist.

Let me assure you that the Reserve and the Guard were just as willing to die defending this great country as the active component. We sacrificed in some cases more, some Reservists and Guard are mobilized on a reduced income.

The Reserve and Guard is a numbers game measured by money. The Reserve command knows it is required to keep a certain number of troops to justify their budget request. You've never been asked for less money next year than you were this year. There are soldiers in each unit that cannot pass PT tests, there are soldiers in each unit that do not come to drill, but yet the command keeps them to keep that number.

Medical hold is a numbers game as well. A lot of soldiers feel that the only improvement was living conditions, but that wasn't until 2 weeks ago, when now you have 16 soldiers in a 24 by 60 double wide with two restrooms. If an intestinal virus was to break out, there would be problems.

There is a grave in Jackson, MS that I see every time I go to visit my father's grave. It's of a World War II veteran, infantry soldier, bronze star recipient, and permanently inscribed on his grave is, I have fought and I have fought well. I did not let my country down, but my country let me down. My desire today for this committee is to see that you all do all you can in your power that not another soldier dies defending this country going to his grave having something like that inscribed on a tomb.

I'd be happy to answer any questions, again, I thank you for allowing me the opportunity to be here, even if I did go over my time.

[The prepared statement of Sergeant Mosley follows:]

Congressional Testimony

Gerry Mosley, First Sergeant, Retired
United Stated Army Reserves

Submitted Before the Subcommittee on National Security,
Emerging Threat, and International Relations

"Does the 'Total Force' Add Up? – The Impact of Health Protection
Programs on Guard and Reserve Units

March 30, 2004

Mr. Chairman and distinguished members of the committee, on behalf of myself and hundreds of other mobilized soldiers of the United States Army Reserves and National Guard, I am honored and pleased to have the opportunity to address the issues this committee has been to charged to investigate. I will truthfully and accurately represent my experience and views as well those of my fellow combat soldiers who supported Operation Iraqi Freedom. My name is Gerry Mosley, and I was the First Sergeant for my company.

Pre-deployment Health Assessment Forms:

Pre-deployment health assessment forms were grossly inadequate for use as medical screenings to determine if soldiers were medically capable of duty in a combat setting. The assessment tool consisted of casual questions. Soldiers were screened for vaccinations, and if any deficiencies were noted, vaccines were administered without proper documentation. Most recent physical exams were reviewed, and dental screenings were performed.

Soldiers with medical conditions that would be adversely affected by deployment were "rubber-stamped" as fit for duty. Medical profiles were ignored. I personally know of soldiers with the following conditions that were deployed to Iraq: (1) Profound hearing loss; (2) Insulin dependent diabetes; (3) A soldier with Tourette's syndrome who would not have access to proper medication; (4) Serious allergies requiring refrigerated medication; (4) Severe cardiac disease with a history of a heart attack; and (6) Unrepaired inguinal hernia. I'm sure that the esteemed committee can appreciate the significance and

validity of my conclusion and recognize that these cases are not isolated and infrequent in nature.

The pre-deployment assessment forms were grossly inadequate in identifying soldiers who should not have been deployed for medical reasons. The process was a numbers game where the Army justified deploying a troop. It was not about sending quality, healthy troops, but rather about sending a quantity of troops.

Post Deployment Assessment Forms

Prior to April 2003, the post deployment questionnaire consisted of two pages and asked six questions. Since April 2003, the form has been extended and addresses more physical and mental health questions. A form is useless, if the screeners do not give credence to a soldier's answers. Significant complaints such as depression, memory loss, and joint pain were belittled and scoffed at by the medical screeners.

It was only after the October 2003 report published by Mark Benjamin with UPI and interventions by Mr. Steve Robinson of NGWRC that more emphasis was placed on better screening procedures. I just completed my medical out-processing screening and can say that the process is better than before October, but remains negligent in it's purpose of assessing soldiers for mental and physical health disparities because those individuals who are responsible for screening soldiers don't listen and validate soldiers' accounts of the physical and mental health problems they are experiencing. A great motto for the process would be: "Blow 'em off, get 'em through, let's get to lunch"._It is astonishing that soldiers are required to sacrifice, of all things, human dignity, to serve their country!

In Theatre Medical Care

Prior to crossing into Iraq, sick call clinics were located at the Kuwait camps; however, there was no diagnostic equipment at Camp Arifjan. For a period of about three weeks after crossing into Iraq, in theatre medical care consisted primarily of combat lifesavers who are usually reserve or guard members who have received minimal training in the management of severe injuries.

To my knowledge, the first Combat Support Hospital was established at Taleel Airbase. Medical evacuations via helicopter were available by radio contact. However, the secure types of radios being utilized were not all programmed with the same protocol and made them useless. Fortunately, a soldier who received a shrapnel injury the second night of the war was lucky enough to be near a unit with a properly programmed radio and was lifted out to Kuwait and then to Spain.

Later, in theatre field hospitals and MASH units that provided adequate care in most cases were established. The most telling incident of in theatre medical care was the experience of one of my soldiers. This soldier complained of persistent bloody, painful urination while in combat and reported to sick call on numerous occasions with such complaint. My commander was told to come to the field clinic and was informed that the Sgt was malingering and should be court-martialed. That soldier has just returned from Walter Reed Medical Center having a cancerous bladder and prostate gland removed. Again, the issue of predeployment numbers games arises. How could the Army miss such an advanced cancer prior to deployment? What justification is given to a member of the United States Army to strip a man of his dignity and medical needs? What

justification is given to a member of the United States Army to assume a man with cancer is malingering, and threatens to throw him in jail? I ask you to ponder for a moment, how you would feel if this man were your son, daughter, mother, sister, brother, husband or wife.

Medical Care Since Returning to the USA

Upon return to American soil, most soldiers have one thing on their mind…getting home to their family!! Upon return from war with injuries or illness that cause a soldier to be unfit for future military service, the inefficient, uncaring, progressively escalating campaign by the Army of inflicting mental duress, called the Medical Evaluation Board process, is started. The United States Army must be proud of the beaurocracy within Fort Stewart that is capable of driving a soldier to the brink of insanity while flippantly turning it's back on the physical and mental health needs of the men and women who have just returned from war. It was a well-spread rumor (actually a well known fact) that the soldier should be cleared with the least possible medical deficiencies noted. The MEB process, from my own experience and observation, is set up to hold a soldier at Fort Stewart as long as possible while doing nothing to accurately diagnose and treat illness. Soldiers' complaints are often ignored, or downplayed. .

My MEB process spanned over a nine-month period. On my physical exam my complaints of depression, tremors, vertigo, severe headaches, ringing in my ears, numbness to both arms and hearing loss were blatantly ignored and, in my opinion, purposefully, left off the Medical Evaluation Board Findings (DA 3947) which has

prolonged my MEB process, which prolongs the time that I can seek competent medical and psychiatric care from the civilian world, and be close to my caring family

My depression had become so severe I went to sick call and was told to return the next day. I refused to leave without seeing a doctor. I was lucky enough to see Dr. Frank, who in the civilian world is a psychiatrist. He started me on medications and referred me to Mental Health. He told me he was going back home after his 90 days were up, "Because I just can't practice medicine the way the Army wants me to!" The Mental Health doctor had me admitted to the Mental Health Ward for PTSD and major depression. I was actually admitted on a second occasion since I had decompensated severely.

I have since been diagnosed with Parkinson's disease by a civilian neurologist after I had signed concurrence with my disability rating. I had been telling the medical personnel at Fort Stewart that family members with health care knowledge suspected that I had Parkinson's, and I was blown off. Now, many, many months have passed without proper medication directly related to an incompetent beaurocracy and incompetent medical care. Soldiers are people, not numbers. Truly, though, is it a question of incompetent medical care or a question of a well-organized government system that achieves just what it is supposed to achieve? Use people, strip them of all human dignity, disrespect them, wear them down, and be pleased when soldiers no longer have the physical and mental capacities to continue to fight to have the same rights and respect as those American citizens, for whom we have fought to preserve those entitlements.

Before October's press coverage, medical care was inadequate. The soldiers' complaints were minimized or nullified. We were talking but they were not listening! There have been many soldiers sent home with medical conditions that should have and could have been treated. After the press coverage, it seemed as though things were improving. More PA's, nurses, and technicians were brought in from other installations or civilians were contracted. Appointments were not as far apart as before. It seemed as though a system was being implemented to speed the process. However, it didn't take long for things to cool off and we were still in the same old holding pattern. You do see care providers more than before. It seems like it is just a "how are you doing process." Competency of care I question, and do so with proof. Instead of receiving specialty consults or aggressive treatments, soldiers get a prescription for a new pill. All we want is PLEASE, FIX ME, DON'T PILL ME!! Look at these bags I hold up for an example. We should have access to competent medical providers.

The decision to MEB a soldier is no more prompt than before. Soldiers who have seen specialists returned to the primary care giver with the specialist's recommendation to be boarded to usually be told that they will not be boarded until other options are exhausted. Make way, another one entering the pattern.

It is my understanding that more deficiencies are being rated in the MEB process than before. Before October, MEB cases were dictated and the soldier signed concurring thinking the Physical Disability Agency would look at all disqualifying conditions. That was not and is not the case. The only things rated are medical conditions listed on the Medical Evaluation Board Proceedings (DA 3947). And if the PDA can sit in

Washington and reduce a soldier's disability rating without ever laying eyes on him or her, using addenda that are sometimes four months old without asking whether the soldier has improved, decompensated, or remains the same, what's the point in a MEB process than can literally span years??? Why not skip the PEB and let the PDA do these ratings. It delayed my process for another month.

On my original DA 3947, the only condition listed by Dr. Brooks was low back pain, and I refused to sign it, because I had other significant ailments. Dr. Brooks refused to list my other conditions until I brought him a copy of Medical Command's guidance that instructed the doctors to list all disqualifying conditions. Even with that, he did not list the incapacitating migraines or vestibular dysfunction with central nervous system etiology. Many times during our required "meeting with our case manager or care giver", I would complain of both of my arms being numb and the tremors. It was after my MEB that I was also diagnosed with severe cervical spondylosis and Parkinson's disease (symptoms of which I did not have prior to January, 2003). After the DA 3947 listed the original conditions on the Letter of Intent and the PTDS and depression, I signed concurring. Once I received notice that my PEB rating had been reviewed by the PDA and reduced, I emailed BG Gina Farrisee asking her to have someone contact me. I did not receive an email or call from anyone. Another example of soldiers talking and commanders not listening. I question if she is so high above another soldier that she feels entititled to disregard his or her communication.

Many soldiers do not hold the rank that I do and were too intimidated to challenge the doctor or the process.

Medical Record Keeping

Medical record keeping is haphazard and inconsistent. Prior to mobilization, Reservists and National Guard personnel kept their medical records at their Unit. Upon mobilization, records accompany the soldier. Record keeping is a soldier/Unit responsibility. Once our unit was cleared to fly, our medical records were placed in a box for cargo loading. On arrival to Kuwait, the cargo with our records was lost. We no longer had proof of vaccinations, profiles, etc. We were required to take both the Anthrax and Smallpox vaccinations in Kuwait. Having no records, our Company used an alphabetical listing of soldiers and as they were vaccinated their name was checked off. Just like cattle through branding stall. We were in Kuwait for two weeks before our records were located.

We did not have enough trucks to load our tents and supplies in so it was a command decision to leave all records locked in one of our storage containers that was going to be left in Kuwait, so, there was no record keeping in Iraq. If a soldier reported to sick call he was usually given a SF 600 (Chronological Record of Medical Care) and returned to the Unit. With no records to place the form in, most soldiers lost or destroyed it. The mobilization station for my unit was For Stewart, Georgia, and even the vaccinations were not properly recorded. The only proper record keeping was done at our Units. The whole process was hurried, and sometimes sloppy.

Again, after the October press coverage, all medical hold soldiers had to report to the hospital and their records were screened. The hospital personnel then kept the records.

There are many instances of soldiers' records being misplaced or lost. This slows down the Medical Evaluation Board (MEB) process. It will also adversely affect the soldier's future VA claim if there is no documentation presented.

Health Prevention

Reservists and National Guardsmen have no organized health prevention in place. Tricare dental is offered at a premium, but not affordable by most soldiers.

Health protection for Operation Iraqi Freedom required chemical suits and gas masks to be issued to all soldiers. We were sent from Fort Stewart, with their knowledge, lacking essential protective gear. Many soldiers did not have the optical inserts for their gas masks, and others were not issued chemical garment over boots because their size was not available. Finally, after being in Iraq for three weeks, we were able to procure over boots for those troops. We were issued anit-malaria pills without instructions on when and how to take them or what the side effects were. According to my commander, we received Doxycycline and Larium.

Family Support Programs

Each Reserve and National Guard Unit has a Family Readiness Group. There are some that are strong, and some that are basically non-functioning. Some unit members only see each other during a drill period and a lot of them do not know anything about their fellow soldiers. In the Reserves, there is a constant effort to strengthen the FRG, but it is usually comprised of very few members, who often are in dire need of support themselves. Some Reservists drive 75-100 miles for drill and their spouse is left at home to care for children and or work outside the home on weekends.

PLEASE ALLOW ME TO MAKE THESE CLOSING COMMENTS

I served my country faithfully for 31 years. The feeling of inequality between the reserves versus active component is still there. I hear it everyday. I can assure you that each time I was fired at by an Iraqi soldier I never once heard " Oh, I'm sorry!! You are a reservist or guardsman!!" Even though the ID card says Active Duty we still hear " you are a Reservist." Well let me assure you that these reservist and guardsmen left their home, their children and family, their church, and were just as willing to die to defend this great country just as the active component did. Maybe you consider my next comment as biased, and if so I am truly apologetic, but I feel the reservist sacrificed more! Some are on a reduced income now.

The reserves and guard is a numbers game, measured by money. The Command knows that it is required to keep so many troops to justify budget request. I know there are soldiers on each unit's book that do not participate, can not pass PT test, are have medical conditions that make them unfit for service. Yet, the command will downgrade profiles, excuse absences, etc to keep that number. Have you ever been asked for less money next year than you were this year? Medical Hold is a numbers game as well. A lot of soldiers feel that the only improvement since October is living conditions.

There is a concern that there is becoming another housing issue. There have been some soldiers that signed saying they would get treatment at home, or a soldier I know needing surgery has been told all measures to prevent surgeries would be exhausted, but, he was cleared medically to fly back to Iraq with the restriction of being unable to wear his bullet resistant vest. I am thankful to report that after I assisted the soldier with

congressional phone calls, he was eventually released to go home for his surgery. The MEB process is a very slow process and in some cases the soldier is required to take another physical or have tests repeated. The slowness is not the personnel at Patient Affairs. The Patient Affairs personnel do their best to treat each soldier with respect and that any delay is not due to their department. Most of the slowness is due to doctors delaying dictation, having to wait for specialty appointments, etc. I have driven 195 miles one-way, at my expense, in my vehicle, to see a specialist. My MEB process has been ongoing since June and, after 9 months I thought it was complete, until it went to the Physical Disability Agency (PDA). I agreed with the PEB on 5 Feb 2004. The PDA reviewed the PEB rating and reduced the rating on PTSD/Depression from 30% to 10%. Tired of being away from my family I concurred on 5 March 2004. I was discharged on March 17. Due to my disability rating I can no longer keep my job with the U. S. Army Reserves since I am being Medically retired. There is a grave in Jackson, MS, and inscribed on the granite is an inscription that sends chills down my spine. Every time I visit my father's grave I pass by the grave of Mr. Baugh, a decorated World War II veteran, and question why would someone put this specific inscription on something so permanent- "I have fought, and I fought well. I did not let my country down, but my country let me down." Today, I asked of this committee to do all in your power that you can to make certain that not another soldier would die, after defending this country, feeling the way described on Mr. Baugh's grave.

I would like to personally thank CPT Shannon McAteer, 1SG Angelo Lindsey, and 1SG Malva Williams, Mr. Bill Hannigan and the entire staff at Patient Affairs, for the genuine concern for the Med Hold soldiers.

Again, I sincerely thank each of you for allowing me to speak on behalf of many of my fellow soldiers willing to die defending this great country. May God forever bless you and the USA!!!

I would be happy to answer any questions you may have.

Upon retiring from the Mississippi State Tax Commission, with 25 years of service as a Senior Law Enforcement Special Agent, Mosley accepted a civilian position with the U S Army Reserves as a Supervisory Unit Administrator for the 296th Transportation Company, Brookhaven, MS 39601

Gerry Mosley entered active duty US Air Force on 22 March 1973. At completion of basic training he was assigned to Technical Training at Shepherd Air Force Base, Wichita Falls Texas (May-July 73) where he trained as a communication specialist, with a top-secret clearance.

In July 1973 he was assigned to the 1946th Comm Sq at Barksdale AFB, Shreveport, La.

In September 1973 he was assigned a Tdy tour to Matagorda Island Air force Range.

On 18 March 1975 he was transferred to the Air National Guard in Jackson MS. He remained a member of the Air Guard until September 1984 when he joined the Army Reserves.

In 1984 he was assigned to the 3390th US Army Reserve Forces School where he taught NBC and Military Police courses to hundreds of soldiers.

In 1995 He transferred to the 1181st Trans Terminal Bn as a Platoon Sgt and assistant First SGT.

In 1997, Mosley transferred to the 647th Trans Co, under the 356th QM BN as First SGT. He excelled in qualifying his soldiers that he was asked to transfer to a sister company and correct the shortcomings of that unit. He gladly accepted the assignment at the 386th Trans Co, Vicksburg, MS until accepting the Unit Administrator's position after retiring from State service. The Army regulation required him to be a member of the unit where he was a civilian employee. He transferred to the 296th, also a sister company under the 356th QM BN, as the First SGT. Mosley has received the MSM-1, ANCOC, AAM-4, ARCOM-3, NDSM, GWOT, AFLM, AFGC, ARSR, Expert rifle since 1984, Drivers badge with over 250,000 miles driven in military trucks.

Mosley holds a Commercial pilot's license with instrument ratings in single and multi engine fixed wing aircraft and has more than 4,000 pilot- in- command hours. He also holds a FAA mechanic's license, in both airframe and power plant.

He is married to Lisa Woods Mosley who is a Registered Nurse near completion of the MSN degree in Nursing Education. They have 2 children. Gabe is 8 years old and Madison who is 7 years old.

Mr. SHAYS. Thank you, Sergeant. I know that you left out a good part of your statement as well.

Sergeant MOSLEY. Yes, I did.

Mr. SHAYS. We do appreciate your statement and we do appreciate your trying to stay close to that 5 minutes, and you did. We'll ask the same of the others.

Specialist Ramsey.

Specialist RAMSEY. Mr. Chairman and distinguished members of the committee, on behalf of myself and hundreds of other mobilized soldiers of the National Guard and U.S. Army Reserve, I'm honored and pleased to have the opportunity to address you today.

Mine will be nowhere near the length of my statement, my statement is over 20 pages, with over 30 documents attached to it. So I'm going to brief in into a much smaller, condensed version.

I was improperly released from Fort Benning, GA, when I returned from serving my country in Kuwait and Iraq. When I returned, I had an injury that was documented in Kuwait. I had damaged my right rotator cuff. I also had other issues and other problems with numbness in my fingers in both hands. I addressed this to the doctor there in Kuwait, he noted it at one point, that I had the numbness in the hands, and addressed it as being overcompensation for the lack of strength in my right shoulder.

I returned with a completed LOD for the right shoulder and a followup visit or a referral for an MRI once I returned to the States. Being in Kuwait, Camp Doha, and in that general area, they did not have the ability to do MRIs or nerve study tests that were required of me once I returned to the States.

When I returned to Fort Benning, our process was to get us out as quickly as possible, not to treat us. I went to the treatment facility there, the out-processing medical treatment facility and spent approximately 15 minutes in the building. Between 3 and 5 minutes were spent with a PA who looked over my paperwork. Once I had established that I had a completed LOD and established that I had a completed referral for medical treatment, she said there would be no problem with me returning to my Reserve unit in Orlando, FL for followup treatment.

At that point, I was under the understanding that I was not being released from active duty, that I was being merely placed over to my Reserve unit for continued treatment. Prior to leaving, I called my wife and told her that I was probably going to be staying in Fort Benning for treatment, based on a conversation I had with a sergeant major that was traveling with me. Obviously to the delight of myself and to my wife and kids, I was coming home and going to receive treatment at my home station.

I returned home to my Reserve unit, reported in the first business day that was available to them and explained my situation, turned over my medical documents that I had. They were astounded that I was released from active duty and even voiced that, that I should not have been released from active duty, and attempted to put me back on active duty. I was then told to seek an orthopedic surgeon and have an appointment for a diagnosis/prognosis and a time before I returned to full duty. I followed the instructions while on my own leave, instead of spending leave with my family, I went and took care of business for the Army.

I went to these appointments, and after several months of going back and forth and having two surgeries on both shoulders and still requiring two more surgeries on my elbows, it has now been told to me that I at first did not qualify for incapacitation pay, which is a basic pay recovery system for your civilian pay. It's not an active duty pay. There's no active duty retirement points. There's no leave accrued. There's no TRICARE for your family for followup benefits. I was told I do not qualify for that, that I had to be put on ADME. Then I was told I did not qualify for ADME because I was released from active duty.

This fight went back and forth between the Florida Army National Guard, the National Guard Bureau and the active Army for several months. Meanwhile, my family and I were going without a paycheck for over 6 months.

Congressman Ric Keller got involved, and Channel 9, our local news channel got involved. They made a difference in this. They got the Army to agree to put me back on active duty starting December 1st and the National Guard to reimburse me for my lost pay from the day I was released from active duty, June 27th through December 1st. This was agreed upon by both parties.

On December 10th, I have now in my possession an e-mail from Colonel Sherman, who's the G–1 of the Army for the medical side, who clearly stated in her e-mail that she was going forward with the ADME, me being placed on ADME. On December 23rd, we had a phone conference call between myself and several other parties, including Colonel Sherman, at which time she said that she was not going to place me back on ADME. Her first response to that was because I had already been paid incap pay and she was not going to mix an incap pay status with an ADME status. An ADME status is an active duty medical extension.

Then later on in the conversation, she further stated that she was not going to take on any new medical issues that she was not apprised of prior. For example, if I had fallen and broken my arm between the time I was released from active duty and December 1st and I required additional treatment for that, she did not want to accept that as a medical treatment. She said that is something that would have happened outside the scope of my active duty time.

I truly understand that. But I'm not coming and asking for anything that I did not report or had documented prior to being released from active duty. When I was released from active duty, I went to the doctor's appointments that were required of me, I went to the MRIs and the nerve study tests which were documented less than a month after I was released from active duty. Those tests clearly stated that I was injured while on active duty.

So after December 23rd, we went back and started looking at the incap issue. I was basically given incap, which is, I have the choice between incapacitation pay versus active duty medical extension. I was never given that choice, I was told that this was all I was going to get. So of course, I try to take as little bit as I can and try to better myself and continue on, I took it.

Now, I'm being told that I'm being sent to Fort Stewart, FL under an incap position. That's an incapacitation pay, which does not give me retirement points, does not give me leave accrual, does

not give me TRICARE for myself or my family, does not give me the normal active duty things I would have if I was on active duty.

I now have, I went on February 11th to Fort Stewart this year, and I met with the doctors, the Army sent me for a fit for duty physical. When I spoke with the doctor there, the orthopedic PA and the orthopedic surgeon, they both put in their document that was signed, the FS 600, that I clearly was injured while on active duty, and it was clearly done while in the line of duty. And it clearly stated that I should be placed back on active duty for medical treatment, and if not back on active duty, that I should receive civilian treatment, paid for by the Army, until these issues are resolved.

I work for the Orange County Sheriff's Department. That's my desire, is to go back to where I work. Now I can't go back as a road deputy. My safety is important to me, but more than that, it's to the other deputies and the civilians that I have work with and beside. I could never forgive myself if I went back injured because I decided that I did not want to continue this fight with the Army and get this treatment and something were to happen to somebody.

I'm being sent back, like I said, to Fort Stewart. I have to report there tomorrow at 13. My flight is going to leave here at 9:30, so I'll be in around 1 a.m., in Florida. I'm going to have to be in a vehicle driving to Fort Stewart, I'm going to have to report on a daily basis in formation, in uniform, while all the time not receiving any type of retirement points, not receiving leave. So I'm going to be just like every other soldier there, but with less. And this is the thanks I get for serving my country, not once but several times. This is not my first deployment.

If you'll notice today, I'm not wearing my combat patch on my uniform. I'm entitled to wear my combat patch and combat stripes, as I've served in combat. But I'm not wearing it, because my combat hasn't ended yet. I've only returned from one battle to another. The military has created another issue for me, another battle. And I feel like in so many cases I'm by myself fighting in a large entity with no resolve here.

So I hope today that by me testifying that this is going to resolve a lot of issues. I'd like to add just one last thing, I'm probably over my time. My medical bills. I have over $15,000 still outstanding in medical bills. It was well over $30,000. Because I signed the paper saying that I would be ultimately responsible for this, even though the military has given written documentation saying that they would pay these medical bills.

My credit has now been affected. I receive on a daily basis at least 5 to 10 calls a day from collection agencies and medical doctors' offices asking me to pay these bills. The military has told me countless times that these bills have been paid, they've been taken care of, they're in the works. And to this date, as late as Friday before coming here, I was receiving calls from Florida Hospital still saying that I owed over $15,000 for surgeries.

So whatever is said today by anybody that any medical bills have been taken care of, I can tell you that some of them have been, only because of the issues and them finding out I'm going to be testifying. But for the most part, they have not been. This right here is just a stack of medical bills that I get on a daily basis that have

not been paid. And of course, this is all my documentation and medical treatments that I've had.

I just ask that this committee help me and other soldiers in my situation, so we are no longer having to face these issues. Thank you for the time.

[The prepared statement of Specialist Ramsey follows:]

Congressional Testimony

John A. Ramsey SPC.
Florida Army National Guard

Submitted Before the Subcommittee on National Security,
Emerging Threat, and International Relations

"Does the 'Total Force' Add Up? – The Impact of Health Protection
Programs on Guard and Reserve Units

March 30, 2004

Mr. Chairman and distinguished members of the committee, on behalf of myself and hundreds of other mobilized soldiers of the National Guard and United States Army Reserves, I am honored and pleased to have the opportunity to address the issues this committee has been to charged to investigate. I will truthfully and accurately represent my experience and views as well those of my fellow combat soldiers who supported Operation Iraqi Freedom. My name is John A. Ramsey, and I am a member of Detachment 1, Thirty Second Army Air and Missile Defense Command (Det 1, 32nd AAMDC).

Pre-deployment Health Assessment:

The pre-deployment process was handled poorly. There were no true physical exams conducted on all soldiers deployed from my unit. The physical exam process was more or less records checks that were rushed through. There should have been full physicals given to all soldiers thus saving the military and tax payer a great deal of money, and saving soldiers and their families a great deal of unnecessary hardship. As well as preventing hundreds of soldier's from the painful experience of being forgotten on active duty medical extensions (ADME). My unit went through a pre-deployment heath assessment in Florida; however, these efforts were not accepted by the Active Army (Fort Benning). Fort Benning health assessment was even less productive compared to Florida's. Several soldiers were required to receive same vaccinations over because of poor records maintenance of vaccinations received in Florida according to Fort Benning, however, the shots were given and it was said later that the medical staff at Fort Benning was not looking through individual medical files properly. For example, I

had a HIV blood test performed in Florida, but because the results were not in the medical file when we arrived at Fort Benning I was required to give another sample. The Medical staff at Fort Benning was informed by my unit that the HIV test was just performed days prior and that the result could be obtained thus preventing the retesting of several soldiers, the response was that they would not accept the units records and the test would be administered a second time.

Deployment

I was deployed to Fort Benning, GA on January 23, 2003 Det 1, 32 AAMDC deployed with all our current up to date qualifications (i.e. Weapons qualifications, NBC qualifications as well as many more) these qualification records were not accepted. My unit was then required to re-qualify prior to leaving for Kuwait. Just another example of needless spending. On February 23, 2003 my unit was deploying to Kuwait, I volunteered for a baggage detail. This consisted of loading military equipment on a Semi-Trailer, and an Airplane deploying to Kuwait. During this detail, I injured my right shoulder. The Non Commissioned Officer in charge wrote a statement and documented the injury. When I arrived in Kuwait, and when the first opportunity arose I went to the Troop Medical Clinic at Camp Doha where I was told that the injury appeared to be a strained muscle and was then given muscle relaxants. I returned for a follow-up, at which time I was sent to physical therapy. The Physical Therapy Doctor came to the conclusion, after several weeks of therapy, that I may have damaged my rotator cuff. I advised him that I was having pain in my left should and numbness in the ring and pinky fingers of both hands, he stated that it was because I was over compensating my left side

for the lack of strength on my right side. I was given an injection into the right shoulder joint with no relief. The Physical Therapy Doctor told me that he was going to give me a referral for tests to be performed when I returned to the states. Because of the documented injury, a Line of Duty investigation was conducted (LOD) and completed. During my deployment to Kuwait and Iraq, I continued to perform my mission dealing with the pain. I was given an opportunity of a lifetime to support my country and our way of life as well as passing the freedom of democracy onto the people of Iraq. It was clear to me that during the war that I was honored to participate in would require sacrifices to include sucking up some pain and driving on. I never complained but feared that I would be sent home prior to completing the mission of my unit due to my injuries. Prior to leaving Kuwait, a post deployment assessment form (DD Form# 2796 pg.1-2) (see attachments 1-2) was completed by me on May 5, 2003. On this form, I started listing my medical concerns and was stopped by the certifying Officer, Major Apelian. Major Apelian stated that by listing my injuries on DD Form 2796 that information would hold up the process of returning me to the states for treatment. The Major did identify in the comments block that I did have a referral. However, she did not indicate for what.

Post Deployment Assessment

I returned to Fort Benning on June 11, 2003. I had a conversation with the Staff Sergeant Major (SGM) Hinckley (a member of my unit) that was traveling with me; he stated that I would most likely remain at Fort Benning for medical treatment. I called my wife and told her that I would be staying at Fort Benning for medical treatment, at which time she stated that she was going to travel with our children to Fort Benning that

weekend to see me. I told her that I would call her when I knew for sure that I would be staying. On June 13, 2003 I went to the Fort Benning medical out-processing center where I was given several forms to fill out as part of the Return from active duty (Refrad) process. (See attachment 3- 16). During this time I spent approximately fifteen minutes in the building, approximately three to five minutes was spent talking with First Lieutenant (1LT) Muellner (PA). 1LT Muellner asked me if I had any medical problems. I told her that I was injured while deployed. She stated that I would need a LOD completed. I then stated that a LOD had been completed prior to me leaving Kuwait. 1LT Muellner then stated that I would need a referral to see a doctor, at which time I told her that I was given one prior to leaving Kuwait, she stated that I was the first soldier to return from deployment with this type of competed paperwork. While she was reading, I asked 1LT Muellner if I would be required to remain at Fort Benning for medical treatment or would I be sent back to my unit in Florida. 1LT Muellner stated that I was not required to remain at Fort Benning that I could receive the same medical treatment in Florida as I can at Fort Benning. During this time I never stated that I did not want medical care or that I did not want to remain on active duty for medical treatment. 1LT Mullner wrote on several medical documents that I would be returning home for follow-up health care at home station. This lead me to believe (and no one told me otherwise), that I was going to return to my reserve unit for continued treatment while still on active duty orders. I was given several checklists for tracking post deployment processes (Attachments # 3-8), however the majority of the out processing check lists were not completed, or signed off on. (Example: Attachment # 7-8 (The Fort Benning Demobilization out processing checklist), identifies medical, personnel, dental, and other

requirements such as finance, and the only portion filled out is finance, had this checklist been completed many of the problems I am faced with now may have been avoided. The Medical section of this Demobilization out-processing checklist has the following five (5) medical questions: Medical screening complete and is further treatment required? Quarantined? Assigned to Quarters? Pregnant? Received medical briefing? and the final statement is; completed out-processing, and requires a Medical representatives' signature and date. I attribute the non-completion of these checklists to pushing/rushing soldiers through the re-deployment process, and a total lack of responsibility by the Fort Benning re-deployment out-processing Center. On June 14' 2003 at approximately 4am I was on an airplane heading home. I feel that the soldiers were let down by the National Guard and the Active Army and these organizations are not being held accountable for their gross negligence dealing with Army Regulations regarding the pre-deployment, mobilization, and re-mobilization of the most precious resource in there charge; Soldiers!

Return to home station for continued health care

On June 17, 2003 I reported to Det 1, 32 AAMDC. Florida National Guard has alternate work week schedules and the headquarters was closed on June 16, 2003. I turned over all of the medical documents, and at that time was told by SGT Venderwest, (Personnel Clerk at Det 1, 32 AAMDC), and Mr. Till (Medical Branch, Surgeon General Office, Florida State Headquarters), I should not have been released from active duty. The unit then asked Mr. Till for guidance, and Mr. Till stated that I would be put on Active Duty Medical Extension (ADME), but first I needed to get a doctor to give a prognosis, diagnosis and expected date to return to full duty. I was instructed by Mr.Till to select an orthopedic doctor in my area and make an appointment. I did so and made an appointment with Dr. Christensen on June 18, 2003. Dr. Christensen told me that he

could not give any of the requested information until the following tests were done, Magnetic Resolution Imaging (MRI) of the right shoulder, neck, and a nerve study test of the right hand arm and shoulder. Dr. Christensen was extremely upset with manner in which my unit requested the above information. The request was sent on a 3x3 sticky. Dr. Christensen stated that he was in the military for over twenty years and had never received a request in such an improper way. He further stated that I should be in a military hospital not a civilian doctor's office. He further stated that he would not be able to answer any of the above questions with out the requested tests and further stated that if the military wanted any questions answered then they needed to request them on a proper memorandum format and with the proper letter head. The above tests were scheduled in the month of July. I reported this to my unit and Mr. Till. I was unable to talk with or explain to Dr. Christensen of the problems on my left side because of his continued discussion of disgust of the sticky note. Because of this Mr. Till told me I should try to see my primary physician in order to move the testing dates up to prevent me from being dropped from active duty. During this time I was on Active Duty Leave. I scheduled an appointment with my primary physician on June 26, 2003 at which time an MRI of my left shoulder and a nerve study test of the left side was requested. The MRI tests of the left and right shoulders and of the neck were done on July 14, 2003. I received the results approximately two days later at which time I turned them over to my reserve unit and Mr. Till. On July 21, 2003 a nerve study test was done on the left and right arms, hands and shoulders. I received the results of these tests on July 23, 2003. I then had a return visit with Dr. Jones (per my request for a different doctor) on July 24, 2003 who is in the same practice of Dr. Christensen. Dr. Jones reviewed the tests and stated that I would need to see another Doctor in his practice for the shoulders and hands. He further stated that there was an unidentified growth between my fifth and sixth vertebra that he wanted a repeat of the MRI at the same location of the first in three months to see if there was any change in size. His concern was that it might be cancer. He further stated that he wanted me to return to him for the results of that test being that this is what he specializes in. Dr. Jones signed the military

disability form stating that I would be unable to return to full duties for at least three months. It was later questioned and accused of altering this form prior to submitting it to the military. However, to date I have not heard anything reference that accusation.

During this time I asked why I was released from active duty. I was told that it was based on the DD Form 2697 report of medical assessment (attachments 13-14) question # 15 & 17. Question# 15 was "do you have conditions which currently limit your ability to work in your primary military specialty or require geographic or assignment limitations" I answered "no" because I felt that I could do my job for the most part. Question# 17 "do you have any other questions or concerns about your health" I answered "no" because I had no new question from the last time I had spoken with the Doctors in Kuwait. This form is a basic tracking form for the VA and clearly states the following- "Disclosure: voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim." Not a form to decide the active duty or medical status of a soldier. There is an established Army Regulation (Regulation 135-xx) regarding Active Duty Medical Extinction (attachment 17), clearly states that reserve members may be retained on active duty when the injury or illness occurred in the line of duty, and prevents the soldier from performing his/her normal military duties. There is a document that walks the health provider through the process (attachment 18).

The following requirements are:

a. Consent to remain on active duty.

b. Physician's statement that medical treatment for more than 30 days.

c. Line of duty determination.

d. DA Form 4187, signed by the Commander.

I qualified for ADME per the above Army Regulation, however because Lieutenant Colonel (LTC) Sherman stated that because I could still perform my Military Occupational Specialty (MOS) per my answer on (attachment 13) Answer# 15, she was not going to put me on ADME. LTC Sherman further stated that I could still perform my MOS with a temporary profile, there for

I did not qualify for ADME (attachment 19). There is no Army Regulation that states what LTC Sherman would have you believe nor is there an Army Regulation that states you can interpret the Army Regulation if you don't agree with them or are unclear of what they mean. Once again I would like to point out that the Regulation states normal military duties, a soldiers MOS is only part of his/her normal military duties. As well as every soldier I have spoken with that has remained on ADME either performs some part of they're MOS or a similar job while awaiting discharge from ADME.

I returned to the doctor's office on August 5, 2003 and met with Dr. Halperin. He gave me an injection in the right shoulder and sent me to physical therapy. He stated that we would work on the most painful complaint first (right shoulder). I attended physical therapy three days a week until my return visit on September 02, 2003. I returned to Dr. Halperin, he gave me another injection. When there was not relief from the injection, he referred me to Dr. Schwartzberg for a second opinion. During this time I was being told by Major (MAJ). Rooney, (Det 1, 32 AAMDC G1 Plans Officer), Mr. till and Staff Sergeant O'Brien (Det 1, 32 AAMDC Medical Operations Non commissioned Officer), that I was going to be put on ADME and that I did not qualify for Incapacitation Pay (INCAP). They further stated that I was going to be back paid as well.

On September 11, 2003 I met with Dr. Schwartzberg, at which time he advised me that I would be a good candidate for surgery, I agreed and the military (Florida States Surgeons Office – Sergeant First Class (SFC) Dressel) agreed to pay for it and all the care relating to my right shoulder (in writing). The surgery was performed on September 26, 2003 where the right shoulder was repaired as well as an injection in the left shoulder. I had a return visit with Dr. Schwartzberg on October 02, 2003. He requested that I return to physical therapy as soon as possible. On October 16, 2003 I returned to Dr. Schwartzberg's office reference my left shoulder, he had me start physical therapy on the left side. During the surgery on the right shoulder, at that time, the doctor recommended performing the same surgery on the left shoulder. I agreed and cleared it with the military (state of Florida) this was also put in writing. The

surgery was scheduled for November 14, 2003. During this time I went from not qualifying for INCAP to not qualifying for ADME. What this amounted to was that the army did not want to pay for the care and the Florida State Headquarters did not want to pay. And I was stuck in the middle.

I returned to Dr. Schwartzbergs for a follow up after the surgery on December 02, 2003. During this time it had been told to me that I would be going back on active duty. Because of this information, I did not start back to physical therapy until late December. It was also due to the holidays.

I contacted Congressmen Rick Keller on September 02, 2003 to request assistance in this matter. After several months, Congressmen Keller got the Active Army to agree to put me back on active duty starting December 01, 2003 and got the Florida State Headquarters to agree to back pay me from the date of release to December 01, 2003. Congressmen Keller between November 20-26 2003 told this to me. Approximately two or three weeks later, the Active Army changed their minds and refused to put me back on active duty. It was first said that it was due to my back pay being INCAP. LTC Mary Sherman Headquarters Department of the Army (703-695-7874) refused to mix INCAP pay and ADME. On December 23, 2003 during a conference call with myself, Terri finger (Representative from Congressman Rick Keller's office), MAJ Rooney, LTC Radcliff (Det 1, 32 AAMDC Full Time Staff Officer in Charge), SSG O'Brien, LTC Sherman, MAJ Etzel (Legislative Liaison for Headquarters Department of the Army) and Mr. Steve Howard (Surgeon Generals Office, Florida State Headquarters) LTC Sherman stated that she did not want to put me on ADME because she did not want to except the other injuries that were not noted on the first LOD or mix two different pays. Although this was documented by civilian doctors prior to me being released from active duty. And had the Army kept me at Fort Benning rather than releasing me, a military doctor would have documented these injuries. During this call it was agreed upon between Florida State Headquarters and LTC Sherman that I would be sent to Fort Stewart for a fitness for duty physical to document my injuries. This also changed,

because Florida State Headquarters and the Army don't want to agree on who is going to pay for this, it has been decided that I will now have my medical files sent to the Florida Army National Guard Medical Review Board to determine my status in the military. Once again they have basically made untruthful statements to me. And as of December 25, 2003 my pay once again stopped.

The Florida Army National Guard requested that I have a disability form signed by Dr. Halperin, however they would not authorize the visit. SSG O'Brien wrote to me that this was being requested and that he would work on getting the approval for the visit (attatchment#26). SFC Dressel also stated that he would get the approval for the visit during a conference call with SSG O'Brien and myself. As of January 21, 2004, this changed. I was then told to go to the Doctor's office and pay for the visit, if the doctor states that it's an injury incurred in the line of duty and the Florida Army National Guard approves the LOD, I would be reimbursed for the visit and treatment. On January 29, 2004 I went to see Dr. Halperin however because the Florida Army National Guard did not pay any of the medical bills that they agreed to in writing to pay, I was going to be turned away. I was able to convince them that I needed to see the doctor. Linda Thomas with the Orlando Orthopedic billing collections office spoke with MAJ Rooney on the phone and explained to him that I will not be allowed to continue physical therapy or any other doctors visits until the bill is paid in full. There was over eleven thousand dollars due for my medical treatment to just that office. To date I am receiving collection calls almost every day for bills not paid by the military. These bills are well over fifteen thousand dollars. I was then seen by Dr. Halperin who filled out the military disability form stating that the injuries to my elbows and hands occurred while in the line of duty. He further stated that it will require surgery and it will be approximately six months before I can return to full duties. He stressed that the six months is an estimate only. Blood tests were requested as well as taking an mrol dose pack. This doctor wanted me to return in one month to review the lab results and look at further treatment. This was not possible because the military refused to pay for the visit. Several days later the

Florida Army National Guard did approve the visit from January 29, 2003(after the visit took place). I called MAJ Rooney several times on January 29, 2003 reference to these current problems. He explained to me that this is currently how the system is working. He further stated that it would be a while before anything would be done because he and his staff as well as the contact people at Florida Army National Guard Headquarters were extremely busy working on deploying 600 or more soldiers to Iraq.

On January 30, 2004 MAJ Rooney notified me that Mrs. Sapp (Surgeon Generals Office Florida State Headquarters) spoke with the billing and collection department of Orlando orthopedic center. He further stated that the past due bills would be paid in full. MAJ Rooney then instructed me to contact the Orlando orthopedic center, billing and collection department to verify this statement. I spoke with Linda Thomas, she stated that she had been in contact with Mrs. Sapp; she further stated that Mrs. Sapp assured her that the bill would be paid. However Linda further stated that if she did not receive a payment by February 14, 2004 I would not continue treatment with Orlando orthopedic center.

On February 3, 2004 I contacted Terri finger and MAJ Etzel reference to the physical that was requested by them and LTC Sherman on December 23, 2003. They stated that the requested physical should have taken place and that they would be looking into why it had not taken place. Later that same day, I was notified that MAJ Etzel had spoken with SFC Dressel. MAJ Etzel stated that SFC Dressel was now currently working on getting me an appointment at Fort Stewart Hospital. I was then advised to contact MAJ Rooney to update him on the new information. I made this call to MAJ Rooney at which time he called SFC Dressel, and we had a three-way call. SFC Dressel stated that he was working on an appointment for me at Fort Stewart. I asked why now after his previous statement. He stated that after talking with his boss (LTC Cornelison), it was determined that the Florida medical review board would pass this case off to Fort Stewart for further review, so to save time he was sending me to Fort Stewart for a fitness for duty physical. I told SFC Dressel that MAJ Etzel and Terri finger both advised me to notify the doctor at Fort

Stewart of any and all injuries and illnesses that may have occurred while on active duty. SFC. Dressel then stated that I was only allowed to discuss my right shoulder for the purpose of this fit for duty physical. This information was relayed to Terri finger.

On February 4, 2004 I contacted the patient affairs office at Winn Hospital located at Fort Stewart. I was told that there was an appointment on either February 11 or 23, 2004. Within two hours of receiving this information, I received a call from MAJ Rooney; he stated that SFC Dressel notified him of an appointment for me at Winn Hospital on February 11, 2004 at 830am. He further stated that the orders were being faxed to me as we spoke on the phone. He stated that the orders were as follow: February 10, 2004 was for travel and February 11, would be for the appointment and travel back to home of record. On February 5, 2004 I contacted MAJ Rooney in reference to my orders, I asked him why February 10, was not listed on the orders. He stated that he would check into it and call me back. On February 6, 2004 MAJ Rooney called me back and stated that the orders were valid and that February 10th was listed on the computer and even though it was not on the printed orders it was still authorized as a day of travel. MAJ Rooney further stated that I was to take all of my medical files to the scheduled appointment, and that I was to let the doctor know of all my medical problems.

On February 11, 2004 I reported to the orthopedic section of the Winn hospital, at which time I was advised that there was no scheduled appointment for me and further stated that I was not in their computer system. They did however state that if I go to patient registration and get put into the computer, they would fit me in to an open slot.

Orthopedic P.A. Terry Clark saw me. P.A. Clark read and documented my medical file, and concurred with the civilian doctors. He further stated that my injuries were incurred in the line of duty; he further stated that I should be place back on active duty as soon as possible for continued care. MAJ Kurt Hensel orthopedic surgeon Winn Hospital who also agreed with P.A. Clark and stamped and signed Standard Form 600 filled out by P.A. Clark. I took this form over to patient affairs, where I was told that I needed to get a P2 or P3 profile, and if it was going to be a P3

profile, the doctor needed to start a medical evaluation board. I went to the doctor, he refused to do either, he stated that I was in the middle of treatment and attempting to get further treatment, there for he could not start a medical evaluation board for something that is still being treated. I relayed this back to patient affairs; they stated that they would notify SFC. Dressel. Also, they were missing several documents from my file, most importantly the first LOD that was completed in Camp Doha, Kuwait. I provided them with a copy; I also copied two documents sent to them by SFC. Dressel (attatchment27-28), the first document was a commanders memorandum, it stated that I currently have a P3 permanent profile and that I currently have two LOD Investigations in progress for both shoulders. Both statements were false. I understand that there is a formal investigation in progress for the left shoulder and at this time that is all. The second document I copied was a memorandum from SFC Dressel, he was requesting a fit for duty physical to be done on both the left and right shoulders.

On February 12, 2004 I returned to my reserve unit and spoke with SSG O'Brien, he stated that he now had approval for me to see Dr. Halperin two times. He further stated that the blood work requested by Dr. Halperin was approved back in December 2003. I questioned this because the request for blood tests was made on January 29, 2004. SSG O'Brien further stated that SFC Dressel was requesting another fit for duty physical at Winn Hospital. I asked why? SSG O'Brien stated the following; SFC Dressel told him that the doctor conducting the physical was a new doctor and did not know how to do them; he further stated that I was sent there for my right shoulder only. I asked SSG O'Brien to call SFC. Dressel to see if we could get to the bottom of these statements. A conference call took place with SSG O'Brien, SFC Dressel, and myself. SFC Dressel stated first that I was told to go to Fort Stewart for the right shoulder only and that because the doctor was new to this, that I would need to go back to see a surgeon. He further stated that he instructed the hospital to perform a line of duty for the right shoulder only. I then read to SFC. Dressel his memorandum that he sent to the hospital, he then stated " Oh, I thought I called them and told them to change it to just the right shoulder". I then had SSG O'Brien read

the Standard Form 600(doctors notes) to him, during this time SFC Dressel stopped him from reading and stated that he wanted me to know that Florida Army National Guard had approved twelve more visits to physical therapy for the left shoulder. I asked, is that also for the right shoulder? He stated no and that the prescription from the doctor (Orlando orthopedic center) stated only the left. I then stated no that is not correct, I asked the doctor if it was for the left only and he stated are we treating you for both, I answered yes, he then stated well then its for both right. SFC. Dressel then stated that it was written left only, I then stated that it was written as follows: physical therapy x4 weeks. SFC. Dressel then stated yes you are correct and there for you need to go back to the doctor and let him know that the military is anal and we require everything spelled out. At this time SSG O'Brien continued reading the Standard form 600, when he read that I was to be put back on active duty, SFC. Dressel stated, that is not going to happen and it's not an option. SSG. O'Brien continued to reading. When he said I was to continue physical therapy on both shoulders, SFC. Dressel asked if there was a time limit put on that and, SSG O'Brien stated "no". SSG O'Brien then stated that the doctor stated that I couldn't perform my MOS. I then told SFC. Dressel that this was prepared by an orthopedic P.A. and signed off by an orthopedic surgeon. SFC. Dressel then stated that he did not know that it was signed by a surgeon. He further stated that I would go to physical therapy for both shoulders for the next four weeks at which time he would then request another fit for duty physical. I asked him about my neck, hands, and elbows? He stated that the unit needed to complete an LOD. For each and that this would not be part of the next appointment. He further stated that it would be at least April before there was an answer on the completion of LOD's. SFC. Dressel then stated that while he was at a conference with LTC Sherman, he took my medical file (which were incomplete) and showed it to an orthopedic P.A. that stated that I was fine and ready to return to full duty. This Orthopedic PA has never examined me nor is he in involve in my medical treatment plan. SFC. Dressel further stated that this was why he requested a fit for duty physical for me. This statement contradicts his previous statement, he previously stated that after talking

with his boss (LTC Cornelison), it was determined that the Florida medical review board would pass this case off to Fort Stewart for further review, so to save time he was sending me to Fort Stewart for a fitness for duty physical. SFC. Dressel clearly violated the federal HIPPA law when he removed my medical files from his office and showed/discussed them with This Orthopedic PA who has no involvement in my medical treatment what so ever.

Medical bills not paid to date.

To date, there remains over $15,000.00 of medical bills that have not been paid. As late as march 10, 2004 there was over $25,000.00 of medical bills unpaid. The Florida Army National Guard continued to state that all the bills were either paid or being processed for payment. This has been a repeated statement every time I bring the issue to the Florida Army National Guard. The lack of payment has interfered with my medical treatment on several occasions to include stopping my physical therapy and any follow-up doctors appointments as of February 09, 2004. When the National Guard Bureau, Active Army

and the Florida Army National Guard found out that I was going to be testifying in front

of the Subcommittee on National Security, Emerging Threat, and International Relations on march 30, 2004, I started getting calls from the National Guard legislative liaisons office, the Army Surgeon General's Office, as well as a request to meet with LTC Cornelison. The Army Surgeon General's Office (Anne Price) wanted to know what medical bills were not paid, and whether or not I had been back paid.

I was told that this information was requested by LT General Peak and that he wanted it to be kept quiet that he was looking into these issues. Mrs. Price further stated that there

was nothing they could do to assist in my matters. Basically her office was on a fact-finding mission only.

I received several calls from Mrs. Price within a week's period. During one of our conversations, she stated that tri care informed her that my military ID card was showing as active duty. However no one can tell me what that means.

On march 17, 2004 I went to my unit and met with LTC Cornelison and MAJ Rooney, our conversation consisted of LTC Cornelison telling me that he felt that we were on the same team and striving for the same goals. He further stated that he wanted me to know that to his knowledge I had not been denied medical care and that the medical bills had been addressed. After our conversation, I believe that he conceded to the fact that medical treatment was not 100% forthcoming as well as the medical bills were not properly handled, as he had previously believed. I will say that per some of the e-mails given to me by LTC Cornelison clearly shows that he and his staff as well as my unit had been vigorously working my issues for some time. I also believe that a point came that my issues were dropped to the side because of lack of cooperation from the active Army and the Army National Guard. This is clearly seen in the response from the Office of the Adjutant General, Department of Military Affairs (Colonel U.S. Army RET Michael G. Jones) that was sent to Congressman Keller's office and Senator Nelson's office. The exact same document was sent to both the Congressman and the Senator, however the response was addressed to only Congressman Keller Attention Terri Finger. The writer of this document failed to address it to the Senator. I found this to be quite embarrassing as a member of the Florida Army National Guard that the writer of this document showed

little to no respect for these public leaders. (Attachment 20-25). Note: See further supporting documentation (attachment 29-30)

Returning to Fort Stewart for medical treatment in a INCAP status

On march 17, 2004 I was notified by MAJ Rooney that I was going to be sent to Fort Stewart for continued medical care. He further stated that I would not be placed back on active duty. MAJ Rooney stated that I would be sent there in a INCAP status, which means that I will be paid the same pay as a active duty E-4 however I would not be entitled to tri care for me or my family, I would not earn any retirement points nor would I earn any leave. I told MAJ Rooney that I could not go until April 1, 2004, this would allow me time to get my family affairs in order and allow me to testify in front of this committee. Maj. Rooney agreed and had the consent of the Florida Army National Guard as well (LTC Cornelison). On march 20, 2004 at approximately 9am I received a call from MAJ Rooney, he stated that the National Guard Bureau wanted me to report to Fort Stewart that day or no later than March 21, 2004. I told him that I could not leave on such short notice and stated that I felt that this could interfere with my testimony. He stated that he would relay my concerns. I then called Terri Finger and told her what I was told. She made contact with a member of the National Guard Bureau who told her that if I did not report by March 21, 2004, the National Guard Bureau would testify that I refused medical treatment. Later in the afternoon of March 20, 2004 MAJ Rooney called me back stating that I would be required to report to Fort Stewart on March 31, 2004 at 1300hrs.

I want to take a moment to tell you about a few people that I feel have gone over and beyond the call of duty to assist me and other soldiers. Congressman Rick Keller and

Terri Finger, who have supported and assisted in every way they possibly could with my medical and pay issues. SSG O'Brien, who has taken the time to listen to me vent my frustration on several occasions as well as he attempted to answer any questions I had in a timely manner. MAJ Rooney, Who put himself in many difficult positions to try and assist my family, and me continually contacting the same people over and over to try and resolve my issues. SSG Cockerline who recently retired. He was my unit supply Sergeant, he always went over and beyond the call of duty when it came to providing the best of military clothing, equipment, and special items that distinguished our unit. He always did everything he could to make our deployments as easy and successful as possible, always finding ways to support soldiers on pre-deployment. Doing his best Getting soldiers in and out of the unit as soon as possible giving soldiers the opportunity to spend much more quality time with our families prior to deployment.

This concludes my testimony; I sincerely thank each of you for allowing me to speak on behalf of many of my fellow soldiers and myself.

I would be happy to answer any questions you may have of me.

I have been with the Orange County Sheriffs Office since 2000 as a Road Deputy. Prior to the Sheriffs Office, I worked for the Sanford Police Department from 1996-2000. While at the Sanford Police Department I worked as a patrol officer, property crimes investigator, persons crimes investigator, sex crimes investigator, auto theft investigator and later was assigned to the Seminole Auto Theft Task Force. And have been lead investigator reference homicide investigations.

I am a prior member of the United States Marine Corps and have been a member of the Florida Army National Guard since 1995.

I am a shareholder in two corporations that I and my best friend Dean Barnes along with Joy Rogers started in 2000/2004. EYE CAN INC. A roll-off can company handling construction debris and yard waste, and EYE ROC INC. A new construction cleaning company.

140987

Return to your health care provider for a TB test on [illegible]

33348

POST-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: **(Military personel and DoD civilian Employees Only)** Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

[redacted]

Last Name: Ramsey

First Name: John MI: A

Deployed Unit: 32d AAMDC

Today's Date (dd/mm/yyyy): 05 / 06 / 2003

Social Security Number: [redacted] - [redacted] - [redacted]

DOB (dd/mm/yyyy): [redacted] / [redacted] / [redacted]

Date of arrival in theater (dd/mm/yyyy): 03 / 02 / 2003

Date of departure from theater (dd/mm/yyyy): / / 2003

Gender
- ● Male
- O Female

Service Branch
- O Air Force
- ● Army
- O Coast Guard
- O Marine Corps
- O Navy
- O Other

Component
- O Active Duty
- ● National Guard
- O Reserves
- O Civilian Government Employee

Pay Grade

O E1	O O1	O W1
O E2	O O2	O W2
O E3	O O3	O W3
● E4	O O4	O W4
O E5	O O5	O W5
O E6	O O6	O Other
O E7	O O7	
O E8	O O8	
O E9	O O9	
	O O10	

Location of Operation
- O Europe
- ● SW Asia
- O SE Asia
- O Asia (Other)
- O South America
- O Australia
- O Africa
- O Central America
- O Unknown

Deployment Location (CITY, TOWN, or BASE): Kuwait

List country (IF KNOWN): Iraq

Name of Operation: Operation Iraqi Freedom

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
●	O	O	Medical threat debriefing completed
●	O	O	Medical information sheet distributed
O	O	●	Post-Deployment serum specimen collected, if required

33348

DD FORM 2796, MAY 1999. ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

White - Permanent Medical Record; Yellow - Army Medical Surveillance Activity; Pink - Service Member Copy

Attachment #1

140987

33348

PLEASE FILL IN SOCIAL SECURITY # [redacted] - [redacted] - [redacted]

1. Would you say your health in general is. O Excellent O Very Good O Good ● Fair O Poor
2. Do you have any unresolved medical or dental problems that developed during this deployment? ● Yes O No
3. Are you currently on a profile or light duty? ● Yes O No
4. During this deployment have you sought, or intend to seek, counseling or care for your mental health? O Yes ● No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health? O Yes ● No

   Please list your concerns [illegible]

6. Do you currently have any questions or concerns about your health? O Yes O No

   Please list your concerns.

Service Member Signature

I certify that responses on this form are true.

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

- O None
- O Cardiac
- O Combat / Operational Stress Reaction
- O Dental
- O Dermatologic
- O ENT
- O Eye
- O Family Problems
- O Fatigue, Malaise, Multisystem complaint
- O GI
- O GU
- O GYN
- O Mental Health
- O Neurologic
- O Orthopedic
- O Pregnancy
- O Pulmonary
- O Other

EXPOSURE CONCERNS (During deployment)

Provider see questions 5&6 on this form

- O Environmental
- O Occupational
- O Combat or mission related
- O None

Comments: Referral Stabilized -

I certify that this review process has been completed.

Provider's signature and stamp.

APPLIAN McARIE 801

Date (dd/mm/yyyy) 05 / 06 / 2003

33348

DD FORM 2796, MAY 1999 ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

White - Permanent Medical Record; Yellow - Army Medical Surveillance Activity; Pink - Service Member Copy

Attachment #2

REDEPLOYMENT/POST-DEPLOYMENT AND RECONSTITUTION CHECKLIST

[illegible]

AUTHORITY: 10 US Section 3013, Secretary of the Army; Army Regulation 600-8-101, Personnel Processing (In, Out, and Mobilization Processing), and EO 9397 (SSN).

PURPOSE: To ensure Soldiers and civilians are properly reconstituted as part of Army unit reconstitution.

ROUTINE USES: The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.

1. DATE (YYYYMMDD) 2003 06 13	2. NAME (LAST, FIRST, MIDDLE) Ramsey John A.	3. SSN [redacted]
4. SERVICE ABBREVIATION: [X] USA [ ] USAR [ ] ANG [ ] USN [ ] USMC [ ] USAF [ ] USCG	5. COMPONENT: [ ] ACTIVE [X] GUARD [ ] RESERVE [ ] NON-MILITARY	6. STATUS: [ ] TPU [ ] AR [ ] RET [ ] IRR [ ] MOB [ ] IMA [ ] ACR [ ]
		7. PAY PROCESSING: F-4
		8. E-MAIL ADDRESS: [redacted]
9. NON-MILITARY STATUS: [ ] DOD [ ] DAC [ ] CONTRACTOR [ ] RED CROSS [ ] AAFES [ ] OTHER (Specify)	10. TRAVEL STATUS: [X] a. UNIT ORDER [X] b. INDIVIDUAL	11. DATE OF BIRTH (YYYYMMDD) [redacted]
12. JOB TITLE: 92A	13. ASI	14. CITIZENSHIP COUNTRY
15. LANGUAGE SPECIALTIES	16. BEFRAD ISSUE (YYYYMMDD)	17. DEPLOYMENT COUNTRY: Kuwait/Iraq
18. PARENT UNIT	19. PARENT UIC	20. UNIT DSN PHONE NUMBER
		21. UNIT PHONE NUMBER: 407-856-6575

OVERALL STATUS OF EACH SECTION

22. Redeployment Unit: [ ] CO [ ] NO/CO	23. Personnel: [ ] CO [ ] NO/CO	24. Finance: [ ] CO [ ] NO/CO	25. Mobilization: [ ] CO [ ] NO/CO	26. Security: [ ] CO [ ] NO/CO
27. Medical: [ ] CO [ ] NO/CO	28. Dental: [ ] CO [ ] NO/CO	29. Vision: [ ] CO [ ] NO/CO	30. Legal: [ ] CO [ ] NO/CO	31. Supply and Logistics: [ ] CO [ ] NO/CO

SECTION I - RECONSTITUTION VALIDATION

Part A. Accuracy Statement: I understand I am certified for reconstitution and to the best of my knowledge, all information contained in this document is correct and current.

1. PRINTED NAME OF SOLDIER	2. RANK	3. TITLE

Part B. Commander's Acknowledgement: Commanders may approve a individual for reconstitution based on the certifying official's recommendation, criticality, and mission needs, unless otherwise indicated. I Acknowledge the CHECKLIST findings.

1. PRINTED NAME (CDR or AO)	2. RANK	3. TITLE	
4. SIGNATURE	5. ADDRESS		
6. PHONE NUMBER	7. E-MAIL ADDRESS	8. DSN NUMBER	9. FAX NUMBER

Part C. RECONSTITUTION VERIFICATION: All requirements are indicated and as requirements are completed.

1. PRINTED NAME OF VALIDATING OFFICIAL	2. RANK	3. TITLE	
4. SIGNATURE OF VALIDATING OFFICIAL	5. ADDRESS		
6. PHONE NUMBER	7. E-MAIL ADDRESS	8. DATE (YYYYMMDD)	9. FAX NUMBER

The Redeployment, Post-deployment and Reconstitution Checklist is filed in the packet to complete the action. A copy remains at the gaining organization.

Attachment #3

Post-Deployment (1 of 3)

NAME (Last, First, Middle)	SSN
Ramsey, John A.	[redacted]

"C" INDICATES TO BE COMPLETED BY CIVILIANS

SECTION II - PERSONNEL	PH	NO GO	GO	DAT (YYYYM
1. Common Access Card (CAC)/determine eligibility of DEERS status	2,3			
2. Records update and Evaluation Reports completed (OER/NCOER)(if required).	1,2			
3. SGLV 8286/DD FORM 93 review/revised date:	2,3			
4. Promotion/Awards during mobilization documented?	1,2,3			
5. Army Education Center.	2,3			
6. Required Training	1,2,3			
7. Mandatory Briefings	1,2			
8. Received ACAP individualized career counseling DD Form 2648	2,3			
9. DD Form 214 prepared and hand delivered/or mailed (Except for Title 10 AGR)	2,3			
10. REFRAD orders issued.	1,2,3			
11. Completed DA Form 31 for scheduled post-deployment leave	2,3			
12. Photo Official of record updated (DA Form 5500-R)	2,3			
13. Family Care Plan reviewed/updated (DA Form [illegible])	2,3			
14. [illegible] date and [illegible] for all deployments.	2,3			
15. [illegible] information updated in CPMS/CAC/[illegible]	1,2,3			
16. Re[illegible] on redeployment rights	1,2,3			
17. Completed your civilian employer. (RC only)	2,3			
18. Completed command climate survey (RC Only)	1,2			
19. SGLI/FSGLI transactions submitted	1,2,3			
20. Received information on 18 year sanctuary (retirement). If applicable (RC Only)	2,3			
21. Individual family assistance counseling provided/C	2,3			
22. Chaplain appointment or visit attended	1,2,3			
23. Signature of Certifying Official: 24. Rank/Title	25. Date			

SECTION III - FINANCE				
1. Received Redeploy Finance Brief	1,2			
2. Completed full pay action to close out DoD charge cards prior to reverting back to RC status. (RC only)	1,2,3			
3. Discontinued (Stop) (Change) allotment's (AC Only)	2,3			
4. Established, verified Direct deposit changes completed	2,3			
5. Settle any travel claim's) TCS/PERAD Orders	2,3			
6. Number of days of Accrued Leave to be paid upon separation	2,3			
7. Signature of Certifying Official: 8. Rank/Title	9. Date			

Attachment #4

Post-Deployment (2 of 3)

NAME (Last, First Middle): Ramsey, John A

SSN: [redacted]

"C" indicates to be completed by civilians

SECTION IV - INSTALLATION	PH	NO GO	GO	DATE (YYYYMMDD)
1. DBOS: Transportation Branch:				
(a) Completed HHG/personal property arrangements?	2,3			
(b) Requires transportation arrangements?	2,3			
2. DBOS: Housing Division:				
(a) Cleared Quarters, BOQ or BEQ?	2,3			
3. DCFA: Army Community Service (ACS) Division:				
(a) Family Support-GP/ACS information provided?	2,3			
4. G3/DPTM: Security Division:				
(a) Security File Reviewed?	2,3			
(b) Security Debriefl?	2,3			
5. Signature of Certifying Official	6. Rank/Title		7. Date	

SECTION V - SECURITY	PH	NO GO	GO	DATE (YYYYMMDD)
1. Debriefed by S-2 Reverse SF 312 completed if access withdrawn "C"	1,2,3			
2. Government and personnel computers checked for sensitive data "C"	1,2,3			
3. Government information programs on personal computer purged "C"	1,2,3			
4. Signal security- Terminate log-onsve-mail/passwords "C"	1,2,3			
5. DD Form 577 sign cards & DA Form 1688 canceled "C"	1,2,3			
6. Badges or devices for secure areas turn-in "C"	1,2,3			
7. All classified material accessed by individual properly accounted for "C"	1,2,3			
8. Any combination known to the individual changed. "C"	1,2,3			
9. Signature of Certifying Official	10. Rank/Title		11. Date	

SECTION VI - MEDICAL				
1. TRICARE Enrollment Appl.	3			
2. Received Medical health records review (if applicable)	3		✓	
3. Complete DD Form 2697 for in-Theater exposures?"C"	1		✓	JUN 13 2003
4. Has Medical Surveillance Program had clinical evaluation?	2			
5. Hospitalized/medical treatment prohibiting demobilization?	2,3			
6. Medical Protection System (MEDPROS).	2			
7. DD 2766 (Adult Pre & Chronic Care Flow sheet) original returned to med record.	3			
8. Medical Line of Duty (LOD) received (if required) Completion of DD Form 261	1,2,3		✓	
9. Conduct initial TB Test	3		✓	~~JUN 13 2003~~
10. Suspense follow-up 90 Day TB Test	3			
11. Conduct HIV Test	3		✓	JUN 13 2003
12. Required Immunizations	2,3			
13. Received OWCP process for occupational illness and injury reporting."C"	2,3			
14. Receive copy of DD2349 (Medical Profile) prior to release	2,3			
15. Signature of Certifying Official	Alyson Mueller 1LT, USAR PA-C		16. Date JUN 13 2003	

SECTION VII - DENTAL				
1. Complete dental record/care (while on active duty) reviewed?	1,2,3			
2. Verify dental class	1,2,3			
3. Pantographic X-Ray in dental record	1,2,3			
4. VA Dental Care.	1,2,3			
5. Signature of Certifying Official	6. Rank/Title		7. Date	

Attachment #5

Post-Deployment (3 of 3)

NAME (Last, First, Middle)		SSN
Ramsey, John A.		[redacted]
"C" INDICATES TO BE COMPLETED BY CIVILIANS		
SECTION VIII - VISION		
1. Vision screening		
2. Vision classification		
3. Signature of Certifying Official	4. Rank/Title	5. Date
SECTION IX - LEGAL		
1. Counseled on insurance and civil matters and legal rights?		1,2,3
2. Briefed on Uniformed Services Employment and Reemployment Rights Act?		1,2,3
3. Briefed on Soldiers and Sailors Civil Relief Act Rights		1,2,3
4. Has soldier/civilian been counseled on claims filing procedure "C"		1,2,3
5. Signature of Certifying Official	6. Rank/Title	7. Date
SECTION X - SUPPLY AND LOGISTICS		
1. Weapon's issued accounted for Turned in. Weapon's) serial number(s): "C"		2,3
2. Theater specific CIF/CDE turn-in? "C"		1,2,3
3. Chemical Defensive Equipment		2,3
4. Personal military clothing and basic issue		1,2,3
5. Hand receipt updated/cleared "C"		1,2,3
6. Signature of Certifying Official	7. Rank/Title	8. Date

Attachment #6

DEMOBILIZATION OUT PROCESSING CHECKLIST

PRINT NAME: Ramsey (LAST) Jon (FIRST) A (MI) DATE: _____

COMPONENT: Active___ Reserves___ National Guard ✓ SDS CO___ PLT___

LAST THEATER UNIT OF ASSIGNMENT: DET 1 32d AA MDC

CIVILIAN CATEGORY: DoD___ RED CROSS___ CONTRACTOR___ RANK: ___

HOME ADDRESS: [redacted] PHONE: [redacted]

SSN: [redacted] - [redacted] [redacted] SEX: (M) / F MOS/AOC/OCC: 92A

PERSONNEL REQUIREMENTS: **REMARKS**

1. DD Form 214 worksheet completed (DEMOB / ETS only) Received? Y / N Date: _____ Y / N / N/A_____
2. SGLV 8286 reviewed / revised Y / N / N/A_____
3. DD Form 93 reviewed / updated Y / N / N/A_____
4. Family Care Plan reviewed / updated Y / N / N/A_____
5. AC ID turned in / Reserve ID issued Y / N / N/A_____
6. Award(s) posted Y / N / N/A_____
7. Evaluation report completed Y / N / N/A_____
8. LOD required / initiated Statement of charges Y / N / N/A_____
9. Have airline ticket Y / N / N/A_____
10. DA Form 31 completed (if required) (Y) / N / N/A DSP 6/13/03
11. Received safety briefing Y / N / N/A_____
12. Chaplain visit Y / N / N/A_____
13. Restricted by commander (or admin action) Y / N / N/A_____
14. Security clearance current Y / N / N/A_____
    a. Requires update Y / N / N/A_____
    b. Security clearance passed Y / N / N/A_____

COMPLETED OUT-PROCESSING (LOG rep signature / date: _____

MEDICAL REQUIREMENTS:

1. Medical screening complete Y / N / N/A_____
   Further treatment required? What? _____ Y / N / N/A_____
2. Quarantined Y / N / N/A_____
3. Assigned to Quarters / MTF Y / N / N/A_____
4. Pregnant Y / N / N/A_____
5. Received medical briefing Y / N / N/A_____

COMPLETED OUT-PROCESSING (MEDIAL Rep Signature / Date) _____

DENTAL REQUIREMENTS: **REMARKS**

1. Dental screening complete Y / N / N/A_____
   Further treatment required? What? _____ Y / N / N/A_____
2. New ponographic x-ray needed

COMPLETED OUT-PROCESSING (DENTAL Rep Signature / Date) _____

Attachment #7

FINANCE REQUIREMENTS"
1. Pay entitlements verified — Y / N / N/A
2. Travel voucher initiated — Y / N / N/A
3. Debts settled — Y / N / N/A
4. Transition leave elected — Y / N / N/A
COMPLETED OUT-PROCESSING (FINANCE Rep Signature / Date) 6/13/

LEGAL AFFAIRS REQUIREMENTS:
Pending civil / military charges — Y / N / N/A
COMPLETED OUT-PROCESSING (LEAGAL Rep Signature / Date) _____

PROVOST MARTIAL (PM) REQUIREMENTS:
Received vehicle from storage — Y / N / N/A
COMPLETED OUT-PROCESSING (PM Rep Signature / Date) _____

LOGISTICS REQUIREMENTS:
1. OCIE turned in — Y / N / N/A
2. CDE turned in — Y / N / N/A
3. Mask turned in — Y / N / N/A
4. Weapons turned in — Y / N / N/A
5. "Statement of Charges" completed — Y / N / N/A
COMPLETED OUT-PROCESSING (LOG Rep Signature / Date) _____

TRANSPORTATION REQUIREMENT:
1. HHQ / personal property — Y / N / N/A
2. Travel arrangements required — Y / N / N/A
COMPLETED OUT-PROCESSING (TRANS Rep Signature / Date) _____

ARMY COMMUNITY SERVICES (ACS) REQUIREMENTS:
Family information / assistance required — Y / N / N/A
COMPLETED OUT-PROCESSING (ACS Rep Signature / Date) _____

HOLDOVER? — Y / N / N/A

****NOTE Any item circled no (Y / N / N/A) denotes problem area!!!****

I certify that I have received my DD Form 214.
I have received this checklist and affirm that the information herein is correct to the best of my knowledge.

_____
(Individual. signature / date)

_____ (Commander's signature / Date)

_____ (OIC / NCOIC's signature / Date)

Attachment #8

POST-DEPLOYMENT Health Assessment

33348

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: (Military personnel and DoD civilian Employees Only) Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand the question, ask the administrator.

Demographics

Last Name: Ramsey

First Name: John MI: A

Name of Your Unit or Ship during this Deployment: 1st Inf Armor

Today's Date (dd/mm/yyyy): 13 / 06 / 2003

Social Security Number: [redacted]

DOB (dd/mm/yyyy): [redacted]

Date of arrival in theater (dd/mm/yyyy): 03 / 03 / 2003

Date of departure from theater (dd/mm/yyyy): 14 / 06 / 2003

Gender
- ● Male
- ○ Female

Service Branch
- ○ Air Force
- ● Army
- ○ Coast Guard
- ○ Marine Corps
- ○ Navy
- ○ Other

Component
- ○ Active Duty
- ● National Guard
- ○ Reserves
- ○ Civilian Government Employee

Pay Grade

○ E1	○ O1	○ W1
○ E2	○ O2	○ W2
○ E3	○ O3	○ W3
● E4	○ O4	○ W4
○ E5	○ O5	○ W5
○ E6	○ O6	
○ E7	○ O7	○ Other
○ E8	○ O8	
○ E9	○ O9	
	○ O10	

Location of Operation
- ○ Europe
- ● SW Asia
- ○ SE Asia
- ○ Asia (Other)
- ○ Australia
- ○ Africa
- ○ Central America
- ○ Unknown
- ○ South America
- ○ North America
- ○ Other _____

To what areas were you mainly deployed:
(mark all that apply - list where/date arrived)

- ● Kuwait — Camp Doha
- ○ Qatar
- ○ Afghanistan
- ○ Bosnia
- ○ On a ship
- ● Iraq
- ○ Turkey
- ○ Uzbekistan
- ○ Kosovo
- ○ CONUS
- ○ Other

Name of Operation: OIF

Occupational specialty during this deployment (MOS, NEC or AFSC): 92A

Combat specialty: _____

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
○	○	○	Medical threat debriefing completed
○	○	○	Medical information sheet distributed
○	○	○	Post-Deployment serum specimen collected

DD FORM 2796, APRIL 2003 ASD (HA) APPROVED 33348

Attachment # 9

Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY# [redacted] – [redacted] – [redacted]

Post-Deployment Health Care Provider Review, Interview, and Assessment

Interview

1. Would you say your current health in general is: O Excellent O Very Good O Good ● Fair O Poor
2. Do you have any medical or dental problems that developed during this deployment? ● Yes O No
3. Are you currently on a profile or light duty? O Yes ● No
4. During this deployment have you sought, or do you now intend to seek, counseling or care for your mental health? O Yes ● No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health? O Yes ● No
   Please list concerns:
6. Do you currently have any questions or concerns about your health? ● Yes O No
   Please list concerns: Torn Rotator cuff -

Health Assessment

After my interview/exam of the service member and review of this form, there is a need for further evaluation as indicated below. (More than one may be noted for patients with multiple problems. Further documentation of the problem evaluation to be placed in the service member's medical record.)

REFERRAL INDICATED FOR:

- ☒ None
- O Cardiac
- O Combat / Operational Stress Reaction
- O Dental
- O Dermatologic
- O ENT
- O Eye
- O Family Problems
- O Fatigue, Malaise, Multi-system complaint
- O Audiology
- O GI
- O GU
- O GYN
- O Mental Health
- O Neurologic
- O Orthopedic
- O Pregnancy
- O Pulmonary
- O Other _____

EXPOSURE CONCERNS (During deployment):

- O Environmental
- O Occupational
- O Combat or mission related
- ☒ None

Comments: Will pt. i have ortho re: Rt shoulder injury

I certify that this review process has been completed.
Provider's signature and stamp:

This visit is coded by V70.5 _ _ 6

Date (dd/mm/yyyy) __ / __ / ____

End of Health Review

DD FORM 2796, APRIL 2003 ASD (HA) APPROVED 33348

Attachment #10

Please answer all questions in relation to THIS deployment

1. Did your health change during this deployment?

- ● Health stayed about the same or got better
- ○ Health got worse

2. How many times were you seen in sick call during this deployment?

0	6

No. of times

3. Did you have to spend one or more nights in a hospital as a patient during this deployment?

- ● No
- ○ Yes, reason/dates: _____

4. Did you receive any vaccinations just before or during this deployment?

- ● Smallpox (leaves a scar on the arm)
- ● Anthrax
- ○ Botulism
- ● Typhoid
- ○ Meningococcal
- ○ Other, list: _____
- ○ Don't know
- ○ None

5. Did you take any of the following medications during this deployment?
(mark all that apply)

- ○ PB (pyridostigmine bromide) nerve agent pill
- ○ Mark-1 antidote kit
- ● Anti-malaria pills
- ○ Pills to stay awake, such as dexedrine
- ○ Other, please list _____
- ○ Don't know

6. Do you have any of these symptoms now or did you develop them anytime during this deployment?

No	Yes During	Yes Now		No	Yes During	Yes Now	
○	●	○	Chronic cough	●	○	○	Chest pain or pressure
○	●	○	Runny nose	●	○	○	Dizziness, fainting, light headedness
○	●	○	Fever	●	○	○	Difficulty breathing
○	●	○	Weakness	●	○	○	Still feeling tired after sleeping
○	●	○	Headaches	●	○	○	Difficulty remembering
○	●	○	Swollen, stiff or painful joints	●	○	○	Diarrhea
●	○	○	Back pain	●	○	○	Frequent indigestion
●	○	○	Muscle aches	●	○	○	Vomiting
○	●	○	Numbness or tingling in hands or feet	●	○	○	Ringing of the ears
○	●	○	Skin diseases or rashes				
●	○	○	Redness of eyes with tearing				
●	○	○	Dimming of vision, like the lights were going out				

7. Did you see anyone wounded, killed or dead during this deployment?
(mark all that apply)

○ No ● Yes-coalition ○ Yes-enemy ○ Yes-civilian

8. Were you engaged in direct combat where you discharged your weapon?

● No ○ Yes (○ land ○ sea ○ air)

9. During this deployment, did you ever feel that you were in great danger of being killed?

● No ○ Yes

10. Are you currently interested in receiving help for a stress, emotional, alcohol, or family problem?

● No ○ Yes

11. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

None	Some	A Lot	
●	○	○	Little interest or pleasure in doing things
●	○	○	Feeling down, depressed, or hopeless
●	○	○	Thoughts that you would be better off dead or hurting yourself in some way

33348

DD FORM 2796, APRIL 2003

Attachment #11

12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you...

No	Yes	
●	○	Have had any nightmares about it or thought about it when you did not want to?
●	○	Tried hard not to think about it or went out or your way to avoid situations that remind you of it?
●	○	Were constantly on guard, watchful, or easily startled?
●	○	Felt numb or detached from others, activities, or your surroundings?

13. Are you having thoughts or concerns that...

No	Yes	Unsure	
●	○	○	You may have serious conflicts with your spouse, family members, or close friends?
●	○	○	You might hurt or lose control with someone?

14. While you were deployed, were you exposed to:
(mark all that apply)

No	Sometimes	Often	
●	○	○	DEET insect repellent applied to skin
●	○	○	Pesticide-treated uniforms
●	○	○	Environmental pesticides (like area fogging)
●	○	○	Flea or tick collars
●	○	○	Pesticide strips
○	○	●	Smoke from oil fire
○	●	○	Smoke from burning trash or feces
○	●	○	Vehicle or truck exhaust fumes
●	○	○	Tent heater smoke
●	○	○	JP8 or other fuels
●	○	○	Fog oils (smoke screen)
●	○	○	Solvents
●	○	○	Paints
●	○	○	Ionizing radiation
●	○	○	Radar/microwaves
●	○	○	Lasers
●	●	○	Loud noises
●	○	○	Excessive vibration
○	●	○	Industrial pollution
○	○	●	Sand/dust
○	○	○	Other exposures _____

15. On how many days did you wear your MOPP over garments?

3	0

No. of days

16. How many times did you put on your gas mask because of alerts and NOT because of exercises?

2	0

No. of times

17. Did you enter or closely inspect any destroyed military vehicles?

● No ○ Yes

18. Do you think you were exposed to any chemical, biological, or radiological warfare agents during this deployment?

○ No ● Don't know
○ Yes, explain with date and location

_____
_____
_____

Attachment #12

REPORT OF MEDICAL ASSESSMENT	REPORT CONTROL SYMBOL DD-HA(AR)1939

PRIVACY ACT STATEMENT

AUTHORITY: PL 103-160, EO 9397.
PRINCIPAL PURPOSE: To be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty.
ROUTINE USES: A copy of this form will be released to the Department of Veterans Affairs.
DISCLOSURE: Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.

SECTION I - TO BE COMPLETED BY SERVICE MEMBER. *Any service member who requests a physical examination may have one.*

1. NAME *(Last, First, Middle)*	2. SOCIAL SECURITY NUMBER	3. RANK
Ramsey, John Alexander	[redacted]	E-4

4. COMPONENT	5. UNIT OF ASSIGNMENT
DET 1 32d AAMDC	DET 1 32d AAMDC

6a. HOME STREET ADDRESS *(Or RFD, including apartment number)*	b. CITY	c. STATE	d. ZIP CODE	7. HOME TELEPHONE NUMBER *(Include area code)*
[redacted]	Orlando	Fl	[redacted]	[redacted]

8. DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY *(YYMMDD)*	9. DATE ENTERED ON CURRENT ACTIVE DUTY *(YYMMDD)*
2003 01 26	2003 01 23

10. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS *(X one. If "Worse," explain.)*

- [X] THE SAME
- [ ] BETTER
- [ ] WORSE

11. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU HAD ANY ILLNESSES OR INJURIES THAT CAUSED YOU TO MISS DUTY FOR LONGER THAN 3 DAYS? *(X one. If "Yes," explain.)*

- [X] NO
- [ ] YES

12. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU BEEN SEEN BY OR BEEN TREATED BY A HEALTH CARE PROVIDER, ADMITTED TO A HOSPITAL, OR HAD SURGERY? *(X one. If "Yes," explain.)*

- [ ] NO
- [X] YES

13. HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE? *(X one. If "Yes," explain.)*

- [X] NO
- [ ] YES

14. ARE YOU NOW TAKING ANY MEDICATIONS? *(X one. If "Yes," list medications.)*

- [X] NO
- [ ] YES

15. DO YOU HAVE ANY CONDITIONS WHICH CURRENTLY LIMIT YOUR ABILITY TO WORK IN YOUR PRIMARY MILITARY SPECIALTY OR REQUIRE GEOGRAPHIC OR ASSIGNMENT LIMITATIONS? *(X one. If "Yes," explain.)*

- [X] NO
- [ ] YES

16. DO YOU HAVE ANY DENTAL PROBLEMS? *(X one. If "Yes," explain.)*

- [X] NO
- [ ] YES

17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH? *(X one. If "Yes," explain.)*

- [X] NO
- [ ] YES

18. AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY? *(X one. If "Yes," list conditions for which you will ask for VA Disability.)*

- [ ] NO
- [ ] YES
- [X] UNCERTAIN

19. CERTIFICATION. I certify that the information provided above is true and complete to the best of my knowledge.

a. SIGNATURE OF SERVICE MEMBER	b. DATE SIGNED
[signature]	2003 06 13

DD FORM 2697, FEB 95 (LG)

Designed using Perform Pro, WHS/DIOR, Feb 95

Attachment # 13

SECTION II - TO BE COMPLETED BY INDIVIDUALLY PRIVILEGED HEALTH CARE PROVIDER

This Report of Medical Assessment is to be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty. The assessment will cover, as a minimum, the period since the service member's last medical assessment/physical examination, or the period of this call or order to active duty. Any service member who requests a physical examination may have one. Any service member who has indicated "yes" to Item 18 will have an appropriate physical examination. If the last examination is more than 12 months old and/or there are new signs and/or symptoms. If the service member answers "Worse" to Item 10 or "Yes" to Items 11, 12, or 14 through 18, documentation of the injury, illness, or problem should be included in the service member's medical or dental record.

20. HEALTH CARE PROVIDER COMMENTS *(All patient complaints must be addressed)*

R) shoulder injury in Phila - has orth. wt. Has referral
+ PT & c orthopedics -
would prefer + d c home station
LOD implied

21. WAS PATIENT REFERRED FOR FURTHER EVALUATION? *(X one. If "Yes," specify where.)*

- [X] NO
- [ ] YES PT - c home station

22. PURPOSE OF ASSESSMENT *(X one. If "Other," explain.)*

- [X] SEPARATION *(Includes discharge from military service and release from active duty, including release of National Guard and Reserve personnel voluntarily or involuntarily called or ordered to active duty.)*
- [ ] RETIREMENT
- [ ] OTHER

23. MEDICAL FACILITY	24. DATE OF ASSESSMENT (YYMMDD)
MACH, FT BENNING, GA 31905	JUN 13 2003

25. HEALTH CARE PROVIDER

a. NAME (Last, First, Middle Initial)	b. GRADE/RANK	c. SIGNATURE
Aysan Moshiri 1LT, USAR PA-C		

DD FORM 2697, FEB 95 (BACK)

Attachment #14

READINESS PROCESSING CENTER QCC PW

POST-DEPLOYMENT WORKSHEET

ADMIN DATA

NAME (LAST, FIRST, MI)		SSN	GRA.
Ramsey John A		[redacted]	E-4
COMPONENT	UNIT NAME	UIC	OPERATION
DET 1	32d AA MDC	[illegible]	OEF

RECEIVED MEDICAL THREAT BRIEF. YES ✓ NO ____

RECEIVED SOLDIER'S REDEPLOYMENT GUIDE. YES ✓ NO ____

RESERVE/NG RECEIVED SEPARATION BRIEFS. YES ✓ NO ____

SIGNATURE/DATE [signature] 06-13-03

FORMS SCREENING

FOLLOWING FORMS CHECKED FOR COMPLETENESS:

DD 2796 ✓ DD 2697 ✓ DD 2766 ____ SF-600 ✓ WORKSHEET ✓

SCREENER NAME: [signature] DATE: 13JUN03

LAB

BLOOD DRAWN. YES 13JUN03 NO ____ LAB TECH INITIALS [signature]

IMMUNIZATIONS

SHOTS GIVEN (Specify) [illegible] 6JUN03 PPD [illegible]

SHOTGIVER INITIALS ____

HEALTH CARE PROVIDER

PRESCRIPTIONS WRITTEN:

EYEGLASSES: [illegible]

HEARING AID BATTERIES: N/A

30 DAY SUPPLY MEDS: N/A

PRIM ✓ MEF ____ DOXY ✓ CHLOR ____

CONSULTS: [illegible]

REFRAD PE: YES ____ NO ✓

HCP REMARKS:

ADVISED TO REPEAT PPD 3-6 MONTHS POST-DEPLOYMENT ✓

Alysan Mueller
1LT, USAR
PA-C

REFRAD PE COMPLETED N/A

LOD (2173) COMPLETED N/A ✓

RSRP QUALIFIED

AUTHORIZATION FOR CONTINUED CARE (HOME STATION) N/A ✓

JUN 13 2003

REV 5 JUN 03

Attachment #15

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

JUN 13 2003 MARTIN ARMY COMMUNITY HOSPITAL, FORT BENNING, GEORGIA 31905

S: RSRP: ACTIVE DUTY___ NG X USAR___

REFRAD PE REQUESTED: YES___ NO X N/A (ACTIVE DUTY)___

LOD(DA 2173) REQUIRED: YES X NO___ N/A___

HOME STATION F/U REQUIRED: YES X NO___ N/A___

ADME REQUIRED: YES___ NO X N/A___

O: DEFERRED EXAM

CONSULT: NO X YES___ CLINIC: Fl. i home station

REFRAD PE COMPLETED: YES___ N/A X

A/PLAN: RTD WITH AD UNIT___

REFRAD X

TO PAD FOR: LOD___ AUTHORIZATION FOR HOME STATION CARE___

DELAY REFRAD___

REASON: PENDING CONTINUED TX___

PENDING MEB/PEB___

AM Alyssa Mueller 1LT, USAR PA-C

LOD COMPLETED___ N/A___ JUN 13 2003

AUTHORIZATION FOR HS CARE COMPLETED___ N/A___

ADME COMPLETED___ ADME NOT REQUIRED___

SPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
ONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

TIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. WARD NO.

AME Ramsey, John A. RANK E-4

N [redacted] DOB 11-17-79

T 1 IT 32d AAMDC RA___ NG ✓ USAR___ OTHER___

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

pdated 01 Jun 2003)

Attachment #16

DEPARTMENT OF THE ARMY
OFFICE OF THE DEPUTY CHIEF OF STAFF, G-1
300 ARMY PENTAGON
WASHINGTON DC 20310-0300

REPLY TO ATTENTION OF

DAPE-MPE-RC

16 SEP 2002

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Retaining Reserve Component (RC) Members on Active Duty Medical Extension (ADME)

1. Procedural Guidance for Reserve Component (RC) Soldiers on Active Duty Medical Extension (ADME) posted to the DCS, G-1 website is extended until it can be included in the next revision of Army Regulation 135-XX. This guidance applies to RC members that require extended health care or evaluation for more than 30 days beyond their initial release from active duty (REFRAD), annual training (AT), active duty for training (ADT), active duty for special work (ADSW), and inactive duty training (IDT).

2. In compliance with 10 USC § 1074(a), RC members may be retained on active duty when the injury or illness occurred in the line of duty, and prevents the soldier from performing his/her normal military duty. The FY 2000 NDAA (Public Law 106-65) amended 10 USC § 1076(a)(2). Request will be submitted to the appropriate component and will consist of the following:

a. Consent to remain on active duty.

b. Physician's statement that medical treatment is required for more than 30 days.

c. Line of Duty determination.

d. DA 4187, signed by the Commander.

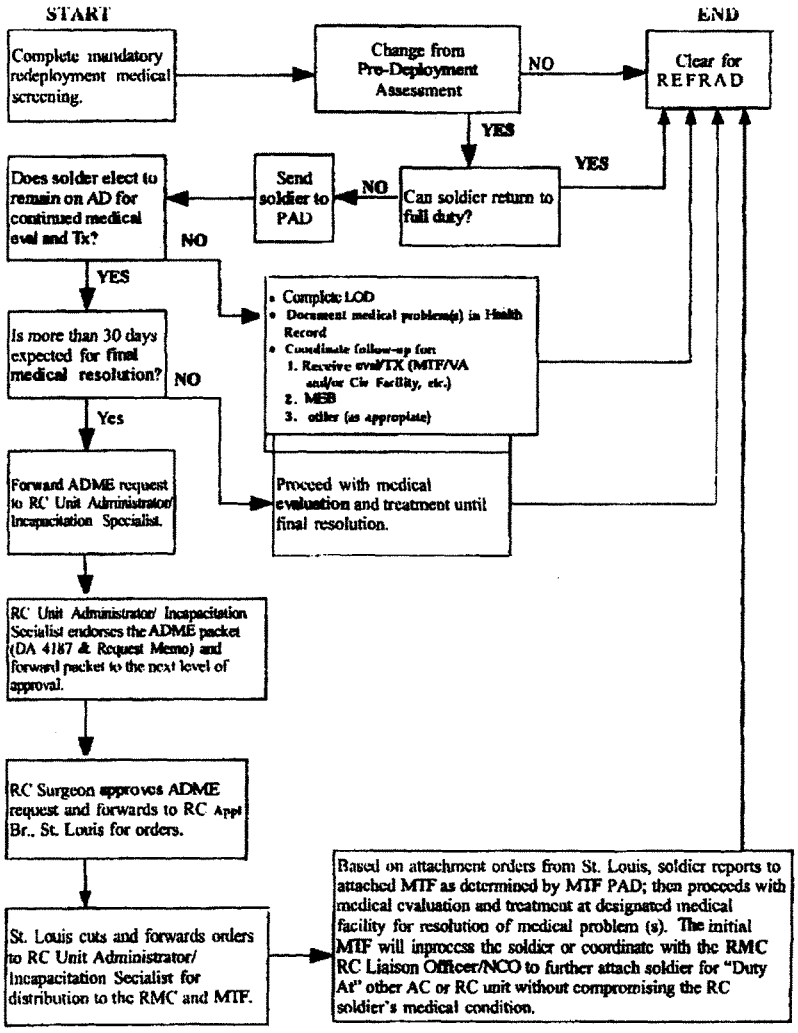
3. DA PERSCOM will publish ADME orders.

4. The ADME guidance is located on the DCS, G-1 home page, http://www.odcsper.army.mil under Military Personnel Management.

Printed on Recycled Paper

Attachment #17

Figure 3
Demobilization
Medical Flow Sheet



Attachment #18

Dressel, John G SFC FL-ARNG

From: Cornelison, Bruce J LTC FL-ARNG
Sent: Tuesday, September 23, 2003 11:30 AM
To: Sherman, Mary P LTC Army G-1
Cc: Wilks, Susan L MSG Army G-1; Dressel, John G SFC FL-ARNG
Subject: FW: Ramsey

Ma'am
Request status on this ADME issue.

-----Original Message-----
From: Cornelison, Bruce J LTC FL-ARNG
Sent: Wednesday, September 10, 2003 8:54 AM
To: Sherman, Mary P LTC Army G-1
Subject: RE: Ramsey

Ma'am
The best course of action is still for him to return to active duty for medical care. If he was regular army, he would not be manning his fighting position with this type of injury.

-----Original Message-----
From: Sherman, Mary P LTC Army G-1 [mailto:Mary.Sherman@us.army.mil]
Sent: Tuesday, September 09, 2003 10:25 PM
To: 'Dressel, John G SFC FL-ARNG'
Cc: Cornelison, Bruce J LTC FL-ARNG
Subject: RE: Ramsey

There is nothing here that tells me that the soldier can not perform his normal military job even within the confines of a temp profile. We are not denying medical
care - and it appears he is getting that through MMSO.

mps

LTC Mary P. Sherman
LTC Mary P. Sherman, AN
MEDICAL POLICY, G1
703-695-7874
DSN 225-7874
FAX 703-695-6054
mary.sherman@hqda.army.mil

HQDA, Office Deputy Chief of Staff, G-1
ATTN: DAPE-MPE-RC
300 Army Pentagon
Washington, DC 20310-0300

"Courage is not the absence of fear, but rather the judgment that something else is more important

Attachment #19

RIC KELLER
[illegible] District, Florida

Committee
EDUCATION AND THE WORKFORCE
Subcommittees
Education Reform
21st Century Competitiveness
Workforce Protections

Committee
JUDICIARY
Subcommittees
Crime, Terrorism, and Homeland Security
Courts, the Internet and Intellectual Property

Congress of the United States
House of Representatives
Washington, DC 20515–0908

[illegible] House Office Building
Washington, DC 20515-0908
(202) 225-2176
Fax: (202) 225-0999

District Office
606 East Robinson Street
Suite 650
Orlando, FL 32801
(407) 872-1962
FAX: (407) 872-1944

www.house.gov/keller

February 26, 2004

Mr. John A. Ramsey
[redacted]

Dear Mr. Ramsey:

Enclosed is a copy of the reply that I received from the Florida National Guard in response to my inquiries on your behalf. Thank you for allowing me to obtain this information and provide it to you. I hope it will be of some assistance. I am mailing the original reply to you.

As you know, I also submitted an inquiry on your behalf to the National Guard Bureau. I will keep you informed when I receive new information. Thank you for your attention to this correspondence.

Sincerely,

Ric Keller
Member of Congress

RK:tkf
Enclosure
District Tel (407) 872-1962
District Fax (407) 872-1944
District Staff Terri K. Finger

Attachment # 20

RECEIVED FEB 2 6 2004

STATE OF FLORIDA
Department of Military Affairs
Office of the Adjutant General

St. Francis Barracks, P.O. Box 1008
St. Augustine, Florida 32085-1008

February 23, 2004

Office of the Honorable Ric Keller
Representative in Congress
Attention: Ms. Terry K. Finger
605 East Robinson Street, Suite 650
Orlando, Florida 32801

Dear Ms. Finger:

Thank you for your recent inquiry on behalf of Specialist (SPC) John A. Ramsey, a member of the Florida National Guard. As you recall, SPC Ramsey has requested assistance concerning injuries sustained while on active duty. We are responding to Senator Nelson's office along similar lines.

Our review of this matter indicates the following.

- SPC Ramsey was injured on active duty with the U.S. Army at Fort Benning, Georgia, on February 2, 2003. He reported his injury to be pain in the right shoulder.

- SPC Ramsey left active duty in June 2003. At the time of his release, SPC Ramsey signed his Report of Medical Assessment (DD Form 2697) and Post-Deployment Health Assessment (DD Form 2796) indicating his physical condition was the same as it had been before entering active duty. We have learned there was some medical documentation which pointed to a torn rotator cuff of the right shoulder. Normally, soldiers injured on active duty receive medical treatment by active duty physicians. In this case, SPC Ramsey left active duty without final medical treatment contrary to the advice of active duty medical staff.

- For prior active duty service members in his circumstances, DoD's Military Medical Support Office (MMSO) provides authorization for follow up medical treatment. Payments are made through the TRICARE system. (The Florida National Guard is not funded by federal or state sources to reimburse such medical treatment nor is it delegated authority to approve such treatments.)

- When SPC Ramsey's physical condition became known, we made application to return SPC Ramsey to Active Duty Medical Status in so his shoulder injury might be treated by Army medical staff. National Guard Bureau (NGB), the authority in this matter, initially denied this request because of statements made by SPC Ramsey concerning his health at the time of his departure from active duty.

- The Florida National Guard subsequently petitioned NGB on SPC Ramsey's behalf. NGB staff then offered SPC Ramsey the choice between returning to active duty to resolve any lingering injury or receipt of Incapacitation (INCAP) entitlements. As you know, INCAP is a work offset financial assistance program. INCAP could be authorized for a period immediately following SPC Ramsey's release from active duty. If SPC Ramsey were to

Attachment #21

return to Active Duty Medical Status, the effective date would be December 1, 2003. SPC Ramsey elected to receive INCAP entitlements. The Florida National Guard has paid SPC Ramsey 180 days of lost salary for his right shoulder as authorized by military regulation Authority to extend INCAP beyond 180 days now rests with NGB.

- Late last year, SPC Ramsey indicated he also had pain in his left shoulder. Although it was not clear this pain was directly related to injuries received while on active duty, we were able to obtain MMSO approval for civilian orthopedic care. Earlier this year, SPC Ramsey indicated he also had injuries to his wrists and elbows as well as a cyst on his neck and requested medical follow up at federal expense. Formal Line of Duty (LOD) investigations are underway concerning injuries to his left shoulder, wrists, elbows, and neck cyst. These reviews are necessary to substantiate SPC Ramsey's case.

- A request for extension of SPC Ramsey's INCAP payments was submitted by our Medical Office to NGB on February 19th. Approval of this request by NGB is dependent upon results discovered by the LOD investigations mentioned previously.

- SPC Ramsey was evaluated by Fort Stewart medical staff in a Fitness for Duty examination on February 11, 2004. Physicians at Fort Stewart recommended more physical therapy for both shoulders. These therapy sessions have been scheduled on SPC Ramsey's behalf.

- SPC Ramsey makes mention of orthopedic medical bills he received from an Orlando TRICARE provider. We contacted this provider and the billing statements were resolved promptly to the soldier's benefit.

We understand full well this is a complicated situation, but want to assure you the Florida National Guard has worked vigorously to support SPC Ramsey's medical claims. Please feel free to contact SPC Ramsey's medical liaison, Sergeant First Class Dressel at (904) 823-314 for additional information.

Sincerely,

Michael G. Jones
Colonel, U.S. Army (Ret)
Florida Department of Military Affairs

Copy Furnished:
Deputy Chief of Staff, Personnel
The Honorable Bill Nelson

Attachment #22

United States Senate

WASHINGTON, DC 20510-0905

BILL NELSON
FLORIDA

February 27, 2004

SPC John A. Ramsey, FLARNG
[redacted]

Dear Specialist Ramsey:

In response to my inquiry on your behalf, I am enclosing a copy of the correspondence I received from the State of Florida, Department of Military Affairs, Office of the Adjutant General. I appreciate you giving me the opportunity to look into this issue.

If I can assist you with any other matter, please do not hesitate to let me know.

Sincerely,

Bill Nelson

BN/js

Enclosure

United States Senator Bill Nelson, 225 East Robinson Street, Suite 410, Orlando, Florida 32801
Telephone (407) 872-7161 • Fax (407) 872-7165

Attachment #23

STATE OF FLORIDA
Department of Military Affairs
Office of the Adjutant General
St. Francis Barracks, P.O. Box 1008
St. Augustine, Florida 32085-1008

February 23, 2004

Office of the Honorable Ric Keller
Representative in Congress
Attention: Ms. Terry K. Finger
605 East Robinson Street, Suite 650
Orlando, Florida 32801

Dear Ms. Finger:

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Our review of this matter indicates the following.

- SPC Ramsey was injured on active duty with the U.S. Army at Fort Benning, Georgia, on February 2, 2003. He reported his injury to be pain in the right shoulder.

- SPC Ramsey left active duty in June 2003. At the time of his release, SPC Ramsey signed his Report of Medical Assessment (DD Form 2697) and Post-Deployment Health Assessment (DD Form 2796) indicating his physical condition was the same as it had been before entering active duty. We have learned there was some medical documentation which pointed to a torn rotator cuff of the right shoulder. Normally, soldiers injured on active duty receive medical treatment by active duty physicians. In this case, SPC Ramsey left active duty without final medical treatment contrary to the advice of active duty medical staff.

- For prior active duty service members in his circumstances, DoD's Military Medical Support Office (MMSO) provides authorization for follow up medical treatment. Payments are made through the TRICARE system. (The Florida National Guard is not funded by federal or state sources to reimburse such medical treatment nor is it delegated authority to approve such treatments.)

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- The Florida National Guard subsequently petitioned NGB on SPC Ramsey's behalf. NGB staff then offered SPC Ramsey the choice between returning to active duty to resolve any lingering injury or receipt of Incapacitation (INCAP) entitlements. As you know, INCAP is a work offset financial assistance program. INCAP could be authorized for a period immediately following SPC Ramsey's release from active duty. If SPC Ramsey were to

Attachment #24

return to Active Duty Medical Status, the effective date would be December 1, 2003. SPC Ramsey elected to receive INCAP entitlements. The Florida National Guard has paid SPC Ramsey 180 days of lost salary for his right shoulder as authorized by military regulation Authority to extend INCAP beyond 180 days now rests with NGB.

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We understand full well this is a complicated situation, but want to assure you the Florida National Guard has worked vigorously to support SPC Ramsey's medical claims. Please feel free to contact SPC Ramsey's medical liaison, Sergeant First Class Dressel at (904) 823-314 for additional information.

Sincerely,

Michael G. Jones
Colonel, U.S. Army (Ret)
Florida Department of Military Affairs

Copy Furnished:
Deputy Chief of Staff, Personnel
The Honorable Bill Nelson

Attachment #25

FAX HEADER SHEET

TO: John Ramsey

FROM:

SSG TIMOTHY B. O'BRIEN
32d Army Air and Missile Defense Command
Medical Administration NCO

HQ, Det 1, 32 AAMDC
Florida Army National Guard
8385 Deerlyler Dr.
Orlando, FL 32827-5814

COMMWORK: (407)850-4314
DSN: 864-0142
FAX: (407)[redacted]
CELL: ([redacted]
SIGNCOM: 344-4314

E-mail: timothy.obrien@fl.ngb.army.mil

SUBJECT: Formal LOD / Drs Letter

DATE/TIME: 21 JAN 04 1345

PAGES: H + 5

REMARKS: John, as you can see by the checklist I've got some things I need you to do. Unfortunately there seems to be no one at State, so I can't find out how you can get the necessary forms filled out by the Dr. when you aren't currently authorized to see him for these problems. (Elbows & wrists). I'll keep trying till I know.

SSG O'Brien

Attachment #26

DETACHMENT 1 32nd ARMY AIR MISSILE DEFENCE COMMAND
Florida Army National Guard
8385 Daetwyler Drive
Orlando, FL 32827

AFVL-CMDT 12 January 2004

MEMORANDUM FOR THE STATE SURGEON'S FIT FOR DUTY BOARD.

SUBJECT: Commanders Narrative on Fitness for Duty of SPC John A. Ramsey

1. SPC John A. Ramsey is an Equipment and Parts Specialist (MOS 92A) and is assigned to this command. SPC Ramsey is currently not able to perform his MOS because of his medical condition.

2. SPC Ramsey is unable to take or pass an Army Physical Fitness Test (APFT). Currently, he has a P3 profile for Sit-up event, and the nature of his current injuries probably qualify him for a P3 profile for Push-up event as well.

3. He has two open Line of Duty investigations (LODs), one for each shoulder and he has had surgery on both shoulders.

4. SPC Ramsey has been receiving medical treatment for his condition from a civilian physician. This physician has stated that, in addition to the injuries to his shoulders, he believes, SPC Ramsey to have some additional injury or damage to both elbows and both wrists. At this time, those injuries are not being treated.

5. SPC Ramsey's civilian physician has further noted a growth of some sort on SPC Ramsey's neck and states that it may be a tumor on his spine.

David J. Pearce

DAVID J. PEARCE
MAJ, AV, FLARNG
Acting Commandant

Attachment # 27

DEPARTMENTS OF THE ARMY AND THE AIR FORCE
FLORIDA NATIONAL GUARD
Office of the Adjutant General
St. Francis Barracks, P.O. Box 1008
St. Augustine, Florida 32085-1008

OTSS-LOD 13 January, 2004

MEMORANDUM FOR Commander, USA MEDDAC, ATTN: Patient Affairs Branch (Ms. Carver), Winn Army Community Hospital, Fort Stewart GA 31313-5300

SUBJECT: Request for Fitness for Duty Evaluation – RAMSEY, John A., SPC, [redacted]

1. Request a Fit for Duty Evaluation for SPC Ramsey. SPC Ramsey has had surgeries on both shoulders and LODs for both. Request a review for retention.

2. Enclosed is a copy of his medical records and the Commander's request.

3. If any addition information is needed the POC is SFC John Dressel, 904-823-0314 or DSN: 822-0314.

Encls
as

JOHN DRESSEL, SFC
SFC, FLARNG
AGR Admin NCO

Attachment #28

DETACHMENT 1, 32D ARMY AIR AND MISSILE DEFENSE COMMAND
FLORIDA ARMY NATIONAL GUARD
P.O. Box 620728
Orlando, Florida 32862-0728

AFVL-GA 08 January 2004

MEMORANDUM FOR FLARNG Headquarters, Office of the State Surgeon (OTSS-HSS), 2305 State Road 207, St. Augustine, FL 32085

SUBJECT: Request for Authorization for Doctor's Visit for SPC John A. Ramsey[redacted]

1. Request SPC John A. Ramsey[redacted] be authorized to see Dr. Halperin of Orlando Orthopedic Center. Dr. Jones originally saw SPC Ramsey in July 2003 who referred him to Dr. Halperin. Dr. Halperin saw SPC Ramsey in August 2003. At that time he was referred to a specialist in upper extremities for surgery on both shoulders. Dr. Halperin stated that he wanted to see SPC Ramsey again after the shoulders were taken care of.

2. SPC Ramsey is currently receiving Physical Therapy for both his left and right shoulders, and he is ready to go back to Dr. Halperin so that he can continue with the rest of the care he needs i.e. his elbows and wrists. A Nerve Study test done in July determined that SPC Ramsey also has injuries in both elbows and wrists. This study was done here in Florida by a civilian doctor because the tests were not available in Kuwait and Ft. Benning told him since he had a referral from a doctor in Kuwait and a completed LOD that he would be returned to his Home Station for care.

3. Request authorization is given as quickly as possible because of the level of pain SPC Ramsey is currently experiencing.

TIMOTHY B. O'BRIEN
SSG, 91W30, FLARNG
Medical Administration NCO

Attachment # 29

DETACHMENT 1, 32D ARMY AIR AND MISSLE DEFENSE COMMAND
FLORIDA ARMY NATIONAL GUARD
8385 Daetwyler Drive
Orlando, Florida 32827-0728

AFVL-G1 10 September 2003

MEMORANDUM FOR RECORD

SUBJECT: SPC John Ramsey, [redacted]

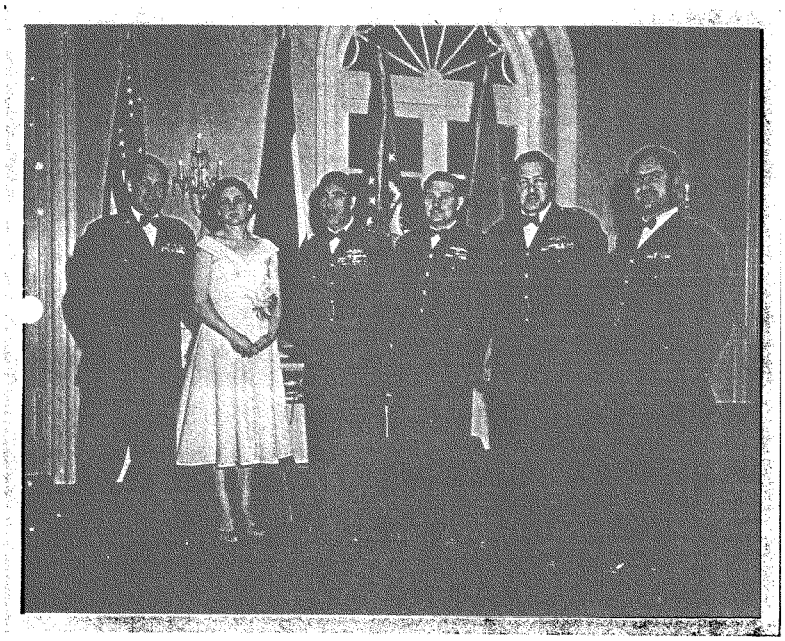
1. On January 23, 2003 SPC Ramsey was mobilized by the Florida Army National Guard in support of Operation Enduring Freedom / Operation Iraqi Freedom. During this deployment, SPC Ramsey was injured. SPC Ramsey returned from the Middle East during the month of June, where he was inadvertently released from the active Army to the Florida Army National Guard for further medical treatment. However, it has now been determined that SPC Ramsey should not have been released from Fort Benning, Ga., prior to receiving medical treatment for his injury. At this time SPC Ramsey is currently under medical treatment in Orlando, FL and the Florida National Guard Bureau is working vigorously with Fort Benning, GA to reinstate SPC Ramsey's orders and pay from the date of separation.

2. POC is the undersigned, (407) 650-4318.

JOHN C. ROONEY
MAJ, AV, FLARNG
G1 Plans Officer

Attachment # 30

17 MARCH 1957
COCKTAILS - BUFFET
IN HONOR OF
CMDR OF TACTICAL AIR GROUP
ROYAL IRAQ A. F.
COL. JASSAM MOHAMMED
HOST
GENERAL & MRS CHARLES BONDLEY, JR.
CAPITOL & MITCHEL RM
730 P M



Mr. SHAYS. Thank you, Specialist Ramsey. We will be helping.

Mrs. Ramsey.

Mrs. RAMSEY. I would like to thank the committee for the honor and privilege to testify from a wife's perspective regarding Reserve military family life. My husband, Specialist John A. Ramsey, comes from a family with a proud history of serving the U.S. military. His grandfather, Charles J. Bondley, Jr., a graduate of West Point, was a two star general in the Air Force who served during World War II alongside General MacArthur and General LeMay. His father, Thomas W. Ramsey, Sr., also served two tours of duty during the Vietnam War in the Army. His brother and half sister are currently in the military.

While John was a Reserve, he has been called to active duty to support the firefighters during the wildfires in central and west Florida, Operational Noble Eagle and Operation Enduring Freedom and also Operation Iraqi Freedom. During his deployment of Operation Iraqi Freedom, John was injured while loading heavy equipment overhead. At no time was I notified of his injury, medical treatment or progress of his recovery, either by the U.S. military or his unit. The family residence program did e-mail a couple of times, but nothing newsworthy concerning John. I received no phone calls or personal visits from any military personnel. On the other hand, the Orange County Sheriffs Office, John's civilian employer, called me monthly.

John was deployed for 5 months in Kuwait and Iraq. This period was very stressful on our two children, Chris, age 7, and Sarah, age 2. Chris received counseling at his school and my daughter was also having a difficult time with John's absence. Our children had a hard time with it. Even now our family struggles with the emotions due to John's absence.

We supported and continue to support the efforts in Iraq. However, if it hadn't been for mine and John's family, as well as the Orange County Sheriffs Office, during his deployment things would have probably been emotionally and physically devastating, especially since I felt completely isolated from the military.

John contacted me upon arriving in Benning, GA, saying that he would be receiving medical treatment and be staying there. He was given an LOD and referral for medical treatment. The U.S. military released him to his unit to have his medical care administered through them. Approximately 2 weeks after returning home, he was discharged from active duty. His unit assured him that this deactivation was a mistake and that they were taking action to reinstate him. His unit and the Florida National Guard fought with the Florida National Guard Bureau and the U.S. Army to place him back on active duty.

In that 8 months that they fought, John had two military authorized surgeries and was going through physical therapy. His civilian doctors discontinued medical treatment and physical therapy in February due to non-payment of his medical bills by the military. As of today, the military still has not paid all his medical bills resulting in our receiving collection calls and notices on a regular basis.

These 8 months from the time John returned home to the end of June 2003 through March 2004 have been extremely stressful,

emotionally exhausting and financially devastating. We did finally receive payment in December from June to December, only after the help of Florida Congressman Ric Keller and WFTB Channel 9's Josh Einiger being involved in the negotiations. But in that 8 months, we had completely depleted our savings account, had to borrow money from our parents and children's savings accounts to pay our monthly expenses.

It then took the military another 3 months to issue John's check for December to February, which has started the debt cycle all over again. It's extremely difficult to budget for monthly payments when the military is only paying ever 3 to 6 months, if at all.

The military is demanding copies of our 2002 and 2003 tax returns with no explanation of why they need them. John has started smoking due to all the stress the military has caused him. And Sarah, our daughter, doesn't understand why her father can't play with her.

As my husband was saying now, the military is going to send him back to Benning, GA, to continue his medical treatment, other than being treated by the civilian doctors who initiated his initial treatment, however, they seem to want him to report on a voluntary basis, since they are not wiling to restate him back to active duty. In his absence, I will have to resume all the household responsibilities alone again, with no projected date of his return, while comforting two children for the third time the military has taken their father from them.

After considering my past experience with the military, I have serious doubts as to John receiving proper medical treatment and am skeptical whether he will be paid. I also have massive concerns as to the treatment he will receive by the active military personnel who he will be reporting to. Thank you.

[The prepared statement of Mrs. Ramsey follows:]

Congressional Testimony

Laura Ramsey
Wife of John A. Ramsey SPC.
Florida Army National Guard

Submitted Before the Subcommittee on National Security,
Emerging Threat, and International Relations

"Does the 'Total Force' Add Up? – The Impact of Health Protection
Programs on Guard and Reserve Units

March 30, 2004

I would like to thank the committee, and I am honored for the privilege to testify on a wife's perspective regarding reserve military family life. My husband, Specialist John A. Ramsey, is a member of the 32nd Army Air Missile Defense Command. He comes from a family with a proud history of serving in the United States Military. His grandfather, Charles J. Bondley, Jr., a graduate of West Point, was a two star general in the Air Force who served during WWII alongside General McCarthy and General Lamay. His father, Thomas W. Ramsey, Sr., served two tours of duty during the Vietnam War in the army. His brother and half sister are currently in the military.

John enlisted in the United States Marine Corp in 1989 serving two years before being honorably discharged on a family hardship due to his grandmother's, for whom he was the guardian, deteriorating health. After acquiring her much-needed medical treatment and establishing a safe home environment, he wished to continue serving his country. In 1995, he reenlisted in the military through the Florida Army National Guard as a reservist. Since then he has been called to active duty, to support the firefighters during the wildfires in Central and West Florida (1998 & 2000), Operation Noble Eagle and Operation Enduring Freedom (2001-2002), and Operation Iraqi Freedom (2003).

During his deployment of Operation Iraqi Freedom, John was injured while loading heavy equipment overhead. He reported his injury to his First Sergeant and was sent to the Troop Medical Clinic in Kuwait for treatment. He informed me of his injury by email stating that he was being treated for a strained or pulled muscle in the right shoulder but was in enormous pain. Though I was concerned for his well being, my mind was put at ease because he assured me he was receiving medical care and treatment.

Meanwhile, the war with Iraq had begun and John stayed with his unit to help

support the efforts of the war. During the war, my contact with him was lost. At no time was I notified of his injury, medical treatment, or progress of recovery either by the United States Military or his Army National Guard Unit. The only news I received via the military came from a non-deployed, close friend serving in the same Army National Guard Unit. The Family Readiness Program did email me a couple of times but with nothing "news worthy" concerning John. I received no phone calls nor personal visits from any military personnel. On the other hand, the Orange County Sheriff's office, John's civilian employer, called me monthly. The following individuals from the Sheriff's office called to check on how the children and I were coping and to inquire if we needed any assistance: (1) the Human Resources Department, (2) the secretary for Director Ford, (3) John's Sergeant, and (4) a couple of fellow deputies.

John was deployed for five months in Kuwait and Iraq. This period was very stressful on our two children Chris, age seven, and Sarah, age 2, (turned three while John was deployed). Chris received counseling at his school, Shenandoah Elementary along with several other children whom had parents deployed to Iraq. He is not an openly emotional child, but I could tell he was having problems dealing with his father's absence, especially as to the reason his father was in Iraq. I did my best to explain what was happening in Iraq and why the United States and its allies were attempting to help free the Iraqi people. At first, we watched the news coverage of the War together, but it did not take long to see that this increased his anxiety and furthered his lack of understanding of the war. Soon, if I had the news on, he would leave the room in tears, so I stopped watching the news while he was around.

Sarah was also having a difficult time with John's absence. She is very close to her father and did not understand why he was not coming home at night. Upon arriving home after I picked her and Chris up from my parents, who regularly pick them up from daycare and school, she would often search the house for John all the while calling out "Daddy we're home." I attempted to explain that her daddy was not home and why he was not home. I continually reminded her that he had left on the bus, reassuring her that he would return home soon. She related to his being on a bus, since the last time she had seen him was the night he left on the bus for Ft. Stewart, Georgia.

Even though our family was struggling with our emotions due to John's absence, we supported and continue to support the efforts in Iraq. However, if I had not had mine and John's families, as well as, the Orange County Sheriff's Department's support during his deployment, things probably would have been emotionally and physically devastating, especially since I felt completely isolated from the military.

Upon John's return to the Ft. Stewart, Georgia in June 2003 he was given an MRI ordered by the doctors in Kuwait since the physical therapy and Cortisone shots given him there had not relieved his pain. He was diagnosed with a torn rotator cuff of both shoulders. He contacted me to inform me he would be staying in Georgia to receive medical treatment. He was given an LOD and a referral for medical treatment. But the United States Military released him to the Florida Army National Guard to have his medical care administered through them.

When John returned home, he was instructed by his Army National Guard Unit to make his own doctors' appointments with civilian doctors updating them of the medical findings. Approximately two weeks after returning home John was discharged from

active United States Military duty, even though he was still receiving medical treatment for his injuries that occurred in Kuwait while on active duty. His Army National Guard Unit assured him that the deactivation was a mistake and that they were taking action to have him reactivated. John continued to seek medical treatment as instructed. In the meantime, the United States Military stopped his pay.

For eight months John's Army National Guard Unit and the Florida National Guard have fought with the Florida National Guard Bureau and United States Army to have him placed back on active duty. In that eight months John had two military authorized surgeries, the right shoulder on 9-26-03 and the left shoulder on 11-14-03, and was going through physical therapy. His civilian doctor discontinued medical treatment and physical therapy in February due to non-payment of his medical bills by the military. As of today, the military still has not paid all of his medical bills resulting in our receiving collection calls and notices on a regular basis.

These eight months, from the time John returned home at the end of June 2003 through March 2004, have been extremely stressful, emotionally exhausting, and financially devastating. Since it took the military six months to issue John's pay for June to December, we completely depleted our saving account and had to borrow money from my parents and the children's savings accounts to help pay our monthly expenses. This payment took place only with the help of Florida Congressman, Rick Keller, and WFTV Channel 9, Josh Einiger becoming involved with the negotiations. Upon receiving the December check we thought we had cleared the hurtle since we were able to pay back most of the money we had borrowed and pay off most of the debt we had accumulated during John's surgeries and partial rehabilitation. However, it took the military three

months to issue John's check for December to March, which has started the debt cycle over again. It is extremely difficult to budget for monthly payment when the military is only paying every three to six months, if at all.

The utilities and phone companies have threatened to discontinue service and the mortgage company has threatened to foreclose on our home due to late payments. Creditors have placed collection notices on our credit reports. The military has demanded copies of our 2002 and 2003 tax returns with no explanation as to why they need them. I have lost time at work, resulting in lose of pay, to take John to and from his doctors' appointments and surgeries. John has started smoking due to all the stress the military has caused him. Sarah does not understand why her daddy cannot pick her up and play with her as he had done before leaving for Kuwait.

Now, the military has decided to send John back to Ft. Stewart, Georgia the first of April to have his medical treatment continued by military doctors rather than the civilian doctors who initiated his treatment. However, they seem to want him to report on a voluntary basis since they are unwilling to reinstate him to active duty. Thus the children and I would not be entitled to any benefits that we would have received if he were placed back on active duty.

In his absence, I would have to resume all of the household responsibilities alone again, with no projected date of his return, while comforting two children that, for the third time in their short life, the military will have taken their father away. Considering my past experience with the military I have serious doubts as to John receiving proper medical treatment and am skeptical as to whether he would be paid. Also, I have massive

concerns as to the treatment he would receive from the active military personnel to whom he would be reporting.

Mr. SHAYS. Thank you, Mrs. Ramsey. It's very important that we heard your perspective, and we thank you.

Sergeant Emde.

Sergeant EMDE. Good morning, Mr. Chairman and members of the Subcommittee on National Security, Emerging Threats and International Relations. My name is Scott Emde, and I have been a member of the Virginia National Guard Reserves and active Army since 1980.

On January 10, 2002, I was activated for Operation Enduring Freedom and reported to Fort Bragg to train for a mission overseas. Most of the teams were sent to Afghanistan, but mine was sent to Qatar. In June, my shoulder was injured and I was diagnosed with a torn rotator cuff. Twelve hours later I was on a plane and the following day arrived in Landstuhl, Germany, where I assumed I would receive treatment and return to Qatar to be with my teams. I remained in Germany for 2 to 3 weeks and then was taken to Walter Reed for further diagnosis.

Once I arrived at Walter Reed, I was told I would have to stay in the hotel on base as there were no rooms for enlisted people. The rooms were nice, but they were $30 to $35 a night, and I would be there weeks before I had an appointment. Additionally, I came back from Qatar with four big boxes totaling roughly 1,000 pounds. These boxes had to be stored in my hotel room, and there was no room in the hotel, and I had to climb over the boxes to get where I needed to go.

The 3 week stay for the doctor's appointment was a bit unexpected, and the hotel bill was a bit of a strain financially. This was of course paid back when I was able to file a travel voucher. Luckily, the equipment was only a minor inconvenience, as my wife drove up from the Hampton Roads area with a U-Haul trailer and the equipment was stored at my house. After the 3-weeks were up, I saw Dr. Doukas and a surgery date was set for October 30th, 3 months later.

I was sent to Fort Bragg, where I spent the first half of the day at battalion headquarters briefing the commander on situation reports and various ODAs in the countries of the world. I kept up with the rest of the 20th group as they were getting ready to deploy to Afghanistan. The second half of the day was spent running company B operations with another enlisted soldier. Shortly after we received all the teams back, I went to Walter Reed for my surgery.

Immediately after surgery, my wife drove me 3 hours home to the Hampton Roads area to recover. Physical therapy started the following week at Fort Eustis for 6 weeks. Then I had to report to Fort Bragg for 4 to 6 weeks for therapy and clear post. Then I was sent to Walter Reed as a medical hold and that very afternoon sent home again, as there was no room at the inn.

I continued therapy and volunteered in the PT department as I waited for orders. This went on for 6 weeks. I then drove back up to Walter Reed for a followup and visited a neurologist for problems I had in my neck. He wrote orders for an MRI and a CAT scan to be done at Langley Air Force Base. Since they didn't have the equipment at Langley, I was then sent to Portsmouth Naval Hospital, who didn't want to accept the doctor's order because there

was no reason for tests given on the slip. When I called Walter Reed for the correction, the doctor had left for vacation.

I kept calling to arrange for treatment between Portsmouth and Walter Reed, and it was during this time that my orders were set to run out. So I filled out the paperwork to extend the orders with the hope of a continuous pay check. This did not happen in March and again in June. I have noted 145 phone calls calling to extend my contract in the Army, check on pay issues and make medical appointments, calling everywhere from Walter Reed to the National Guard Bureau in Washington and to Fort Bragg, NC. This is by no means the total amount made.

The last time that I didn't receive orders, I went without a pay check for 2 months. After my therapy ended in October, I reported to Fort Bragg and they had no knowledge of my existence. I had fallen through the proverbial cracks. With the process that frequently takes 3 to 4 days, mine took 3 to 4 weeks. Instead of extending my orders to the suggested date, they were extended for a couple of days at a time.

The problem with this was that it took several days to process the paperwork and the orders were late by the time they were sent to Fort Bragg, so the process began again. I finally signed out at 14:20 on November 7, 2003.

But I must say, I'm more fortunate than these people beside me. Even with all the problems I encountered, I was very pleased with my medical experience. Like my wife, I was very skeptical of the idea of military surgeon working on my shoulder, especially when no x-ray or MRI was done for diagnosis. And then again when I was told it would be an open procedure and not done otoscopically.

As a nurse working in the same day surgery setting for Sentara Hospital, in my opinion the health care I received was as good or better than any I have seen. I particularly appreciated the physicians seeing me in such a short timeframe on the days that I had to drive 3 hours for two appointments that were 4 to 5 hours apart. The physical therapy was an eye opening experience but went smoothly despite being transferred from one installation to another.

[The prepared statement of Sergeant Emde follows:]

Testimony of Scott Emde
March 30, 2004
Subcommittee on National Security,
Emerging Threats and International
Relations

Good morning Mr chairman and members of the subcommittee on National Security, Emerging Threats and International Relations. My name is Scott Emde, and I have been a member of the Virginia National Guard, Reserves, and Active Army since 1980.

On January 10, 2002 I was activated for Operation Enduring freedom and reported to Fort Bragg N.C. to train for a mission overseas. In April that year my shoulder was injured during training. I reported to our company medic and was told it was his opinion the injury wasn't serious and to continue to train. In May, our unit was shipped overseas. Most of the teams were sent to Afghanistan and mine was sent to Qatar. In June, while stationed at Snoopy AFB and training for a mission to Djibouti, my shoulder was injured again and I went to a physician for pain medication so I might sleep at night. At this time I was diagnosed with a torn rotator cuff and was told I would be on a plane to Germany in 72 hours. As fate would have it, I was on a plane in 12. I spent one night in Oman, and the following day arrived in Landstuhl, Germany where I assumed I would receive treatment and return to Qatar. I remained in Germany for two or three weeks and was taken to Walter Reed for further diagnosis.

Once I arrived at Walter Reed I was told I would have to stay in the hotel on base as there were no rooms available for enlisted personnel in the barracks. The rooms were nice, but they were 30 to 35 dollars a night and it was to be three weeks before I had an appointment.. Additionally, I came back from Qatar with four big boxes totaling roughly 1000 pounds. These boxes had to be stored in my hotel room. There was no room to walk, I had to climb over the boxes to get to the bathroom. The three week stay for the doctor's

appointment was a bit unexpected and the hotel bill was a bit of a strain financially. This was of course paid back when I was able to file a travel voucher. Luckily, the equipment was only a minor inconvenience as my wife drove up from the Hampton Roads, Virginia area with a U-haul trailer and the equipment was then stored at my house. After the three weeks were up I saw Dr. Doukas and a surgery date was set for October 30, three months later.

I was sent to Ft. Bragg where I spent the first half of the day at 3rd Group Battalion Headquarters briefing the commander about situation reports on Bco, 3rd Group ODAs, Bco 20th Group ODAs, in various countries of the world, and kept up with the rest of 20th Group as they were getting ready to deploy to Afghanistan. The second half of the day was spent running B company's operations with another enlisted soldier. A great deal of time was spent dealing with pay problems. The rest was spent helping solder's families with health problems, reassuring families when they heard stories on the news, sending and receiving soldiers overseas, and other logistical issues. Luckily, I did get to drive home to see my family on some of the week-ends.

Shortly after we received all the teams back, I went to Walter Reed for my surgery. Immediately after surgery, my wife drove me three hours home to the Hampton Roads area to recover. Physical therapy started the following week at Fort Eustis for six weeks. Then I had to report to Fort Bragg for four to six weeks for therapy and clear post. Then I was sent to Walter Reed as a Medical Hold and that very afternoon sent home as there was again, no room at the inn. I continued therapy and volunteered in the PT department as I waited for orders. This went on for six weeks. I drove up to Walter Reed for a follow up and visited a neurologist for problems I had in my neck. He wrote orders for an MRI, CAT scan to be done at Langley AFB.

Since they didn't have the equipment at Langley, I was then sent to Portsmouth Naval Hospital who didn't want to accept the doctor's order because there was no reason given on the slip. When I called Walter Reed for a correction, the doctor had left for vacation. I kept calling to arrange for treatment between Portsmouth, and Walter Reed. It was during this time, my orders were set to run out so I filled out the paperwork to extend the orders with the hope of a continuous paycheck. This did not happen in March, and again in June. I have noted 145 phone calls trying to extend my contract in the Army, check on pay issues, and make medical appointments calling everywhere from Walter Reed to the National Guard Bureau in Washington to Fort Bragg, N.C.. This is by no means the total amount made. The last time I went without a paycheck for two months. After my therapy ended in October, I reported to Fort Bragg. They had no knowledge of my exsistance. I had fallen through the perverbial cracks. With a process that frequently takes three to four days, mine took three to four weeks. Instead of extending my orders to the suggested date, they were extended for a couple of days at the time. The problem with that was it took several days to process the paperwork and the orders were late by the time they were sent to Fort Bragg - and so the process began again. I finally signed out at 14:20 on 07 November 2003.

Even with all the problems I encountered, I must say I was very pleased with my medical experience. Like my wife, I was very skeptical with the idea of a military surgeon working on my shoulder especially when no x-rays or MRI was done for diagnosis and then again when I was told it would be done open and not orthoscopicly. As a nurse working in the Same Day Surgery setting for Sentara Hospital, in my opinion the health care I received was as good or better than any I have ever seen. I particularly appreciated the physicians seeing me in a short time frame on

the days I had two appointments four to five hours apart. The physical therapy was an eye opening experience but went smoothly despite being transferred from one installation to another.

Mr. SHAYS. We appreciate your statement.

Mrs. Emde.

Mrs. EMDE. Good morning, Mr. Chairman and members of the subcommittee.

As a spouse of an activated National Guardsman, I felt both pride and fear as my husband shipped out for Operation Enduring Freedom in early May 2002, after 5 months training at Fort Bragg. When he called in June to say that he had injured a shoulder and would be shipped home, my first thought was that I did not want him seeing a military doctor. After being raised in Tidewater, VA, home of numerous military bases, Army, Navy, Air Force and Marines, I had heard many, many horror stories of treatment by military doctors and the incompetence of their nurses and staff.

My husband was fortunately assigned to Walter Reed Medical facility. After his surgery, and I met his surgeon in October 2002, I was very, very pleased. His surgeon came out personally to speak with me, took time to explain the surgery, post-operative treatment, even went as far as giving me his home telephone number so that I could reach him in case I had any questions.

Despite the good medical attention my husband did receive, the administrative runaround was deplorable. We had his orders lapse four times during that time. One of the times we went 2 months without pay. During that time, our mortgage was late, I was called daily at my office by our mortgage company, it was reported to the credit bureau that we were late on payments. That stays with us. It will stay with us for many years to come.

It hasn't affected us as far as trying to refinance our mortgage now to get a lower interest rate. I had checks bounce because of an automated payment that I could not stop coming out from a schedule, it would come out on the 17th, payment did not come on the 15th as was expected. I had to pay bank fees. Those were never reimbursed to us. It's something we will live with forever.

The stress that something like this causes on a National Guard family is just extreme. I can't imagine how families who have only one income and encounter these types of pay glitches survive. We were fortunate that we are a two income household and we were able during these periods to pay for utilities, food, gas, all the standard costs of living.

It's hard enough for National Guard families to have their lives disrupted for activation to full duty. However, the delay in prompt medical treatment and surgery because of lack of doctors, lapses in pay are both deplorable and unnecessarily add to this hardship. For both my family and others of the National Guard who have had problems similar to ours, I thank the subcommittee for their time and effort on our behalf.

[The prepared statement of Lisa Emde follows:]

Testimony of Lisa Emde
Spouse of SFC Scott T. Emde

March 30, 2004
Subcommittee on National Security,
Emerging Threats and International Relations

Good morning Mr. Chairman and members of the Subcommittee on National Security, Emerging Threats and International Relations. My name is Lisa Emde. As a spouse of an activated National Guardsmen I felt both pride and fear as my husband shipped out to the desert for Operation Enduring Freedom in early May 2002 after five months of training at Ft. Bragg NC. When he called in June to say that he had injured his shoulder and would be shipped home, my first thought was that I did not want him seeing a military doctor. Being raised in Tidewater Virginia home of numerous military bases for the Army, Navy, Air Force and Marines, I had heard many horror stories of the incompetence of military doctors.

My husband was assigned to Walter Reed Medical Facility. He was flown back to the states by military lift and assigned a room at the guesthouse. My children and I drove up to Washington and after much to do also got a room at the overcrowded guesthouse. My husband was told that he could not see a doctor until the following week and that he could go home until that time. At a cost of $30.00 per day, we decided that going home would be the best course of action. I was dismayed to discover that it was up to us to get his military issued gear home. His gear consisted of four large crates with weights up to 250 pounds. I had to rent a U-haul and fortunately, we found two orderlies to assist me in loading the trunks. We were unable to turn in his gear because there was no one at his home unit as they were all still deployed. Once home, we had quite a time unloading and storing the trunks.

My husband made the six hour roundtrip drive in order to return to Walter Reed for his appointment, which lead to months of physical therapy, a diagnosis of a rotator cuff torn in several places and ultimately, months later, surgery followed by more physical therapy. Those first few days of confusion and disorganization seemed to set the pattern for what occurred over the next year. His surgery was finally set for late October 2002. I must say that after meeting his surgeon I was pleased to have my fear of military doctors put to rest. His surgeon was very professional yet he explained everything in layman's terms, even going so far as to give me his home telephone number because we were driving home that evening after the surgery.

While the medical attention my husband received was quite good, the run around he received for station duty or lack of station duty was deplorable. Because he was attached to Walter Reed and they could not billet him, it took months with my husband nagging to get a duty assignment or reassignment to Ft. Bragg. His physical therapy was set up for Ft. Eustis, which is located near our home. He repeatedly asked to be assigned for duty during this period and was told to just hold tight. He finally resorted to volunteering at the hospital and Red Cross at Ft. Eustis.

During my husbands recovery period his orders lapsed four times, because we were told that there was only one person who was responsible for reissuing orders due to medical extensions. This person was notified through proper channels for the need of the extensions with what should have been adequate time (at least a month out) to produce the orders before any lapse occurred. During three of the lapses in orders, we went from one to three weeks without pay. During the second to last lapse, we went without pay for eight weeks. During that eight-week period, our mortgage company threatened us and called my office almost daily. Even with the Soldiers/Sailors Relief Act, it seems that they can harass you and report to the credit agencies your late payment. We were fortunate that we are a two-income household and were able to pay for utilities, food and such. I shudder to think of the repercussions to families who rely on only the one income of the activated member. Even with of my income at one point, I had checks bounce because of an automated payment that was to be deducted on the 17th of the month, after a pay that did not come. On another instance, I was unable to pay for my daughters skating lessons. I cannot adequately relay to you, the extreme stress on our family because of these pay glitches.

It is hard enough on National Guard families to have their lives disrupted by activation of these members to full duty. However, the delay in prompt medical treatment/surgery because of lack of doctors and lapses in pay are both deplorable and unnecessarily add to this hardship. For both my family and others of the National Guard who have had problems similar to ours, I thank this subcommittee for their time and effort on our behalf.

Mr. SHAYS. I thank you for your testimony, Mrs. Emde.

Specialist McMichael, thank you very much for being here.

Specialist MCMICHAEL. Yes, sir. Good morning, Mr. Chairman and distinguished members of the committee. I'd like to thank you from the bottom of my heart for giving me the opportunity to speak here today.

My fellow medical hold soldiers and I have prayed for a chance to tell our story. I tried to include a few of their stories in my written statement. I realize that my poor writing ability fails to do them justice. I can only hope that what I've written sparks some sort of interest. Between my speech and written statement, I hope to raise enough questions that somewhere, someone will look more closely at what's going on at Fort Knox.

The Army has repeatedly maintained that there is no difference between the active duty soldiers and the National Guard and Reserve soldiers when it comes to their treatment. I invite each member to come to Fort Knox and see how we are treated and how we are forced to live. Compare our living conditions to the active duty soldiers. I ask that this committee also take a close look at the physical evaluation board and the rulings and decisions. Many of my fellow soldiers had their injuries or illnesses declared as existing prior to entering active service. You just have to ask, if they are in such bad shape they can no longer remain on active duty, why were they ever brought to active duty in the first place?

The few soldiers who do receive a disability rating or severance are awarded amounts that are so low they're insulting. I ask you, how can they justify awarding 10 percent to a soldier who broke his back? This man can never pick up his children again, he's permanently disabled and can never enjoy what you or I take for granted.

Soldiers have repeatedly asked, why such low awards? No one has answered the questions. We are told that the VA will take care of us. I thought that was the Army's responsibility. Soldiers come to me every day with horror stories of medical care gone wrong, and in some cases absolutely refused. I agreed to come here today because someone has to speak for these soldiers. Someone needs to ask Congress to come to Fort Knox to hear their stories. Whoever comes to Fort Knox needs to speak with the individual soldiers on a one on one basis, without the command standing over top of them.

They need to talk to the individual soldiers, not just the ones that are hand picked by the command. The soldiers do want to talk to you. However, they fear retaliation. I've been in the military for 18 years. Retaliation is real. It happens.

I don't want the committee to also think everything I have to say is negative. There have been a few positive things that have occurred in medical hold. Two officers in particular I want to talk about, one is Lieutenant Fannon. When I arrived at Fort Knox, he was the only medical officer who reviewed our cases. This is one man reviewing 300 soldiers' cases. It was his job to review every single soldier and see every single one of us to receive the medical care we needed. This officer showed that he cared about us, one of the few that actually did. Often he was the only person who was on our side.

The other officer I have to tell you about is the hospital chaplain, Major Norwood. It doesn't matter what your religious affiliation is, this man would talk to you. I have sent many soldiers to him that have had problems and needed someone to talk to, because they could not talk to the behavioral health representatives.

I have to tell you, this man has saved lives. There are soldiers who have reached such levels of hopelessness and frustration that suicide seemed like the only way out. Many have talked to him and I know for a fact he has saved lives.

Soldiers in the barracks are resorting to alcohol and even drugs. Recently several soldiers were punished for illegal drug use. If you ask the soldier, I ask you, if the soldiers were not feeling so lost and hopeless, would alcohol and drugs be such a problem? I think that bringing these issues to light is the first step toward fixing the problem.

The projected mission requirements mentioned by the Army have shown that more and more Guardsmen and Reservists are going to be called to active duty. This can only mean a steady stream of soldiers coming through medical hold. Some of the other members here have mentioned some other issues, well, First Sergeant mentioned medication. That seems to be the answer to everything in the Army, better living through chemicals. There are soldiers in my barracks who are taking twice the medication that he is. I once lined up all my empty pill bottles on the wall as a political statement and was punished for it—or excuse me, I was reprimanded.

I've been in medical hold since May 28th of last year. My unit has never called, they've never called the Army to see how I'm doing, they've never called my family, they've never notified my family, they've never even asked how I am. And you were talking about orders expiring, my orders are set to expire in 15 days. I'm just waiting to see whether I'm going to be paid after that.

Thank you.

[The prepared statement of Specialist McMichael follows:]

STATEMENT BY
SPC TIMOTHI M. McMICHAEL
A COMPANY, MEDICAL HOLD
FORT KNOX, KY 40121

BEFORE THE SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS AND INTERNATIONAL RELATIONS

The Hearing entitled
"Does the 'Total Force' Add Up? – The Impact of Health Protection Programs on Guard and Reserve Units"

March 30, 2004

Good Morning Congressman Shays and members of the committee I would like to thank you for giving me the chance to speak here in regards to the current plight of medical hold soldiers at Fort Knox. I can only hope that through my statement or testimony the committee will decide to send someone to Ft Knox to look into the conditions there. The soldiers would welcome the chance to talk to anyone that would listen to them on a one on one basis.

I would like to start with a brief background as to how I ended up mobilized for active duty. I was a member of the Inactive Regular Reserve, (IRR), from August of 2001 until February 27, 2003. I was contacted on or around the 23rd of that month by the retention NCO of the 463rd Combat Heavy Engineer Company about mobilizing with her unit. I had been a part of that unit many years before and told her I would be more then happy to help them out. She stated that they needed me badly and said she would arrange for an extension and bring me out of the IRR. The 27th of February was the day I was brought back to the regular reserve and assigned to the Headquarters and Headquarters Company of the 463rd Combat Heavy Engineers. I arrived at the unit only to be told that they no longer needed me for the deployment. They had all ready filled the slot. I asked the unit clerk what I should do for the next six months. He replied I could always attend drill. I informed him that I lived 300+ miles away and that wasn't going to happen. I asked them to find a deploying unit that needed me. The 380th Quartermaster Battalion was found to need to be in need of a soldier with my skills. I was transferred to that unit and met up with them at their mobilization station, Ft McCoy. The unit detachment at Ft McCoy was comprised of 61 soldiers. They consisted of 7 officers, 1 Chief Warrant Officer and 1 Sergeant Major with 52 enlisted soldiers. These soldiers were not all originally from this unit. I was informed that approximately 50-60% of the soldiers were from other units. The soldiers were assigned in order to bring the unit up to its required deployment strength. I feel that the Army needs to take a serious look at the consequences of this action. This unit experienced problems far beyond what is normal for such a small unit. I was informed of numerous Inspector General complaints as well as Congressional complaints filed by the soldiers of the 380th. I actually witnessed a Sergeant First Class throw away the fax a soldier had received from her Congressman's Office. She had received a blank form so that she could file a complaint. I pulled it out

of the trash and made sure she received it. I have served in one form or another for 18 years in the military and can say without a doubt that this was the single worst unit I have ever been apart of. This Committee wants to hear about the medical hold issues and therefore I will not get into the full details of what I witnessed while assigned to the 380th. I hope that some where down the line I can give a full accounting of what occurred.

The original injury that brought me into the medical hold quagmire was a simple accident. I tore the muscles in my stomach while preparing for a physical fitness test. I went on sick call and was informed that I had ruptured my abdominal wall. I was then assigned to the medical hold unit. I have had to divide my medical hold experiences based on the two military bases where they occurred. The important points of my medical care received at Ft McCoy are listed first.

I was referred to a civilian gastroencrinologist, (GNT) because the doctor at Ft McCoy wasn't sure that there wasn't another cause for my stomach pain. The GNT sent me to see a surgeon to repair the umbilical hernia he had found. I had been diagnosed with left sciatica shortly after I was assigned to medical hold. I finally went to see a doctor when it reached the point when I could not walk. I was put on 10 days quarters, to cover me until I went in for an epidural injection. The next day MSG Canaday, my supervisor, SFC Swansinger, med hold NCOIC, and SFC Cox, the medical clinic NCOIC, informed me that my epidural had been moved up to the next day and that I had to move out of my semiprivate room on the second floor to the open bay on the 1st floor. MAJ Piper, the Physician Assistant who is in charge of the medical care for all medical hold soldiers, was concerned that I might hurt myself walking up the stairs. I was told the fact that I had been going up a down those same stairs for the last 4 weeks was immaterial. I asked about the other soldiers who were on crutches or had other back, neck or leg injuries and was told to "shut the hell up"..."it's none of your God damn business." I had the epidural injection and notified MAJ Piper that the anthesiiologist had stated that I would need at least 1-2 more injections. He stated that he had nothing in front of him stating that. I had to go to the hospital for a contrasting CT and picked up a note from the anthiesiologist while I was they're stating that I would need the further injections. I supplied the note about the epidurals to MAJ Piper who then stated "NO!" I was amazed that here was a "physician's assistant" over ruling a doctor. The GNT doctor called to inform me that they were sending me to the Mayo Clinic. Tuesday morning the Mayo Clinic called stating they wanted me there the following Wednesday morning. I informed MAJ Piper who then informed me that all my appointment were cancelled and he was sending me to Ft Knox because I had too many "issues". I was then transferred to Ft Knox the following Tuesday. Ft McCoy conveniently forgot to send all of the doctor's reports to Ft Knox. Ft Knox decided there wasn't anything seriously wrong with me and was going to send me home. I had to get the surgeon from the civilian hospital to fax down his report that I needed immediate umbilical hernia repair. I was operated on at Ft Knox 6 days later. I was the exception to the rule at that time. Soldiers had been at Ft Knox waiting 3-4 months for surgery at that time. The soldier who also received a hernia operation at the same time as I did had been their 4-5 months at that time.

The amount of time it takes to get into a specialty clinic has declined since I first arrived at Ft Knox. Soldiers would routinely wait 3-4 months to see orthopedics. I have seen soldier get into orthopedics to see a PA in as little as one week. It often takes a little longer to get to see a doctor. However, many soldiers have come to me to complain that they are no longer able to get second opinions from orthopedics. I would not normally think this is an issue of concern, but if someone is facing surgery they need that second opinion.

There are several issues about the living conditions experienced by the Medical Hold soldiers at Ft Knox, which I have been asked to address here today. I admit that while each of the issues taken by itself may not appear to be of much importance. However, when taken as a whole, the quality of life for the med hold soldiers takes on an ominous feeling.

First, I need to talk about how the conditions were when I first arrived. The soldiers were housed in two barracks building 853 and building 6822. Building 6822 was a "World War II" style barracks. This consisted of open bays; shower room and individual toilet stalls. This barracks was so old and dilapidated that the soldiers were not permitted to install air conditioners in the windows. They were even limiting the number of fans that could be used. The building next door was condemned, which raised serious concerns as to whether or not our building had also been condemned. (The soldiers at Ft McCoy were at one time housed in buildings that had been condemned. The command had actually gone through and removed the condemned signs prior to their occupancy. There were some buildings, reportedly, where they missed a few signs.) The soldiers were concerned as to the structural safety of building 6822. The command moved the soldiers out of 6822 on July 28th. The roof collapsed on July 30th. It turns out the soldiers actually weren't supposed to move out until August 1st or 2nd. The command saved some soldier's lives by moving us early.

The condition of building 1475 when we arrived was horrendous. The general appearance of this building was unbelievable. Paint was peeling just about everywhere. The several showers had some type of black tar dripping from the ceiling. Rust and calcium deposits in every shower stall. The water pressure was gone in several showers. The sewer pipes were so clogged it would back up into the stationary tubs. Pipes were leaking all over the place. The air conditioners were on in the rooms at that time, some leaking out in the middle of the floors. The safety runners on the stairs are broken or missing in a lot of places. Tiles were broken, stained or missing in every hallway. There was a reoccurring problem with the hot water in building 1475-there was none. (I must definitely give credit to the FT Knox repair people. I personally called them about the hot water problem several times and each time they were there quickly.) The unit that had had the building before us did not make many repairs prior to departing. The overall cleanliness was poor. It proved to be almost impossible to get any kind of cleaning supplies from the Med hold supply office. The soldiers resorted to purchasing their own cleaning supplies to try and improve the place. Soldiers from 1475 attended some type of repair classes so they could do some of the work themselves. The soldiers are trying, but their hands are tied due to a lack of supplies and funding.

The Assistant Secretary of Defense, (Health Affairs), David S. C. Chu has issued a memorandum dated 29 OCT 03 which addresses the living conditions for medical hold soldiers. The attached memorandum, (exhibit 1), states the following:

> All members of the Armed Forces who are in a "medical hold" status and are required to reside away from their private residences while in "medical hold" shall be provided uniform lodging in quality and type for the area where they are located. It is particularly important that Reserve Component members on active duty receive the same quality and type of lodging and support including transportation that other active duty members receive. Such accommodations may consist of visiting quarters, temporary lodging facilities, or equivalent rental accommodations on the private economy typically provided to TDY personnel when such visiting quarters or temporary lodging facilities are not available. In all cases, the actual housing provided shall accommodate the medical condition of the member.

The memorandum also provides a copy of Army Regulation 210-50, table 4-2. This table lists the minimum standards of acceptable space and privacy for soldiers. This becomes particularly important when discussing building 1474. This building houses officers and senior enlisted soldiers. I have to be brutally honest here; building 1475 is in better condition then 1474. I have set in on discussion groups in building 1474 and walked feeling sorry for the officers forced to live in such deplorable conditions. I am hoping that maybe the committee can get a better answer out of the command then I could. Why is Ft Knox disregarding a memorandum written by an Assistant Secretary of Defense? Why is Ft Knox disregarding an Army Regulation?

This brings me to an important issue that I have brought to the attention of the command numerous times. I have stated that there is a serious safety issue that needs to be address with regards to building 1475. There is no master key for the building. I have never before in my military career been in a building that did not have a master key for every room. The only way anyone can get in a room is if there is a spare key in the key box in the platoon sergeant's office. If there is no spare or there is no one with a key to the key box they are out of luck. What happens if a soldier hurts himself and we need to get into the room? They have to break down the door. This is the first time I have ever seen a building where the CQ does not have a master key. I have witnessed soldiers climbing out second story windows in order to climb into their window so they can get back in their room. This is unacceptable, and unfortunately almost impossible to fix. I spoke with the post locksmith. He stated that the locks in 1475 were so screwed up that they would need at least 5-7 master keys. There are that many different types of locks in that building. The command responds to any question about the keys with "we are working on it".

The national attention Ft Knox Med hold received last fall has resulted in some gains. There were promises of new carpet, beds, plumbing etc. We received new mattresses, not enough came in for every single one to be exchanged but many were. They installed new toilet paper dispensers in November. They just installed new wall

lockers three weeks ago. I have been informed that as with everything else it all comes down to money. The more money that becomes available the more work they will do on our barracks. I have a question for this committee. How much money did Ft Knox spend on the new landscaping and plants at the main gates?

I arrived at Ft Knox and was issued a pillow, pillowcase and two sheets from building 853's supply. The supply office in 853 was responsible for both 6822 and 853. The soldiers transferred from building 6822 to 1475. They took what sheets and so forth that they had with them. Many soldiers were ordered to turn their sheets back to 853 shortly after the transfer. I was ordered to turn in my sheets and pillow around the middle of September. I was also threatened with a payroll deduction if I did not return my sheets. The soldiers went the entire month of September with no linen. They had no sheets, pillows or blankets. The soldiers complained to the Sergeants' in charge. The NCOIC of building 1475 was a SGT Pyatt. He kept stating at formation that the command was aware of the situation and was working on it. The supply specialist for 1475 stated something about previously soldiers had not turned in their blankets and that was why they did not want to give us any new blankets. I do not know whether or not this is true and do not care. I only cared about the fact that my soldiers did not have any sheets or blankets. I have to draw your attention to the fact that many of these soldiers were recently returned from the desert. The desert was reaching 140 degrees while Ft Knox was reaching the low to mid 40's at that time. They were suffering. I personally phoned a local newspaper to give them the story. I then phoned my Congressman. I was on the phone with my Congressman when the Assistant NCOIC of the building SGT Whistle came running in and screamed at me that I could not be talking to me Congressman. I stated that I could and that I would continue talking with my Congressman's office until I was finished. This was on a Thursday. The linen arrived at the barracks on Friday. I can not say whether one had anything to do with the other, nor do I care. The following Tuesday I was called into the Commander's office to have a conference with the Commander and the First Sergeant in order to have the chain of command explained to me. The Commander informed me at that time that she had not learned of the linen issue until the previous Thursday. She then proceeded to inform me of her displeasure at the numerous IG complaints she had received. (I believe she stated 8 at that time.) I reiterated my concern that the soldiers were experiencing a 100 degree difference between where they had been and where they were now. The soldier's were suffering. The Hospital Chaplain had held a meeting the week before with the lower enlisted, everyone from 1475 complained about the linen issue. The soldiers had ended up going for around 30 days without linen or blankets before they were issued. I was asked why I was so concerned about this when this particular issue actually had no relevance to me. I had my own sheets, blankets and pillows. I was only concerned about my fellow soldiers.

There have been serious issues regarding the command structure of Med Hold in the past. I arrived July 22nd and Sergeant's/E-5s, (SGT), were in charge of the soldiers in building 6822. Three days after I arrived there were too many soldiers arriving so they opened up building 6823, with E-5s in charge. The move to building 1475 saw the continuation of the E-5 command. The number of soldiers in building 1475 approached

160 in early September/October. Sgt Pyatt was the Non-commissioned-Officer-in-Charge, (NCOIC) and SGT Whistle his assistant. There were three platoons of about 50 soldiers. E-5s commanded the platoons. There was also a platoon of senior NCOs that fell in with our formations for accountability and any additional information that needed to be put out. Nominally they fell under the command of the building NCOIC, SGT Pyatt, but they tended to do their own thing. The senior NCOs had some authority issues and confrontations with SGT Pyatt. I personally heard the phrase "Don't confuse your rank with my authority", uttered many times. I was one of the soldiers who complained about E-5s being in charge. I made the complaint that they were not qualified to handle that many soldiers. Staff Sergeant's/E-6s and Sergeant First Class/E-7s receive training at their Basic Non-commissioned Officer's Course and Advanced Non-commissioned Officer's Course on how to handle and help soldiers. They learn how to spot a soldier in crisis and how to get a soldier the help he/she may need. I warned the Commander and 1SG back in October that sooner or later someone was going to try either committing suicide or homicide. I informed them that the E-5s were unable to cope with such a large number of soldiers. There were several senior Non-commissioned Officers, (NCOs), including Command Sergeant Major, (CSM), Abitz who were lobbying for E-7s to take over the command of building 1475. Building 853 had E-7s in charge and a normal platoon/squad structure at that time. The entire med hold number around 462 soldiers at that time. The 1LT who commanded was assisted by a First Sergeant, (1SG), with one SSG and 2 SGTs to assist on the administrative side of things. The shear complexity of having to provide for two buildings, in my opinion, was staggering. This had to have lead to the linen issue as well as the barracks maintenance issue. The command rectified the situation by placing the E-7s in charge. The med hold was split into two separate companies, one of which is commanded by a captain. This seems to have freed up the command so they are able to devote more attention to the individual soldiers.

I was approached by many of my fellow soldiers after they heard I would be appearing before this committee. I asked my fellow soldiers to tell me their stories. I was given permission by several of these soldiers to relate their stories to you. The following section, with the attached exhibits, contains just a few of the horror stories that are created everyday at Ft Knox.

The story that I have to start with is the story of SGT Corcoran-Booker. I picked her story to tell you because it is a prime example of how the Army discriminates against National Guard and Reserve soldiers. I have attached a copy of the result from SGT Corcoran-Booker's Physical Evaluation Board Proceedings, (PEB). (Exhibit 2)

SGT Corcoran-Booker was quietly going about her business serving with her unit in Iraq. She had a toothache and didn't think much about it. She put off getting it taken care of until she became serious ill while in the field. She was taken to the field hospital where they subsequently discovered that the infection had spread to her pancreas. The result of this spread was the destruction of her body's ability to produce insulin, type I diabetes. She was evacuated back to Ft Knox where she under went a Medical Board. The results of the medical board and other supporting documentation where sent to the PEB at Ft Sam Houston. The finding of the PEB was that she was entitled to no disability benefits and no severance. They declared that her condition existed prior to service, (EPTS). The PEB actually went on to state, "The USAPDA has determined that

all diabetes developing within 2 years of entry/activation is EPTS." I find it totally amazing that all diabetes is declared as existing prior to service. The Army sits here and states that there is no difference between Active Duty and National Guard/Reserve soldiers. The PEB just stated that there is. A soldier on active duty for two or more years receives disability for diabetes. A soldier serving less then two years does not. The minimum enlistment in the Active Duty Army is two years.

SGT Corcoran-Booker will win her appeal of this decision for several reasons. The most important is the simple fact that had the diabetes existed prior to active duty as the PEB claims she would have been dead long ago. It does not matter whether she wins the appeal or not, she should not have placed in this position in the first place. The way she has been treated is an embarrassment to the Army.

I also need to mention a soldier by the name of SGT Gino Hults. SGT Hults was only a specialist when I first arrived at Ft Knox. I was at the promotion ceremony for him last December. (I believe that was the right month.) There have been so few promotions for the soldiers in med hold. I can only assume it is because their units have forgotten about them. I digress, back to Gino's story. This is a soldier with one of the most upbeat positive attitudes that I have seen in a long while. I recently sat down and spoke with him. I was stunned and shocked to discover that he has been in med hold for over 3 (three) years. I do not have all the details of what is wrong with him or what he is currently waiting there for. I can only ask that the committee review his case and try to find some help for this soldier. Why is he still at Ft Knox? Why does he have to be there, can't he be sent home for his medical care? This would at least let him be near his family. I would like to formally request that Congress look into the individual soldiers and the length of time they have spent in med hold. I would think that anyone who has spent more then one year in medical hold should be returned home to receive medical care near his family. How many more Gino Hults are out there?

SGT Hults is not the only soldier who has spent an unreasonable amount of time in med hold. There is a soldier at Ft McCoy who has spent 6 (six) months waiting for a dental plate. SGT Michael Nicholas spent from February to August of 2003 waiting for a dental plate. I would like to know why this soldier had to sit in medical hold at Ft McCoy for six months for something which could have been bought from a local civilian dentist in less the 14 days? This is something that needs to be looked into. This soldier spent 6 months separated from his family due to essentially bureaucratic red tape. The Army wasn't allowed to get his dental plate from a local dentist. Where was the consideration for the soldier's morale? Did anyone care about his family? How many soldiers are still sitting at Ft McCoy waiting for medical care? I left Ft McCoy on July 22nd last year. I had a chance to see the manning roster for med hold at McCoy prior to my leaving. SGT Nicholas was not the only person who had been there for such a long time. I recently spoke with SGT Nicholas, who is now stationed at Ft McCoy. I asked his permission to present his name and story to this committee. SGT Nicholas informed me that there were still soldiers at McCoy who are waiting for the proper medical care they deserve. The medical holdover at Ft McCoy has a list of every soldier assigned, which includes when they were first assigned. I tried to obtain a copy of this, with the appropriate privacy issues blacked out, I was denied.

I would also like to give you a brief synopsis of SGT Madeline Dreasky's tale. SGT Dreasky is currently pending a physical evaluation board. She recently fell and hurt her neck. She was referred to the orthopedic clinic from the emergency room for this injury. The decision of the orthopedic doctor was that since she was being medically boarded out she could just wait and take care of it after she leaves. He actually refused to treat her because she was already being medically discharged for another reason. This would in and of itself be a sad story. However, what makes this tragic is the fact that I have heard this story from many other soldiers. I have attached a copy of the orthopedic report as exhibit 3.

The final soldier I would like to talk about is CPT Anthony N. Harmon. CPT Harmon and I first met at Ft McCoy. He was assigned to the 6015th General Services Unit, which is mobilized to provide support at Ft McCoy. CPT Harmon worked at Ft McCoy as a Judge Advocate General Attorney helping the deploying soldiers with their legal problems. This is a soldier who went out of his way to help as many people as he could.

CPT Harmon was involved in a traffic accident on 4 NOV 03 where he sustained several injuries. He was advised to remain home by his civilian doctor and was granted convalescent on 20 NOV 03. He was granted an extension of convalescent leave on 5 DEC 03. I have attached the notes he supplied me verifying his story, (exhibit 4). The letter from his commander dated 8 JAN 04 is what I would like to call to the attention of the Committee. His commander alludes to an "alleged" injury. There is ample documentation to support that he was injured in the accident. The orders his Commander dictates in paragraph three should be of particular concern to the committee. I personally fail to see what CPT Harmon has done to warrant such language or actions.

I have spoken at great lengths with CPT Harmon and I am sure that my brief outline of his story fails to do him justice. I can only hope that the members of this committee will take the time to also talk to him.

The individual soldiers I have mentioned are but a drop in the bucket compared to who is still out there. I have spoken probably with hundreds of soldiers since I was placed in med hold. I can only say that the uniform consensus is one of frustration, disappointment and anger. I have had soldiers with 15, 20 even 25 years in the military tell me they are disgusted. Soldiers have told the various reporters who have come by to interview them that they are no longer proud to wear the uniform. What happened? This is a question that has to be answered before an entire generation of soldiers slipped away. The Army cannot afford to lose the number of Senior Non-Commissioned Officers it is losing everyday. The Army has to do something to encourage them to stay.

The testimony of COL Armstrong before the Total Force Subcommittee of the Committee on Armed Services dealt with Reserve Component Healthcare. COL Armstrong made several statements, which I think need to be clarified,

1. **"The vast majority of the medical holdover population handled at Fort Knox never deployed with their unit, many of whom had chronic diseases or injuries requiring extensive treatment regimens."** This was true in the beginning. The majority of the medical hold soldiers at Ft McCoy, Ft Knox and Camp Atterbury consisted of soldiers who could not deploy with their units. The Army has since instituted a new policy consisting of a "25 day grace period". Medical issues discovered within the first 25 days result in the soldier being demobilized and returned to their unit. This has contributed significantly to reducing the number of non-deployed medical holdover soldiers. The makeup of the soldiers at the Ft Knox med hold has gradually shifted toward a majority comprised of soldiers returning from the desert. The soldiers who had never gone overseas have gradually been replaced. The vast majority of them have departed through the medical boards. There have occasionally been soldiers that have left FT Knox to join back up with their units in the desert.
2. **"Soldiers that had significant mobility issues were housed within the hospital itself."** Col Armstrong made this statement on 21 JAN 04. Col Pierce, the hospital commander, also stated the same thing during an interview with a local television reporter. She stated that the 7th floor of the hospital was for the mobility impaired soldiers. This news broadcast occurred sometime at the end of November. The television station received a call immediately following the broadcast instructing them to return to the hospital and take a close look at the nameplates on the door of each room on the 7th floor. The fact is that at the time of Col Pierce's statement the overwhelming majority of the rooms were occupied by Officers and Senior Enlisted. The Officers and Senior Enlisted were removed from the 7th floor a couple of weeks later. They currently occupy building 1474, which is addressed later in this report. I would like to inform the committee of the fact that when the officers and senior enlisted moved off of the 7th floor, the majority of the hospital rooms were transformed into offices. I also know for a fact that a soldier recovering from a broken back was placed on the second floor of building 853. This means that he has to walk up three flights of stairs to go to his room. The sergeant in charge of BLDG 1475 attempted to put another soldier with a broken back on the third floor of that building. Several soldiers informed him that this was not acceptable behavior and that they would take this up with JAG and the IG. He gave in and assigned the soldier to the first floor. I would ask that the committee simply ask COL Armstrong for the total number of soldier with mobility issues and how many are house in the hospital.
3. **"Medical holdover soldiers are part of the company chain of command to assist with command and control, appointment management and assignment of other duties within their military occupational specialty that are within limits of their medical profiles."** This statement of COL Armstrong's appears to be a blanket generality of the ideal conditions, which the command hopes to achieve. The reality of the situation at FT Knox is very much the opposite. I am

a 71L10, administrative specialist. I currently work as a permanent 12 to 8AM CQ, (charge of quarters). I am not doing my military occupational specialty, (MOS). I have interviewed many of my fellow medical hold soldiers and have found that the vast majority are not working anywhere near their MOS. I found an E-7, (Sergeant First Class) handing out towels at a base gym. I found a 95B, (Military Police officer) sweeping and mopping floors. How many soldiers work anywhere even remotely close to their MOS? I understand that many of the soldiers are limited by their profiles. Ft Knox is a basic training base as well as an advanced individual training facility. There are enough individual units and training units that enough jobs could be found to supply every soldier who wants a job. However, make busy jobs do absolutely nothing for the morale of the soldier. I have noticed a significant increase in the quality of the jobs soldiers are doing since SFC King took over as the 1SG in med hold. Soldiers would be sitting at desks in the hospital and their entire job consisted of waiting to answer one phone, when I arrived at Ft Knox. I have seen soldier trained as military truck drivers emptying trashcans. Why can't a soldier who is a qualified truck driver be assigned to drive some vehicle somewhere on Ft Knox? There has to be a unit or office somewhere that needs someone to drive supplies. The motor pool at FT Knox has hundreds of vans sitting there not being used. Why can't more of the vans be supplied to med hold, with the corresponding drivers? Why can't the drivers be utilized to start some sort of shuttle service on Ft Knox? Ft Knox currently has no shuttle service at all. Ft McCoy, as small as it is, had an on base shuttle service.

4. **"Soldiers are provided transportation to and from the hospital to meet appointment schedules, to and from the Post Exchange and Commissary, entertainment and dining facilities."** There are three vans assigned to the med hold unit. They consist of an off-post duty van, a sick call van and an on-post duty van. The post will not release any other vans. The post has a parking lot full of vans that just sit there, never moving. The members of my chain of command have repeatedly asked for more vehicles. Their requests were repeatedly turned down. The med hold transportation protocols dictate that soldiers needing to go off-post for a doctor will note their appointment in the appropriate log at the 7th floor CQ desk. The duty driver will contact the soldier the next morning and inform them of when they will be picked up for their appointment. However, if one soldier has an appointment at 7AM and another at 11AM both soldiers leave at the same time. The 11AM soldier gets dropped off at his appointment 4 hours early. The 7AM soldier is picked up after his appointment and then goes with the driver to wait until the 11AM soldier is done with his appointment. Ft McCoy has several vehicles, which are used to take the soldiers to their appointments. The rules at Ft McCoy require a soldier to depart 1-2 hours before his appointment, not half a day early. Why can't Ft Knox be ordered to release more vehicles for the use of med hold? The COL also states that the vehicles transport the soldiers to the PX, Commissary and other entertainment venues. The common terms for these types of trips are "morale runs". These tended to happen haphazardly in the past. There have even been periods of time where the duty drivers were not permitted to take soldiers to the airport or even off-post churches. These trips

would be forbidden until enough people complained and then they would start back up again there was another shortage of duty drivers. The duty driver would make PX or Walmart runs one week but the next week the van might not be available. There has been no readily apparent consistency in “”morale runs” since I have been here. I must say that recently there have been a number of trips to Walmart and the PX and the soldiers have been lead to believe that this is a permanent program.

What has occurred to me since the command found out I was going to testify.

1. I received a warning, granted it was set in a conversational tone and manner that I had better be sure of what I say. I had better be able to back everything up because I will be held accountable. I had better be able to prove what I have to say.
2. I was accused of being disrespectful and insubordinate to a field grade officer.
3. Last Monday I am called into a 1LT Richardson office to give her my medical records. She is one of the case managers. She is not my case manager, he was on leave. She states that LTC Angelo, (the Chief Surgeon), wants to review my records. He writes a review that actually includes to facts, which not true. I receive my records the next morning in time for my second appointment of the day.
4. My medical records were confiscated while I was at a clinic in the hospital. I went to leave the clinic and asked for my records. I was told they were not allowed to give them back to me. A member of the staff, who I refuse to identify at this time, stated that they had been told that the General wants to review my records. I was instructed to wait until some CPT came down to see me. A CPT Dietz, (I am not sure of the spelling.), came down and started to inform me that they need to onto my records for “Coding purposes”. I asked him what was this about the General wanting to see my records. He pulled me out into the hallway and stated that was not the case. He restated the story about coding. The individual clinics fill out coding sheets every time you visit them. I noticed his branch of service on his collar was either infantry or cavalry. I wonder why he had to read my medical records? I was informed that he was a member of LTC Angelo’s staff. Does this still give him the right to look in my records? The CPT left before my doctor came out of the clinic with my records in hand. I asked him what was going on and he informed me that he had been ordered to do a review of my records. They had actually been holding my records to get them to him. I only have one more question. Where did his review of my medical records go? It’s not in my medical records. Did that go to the General?
5. MAJ Roberts, my case manager, is ordered to tell me face to face about an appointment I already know about and to make me sign the acknowledgement. (Exhibit 5) I have never missed an appointment while at Ft Knox. I did reschedule two appointments because I was an inpatient at civilian hospitals at the time.

6. MAJ Moore from Legislative Affairs calls and speaks to me right after I returned from a medical procedure. I still had several medications floating around my system. She asks about where I am staying. I tell her about the trouble finding a place because the military bases are full right now and the hotels are too expensive. She offers to get me a room at Malone House. She then offers to help with my statement. I inform her it is not done due to the medications I have been on the past several days. She asks what ones, I tell her. The next thing I know she is ordering me not to drive and stating that she will get a hold of my Commander and inform her that she has to fly me out to DC. I obey her order and do not depart that evening as planned. I go to my doctor the next morning and get it in writing from him that I can drive to Walter Reed. I give it to the command and return to the barracks to pack. I am in the middle of packing when I receive a call from the first sergeant telling the per COL Mays, COL Pierce's assistant I am ordered to stop packing and wait. I am later called into the Commanders office where I am told that I will not be driving to DC on my own. They are not sure how I will be getting to DC but that I should wait for notification back at the barracks. I am informed that MAJ Moore has complained to several people and the there is a General involved as well as a couple of IGs and a bunch of Colonels. I am notified at 1526 that I have 34 minutes to pack for a flight. MAJ Moore had relayed to the command at FT Knox that I was being forced to drive. This is not an adequate representation of the truth. I had asked to drive. She stated that I was denied any assistance in finding a place to stay by my command. It is not their responsibility. It is Walter Reeds. Walter Reed was going to issue me a statement of "non-availability" to cover me for the cost of staying in a hotel. I was given a list of hotels and had called many of them already when I spoke with MAJ Moore. MAJ Moore also mentions concern over whether or not I can testify if I am on so mush medication. I wonder where her motives lie.

The following are some of the key points that need to be addressed concerning Behavioral Health at Ft Knox:

1. The Behavioral Health personnel seem to be more concerned with basic trainees than with the Med Hold soldiers.
2. Soldier with alcohol or drug problems routinely ask for drug and alcohol counseling and a denied. I have witnessed soldiers with alcohol problems being turned away. My roommate at Ft McCoy was sent to Ft Knox for evaluation by the BHD. He stated that he was told that he was National Guard and that they were unable to help him. They sent back to Ft McCoy where he received two DUI and was reduced to E-1.
3. I have witnessed soldiers with behavioral problems spend months waiting to get in to see BHD. I dealt with a soldier who actually went AWOL because no one would see him at BHD. I talked him into returning. He had spent 3-4 months waiting on a psychological chapter.
4. The doctors in BHD seem more concerned with how long a soldier has been in med hold then in helping him with his problems.
5. A soldier in 1475 was seen at BH on Tuesday and on Wednesday tried to commit suicide. The night before he was seen in BHD he had mixed alcohol and a lot of

Valium. He had been taken to the ER and had his stomach pumped. The 1SG took him to the BHD on Tuesday morning. They refused to put him into the drug and alcohol treatment program. I was told that it was an inpatient program and that had he gone into it he would not have been in the barracks Wednesday night. The Troop Commander and the Company Commander were asked why he was returned to the barracks Tuesday. They stated, "We're looking into it." I found out a week after he had tried to commit suicide that he had also stated that he was going to get a gun and kill everyone in the barracks.

6. The overall feeling is that Med Hold soldiers do not seem to matter. The Army has said that there is no difference between Active Duty and Reserve Soldiers. I understand that there is a long history of basic trainees committing suicide. That does not give the BHD office the right to take a basic trainee before a med hold soldier. They need to learn that the med hold soldiers are in just as much crisis as the basic trainees if not more.
7. I personally have had three appointment cancelled on me by my doctor. All of the appointments were cancelled because he was not going to be in the office. One of the days that had been cancelled I went to the office any way to get a prescription refilled. He was in the office. An active duty person took up my appointment. I did not push the issue that day because I was seen and had my script renewed. He did however, spend a great deal of time trying to get a hold of someone in my command or my doctor to discuss the fact that I had been in med hold for so long. I felt that this was addressing my issues or problems but rather ignoring them in favor of "getting me out of here".
8. I later went to the BHD office requesting to see another doctor and was told NO. When the doctor I was requesting not to see came to get me in the waiting room that I did not want to talk with him I was accused of disrespect and insubordination. I do have the right to refuse treatment and have let the command know that I refuse treatment from him.
9. The Murder/suicides that took place at Ft Bragg resulted in the Army saying that returning soldiers will be counseled. I worked in the SRC at Ft McCoy an I know that soldiers who request counseling upon their return are routinely denied any type of counseling. The questionnaire they fill out has a box they check to request to speak to someone. The questionnaires are often not even looked at until after long after the unit has already left for home.

I must apologize for the short content of this statement. I have found it exceedingly difficult to compose a dispassionate reporting of the medical hold issues while still maintaining my own medical care and treatment. I have many more facts and notes which I would like more time to compile for more effect.
Thank You.

Exhibit 1a

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

OCT 2 9 2003

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE

SUBJECT: Personnel on Medical Hold

This memorandum establishes policy applicable to military personnel placed on "medical hold" while awaiting medical care and/or resolution of their deployment or separation status because of a medical issue.

All active duty personnel, to include Reserve Component members on active duty orders for more than 30 days, have the highest priority for health care appointments. TRICARE has established access to care standards for routine and specialty care – no longer than one week for non-urgent, routine medical care, and no longer than one month for specialty care appointments. These standards represent the *minimum* threshold for access to health care. For all personnel on "medical hold," medical commanders will ensure that specialty care services are available uniformly within two weeks of identifying the need for an appointment.

If health care services are not available within the medical treatment facility according to these standards, medical commanders shall promptly refer patients to other military, Veteran Affairs, or civilian sources of care, to include both TRICARE network or non-network providers.

All members of the Armed Forces who are in a "medical hold" status and are required to reside away from their private residences while in "medical hold" shall be provided uniform lodging in quality and type for the area where they are located. It is particularly important that Reserve Component members on active duty receive the same quality and type of lodging and support including transportation that other active duty members receive. Such accommodations may consist of visiting quarters, temporary lodging facilities, or equivalent rental accommodations on the private economy typically provided to TDY personnel when such visiting quarters or temporary lodging facilities are not available. In all cases, the actual housing provided shall accommodate the medical condition of the member.

Given the significant number of personnel currently on medical hold, I request weekly Service reports be submitted through December 31, 2003 to the Assistant

Exhibit 1b

Secretary of Defense (Health Affairs) detailing the total number of personnel on medical hold; the number on medical hold for more than 30 days; and the number on medical hold for more than 60 days, displayed by active duty and activated Guard and Reserve Component members. Reporting periodicity will be re-evaluated after this initial 60-day period.

Existing policies for periodic medical and dental assessments and pre- and post-deployment screening must also be adhered to for all active duty and Reserve Component members to ensure individual medical readiness. The Assistant Secretary of Defense (Health Affairs) has already requested a quality assurance report on pre- and post-deployment screening from each of the Services.

This policy and reporting requirement is effective immediately.

David S. C. Chu

cc:
Service Chiefs of Staff
ASD (HA)
ASD (RA)
Assistant Service Secretaries (M&RA)

Exhibit 1c

a. The installation commander will operate and maintain UPH and GH in accord with this regulation, and will ensure that the level of living experienced by UPH and GH residents meets or exceeds the following standards:

(1) The housing must provide a decent, safe, sanitary, and habitable accommodation in good repair. Additionally, UPH(TDY) and GH should provide a level of facilities, operations, and services comparable to a good quality, modestly-priced commercial hotel or motel.

(2) The minimum space and privacy standards for UPH in table 4-2 will be used to determine adequacy. These standards will apply worldwide. Housing managers should avoid confusing these standards with construction design standards. (See para 4-2c .)

Table 4-2. iMnimum standards of acceptable space and privacy, existing UPH inventory (See notes 1 and 2.)

Grade: 03 and above and CW3, CW4, and CW5 **UPH(PP):** 400 square feet net living area: living room, bedroom, private bath, access to kitchen or officer dining facility receiving APF support. **UPH(TDY):** 250 square feet net living area: private room, private bath.
Grade: 01, 02, W01, and CW2 **UPH(PP):** 250 square feet net living area: sleeping/living room, private bath **UPH(TDY):** 250 square feet net living area: private room, private bath.
Grade: E7 thru E9 **UPH(PP):** 270 square feet net living area: private room, private bath. **UPH(TDY):** 250 square feet net living area: private room, bath shared with not more than one other.
Grade: E5 and E6 **UPH(PP):** 135 square feet net living area: private room, bath shared with not more than one other. (See notes 3 and 4.) > **UPH(TDY):** 135 square feet net living area: private room, bath shared with not more than one other. (See note 3.)
Grade: E1 thru E4 (except E1 recruits and trainees) **UPH(PP):** 90 square feet net living area: not more than four per room, central bath. (See note 3.) **UPH(TDY):** 90 square feet net living area: not more than four per room, except in open bay, central bath. (See note 3.)
Grade: E1 recruits and trainees **UPH(PP):** 72 square feet net living area: open bay, central bath. **UPH(TDY):** 72 square feet net living area: open bay, central bath.

Notes:

1. The net living area of a private room or suite is measured from the inside face of the peripheral wall and includes all such enclosed, unshared spaces and partitions. The net living area is a shared room comprises the clear area in the sleeping room allocated for an individual's bed, locker, and circulation: it excludes lounges, bathrooms, hallways, door swing areas, and storage areas designated for military mobility and/or field gear or equipment. In open bay, net living area is one equal share per person. The open bay comprises all within the peripheral walls.

2. Standards for permanent party civilians are based on the comparable military grades in table 3-1. TDY civilians are housed as officers.

Exhibit 2

Ireland ACH

PHYSICAL EVALUATION BOARD (PEB) PROCEEDINGS
For use of this form, see AR 635-40; the proponent agency is USAPDA

1. NAME (Last, First, Middle Initial) CorcoranBrooker, Clare E.	2. RANK SGT	3. PEBD: 98.09.[illegible] BASD: UNKNOWN
4. SOCIAL SECURITY NUMBER [redacted]	5. PMOS 55B10	6.BRANCH / COMPONENT TEMPORARY TOUR OF ACTIVE DUTY: RESERVES
7. THE PEB CONSISTED OF THE INDIVIDUALS INDICATED IN EXHIBIT A		
DATE CONVENED 04.02.05	AT (Location Including ZIP Code) FORT SAM HOUSTON, TEXAS 78234-5010	

c. Intentional misconduct, willful neglect or unauthorized absence
d. While entitled to basic pay (Incurred or aggravated)
e. In LD in the time of national emergency on after 14 SEP 75 (Incurred or aggravated)
f. Proximate result of performing duty
g. Recommended disability percentage

8. THE BOARD CONSIDERED THE MEMBER'S CONDITION DESCRIBED IN THE RECORDS.
EACH DISABILITY IS LISTED BELOW in descending order of significance

VA CODE a	DISABILITY DESCRIPTION b	c	d	e	f	g
7913	ADULT ONSET TYPE 1 DIABETES MELLITUS, REQUIRING INSULIN AND RESTRICTED DIET. (MEBD DIAG 1, NARSUM) (MEBD DIAG 2 NOT UNFITTING, NOT RATED) Based on a review of the objective medical evidence of record, the findings of the PEB are the Soldier's medical and physical impairment prevents reasonable performance of duties required by grade and military specialty. There is compelling evidence to support a finding that the current condition existed prior to service (EPTS) and was not permanently aggravated by such service. ~~The USAPDA has determined that all disabilities developing within 2 years of unsatisfactory in EPTS. Soldier was activated July 2003, discharged 25 October 2003.~~ The voting membership of the PEB in this case included an officer of the Reserve Component. You are advised that a member of an armed force may not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury that he/she has.	N	N	N	N	---%

9. THE BOARD FINDS THE SOLDIER IS PHYSICALLY UNFIT AND RECOMMENDS A COMBINED RATING OF: ---%

AND THAT THE SOLDIER'S DISPOSITION BE: Separated from the service without disability benefits

10. IF RETIRED BECAUSE OF DISABILITY, THE BOARD MAKES THE RECOMMENDED FINDING THAT:

A. THE SOLDIER'S RETIREMENT IS NOT BASED ON DISABILITY FROM INJURY OR DISEASE RECEIVED IN THE LINE OF DUTY AS A DIRECT RESULT OF ARMED CONFLICT OR CAUSED BY AN INSTRUMENTALITY OF WAR AND INCURRING IN LINE OF DUTY DURING A PERIOD OF WAR AS DEFINED BY LAW.

B. EVIDENCE OF RECORD REFLECTS THE SOLDIER WAS NOT A MEMBER OR OBLIGATED TO BECOME A MEMBER OF AN ARMED FORCE OR RESERVE THEREOF, OR THE NOAA OR THE USPHS ON 24 SEPTEMBER 1975.

C. THE DISABILITY DID NOT RESULT FROM A COMBAT RELATED INJURY AS DEFINED IN 26 U.S.C. 104.

11. EXHIBITS (Identify each)

A. Appointing Orders	E. Orders	I. Ret Points
B. Medical Board Proceedings	F. Flag Stmt	J. LES
C. Cdr's Stmt	G. PQR	K. APFT
D. LOD	H. DD Form 214	

12. TYPED NAME, GRADE, BRANCH OF PRESIDENT	SIGNATURE	DATE
MARTIN L. REYES, COL, TC	Martin L. Reyes	04.02.[illegible]

DA FORM 199, JUN. 97

Exhibit 7

[redacted]

Exhibit 4a

DEPARTMENT OF THE ARMY
Mobilization Support Battalion
2770 W. 12th Ave
Fort McCoy, Wisconsin 54656-5125

AFRC-FM-COM-S

8 January 2004

MEMORANDUM FOR CPT Anthony N. Harmon, [redacted], 1332 Halladay Drive, Batavia, Illinois 60510-4525

SUBJECT: Order to Report; Revocation of Pass Privileges

1. Through a telephone conversation on 7 January 2004, I ordered you to report to my office at 1300 on 8 January 2003. I will ensure that you are escorted from my office to the Troop Medical Clinic for your 1330 appointment. After your appointment, you will be escorted to either an appropriate medical facility, or on post billeting.

2. You have been on an extended absence from your duties for an alleged injury caused by a car accident that occurred approximately 70 days ago. You have been directed to report back to Fort McCoy for a military medical official to review your fitness for duty status. To date, you have failed to report as required.

3. Effective immediately, I am revoking your off post pass privileges. You are required to stay on post until I direct otherwise. If you feel for any reason that you must leave post, you shall request directly from me permission to leave post. Your request must include the reason that you need to leave and the time that you will return to post. You must notify CPT Kurt Mueller, HHC Commander, or me directly that you have returned if your request to leave post is granted. I will consider you Absent Without Leave if you fail to notify me or CPT Mueller that you have returned to post.

4. I expect you to comply fully with this order. I also expect you to seek clarification directly from me if you have any questions about the revocation of your pass privileges. I will consider UCMJ action if you fail to comply with this order.

MICHAEL A. McFADDEN
LTC, MP
Commanding

Exhibit 4b

DEPARTMENT OF THE ARMY
STAFF JUDGE ADVOCATE OFFICE
HEADQUARTERS, FORT McCOY
100 E. HEADQUARTERS ROAD
FORT McCOY, WISCONSIN 54656

REPLY TO ATTENTION OF

AFRC-FM-JA

5 December 2003

MEMORANDUM FOR CPT Anthony N. Harmon, 1332 Halladay Drive, Batavia, Illinois, 60510

SUBJECT: Extension of Convalescent Leave

1. Your request for an extension of convalescent leave has been approved. A review of your current medical information by the Fort McCoy Troop Medical Clinic resulted in their recommending approval of your request. Your request was subsequently approved by the 6015th Garrison Support Unit, Headquarters and Headquarters Company for the period 8 December 2003 through 7 January 2004. The Fort McCoy Troop Medical Clinic can only recommend convalescent leave in thirty (30) day increments.

2. Continue to supply MAJ South with copies of your medical records as they are accumulated and appointments with medical providers. It is your responsibility to ensure that she has all your medical records. Make sure each provider has a medical release signed by you releasing your records to the United States Army.

3. We wish you a speedy recovery and look forward to your return.

RHETT S. BILEK
COL, JA, USAR
Deputy SJA for Soldier Readiness

Exhibit 4c

DEPARTMENT OF THE ARMY
Headquarters, Fort McCoy
100 E. Headquarters Rd.
Fort McCoy, Wisconsin 54656

REPLY TO ATTENTION OF

AFRC-FM-JA

20 November 2003

MEMORANDUM FOR CPT Anthony N. Harmon, 1332 Halladay Drive, Batavia, IL 60177

SUBJECT: Direct Order Regarding Convalescent Leave and Reporting Requirements

1. You are authorized convalescent leave at home through 08 December 2003. You are then ordered to report to me at the Fort McCoy Legal Assistance and Claims Office, Building 106, at 0730 hours, 09 December 2003 with follow up at the TMC to see MAJ Piper. You are to bring all your medical records with you. At that time the Fort McCoy TMC will determine whether follow up care, if any, will be performed at Fort McCoy or Fort Knox, Kentucky. Continued care at home is not an option. Failure to report will place you in an AWOL status.

2. You are ordered to stay at home pursuant to your convalescent status except for required medical appointments. You will report daily, by telephone, Monday through Friday except for holidays, to either LTC Wilson or myself regarding your condition and provide the dates and providers for each of your medical appointments, care or treatments. LTC Wilson can be contacted at 608-388-7822; myself at 608-388-7354.

3. We wish you a speedy recovery and look forward to your return.

RHETT S. BILEK
COL, JA, USAR
Deputy SJA for Soldier Readiness

Exhibit 4d

LOYOLA
UNIVERSITY
HEALTH SYSTEM
Loyola University Chicago

Loyola University Medical Center
2160 South First Avenue
Maywood, Illinois 60153

December 5, 2003

RE: HARMON, Anthony
MR: [redacted]

To Whom It May Concern:

Mr. Anthony Harmon was seen in the Neurology Outpatient Clinic on December 4, 2003. Since his last visit, he had an MRI of the brain that was unremarkable. MRI of the cervical spine showed no evidence of fracture and normal vertebral body alignment. There were no abnormalities of the craniocervical junction. There was no evidence of cord compression. There was minimal disc bulging at C4-5. At C5-6, there was disc bulging with a small superimposed right postereolateral disc herniation. No abnormalities were noted at C6-7 or at C7-T1. Results of neuropsychological testing demonstrated antegrade memory of the normal mean for his age with above average verbal IQ. Because of the potential fragmentation and difficulties with sleep, we plan to prescribe him Trazodone starting with 50 mg daily. Based on the results of the neuropsychological testing, we believe that he is not fit to return to duty at this point. He will return to clinic in one month and will be further evaluated.

Sincerely,

Jose Biller, M.D.
Professor of Neurology and Neurological Surgery
Associate Chairman Department of Neurology

JB:mb
CC: Major Frank Piper

LOYOLA
UNIVERSITY
HEALTH SYSTEM
Loyola University Chicago

Loyola University Medical Center
2160 South First Avenue
Maywood, Illinois 60153

Exhibit 4e

November 24, 2003

RE: HARMON, Anthony
MR: [redacted]

LETTER TO THE CHART

Anthony Harmon was seen in the Neurology Outpatient Clinic today. He was initially seen on November 4, 2003 in the Emergency Room after sustaining a motor vehicle accident. He was diagnosed to have a post concussion syndrome. At the time of the evaluation in the E.R., he had some headaches and posterior neck discomfort. He had no diplopia. He had no nausea or vomiting. He had no seizures, limb weakness or paresthesias. Neurologic examination was unremarkable, except for mild posterior neck tenderness to palpation. CT scan of the brain was normal. Lumbosacral spine x-ray was normal. Cervical spine x-ray was normal except for some arthritic changes from C3 to C7.

The patient was advised to discontinue vicodin and instead, try tylenol #3 if pain remained a major issue. A consideration was given to use non-steroidal anti-inflammatory drugs like naproxen and a trial of muscle relaxants like flexeril. In addition, he was advised to use heat compresses to the neck region and was told not to drive for the next 72 hours. He was also told to return to the Neurology Clinic in 1 month.

The patient returned to clinic on November 24th.

Exhibit 4f

RE: HARMON,Anthony
MRN: 1388400

Since his last evaluation in the E.R., he has had persistent headaches, nausea, occasional vomiting, persistent dizziness and some discomfort in the lower back and neck. Neurologic examination remained stable except for some posterior neck muscle tenderness. Blood pressure was 128/60 mm Hg and pulse was 80 and regular.

IMPRESSION: Post concussive syndrome.

RECOMMENDATIONS: MRI of the brain. MRI of cervical spine. EEG. Trial of naproxen 375 mg b.i.d. Phenergan suppositories for nausea and headaches. Flexeril 10 mg t.i.d. No driving until he returns to clinic December 9th. Avoid heavy lifting.

Sincerely,

José Biller, M.D.
Professor of Neurology and Neurological Surgery
Associate Chairman Department of Neurology

JB:mb
CC: Major Frank Piper
Troop Medical Clinic
Fort McCoy, Wisconsin 54656

Ex. L. 1 4

RADIOLOGY IMAGING REPORT

LOYOLA UNIV MED OUTPT CTR

Patient Name:	HARMON, ANTHONY N		
Sex:	M	**Patient Status:**	Outpatient
DOB:	05/21/1966	**Patient Location:**	LMOC
Visit #:	138840013104	**Signs/Symptoms:**	NECK PAIN
Accession:	3715961 **MRN:** [redacted]	**Indications:**	HA S/P MVA
		Comments:	MRI CERVICAL & BRAIN
Exam:	**(LUMOC) MRSPC2 - MR CERVICAL SPINE CORD WITHOUT CONTRAST**		
Completed:	11/26/03 2:32 pm		
CPT:	72141		

Interpreting Radiologist: GREENLEE, WILLIAM MD

Requesting Provider:	BILLER, JOSE, M.D. 2160 S. 1st Ave. Maywood, IL 60153	**Attending Provider:**	BILLER, JOSE, M.D. 2160 S. 1st Ave. Maywood, IL 60153

MRI CERVICAL SPINE--WITHOUT CONTRAST

CLINICAL INFORMATION: 37 YEAR OLD MALE IN A MOTOR VEHICLE COLLISION, PERSISTENT NECK PAIN.

PROCEDURE: SAGITTAL T1, PROTON DENSITY AND T2 WEIGHTED IMAGES WERE OBTAINED, FOLLOWED BY AXIAL GRADIENT RECALL T2 WEIGHTED IMAGES.

COMPARISON: NONE.

FINDINGS: NO FRACTURE IS SEEN. ALIGNMENT OF THE VERTEBRAL BODIES IS WITHIN NORMAL LIMITS. THE CRANIOVERTEBRAL JUNCTION IS UNREMARKABLE. NO FOCAL LESIONS ARE IDENTIFIED WITHIN THE CERVICAL SPINAL CORD. THERE IS NO EVIDENCE OF CORD COMPRESSION.

AT C2-3 AND C3-4, NO SIGNIFICANT ABNORMALITIES ARE SEEN.

AT C4-5, THERE IS MINIMAL DISC BULGING. THERE IS NO SIGNIFICANT CENTRAL SPINAL STENOSIS OR FORAMINAL STENOSIS.

AT C5-6, THERE IS DISC BULGING WITH A SMALL SUPERIMPOSED RIGHT POSTEROLATERAL DISC HERNIATION, EXTENDING INTO THE RIGHT NEURAL FORAMEN. THERE IS NO SIGNIFICANT CENTRAL SPINAL STENOSIS OR LEFT FORAMINAL STENOSIS. THERE IS MILD RIGHT FORAMINAL STENOSIS.

THIS REPORT ELECTRONICALLY SIGNED AND APPROVED BY THE ATTENDING RADIOLOGIST

Note: The information contained in this radiology report is confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination or copying of this report is strictly prohibited. If you have received this report in error please contact the Loyola University Medical Center Radiology Department at: (708) 216-6208.

Dictated by: GREENLEE, WILLIAM MD
Transcribed by: Interface, ADT 11/26/2003 5:38:00P
Signed By: GREENLEE, WILLIAM MD 11/26/2003 5:38:00P

RADIOLOGY IMAGING REPORT

LOYOLA UNIV MED OUTPT CTR

Patient Name:	HARMON, ANTHONY N		
Sex:	M	**Patient Status:**	Outpatient
DOB:	05/21/1966	**Patient Location:**	LMOC
Visit #:	138840013104	**Signs/Symptoms:**	NECK PAIN
Accession:	3715961 **MRN:** [redacted]	**Indications:**	HA S/P MVA
		Comments:	MRI CERVICAL & BRAIN
Exam:	**(LUMOC) MRSPC2 - MR CERVICAL SPINE CORD WITHOUT CONTRAST**		
Completed:	11/26/03 2:32 pm		
CPT:	72141		
		Interpreting Radiologist:	GREENLEE, WILLIAM MD
Requesting Provider:	BILLER, JOSE, M.D. 2160 S. 1st Ave. Maywood, IL 60153	**Attending Provider:**	BILLER, JOSE, M.D. 2160 S. 1st Ave. Maywood, IL 60153

AT C6-7 AND C7-T1, NO SIGNIFICANT ABNORMALITIES ARE SEEN.

IMPRESSION: THERE IS A SMALL RIGHT POSTEROLATERAL DISC HERNIATION AT C5-6, RESULTING IN MILD RIGHT FORAMINAL STENOSIS AT THIS LEVEL. THERE IS MINIMAL DISC BULGING AT C4-5. OTHERWISE NORMAL UNENHANCED MRI EXAMINATION OF THE CERVICAL SPINE.

THIS REPORT ELECTRONICALLY SIGNED AND APPROVED BY THE ATTENDING RADIOLOGIST

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Dictated by: GREENLEE, WILLIAM MD
Transcribed by: Interface, ADT 11/26/2003 5:38:00P
Signed By: GREENLEE, WILLIAM MD 11/26/2003 5:38:00P

Exhibit 5

Bark - 23 Mar 04
TUES.

Tell Mr Michael Rau to give
"he has a 16 Apr appt @ W. R E
Dr. Ecklund"
then document in our
records what you told him &
when. Per LTC Angelo

(? this date?)

I Acknowledge that I have
AN Appointment with Dr Ecklund
ON 16 APR as well as
28 MAR - 2 APR 04 for various
appointments.

Timothy M. Mallon

James M. Roberts MAJ.
28 Mar 04 / 0920

Mr. SHAYS. Thanks to all of you. We'll start the questions with Mr. Schrock. I think we'll do 5 minutes for Members then we'll do a second round.

Mr. SCHROCK. Thank you, Mr. Chairman. It's sort of like deja vu all over again, we've been hearing this over and over again. I know it takes time to get problems solved. But I think when we get to the point where people's credit is being ruined, they have to pay for hotel advances out of their own pay instead of getting per diem like it was when I was active duty Navy, I don't know what the answer is. We've had folks here before, actually, we need to address the questions of the four gentlemen sitting behind you, and make no mistake about it, we will.

As good as it was to have the men here testify, it's even to me more important to have the wives testify. Because the impact some of these situations have had on the family are just outrageous, and we simply have to get this fixed. I screamed about it, literally screamed about it at a hearing a month ago, and maybe some of the problems are getting solved. I certainly hope they are.

But if we don't, then we may have to have a hearing every other day. And if we have to go to Fort Knox to do it, then we're going to have to go to Fort Knox to do it. I don't want this young men and women hand picked, I want to be able to walk into a barracks and say, what's your situation. And for you to be on medical hold for 10 months now, and nobody's checking on you, something is wrong somewhere. And I think those are the questions we need to address to the Generals, the Admiral and the Secretary.

Fit for duty is supposedly what it's all about. And the Army is required to provide annual medical screenings, annual dental screenings, selected dental treatment and a physical exam every 2 years for early deploying Reservists over age 40, and every 5 years for early deploying Reservists under age 40.

To the gentleman, how often did you receive physical examination? First Sergeant?

Sergeant MOSLEY. I work full time as a civilian for the Army Reserve now, sir, so we're a forward support protection package, we're required once we get 40 years old to have a physical exam every 2 years. And I scheduled a physical exam for the troops in my unit, so I had mine every 2 years, sir. I have a copy of the one that was done in May 2002, so that the only deficiency I had, sir, was a hearing loss, and that profile was downgraded so I could go.

Mr. SCHROCK. Specialist Ramsey.

Specialist RAMSEY. Yes, sir. My last physical was in 2000. Any physical after that, I did not receive one. It was more of just a records check. My unit is a rapid deployable unit. We have the responsibility of deploying within 72 hours wherever for air defense. So on a year basis, actually every 6 months, we go and do what they call a MOB station, go through all the shots records and update all our medical files. But my last physical was in 2000.

Mr. SCHROCK. Any dental at all?

Specialist RAMSEY. No, sir. The last—I was deployed in 2001, the end of 2001 and when I reached Fort Bliss, where our command unit is housed, when I reached there they did a panoramic x-ray. That was the last one I had, was in 2001. I have not had any dental updates since then.

Mr. SCHROCK. Sergeant Emde.

Sergeant EMDE. Like the First Sergeant, I am required to have an over 40 physical every 2 years. I recently went to Fort Eustis and had my physical done in May of last year. I had my dental things taken care of right about the same time.

Mr. SCHROCK. Specialist McMichael.

Specialist MCMICHAEL. Sir, my last physical was in November 2000. I was in the IRR, inactive regular Reserve, from August 2001 until a local unit pulled me out of the inactive regular Reserve and mobilized me February 27th of last year. My physicals are current and up to date.

As for dental, I haven't had a panagraph or anything like that in probably 10 years. But I did have dental work done at Fort McCoy, which I have to praise their ability. They did good.

Mr. SCHROCK. Specialist Ramsey, did you want to make a comment?

Specialist RAMSEY. Yes, I just wanted to add one thing. I was, because I stayed so close in contact with my Reserve unit in Orlando, FL, I was under the understanding that our annual physicals were coming up and I was on that list. But because I was currently on incap and not allowed to attend drills, because of not receiving retirement points, I was passed over for that particular physical, as well as my TB test. I received a TB test prior to leaving Kuwait, back to the States. I was supposed to get another one 6 months later for followup. I still have not received that.

Mr. SCHROCK. First Sergeant, I know my time is up, but explain the pills, would you? What are they?

Sergeant MOSLEY. There's probably 16 or 18 pills a day in there for Parkinson's disease, which my shaking is about 50 percent of what it was 3 weeks ago. Pills in there, there's Neurontin for the backaches, there's Percoset, Vioxx, there's pills there for depression and PTSD.

Mr. SCHROCK. Sounds like you're over-medicated to me.

Sergeant MOSLEY. That's what my statement was. If I was to take every pill they told me to take here, sir, I wouldn't be waking up in the morning.

Mr. SCHROCK. Mr. Chairman, I know my time is up, thank you for letting me have the time. As bad as the medical problems are, and they are, this financial problem, people's credit being affected, bills not being paid that are supposed to be paid, to me this is a horrible, horrible situation. And if a man or woman is trying to get better medically and they have all this burden on them, how in the dickens can they with all these medical bills?

I think it's absolutely abhorrent that the military services aren't paying these bills and making sure these young men and women are paid. It's ridiculous. We need to get our hands around that and get around it real quick, or we're going to have some real bad problems with these folks, and nothing they created. Thank you.

Mr. SHAYS. Thank you, Mr. Schrock.

Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman. I want to thank all the witnesses for their service and for the difficulty they've gone through, I regret that. There's nothing that you testified to that I'm unclear on. I think that all of you made very certain and very clear

what the circumstances are, and I'm anxious to hear from the next panel as to what we're doing about that, and what we're going to do about it. But I would like to give any of you that feels you might not be asked a question you want to answer or something that you haven't yet had a chance to say, I'd like to give you the opportunity to do that, if there's anybody who feels that their opening statement wasn't adequate enough.

Specialist RAMSEY. I just wanted to add to what Mr. Schrock was bringing up, the financial issues. My wife and I also, as soon as I returned from active duty, we tried to refinance our house. We're at a 7 percent under the Soldiers and Sailors Relief Act, which I am not able to receive right now, because I'm no longer on active duty. My interest rate on my home is at 7 percent. I had the opportunity to refinance at 5 and a quarter percent.

Because I was late on my mortgage in November and December, never been late on my mortgage any other time before that, because I was late on that, that affected my credit to the point where they were, the mortgage company that I was looking at actually offered me a better rate of 7 and three quarter percent, and I'm at 7 and a quarter. So actually, they were going to offer me what they thought was a better rate, which actually was going up.

Specialist MCMICHAEL. I do want to mention the medication again. We have some soldiers at Fort Knox who are so medicated they can't even get out of bed to make formation. I personally take 60 milligrams of MS Contin, which is a morphine derivative, every 12 hours. A member of legislative affairs made a comment to one of the clerks that work for you that she didn't feel I was going to be able to testify here, that I would not, as I understand it, be able to make a coherent thought to where I could talk to anybody.

This is just the tip of the iceberg with medication. There's a Sergeant Major Abbotts at Fort Knox that would welcome the chance to speak to any one of the members of the committee, he's in the same boat, taking a ton of medicine. Soldiers that are diagnosed with post-traumatic stress disorder, they're basically medicating these guys out of this world. Some of them don't even know where they are.

Mr. TIERNEY. Mr. Chairman, I don't know that the next panel is going to talk about anything other than process, how this works. But I would think there are two distinct issues. One Mr. Schrock brings up about the financial implications and what the military is actually doing, and the second is the medications and how they're being distributed and all that. So whether it requires further hearings or simply a followup by this committee in terms of aggressive oversight, those are at least two issues that I would like to recommend this committee look into in great detail.

And I want to thank again all the witnesses for your testimony.

Mr. SHAYS. Thank you. We actually are doing that in conjunction with the full committee, trying to make sure we spread that workload.

Mr. Ruppersberger, you are entitled to go next, since you are full committee, but if you don't mind waiting for Mrs. Davis, we'll have her go next, if that's OK. Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

I do have a question, but I would like to say something to the Emdes and the Ramseys. In my prior life, before coming to Congress, I was a real estate broker. I can tell you, if you have 100 percent A plus credit everywhere but you're late 1 day on your mortgage, it will stop you from refinancing. So I can't help you, Mr. Ramsey, but Mr. and Mrs. Emde, if you will talk to my staff afterwards, we'll see if we can get a letter from the Services and see if we can't clear up your credit on your mortgage.

The one thing I do want to ask each and every one of you, did any of you have a pre-existing condition that should have been caught before you were activated, or do you know of anybody that had a pre-existing condition in your unit? Particularly you, Sergeant Mosley. How long have you had Parkinson's?

Sergeant MOSLEY. They just diagnosed me in March. I've been on my medicine 3 weeks. I had gone on my June 12, 2003 physical exam, I indicated stiffness in my joints, numbness in my arms and shakiness that I couldn't control. That was June 2003. It was only after my medical evaluation board was finished and I agreed if they sent me to a civilian neurologist to find out where my vertigo was from and the other problems, and they did the MRI and diagnosed me with the cervical spondylosis and the Parkinson's disease.

Mrs. DAVIS. But you had the shaking in June 2003?

Sergeant MOSLEY. When I came back, I had some minor shaking. I'm glad you didn't see me 2 weeks ago.

Mrs. DAVIS. Did they do anything when you said you had the shaking?

Sergeant MOSLEY. They kept telling me it was just nerves and the pain, like the pain in my back and my neck, they just kept saying it was pain, that's why I wasn't sleeping good, that's why I was having some of the dreams I was having, and side effects of medicine.

You know, when you have a soldier go to a psychiatrist, and I'm not talking about me, but I know the soldier that did this, tell him how depressed he is and what his suicidal thoughts are, and he's threatened with malingering and UCMJ, he leaves and within about 3 weeks cuts his wrists. Soldiers are talking, like I say, but the folks there just aren't listening.

Mrs. DAVIS. I'll be leaving for Iraq in 3 weeks. I look forward to seeing some of my Virginia Guard and Reserve there.

Sergeant MOSLEY. Have you taken the anthrax shot, ma'am?

Mrs. DAVIS. The anthrax shot? I live on a farm. I'm not worried about anthrax.

Sergeant MOSLEY. I hear you.

Specialist RAMSEY. To answer your question, ma'am, no, I did not have any pre-existing. I was 100 percent healthy. The only condition that I had is, I had a hernia surgery, a bilateral repair on both sides in 2001. And I had some complications from it. That was the only issue. I was cleared for full duty prior to leaving. It was not interfering with my civilian job nor my military duties.

Mrs. DAVIS. Did they do a full physical before you left?

Specialist RAMSEY. No, ma'am, they did not.

Mrs. DAVIS. They just cleared you?

Specialist RAMSEY. They cleared me. They looked through my service record.

Mrs. DAVIS. On your word?

Specialist RAMSEY. Yes, ma'am. They looked through my service record, they looked through the civilian doctor's notes from my surgery and then cleared me to go on.

Mrs. DAVIS. Scott Emde.

Sergeant EMDE. I received a full physical prior to going overseas. I had no pre-existing medical conditions whatsoever.

Mrs. DAVIS. Thank you, Scott. Specialist McMichael.

Specialist MCMICHAEL. Prior to being deployed, actually in 1992 I received knee surgery and was awarded a permanent profile because I could no longer run. It was P3, meaning I was nondeployable. During preliminary review with the 88th Reserve Support Command, a colonel took my P3 profile, downgraded it to a P2 so that I could be deployed. My P3 profile was actually awarded by a medical evaluation board.

I had already been through medical board once before, was found fit for duty and retained at a permanent profile. That was the only thing wrong with me, it did not affect my ability. I actually wanted to go. What happened to me occurred at Fort McCoy while I was training and has nothing to do with my knees.

I do know of soldiers at Fort Knox, Sergeant Major Abbots that I mentioned as well, he had neck surgery about 3 months before he was deployed. His civilian doctor had stated, he is not to be deployed. Well, they sent him to the desert, he came back and had to have surgery. There are other soldiers in the same boat.

First Sergeant mentioned behavioral health and psychology. There's a soldier over here at Walter Reed right now that's a friend of mine that was at behavioral health. He had made a suicidal gesture earlier that week, was sent to behavioral health. The next day he slit his wrists. Behavioral health refused to help him. I know of other soldiers who have gone to behavior health and asked for drug or alcohol counseling, well, you're National Guard, no, you're not entitled to it. There's a Specialist Anderson, who's now Private Anderson because they refused to help him and he ended up getting two more DUIs.

Myself, I have gone to behavioral health because I have family issues. And the psychologist, his main concern was how long I've been in medical hold, not with helping me. I've had appointments canceled with behavioral health and the soldiers—that's why I mentioned Chaplain Norwood, because the soldiers at Fort Knox, the behavioral health doesn't care about them. They go outside to outside agencies, some have gone to the VA to find people to talk to.

That's all I have to say.

Mrs. DAVIS. I thank you all very much, and Mr. Chairman, thank you so much for allowing me to be a part of the hearing.

Mr. SHAYS. We are delighted you are. And by the way, her offer to assist you in the issue of financing issues, take her up on it. I think it will be very helpful to you.

Mr. Ruppersberger.

Mr. RUPPERSBERGER. First, I'm sorry I was late. I have read the files and been briefed on your testimony. There's no question we have a serious issue. First thing, the issue generally of our military we have to deal with, because terrorism is, the war with terrorism

is not going to stop, and we do need to move on and finish what we have started.

However, the total force transformation, and I believe now that the use of National Guard and Reserve is more now than it was during World War II, so there are issues here, and that's the reason we're having this hearing. First, I want to thank you all for your service, and understand that you're going through a lot of difficulty and family issues. We're having this hearing, and I want to thank the chairman for having the hearing today, because we're trying to get to the issue to make it better.

To begin with, Specialist Ramsey, could you, I want to get into the area of the difficulties in receiving adequate care you experienced. Do you believe they were caused by ineptitude of doctors, by the incompetence of file clerks, or by incompatible recordkeeping systems between the Reserve component and the active component?

Specialist RAMSEY. Yes, sir, that's correct. All the above.

Mr. RUPPERSBERGER. Could you explain a little bit what your analysis of those issues are?

Specialist RAMSEY. For example, in Fort Benning they have post-deployment checklists that you're required to check off from each station prior to leaving and being redeployed to your home residence. They have so many of them that the different sections, for example, finance, medical, what have you, personnel, they choose to check off whichever ones they want to check off. There's not one standard form there. It's easier for them to push us through and send us home than it is to do the extra paperwork or go through the extra log or chart and treat us for the injuries that were incurred while on active duty.

Mr. RUPPERSBERGER. OK. Sergeant Emde, first you noted that you made hundreds of phone calls to check on your payments, active duty status, medical appointments. How many phone calls have you made where you feel you got the service or response you were looking for, or do you feel you were just passed from one person to another, in a bureaucratic maze?

Sergeant EMDE. I would say probably roughly a quarter of them. A lot of the problems were people not being around when I needed to make an appointment or a lot of the problem for me anyway, since I was at Walter Reed and I was trying to get some of my care at a Naval facility, the computers didn't mesh. Therefore, their procedures or the Navy's way of doing things didn't quite mesh up with the way the Army did their thing. And their protocols, such as one I noted that the physicians at the Naval facility wanted to know why this doctor wanted an x-ray. To me, that's absurd, but that's the Navy's way. And had Walter Reed known about that, then that may have been——

Mr. RUPPERSBERGER. Was it because of a lack of control of one person that you could go to to coordinate this, did you see a lot of duplication of effort? What would you have recommended if you were a general that you could have done to fix your problem?

Sergeant EMDE. If there was perhaps a central person that took care of everything, that may have alleviated some of it. But other parts of it, there were two physicians I was seeing up at Walter Reed, one for neurology, one for my shoulder. When the doctor I

had for my shoulder, when he went on vacation, when he got back, the neurologist left. So that was like 6 weeks that I was unable to get any help whatsoever from that.

Mr. RUPPERSBERGER. Were these pre-existing conditions? I was not here for your testimony. Were these pre-existing conditions?

Sergeant EMDE. No, they were not. Prior to me being deployed?

Mr. RUPPERSBERGER. Yes.

Sergeant EMDE. No, sir.

Mr. RUPPERSBERGER. OK. Mrs. Emde, the issues that you were dealing with and the help and support, was the family support center at your husband's base, was there a family support center there?

Mrs. EMDE. There was no family support whatsoever. I received, he was actually under active orders for almost 2 years. And during that 2 year period, I received one call from the Virginia National Guard basically to tell me about my commissary rights. That was it.

Mr. RUPPERSBERGER. Were you told there was going to be support?

Mrs. EMDE. Oh, yes. We were told there would be support, that if we had any questions, we could call this number. When we had pay glitches, I called numbers, didn't get anything.

Mr. RUPPERSBERGER. What happened when you called those numbers?

Mrs. EMDE. We were told that they could not handle it, it was an active duty issue.

Mr. RUPPERSBERGER. Was this the National Guard number you got?

Mrs. EMDE. Right. The National Guard could not help us.

Mr. RUPPERSBERGER. Then did you go——

Mrs. EMDE. He had been under active duty and we no longer fell under their umbrella. So they did not help us.

Mr. RUPPERSBERGER. Then what did you do? Did you go to the active, the career?

Mrs. EMDE. When he had the medical extension orders. We were told that there was only one person who could extend his orders, and this person was Bob Vail, and it took, during the four lapses, there were lapses of 2 weeks, 3 weeks, the longest that we personally experienced was 2 months.

Mr. RUPPERSBERGER. One last question. If you could have the authority to fix the problem, the frustrations you were going through, what would you have liked to have seen?

Mrs. EMDE. More administrative help in order to process——

Mr. RUPPERSBERGER. A special person to coordinate between National Guard and career, or do you feel——

Sergeant EMDE. From my understanding, the National Guard Bureau has one person that takes care of ADME orders. And I called up there, the process goes through my chain of command at Dove Street in Richmond, and then it goes straight to the National Guard Bureau. This man goes through, reviews everything and then it goes up to a colonel to get processed or get accepted. Then it's OKed, this colonel gives the authority to cut the orders, as I understand the process.

I cannot see for the life of me how one person can review every single pay problem that is reviewed medically for the National Guard. It's just—but that's what I was told, and that's where the system bogged down.

Mr. RUPPERSBERGER. Thank you.

Mr. SHAYS. I thank the gentleman. I'll proceed to now ask some questions.

We basically had the active so-called component, the active force and the Reserve component, Reserve and National Guard. It is very clear to this committee that they are not equal in a whole host of ways. And they are not treated in the same way. And as my colleague just said, you all are expected to perform in the same way.

We know that the health provisions for active are different than for those in the Reserve component. We know the pay has gotten all screwed up. That has to impact your health. When you are thinking you might lose your house and the frustration of thinking that you can lower your mortgage costs and then find out you can't, it would drive me crazy.

We know that the training isn't equal, and we also know the equipment and protective gear is not equal. In Iraq, we had some of our Connecticut National Guard trying to get their Humvees to have the same basic armament that the others had. They had to do makeshift efforts, literally go into Iraqi garages to have steel plates put on.

So we know that in this committee, looking at all these issues. Today we're looking pretty much at health, and obviously the pay is a factor. Sergeant Mosley, you were in Iraq, correct?

Sergeant MOSLEY. Yes, sir.

Mr. SHAYS. When were you in Iraq?

Sergeant MOSLEY. Cross with the 3rd FSB and the 2nd and the 7th on March 19th, sir.

Mr. SHAYS. March 2003, right?

Sergeant MOSLEY. Yes, sir, first day of the conflict.

Mr. SHAYS. Specialist Ramsey, you were in Kuwait?

Specialist RAMSEY. Yes, sir, I was in Kuwait and Iraq. I was assigned directly to the commanding general of the 32nd Army Missile Defense.

Mr. SHAYS. And you were there——

Specialist RAMSEY. I was in and out of Iraq anywhere from the late part of March all the way up to my last trip into Iraq, which I think was toward the end of May.

Mr. SHAYS. And Sergeant Emde, you were Qatar, is that correct?

Sergeant EMDE. Yes, sir.

Mr. SHAYS. When were you there?

Sergeant EMDE. I was there in the May and June timeframe of 2002.

Mr. SHAYS. It was our expectation that before you would be sent into a combat zone, that you would have gone through a very compressive physical. I want to know if that was done for you, and each of the three gentlemen I'd ask. Before you went.

Sergeant MOSLEY. No, sir, Mr. Chairman, we did not.

Specialist RAMSEY. No, sir, no type of physical.

Sergeant EMDE. Yes, sir, we did.

Mr. SHAYS. Thank you. When you got back from the battle zone, were you given any kind of general physical to determine how you might be different than the, well, actually they didn't see how you went in. But were you given a physical on the way home?

Sergeant MOSLEY. I was, because I went through the medical evaluation board process, sir.

Mr. SHAYS. Right.

Sergeant MOSLEY. But when our unit came back on August 22nd, they were told, my commander was told, you've got 3 days to completely de-MOB and be off of Fort Stewart, 156 soldiers they're going to try to——

Mr. SHAYS. So they weren't all given physicals?

Sergeant MOSLEY. No, sir, they were not.

Mr. SHAYS. OK. Specialist Ramsey.

Specialist RAMSEY. No, sir, I was not given any type of physical. I reported to Fort Benning from Kuwait on the evening of, I believe the 11th or the 12th, Wednesday evening. Thursday morning we went and spent 2 hours doing out-processing, a few of the check points. On Friday, we went to medical and did the out-processing there, and then went to personnel and finished out-processing. At 4 a.m., on Saturday I was on an airplane heading for Florida. I spent between 3 and 5 minutes in the physician's assistant's office, a Lieutenant Mulener, who basically just fanned through my paperwork, said I had the appropriate documents to receive medical treatment at my home station and even wrote in there to receive medical treatment at home station. Then I was sent on my way.

Mr. SHAYS. Thank you.

Sergeant EMDE. Yes, sir, as part of the out-processing system at Fort Bragg, all the National Guard Reservists that I saw there had complete physicals done.

Mr. SHAYS. So you went in, you had a physical and when you got back you had a physical?

Sergeant EMDE. Yes, sir.

Specialist MCMICHAEL. Sir, I need to make a statement about the physicals. I worked at Fort McCoy. While I was on medical hold, I was assigned to the SRC, which demobilized the soldiers. And physicals were actively discouraged. When a unit came to de-MOB, they were told, well, you can have a physical if you want. But you're going to be here another 2 weeks while your unit goes home. And soldiers would be briefly assigned to medical hold for about a week to 2 weeks while the results of the physical, blood tests and other whatever tests had to be done. And that's just for a basic physical that didn't find anything wrong. They actively discouraged the soldiers from requesting physicals.

I believe it was the——

Mr. SHAYS. You're speaking in your capacity as a nurse?

Sergeant MCMICHAEL. No, my job was to do the DD–214s for soldiers when they came back. This was at Fort McCoy, WI, which was a mobilizationsite. I believe it was the commanding general of the Wisconsin National Guard actually went so far as to order all his National Guardsmen will receive a physical when they de-MOB. At McCoy, they actively discouraged it.

My unit spent 4 months at Fort McCoy. They hired Iraqi civilians to do our job, my unit went home the first of June. I was still

on med hold, I stayed. But they did that with my unit when they de-MOBed. They said, if you want a physical, fine, you can have it, but you're going to stay.

Mr. SHAYS. I need to—sorry, Sergeant Emde, you're the nurse. Specialist McMichael, I need you to explain what medical hold for 10 months means.

Specialist MCMICHAEL. When I was originally injured, I ruptured my abdominal wall. That was back in April. I was assigned to medical hold in May, right when my unit went to demobilize.

Mr. SHAYS. Describe to me what medical hold means.

Specialist MCMICHAEL. Medical hold means you're going to sit around, you're going to see the doctors when you have a doctor's appointment. The big thing——

Mr. SHAYS. Does it mean that you perform active duty while you're on medical hold?

Specialist MCMICHAEL. Right, you're on active duty. At Fort Knox, they try to find you jobs. You're supposed to have a job working in your military occupational specialty, your MOS. A lot of soldiers don't, because they're not able to perform their job with the restrictions they have on medical hold. Some people have lifting, different types of restriction. While you're on medical hold, you're still on active duty, you're still at whatever military base. In my case, I'm at Fort Knox, I'm in the barracks with about 150 other medical hold people.

At McCoy, they have a medical hold, I'm not sure what the numbers were. Your job on medical hold is to go to your appointments and to get well. Some of the bases have—they want you to be gainfully employed, doing something——

Mr. SHAYS. I understand that. And I'm sorry, I'm running over, and I'll let all the Members come back. So you're on medical hold, you are being given assignments, and you will be on medical hold for how much longer?

Specialist MCMICHAEL. I'm scheduled to have surgery here at Walter Reed on the 16th. Fort Knox, it took 4 months to see the neurosurgeon here from Walter Reed. I'm going to have surgery to repair something that occurred to my neck.

Mr. SHAYS. So when you have surgery, then what happens?

Specialist MCMICHAEL. I'm being medically boarded as well, and I'm anticipating another 3 to 6 months in medical hold before I'm medically discharged.

Mr. SHAYS. Let me just ask any of you here, do you believe what you are telling us is unique to you or systemic to the issue? In other words, that you are typical of others, there are many others like you, or do you think that you're unique and that my staff has just done a wonderful job of finding you?

Sergeant MOSLEY. I would say we're very systemic, Mr. Chairman. I was on med hold for 10 months.

Mr. SHAYS. So you're saying my staff didn't do a very good job here, right? [Laughter.]

Sergeant MOSLEY. Oh, no, sir, I wouldn't say that. I'd say some of the Army folks would be guilty.

Mr. SHAYS. The bottom line though is you believe you are more typical than unique. Would anyone disagree with that? I'll assume that if others don't comment that you consider yourself more typi-

cal of the problem rather than unique. That's the way we'll leave it unless someone wants to counteract that.

Specialist RAMSEY. Sir, I just want to add one thing to that. I think the reason that your staff found us is because there are very few people that will stand up and speak their mind and stand up against the Army.

Mr. SHAYS. You know what? I think that's very true.

Specialist RAMSEY. And I'd just like to add one thing to what he was saying, what you were addressing about having an assignment or working while you're on active duty medical extension. Per Colonel Sherman, the G–1 who decides who does and who does not get active duty medical extension, in her e-mails and in her phone conversations that I have taped, she has made it very clear that if you can perform your military job, you do not qualify for active duty medical extension. However, in the Army regulations it says, you must not be able to perform your normal military duties. She has interpreted on her own that my MOS, military job, is what it stands on.

There's many soldiers out there that are still performing either their same MOSs or some type of an activity at a post as we speak.

Mr. SHAYS. Mr. Ramsey, let me just be clear about this. You basically would like to be home with your family in your job working as a sheriff, correct?

Specialist RAMSEY. Yes, sir.

Mr. SHAYS. If you do that, you then give up any hope of getting medical attention and have these significant bills paid for, is that correct?

Specialist RAMSEY. Sir, I cannot return to my civilian employer because of workers comp issues and health insurance issues. They will not accept me back until I am cleared by the military and by a physician. They've made that very clear. The military has even gone as far as calling them and asking them if they can put me on a light duty status, and they've made it very clear to them that they're not in the practice of taking up the slack for the military where they fall short in medical care for soldiers.

Mr. SHAYS. OK. I'd like to welcome our ranking member to the committee. Nice to have you here, Mr. Kucinich. You have the floor.

Mr. KUCINICH. Thank you, Mr. Chairman. I have a statement that I would appreciate if the Chair would put into the record.

Mr. SHAYS. We will put your statement into the record, and I thank you for that.

Mr. KUCINICH. And an accompanying letter with that statement.

[The prepared statement of Hon. Dennis J. Kucinich and the accompanying letter follow:]

Statement of Rep. Dennis J. Kucinich
Ranking Minority Member
U.S. House of Representatives
Subcommittee on National Security, Emerging Threats and International Relations

Hearing on "Does the 'Total Force' Add Up? – The Impact of Health Protection Programs on Guard and Reserve Units"

March 30, 2004

Good morning and thank you, Chairman Shays, for continuing to hold these hearings on the treatment of our nation's National Guard and Reserve soldiers.

The Reserve Component of the U.S. military has always been treated as a second-class citizen by the Active Component, derisively termed "weekend warriors." Yet, we are now depending on these men and women each and every day for peacekeeping operations, in the war in Iraq, and for homeland security.

Over 6,500 Ohio National Guard soldiers have answered the call to duty since September 11 and the current activation levels of Reserve and National Guard soldiers nationally has surpassed even those during World War II. In Iraq, our nation will be increasingly reliant on Guard and Reserve soldiers, where they already comprise nearly 40% of the troops serving there.

As such, our Guardsmen and Reserve soldiers deserve to be treated equally, fairly, and with the dignity due them, including proper care, treatment, and protection of their health.

Today, we will hear from several soldiers and their families about the outrageous mistreatment they suffered in trying to obtain care for their injuries, and about the stress and toll it took on their

families. We will hear about the military's shoddy recordkeeping system, hurried physical screenings, long waits for surgery or appointments to see a doctor, even keeping medical hold soldiers in unsanitary, overheated, run down barracks, as was reported at Fort Knox.

In fact, the General Accounting Office, the investigative arm of Congress, recently reported that in a survey of troops serving in Kosovo and Afghanistan, between 38% to 98% of units surveyed didn't even have complete health assessment forms, and up to 46% of soldiers were missing an immunization. The Pentagon didn't even establish a qualitative assurance program until just recently. It seems that many of our soldiers have been rushed into the battlefield and rushed out of military treatment facilities without even so much as a physical exam.

Mr. Chairman, our Guard and Reserve soldiers are not mere numbers to be deployed, they are human beings serving on the front lines of our military to protect all of us here. I know they are proud men and women who do not complain easily. Yet, they cannot stand by quietly any longer. They deserve to be treated with respect, with honesty, and with full access to doctors, insurance, health benefits, and disability pay afforded to all our brave soldiers.

Finally, I think it is important to understand that many Members of Congress have pointed out these and other deficiencies in the treatment of our soldiers. For example last December I, and 19 of my colleagues, sent a letter to the President asking about the same problems we will hear about today. I have yet to receive a response.

I'd like to welcome the soldiers and their wives here today, and thank them for appearing before the Subcommittee. Mr. Chairman, I look forward to listening to the testimonies this

morning, and will be eager to hear how the Pentagon intends to fix some of these problems.

Congress of the United States
Washington, DC 20515

December 2, 2003

The Honorable George W. Bush
President of the United States
White House
1600 Pennsylvania Ave
Washington, D.C. 20500

Dear President Bush:

We, Members of Congress, believe that our troops in Iraq are receiving an unacceptably low level of support from the Administration in the key areas of essential equipment, access to healthcare, pay, and morale. With 130,000 troops in Iraq and more deployments currently scheduled, the following areas need the Administration's immediate attention:

The Troops Lack Proper Equipment

- **Helicopter Anti Missile Protection:** Many U.S. helicopters in Iraq lack standard anti-missile equipment that might have prevented the attack on a Chinook helicopter that killed 15 U.S. troops. (Reuters, November 5, 2003)

- **"Interceptor" Body Armor**: There is a severe shortage of the highest quality "Interceptor" body armor-Kevlar bulletproof vests with removable ceramic inserts for our troops. Some of the soldiers killed in action only had Vietnam-era "flak jackets" which ultimately failed to stop enemy bullets. According to various news reports, mothers and fathers of U.S. servicemen and women are actually purchasing ceramic plates for these Interceptor vests and sending them to their sons and daughters in Iraq. Soldiers who have neither the Interceptor jackets nor the ceramic inserts are having the ceramic inserts sent to them, and they are using duct tape to attach them to the backs of their flak jackets. However, news reports also indicate that the Administration, in an effort to win allies in this conflict, has pledged to give some foreign troops body armor while American troops are going without. (Congressional letter to Armed Service Committee, November 4th, 2003)

- **Bio/Chem Protective Suits:** According GAO testimony in the House Government Reform Subcommittee on National Security, Emerging Threats and International Relations, 250,000 defective bio/chems suits remain unaccounted for. The Pentagon is unable to locate and confirm that these suits are not in the field because the DOD inventory systems are so poor. To make matters worse, the $200 replacement suits remain in short supply and GAO reported that several military units were selling these brand new protective suits over the internet for $3 apiece.

- **Other Equipment Concerns**: Many other important military items that protect troops are also reportedly in short supply. They do not have portable jammers that block radio signals

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used to detonate remote controlled bombs. The Army says helicopter blades and engines are rapidly being "eaten by the sand." The heat and terrain are shredding tires on Humvees. And the tracks for the Bradley fighting vehicles are in low supply. (In Need Of Repair ABCNEWS.com September 15, 2003)

The Troops Lack Health Care

- **Veterans Lose Benefits:** The Administration cut off access to its health care system for approximately 164,000 veterans. The 2004 budget proposed increasing the fees that veterans must pay for care — raising the co-payment for a 30-day supply of drugs from $7 to $15, and requiring a $250 annual fee for low-priority veterans. The bottom line is that major veterans groups claimed the budget fell $1.5 billion short of adequately funding veterans' care. (Washington Post, 1/17/03) (USA Today, 6/17/2003)

- **Poor Healthcare for Wounded Soldiers:** Hundreds of sick and wounded U.S. soldiers at Fort Stewart and Fort Knox, including some who served in Operation Iraqi Freedom are waiting weeks and sometimes months for medical treatment. The Reserve and National Guard soldiers are on what the Army calls "medical hold," while the Army decides how sick or disabled they are and what benefits -- if any -- they should get as a result. Some of the soldiers said they have waited six hours a day for an appointment without seeing a doctor. Others described waiting weeks or months without getting a diagnosis or proper treatment. Soldiers say they have to buy their own toilet paper. (United Press International, October 17 and 29, 2003)

- **No Healthcare for National Guard and Reserve Members:** The Administration also announced its formal opposition "to a proposal to give National Guard and Reserve members access to the Pentagon's health-insurance system" despite "a recent General Accounting Office report estimated that one of every five Guard members has no health insurance." (Gannett News Service, October 23, 2003)

The Troops Get Less Pay and Benefits

- **Army Times Editorial: Nothing but lip service:** (June 30, 2003)

> "In recent months, President Bush and the Republican-controlled Congress have missed no opportunity to heap richly deserved praise on the military. But talk is cheap — and getting cheaper by the day, judging from the nickel-and-dime treatment the troops are getting lately.
>
> For example, the White House griped that various pay-and-benefits incentives added to the 2004 defense budget by Congress are wasteful and unnecessary — including a modest proposal to double the $6,000 gratuity paid to families of troops who die on active duty. This comes at a time when Americans continue to die in Iraq at a rate of about one a day.
>
> Similarly, the administration announced that on Oct. 1 it wants to roll back recent modest increases in monthly imminent-danger pay (from $225 to $150) and family-separation allowance (from $250 to $100) for troops getting shot at in combat zones.

> Then there's military tax relief — or the lack thereof. As Bush and Republican leaders in Congress preach the mantra of tax cuts, they can't seem to find time to make progress on minor tax provisions that would be a boon to military homeowners, reservists who travel long distances for training and parents deployed to combat zones, among others.
>
> Incredibly, one of those tax provisions — easing residency rules for service members to qualify for capital-gains exemptions when selling a home — has been a homeless orphan in the corridors of power for more than five years now.
>
> The chintz even extends to basic pay. While Bush's proposed 2004 defense budget would continue higher targeted raises for some ranks, he also proposed capping raises for E-1s, E-2s and O-1s at 2 percent, well below the average raise of 4.1 percent." ...
>
> "Taken piecemeal, all these corner-cutting moves might be viewed as mere flesh wounds. But even flesh wounds are fatal if you suffer enough of them. It adds up to a troubling pattern that eventually will hurt morale — especially if the current breakneck operations tempo also rolls on unchecked and the tense situations in Iraq and Afghanistan do not ease." ...

- **Military Children Suffer:** The Administration's 2004 budget proposes a $1.5 billion cut to military family housing, $174 million cut to schools near military bases, and the Administration left out one million children living in military and veteran families from the child tax credit passed earlier this year. (House Appropriations Committee Democrats, Education and Workforce Committee Democrats, Children's Defense Fund)

- **Troops Go Home, but Pay For It:** Our troops serving in Iraq and Afghanistan who participate in the Rest and Recuperation Program are granted leave for a few weeks to visit home. However, these soldiers are responsible for any travel to and from the approved port of debarkation in the United States, which leaves many of the members stranded or forced to foot the bill for connecting flights and transportation to their homes.

- **Calling Home Costs Money:** The lack of telephones in Iraq has created the situation where and our men and women are paying $2 a minute to call home. (Day One In Iraq, Lawrence J. Korb, November 5, 2003)

A total of 394 soldiers have been killed fighting this war; 256 of these deaths have occurred since May 1, when you declared an end to major combat operations. There have been approximately 2200 U.S. casualties in Iraq. These startling numbers and the treatment of the soldiers still in Iraq have led to poor morale amongst the troops.

<u>Low Morale Amongst Our Troops</u>

- **Stars and Stripes Morale Expose:** A broad survey of U.S. troops in Iraq by a the Stars and Stripes found that half of those questioned described their unit's morale as low (49%) and

their training as insufficient (52%) and said they do not plan to reenlist (49%). 35% of the surveyed soldiers claimed they did not have adequate equipment nor a clear mission. (Washington Post, October 16, 2003) (Stars and Stripes, October 15, 2003)

- **Questions about AWOL:** The GI Rights Hotline, a national soldiers' support service, has logged a 75 percent increase in calls in the last 12 weeks, with more than 100 of those calls from soldiers, or people on their behalf, asking about the penalties associated with going AWOL - "absent without leave" - according to volunteers and staffers who man the service. (NY Post, October 5, 2003)

- **13 Soldiers Take Own Lives:** Officials said Thursday that at least 13 U.S. soldiers have committed suicide in Iraq, representing more than 10 percent of American non-combat deaths there. At least 11 U.S. Army soldiers have committed suicide during Iraq operations, most with self-inflicted gunshot wounds, and two Marines have committed suicide using firearms. 478 soldiers had been evacuated from Iraq for mental health reasons as of Sept. 25. (Reuters, 16 October 2003)

We see a large inconsistency between your words and the actions of your Administration. While you continuously praise the troops, the actions of your Administration are harmful to the troops. Mr. President, we believe the soldiers fighting this war deserve some answers. Please respond to the following questions:

1) When will every U.S. helicopter in Iraq obtain anti-missile equipment?
2) When will every U.S. soldier have the "Interceptor" body armor-Kevlar bulletproof vests with removable ceramic inserts?
3) When will the Pentagon be able to confirm that every one of the 250,000 defective bio/chems suits is recovered and removed from circulation?
4) When will your Administration restore all troop pay cuts?
5) When will your Administration reverse its current course and increase funding for military schools and military housing?
6) Why did you sign a tax cut bill that left out many soldiers whose children should have been eligible for the expanded child tax credit?
7) When will the Pentagon provide free travel to the soldiers who are participating the Rest and Recuperation Program?
8) What steps is the Pentagon taking to improve morale amongst the troops in Iraq?

We look forward to your prompt answers.

Sincerely,

Dennis J. Kucinich Jim McDermott Barbara Lee

Pete Stark

12/2/03

Jan Schakowsky Danny K. Davis Edward J. Markey

Gregory W. Meeks

Diana DeGette

Hilda L. Solis

Betty McCollum

Maxine Waters

Sheila Jackson Lee

Ted Deutch

John Conyers Jr.

Stephanie Tubbs Jones

Lynn C. Woolsey

Paul M. Tonko

Mr. KUCINICH. As the Chair knows, and as the Chair has recognized over the past few years, many of us have expressed our concern about the treatment of our troops, about whether or not they were, they had proper equipment, whether their health care was sufficient, whether their pay and benefits were appropriate, and raised questions about morale. This hearing that you're having, Mr. Chairman, is very important, because it continues this committee's work and oversight in raising questions about just how well those who serve this country in the military are being provided for.

I had the chance to look at Specialist McMichael's testimony. It was very telling in many areas. One area in particular I would just like to focus on, just for the purpose of a brief question, is the area where Specialist McMichael stated in his written statement that some soldiers may or have even attempted suicide because of the indifferent treatment they received. And this is an issue that many Members of Congress raised back in December. It's an issue that Specialist McMichael raised, not only with respect to Fort Knox but also with respect to Fort Bragg.

So I guess I'd like Specialist McMichael to say for the record, do you believe this kind of mental stress and anguish, which is apparently resulting in suicide, is widespread from your experience?

Specialist MCMICHAEL. Yes, sir. From what I've read in reports, it's not just Fort Bragg and Fort Knox, I understand there was a suicide at Fort Campbell as well as Fort Carson. It is widespread. The soldiers in medical hold at the different bases, the living conditions, the differences, well, you're National Guard, you're Reserve, create a level of frustration where they have no outlet. Some soldiers are flat out refusing treatment just to get out of there. They're taking the first amount that's offered to them by the medical boards to get away from it, just to get out of that situation.

I personally in my position in the unit, a lot of soldiers come to me and a lot of them tell me their stories. That's why I was able to refer some of them to the chaplain. I actually had a soldier go AWOL, but I talked him into coming back, because he couldn't get in to see behavioral health. He told me that he had spent 3 to 4 months just waiting to see behavioral health.

Soldiers have gone to behavioral health with problems, saying, I'm depressed, soldiers have admitted that they want to hurt themselves and they've been denied treatment. Soldiers have said, I have an alcohol problem. Well, you're National Guard, you're not allowed. Not that they're not allowed, they would not let them into the alcohol treatment problem.

Mr. KUCINICH. So you're saying that when soldiers have expressed a cry for help, they are ignored?

Specialist MCMICHAEL. Repeatedly, sir. At one point in time I protested because we had E5s, which are sergeants, in charge of our building, because they aren't able to tell when a soldier is in crisis. That was my big issue, is that there were soldiers in crisis. They brought some in. We've got some platoon sergeants and squad leaders now that will sit there and talk to some of the soldiers.

I'm sure that since Mark Benjamin brought all this to light, all the stuff that's going on with medical hold, there have been changes. I'm not saying things are totally deplorable. There has been some improvement. But soldiers, in the realm of mental

health, it seems the policy is, well, here's medication. More and more the answer is, well, here's some medication, go take this, take that.

Soldiers don't want medication. They want someone to talk to. They're going to outside agencies. They're going to the VA. They're going to churches off post to go find somebody to talk to, because they feel that they can't talk. Myself personally, I've had appointments canceled, doctor's not going to be there. The doctor was there on the one appointment. I went there that day. An active duty soldier had my appointment with the psychiatrist. I went there because I had issues that I wanted to discuss. They were only concerned with how long I'd been here, not helping me.

And I'm just the tip of the iceberg. The soldiers at Fort Knox, go talk to them one on one. They'll tell you. Sergeant Major Abbots has post-traumatic stress disorder. The reason I use his name is because a lot of soldiers are afraid to talk and a lot of them asked me not to present my name to the committee. Sergeant Major Abbotts had told me, he and I have talked repeatedly and at great length. He gave me permission to use his name because he wants to talk to you guys.

But a lot of soldiers have been denied mental health. And they feel they have nothing left.

Mr. KUCINICH. Mr. Chairman, one of the things that occurs in hearing Mr. McMichael and also in reading his testimony is that there appears to be a lack of appropriate attention paid to service personnel who are expressing a need for mental health care. And it would be interesting to have the committee staff maybe probe a little bit more deeply into this issue of how is it that we're starting to see what some describe as an increase in suicides. Are service personnel actually asking for help and they're being spurned, and therefore in their desperation, they take other alternatives that are deadly.

Mr. SHAYS. If the gentleman will yield, you'll have an opportunity I think to kind of pursue that issue with the next panel. And we do thank again that panel for waiting.

Mr. KUCINICH. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. Let me just allow the two spouses to respond to this question, and then we're going to come back after the votes. We have two votes, a journal vote and a motion on PAY-GO. The question I would ask is, it's the general philosophy of the military to recruit the solder and retain the family. I'd like to know, Mrs. Ramsey and Mrs. Emde, are you feeling retained?

Mrs. RAMSEY. No. As Mrs. Emde stated, my husband has been in the Reserve for quite some time. When he went to deploy to Iraq, we did have a conference and we were promised a bunch of stuff. The family residence program was supposed to be there to help. They did have ceratin programs right at the time he was deploying. But after that, there was nothing else. There was no other kind of support. I never heard from his unit.

Luckily, I did have a friend of ours that's also in the active Reserve that stayed back. He was not deployed, he was undeployable, that actually kept me up to date on a lot of things that were going on. I don't know if the family residence program took that as an assumption that I was being updated and I was informed of what

was going on, but as far as the family residence program, it's nonexistent.

Mr. SHAYS. Would you like to see your husband leave the Reserve?

Mrs. RAMSEY. At this point, with everything we've been through, yes, sir.

Mr. SHAYS. When I said Reserve, the National Guard. Your recommendation to your loved one is, let's get out?

Mrs. RAMSEY. At this point, with the hell the military has put us through for the last 9 months, yes, sir, absolutely.

Mr. SHAYS. OK. We need honest answers. Mrs. Emde.

Mrs. EMDE. Well, I look at his age and I want him out.

Mr. SHAYS. He looks young to me.

Mrs. EMDE. I know he doesn't like to hear that.

I just worry about him. I want him around later on. But he is, I guess in May he re-ups, and he plans to re-up and stay in. So I'll support his decision.

Mr. SHAYS. But that's in spite of your feelings, not because of them?

Mrs. EMDE. Right.

Mr. SHAYS. I want to thank all of you. You've been wonderful witnesses. I'd like to thank the committee members as well. We have our second panel when we get back, I apologize to our second panel, we'll have some votes and then we'll come back. But thank you all very much. We appreciate each and every one of you. Thank you.

We are in recess.

[Recess.]

Mr. SHAYS. The subcommittee will come to order.

I want to welcome our second panel. Two will be testifying, but we will have more participants to respond to questions. We have Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, Department of Defense, who has come before our committee on a number of occasions and we appreciate that. He is accompanied by Lieutenant General George P. Taylor, Jr., Surgeon General, U.S. Air Force, Department of Defense, and Rear Admiral Brian Brannman, Deputy Chief, Fleet Operations Support, Bureau of Medicine and Surgery, U.S. Navy, Department of Defense, and Wayne Spruell, Principal Deputy Assistant Secretary of Defense, Reserve Affairs, Manpower and Personnel.

And our second testimony will come from Lieutenant General James B. Peake, the Surgeon General, U.S. Army, Department of Defense.

Gentlemen, as you know, we swear in our witnesses. If you would stand, please, and raise your right hands.

[Witnesses sworn.]

Mr. SHAYS. Thank you. Note for the record, all of our witnesses have responded in the affirmative.

Dr. Winkenwerder, you have the floor. Given the importance of your testimony and the importance that only two testify, 5 minutes and another 5 minute rollover if you need it. That will be the same for you, General, as well.

STATEMENTS OF WILLIAM WINKENWERDER, JR., M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE, ACCOMPANIED BY LIEUTENANT GENERAL GEORGE P. TAYLOR, JR., THE SURGEON GENERAL, U.S. AIR FORCE; REAR ADMIRAL BRIAN C. BRANNMAN, DEPUTY CHIEF, FLEET OPERATIONS SUPPORT, BUREAU OF MEDICINE AND SURGERY, U.S. NAVY, AND WAYNE SPRUELL, PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE, RESERVE AFFAIRS, MANPOWER AND PERSONNEL; AND LIEUTENANT GENERAL JAMES B. PEAKE, SURGEON GENERAL, U.S. ARMY

Dr. WINKENWERDER. Thank you, Mr. Chairman. Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today to discuss the Department of Defense's Force Health Protection programs and how they impact our Reserve component service members and their families.

Today we have nearly 190,000 activated National Guard and Reserve service men and women, including those serving in Afghanistan and Iraq. We are firmly committed to protecting their health. Despite serving in some of the most austere and tough environments imaginable, today our disease and non-battle injury rates among deployed personnel are the lowest ever. The Services have improved medical screening to ensure forces are healthy, and they have enhanced theater surveillance, allowing commanders and medics to identify health hazards.

I would just state flatly and emphatically that the lessons from the Gulf war have been learned and those lessons are being put into place today. The Services evaluate all members, pre- and post-deployment and permanent health records are maintained. There is some good news that we've learned as we've looked over all those records of post-deployment health assessments of Reservists returning, and that is that they themselves have reported to us that over 92 percent indicate that their health status upon return from deployment is either good, very good or excellent.

Pre-deployment health assessments ensure that Guards and Reserve members are fit and healthy to carry out their duties. Improved pre-deployment screening in fact contributed to the backlog of activated Reservists who were waiting clearance to deploy who we heard from just earlier. The Army has worked to alleviate this backlog, and the number of troops in this status is steadily declining.

I would note to you that of the roughly 4,000 plus service members that were in that status, Reservists in the November time period, roughly 3,000, actually a bit more than that, about 75 percent have been processed through. There still are some. We heard from one or two of them today. But considerable progress has been made.

I'm also pleased with the good news that 97 percent of Reservists and Guardsmen who are reporting to mobilize are fit to deploy. In general, the Guardsmen and Reservists are fit and healthy.

Post-deployment health assessments gather information to evaluate concerns that may be related to deployment. About 127,000 Guardsmen and Reservists have had post-deployment health assessments done. Licensed medical providers determine the need for

referrals for appropriate medical followup. I noted in the comments from the panel who just spoke about the importance of engagement with that licensed provider, and I would very much agree with that. This is not nor should it be a process for just moving people through. People need to be carefully examined and asked the appropriate questions.

About 20 percent of Reservists, according to our data, require referrals. And this is a rate that's comparable to that for active duty. In January, the Department began a quality assurance program to monitor the Services' pre- and post-health assessment programs. This QA program monitors compliance with regard to completion of work and includes periodic visits to military bases to assess compliance with all the protocols.

The Services continue to immunize troops from disease and agents that can be used as biological weapons, including anthrax to smallpox. To date we have vaccinated over 1 million Service members against anthrax, and more than 580,000 against smallpox. Both programs are built on safety and effectiveness and they are validated by outside experts.

To support combat operations in Afghanistan and Iraq, medical care was provided far forward, available in most cases within minutes of injury. Over 98 percent of casualties who arrived at medical care survived their injuries. Over one-third were returned to duty within 72 hours. It's clear that far forward medical care, improved personal protection and solid procedures are saving lives, they're saving many lives, and that's good news.

For those who are seriously ill or injured, we rapidly evacuate to definitive care, using intensive care teams to treat patients during transit. Specialized programs available at our larger medical centers, particularly Walter Reed and Bethesda Naval are in place, and Walter Reed has a world class amputee management program. I'm sure General Peake would be glad to talk more about that.

Mental health is integral to overall health. And the Services have full mental health service programs for personnel at home and for deployed. Suicide prevention and stress management programs are supported by the leadership and tailored to the operation. In 2003, 24 soldiers deployed to Iraq and Kuwait committed suicide. That's a rate of about 17 per 100,000, compared with an overall Army suicide rate of about 12.8 per 100,000. This rate is higher than normal, but it is, I should note, and it's very important to understand, it's actually below the age and gender adjusted rate for the civilian population. Above the normal Army average, that age and gender adjusted rate in the civilian population is about 21 per 100,000.

Of course, every suicide is a tragic loss, and the Army is significantly beefing up its effort and requiring suicide prevention training for all personnel in units now deploying. General Peake I'm sure will be glad to talk in more detail about this important matter.

I want to commend the Army for its actions in performing a study that's never been performed before that I'm aware of in the history of warfare, looking at the mental health status of service members during conflict.

Malaria remains a threat overseas. Along with other preventive measures, the Department uses chloroquine, doxycycline, pri-

maquine and mefloquine for malaria prevention. While all are FDA approved, precautions for these medications must be followed. Investigations to date have not identified mefloquine, or Larium, as a cause in military suicides. The FDA last year cautioned that mefloquine should not be prescribed for persons with a history of depression. DOD follows FDA guidelines on the use of mefloquine. Our policy is that every service member who receives this medication also should receive information about possible adverse effects. I've also directed a study to assess the rate of adverse events associated with mefloquine as prescribed to the deployed service members.

The Department has improved the transition of care for service members to the Veterans Administration. VA counselors today advise our seriously injured on benefits, disability ratings and how to file claims before the member is actually discharged from the hospital. We have implemented the first stage of the computerized medical record and we are pursuing full sharing of health information with the VA.

While we are able to monitor the health status of active duty troops after deployment, we need to improve the visibility of health care obtained by deactivated Reserve component members. I recently assembled a task force to determine ways for us to better monitor the health status of Guardsmen and Reservists after their return to civilian life.

TRICARE eligibility for up to 6 months; that Congress recently passed last year, following deactivation, and eligibility for service through the VA for up to 2 years provides an excellent way to capture information and followup medical concerns. Let me be clear. We aim to ensure that all returning Guardsmen and Reservists get the care that they need.

Ensuring medical readiness of activated Reservists and providing health coverage for their families is one of our highest priorities. As we proceed, we must carefully review the need for permanent entitlements and benefits to Reservists who have not been activated. That's a topic that's been under discussion. And perhaps we believe the best way to do that is to look at the issue carefully through a demonstration program to test program feasibility and effectiveness.

Let me just close by saying that I've been on the job now for 2½ years and I've had the opportunity to visit military medical units worldwide. I'm extremely proud of the men and women who serve in the military health system. They are courageous, dedicated, caring professionals. They are America's best and I'm proud to serve with them. Our Reservists and Guardsmen are doing a superb job. With your support, we will continue to offer world class health care to the men and women serving in our military.

With that, I'd be glad to answer any questions.

[The prepared statement of Dr. Winkenwerder follows:]

Prepared Statement

of

The Honorable William Winkenwerder, Jr., M.D., M.B.A.

Assistant Secretary of Defense for Health Affairs

on

Health Protection Programs for Guard and Reserve

Before the

House of Representatives Committee on Government Reform

Subcommittee on National Security, Emerging

Threats and International Relations

March 30, 2004

Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today to discuss the Department of Defense's Force Health Protection programs and how they impact our reserve component service members. Today, we have nearly 190, 000 National Guard and Reserve service men and women activated for federal service, including those serving in Afghanistan and Iraq. DoD is firmly committed to protecting the health of our Reserve component members.

Protecting our forces is a primary mission of the Military Health System. Our Force Health Protection program is designed to ensure that all members of the total force – active, Guard and Reserve – receive the same world class of health care. The objectives of the Force Health Protection program are to recruit and maintain a healthy and fit force, to prevent disease and injury, and to provide medical and rehabilitative care to those who become ill or injured.

The rigorous medical requirements of the armed forces entrance physical examination and our periodic physical examinations, HIV screenings, annual dental examinations, physical fitness training and testing, immunizations and regular medical record reviews contribute to maintaining a healthy force. One of our most recently developed DoD policies requires all deployable forces to achieve a new Individual Medical Readiness (IMR) standard. The IMR is now used as the measure for the services' preparation of service members to deploy and execute the mission. The services are now using a common set of individual medical readiness standards to monitor the collective readiness of the force. For service members to be fully medically ready, all immunizations must be current and they must not need any dental work done. They must have all medical readiness lab tests done, including HIV tests, have no deployment-limiting medical conditions, have completed a current health assessment, and have all the medical equipment they need, including ear plugs, eyeglasses and mask inserts. By tracking the

individual medical readiness against this standard, commanders can monitor the percentage of personnel who meet each of the criteria. This is an important new commander's tool.

Pre-deployment health assessments ensure that deploying Guard and Reserve members are still as fit and healthy to carry out the mission as previously documented. More than 193,000 pre-deployment health assessments have been done on reserve component troops since January 2003. Until October 2003, Army policy was to hold those reserve component troops called to active duty, but found not medically fit to deploy, on active duty until treatment returned them to deployable status or they were medically separated. The unexpectedly large number of Guardsmen and reservists activated but not medically fit for deployment created a backlog of more than 4,400 Army National Guard and Reserve members in medical holdover status. A total of 3,265 of those troops were mobilized but did not deploy. Since October, the Army policy is consistent with the other services and activated reserve component members have 25 days for deployability evaluation. If they are not found to be fit for duty at the end of that 25-day period they are returned to their home station. As of March 17, 2004, 1,103 Army National Guard and Reserve troops remain on medical hold from October 2003 and earlier. This is about 25 percent of the original group. The total number of Army Guard and Reserve on medical hold status as of March 17, 2004 was 4, 372.

Our post-deployment health assessments gather information from deployed service members to help medical personnel evaluate health concerns or problems that may be related to deployment. Almost 127,000 Guardsmen and reservists have had post-deployment health assessments done. Face-to-face health assessments with licensed health care providers determine referrals for appropriate medical follow-up. The Reserve Component referral rate – 22 percent – is comparable to the active component referral rate of 17 percent. Blood samples are taken

within 30 days and are archived. Pre- and post-deployment health assessments and deployment health records are maintained in the individual's permanent health record, which is available to the VA upon the service member's separation from the military.

In January, I published written policy establishing the DoD deployment health quality assurance program, as directed by the Congress and recommended by the General Accounting Office. A key element of this program is the Defense Medical Surveillance System (DMSS), which provides periodic reports on centralized pre- and post-deployment health assessments. The quality assurance program also requires periodic reports on service-specific deployment health quality assurance programs, periodic visits to military installations to assess deployment health programs and an annual report on the DoD-wide program. DMSS retains copies of, and maintains centralized databases for, deployment health assessments. DMSS provides weekly reports on post-deployment health assessments and monthly reports on pre- and post-deployment health assessments. The post-deployment reports include data on service members' health status, medical problems, mental health, exposure concerns, blood samples, and referrals for post-deployment care. Since January 2003, more than 92 percent of the reserve component members returning from deployment have reported their health status as good, very good, or excellent.

In theater, deployed Army, Navy and Air Force preventive medicine units are performing comprehensive occupational and environmental health surveillance in support of Operation Iraqi Freedom and Operation Enduring Freedom. All reports are archived centrally at the U.S. Army Center for Health Promotions and Preventive Medicine (USACHPPM). USACHPPM deployed and maintained a forward liaison and a specialized preventive medicine augmentation team to perform in-theater surveillance and facilitate support in OIF/OEF. When an environmental exposure is identified, DoD records the names of all service members possibly exposed and the

samples are identified with a date/time and location that could potentially be linked to personnel present. This information is archived and available if needed after deployment.

We continue to protect our deploying troops with appropriate vaccines against potential biological weapons. The Department has succeeded in protecting many hundreds of thousands of service members from two deadly diseases - anthrax and smallpox. DoD led the nation in collecting and sharing information about safely administering smallpox vaccine. We protected more than 580,000 people against smallpox in a sophisticated immunization program that included education, screening, and follow-up. Military healthcare workers repeatedly were asked to help our civilian colleagues in improving the preparedness efforts of the communities in which we live.

Our Anthrax Vaccine Immunization Program has now protected over a million service members. Despite the current high operations tempo, we have delivered 82 percent of those doses on time and are working diligently to improve this rate even further. The supply of anthrax vaccine increases steadily.

Our Vaccine Healthcare Center Network is a network of specialty clinics to provide the best possible care in rare situations where serious adverse events follow vaccination. In all our vaccination efforts, we focus on keeping individual service members healthy, so they can return home safely to their families and loved ones. The National Academy of Science' Institute of Medicine, in a congressionally mandated report, concluded that anthrax vaccine is an effective vaccine to protect humans against all forms of anthrax, including inhalational. They also concluded that the vaccine is safe. It is fairly common for people to experience some local discomforts, such as redness, itching or swelling, but these are comparable reactions to those observed with other vaccines given to adults. Most recently, on December 30, 2003, the Food

and Drug Administration issued a final rule and order concluding, "the licensed anthrax vaccine is safe and effective for the prevention of anthrax disease, regardless of the route of exposure."

The Centers for Disease Control and Prevention tracks possible reactions to these and other vaccines through the Vaccine Adverse Event Reporting System(VAERS), which is co-sponsored with FDA. DoD encourages all service members to report any reactions to VAERS. Like all vaccines, most adverse events with the small pox and anthrax vaccine are minor and temporary. Serious events, such as those requiring hospitalization, are extremely rare.

In terms of casualty care in today's military, medical care is available within minutes after injury and is saving lives. Based on current analysis, more than 98 percent of those wounded have survived and one third have returned to their units for duty within 72 hours. Irrespective of the cause of a military member's illness or injury, or of the member's military component, our focus is to provide the care needed and whenever possible, to return that person to duty. Clearly some injuries are much more serious than others, but it is also clear that military medicine, improved personal protection devices, and operational risk management techniques are saving lives. For Operation Iraqi Freedom, the rate of non-combat disease or injury is lower than in any previous U.S. conflict. Cumulative data through March 4, 2004, shows that four out of 100 deployed personnel sought clinical care in theater for a health concern or complaint each week . At home, the usual rate of clinic visits for active duty military personnel is at least twelve out of 100 per week.

As of March 13, 2004, data from the Transportation Command shows 18,004 total evacuations out of theater. Service members were transported from the theater of operations for medical care that couldn't be provided in theater, including a wide variety of medical conditions, very few of which were life threatening. With our smaller, more flexible healthcare capabilities

in theater, we can expect to evacuate patients for medical care not available in theater. The vast majority of medical evacuations – 92 percent – were routine. The remaining eight percent were urgent or high priority.

We are moving toward implementing fully automated patient care records systems, and we are working with the service surgeons general to establish a trauma registry that will capture information from the point of care.

Of course, physical trauma isn't the only kind of injury that deployed service members can face. Behavioral health issues, from combat stress to acute anxiety reactions, threaten our troops and we've made a great deal of progress in the areas of prevention, identification, and care of these potential risks.

At the request of the Operation Iraqi Freedom leadership, General Peake, the Army Surgeon General, sent a 12-person Mental Health Advisory Team to Iraq and Kuwait from August to October 2003, to assess behavioral health care for OIF soldiers and mental health issues. The advisory team's recommendations include adapting current garrison-based Army suicide prevention initiatives to the OIF deployed force. The team briefed its findings and recommendations to the coalition forces Commander and the commander of the joint task force, and is scheduled to brief Congress.

While we monitor stress casualties, we have a renewed focus on suicide prevention during this deployment. As of March 18, 2004, the Office of the Armed Forces Medical Examiner has classified 26 service members' deaths as suicide for those deployed to Iraq and Kuwait during 2003 and 2004. The 26 confirmed Army and Marine Corps suicides during Operation Iraqi Freedom represent an annualized rate of 15.9 suicides per 100,000 soldiers per year. This rate compares with a rate of 9.1 to 14.8 per 100,000 in the Army between 1995 and

2002. It is important to note that suicide rates in the military are lower than in the civilian population. In the overall U.S. male population, when age-matched with the Army, the rate is 20.5 per 100,000. Of course, every suicide is a tragic loss. The Human Resources Policy Directorate is funding additional Applied Suicide Intervention Skills Training for personnel in units preparing for OIF deployment.

We continue to deploy troops to areas where malaria is an endemic hazard. In 2003, we had 80 cases in Liberia, 44 between Afghanistan and Iraq, and 10 in South Korea. Studies have shown that troops need constant reminders and reinforcement to keep up their guard against the biting insects that transmit disease. Preventive measures include applying skin repellant several times a day, use of repellant-impregnated uniforms, using bed nets and taking preventive medications as prescribed.

The preventive medications for malaria most often used by the U.S. military are chloroquine, doxycycline, primaquine and mefloquine, also called Larium. All of these are FDA-approved drugs. As with any medication, precautions in prescribing and taking the medication must be taken. Investigations to date have not identified mefloquine as a cause in military murders or suicides. However, according to the FDA, mefloquine should not be prescribed for persons with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of seizures. DoD follows FDA guidelines on the use of mefloquine, and it is DoD's policy that every service member who receives this medication also receives information about possible adverse effects.

I have directed a study to assess the rate of adverse events, to include suicide and neuropsychiatric outcomes, associated with antimalarial medications, particularly mefloquine,

prescribed to deployed service members. DoD will appoint a panel of experts in malaria and malaria medications that can articulate the best science options and provide guidance on how best to perform the study.

While we protect the health of deployed service members, we are also working to support their families back home. We endeavor to make sure every reserve family member is in contact with a commander's family support group, ombudsman, key volunteer network, or family readiness point of contact. We issue members and eligible family members a distinct identification card (ID) authorizing them to receive Uniformed Services' benefits and privileges. The ID card serves as proof that individuals have been pre-enrolled in the Defense Eligibility Enrollment System (DEERS). This is an important first step in obtaining family member medical treatment when the service member is called to active duty for 31 consecutive days or more. Eligible family members may be treated on a space-available basis at any military medical treatment facility. Availability is often very limited. However, TRICARE offers several cost-effective options, including a fee-for-service type option — TRICARE Standard, a preferred-provider organization type option — TRICARE Extra, and an HMO type options that require enrollment – TRICARE Prime.

The Soldiers' and Sailors' Civil Relief Act provides financial protection to anyone entering or called to active duty, including members of the National Guard and Reserve when in active federal service. Protections commence on the date the service member enters active duty. It covers such issues as rental agreements, security deposits, prepaid rent, eviction, installment contracts, credit card interest rates, mortgage interest rates, mortgage foreclosure, civil judicial proceedings, and income tax payments. All military services have legal assistance officers available to assist families with legal problems during periods of active duty. Typical legal

services involve wills, powers of attorney, child support, income tax returns, and contractual disputes.

Children of Reservists on active duty are also eligible patrons of DoD Child Development Programs at over 300 locations. DOD programs offer quality care at approximately 800 child development centers and 9,000 family childcare homes.

In the case of extreme financial difficulties, the Services each have a relief society and other options. The Services keep those family members informed of the help DoD offers through the *Reserve Family Member Benefits Guide*, which DoD distributes to key family support organizations throughout the total force. These guides are also available on line at DoD's DefenseLINK web site. In addition to those valuable guides, the Army's Center for Health Promotion and Preventive Medicine offers a manual entitled *A Soldier and Family Guide to Redeploying*, which covers such topics as assessing medical health, reunions with loved ones, the expectations of both soldiers and spouses, and what children may feel. All the services offer this type of program.

After service members return from deployments, military and VA providers use the jointly developed Post-Deployment Health Clinical Practice Guideline to give health care focused on post-deployment problems and concerns. The guideline provides a structure for the evaluation and care of service members and veterans with deployment-related concerns. The Deployment Health Clinical Center provides health care professionals access to expert clinical support for patients with difficult symptoms and illnesses, as well as deployment-related information.

While we are able to monitor the health status of active duty troops after deployments, we need to improve the visibility of the health care obtained by deactivated reserve component

members post-deployment. I have recently assembled a task force whose job is to put systems in place that allow us to better monitor the health status of Guardsmen and reservists after their return to civilian life. The extended period of eligibility for TRICARE following deactivation, for up to six months and their eligibility for VA health care benefits provides an excellent way for us to capture information and follow-up medical concerns. After deployment, our goal for injured or ill service members is, when necessary, to effect a seamless transition of care from DoD to VA's health care system. An injured service member's ability to return to full duty is based on a careful health evaluation by a physician. If a member is found to be unfit for continued active duty by their attending physician, the service member is referred to a Physical Evaluation Board where it is determined if the individual is fit to perform duties. All members referred to a Physical Evaluation Board must attend Disability Transition Assistance Program training. During this training, a counselor from VA informs members of VA benefits, disability ratings and how to file a claim. Prior to separation, members with disabilities are required to file, or decline to file, a claim with VA for compensation or health care benefits. I am informed that VA has recently hired personnelto assist with that process.

At the time of demobilization, all reserve component members are offered a separation physical examination. Those deactivated but not referred to the Physical Evaluation Board, are required to receive mandatory pre-separation counseling through the Transition Assistance Management Program (TAMP). Separating members are required to fill out a pre-separation counseling checklist, and to receive both a briefing and a booklet on VA benefits and health care services.

The Federal Health Information Exchange transfers electronic health information on separating Service members to VA. Currently, DoD sends VA laboratory results, outpatient

military treatment facility pharmacy data, radiology results, discharge summaries, demographic information and admission, disposition and transfer information, allergy information and consult results. I understand that this valuable medical information is now being used widely and regularly by medical providers in the VA system. DoD and VA have created integration points that will permit VA to access the Defense Enrollment and Eligibility Reporting System – DEERS - in real time by the end of 2005. To further strengthen DoD/VA electronic medical information exchange, while leveraging departmental systems investments, we are working with our VA counterparts to ensure the interoperability of our electronic medical records by the end of FY 2005.

As you can see, DoD has made tremendous progress in instituting truly total force health care. The groundwork has been laid for even greater progress in the near future and I am firmly committed to continued improvement in protection for the health of all our service members. The medical personnel of our combined services, active and reserve, have my heartfelt appreciation and full support for the outstanding work they are doing to develop and implement the force health protection programs necessary to keep our military fully fit and capable.

Mr. SHAYS. Thank you, Dr. Winkenwerder. General Peake.

Lieutenant General PEAKE. Mr. Chairman, distinguished members of the committee, I am Lieutenant General James Peake, the Army Surgeon General, and I thank you for the opportunity to appear before you today.

Mr. Chairman, I recall the day that you joined us in the Army Operations Center and heard all the areas of the operation and the extent of the current operations. At that time we were engaged in Afghanistan. And I remember what you said, your comment that from what you saw that day, the story of Army contributions was not really widely known.

I believe in that same vein there is much to tell about military medicine and the positive things that have been done, particularly as it relates to our Reservists who play such an important role in the total force readiness. In the Army, we have a selective Reserve of about 213,000 and a National Guard of about 377,000. And we've mobilized from Noble Eagle, Enduring Freedom through Iraqi Freedom some 240,000 of them. They are important as a group and as individuals, and we care about them.

Reserve medical readiness has been and is an issue from dental readiness to medical screening. Following Desert Shield and Storm and well before September 11, there has been increasing attention paid to this issue. The Army from 1995 to now has invested nearly $.4 billion in National Guard and USAR medical and dental screening. Since 1999, this has been more programmatically funded, as the FEDS-Heal program expanded access to USAR soldiers. Before that it was mostly Guard and it was all targeted at the early deployers. At least 120,000 USAR soldiers have been touched by that program, and an even larger proportion of dollars were used for the Guard over a longer period of time.

The current emphasis from Lieutenant General Helmly and Lieutenant General Schultz is apparent in the numbers, 34,000 dental exams in 2003 and already in 2004 we have had 32,000 plus dental exams done. And it is apparent as fewer soldiers are arriving at our MOB stations in a non-deployable status.

On the front end of dental readiness, we have piloted a program that we want to expand to all of our advanced individual training sites, bringing all soldiers, active and Reserve, up to deployable status before they return to their first unit active or Reserve. We believe that this not only is good for deployability, but it sets the right culture in terms of dental wellness being an important contributor to readiness. And Lieutenant General Dennis Cavin, our war fighter trainer, has carved out the time out of the training time to be able to do this kind of general readiness.

To get accountability built into the system, the measurements of the individual medical readiness that we are promulgating as a military health standard is a real step forward and will give commanders and we medics the tools to ensure that both our active and our Reserves have the right medical status for deployment or a plan to fix it on a real time basis.

The pre- and post-deployment medical screening is being done and recorded. This is not a passive screening as it has been wrongly, I think, described in the press, but rather it is a process that includes filing out a form for self reporting for sure, self reporting

your status and concerns. And this is followed by a face to face review of that self report tool with a provider who explores any issue, create a followup plan and further evaluations, laboratory work or consultations as might be indicated.

Further, as you know, a serum sample is placed in our serum repository with approximately 30 million samples on record. Yes, GAO did take a look at this some time ago when we were in the Balkans, and we did not do very well with compliance. We have made a concerted effort to do this better. The key is getting information into the central data bank. We initiated electronic records for this process in Kuwait. Nearly 100 percent now are transmitted overnight to our data base from Kuwait. Nearly 50 percent are coming electronically out of Iraq, and even in that really more austere environment.

The GAO team has just completed their first visit with us, a visit to Fort Lewis. They reviewed 194 records of soldiers deployed to OIF from Fort Lewis from June to November 2003. Pre-deployment surveys were located on 100 percent of these; 255 of soldiers who returned to Fort Lewis from OIF from June to November 2003 were reviewed. Post-deployment surveys were located for 100 percent of these. A smaller percent of this group did not have a pre-deployment, about 60 percent did.

Documentation of required immunizations was also audited. The assessment of my officer on the ground that was there with them said, I think the GAO team left with a very favorable impression of the results of increased emphasis on this program. I look forward to the rest of their visits to our installations.

I want to give you a flavor of why I believe we are doing better. And it's not just pronouncements from Washington. It is the quality of our people in the field. Their enthusiasm for doing what is right in an area which, however important, might sometimes seem mundane.

This note was forwarded to me. "I have attached the model we use for our reintegration process. We have made several adjustments, to include adding the tobacco cessation program, clinical practice guideline to one station and going all electronic by preloading the 2796 the night before. Almost all the ideas for improvement are coming from my soldiers who see something that could be done better. I have a great group, sir, Jim Montgomery produced the model, Kathy McCroary is the mastermind behind the setup, Sergeant Stanton is the data quality person. She has a team that loads 100 percent of the data every night.

Tamara Baccinelli, civilian, codes every post-deployment encounter by 1400 hours daily. The soldiers are pre-screening MEDPROS and filling out the checklist to ensure that every soldier receives the immunizations they need. The stress management team sees every returning warrior also. They produce a list of soldiers daily that they have concerns about, and we see them that same day. During the reintegration, ortho and physical therapy are available for the soldiers, and they like that. We are doing all of this and maintaining a walk-in clinic for the community. To date, I can think of only one patient that we have sent downtown because of the reintegration process.

The community has been great, they know what is going on and they are waiting a little longer to be seen and doing it gladly. The Red Cross has dressed up my lobby so it looks like a World War II welcome home canteen. The soldiers love it, they sit, talk and eat for hours. Personally, I've never enjoyed myself more."

How can we be better? We really need to move forward on the clinical, the CHCS II, our computerized patient record, a joint system that will be promulgated across all three Services over the next 30 months. It offers structured notes, a longitudinal, queriable patient record. It takes investment to keep that kind of a program moving.

We get better because we look at ourselves critically, and we want to know our faults, so we look and we listen and we will listen to the panel before us and track those down. But when we find them, we fix them.

It is why we proactively have sent teams into the combat zone to look at pneumonia, to look at leishmaniasis, to look at the status of mental health. It is why we have aggressively used environmental surveillance teams to go into theater to sample soil and air and water, asses risk, mitigate it where found, and importantly, archive that information at our Center for Health Promotion and Preventive Medicine so we can go back should questions arise in the future and answer with more than just conjecture.

We are good, and we get better because of our great people, like this officer who volunteered to come back and serve with the Reserve, who writes: I am with the 1967th Eye Surgery Team in Baghdad. We are attached to the 31st Combat Support Hospital here in the Green Zone. Although my role is rather minor, I am delighted to be here. I find it interesting as an older fellow to observe the young soldiers in the theater. I feel so proud of them. They have such a difficult job, but go about it in a very positive fashion.

I saw a young Marine lieutenant a couple of days ago in the emergency room who had a rather severe arm injury along with some minor facial trauma. I doubt that he will ever serve again. He had to have been in a great deal of pain, but his only question was, "When do I go back to my Marines?" I think this attitude is the norm here.

The 31st has an extremely impressive staff and I greatly enjoy working with them. I think the service they provide is truly superb in every respect. I would hypothesize that the emergency care provided here is as good or better than any trauma center in the United States. If I were wounded, I would be very comfortable being treated here."

We are good because of people like that, and because of our young soldiers on the front line, soldiers like Specialist Billie Grimes, a 26 year old female Reservist with a bachelors degree, a Reserve medic who joined the active force to serve in Iraq and who is the middle person on this Time Magazine cover.

I thank you, Mr. Chairman and this committee, for your support of these men and women and the thousands more like them across our military, and I look forward to answering your questions.

[The prepared statement of General Peake follows:]

Chairman Shays, Congressman Kucinich, Distinguised members of the committee. I am LTG James Peake, The Army Surgeon General. Thank you for the opportunity to appear before you today.

Mr Chairman, I recall the day that you joined us in the Army Operations Center and heard all of the areas of operation and the extent of the current operations ... at the time we were engaged in Afghanistan. I remember your comment that, from what you saw that day, the Story of Army contributions was not really widely known.

I believe that, in that same vein, there is much to tell about military medicine and the positive things that have been done... particularly as it relates to our reservists who play such an important role in the total force readiness. In the Army, we have a Selective Reserve of 213 thousand, a National Guard of 377 thousand and we have mobilized from Operations Noble Eagle, Enduring Freedom, and thru Iraqi Freedom some 240 of them. They are important as a group, and as individuals.... and we care about them.

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On the front end of dental readiness We have piloted a program that we want to expand to all of our Advanced Individual Training sites bringing all soldiers active <u>and reserve</u> up to deployable status before they return to

their first unit active or reserve. We believe this not only is good for deployability, but it sets the right culture that dental wellness is important... and the warfighter trainer has carved the time out to do this.

To get accountability built into the system, the measurement of individual medical readiness that we are promulgating as a military health standard is a real step forward and will give commanders, and we medics, the tool to insure both our active and our Reserves have the right medical status for deployment or a plan to fix on a real time basis.

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GAO team left with a very favorable impression of the results of increased emphasis on this program."

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checkout lists to ensure every soldier receives the immunizations they need, ...

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HOW CAN WE BE BETTER? We really need to move forward on the fielding of our CHCS II, computerized patient record… a joint system that will be promulgated across the 3 services over the next 30 months. It offers structured notes and a longitudinal, queriable patient record. It takes investment to keep that kind of program moving.

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And because of our Young soldiers on the front lines, soldiers like SPC Billie Grimes, a 26 year old female reservist with a bachelor's degree… a reserve medic who joined the active duty to serve in Iraq and who is the middle person in the trio of soldiers on the cover of Time Magazine.

I thank you Mr Chairman and this committee for your support of these men and women and the thousands more like them across our military. I look forward to answering your questions.

Mr. SCHROCK [assuming Chair]. Thank you, General Peake and Admiral and General Taylor, Mr. Spruell, thank you all for being here as well.

I can't imagine the men and ladies who spoke earlier are the exception rather than the rule. I hope they're the exception, but I gather they may not be. How do we know that we are truly deploying fit people to the battlefield if we're not doing physicals on them? It seems to me there are a lot of people slipping through the cracks that might have been screened and pulled out before they went into battle. Is that the exception or is that the rule?

Dr. WINKENWERDER. Let me speak first on that. I think we know because I believe that we have a process that does identify individuals' health status before they deploy. I don't think there is any hesitation on the part of people managing that process or the individual medical providers who see the service member across the examining table to pull that person out if he or she has a deployment limiting condition or doesn't have the appropriate physical status to ensure that they can safely deploy.

We have, as I said, about 3 percent to date through that first 30 days from the Reservist community, after they are called up and mobilized, that we determine now are not medically fit. We don't have the precise similar comparative statistic for active duty, because it's a more regular, ongoing care situation. However, I would say that we don't really have any indicators to suggest that we're not appropriately picking up and screening these individuals. I think there's a high level of confidence that people that are deploying are fit and healthy to deploy and those that are being held back are being held back for the right reasons.

Let me also add, I think there is an important change that we've initiated in the overall medical readiness approach within the military. And that is that the services are moving to begin, I think with the Air Force and the Army and Navy are coming on with that, to have an annual, an annual, once a year health assessment, where the individual sits down and goes through a checklist and gets assessed. That's a change for us. We believe with that process being implemented the need for a complete physical exam prior to deployment just doesn't make sense.

Mr. SCHROCK. Before we go further, General Taylor, I understand you have a flight at 1:30. So don't hesitate, don't miss the plane. I've been on a plane and it's murder getting out of airports.

Lieutenant General TAYLOR. Yes, sir, I think they'll wait for me, though.

Mr. SCHROCK. Oh, it's an Air Force plane. Oh. [Laughter.]

I didn't realize that. I thought it was a commercial plane. In that case, we'll expect you here the rest of the day, right? [Laughter.]

General Peake, did you have a comment?

Lieutenant General PEAKE. Yes, sir. Actually, if you think through that previous panel, there was screening for all of them. The gentleman who was on the far left, I believe his name, he came out of the IRR, that's a different issue. They're not part of the SELRES and so forth, and had, as he described, multiple sequential problems. The First Sergeant described having every 2 year physical examinations, which sort of suggests that maybe that's not necessarily the appropriate standard.

As a physician, I can tell you, the most important thing is a quality history. That's what our process tries to get at, is getting a good history that points then in the direction so we can do the appropriate interventions, whether they're diagnostic interventions or therapeutic interventions or laboratory tests or whatever. So what we want to do is, we don't want people in theater that are not medically ready to be there. It just puts a logistical burden and a burden on the unit to do that.

Mr. SCHROCK. Sergeant Mosley said that he had, I think he said he had physicals every 2 years. You think it should be more than that?

Lieutenant General PEAKE. No, sir, I don't.

Mr. SCHROCK. I thought you just said that.

Lieutenant General PEAKE. I'm just saying, the point is, he did have those physicals every 2 years.

Mr. SCHROCK. So there is a record.

Lieutenant General PEAKE. Yes, sir. And if you listen to Specialist Ramsey, he had his physical, I think he said in 2000. That's within the 5-year time. So we had that. And he did not have a problem before he went over.

So they're really kind of different pieces that we heard about over here that didn't necessarily say we weren't doing an appropriate job totally of screening folks going in. I think there's a lot of attention being paid to that, sir.

Mr. SCHROCK. And don't get me wrong, I think you're doing a good job, and I know you're trying to put this many people through this big a pipe at one time, and I know it's very difficult to do that.

Lieutenant General PEAKE. If I could just followup, one of the things that we stumbled on and frankly, it occurred in November when we went down and looked at Fort Stewart, as we were prompted to do. We had a policy that if somebody came on and they were non-deployable, we kept them. Now with that 25 day rule, it allows us to do a look, and so those 3 percent or 3.3 percent or so are going back home, because they were non-deployable. And now what we're doing is following through with their units to make sure that they don't just go back into the black hole, but in fact there is followup through their chain of command.

Mr. SCHROCK. I have several more questions, but I see my initial time is up. I yield to Mr. Tierney.

Mr. TIERNEY. I was just curious if anybody on this panel can solve for us the dilemma that some of the first panel testifiers had in terms of getting their medical bills paid. What's the process that we have to deal with an issue where there are mounting medical bills and their credit is being affected and yet they can't seem to get those issues resolved?

Dr. WINKENWERDER. Let me comment on that, Congressman. I heard the individual story. I actually spoke with Specialist Ramsey and his wife in between sessions. I for the life of me could not understand why there was so much difficulty to do what was obviously the right thing. And so it was disturbing to me to hear his comments.

What he had indicated in that conversation was that it seemed to be some debate about who should pay the bill. It's totally inappropriate. This is an issue where if the injuries take place, they

take place as a result of active duty or while on active duty, no questions should be asked.

Mr. TIERNEY. So we have a process that currently exists that should have resolved this, is what you're saying?

Dr. WINKENWERDER. Should have, but obviously didn't.

Mr. TIERNEY. Without putting too much of a burden on you, are you now going to take personal responsibility for Mr. Ramsey's situation or designate it to somebody who might help him out?

Dr. WINKENWERDER. I think someone will be looking, I will ensure that someone looks into it and resolves it. I couldn't understand from what was described to me, if the facts were as he presented them, why the bills still wouldn't have been paid.

Mr. TIERNEY. What normally would happen? He would submit the bills or the provider would submit the bills to the military and they would just get paid?

Dr. WINKENWERDER. In this case, it sounded like there may have been some discussion or debate as to whether it was the Guard unit or whether it was the active unit that was going to pay for it. That was the description. Who knows if that was the case or not.

But if that was true, that's not appropriate.

Mr. TIERNEY. There's got to be a way to stop that from happening over and over.

Dr. WINKENWERDER. No question should be asked about that.

Mr. TIERNEY. Thank you.

Lieutenant General PEAKE. I'd just like to comment on that, in fact, it is legitimate to ask a question, because if it is, and I'm not, in fact, on March 23rd there were PGBA, which is our bill payor, was, bills were forwarded to pay for Specialist Ramsey $7,600 for the left shoulder, $6,300 for the right shoulder. So that is in the process as of the 23rd. But the point is, it's appropriate to ask the question, sir.

Mr. TIERNEY. I don't have any problem with the question being asked, sir, it's resolving it in quick enough time that their financial situation doesn't become critical.

Lieutenant General PEAKE. I agree with you.

Mr. TIERNEY. We all expect it to get paid out of the proper account, but hopefully we have a process where that moves expeditiously, so that the individual soldier doesn't end up having his family and himself have that kind of additional burden, that's all.

Lieutenant General PEAKE. Sir, I couldn't agree with you more.

Mr. TIERNEY. Is there anybody on this panel that can address for me what we do in terms of oversight on medical prescriptions? What is the process for making sure that our providers within the Service are in fact issuing the right amounts of medication and who oversees that, what kinds of reviews are done to assure that they're not being overmedicated or given the wrong medications?

Dr. WINKENWERDER. Let me turn to General Peake, General Taylor and Admiral Brannman on that.

Lieutenant General PEAKE. Sir, we have a very good system of quality assurance within the military. I do appreciate the sense that some people feel like that are, it may have an appearance of overmedication. One of the issues about mental health in this country is, many of the people that suffer from depression don't get the

medicines that they need, they don't get medicated for it. So you know, what we have are credentialed, qualified providers that are taking care of folks and prescribing the appropriate medications. Sometimes you're on a regime of medicines that may seem like a lot, but we're trying to work out the appropriate combination.

Mr. TIERNEY. I don't mean to interrupt you, but this isn't unique to the military, so I don't ask this in terms of saying like, oh, gee, the military is making mistakes that regular hospitals don't. But I do think it's an issue that happens in almost all medical settings, and I see complaints from medical professionals, from the doctors, from nurses and from patients that there probably in all medical settings might not be enough of a holistic approach, someone watching what the total prescriptive scenario is.

Lieutenant General PEAKE. Right, sir, and we have actually a program, PDTS, which has actually won some awards that allows us to look across and find out what all the medications, even if they are coming from disparate providers. So in some ways, we're a step ahead of some other organizations that can do that.

But it is an issue that, the other thing we're trying to do with TRICARE actually is to get a primary care provider for folks to allow those kinds of disparate things to come together and say, well, are we doing the right thing from a more holistic picture. And it's one of the advantages of having a primary care provider.

Mr. TIERNEY. I suspect we might have another hearing or two, as the chairman indicated, about that process, and perhaps even the program that you're talking about, to see how it's working and whether we can be helpful in it having it work a little more effectively or take individual scenarios. Some of it we heard. When the Sergeant lifted up the bag of pills, even as a lay person, I thought that was a little over the top. But I've seen that in other settings, not just military settings.

Dr. WINKENWERDER. Yes, sir.

Mr. TIERNEY. So I think we probably need to have hearings, it probably can't be resolved here today, but we'll have to followup on that and see what's going on there.

I yield back my time. Thank you.

Mr. SCHROCK. Thank you, Mr. Tierney. Chairman Shays.

Mr. SHAYS. Dr. Winkenwerder, I believe that there has been progress that's been made and I also believe that obviously you can't be held accountable for the failure to have equal treatment as it relates to pay and training and equipment and protective gear. Tell me your biggest challenge, though, as it relates to health care being provided on an equal basis for our Reserve components. What are your biggest challenges?

Dr. WINKENWERDER. Thank you, that's a great question, Congressman. From my perspective, we need to do and are working very hard to do the following. To make it easy for Reservists and Guardsmen and their families to get onto the TRICARE benefit. That's sort of No. 1.

Second, we want to make it easy and understandable for them to continue their benefit for the period after active service while they are still eligible. And then——

Mr. SHAYS. Define while they are still eligible. What does that mean?

Dr. WINKENWERDER. Well, under the temporary provisions that the Congress passed last fall, there's a continuation of benefits that goes for 6 months. And those activated Reservists and Guardsmen continue to be eligible for TRICARE for 6 months after their active duty period. And that should help ensure that there's coverage for needed medical care, that along with the fact that they're eligible for VA as well.

So that's two things. And the third I think is ensuring the movement, appropriate movement of accurate medical information throughout the system. So we're working real hard, and part of the charge that I gave to the task force that I described is to develop, and it's already been developed by the Army, a data base that captures the pre-deployment health information that's in-theater and the post-deployment information all in a data base, so that, and then to be able to transfer that data to the Reserve or Guard unit or to the VA hospital.

Mr. SHAYS. What is the deadline of the task force?

Dr. WINKENWERDER. I am looking for their report, for their initial report here within the next couple of weeks. They've been at it for about 4 weeks. We're both looking at the process for followup care and ensuring that people understand their benefits and can get the care that they need, as well as the medical informatics piece of this. So both pieces are important.

Mr. SHAYS. What's challenging for someone who's a Reservist or a National Guard is that they may be living at a higher level of pay than they're going to receive once they've been activated. Their mortgage may be higher than their actual pay, and, and, and. That's the reality that we don't really have a good resolution of.

But the one area that it seems to me is like a no-brainer, I was looking at Ed Schrock and thinking, he served in the military and the frustration I think he felt, I feel it differently, not having served in the military but knowing that I sent them overseas. I'm not clear why someone has to come to a Member of Congress or go to the media before somebody, and I don't want to say some idiot, because it strikes me that you would have to feel extraordinarily frustrated that they would allow it to get to that point.

Is there no one in the system that can kind of break through the bureaucracy? Are people not empowered to see something happening that needs to be dealt with? That's the question I'd like answered.

Dr. WINKENWERDER. You're correct in identifying my frustration with eliminating, totally eliminating the individual cases of this sort that we heard about this morning. I believe we're making great progress, I really do. And we have given it very high attention. I receive a report weekly, generated by each of the three Services, that identifies every single individual going through this medical hold over and medical extension process. That was not in place earlier.

I think it's fair to say there was not the focus or attention that there needed to be if one looks back 12 months ago. I think the way I would describe this is that the system that was in place basically was something that, if it had problems, they were not blatantly obvious because 15,000 or 20,000 or 25,000 Guardsmen and Reservists were about all that were being called up in the past years.

We are obviously in a very different situation today. So the system was stressed, we had to identify new and better ways to take care of people. One could argue that those should have been in place all along. But make no mistake about it, we understand, we appreciate that there are truly some issues that need to be addressed, and we're aggressively addressing them.

Mr. SHAYS. Let me say, I made an assumption, falsely, General Peake, that if you wanted to elaborate you would join in on this dialog. So I apologize for not making that clear. Is there any question that I have asked that you want to comment on?

Lieutenant General PEAKE. I would just, I think I would just echo the Secretary, we take this very seriously. There's not a single one of us that wanted to sit back and hear the kind of specific issues that we heard from the first panel. But I don't, I would not suggest that I believe those represent really the majority. They are issues that we need to address. Some of them were administrative, some of them were medical. And we clearly have our, there's an overlap in those, and we will work those issues that we heard here.

But I think we are making the right strides forward to take care of our soldiers, to recognize that they are an important part, an absolutely essential part of the total force. There is this notion that sometimes there's a perception that we treat a Reservist differently. In fact, Reservists have sometimes different circumstances that require to take care of them properly we need to treat them differently. In fact, our standards of access, we have increased them so that we don't keep people at a medical hold site at a longer time.

Mr. SHAYS. Well, for me the bottom line is the Reservists and National Guard sometimes don't have, I don't want to say hand me down equipment, but I kind of had the sense like, I was the younger brother, I had three older brothers, I got their clothes. And I think they do get that. It didn't matter as much when we weren't calling as many because they could get new equipment. It matters a lot more now that they're an integral part of whatever we do when we go into battle now. I mean, in other words, there are slots that can't be filled by anybody by the Reservists and National Guard.

Let me just ask to hear from both the Navy and the Air Force, I'm gathering, General Peake, that we asked you to testify because we're seeing more of the Reserve and National Guard in the military, the Army is so much larger. But maybe we should hear from the Navy and Air Force about their challenge. Why don't we start with the Navy, only because my brother was in the Navy, sir.

Admiral BRANNMAN. I think all of us, throughout our service careers, strive to assure there's a total force, or one force. You can't tell us apart. In the deployments I've been on, particularly most recently, several years ago I was in a joint forces command, we're all wearing camis, you can't tell other than looking at the name tape whether it's a sailor, airman, marine, soldier, active or reserve. I think that's a situation you're going to find on the front lines today in the Persian Gulf, in Iraq or in Afghanistan.

And that's truly the way we endeavor to treat our folks when they're on board in our treatment facilities. This is a family business. That's the way—I grew up in a Navy family, but that's, we're

taking care of our neighbors, we're taking care of the people we work with day to day. So there is a commitment to those people that we serve to take care of them the right way. We hold ourselves to the same standards that are being held in your own community. We use the same accreditation organizations and we beat their standards if you look at our scores on various things.

The issues that were described here are not the things that you want to have happen in my hospitals or anybody's facilities. You search those things out and you try and find out why they're occurring and take care of them. But this is a new ball game we're in right now in terms of the large number of folks we've got, and with the Reserves being mobilized and integrating them into the system, I think there have been some growing pains, but I think there's a strong commitment amongst all of us to make sure these things are identified, you shine the light of day on them, get them fixed and get on with it.

Mr. SHAYS. I have a red light, and the chairman will probably want to move on, but let me just hear from you, General Taylor, if that's all right, Mr. Chairman.

Lieutenant General TAYLOR. Yes, sir. The Air Force has a long experience in dealing with total force from the Persian Gulf war forward. A large portion of our mobility forces, most of our air medical evacuation comes out of the Guard and Reserves. And over the past 15 years, it's very common to see units that look blended. In fact, we're sending out blended units today with Guard and Reserve.

So we're very used to folks coming on active duty and then off active duty, primarily through volunteer status. But we've also activated folks. So we're pretty used to folks coming on and off. And we knew fairly early that we had to run as smooth a system as possible.

So based on that experience, the Assistant Secretary of the Air Force for Manpower and Reserves set up a very fixed process of ensuring that we timely took care of people that were on hold, placed on medical hold, either coming in or going out. He personally approves every single extension on hold. So we've had a very strong process even from very early in the entire——

Mr. SHAYS. And you can do that because your numbers are smaller or because you haven't encountered the same kind of challenges?

Lieutenant General TAYLOR. I think because we smooth flow the call-up, the call-up is more smooth flowed over time. Because we do 90 day rotations or 180 day rotations and we haven't had to do very long periods of time. We also haven't had the volume, very clearly, that the Army has called for, so we're able to handle this.

Finally, our greatest worry has been, the Congress has set up a very wonderful benefit, medical benefit for folks when they're activated through the TRICARE system and the military health care system. Our greatest nightmare has been that the families wouldn't understand what this benefit was. So we've worked very hard, the Guard and Reserves have worked very hard to ensure that locally, benefits advisors were in place to make sure the families knew what these benefits were and how to take care of them if issues arose.

Mr. SHAYS. Thank you. Thank you, Mr. Chairman. Thank you, Mr. Ruppersberger.

Mr. SCHROCK. Thank you, Mr. Chairman.

Before I recognize Mr. Ruppersberger, let me make a comment that the Admiral made. He said we're in a whole new ball game, and we are. But I think we knew what the ball game was going to look like, and I just can't imagine why some of these things couldn't have been foreseen. That's something I still haven't worked out in my mind. When I heard Mr. Emde say that he started out in Fort Eustis in Virginia, which is Army, and got transferred to Langley, which is Air Force, then across the bay to Portsmouth Naval, which is Navy, Navy couldn't do something or other because the paperwork wasn't filled out correctly.

And I don't blame Navy for that at all, and you were talking to me earlier about this, Admiral. There is some system going into place where everybody's kind of talking about the level playing field, the same sheet of music. How quick is that going to be put in place?

Admiral BRANNMAN. I think as we speak, right now. The difficulty between Walter Reed and Portsmouth is that they're not in the same region right now. But within the Portsmouth, Fort Eustis, Langley Air Force Base area, they basically try to function as one organization, as one health care system across the board. We are, as each day passes, basically expanding that network. We are pushing, as technology will allow us, we are pushing that network out.

The most recent change now is going from a large number of regions down to three, which were all the east coast, all the southeast, all the western areas, and interlocking our systems. Basically, if you're getting health care on one side of the system, you're getting it all the way across.

Mr. SCHROCK. Well, that's interesting, because I represent that area. And until I heard Mr. Emde, I thought everything was moving smoothly, but I guess every once in a while, one falls through. And I understand that. But as you say, they are working together very well.

Mr. Ruppersberger.

Mr. RUPPERSBERGER. In order to really resolve the problem, and you're saying that there is a plan, the plan is starting to work, we really need to get to the root, I think, of the medical care problem. I'm wondering whether or not we need to do more as it relates to the medical care problem when the Reserves members are working in the private sector, before they're being activated, and whether we need a better system. Because if we have people that are coming on the weekends, once a month or whatever, and they're not ready and they're called up right away, then that not only hurts them, it hurts our country, it hurts anybody in Afghanistan, Iraq or wherever we are.

What can we do? I should ask each individual, but I'm wondering whether or not there's a better way to give and to provide the medical insurances necessary, so when, and it looks like we're going to be at war with terrorism for a long time, this isn't going to stop, do you think we can really take the individuals that are working for small companies and roll them into a plan?

Now, of course, there's a cost issue whenever you talk about that. So could you comment, I guess the whole panel comment on that issue, and maybe that's where we need to start before we even activate them to the next level.

Dr. WINKENWERDER. Yes, Congressman, let me talk about that. We currently, under the provisions that were just passed last fall by the Congress, there is now authorization for the Reserve units to perform screening, medical and dental exams and followup care that to my understanding did not exist before. So I think that's a very important new change, it is a permanent change.

Mr. RUPPERSBERGER. Explain that, though. That means that the Reserve will provide for the medical care and the physicals and——

Dr. WINKENWERDER. Screening.

Mr. RUPPERSBERGER. Screening.

Dr. WINKENWERDER. That's correct.

Mr. RUPPERSBERGER. We have a large amount of Reserve and National Guard throughout the country. Has it been implemented yet?

Dr. WINKENWERDER. It's being implemented as we speak.

Mr. RUPPERSBERGER. Every Reserve and National Guard unit in the country?

Dr. WINKENWERDER. Well, I spoke about 3 weeks ago with General Helmly, and all the Reserve component chiefs, and they indicated to me that they were implementing this new provision. So I think that's a key step forward.

The second is what we've talked about. I don't know if you were here earlier when we spoke about this whole new metric called individual medical readiness. It's a new system that we put into place for active and Reserve and Guard that identifies all the things that an individual needs to do to be medically ready and identifies the interval of time that those types of things need to be done on a regular basis, so that what's important is that we have a clear set of expectations, not just for our medical leaders, but for our Reserve component and active component line commanders, so that they know what they are accountable to do, to have all their troops, sailors, soldiers and so forth ready.

This is a system that's being implemented. It was actually developed by all three Services together. Air Force had a little bit of a lead time on it and had been working on something similar to this for the past couple of years, so they're a little further ahead than Army and Navy. But it is being implemented, we are looking at the performance on a monthly basis. So I think that's another very key component. The question you raised is whether health insurance, does that factor in here.

Mr. RUPPERSBERGER. Before that, let me ask you this question. Is health insurance available to any member of the Reserve and National Guard?

Dr. WINKENWERDER. If they are not on active duty or have not been called up, they would obtain health insurance through their employer.

Mr. RUPPERSBERGER. You didn't answer my question. Is it available to any member of the National Guard or to the Army Reserve?

Dr. WINKENWERDER. Let me have Mr. Spruell answer.

Mr. SPRUELL. I would just point out, Congressman, that about 80 percent of the Guard and Reserve members today have civilian employer health insurance. Of the other 20 percent, they're mostly young and single and they make a conscious decision, to a great extent, not to elect health insurance. They would probably do the same thing if the military would offer them coverage, for which they would have to pay.

Mr. RUPPERSBERGER. But still, is there any insurance available to Army Reserve and National Guard? That's the question.

Mr. SPRUELL. Through their civilian employers, yes, sir.

Mr. RUPPERSBERGER. Not civilian. I mean, does the DOD provide for those individuals that do not have medical insurance through their employer or might want to choose? There's no plan now that exists for that?

Dr. WINKENWERDER. The current benefit covers those who are activated. Those who are activated.

Mr. RUPPERSBERGER. I know that. So what we're really saying then is, we don't have a plan, even though we have a large group of people, we don't have a medical insurance plan for anyone who decides to join the Reserve or National Guard, until they are activated? Is that the case?

Dr. WINKENWERDER. With some exceptions.

Mr. RUPPERSBERGER. I'm not trying to trick you.

Dr. WINKENWERDER. I understand you're not, and I'm trying to be as clear as I can. Currently, with the temporary provision that the Congress passed last fall, there was a provision that would have us implement a buy-in into TRICARE where the Reserve member and family could buy in, if he or she was unemployed and did not have access to employer based insurance. That's a temporary provision that goes away at the end of this year.

Mr. RUPPERSBERGER. It seems to me, I talked in the beginning about the root cause of the problem. When you have a large group of people and now that we have asked more of our National Guard and our Reserve, it would be in the best interest of our country, I think, of our military, of our men and women on the front lines to at least evaluate whether or not as a group we should provide something there.

Now, again, cost is an issue, we have to look at it. But in the end, if we have people that are not healthy on the front lines, that's not helping anybody, including our country, the men and women that are with those individuals.

Dr. WINKENWERDER. Let me answer one part of that. We do want to evaluate that. And we are suggesting a demonstration project to look at that issue, because this is, if it were to be done in such a major move, costing quite a lot of money and the question is, would it have any impact on either readiness, retention or recruitment. We believe it is something that ought to be studied.

Mr. RUPPERSBERGER. Because, you mentioned another issue that's very important, because of some of the issues that have occurred, and the problems that have occurred. It seems to me we need incentives for recruitment and that would be a strong incentive.

But more so when you mentioned the individual who was young and might not think they need insurance because they want to use

that money for something else, those people, those individuals might not be ready for when we need them. So I think it's something we really have to look at and raise the issue. Mr. Spruell.

Mr. SPRUELL. I was just going to point out, sir, that we do offer the TRICARE dental program, which is the same one that active family members have, for selected Reserve members and their families. About 30,000 out of 870,000 selected Reservists have opted to take that.

Mr. RUPPERSBERGER. You say selected.

Mr. SPRUELL. The selected Reserve consists of the units and individuals with the highest priority, highest readiness folks.

Mr. RUPPERSBERGER. OK.

Admiral BRANNMAN. If I could make a comment, part of that, the argument is going to discuss about insurance, we're trailing the duck here. Where our focus really is going in DOD today is to get these guys healthy and keep them healthy. We have initiated with our active force and into our Reserve forces our preventive health assessment system, where in addition to the physicals, we're testing you on a semi-annual basis to ensure that you're fit.

And part of that, as part of that fitness process, is to sit down with you, have you do a health assessment which we track and it has a list of indicators on there that if you answer yes to any of these issues on here, then you have to have a followup medical examination to pick up problems early. We're going toward a prevention and a health based system just so we head these things off——

Mr. RUPPERSBERGER. As you should. That's the way it's done.

Admiral BRANNMAN. And that's the system that we really are banking on for the future, is force health protections starts before the war starts. You start with the soldier, the sailor, the airman, the marine when you recruit them. They're part of the team and you take care of their health from day one, so that we don't end up with a first sergeant ready to mobilize who's got a bag full of prescription drugs. You knew that individual was developing stuff when he was a private, and you're keeping track of him, keeping him in a healthy lifestyle. That's the direction we're moving for today.

Mr. RUPPERSBERGER. I agree with what you said, and that's the way we want it to work. Implementation is another matter. But the bottom line, you need to set up a system. It seems to me that if we're going to be relying on our National Guard and Reserve, and also recruitment and retention, too, we need to deal with the issue of benefits, but we need a system that works. If you have individuals and Reserve National Guard that are not ready from a medical perspective, as the career, and you put them all on the front line together, then you're going to have an issue that could be a deterrent to our country, to our men and women in the military.

What I'm doing is just raising the issue. I think we have to look at the whole system, especially whether or not we need to provide that incentive, so that we make sure everybody who's a member is going to be taken care of, there's a system of prevention, there's a system of examinations and then you prevent it before you get to the level where it gets worse or before you're activated and you're over in Iraq or Afghanistan and all of a sudden you have this se-

vere medical problem that's taking the space of somebody that might have gotten shot.

So I'm raising that issue, I would hope you would take it back and we can follow through on whether or not we should provide. But of course, cost is an issue. But that cost factor could be brought down if you put the right system in place, medical system. Thank you.

Mr. SCHROCK. Thank you. Is there anything that you gentlemen would like to add for the record?

Dr. WINKENWERDER. Just to say that we're absolutely committed to a world class health system for all of our forces, active and Reserve. You've identified, and this panel that preceded us identified some issues. We're committed to addressing those issues, to solving problems and to continual improvement. I've got great confidence that the Army, Navy and Air Force are focused to solve the problems that have been identified.

Mr. SCHROCK. Great. I appreciate that. I appreciate this panel, and I appreciate the last panel. I think we need to remember, we recruit soldiers and we re-enlist families. If we don't keep mom and the kids happy, dad's not going to hang around very long. I think the one thing we need to more of, I guess, is that we heard some stories today, hopefully they are unique. If they're not, then we need to get our hands around it.

I think the one thing that I'm troubled about is the medical issue, is the financial difficulties we've caused folks. The Ramseys brought up an example. My guess is they had perfect credit ratings until this happened and now their credit has been damaged, maybe forever. When I was in the Navy I ran into this, somebody had a Social Security Number very close to mine, and it caused me incredible grief for 2 or 3 years, and cost lots of money to get it fixed.

We created this problem for the Ramseys, and I include myself in that, and we need to fix it. I want their banking institution to know that we did that, and get them back on even keel. Because I'll tell you, the Ramseys, if you try to get a loan or refinance your house, you're going to buck up against this for years and years to come, and we owe it to you and the others we've created this problem for to fix that, and I hope we'll do that. That's the one thing I want to leave you with. I don't want to hear any more stories about people being damaged financially.

And it wasn't done intentionally, I understand that. But the fact is, it was, and we need to get that fixed.

Again, I thank the first panel, I thank you gentlemen for coming here, and this hearing is adjourned.

[Whereupon, at 1:05 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[Additional information submitted for the hearing record follows:]

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8TH DISTRICT, FLORIDA

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March 29, 2004

The Honorable Christopher Shays, Chair
National Security, Emerging Threats &
International Relations Subcommittee
B-349C, Rayburn House Office Building
Washington, DC 20515

Dear Mr. Shays:

I am pleased to tell you and the Subcommittee about the situation of my constituent, Specialist John A. Ramsey, SSN 261-61-6626, a member of Detachment 1, 32nd Army Air and Missile Defense Command, Florida Army National Guard, Orlando, Florida. Specialist Ramsey was mobilized for federal Presidential recall in January 2003 to perform Supply Administrative Logistics duties overseas in support of Operation Enduring Freedom. He returned to the United States in June 2003 and completed his out-processing at Fort Benning, Georgia. During his active duty service, he injured his right shoulder in a non-combat incident and a line of duty (LOD) investigation was initiated. The LOD determined the accident occurred during the performance of his duties and his injury appeared to be a torn rotator cuff in his right shoulder. During his medical out-processing, he was told to obtain medical care for the injury through his home unit.

Since then, Specialist Ramsey has been unable to return to his civilian job as an Orange County Deputy Sheriff because he must be medically cleared to perform his Florida Guard responsibilities before the Sheriff's office will allow him to return to the patrolman position he held before mobilization. At the same time, the Sheriff's Office continues to pay him a monthly stipend of $800 that he and other deputy sheriffs recalled to active duty received to bridge the gap between their active duty and civilian salaries. During the period of July through November 2003, Mr. Ramsey was treated by numerous Central Florida civilian medical specialists and underwent two surgeries. In addition, he experienced great financial hardship as he was forced to spend his family's savings to cover normal monthly expenses while he was in limbo between his military and civilian jobs.

Specialist Ramsey contacted me last fall seeking assistance in obtaining reinstatement to active duty so he could be treated by military medical specialists and obtain payment of civilian medical bills that had not been paid by the Defense Department. He suffered from ailments in addition to the right shoulder injury including pain and restricted movement in relation to his left shoulder for which the Florida Guard had authorized

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surgery that took place in mid-November 2003, and problems with his elbows and wrists and numbness in fingers. His civilian doctors told him these injuries were related to his original right shoulder injury. He also had a growth of unknown origin on his neck that had been documented in his active duty service medical record while overseas but could not be diagnosed due to the absence of proper diagnostic equipment.

My staff made inquiries to the Florida National Guard and the National Guard Bureau (NGB) in November 2003. Just before Thanksgiving, with Specialist Ramsey's financial situation growing increasingly dire, and with the assistance of the House Armed Services Total Force Subcommittee, I contacted the Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs. I was assured of three things: (1) Specialist Ramsey would be placed on active duty on December 1, 2003 and sent to Fort Stewart's Winn Army Hospital in Georgia for medical treatment; (2) his outstanding medical bills would be paid; and (3) I was advised that it would be up to the Florida National Guard would make a determination early the following week concerning back pay for Mr. Ramsey. The Florida Guard contacted me the following week and told me Mr. Ramsey was going to be paid for the period of July through November 2003.

Specialist Ramsey was never sent to Winn Army Hospital or any other military medical facility for treatment. He was paid Incapacitation (INCAP) pay for the period of July through November 2003 and told he was not going to be placed on Active Duty Medical Extension (ADME) for further treatment. This was because the Army did not want to pay for medical treatment of any injuries not related to his original injury or in any way mix the payments of INCAP and ADME funds. On February 11, 2004, Mr. Ramsey had a military medical evaluation and his injuries were found to have occurred while on active duty. The NGB now wants to send him, in an INCAP status, to Fort Stewart for military medical treatment starting March 31st -- the day after the hearing.

I am amazed and disappointed that the Florida Guard and the NGB will not request reconsideration from the Army for Mr. Ramsey to be placed on ADME to receive medical treatment by active duty military medical doctors -- especially in light of the February 11th medical evaluation linking his current medical problems to his period of active duty service. Their latest proposal would, indeed, treat Mr. Ramsey's injuries but ignores the fact that his injury occurred on active duty. I believe ADME is a viable option for him that needs to be reviewed by the Army.

I also am displeased with the very slow pace in which Mr. Ramsey's medical bills are paid. It appears the only way this issue has received any serious attention was the knowledge that Mr. Ramsey was to testify today at this hearing.

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I am glad the Subcommittee has the opportunity to hear about Mr. Ramsey's situation. While I fervently support our men and women in uniform and their leadership, I must say that this episode gives me pause about the promises our uniformed leadership makes to its personnel to "take care" of them in exchange for sending them to dangerous and hostile locations. Mr. Ramsey's situation troubles me because he returned to this country nine months ago, and his major concerns still have not been resolved in a manner satisfactory to him and to me. I hope this situation is not a typical example of the assistance that is being given today to servicemembers, including Reservists and Guardsmen, returning from overseas.

Thank you for the opportunity to provide this information to you.

Sincerely,

Ric Keller
Member of Congress

RK:tkf