



DEPARTMENT OF THE NAVY  
OFFICE OF THE CHIEF OF NAVAL OPERATIONS  
2000 NAVY PENTAGON  
WASHINGTON, D.C. 20350-2000

AND  
HEADQUARTERS, UNITED STATES MARINE CORPS  
WASHINGTON, DC 20381-0001

IN REPLY REFER TO  
**OPNAVINST 6400.1B**  
**BUMED-22/CMC (MED)**  
**25 Jan 2000**

OPNAV INSTRUCTION 6400.1B

From: Chief of Naval Operations  
Commandant of the Marine Corps  
To: All Ships and Stations  
Subj: CERTIFICATION, TRAINING, AND USE OF INDEPENDENT DUTY  
HOSPITAL CORPSMEN (IDCs)  
Ref: (a) OPNAVINST 6320.7  
Encl: (1) Abbreviations and Definitions  
(2) IDC Recertification Process  
(3) IDC Education and Training Guidelines  
(4) Guidelines for the Clinical Use of Independent Duty  
Hospital Corpsmen in Fixed Medical Treatment  
Facilities (MTFs)

1. Purpose

a. To update Department of the Navy (DON) policy and assign responsibilities for the certification, training, and utilization of independent duty corpsmen (IDCs): NEC HM-8402 Submarine Force IDC, NEC HM-8403 Special Amphibious Reconnaissance IDC, NEC HM-8425 Surface Force IDC, NEC HM-8491/532X Special Operations IDC, and NEC HM-8494 Deep Sea Diving IDC.

b. To introduce IDC core competencies in appendix A and provide requirements and procedures for IDCs obtaining continuing education units (CEU). This is a complete revision and must be read in its entirety.

2. Cancellation

a. OPNAVINST 6400.1A and BUMEDINST 1520.28.

b. This instruction supersedes the provisions of reference (a) as it pertains to IDCs.

3. Background. The IDC Navy enlisted classification codes (NECs) were established to perform the unique military medical function of those who provide primary care medical support to operational units at sea and in remote or isolated environments in the absence of a medical officer. By virtue of being the senior medical department representative (SMDR), IDCs must be capable of

**OPNAVINST 6400.1B**

**25 Jan 2000**

fulfilling a variety of high level administrative and clinic needs. They are an integral component of the Navy health care team, valued as clinical health care extenders who also routinely fill leadership, training, and high-visibility administrative positions.

4. Applicability and Scope. Applies to all active duty, training and administration of Reserves (TAR), and Reserve IDCs.

5. Definitions. See enclosure (1).

6. Policy

a. IDCs must maintain their clinical skills following the guidelines of this instruction. IDCs, assigned to MTFs are required to participate in a formal, physician-supervised, recertification program sufficient to assure competency in each of the functional areas appropriate to the MTF detailed in enclosures (2) and (3) and appendix A. Competency implies a level of proficiency sufficient to allow the IDC to provide proper routine health care and to provide preliminary diagnosis and initial treatment or stabilization of more complex conditions independent of direct physician supervision. An assignment to an MTF for core competency recertification does not preclude other administrative or leadership duties.

b. Every IDC is required to participate in a continuing education program to earn a minimum of 12 CEUs annually. CEUs may consist of self-study correspondence courses, computer-generated training materials, audio cassette tapes, films, textbooks, Bureau of Medicine and Surgery (BUMED) approved courses, locally developed programs, and other pertinent materials that award CEUs. Appendices B and C provide a sample format for requesting CEU approval and background information for the development of local CEU programs.

c. All MTFs must have an established formal IDC recertification program adhering to the guidelines contained within this instruction. MTF assigned IDCs' core competencies will be reviewed periodically. Training must be of sufficient scope to give the IDC the experience necessary to identify and manage conditions within the IDC scope of care, detailed in appendix A.

d. IDCs assigned to fixed MTFs for recertification must perform within their defined scope of practice. This scope will be determined by their physician supervisors (using appendix A), and following the guidelines contained within enclosure (4).

25 Jan 2000

e. Acute and dire emergencies demand that IDCs provide compassion, reasonable comfort, and care to the utmost of their ability, even though these conditions may well require skills far beyond those expected of an IDC. In this latter circumstance, no IDC, in lieu of a physician, can properly be called upon to answer for an untoward event, provided the care rendered was in keeping with the expected requisite skills of an IDC.

## 7. Responsibilities

a. The Chief, BUMED, the Assistant Chief for Operational Medicine and Fleet Support (MED-02), and the Assistant Chief for Health Care Operations (MED-03) will jointly:

(1) Serve as the DON focal points for this program.

(2) Monitor and ensure compliance with this instruction through review of inspector general inspections.

b. The Medical Officer of the Marine Corps (Headquarters Marine Corps, Code HS) will:

(1) Serve as the Marine Corps focal point for this program.

(2) Monitor and ensure compliance with this instruction through review of commanding general inspections.

c. The fleet commanders in chief (CINCs) and other immediate superiors in command (ISICs) will ensure all officers in command of units with medical facilities comply with applicable portions of this instruction. CINCs and ISICs will ensure recertification reviews, training, monitoring, and evaluation of the care provided by IDCs are conducted under the provisions contained within.

(1) Force and naval construction brigade medical officers are program directors for their respective subordinate commands.

(2) Senior force, naval construction regiment and battalion corpsmen are the program managers for their respective subordinate commands.

(3) Program directors will appoint group, squadron, regiment, battalion, and shipboard medical officers as IDC physician supervisors by letter.

(4) Senior group, squadron naval construction regiment and battalion corpsmen will assist in the management of the program.

**OPNAVINST 6400.1B**

**25 Jan 2000**

d. The Commanding Generals, Marine Forces Atlantic; Marine Forces Pacific; and Marine Reserve Forces will ensure all Marine expeditionary forces (MEF) and subordinate commands with organic medical assets and assigned IDCs, comply with applicable portions of this instruction. They will also ensure recertification reviews, training, monitoring, and evaluation of the care provided by IDCs are conducted under the provisions of this instruction.

(1) MEF surgeons will ensure that appropriate program director appointments are made in major medical clinics and subordinate commands i.e., Marine air wing (MAW), division (DIV), and force service support group (FSSG).

(2) Senior MEF, MAW, DIV, Marine Force (MARFOR), and FSSG corpsmen are appointed by letter as program managers.

(3) Marine air group (MAG), battalion aid station (BAS), and group aid station (GAS) medical officers immediately in charge of IDCs are appointed as their physician supervisors, whenever possible.

(4) Senior IDCs assist in the management of the program.

e. The Commander, Navy Personnel Command (NAVPERSCOM) will include in orders for IDCs, the requirement that detaching commands will certify an IDC as clinically competent in each of the functional areas of appendix A before executing detaching orders. If an IDC fails to demonstrate competency before detachment, the detaching activity will advise NAVPERSCOM (NPC-407) and the receiving command, and send information copy to BUMED (MED-02 and MED-00HC) by message. The IDC's orders will be held in abeyance pending NAVPERSCOM determination of suitability.

f. Members reporting to refresher training must be clinically recertified before reporting. All IDCs being assigned from shore to sea duty will attend refresher training enroute.

g. The Assistant Chief for Education, Training, and Personnel (MED-05) will:

(1) Provide technical assistance for training.

(2) Implement the following:

(a) A standard formal training course that provides certification of an IDC to perform duties independent of a medical officer before initial assignment.

(b) A standard formal refresher training course for IDCs reassigned to duty independent of a medical officer.

(c) A training program within fixed MTFs that will provide continuing education and clinical skills training for IDCs leading to recertification while serving onboard the MTF and before assignment to duty independent of a medical officer.

(d) A standard continuing medical education (CME) program adapted to the needs of IDCs assigned to operational forces, or other isolated situations, independent of a medical officer.

(3) With fleet CINCs and Fleet Marine Forces (FMs), develop, review, and issue changes to courses and course materials designed to provide CME to IDCs assigned to the operational forces or other isolated situations.

(4) Designate this program a medical inspector general review requirement.

h. Commanding officers and officers in charge, with the assistance from command master chiefs, will:

(1) After consultation with the appropriate staff such as their director of clinical services (DCS), director of nursing services (DNS), director for ancillary services (DAS), clinic directors, department heads, and members of the executive committee of the medical staff, draft an IDC competency certifying program encompassing the functional areas detailed in appendix A. The program must be in the form of specific written command directives that are reviewed and updated periodically. If functional area training is not available within the MTF, all efforts will be made to secure the necessary training through other local resources (e.g., affiliated civilian hospitals, university centers, etc.). Enclosure (4) provides guidance in the clinical employment of IDCs whether attaining or maintaining their competencies.

(2) Monitor and ensure compliance with this instruction within their facilities. MTFs having cognizance over medical clinics will administer the IDC Recertification Program under their IDC program director and manager.

(3) Assure CEU opportunities are available for IDCs attached to their commands, including funding for CEUs, if they are not available locally. IDCs assigned to non BUMED activities who are unable to fund CEUs may request funding support from BUMED

**OPNAVINST 6400.1B**

**25 Jan 2000**

(MED-561) via the chain of command. Forward all requests to the respective CINC via the IDC's type commander (TYCOM). The CINC will then submit a prioritized roster of candidates to BUMED (MED-561) for funding consideration. Forwarding endorsements must verify nonavailability of funds. BUMED will consider such requests contingent upon availability of funds. Appendix D provides a sample format for requesting CEU funding. It is highly recommended commands incorporate CEU funding into their yearly operating targets (OPTARS).

(4) Appoint, in writing, a physician and senior IDC with operational experience as program director and program manager respectively to administer the IDC Recertification Program.

(5) Ensure all IDCs attached to the command are fully included in the Recertification Program.

(6) Appoint, in writing, physician supervisors, preferably with operational experience, to ensure adequate oversight of the IDCs' clinical activities. This will ensure IDCs maintain their clinical skills so they are deployable world wide. Ideally, no more than three IDCs should be assigned to one physician supervisor.

(7) Establish an IDC certification record. Appendix A may be reproduced locally and used as a documentation record within this file. Once the MTF's criteria are met in each functional area, the physician supervisor will initial the certification record. Include written, semiannual counseling pages showing the IDC's progress in acquiring competency in each of the functional areas reviewed and documented. Draft a plan of action and milestones (POA&M) for the next 6 months to address the attainment of remaining competencies and to address competency maintenance activities.

i. The IDC program director must be a senior medical officer with operational experience and significant knowledge of the role of the IDC in an operational environment. The program director is:

(1) Responsible to the commanding officer or officer in charge for oversight and direction of the program.

(2) Responsible to provide a periodic (at least annually) assessment of the program to the executive steering committee.

(3) Responsible for assessing the clinical skills of the IDC and certifies clinical competence before permanent change of station (PCS) or operational temporary additional duty (TAD) of the IDC.

j. The IDC program manager must be a senior IDC with operational experience who has been appointed by the commanding officer or officer in charge to manage the command IDC Recertification Program. The program manager will:

(1) Coordinate the training of the individual IDC.

(2) Provide military leadership, instruction, and supervision in concert with the physician supervisor.

(3) Be responsible for all administrative tasks of the program (including training folder maintenance, clinic rotation schedules, etc.).

(4) Be responsible for MTF (fixed and non-fixed) IDC orientation.

(5) Be responsible for peer review issues.

k. The physician supervisor:

(1) Understands the scope and responsibilities of an IDC.

(2) Provides instruction, supervision, and consultation as requested and required.

(3) Ensures the quality of care provided by the IDC is subject to a comprehensive program of monitoring and evaluation for quality and appropriateness following this and other applicable instructions. It is the physician supervisor's direct responsibility to ensure, in writing, the IDC has met the standards for competency in the preliminary diagnosis and the initial treatment or stabilization of all functional areas selected by the physician supervisor, and the IDC is fully competent to perform the procedures detailed in appendix A. Additionally, the physician supervisor should judge the IDC's knowledge, professionalism, awareness of limitations, history taking, examination, technical, and patient interaction skills.

(4) Reviews and evaluates treatment rendered by each IDC. As a minimum standard, this review will consist of:

(a) A matrix indicating the following:

1. Adherence to certain administrative requirements; e.g., name and IDC status clearly indicated on chart.

**OPNAVINST 6400.1B**

**25 Jan 2000**

2. Adequate documentation of patient encounters; e.g., recording of chief complaint and objective findings, studies ordered, the assessment is consistent with findings, therapy consistent with assessment, recommendations for follow on care, specific patient education, and instruction provided, etc.

3. Appropriate use of diagnostic techniques and procedures.

4. Appropriate referral to other medical personnel.

5. Appropriate use of therapeutic modalities.

(b) A written report, submitted quarterly, to the IDC program director via the IDC program manager for review and inclusion in the IDC's training folder. This report should include:

1. The IDC's name and the clinic to which assigned during this reporting period.

2. A summary of their performance to include comments on the items on the above matrix.

3. The number of medical records reviewed.

4. Specific comments. Both the physician supervisor and the IDC should sign the report. Semiannually, include the IDC's POA&M with this written report for review, comment, and filing.

(c) Documentation of IDC performance will be based upon specific review of a minimum of 10 percent of the total medical records (but need not exceed 25 per quarter for all IDCs). More records may be reviewed more frequently as appropriate. The total number of charts reviewed is left to the discretion of the physician supervisor as set by local command directives. The number deemed sufficient to demonstrate an adequate knowledge of both patient care principles and specific functional competency may vary depending upon the functional area and the experience of the IDC. Those IDCs at geographically remote locations will have the review performed at least every 6 months. The 6-month minimum may be waived for IDCs assigned to deployed units. In such instances, the required physician review must be completed at the next available opportunity.

(5) In the absence of the physician supervisor, an alternate physician supervisor must be designated in writing to proctor IDCs until return of the permanent physician supervisor.

1. IDCs will:

(1) Maintain certification.

(2) Maintain operational readiness and be fully prepared for operational deployment upon short notice.

(3) Obtain a minimum of 12 CEUs annually.

8. Action

a. Commanding officers and officers in charge of fixed MTFs, with the assistance of the command master chief, must maintain a recertification program for assigned IDCs as outlined in this instruction.

b. IDCs must be assigned by letter to a physician supervisor, and physicians must be appointed by letter as IDC supervisors. Sample appointment, assignment, and authorization letters are provided in appendix E.

c. Commanding officers and officers in charge of nonfixed MTFs, with the assistance of the command master chief, will ensure all IDCs under their cognizance remain certified and clinically competent per this instruction and other applicable fleet or FMF directives. They will ensure and verify, in writing, all IDCs deploying to sea duty are clinically recertified before detaching.

d. Commanding officers of shore duty non MTF facilities with assigned IDCs, with the assistance of the command master chief, must liaison with MTFs located in their area and arrange for their IDCs to participate in established recertification programs.

e. Commanding officers or officers in charge must ensure timely and proper review of any serious allegation of improper conduct or substandard medical care by IDCs. The commanding officer or officer in charge may temporarily suspend the certification and clinical practice of an IDC pending review by the chain of command and any formal administrative or disciplinary actions taken.

f. IDCs must complete their clinical recertification before detachment from the MTF. Refresher training cannot be expected to provide the necessary clinical exposure.

OPNAVINST 6400.1B

25 Jan 2000

9. Reports. The reporting requirements contained in this instruction are exempt from reports control per SECNAVINST 5214.2B.



R. A. NELSON

Surgeon General of the Navy



J. E. RHODES

By Direction

Distribution:

SNDL, Parts 1 and 2

MARCORPS PCN 7100000000 and 71000000100

ABBREVIATIONS AND DEFINITIONS

1. Battalion Aid Station (BAS).
2. Basic Cardiac Life Support (BCLS).
3. Basic Trauma Life Support (BTLS).
4. Bureau of Medicine and Surgery (BUMED).
5. Bureau of Naval Personnel (BUPERS).
6. Catalog of Navy Training Courses (CANTRAC).
7. Certification. Denotes successful qualification for continued duties as an IDC, independent of a medical officer through successful completion of the training program outlined in this instruction.
8. Commander in Chief (CINC).
9. Continuing Medical Education (CME).
10. Continuing Education Units (CEU). Authorized educational activities that serve to maintain, develop, or increase the knowledges, skills, and professional performance the IDCs use to provide services to their patients.
11. Director of Ancillary Services (DAS).
12. Director of Clinical Services (DCS).
13. Director of Nursing Services (DNS).
14. Department of the Navy (DON).
15. Fleet Marine Force (FMF).
16. Force Service Support Group (FSSG).
17. Group Aid Station (GAS).
18. Immediate Superior in Command (ISIC).
19. Independent Duty Corpsmen (IDCs). IDCs are Hospital Corpsmen in pay grades E-5 through E-9 who have completed an advanced Hospital Corps "C" School, or sanctioned equivalent training which results in an IDC NEC being awarded. An IDC is a supervised

**OPNAVINST 6400.1B**

**25 Jan 2000**

health care provider who provides primary care support to operational units. They are certified to perform their duties independent of the direct presence of a medical officer as defined within this instruction. IDCs perform their clinical, administrative, and logistical duties as the SMDR for the submarine force, special amphibious reconnaissance units, the surface force, special operations, and for deep sea diving. IDCs may be assigned to fixed MTFs, to units of the operational forces, or to isolated and geographically remote duty stations where no medical officer is assigned.

20. Marine Air Group (MAG).

21. Marine Air Wing (MAW).

22. Marine Expeditionary Force (MEF).

23. Medical and Dental Treatment Facilities (MTF/DTF)

a. Fixed

(1) Naval hospitals.

(2) Naval medical and dental clinics, regardless of claimancy.

b. Nonfixed

(1) Medical and dental facilities afloat (hospital ships, sickbays, and dental spaces aboard ships).

(2) Medical departments of operational squadrons, groups, and detachments.

(3) Organic medical assets of the FMF.

(4) Field medical and dental units in support of construction battalions.

(5) Fleet hospitals.

24. Navy Enlisted Classification Code (NEC).

25. Navy Personnel Command (NAVPERSCOM).

26. Obstetrics and Gynecology (OB/GYN).

27. Operating Targets (OPTARS).

28. Organic Medical Assets (Marine Corps). All medical department personnel along with their associated consumable and nonconsumable equipment assigned to a Marine Corps unit, regardless of size.
29. Permanent Change of Station (PCS).
30. Physician Supervisor. A medical officer assigned supervisory responsibility for the IDC's ongoing recertification training. The physician supervisor is responsible for the health care rendered by the IDC. The physician supervisor will be familiar with the role of the IDCs and their operational environment either through firsthand experience or through an orientation to the role and responsibilities of the IDC conducted by a senior IDC of the command. This orientation will be documented in the physician supervisor's training record or credentials file.
31. Plan of Action and Milestones (POA&M).
32. Primary Care. An approach to patient care which emphasizes first contact health assessment, health maintenance, preventive medicine, and treatment.
33. Program Director. A senior medical officer with operational experience and with significant knowledge of the role of the IDC. The program director is responsible to the commanding officer or officer in charge for oversight of the IDC program.
34. Program Manager. A senior IDC with operational experience who has been appointed by the commanding officer or officer in charge to manage the command IDC program.
35. Recertification. An ongoing training process that verifies the IDC possesses requisite clinical skills and knowledge to perform specific medical and dental care.
36. Refresher Training (REFTRA). A course of instruction directed by Fleet CINCs designed to refresh the IDC's administrative skills and to provide updates on Fleet health programs.
37. Senior Medical Department Representative (SMDR).
38. Subjective, Objective, Assessment, Plan (SOAP).
39. Supervision. The process of reviewing, observing, training, and accepting the responsibility for the assigned IDCs clinical performance. The following levels of supervision are pertinent:

**OPNAVINST 6400.1B**

**25 Jan 2000**

a. Direct. The supervisor is involved in the decision making process. This level of supervision is for all IDCs who are either undergoing their initial evaluation period with their physician supervisor (usually upon newly reporting for recertification); in the process of gaining experience through direct patient care in a particular functional area; or undergoing remedial training. Direct supervision may be subdivided as follows:

(1) Verbal. The supervisor is contacted by direct conversation, telephone, radio, or message before the IDC implements or changes a regimen of care.

(2) Physically Present. The supervisor is present through all or a significant portion of care. In a fixed MTF, direct supervision is reflected by the physician's cosignature of the patient's record before the patient's departure from the facility.

b. Indirect. The supervisor is not required to be involved in the decision-making process at the time decisions are made. This supervision is primarily accomplished through retrospective review of records, evaluation of appropriateness of consultation and referral, and evaluation of events identified through occurrence screens. Retrospective record reviews must assess the adequacy of the history and physical examination; appropriateness of tests and diagnoses; and planned course of treatments, including use of drugs and minor surgical procedures. Review of care also assesses his or her judgement in restricting independent practice to the authorized scope of practice. This level of supervision is reserved for those IDCs who have:

(1) Successfully completed their initial physician supervisor evaluation period (probation).

(2) Successfully demonstrated competency of the functional area (appendix A) to which the supervision applies.

39. Temporary Additional Duty (TAD).

40. Training and Administration of Reserves (TAR).

41. Type Commander (TYCOM).

25 Jan 2000

## IDC RECERTIFICATION PROCESS

1. Initial Certification. Granted upon awarding of an IDC NEC. The IDC is certified to serve in operational and isolated duty stations independent of a medical officer. Upon graduation, the following statement, signed by the commanding officer, must be entered in the enlisted service record, page 13, Administrative Remarks: "Certified to perform duties independent of a medical officer by successful completion of a prescribed IDC Class "C" School, or sanctioned equivalent training listed in the Catalog of Navy Training Courses (CANTRAC) for the NEC."

2. Recertification. The detaching shore command to which the IDC is assigned is responsible for providing physician-supervised recertification before the IDC's transfer to an operational unit. The following entry, signed by the IDC program director, must be entered in the enlisted service record, page 13, Administrative Remarks: "Recertified to perform clinical duties independent of a medical officer." The requirement to maintain clinical certification is based on the IDC's primary NEC. Certification is not permitted to lapse when an IDC is detailed to a nonIDC billet (detailed NEC assignment).

3. Failure to Certify. IDCs are required to maintain current recertification to retain eligibility for special pays, (i.e., diving, selective reenlistment bonus, special duty assignment pay, etc.). Failure to maintain IDC recertification or requisite component NEC qualifications will result in loss of the IDC NEC and termination and pro rata recoupment of special pays. At the commanding officer's discretion, IDCs who demonstrate clinical deficiencies and are not otherwise relieved for cause, are authorized continued special pays for which they are eligible, for a period of retraining not to exceed 6 months. Upon completion of the retraining or clinically supervised probation period, the commanding officer must either approve recertification or initiate involuntary removal of the IDC NEC providing supportive documentation. Submit all requests for voluntary and involuntary removal of the IDC NECs to Enlisted Personnel Management Center (EPMAC), Code 51, via NAVPERSCOM (NPC-2210).

4. Monitoring and Evaluation

a. Monitoring and Evaluation of IDCs

(1) Immediately upon assignment to an MTF, the IDC's clinical skills must be assessed by a physician supervisor. The care provided by the IDC during this initial evaluation period must be monitored under direct supervision as defined within this

Enclosure (2)

**OPNAVINST 6400.1B**

**25 Jan 2000**

instruction. The length of the assessment period will be determined by the physician supervisor, based on the IDC's documented performance.

(2) The IDC will then begin the recertification process whereby, through a structured program, competency is demonstrated and documented. This period of training is monitored by direct supervision as defined within this instruction.

(3) When the physician supervisor is confident the IDC has demonstrated sufficient competence in a particular clinical area, that portion of appendix A is initialed and a statement entered in the IDC's certification record. At the semiannual evaluation, the IDC program manager makes a page 13 entry to the enlisted service record.

(4) After recertification, IDCs may provide care within their scope of practice (defined as the functional areas initialed in appendix A) under either direct or indirect supervision depending on patient status. The IDC may be assigned duties other than clinical areas within an MTF as long as he or she is seeing patients to reinforce clinical skills on a regular basis (at least 8 hours per week).

(5) Evaluation of the IDC under indirect supervision requires a periodic review by the supervising physician. At a minimum, the physician supervisor must:

(a) Perform a monthly documented medical record review to assess the IDC's clinical performance and discuss clinical strengths and opportunities to improve care. The 6-month minimum may be waived for deployed forces if compliance would jeopardize the operational mission. In such instances, required reviews must be completed at the next available opportunity.

(b) Submit a quarterly written report to the IDC program director summarizing the IDC's performance. Include a copy of the report in the IDC's certification record.

(c) Submit a semiannual POA&M to the IDC program director outlining the next 6 months proposed clinical competency goals and duties, clinic rotations, or other training scheduled to attain these goals.

(6) All care provided by the IDC is under either the direct or indirect supervision of a physician supervisor who is responsible for monitoring and evaluating the IDC's clinical performance. At all times, the physician is responsible for the care of the patient.

25 Jan 2000

b. Clinical Deficiencies. Identified deficiencies in clinical skills or knowledge must result in documented counseling and instruction by the supervising physician to correct problem areas (appendix A may be used). The IDC must be afforded an opportunity to demonstrate a sufficient level of clinical competence under direct supervision following any period of structured guidance. If the IDC subsequently continues to demonstrate significant deficiencies in clinical skills and knowledge, the supervising physician, with the program manager and program director, must determine the appropriate course of action and make such recommendations to the commanding officer.

c. Certification Record. The program manager must maintain a 4-part certification record on each IDC. It must consist of, at a minimum:

(1) Copies of all recertification pages (may use a copy of appendix A for this purpose), and page 13 to the enlisted service record, detailing the competencies defining the IDC's scope of care achieved during recertification.

(2) Education and training records listing all self-study correspondence courses, computer-generated training materials, audio cassette tapes, films, textbooks, BUMED approved locally developed programs, and other pertinent materials that award CEUs.

(3) Cumulative physician supervisor evaluations (quarterly, semiannual, and all special reports).

(4) Adverse entries and actions taken.

d. Upon receipt of PCS or TAD orders, which require duties independent of a medical officer, the IDC program director (via review of the IDC's certifying record and input from the supervising physician) must assess the clinical skills of the IDCs and certify their clinical competence to the receiving command by a final page 13 entry to the enlisted service record. By signing the final certifying entry, the IDC program director, representing the commanding officer of the MTF, certifies the IDC has met the MTF's standards for competency in the preliminary diagnosis and the initial treatment or stabilization of all functional areas documented by the physician supervisor and is competent to perform the procedures detailed in appendix A. The receiving command must be made aware of any functional area competencies not attained.

e. Upon PCS of the IDC, the program manager of the transferring command will retain a copy of the IDC certification and training record for 1 year. The original will be mailed to the receiving command via certified mail.

25 Jan 2000

## IDC EDUCATION AND TRAINING GUIDELINES

1. Initial Training. BUMED must ensure the development and monitoring of sanctioned formal training programs to prepare and certify IDCs to perform duties independent of a medical officer. These programs of instruction must include adequate didactic instruction and practical application of skills, combined with clinical rotations emphasizing hands on experience. Successful completion of these courses of instruction and the awarding of an NEC at the time of graduation signifies the member is a certified IDC. The certification must be documented by an appropriate service record entry.
2. Refresher Training (REFTRA). BUMED must ensure the development and monitoring of sanctioned formal refresher training programs to provide instruction to IDCs before reporting for duty independent of a medical officer and for the maintenance of essential knowledges and skills. All IDCs are required to attend refresher training before an operational assignment whether with, or independent of, a physician.
3. CME Programs. Each IDC must participate actively in a CME program. IDCs must complete a minimum of 12 CEU credits unless assigned to an operational unit whereby compliance would adversely effect the unit's mission. CEUs can be received through many sources. IDCs are strongly encouraged to keep their medical education current through regular, consistent study of medical publications, references and computer aided training, and through attendance at medical lectures given by local professional medical staff. However, CEUs may only be earned by participating in BUMED (MED-05) approved CEU activities. The 12 CEUs must be of a clinical nature. The physician supervisor may also direct an IDC to complete specific continuing education courses to correct identified clinical deficiencies.
4. IDC Recertification Program. When transferred to fixed MTFs, IDCs will rotate through appropriate clinics to maintain their skills and experience; attend appropriate departmental teaching conferences and rounds; and participate in internal and external conferences, workshops, and seminars consistent with their duties. The IDC's overall education and training program must include, but is not limited to, meeting the IDC minimal scope of practice and performance skills found in appendix A.
  - a. Based on physician supervisor assessment, the fixed MTF or cognizant operational medical authority must schedule appropriate clinical rotations, clinical education, and skills maintenance

**25 Jan 2000**

training on a quarterly basis, or when operationally feasible. Upon completion, these educational experiences must be documented in the IDC's training record.

b. Funding to accommodate effective clinical rotations and CME must be budgeted by the MTF or cognizant operational TYCOM through unit TAD TAR budget.

5. Training Record

a. The IDC program manager will maintain a training record as a part of the certification record on each IDC. This record must reflect, at a minimum, the following information: formal schools attended; other courses attended; continuing education completed or attended; and correspondence courses completed. Entries concerning attendance at formal schools and other formal courses of instruction must cite locations, dates of completion and, if applicable, final grades. Document continuing education and correspondence course completion dates, along with the number of credits awarded, if applicable. File all training records per enclosure (2).

b. The physician supervisor will review the IDC training record at least quarterly.

c. The IDC program director will review the IDC training record as part of regularly scheduled inspections.

GUIDELINES FOR THE CLINICAL USE OF INDEPENDENT  
DUTY HOSPITAL CORPSMEN IN FIXED MEDICAL TREATMENT FACILITIES

1. Use of IDCs. IDCs must be assigned duties consistent with their skills and expertise, as well as the needs of the command and the Navy.

a. IDCs must function under the supervision of a physician.

b. IDCs, under the authority of the physician supervisor, may initially assess or triage patients. They may write orders within their scope of practice.

c. IDCs must wear an identification badge to ensure the patient is aware of their name and role. It must be clearly visible with the words "Independent Duty Corpsman" imprinted below the name.

d. IDCs must sign the medical record of each patient examined, treated, or referred for treatment, and print or stamp his or her name, rate, title, and last four digits of social security number beneath the signature.

e. Care by the IDC requires physician review:

(1) During the assessment period before recertification, the physician supervisor must countersign all health records before the departure of the patient.

(2) In a geographically remote location, all physician responsibilities for IDC review found in enclosure (2), paragraph 4a(5) should be accomplished as operationally feasible. The maximum time interval between reviews should not exceed 6 months.

f. Recertified IDCs must be authorized, in writing, by their physician supervisors to prescribe or provide medications carried on the MTF formulary. Any restrictions or exceptions (e.g., controlled medicinals) must be plainly stated. Keep this letter in the IDC's certification record with a copy provided to the pharmacy.

g. Within the established scope of practice, the certified or recertified IDC may provide care for active duty patients under indirect supervision. All other patients require direct supervision.

25 Jan 2000

h. The IDC must refer to a physician for formal, written consultation, any patient who presents with the same complaint twice in a single episode of illness. This does not apply either to patients returning for continuing treatment of previously documented, stable, chronic illnesses, or to patients returning as directed for followup evaluation of resolving acute illnesses.

i. IDCs must not give telephone consultations.

2. Supervision and Review

a. Commanding officers and officers in charge must assign each IDC a physician supervisor by letter, with copies placed in the IDC's service record and training file.

b. IDCs must function under the physician supervisor, who will provide, at established intervals, written evaluation of the IDC's performance. These reviews must include a sufficient number of health records to assess the compliance with sound patient management practices and adequacy of medical record documentation.

c. Commanding officers and officers in charge must appoint by letter, a senior medical officer with operational experience as the IDC program director to oversee the IDC program.

d. Program directors must appoint physician supervisors by letter, with a copy placed in the certification record of each IDC under the physician supervisor's cognizance.

e. Commanding officers and officers in charge must appoint a senior IDC by letter as the IDC program manager.

f. Submit questions regarding assignment of an IDC to duties and responsibilities which may constitute a deviation from this instruction through the chain of command to BUMED (MED-02).

Appendix A Competencies Defining IDC Scope of Care

Appendix B Sample Appointment, Assignment, and Authorization Letters

Appendix C Essentials for Submitting Request for IDC Continuing Education

Appendix D Sample Request for IDC CEU Funding

Appendix E Sample Request for CEU Approval (Locally Developed Program)

APPENDIX A

COMPETENCIES DEFINING IDC SCOPE OF CARE

1. IDCs are expected to exercise independent clinical judgment and decision making augmented by established protocols or through contact with a definitive care provider. In addition to their principal role of diagnosing and treating routine minor illnesses and injuries, the IDC must be able to recognize the presence of non-routine urgent or emergent conditions, stabilize if necessary (using protocols established by physician supervisors), and initiate prompt referral to a higher level of care.

2. By initialing each section below, \_\_\_\_\_, the physician IDC supervisor, certifies the IDC, \_\_\_\_\_, has demonstrated sufficient competency in each of the functional areas below and is able to provide proper health care independent of direct physician supervision. Implicit in this certification is the determination the IDC has demonstrated a thorough understanding of the indications, contraindications, and potential risks associated with the performance of any invasive procedures listed. These basic competencies reflect the skills an IDC must attain through experience, education, and training to provide health care in today's operational arena.

\_\_\_\_ Patient Assessment

- Complete medical history
- Technically proficient physical exam with vital signs
- Complete and accurate documentation in the subjective, objective, assessment, plan (SOAP) format
- Develop an appropriate diagnosis and treatment plan
- Patient interaction skills - professionalism, respect, empathy, sensitivity to psychosocial concerns, privacy awareness, discretion, confidentiality, etc.

\_\_\_\_ Emergency Medical Procedures

- Demonstrate knowledge and skill to safely remove a casualty from danger
- Demonstrate knowledge and skill in positioning a patient appropriate to an injury
- Demonstrate knowledge and skill in triaging of mass casualties
- Attain or maintain certification in BCLS and BTLS to include:
  - Airway management/maintenance using oral, nasopharyngeal and endotracheal airways

25 Jan 2000

- Assisted ventilation with oxygen therapy via nasal catheter, cannula or mask
- Control hemorrhage via direct pressure, pressure points, pressure dressing, tourniquet, or hemostat
- Manage respiratory distress, including sucking chest wound

3. The IDC must demonstrate proficiency in the preliminary assessment and initial treatment, stabilization, or referral of:

Internal Medicine

- Chest pain differential
- Fluid and electrolyte disorders
- Heat or cold injuries
- Chemical and thermal burns
- Cardiovascular shock
- Headache
- Depressed levels of consciousness
- Gastrointestinal disorders
- Respiratory distress
- Drug overdose or poisoning
- Uncomplicated hypertension
- Uncomplicated diabetes
- Communicable or infectious diseases (including antibiotic prescription)
- Adverse drug reactions
- Acute pain
- Weakness and malaise

Orthopedics

- Fractures
- Strains and sprains
- Low back pain
- Minor musculoskeletal injury

Surgery

- Abdominal pain versus acute abdomen
- Inguinal hernia
- Multiple trauma patient
- Penetrating wounds
- Animal and human bites

Psychiatry

- Acute psychosis
- Suicidal ideation or attempt
- Crisis intervention
- Substance use and abuse

Urology

- Testicular torsion
- Urinary stone
- Sexually transmitted disease (Male)
- Bladder infection
- Prostatitis
- Epididymitis
- Penile trauma
- Kidney infection

Ophthalmology

- Penetrating eye injuries
- Eye pain
- Acute vision change
- Conjunctivitis
- Cornea abrasion
- Conjunctival foreign body

Dermatology

- Psoriasis
- Acne
- Warts
- Herpes (simplex, zoster, etc.)
- Scabies
- Lice
- Immersion dermatitis
- Plantar warts
- Corns and calluses

OB/GYN

- Intrauterine pregnancy
- Pelvic pain
- Pelvic inflammatory disease
- Abnormal vaginal bleeding
- Ectopic pregnancy
- Vaginitis
- Sexually transmitted disease (Female) to include culture of cervix
- Family planning (using approved contraceptive protocols)
- Vaginal trauma
- Breast mass
- Sexual assault

**OPNAVINST 6400.1B**

**25 Jan 2000**

— Dental

- Dental abscess
- Symptomatic caries
- Lost restoration
- Fractured tooth
- Lip or tongue laceration
- Jaw fracture
- Traumatically mobilized teeth

— Ear, Eyes, Nose, and Throat (EENT)

- Otitis media and externa
- Cerumen impaction
- Foreign body
- Pharyngitis
- Nosebleed
- Rhinitis or upper respiratory infection
- Uncomplicated allergic conditions

— Occupational Health and Preventive Medicine

- Medical surveillance programs to include:
  - Noise exposure
  - Asbestos exposure
  - Heat exposure
  - Immunization programs
  - Sanitation inspections
- Diving-related disorders

— Chemical, Biological, and Radiation Procedures

- Apply chemical decontamination kit
- Administer antidotes and pre-treatments
- Assess, process, and decontaminate the contaminated wounded patient

4. IDCs will be fully competent to perform the following procedures:

— Medical and Surgical Procedures

- Local anesthesia
- Digital block anesthesia
- Primary and Secondary skin closure and suture removal
- Wound care including débridement, wound irrigation, and applying and changing sterile dressings
- Insert nasogastric tube
- Perform venipuncture
- Initiate, maintain, discontinue, and document intravenous fluid therapy

Medical and Surgical Procedures (continued)

- Mental status examination
- Vision screening
- Obtain and basic interpretation of audiograms
- Removal of foreign object by forceps or superficial incision
- Cast application for nondisplaced extremity fractures
- Perform urethral catheterization
- Incise and drain superficial abscesses
- Apply hot and cold therapy
- Comfortable use of vaginal speculum to visualize cervix
- Basic bimanual pelvic exam
- Basic breast exam (before referral)
- Administer medications (oral, sublingual, subcutaneous, intramuscular, topical, rectal, and intravenous)
- Pack and prepare sterile packs
- Perform the following emergency treatment:
  - Parenteral IV therapy
  - Needle thoracostomy
  - Gastric lavage
  - Endotracheal intubation

Laboratory procedures

- Dipstick urinalysis
- Microscopic urinalysis
- White blood cell count and differential
- Hematocrit
- Serological test for syphilis
- Gram stain
- Collection of culture specimen (pharyngeal, wound, rectal, urethral, vaginal, etc.)
- Malaria smear
- Wet (Saline) prep
- KOH prep (potassium hydroxide)
- Wright stain
- Mono-spot
- Urine pregnancy test (HCG)

SEMIANNUAL IDC COUNSELING PAGE

Include progress in acquiring competency in each of the above functional areas with each IDCs semiannual counseling. A POA&M for the next 6 months must be drafted to address the attainment of remaining competencies and to address maintenance activities. Any combination of didactic classroom lectures, clinic rotations, or non MTF training opportunities may be used. Hands on practical exposure to physical evaluation is strongly encouraged.

Plan of Action and Milestones:

---

---

---

---

---

---

---

---

---

---

\_\_\_\_\_  
Physician IDC Supervisor  
Name and Date

\_\_\_\_\_  
Independent Duty Corpsman  
Name and Date

APPENDIX B

SAMPLE APPOINTMENT, ASSIGNMENT, AND AUTHORIZATION LETTERS  
SAMPLE ASSIGNMENT AS PHYSICIAN SUPERVISOR LETTER

SSIC  
Orig. Code  
Date

From: (Appointing Authority)  
To: (Name of Medical Officer)

Subj: ASSIGNMENT AS INDEPENDENT DUTY CORPSMAN (IDC) PHYSICIAN  
SUPERVISOR

Ref: (a) OPNAVINST 6400.1B

1. Per reference (a), you have been assigned as the IDC physician supervisor for (name of IDC).
2. As the assigned physician supervisor, you must supervise and formally review the health care rendered by (name of IDC), consistent with reference (a).
3. You are directed to become completely knowledgeable with reference (a) and to ensure all of the supervision and reviewing requirements of this directive are fulfilled.

Signature

Copy to:  
Service Record  
Program Director  
Program Manager  
IDC Certification Record

**OPNAVINST 6400.1B**

**25 Jan 2000**

SAMPLE DESIGNATION OF PHYSICIAN SUPERVISOR LETTER

SSIC  
Orig. Code  
Date

From: (Appointing Authority)

To: (Name of IDC)

Subj: ASSIGNMENT OF INDEPENDENT DUTY CORPSMAN (IDC) PHYSICIAN  
SUPERVISOR

Ref: (a) OPNAVINST 6400.1B

1. Per reference (a), (name of medical officer), has been designated to serve as your physician supervisor. In the absence of your physician supervisor, a designated medical officer assigned to your clinical area must serve in lieu of your physician supervisor.

2. Your designated physician supervisor has been directed to provide ongoing review of, and assist with, your delivery of health care to patients at this facility. Your supervisor has been specifically directed to meet with you on a periodic basis and to review a sufficient number of the medical records you have completed.

Signature

Copy to:

Service Record

Program Director

Program Manager

Physician Supervisor

IDC Certification Record

SAMPLE AUTHORIZATION TO PRESCRIBE MEDICATION

SSIC  
Orig. Code  
Date

From: (Physician Supervisor)  
To: (Name of IDC)

Subj: AUTHORIZATION TO PRESCRIBE MEDICATION

Ref: (a) OPNAVINST 6400.1B  
(b) (IDC Specific MTF Formulary)

1. As a result of your certification per reference (a), you are authorized to prescribe medications contained within reference (b). Additional restrictions are listed below:

Signature

Copy to:  
Service Record  
Program Director  
Program Manager  
IDC Certification Record  
Pharmacy

APPENDIX C

ESSENTIALS FOR SUBMITTING REQUEST FOR  
INDEPENDENT DUTY CORPSMAN CONTINUING EDUCATION

1. Essential 1. A written statement of the IDC CEU mission, formally approved by the commanding officer. The mission statement should:

a. Describe the goals of the overall IDC CEU program in a concise manner.

b. Indicate the scope of the IDC CEU effort.

c. Outline the characteristics, NECs, of the potential participants.

d. Describe the general types of activities and services provided.

2. Essential 2. Establish procedures for identifying and analyzing the medical education needs and interests of the IDC community.

a. Document the process used to identify CEU needs, including data sources that go beyond the sponsor's own perception of need.

b. State the overall needs identified by the above process and indicate how this assessment is used in planning educational activities.

3. Essential 3. The objectives are explicit for each IDC CEU course.

a. State the expected learning outcomes in performance objectives reflecting the appropriate knowledges, skills, and attitudes to be attained.

b. Make these objectives known to prospective participants.

4. Essential 4. Evaluate the effectiveness of the overall medical education program and use this information in CEU planning.

a. Periodically review the extent to which the IDC CEU mission is being achieved by its students.

**OPNAVINST 6400.1B**

**25 Jan 2000**

- b. Show that these evaluations assess the:
    - (1) Extent to which educational objectives are being met.
    - (2) Quality of instructional process.
    - (3) Student's perception of enhanced professional effectiveness.
  - c. Use evaluation methods that have BUMED approval.
  - d. Demonstrate that evaluation data are used in planning future CEU classes.
5. Essential 5. Management procedures and other necessary resources are available and effectively used to fulfill the medical education mission.
- a. Document an organizational structure for a medical education program and its administration, designating an entity responsible for IDC CEUs, and delineating its authority.
  - b. Identify responsible individuals who will maintain continuity of IDC CEU administration.
  - c. Describe an internal review or quality assurance process.
  - d. Use competent faculty.
  - e. Provide appropriate facilities for medical education programs.
  - f. Have mechanisms to record and verify participation.
6. Essential 6. Ensure the Essentials are met by activities that are jointly sponsored.
- a. Provide evidence that jointness is integral to the planning and implementation of each sponsored medical education teaching activity.
  - b. Conduct an evaluation of each jointly sponsored IDC CEU activity.

APPENDIX D

SAMPLE REQUEST FOR INDEPENDENT DUTY CORPSMAN  
CONTINUING EDUCATION FUNDING

SSIC  
Orig. Code  
Date

From: (Name of Applicant)  
To: Chief, Bureau of Medicine and Surgery (MED-561), 2300 E  
Street, NW, Washington, DC 20372-5300  
Via: Commanding Officer (Applicant's Command)  
(Others as appropriate)

Subj: REQUEST FOR FUNDING OF INDEPENDENT DUTY CORPSMAN  
CONTINUING EDUCATION

Ref: (a) OPNAVINST 6400.1B

Encl: (1) Course or Meeting Announcement, Flyer, or Brochure

1. Per reference (a), I request approval to attend (the short course, workshop, seminar, conference, meeting) described in enclosure (1) and listed below on temporary additional duty orders.

- a. Title of course or meeting.
- b. Location.
- c. Inclusive dates of course or meeting.
- d. Cut off date for registration.
- e. Sponsor of course or meeting.
- f. Course or meeting fees.
- g. Estimated travel cost.

(1) Contract airfare is available and will be used: Yes/No

(2) Government transportation request will be used: Yes/No

(3) Privately owned vehicle will be used in travel: Yes/No

**OPNAVINST 6400.1B**

**25 Jan 2000**

h. Per diem requested for meeting site location: Yes/No

(1) Government quarters are available: Yes/No

(2) Government messing is available: Yes/No

i. Estimated miscellaneous expenses:

j. CEU credits to be awarded:

2. I have/have not received orders for RAD/RET/PCS moves. My projected rotation date from my current duty station is:

3. Attendance at the above course or meeting will provide for continuing education as described in enclosure (1).

4. I am a member/nonmember of the sponsoring agency or organization.

5. I understand that any advance payment of fees or related expenses from personal funds will be my responsibility if this is not approved.

Signature

APPENDIX E

SAMPLE REQUEST FOR CEU APPROVAL  
(Locally Developed Program)

From: Commanding Officer of Activity  
To: Chief, Bureau of Medicine and Surgery (MED-561), 2300 E  
Street, NW, Washington, DC 20372-5300

Via: (as appropriate)

Subj: REQUEST FOR APPROVAL OF A PLANNED INDEPENDENT DUTY  
CORPSMAN CONTINUING EDUCATION PROGRAM

Encl: (1) Curriculum Vitae and Privacy Act Statements  
(2) Lesson Plan and Handouts  
(3) Tests

1. Enclosures (1) through (3) are submitted for review and certification as an IDC CEU program.

a. Title of Course. (May be a seminar, conference, or hospital meeting.)

b. Course Director. (Contact point, full address, and telephone number.)

c. Date.

d. Number of Hours Requested. (May be hour for hour or a fixed number for a seminar or conference. Breaks and meal times shall not be included.)

e. Goals and Objectives.

f. Target Group. (Who will attend? Specify the NEC category affected.)

g. Teaching Methodology. (Lectures, self-assessment, audio-visuals, tapes, etc.)

h. Method of Evaluation. (Tests, practical, etc.)

2. This command or activity accepts the responsibility of documenting individual participation by awarding formal or informal certificates or statements signed by program director.

Signed by the Commanding Officer or  
Course Director, as appropriate.