CDC/ATSDR Commissioned Corps Happenings

The Official Newsletter of the CDC/ATSDR Director's CC-PAC

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CDC/ATSDR Office of Commissioned Corps Personnel (OCCP) staff is Ex-Official members of the committee and provide support services.

Note from the Chair

The CCPAC and OCCP have been extremely busy with several important projects; which is one reason this newsletter is a little lengthy. We have continued to work on transformation workgroups, advising OFRD on revisions to the immunization requirements for deployment, and reviewing and commenting on key policies proposed by the Office of Commissioned Corps Force Management (OCCFM), including the readiness and response plan and the 6th precept. We have also been working on a document describing the important role of Commissioned Corps officers at CDC/ATSDR and some recommendations to strengthen the Corps at CDC/ATSDR, on which we will be seeking your input shortly. You can read more details about each of those activities in this newsletter.

In the last month, the Corps has been more in the spotlight at CDC/ATSDR. We had an all-hands meeting with Dr. Gerberding on Corps issues on March 1, and on March 25 RADM Ken Castro, CAPT Austin Hayes, and I joined Dr. Gerberding in a brief meeting with Secretary Leavitt to discuss our concerns with transformation. Dr. Gerberding expressed her strong support for the officers at CDC/ATSDR and called upon officers to fulfill their obligations to become "basic ready" and become more visible in communications by identifying themselves with their rank. She also assured the officers that she would meet with the Secretary to ensure that public health practice and research are incorporated into transformation in a meaningful way. During our meeting with the Secretary that followed, we were able to describe our concerns. The Secretary listened carefully to our concerns, and he expressed a keen understanding of these issues. Dr. Gerberding summarized the meeting in her email to officers on March 28:

> "I appreciated the large turn out of uniformed Corps officers during Secretary Leavitt's visit to CDC. CAPT Simone, RADM Castro, RADM (ret) Thacker, and CAPT Hayes briefed Secretary Leavitt on some of the Commissioned Corps transformation issues concerning CDC. Key points included our support for the Corps transformation, our dramatic improvement in readiness over the past few weeks (42% to 58% - at the top for HHS in terms of short term improvement), our desire to have more input and have the input respected as the transformation moves forward, an explanation of how CDC's public health mission is not the same as those associated with clinical service delivery, and our concern that the promotions and reward systems are penalizing CDC officers. Secretary Leavitt asked many excellent questions and indicated he intends to be personally engaged in defining the mission and transformation of the Commissioned Corps. He also summarized his understanding of some of the points that were presented by CAPT Simone and RADM Castro:

1) The Corps mission and force requirements to accomplish that mission need to be planned and articulated
2) Evolution of the Corps workforce composition and capability to match the mission is important, but will evolve over time
3) The Corps public health mission needs to be recognized and rewarded in the same way that the clinical and research missions are recognized and rewarded.

We realize there are additional issues that need to be addressed, but I am very encouraged that Secretary Leavitt is committed to making the Corps a success for HHS and for CDC. I will update you as this moves forward. Thanks! "

We assured the Secretary that we stand ready to assist in any way that we can. We will keep officers updated on the next steps as we learn more.

Finally, on behalf of all of the members of the CCPAC, I want to thank CAPT Ed Kilbourne for all his efforts this past year as the Vice-Chair of the CCPAC. CAPT Kilbourne has taken on a new assignment that requires his full attention. CAPT Sven Rodenbeck will assume his duties as SG PAC representative for ATSDR and Vice-Chair of the CCPAC.

Submitted by: CAPT Pattie Simone

All-Hands Meeting on March 1, 2005

Dr. Gerberding's All-Hands Meeting with CDC/ATSDR Commissioned Corps officers was a very important step in our continued efforts to provide input to the Director on Commissioned Corps issues. During the All-Hands meeting Dr. Gerberding made the following points:

Dr. Gerberding is committed to a strong and visible Public Health Service Commissioned Corps at CDC/ATSDR

- There is a great history of the Public Health Service Commissioned Corps at CDC/ATSDR
- Recently, the Public Health Service Commissioned Corps has been undergoing a transformation, but unfortunately the process has been plagued with poor communication and unclear direction
- Dr. Gerberding has been doing what she can to influence that process
- Dr. Gerberding expressed her strong commitment to the Public Health Service Commissioned Corps and Officers at CDC/ATSDR
- Dr. Gerberding also strongly affirmed the important role that the Public Health Service Commissioned Corps plays in the CDC/ATSDR mission
- Dr. Gerberding is committed to doing all that she can to keep the Public Health Service Commissioned Corps strong at CDC/ATSDR (even becoming an officer herself if she has to)

Dr. Gerberding is concerned about the recent trends associated with Public Health Service Commissioned Officers at CDC/ATSDR

- Recent statistics about the unprecedented rate that officers are leaving the Public Health Service Commissioned Corps (flag officers, retirements, and terminations and activations including EIS officers) at CDC/ATSDR
- These data shows many officers at CDC/ATSDR have not felt that their important public health work is being valued by some areas of the Public Health Service Commissioned Corps, and she knows that some officers have been getting negative feedback about being an Officer here at CDC/ATSDR
- Dr. Gerberding is planning on meeting with the Secretary to:
    - share our concerns,
    - learn more about what he envisions the Public Health Service Commissioned Corps will look like in 5 years, and
    - getting a firm commitment from him that the important public health practice and research that we do here at CDC/ATSDR is valued by the Public Health Service Commissioned Corps and that that value will be incorporated in a meaningful way in the transformation

Dr. Gerberding needs all CDC/ATSDR Commissioned Officers to fulfill their commitments to the Public Health Service Commissioned Corps

- We are part of the Public Health Service Commissioned Corps, and as officers we ***must*** fulfill basic commitments that included:

- Meeting the Basic Readiness standards as required by Manual Circular Number 377 (http://dcp.psc.gov/PDF_docs/Man_circ_377.pdf)
- ***All*** officers are required to meet basic readiness standards by May 1, 2005, or face possible disciplinary action (The Corps has not yet distributed guidance on how officers who do not meet this directive will be handled.)
- Dr. Gerberding also called upon your supervisors to support you in anyway they can in this effort
- Dr. Gerberding asked CAPT Hayes and his staff to track our progress and support the officers in any way they can
- Include your rank in emails and other written materials

The CDC/ATSDR Director's CCPAC will be holding more informational meetings in the near future. We look forward to your participation.

Submitted by: CAPT Sven Rodenbeck

Summary of CDC/ATSDR Director's CCPAC Meeting: October 2004 – February 2005

The CCPAC is actively working on a variety of issues that concern all Commissioned Officers at CDC/ATSDR.

Transformation: The CCPAC continues to monitor activities that involve the Transformation of the Corps. In October 2004 a systematic Transformation Option Memo was disseminated to all agency Heads within HHS for comment and response. To maintain the integrity of the process the memo was not released to all Corps officers, however, CCPAC members were involved in the CDC/ATSDR response. To date, no further information is available; we eagerly await additional information from the Assistant Secretary for Health (ASH) office on this issue.

Decline in number of officers: CDC/ATSDR senior leadership is concerned regarding the overall decline in Corps officers at the agency. This is largely in part attributed to Retirements, Inactivation's and Terminations. CAPT Jeffrey Sacks, NCCPHP has actively and accurately tracked the declination of Corps officers. The data reminds us of the key roles that Corps officers hold in the agency and a tremendous amount of expertise that is being lost.

Communication: CCPAC is committed to providing its stakeholders with open and accurate information, we are continuing to partner with OCCP to distribute email messages to officers at large, publishing of the CCPAC Newsletter, conducting Brown Bag sessions within CIOs, and communicating through OCCP website at www.cdc.gov/od/occp.

Charter: Senior leadership at CDC/ATSDR approved and adopted the CCPAC charter which authenticates our role and establishes the infrastructure of the committee. The Charter is available for viewing on the OCCP web page under the "CC PAC Committee" link.

Coordination of deployments: The Directors Emergency Operations Center (DEOC) and CCPAC representative CDR Greim are currently developing the Resource Tracking System (RTS). Once finalized this system will allow senior leadership to identify deployable officers and specific skill sets to meet the deployment request. RTS will allow management the ability to track CDC/ATSDR staff anywhere in the world, which will better facilitate accountability.

Communication and recruitment workgroup: HHS has formed a Communication and Recruitment Work Group in which CCPAC has representation through LCDR Moffet and CDR Davenport. The primary focus of this WG will primarily be on transparent communication to all Corps and retention. The first meeting was held in Washington, DC in which a planning and goal session took place.

Internationally-assigned officers: CCPAC represents all officers at CDC/ATSDR worldwide. CAPT Jordan Tappero is the international based committee member and actively participates in the monthly meetings. Currently, the committee is in talks with OCCFM to finalize the process of Education Expenses to those officers assigned overseas. The current policy is for the officer to pay out of pocket for dependent educational expenses which can be a hardship to the officer. What we are proposing will better align the process with the military, the expenses be paid by the HHS, thus eliminating the need to process a reimbursement request.

OFRD immunization requirements: The CCPAC continues to engage OCCFM in redefining immunization requirements for all Corps officers. Thanks to the work of the CCPAC Immunization Subcommittee the suggested revisions (endorsed by CDC Medical Advisory Board) will better align Corps requirements, with the immunization recommendations by the Advisory Committee on Immunization Practices (ACIP). The revisions are in the final stages of approval and will be distributed to all officers.

Readiness: CCPAC and OCCP continue to encourage officers to meet the Basic Readiness Standards by the May 1, 2005 deadline. Officers are encouraged to use the Readiness Sessions that OCCP is sponsoring a schedule of activities are listed on the OCCP web page. As of March 4, about 51% of CDC officers and 66% of ATSDR officers meet all of the requirements of "Basic Readiness."

Role of CC officers at CDC/ATSDR: We are currently developing a white paper on the "Transforming the Public Health Service Commissioned Corps: CDC/ATSDR Perspective." The intent of the paper is to better articulate how the Corps officers role in public health differs from its civil servant counterparts. The document will incorporate the uniqueness of Corps officers and their contribution to Public Health. A Subcommittee has been formed to under take this important issue, however the committee at large will be engaged in comment before a recommendation is made to senior leadership.

Basic Officer Training Course (BOTC): OCCP is currently scheduling BOTC training for all officers who have not been afforded the opportunity to take the class. The next scheduled class is April 15-17 in partnership with National Center for HIV, STD and TB Prevention (NCHSTP) for those officers assigned to the Global AIDS Program (GAP) at the Georgia Tech facility. Officers are encouraged to utilize these training opportunities to advance their career. OCCP will always communicate where training opportunities exists.

Submitted by: Mr. Aaron Arnold

CDC/ATSDR Offers BOTC Courses Taught by CDC/ATSDR Officers

Since the successful completion of BOTC has been included in the promotion benchmarks of most categories, the number of commissioned officers seeking to take the BOTC course has increased sharply. This has put an enormous burden on the staff and resources of the Commissioned Officer Training Academy (COTA), Office of Commissioned Corps Operations (OCCO). To help alleviate this burden, the COTA has started training senior officers in various agencies to be BOTC associate instructors. These associate instructors are then qualified to teach BOTC courses at their respective agencies with minimal help from COTA staff. Five CDC/ATSDR officers began associate instructor training in November 2004. Those officers are:

CDR Amy Collins, CDC/NCCDPHP, Atlanta, GA
CAPT Austin Hayes, CDC/OCCP, Atlanta, GA
CAPT Janice Huy, CDC/NIOSH, Cincinnati, OH
CDR Alan Parham, ATSDR, Atlanta, GA
CAPT John Steward, CDC/OCCP, Atlanta, GA

These CDC/ATSDR associate instructor trainees assisted in conducting a BOTC training course February 23-25, 2005 at CDC/NIOSH in Cincinnati, Ohio. While CDR Dana Taylor from COTA was there for support and presented some modules, our instructors planned and taught much of the course using the same module presentations, work books, and handouts used in COTA courses. The majority of the attendees came from NIOSH, but officers from CDC/ATSDR (Atlanta, GA), the Bureau of Prisons (Lexington, KY), Food and Drug Administration (IN and NC), Immigrations, and US Park Service (CA) were also present. In all, there were 34 officers in attendance, and by all accounts, the course was an overwhelming success.

CDC/ATSDR associate instructor trainees will also be assisting with another BOTC course in Atlanta on Friday through Sunday, April 15-17, 2005. The course will be held at the Georgia Tech University Conference Center. Currently, the course attendance has reached its capacity, any officers desiring to signup will be placed on a wait list and will only be contacted should a vacancy arise. To register, please send Aaron Arnold (ala8@cdc.gov) an email with the following information:

Name
PHS Rank and Serial Number
Email Address
Office Phone Number

All course participants must be in uniform and attend the 3 full days, each day (8:00 AM to 4:30 PM), to receive credit for the course. Each officer is responsible for ensuring his/her own supervisor's approval at the time of sign up. Officers are expected to be an authorized seasonal uniform and adhere to PHS grooming standards. The BOTC course is only open to those officers who have not taken a BOTC course in the past. Any travel expenses are the responsibility of the officer's program.

Additional BOTC courses offered by CDC/ATSDR will be advertised in upcoming issues of this newsletter.

Submitted by: LCDR Stephen Martin

Commissioned Corps Transformation

New Mission Statement for the US Public Health Service Commissioned Corps

"Protecting, promoting, and advancing the health and safety of the Nation"

As America's uniformed service of public health professionals, the Commissioned Corps achieves this mission through:

- rapid and effective response to public health needs
- leadership and excellence in public health practices, and
- the advancement of public health science.

This article will provide a brief update of what has happened since our last newsletter regarding the Transformation Workgroup and to provide you information about the newly established Transformation Resource Groups.

Transformation Workgroup
As you may recall, the Transformation Workgroup consisted of a senior office from each of the Department's agencies, the Bureau of Prisons, and the Coast Guard. In addition, the Transformation Workgroup was supported by a Resource Group composed of senior and junior officers, senior officers from the Office of Public Health Science (OPHS) and the Office of the Surgeon General (OSG), and the Lewin Group who is the outside contractor for the Transformation. During the course of this process, the Transformation Workgroup identified seven issues and developed options for each of these areas for the Secretary.

The workgroup developed options primarily addressing major overarching programmatic concerns. However, throughout the process, the Transformation Workgroup discussed the impact that any of these options might have on the officers. In addition, members of the Transformation Workgroup briefed agency leaders an on-going basis. All of the options for the seven issues were provided to the DHHS agencies and operating divisions.

Resource Workgroup
As an outgrowth of this process, in the fall of 2004, a second Resource Workgroup was created to address recruiting Commissioned Corps officers. This Resource Workgroup is co-chaired by RADM Knouss and RADM Williams and includes senior and junior officers representing most of the DHHS agencies and provides guidance and technical assistance to a contractor, ORC Macro. The Resource Group meets at least monthly to discuss the progress being made by the contractor, review the deliverables, and to make recommendations for next steps.

From the contractor's perspective, the work plan for the recruitment contract has two main objectives. These objectives are to raise the awareness of the Commissioned Corps among the general public and to enhance the recruitment efforts of the Corps. Both of these objectives will use our new mission statement as the basis for all of the messages and materials that are being proposed. One example of an approach that the contractor has proposed to increase recruitment is to develop profiles of officers that include narratives in conjunction with visuals of officers in various roles. The profiles are designed to show the impact officers have on public health. Some of you may already have been asked by your Agency Liaison or Chief Professional Officer (CPO) to participate in this process.

Finally, although clinical practice seems to be the area where there Corps envisions the most significant recruitment and expansions, the members of the Resource Workgroup and the Transformation Resource Workgroup continue to emphasize that good public health practice requires a multidiscipline team to address today's broad range of public health issues in order to protect, promote and advance the health and safety of our Nation.

Submitted by: CDR Marsha Davenport

CDC/ATSDR Reviews of Draft Commissioned Corps Policies

Recently, CDC/ATSDR leadership and the CCPAC were given the opportunity to review two important draft Commissioned Corps policies pertaining to the ongoing transformation. Both draft plans, if implemented, could have an impact on Commissioned Corps officers at CDC/ATSDR. The following offers a brief description of each draft policy and the CDC/ATSDR action taken to date.

USPHS Commissioned Corps Readiness and Response Plan

If implemented, the plan would augment the current OFRD deployment scheme with a new hierarchy by placing officers into one of four readiness response categories or "Alert Levels." *Alert Level 1* will be the Secretary's Rapid Deployment Force (RDF), consisting of five separate teams of 75 members each. Three of the teams (RDF Teams 1, 2, and 3) will be located in the Washington D.C./Baltimore, MD area, with members coming primarily from NIH, FDA, HRSA, CMS, SAMHSA, and IHS. These teams will have a clinical focus, with capabilities in preventative medicine, laboratory testing, and mental health. RDF Team 4 will be located in Atlanta, GA, and will be composed mainly of officers from CDC/ATSDR. This team will have a clinical focus with expertise in disease investigation and epidemiology, chemical, biological, radiological, and nuclear (CBRN) hazards, hazardous substances, and occupational and environmental health. RDF Team 5 will be based in Phoenix, AZ with members primarily from the Indian Health Service. This team will also be clinical in nature with expertise in environmental health. One or more of the five teams will deploy at a time in units of 50 officers.

All RDF team members will be required to be current in clinical practice, Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), responding to CBRN events, the Incident Command System, and other unspecified subjects related to emergency preparedness and response. Each Team member will spend a minimum of 112 hours per year working in their clinical role and a minimum of two weeks per year either deployed to an event or in a field exercise where they are required to provide services in their actual deployment role. All five RDF teams will be constantly on "Alert" status, with one team at a time being the primary response unit. The RDF teams must be able deploy within 4 hours of notification for up to 14 days, and be completely self-sustaining for the first 72 to 96 hours.

Active-duty officers not placed on one of the five RDF teams will fall into Alert Level 2 or Alert Level 3. All members of these alert levels will be required to meet basic readiness standards. *Alert Level 2* will consist of 21 teams of 100 officers, with the teams being divided into seven monthly deployment rosters (3 teams per month). Alert Level 2 officers must be able to deploy within 24 hours of notification for up to 14 days. *Alert Level 3* will be composed of 35 teams of 100 officers, with the teams being divided into seven monthly deployment rosters (5 teams per month). The difference is that Alert Level 3 officers will have 48 hours to deploy after receiving notification, so these teams will be composed primarily of officers in remote duty locations.

Finally, 2,000 officers in the Inactive Reserve Corps will constitute *Alert Level 4*. These members must be called to active duty prior to deployment, so they will have 72 hours to deploy after notification.

In addition to describing the four Alert Levels, the plan included bulleted lists of action items and a proposed budget to begin implementing the new deployment scheme. Upon review, the CCPAC recommended that CDC/ATSDR "NON-CONCUR" with the plan as written. The concept of teams that train and deploy together was well supported, however there were many other concerns. The major concern was that input from important groups, including the Surgeon General's Policy Advisory Committee (SG PAC), CPOs, and the Policy Advisory Committee Chairs, was not sought in developing the plan. More specific CCPAC concerns with the plan were:

1. *Emphasis on clinical role*: The emphasis on the clinical role neglects the important role of public health activities in response efforts.
2. *Definition of clinically current*: Officers in clinical categories do maintain their clinical license, and some medical officers elect to perform 112 hours of clinical service per year to qualify for special pays. However, it is questionable that this amount of clinical experience would prepare officers to deliver primary care services in an emergency response setting.
3. *Time commitment*: The total time commitment required by the plan may result in RDF officers being away from their assigned duty station for 20% of the time or more. This will not only negatively impact the public health mission of the agency, but it will also make the officers less desirable candidates for positions in the agency.
4. *Coordination with other response teams*: Although one of the stated goals of the RDF is to augment NDMS and hospitals in emergencies, it is unclear how Alert Level 1, 2, and 3 teams will integrate with other response entities.
5. *Staffing*: CDC/ATSDR currently does not have staff with the appropriate skills and training to fill the clinical positions proposed for RDF Team 4.

6. *Funding*: The proposed funding is most likely inadequate for the proposed activities.

Based on input from the CCPAC, the CDC/ATSDR leadership replied to the Office of the Secretary with a "non-concurrence," urging further discussions with the agencies and Corps leadership and revisions to the plan based on those discussions. Most other agencies responded with a "non-concurrence" as well. Based on the comments from the various agencies, a revised plan is forthcoming. This newsletter will keep you informed as further details about the Readiness and Response Plan become available.

6th Promotion Precept

This new precept is being designed to recognize officers who serve in duty assignments classified as isolated hardship, hazardous, or hard-to-fill (HHH). These assignments can place great burdens on the officers' family members and may adversely affect officers' ability to pursue career development goals. As a result, the 6th precept will specifically recognize the sacrifices made by officers who serve in HHH assignments and ensure that those officers are not disadvantaged in the career development process.

The document brought before the CCPAC was seeking input into defining HHH positions and responses to a proposed decision matrix used to implement and score the 6th precept. The following table of discussion points was offered:

Assignment Precept Decision Matrix					
	Discussion Points	Option 1	Option 2	Option 3	Option 4
1	Number of points awarded and how	0-5, on a sliding scale	0-3, on a sliding scale	5 or 0, a single point	3 or 0, a single point
2	HHH assignment types	All 3	combination of any 2	Any single 1	
3	How far back do we provide credit	Since last promotion	5 years back	3 years back	Anytime during a career
4	Amount of time spent in assignment	180 days	1 year	2 years	5 years
5	Title of the Precept	Assignment	Critical Needs	3 H (hardship, hazardous, hard-to-fill)	6th
6	Increased points for increased durations	Yes	No		
7	Different duration requirements for different assignments	Yes	No		

Based on the CCPAC review, CDC/ATSDR recommended to drop the 6th precept altogether. The basis for this recommendation was that the proposed matrix is overly complicated and would rely on complicated definitions that may not capture all the possible permutations. It was felt that credit for these assignments would be better captured through the existing system of awards and existing precepts, including the Hazardous Duty Award and the Isolated/Hardship Award. For the purposes of filling hard-to-fill positions, consideration should be given to following the recent Senate Armed Services Committee recommendations of using extra pay to fill hard-to-fill positions.

The CDC/ATSDR response was echoed by most other agencies in that the 6th precept should be abandoned. Based on the responses, the Office of Commissioned Corps Force Management will be convening a workgroup that will re-evaluate how the "spirit" of the 6th precept could be implemented. This newsletter will keep you informed as more information about the 6th precept becomes available.

Submitted by: CDR Sally Brown Kiefer

Commissioned Officers: Are we really any different from our Civil Service colleagues?

The recent events concerning Transformation as well as the state of national preparedness for terrorist threats has forced us, as commissioned officers, to take another look at what it means to be a Commissioned Officer (CO). Are we that different from our civil service colleagues? Do we represent a unique resource to carry out the mission of the Department of Health and Human Services? How do these questions apply specifically to COs at CDC/ATSDR? In order to better define what it means to be a CO, CCPAC took a long, hard look at some of the differences between us and our Civil Service colleagues.

During our discussions we were able to easily and rapidly identify nine areas in which COs have certain unique attributes as COs. These areas include: 1) duty hours, 2) ease of reassignment, 3) skill diversity and depth of knowledge, 4) deployability readiness, 5) physical fitness, 6) visibility, 7) licensure, 8) clinical skills and 9) operation. Some of these categories are relatively new (due to changes with the Transformation) and are in the midst of being completely phased in. In addition, not every officer will necessarily display a differentiating characteristic in every category. However, all of the identified areas do represent categories in which COs have tangible, distinct differences from their CS colleagues. Many people will disagree as to whether or not these differences make COs better or worse than their CS colleagues and will probably depend on the individuals disagreeing, their viewpoint and overall role in DHHS (e.g., a CS agency supervisor or a CO workforce recruiter may never agree). The truth of the matter is, the differences are just that, differences. They do not make an overall better or worse employee but rather provide different attributes. The goal of this article is to point these attributes out and recognize that as COs, we have accepted a large number of additional obligations and responsibilities.

COs are subject to *duty hours* which essentially never end! Although our primary duty requirements include a 40-hour work week, we are essentially always on call for deployment. This may benefit our Agency in enhanced focus on the job rather than on "hours worked," decreased financial costs since there is no overtime pay and overall increased CO availability. *Reassignment* is a natural progression of events during a CO's career. As COs develop their skills, agency needs change, billets are outgrown and personnel reassignment will occur. This process can be much lengthier with our CS colleagues due to necessary administrative requirements, whereas it can be often streamlined for COs. Advancement criteria in the PHS, is in part, based on mobility (geographic and programmatic). This mobility results in the development of CO *skill diversity and enhanced overall depth of knowledge*, which usually benefits the Agency where the CO is assigned. As COs, we have a mandatory responsibility to be ready for *emergency deployment* in a pre-selected deployment role 24 hours a day, seven days a week. All officers have the same basic obligatory requirements for deployment and perhaps even more, depending on their specific deployment role. In addition, COs can be militarized by Presidential Executive Order. The PHS has instituted mandatory *physical fitness* requirements for all COs. There are numerous ways to meet these requirements but acceptance of a commission now also represents a commitment to physical activity and the importance of physical fitness in our daily lives.

COs who are members of certain categories are expected to maintain their *licensure* requirements (if applicable). This is not negotiable and serves to also distinguish us from our CS colleagues, since they are not under a similar universal obligation. Certain categories of COs (e.g., Medical) are required to maintain their *clinical skills* in order to receive financial compensation for their training and education. This is a direct incentive for such COs to maintain their skills in contrast to most analogous CS positions, in which additional pays are administered without such a requirement. Maintenance of clinical skills bridges the gaps between clinical medicine and public health, facilitates credibility among clinical practitioners and optimizes public health practice by practical experience and application.

Officers can also serve in positions whose duty requirements and responsibilities (billet) exceed their current rank. In contrast, civil servants may not occupy a position grader higher than their current grade. This can facilitate efficient management of capable personnel, increases human resource management flexibility and overall *operation*. Since COs are expected to be functioning at a higher level (eg, an O-4 Officer may hold an O-5 billet) than currently ranked to be sincerely considered for promotion to an equivalent rank, this helps to insure that promotion is still based on job performance and ability. Finally, perhaps the most distinguishing feature is our *visibility*. The uniform we wear rapidly distinguishes us from all other government employees as members of a uniformed service that has a trained cadre of health professionals dedicated to protecting public health. This provides a unique (and often underutilized) method for DHHS and our agencies to disseminate information due to what the uniform represents including duty, competence and authority.

The dedication of our CS colleagues can never be questioned as they work with the same fervor, perseverance and commitment that we as COs do. However, the additional responsibilities and requirements that COs accept serve to distinguish us from our civil service colleagues. Although many will argue if that is an overall better or worse attribute depending on their individual position and role, it is important to remember that as COs we *do* have unique and distinct attributes and are not just part of an alternative employment system. There is a history and culture that transcends two centuries of our nation's history, which should stand to remind us of these differences and prompt us as COs to take pride in our choice to accept that commission.

Submitted by: LCDR Joshua Schier

Do You Know?

Do you know that officers who deploy through CDC/ATSDR get the same recognition as officers who are deployed by the Officer of Force Readiness and Deployment (OFRD), Office of the Surgeon General (formerly the Commissioned Corps Readiness Force or CCRF)?

Yes!!!!!

OFRD has included CDC/ATSDR deployed officers on the award nominations for every deployment that has included both OFRD and CDC/ATSDR agency deployments.

Do you know that a CDC/ATSDR officer received the 2005 VADM C. Everett Koop Junior Officer of the Year Award by the Reserve Officers Association (ROA)?

LCDR Daphne Moffett, ATSDR Division of Toxicology and current Science Professional Advisory Committee (SciPAC) Chair, was presented with the award during the Mid-Winter Reserve Officers Association meeting, February 14, 2005. Criteria for judging included: exemplary performance and accomplishments in USPHS assignments; civic accomplishments, including offices held and other accomplishments; demonstrated leadership abilities; and notable contributions to the mission of the USPHS. LCDR Moffett has distinguished herself among officers through her involvement in numerous Corps Activities, including the SciPAC and the Atlanta Area PHS Honor Guard, has worked in each of her PHS assignments to promote the mission and goals of the USPHS and agency, and has shown great leadership abilities throughout her career.

Congratulations!!!!

Do you know what color socks are appropriate for the Summer Khaki and Working Khaki uniforms?

Only "khaki" socks are permitted with brown shoes and only black socks are permitted with black shoes. Some officers may be interpreting "brown" (khaki) as including any shade of brown from "chocolate" to "light brown". "Brown" socks are not appropriate. Khaki socks are available through any Navy Uniform store (e.g., Dobbins).

Do you know what the suggested format is to identifying ourselves as Corps officers in our communications?

The Commissioned Corps has not issued formal approval of name formats for officers. As soon as approval is received, we'll be sure to distribute. However, in the interim, please use the formats noted below.

Letters

Jan Smith, M.D., M.P.H.
Captain
U. S. Public Health Service

Memo

Bill Smith, M.P.H.
LCDR, USPHS

Email

Can be either abbreviated or spelled out rank with degrees.