

**U.S. Department of  
Homeland Security**

**United States  
Coast Guard**



---

# **COAST GUARD HEALTH PROMOTION MANUAL**

**COMDTINST M6200.1C  
09 July 2015**





COMDTINST M6200.1C  
09 JUL 2015

COMMANDANT INSTRUCTION M6200.1C

Subj COAST GUARD HEALTH PROMOTION MANUAL

- Ref: (a) Coast Guard Weight and Body Fat Standards Program Manual, COMDTINST M1020.8 (series)  
 (b) Coast Guard Medical Manual, COMDTINST M6000.1 (series)  
 (c) Coast Guard Periodic Health Assessment (PHA), COMDINST 6150.3 (series)  
 (d) Weight Management Self-Help Guide, COMDTPUB P6200.3 (series)  
 (e) Crew Endurance Manual, COMDTINST M3500.2 (series)  
 (f) Coast Guard Drug and Alcohol Abuse Program Manual, COMDTINST M1000.10 (series)

- PURPOSE.** This Manual establishes policy, assigns responsibilities, and provides guidelines regarding physical fitness, nutrition, stress management, weight management, health risk reduction, substance abuse prevention, and unit health promotion program planning. It clarifies the roles and responsibilities for Commandant (CG-1111), the Health, Safety, and Work-Life Service Center (HSWL SC), Unit Health Promotion Coordinators (UHPC), Regional Health Promotion Managers (HPM), Substance Abuse Prevention Specialists (SAPS), the Substance Abuse Prevention Program Supervisor (SAPPS), Command Drug and Alcohol Representatives (CDAR), Food Service (FS), and Health Service (HS) personnel with respect to the Health Promotion program.
- ACTION.** All Coast Guard unit commanders, commanding officers, officers-in-charge, deputy/assistant commandants, and chiefs of headquarters staff elements will comply with the provisions of this Manual. Internet release is authorized.
- DIRECTIVES AFFECTED.** Coast Guard Health Promotion Manual, COMDTINST M6200.1B, is cancelled.

DISTRIBUTION – SDL No. 165

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z
A	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X					
B	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
C	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
D	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X			X			X			
E	X	X		X	X			X	X										X							
F																	X	X	X							
G			X	X																						
H																										

NON-STANDARD DISTRIBUTION:

4. DISCLAIMER. This guidance is not a substitute for applicable legal requirements, nor is it itself a rule. It is intended to provide operational guidance for Coast Guard personnel and is not intended to nor does it impose legally-binding requirements on any party outside the Coast Guard.
5. MAJOR CHANGES.
  - a. Chapter 1. Removal of references to the Personal Wellness Profile (PWP).
  - b. Chapter 2. Removal of references to the PWP.
  - c. Chapter 3. Cutters may designate a section of the weather deck as a tobacco use area (smoking and smokeless). Designated areas must be a sufficient distance away, from entrances and exits, so as not to allow smoke to be drawn into the interior of the ship through doors, hatches, or air intake units/vents.
  - d. Chapter 3. Coast Guard Housing Manual, COMDTINST M11101.13 (series) will determine smoking policy in government housing.
  - e. Chapter 4. Provides a more defined definition of who will be allowed to exercise.
  - f. Chapter 5. New requirements for medical officers. Medical officers will offer various alternatives for individuals on weight probation to include consultation to HPMs and use of CGSUPRT.
  - g. Chapter 7. Numerous updates to chapter associated with updated substance abuse policy.
  - h. Appendix A. Numerous changes that correlate to the changes in Chapter 7.
  - i. Appendix B. Appendix B, the instruction to the Personal Wellness Profile, was removed. (Due to the removal of Appendix B the previous Appendixes C, D, E, F, in COMDTINST M6200.1B are now Appendixes B, C, D, E, in COMDTINST M6200.1C).
  - j. Appendix E. Removed Deployable Operations Group added Deployable Special Forces.
  - k. Appendix F. Removed all references to the Personal Wellness Profile.
6. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS.
  - a. The development of this directive and the general policies contained within it have been thoroughly reviewed by the originating office in conjunction with the Office of Environmental Management, and are categorically excluded (CE) under current USCG CE # 33 from further environmental analysis, in accordance with Section 2.B.2 and Figure 2-1 of the National Environmental Policy Act Implementing Procedures and Policy for Considering Environmental Impacts, COMDTINST M16475.1 (series). Because this directive contains guidance on documents that implement, without substantive change the applicable directive and other guidance documents, Coast Guard categorical exclusion #33 is appropriate.
  - b. This directive will not have any of the following: significant cumulative impacts on the human environment; substantial controversy or substantial change existing environmental conditions; or inconsistencies with any Federal, state, or local laws or administrative determinations relating to the environment. All future specific actions resulting from the

general policies in this directive must be individually evaluated for compliance with the National Environmental Policy Act (NEPA), DHS and Coast Guard NEPA policy.

7. DISTRIBUTION. No paper distribution will be made of this Manual. An electronic version will be located on the Coast Guard Directives System (CGDS) sites located at: Internet: <http://www.uscg.mil/directives>; Intranet: <http://cgweb.comdt.uscg.mil/CGDirectives/Welcome.htm> and CG Portal: <https://cgportal2.uscg.mil/library/directives/SitePages/Home.aspx>
8. RECORDS MANAGEMENT CONSIDERATIONS. This Manual has been evaluated for potential records management impacts. The development of this Manual has been thoroughly reviewed during the directives clearance process, and it has been determined there are further records scheduling requirements, in accordance with Federal Records Act U.S.C. 3101 et seq., National Archives and Records Administration (NARA) requirements, and the Information and Life Cycle Management Manual, COMDTINST M5212.12 (series). This policy does not have any significant or substantial change to existing records management requirement.
9. Definitions. Resources, definitions, and commonly used terminology are provided in Appendix A.
10. FORMS/REPORTS. The forms referenced in this Manual are available in USCG Electronic Forms on the Standard Workstation or on the Internet: <http://www.uscg.mil/forms/>, CG Portal at <https://cgportal.uscg.mil/delivery/Satellite/uscg/References>; and Intranet at <http://cgweb.comdt.uscg.mil/CGForms>.
11. REQUESTS FOR CHANGES. Units and individuals may recommend changes in writing via the chain of command to COMMANDANT (CG-111), U. S. COAST GUARD STOP 7907, 2703 MARTIN LUTHER KING JR. AVE SE, WASHINGTON DC 20593-7907.

Maura K. Dollymore /s/  
Rear Admiral, U.S. Public Health Service  
United States Coast Guard  
Director, Health, Safety, and Work-Life



## TABLE OF CONTENTS

## CHAPTER 1. HEALTH PROMOTION PROGRAM OVERVIEW

A. Policy .....	1-1
B. Overview .....	1-1
C. Program Elements .....	1-1
D. Organizational Benefits .....	1-1
E. Purpose .....	1-1
F. Applicability .....	1-2
G. Program Implementation .....	1-2
H. Duties and Responsibilities .....	1-2

## CHAPTER 2. DISEASE PREVENTION AND HEALTH RISK REDUCTION

A. Introduction .....	2-1
B. Health Risk Assessments (HRA) .....	2-1
C. Health Risk Assessments Overview .....	2-1
D. Duties and Responsibilities .....	2-2

## CHAPTER 3. NICOTINE USE POLICY

A. Introduction .....	3-1
B. Definition.....	3-1
C. Discussion .....	3-1
D. Policy .....	3-1
E. Tobacco Cessation Resources .....	3-3
F. Nicotine Replacement Therapy (NRT) and Tobacco Cessation Aids.....	3-3
G. Duties and Responsibilities .....	3-3

## CHAPTER 4. PHYSICAL FITNESS

A. Introduction .....	4-1
B. Policy .....	4-1
C. Duties and Responsibilities .....	4-2

## CHAPTER 5. NUTRITION AND WEIGHT MANAGEMENT

A. Weight Management Overview.....	5-1
B. Nutrition Overview.....	5-1
C. Dietary Supplements Overview.....	5-1
D. Choosing Healthy Options for Wellness (CHOW) .....	5-2
E. Policy .....	5-2
F. Duties and Responsibilities .....	5-2

CHAPTER 6. STRESS MANAGEMENT

A. Introduction .....6-1  
B. Policy .....6-1  
C. Duties and Responsibilities .....6-2

CHAPTER 7. SUBSTANCE ABUSE PREVENTION PROGRAM (SAP)

A. Introduction .....7-1  
B. Program Overview .....7-1  
C. General Policy .....7-2  
D. Applicability .....7-3  
E. Duties and Responsibilities .....7-3  
F. Training and Education Requirements .....7-9  
G. Medical Referrals, Screenings, and Action for Substance Abuse .....7-10  
H. Treatment.....7-13  
I. Support Plans for Substance Use Disorders .....7-15  
J. Rehabilitation Failure .....7-18  
K. Paperwork and Records Management for Substance Abuse Cases.....7-18

APPENDIX A. RESOURCES, DEFINITIONS, AND COMMONLY USED TERMINOLOGY .....A-1  
APPENDIX B. EXERCISE GUIDELINES ..... B-1  
APPENDIX C. PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q) .....C-1  
APPENDIX D. FITNESS ASSESSMENT PROTOCOLS AND PROCEDURES .....D-1  
APPENDIX E. SAMPLE UNIT FITNESS INSTRUCTION .....E-1

LIST OF TABLES

Table 6-1: Operational Stress Control Continuum .....6-1  
Table D-1: 1.5 Mile Norms for Men (Minutes: Seconds) .....D-5  
Table D-2: 1.5 Mile Norms for Women (Minutes: Seconds) .....D-5  
Table D-3: 1 Mile Walk Test Male Norms Max VO2.....D-6  
Table D-4: 1 Mile Walk Test Female Norms Max VO2 .....D-6  
Table D-5: 1 Mile Walk Test Norms in Minutes.....D-6  
Table D-6: Push Up Test Norms for Men 1 Minute Test .....D-7  
Table D-7: Push Up Test Norms for Women 1 Minute Test.....D-8  
Table D-8: Push Up Test Norms for Modified Push Up .....D-8  
Table D-9: Sit-Up Norms for Men 1 Minute .....D-9  
Table D-10: Sit-Up Norms for Women 1 Minute.....D-9  
Table D-11: Test Scores for the Curl-up .....D-10  
Table D-12: Portland State University Curl Up Norms .....D-10  
Table D-13: Sit and Reach Flexibility Norms for Men (inches) .....D-11



Table D-14: Sit and Reach Flexibility Norms for Women (inches) .....D-12  
Table D-15: Vertical Jump Test Norms Men .....D-12  
Table D-16: Vertical Jump Test Norms Women .....D-12  
Table D-17: 300 Meter Run Norms Males .....D-13  
Table D-18: 300 Meter Run Norms Females.....D-13







**CHAPTER 1. HEALTH PROMOTION PROGRAM OVERVIEW**

- A. Policy. The Coast Guard is committed to supporting the health of its workforce through health promotion policy, programs, education, and services to ensure mission readiness. All members (Coast Guard Active Duty (AD) and Selected Reserve (SELRES)) are required to adhere to Commandant physical activity and weight and body fat standards. In addition, these members as well as civilian personnel are strongly encouraged to adopt a healthy lifestyle including eating nutritious foods that enhance performance, avoiding tobacco use, getting enough sleep, using alcohol prudently, obtaining preventive evidence-based screening tests, and learning how to effectively manage stress. Based on the principle that leadership plays an integral part in a successful health promotion program, commanding officers and officers-in-charge are required to implement and adhere to all policies contained herein particularly the requirements to annually review the Commanding Officer Health Risk Appraisal (HRA).
- B. Overview. A healthy and fit Coast Guard workforce is critical for optimal mission performance. An abundance of research shows that lifestyle factors such as dietary choices, exercise habits, stress management methods and alcohol/tobacco use are key determinants of health outcomes, risk of injury, and work performance. Implementation of this program helps participants stay physically fit for duty, maintain a healthy weight, and reduce risks attributed to lifestyle imbalances. The program also helps commands establish a work environment that supports healthy life practices. Collectively, program elements help ensure that the Coast Guard workforce is able to fulfill mission requirements and help members live healthy, balanced and satisfying lives.
- C. Program Elements. The core elements of the Coast Guard Health Promotion Program are:
1. Health promotion programming.
  2. Disease prevention and health risk reduction.
  3. Nicotine abstinence.
  4. Physical fitness.
  5. Nutrition and weight management.
  6. Stress management.
  7. Substance abuse prevention and treatment.
- D. Organizational Benefits. Research shows that organizations that implement health promotion policies and programs experience significantly lower health care costs, fewer disability claims, decreased absenteeism and increased productivity, morale, and retention. The policies, programs and interventions developed by the Coast Guard Health Promotion Program are well researched and proven effective. They adhere to recommendations made by the U.S. Centers for Disease Control and Prevention (CDC), the Department of Health and Human Services (HHS), Healthy People 2020 national goals, scientifically reputable health organizations, and the Department of Defense (DoD). The guidance in this Manual will supersede the guidance in the previously mentioned references unless required by applicable law.
- E. Purpose. This Manual:
1. Establishes policy for alcohol screening and treatment, and substance abuse prevention and education, for all active duty and selected reserve personnel.

2. Provides policy and practical guidance that promotes healthy behavior related to weight management, physical fitness, nutrition, stress management, and health risk reduction.
  3. Establishes nicotine use policy for all personnel, and provides guidance to commands on workplace tobacco use.
  4. Sets forth and describes unit Health Promotion Program requirements.
  5. Identifies the responsibilities for stakeholders in health promotion outcomes.
- F. Applicability. Policy and programs within this Manual apply to all Coast Guard active duty personnel and reservists on active duty for 31 or more consecutive days and, when specified, to other reservists and civilian personnel.
- G. Program Implementation. The following entities are responsible for implementation of the policies in this Manual:
1. Accession Points and Training Centers. Training Center Cape May, Training Center Yorktown, Training Center Petaluma, Aviation Training Center Elizabeth City, Officer Candidate School, and the Coast Guard Academy are required to include health promotion training in their curricula.
  2. Leadership and Class A and C schools. The Chief Petty Officer Academy and Chief Warrant Officer Professional Development School will include health promotion curricula in their training schedules. In addition, an introduction to the Health Promotion Program is provided during some Class “A” and “C” schools. The curricula at Food Service Specialist Class “A” and “C” schools will incorporate health promotion elements, with a strong emphasis on nutrition.
  3. Regional Level. Coast Guard health promotion initiatives and policy are implemented by regional Health Promotion Managers (HPMs) and Substance Abuse Prevention Specialists (SAPSs). They are field level subject matter experts and are charged to assist commands with development of unit programs. HPMs and SAPSs also provide program guidance and consultation to Leadership, Class “A”, and Class “C” schools within their AOR.
  4. Command and Unit Level. Endorsement and visible support by command leadership (commanding officer, executive officer, officer-in-charge, command master chief, and executive petty officer) is critical for the success of Health Promotion Programs at the unit level.
- H. Duties and Responsibilities. This section outlines the duties and responsibilities for overall program development. Refer to the succeeding chapters for specific guidance related to each program element.
1. Commandant (CG-11). The Health Safety and Work-Life (HSWL) Directorate serves as authority over the policy and programs outlined in this Manual, which are managed by Commandant (CG-111), the Office of Work-Life.

2. Commandant (CG-1111). The Behavioral Health Services Division of the Office of Work-Life (CG-111) provides leadership and oversight for all division functions. Commandant (CG-1111) will
  - a. Policy.
    - (1) Develop vision and a strategic plan for the Health Promotion Program.
    - (2) Initiate changes to this Manual in response to organizational needs and to reflect changes in best practices and advances in health promotion.
  - b. Program Development.
    - (1) Serve as liaison to external partners including the Department of Homeland Security (DHS), Department of Defense (DoD), Department of Health and Human Services (HHS), inter-agency health promotion stakeholders, and other national health organizations.
    - (2) Inform key stakeholders within Commandant (CG-11) of health promotion priorities and required action.
    - (3) Establish quality improvement measurement standards in collaboration with the HSWL SC to evaluate health promotion field operations.
    - (4) Provide oversight for research and evaluation of the health-related behavior of Coast Guard personnel.
  - c. Resource Management.
    - (1) Secure funding and provide financial oversight for Behavioral Health Services Division programs.
    - (2) Work collaboratively with the HSWL SC to identify HSWL Regional Practice (RP) staffing requirements and develop resource proposals to meet those needs.
    - (3) Develop the funding structure for the Behavioral Health Services Division and communicate funding responsibilities to the Health Promotion Program Manager (HPPM), Substance Abuse Program Manager (SAPM), and HSWL SC.
  - d. Training and Education. Provide professional development opportunities to Behavioral Health Services Division staff to maintain subject matter expertise.
  - e. Marketing.
    - (1) Communicate to leadership the functional benefits of the program to operational readiness.
    - (2) Oversee the development of the communication and marketing plan to ensure concise and consistent promotion of program vision, services, and benefits.
    - (3) Use a variety of media and technology to communicate program goals and objectives, policy, initiatives, and expected outcomes.
3. Health Promotion Program Manager (HPPM). The HPPM, under the direction of the Behavioral Health Services Division Chief, will:
  - a. Program Development.

- (1) Develop and disseminate the annual Health Promotion Program strategic plan.
  - (2) Assess the Health Promotion Program by evaluating quarterly productivity reports against needs assessments developed from Health Risk Assessment (HRA) reports.
  - (3) Serve as liaison to the Office of Military Personnel, Commandant (CG-122), on health promotion issues associated with weight and body fat standards for military personnel, as directed by Reference (a).
  - (4) Serve as the physical fitness subject matter expert to Coast Guard programs internal and external to Commandant (CG-11).
  - (5) Serve as liaison to the HSWL SC to support policy initiatives and collaborate on all aspects of program implementation and evaluation.
  - (6) Work in collaboration with the Food Service and Substance Abuse Prevention Program Managers and the Morale, Well-being, and Recreation (MWR) Program Managers on cross-program initiatives to ensure consistent implementation and management.
  - (7) Facilitate the development, evaluation, and implementation of education programs and training curricula to improve health-related behavior.
  - (8) Develop and evaluate programs to improve the physical fitness of Coast Guard members and beneficiaries.
  - (9) Coordinate workgroups with HPMs and other personnel as appropriate to address health promotion program issues and emerging initiatives.
  - (10) Develop, disseminate, and analyze the program evaluation plan in collaboration with the HSWL SC.
  - (11) In conjunction with the HSWL SC, standardize HPM position descriptions and requirements.
  - (12) Establish standards for the Health Promotion Program and services.
  - (13) Develop initiatives for the Health Promotion Program in collaboration with key stakeholders.
- b. Policy.
- (1) Serve as the subject matter expert on all health promotion policy and provide policy interpretation to personnel.
  - (2) Develop Health Promotion Program policy.
- c. Resources.
- (1) Evaluate and/or develop select standard reference and educational materials to be provided by Commandant (CG-1111) to all HPMs.
  - (2) Participate on HSWL SC and HPM hiring panels to provide technical expertise.
- d. Budget.



- (1) Provide funds to HSWL SC for disbursement to HSWL Regional Managers (RM) for purchase of supplies such as books, and other tools necessary to conduct health promotion workshops, seminars, health screenings, and, to instruct a minimum of one regional UHPC "C" School, annually.
  - (2) Secure funding to support development, evaluation, and maintenance of a standardized UHPC "C" School curriculum and meet training quota needs.
- e. Training and Education.
- (1) Funds permitting coordinate a minimum of one health promotion meeting annually to address programmatic issues and initiatives.
  - (2) Funds permitting provide a minimum of one annual professional development opportunity for HPMs.
  - (3) Coordinate development, evaluation, and maintenance of a standardized UHPC "C" School curriculum with FORCECOM FC-51, Training and Education Branch, and with the HSWL SC.
- f. Marketing.
- (1) Develop a Health Promotion Program communication/marketing plan to ensure concise and consistent promotion of program vision and services, to include monthly awareness campaigns and program initiatives.
  - (2) Develop ALCOAST messages to promulgate changes in health promotion policy and implement program initiatives.
  - (3) Provide program marketing guidance and materials to HPMs in coordination with HSWL SC.
  - (4) Develop and maintain health promotion content on the Commandant (CG-111) website.
  - (5) Establish and maintain information networks, such as the health promotion place on the Coast Guard Portal.
  - (6) Prepare and deliver briefings on health promotion topics as requested and required.
4. HSWL SC will:
- a. Assist Commandant (CG-1111) in the development of the Health Promotion Program strategic plan, marketing plan, measurement and evaluation.
  - b. Designate a health care provider liaison with Commandant (CG-111) responsible for participating in the development of disease prevention initiatives.
  - c. Conduct quality improvement site visits with each HSWL RM, in accordance with HSWL SC compliance inspection checklists.
  - d. Collect and report health promotion data quarterly to support Commandant (CG-1111) program evaluation efforts.
  - e. Analyze program data and provide Commandant (CG-1111) with a program summary report annually, or as requested due to emergent needs.

- f. Participate in Commandant (CG-1111) teleconferences, meetings, and web-based trainings.
  - g. Assist in developing the annual Commandant (CG-1111) health promotion conference/fitness symposium.
  - h. Manage and disburse funds in collaboration with Commandant (CG-1111) to support HP field operations for targeted funded activities.
  - i. Develop and implement a system to track training and other services provided by HPMs and provide reports to Commandant (CG-1111) on outcomes.
  - j. Collaborate with Commandant (CG-1111) for the development and ongoing evaluation of a standardized UHPC "C" School curriculum.
  - k. Serve as liaison to Coast Guard medical communities to support policy initiatives and collaborate with clinics and Independent Duty Health Services Technicians (IDHS).
5. Regional Health Promotion Manager. Regional HPMs are attached to the HSWL SC RPs. HPMs are health promotion subject matter experts. They will provide guidance to commands, training and oversight to UHPCs, and health promotion services to Coast Guard beneficiaries. Within their area of responsibility (AOR), all regional HPMs will:
- a. Program Development.
    - (1) Coordinate with HSWL SC staff and the HSWL RM to implement the health promotion program.
    - (2) Participate in Commandant (CG-1111) teleconferences, meetings, and/or web-based training.
    - (3) Collaborate with Commandant (CG-1111) and the HSWL SC on updates to policies, manuals, publications, and training materials.
    - (4) Maintain a record (electronic or paper) for each unit within their AOR to include current UHPCs and other command contact information, UHPC designation letters, copies of local health promotion instructions, and a record of services/training provided to each unit and UHPC for the past year.
    - (5) Provide HSWL SC staff with periodic service delivery reports and program data in accordance with Commandant (CG-1111) and HSWL SC quality improvement guidelines and reporting requirements to assist with the development of program initiatives, funding requirements, strategic plans, and program evaluation.
    - (6) Identify and disseminate national, state, and regional health promotion resources for use by CG beneficiaries throughout the AOR. To ensure resources and services are being identified for beneficiaries throughout the AOR.
    - (7) Establish and maintain collaborative working relationships with unit commands, UHPCs, Coast Guard Medical Officers, MWR Officers, SAPS, Food Service Specialists (FS), and the various members of the HSWL RP Staff.
    - (8) Recommend members who present with clinical risk factors to follow-up care.
    - (9) Inform the HSWL SC staff and Commandant (CG-1111) of health promotion needs, issues, activities, and outcomes occurring within their AOR.

- (10) Maintain a National Academy of Sports Medicine, Certified Personal Trainer certificate (or equivalent approved by program manager).
  - (11) Complete annual Health Insurance Portability Accountability Act Training.
  - (12) Maintain a CPR certification.
  - (13) Complete a health promotion director course or provide documented equivalent experience approved by program manager. Recommended courses are: Health Promotion Director Course by Cooper Institute, Certified Health Education Specialist (CHES), ACSM/National Society of Physical Activity Practitioners in Public Health (ACSM/NSPAPPH).
- b. Resource Management.
- (1) Develop and submit an annual spend plan via the chain of command to the HSWL SC. This should address the following needs:
    - (a) Health screening supplies;
    - (b) Stress Profilers;
    - (c) UHPC course textbooks and related materials;
    - (d) Educational materials; and,
    - (e) Travel funds.
  - (2) Maintain a current electronic and/or physical resource library.
- c. Training and Education.
- (1) Funds permitting, attend the annual Health Promotion Symposium as directed by Commandant (CG-1111); and, attend at least one annual professional development conference, meeting, or symposium.
  - (2) Contact all commands annually via e-mail, site visit, or telephone to review the command's Health Risk Assessment (HRA) Report. Document communication and recommendations in an individual unit folder; folder can be hard copy or electronic. Make specific recommendations for the commanding officer and UHPC for improvement in all categories where 50 percent or greater of the crew are considered to be "unhealthy."
  - (3) Coordinate and facilitate at least one UHPC course annually within the AOR.
  - (4) Co-instruct, with supervisor approval, a minimum of one UHPC course outside their AOR annually.
  - (5) Provide health promotion trainings at Coast Guard leadership and professional development schools when operationally capable and with supervisor approval.
  - (6) Complete the Coast Guard Instructor Development Course "C" School.
  - (7) Provide ongoing mentoring, training, and resources to all primary UHPCs via telephone, email, and/or in person.
  - (8) Provide annual training to all UHPCs on health promotion policy and UHPC responsibilities as prescribed in this Manual.

- (9) Serve as the advisor to commands on health promotion programming issues.
  - (10) Provide guidance on health promotion issues to all individual customers as requested.
  - (11) Conduct a minimum of six trainings annually within the AOR, to include any of the following topics: weight management, nutrition, stress management, nicotine cessation, healthy lifestyle, physical fitness, and risk reduction.
  - (12) Provide HPM program briefing in person or telephonically to all new UHPCs, those not able to attend the HPC course, but are functioning as UHPCs, and UHPCs that have not attended a HPC course within the past 24 months.
- d. Marketing.
- (1) Develop and implement a marketing strategy tailored to the needs of their AOR using a variety of media. Submit this plan, with their annual spend plan, to the HSWL SC Work-Life Division Chief. The marketing plan should address the following:
    - (a) Unit Choosing Healthy Options for Wellness (CHOW) assessment;
    - (b) Tobacco cessation;
    - (c) Commandant (CG-1111) sponsored weight management programs;
    - (d) Physical Health Instruction Training (PHIT) Program or equivalent exercise program, which follows the same methodology;
    - (e) Stress Profilers and or Operational Stress Control; and,
    - (f) Unit HRA executive summary.
  - (2) Market Commandant (CG-1111) program initiatives to partner providers, commands and supervisors, and individual end-user customers.
6. Commanding Officers and Officers-in-Charge will:
- a. Administrative.
    - (1) Designate a primary UHPC in writing. Units also have the option to designate one or more alternate UHPCs. Alternate UHPCs are highly recommended for larger units. Submit a copy of the designation letters to the regional HPM. A sample of the designation letter can be found at the following website: [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp) under UHPC Resource Material. The UHPC is not required to attend training prior to designation by the command, but will submit a training request via email to their HPM for a class as soon as possible within their first year of assignment.
    - (2) Ensure newly designated UHPCs (or those not able to attend the HPC course, but are functioning as UHPCs, and UHPCs that have not attended an HPC course within the past 24 months) are briefed and certified by the regional HPM before assuming duties.
    - (3) The UHPC must meet the following qualifications:
      - (a) Be free of tobacco products for a minimum of twelve months;

- (b) Be compliant with the weight and body standards for Coast Guard military personnel in accordance with reference (a);
  - (c) Possess good communication and leadership skills, an approachable and empathetic demeanor, and a willingness to implement fitness programs and assist others in reaching their health goals;
  - (d) Be enthusiastic about all healthy lifestyle behaviors, not just physical fitness, and committed to the essential elements of health promotion;
  - (e) Abstain from alcohol or use it responsibly;
  - (f) Have at least two years remaining at a shore unit or one year remaining on an afloat unit, when operationally possible;
  - (g) Hold rank of petty officer or above (exceptions made for small units). At the commanding officer's discretion, a reservist, auxiliariarist, or civilian employee may represent the unit if they meet all other qualifications; and,
  - (h) Meet the minimum boat crew fitness qualifications prior to attending the UHPC "C" School.
- (4) Ensure the UHPC is listed on the indoctrination check-in sheet for all reporting members.
- b. Funding. Commands are authorized to use appropriated funds for unit health promotion programs as authorized by the Financial Resource Management Manual (FRMM), COMDTINST M7100.3 (series). Non-appropriated funds may also be available to support health promotion activities, as authorized in the Coast Guard Morale, Well-Being, and Recreation Manual, COMDTINST M1710.13 (series).
- c. Program Planning.
- (1) Establish and actively support an environment that enables unit members to routinely engage in healthy lifestyle behaviors and make informed health choices. This includes, work time for physical fitness training, tobacco free-environment, healthy food choices, and stress and health risk reduction.
    - (a) Review annually the Executive Summary of the command's HRA. In consultation with their regional HPM evaluate the report and develop an annual Unit Health Promotion Program plan; and,
    - (b) Grant UHPC work time weekly to fulfill UHPC roles and responsibilities to include, but not limited to, developing and implementing a unit Health Promotion Plan, coordinating unit fitness activities, administering fitness tests, and providing support to members on the weight program.
  - (2) Grant excused absences for active duty members and civilian employees to take part in one-time or occasional programs that are of short duration. Examples of these include: an officially sponsored federal fitness day event, an agency sponsored health screening, a fitness center orientation, or a smoking cessation program consisting of several brief classes. Any additional questions regarding the use of official duty time in health and fitness activities and its applicability to civilian employees should be directed to the servicing Command Staff Advisor.

7. Unit Health Promotion Coordinator (UHPC). UHPCs are not subject matter experts in health promotion. However, upon completion of the UHPC course, UHPCs will have the fundamental knowledge and skills to provide individual guidance and coordinate unit programs. UHPCs will:
  - a. Program Planning.
    - (1) Establish a health promotion committee. Committee membership will include: UHPC, Medical Officer (where available), Command Drug and Alcohol Representative (CDAR), Command Master Chief (CMC), unit food service officers or FS specialists, corpsman, morale officer, and other interested individuals as approved by the command.
    - (2) Coordinate with the Regional HPM to assess the needs and interests of unit members using the command HRA report, and unit surveys.
    - (3) Establish a funding mechanism, by partnering with the command, to support unit initiatives, and coordinate with HPM (e.g., Coast Guard Foundation Shipmate Fund, DoD equipment) and morale officer for financial and other logistical support of Health Promotion Program elements such as fitness equipment.
    - (4) Act as the liaison for the regional HPM.
      - (a) Refer members requesting assistance beyond the scope of the UHPC's training to the regional HPM for further guidance; and,
      - (b) Consult with the regional HPM for guidance on purchases, resources, environmental assessments, unit fitness policies, CHOW, and weight management compliance and education.
    - (5) Maintain educational material and a resource list of local and national resources for all health promotion program elements (e.g., substance abuse, tobacco cessation, physical fitness, weight management, nutrition, and stress management). Refer to the regional HPM and the following web page for resources [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp)
    - (6) Partner with Coast Guard Medical Officers to develop and deliver health promotion activities.
    - (7) Utilize community and Department of Defense (DoD) resources for health promotion activities.
  - b. Training and Education.
    - (1) Attend the UHPC course within one year of appointment as the UHPC.
    - (2) Contact the regional HPM to receive initial training and for guidance on current program policies and initiatives via email, telephone, or in person prior to performing duties as a UHPC. This is especially important for those not able to attend the HPC course, but is functioning as UHPCs, and UHPCs that have not attended an HPC course within the past 24 months.
    - (3) Coordinate or provide one all-hands health promotion training at the unit annually, providing an overview of all program elements (e.g., tobacco cessation,

- physical fitness, weight management, nutrition, and stress management) in coordination with and approval of the regional HPM.
- (4) Educate commands on elements and requirements of the health promotion program.
- c. Program Marketing.
- (1) Distribute health promotion information, initiatives, and policy updates to all unit members via bulletins, emails, presentations (electronic or hard copy), and other available media as provided and/or approved by the regional HPM.
  - (2) Establish and maintain a health promotion resource library for all health promotion program elements (e.g., tobacco cessation, physical fitness, weight management, nutrition, and stress management).
  - (3) Promote participation in unit health promotion activities and programs, to include civilian employee participation, and family members when permitted.
- d. Data Collection.
- (1) Provide weight probation data to the regional HPM at least every 30 days using the MAW Participant Tracking Form or as directed by the regional HPM. A sample of the tracking form can be found at the following website: [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp), under UHPC Resource Material.
  - (2) Provide data on health promotion activities to the regional HPM once a quarter using the UHPC Data Collection Form or as directed by the regional HPM. A sample of the tracking form can be found at the following website: [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp), under UHPC Resource Material.
8. Food Service Officer (FSO). FSOs have the fundamental knowledge and skills to prepare nutritious meals that meet the following guidelines. FSOs will:
- a. Provide nutrition information on menu items to enable patrons to make informed choices, wherever possible.
  - b. Serve portion sizes in accordance with the Armed Forces Recipe Service (AFRS) recommendations.
  - c. Maximize use of healthy cooking techniques in meal preparation. Examples include:
    - (1) Baking versus frying.
    - (2) Steaming versus boiling vegetables.
    - (3) Avoiding use of butter and lard or oils high in saturated fat (palm tree or coconut oils).
    - (4) Maximizing use of whole grains (such as brown rice and whole wheat bread) versus processed and refined grains (such as white rice and white bread).
    - (5) Offering fruit and vegetables for snacks versus chips and candy.

COMDTINST M6200.1C

- d. Collaborate with the Regional HPM, UHPC and/or the unit Health Services Technician to enhance health promotion efforts throughout the unit.
- e. Complete the CHOW assessment annually in coordination with the trained UHPC and seek additional support from the HPM as needed.



**CHAPTER 2. DISEASE PREVENTION AND HEALTH RISK REDUCTION**

- A. Introduction. Early detection and prevention of health risk, disease, and injury is a key component of the Health Promotion Program. Periodic evidence-based screenings (Periodic Health Assessment (PHA)) administered by health care providers are required for active duty and selected reserve personnel and strongly advised for other beneficiaries. Health screenings provided by regional HPMs include stress assessments, blood pressure screenings, body fat composition, and physical fitness assessments. Unit training can be provided on a wide range of topics such as weight management, performance nutrition, stress management, and tobacco cessation.
- B. Health Risk Assessments (HRA). HRAs are methods that provide information on personal and organizational health risks and specific guidance on how to reduce modifiable risk factors through behavior change. An HRA can generate a personalized report for the member and a summary report for the Coast Guard unit and the organization as a whole. The Coast Guard utilizes HRAs to enhance the health of the individual Coast Guard member and the organization. The HRA evaluates several key components of health behavior:
1. Nutrition and weight management.
  2. Physical activity.
  3. Risk reduction- alcohol, tobacco, and cardiovascular risk factors.
  4. Stress and sleep habits.
- C. Health Risk Assessments Overview. The Health Promotion Program uses three HRA methods to assess individual and organizational health behaviors.
1. Health Risk Appraisal. This is a mandatory health behavior survey completed annually by all military personnel during their PHA. It is a snapshot assessment that provides an overview of the health behaviors of each individual. Requirements and guidance for completion of the HRA are found in References (b) and (c). The command HRA Executive Summary is a report that indicates organizational health risks and will be used to develop unit-level health promotion plans to reduce modifiable risk factors and improve overall health and readiness.
  2. Stress Profiler. The Stress Profiler is a personal assessment that identifies risk factors, signals, and symptoms of stress overload.
    - a. All members may request a Stress Profiler and commands may arrange for all-hands training using the Stress Profiler.
    - b. The regional HPM will act as the POC for Stress Profiler materials, guidance, implementation and unit training.
  3. Survey of Health Related Behaviors (HRB). This comprehensive survey is administered triennially as part of a joint study with the DoD. The research-based findings of the HRB are used to establish and modify health promotion program policy, set program goals and objectives, and assist Commandant (CG-11) to evaluate the effectiveness of health, safety, and work-life services.

D. Duties and Responsibilities.

1. Behavioral Health Division (CG-1111) will:
  - a. Provide funding and resources to support HRA implementation.
  - b. Annually collect organizational HRA data and analyze to establish program goals, identify health behavior trends in the workforce, and evaluate program effectiveness.
  - c. Ensure that required notices of Privacy Act System of Records are current.
  - d. Review records schedules (Section II of Information and Life Cycle Management Manual COMDTINST M5212.12 (series)) to ensure that the rules for disposition of health promotion records are identified and applied properly according to their Single Subject Identification Code (SSIC) number.
2. HSWL SC will:
  - a. Assist Commandant (CG-1111) to collect and analyze data and determine direction of future health promotion programs.
  - b. Ensure that all HPMs are adhering to standardized methods for collecting, handling, storing, and protecting HRA records and data.
3. Commanding Officers and Officers-in-Charge will:
  - a. Contact the regional HPM at least annually to receive and review the HRA Executive Officer Report in order to:
    - (1) Establish unit wellness goals and objectives that support overall unit mission readiness;
    - (2) Plan, implement, and evaluate appropriate wellness interventions that ensure unit health and well-being.
  - b. When directed and as operations permit, provide opportunity for selected members to participate in the triennial survey of HRB.
4. Regional Health Promotion Managers (HPM) will:
  - a. Provide HRA data from the AOR to Commandant (CG-1111) as requested.
  - b. Notify the HSWL RP (clinic) of upcoming health promotion events in anticipation of potential referrals and for coordination of health information messaging and/or shared participation (as applicable).
5. Unit Health Promotion Coordinators (UHPC) will:
  - a. Refer members on weight probation for guidance to a Coast Guard approved provider for services (e.g., a Coast Guard Primary Care Manager, CG SUPRT, and/or HPM).
  - b. Provide quarterly reports to the regional HPM on events or interventions that improve the health of the unit.

**CHAPTER 3. NICOTINE USE POLICY**

- A. Introduction. This Chapter sets policies and procedures to control tobacco/nicotine use on all Coast Guard installations and bases, facilities, vehicles, ships, aircraft, and equipment. These procedures apply to all organizational elements, active duty, reservists, civilian employees, as well as all visitors, contractors and their personnel, and personnel of other agencies that operate within or visit Coast Guard facilities.
- B. Definition. For purposes of this policy, the terms “tobacco use” and “tobacco products” mean tobacco and nicotine products, including electronic or e-cigarettes, smoking (e.g., cigarette, cigar, pipe), smokeless tobacco products (e.g., spit, lug, leaf, snuff, dip, etc.) and all other nicotine delivery systems and products as defined by Commandant (CG-1111) and or the U. S. Centers for Disease Control and Prevention. Nicotine Replacement Therapy (NRT) products containing nicotine and approved for use by the Food and Drug Administration (FDA) are not considered “tobacco products.”
- C. Discussion. Nicotine is a highly addictive psycho-active substance. Persons dependent on nicotine find it difficult to quit and often require multiple attempts using multiple intervention modalities to overcome the addiction. As with other substance abuse, nicotine use generates physiological change and causes significant health risk conditions. To this end, tobacco cessation is not simply a “will power” decision, but rather requires appropriate medical and health behavior interventions. With this understanding in mind, the Coast Guard has implemented a variety of programs to help individuals remain tobacco-free.
- D. Policy. It is Coast Guard policy to discourage the use of all forms of tobacco products and to protect people from exposure to environmental tobacco smoke (ETS), unsanitary conditions created by the use of spit tobacco, and the potential addiction to nicotine products. The use of any tobacco product in public detracts from a sharp military appearance and is discouraged. Where conflicts arise between the rights of non-nicotine users and nicotine users, the rights of the non-user will prevail.
1. Workplace.
    - a. Use of tobacco products is prohibited by law for all members under the age of eighteen, except in Alaska where the legal age for purchase and use of tobacco products is nineteen.
    - b. It is the intent of the Commandant to create and maintain a nicotine-free environment throughout the entire Coast Guard workplace. To this end, “tobacco use” is prohibited in the workplace in order to protect the health of all persons, including nicotine users, from contact with tobacco or nicotine products. For purposes of this policy, the term “workplace” includes any area inside a building or facility, over which the Coast Guard has custody and control, where work is performed by military personnel, civilian employees, or personnel under contract to the Coast Guard.
    - c. The use of “tobacco products” is permitted only in designated areas. Tobacco use is prohibited at all times in all non-designated tobacco use areas on all Coast Guard facilities, bases, and installations. To this end, tobacco use is prohibited in all outdoor spaces not designated as a tobacco use area.
    - d. Where permitted, tobacco spit will be held in containers with sealing lids to prevent

- odor and accidental spills. Tobacco spit and other tobacco product residue will be disposed of in a sanitary manner which prevents public exposure.
- e. The use of all tobacco products is prohibited in all Coast Guard government vehicles (cars, trucks, buses, vans) by all personnel, military, civilian or auxiliary.
  - f. The use of all tobacco/nicotine use is prohibited in all Coast Guard aircraft or any other aircraft contracted for use in Coast Guard operational/training missions.
  - g. Cutters may designate a section of the weather deck as a tobacco use area (smoking and smokeless). Designated areas must be a sufficient distance away from entrances and exits, so as not to allow smoke to be drawn into the interior of the ship through doors, hatches, or air intake units/vents.
  - h. Tobacco/nicotine will be used only during regularly scheduled breaks available to all personnel, which includes breaks during formal training. Additional breaks for members to use tobacco will not be permitted.
  - i. The use of all tobacco/nicotine is prohibited by recruits at Training Center Cape May and officer candidates at Officer Candidate School.
  - j. The cadets at the Coast Guard Academy will follow the policies set in the Cadet Regulations.
  - k. Shore facilities will ensure designated tobacco/nicotine areas will be away from entrances and exits and will not be located in areas commonly used by non-tobacco users. Designated areas must be a sufficient distance away, at least 50 feet, so as not to allow smoke to be drawn into the indoor facility through door openings, windows, and air intake units/vents.
  - l. The use of tobacco/nicotine is prohibited on small boats. The risk of ETS and hazardous material interactions is higher in these environments and every precaution should be taken to eliminate these risks.
  - m. Tobacco/nicotine products will not be used while aboard or operating any Coast Guard machinery, equipment, craft, or vehicle.
2. Lodging, Dormitories, and Housing.
- a. The Policy regarding tobacco use in Coast Guard controlled individual assigned family quarters is contained in the Coast Guard Housing Manual, COMDTINST M11101.13 (series).
  - b. Tobacco use is not allowed in Coast Guard controlled bachelor living quarters.
  - c. Tobacco use is prohibited in all common spaces of family housing units and Coast Guard controlled bachelor living quarters. Common space is defined as any space within a building that is common to occupants and visitors. These areas include, but are not limited to, corridors, laundry rooms, lounges, stairways, elevators, lobbies, storage areas, and restrooms.
  - d. If smoke or odor from tobacco products from a designated tobacco use area (smoking and smokeless) seeps into common areas, the rights of the non-user (including children) will prevail.

3. **Recreational and Coast Guard Exchange Facilities.** Workers and patrons are entitled to the same protection and consideration that is afforded to our personnel in the workplace. Accordingly, smoking in Coast Guard exchanges or MWR facilities or at MWR activities is prohibited unless a tobacco use area is designated.
4. **Sales of Tobacco Products.**
  - a. The sale of tobacco products from vending machines is prohibited.
  - b. The sale of tobacco products is prohibited to anyone under the age of 18 years unless superseded by state law.
  - c. The distribution and advertisement of tobacco products in Coast Guard facilities, publications, and official correspondence is prohibited.
- E. **Tobacco Cessation Resources.** In addition to Coast Guard resources, tobacco cessation programs are available through local hospitals, clinics, and national health websites. Many states offer tobacco quit-lines for telephonic support. Members are encouraged to use the program or service that best helps them achieve freedom from nicotine addiction. Regional HPMS can be contacted for information on tobacco cessation programs and resources.
- F. **Nicotine Replacement Therapy (NRT) and Tobacco Cessation Aids.**
  1. TRICARE guidelines allow patients to obtain specified smoking cessation products at no cost through MTFs and TRICARE Mail Order Program (TMOP). Limitations to the program exist such as the number of cessation attempts and patient populations that are Medicare ELIGIBLE. For more information on this smoking cessation program, contact your local MTF or the Work-life Tobacco Cessation Web-site below:  
[http://www.uscg.mil/worklife/tobacco\\_cessation.asp](http://www.uscg.mil/worklife/tobacco_cessation.asp).
  2. Each DoD or Coast Guard MTF establishes its own requirements for obtaining tobacco cessation aids and should be contacted directly (e.g., participation in a smoking cessation program).
- G. **Duties and Responsibilities.**
  1. Behavioral Health Division, Commandant (CG-1111), will:
    - a. Ensure Coast Guard wide tobacco awareness, education, and behavior change programs reflect the current state of tobacco cessation science to meet the needs of all categories of beneficiaries.
    - b. Establish program evaluation measures for tobacco cessation efforts throughout the Coast Guard.
    - c. Maintain a website that lists latest changes to the tobacco cessation policy and resources.
    - d. Generate ALCOASTs and other Coast Guard wide marketing materials to support tobacco cessation efforts.
    - e. Establish goals and develop strategies for reducing the rate of Coast Guard tobacco use based on Coast Guard Health Related Behavior Survey data and Healthy People 2020 goals.

2. HSWL SC will:
  - a. Support Commandant (CG-1111), Coast Guard medical, pharmacy, and dental officers, and regional HPMs in upholding these policy guidelines.
  - b. Provide funding to regional HPMs for tobacco awareness and cessation programming.
  - c. Support and encourage continuing education training in tobacco awareness and cessation for regional HPMs and medical personnel.
3. Commanding Officers and Officers-in-Charge will:
  - a. Administrative Support.
    - (1) May designate appropriate sites for the use of tobacco products (smoking and smokeless) and ensure areas are clearly marked. These areas will be at least 50 feet from the vicinity of building entrances and exits or areas in clear public view. It is up to the discretion of each commanding officer and officer-in-charge if and where these sites may exist. Note: Current nicotine use policies and practices will remain in effect for all Coast Guard civilian employees represented by a union. Changes to current policies and practices may only be made in accordance with statute and applicable negotiated agreements.
    - (2) Will post notices at the entrance of all facilities that state smoking is not allowed except in designated areas.
    - (3) Will enforce compliance with this policy and ensure each member of the command is familiar with this instruction.
  - b. Program Planning.
    - (1) Actively promote tobacco avoidance and cessation by use of a variety of educational media and scheduling at least one annual all-hands tobacco awareness activity.
    - (2) Ensure tobacco cessation programs address the use of smokeless tobacco products and other nicotine delivery systems and ensure that smoking restrictions do not promote the use of smokeless tobacco products.
    - (3) Encourage members to use available tobacco cessation resources and when operations permit, allow members and civilian employee's time during the work day to engage in educational, prevention, and cessation activities via classroom, computer, and telephone.
    - (4) Prohibit smokers from engaging in tobacco use during unscheduled break times that are not available to all crewmembers.
    - (5) Hold tobacco users accountable for appropriately discarding smoking materials and/or spit tobacco.
4. Coast Guard Clinic Staff and Health Services Technicians will:
  - a. Administrative Support.
    - (1) Screen patients to assess the appropriateness of nicotine replacement therapy, contraindications for use, and if policy permits, prescribe therapy when needed

for tobacco cessation.

- (2) Conduct brief tobacco use survey as part of annual PHA screenings.
- (3) Refer patients to the regional HPM for tobacco cessation education and resources.

b. Program Planning and Support.

- (1) Maintain a supply of educational materials on the risks of tobacco use and provide support materials for cessation programs available to help members end tobacco addiction.
- (2) Require medical and dental providers to inquire about the member's tobacco use history during medical and dental screenings.
- (3) Implement standards of care in accordance with the U.S. Preventive Services Task Force (USPSTF) on tobacco use.
- (4) Provide information on tobacco use cessation programs to eligible military personnel and beneficiaries, attached commands, and independent units within AOR.
- (5) Ensure all tobacco users receive, if requested, assistance and/or referral for cessation.
- (6) In conjunction with regional HPMs, promote organizational and local tobacco cessation resources that incorporate cognitive and behavioral change strategies and the use of nicotine replacement therapy when appropriate.
- (7) Be strongly encouraged to obtain training and education on state of the behavioral science for tobacco addiction and cessation.

5. Regional Health Promotion Managers will:

- a. Maintain and disseminate supplies or resources of tobacco educational materials and a resource list for services within the AOR that can assist members with their tobacco cessation efforts.
- b. Recommend tobacco prevention and control awareness training to all AOR units with 20 percent or higher nicotine use as measured by the HRA.
- c. Provide Coast Guard medical providers in AOR with current tobacco cessation resources.
- d. Support national tobacco cessation campaigns and initiatives identified by Commandant (CG-1111) by implementing an annual marketing campaign that reaches 100 percent of units within their AOR.
- e. Train UHPCs on the Coast Guard tobacco policies and how to conduct brief tobacco cessation readiness to quit screenings.

6. Unit Health Promotion Coordinators will:

- a. Advise the command of deficiencies in and non-compliance with policy.

COMDTINST M6200.1C

- b. Brief all members reporting to the unit on the tobacco use policy and refer members who wish to quit to HPM.
- c. Conduct at least one annual unit tobacco awareness activity under the guidance of the regional HPM.
- d. Coordinate unit/group tobacco cessation activities under the guidance of the regional HPM.
- e. Provide tobacco cessation resources (e.g., UCANQuit2, TRICARE Quit line, CG SUPRT, and other local resources) to unit members and their dependents wanting to become tobacco free.



## CHAPTER 4. PHYSICAL FITNESS

### A. Introduction.

1. Coast Guard personnel (AD and SELRES) have a duty to be operationally ready to respond to situations affecting public safety and/or national security. A physically fit member has a greater chance of successfully meeting physical requirements and higher stress levels in operational and emergency situations. Command and individual responsibilities with respect to physical fitness readiness are covered in this chapter. Certain operational duty assignments (e.g., Maritime Safety and Security Teams and boat crews) have specific physical fitness requirements outlined in their respective program instructions.
2. Physical activity also has beneficial effects for general health and wellness. Engaging in regular physical activity is an effective way to reduce stress, manage weight, decrease risk of disease and injury, improve physical appearance, and improve morale. Years of research categorically supports the premise that exercise leads to improved physical function, decreased risk of chronic disease, and decreased disability.
3. Guidelines for general health are set forth by the U.S. Centers for Disease Control, U. S. Department of Health and Human Services, and the American College of Sports Medicine. In the 2008 Physical Activity Guidelines for Americans, the U.S. Centers for Disease Control, recommended:
  - a. Two hours and 30 minutes (150 minutes) of moderate-intensity aerobic activity (e.g., brisk walking) every week.
  - b. Muscle-strengthening activities on two or more days a week that work all major muscle groups (e.g., legs, hips, back, abdomen, chest, shoulders, and arms).
4. To support the physical readiness of Coast Guard, all AD and SELRES are required to develop Personal Fitness Plans, Form CG-6049. The completed Personal Fitness Plan shall be submitted to their supervisors in the months of April and October; the latest copy of this form shall be kept on file with the UHPC. In addition, commanding officers/officer-in-charge shall provide all active duty personnel the opportunity to participate in fitness enhancing activities, as outlined in Paragraph C.4 of this chapter.

### B. Policy. In order to have an operationally physically ready workforce, and to promote general health and wellness, the following policy applies.

1. All active duty members shall:
  - a. Engage in fitness activity as outlined in their Personal Fitness Plan (PFP), Form CG-6049, a minimum of 180 minutes per week. It is strongly recommended that the fitness plan include 150 minutes of cardiorespiratory activity and 30 minutes of strength training. These requirements are based on the guidelines summarized above in Paragraph 3.
  - b. Exercise so that the physical activity produces a training effect, as measured by a medium to vigorous level of intensity. (Refer to Appendix B for

examples of exercise intensity.)

- (1) Because the effects of physical activity are cumulative, exercise sessions may vary in length, with a minimum of 10 minutes, in order to be beneficial. In general, physical activity sessions should be spread out over at least three days per week.
- (2) If a member is unable to participate in fitness enhancing activity due to medical conditions, a [Duty Status Form SF 600](#) from their primary care manager to their current supervisor is required. The Duty Status Form can be found at <http://www.uscg.mil/worklife/WeightGuide.asp>.

2. For reservists:

- a. Reservists on active duty for 31 days or more continuously shall follow the above policy for active duty members in Paragraph 4.B.1.
- b. All Ready Reservists are recommended to follow the guidance above in Paragraph 4.B.1.

C. Duties and Responsibilities.

1. Commandant (CG-11). The HSWL Directorate shall establish the Coast Guard Fitness Advisory Committee herein referred to as the FAC. This inter-directorate team is charged with providing guidance to Coast Guard leadership on physical fitness and exercise guidelines for Coast Guard personnel to improve mission performance and physical readiness using the latest scientific information.
2. Behavioral Health Services Division, Commandant (CG-1111), shall:
  - a. Provide subject matter expertise for physical fitness policy across all programs both within and outside of the HSWL Directorate, ensuring the scientific and operational validity of program content and structure.
  - b. Establish physical fitness curriculum and provide instruction and course materials for the UHPC Course.
  - c. Design educational, promotional and behavior change initiatives for improving the physical fitness of Coast Guard members and beneficiaries.
  - d. Review physical fitness and health promotion curricula for all Coast Guard Leadership Development Center schools and programs, to include:
    - (1) Apprentice Leadership Program.
    - (2) Chief Warrant Officer Academy.
    - (3) Chief Petty Officer Academy.
    - (4) Boat Forces Command Cadre School.
    - (5) Prospective Command Afloat School.
    - (6) Officer Candidate School.
    - (7) Senior Leadership Schools.

3. HSWL SC shall:
  - a. Assist Commandant (CG-1111) in developing physical fitness training curricula to be implemented by regional HPMs and UHPCs.
  - b. Assist Commandant (CG-1111) with evaluating of physical fitness initiatives.
4. Commanding Officers and Officers-in-Charge. As an integral factor in mission readiness and an essential component of total wellness, physical fitness activities will be required at all levels of the command. To support this objective, commanding officers and officers-in-charge shall:
  - a. Develop a detailed unit fitness policy (Appendix E) that addresses mandatory participation by military members, and voluntary participation by civilian employees in physical fitness activities during the workday. The regional HPM can provide guidance in the development of local policy. The plan will be reviewed by the Regional HPM who will assist commands in tailoring it to ensure safe and beneficial results. In developing this policy, commanding officers and officers-in-charge may:
    - (1) Limit the working hours during which fitness activity may be performed to prevent or mitigate disruptions to unit or work-group efficiency and effectiveness.
    - (2) Exclude participation by incumbents of civilian employee positions assigned activities that cannot be paused during assigned working hours without adversely affecting work being performed by other members, employees or work-groups, due to activity interdependency.
  - b. Ensure all members (AD and SELRES) complete the Personal Fitness Plan (PFP) Form CG-6049, every April and October.
  - c. Operations and workload permitting, allow all military members (AD and SELRES) time for exercise and physical activity a minimum of 180 minutes per week during normal working hours. Commands do not have to comply when the unit is on a tropical hours schedule or deployed; however, military members are still required to adhere to the 180 minutes per week exercise standards as outlined in Paragraph 4 B. of this Chapter. Commanding officers of training centers may waive fitness enhancing activity and PFP requirements for military students if they determine course requirements fulfill the fitness enhancing activity requirement, or if fitness enhancing activity cannot be reasonably accommodated in the training schedule.
  - d. Reflect compliance with this policy in the member's personnel evaluation under health and wellness parameters.
  - e. Consistent with the provisions of paragraph 4.C.4.a., and operations permitting, allow all civilian general schedule, wage grade, and senior executive service employees work time for voluntary participation in physical fitness activities in accordance with the following:
    - (1) Excused absences will not exceed 60 minutes, inclusive of time for showering and changing, on any given day, up to 180 minutes each week.

Unused time shall not carry over to any subsequent pay period. Excused absence can be combined with authorized breaks or in conjunction with the regularly scheduled lunch period with supervisory approval. It may not be used before an employee reports for duty or to allow for an employee's early departure. Participants must physically report to work before engaging in their fitness activity and must report back to work if the fitness activity is prior to departure at the end of the day.

- (2) Excused absence for exercise must be recorded in Web TA or other approved time and attendance systems.
- (3) Use of time for physical fitness activities by part-time employees should be pro-rated to correspond with the number of hours worked per pay period. When calculating such time, the number of hours worked bi-weekly should be divided by 80 to come up with the percentage of the maximum time allowed for part-time employees. (Example: Employee works 40 hours per pay period 40 divided by 80 equals .50. .50 multiplied by 180 min (amount of time allowed to work out) equals 90 minutes per week.)
- (4) Physical fitness activities are subject to approval, based on office/team workload, operational tempo, or other mission priorities. The Commanding Officer will have the final authority to determine when (day and time) the employee may participate, and may modify or suspend participation without notice based on workload. Commands are strongly encouraged to support this program whenever possible.
- (5) Employees with a current unsatisfactory annual performance evaluation, or who are operating under a Performance Improvement Plan are prohibited from participation in the program. Further, whenever performance or conduct issues arise, the supervisor, at his/her discretion, may restrict, deny, or revoke employee participation in this program until the performance or conduct issues have been satisfactorily resolved. Failure to adhere to the program guidelines and procedures may result in disciplinary action.
- (6) An eligible employee must complete a Personal Fitness Plan, Form CG-6049, and submit it to his/her supervisor along with an electronic or written request to participate in physical activity. Employees can obtain this form at: <http://www.uscg.mil/forms>.
- (7) The supervisor will review the Personal Fitness Plan, Form CG-6049, and either approve or disapprove the request. Employees and supervisors may contact their UHPC or regional HPM for guidance and/or assistance with completing, reviewing, and/or revising the Personal Fitness Plan, Form CG-6049.
- (8) The supervisor will maintain the approved request on file and provide the employee with a copy.

- (9) An eligible employee approved to participate in the program must maintain a current written or electronic log of their exercise activity. Employees can obtain a sample exercise log at: [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp) or from their UHPC or regional HPM. The log must be provided to the supervisor upon request.
- (10) Employees voluntarily participating in the physical fitness program may be allowed to engage in activities located outside the confines of the Coast Guard base, installation, or facility. Examples of these activities include walking, jogging, biking, and working out at an offsite health facility.
5. Regional Health Promotion Manager shall:
- a. Provide subject matter guidance for physical fitness initiatives, ensuring the safety and scientific validity of program content and training components.
  - b. Provide on-site unit fitness training when requested. This includes teaching commands and individual members how to develop and execute a safe and effective exercise program, using the Physical Health Instruction Training (PHIT) or equivalent exercise program which follows the same methodology.
  - c. Provide technical support and assistance for conducting fitness assessments.
  - d. Devise educational and promotional initiatives for improving the physical fitness of Coast Guard members and beneficiaries in their AOR.
  - e. Conduct body fat composition screenings as requested by beneficiaries.
  - f. Provide guidance to beneficiaries on developing a personal fitness plan.
  - g. Train UHPCs to conduct PHIT or equivalent exercise program approved by the regional HPM which follows the same methodology.
  - h. Maintain a National Academy of Sports Medicine, Certified Personal Trainer certificate (or equivalent approved by program manager). Training for this certification will be funded by Commandant (CG-1111).
6. Unit Health Promotion Coordinator (UHPC) shall:
- a. Promote physical fitness. Potential tools that can be used include: all-hands training, incentive and awards programs, on-duty workout time, unit challenges, educational e-mails and/or newsletters, and other methods as approved by the regional HPM and unit command.
  - b. Schedule appropriate fitness-related activities and events for unit members and family members.
  - c. Administer and review Physical Activity Readiness Questionnaire (PAR-Q) screening forms for all civilian participants in physical fitness testing (Appendix C).
  - d. Conduct fitness assessments (Appendix D) as requested or required by members or the command, and monthly for all members on weight probation.
  - e. Instruct PHIT and /or other exercises, as approved by the regional HPM.

- f. Collaborate with the regional HPM to assist members in development of Personal Fitness Plans, Form CG-6049, that produce a training effect or promote weight and/or body fat loss.
  - g. Maintain the most current copy of their unit's Personal Fitness Plans, Form CG-6049, electronic or hard copy.
  - h. Review the physical fitness activity logs at least weekly of members on weight probation; and consult the regional HPM when there is no progress within two weeks.
  - i. Develop a Unit Physical Fitness Instruction in coordination with the regional HPM and using the template provided in Appendix E that promotes compliance with physical fitness requirements and mission readiness of all crewmembers. The plan must be approved by the regional HPM when it includes group physical fitness activities.
  - j. Educate members on the benefits of exercise and food log documentation. Refer to the following web site for sample logs:  
[http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp).
  - k. Consult with regional HPM when assisting overweight or over body fat members in designing exercise programs that promote healthier lifestyles and loss of excess body fat.
7. Coast Guard Active Duty Members and Reservists shall:
- a. Complete and submit the Personal Fitness Plan, Form CG-6049, to their supervisor in the months of April and October.
  - b. Obtain guidance as needed for the development of the PFP from the UHPC and/or the regional HPM.
  - c. Adhere to the physical activity requirements as outlined above in Paragraphs B.1 through B.2. of this chapter.

**CHAPTER 5. NUTRITION AND WEIGHT MANAGEMENT**

- A. Weight Management Overview. There are individual and organizational benefits associated with personnel maintaining healthy weight and body fat composition. While compliance with Commandant Weight standards supports a positive military appearance and promotes awareness of diet and exercise, members should work to achieve healthy standards that lower risk factors and maximize mission readiness. At the same time, research has shown that even modest weight loss can have a significant positive impact on health and fitness for duty. Being overweight and obesity are serious challenges to personal wellness and mission readiness. Numerous diseases and health risks are associated with being overweight and obese, particularly the increased risk of cardiovascular disease, hypertension, joint diseases, and diabetes. More directly related to mission readiness, excess body fat makes physical activity more difficult. In general, overweight personnel are less fit than others and do not have the muscular strength, endurance, and flexibility to perform essential job-related physical activities.
- B. Nutrition Overview. A healthy diet serves two purposes. It supports maximum performance and fitness (i.e., performance nutrition) and it protects against disease and illness (i.e., nutrition for health). Both of these elements have impact on personal and organizational effectiveness. When personnel are eating the right foods in the right amounts at the right time, performance opportunities are greatly enhanced. Low fat and cholesterol-free products are examples of foods that enhance health and reduce the risk of disease. A properly fed workforce is more mission ready and physically capable, with lower health care costs. This is accomplished by focusing on:
1. Food intake for performance.
  2. Caloric intake for successful weight management.
  3. Policy that supports an environment for healthy food choices.
- C. Dietary Supplements Overview.
1. Definition. A dietary supplement (DS) is a preparation intended to supplement the diet and provide nutrients, such as vitamins, minerals, fiber, fatty acids, amino acids, or micronutrients that may be missing or may not be consumed in sufficient quantities in a person's diet. DSs are consumed for many reasons, including weight loss/gain, muscle growth, physical performance enhancement and recovery, disease prevention, and to cure disease or illness.
  2. Non-regulated. Because DSs are not classified as either a food or a pharmaceutical product, they are not regulated by the Food and Drug Administration unless a product or ingredient is proven to be harmful. Product labels must list ingredients but the efficacy of product claims, quality, and quantity of ingredients may not be accurate. Consequently, a DS product may contain ingredients which pose a health risk, are prohibited for active duty and reserve personnel, or may cause harmful side effects when used with prescribed or over the counter medications. As a preventive measure, all personnel are strongly encouraged to be informed health consumers when DS products are used, primarily considering the efficacy, health risk, legality, and Coast Guard prohibition/restrictions before using a product. Coast Guard Pharmacy Officers, primary care providers, HPMs, and Coast Guard sanctioned resources, such as the Human Performance Resource Center

website (<http://humanperformanceresourcecenter.org>) should be the primary source for guidance.

- D. Choosing Healthy Options for Wellness (CHOW). CHOW is an assessment that evaluates the types of food options available at a unit or base, encourages policy that educates and supports healthy eating, and identifies environmental factors that promote healthy food choices. It utilizes a scoring system to assess how well a unit is doing in promoting healthy eating and providing individuals with the opportunity to make healthy food choices. The following web site contains a link to the CHOW evaluation from [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp).

E. Policy.

1. Although healthy weight management is largely an issue of personal accountability, it is also the responsibility of leadership throughout the Coast Guard to support healthy weight management behaviors by activating local policy, creating work environments that support healthy behavior, and leading by example.
2. All Coast Guard units will annually complete applicable sections of the CHOW assessment. The regional HPM will provide the appropriate materials and guidance to complete this task.

F. Duties and Responsibilities.

1. Behavioral Health Services Division, Commandant (CG-1111), will:

- a. In coordination with the Food Service Program Manager, ensure nutrition information and instructions in healthy cooking methods are included in FS school curricula.
- b. Annually collect Coast Guard-wide data to analyze the eating behavior trends of the workforce.
- c. Establish goals with outcome measurements for improving healthy eating and weight management behaviors.
- d. Work in coordination with the Office of Military Personnel, Commandant (CG-133), and the Office of Health Services, Commandant (CG-112), to address issues and develop policies related to performance nutrition, DS use, and weight management.
- e. Inform Coast Guard senior leadership about the latest trends and state of the science in nutrition, DS, weight loss science management, and policy as promulgated by DoD, CDC, the National Institutes of Health, and other government agencies and scientific institutions. Procure, develop, review, and disseminate state of the science information on healthy eating and weight management behavioral change.
- f. Develop methods to assess healthy food choice environment in the workplace, to include policy, food choices, and food services.
- g. Ensure the most current dietary guidelines are available to HSWL providers, to include HPM, HS personnel, and Medical Officers.

2. HSWL SC will:

- a. Assist Commandant (CG-1111) in implementing the Coast Guard nutrition and weight programs initiatives.



- b. Ensure access is available to nutritional counseling for members needing these services. Treatment for diagnosed eating disorders will be handled in accordance with Chapter 5 of Reference (b).
3. Commanding Officers and Officers-in-Charge will:
- a. Direct members on weight probation to contact the UHPC for information on weight management planning, techniques, and resources.
  - b. Annually complete applicable sections of the CHOW assessment. Units should coordinate with the regional HPM to complete this assessment.
4. Medical Officers will:
- a. Promote Commandant (CG-1111) sponsored weight management initiatives and programs.
  - b. Promote Coast Guard sponsored DS resources.
  - c. Discuss weight management options with members on weight probation, including but not limited to:
    - 1. Contacting the regional HPM for guidance in developing a successful weight management program, while continuing to follow up and address weight related health concerns, underlying causes of weight, and psychological motivators for over-eating and/or poor nutritional choices.
    - 2. Using CG SUPRT for weight management information.
5. Regional Health Promotion Managers (HPM) will:
- a. Provide nutrition, weight management, and DS training and education to units as requested.
  - b. Provide beneficiaries basic counseling for weight management planning and techniques, and provide appropriate recommendation to primary care manager or licensed professionals as needed.
  - c. Assist as requested by unit food services personnel in planning menus and educational activities, which promote healthy, nutritional food choices.
  - d. Review and disseminate appropriate weight management materials.
  - e. Review and provide recommendation for CHOW assessment submitted by the unit FSO or UHPC.
  - f. In coordination with the UHPC, assist members on weight probation with dietary guidance to achieve weight loss and caloric estimates for safe weight loss.
  - g. Ensure members, UHPCs, and commands are informed of current information and resources to make informed health consumer choices for DS.
6. Unit Health Promotion Program Coordinator (UHPC) will:
- a. Provide personnel with resources and information, as approved by the HPM, on nutrition, dietary supplements, weight management, and exercise.

- b. Coordinate with the HPM and unit FSO for annual implementation of a unit CHOW assessment and follow up action plan.
- c. Ensure members on weight probation are informed that the following will be completed within 10 days of being placed on the weight program:
  - (1) Know who the regional HPM is and their contact info.
  - (2) Complete a new Personnel Fitness Plan, CG-6049. (Consult with regional HPM to ensure exercise routine is appropriate for safe and effective weight loss.).
  - (3) Start a fitness log and submit the log weekly to the UHPC. Consult with Regional HPM if member on weight probation is not losing the required weight or is losing the weight too quickly. Average should be 1 pound per week.
  - (4) Complete a daily food log for at least seven days, such as the “Super Tracker” tool at ChooseMyPlate.gov; or alternate log as approved by the regional HPM. The “Choose My Plate” tool can be found at the following site [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp) under UHPC Resource Material. The log will be submitted to the UHPC and forwarded to the HPM if request.
  - (5) Complete a monthly physical fitness evaluation.
- d. Conduct monthly physical fitness evaluations for members on weight probation in accordance with Appendix D. Do not conduct the test until the member has been cleared by medical. Physical fitness evaluation will consist of at least:
  - (1) 1.5 mile run or 1 mile walk test max VO2.
  - (2) Push up test.
  - (3) Curl up test.
- e. Provide all members on weight probation and others requesting information on weight management with reference (d).
- f. Refer members on weight probation to the regional Transition Relocation Manager (TRM) for a review of benefits and transition resources.
- g. Provide a monthly report to the HPM on the status of members on weight probation. Use the MAW Participant Tracking Form found at the following site [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp) or the electronic case management information system, as directed by Commandant (CG-1111).

7. Members on Weight Probation will:

- a. Upon being placed on weight probation, contact the UHPC within 72 hours to discuss plan of action and complete the following within 10 days:
  - (1) Complete the Personal Fitness Plan, Form CG-6049.
  - (2) Start a workout log, which will be turned into the UHPC (may be e-mailed) at least weekly; (sample workout log may be found at the following site [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp)).

- (3) Log daily food intake for at least seven days, using the “Super Tracker” tool at ChooseMyPlate.gov or alternate tool that is approved by the regional HPM and submit the log to the UHPC. The “Choose My Plate” tool can be found at the following site [http://www.uscg.mil/worklife/health\\_promotion\\_coordinator.asp](http://www.uscg.mil/worklife/health_promotion_coordinator.asp) under UHPC Resource Material.
  - b. After being cleared by medical, perform a physical assessment (see 6.d. above). Perform the assessment every month until off of probation. (SELRES must perform assessment during monthly drill)
8. Unit Food Service Specialists will:
- a. Plan menus to ensure all members have daily access to nutritionally sound food choices.
  - b. Collaborate with the regional HPM to increase knowledge and develop healthy food preparation and planning techniques.
  - c. Coordinate with regional HPM and UHPC to complete an annual CHOW assessment.

This page intentionally left blank.

**CHAPTER 6. STRESS MANAGEMENT**

- A. Introduction. Operational readiness and safety are closely tied to the ability of personnel to endure the physical, mental, and environmental demands of work, social, and family systems. Effective stress management promotes operational risk reduction by enhancing personal readiness. The purpose of effective and healthy stress management programs for the Coast Guard is to identify and control risk factors that can reduce human endurance and thereby compromise safety and operational readiness. Appropriate referral to an individual trained in stress management includes but not limited to, Medical Officer, EAP, and Chaplain.
- B. Policy. Assessing and responding to the impact of stress on crewmembers and unit readiness is the responsibility of leaders at all levels.
1. When managed effectively, stress can help individuals reach personal and job performance goals. However, when ineffective or inappropriate coping responses are used, the results can be harmful and unhealthy to the individual, the family, and operational readiness.
  2. Coast Guard leadership will assist members in managing stress in the following ways:
    - a. Be familiar with Operational Stress Control (OSC) as modeled by the following Stress Continuum :

READY (Green Zone)	REACTING (Yellow Zone)	INJURED (Orange Zone)	ILL (Red Zone)
<p><b>Definition</b></p> <ul style="list-style-type: none"> <li>- Adaptive coping and mastery</li> <li>- Optimal functioning</li> <li>- Wellness</li> </ul> <p><b>Features</b></p> <ul style="list-style-type: none"> <li>- Well trained and prepared</li> <li>- Fit and focused</li> <li>- In control</li> <li>- Optimally effective</li> <li>- Behaving ethically</li> <li>- Having fun</li> </ul>	<p><b>Definition</b></p> <ul style="list-style-type: none"> <li>- Mild and transient distress or loss of optimal functioning</li> <li>- Always goes away</li> <li>- Low risk for illness</li> </ul> <p><b>Features</b></p> <ul style="list-style-type: none"> <li>- Irritable, angry</li> <li>- Anxious or depressed</li> <li>- Physically too pumped up or tired</li> <li>- Loss of complete self control</li> <li>- Poor focus</li> <li>- Poor sleep</li> <li>- Not having fun</li> </ul>	<p><b>Definition</b></p> <ul style="list-style-type: none"> <li>- More severe and persistent distress or loss of function</li> <li>- Leaves a "scar"</li> <li>- Higher risk for illness</li> </ul> <p><b>Causes</b></p> <ul style="list-style-type: none"> <li>- Life threat</li> <li>- Loss</li> <li>- Inner conflict</li> <li>- Wear and tear</li> </ul> <p><b>Features</b></p> <ul style="list-style-type: none"> <li>- Panic or rage</li> <li>- Loss of control of body or mind</li> <li>- Can't sleep</li> <li>- Recurrent nightmares or bad memories</li> <li>- Persistent shame, guilt, or blame</li> <li>- Loss of moral values and beliefs</li> </ul>	<p><b>Definition</b></p> <ul style="list-style-type: none"> <li>- Persistent and disabling distress or loss of function</li> <li>- Clinical mental disorders</li> <li>- Unheaded stress injuries</li> </ul> <p><b>Types</b></p> <ul style="list-style-type: none"> <li>- PTSD</li> <li>- Depression</li> <li>- Anxiety</li> <li>- Substance abuse</li> </ul> <p><b>Features</b></p> <ul style="list-style-type: none"> <li>- Symptoms and disability persist over many weeks</li> <li>- Symptoms and disability get worse over time</li> </ul>
Unit Leader Responsibility	Individual, Peer, Family Responsibility		Caregiver Responsibility

Table 6-1: Operational Stress Control Continuum

- b. Know personnel well enough to recognize when members are “not in the Green Zone.”
- c. Take appropriate actions when personnel are found to be “Reacting,” “Injured,” or “Ill” (Yellow, Orange, or Red Zones).
- d. Be aware of and understand the four sources of stress injuries: loss, trauma, inner conflict, and wear and tear.
- e. Recognize that many personnel will experience stress injuries sooner or later and that early command response is essential to keep personnel from becoming further injured or ill.

C. Duties and Responsibilities.

1. Behavioral Health Division, Commandant (CG-1111) will:
  - a. Provide professional oversight for stress management initiatives.
  - b. Provide funding for stress management supplies and education materials.
  - c. Review, procure, and disseminate appropriate stress management awareness, education, and behavior change materials.
2. The Employee Assistance Program Manager (EAPM) will design and implement effective stress management programs.
3. HSWL SC will: provide stress management-related materials and funding to regional HPMs.
4. Commanding Officers and Officers-in-Charge will:
  - a. Be aware of the unit’s stress climate and the signals of stress that members may display. Refer to [http://www.uscg.mil/worklife/stress\\_management.asp](http://www.uscg.mil/worklife/stress_management.asp) to access the Navy and Marine Corps Combat and Operational Stress Control for tools to evaluate stress.
  - b. Ensure information is available to all members on support resources such as CG SUPRT (Employee Assistance Program) 1-855-CGSUPRT (247-8778) Web (for EAP): [www.CGSUPRT.com](http://www.CGSUPRT.com)
  - c. Ensure crews and individuals receive appropriate and timely assistance to avoid stress injury or illness.
  - d. Proactively create stress awareness during operational transitions and high stress situations such as:
    - (1) PCS moves;
    - (2) Underway deployments;
    - (3) Disaster relief missions; and,
    - (4) High evolution operational tempos.
  - e. Contact the regional HPM to provide training and education to crew members as deemed necessary.

**CHAPTER 7. SUBSTANCE ABUSE PREVENTION PROGRAM (SAP)**

- A. **Introduction.** A responsibility of senior leadership is to establish clear and quantitative guidelines for the health and readiness of the members they lead. Evidence-based medicine should be used to establish those guidelines when possible. A positive command climate that promotes responsible low risk alcohol use and provides alcohol-free alternatives for off-duty recreation is essential to minimizing personnel and operational risks. Commands and leaders should be mindful that, even with the best prevention strategies and programs, there are times that a Coast Guard member requires assistance in seeking treatment and educational resources.
1. **Spectrum Use Disorder.** This program outlines the steps necessary for a command to appropriately address these situations and provide members with alcohol use guidelines, treatment, and/or education they are entitled regardless of any personnel action associated with alcohol misuse or abuse. Substance abuse is a spectrum use disorder. This requires education and treatment that coincides with the severity of the disorder and where the member is on this spectrum (e.g., abstinence, use, misuse, abuse, dependency).
  2. **National Guidelines.** The strategy of the Coast Guard SAP Program is to reduce the negative consequences related to substance use. This policy encourages self-control, personal responsibility, and supports a zero tolerance illicit drug policy. The Coast Guard uses the National Institute of Alcohol Abuse and Alcoholism (NIAAA) guidelines for responsible drinking. Detailed information on these guidelines can be found at <http://niaaa.nih.gov/alcohol-health>. Coast Guard members are encouraged to either abstain or engage in low risk alcohol consumption guidelines.
  3. **Medical Model.** Drug abuse and dependency, which includes the abuse of or dependency on alcohol is a brain disease. Drug abuse and dependency are seen as a continuum or constellation of symptoms. Addiction in all of its forms affects not only the afflicted member, but also society, family, friends, co-workers, and commands.
- B. **Program Overview.** The goals of this program are to provide guidance. This guidance comes in the form of suggested national guidelines whose intent is to inform commands about substance abuse; establish policy; provide commands and individuals with substance abuse prevention training; implement strategies to prevent substance misuse and abuse; consult with commands on substance related issues when requested; and finally, educate commands about substance use and abuse. This program intends to:
1. **Establish the Legal Drinking Age.** No alcohol use before the age of 21. The only exception to this is when a member is on authorized leave status and the member will comply with the minimum legal drinking age for the jurisdiction in which they are present.
  2. **Raise Awareness of Substance Abuse Issues.** Help each member and command understand how to approach and deal with substance misuse, abuse, and chemical dependence, which are referred to as Substance Use Disorders (SUD).
  3. **Encourage, Teach, and Support Low Risk Guidelines for Alcohol Use.** The Substance Abuse Prevention Program has adopted a risk management model for alcohol consumption. Low Risk drinking guidelines have been established by the NIAAA. Key behaviors for low risk alcohol use as defined by Commandant (CG-1111) include the 0,1,2,3 model.

These guidelines suggest:

- a. There are occasions where “zero” drinks is the low risk option. Examples are when one is driving, using machinery, cleaning a weapon, pregnant, or on medication.
  - b. Consuming no more than one “standard alcoholic beverage” per hour.
  - c. Two standard drinks per occasion and never to exceed three. Gender guidelines have been established by the NIAAA because males and females process alcohol differently. Citations are included in this section to elucidate the physiological and absorption differences for males and females. The guidelines suggest that for males, consuming no more than four standard drinks per day and not exceeding fourteen drinks per week and three drinks per day for females not exceeding seven drinks per week are the low risk recommendations. For further clarification, please see:  
<http://rethinkingdrinking.niaaa.nih.gov/IsYourDrinkingPatternRisky/WhatsLowRiskDrinking.asp> and  
<http://health.gov/dietaryguidelines/dga2010/dietaryguidelines2010.pdf>.
  - d. The World Health Organization (WHO) released their 2014 World Cancer Report <http://www.meltingmama.net/files/noamountofalcoholissafe.pdf> noting that “no amount of alcohol is safe and is causally related to several cancers.” Drinking guidelines established by the WHO are to “limit consumption to 20g daily for men and 15g daily for women (1.5 drinks for men and 1 drink for women by US standards.”
  - e. Checking with a health care provider to ensure it is safe to consume alcohol with prescribed medication or diagnosed medical condition (e.g., pregnancy).
  - f. Avoiding any activity requiring strict focus and attention or coordination and balance (e.g., cleaning a weapon, climbing a ladder, operating machinery).
4. Provide Periodic Prevention Training. Provide members, cadets, recruits, and commands with prevention training, early problem identification skills, and resources for screening and treatment.
  5. Support Commands. Assist commands by providing the tools and procedures to deal with irresponsible use of alcohol.
  6. Outline Zero Tolerance for Drug/Substance Misuse and Abuse. Support zero tolerance for the intentional and wrongful use of illegal drugs and the wrongful misuse of prescription medication. This also pertains to the wrongful use of any non-controlled substance used with the intent to induce intoxication, excitement, or impairment of the central nervous system. This will also pertain to “substances” used for the purposes for obtaining a “high” which include, but is not limited to, gases, aerosols, and manufactured or yet to be manufactured designer drugs (e.g., spice, bath salts, etc.).
  7. Support Mission Readiness. Ensure that members are aware of how substance abuse interferes with Coast Guard mission readiness and a safe work environment.

C. General Policy.

1. Commanding officers will institute a substance abuse prevention plan that leverages all unit leaders. Guidelines for development of this plan are provided in depth to the Command Drug and Alcohol Representative (CDAR) via the CDAR course.
2. The policy outlined in this Chapter directly correlates with the drug and alcohol related



policies reflected in Reference (f). Commands will use Reference (f) and this policy to appropriately document and handle alcohol-related issues at their unit.

- D. Applicability. Policy in this Chapter applies to all Coast Guard active duty personnel, including reserve members on active duty. In accordance with Section 703 of the 2012 NDAA, reservists in an Inactive Duty Training (IDT) and Active Duty Training (ADT) drilling status are entitled to behavioral health support screenings, such as assistance with substance abuse. Reservists no longer in an IDT or ADT drilling status are responsible for any follow up care required as a result of behavioral health support screenings unless a Line of Duty investigation determined that the issue was incurred or aggravated in the Line of Duty. See Administrative Investigations Manual, COMDTINST M5830.1 (series), for more guidance.
- E. Duties and Responsibilities.
1. Commandant (CG-1111). Responsible for the medical training, education, and evaluation policies of the SAP Program.
  2. Substance Abuse Program Manager (SAPM). The SAPM serves as the manager for the SAP Program within Commandant (CG-1111) and as a liaison to the Department of Defense and other agencies. Specific duties of the SAPM include:
    - a. Coordinate with Coast Guard Personnel Services Command (CG PSC) and the HSWL SC to provide staffing for Coast Guard Substance Abuse Prevention Specialist (SAPS) billets.
    - b. Draft, oversee, and coordinate medical guidance and clearance in development of substance abuse training and education curricula for Coast Guard personnel both on-line and face-to-face.
    - c. Ensure Medical Officers involved in evaluating, screening, or diagnosing substance abuse patients are afforded the opportunity to receive the Coast Guard Addictions Orientation for Health Care Provider-Medical Officer (AOHCP MO) course or civilian equivalent specialized training regarding substance abuse and diagnosis.
    - d. Collaborate with the Substance Abuse Prevention Program Supervisor (SAPPS) at the HSWL SC to develop, establish, maintain, and oversee all training and educational requirements for Medical Officers, SAPPS, SAPSs, and CDARs.
    - e. Develop policy and manage budget for the SAP Program.
    - f. Establish and oversee performance standards for the SAPPS and SAPS.
    - g. Conduct outcome and research activities in the areas of substance abuse, prevention, screening, diagnosis, treatment, and follow-up care. Disseminate those results. When possible, create actionable items that provide efficiencies in the aforementioned areas.
    - h. Establish collaborative and effective communication pathways with the SAPPS, SAPSs, CDARs, and other field components.
    - i. Responsible for oversight, implementation, and modifications to the substance abuse segment of the electronic case management system or its electronic medical record (EMR) equivalent.

3. Substance Abuse Prevention Program Supervisor (SAPPS). Responsible for coordinating the implementation of the SAP policy and for supporting all Commandant (CG-1111) priority initiatives related to this program. The SAPPS will:
  - a. Provide direction, oversight, and supervision of SAPSs.
  - b. Advise commands on the availability of education, treatment, rehabilitation resources, and procedures for obtaining them.
  - c. Process all requests; self, command, and incident referrals for alcohol/drug rehabilitation.
  - d. Approve selection of the medical screening provider.
  - e. Oversee implementation and maintenance of support and aftercare plans.
  - f. Liaison with unit commanding officers, other military services, state and federal programs, and local civilian treatment facilities as appropriate.
  - g. Establish, track, and maintain Personnel Qualification Standards (PQS) for the SAPSs.
  - h. Complete annual Health Insurance Portability and Accountability Act (HIPAA) training related to substance abuse patient records.
  - i. Ensure SAPSs complete annual HIPAA training.
  - j. Participate in Headquarters-sponsored teleconferences, meetings, and workgroups related to the SAP Program.
  - k. Assign each SAPS an area of responsibility (District) with oversight for CDARs assigned to that AOR.
  - l. Supervise field operation of the electronic data collection system as designated by Commandant (CG-1111).
  - m. Provide quality assurance standards and oversight to the SAPSs to include accurate and timely documentation of cases in the electronic data collection system.
  - n. Oversee compliance of SAPSs with all applicable policies and procedures and related competencies.
  - o. Establish and maintain collaborative and effective communication pathways with the SAPM, SAPS, and other field components.
  - p. Inform the SAPM of all issues affecting program implementation and/or effectiveness that require Commandant (CG-1111) visibility, guidance, and/or intervention.
  - q. Produce reports for Commandant (CG-1111) as directed.
  - r. Advocate for the needs of the SAPSs and the SAP Program.
4. Substance Abuse Prevention Specialist (SAPS). HSWL SC personnel assigned to detached duty at large commands. SAPS serve a number of functions, including providing resources and assistance with prevention training, education, and screening for treatment options. However, one critical function is to provide case management. This clinical role ensures members are appropriately screened and referred for treatment. It is vital that clinical roles

remain separate from command roles (i.e., those that CDARS perform); therefore, SAPS will not serve as CDARs. SAPS will:

- a. Maintain a roster of unit CDARs within the assigned area of responsibility (AOR).
- b. Connect with CDARs on a frequent basis to ensure all referrals (self, command and incident) are being captured in the electronic data collection system. Notify CDARs of any changes in program policy or procedures.
- c. Notify the SAPPs of all issues affecting program implementation and/or effectiveness.
- d. Assist CDARs in developing unit prevention plans and conducting general alcohol awareness and prevention education as outlined in Section F.1. of this Chapter.
- e. Assist CDARs with developing support and aftercare plans.
- f. Advise and assist AOR units on all matters pertaining to policy interpretation, substance abuse screenings, treatment, and aftercare. NOTE: Never diagnose or infer a diagnosis. Failure to comply will result in removal from position and may lead to further administrative action.
- g. Approve selection of a Coast Guard Addiction Orientation for Health Care Provider (AOHCP) trained medical screening provider or obtain guidance from the SAPPs when needed.
- h. Ensure complete and accurate data entry into the electronic data collection system for all alcohol incidents and referrals within the assigned AOR through timely input from CDAR.
- i. Provide guidance and quality assurance to CDARs for reporting substance related issues, as directed by the SAPPs and SAPM.
- j. When stationed at Training Center Cape May or the U.S. Coast Guard Academy, provide recruits, officer candidates, direct commission officers, and cadets with:
  - (1) An initial orientation on Coast Guard substance abuse policies and the impact of substance abuse on the Coast Guard.
  - (2) An initial survey or questionnaire (e.g., Alcohol Use Disorders Identification Test) to assist in identifying personnel who are “at risk” for substance abuse.
  - (3) Prevention-based educational programs to reduce the risk of future alcohol or other substance misuse for personnel identified as high risk.
  - (4) Educational courses to fulfill basic alcohol education requirements, as outlined by the SAPM.
- k. Conduct prevention training as outlined in Section F.1 of this Chapter.
- l. Complete the Addiction Orientation for Health Care Providers Substance Abuse Prevention Specialist (AOHCP SAPS) course.
- m. Complete annual HIPAA training related to substance abuse patient records.
- n. Ensure CDARs complete annual HIPAA training.

5. Commanding Officers and Officers-in-Charge will:
  - a. Designate a CDAR in writing.
    - (1) Commands with less than 15 members and collocated with a larger command may request permission from that command to designate the larger unit's CDAR as their unit CDAR.
    - (2) Commands with 15 or more members will designate a CDAR.
    - (3) Commands with 50 or greater members will designate, at a minimum, one primary and one alternate CDAR.
    - (4) Members designated as a CDAR:
      - (a) Must be an E-5 to E-8 of any rating or an officer (O-1 to O-3).
      - (b) Should be mature, reliable, and fully understand the sensitive nature of this role.
      - (c) Understand that he/she works as an extension of the command and as a resource for the member.
  - b. Place the CDAR on all unit check-in/out lists and collateral duty lists.
  - c. Ensure members selected for CDAR attend the CDAR course prior to accepting the appointment. Training is conducted by the SAP as per training and educational requirements outlined in Section F of this Chapter.
  - d. Ensure unit CDAR submits updates to the SAPPS in accordance with Sections G, H, and I of this Chapter.
  - e. Ensure all required steps are completed by the CDAR to accurately and completely document all substance abuse incidents in accordance with Reference (f), to include:
    - (1) Assisting with implementation of a pre-treatment plan.
    - (2) Facilitating completion of appropriate treatment (if required).
    - (3) Documenting corrective action (if necessary).
    - (4) Assisting with implementation, oversight and monitoring of aftercare.
  - f. Promote responsible attitudes toward the use of alcohol, both on and off Coast Guard facilities. Guidelines for appropriate use of alcohol may be found at the NIAAA web site: <http://rethinkingdrinking.niaaa.nih.gov/>.
  - g. Ensure a unit Alcohol Abuse Prevention Plan is developed, implemented and updated yearly. SAPSs are available to assist as referenced in Section E.4.e of this Chapter.
  - h. Ensure that the CDAR participates in one or more of the following unit committees: safety, morale, health promotion, or training.
  - i. Ensure members are afforded the treatment and educational opportunities outlined in Sections F, G, and H of this Chapter.
  - j. Use all available Coast Guard approved resources (e.g., CG SUPRT, Work-Life staff, TRICARE providers) to identify potential risk factors for substance abuse within a

- unit and establish protective factors to address and reduce the risk.
- k. Cultivate an environment where members can seek assistance for actual or perceived issues with substances (reduce stigma and increase help seeking behavior).
  - l. Ensure the CDAR provides copies of all documentation to the receiving command when members on an Aftercare Plan are transferring.
  - m. Remove member as the CDAR if they have a negative consequence (e.g. arrest, DUI, drug incident, conduct unbecoming) as a result of substance abuse. Commands should contact SAPPS or Commandant (CG-1111) for guidance.
6. Command Drug and Alcohol Representative (CDAR). Unit members who serve as an advisor to their command in the administration of the unit's substance abuse program. CDAR is a collateral duty and is administrative and educative in nature. Each CDAR will:
- a. Contact the SAPS within 24 hours of commanding officer notification of a potential substance related issue.
  - b. Collaborate with the SAPS to provide administrative support to command regarding prevention strategies and treatment options.
  - c. Collaborate with the SAPS to prepare the appropriate Administrative Remarks, Form CG-3307.
  - d. Schedule and document required unit alcohol training in accordance with Section F of this Chapter.
  - e. Prepare and prominently display prevention awareness materials.
  - f. Collaborate with the SAPS to initiate substance abuse screenings, referrals, treatment, Aftercare, and Support plans. NOTE: Never diagnose or infer a diagnosis. Failure to comply will result in removal from position and may lead to further disciplinary action.
  - g. Ensure that all documentation is complete before arranging treatment or training via the SAPS.
  - h. Keep the command informed of the status of personnel undergoing treatment, including expected date of completion and/or return, prognosis, and personal needs (e.g., pay, orders, etc.).
  - i. Collaborate with the SAPS to develop Support and Aftercare Plans.
  - j. Monitor the mandatory Pre-Treatment and Aftercare Plans with the commanding officer.
  - k. Provide updates to the SAPS for all members who are:
    - (1) Assigned an Aftercare Plan.
    - (2) Transferred or separated from service while in aftercare.
  - l. Provide copies of all documentation to the receiving command when members on an aftercare plan are transferring.
  - m. Complete annual HIPAA training related to substance abuse patient records.

- n. Provide the SAPS with all required data for entry in the electronic data collection system as directed.
7. Coast Guard Health Services Personnel.
- a. Medical Officers will:
    - (1) Facilitate substance abuse screening services when needed, in coordination with the SAPS or SAPPS. For ships underway, where the MO is an IDHS, they should schedule a screening immediately upon return to homeport or port call where a MO is available. Contact a SAPPS for guidance.
    - (2) Provide substance abuse screenings in accordance with their training, professional experience, and clinical privileges (AOHCP MO).
    - (3) Begin screening process within 72 hours of a request for consult (as defined by the HSWL).
    - (4) Attend the AOHCP course and refresher training.
    - (5) Notify the SAPS within 24 hours for all medical referrals and provide required data to the SAPS for entry into electronic data collection system in accordance with Section K.2 of this Chapter.
  - b. Medical record custodians will assist the CDAR as needed to locate required information within the member's medical record.
  - c. Health care providers and medical record custodians will ensure entries are made on the Chronological Record of Medical Care, Form SF-600, in accordance with Section G.3.c of this Chapter.
  - d. Provide needed feedback to SAPS to "flag" duty status in electronic data collection system.
8. Member Responsibilities. Each member will:
- a. Support abstinence or low risk drinking among other service members.
  - b. Support and create a culture where members are actively supporting others in their recovery.
  - c. Use the low risk guidelines when consuming alcohol or choose to abstain when any use may affect the readiness or safety of the member or unit.
  - d. Complete all mandatory alcohol awareness and prevention trainings as required.
  - e. Seek assistance from medical (self-referral) for screening when there is concern or indication that substance use is having a negative impact.
  - f. If mandated, fully and completely follow all treatment plans (treatment, aftercare, support) as designed by the MO. Members not adhering to aspects of their prescribed treatment plan or medical direction e.g. attending scheduled appointments, abstinence from alcohol or illicit drug consumption may be subject to further administrative action including discharge.

- F. Training and Education Requirements. Commandant (CG-1111), in coordination with the HSWL SC, is responsible for the development, implementation, and evaluation of substance abuse training and education programs. These trainings are tailored to meet the needs of Coast Guard and SAP personnel. This section outlines these requirements.
1. Coast Guard Personnel. The SAPS will provide the following training.
    - a. Accession Points. Universal substance abuse prevention training will be conducted at Training Center Cape May and the Coast Guard Academy.
      - (1) Coast Guard Academy. Cadets, officer candidates, and direct commission officers will complete an orientation on substance abuse awareness and current policy.
      - (2) Training Center Cape May. All recruits will complete training on drug and alcohol risk management, substance abuse policy, and the availability of substance abuse treatment resources.
    - b. Training Centers. Prevention training will be conducted at all “A” and select “C” schools, to include Chief Warrant Officer Professional Development, Officer Candidate School, and Chief Petty Officer Academy.
    - c. Substance Abuse Prevention Training. Substance abuse prevention training uses a universal, selective, and indicated model. Universal prevention training is directed towards the active duty population. Focus is on subgroups that are not at “high risk” for developing a SUD. Selective prevention training is directed towards members whose behavior places them at higher “risk” and warrants additional education (e.g., heavy drinkers). Indicated prevention is for members whose behavior clearly puts them “at risk” for developing a SUD. Incident, self, and command referrals would be a target population. Additional training available is:
      - (1) On-Line Mandated Training (Universal). This required training is for all active duty and reserve personnel and meets the mandated training requirement. On-Line Mandated training addresses Coast Guard policy in addition to signs, symptoms, and consequences of substance abuse, including impact on readiness and morale. Civilian employees’ attendance is at the commanding officer’s discretion.
      - (2) Substance Abuse Prevention -All Hands. This command-driven training is for all active duty and reserve personnel. This targeted, yet customized prevention training, addresses Coast Guard policy in addition to signs, symptoms, and consequences of substance abuse. The principle focus includes impact on readiness and morale. This training is conducted as a result of a commander’s concern for their unit. This training can be conducted by SAPS or Command’s designee (e.g., Chiefs Mess).
      - (3) Leadership Consultation. This training is available for senior leadership and active duty and civilian supervisors and managers. This training addresses roles and responsibilities, pre-treatment and aftercare guidance, and resources to enhance leadership’s ability to identify and deal with substance abuse issues in the workplace. This should be conducted by SAPS.

2. Substance Abuse Prevention Program Training.
  - a. SAPS Training. The following training, education, and experience are required for the SAPS position.
    - (1) Proficiency with Coast Guard workstations, software/applications, and electronic records management systems (e.g., Direct Access, electronic data collection system, Coast Guard Business Intelligence).
    - (2) CDAR School prior to accepting appointment as a SAPS. If certification is older than one year, the course must be repeated.
    - (3) Complete AOHCP SAPS within 6 months of assuming duties.
    - (4) Complete Navy Substance Abuse Prevention School within 6 months of assuming duties (as resources permit).
    - (5) Additional training through government or community agencies and civilian programs as required by the SAPM.
    - (6) Complete Coast Guard Instructor Development Course (IDC) within 6 months of assuming duties.
  - b. CDAR. Attend the CDAR course prior to command designation. The CDAR competency code will be assigned upon completion of training and command designation, in accordance with the U.S. Coast Guard Competency Management System Manual, COMDTINST M5300.2 (series).
3. Primary Intervention: Prime for Life (PFL or myPRIME). An evidence-based alcohol and drug program for members who show signs of misusing alcohol.
  - a. Commands may prescribe PFL to members regardless of diagnosis. PFL is required for members who receive an alcohol incident, which is documented in accordance with Section K.3.a. of this Chapter or when recommended by a CG MO.
  - b. Other courses may be considered, but require pre-approval of the SAPPS.
  - c. This course replaces Navy's IMPACT class, Brief Alcohol Screening and Intervention for College Students (BASIC), or its civilian equivalent.

G. Medical Referrals, Screenings, and Action for Substance Abuse.

1. Referral. The preferred method of addressing potential or suspected abuse is through a medical referral (e.g., command, self, or incident). This method is a means of early intervention in the progression of substance misuse and abuse leading to a disorder.
  - a. Command Referral. Initiated by the command with the intention to ensure the member receives appropriate screening and treatment, if necessary.
    - (1) A command referral is at the discretion of the command and can be based on any credible factor that indicates substance abuse such as third person account, personal observation, or noticeable change in job performance.
    - (2) A command referral where no alcohol or drug incident has occurred and is not intended as disciplinary or punitive. A copy of the referral, screening, and treatment plan will be maintained in the member's medical record. A command



referral for alcohol misuse is not maintained in the member's Personal Data Record (PDR). The primary reason for this referral is the health and safety of the member.

- (3) A command referral resulting in a diagnosis that requires treatment will result in administrative action if the member refuses, fails, or does not complete treatment. The health of the member takes priority over career and advancement. A copy of the referral, screening, and treatment plan will be maintained in the member's medical record.
- b. Self-Referral. Initiated by the member to receive appropriate screening and treatment if necessary.
- (1) Request must be made to a Chaplain, Command, CDAR, SAPS, or healthcare care provider.
  - (2) There can be no credible evidence of involvement in an alcohol incident.
  - (3) Members may self-refer for drug abuse; however, self-referral may result in determination of a drug incident and administrative actions in accordance with Reference (f).
  - (4) A self-referral for alcohol related issues is not intended as administrative or punitive and should not be maintained in the member's PDR. A copy of the referral, screening, and treatment plan will be maintained in the member's medical record.
  - (5) A self-referral resulting in a diagnosis (e.g., current version of DSM) will result in administrative action if treatment is required and the member refuses, fails, or does not complete treatment. The member's refusal, failure, or incomplete treatment requires a copy of the referral, screening, and treatment plan be maintained in the member's medical record. The health of the member takes priority over career and advancement.
- c. Incident Referral. Initiated by the command where consumption of substances were considered a contributing factor to an incident.
- (1) A description of the criteria for an alcohol/drug incident can be found in Reference (f). The following are examples of substance-related incidents that require medical screening:
    - (a) Driving or operating motorized vehicles while impaired (e.g., DUI/DWI/OWI);
    - (b) Drunk in public;
    - (c) Drunk and disorderly conduct;
    - (d) Alcohol-related arrest;
    - (e) Domestic violence where alcohol is a factor;
    - (f) Unfit for duty due to alcohol intoxication or impairment;
    - (g) Underage drinking; and,

- (h) Determination of a drug incident.
  - (2) Referrals resulting from an alcohol or drug incident will be documented in the PDR as per K.3.a of this chapter and copies of the referral, screening, and treatment plan will be maintained in the member's medical record.
  - (3) All members receiving an alcohol incident will be enrolled in the Prime for Life (or myPRIME) Program.
2. Medical Screening.
- a. Process will begin within 72 hours of a request for consult (MO notification). Medical Officer will determine need based on severity and schedule screening accordingly.
  - b. Should be conducted by an AOHCP trained Coast Guard MO however, TRICARE approved Substance Abuse Rehabilitation Programs or DoD MTF screening facilities may be used as an alternative. In all cases, the SAPS will approve selection of the screening provider with preference for an AOHCP trained MO.
  - c. Selected Reserve members while in an IDT or ADT drill status are authorized referral for substance abuse screening and diagnosis.
3. The following actions are taken when a member is diagnosed with a substance use disorder (alcohol or drug) and is awaiting treatment:
- a. Commands will:
    - (1) Review the evaluation and treatment recommendations provided by the screening facility and treat this diagnosis as any other illness and ensure treatment is initiated immediately.
    - (2) Collaborate with the CDAR and the SAPS to establish a Pre-Treatment Plan. The plan will include:
      - (a) Member is to abstain from alcohol until further evaluation and recommendation from the treatment facility.
      - (b) Weekly, documented meetings with the CDAR.
      - (c) Attendance of an abstinence-based, twelve-step or "at risk" programs a minimum of twice a week.
  - b. CDAR will:
    - (1) Collaborate with the SAPS to prepare the appropriate Administrative Remarks, Form CG-3307, for incident referrals, in accordance with Section K.3.a. of this Chapter.
    - (2) Monitor the member's Pre-Treatment Plan with the commanding officer and provide updates to the SAPS.
  - c. Health care providers and health record custodians will ensure the following entries are made in the member's medical record:
    - (1) Reason for referral.

- (2) Screening facility and location.
- (3) Diagnosis.
- (4) Treatment recommendations; to include American Society of Addiction Medicine (ASAM) Patient Placement Criterion treatment level.
- (5) Pre-Treatment Plan.

#### H. Treatment.

1. All treatment must be authorized by a Coast Guard MO.
2. Commands must obtain guidance from SAPS prior to pursuing treatment for a member.
3. The SAPPS must authorize any patient treatment plan with a substance abuse diagnosis. The SAPS will review all other treatment plans.
4. Commands must verify members' compliance with all aspects of outpatient treatment programs (e.g., attendance at group therapy sessions or 12-step meetings) until all requirements is completed.
5. The Coast Guard SAP follows the treatment model published by the ASAM. This model is based on Patient Placement Criteria. The following are the ASAM recommended levels:
  - a. Level I Outpatient Treatment (OP).
    - (1) Personnel diagnosed as Alcohol Use Disorder (DSM-V code 305.00, mild; 303.90 moderate) and recommended for outpatient treatment as determined by the screening facility.
    - (2) MTFs or TRICARE facilities that offer this type of treatment may be used.
  - b. Level II Intensive Outpatient/Partial Hospitalization (IOP).
    - (1) Personnel recommended for this level require a greater level of care than that provided by Level I OP.
    - (2) Level II consists of daily classroom instruction and individual/group counseling sessions.
    - (3) Members who are assigned Temporary Duty (TDY) will normally be berthed at the Bachelor Enlisted Quarters or Bachelor Officer Quarters closest to the facility.
    - (4) The length of treatment will vary depending on the member's degree of need.
    - (5) MTFs or TRICARE facilities that offer this type of treatment may be used.
  - c. Level III Residential/Inpatient.
    - (1) Personnel diagnosed as having a SUD mild, moderate or severe (DSM-V code 303.9) may be referred to treatment.
    - (2) Inpatient rehabilitation is an intensive residential treatment program that provides treatment and berthing on site.

- (3) Members who have other primary diagnosis which would undermine or interfere with their treatment for a SUD may require a referral to an MTF with additional on-site treatment facilities.
- d. Level IV Medically Managed Intensive Inpatient Treatment (Detoxification).
  - (1) In a medical emergency the member will be taken to the nearest MTF or local civilian hospital emergency room.
  - (2) Detoxification normally consists of three to seven days in a hospital setting.
  - (3) Refer to “Medical Screening” in Section G.2 of this Chapter for the required documentation.
6. Selection of a Treatment Facility (Treatment Placement).
  - a. Treatment may be provided by a local MTF. If a local MTF does not offer the recommended treatment, a TRICARE facility should be utilized.
  - b. Vetted civilian facilities (TRICARE) may be used. Consult with your District SAPS for vetted civilian providers.
7. Treatment Grading. Treatment programs recommended by a MO, SAPPS, or authorized TRICARE provider will not be downgraded to a lower level of care by the command. Only higher medical authorities may change treatment options.
8. Pre-existing Condition. In accordance with Reference (b), Section 5.B.5., a member diagnosed within the first 180 days of enlistment as drug/alcohol abusive or dependent (or SUD moderate or severe: DSM-V) is considered physically disqualified for enlistment. Separation is based on the diagnosis, not the incident itself. Commanding officers and officers-in-charge will process these members in accordance with COMDTINST M1000.4, Paragraph 1.B.12. The Coast Guard is not obligated to offer treatment prior to separation. Commands should not offer treatment if said treatment will delay separation beyond 180 days of active Coast Guard service.
9. CDAR Responsibilities for Treatment Placement. The CDAR will facilitate placing members into treatment and will ensure that all documentation required by the facility is complete. The CDAR will accomplish this responsibility with the assistance and guidance of the command, the member’s Primary Care Manager (PCM), their district SAP and the HSWL SC SAPPS. The CDAR will take the following steps:
  - a. Contact your District SAPS first and foremost. The SAPS will guide and assist ensuring that all required documentation is completed.
  - b. Prior to seeking substance abuse treatment, contact SAPS for approval and authorization of treatment facility.
10. If not already handled by the SAPS, ensure that a Coast Guard Substance Abuse Screening Assessment is provided to the SAPS or MO.
11. Refusal of Treatment. Members diagnosed with a SUD (DSM-V codes beginning with 290 to 300 series, drug or alcohol) who refuse treatment will:
  - a. Sign Administrative Remarks, Form CG-3307 (P&D 18), in accordance with Section K.3.a. of this Chapter, acknowledging that they may be waiving their right to benefits

under the Department of Veterans Affairs (VA) for treatment for SUD.

- b. Be processed for separation from the Coast Guard in accordance with Reference (f).
  - c. Have entered in their medical record, on a Chronological Record of Medical Care, Form SF 600, the refusal of treatment as noted by the completed Administrative Remarks, Form CG-3307 (P&D 18).
12. Family Member Involvement. Treatment of active duty members at some civilian and TRICARE facilities and MTFs may involve family members as prescribed by the treatment facility. Additionally, the member's primary treatment coordinator must deem it an essential component to a successful outcome. With the advent of technology, this may be achieved via multiple electronic modalities.
13. Funding for Education and Treatment. As a precondition for Coast Guard funding of treatment, commands are to ensure pre-treatment plans and pre-education plans include the term of employment: "abstain from alcohol."
- a. Alcohol education (e.g., Prime for Life, myPRIME) will be funded by the member when ordered by civilian authority.
  - b. Alcohol education (e.g., Prime for Life (PFL)) will be funded by the command when directed by Coast Guard required screening. This will normally involve only local travel and little or no course fee.
  - c. Local treatment through vetted TRICARE facilities and MTFs reduces the cost of travel associated with medical care. The availability of local facilities that offer substance abuse rehabilitation treatment is limited in some areas. If travel to obtain substance abuse related medical care is beyond the scope of the local area, commands must request a Treatment Authorization via the HSWL SC SAPPS prior to receiving treatment.
  - d. Commands are strongly encouraged to transport members to and from treatment if needed. Commands should consider treatment level, acceptance of treatment, ability to travel due to physical, and/or legal restriction (e.g., driving license suspended). Travel by privately owned vehicle to inpatient rehabilitation is not recommended and strongly discouraged.
  - e. If and when medically required and approved as a non-medical attendant, spouses may be authorized travel related to treatment. If not overseas, this travel would be accomplished using unit funds. Contact the HSWL SC for guidance to travel.
- I. Support Plans for Substance Use Disorders. The Support Plan is an essential part of the rehabilitation process and members will fulfill requirements as established by the treatment facility or CG Medical Officer. For Incident Referrals, the CDAR should notify the Command, referring MO and their District SAPS so treatment milestones (or the lack of) can be recorded in electronic data collection system as per E.4.b&h., (e.g., medical record).
- 1. Level II Support Plan. For members not diagnosed as "moderate or severe (DSM IV: abusive or dependent)," the plan should include:
    - a. Abstinence. Abstaining from using alcoholic beverages for at least the first 90 days.

- b. Meet with the CDAR. Meeting with the CDAR on a weekly basis for 90 days. These meetings can be informal and are meant to be an opportunity for the member to “check-in” with the CDAR.
  - c. Support Program. Participating in a twelve-step, abstinence-based group support program at least twice weekly for 90 days.
  - d. CDAR Reports. Completing and submitting an electronic data collection system case management report. When possible, schedule a quarterly meeting with the MO and the executive officer/executive petty officer to review current case load.
  - e. Other Supporting Plans. Commands are strongly encouraged to incorporate the Individual Development Plan and a dietary and fitness plan to help with behavior change. HSWL Regional Practice Health Promotion Managers can assist with this. The use of CG SUPRT is strongly encouraged to obtain assistance from a health coach.
  - f. Plan for Responsible Alcohol Use. Upon completing the support plan, the member may be allowed to use alcohol in a responsible and abuse-free manner (after the initial 90 days post-treatment). Use of the 0,1,2,3 model outlined earlier in this instruction is strongly recommended. Members diagnosed with a SUD will follow the aftercare/support plan established by the discharging treatment facility.
  - g. Immediate inclusion into prevention education e.g. Prime for Life or myPRIME.
  - h. Adherence to Medical Direction. Members not adhering to aspects of their prescribed treatment plan or medical direction e.g. attending scheduled appointments, completion of prevention education (PFL or myPRIME), abstinence from alcohol or illicit drug consumption may be subject to further administrative action including discharge.
2. Level II Support Plan Documentation. The support plan will be documented in the member’s medical record on a Chronological Record of Medical Care, Form SF-600, to include successful treatment completion, treatment facility diagnosis, type of treatment, dates of treatment, and support requirements.
  3. Aftercare Plan for SUD.
    - a. Aftercare Plan. The MTF, TRICARE, or civilian treatment facility will provide a written aftercare plan during the terminal phase of the rehabilitation program.
    - b. The command is responsible for implementing, documenting, and actively supporting aftercare programs. There may be some circumstances where operational commitments may force the unit commander to modify the implementation of the aftercare plan. This plan will be individually tailored to the member’s needs and must include, but is not limited to the following:
      - (1) Abstinence is the only low risk option for a member with a severe SUD diagnosis.
      - (2) The aftercare period for a severe SUD diagnosis is normally 12 to 18 months.
      - (3) Because relapse is a condition of the disease of SUD, non-compliance with the abstinence portion of the member’s treatment plan in itself is not reason for separation. Behaviors associated with relapse, (e.g., “slips,” intoxication, being

late or leaving early from work, on the job injury, declining work performance, mood change, irritability, argumentativeness, isolation, another alcohol-related incident) may provide sufficient justification for further administrative action.

- (4) Meet with the CDAR on a weekly basis for the first six months. The CDAR will then determine the frequency of meetings thereafter.
- (5) Participation in a 12-step or abstinence-based group support program at least twice weekly, operations permitting, for 12 months. Alcoholics Anonymous is the recommended 12-step program focusing on abstinence. Other 12-step and support groups must be approved by the SAPS.
- (6) Al-Anon, Ala-Teen, and other family support groups are also recommended to aid the member and the family in recovery from the effects of SUDs.
- (7) Meet with the primary care manager or MO quarterly or as needed.
- (8) The voluntary use of alcohol-inhibiting drugs, such as Disulfiram (Antabuse) or Naltrexone is recommended when clinically supported.
- (9) Pharmacotherapy such as Campril or other “anti-craving” medications may be prescribed.

#### 4. Documentation for Aftercare Plan for SUD.

- a. Aftercare plans must be documented in the member’s medical record on a Chronological Record of Medical Care, Form SF-600 to include:
  - (1) Successful treatment completion.
  - (2) Treatment facility diagnosis.
  - (3) Type of treatment.
  - (4) Dates of treatment.
  - (5) Aftercare requirements.
- b. All electronic medical record documentation defined by the SAPM will be completed.

#### 5. Progress Reports for SUD Cases.

- a. Quarterly Meeting. The member, the CDAR, and the commanding officer/officer-in-charge (or representative) will meet quarterly to evaluate progress during the required aftercare period.
- b. Initial Report. Upon the member’s return to the unit, the CDAR will forward a copy of the following to the SAPPS (Eyes Only), and a copy of the narrative summary will be placed in the member’s medical record:
  - (1) Narrative summary of the rehabilitative treatment.
  - (2) Support plan or the aftercare plan.
  - (3) Initial CDAR referral and follow-up report.
- c. Follow-up Reports. If designated, the CDAR will submit quarterly electronic data collection system reports to their SAPS.

J. Rehabilitation Failure. A rehabilitation (treatment) failure occurs when a member does not complete an alcohol treatment program or aftercare plan due to noncompliance. (The drinking of alcohol alone does not constitute a rehabilitation failure. Consult an AOHCP MO for advice). Non-compliance with treatment includes:

1. Being discharged against medical advice (AMA).
2. Being asked to leave the treatment facility, not actively participating in required activities or leaving treatment before designated treatment is complete.
3. Having an alcohol incident during treatment or the aftercare program. In such cases, the member will be processed for separation in accordance with Reference (f).

K. Paperwork and Records Management for Substance Abuse Cases.

1. Confidentiality. All correspondence, health, and personnel records regarding alcohol problems are “For Official Use Only” and will be handled in accordance with HIPAA and all other applicable records management requirements.
2. CDAR Documentation.
  - a. The CDAR will complete all documentation requirements as instructed by the SAPS in the CDAR Course. CDARs are expected to remain current on documentation requirements and keep abreast of all changes as directed by the SAPPS.
  - b. Anytime a member needs to receive treatment for alcohol or substance misuse the CDAR will contact the SAPS or SAPPS and follow the requirements as outlined in this Chapter.
  - c. All data, including alcohol incident, self-referral, command referral, and subsequent case-related information will be entered into the electronic data collection system by the SAPS as directed by the SAPPS.
  - d. The CDAR, under no circumstances, will maintain separate case files or keep copies or electronic files of medical and personnel documents.
  - e. CDARs may maintain a password protected spreadsheet as an electronic reminder list to assist in appointment scheduling or to monitor a member’s progress through the various phases of alcohol abuse treatment and recovery.
3. Administrative Documentation.
  - a. Personal Data Record (PDR) Entries. The only documents authorized in a member’s PDR, pertaining to an alcohol or drug incident, are the appropriate Performance and Discipline (P&D) Administrative Remarks, CG-3307 entries, located in Enclosure (6) of The Personnel and Pay Procedures Manual, PPCINST M1000. 2 (series). The CDAR, in coordination with the SAP and the command, will ensure that all entries made in the member’s PDR completely and accurately document the circumstances of each incident and confirm that the member has been referred for medical evaluation. Documentation for a command or self referral will not be placed in the member’s PDR.
  - b. Medical Record Entries. Any medical actions resulting from alcohol problems must be documented in the member’s medical record. The CDAR, SAPS, and health



record custodian will ensure that entries are made in the member's medical record on a Chronological Record of Medical Care, Form SF-600. Documentation will include, but is not limited to the appropriate reports or summaries for all medical actions taken. At a minimum, such documentation includes:

- (1) Reason for referral, name of physician and facility evaluating the member, results and/or recommendations from alcohol screening, and SUD diagnosis (in accordance with DSM-V).
  - (2) Details of pre-treatment plan or intervention prior to separation from the Coast Guard.
  - (3) Details of outpatient or inpatient treatment (e.g., name of treatment facility, type of treatment, and dates of treatment), recommended aftercare program, and actual aftercare program instituted. If the treatment plan is not completed provide a detailed summary of the reason(s) why. Narrative summaries from the treatment facility will be obtained and filed in the member's medical record.
  - (4) Aftercare interviews conducted and reports submitted to the SAPS. Appropriate notation when aftercare report status is completed.
  - (5) Referral for re-evaluation, revision of treatment or aftercare plan, or institution of a second aftercare plan.
  - (6) Rehabilitation failure or refusal of treatment.
- c. Record Keeping by the SAPS. The SAPS will maintain a secure electronic file, in the electronic data collection system, on all members for whom alcohol rehabilitation (outpatient or inpatient) has been requested and when alcohol incidents have occurred, as directed by Commandant (CG-1111). This process will be identified and clarified by the SAPM.

This page intentionally left blank.

## **APPENDIX A. Resources, Definitions and Commonly Used Terminology**

The following definitions are for use within the SAP Program. They do not change the definitions found in statutory provisions, regulations, or directives, which address personnel administration, medical care, or determination of misconduct and criminal or civil responsibilities for persons, acts, or omissions.

1. Abstinence-Based. Requiring the non-use of alcohol in any form.
2. Aftercare or Support Plan. A monitored program of continued care, immediately following completion of a formal inpatient or outpatient treatment program for SUD. Aftercare plans are usually generated by the discharging facility or physician while a support plan is generated by the Command/CDAR or individuals overseeing the member's recovery.
3. Al-Anon. The Al-Anon family groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope to solve their common problems of fear, insecurity, lack of understanding of the alcoholic, and disordered personal lives resulting from alcoholism. Al-Anon is listed in the telephone directory. The Al-Anon Family Group Headquarters address is 1600 Corporate Landing Parkway, Virginia Beach, VA 23454-5617. Their telephone is 1-888-425-2666, and their website is <http://www.al-anon.alateen.org/>
4. Ala-Teen. Ala-Teen is a fellowship of young people, 12 to 20 years of age, who are the offspring of alcoholics. They meet together to help themselves and each other to learn about SUDs, to cope with the troubles brought about by alcoholism, to make a new life, and to set goals for themselves. Ala-Teen is listed in the telephone directory or information can be obtained through Al-Anon. The Ala-Teen address is the same as shown above for Al-Anon. The website is <http://www.al-anon.alateen.org/>.
5. Alcohol Use Disorder. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 11 criteria occurring within a 12 month period. This diagnosis is made by a trained professional.
6. Alcoholic. Pejorative reference to individuals who misuse alcohol.
7. Alcoholics Anonymous (A.A.). A.A. is a worldwide fellowship of men and women who share their experiences, strength, and hope with each other that they may solve their common problem and help others to recover from SUDs. Local A.A. chapters can be found in the white/yellow pages of almost any telephone book. The A.A. World Services address is 475 Riverside Dr., New York, NY 10115, (212) 870-3400 or via the web at <http://www.aa.org/>. A.A. World Services may also be contacted for information on A.A. Internationalists/Loners for members who are stationed aboard ship or on isolated duty.
8. Alcohol Incident. Any behavior in which alcohol is determined, by the commanding officer, to be a significant or causative factor that results in the member's loss of ability to perform assigned duties, brings discredit upon the Uniformed Services, or is a violation of the Uniform Code of Military Justice, Federal, state, or local laws. The member need not be found guilty at court-

martial, in a civilian court, or be awarded non-judicial punishment for the behavior to be considered an Alcohol Incident. The member must actually consume alcohol for an alcohol incident to have occurred. Underage drinking by itself is considered an alcohol incident.

9. Addictions Orientation for Health Care Providers (AOHCP). A training course for medical officers and Substance Abuse Prevention Specialists performing drug and alcohol assessment screenings and newly assigned Substance Abuse Prevention Specialists.
10. Command Drug and Alcohol Representative (CDAR). Unit members who serve as consultants and advisors to their command in the administration of the unit substance abuse program. A CDAR's duties are a collateral responsibility and non-medical in nature. Every unit shall have a designated CDAR. CDARs are expected to manage substance abuse cases administratively and in a timely manner to minimize impact to their unit's mission(s).
11. Command Referral. A commanding officer or officer-in-charge may direct a member to be screened when substance abuse or dependency is suspected.
12. Continuum of Care. A medical model of care provided by the Department of Defense and civilian substance abuse/dependency treatment facilities. Members recommended for treatment will be referred to the appropriate level of care as determined by a qualified screener utilizing the ASAM Patient Placement Criteria. The member's medical care requirements will be continually evaluated throughout the multilevel treatment process ensuring individual needs are met.
13. Detoxification. The medically-supervised process of eliminating excess alcohol (or other drugs) from the body. This is usually done in an inpatient setting for a period of 3 to 7 days.
14. Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychiatric Association. A manual used by mental health professionals, which establishes uniform criteria and diagnostic codes for mental health problems including alcohol abuse and dependence. For purposes of this Instruction, substance abuse-related diagnoses should be reported using criteria.
15. Family Member. Includes married partners, Coast Guard or DoD registered same-sex domestic partners, minor dependents, and adult dependents.
16. Headquarters Substance Abuse Program Manager. The person assigned to Commandant (CG-1111) who manages policy, administration, and financial resources of the Coast Guard's SAP Program.
17. HSWL-SC Substance Abuse Prevention Program Supervisor (SAPPS). The CWO (MED) assigned to HSWL SC for primary duty as the SAPPS. The HSWL SC SAPPS provides guidance on substance abuse treatment resources and collects required CDAR report data and manages the Work-Life Information Management System (WIMS) for alcohol incidents.
18. Intoxication. A state of impaired mental and/or physical functioning resulting from the presence of alcohol or other intoxicants in the body. Intoxication may

be legally defined as per Uniform Code of Military Justice (UCMJ) Manual, Article 111, and terms that are outlined by state and/or local laws.

19. Medical Officer. Physicians, physician assistants, and nurse practitioners (NP) who are members of the Coast Guard or Public Health Service detailed to the Coast Guard. Civilian medical practitioners (under contract to the Coast Guard or General Schedule employees) assigned to a medical treatment facility are considered medical officers to the limits defined by the language of their contract and/or job description.
20. Patient Placement Criteria (PPC). Personnel are evaluated for placement in the Continuum of Care, utilizing the following seven dimensions reflecting the severity of the individual's problem. (ASAM criterion)
  - a. Acute intoxication and/or withdrawal potential.
  - b. Biomedical conditions or complications.
  - c. Emotional and behavioral conditions.
  - d. Treatment acceptance and/or resistance.
  - e. Relapse potential.
  - f. Recovery environment.
  - g. Operational commitments/patient availability for care.
21. Primary Care Manager (PCM). The medical officer or civilian TRICARE provider charged with managing healthcare, including the authorization of referrals for a prescribed area.
22. Qualified Screener. An AOHCP Coast Guard medical officer. Other licensed physician or psychologist who is trained and privileged to provide diagnostic screening for SUDs. Coast Guard medical officers may request drug and alcohol screening privileges to the Professional Review Committee through the normal privileging process. Attendance at the Addictions Orientation for Health Care Providers (AOHCP) or equivalent (e.g., Certified Addictions Counselor program), or documented professional experience and training in SUDs (last three years), are required for obtaining drug and alcohol screening privileges. The Professional Review Committee will evaluate non-AOHCP training and experience requests for SUD screening privileges.
23. Recovering Alcoholic. A person who's SUD has been suppressed through abstinence and whose sobriety is maintained through a continuing personal program of recovery.
24. Rehabilitation. Restoration to a normal or optimum state of health and constructive activity through medical treatment, physical and/or psychological therapy.
25. Relapse. A return to an addictive drinking pattern.
26. Responsible Alcohol Consumption. According to the National Institute of Alcohol Abuse and Alcoholism, responsible alcohol use is defined as no alcohol

consumption under 21 years of age, no driving under the influence of alcohol, no more than one standard drink per hour and no more than four standard drinks per occasion not to exceed 14 per week for males. Three standard drinks per day not to exceed 7 per week for females.

27. Self-Referral. Members who, on their own accord, seek personal assistance for a perceived alcohol-related problem without occurrence of an alcohol incident.
28. Slip. The short term minimal consumption of alcoholic beverages by someone diagnosed with severe SUD. In 12 Step terms, "Sobriety Loses Its Priority."
29. Spouse. A person whose relationship to the sponsor leads to eligibility for TRICARE medical benefits.
30. Standard Drink. A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). A 12 ounce beer, 8 ounces of malt liquor, 5 ounces of table wine or 1.5 ounces of 80 proof spirits (hard liquor).
31. Substance Abuse. The use of a substance by a member, which causes other (performance of duty, health, behavior, family, community) problems or places the member's safety at risk.
32. Substance Abuse Prevention Specialists (SAPS). HSWL SC personnel assigned to detached duty at major commands that form the Substance Abuse Prevention Program their primary purpose is substance abuse prevention education, CDAR oversight and resource provision for the area of substance abuse.
33. Tolerance. Generally speaking, the amount of alcohol that a person consumes. Clinical definition is the resistance of the body to the pharmacological effects of alcohol or drugs, gradually increasing as use continue, and the body adapts to it.
34. Treatment. Includes inpatient/outpatient medical treatment, counseling, or other appropriate care administered to members in an effort to redirect life patterns and attitudes.
35. Twelve Step/Support Group Meetings. Support groups that meet to help individuals and/or their families cope with the various residual effects of alcohol misuse. The only twelve step or support group meetings authorized for Coast Guard members' aftercare must be "abstinence-based".
36. Withdrawal Symptoms. Characteristic reactions and behaviors resulting from abruptly stopping the use of alcohol or drugs that the body has become reliant upon. Withdrawal symptoms vary in intensity depending on the time, duration, and amount of a substance used. Common reactions include insomnia, anxiety, tremors ("the shakes"), sweating, seizures, and hallucinations ("DTs"). Withdrawal symptoms from alcohol and various drugs can be fatal.

**APPENDIX B. EXERCISE GUIDELINES**

- A. Health-related components of Physical Fitness. There are five components of physical fitness: (1) body composition, (2) flexibility, (3) muscular strength, (4) muscular endurance, and (5) cardiorespiratory endurance. A well-balanced exercise program should include activities that address all of the health-related components of fitness. Aerobic activities develop cardiorespiratory endurance and burn calories to aid in achieving a healthy body composition. Muscle-strengthening activities develop muscular strength and endurance and assist with the development of a healthy body composition. Activities such as stretching and yoga help improve flexibility.
- B. Guidelines. Physical activity guidelines for adults are presented below. Directions for completing a personal fitness plan can be found in reference (a).
- C. Aerobic Activities.
1. According to the Centers for Disease Control, adults should perform 2 hours and 30 minutes (150 minutes) per week of moderate-intensity aerobic activity OR 1 hour and 15 minutes (75 minutes) per week of vigorous-intensity OR an equivalent mix of both.
  2. Aerobic activity should be performed for at least 10 minutes at a time and spread throughout the week.
  3. For greater health benefits, 5 hours (300 minutes) per week at a moderate-intensity level or 2 hours and 30 minutes (150 minutes) at a vigorous-intensity level or an equivalent mix of both is recommended.
  4. The American College of Sports Medicine states that moderate-intensity physical activity between 150-250 minutes per week is effective in preventing weight gain, but will provide only modest weight loss. Physical activity greater than 250 minutes per week is recommended for weight loss and the prevention of weight gain.
    - a. Examples of moderate-intensity physical activities.
      - (1) Walking briskly (about 3 miles per hour or faster but not race walking).
      - (2) Water aerobics.
      - (3) Bicycling, riding less than 10 mph.
      - (4) Tennis (doubles).
      - (5) Ballroom dancing.
      - (6) General gardening.
    - b. Examples of vigorous-intensity physical activities.
      - (1) Race walking, jogging, and running.
      - (2) Bicycling 10 mph or faster.
      - (3) Swimming laps.

## Appendix B to COMDTINST M6200.1C

- (4) Aerobic dancing.
  - (5) Jumping rope.
  - (6) Heavy gardening (continuous digging or hoeing with heart rate increases).
  - (7) Hiking uphill or with a heavy backpack.
- c. Muscle-Strengthening Activities.
- (1) Muscle-strengthening activities should be performed on 2 or more days per week.
  - (2) Muscle-strengthening activities do not count toward the aerobic activity total.
  - (3) All major muscle groups should be worked. These are the legs, hips, back, abdomen, chest, shoulders, and arms.
  - (4) Exercises for each muscle group should be repeated 8 to 12 times per set. As exercises become easier, increase the weight or do another set.
  - (5) Examples: Lifting weights, working with resistance bands, or doing exercises that use body weight for resistance (e.g., push-ups, sit-ups, etc.).
- d. Flexibility.
- (1) Each time you perform aerobic or strength-training activities, take an extra 10 minutes to stretch the major muscle groups.
  - (2) Hold stretches for 10 to 30 seconds and repeat each stretch 3 to 4 times.



**APPENDIX C. PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)**

The PAR-Q is on form CG-6200 and is located on the following site:

[http://www.uscg.mil/worklife/fitness\\_help.asp](http://www.uscg.mil/worklife/fitness_help.asp)

U.S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-6200 Rev. (04-07)	<b>PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)</b>
A PAR-Q should be completed by all nonmilitary participants (civilians, beneficiaries, retirees, and auxiliaries). It is highly encouraged for all military participants.	
<b>READINESS ASSESSMENT</b>	
1. Has your doctor said you have heart trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know or I do not remember	
2. Do you frequently suffer from pain in your chest? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know or I do not remember	
3. Do you often feel faint or have spells of dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know or I do not remember	
4. Has a doctor ever said your blood pressure was too high? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know or I do not remember	
5. Has a doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise or might be made worse with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know or I do not remember	
6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know or I do not remember	
7. Are you over age 65 and not accustomed to vigorous exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know or I do not remember	
If a participant answers yes to any question, vigorous exercise, or exercise testing should be postponed until medical clearance is obtained. "I do not know" answers should be researched further to determine testing suitability.	
<i>I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.</i>	
Name _____ Date _____	
Signature _____ Witness _____	
Reference: PAR Q Validation Report, British Columbia Ministry of Health, 1978.	
<b>PRIVACY ACT STATEMENT</b>	
<b>Authority:</b> 5, 10, and 14 United States Code and Executive order	
<b>Principle Purpose:</b> To complete a Physical Activity Readiness Questionnaire (PAR-Q) prior to beginning an exercise program or test.	
<b>Routine Uses:</b> Used to determine health & fitness readiness according to military standards. Information will be released to authorized personnel involved in health assessment.	
<b>Disclosure:</b> Voluntary; however, failure to furnish the requested information will impede on determining the health and fitness process.	
U.S. DEPT. OF HOMELAND SECURITY, USCG, CG-6200 (Rev. 04-07)	Reset



**APPENDIX D. FITNESS ASSESSMENT PROTOCOLS AND PROCEDURES**

- A. Purpose. These protocols should be used to administer all fitness tests and assessments throughout the Coast Guard including the Deployable Special Forces, Law Enforcement Teams, Maritime Law Enforcement Academy and other training schools where fitness tests are required. Protocols are taken from the Cooper Institute's Physical Fitness Assessments and Norms, for Adults and Law Enforcement 2009.
- B. Safety. There is a natural risk of injury for all personnel participating in physical activity, even those related to improving health. The environment and the characteristics of the participants also contribute to the overall injury risk. Members should seek the advice of the Regional Health Promotion Manager (HPM) or Unit Health Promotion Coordinator (UHPC) for information concerning these risks and how to minimize the possibility of injury. To reduce the potential for injury, commands are responsible to ensure member's level of physical fitness, including acclimatization to environment and what is appropriate for any physical demands required operationally.
1. Support Personnel. The UHPC will ensure at least one Cardio Pulmonary Resuscitation (CPR)-certified monitor, in addition to the UHPC conducting the test, is present for every 25 members participating in a test. Monitors cannot be test participants and do not have to be members of the medical staff.
  2. Medical Emergency Assistance. A safety plan must be in place for summoning emergency assistance. At a minimum, the plan must include telephone numbers and procedures for summoning aid, clear directions for emergency response personnel to avoid confusion and ensure prompt arrival. Include guidance for contacting base security personnel to assist with rapid access of emergency personnel to test site. Cellular phones, walkie-talkies, and other two-way communication devices are acceptable. When a swim test is conducted, at least one certified lifeguard must be present.
- C. Test Site Selection and/or Certification. The UHPC will select the most level 1.5- mile course available. The course will be free of steep inclines and declines, surface irregularities, and sharp turns. Verify or measure course distance with measuring wheel 7 (Usually available from recreation services). A bike odometer may only be used if measuring wheel is not available. Do not use automobile, motorcycle odometers, or GPS devices.
- D. Weather Safety Concerns. The fitness testing shall not to be conducted under harsh environmental conditions. Specifically, the test should not be conducted outdoors when wind chill is 20 degrees Fahrenheit or lower, or when hot weather "black flag" conditions exist (wet bulb globe temperature [WBGT]) of 90 degrees Fahrenheit or higher.
- E. Pre-physical Activity Questions. Prior to the testing, members must be asked pre-physical activity questions. Members recovering from a recent illness or reporting a change in health or risk factors (specifically, a tightness or discomfort in the chest, arms, or neck associated with activity or exercise) are not to be tested. Members reporting a change in risk factors will be referred to medical for an evaluation and medical clearance.
- F. Warm-Up. The UHPC must lead participants in a five to ten minute dynamic warm-up exercise session prior to the start of the tests. The warm up session is not designed to tire members.

- G. Hydration. Adequate fluid intake is vital to safe participation in any physical exercise. Members are encouraged to drink water before and after physical activity, especially in hot weather.
- H. Cool-down. At end of the physical activity, members are required to participate in a cool down period to allow the heart rate to decline gradually. Cool down should last at least five minutes. Without cool-down, members may become dizzy or light-headed.
- I. Injury Reporting. If members are injured during any physical activity, either command-authorized or personal, they shall report their injury to their supervisor and insure they are Fit For Duty or have the appropriate duty status.
- J. Fitness Norms. The norm charts included in this appendix are a representation of how individuals compare to others with regard to performance on the physical fitness tests. The Cooper Institute has one of the largest and most valid data bases in the world with respect to fitness norms. There are two types of norms that the Coast Guard uses for fitness testing:
1. Age and Gender Norms. Age and gender norms are a representation of how individuals in a specific age and gender group compare to one another with regard to performance on physical fitness tests. Age and gender norms are acceptable for use in all Coast Guard fitness tests unless specified by the specific unit instruction.
  2. Absolute Norms. Absolute norms are minimal scores or “cut-points” that have been determined in law enforcement validation studies as the fitness standard that must be attained by everyone regardless of age, gender, or handicapping conditions for the person to be considered fit for duty. Absolute norm tables are not depicted in this appendix but can be found in the manuals that require absolute norm standards.
- K. Procedure and Order of Testing. Following a standardized protocol for order of testing ensures that every fitness assessment is delivered fairly every time. In the case of mandatory fitness tests, where members are required to pass a battery of tests for selection, assignment or maintenance of a unit fitness standard, the member must pass all components of the fitness test at one time. If one component of the test is failed, the entire test battery must be repeated during re-assessment, not just the portion of the test that was failed. According to the National Strength and Conditioning Association, a battery of fitness tests should occur in the following order:
1. Non-Fatiguing Tests (height/weight measurements, body fat tests, vertical jump), then rest for two minutes.
  2. Muscular Strength (sit ups, 1 repetition maximum bench press), then rest for five to ten minutes.
  3. Speed (300 meter run), then rest for five to ten minutes.
  4. Muscular Endurance (push up), then rest for five to fifteen minutes.
  5. Cardiovascular Endurance (1.5 mile run), then cool down for five minutes.
  6. Flexibility.

L. 1.5 Mile Run Test.

1. Test Description. This is a test which measures cardiorespiratory fitness. The runner covers a distance of 1.5 miles in as short a time as possible without undue strain. Aerobic capacity is determined from total elapsed time. The 1.5 mile norms for men and women are based on the Physical Fitness Assessments and Norms for Adults and Law Enforcement. These tables do not represent the pass/fail norms for any specific Coast Guard qualification requirement.
2. Required Equipment.
  - a. Stop watch to time the run to the nearest second.
  - b. An accurately measured, flat, 1.5 mile course or ¼ mile track (6 laps = 1.5 miles).
3. Test Guidelines. The following are some guidelines to be followed in preparation for the 1.5 mile run test.
  - a. Members should not eat a heavy meal or smoke for at least two to three hours prior to the test.
  - b. Members should warm up and stretch thoroughly prior to the test.
  - c. Members should practice pacing themselves prior to the test.
  - d. Members may attempt to run too fast early in the run and become fatigued prematurely. Running partners may accompany members around the track to help pace them.
4. Test Administration.
  - a. Participants should be in good health and currently used to running, not beginners. Before testing, verify that the pre-test screening items have been completed (i.e., PAR Q). The tester should have participants warm-up and cool down after the run.
  - b. Participants should be dressed in clothes ready to exercise, preferably exercise shorts or pants and running shoes.
  - c. Instruct participants to:
    - (1) Warm up by walking at a moderate pace for two to five minutes.
    - (2) The participant runs 1.5 miles as fast as possible. If a 440 yard track is used, 6 laps must be completed using the inside lane (lane 1). If using a 400 meter track, an additional 15 yards must be run after the six laps are completed.
    - (3) During the administration of the test, the participants can be informed of their lap times. Finish times should be called out and recorded.
    - (4) Upon test completion, a mandatory cool down period is enforced. The participants should walk slowly for about five minutes immediately after the run to prevent pooling of blood in the lower extremities.
    - (5) If participants experience any pain or severe shortness of breath or other abnormal signs, they should walk or stop and seek medical attention if necessary.

M. 1.5 Mile Treadmill Test.

1. Test description. The 1.5 mile run event may be conducted on a treadmill at CO's discretion where appropriate facilities and equipment are reasonably available. Treadmill shall have following features:
  - a. Motor-driven running surface belt with emergency stop button.
  - b. Adjustable speed displayed in miles per hour.
  - c. Inclination adjustment.
  - d. Odometer that accurately measures distance traveled in miles.
  - e. 1.5 Mile run and/or Walk Event may be conducted on a treadmill as follows:
    - (1) Member straddle treadmill belt with treadmill inclination set at 1.0 percent. Neither the treadmill belt nor stopwatch is running.
    - (2) UHPC will signal start and member will start the treadmill at desired speed. Member is required to step onto the belt as soon as it starts moving, i.e., not wait until the belt has reached its programmed speed. As soon as member starts running, the UHPC will start the official time using a stopwatch.
    - (3) UHPC will announce the start and call time within two minute intervals until the member has traveled 1.5 miles.
    - (4) Treadmill speed may be adjusted to member's comfort anytime during test.
    - (5) Member may momentarily touch the treadmill's safety bar with fingertips or open palm for safety to recover balance. Member may not, however, grab or hold onto the bar for any reason other than to recover balance.
    - (6) Member is allowed to briefly pause the treadmill to retie a shoelace. No distance shall be counted towards the member's score during the pause. The stopwatch, however, will continue to run.
    - (7) Time is recorded with a stopwatch to nearest second. Although most treadmills are equipped with an accurate time display; only the time recorded by stopwatch shall be used for official scoring. This is done to account for the time to retie a shoelace.
2. Treadmill Test conclusion. The treadmill event is ended when the member:
  - a. Stops running or walking other than to retie shoelace or to remove a foreign object from their shoe (for safety purposes). If this should occur the member must pause the machine.
  - b. Completes 1.5 miles.
  - c. Supports body weight by holding onto or leaning against the treadmill support bar other than to momentarily regain balance (treadmill test only).
  - d. Changes treadmill inclination.

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	< 9:17	< 9:33	< 9:51	< 10:37	< 11:26
Excellent	9:18-10:09	9:34 – 10:46	9:52 – 11:15	10:28 – 12:08	11:27 – 13:23
Good	10:10-11:29	10:47 – 11:54	11:16 – 12:24	12:09 – 13:35	13:24– 15:04
Fair	11:30-12:38	11:55 – 12:58	12:25 – 13:50	13:36– 15:06	15:21 – 16:46
Poor	12:39-14:00	12:59 – 14:34	13:51 – 15:24	15:07 – 16:58	16:46 – 19:10
Very Poor	> 14:00	> 14:34	> 15:24	>16:58	>19:10

**Table D-1: 1.5 Mile Norms for Men (Minutes: Seconds)**

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	<10:28	< 11:00	<11:33	<12:53	<14:05
Excellent	10:29 – 11:58	11:01 – 12:24	11:34 – 13:23	12:54 – 14:34	14:06– 16:33
Good	11:59 – 13:24	12:25 – 14:08	13:24 – 14:53	14:35 – 16:35	16:34 – 18:27
Fair	13:25 – 14:50	14:09 – 15:43	14:54 – 16:31	16:36 – 18:18	18:28–20:16
Poor	14:51– 16:46	15:43 – 17:38	16:32 – 18:37	18:19 – 20:44	20:16 – 22:52
Very Poor	>16:46	> 17:38	>18:37	>20:44	>22:52

**Table D-2: 1.5 Mile Norms for Women (Minutes: Seconds)**

N. One Mile Walk Test.

1. Test Administration. The purpose of this test is to estimate cardiorespiratory fitness level (VO<sub>2</sub> max).
2. An accurately measured course of exactly one mile is necessary. A ¼ mile running track is ideal. A pulse rate monitor device is required for this test. Clients are instructed to walk one mile *as fast as possible*. Running or jogging is *not* allowed. **Immediately upon completion** of the one mile walk, the pulse rate should be recorded from the pulse rate monitor. Do *not* use a ten second pulse check, this will invalidate the test. After completing the test, the client should continue walking slowly for 5 minutes to cool down.
3. Calculation of Estimated VO<sub>2</sub> max. Knowing the client's weight (WT), age, sex, one mile walk time (T) and one mile walk heart rate (HR), a good estimate of VO<sub>2</sub> max can be obtained by using the following formula:

$$\text{VO}_2 \text{ max} = 132.853 - (0.0769 \times \text{WT}) - (0.3877 \times \text{AGE}) + (6.3150 \times \text{SEX}) - (3.2649 \times \text{T}) - (0.1565 \times \text{HR})$$

WT = Weight in pounds AGE = Age in years SEX = 0 for female, 1 for male

T = Walk time in minutes and seconds, to the nearest tenth of a minute  
(seconds divided by 60 = tenths of a minute)

HR = Heart rate in beats/minute at the end of the walk

Compare with norms for VO<sub>2</sub> max in this section to determine percentile ranking and fitness category.

Source: Kline, et. Al. Estimation of VO<sub>2</sub> max from a one mile track walk. *Medicine and Science in Sports and Exercise* 19(3):253-259, 1987.

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	55.5	54.1	52.5	49.0	45.7
Excellent	55.4-51.1	54.0 – 48.3	52.4 – 46.4	48.9 – 43.3	45.6 – 39.6
Good	51.0-45.6	48.2 – 44.1	46.3 – 42.4	43.2 – 39.0	39.5– 35.6
Fair	45.5-41.7	44.0 – 40.7	42.3 – 38.4	38.9– 35.5	35.4 – 32.3
Poor	41.6-38.0	40.6 – 36.7	38.3 – 34.8	35.4 – 32.0	32.2 – 28.7
Very Poor	< 38.0	< 36.7	< 34.8	<32.0	<28.7

**Table D-3: 1 Mile Walk Test Male Norms Max VO<sub>2</sub>**

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	49.6	47.4	45.3	46.1	41.0
Excellent	49.5 – 43.9	47.3 – 42.4	45.2 – 39.6	46.0 – 36.7	39.9– 36.7
Good	43.8 – 39.5	42.3 – 37.7	39.5 – 35.9	36.6 – 32.6	36.6 – 32.6
Fair	39.4 – 36.1.	37.6 – 34.2	35.8 – 32.8	32.5 – 29.9	32.5–29.9
Poor	36.0– 32.3	34.1 – 30.9	32.7– 29.4	29.8 – 26.8	29.8 – 26.8
Very Poor	<32.3	< 30.9	<29.4	<26.8	<26.8

**Table D-4: 1 Mile Walk Test Female Norms Max VO<sub>2</sub>**

	Men Under 40	Men Over 40	Women Under 40	Women Over 40
<b>Excellent</b>	13:00 or less	14:00 or less	13:30 or less	14:30 or less
<b>Good</b>	13:01-15:30	14:01-16:30	13:31-16:00	14:31-17:00
<b>Average</b>	15:31-18:00	16:31-19:00	16:01-18:30	17:01-19:30
<b>Below Average</b>	18:01-19:30	19:01-21:30	18:31-20:00	19:31-22:00
<b>Low</b>	19:31 or more	21:31 or more	20:01 or more	22:01 or more

**Table D-5: 1 Mile Walk Test Norms in Minutes**

O. Push Up Test.

1. Test Description. This test measures muscular endurance of the upper body (anterior deltoid, pectoralis major, and triceps). All fitness assessments should follow the protocol below for the push up test with these exceptions:
  - a. Some health risk assessments require a maximum push up test. Follow the same protocol as the one minute push up test but continue the test until fatigue or until proper form can no longer be maintained. No resting is allowed.
  - b. Some health risk assessments require female participants to use the maximum push-up test in the modified position. The modified push up is performed on the hands and knees with the back straight and hands slightly in front of the shoulders in the up



position. Continue the test until fatigue or until proper form can no longer be maintained. No resting is allowed.

2. Required Equipment.

- a. Gym mat or suitable flooring.
- b. Stop watch or timing device.

3. Test Administration.

- a. Have the member place his/her hands slightly wider than shoulder width apart, with fingers pointing forward. The administrator places one fist on the floor below the subject's chest. If a male is testing a female, a 3 inch sponge should be placed under the sternum to substitute for the fist.
- b. Starting from the up position (elbows extended), the subject must keep the back straight at all times and lower the body to the floor until the chest touches the administrators fist.
- c. Subject then returns to the starting position. This is one repetition.
- d. Resting can only be done in the up position. Both hands must remain in contact with the floor at all times. Exception: Some health risk assessments do not allow any resting and does not have a time limit. The test is terminated when the participant can no longer maintain proper form or until fatigue.
- e. The total number of correct pushups completed in one minute is recorded as the score.

<b><u>Men</u></b>	<b>20 – 29 yrs</b>	<b>30 – 39yrs</b>	<b>40 – 49 yrs</b>	<b>50 – 59 yrs</b>	<b>60 + yrs</b>
<b>Superior</b>	62+	52+	40 +	39 +	28 +
<b>Excellent</b>	47 – 61	39 – 51	30 – 39	25 – 38	23 – 27
<b>Good</b>	37 – 46	30 – 38	24 – 29	19 – 24	18 – 22
<b>Fair</b>	29 – 36	24 – 29	18 – 23	13 – 18	10 – 17
<b>Poor</b>	22 – 28	17 – 23	11 – 17	9 – 12	6 – 9
<b>Very Poor</b>	13 – 21	9 – 16	5 – 10	3 – 8	2 – 5

**Table D-6: Push Up Test Norms for Men 1 Minute Test**

<b><u>Women</u></b>	<b>20 – 29 yrs</b>	<b>30 – 39 yrs</b>	<b>40 – 49 yrs</b>
<b>Superior</b>	42+	39+	20 +
<b>Excellent</b>	28-41	23-38	15-20
<b>Good</b>	21-27	15-22	13-14
<b>Fair</b>	15-20	11-14	9-12
<b>Poor</b>	10-14	8-10	6-8
<b>Very Poor</b>	3 – 9	1-7	0-5

**Table D-7: Push Up Test Norms for Women 1 Minute Test**

\*\* Coopers doesn't have full body push up norms for women over 50.

<b>Women</b>	<b>20 – 29 yrs</b>	<b>30 – 39 yrs</b>	<b>40 – 49 yrs</b>	<b>50 – 59 yrs</b>	<b>60 + yrs</b>
<b>Superior</b>	45 +	39 +	33 +	28 +	20 +
<b>Excellent</b>	36 – 44	31 – 38	24 – 32	21 – 27	15 -19
<b>Good</b>	30 – 35	24 – 30	18 – 23	17 – 20	12 – 14
<b>Fair</b>	23 – 29	19 – 23	13 – 17	12 – 16	5 – 11
<b>Poor</b>	17 – 22	11 -18	6 – 12	6 – 11	2 – 4
<b>Very Poor</b>	< 16	< 11	< 6	< 6	< 2

**Table D-8: Push Up Test Norms for Modified Push Up**

P. Sit-Up Test.

1. Test Description. This is an easily administered test for measuring abdominal strength/endurance. The subject does as many bent knee sit-ups as possible in one minute.
2. Required Equipment.
  - a. Gym mat or suitable flooring.
  - b. Stop watch or watch with a second hand.
3. Test Administration.
  - a. Test subject should be screened for lower back impairment or pain. Persons suffering back pain or high, uncontrolled blood pressure, should not do this test.
  - b. Be sure participants are well instructed in the proper technique. Describe and if needed, demonstrate the correct technique. They may want to practice once or twice before beginning the test.
  - c. Instruct the subjects to:
    - 1 Lie on their back on a mat, knees bent at a 90 degree angle, feet shoulder width apart with heels on the floor and hands cupped behind the ears. Exemption: Some health risk assessments require arms to be crossed in front of the body with fingertips on shoulders.
    - 2 A partner holds the feet down firmly.
    - 3 The subject then performs as many correct sit ups as possible in one minute.

- 4 In the up position, the individual should touch elbows to knees and then return until the shoulder blades touch the floor.
- 5 Breathing should be as normal as possible, making sure the subject does not hold their breath.
- 6 Neck remains in the neutral position. Do not pull on the head or neck.

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60 – 69
Superior	62+	55+	51+	47+	43+	39+
Excellent	51 – 61	47 – 54	43 – 50	39 – 46	35 – 42	30 – 38
Good	47 – 50	42 – 46	39 – 42	34 – 38	28 – 34	22 – 29
Fair	41 – 46	38 – 41	35 – 38	29 – 33	24 – 27	19 – 21
Poor	36 – 40	33 – 37	30 – 34	24 – 28	19 – 23	15 – 18
Very Poor	<36	<33	<30	<24	<19	<15

**Table D-9: Sit-Up Norms for Men 1 Minute**

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60 – 69
Superior	55 +	51 +	42 +	38 +	30+	28 +
Excellent	46 – 54	44 – 50	35 – 41	29 – 37	24 – 29	17 – 27
Good	36 – 45	38 – 43	29 – 34	24 – 28	20 – 23	11 – 16
Fair	32 – 35	32 – 37	25 – 28	20 – 23	14 – 19	6 – 10
Poor	28 – 31	24 – 31	20 – 24	14 – 19	10 – 13	3 – 5
Very Poor	< 28	< 24	<20	<14	<10	<3

**Table D-10: Sit-Up Norms for Women 1 Minute**

Q. Abdominal Curl Ups.

1. Test Description. The abdominal curl-up is an alternative to sit-ups when testing for abdominal strength/endurance. The advantages suggested for this test is that it puts less strain on the back, better isolates the abdominal muscles and minimizes the hip flexors.
2. Required Equipment.
  - a. Gym mat.
  - b. Ruler.
  - c. Small blocks for fingers to touch in order to signal person when they have moved hands 3 inches forward.
  - d. Stop watch with second hand.
3. Test Administration.
  - a. Test subject should be screened for lower back pain. People suffering from back pain or uncontrolled high blood pressure should not do this test.
  - b. Instruct subject to:
    - 1 Lie on their back on a mat with knees bent, feet shoulder width apart.

- 2 Arms are fully extended by the sides, palms down with fingers extended. A piece of masking tape is placed perpendicular to the fingertips of each hand such that the fingertips are at the front edge of the tape. Another piece of tape is placed parallel to and three inches in front of the tape at the fingertips.
  - 3 While holding participant's feet, participant must move both hands along the floor a distance of three inches by flexing the trunk (fingertips are moving from one piece of tape to the next). Upon returning to the floor (shoulder blades touching the floor), one repetition is counted.
  - 4 Instruct the subject to do as many curl-ups in one minute as they can without undue strain and while breathing as normally as possible.
4. Test Scores for the Curl-up. The Cooper Institute does not have norms for the one minute curl up test, nor are there published norms derived from large population studies. The norms below are based on a study published in the Medicine and Science in Sports and Exercise, Volume 13, pages 54-59, 1981. The scores listed above are based on preliminary research and should be used only as a general guideline. Persons can also use their first time test scores as a baseline by which to show future change and improvement with training.

Age	18-29		30-39		40-49		50-59		60+	
Sex	F	M	F	M	F	M	F	M	F	M
<b>Advanced</b>	>45	>50	>40	>45	>35	>40	>30	>35	>25	>30
<b>Intermediate</b>	25-45	30-50	20-40	22-45	18-35	21-40	12-30	18-35	11-25	15-30
<b>Beginner</b>	<25	<30	<20	<22	<18	<21	<12	<18	<11	<15

**Table D-11: Test Scores for the Curl-up**

	15 – 19 yrs	20 – 29 yrs	30 – 39 yrs	40 – 49 yrs	50 – 59 yrs	60 – 69 yrs
Men						
<b>Excellent</b>	60+	54+	45+	39+	33+	29+
<b>Desirable</b>	53 - < 60	46 - < 54	39 - < 45	33 - < 39	28 - < 33	21 - < 29
<b>Needs Improving</b>	48 - < 53	41 - < 46	34 - < 39	28 - < 33	23 - < 28	15 - < 21
<b>Caution</b>	< 48	< 41	< 34	< 28	< 23	< 15
Women						
<b>Excellent</b>	53+	45+	36+	31+	24+	20+
<b>Desirable</b>	45 - < 53	39 - < 45	30 - < 36	25 - < 31	15 - < 24	15 - < 20
<b>Needs Improving</b>	40 - < 45	31 - < 39	25 - < 30	19 - < 25	6 - < 15	5 - < 15
<b>Caution</b>	< 40	< 31	< 25	< 19	< 6	< 5

**Table D-12 Portland State University Curl Up Norms**

R. Flexibility: Sit and Reach Test.

1. Test Description. This test measures flexibility of the hamstrings and low back. Flexibility is not considered a good predictor of overall fitness and is not recommended for inclusion in testing for qualification or selection to a specific team or assignment.
2. Required Equipment.
  - a. Gym mat.
  - b. Flexibility box, or 12” high box and yardstick on box with 15” mark at the edge.
3. Test Administration.
  - a. Test subject should be screened for lower back impairment or pain. Persons suffering back pain should not do this test.
  - b. Be sure participants are well instructed in the proper technique. Describe and if needed, demonstrate the correct technique as follows:
  - c. Have subject warm up with slow stretching movements before attempting this test. An example of a good warm up stretch is a sitting toe touch.
    - 1 Remove shoes.
    - 2 The feet are placed squarely against the box with the feet no wider than eight inches apart. Toes are pointed directly toward the ceiling.
    - 3 The knees should remain extended throughout the test.
    - 4 The hands are placed one hand on top of the other, fingertips even.
    - 5 The yardstick is set on the box such that the 15” mark is flush with the edge of the box.
    - 6 The subject leans forward without lunging or bobbing and reaches as far down the yard stick as possible. The hands must stay together and even and the stretch must be held for one second. Neck should remain in the neutral position.
    - 7 Record the reach to the nearest ¼ inch.
    - 8 Three trials are allowed; the best of the three trials is recorded. Exhaling on the reach is recommended.

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	≥23.4	≥23	≥22	≥21.3	≥20.5	≥20
Excellent	21.7-22.6	20.5-21.8	19.5-21	18.5-20	17.5-19	17.3-19
Good	19-21.4	18.5-20	17.5-19	16.3-18	15.5-17	14.5-16.5
Fair	16.5-18.7	16.5-18	15.5-17	14.3-16	13.3-15	12.5-14
Poor	13.2-16	14.4-16	13-15	12-14	10.5-12.5	10-12
Very Poor	<13.2	<14.4	<13	<12	<10.5	<10

**Table D-13: Sit and Reach Flexibility Norms for Men (inches)**

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	>/=24.3	>/=24.5	>/=24	>/=22.8	>/=23	>/=23
Excellent	22.5-24.3	22.5-23.8	21.5-22.5	20.5-21.5	20.3-21.5	19-21.8
Good	21.5-22.3	20.5-22	20-21	19-20	18.5-20	17-18
Fair	20.5-21.3	19.3-20.3	18.3-19.5	17.3-18.5	16.8-18	15.5-17
Poor	18.5-20	17-19	16.5-17.8	15-17	14.8-16	13-15.2
Very Poor	<18.5	<17	<16.5	<15	<14.8	<13

**Table D-14: Sit and Reach Flexibility Norms for Women (inches)**

S. Vertical Jump Test.

1. Test Description. This test is a measure of jumping or explosive power.
2. Required Equipment.
  - a. Yardstick taped to a smooth wall, and
  - b. Chalk dust or chalk for marking extension when jumping
3. Test Administration.
  - a. Subject stands with one side toward the wall and reaches up as high as possible to mark his/her standard reach.
  - b. Subject jumps as high as possible and mark the spot on the wall above his/her standard reach mark. Prior to jump, one foot must remain stationary on the floor.
  - c. Score is the total inches, to the nearest ½ inch.
  - d. The best of three trials is the score.

Age (years)	20-29	30-39	40-49	50-59
Superior	>26.5	>25	>22	>21
Excellent	24-26.5	22-24.5	19-21.5	17-20.5
Good	21.5-23.5	20-21.5	17-18.5	15-16.5
Fair	20-21	18.6-19.5	15.5-16.5	13.5-14.5
Poor	17.5-19.5	16.5-18.5	14.0-15.0	12-13
Very Poor	< 17.0	<16.0	<13.5	<12

**Table D-15: Vertical Jump Test Norms Men**

Age (years)	20-29	30-39	40-49
Superior	>18.5	>17.0	>13.5
Excellent	17.5-18.0	15-16.5	13-13.5
Good	16.0-17.0	13.5-14.5	11.5-12.5
Fair	14.0-15.5	12-13	9.5-11
Poor	12.5-13.5	11-12	7.5-9
Very Poor	< 12	<11	<7.5

**Table D-16: Vertical Jump Test Norms Women**

T. 300 Meter Run Test.

1. Test Description. This test is an assessment of anaerobic power.
2. Required Equipment.
  - a. 400 meter running track, or
  - b. Any measure 300 meter flat surface that provides good traction
3. Test Administration.
  - a. Allow subject to warm up and stretch before beginning test.
  - b. If using a 400 meter track, participant runs  $\frac{3}{4}$  of one lap (inside lane) at maximum level of effort.
  - c. Time used to complete distance is recorded in seconds.
  - d. Participant should walk for three to five minutes immediately following test to cool down. This is an important preventiionty consideration.

Age (years)	20-29	30-39	40-49	50-59
Superior	<46	<46	<52	<58
Excellent	48-50	47-51	53-57	59-66.4
Good	51-54	52-55	58-64	67-74
Fair	55-59	56-59	65-72	75-83
Poor	60-66	60-68	73-83	84-95
Very Poor	>66	>68	>83	>95

**Table D-17: 300 Meter Run Norms Males**

Age (years)	20-29	30-39	40-49
Superior	<54.3	<56.5	<65
Excellent	56-58.3	60-66	66-72
Good	59.7-61	66.5-71	72-79
Fair	62.7-71	72-79	80.5-94
Poor	74.5-78	80.5-86	101.8-110
Very Poor	>78	>86	>110

**Table D-18: 300 Meter Run Norms Females**

\*\* Coopers does not have 300 meter run norms for women over 50.





**APPENDIX E. SAMPLE UNIT FITNESS INSTRUCTION**

STASARINST 6200.1H

22 NOV 14

STATION NORTH BEACH INSTRUCTION 6200.1H

Subj: STA NORTH BEACH PHYSICAL FITNESS PROGRAM

Ref: (a) Weight and Body Fat Standards Program Manual, COMDTINST M1020.8 (series)  
(b) Health Promotion Manual, COMDTINST M6200.1 (series)

1. PURPOSE. To improve unit readiness while providing its members the tools to adopt healthy habits that they can carry with them throughout their Coast Guard career and beyond.
2. ACTION. All active duty personnel assigned to STA NORTH BEACH (NB) shall comply with this instruction. Reservists and civilian employees are strongly encouraged to participate.
3. DIRECTIVES AFFECTED. Station North Beach Physical Fitness Program, STASARINST 6200.1G is hereby cancelled.
4. DISCUSSION.
  - a. Being healthy involves more than merely having a “healthy weight.” It also involves eating well, exercising regularly, and avoiding harmful habits like tobacco and excessive alcohol use. Physical fitness is recognized as the factor most associated with significant improvements in all areas of wellness. STA NB recognizes the importance of having a crew that is fit and ready for deployment to accomplish all Coast Guard missions wherever the need arises. This instruction consolidates reference (a) with the STA NB physical fitness program.
  - b. The STA NB Physical Fitness Program incorporates these main components:
    - (1) Formal unit-based workout program;
    - (2) Semi-annual weigh-ins;
    - (3) Semi-annual fitness assessments; and
    - (4) Completion of Personal Fitness Plans.
  - c. Supportive leadership is the cornerstone of this program and must exist for the program to be effective. All members have the opportunity to positively influence the health and readiness of their co-workers and subordinates.
  - d. This initiative represents a major lifestyle change for some people and hopefully, all members will realize the value and benefits of the program, not only in increased physical ability to meet the Coast Guard’s missions, but also in personal health.

5. DISCLAIMER. This paragraph provides a disclaimer as to who this guidance affects. See THE COAST GUARD DIRECTIVES SYSTEM, COMDTINST M5215.6 (series) Enclosure (5) for the required wording of this paragraph. Legal will provide other wording if deemed necessary
6. MAJOR CHANGES. List all major changes of significance
7. IMPACT ASSESSMENT. This paragraph will state that a resource impact assessment has been conducted. See THE COAST GUARD DIRECTIVES SYSTEM, COMDTINST M5215.6 (series) Appendix A, Paragraph G of this Manual for further guidance.
8. ENVIRONMENTAL ASPECT and IMPACT CONSIDERATIONS. This paragraph is required in all instructions, manuals, and notices. See THE COAST GUARD DIRECTIVES SYSTEM, COMDTINST M5215.6 (series), Chapter 1, Paragraph I for an explanation of impact considerations and required wording for the paragraph when not applicable
9. DISTRIBUTION. This paragraph tells the reader how the directive will be distributed throughout the Coast Guard. See THE COAST GUARD DIRECTIVES SYSTEM, COMDTINST M5215.6 (series) Chapter 6, Paragraph J.2 for the required wording for this paragraph
10. PROCEDURE.
  - a. Formal unit-based workout program
    - (1) The importance of having a unit-based workout program is to make working out more inclusive, thus providing additional support for those who are just beginning a fitness program. All Unit workout plans must be a balanced program that includes activities to develop all the health-related components of fitness: cardio-respiratory endurance, muscular strength and endurance, flexibility, and healthy body composition.
    - (2) Department heads shall manage this program in close consultation with their Unit Health Promotion Coordinator (UHPC). Department heads are directly and personally responsible for the compliance of each member with this instruction's requirements. It is imperative to the success of the program that they maintain a positive attitude, visible role model, demonstrating their personal commitment and sense of duty to their and their subordinates health and suitability for world-wide deployment.
    - (3) All military members within the unit are required to participate. Reservists and civilian participation is highly recommended and encouraged.
    - (4) Unit workouts will occur at a minimum of three times a week for one hour during normal working hours at a time to be determined by each department head.
    - (5) In addition to the three times a week unit workouts, each member is allowed and encouraged to work out one (1) hour daily for the remaining weekdays.
    - (6) Commands, with the assistance of a designated UHPC and regional HPM, are required to outline a physical fitness program for their unit. The primary focus of these programs will be on activities that produce a training effect (e.g., cardiorespiratory endurance activities such as running, cycling, and brisk walking and muscular strength and endurance activities such as weight lifting and other resistance exercises) in order to improve mission readiness and meet Coast Guard boat crew and law enforcement

physical fitness standards. Unit workout plans will be re-evaluated by department heads and UHPCs on a semi-annual basis, following the fitness assessments in April and October. This will provide opportunity for Unit workout plans and Personal Fitness Plans to be evaluated for their effectiveness.

- (7) Department Heads shall ensure members assigned to detached locations comply with the spirit of the program via regular fitness activities similar to those activities of the division physical fitness program.
  - (8) Prior to a civilian member participating in this fitness program, a Physical Activity Readiness Questionnaire (PAR-Q) will be completed by the member and reviewed by the UHPC. If all answers on the PAR-Q are “no”, the member is cleared to participate immediately. If any answers are “yes”, the member shall follow the steps in the next paragraph.
  - (9) Civilian members who have any positive responses to the PAR-Q questions are required to see their health care provider. The health care provider will determine the extent of the member’s ability to participate in the fitness program. If not cleared for full participation, the member will be required to participate in the program in accordance with any limitations recommended by the health care provider and the member must make a follow-up appointment to be re-evaluated for full participation in the fitness program.
  - (10) Members who exceed MAW standards are still required by reference (a) to see a health care provider to determine if the members can preventively lose weight and participate in an exercise program.
- b. Semi-annual Weigh-ins:
- (1) In accordance with reference (a), all active duty and participating reserve members are required to be weighed on a semi-annual basis during the months of April and October. STA NB’s Admin will administer the weight probation program. Selected reserve members who exceed MAW will have limits imposed on the types of duties that they can perform and will be required to participate in physical fitness activities during IDT drills and annual training (ADT).
  - (2) For members exceeding their MAW, a tensiometer tape will be used to ensure the accuracy of body fat measurements. Members exceeding both their MAW and body fat percentage will be placed on probation, during which they must lose their excess weight or body fat. Once placed on probation, the member will be required to complete a record of food intake for a 2-week period using a log provided by their UHPC. This log is to be used to raise individual awareness of dietary habits and as reference material during the initial consultation with a medical officer and discussion with a regional HPM. Department heads will be personally involved in monitoring a member’s compliance with the weight probation program requirements, including ensuring a member is referred to the regional HPM. The UHPC can be used to assist in these monitoring activities but shall not be expected to enforce the requirements.
- c. Semi-Annual Fitness Assessment:
- (1) STA NB will use the physical fitness standards followed by Coast Guard boat crew and law enforcement personnel. These standards are required to ensure members have

sufficient strength and endurance to perform duties during normal and adverse conditions. Only those members found by a health care provider to be medically incapable of completing the primary battery test requirements will be administered an alternate test. Appendix E of reference (b) contains assessment standards and protocols for primary and alternate test batteries.

- (2) All military members (active duty and reservists) assigned to STA NB will complete the Physical Fitness Assessment twice a year in April and October. UHPCs are responsible for the scheduling and administering of the fitness assessment. A makeup fitness assessment will be scheduled within 2 weeks for those members unable to participate in the all-hands session.
- (3) All members who attain the minimum boat crew/LE standards for all components of the fitness assessment will be granted 4 hours of special liberty. All members who attain fitness scores in all components of the assessment that fall into the “good” category or higher will be granted 8 hours of special liberty. Civilian employees will also be given the opportunity for a time off award under the same circumstances as military members. Department heads shall submit time off awards for their civilians meeting the requirements. (Reservists who achieve a “good” or higher should also be recognized through authorized means – consult COMDTINST 5320.3 Reserve Force Readiness System (RFRS) Staff Responsibilities for guidance.)

d. Personal Fitness Plans:

- (1) Physical training works best when you have a plan. Keys to beginning and maintaining a successful program include starting slowly, increasing intensity and duration gradually, finding a training partner, varying the activities and intensity of the program and expecting fluctuations and lapses.
- (2) Upon reporting to STA NB, all military personnel shall develop a Personal Fitness Plan, Form CG-6049, which will be presented to their supervisor. Personal Fitness Plans shall address the health-related components of physical fitness and be well-balanced (e.g., incorporate specific activities that maintain and/or improve cardiorespiratory endurance, muscular strength and endurance, flexibility, and a health body composition). Personal Fitness Plans shall also include at least 3 days a week of vigorous physical activity. For assistance with completing a Personal Fitness Plan, contact your regional HPM.
- (3) Depending on the physical fitness of the member, engaging in a regular physical exercise during pregnancy is perfectly prevention and can help ease some pregnancy symptoms. Members who are pregnant are required to obtain a recommendation from their Obstetrics and Gynecology (OB/GYN) doctor during their first prenatal appointment on whether their condition allows them the ability to engage in a regular exercise program. After an exercise prescription has been obtained and the member is cleared by their OB/GYN doctor for exercise, the member may participate in the STA SAR fitness program according to the health care provider’s recommendations.

e. Unit Health Promotion Coordinator (UHPC):

- (1) Units shall maintain at least one trained UHPC to help administer this program.

- (2) UHPCs will assist Department Heads with the administration of their unit-based workout program.
- (3) UHPCs will be included on the check-in sheet for newly arriving members. During the check-in process, UHPCs will review the PFP with the new member.
- (4) UHPCs will lead the Unit Health Promotion Committee which will include representatives from the Galley, Morale Committee, and the unit CDAR. The committee will continually review the effectiveness of the fitness program and, when necessary, suggest revisions to ensure the program's purpose is met. The Health Promotion Committee will coordinate quarterly all-hands wellness events. The UHPC chairperson is the owner of this instruction and will report directly to the commanding officer.

11. RECORDS MANAGEMENT CONSIDERATIONSS. This paragraph is required in all instructions, manuals, directive change notices, and notices. See THE COAST GUARD DIRECTIVES SYSTEM, COMDTINST M5215.6 (series)Chapter 11 of this Manual for an explanation of impact considerations and required wording for the paragraph when not applicable

12. POLLUTION PREVENTION (P2) CONSIDERATIONS. Pollution Prevention considerations were examined in the development of this directive and have been determined to be not applicable.

13. FORMS/REPORTS.

- a. Physical Activity Readiness Questionnaire (PAR-Q);
- b. Fitness Assessment Standards and Protocols;
- c. Personal Fitness Plan, Form CG-6049;
- d. Physical Activity Readiness Medical Examination Form (PARmed-X); and,
- e. Nutrition Log.