

of volatile options positions, liquidation could be uncertain and, moreover, could contribute to market instability. Nevertheless, if OCC was unable to liquidate collateral or forced to liquidate in a chaotic market, OCC would be exposed to loss due to a decrease in collateral value. The proposal addresses those problems.

Under the proposal, OCC would be authorized specifically to defer collateral or position liquidation and to hold any collateral or options positions not liquidated. To protect against a change in the value of collateral or options positions, OCC would be authorized to execute hedging transactions including the purchase or sale of underlying interests and the purchase or sale of securities options or futures positions.<sup>10</sup> The proposal also would authorize OCC to borrow funds from its clearing funds to finance such protective or hedging transactions.<sup>11</sup>

<sup>10</sup> For example, OCC could purchase underlying equity securities to hedge exposure on short options positions and could buy or sell stock index futures contracts to hedge exposure from short stock index options. OCC also could engage in stock options transactions to hedge against a decline in value of equity securities held as margin deposits.

<sup>11</sup> See Securities Exchange Act Release No. 18900 (June 17, 1980), 45 FR 41920. In setting out the standards to be used by the Division of Market Regulation ("Division") in reviewing and making recommendations with respect to the registration of clearing agencies, the Division has stated that, in addition to the defaults of participants, the clearing fund should be used to protect the clearing agency from losses (not including day-to-day operating expenses) such as losses of securities not covered by insurance or other resources of the clearing agency. The Release specifically provides for temporary use of a limited portion of the clearing fund to meet unexpected and unusual clearing agency requirements for funds. The Release however, further suggests that a portion of the clearing fund may be used for a legitimate purpose for a longer period of time, provided that: (1) The funds are properly protected; (2) the funds are used to facilitate the process of clearance and settlement; and, (3) participants and the Commission specifically approve such use during registration proceedings. *Id.*, 45 FR at 41929. Nevertheless, in an Order concerning the structure of National Securities Clearing Corporation's ("NSCC") clearing fund, the Commission recognized that the universe of permissible uses is larger than unanticipated uses and specifically approved certain other uses. In that Order, the Commission approved NSCC's short-term pledge of clearing fund assets other than cash as collateral for loans to satisfy temporary losses or liabilities incident to its clearance and settlement business. In NSCC's program, the pledge of clearing fund assets, if not repaid within 30 days, results in the pledge being deemed a clearing fund assessment under NSCC's rules. Securities Exchange Act Release No. 18230 (November 10, 1982), 47 FR 51908.

On August 3, 1989, OCC amended the proposal, and Article VIII of OCC's By-laws, to provide that any borrowing by OCC against OCC's clearing funds, if outstanding for more than thirty days, will be considered an actual loss and immediately allocable to clearing members as a pro-rata assessment. See Letter from James C. Yong, Assistant Vice President and Deputy General Counsel, OCC, to Jonathan Kallman, Assistant Director, SEC, dated August 1, 1989. Revised OCC

under the proposal, OCC management must inform OCC's Board of Directors within 24 hours of any determination to authorize hedging transactions.<sup>12</sup>

The Commission notes that any exercise by OCC of the authority granted by the proposal could have implications for OCC, its members, those members' customers, and financial markets generally. OCC's use of its clearing funds, without a pro rata assessment of OCC's members, would decrease available OCC clearing fund assets, but generally not affect adversely assets available to clearing members.<sup>13</sup> OCC's deferral of option position liquidation would alter current expectations of immediate liquidation, but could minimize liquidation losses to customers of a suspended OCC member. Liquidation deferral also would affect the timing and nature of asset liquidation in underlying markets and the effects of such a liquidation on those markets. Moreover, delayed liquidation and hedging activity by OCC could affect liquidity demands and responsibilities applicable to market participants.

The Commission believes, that prudent and thoroughly-considered use by OCC of the authority granted by the proposal should enable OCC to avoid potentially harsh and uncertain consequences that could result from a forced, immediate liquidation in extraordinary circumstances of the assets and positions of a suspended OCC member. In this regard, the

By-law Article VIII, Section 5(f), File No. SR-OCC-87-22.

<sup>12</sup> Under the proposal, a deferral of liquidation or execution of hedging transactions must be based upon a determination by OCC's Chairman or President, taking into account the size and nature of a suspended clearing member's margin deposits and options positions, the market conditions prevailing at the time, the potential market effects of liquidating transactions that might be directed by OCC, and such other circumstances as much officer deems relevant, that the conversion to cash of some or all of the suspended clearing member's margin deposits or the closing out of some or all of the suspended member's unsegregated long positions or short positions would not be in the best interests of OCC, other OCC clearing members, or the general public.

<sup>13</sup> OCC clearing members' contributions to the OCC clearing funds constitute net capital for the purposes of Rule 15c3-1 under the Act. In the event of an OCC pro rata assessment of its members' clearing fund deposits, clearing members must restore their clearing fund contributions with other assets or face suspension by OCC and a potential capital deficit under Rule 15c3-1.

The Commission expects OCC to use its concentration monitoring system to analyze the ability of its clearing members to pay to OCC on a pro rata basis the amount of any loan from the clearing fund and will consider scheduled assessments or special requirements for clearing members who do not reasonably appear able to meet those obligations in light of their open options positions and trading activity.

Commission notes that OCC has represented that it would consult, if feasible and prudent under the circumstances, with the Commission and appropriate authorities prior to or contemporaneous with exercise of its authority under the proposal. Those authorities, based on the circumstances, could include SIPC, registered securities exchanges, the National Association of Securities Dealers, OCC clearing banks, the Commodity Futures Trading Commission, and futures contract markets. The Commission believes that such consultation would place OCC in the best position to analyze the overall effects of its actions concerning liquidation and hedging activity.

Nevertheless, the Commission recognizes that in some situations prompt action by OCC may be necessary and consultation infeasible.

#### IV. Conclusion

For the reasons discussed above, the Commission finds the proposal is consistent with the Act and Section 17A in particular.

Accordingly, *It is therefore ordered*, under section 19(b)(2) of the Act, that the proposal (SR-OCC-87-22) be, and it hereby is, approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Dated: August 8, 1989.

Jonathan G. Katz,  
Secretary.

[FR Doc. 89-19070 Filed 8-14-89; 8:45 am]  
BILLING CODE 8010-01-M

## SELECTIVE SERVICE SYSTEM

### Proposed Health Care Personnel Delivery System (HCPDS)

AGENCY: Selective Service System.

ACTION: Request for comments.

**SUMMARY:** The Selective Service System seeks public comments on the development of its Health Care Personnel Delivery System (HCPDS).

**DATE:** Comments from the public should be submitted in writing no later than September 29, 1989.

**ADDRESS:** Send comments to Richard S. Flahavan, Associate Director for Operations, Selective Service System, 1023 31st Street, NW., Washington, DC 20435, telephone (202) 724-0851.

**SUPPLEMENTARY INFORMATION:** Section 10(h) Military Selective Service Act, as amended by section 715, Pub. L. 100-180, approved December 4, 1987, in pertinent part, provides:

The Selective Service System (SSS) is a component of the Department of Defense (DOD) and is responsible for the administration of the Selective Training and Service Act (STSA) and the Military Selective Service Act (MSSA). The SSS is a federal agency that is part of the DOD and is responsible for the administration of the STSA and the MSSA. The SSS is a federal agency that is part of the DOD and is responsible for the administration of the STSA and the MSSA.

The Health Care Personnel Delivery System (HCPDS) is a proposed system that would allow health care personnel to be assigned to military units. The HCPDS would be a part of the SSS and would be responsible for the administration of the HCPDS. The HCPDS would be a part of the SSS and would be responsible for the administration of the HCPDS.

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"The Selective Service System shall be maintained as an active standby organization with (1) a complete registration and classification structure capable of immediate operation in the event of a national emergency (including a structure for registration and classification of persons qualified for practice or employment in a health care occupation essential to the maintenance of the Armed Forces) \* \* \*"

The Health Care Personnel Delivery System (HCPDS), when implemented, will enable the Selective Service System to fulfill its statutory responsibility.

Samuel K. Lessey, Jr.,  
Director of Selective Service.

## Health Care Personnel Delivery System—(HCPDS)

### Part I—Introduction

1. *General.* Section 715 of Public Law 100-180, signed by the President on December 4, 1987, directed the Selective Service System (SSS) to develop a system, capable of immediate operation in the event of a national emergency, for the postmobilization registration and delivery of health care personnel to the Department of Defense (DOD) in the required number, mix, and time frame.<sup>1</sup> This paper recommends an operational concept for a standby Health Care Personnel Delivery System (HCPDS) as prescribed by that law. This operational concept will be the basis for developing detailed implementing policies and procedures, including an automated data processing (ADP) functional description. A system flow chart which presents a graphic overview is at Annex A. Subsequent implementation will include development of an HCPDS mobilization timetable, prototype forms, reports, operational manual policies and procedures, and other specific details and products as required. Although the operational concept presented is consistent with the latest position of DOD and selected Federal agencies, it remains subject to change as:

May be directed by Selective Service leadership.

Progress is made in obtaining more definitive delivery schedules from DOD.

DOD initiatives directed at reducing wartime military health care personnel shortfalls reduce mobilization requirements.

May be required upon receipt of comments from DOD and outside sources, including health care personnel associations.

2. *Scenario.* Selective Service was charged to develop a postmobilization system. Accordingly, the HCPDS components covered here are those which are crucial to responding to DOD's initial mobilization requirements in a worst case, conventional conflict

scenario involving little or no warning. Maximum effort is being devoted to ensuring that the initial postmobilization components are operational as soon as practicable within the constraints imposed. Within that context, this paper provides for those crucial HCPDS components.

3. *Definition of Terms.* See Annex B, Definitions, Abbreviations, and Acronyms.

4. *Objectives.* This operational concept is based upon the following objectives and characteristics: rapid response, equity, flexibility, simplicity, workability, acceptability, balancing military and civilian needs, paralleling the procedures of the Registrant Information and Management System (RIMS) where practicable, and interfacing with RIMS.

5. *Facts—*a. *Congressional and presidential authorization required.* No Selective Service processing of health care personnel (registration, classification, selection, or issuance of induction orders) can be undertaken until the Congress provides statutory authority and the President directs such processing.

b. *Legislation.* A standby legislative package was coordinated previously with DOD, including the Joint Chiefs of Staff (JCS) and the military services. That legislative package, when enacted, would provide the authority to process health care personnel for induction upon mobilization. The Office of the Assistant Secretary of Defense for Force Management and Personnel (OASD-FM&P) now has this legislative package and plans to include it in a DOD Emergency Actions Packet. The HCPDS concept was developed within the framework of that proposed legislation. Changes to this legislation have been developed and submitted to DOD by letter to ensure full compatibility with the HCPDS.

c. *Inability to meet DOD requirements.* DOD understands that Selective Service cannot meet DOD's "worst-case scenario" mobilization requirements for health care personnel. Selective Service will be reviewing options to ensure that time frames are as realistic and short as possible. The speed with which Selective Service can implement HCPDS and begin making first health care personnel deliveries is dependant upon the level of preliminary preparation authorized and achieved. Technical advancements and improved contingency agreements will be reviewed to reduce time frames.

d. *Continued DOD recruiting.* DOD plans to undertake a major health care personnel recruiting effort upon any mobilization and continue recruiting

from among health care registrants at least through M+90, the same as DOD plans for recruiting untrained manpower from among regular registrants. Selective Service will not accept and process health care personnel as volunteers for induction during that period at mobilization. A proposed revision to the Military Selective Service Act (MSSA) provides authority for the addition of a volunteer program by regulation should the need arise.

e. *Inclusion of females.* No question exists that Congress will make the final decision at the proper time, whether to include females with males, and the mix, if other than on a full share basis, in any health care personnel draft. This concept envisions including females without restriction. To be prepared for any contingency, the HCPDS will be constructed to accommodate males alone or any mix of the two as prescribed by proper authority.

6. *DOD Mobilization Requirements.* DOD continues to refine the numbers of health care personnel needed for mobilization. Annex D shows DOD's requirements by individual titles of specialties provided to Selective Service. These requirements listed shortfalls of 109,948 health care personnel which could require delivery starting at D+10 in a worst case scenario. The mobilization requirements are based on assumptions and computer modeling and subject to change. The HCPDS will be flexible enough to respond to such changes, i.e. in specialties, numbers, and/or delivery times.

7. *Use of RIMS Methods.* RIMS, the system designed to process regular registrants, has been evaluated in many mobilization exercises. The system has been enhanced and has proven an effective registrant processing system. Portions of the HCPDS concept are modeled on some of the tested operational and ADP methods, forms, and reports where practicable. Functionally, HCPDS will perform many RIMS tasks and operations, but the "how" and "when" of actually performing these operational and ADP tasks in many instances are quite different. The integration of the health care system with current systems and procedures enables Selective Service to accelerate development, conserve resources, and provide for ease of administration vs. a "standing start." Besides annotating the records of dual registrants, discussed later herein, this integration of systems may very well impact the existing regular registrant RIMS in some other ways.

**8. Follow-on Developmental Efforts.**

Selective Service follow-on efforts will include the development of additional HCPDS components, a "steady-state" operating system, logistical support plans and agreements, and plans for exercising and, if necessary, refining the system components.

a. *HCPDS components.* Additional HCPDS components, not critical to meeting the initial requirements, include the induction of overseas registrants, a Compliance System Component, and an Alternative Service System Component. These important components will be added later and utilize as much of the existing systems as practicable.

b. *"Steady-state" system.* After any postmobilization activation and initial operations, Selective Service expects a transition to a "steady-state" operating system for health care registrants similar to that being developed for regular registrants. To the extent practicable, HCPDS emergency procedures will be designed for the transition to a steady-state HCPDS operation.<sup>2</sup>

**9. Coordination and Approval.—a.**

*General.* Selective Service has informally coordinated this paper with other Federal agencies. Approval of an operational concepts for HCPDS by the Director is required before finalizing a detailed functional description and building an automated system.

b. *Coordination with DOD.* Coordination with DOD is required on proposed legislation, the registration proclamation, requirements, and proposed induction policies and procedures.

c. *Coordination with other Government agencies.* Coordination with several other government agencies is also required. There are many agencies with mobilization authorities, responsibilities, and plans which relate to this project. Interagency factors will be identified and addressed to make HCPDS an integral part of overall national policies and plans. The following agencies have roles which interface with the Selective Service System in the development of the HCPDS procedures.

- (1) Policy planning agencies
  - Office of Management and Budget (OMB)<sup>3</sup>
  - Department of Health and Human Services (DHHS)
  - Federal Emergency Management Agency (FEMA)
  - Veterans Administration (VA)
- (2) Support agencies
  - U.S. Postal Service (USPS)
  - Department of State (DOS)

Internal Revenue Service (IRS)  
Social Security Administration (SSA)  
Government Printing Office (GPO)  
Department of Justice (DOJ)  
Other agencies as required.

d. *Interface with health care associations.* This HCPDS concept has been the subject of informal discussion with several health care associations.<sup>4</sup> Additional such coordination with these associations is planned as the concept is further refined.

e. *Public comment.* Publication in The Federal Register is planned.

10. *Maintenance of System.* A completed and tested HCPDS plan would go "on the shelf" and be periodically reviewed, updated, and tested to keep it viable for implementation.

**Part II—Registration**

1. *General.—a. Who.* The registration of civilian health care personnel will be required as specified in a Presidential Proclamation. Active duty military personnel and lawfully admitted nonimmigrant aliens are exempt from registration as provided by the MSSA. Those registered will include only individuals who are professionally qualified, or who later become so qualified, and who are age 20 through 44 inclusive.<sup>5</sup> Males already registered as regular registrants are required to register again as health care personnel. Both their regular registrant records and HCPDS records will be annotated.<sup>6</sup> A registrant will be registered in no more than one medical specialty at a time, the specialty with the highest education and/or experience requirements, with due consideration being given to skill specialties considered in critically short supply.

b. *Where.* Registration sites now used for regular registrants will be used. The current sites for regular registration are U.S. Postal Service (USPS) classified sites within the States, possessions, and territories, and Department of State (DOS) posts overseas. Additional registration sites will be used if required.<sup>7</sup>

c. *How.* Registration of health care personnel will be conducted in two major phases: an initial mass registration followed by continuous registration. Special supplemental registration(s) of additional health care personnel would be conducted if dictated by the developing situation. Registration procedures will parallel those currently used for regular registrants where possible. Where necessary, existing procedures will be modified or new procedures developed.

d. *Support.* Rapid collection of registration information requires ADP

support by outside agencies and/or contractors because regular registrant induction processing would utilize fully the available processing capability. Forms and materials will be distributed initially by the printing contractor, in predetermined size packs, using USPS and DOS distribution plans.

Replacement USPS stocks will be positioned at USPS Management Sectional Centers (MSC) until adequate stocks are placed in the two USPS Supply Centers. DOS replacement stocks will be positioned at Selective Service National Headquarters.

e. *Flow chart.* See the system flow chart, annex A.

2. *Initial Mass Registration.* Persons who are of registration age on the base date established and who are qualified as health care specialists will be required to register in the mass registration. The base date will be a date about six months in advance of the first day of the mass registration. Both these dates will be established in the registration proclamation. This registration will last approximately seven days including weekends in order to accomplish the anticipated 3.4 million registrations.

3. *Continuous Registration.* Continuous registration commences two weeks after the end of the initial mass registration. The following persons will be required to register: Those becoming newly qualified as health care specialists required to register; Those qualified health care personnel of an age and of a health care occupation required by a registration proclamation to be registered;<sup>8</sup> Those required to register previously who failed to do so.

4. *Special Mass Registration.* To cover additional specialties and/or age groups, special mass registrations could be conducted, but will be avoided if at all possible.<sup>9</sup>

5. *Registration Material Production and Distribution.—a. Items for registration sites.* Stocks of the following items required to implement health care personnel registration will be printed and delivered to each using site in the Continental United States (CONUS): Registration Forms; Instruction/Information sheets for the persons completing registration forms; Instruction sheets for registration site personnel; Mailing/control forms for use by registration site personnel.<sup>10</sup>

b. *Advance arrangements.* Camera ready prototypes of each item will be prepared in enough copies to satisfy printing at regionally located contractor sites. Emergency requisition will be placed with UNICOR,<sup>11</sup> or other GPO approved printing facilities, in advance

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for expedited action on M-Day, or earlier, in event authority to print should be received prior to M-Day. Requisitions will specify various sized packages of the items for direct delivery to the using sites. Electronic delivery of prototype forms and materials for use at DOS posts is being explored.

*c. Distribution.*

(1) *USPS.* Shipments to USPS sites will be presorted by the contractor into MSC groupings and addressed to the ultimate registration site.

(2) *DOS.* Predetermined sized packages will go forward to each DOS post via Air Pouch to ensure the most reasonable delivery time if a program of electronic transmission cannot be implemented.

(3) *Other possibilities.* Additional means of providing registration forms to registrants will be explored as backup for supplemental methods of facilitating the registration of health care personnel, such as by direct mail or as stuffers in health care oriented newspapers or periodicals (involving a mail-in registration form), or through the use of registrars who would report to facilities having large concentrations of health care personnel to be registered.

*6. Collection of Registration Information—*a. *USPS Sites—*(1) *Initial mass registration.* Initially, each individual registration site will forward completed forms on a daily basis to a predesignated control and processing point for counting, batching, keying, and microfilming/indexing during the mass registration period where practicable. That facility will accomplish the stated control measures before forwarding the source documents to the selected input points for collection and initial processing of the registration input. IRS, SSA, UNICOR, and/or other agencies may be used in this regard. Input will be collected and transmitted to the Selective Service Data Management Center (DMC) on a daily basis. After collection of the registration input, original source documents would be forwarded to Selective Service as established in Memoranda of Understanding.

(2) *Continuous registration.* During continuous registration, forms will be forwarded every Friday. The input center(s) will forward input results to the DMC, which will consolidate and process the input from all registration sites. The DMC will produce listings and resolve abnormal file conditions utilizing available resources. In each instance tape or other appropriate backup will be provided to SSS along with the original source document(s).

b. *DOS.* State Department posts will return completed forms to the single

designated Selective Service control processing point on a weekly basis using Air Mail or Air Pouch. Further processing would be identical to that shown in 6a above.

*c. Transmittal and control.* Control/report forms will be mailed each time a site forwards completed registration forms or transmitted registration data. One copy will be enclosed with the mailing. If transmitted electronically or by magnetic tape, a header will contain information normally included on the hard copy control/report form mailed with completed forms.

*7. Error Correction.* Error correction and/or data base editing will be accomplished by SSS primarily using written contact with the registrant.

*8. Registration Acknowledgments.* Official registration acknowledgments will be mailed in the same manner as for regular registrants.

### Part III—Selection and Induction

*1. General.* The proposed selection and induction portion of the HCRDS Induction, Claims, and Appeals automated system parallels, inasmuch as practicable, the current version of the RIMS Manual which describes regular registrant procedures that are ready to become operational in the event of a full-scale military mobilization; it is essentially a one-step combined examination/induction process.

*2. PSG-M Assignment.* The first step in the induction process is the assignment of a Random Sequence Number (RSN) and Priority Selection Group—Medical (PSG-M) to each registrant record. Health care personnel registering in the initial mass registration will have their registration records established in the HCPDS data base as a group on the same date and will be assigned RSN's from a Selective Service lottery held upon mobilization. All registrants from the initial mass registration will be assigned to the First Priority Selection Group—Medical (PSG-M) for 365 consecutive days, which period constitutes their year of prime vulnerability. The clock will start on the same day for all initial mass registrants. The first priority group will also include other health care personnel, either late mass registrations or continuous registrants who register later, using their accession date as a start date. Each of these registrants will remain in the first priority for an individual 365 day period, starting with the establishment of a valid registration record in the data base. An RSN from a lottery table will be assigned to each new record.

*3. Selection.* Selection of health care registrants for induction within their specialty is based upon: Priority

Selection Group—Medical; Year of Birth (YOB), within the PSG-M, from youngest to oldest; Random Sequence Number within each individual YOB group.

If registrants are depleted in the First Priority Selection Group, selection continues from the second and then progressively lower selection groups.

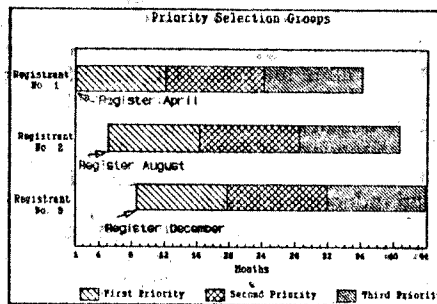


Illustration No. 1

This illustration shows three registrants: the first registered at the completion of the initial mass registration in month 1 (e.g. April); the second and third registered later when they became qualified as health care personnel, one in month 4 (August), and the other during month 8 (December). From months 8 through 12 (December through March) all are in the First PSG-M together. If none of the three are reached for induction, Registrant No. 1 moves to the second priority group in month 13 (i.e. the next April), Registrant No. 2 moves to second priority the next August, and registrant No. 3 the next December.

*4. Overall.* In order to ensure that DOD requirements are met, enough registrants must be ordered for induction to cover losses due to postponement, deferment and exemption requests, failures to report, and disqualifications by DOD.

a. *DOD rejection rates.* Under the former "doctors' draft," registrants practicing their professions in the private sector were considered able to do the same in a military health care environment notwithstanding physical conditions which would cause rejection as a regular registrant. If similar standards are applied under an HCPDS scenario, the DOD rejection rate for health care personnel should be significantly lower than that estimated for regular registrants.

b. *Other fall-out rates.* It is likely that the overall rate will vary depending upon the specialty called and the demographics of the population being

ordered. Registrants in the technical level specialties will have different postponement, deferment, and exemption rates than will physicians. Populations which are principally female, such as nurses or dental technicians, may have many mothers who could request hardship deferments.

Estimates of the expected fall-out rate will be made using the best historical and demographic data available. These losses will then be converted to an overcall factor and this factor applied to each specialty required by DOD in order to determine the PSG, YOB, and RSN cut off number used to select the registrants to be called for induction.

5. *Sequence of Processing.* The sequence of SSS actions for selection and induction follows:

a. Receive specific requisition from DOD.

b. Calculate the number of registrants to be ordered for induction by specialty to meet the DOD requirement and set PSG-M/YOB/RSN cut-off for each specialty.

c. Select and order registrants for induction by specialty according to the order of call shown below.

d. Process registrant claims for postponement, deferment, and/or exemption.

6. *Order of Call.* Registrants will be selected for induction in the following sequence:

a. Registrants whose claims have been denied, registrants whose "reexamination believed justified" dates have expired, and registrants who have been classified 1-A-OM.

b. Registrants whose postponements have expired in the order of the date of expiration of the postponement. If necessary, the RSN shall be used as a tie breaker for registrants in a postponement expired status.

c. Registrants whose deferments have expired or who no longer qualify for exemption in RSN sequence. Selection will begin with registrants from the youngest YOB groups, then by RSN.

d. Registrants in the First Priority Selection Group—Medical. Selection will begin with registrants from the youngest YOB group, then by RSN.

e. Registrants in the Second and succeeding lower Priority Selection Groups—Medical in the same manner as above.

7. *Induction.* a. *Assignment to local board and area office.* Assignment to a Local Board and Area Office will be made at the time the registrant is initially selected for induction based on the registrant's permanent address. The ZIP Code Assignment File will be used to determine the local board/area office

covering the registrant's permanent address ZIP Code.

b. *Scheduling to MEPS and issuance of induction order.* Registrants will be scheduled to a MEPS on the basis of their permanent address ZIP Code in accord with the ZIP Code Assignment File. An alternate MEPS, as specified in the file, will be used to adjust for overfill/underfill at the individual MEPS. The first induction notice will be mailed to the current address.

Registrants will be ordered by mailgram to report to the MEPS on a date not earlier than 10 days from the date of mailing of the order. The orders will specify the documentation required to determine professional qualifications and thus each will be tailored to the specialty called. Registrants initially ordered for induction will be issued an "Order to Report for Induction." Previously ordered registrants will be issued either an "Order to Report for Induction" or a "Notice of Rescheduled Induction Reporting Date" depending on their current status. Procedures will be the same as those which exist in RIMS. Registrants residing overseas will be issued orders by letter and will be scheduled to report to an overseas military location.

c. *MEPS processing.* When an ordered registrant appears at the MEPS, he is examined to determine physical, moral, and professional/technical qualifications. The results of this processing are entered into the MEPS reporting system and transmitted to SSS via MEPCOM.

8. *Information for registrants.* A publication similar to the current Information for Registrants booklet will be available to the public at Post Offices and all Selective Service Offices to provide additional information on induction and claims processing.

9. *Dual Registrants.* Dual registrants are those who register both as regular and as health care registrants. As mentioned in Part II—Registration, records of dual registrants will be annotated to denote inclusion in both data bases. Once a record is annotated on the RIMS data base, processing as a regular registrant ceases and further processing takes place under HCPDS procedures from the HCPDS data base.<sup>13</sup>

#### Part IV—Classification, Claims, and Appeals

1. *General.* Classification is the exercise of the authority to determine claims or questions on inclusion or exemption from training and service under the MSSA. The narrative in this Part and the flow chart at Annex A describe the proposed classification,

claims, and appeals component of the HCPDS concept. This component is crucial to ensuring the protection of all registrants' rights. The basic classification structure established for RIMS will be used for health care registrant processing. Where practicable, this system will incorporate current regular registrant processing procedures contained in RIMS.

2. *Classification Structure.* The various classification bodies and the authority of each are as follows:

a. Upon activation of HCPDS, the Director of Selective Service assigns classification 1-HM (not currently subject to induction processing) to all health care registrants. Upon receipt of a requisition for health care personnel from the Secretary of Defense, all health care registrants selected for induction are assigned to Class 1-AM (available for unrestricted military service). In addition, the Director will classify a health care registrant into an appropriate class when the Secretary of Defense has certified the registrant to be a member of the Armed Forces, active or reserve, or the registrant has been found disqualified for service.

b. The Director will authorize Area Offices to classify a health care registrant who has been ordered to report for induction into any administrative classification for which he has filed a claim and documented his eligibility. Area Office personnel will initially decide administrative claims. Claims denied by Area Office personnel are subject to Local Board review, when requested by the registrant.

c. A Local Board may classify a health care registrant into any judgmental class that he has requested and for which he is eligible. Claims denied by a Local Board are subject to appeal when requested by the registrant, the State Director, or the Director.

d. A District Appeal Board may classify a health care registrant into any class that he requested and for which he is eligible when a Local Board denial of a claim is appealed.

e. The National Appeal Board may classify a health care registrant into any class that he requested and for which he is eligible when a District Appeal Board denial of a claim is appealed to the President (National Appeal Board).

#### 3. *Classifications—Deferments—Exemptions—*

a. *Classification categories.* To expedite the classification process and reduce the volume of claims to be decided by the Local Board, the classification categories have been divided into two groups: administrative and judgmental. Administrative classification claims are

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established on the basis of official documents required for each classification. Judgmental claims for reclassification are those requiring a Local Board to determine whether the evidence submitted meets the criteria established for the requested classification. Administrative and judgmental classifications are identified in annex E. Health care registrant classifications will contain an "M" suffix for prompt identification and for statistical purposes.

b. *Registrant's responsibility.* Upon issuance of an Order to Report for Induction, a registrant may file a written claim for postponement of induction and/or reclassification with any Selective Service Area Office. The registrant's induction date is automatically delayed by the submission of a claim, pending resolution of the claim. A registrant must file concurrently all claims for classes for which he believes he is eligible, within the time period designated on his induction order. Any registrant who files a claim must document his eligibility to the satisfaction of the Area Office or the Local Board depending on the type of claim filed. The registrant may submit a statement as well as statements of other persons to prove the factual basis of his claim, in addition to any specific form(s) or other type of documentation required for the classification requested. Registrants, who do not file claims or whose claims are denied, are expected to report for induction as ordered.

Health care registrants are required to report changes in their status on which a claim is based to Selective Service within 10 days of the date such change occurs.

4. *Postponements.* Postponement does not cancel an induction order, but results in a rescheduled induction reporting date. Postponement is a statutory or administrative delay of a registrant's induction reporting date. Health care registrants will be eligible for postponements the same as regular registrants and for the same reasons as prescribed in RIMS. Each postponement shall be granted to a specific date but may be terminated at any time prior to the expiration date if the reason for which it was granted ceases to exist. At the expiration or termination of a postponement, the health care registrant will be rescheduled for induction.

a. *Types of postponements.* There are two types of postponements, statutory and administrative.

Statutory postponements are those authorized by the MSSA to permit satisfactory, full-time students to complete the term or semester in which

they are enrolled at the time they are ordered for induction. If the registrant is in the last academic year, the postponement may be granted until the end of that academic year.

Administrative postponements are those specifically authorized by Selective Service regulations. A health care registrant may be granted an administrative postponement for the reasons and periods prescribed in RIMS when: there is a family emergency beyond the registrant's control; the registrant incurs an illness or injury; the registrant is scheduled for a state or national examination to be eligible to practice his profession or occupation; the registrant has been accepted at a military service academy or for one of the specified Reserve Officer Training Corps programs; or, the registrant is scheduled to be inducted on a religious holiday observed historically by the registrant's recognized church, religious sect, or organization.

b. *Postponing authorities.* Registrants who believe they qualify for postponement at the time they are ordered for induction should file a claim with the Area Office and furnish the required documentation. Area Office personnel will decide the claim based on the documentation submitted by the registrant. When a claim for student postponement is denied by the Area Office, the registrant may request the Local Board to review his claim. Other postponement denials are not subject to review or appeal. The MEPS Liaison Officer (MLO) who represents Selective Service at the MEPS is authorized to grant a postponement of not more than ten days to a registrant when an emergency occurs while the registrant is enroute to, or during processing at the MEPS.

5. *Basic Claims and Appeals Process.* Health care registrants will be eligible to file claims for all postponements, deferments, and exemptions available to regular registrants. The filing of a claim will delay the registrant's reporting date until the claim is decided.

a. *Claims.* Claims for postponements and administrative classifications, to include documented separations from military service because of hardship or conscientious objection, will be initially decided by Area Office personnel, with denials of student postponements and administrative classifications subject to Local Board review when requested by the registrant.

(1) Claims for judgmental classifications, i.e., community essentiality, occupational deferment, hardship, conscientious objection, ministerial and ministerial student status, must be decided by the

registrant's Local Board. Conscientious objector claimants are required to appear personally before the Local Board unless previously separated from military service for reasons of conscientious objection. Other judgmental claimants and registrants requesting Local Board review of Area Office denials may ask to appear before the Local Board to discuss the claim. Persons appearing before a Local Board are permitted to present up to three witnesses, use an interpreter if one is required, be accompanied by an advisor, and submit additional written or oral information to support their claim. Registrants may not be represented at their personal appearance by anyone acting as an attorney or legal counsel.

(2) Registrants are eligible for deferment or exemption only so long as the reason for the deferment or exemption exists. Upon expiration of a registrant's deferment or termination of a deferment or exemption, the registrant will be returned to the available pool and ordered for induction with the next call for the specialty involved before those not previously ordered are selected.

b. *Appeals.* The HCPDS appeals process corresponds to the appeals system established by RIMS for regular registrants. Health care registrants will be offered the opportunity to request the Local Board to review and decide any claim for student postponement or administrative classification denied by the Area Office. A Local Board decision to deny an administrative classification may be appealed to the District Appeal Board when the denial decision is not unanimous. Any Local Board decision to deny a claim for judgmental reclassification may be appealed to the District Appeal Board. A District Appeal Board claim denial may be appealed to the President (National Appeal Board) if the vote to deny is not unanimous. The decision of the National Appeal Board is final and is not subject to further review or appeal.

A health care registrant may appear personally before a District Appeal Board or the National Appeal Board, as applicable, to discuss his claim. A person appearing before an appeal board may use an interpreter if one is required, be accompanied by an advisor, and submit additional written or oral information to support his claim. Registrants may not present witnesses or be represented at their personal appearance by anyone acting as an attorney or legal counsel.

6. *Special Health Care Personnel Provisions—*a. *Special health care personnel deferments.* In addition to all

deferments and exemptions available to regular registrants under RIMS, two new classes are provided under this system:

(1) *Community essentiality deferments.* A Class 2-EM (community essentiality deferment) is being added to the judgmental classification category for the health care registrants determined essential to the health care within their own communities. To qualify, health care registrants must be engaged in direct patient care. Class 2-EM will apply only to health care registrants.

(2) *Occupational deferments.* Eligibility for occupational deferment may be extended at the direction of the National Security Council to those staffing certain health care facilities, performing health care in a civilian capacity related to war activities, teaching in medical schools, or engaged in research and development relating to long term public health. Class 2-AM is designated for this type deferment, if and when authorized.

b. *Health care advisory boards—(1) State and local health care advisory boards.* While both types of these claims will be decided by the Local Board, it is important for the Local Board to have an advisory board, fully cognizant of the civilian community health care needs, to recommend on the validity of grounds for deferment. These boards will make recommendations to the Local Boards on the advisability of granting deferments. Section 10(b)(3) of the MSSA authorizes the creation of such boards. Specific criteria for establishing these review boards will be included in Selective Service regulations. These boards will review only the two types of deferment claims specified in 6a(1) and 6a(2), above.<sup>14</sup>

(2) *National health care personnel advisory committee.* A National Health Care Personnel Advisory Committee will be established by regulation. The purpose of this committee will be to advise the Director on the administration of those portions of the MSSA pertaining to the induction of health care personnel. Members of the committee will be appointed by the Director from among persons who are outstanding in the health occupations or who have extensive knowledge or background in health care matters.

c. *No advance DOD examinations.* SSS will adjudicate all claims prior to claimants' DOD examination and acceptance.<sup>15</sup>

d. *Forms and reports.* Many existing RIMS forms and management reports will be modified and used for HCPDS. Materials and publications pertaining only to health care registrant processing

will be identified and developed as the need arises.

e. *Area office terminal system (AOTS).* A modified AOTS will be used to transmit data to the DMC to update health care registrant records.

7. *Area Office Operational and Administrative Procedures.* The Local Boards, Appeal Boards, and Area Offices designed to function under RIMS will perform like duties for Health Care Personnel. The Area office is responsible for all administrative and operational support for the one or more Local Boards within its jurisdiction. The Area Office Manager is in immediate charge of the Area Office and responsible for carrying out the functions of that office.

a. *Area Offices are responsible to:* assist registrants in filing claims; receive claims; accomplish postponements and administrative classification actions; prepare registrant files for Local Board Classification actions; schedule personal appearances before Local Boards; assist Local Boards in the conduct of their meetings; record official board actions; transmit registrant information to the DMC to update the registrant data base; and, respond to inquiries from registrants, the media, and the public.

b. Upon receipt of a registrant's claim for postponement or reclassification, Area Office personnel will verify that the registrant has been ordered to report for induction and, if so, prepare an individual Registrant File Folder. The File Folder will be used for filing all documents pertaining to the registrant and for recording official actions relative to the registrant's claim(s) or circumstances.

c. *Health care registrant file folders:* will be maintained in the Area Office in a file system separate from that of regular registrants. The HCPDS filing system will parallel the regular registrant structure, but must provide for specialty categories and priority selection group divisions where required.

#### Annex Description:

- A System Flow Chart
- B Definitions, Abbreviations, and Acronyms
- C Amendment to MSSA of December 4, 1987
- D DOD Mobilization Shortfall Requirements Beginning at D+10
- E SSS Classifications

#### Footnotes

1. The amendment to the law and "legislative intent" materials are at Annex C. Although the wording of the amendment calls for a Selective Service Health Care Personnel Delivery System (HCPDS) on the same basis as the system for delivering regular

registrants, specific constraints were included in the legislative intent materials which preclude peacetime registration. No additional funds have been appropriated to carry out this new requirement.

2. During the initial days of mobilization, with inductees required as soon as possible, the Nation cannot afford the extra time required to classify and examine registrants before forwarding them for induction. The RIMS emergency procedures necessary to provide inductees as quickly as possible lead to the development of the "one-step" process at MEPS, examination and immediate induction of those registrants found qualified. These procedures, although suitable for use during the early stages of an emergency, are not intended for long term, steady state operation. Selective Service can only estimate reporting rates because of the uncertainty regarding the number of registrants who will file claims for deferment or exemption. Registrants will not know when they report for induction whether or not they will be found qualified and inducted or disqualified and sent home. Therefore, transition to a system which provides for more orderly scheduling and flow of registrants to MEPS will occur as soon as practicable. Procedures will call for "two-step" processing whereby registrants will receive a preinduction examination and have their claims for deferment or exemption processed before being ordered to report for induction. Such a system will eliminate many of the show rate uncertainties inherent in the emergency procedures and provide greater registrant convenience. The steady state system is intended for implementation as a follow on to the emergency induction procedures. However, it could be implemented directly if advance warning were available during a slow build up scenario.

3. At the appropriate time, OMB would be involved in the coordination of the proposed health care personnel legislation with other interested agencies.

4. The following organizations have requested and received a briefing at Selective Service (or materials by mail in lieu thereof at their request):

American Medical Association  
 American Nurses Association  
 American Association of Nurse Anesthetists  
 Service Employees International Union  
 American Osteopathic Association  
 American Academy of Family Physicians  
 American Academy of Physicians Assistants  
 American Physical Therapy Association  
 American Dental Association  
 National Medical Association

5. The proposed revision to the MSSA calls for liability for registration and service to age 55 to provide a margin of additional registrants, if needed, but the proposed proclamation will call for registration of only those age 20 through 44, as DOD's requirements would likely be met by this age group.

6. As a part of the registration record processing, the HCPDS registration records will be compared to the records in the regular registrant data base. Whenever a "match" is achieved, both records would be flagged to

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indicate inclusion of the registrant on both data bases. Additional processing of the regular registrant record would not occur, but that record would be retained in an inactive status.

7. For example, the feasibility of having registrars visit facilities with large concentrations of health care personnel will be explored as backup methods of facilitating the registration of health care personnel.

8. Registration under continuous registration would be required within 15 days of the date the person became liable. In the case of immigrant aliens entering the country, this would be 15 days after such entry is otherwise required to register.

9. If the situation required it, another proclamation would be issued to require the registration of health care personnel in additional age groups and/or specialties, as required.

10. The control form could prove to be similar to the SSS Form 6 currently used by registration sites to control and submit regular registration forms to the DMC.

11. UNICOR is a part of the Department of Justice, Bureau of Prisons, and is involved in production work by prisoners which has proven to be of good quality.

12. Year of birth has been included as the second factor on which records would be sorted in the selection procedure in order to ensure that a youngest first order of induction is maintained. A youngest first selection

order has several benefits. Younger registrants generally will be less critical to the continued maintenance of an adequate level of health care services in their communities. They also will have had less time to establish practices resulting in fewer claims for community essentiality and postponements to settle business affairs. Reduced claim rates will speed deliveries to DOD. There should be minimal increase in financial hardship claims because health care registrants are to enter military service as commissioned officers, as warrant officers, or in advanced enlisted grades as determined by the DOD. This may be offset, however, by an increased claim rate from younger people having younger children and thereby more frequently claiming family hardship.

13. Men who would be required to register both as regular registrants and as health care registrants represented a potential problem area. In a future draft, unless special provision were made, a man between age 20 and age 26 qualified in a health care occupation would have two Selective Service records: one in RIMS and one in HCPDS. He could be reached for induction and processed under either system, in effect giving him double exposure to the draft until age 26. Female health care registrants would not be subject to induction under the regular registrant system and male registrants 26 and older would not be subject to induction under both systems at the same time. Additionally,

induction of health care registrants as regular registrants would deplete the pool of much needed health care personnel. In an effort to eliminate potential problems, this concept calls for processing all health care registrants under HCPDS procedures only.

14. Advisory Committees, composed of representatives of health care professions, were used in the past and were effective in reviewing and making recommendations to Local Boards on such claims.

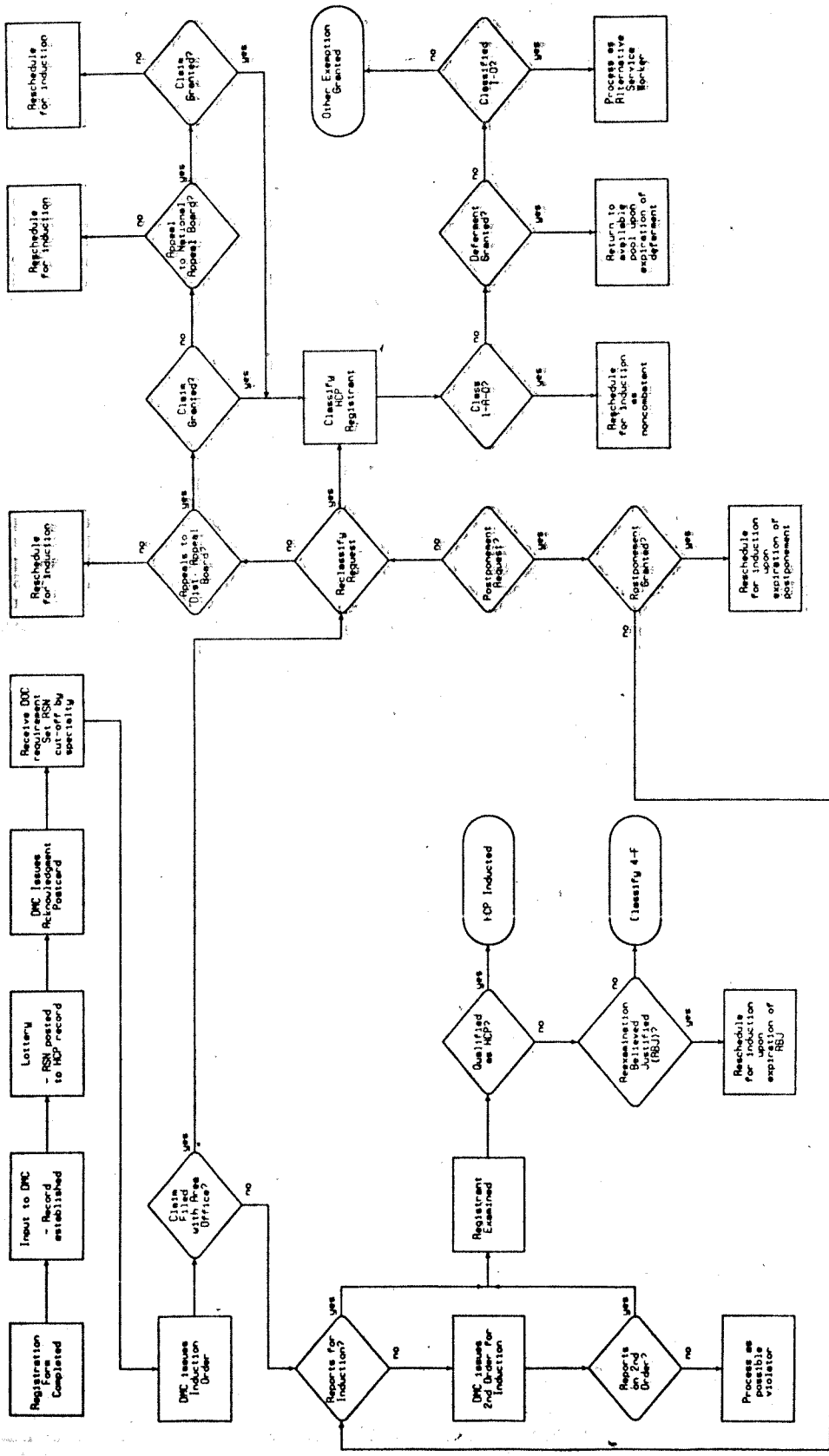
15. The primary reason for the provision in RIMS to examine regular registrants prior to considering their judgmental claims was to reduce the Local Board workload by eliminating claim processing for registrants who would be rejected at the MEPS. Historically, the rejection rate of personnel in the "doctors' draft" was extremely low compared to the rate for regular registrants, resulting in no significant reduction in the number of claims requiring Local Board adjudication. Another factor that influenced this decision is the MEPS workload at the time health care registrants would begin reporting for processing. MEPS capacities could be strained by adding health care personnel processing to the ongoing processing of regular registrants. Judgmental claims processing by Local Boards prior to examination would eliminate MEPS processing of those who would eventually be granted deferments or exemptions.

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ANNEX A SYSTEM FLOW CHART

OVERVIEW OF HCPCS - Rev. 89 A



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**Annex B—Definitions, Abbreviations, and Acronyms**

**Base Date.** A date selected in advance, and incorporated into the initial registration proclamation, on which any given person would have been practicing or performing his specialty. This date will be used in determining an individual's eligibility and liability to register as a health care specialist registrant.

**Class.** A category designated by Selective Service for grouping and processing registrants according to established criteria (also called "classification").

**Classification.** (1) The initial exercise of the authority to determine a registrant's claims or questions with respect to a registrant's inclusion into a specific class for, or exemption from, training and service under the Military Selective Service Act (MSSA), by the official act of designating a registrant's class; and/or,

(2) The subsequent exercise of aforementioned authority by designating a new class for a registrant (i.e., reclassification).

(3) A category designated by Selective Service for grouping and processing registrants according to established criteria (also called "class").

**Community Essentiality.** The providing of direct health care services essential to the maintenance of national health, safety, and interest in a community, and which cannot be provided by anyone other than the health care registrant applying for Class 2-EM (Registrant Deferred Because of Community Essentiality).

**CONUS** Continental United States (in this paper includes the fifty States, the District of Columbia, and all off-shore possessions, territories, and protectorates).

**Continuous Registration.** Ongoing registration of persons liable for registration as prescribed in a Presidential Proclamation and implementing Selective Service Regulations.

**Credentialing.** The verification process of reviewing licenses, diplomas, training certificates and related materials for professional qualification of health care personnel. Credentialing will be accomplished by medical department personnel from the uniformed services in support of The Military Entrance and Processing Command (MEPCOM).

**D-Day.** The day hostilities commence.

**Health Care Personnel.** Persons who are qualified or become qualified for practice or employment in an occupation to provide health care, to

humans or animals, which has been deemed essential by the President to meet the needs of the Armed Forces, without regard to whether such persons meet standards prescribed by the Secretary of Defense.

**Health Care Registrant.** A person registered under authority of (proposed) Section 3(a)(2) of the Military Selective Service Act, (i.e., a person qualified for practice or employment in an occupation to provide health care to humans or animals).

**Health Care Advisory Board.** A group of not less than three civilian members appointed by the Director to review health care personnel claims for deferment from induction base upon reasons of community essentially or occupation. It makes recommendations to Local Boards.

**M-Day.** The day SSS commences mobilization.

**Mass Registration.** Registration of specific categories of persons over a specified, limited period of time as set forth in a Presidential Proclamation.

**MSSA.** The Military Selective Service Act, as amended (50 U.S.C. App. 451 *et seq.*).

**National Health Care Personnel Advisory Committee.** A committee, to be authorized by Selective Service Regulations and appointed by the Director, to provide advice to the Director of Selective Service on selection, classification, induction, and related policies pertaining to health care personnel.

**Regular Registrants.** Registrants currently registered under RIMS.

**RIMS.** The Selective Service System's Registrant Information and Management System, which represents the policies, procedures, and automated data systems for processing regular registrants for induction or alternative service.

**Annex C—Amendment to MSSA of December 4, 1987**

Public Law 100-180, section 715, National Defense Authorization Act for Fiscal Year 1988/1989, December 4, 1987, amended section 10(h) of the MSSA. Section 10(h) now reads as follows:

SEC 10(h). The Selective Service System shall be maintained as an active standby organization with (1) a complete registration and classification structure capable of immediate operation in the event of a national emergency (including a structure for registration and classification of persons qualified for practice or employment in a health care occupation essential to the maintenance of the Armed Forces) and (2) personnel adequate to reinstitute immediately the full operation of the System, including military reservists who are trained to operate such System and who can be

ordered to active duty for such purpose in the event of a national emergency.

Italic portion shows language added by amendment.

Also attached are excerpts from the House and Senate Committee Reports on this legislation.

Section 715—Standby Capability for Selective Service Registration of Health Care Personnel

Although the committee has proposed a number of provisions to increase the number of health professionals with critical combat skills in the active and reserve forces during peacetime, the committee believes that a back-up system for the rapid registration of health care professionals after the declaration of a national emergency should be implemented. The committee, therefore, recommends authorizing the Selective Service System to implement a system for the post-mobilization registration of health care professionals.

Specifically, the committee envisions that the Selective Service System would perform the following tasks under this authority: (1) design a computer program to facilitate registration in the event of a national emergency—no names or lists would be included; (2) develop adjudication procedures for claims and appeals in the event of registration; and (3) produce sample forms for registration but not distribute them unless registration is authorized in the future.

The committee emphasizes that this authority neither encompasses a peacetime draft nor a peacetime registration system; rather, it would only permit the Selective Service System to develop a structure for the possible registration and classification of health care professionals to be implemented after the President declares a national emergency and after Congress passes legislation providing specific registration and conscription authority.

The committee believes that a system for the post mobilization registration of health care professionals would help address medical readiness personnel shortfalls as well as provide a safeguard against disaster in the event that major hostilities erupt before voluntary initiatives produce adequate numbers and kinds of military health professionals. The committee emphasizes however, that the Department of Defense must actively pursue other medical readiness initiatives and work closely with professional health associations to attract and retain health professionals committee to military service because effective voluntary programs are the first line of defense.

(Committee on Armed Services, U.S. House of Representatives, House Report 100-58, p. 213)

**TITLE VII—HEALTH CARE PROVISIONS**

Post-Mobilization Registration of Health Care Professionals

The Selective Service has requested authority to spend funds to design and develop a standby system to prepare for the post-mobilization registration and classification of persons with essential health

care delivery skills. This standby system will reduce the time it would require Selective Service to call up health care personnel in the event of war or national emergency.

The provision recommended by the committee (sec. 703) provides authority for

Selective Service to expend funds to develop such a standby system. This provision does not grant authority to Selective Service to register or to induct medical personnel.

(Committee on Armed Services, U.S. Senate, Senate Report 100-57, p. 149)

**Annex D—DOD Mobilization Shortfall Requirements Beginning at D+10**

DOD requirements include the following numbers and specialties:  
Numbers: (Source: DOD FY '88-'92 Program Objective Memoranda)

Manpower category	D+10	D+30	D+60	D+90	D+180
Physicians.....	4,867	690	259	144	74
Nurses.....	25,091	3,905	581	789	561
Medical enlisted.....	41,826	23,444	5,364	1,328	1,025
<b>Total:</b> .....	<b>71,784</b>	<b>28,039</b>	<b>6,204</b>	<b>2,261</b>	<b>1,660</b>

**Job Categories:**

- Physicians
- Aerospace Medicine
- Thoracic Surgery
- Orthopedic Surgery
- Occupational Medicine
- Anesthesiology
- General Surgery
- Neurosurgery
- Urology
- Otolaryngology
- Psychiatry
- Allergy
- Neurology
- Dermatology
- Radiology
- Colon-Rectal Surgery
- Pathology
- Ophthalmology
- Internal Medicine
- Emergency Medicine
- Dentists
- Oral Surgery
- Prosthodontics
- Periodontics
- Endocrinology
- Gen Dentistry

**Miscellaneous**

- Allied Specialists
- Physiology
- Entomology
- Clinical Psychology
- Medical Technology
- Audiology/Speech Therapy
- Environmental Health
- Podiatry
- Dietetics
- Physical Therapy
- Registered Nurses
- Medical/Surgical Nursing
- Surgical Nursing
- Certified Registered Nurse Anesthetist
- Mental Health Nursing
- Medical Care Technicians
- Licensed Practical/Vocational Nursing and Other
- Medical Care and Treatment Personnel
- Other Specialists/Technicians
- Dental Laboratory
- Medical Administration
- Radiology

- Respiratory Therapy
- Medical Laboratory
- Dental Assistance
- Operating Room
- Pharmacy
- Dietetic
- Medical Supply
- Medical Equip Repair
- Psychiatric
- Physical Therapy
- Environmental Health
- Orthopedic
- Veterinary
- Occupational Therapy
- Optical
- Ophthalmology
- Optometry

**Annex E—SSS Classifications**

This Attachment set forth Selective Service Classifications which would be assigned to health care registrants under HCPDS, using the suffix "M" to designate them as a separate group. These classes would be assigned at such time as authorized and necessary to do so in connection with their processing under HCPDS.

**Administrative Classifications**

Classification	Description
1-AM:	Registrant Available for Unrestricted Military Service.
1-CM:	Member of the Armed Forces of the United States, the National Oceanic and Atmospheric Administration, or the Public Health Service
1-D-DM:	Deferment for Certain Members of a Reserve Component or Student Taking Military Training.
1-D-EM:	Exemption of Certain Members of a Reserve Component or Student Taking Military Training.
1-HM:	Registrant Not Currently Subject to Processing for Induction or Alternative Service.
1-O-SM:	Conscientious Objector to All Military Service (Separated).
1-WM:	Conscientious Objector Ordered to Perform Alternative Service in Lieu of Induction.
3-A-SM:	Registrant Deferred Because of Hardship to Dependents (Separated).
4-AM:	Registrant Who Has Completed Military Service.
4-A-AM:	Registrant Who Has Performed Military Service for a Foreign Nation.
4-BM:	Official Deferred by Law.
4-CM:	Alien or Dual National.
4-FM:	Registrant Not Acceptable for Military Service.
4-GM:	Registrant Exempted from Service Because of Death of Parent or Sibling While Serving in the Armed Forces or Whose Parent or Sibling is in a Captured or Missing in Action Status.
4-TM:	Treaty Alien.
4-WM:	Registrant Who Has Completed Alternative Service.
1-A-OM:	Conscientious Objector Available for Noncombatant Military Service Only.
1-OM:	Conscientious Objector to all Military Service.
2-AM:	Registrant Deferred Because of Occupation.
2-EM:	Registrant Deferred Because of Community Essentiality.
2-DM:	Registrant Deferred Because of Study Preparing for the Ministry.
3-AM:	Registrant Deferred Because of Hardship to Dependents.
4-DM:	Minister of Religion.

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Health Care Personnel Delivery System (HCPDS), 54 Federal Register 33644-33654, August 15, 1989 for more information, see: <<http://www.MedicalDraft.info>>

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