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HEALTH SERVICE SUPPORT IN CORPS AND ECHELONS ABOVE CORPS

HEADQUARTERS, DEPARTMENT OF THE ARMY

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PREFACE

This field manual (FM) establishes command, control, communications, computers, and intelligence (C4I) doctrine for the provision of health service support (HSS) in corps and echelons above corps (EAC). It discusses all levels of care within the theater. Force heath protection in a global environment is the overarching concept of support for providing timely medical support to the tactical commander; it is executed by the HSS system. This manual is designed for use by HSS commanders and their staffs involved in the planning and execution of HSS operations in corps and EAC.

The Army Medical Department (AMEDD) is in a transitional phase with terminology. This manual uses the most current terminology, however, other FM 4-02-series and FM 8-series may use the older terminology. Changes in terminology are a result of adopting the terminology currently used in the joint, and/or North Atlantic Treaty Organization (NATO), and American, British, Canadian, and Australian (ABCA) Armies publication arenas. Therefore, the following terms are synonymous—

- *Health service support* and *combat health support* (*CHS*).
- *Medical logistics, health service logistics* (*HSL*), and *combat health logistics* (*CHL*).
- *Levels of care, echelons of care,* and *roles of care*.
- *Combat stress control* (*CSC*), and *combat operational stress control* (*COSC*).

This publication implements or is in consonance with the following NATO Standardization Agreements (STANAGs), ABCA Quadripartite Standardization Agreements (QSTAGs), and Quadripartite Advisory Publication (QAP) 82, ABCA Armies Medical Interoperability Handbook.

NATO STANAG	ABCA QSTAG	TITLE
2068		Emergency War Surgery
2131		Multilingual Phrase Book for Use by the NATO Medical Services (AMedP-5)(B)
2132	470	Documentation Relative to Medical Evacuation, Treatment and Cause of Death of Patients
2350		Morphia Dosage and Casualty Marking
	230	Morphia Dosage

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations in a letter format directly to the Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052.

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

CHAPTER 1

THE HEALTH SERVICE SUPPORT SYSTEM IN THE CORPS AND ECHELONS ABOVE CORPS

Section I. INTRODUCTION TO THE HEALTH SERVICE SUPPORT SYSTEM IN CORPS AND ECHELONS ABOVE CORPS

1-1. Focus of Health Service Support

a. As the battlefield becomes increasingly lethal, sustaining the health of the fighting forces becomes a critical factor in the success or failure of the mission. Comprehensive planning enhances the capability of medical units to provide effective HSS, and ultimately, increases the chances for survival of the wounded soldier. Forward support characterizes the role that HSS must assume. The thrust of HSS is to rapidly clear the battlefield of casualties, provide immediate medical care to maximize the return to duty (RTD) rate or to stabilize patients requiring further evacuation to a higher level of care.

b. The provision of timely and effective HSS is a team effort which integrates the clinical and operational aspects of the mission. Coordination and synchronization are key elements to ensure that a seamless system of health care delivery, that exists from the point of injury through successive levels of care to the continental United States (CONUS)-support base, is achieved. (Refer to FM 4-02 for additional information on the AMEDD team.)

c. Consistent with military operations, HSS also operates in a continuum across strategic, operational, and tactical levels. In addition to maintaining a healthy and fit deployable force, the effectiveness of the HSS system is focused and measured on its ability to—

- Provide prompt medical treatment consisting of those measures necessary to locate, recover, resuscitate, stabilize, and prepare patients for evacuation to the next level of care and/or RTD.

- Employ standardized air and ground medical evacuation units/resources. The use of air ambulance is the primary and preferred means of medical evacuation on the battlefield. Its use, however, is mission, enemy, terrain and weather, troops and support available, time available, civil considerations (METT-TC) driven and can be affected by weather, availability of resources, nuclear, biological, and chemical (NBC) conditions, and air superiority issues. Medical evacuation provided at Levels I and II is by Army air and ground medical evacuation platforms (vehicle or rotary-wing aircraft). Extended distances on future battlefields may require the use of United States Air Force (USAF) fixed-wing assets to effect evacuation from Level II to Level III.

- Field flexible, responsive, and deployable hospitals designed and structured to support a Force Projection Army and its varied missions. These hospitals provide essential care to all patients who are evacuated out of theater and definitive care to those soldiers capable of RTD within the theater evacuation policy.

- Provide a medical logistics system (to include blood management) that is anticipatory and tailored to continuously support missions throughout full spectrum operations. Refer to FM 4-02.1 and FM 8-10-9 for additional information.

- Establish preventive medicine (PVNTMED) programs to prevent casualties from disease and nonbattle injury (DNBI) through medical surveillance, occupational and environmental health (OEH) surveillance, health assessments, PVNTMED measures (PMM), and personal protective measures. Refer to Army Regulation (AR) 40-5, FM 4-02.17, FM 4-25.12, and FM 21-10 for additional information on PVNTMED services.

- Provide veterinary services to enhance the health of the command through three broad-based functional areas—food inspection services, animal medical care, and veterinary PVNTMED (to include the prevention of zoonotic diseases transmissible to man). As the Department of Defense (DOD) Executive Agent, the Army provides veterinary medicine support to the USAF, US Navy (USN), US Marine Corps (USMC), and Army forces, as well as other federal agencies, host nation (HN), allies, and coalition forces, when directed. For additional information on veterinary operations and activities refer to FM 8-10-18.

- Provide dental services to maximize the quick RTD of dental patients by providing operational dental care and maintaining the dental fitness of theater forces. For additional information on dental services operations and activities refer to FM 4-02.19.

- Provide COSC to enhance unit and soldier effectiveness through increased stress tolerance and positive coping behaviors. For additional information, refer to FM 6-22.5, FM 8-51, and FM 22-51.

- Provide medical laboratory functions in HSS operations to—

  - Assess disease processes (diagnosis).

  - Monitor the efficacy of medical treatment.

  - Identify and confirm use of suspect biological warfare (BW) and chemical warfare (CW) agents by enemy forces.

- Deploy C4I units capable of providing the requisite C4I to enhance split-based operations capability.

- Ensure maximum use of emerging technology to improve battlefield survivability.

d. The theater HSS system provides support to mobilization, deployment (reception, staging, onward movement, and integration [RSO&I]), reconstitution, redeployment, and demobilization operations.

1-2. Principles of Force Health Protection in a Global Environment

The six principles that must be applied to HSS operations are conformity, proximity, flexibility, mobility, continuity, and control.

a. *Conformity* with the tactical plan is the most basic element for effectively providing HSS.

b. The principle of *proximity* is to provide HSS to sick, injured, and wounded soldiers at the right time and to keep morbidity and mortality to a minimum.

c. *Flexibility* is being prepared to shift HSS resources to meet changing requirements. Changes in tactical plans or operations make flexibility in HSS planning and execution essential.

d. The principle of *mobility* is to ensure that HSS assets remain close enough to support maneuvering combat forces. The mobility and survivability (such as armor plating) of medical units organic to maneuver elements must be equal to the forces being supported. Major HSS headquarters in the corps and EAC continually assess and forecast unit movement and redeployment. Health service support must be continually responsive to shifting medical requirements of the battlefield.

e. *Continuity* in care and treatment is achieved by moving the patient through a progressive, phased HSS system, extending from the forward area of the combat zone (CZ) to an area as far rearward as the patient's condition requires, possibly to the CONUS. Each type of HSS unit contributes a measured, logical increment in care appropriate to its location and capabilities.

f. *Control* is required to ensure that scarce HSS resources are efficiently employed and support the tactical and strategic plan. It also ensures that the scope and quality of medical treatment meet professional standards and policies. In a joint and multinational environment it is essential that coordination be accomplished across all services and multinational forces.

1-3. Levels of Medical Care

a. A basic characteristic of organizing HSS is the distribution of medical resources and capabilities to facilities at various levels of location and function. The scope and functions may be expanded or contracted as required. As a general rule, *no level will be bypassed* except on grounds of efficiency or battlefield expediency. The rationale for this rule is to ensure the stabilization/survivability of the patient through advanced trauma management (ATM) and far forward surgical intervention prior to movement between medical treatment facilities (MTFs).

b. Levels of medical care describe the five levels of treatment within the military health care system. Each level has the same capabilities as the levels before it, but adds a new treatment capability that distinguishes it from the previous level. The five levels are—

- *Level I*—The first medical care a soldier receives is provided at this level. This care includes immediate lifesaving measures, ATM, disease prevention, COSC, casualty location, collection, and evacuation from the supported unit to the supporting medical treatment element. Level I elements are located throughout the CZ and communications zone (COMMZ). These elements include the first aid (self-aid/buddy aid) and enhanced first aid (combat lifesaver [CLS]), trauma specialist (or other military occupational specialty [MOS] 91W provider), and battalion aid station (BAS). Some or all of these elements are found in maneuver, combat support (CS), and combat service support (CSS) units. When

Level I medical care is not present in a unit, this support is provided to that unit by Level II medical units on an area support basis.

- *Level II*—This level duplicates Level I and expands services available by adding dental, laboratory, x-ray, and patient-holding capabilities. Emergency care and ATM, including beginning resuscitation procedures, are continued. (No general anesthesia is available.) If necessary, additional emergency measures are instituted; however, they do not go beyond the measures dictated by the immediate needs. Level II units are located in the CZ (brigade, division, and corps support areas) and the COMMZ. Level II HSS may be provided by a forward support medical company (FSMC), main support medical company (MSMC), division support medical company (DSMC), brigade support medical company (BSMC), division air cavalry medical company (DACMC), area support medical company (ASMC), or a medical troop. Optometry is located at some Level II units; also, PVNTMED and mental health (MH)/COSC support are now located in some Level II medical units on an area support basis. For patients requiring far forward surgical intervention prior to evacuation, a forward surgical team (FST) may be collocated with a medical company to provide this support.

- *Level III*—Level III care is provided in combat support hospitals (CSHs) staffed and equipped to provide medical, surgical, and psychiatric care to all categories of patients. Patients are further stabilized to withstand evacuation to the COMMZ or out of theater. For a discussion of the corps CSH refer to FM 4-02.10.

- *Level IV*—This level of care is provided by a CSH, which has same treatment capabilities as the Level III CSH. The difference in the two hospitals is mobility factors and modularity. This level of care provides further treatment to stabilize those patients requiring evacuation to CONUS. This level also provides area HSS for EAC soldiers or those located within the COMMZ. This level of care is augmented with medical and surgical specialty teams as required by the patient workload. For a discussion of the EAC CSH refer to FM 4-02.10.

- *Level V* (*Continental United States Support Base Level of Care*)—This definitive level of care is provided in the CONUS support base. The patient is treated in hospitals staffed and equipped to provide the most definitive care available. Hospitals used to provide this care are not limited to US Army hospitals. Hospitals from the other military Services, the Department of Veterans Affairs, and the civilian health care systems may also be used. Civilian hospitals include those hospitals that are members of the National Disaster Medical System (NDMS).

1-4. Army Medical Department Battlefield Rules

The AMEDD has developed HSS battlefield rules to aid in establishing priorities and in resolving conflicts between competing priorities within HSS activities.

a. These battlefield rules are (in order of their priority) to—

- Be there (maintain a medical presence with the soldier).

- Maintain the health of the command.
- Save lives.
- Clear the battlefield.
- Provide state-of-the-art medical care.
- Ensure early RTD.

b. These rules are intended to guide the HSS planner to resolve system conflicts encountered in designing and coordinating HSS operations. Although medical personnel seek always to provide the full scope of HSS in the best possible manner, during every combat operation there is inherent possibility of conflicting support requirements. The planner or operator applies these rules to ensure that the conflicts are resolved appropriately.

c. The rationale for the battlefield rules is based on the prevention of disease and injury and the evolving clinical concept, which demonstrates that with good medical care the trauma victim will probably survive the injury.

1-5. The Medical Threat

a. The *medical threat* is a collective term used to designate all potential or continuing enemy actions and environmental situations that may render a soldier combat ineffective. The medical threat is important because it applies (as a whole) to the troops deployed on a specific mission and/or operation and may result in the unit being unable to satisfactorily complete its mission. A *health threat* is more individualized in nature and may not be of military significance. Threats to an individual soldier's health can include genetic and/or hereditary conditions which manifest themselves in adulthood, an individual (single) exposure to an industrial chemical or other toxin where others are not exposed, or other allergies, diseases, injuries, and traumas which affect a single individual's health rather than the health of the unit. For example, an individual who has a food allergy inadvertently eats the offending food; he may become incapacitated with diarrhea after the exposure. This incapacitation causes the soldier to be combat ineffective; but the remainder of the unit is not affected by his condition. However, in a unit where 40 to 50 percent of its personnel contract *Salmonella* (an infectious disease which causes diarrhea), the unit can no longer complete its mission. The significant difference in these terms lies with the effects on the ability of a military unit to successfully execute its mission. Predeployment medical screening is used to determine if an individual soldier is physically and mentally ready to be deployed; medical conditions, such as diabetes, fractures, severe sprains, or other diseases and injuries, can disqualify the individual from being deployed. Soldiers who are deployed are healthy, fit, and emotionally prepared for the deployment; the medical threat they are to face in the area of operations (AO) is operationally significant as it affects the entire unit, rather than the individual soldier.

b. In addition to wounds and injuries from conventional weapons and munitions, the medical threat is comprised of the following categories:

- Environmental injuries and conditions include heat and cold injuries resulting from inadequate acclimation to the AO and inadequate clothing and equipment for the environmental conditions. Acute mountain sickness and other illnesses are related to rapid deployment to high terrestrial elevations.

- Endemic and epidemic diseases in the AO include diseases of military significance, diarrheal diseases caused by drinking contaminated or impure water (not adequately treated), eating contaminated foods, and not practicing good individual and unit PMM. These diseases may also be the result of disease transmission by arthropod vectors.

- Diseases and injuries caused by contact with domesticated animals, wild animals, reptiles, and poisonous or toxic plants.

- Diseases and injuries caused by physical or mental unfitness resulting from continuous operations, inadequate diet, and mental stressors.

- Diseases and injuries resulting from exposure to weapons of mass destruction (WMD) (NBC agents to include radiation, BW and CW agents, and high yield explosive weapons).

- Injuries resulting from OEH hazards to include the exposure to toxic industrial materials (TIM) and noise.

c. For additional information on the medical threat refer to FM 4-02.17.

1-6. Medical Intelligence

Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or the AO and which is significant to HSS or general military planning. Until medical information is not processed or analyzed, it is not considered to be medical intelligence. Medical information pertaining to foreign nations is processed by the Armed Forces Medical Intelligence Center (AFMIC). For additional information on medical intelligence, refer to FM 4-02, and 4-02.17.

1-7. Command Surgeon

a. At all levels of command, a command surgeon is designated. This AMEDD officer is a special staff officer charged with planning for and executing the HSS mission. Depending upon the level of command, this officer may be dual-hatted as a medical unit commander; further, he may have a small staff section to assist him in his planning, coordinating, and synchronizing the HSS effort within his AO.

b. The command surgeon is responsible for ensuring that all AMEDD functional areas are considered and included in operation plans (OPLANs) and operation orders (OPORDs). The command surgeon retains technical supervision of all HSS operations. At the higher levels of command, the scope of duties and responsibilities expand to include all subordinate levels of command.

c. The duties and responsibilities of command surgeons may include, but are not limited to—

- Advising the commander on the health of the command.

- Developing and coordinating the HSS portion of OPLANs to support the combatant/ tactical commander's decisions, planning guidance, and intent.

- Determining the medical workload requirements (patient estimates) based upon the casualty estimate developed by the Assistant Chief of Staff, Personnel (G1) and/or Adjutant, US Army (S1).

- Determining, in conjunction with the staff judge advocate (SJA) and the chain of command, the eligibility for medical care in a US Army MTF. (Refer to Appendix A for additional information.)

- Maintaining situational understanding (SU) by coordinating for current HSS information with surgeons of the next higher, adjacent, and subordinate headquarters.

- Recommending task organization of HSS units/elements to satisfy all mission requirements. (A discussion of the medical multifunctional task force [MMTF] and recommended augmentation staffing is provided in Appendix B.)

- Recommending policies concerning support of civil-military operations (CMO).

- Monitoring the availability of and recommending the assignment, reassignment, and utilization of AMEDD personnel within his AO.

- Developing, coordinating, and synchronizing health consultation services (to include telemedicine [TELEMED] and teleconsultation, as appropriate).

- Evaluating and interpreting medical statistical data.

- Recommending policies and determining requirements and priorities for medical logistics (to include blood and blood products, medical supply/resupply, medical equipment maintenance and repair services, production of medicinal gases, optometric support, and fabrication of single- and multivision optical lens, and spectacle fabrication and repair).

- Recommending medical evacuation policies and procedures.

- Monitoring medical regulating and patient tracking operations.

- Determining HSS training requirements.

- Developing policies, protocols, and procedures pertaining to the medical and dental treatment of sick, injured, and wounded personnel. These policies, protocols, and procedures will be in consonance with applicable regulations, directives, and instructions; higher headquarters policies; standing

operating procedures (SOPs); applicable STANAGs and QSTAGs; Memorandums of Understanding (MOU) or Agreement (MOA); Status of Forces Agreements (SOFAs); and the Joint Readiness Clinical Advisory Board (JRCAB) Deployable Medical System (DEPMEDS) Administrative Procedures, Clinical and Support Guidelines, and Patient Treatment Briefs (available at website: http://www.armymedicine.army.mil/jrcab/index.htm).

- Ensuring field medical records are maintained on each soldier at the primary care MTF in accordance with AR 40-66 and FM 4-02.4.

- Ensuring compliance with the theater blood bank service program.

- Ensuring a viable veterinary program (to include inspection of subsistence and outside the continental United States [OCONUS] food production and bottled water facilities, veterinary PVNTMED, and animal medical care) is established.

- Ensuring a medical laboratory capability or procedures for obtaining this support from out of theater resources are established for the identification and confirmation of the use of suspect BW and CW agent by opposition forces. This also includes the capability for specimens/samples packaging and handling requirements and escort/chain of custody requirements. (Refer to Chapter 5 of this publication, FM 4-02.7, and FM 8-284 for additional information.)

- Planning for and implementing PVNTMED operations and facilitating risk communications (to include PVNTMED programs and initiating PMM to counter the medical threat). (Refer to FM 4-02.17 for additional information on the medical threat.)

- Planning for and ensuring pre- and postdeployment health assessments are accomplished.

- Establishing and executing a medical surveillance program (refer to DOD Directive [DODD] 6490.2, DOD Instructions [DODI] 6490.3, Joint Chiefs of Staff Memorandum MCM 0006-02, AR 40-66, and FM 4-02.17 for an in-depth discussion).

- Establishing and executing an OEH surveillance program (FM 3-100.4).

- Recommending COSC, MH, and substance abuse control programs.

- Coordinating for medical intelligence with the supporting intelligence officer/section/unit. Pursuing other avenues to obtain medical intelligence and/or medical information such as the—

  - Armed Forces Medical Intelligence Center.

  - United States Army Center for Health Promotion and Preventive Medicine (USACHPPM).

  - Centers for Disease Control and Prevention (CDC).

- United States Public Health Services.

- International organizations (United Nations [UN], the World Health Organization [WHO], or the Pan American Health Organization [PAHO], and other nongovernmental organizations [NGOs]).

- Information gathered from site visits to HN medical facilities.

- Ensuring that the general threat, medical threat, and medical intelligence considerations are integrated into HSS OPLANs and OPORDs.

- Identifying commander's critical information requirements (CCIR), priority information requirements (PIR), essential elements of friendly information (EEFI), and friendly forces information requirements (FFIR) as they pertain to the medical threat; ensuring they are incorporated into the command's intelligence requirements.

- Coordinating for humanitarian assistance, disaster relief, medical response to WMD or terrorist incidents, and refugee and domestic support operations (DSO), when authorized.

- Advising commanders on HSS NBC defensive actions (such as immunizations, use of chemoprophylaxis, pretreatments, and barrier creams).

- Ensuring individual informed consent is established before the administration of investigational new drugs (IND) as described in Executive Order 13139.

- Assessing special equipment and procedures required to accomplish the HSS mission in specific environments such as urban operations (UO), mountainous terrain, extreme cold weather operations, jungles, and deserts. Requirements are varied, depending upon the scenario, and could include—

  - Obtaining pieces of equipment or clothing not usually carried (piton hammers, extreme cold weather parka, jungle boots, or the like).

  - Adapting medical equipment sets (MESs) for a specific scenario to include adding items based on the forecasted types of injuries to be encountered (such as more crush injuries and fractures in UO or mountain operations). In certain scenarios (such as UO), some medical supplies and equipment may not be carried into the fight initially (such as sick call materials), but rather brought forward by follow-on forces. In mountain operations, bulky or heavy items (such as extra tentage) may not accompany the force because of the difficulty in traversing the terrain.

  - Having individual soldiers carry additional medical items, such as bandages and intravenous (IV) fluids.

- Recommending disposition instructions for captured enemy medical supplies and equipment. Under the provisions of the Geneva Conventions, medical supplies and equipment are protected from intentional destruction and should be used to initially treat sick, injured, or wounded enemy prisoners of war (EPW). (Refer to FM 4-02 for additional information on the Geneva Conventions.)

- Submitting to higher headquarters those recommendations on medical problems/ conditions that require research and development.

- Recommending theater policy for medically evacuating contaminated patients.

- Coordinating and monitoring patient decontamination operations to include—

  - Theater policies on patient decontamination operations.

  - Layout and establishment of patient decontamination station.

  - Use of collective protection.

  - Use of nonmedical soldiers to perform patient decontamination procedures under medical supervision.

This paragraph implements STANAGs 2132 and 2350 and QSTAGs 230 and 470.

d. The command surgeon is responsible for the standard of care which is provided to sick, wounded, and injured soldiers by subordinate medical personnel.

(1) The command surgeon must ensure that standardized protocols for the alleviation of pain (to include the administration of pain relief medications by nonphysician health care providers) are established and disseminated. Further, he must ensure and certify that each trauma specialist (or other MOS 91W provider), working under the supervision of a physician, has received sufficient training to—

- Recognize when pain management measures and medications are required.

- Provide pain management measures (elevation, immobilization, and ice [when available]).

- Select the appropriate medication (such as acetaminophen, ibuprofen, or morphine sulfate); determine the mode of administration (oral or parenteral); and be knowledgeable of the possible side effects and how to treat them; and administer the appropriate medication.

- Document the treatment provided (Department of Defense [DD] Form 1380) to include the marking of individuals who have received morphine sulfate. (Refer to FM 8-10-6 for additional information.)

(2) The command surgeon is also responsible for ensuring that all controlled substances are stored, safeguarded, issued, and accounted for in accordance with the provisions of AR 40-3. The MES for

the trauma specialist includes morphine sulfate. When the mission supported involves a high risk of trauma, the command surgeon may authorize the trauma specialist to carry morphine sulfate to alleviate severe pain caused by trauma or wounding. This medication must be accounted for when issued to the trauma specialist and upon mission completion.

SECTION II. HEALTH SERVICE SUPPORT AT ECHELONS ABOVE CORPS

1-8. Joint and Multinational Health Service Support

a. Health Service Support and the Command Surgeon in Joint Operations.

(1) In joint operations, each Service operates its own health care delivery system. However, health care facilities, medical equipment, supplies, and personnel may be provided, on a joint basis, when directed by the joint force commander (JFC). Although joint staffing is not a requisite to joint use, staff augmentation from Service components may be required.

(2) Upon activation of a joint task force (JTF), a command surgeon is designated from one of the component Services. Joint Publication (Pub) 4-02 states that a joint force surgeon (JFS) should be appointed for each combatant command, subunified command, and JTF. As a specialty advisor, the JFS reports directly to the JFC. The JFS coordinates HSS matters for the JFC. The JFS's staff should be jointly manned, when possible, and should be of sufficient size to effectively facilitate joint coordination of HSS initiatives; rationalization, standardization, and interoperability (RSI); review of plans; and integration with overall operations. The command surgeon must assess component forces HSS requirements and capabilities and provide guidance to enhance effectiveness of HSS through shared use of assets. The JFSs usually have responsibility for—

- Assisting the JFC in formulating a recommended theater evacuation policy for the TO.
- Assisting component commands in identifying what HSS capabilities each component requires and who is responsible for providing these services/support.
- Advising the JFC on the HSS aspects of combat operations, COSC, reconstitution policies, PVNTMED programs and activities, and other factors that could effect operations.
- Advising the JFC on HSS aspects of NBC defensive actions/issues (to include immunizations, chemoprophylaxis, pretreatments, and barrier creams).
- Informing the JFC about the status of HSS units, identifying any shortfalls or deficiencies, and recommending solutions.

- Monitoring the status of patient beds, medical logistics (including blood and blood products), staffing, designation of a single integrated medical logistics manager (SIMLM), and other issues effecting medical readiness; and recommending solutions to the JFC.

- Informing the JFC about the status of medical assistance and PVNTMED support required and provided to civilian detainees/retainees and EPW.

- Coordinating the delivery of health care to or received from allies, coalition partners, HN, other friendly nations, or contractors on the battlefield.

- Supervising the activities of the Theater Patient Movement Requirements Center (TPMRC) and Joint Blood Program Office (JBPO).

- Preparing the HSS Annex Q to OPLAN. (Refer to FM 4-02 for a planning checklist for joint operations.)

- Preparing patient estimates based on casualty planning factors established by the component commands.

- Coordinating veterinary support within the theater of operations (TO)/AO.

- Advising the JFC on HSS aspects of the Geneva Conventions.

- Informing the JFC on the available medical laboratory support required for the identification and confirmation of suspect BW and CW agent use against US forces.

(3) Liaison must be established between the JFS and each Service component command surgeon to ensure that mutual understanding of technical medical and dental procedures, unity of purpose and action, and joint HSS is maintained.

(4) For additional information on the duties and responsibilities of the JFS, refer to Joint Pub 4-02.

b. *Health Service Support to Multinational Operations*. One of the most difficult aspects of multinational operations concerns the RSI of equipment, supplies, and procedures. This task is compounded by differences in terminology, language, and doctrine.

(1) *Communications*. To ensure mission success, it is imperative that communications are quickly established with all participating Services, agencies, or nations.

- Initial communications can be facilitated by exchanging liaison teams who will have direct interface with the operation's participants. When possible, liaison personnel should be deployed early in the planning/organization phase of the operation.

- Compatible communications equipment may pose a severe problem for a multinational force. Even within joint and interagency operations, the US experiences interoperability

problems with communications equipment; these difficulties are magnified when US forces are engaged in multinational operations. Depending upon the size of the multinational force, one nation may be required to provide communications equipment to all elements for command and control (C2) purposes. Depending upon the topography in the AO and dispersion of forces, the planning for and effective use of messengers and wire communications may also assist in alleviating this situation.

This paragraph is in consonance with STANAG 2131.

- A glossary of standardized operational and medical terminology and their definitions must be compiled. Due to differences in language, translation, and usage, the operational and medical terminology of one nation may not be understood by one or more of the coalition partners. Providing a reference guide of operational terms can aid in the synchronization of military efforts, and misinterpretation can be minimized. North Atlantic Treaty Organization STANAG 2131 (Department of the Army [DA] Pamphlet 40-3) provides a multilingual medical phrase book which contains basic medical questions in some of the languages of the NATO nations. If the languages addressed in this phrase book do not include the phrases in all the languages of the multinational force, it should be supplemented with the appropriate information.

(2) *Standardization*. Within alliances, standardization can be accomplished in many areas. The specifications and requirements for equipment, treatment protocols, and procedures can be developed by working groups and adopted for use by each nation. An example of this is the NATO standard litter which can be interchangeably used in all ambulances employed by the member nations. In coalitions there is not sufficient time permitted to reach standardization agreements of this nature. Due to the short duration and limited purpose of these arrangements, there is usually only sufficient time to standardize principles and time-sensitive procedures, such as report formats or radio frequencies to be used, rather than materiel development issues. Whenever possible, international standardization agreements (ISAs) (such as NATO STANAGs and ABCA Armies QSTAGs) should be used as a starting point for coalition standardization. As mentioned earlier, those agreements pertaining to policy, procedures, and treatment protocols are more easily adapted to the coalition operation. Likewise, in joint operations the adoption of multiservice treatment protocols and procedures (such as those prescribed in FM 8-285 for treatment of chemical agent and conventional military chemical injuries) facilitates the accomplishment of the medical mission.

(3) *Command and control*. As coalitions are ad hoc agreements of countries sharing a common interest, it may not be possible to establish C2 over all participants, as each nation may have its own specific requirements which limit the authority it will permit international or national commanders to exercise over its forces. Thus, command in the formal sense may not exist, and a system of cooperation may be required in its place. Hasty agreements must be made to formulate workable methods. These are always specific to the situation and must be decided by commanders and staffs, taking into consideration the mission, requirements, and capabilities of the participating forces. Regardless of the type organization and/or agreements made by the coalition forces, specific guidance must be provided to the various national contingents as to how the coalition will operate.

(4) *Rationalization*. Rationalization consists of those actions that increase the effectiveness of coalition forces through more efficient or effective use of defense resources committed to the coalition. Rationalization applies to both weapons and materiel resources and nonweapons military measures. As the US is a signatory of the Geneva Conventions, the provisions of these conventions must be adhered to by US forces. Specific information on the protected status of medical personnel, self-defense and the defense of patients in their care, and the protected status of medical facilities, vehicles, and aircraft is provided in FM 4-02.

(5) *Additional information*. For additional information and a HSS planning checklist for multinational operations, refer to FM 4-02.

1-9. Army Service Component Command

a. Each unified and subordinate unified command has an Army Service Component Command (ASCC) assigned. The ASCC supports the theater combatant commander by conducting Army operations in support of the combatant commander's established objective. The Army contributes forces to perform combat, logistics, and support activities in the theater.

b. Health service support for the Army component in a TO is the responsibility of the ASCC. The command surgeon is on the commander's special staff (Deputy Chief of Staff, Medicine [DCSMED]). A detailed discussion of the DCSMED is provided in paragraph 1-10 below.

c. For a detailed discussion of the ASCC commander's functions and responsibilities, see FM 100-7.

1-10. The Army Service Component Command Surgeon/Deputy Chief of Staff, Medicine

Normally, the medical command (MEDCOM) commander or the senior medical commander in the COMMZ functions as the ASCC command surgeon/DCSMED, he—

- Has staff responsibility for HSS provided to the theater.
- Has staff responsibility for planning, coordinating, and developing policies for the HSS of Army forces.
- Provides advice concerning the health of the command and the occupied or friendly territory within the ASCC AO.
- Determines the medical threat and provides advice concerning the medical effects of the environment and of NBC weapons on personnel, military working dogs (MWD), rations, and water.
- Recommends changes to the theater evacuation policy and provides input and personnel to the TPMRC, as required.

- Determines the policy for the requisition, procurement, storage, maintenance, distribution, management, and documentation of Class VIII materiel, blood and blood products, and special hospital-peculiar items of subsistence.

- Develops and monitors mass casualty plans.

- Recommends priority of fills for all AMEDD officer and warrant officer (WO) vacancies and makes recommendations concerning the assignment of enlisted personnel with AMEDD specialties within the command.

1-11. Echelons Above Corps Medical Command

a. The EAC MEDCOM is normally the senior Army medical organization in a theater. As such, the commander reports directly to the ASCC commander. The commander may be dual-hatted as the ASCC DCSMED. The ASCC headquarters provides policy, direction, and guidance on operations. The EAC MEDCOM coordinates with other ASCC staff on mutual support requirements. To ensure that adequate HSS is provided throughout the COMMZ, close coordination between the EAC MEDCOM commander and the theater support command (TSC) commander and his staff is required.

b. The EAC MEDCOM headquarters provides C4I for all assigned and attached units. Its major subordinate C4I unit is the EAC medical brigade (MEDBDE).

c. Staff elements of the EAC MEDCOM headquarters conduct normal staff relationships (both command and technical) with the staffs of assigned subordinate medical headquarters.

d. Liaison with the major medical headquarters within the corps is maintained for the evacuation of patients from the CZ and for required reconstitution, reinforcement, and augmentation. The EAC MEDCOM exercises C4I and technical supervision of subordinate HSS units.

e. For additional information refer to Chapter 2.

1-12. Echelons Above Corps Medical Brigade

The EAC MEDBDE provides C4I and technical supervision of assigned or attached medical units. It is assigned to the EAC MEDCOM in the COMMZ based on the general support requirements of the Army COMMZ forces supported. For additional information refer to Chapter 4.

Section III. HEALTH SERVICE SUPPORT IN THE CORPS

1-13. The Corps

Corps are the largest tactical units in the US Army. They are the instruments by which higher echelons of command conduct operations at the operational level. Higher headquarters tailor corps for the theater and

the mission for which they are deployed. They contain organic combat, CS, and CSS capabilities to sustain operations for a considerable period (when deployed as part of a larger ground force). For a more detailed discussion of corps operations, see FM 100-15.

1-14. The Corps Surgeon Section

a. The corps surgeon is a special staff officer in the corps headquarters. This officer has a an 8-man staff section to assist him in planning and executing staff requirements. The corps surgeon has direct access to the corps commander on all HSS matters. With input from the corps MEDCOM commander, he keeps the corps commander and his staff informed on all matters concerning the health of the command, medical readiness, and the HSS aspects of combat operations and effectiveness. As command surgeon, he advises the corps commander and staff on all HSS matters related to personnel, medical threat, operations, and logistics. He normally functions under the coordinating staff supervision of the G1 or directly under the corps Chief of Staff (CofS) depending on the desires of the corps commander. He establishes coordination with surgeons and medical commanders of higher, subordinate, and adjacent headquarters through command channels, except for technical matters, which are coordinated through technical channels.

b. The duties of a command surgeon are discussed in paragraph 1-7. In addition to these duties, the corps surgeon and his staff—

- Provide current information on the corps HSS situation to surgeons of the next higher, adjacent, and subordinate headquarters.
- Develop health consultation services within the corps.
- Evaluate and interpret HSS statistical data.
- Develop, in conjunction with higher headquarters, corps evacuation policies.
- Determine corps HSS training policies and programs as required.
- Ensure compliance with the theater blood bank service program.
- Initiate PVNTMED programs (to include medical surveillance and OEH surveillance) and procedures within the corps.
- Coordinate access to intelligence of medical interest with the Assistant Chief of Staff, Intelligence (G2), and ensure that the medical threat, medical intelligence, and intelligence of medical interest are integrated into HSS OPLANs and OPORDs.

1-15. The Corps Medical Command

a. The corps MEDCOM is the senior Army medical organization in the corps.

b. The commander may be dual-hatted as the corps surgeon. The corps headquarters provides policy, direction, and guidance on operations. The corps MEDCOM coordinates with other corps staffs on mutual support requirements. To ensure that adequate HSS is provided throughout the CZ, close coordination between the corps MEDCOM commander and the corps support command (COSCOM) commander and his staff is required.

c. For additional information on the corps MEDCOM, refer to Chapter 4.

1-16. The Corps Medical Brigade

a. The corps MEDBDE provides C4I, staff, and technical supervision of assigned or attached medical units. The commander may be dual-hatted as the COSCOM surgeon. He provides liaison to the COSCOM headquarters. The COSCOM headquarters, supported by the MEDBDE, provides policy, direction, and guidance on operations within its AO. Assets from the corps MEDBDE may be used to reconstitute, reinforce, or augment forward deployed units.

b. For additional information on the corps MEDBDE refer to Chapter 5.

CHAPTER 2

HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL COMMAND (ECHELONS ABOVE CORPS)

Section I. MISSION, ASSIGNMENT, AND CAPABILITIES

2-1. Mission and Assignment

a. The headquarters and headquarters company (HHC), MEDCOM (EAC) provides C4I, administrative assistance, and technical supervision of assigned and attached units. Units which may be assigned or attached to this organization are provided in Appendix C.

b. When directed, the EAC MEDCOM headquarters provides an early entry capability and facilitates split-based operations with the employment of the MEDCOM (forward). The MEDCOM (forward) (refer to Section II below) is a 35-person module designated from the HHC MEDCOM (EAC) that will provide the connectivity between the EAC MEDCOM in CONUS and the medical units in the theater. It can be deployed as the medical element of the TSC. It is assigned to the ASCC and coordinates with the TSC. Should troop ceiling limitations necessitate the deployment of a smaller-sized element, the MEDCOM task organizes the required capability from the positions designated for the MEDCOM (forward). Task organization is METT-TC dependent.

c. This unit, table of organization and equipment (TOE) 08611A000, is assigned to the ASCC and is allocated on a basis of one per theater.

2-2. Capabilities and Limitations

a. The EAC MEDCOM has the following capabilities:

- Commands and controls theater medical units providing HSS within the TO.
- Provides advice to senior commanders on the HSS aspects of their operations.
- Provides staff planning, supervision of operations, and administration of assigned and attached medical units.
- Coordinates with the TPMRC for medical regulating of patients (from EAC MEDCOM MTFs to appropriate MTFs in the CONUS-support base).
- Provides consultation services and technical advice in medical and surgical services, PVNTMED, nursing, dentistry, veterinary services, optometry, nutrition care, and neuropsychiatric (NP) and MH services to supported units.
- Provides advice and assistance in facility selection and preparation.
- Controls and supervises Class VIII supply and resupply movement.

- Plans for the SIMLM mission, when directed.

- Provides veterinary support for zoonotic disease control and investigation and the inspection of subsistence.

- Provides PVNTMED support for food facility inspection, potable water inspection, pest management, medical and OEH surveillance, and control of medical and nonmedical waste.

- Has general courts-martial jurisdiction over the subordinate MEDCOMs and MEDBDEs.

b. This unit is dependent upon the appropriate supporting elements of the theater for HSS, finance, supplemental transportation, security during tactical moves, rear area security and area damage control, NBC decontamination assistance, and laundry and bath.

2-3. Command Section

The function of the command section (Table 2-1) is to provide C2 and management of all MEDCOM operations. The EAC MEDCOM commander also serves as the ASCC surgeon. This section ensures the synchronization of all clinical and operational aspects of MEDCOM operations.

Table 2-1. Command Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
00B00	O8	COMMANDER	GO
00B00	O7	DEPUTY COMMANDER**	GO
56A00	O6	#CHAPLAIN	CH
01A00	O3	AIDE-DE-CAMP	IMM
01A00	O2	AIDE-DE-CAMP**	IMM
00Z50	E9	COMMAND SERGEANT MAJOR	NC
42L30	E6	EXECUTIVE ADMINISTRATIVE ASSISTANT	NC
88M30	E6	CHAUFFEUR	NC
92G30	E6	ENLISTED AIDE (2)	NC
42L20	E5	EXECUTIVE ADMINISTRATIVE ASSISTANT**	NC
88M20	E5	CHAUFFEUR**	NC

**MEDCOM (FORWARD) STAFF
#ALSO SHOWN IN MINISTRY TEAM SECTION

2-4. Chief of Staff and Section

a. The CofS is the MEDCOM commander's principal assistant for directing, coordinating, supervising, and training the special and coordinating staffs, except in those areas the commander reserves

for himself. The EAC MEDCOM commander delegates the necessary executive management authority to the CofS. The CofS frees the commander from routine details and passes pertinent data, information, and insights from the staff to the commander and from the commander to the staff. For an in-depth discussion of duties and responsibilities of the CofS, refer to FM 101-5.

b. The functions of the CofS section (Table 2-2) are to plan, direct, and coordinate the execution of staff functions. It reviews organizational activities and recommends changes, as necessary, to the MEDCOM commander. This section ensures synchronization of staff activities and ensures that required coordination is accomplished.

Table 2-2. Chief of Staff Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
67A00	O6	CHIEF OF STAFF	MS
67A00	O4	SECRETARY GENERAL STAFF**	MS
42L30	E6	ADMINISTRATIVE SUPERVISOR	NC
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	
42L10	E4	ADMINISTRATIVE SPECIALIST**	

**MEDCOM (FORWARD) STAFF

2-5. Staff Organization and Functions

The MEDCOM staff includes a coordinating, special, and personal staff structure. An in-depth discussion of the composition, duties, and responsibilities of the various staffs and staff members is contained in FM 101-5.

a. *Coordinating staff* (Figure 2-1) officers are the commander's principal staff assistants and are directly accountable to the CofS. Coordinating staff officers are responsible for one or a combination of broad fields of interest. They help the commander coordinate and supervise the execution of plans, operations, and activities. Collectively through the CofS, they are accountable for the commander's entire field of responsibilities. The staff is not accountable for functional areas the commander decides to personally control.

b. *Special staff* (Figure 2-2, page 2-5) officers help the commander and other members of the staff in their professional and technical functional areas. Special staffs are organized according to functional areas.

c. *Personal staff* (Figure 2-2) members work under the commander's immediate control. They also serve as special staff officers as they coordinate actions and issues with other staff members.

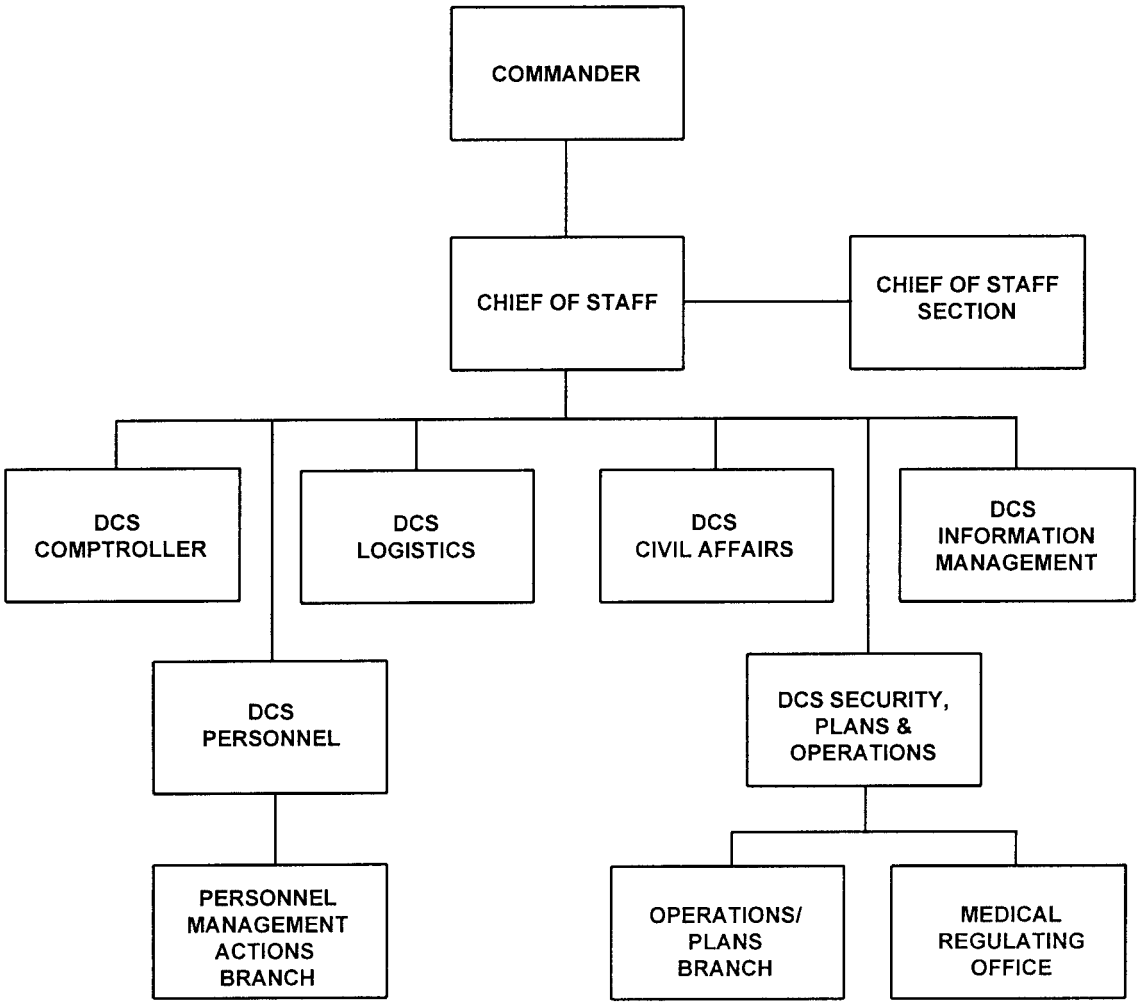

Figure 2-1. Echelons above corps medical command coordinating staff.

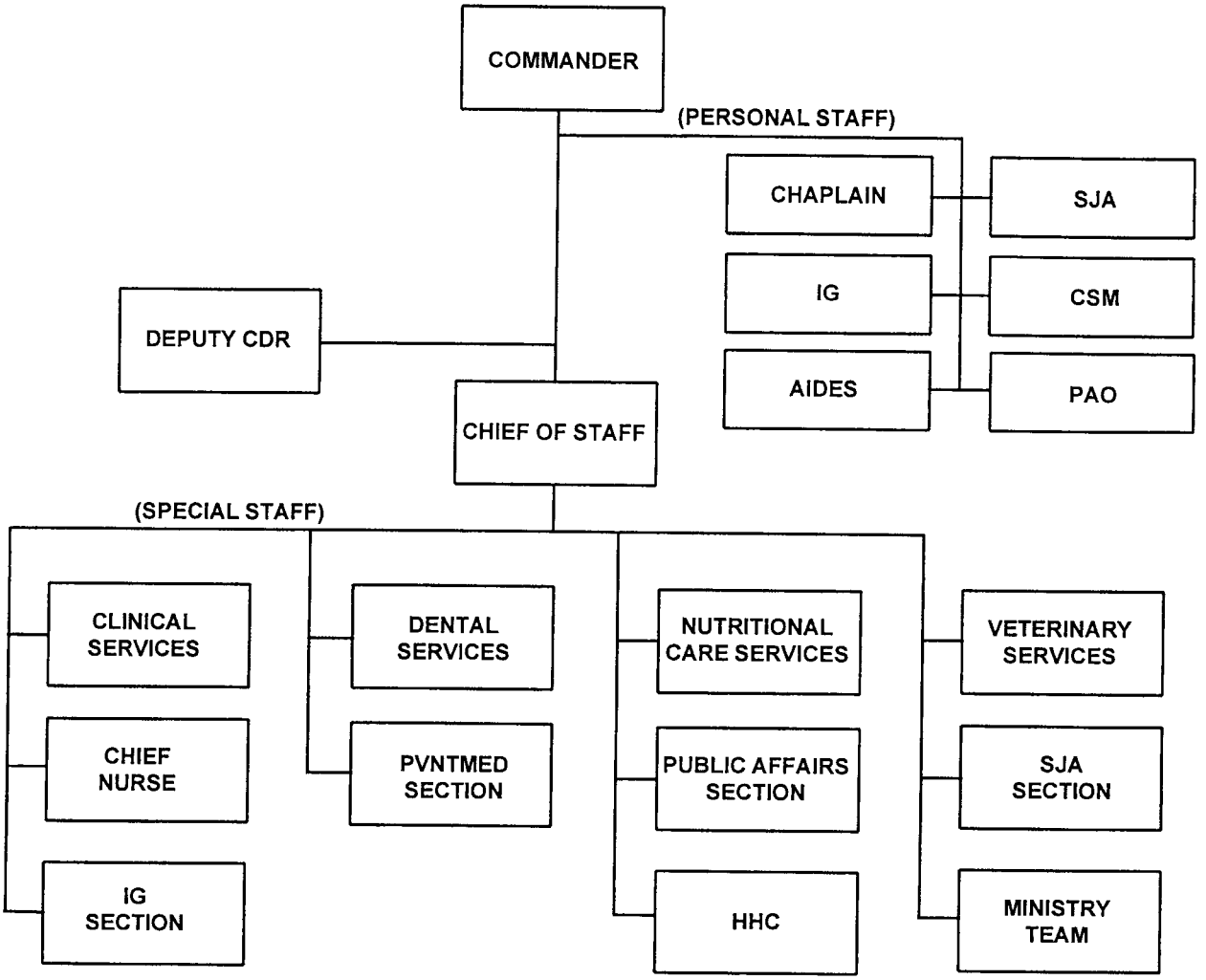

Figure 2-2. Echelons above corps medical command special and personal staffs.

2-6. Deputy Chief of Staff, Personnel Section

a. The Deputy Chief of Staff, Personnel (DCSPER) section (Table 2-3) serves as the principal staff element for all internal MEDCOM matters pertaining to human resource activities. This section is responsible for establishing, monitoring, and assessing MEDCOM human resource policies. This section has primary or coordinating responsibility for MEDCOM strength management; finance support; casualty management; casualty estimates; morale, welfare, and recreation (MWR) activities; education; safety and accident prevention; alcohol and drug abuse programs; and equal opportunity activities. The section

prepares the MEDCOM personnel estimate and recommends priorities of fill for replacement to the MEDCOM commander and the Deputy Chief of Staff, Security/Plans/Operations (DCS SPO). Refer to FM 12-6 and FM 101-5 for additional information. It monitors the Professional Filler System (PROFIS) and the integration of PROFIS personnel into subordinate medical units.

Table 2-3. Deputy Chief of Staff, Personnel Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70F67	O6	DEPUTY CHIEF OF STAFF, PERSONNEL	MS
70F67	O5	HEALTH SERVICE PERSONNEL OFFICER**	MS
42B00	O4	PERSONNEL MANAGEMENT OFFICER	AG
42A50	E9	CHIEF HUMAN RESOURCES SERGEANT	NC
42A40	E7	SENIOR HUMAN RESOURCES SERGEANT**	NC
42L30	E6	ADMINISTRATIVE SUPERVISOR	NC
42A20	E5	HUMAN RESOURCES SERGEANT**	NC
42A10	E4	HUMAN RESOURCES SPECIALIST	
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	
42L10	E4	ADMINISTRATIVE SPECIALIST**	
42A10	E3	HUMAN RESOURCES SPECIALIST (2)	

**MEDCOM (FORWARD) STAFF

b. Personnel management/actions branch (Table 2-4) develops personnel policies for promotions, appointments, demotions, classifications, assignments, reassignments, decorations, awards, separations, and rotations for the MEDCOM in accordance with theater policy. It maintains continuous personnel loss data and obtains summarized personnel information for use in preparing support plans. In coordination with the Deputy Chief of Staff, Civil Affairs (DCSCA), this branch provides policy and guidance on procurement, administration, and utilization of civilian personnel in the command. This branch is also responsible for establishing and monitoring family readiness groups.

Table 2-4. Personnel Management/Actions Branch

AOC/MOS	GRADE	JOB TITLE	BRANCH
70F67	O4	PERSONNEL STAFF OFFICER	MS
42A50	E8	SENIOR HUMAN RESOURCES SERGEANT	NC
42A20	E5	HUMAN RESOURCES SERGEANT	NC
42A10	E4	HUMAN RESOURCES SPECIALIST	
42L10	E4	ADMINISTRATIVE SPECIALIST**	
42A10	E3	HUMAN RESOURCES SPECIALIST	

**MEDCOM (FORWARD) STAFF

2-7. Deputy Chief of Staff, Security/Plans/Operations Section

The DCS SPO (Table 2-5) section is the principal staff section in matters concerning security, plans, intelligence, operations, organization, training, and NBC defensive activities (see also paragraph 2-17). It prepares broad planning guidance, policies, and programs for command organizations, operations, and functions. This section develops policies and guidance for training and training evaluation of the command. This section has two principal functional elements—the operations/plans branch and the medical regulating office (MRO). For additional information on the responsibilities of this staff section, refer to FM 101-5. For a discussion of command post operations refer to Appendix D.

Table 2-5. Deputy Chief of Staff, Security/Plans/Operations Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70H67	O6	DEPUTY CHIEF OF STAFF, SECURITY/PLANS/OPERATIONS**	MS
91Z50	E9	CHIEF MEDICAL NONCOMMISSIONED OFFICER	NC
42L20	E5	ADMINISTRATIVE SERGEANT	NC
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT**	

**MEDCOM (FORWARD) STAFF

a. Operations/Plans Branch.

(1) Within the operations/plans branch (Table 2-6), the intelligence staff acquires, analyzes, and evaluates intelligence, to include medical threat information and medical and OEH surveillance data. In coordination with the PVNTMED officer, it identifies DNBI trends and processes data accordingly. It identifies the commander's CCIR and other intelligence requirements (see paragraph 1-7*c*.) It also presents intelligence assessments, evaluations, and recommendations to the commander. The staff provides threat analysis to support operations security (OPSEC) planning. It develops plans and requirements for terrain studies, mapping, and charting. It collects and distributes weather data. This branch assists the DCS SPO in preparing OPLANs.

(2) The operations staff authenticates and publishes plans and orders. They exercise staff supervision over HSS activities. They assist the commander in developing and training the unit's mission essential task list (METL). They identify training requirements, based on HSS missions and the unit's training status. They are responsible for developing and implementing training programs, directives, and orders. They maintain the unit readiness status reports of each unit in the MEDCOM.

(3) This section coordinates Army airspace command and control (A2C2) and aviation maintenance issues and monitors Army rotary-wing air ambulance operations. This section also coordinates the augmentation, reinforcement, and reconstitution of corps air ambulance assets.

(4) This section provides advice and consultation on NBC defensive operations, force protection matters, and risk assessment and management.

Table 2-6. Operations/Plans Branch

AOC/MOS	GRADE	JOB TITLE	BRANCH
70H67	O5	ASSISTANT CHIEF OF STAFF SECURITY/PLANS/OPERATIONS	MS
67J00	O4	AEROMEDICAL EVACUATION OFFICER**	MS
70H67	O4	INTELLIGENCE OFFICER**	MS
70H67	O4	MEDICAL OPERATIONS OFFICER (2)**	MS
70H67	O4	MEDICAL PLANS OFFICER (2)**	MS
74B00	O4	CHEMICAL OFFICER**	CM
74B00	O3	ASSISTANT CHEMICAL OFFICER	CM
91Z50	E9	CHIEF OPERATIONS SERGEANT	NC
54B50	E8	CHEMICAL OPERATIONS NONCOMMISSIONED OFFICER	NC
91W50	E8	OPERATIONS NONCOMMISSIONED OFFICER	NC
91W50	E8	PLANS NONCOMMISSIONED OFFICER	NC
91W50	E8	INTELLIGENCE MEDICAL SERGEANT	NC
31B40	E7	FORCE PROTECTION SUPERVISOR	NC
42L20	E5	ADMINISTRATIVE SERGEANT	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	
42L10	E3	ADMINISTRATIVE CLERK	

**MEDCOM (FORWARD) STAFF

b. Medical Regulating Office. The MRO (Table 2-7) is responsible to the DCS SPO for maintaining continuous operations (CONOPS) and conducting split-based operations. This office is responsible for medical regulating of all patients in the theater, and preparation of patient statistical reports. This office coordinates with the TPMRC for intertheater evacuation of all patients leaving the theater and for specific patient movement items (PMI) requirements and medical attendant requirements. The MRO interfaces with the TPMRC for intratheater air evacuation when evacuation distances exceed the capabilities of Army rotary-wing aircraft. This section performs patient tracking procedures and monitors in-transit visibility of MEDCOM patients. Refer to Joint Pub 4-02.2 and FM 8-10-6 for additional information on medical evacuation and medical regulating. Additionally this section provides advice and consultation on the maintenance and disposition of medical records (see also paragraph 2-12). Refer to AR 40-66, AR 40-400, and FM 4-02.4 for information on the maintenance and disposition of medical records for deployed forces.

Table 2-7. Medical Regulating Office

AOC/MOS	GRADE	JOB TITLE	BRANCH
70E67	O5	PATIENT ADMINISTRATION OFFICER	MS
70E67	O3	PATIENT ADMINISTRATION OFFICER**	MS
91G50	E8	PATIENT ADMINISTRATION NONCOMMISSIONED OFFICER	NC
91G20	E5	PATIENT ADMINISTRATION NONCOMMISSIONED OFFICER (2)	NC
42L10	E4	ADMINISTRATIVE SPECIALIST**	
91G10	E4	PATIENT ADMINISTRATION SPECIALIST (2)	
91G10	E3	PATIENT ADMINISTRATION SPECIALIST (2)	

**MEDCOM (FORWARD) STAFF

2-8. Deputy Chief of Staff, Logistics Section

a. The Deputy Chief of Staff, Logistics (DCSLOG) section (Table 2-8) has primary responsibility for monitoring logistics support to MEDCOM units, including general supply, maintenance, transportation, field services, and construction support. The DCSLOG integrates those functions that sustain the MEDCOM's assigned and attached units in the AO. This section provides staff supervision and overall coordination for internal logistics support of MEDCOM units.

b. This section monitors, coordinates, and facilitates medical logistics operations within the command. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, optical lens fabrication, and spectacle fabrication and repair. Further, this section uses the medical logistical information contained in the JRCAB DEPMEDS Clinical Policy and Guidelines and Patient Treatment Briefs and current usage information to forecast medical supply usage based on types of medical conditions treated. Refer to paragraph 1-7 for JRCAB website information.

c. This section plans for the SIMLM mission, when designated. It coordinates with and provides medical logistics support to all Services deployed in the theater. This section coordinates with and establishes a liaison with the medical logistics management center (MLMC) forward team. The MLMC forward team provides a centralized, theater-level management of critical Class VIII materiel, PMI, and medical maintenance. The SIMLM mission is executed by the HHD, Medical Logistics Battalion (EAC) and the MLMC forward team. Refer to FM 4-02.1 for additional information on the MLMC.

d. This section coordinates, and facilitates contracting operations in support of the medical mission. (The availability of contracting support for medical services and supplies may be limited by the stringent requirements of the Food and Drug Administration [FDA] for medical supplies and US standards for professional services.)

Table 2-8. Deputy Chief of Staff, Logistics Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70K67	O6	DEPUTY CHIEF OF STAFF, LOGISTICS	MS
70K67	O5	HEALTH SERVICES MATERIEL OFFICER**	MS
70K67	O4	HEALTH SERVICES MATERIEL OFFICER (2)	MS
70K67	O3	HEALTH SERVICES MATERIEL OFFICER**	MS
88D00	O3	TRANSPORTATION OFFICER	TC
670A0	W4	COMMAND MAINTENANCE OFFICER	WO
91A50	E9	CHIEF MEDICAL MAINTENANCE NONCOMMISSIONED OFFICER	NC
91Z50	E9	CHIEF, MEDICAL LOGISTICS NONCOMMISSIONED OFFICER	NC
91J50	E8	MEDICAL LOGISTICS SERGEANT	NC
92Y40	E7	SUPPLY SERGEANT**	NC
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	

**MEDCOM (FORWARD) STAFF

2-9. Deputy Chief of Staff, Civil Affairs Section

The DCSCA section (Table 2-9) integrates CMO planning within the MEDCOM AO. This section conducts area assessments and estimates on the impact of local populace on MEDCOM operations to include the assessment of the host/foreign nation medical infrastructure. Refer to FM 41-10 for additional information on civil affairs (CA) and CMO and refer to FM 8-42 for medical operations in stability operations and support operations (to include humanitarian assistance operations).

Table 2-9. Deputy Chief of Staff, Civil Affairs Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
39C00	O5	CIVIL AFFAIRS OFFICER	CA
39C00	O3	CIVIL AFFAIRS OFFICER**	CA
42L10	E4	ADMINISTRATIVE ASSISTANT	NC

**MEDCOM (FORWARD) STAFF

2-10. Deputy Chief of Staff, Information Management Section

The Deputy of Chief Staff, Information Management (DCSIM) section (Table 2-10) is responsible for all aspects of automation and communications-electronics (CE) support within the MEDCOM. They establish a HSS automation office and are responsible for HSS automation policy and guidance for all subordinate information elements. They identify CE requirements for data transmission services and coordinate these requirements with the signal command. This section also coordinates and facilitates TELEMED support

and requirements for subordinate medical units. This section provides advice and consultation on the interface of medical automation systems with other automated systems within the theater.

Table 2-10. Deputy Chief of Staff, Information Management Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70D67	O6	DEPUTY CHIEF OF STAFF, INFORMATION MANAGEMENT	MS
25A00	O5	COMMUNICATIONS-ELECTRONICS OFFICER**	SC
25A00	O4	COMMUNICATIONS-ELECTRONICS OFFICER	SC
70D67	O4	BIOMEDICAL INFORMATION MANAGEMENT OFFICER	MS
70D67	O3	HEALTH SERVICES SYSTEM MANAGER**	MS
251A0	W2	INFORMATION SYSTEM TECHNICIAN	WO
25Y50	E8	INFORMATION SYSTEM CHIEF	NC
25B30	E6	INFORMATION SYSTEM TEAM CHIEF	NC
25U30	E6	SECTION CHIEF	NC
42L30	E6	ADMINISTRATIVE SUPERVISOR	NC
25B20	E5	SENIOR INFORMATION SYSTEMS OPERATOR-MAINTAINER	NC
25B10	E4	INFORMATION SYSTEM OPERATOR-MAINTAINER	
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	
42L10	E4	ADMINISTRATIVE SPECIALIST	
25B10	E3	INFORMATION SYSTEMS OPERATOR-MAINTAINER	
42L10	E3	ADMINISTRATIVE CLERK	

**MEDCOM (FORWARD) STAFF

2-11. Deputy Chief of Staff, Comptroller Section

This section (Table 2-11) is responsible for budget preparation and resource management analysis and implementation for the command. It provides staff assistance on budget matters; establishes funding ceilings for subordinate units; and monitors budget program execution. This section coordinates funding of humanitarian assistance and disaster relief operations and other operations which may require special and/or additional funding. This section funds approved contractual services and materiel. Further, it monitors and provides advice and assistance on reimbursement for medical services rendered from third parties, other Services, and allied, coalition, and HN forces, as specified by regulation or MOA or MOU.

Table 2-11. Deputy Chief Staff, Comptroller Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70C67	O6	DEPUTY CHIEF OF STAFF, COMPTROLLER	MS
70C67	O4	HEALTH SERVICES COMPTROLLER**	MS
44C50	E8	FINANCE MANAGEMENT ADVISOR	NC
44C30	E6	SENIOR INTERNAL CONTROL ANALYST	NC
44C20	E5	ACCOUNTING ANALYST	NC
44C20	E5	INTERNAL CONTROL ANALYST	NC
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	
42L10	E4	ADMINISTRATIVE SPECIALIST	
44C10	E4	ACCOUNTING TECHNICIAN	

**MEDCOM (FORWARD) STAFF

2-12. Clinical Services Section

a. The Deputy Commander for Professional Services is the director of all clinical services within the command and monitors the standard of care provided in command MTFs. He develops, implements, and monitors clinical policy, consultation services, and medical programs of the command. He provides guidance and consultation on medical ethics issues.

b. The clinical services section (Table 2-12) functions as the command's technical advisors in—

- Neuropsychiatry, MH, and COSC to include establishing and monitoring policies, programs, and consultations services; advising on the medical evacuation priorities, procedures, medications, and types of platforms to use for stress-related or mentally ill patients; and coordinating for reconstitution, reinforcement, or augmentation of forward deployed MH assets.

- Medical and surgical services to include providing consultation support, monitoring patient statistical data on types of wounds, injuries, and illnesses to identify trends, ensuring required professional skills are available and requesting augmentation when required, monitoring care of EPW or personnel in US custody (retained/detained), recommending the designation of MTFs for specific situations or medical conditions (such as for EPW patients only or all cases of head trauma). This section also develops and implements medical and surgical clinical policies and guidelines which are in consonance with the JRCAB DEPMEDS Clinical Policy and Guidelines and Patient Treatment Briefs and STANAG 2068. The JRCAB website is provided in paragraph 1-7. This section identifies medical issues requiring research and clinical investigation.

- Pharmacy to include developing and establishing a theater formulary, monitoring pharmacy operations within the command to ensure compliance with regulatory requirements, providing consultation on prescription and IND, establishing policy and procedures for dispensing over-the-counter drugs, monitoring proficiency of enlisted pharmacy personnel, and establishing training programs as required.

- Optometry to include monitoring the occupational vision program, providing consultation on all matters pertaining to vision evaluation and correction, and developing protocols for the diagnosis and treatment of ocular injuries and diseases in concert with supporting ophthalmologist.

- Medical laboratory to include monitoring medical laboratory operations within the command to ensure adequate capability is available to meet medical laboratory requirements, coordinating for reconstitution, reinforcement, or augmentation of medical laboratory resources, as required, and providing consultation to subordinate medical laboratory specialists.

c. This section ensures that health care providers are properly credentialed and their scope of practice is defined. They also establish quality assurance measures and peer review of technical matters. This section is also responsible for establishing and monitoring professional medical education and training programs and policies.

d. This section, in conjunction with the patient administration officers in the MRO, monitor the maintenance and disposition of patient medical records.

Table 2-12. Clinical Services Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
00B00	O7	DEPUTY COMMANDER, PROFESSIONAL SERVICES	GO
60W00	O6	PSYCHIATRIST	MC
61F00	O6	MEDICAL CONSULTANT**	MC
61J00	O6	SURGICAL CONSULTANT	MC
67E00	O6	PHARMACY OFFICER	MS
67F00	O5	OPTOMETRY OFFICER	MS
01A00	O2	AIDE-DE-CAMP	IMM
91K50	E9	CHIEF MEDICAL LABORATORY NONCOMMISSIONED OFFICER	NC
42L20	E5	EXECUTIVE ADMINISTRATIVE ASSISTANT	NC
88M20	E5	CHAUFFEUR	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	
42L10	E3	ADMINISTRATIVE CLERK	

**MEDCOM (FORWARD) STAFF

2-13. Dental Services Section

The function of this section (Table 2-13) is to serve as the commander's principal consultant and the command's technical advisor in dentistry. It directs the establishment and implementation of policy and programs for all dental activities; this includes preventive dentistry and educational programs, operational dental care (emergency and essential), and oral and maxillofacial surgical procedures. This section ensures oral health surveillance policies, programs, and procedures are developed and implemented within the

theater. It also advises the commander on the dental aspects of humanitarian assistance operations, plans, and programs, as required. Dental policies are also specified in the JRCAB DEPMEDS Clinical Policy and Guidelines and Patient Treatment Briefs. The JRCAB website is provided in paragraph 1-7 above. For additional information on operational dental care refer to FM 4-02.19.

Table 2-13. Dental Services Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
63R00	O6	DENTAL SURGEON**	DC
63H00	O5	PUBLIC HEALTH DENTIST	DC
91Z50	E9	CHIEF DENTAL NONCOMMISSIONED OFFICER	NC

**MEDCOM (FORWARD) STAFF

2-14. Veterinary Services Section

The veterinary services section (Table 2-14) serves as the commander's principal consultant and the command's technical advisor for veterinary activities and employment of veterinary assets. It provides technical supervision of food inspection, animal medical care, and veterinary PVNTMED support. The US Army is the Executive Agent for veterinary services for all Services. Refer to FM 8-10-18 for additional information.

Table 2-14. Veterinary Services Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
64Z00	O6	SENIOR VETERINARIAN**	VC
91R50	E9	SENIOR VETERINARY NONCOMMISSIONED OFFICER	NC

**MEDCOM (FORWARD) STAFF

2-15. Nutrition Care Services Section

The function of the nutrition care services section (Table 2-15) is to serve as the commander's principal consultant and the command's technical advisor in nutrition care. This section ensures coordination required to obtain medical supplemental rations is accomplished and that assigned and attached hospitals have required items to prepare medical diets. This section also coordinates with the ministry team to ensure the availability of rations for hospitalized patients with religion-based dietary restrictions.

Table 2-15. Nutrition Care Services Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
65C00	O6	DIETETIC CONSULTANT	SP
91Z50	E9	CHIEF NUTRITION CARE NONCOMMISSIONED OFFICER	NC

2-16. Chief Nurse Section

The chief nurse section (Table 2-16) serves as the commander's principal advisor on all issues affecting nursing practices and personnel. It develops, plans, and implements policy for infection control and quality assurance nursing programs. The chief nurse (nursing consultant) is responsible for nursing policy, resourcing, and technical supervision of subordinate nursing personnel. This section analyzes and evaluates nursing care and procedures in subordinate units. The chief nurse evaluates HN health care delivery systems and hospitalization capabilities and integrates clinical policy with joint and combined forces. Nursing practice guidelines are provided in the JRCAB DEPMEDS Clinical Policy and Guidelines and Patient Treatment Briefs. This section is also responsible for coordinating, organizing, and implementing required or necessary education and training programs for nursing personnel. See paragraph 1-7 for JRCAB website.

Table 2-16. Chief Nurse Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
66N00	O6	NURSING CONSULTANT**	AN
91Z50	E9	CHIEF CLINICAL NONCOMMISSIONED OFFICER	NC

**MEDCOM (FORWARD) STAFF

2-17. Preventive Medicine Section

a. The PVNTMED section (Table 2-17) serves as the commander's principal consultant and the command's PVNTMED and environmental sciences advisors. This section develops, plans, and implements PVNTMED policies and programs for the theater. These programs include medical surveillance, OEH surveillance, pest management activities, epidemiological investigations, food service facility sanitation and hygiene, and inspection of potable water supplies. This section monitors and analyzes DNBI reports submitted by subordinate medical units. Trend analysis is used to identify shifts from the baseline of diseases within the AO as a shift may indicate the use of BW agents against the deployed force. It also evaluates HN capabilities and integrates PVNTMED policy with joint and/or combined forces.

b. This section advises the commander on the medical aspects of NBC defensive measures. This includes, but is not limited to, policies, programs, and procedures pertaining to immunizations, chemoprophylaxis, barrier creams, pretreatments, and the use of INDs.

c. For additional information on PVNTMED refer to FM 4-02.17.

Table 2-17. Preventive Medicine Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
60C00	O6	PVNTMED OFFICER**	MC
72A67	O5	NUCLEAR MEDICAL SCIENCE OFFICER	MS
72D67	O5	ENVIRONMENTAL SCIENCE OFFICER	MS
91S50	E9	CHIEF PVNTMED NONCOMMISSIONED OFFICER	NC

**MEDCOM (FORWARD) STAFF

2-18. Inspector General Section

This special staff section (Table 2-18) is responsible to the commander for inquiring into and reporting on matters that impact the overall efficiency of the command. This includes the performance of the mission, state of discipline, operating efficiency, and economy. The inspector general (IG) section conducts inspections, investigations, surveys, and studies as the commander directs and as laws and regulations prescribe. The chief of the section serves on the personal staff and is responsible for those functions discussed in FM 101-5.

Table 2-18. Inspector General Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
05A00	O5	INSPECTOR GENERAL	IMM
05A00	O4	INSPECTOR GENERAL	IMM
02A00	O3	ASSISTANT INSPECTOR GENERAL	IMM
91Z50	E9	CHIEF MEDICAL NONCOMMISSIONED OFFICER	NC
42A4B	E7	INSPECTOR GENERAL NONCOMMISSIONED OFFICER	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	
42L10	E3	ADMINISTRATIVE CLERK	

2-19. Public Affairs Section

The function of the public affairs (PA) section (Table 2-19) is to serve as the commander's focal point for command information, public information, and community relations matters. The MEDCOM PA officer (PAO) has the overall responsibility for building understanding of the Army health care services/programs within the theater. Additionally, as the official spokesperson for the command, releases information, as appropriate, on the medical aspects of—

- Incidents, engagements, or accidents involving other commands, Services, and/or allied and coalition forces.

- Controversial issues that are likely to attract national media attention.

Table 2-19. Public Affairs Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70A67	O5	HEALTH CARE ADMINISTRATIVE OFFICER	MS
46A00	O4	PUBLIC AFFAIRS OFFICER	PA
46Z40	E7	PUBLIC AFFAIRS OPERATIONS NONCOMMISSIONED OFFICER	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	
42L10	E3	ADMINISTRATIVE CLERK	

2-20. Staff Judge Advocate Section

The functions of this special staff section (Table 2-20) are to provide legal advice and services to the commander, staff, subordinate commanders, soldiers, and other authorized personnel. The SJA section develops and executes plans and programs in the fields of criminal law and related military justice, administrative law, litigation, environmental law, regulatory law, intelligence activities law, labor and civilian personnel law, and medical jurisprudence. This section advises the commander on the legal aspects of determining eligibility for care in US MTFs.

Table 2-20. Staff Judge Advocate Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
27A00	O5	STAFF JUDGE ADVOCATE	JA
27A00	O3	JUDGE ADVOCATE	JA
27A00	O3	JUDGE ADVOCATE**	JA
270A0	W2	LEGAL ADMINISTRATOR	WO
27D40	E7	SENIOR PARALEGAL NONCOMMISSIONED OFFICER	NC
27D30	E6	COURT REPORTER	NC
27D20	E5	PARALEGAL NONCOMMISSIONED OFFICER	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	
42L10	E3	ADMINISTRATIVE CLERK	

**MEDCOM (FORWARD) STAFF

2-21. Company Headquarters

The HHC (Table 2-21) commander is the special staff officer responsible for soldiers assigned to the MEDCOM headquarters that are not assigned or attached to subordinate commands. Besides his common staff responsibilities, the HHC commander is responsible for: developing the MEDCOM headquarters occupation plan; ensuring local headquarters security, to include constructing defensive positions; arranging for and moving the headquarters; training; conducting MWR activities for headquarters personnel; obtaining or providing food service, quarters, HSS, field sanitation, and supply for headquarters personnel; receiving, accommodating, and orienting visitors and PROFIS personnel; providing and prioritizing motor transportation support (organic to or allocated for use by the headquarters); and maintaining equipment organic to or allocated for use by the headquarters.

Table 2-21. Company Headquarters

AOC/MOS	GRADE	JOB TITLE	BRANCH
05A00	O3	COMMANDER	MS
91W5M	E8	FIRST SERGEANT	NC
92G40	E7	SENIOR FOOD OPERATIONS SERGEANT	NC
92Y30	E6	SUPPLY SERGEANT	NC
42A20	E5	HUMAN RESOURCES SERGEANT	NC
92G20	E5	FIRST COOK	NC
63B10	E4	WHEELED VEHICLE MECHANIC	
74D10	E4	DECONTAMINATION SPECIALIST	
92A10	E4	EQUIPMENT RECORDS/PARTS SPECIALIST	
92G10	E4	COOK	
92Y10	E4	ARMORER	
92A10	E3	EQUIPMENT RECORDS/PARTS SPECIALIST	
92G10	E3	COOK	

2-22. Ministry Team

The ministry team (Table 2-22) provides religious support and pastoral care for assigned staff and subordinate organizations. This team develops, exercises staff supervision over, and implements the commander's religious support program; provides moral and spiritual leadership to the command and community; advises the commander and staff, in coordination with the CA officer, of the impact of the faith and practice of indigenous religious groups in the AO and provides liaison to indigenous religious leaders. Coordinates with subordinate MEDCOM chaplains to ensure availability of rations within the theater for hospitalized patients with religion-based dietary restrictions.

Table 2-22. Ministry Team

AOC/MOS	GRADE	JOB TITLE	BRANCH
56A00	O6	#CHAPLAIN	CH
56A00	O5	ASSISTANT CHAPLAIN	CH
56A00	O4	ASSISTANT CHAPLAIN	CH
56M50	E8	CHIEF ASSISTANT NONCOMMISSIONED OFFICER	NC
56M10	E4	CHAPLAIN ASSISTANT	
56M10	E3	CHAPLAIN ASSISTANT	

#ALSO SHOWN IN THE COMMAND SECTION

Section II. MEDICAL COMMAND (FORWARD)

2-23. Introduction to the Medical Command (Forward)

a. The positions which comprise the MEDCOM (forward) are designated on the TOE from positions within the EAC MEDCOM headquarters (TOE 08611A000). It provides a C4I capability to support expanding HSS forces in a major theater war (MTW). This element is allocated on the basis of one element per developing MTW.

b. The MEDCOM (forward) deploys to interface with the TSC and operate directly under the ASCC. The element facilitates HSS planning, policy development, and technical supervision of deployed HSS resources. The MEDCOM (forward) maintains a technical linkage to various HSS activities at the strategic level. These activities include the Offices of The Surgeons General (all Services), the Defense Logistics Agency (DLA), the AFMIC (subordinate unit of the Defense Intelligence Agency [DIA]), and US Army MEDCOM (USAMEDCOM), and US Army Medical Research and Materiel Command (USAMRMC) and its subordinate units.

c. The MEDCOM (forward) provides a robust planning, controlling, and coordinating capability to facilitate the provision of HSS to expanding forces. The MEDCOM (forward)—

- Provides command and control for follow-on HSS forces.
- Coordinates the RSO&I of arriving medical units.
- Coordinates and synchronizes HSS operations with all Services, allied, coalition, and HN forces operating in the TO, as required.
- Conducts HSS planning.

2-24. Mission of the Medical Command (Forward)

a. The MEDCOM (forward) directs HSS for all operational-level Army medical elements in the AO. When the Army is the lead Service for HSS, it also supports joint and multinational commands. The MEDCOM (forward) assists in establishing medical policy for the theater. It also maintains technical linkages to various HSS activities at the strategic level.

b. The MEDCOM (forward) is responsible for developing plans, procedures, and programs for HSS in the AO. It provides staff planning, staff supervision, training, and administrative support of Army MEDBDEs engaged in operational-level HSS. It provides medical logistics, including medical requirements determination and medical supply control. When deployed the commander of the MEDCOM (forward) is the deputy commander of the CONUS-based MEDCOM headquarters.

c. The MEDCOM (forward) monitors the flow of Class VIII supplies and makes necessary adjustments in coordination with the TSC support operations section/distribution management center (DMC), the ASCC Assistant Chief of Staff, Logistics (G4), and the MLMC deployed team. It directs relocation of and cross-leveling of medical supply items and medical equipment as required by changing tactical operations.

d. It coordinates medical regulating operations with the MEDBDE MROs and the TPMRC, as well as the TSC support operations section/DMC and the movement control agency (MCA). It tracks MTF locations, capabilities, and workloads to plan and manage medical regulating, medical evacuation, and mass casualty operations.

2-25. Assignment

The MEDCOM (forward) is normally assigned to the ASCC.

2-26. Capabilities

a. This MEDCOM (forward) provides—

- Assistance to the ASCC in development of plans and policies for theater-wide HSS. This also encompasses focusing on HSS for the theater, including the requirements of the—
  - Other Services.
  - Governmental agencies.
  - Allied, coalition, and HN forces.
  - Nongovernmental agencies, when authorized.
- Medical C2, planning, and staff supervision for theater-opening HSS forces.

- Medical regulating and coordination for intra- and intertheater medical evacuation.
- Strategic coordination and management of personnel activities and integration of PROFIS personnel.
- Control and supervision of Class VIII (including blood management) activities.
- Medical consultative services and technical advice to medical units, supported commands, and supported Services.

b. The MEDCOM (forward) establishes communications links with its CONUS base and operates in a split-based mode.

2-27. Limitations

This element is dependent upon—

a. Appropriate supporting elements in the AO for finance; personnel and administrative services; field services; physical security; and supplemental transportation.

b. The supporting base operations or collocated medical unit for food service; water distribution; Level I HSS; general supply; power generation; and unit maintenance for the MEDCOM (forward) vehicles and communications equipment.

2-28. Mobility

The EAC MEDCOM (forward) is required to be fully mobile. When deployed, it has sufficient vehicles to provide single lift capability for 100 percent of its personnel and equipment.

2-29. Medical Command (Forward) Organization

The MEDCOM (forward) is organized as depicted in Tables 2-23 through 2-30 (pages 2-22 through 2-26).

2-30. Command Element

The function of the command element (Table 2-23) is to provide C2 for all in-EAC MEDCOM services. The MEDCOM (forward) commander (MEDCOM deputy commander) has overall responsibility for coordination of HSS within the AO. He effects appropriate staff relationships with the TSC and ASCC headquarters and serves as the ASCC surgeon.

Table 2-23. Staffing for the Command Element

AOC/MOS	GRADE	JOB TITLE	BRANCH
00B00	O7	DEPUTY COMMANDER	GO
01A00	O2	AIDE-DE-CAMP	IMM
42L20	E5	EXECUTIVE ADMINISTRATIVE ASSISTANT	NC
88M20	E5	CHAUFFEUR	NC

2-31. Chief of Staff Element

This element (Table 2-24) provides supervision of internal administrative and staff functions of the MEDCOM (forward). It provides requisite synchronization and coordination of staff activities to facilitate planning in time-constrained operations.

Table 2-24. Staffing for Chief of Staff Element

AOC/MOS	GRADE	JOB TITLE	BRANCH
67A00	O4	SECRETARY OF GENERAL STAFF	MS
42L10	E4	ADMINISTRATIVE SPECIALIST	

2-32. Deputy Chief of Staff, Personnel Element

This element (Table 2-25) has primary coordinating responsibility for MEDCOM strength management; finance support; casualty management; casualty estimates; MWR activities; education; safety and accident prevention; alcohol and drug abuse programs; and equal opportunity activities and programs. This element monitors the assignment and arrival of PROFIS personnel, identifies critical enlisted, warrant officer, and officer positions which are vacant and recommends priorities of fill to the commander. This element monitors RTD and coordinates procedures for subordinate hospitals to ensure RTD soldiers are reequipped and released to theater personnel system. For additional information refer to paragraph 2-6.

Table 2-25. Staffing for Deputy Chief of Staff, Personnel Element

AOC/MOS	GRADE	JOB TITLE	BRANCH
70F67	O5	HEALTH SERVICES PERSONNEL OFFICER	MS
42A40	E7	SENIOR HUMAN RESOURCES SERGEANT	NC
42A20	E5	HUMAN RESOURCES SERGEANT	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	

2-33. Deputy Chief of Staff, Security/Plans/Operations Element

The DCS SPO (Table 2-26) functions as the principal staff officer in matters concerning security, intelligence, operations, plans, organization, and training. It is essential in early entry operations that HSS planners receive timely medical intelligence to ensure that the medical capabilities required are employed to mitigate the effects of the medical threat. This element identifies requirements and submits production requests to obtain the needed intelligence support. This element plans for current and future operations and synchronizes the medical aspects of on-going operations. This element monitors air ambulance operations and coordinates and synchronizes aviation support issues, as required. This element also has the resources to advise the commander on the defensive aspects of NBC operations. This element coordinates and synchronizes medical regulating issues with the supporting TPMRC and assists in developing *work arounds* should issues with interoperability of equipment/systems occur.

Table 2-26. Staffing for the Deputy Chief of Staff, Security/Plans/Operations Element

AOC/MOS	GRADE	JOB TITLE	BRANCH
(DCS SPO ELEMENT)			
70H67	O6	DEPUTY CHIEF OF STAFF, SECURITY/PLANS/OPERATIONS	MS
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	
(OPERATIONS/PLANS ELEMENT)			
67J00	O4	AEROMEDICAL EVACUATIONS OFFICER	MS
70H67	O4	INTELLIGENCE OFFICER	MS
70H67	O4	MEDICAL OPERATIONS OFFICER (2)	MS
70H67	O4	MEDICAL PLANS OFFICER (2)	MS
74B00	O4	CHEMICAL OFFICER	CM
(MEDICAL REGULATING ELEMENT)			
70E67	O3	PATIENT ADMINISTRATION OFFICER	MS
42L10	E4	ADMINISTRATIVE SPECIALIST	

2-34. Deputy Chief of Staff, Logistics and Civil Affairs Elements

a. Deputy Chief of Staff, Logistics Element. The medical logistics element (Table 2-27) is the principal advisor to the MEDCOM (forward) commander in all matters pertaining to medical logistics. The focus of this element is to ensure a viable medical logistics system is in place for arriving medical units. This element—

- Coordinates the establishment of the medical logistics system within the theater.
- Plans and facilitates the establishment of the SIMLM mission, if designated.
- Monitors the Class VIII supply and resupply operations and status and identifies requirements for preconfigured Class VIII supply packages and high usage items.

• Monitors, coordinates for, and facilitates the accomplishment of the blood distribution system within theater.

• Coordinates and recommends the use of HN or contract support, as appropriate, to supplement organic resources (refer to FM 4-02.1). (Refer to paragraph 2-8 for additional information on DCSLOG activities.)

b. Civil Affairs Element. The CA officer (Table 2-27) has the primary responsibility for coordinating CMO. He also facilitates the coordination of HN medical matters and interfaces with the ASCC headquarters (refer to paragraph 2-9 for additional information).

Table 2-27. Staffing for the Deputy Chief of Staff, Logistics and Civil Affairs Elements

AOC/MOS	GRADE	JOB TITLE	BRANCH
(DEPUTY CHIEF OF STAFF, LOGISTICS ELEMENT)			
70K67	O5	HEALTH SERVICES MATERIEL OFFICER	MS
70K67	O3	HEALTH SERVICES MATERIEL OFFICER	MS
92Y40	E7	SUPPLY SERGEANT	NC
(CIVIL AFFAIRS ELEMENT)			
39C00	O3	CIVIL AFFAIRS OFFICER	CA

2-35. Deputy Chief of Staff, Information Management Element

The DCSIM element (Table 2-28) coordinates and facilitates the implementation of TELEMED (teleconsultation and telementoring) initiatives to enable medical specialty support in the developing theater. It also coordinates the interface of HSS automated systems requirements with communications capabilities present in the AO.

Table 2-28. Staffing for the Deputy Chief of Staff, Information Management Element

AOC/MOS	GRADE	JOB TITLE	BRANCH
25A00	O5	COMMUNICATIONS-ELECTRONICS OFFICER	SC
70D67	O3	HEALTH SERVICES SYSTEM MANAGER	MS
42L10	E3	ADMINISTRATIVE CLERK	

2-36. Deputy Chief of Staff, Comptroller and Staff Judge Advocate Elements

a. Deputy Chief of Staff, Comptroller Element (Table 2-29). The comptroller is the principal advisor to the deputy commander and staff on the medical aspects of HN support contract matters. He

interfaces with the TSC contracting and HN support divisions to coordinate and monitor HN contract support to MTFs. Refer to paragraph 2-11 for additional information.

b. *Staff Judge Advocate Element* (Table 2-29). The SJA officer is the principal advisor to the deputy commander, the headquarters staff, and subordinate units on the legal application of the Hague and Geneva Conventions. He develops policy guidelines for subordinate units and monitors procedures for compliance. Refer to paragraph 2-20 for additional information.

Table 2-29. Staffing for the Deputy Chief of Staff, Comptroller and Staff Judge Advocate Elements

AOC/MOS	GRADE	JOB TITLE	BRANCH
(DEPUTY CHIEF OF STAFF, COMPTROLLER ELEMENT)			
70C67	O4	HEALTH SERVICES COMPTROLLER	MS
(STAFF JUDGE ADVOCATE ELEMENT)			
27A00	O3	JUDGE ADVOCATE	JA

2-37. Professional Services Elements

Professional services elements (Table 2-30) provide the infrastructure to facilitate operational planning and technical supervision of specific in-theater HSS activities. The senior functional area officers indicated provide for a split-based capability.

a. *Medical Consultant*. This senior physician is responsible for providing advise to senior commanders on the medical aspects of operations and the health status of the command. He plans for and facilitates the provision of conventional HSS to deployed Army special operations forces (ARSOF), and evaluates current and future HSS requirements for the developing theater, and provides recommendations to the commander of HSS capabilities required. When deployed with the MEDCOM (forward) he provides advice to the MEDCOM (forward) on all clinical matters and assumes technical supervision of deployed HSS assets.

b. *Dental Surgeon*. The dental surgeon is the principal advisor on all matters pertaining to dental support. He develops dental policies and programs, and provides technical supervision for all in-theater dental activities. He coordinates and facilitates the establishment of preventive dentistry programs and monitors the provision of operational dental care. Refer to paragraph 2-13 for additional information.

c. *Senior Veterinarian*. The senior veterinarian is the principal advisor on all matters pertaining to veterinary services. He provides staff supervision for the theater-opening forces veterinary elements. He coordinates food inspection activities to include the inspection of local and regional food sources, coordinates and facilitates animal medical care of MWDs deployed with early entry forces and monitors veterinary PVNTMED activities within the AO. Refer to paragraph 2-14 for additional information.

d. *Nursing Consultant*. The nursing consultant is the principal advisor on all matters pertaining to nursing activities. This senior nursing professional facilitates the development of hospitalization policies

and programs for in-theater Army MTFs and provides staff and technical supervision of Army nursing services. Refer to paragraph 2-16 for additional information.

e. *Preventive Medicine Officer*. The PVNTMED officer is the principal advisor on all matters pertaining to PVNTMED. This senior physician facilitates the development of PVNTMED policies and programs for theater-opening forces. He coordinates PVNTMED support requirements and—

- Identifies the medical threat and recommends means to mitigate its effects.

- Facilitates the establishment of medical and OEH surveillance, pest management programs, and the inspection of potable water and field feeding sites.

- Monitors field hygiene and sanitation activities.

- Monitors the medical aspects of NBC defensive operations and makes recommendations concerning required immunizations and the use of pretreatments, chemoprophylaxis, barrier creams, and INDs.

Table 2-30. Staffing for Professional Services Elements

AOC/MOS	GRADE	JOB TITLE	BRANCH
(PROFESSIONAL SERVICES ELEMENT)			
61F00	O6	MEDICAL CONSULTANT	MC
(DENTAL SERVICES ELEMENT)			
63R00	O6	DENTAL SURGEON	DC
(VETERINARY SERVICES ELEMENT)			
64Z00	O6	SENIOR VETERINARIAN	VC
(NURSING SERVICES ELEMENT)			
66N00	O6	NURSING CONSULTANT	AN
(PREVENTIVE MEDICINE ELEMENT)			
60C00	O6	PVNTMED OFFICER	MC

CHAPTER 3

HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL COMMAND (CORPS)

Section I. MISSION AND CAPABILITIES

3-1. Mission and Assignment

a. The mission of the corps MEDCOM headquarters is to provide C4I for all assigned and attached units. Refer to Appendix C for a listing of medical units which may be assigned or attached to the corps MEDCOM.

b. The corps MEDCOM, TOE 08411A000, is assigned to HHC, Corps (TOE 52401L100).

3-2. Capabilities

a. The corps MEDCOM provides—

- Command and control of corps medical units providing HSS in the corps AO.
- Twenty-four hours sustained operations as necessary to conduct split-based operations.
- Advice to senior commanders on the medical aspects of their operations.
- Staff planning, supervision of operations, and administrative support for assigned and attached units.
- Coordination with TPMRC for medical evacuation and medical regulating for evacuation from MEDBDE MTFs to supporting MTFs in the EAC and CONUS.
- Consultation services, technical advice, and support to supported units in the following areas: PVNTMED (including medical surveillance, environmental health, sanitary engineering, and medical entomology); radiological health; nursing services; dental services; veterinary services (including food safety, animal medicine, and veterinary PVNTMED); CMO; COSC and psychiatry; and, nutrition/medical food service.
- Advice and assistance for facility selections and preparation.
- Control and supervision of Class VIII supply and resupply movement.
- The DOD Executive Agent for veterinary services.
- Transportation and logistics support for the human dimensions team (HDT). The HDT conducts field research on soldier and unit cohesiveness, readiness, morale, and stressors affecting well-being

and combat effectiveness. It also provides rapid feedback of results for use in the determination of operational and strategic policy. This team conducts surveys based on standard protocols. It receives focused guidance on human dimensions issues to be investigated through the corps MEDCOM commander, the Office of The Surgeon General, USAMRMC, and the DA staff. Refer to paragraph C-4 for additional information.

- Veterinary support for zoonotic disease control and investigation and the inspection of medical and nonmedical rations.

- Preventive medicine support for food facility inspection, pest management, and control of medical and nonmedical waste.

b. If the corps MEDCOM is the senior medical headquarters in the theater, it may be required to task-organize and deploy an early entry capability to provide C2 for early deploying medical units as discussed in Chapter 2, Section II. Task-organization may vary due to differences in staffing levels and METT-TC considerations.

c. If the corps is the senior Army command within the theater, the corps MEDCOM commander may serve as the Army forces (ARFOR) surgeon.

3-3. Limitations

The corps MEDCOM is dependent upon—

a. The appropriate supporting elements in the corps for finance; mortuary affairs; engineer support for site preparation, waste disposal, and minor construction; transportation services; laundry services; and securing of EPW during processing and evacuation.

b. The HHC, MEDCOM (TOE 08611A000) for general courts-martial convening jurisdiction.

Section II. EMPLOYMENT AND FUNCTIONS

3-4. General

The HHC, MEDCOM (corps) is located in the corps. Due to coordination requirements, the corps MEDCOM should locate within a reasonable distance of the corps and COSCOM headquarters. Depending on threat capabilities and force protection requirements, corps MEDCOM elements may have to be dispersed or relocated to enhance survivability. Medical headquarters should not be located near lucrative enemy targets, however, dispersion, cover, concealment, or relocation needs to be balanced against the headquarters mission accomplishment and acceptable risk.

3-5. Command Section

a. The function of the command section (Table 3-1) is to provide C2 and management of all MEDCOM activities. Personnel of this section supervise and coordinate the operations and administrative

services of the command. In the absence of the commander, the Chief, Professional Services, assumes command (paragraph 3-15).

b. The IG is located in the command section. As his position, at this level, does not have any dedicated administrative personnel to support his mission, an IG section is not shown. The IG conducts investigations, inspections, surveys, and studies as required by the commander and applicable regulations. The IG, with the technical support of other staff sections as required, responds to complaints and/or concerns within areas of the MEDCOM purview. This may encompass matters impacting on the efficiency of the command, performance of the mission, and state of discipline and morale of the command.

Table 3-1. Command Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
00B00	O7	COMMANDER	GO
70H67	O6	DEPUTY CHIEF OF STAFF, SECURITY/PLANS/OPERATIONS	MS
56A00	O5	CHAPLAIN	CH
70F67	O5	DEPUTY CHIEF OF STAFF, PERSONNEL	MS
70K67	O5	DEPUTY CHIEF OF STAFF, LOGISTICS	MS
01A00	O4	INSPECTOR GENERAL	IMM
70D67	O4	BIOMEDICAL INFORMATION MANAGEMENT OFFICER	MS
70H67	O4	INTELLIGENCE OFFICER	MS
01A00	O2	AIDE-DE-CAMP	IMM
00Z50	E9	COMMAND SERGEANT MAJOR	NC
92G30	E6	ENLISTED AIDE	NC
42L20	E5	EXECUTIVE ADMINISTRATIVE ASSISTANT	NC
88M20	E5	CHAUFFEUR	NC
91W10	E3	VEHICLE DRIVER	

3-6. Chief of Staff Section

The function of the CofS section (Table 3-2) is to plan, direct, and coordinate the execution of staff tasks and functions. It reviews organization activities and recommends changes, as necessary, to the MEDCOM commander. For additional information on responsibilities of this section refer to paragraph 2-4 and FM 101-5.

Table 3-2. Chief of Staff Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
67A00	O6	CHIEF OF STAFF	MS
70F67	O4	HEALTH SERVICE PERSONNEL MANAGER	MS
42L20	E5	ADMINISTRATIVE SERGEANT	NC

3-7. The Internal Staff Operations

The MEDCOM's coordinating staff (Figure 3-1) and special and personal staff (Figure 3-2) manage the command's internal operations through coordination with staffs of higher, lower, and adjacent units. The staff sections support the commander by providing accurate and timely information. They produce estimates, recommendations, plans, orders, and monitor execution. The staff streamlines cumbersome or time-consuming procedures by ensuring that all activities contribute to mission accomplishment. Personal staff members work under the commander's immediate control. They also may serve as special staff officers as they coordinate actions and issues with other staff members. All MEDCOM staff sections perform the common staff duties outlined FM 101-5.

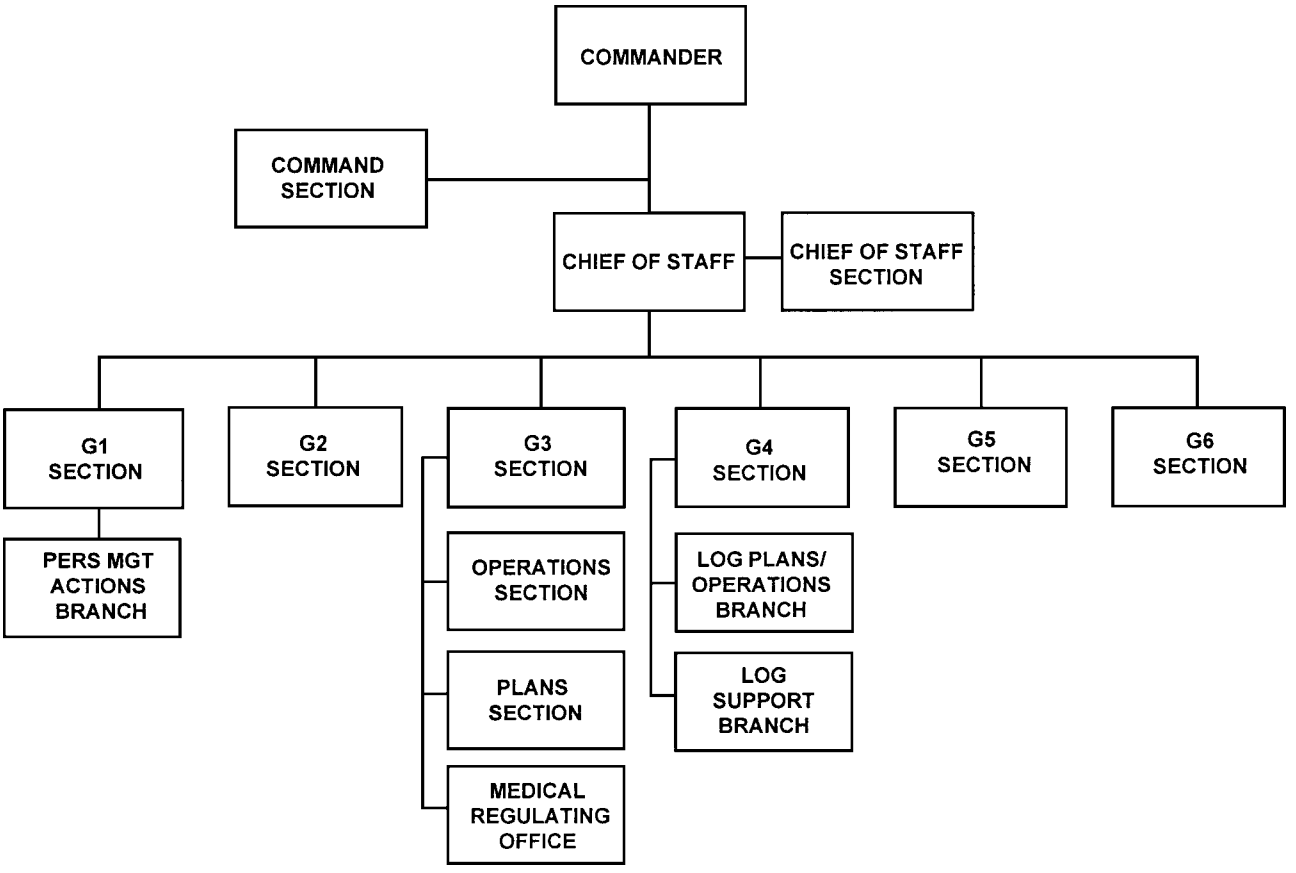

Figure 3-1. Corps medical command coordinating staff.

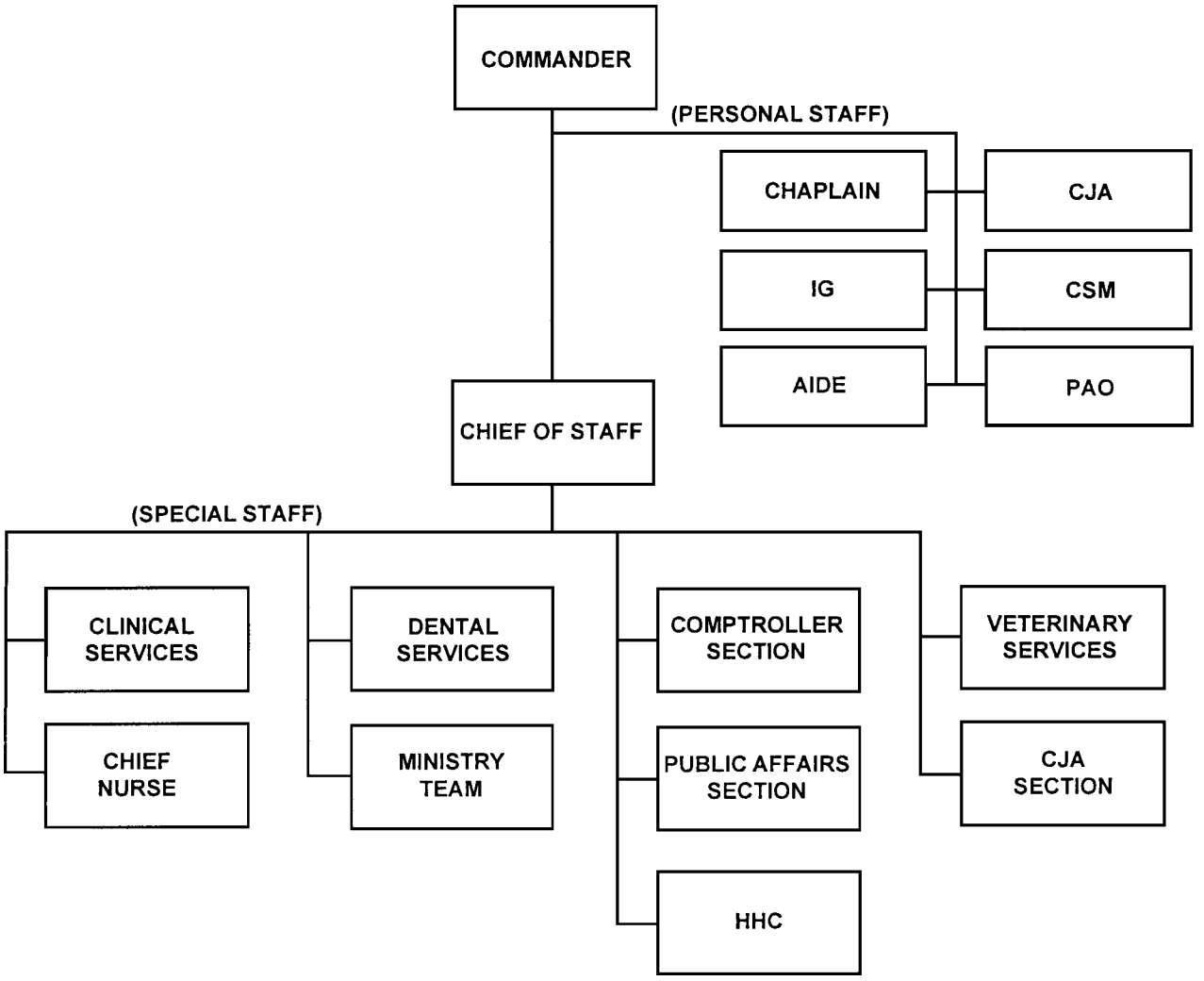

Figure 3-2. Corps medical command special and personal staffs.

3-8. G1 Section

a. The G1 section (Table 3-3) provides overall administrative services for the command, to include human resources administration, mail distribution, awards and decorations, and leaves. This section coordinates with elements of supporting agencies for finance, human resources, and administrative services as required. For additional information refer to paragraph 2-6, FM 12-6, and FM 101-5.

Table 3-3. G1 Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70F67	O6	#DEPUTY CHIEF OF STAFF, PERSONNEL	MS
70F67	O4	PERSONNEL STAFF OFFICER	MS
42A50	E9	CHIEF HUMAN RESOURCES SERGEANT	NC
42L40	E7	ADMINISTRATIVE SUPERVISOR	NC

#ALSO SHOWN IN COMMAND SECTION

b. The personnel management/actions branch (Table 3-4), under the DCSPER, receives and processes requests for personnel actions from corps medical units. These actions include promotions, reassignments, awards, personnel security clearances, personnel accounting, strength management, and so forth.

Table 3-4. Personnel Management/Actions Branch

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70F67	O3	HEALTH SERVICE PERSONNEL MANAGER (2)	MS
42A50	E8	SENIOR HUMAN RESOURCES SERGEANT	NC
42A20	E5	HUMAN RESOURCES SERGEANT	NC
42A10	E4	HUMAN RESOURCES SPECIALIST	
42L10	E4	ADMINISTRATIVE SPECIALIST	
42A10	E3	HUMAN RESOURCES CLERK	
42L10	E3	ADMINISTRATIVE CLERK	

3-9. G2 Section

This section (Table 3-5) performs all source intelligence assessment and estimates at the tactical, operational, and strategic levels for the command. This section identifies the CCIR and other information/intelligence requirements. It coordinates intelligence production requests with the supporting intelligence organizations.

Table 3-5. G2 Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70H67	O4	#INTELLIGENCE OFFICER	MS
74B00	O3	THREAT ASSESSMENT OFFICER	CM
91W50	E8	INTELLIGENCE MEDICAL SERGEANT	NC
96B10	E4	INTELLIGENCE ANALYST	

#ALSO SHOWN IN COMMAND SECTION

3-10. G3 Section

The G3 section, under the direction of the DCS SPO, prepares broad planning guidance, policies, and programs for command organizations and operations. The DCS SPO is shown in the command section.

a. G3 Operations. This section, under the DCS SPO, (Table 3-6) is responsible for security, plans and operations, deployment, relocation, and redeployment of the MEDCOM. It provides a CONOPS capability. It prepares, authenticates, and publishes administrative/HSS plans and orders and OPLANs and OPORDs (to include integration of annexes and appendixes prepared by other staff sections). This section coordinates the displacement of subordinate units and assigned facilities and areas. It assists the commander in developing and training the unit's METL. This section also maintains the unit-readiness status of each unit in the command.

Table 3-6. G3 Operations

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70H67	O6	#DEPUTY CHIEF OF STAFF, SECURITY/PLANS/OPERATIONS	MS
70H67	O5	ASSISTANT CHIEF OF STAFF, SECURITY/PLANS/OPERATIONS	MS
67J00	O4	AEROMEDICAL EVACUATION OFFICER	MS
70H67	O4	MEDICAL OPERATIONS OFFICER (2)	MS
74B00	O4	CHEMICAL OFFICER	CM
70H67	O3	MEDICAL OPERATIONS OFFICER	MS
74B00	O2	ASSISTANT CHEMICAL OFFICER	CM
91Z50	E9	CHIEF OPERATIONS SERGEANT	NC
74D50	E8	CHEMICAL OPERATIONS NONCOMMISSIONED OFFICER	NC
91W50	E8	OPERATIONS NONCOMMISSIONED OFFICER	NC
15P40	E7	AVIATION OPERATIONS SERGEANT	NC
31B40	E7	FORCE PROTECTION NONCOMMISSIONED OFFICER	NC
91W40	E7	OPERATIONS SERGEANT	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	

#ALSO SHOWN IN COMMAND SECTION

b. *G3 Plans*. The function of the G3 plans section (Table 3-7), under the DCS SPO, is to conduct current and long-range operational planning for the command. This section also has responsibility for planning and establishing NBC defense policies and programs. It provides technical supervision of defensive aspects of NBC activities.

Table 3-7. G3 Plans

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70H67	O5	MEDICAL PLANS OFFICER	MS
70H67	O4	MEDICAL PLANS OFFICER (2)	MS
91Z50	E9	CHIEF MEDICAL LOGISTICS NONCOMMISSIONED OFFICER	NC
91W50	E8	PLANS NONCOMMISSIONED OFFICER	NC
91W40	E7	PLANS SERGEANT	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	

c. *Medical Regulating Office*. The MRO (Table 3-8) is responsible for medical regulating of all Army patients in the corps AO, and preparation of patient statistical reports for the corps. It coordinates with the EAC MEDCOM MRO, USAF, and TPMRC for patient movement by air out of the corps AO. The MRO uses the Transportation Command Regulating Command and Control Evacuation System (TRAC2ES) to submit movement requests. In early entry operations, communications systems interoperability may adversely impact the MRO mission. The MRO establishes communications with the TPMRC to develop alternative methods of submitting requests. The MRO maintains CONOPS capability. For additional information refer to Joint Pub 4-02, Joint Pub 4-02.2, and FM 8-10-6.

Table 3-8. Medical Regulating Office

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70E67	O5	PATIENT ADMINISTRATION OFFICER	MS
70E67	O4	PATIENT ADMINISTRATION OFFICER	MS
91G50	E8	PATIENT ADMINISTRATION NONCOMMISSIONED OFFICER	NC
91G20	E5	PATIENT ADMINISTRATION NONCOMMISSIONED OFFICER (2)	NC
91G10	E4	PATIENT ADMINISTRATION SPECIALIST (2)	
91G10	E3	PATIENT ADMINISTRATION SPECIALIST (2)	

3-11. G4 Section

The G4 section (Table 3-9) plans, coordinates, controls, and manages medical logistics in the corps AO. If the corps MEDCOM is the senior MEDCOM in theater, this section plans for the SIMLM mission, if required.

Table 3-9. G4 Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70K67	O6	#DEPUTY CHIEF OF STAFF, LOGISTICS	MS
70K67	O3	HEALTH SERVICES MATERIEL OFFICER	MS
91Z50	E9	CHIEF MEDICAL LOGISTICS NONCOMMISSIONED OFFICER	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	

#ALSO SHOWN IN COMMAND SECTION

a. Logistics Plans/Operations Branch. This branch (Table 3-10) plans, coordinates, controls, and manages Army medical logistics in the corps. It has primary responsibility for monitoring logistics support including supply, maintenance, and transportation services, food service, and construction support to MEDCOM units. It provides staff supervision and coordination of logistics, food service, and supply and transportation support for subordinate units of the command.

Table 3-10. Logistics Plans/Operation Branch

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70K67	O4	HEALTH SERVICES MATERIEL OFFICER	MS
920A0	W3	PROPERTY BOOK OFFICER	WO
92Z50	E9	SENIOR LOGISTICS SERVICES SUPERVISOR	NC
92Y50	E8	SENIOR SUPPLY SERGEANT	NC
92Y40	E7	SUPPLY PLANS/OPERATIONS NONCOMMISSIONED OFFICER	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	

b. Logistics Support Branch. The logistics support branch (Table 3-11) provides technical advice and guidance to the command in areas of health facility planning, transportation, maintenance, and engineer support. It also plans and coordinates the movement of MEDCOM medical assets.

Table 3-11. Logistics Support Branch

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
65C00	O4	DIETITIAN	SP
70K67	O3	HEALTH SERVICES MATERIEL OFFICER	MS
88D00	O3	MOTOR/RAIL TRANSPORTATION OFFICER	TC
670A0	W4	COMMAND MAINTENANCE OFFICER	WO
915A0	W2	UNIT MAINTENANCE OFFICER (LT)	WO
91A50	E9	CHIEF MEDICAL MAINTENANCE NONCOMMISSIONED OFFICER	NC
91Z50	E9	CHIEF NUTRITION CARE NONCOMMISSIONED OFFICER	NC

Table 3-11. Logistics Support Branch (Continued)

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
92A50	E8	LOGISTICS SERVICE NONCOMMISSIONED OFFICER	NC
21T40	E7	AIRCRAFT MAINTENANCE SUPERVISOR	NC
51T40	E7	SENIOR TECHNICAL ENGINEER NONCOMMISSIONED OFFICER	NC
88N40	E7	CHIEF MOVEMENTS SUPERVISOR	NC
91J40	E7	MEDICAL LOGISTICS SERGEANT	NC
92A40	E7	MATERIEL CONTROL SUPERVISOR	NC

3-12. Comptroller Section

The comptroller section (Table 3-12) provides resource management analysis. It also provides management support, program budgeting support, and internal review support. For a detailed discussion of comptroller operations, refer to paragraph 2-11 and FM 101-5.

Table 3-12. Comptroller Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70C67	O5	HEALTH SERVICES COMPTROLLER (2)	MS
70C67	O3	HEALTH SERVICES COMPTROLLER	MS
44C50	E8	FINANCIAL MANAGEMENT ADVISOR	NC
44C10	E4	ACCOUNTING ANALYST	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	

3-13. G5 Section

The G5 section (Table 3-13) provides for the integration of CMO planning within the corps MEDCOM AO. It conducts area assessments and estimates on the impact of the local populace on US MTFs in the corps area to include the assessment of the host/foreign nation medical infrastructure in planning for and executing the HSS mission. The G5 section performs those common staff responsibilities for the command as discussed in FM 101-5.

Table 3-13. G5 Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
39C00	O5	CIVIL AFFAIRS OFFICER	CA
39C00	O4	CIVIL AFFAIRS OFFICER	CA
42L10	E4	ADMINISTRATIVE SPECIALIST	

3-14. G6 Section

The G6 section (Table 3-14) is the principal staff section responsible for all aspects of automation and CE support within MEDCOM and its subordinate units/activities. It develops CE requirements, to include data transmission services, and coordinates requirements with the signal command. The section provides for CONOPS communications/automations capabilities.

Table 3-14. G6 Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70D67	O4	#BIOMEDICAL INFORMATION MANAGEMENT OFFICER	MS
25A00	O3	S6	SC
70D67	O3	BIOMEDICAL INFORMATION MANAGEMENT OFFICER	MS
70D67	O3	HEALTH SERVICE SYSTEM MANAGER	MS
25A00	O2	COMMUNICATIONS-ELECTRONICS OFFICER	SC
254A0	W2	SIGNAL SYSTEMS TECHNICIAN	WO
25Y50	E8	INFORMATION SYSTEMS CHIEF	NC
25U30	E6	SECTION CHIEF	NC
25B20	E5	SENIOR INFORMATION SYSTEMS OPERATOR-MAINTAINER	NC
25U20	E5	TEAM CHIEF	NC
25B10	E4	INFORMATION SYSTEMS OPERATOR-MAINTAINER	
25U10	E4	RADIO RETRANSMISSION OPERATOR	
25U10	E3	RADIO RETRANSMISSION OPERATOR	

#ALSO SHOWN IN COMMAND SECTION

3-15. Clinical Services Section

This special staff section (Table 3-15) serves as the commander's principal consultants and technical advisors for the command in general medicine, PVNTMED, MH, community health, nuclear medicine, entomology, and environmental sciences. The chief, professional services, is responsible for developing and implementing clinical policies and procedures for the commander. For additional information refer to paragraphs 2-12 and 2-17, FM 4-02.10, FM 4-02.17, and FM 8-51.

Table 3-15. Clinical Services Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
60A00	O6	CHIEF, PROFESSIONAL SERVICES	MC
60C00	O5	PREVENTIVE MEDICINE OFFICER	MC
60W00	O5	PSYCHIATRIST	MC

Table 3-15. Clinical Services Section (Continued)

AOC/MOS	GRADE	JOB TITLE	BRANCH
66B00	O5	COMMUNITY HEALTH NURSE	AN
72A67	O5	NUCLEAR MEDICAL SCIENCE OFFICER	MS
72B67	O5	ENTOMOLOGIST	MS
72D67	O5	ENVIRONMENTAL SCIENCES OFFICER	MS
73A67	O5	SOCIAL WORKER	MS
73B67	O5	PSYCHOLOGIST	MS
91S50	E9	CHIEF PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER	NC
91X20	E5	MENTAL HEALTH NONCOMMISSIONED OFFICER	NC
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	

3-16. Dental Services Section

The function of this special section (Table 3-16) is to serve as the commander's principal consultant and the command's technical advisor in dentistry. It directs the establishment and implementation of policy and programs for all dental activities. For additional information refer to paragraph 2-13 and FM 4-02.19.

Table 3-16. Dental Services Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
63R00	O6	EXECUTIVE DENTAL OFFICER	DC
63H00	O5	PUBLIC HEALTH DENTIST	DC
91E50	E8	STAFF DENTAL NONCOMMISSIONED OFFICER	NC
42L20	E5	ADMINISTRATIVE SERGEANT	NC

3-17. Veterinary Services Section

The function of the veterinary services section (Table 3-17) is to serve as the commander's principal consultants and the command's technical advisors in veterinary matters. It also assumes the DOD Executive Agent responsibilities for veterinary support in the corps AO. For additional information refer to paragraph 2-14 and FM 8-10-18.

Table 3-17. Veterinary Services Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
64B00	O6	VETERINARY PREVENTIVE MEDICINE OFFICER	VC
640A0	W2	VETERINARY SERVICES TECHNICIAN	WO

Table 3-17. Veterinary Services Section (*Continued*)

AOC/MOS	GRADE	JOB TITLE	BRANCH
91R50	E9	SENIOR VETERINARY NONCOMMISSIONED OFFICER	NC
42L20	E5	ADMINISTRATIVE SERGEANT	NC

3-18. Chief Nurse Section

The chief nurse section (Table 3-18) functions as the commander's principal advisor on all matters affecting nursing practices and personnel. This section develops plans and implements nursing policy for the command in consonance with the JRCAB DEPMEDS Clinical Policy and Guidelines and Patient Treatment Briefs. For JRCAB website information refer to paragraph 1-7.

Table 3-18. Chief Nurse Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
66N00	O6	CHIEF NURSE	AN
91Z50	E9	CHIEF CLINICAL NONCOMMISSIONED OFFICER	NC

3-19. Command Judge Advocate Section

This section (Table 3-19) provides legal advice and services to the commander, staff, subordinate commanders, soldiers, and other authorized personnel. The CJA section develops and executes plans and programs in the fields of criminal law and related military justice, administrative law, litigation, environmental law, regulatory law, intelligence activities law, labor and civilian personnel law, and medical jurisprudence. This section advises the commander on the legal aspects of determining eligibility for care in US Army MTFs. (Refer to Appendix A for additional information on determining eligibility for care in US Army MTFs.)

Table 3-19. Command Judge Advocate Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
27A00	O4	COMMAND JUDGE ADVOCATE	JA
27A00	O3	TRIAL COUNSEL	JA
27D40	E7	SENIOR PARALEGAL NONCOMMISSIONED OFFICER	NC

3-20. Public Affairs Section

The function of the PA section (Table 3-20) is to serve as the command's focal point for command information, public information, and community relations matters. Refer to paragraph 2-19 and FM 101-5 for additional information.

Table 3-20. Public Affairs Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
70A67	O4	HEALTH CARE ADMINISTRATIVE OFFICER	MS
46A00	O3	PUBLIC AFFAIRS OFFICER	PA
46Z40	E7	PUBLIC AFFAIRS OPERATIONS NONCOMMISSIONED OFFICER	NC

3-21. Headquarters and Headquarters Company

The HHC commander (Table 3-21) is the special staff officer responsible for the soldiers assigned to the corps MEDCOM headquarters that are not assigned or attached to subordinate units. Refer to paragraph 2-21 for additional information.

Table 3-21. Headquarters and Headquarters Company Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
05A00	O4	COMMANDER	IMM
91W5M	E8	1SG	NC
92G40	E7	SENIOR FOOD OPERATIONS SERGEANT	NC
63B30	E6	MOTOR SERGEANT	NC
92Y30	E6	SUPPLY SERGEANT	NC
42A20	E5	HUMAN RESOURCES SERGEANT	NC
63B20	E5	WHEELED VEHICLE MECHANIC	NC
92A20	E5	EQUIPMENT RECORDS/PARTS SERGEANT	NC
92G20	E5	FIRST COOK	NC
63B10	E4	WHEELED VEHICLE MECHANIC	
74D10	E4	DECONTAMINATION SPECIALIST	
92G10	E4	COOK	
92Y10	E4	ARMORER	
92G10	E3	COOK	

3-22. Unit Ministry Team

The function of the Unit Ministry Team (UMT) (Table 3-22) is to provide religious support and pastoral care ministry for assigned staff and subordinate organizations of the command. Refer to paragraph 2-22 for additional information.

Table 3-22. Unit Ministry Team

AOC/MOS	GRADE	JOB TITLE	BRANCH
56A00	O5	#CHAPLAIN	CH
56M40	E7	CHAPLAIN ASSISTANT NONCOMMISSIONED OFFICER	NC

#ALSO SHOWN IN COMMAND SECTION

CHAPTER 4

HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BRIGADE (ECHELONS ABOVE CORPS) AND HEADQUARTERS AND HEADQUARTERS COMPANY, MEDICAL BRIGADE (CORPS)

Section I. MISSION, ASSIGNMENT, AND CAPABILITIES

4-1. Mission, Assignment, and Basis of Allocation

a. *Mission*. The mission of this headquarters is to provide C4I, administrative assistance, and technical supervision of assigned and attached HSS units. Health service support units which can be assigned or attached to the MEDBDE are described in Appendix C.

b. *Assignment*.

(1) The HHC, MEDBDE (EAC) (TOE 08422A200) is assigned to the HHC, MEDCOM (EAC), TOE 08611A000.

(2) The HHC, MEDBDE (corps) (TOE 08422A100) is assigned to the HHC, MEDCOM (corps), TOE 08411A000.

c. *Allocation*.

(1) The HHC, MEDBDE (EAC) is allocated on a basis of up to four per EAC MEDCOM.

(2) The HHC, MEDBDE (corps) is allocated on a basis of up to four per corps MEDCOM.

4-2. Capabilities

a. This unit provides—

- Command and control, staff planning, supervision of operations, and administration of the assigned and attached unit conducting HSS in its AO.
- Task organization for HSS assets to meet projected patient workload requirements.
- Advice to senior commanders in the AO on the medical aspects of their operations.
- Coordination with the EAC/corps MEDCOM MRO or function as the Army/corps MRO if the EAC/corps MEDCOM has not been deployed. In such instances, the MEDBDE MRO will coordinate directly with the TPMRC/Global Patient Movement Requirements Center (GPMRC). The TPMRC/GPMRC serves as the MRO for medical evacuation from the MEDBDE MTFs to supporting MTFs in EAC/CONUS.

- Consultation services and technical advice in nutrition, PVNTMED (environmental health, sanitary engineering, radiological health, and medical entomology), nursing, and MH to supported units.

- Guidance for facilities site selection and preparation.

- Control and supervision of Class VIII supply and resupply movement/distribution.

b. Individuals of this organization, except medical personnel and the chaplain, can assist in the coordinated defense of the unit's area or medical installations. Refer to FM 4-02 for an in-depth discussion on perimeter defense of HSS units.

4-3. Limitations

This unit is dependent on:

a. The EAC/corps MEDCOM to arrange for appropriate elements of the supporting logistical organizations to provide the following support: religious; legal; HSS; administrative services; finance and personnel services; transportation services; area damage control; NBC and decontamination assistance; and laundry/bath services.

b. The quartermaster supply company, or equivalent, for Class I rations.

c. The engineer company or equivalent, for site selection, waste disposal, and minor construction.

d. The HHD movement control battalion for supplemental transportation requirements.

e. The veterinary service detachment for zoonotic disease control and investigation and the inspection of medical and nonmedical rations (to include contaminated rations and disposition recommendations).

f. The PVNTMED detachment for food facility inspection, pest management, and control of medical and nonmedical waste.

4-4. Mobility

a. The HHC, MEDBDE (EAC) is 20 percent mobile.

b. The HHC, MEDBDE (corps) is 35 percent mobile.

Section II. ORGANIZATION AND FUNCTIONS

4-5. Medical Brigade Staff Organization

The MEDBDE is internally organized as depicted in Figure 4-1 and supported by Tables 4-1 through 4-12. The MEDBDE's coordinating staff (S-staff) and special staff sections manage the command's internal operations through coordination with staffs of higher, lower, and adjacent units. The staff's efforts support the commander and subordinate units. The staff supports the commander by providing accurate and timely information. It produces estimates; recommendations; plans and orders; and monitors execution. The staff streamlines cumbersome or time-consuming procedures by ensuring that all activities contribute to mission accomplishment. Chapter 2 discusses the functions of coordinating, special, and personal staff. Refer to FM 101-5 for detailed information on staff duties common to all Army units.

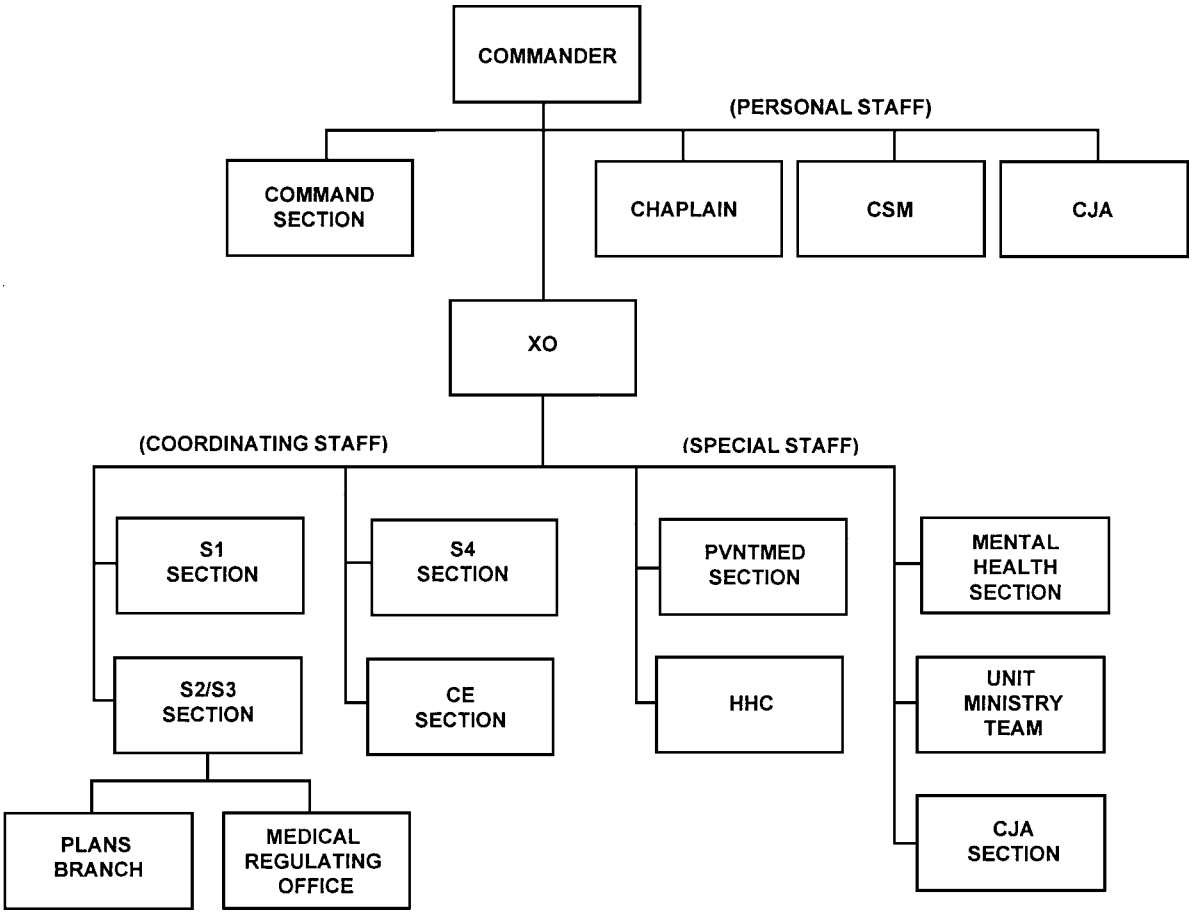

Figure 4-1. Medical brigade headquarters.

4-6. Command Section

The function of the command section (Table 4-1) is to provide C2 and management of all MEDBDE operations, activities, and services. Personnel of this section supervise and coordinate the operational and administrative activities of the command.

a. *Commander*. The commander is the individual appointed to command and control a military unit. He is responsible for all that is or is not accomplished by his unit. Refer to AR 600-20 for a discussion of command policy.

b. *Executive Officer*. The executive officer (XO) is the MEDBDE commander's principal assistant for directing, coordinating, and supervising the coordinating and special staffs, except in those areas the commander reserves for himself. The MEDBDE commander delegates the necessary executive management authority to the XO. The XO frees the commander from routine details and passes pertinent data, information, and insights from the staff to the commander and from the commander to the staff.

c. *Chief of Professional Services*. This senior physician serves as the principal advisor and deputy commander for all matters pertaining to the clinical aspects of the command. He is responsible to the commander for the development and execution of clinical policies and programs. Clinical policies and guidelines are developed in consonance with the JRCAB DEPMEDS Clinical Policy and Guidelines and Treatment Briefs (paragraph 1-7).

d. *Chief Nurse*. The chief nurse is the principal advisor to the commander on all matters pertaining to nursing activities. This senior nursing professional facilitates the development of hospitalization policies and programs for subordinate MTFs and provides staff and technical supervision of Army nursing services within the AO.

e. *Adjutant, US Army*. The S1 serves as the principal advisor to the commander for all internal MEDBDE matters pertaining to personnel activities. This staff officer is responsible for establishing, monitoring, and assessing MEDBDE-unique human resources policies that affect soldiers of the command.

f. *Intelligence Officer, US Army* (*S2*)/*Operations Officer, US Army* (*S3*). The S2/S3 function as the principal staff officer for the commander in all matters concerning security, intelligence, operations, plans, organization, and training.

g. *Logistics Officer, US Army* (*S4*). The S4 serves as staff adviser to the commander for all matters pertaining to logistics. He has primary responsibility for monitoring medical and general logistics support to MEDBDE units.

h. *Communication-Electronics Officer*. The CE officer is the principal staff advisor to the commander for all matters concerning information, communications, and automation support within the MEDBDE and subordinate units/activities.

i. *Chaplain*. The chaplain is a personal staff officer responsible for coordinating the religious activities and operations within the brigade. The chaplain is the advisor to the commander on all religious matters.

j. Command Sergeant Major. The CSM is the senior NCO of the command. He is responsible for providing the commander with personal, professional, and technical advice on enlisted soldier matters and the NCO corps.

Table 4-1. Command Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
05A00	O6	COMMANDER	IMM
60A00	O6	CHIEF, PROFESSIONAL SERVICES	MC
66N00	O6	CHIEF NURSE	AN
67A00	O5	EXECUTIVE OFFICER	MS
70H67	O5	S2/S3	MS
25A00	O4	COMMUNICATIONS-ELECTRONICS STAFF OFFICER	SC
56A00	O4	CHAPLAIN	CH
70F67	O4	S1	MS
70K67	O4	S4	MS
00Z50	E9	COMMAND SERGEANT MAJOR	NC
88M20	E5	CHAUFFEUR	NC
42L10	E4	EXECUTIVE ADMINISTRATIVE ASSISTANT	

4-7. The S1 Section

This section (Table 4-2) provides overall administrative services for the command, to include personnel administration, mail distribution, awards and decorations, and leaves. The S1 section coordinates with elements of supporting agencies for finance, human resources, and administrative services as required. The section receives and processes requests for personnel actions from units assigned to the MEDBDE. These actions include promotions, reassignments, awards, personnel security clearances, personnel accounting, and strength management.

Table 4-2. S1 Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70F67	O4	#S1	MS
70F67	O3	HEALTH SERVICES PERSONNEL MANAGER	MS
42A40	E7	SENIOR HUMAN RESOURCES SERGEANT	NC
42L20	E5	ADMINISTRATIVE SERGEANT	NC
42A10	E4	HUMAN RESOURCES SPECIALIST	
42L10	E4	ADMINISTRATIVE SPECIALIST (2)	
42L10	E3	ADMINISTRATIVE CLERK (3)	

#ALSO SHOWN IN THE COMMAND SECTION

4-8. The S2/S3 Section

a. The S2/S3 Section. This section (Table 4-3) is responsible for security, plans and operations, deployment, relocation, and redeployment of the brigade, and supervising medical evacuation operations, both ground and air. It provides a 24-hour CONOPS capability. It prepares, authenticates, and publishes HSS plans and orders and OPLANs and OPORDs, to include integration of annexes and appendixes prepared by other staff sections. This section (Table 4-3) coordinates the displacement of subordinate units and assigned facilities and areas. It assists the commander in developing and training the unit's METL. It identifies training requirements based on HSS missions and the unit's training status. It is responsible for preparing and performing training programs, directives, and orders. It maintains the unit-readiness status of each unit in the MEDBDE. This section also has responsibility for planning and establishing NBC defense policies and programs. It provides technical supervision of all NBC activities. This section is also the lead staff element for medical and general intelligence matters. It acquires intelligence information and data, analyzes and evaluates the information and data, and presents the assessment, evaluation, and recommendations to the commander. Further, it develops the CCIRs, PIRs, EEFIs, and FFIR for the command.

Table 4-3. S2/S3 Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70H67	O5	#S2/S3	MS
67J00	O4	AEROMEDICAL EVACUATION OFFICER	MS
70H67	O4	MEDICAL OPERATIONS OFFICER	MS
70H67	O3	MEDICAL OPERATIONS OFFICER (2)	MS
74B00	O3	CHEMICAL OFFICER	CM
70B67	O2	MEDICAL OPERATIONS OFFICER	MS
91Z50	E9	CHIEF OPERATIONS SERGEANT	NC
91E50	E8	SENIOR DENTAL NONCOMMISSIONED OFFICER	NC
91W50	E8	INTELLIGENCE MEDICAL SERGEANT	NC
15P40	E7	AVIATION OPERATIONS SERGEANT	NC
74D40	E7	NBC STAFF NONCOMMISSIONED OFFICER	NC
91W40	E7	INTELLIGENCE SERGEANT	NC
91W40	E7	PLANS SERGEANT	NC
42L10	E4	ADMINISTRATIVE SPECIALIST	
42L10	E3	ADMINISTRATIVE CLERK	

#ALSO SHOWN IN THE COMMAND SECTION

b. Plans Branch. This branch (Table 4-4) is responsible for current planning in the MEDBDE AO, to include deliberate and crisis planning. Additionally it plans for future operations in excess of 72 hours and prepares major regional contingency plans for the brigade. Refer to FM 8-42 and FM 8-55 for an in-depth discussion on planning.

Table 4-4. Plans Branch

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70H67	O3	PLANS OFFICER (2)	MS
70B67	O2	MEDICAL OPERATIONS OFFICER	MS
91W50	E8	PLANS NONCOMMISSIONED OFFICER	NC
91W40	E7	PLANS SERGEANT	NC
91W40	E7	HEALTH CARE NONCOMMISSIONED OFFICER	NC

c. *Medical Regulating Office*. The MRO (Table 4-5) is responsible for 24 hour medical regulating and preparation of patient statistical reports for the MEDBDE. It coordinates with the corps/EAC MEDCOM and the TPMRC/GPMRC for the evacuation of patients from corps MTFs to EAC hospitals and/or further evacuation from the corps/EAC. This office monitors and directs patient flow horizontally between MTFs in the corps/EAC MEDBDE AO. Refer to Joint Pub 4-02.2 and FM 8-10-6 for in-depth discussions on medical regulating activities.

Table 4-5. Medical Regulating Office

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70E67	O4	PATIENT ADMINISTRATION OFFICER	MS
70E67	O3	PATIENT ADMINISTRATION OFFICER	MS
91G40	E7	PATIENT ADMINISTRATION NONCOMMISSIONED OFFICER	NC
91G30	E6	PATIENT ADMINISTRATION NONCOMMISSIONED OFFICER	NC
91G20	E5	PATIENT ADMINISTRATION NONCOMMISSIONED OFFICER (2)	NC
91G10	E4	PATIENT ADMINISTRATION SPECIALIST (2)	
91G10	E3	PATIENT ADMINISTRATION SPECIALIST (2)	

4-9. The S4 Section

a. This section (Table 4-6) plans, coordinates, controls, and manages medical and general logistics for subordinate units and other units in the MEDBDE supported area. It has primary responsibility for monitoring logistics support for units of the MEDBDE.

b. The dietitian serves as the commander's principal consultant and the command's technical advisor in nutrition care.

c. The comptroller provides management analysis; management, program budgeting, and internal review support; and advice to the commander on the financial effectiveness of the command, and recommends solutions to the financial/budget issues identified.

Table 4-6. S4 Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
70K67	O4	#S4	MS
65C00	O4	DIETICIAN	SP
70C67	O3	HEALTH SERVICES COMPTROLLER	MS
70K67	O3	HEALTH SERVICES MATERIEL OFFICER (2)	MS
922A0	W2	COMMAND FOOD SERVICE TECHNICIAN	WO
92Z50	E9	SENIOR SUPPLY SUPERVISOR	NC
63Z50	E8	SENIOR MAINTENANCE SUPERVISOR	NC
91J50	E8	MEDICAL LOGISTICS SERGEANT	NC
91M50	E8	SENIOR NUTRITION CARE NONCOMMISSIONED OFFICER	NC
91J10	E4	MEDICAL LOGISTICS SPECIALIST	
42L10	E4	ADMINISTRATIVE SPECIALIST	

#ALSO SHOWN IN THE COMMAND SECTION

4-10. The Communications-Electronics Section

The CE section (Table 4-5) is responsible for information management, automation, and CE support within the brigade and its subordinate units and activities. This section is further responsible for establishing CSS automation policy and providing guidance for all subordinate CE information elements in the command. It develops CE requirements, to include data transmission services, and coordinates requirements with the supporting signal unit. The section provides for a 24-hour CONOPS communications/automations capability.

Table 4-7. Communications-Electronics Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
25A00	O4	#COMMUNICATIONS-ELECTRONICS STAFF OFFICER	SC
70D67	O3	BIOMEDICAL INFORMATION MANAGEMENT OFFICER	MS
25A00	O2	S6	SC
25U50	E8	SIGNAL SUPPORT SYSTEMS CHIEF	NC
25B20	E5	SENIOR INFORMATION SYSTEM OPERATOR-MAINTAINER	NC
25U20	E5	TEAM CHIEF	NC
25B10	E4	INFORMATION SYSTEM OPERATOR-MAINTAINER	
25U10	E4	RADIO RETRANSMISSION OPERATOR	
25U10	E4	SIGNAL INFORMATION SERVICES SPECIALIST	
25U10	E3	RADIO RETRANSMISSION OPERATOR	
25U10	E3	SIGNAL SUPPORT SYSTEM SPECIALIST	

#ALSO SHOWN IN THE COMMAND SECTION

4-11. Preventive Medicine Section

a. The PVNTMED section (Table 4-8) serves as the commander's principal consultant and the command's PVNTMED, environmental science, and veterinary advisors. The section develops plans and implements policies and programs within its AO. It also evaluates HN capabilities and integrates PVNTMED policy with higher headquarters, joint/combined services, and other organizations, as required.

b. The PVNTMED section is a multifunctional section which addresses environmental, PVNTMED, and veterinary issues for the brigade. The myriad of functions it performs requires its personnel to continually monitor, coordinate, and be responsive to units in the EAC MEDBDE AO.

c. For information concerning medical surveillance activities refer to FM 4-02.17. For information on OEH surveillance refer to FM 4-02.

Table 4-8. Preventive Medicine Section

AOC/MOS	GRADE	JOB TITLE	BRANCH
60C00	O5	PREVENTIVE MEDICINE OFFICER	MC
72D67	O4	ENVIRONMENTAL SCIENCE OFFICER	MS
91R50	E8	CHIEF VETERINARY NONCOMMISSIONED OFFICER	NC
91S50	E8	PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER	NC

4-12. Mental Health Section

This section (Table 4-9) is responsible for monitoring the MH of the command. It collects and records social and psychological data, and develops and implements COSC and MH policies and programs.

Table 4-9. Mental Health Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
67D00	O4	BEHAVIORAL SCIENCE OFFICER	MS
91X40	E7	MENTAL HEALTH NONCOMMISSIONED OFFICER	NC

4-13. Company Headquarters

The company headquarters (Table 4-10) is responsible for the soldiers assigned to the headquarters that are not assigned or attached to subordinate units of the MEDBDE. The HHC commander is a special staff officer on the brigade staff. Besides his common staff responsibilities, he is also responsible for the following:

- Commanding and controlling the company.
- Developing the MEDBDE headquarters occupation plan.
- Ensuring local headquarters security, to include constructing defensive positions.
- Arranging and moving the headquarters.
- Training and MWR activities for the headquarters.
- Coordinating food service, billeting, HSS, field sanitation, and supply for headquarters personnel.
- Receiving and accommodating visitors and augmentees.
- Obtaining motor transportation organic to or allocated for use by the headquarters.

Table 4-10. Company Headquarters

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
05A67	O3	COMMANDER	IMM
91W5M	E8	FIRST SERGEANT	NC
92G30	E6	FOOD OPERATIONS SERGEANT	NC
92Y30	E6	SUPPLY SERGEANT	NC
92G20	E5	FIRST COOK	NC
42A10	E4	HUMAN RESOURCES SPECIALIST	
63B10	E4	WHEELED VEHICLE MECHANIC	
74D10	E4	DECONTAMINATION SPECIALIST	
92G10	E4	COOK	
92Y10	E4	ARMORER	
91W10	E3	VEHICLE DRIVER	
92G10	E3	COOK	

4-14. Unit Ministry Team

The function of the UMT (Table 4-11) is to provide religious support and pastoral care ministry for assigned staff and subordinate organizations of the command.

Table 4-11. Unit Ministry Team

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
56A00	O4	#CHAPLAIN	CH
56M30	E6	CHAPLAIN ASSISTANT NONCOMMISSIONED OFFICER	NC

#ALSO SHOWN IN THE COMMAND SECTION

4-15. Command Judge Advocate Section

The functions of this special staff section (Table 4-12) are to provide legal advice and services to the commander, staff, subordinate commanders, soldiers, and other authorized personnel. The Command Judge Advocate (CJA) section develops and executes plans and programs in the fields of criminal law and related military justice, administrative law, litigation, environmental law, regulatory law, intelligence activities law, and medical jurisprudence.

Table 4-12. Command Judge Advocate Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
27A00	O4	COMMAND JUDGE ADVOCATE	JA
27A00	O3	TRIAL COUNSEL	JA
27D30	E6	PARALEGAL NONCOMMISSIONED OFFICER	NC
27D20	E5	PARALEGAL NONCOMMISSIONED OFFICER	NC
27D10	E3	PARALEGAL SPECIALIST	

4-16. Task Organization of Medical Brigade Staff Clinical Operations Section

The MEDBDE commander may task organize his internal headquarters staff to facilitate the execution of the HSS mission. This may be done by consolidating functional assets within one staff section, even though the assets are identified in different sections of the TOE. The clinical resources of the MEDBDE headquarters are assigned to the command section (chief, professional services and chief nurse), the S2/3 Section (senior dental NCO), the S4 section (dietitian and senior nutrition care NCO), PVNTMED section (PVNTMED officer, environmental science officer (ESO), senior PVNTMED NCO, and senior veterinary NCO), and the MH section (behavioral science officer and MH NCO). Task organization of these resources enables the chief, professional services to consolidate his span of control and more effectively accomplish the clinical mission of the MEDBDE.

a. The chief, professional services has the responsibility to monitor the impact of all of the AMEDD functional areas on the clinical services provided within the command. He accomplishes this

mission through the activities of his staff and coordinating and synchronizing clinical requirements with other MEDBDE staff sections. He coordinates with the—

(1) S1 for all personnel matters relating to clinical staff personnel. The chief, professional services recommends priority of fill and assignment of all clinical personnel to subordinate MTFs

(2) S2/3 for medical intelligence support. The clinical operations section develops, recommends, and submits PIRs and EEFIs for information impacting clinical operations (to include the potential enemy use of NBC weaponry and TIMs releases). This includes medical threats within the AO and potential diseases present in and the health status of enemy forces who may become EPW or retained/ detained personnel (to include new or exotic diseases in enemy forces).

(3) S2/3 for operational, planning, and medical regulating support. The clinical operations section monitors current operations and assists in planning future operations by providing clinical input into the development of HSS estimates and plans. They must evaluate proposed courses of action (COA) for their impact on clinical capabilities and activities and recommend whether they are feasible from a clinical viewpoint. Further, the clinical operations section must closely monitor medical regulating activities, bed status and/or OR delays, if any, of subordinate hospitals, PMI requirements, delays in the timely evacuation of patients to and from MEDBDE MTFs, and requirements for providing medical attendants for en route patient care on USAF evacuation assets, if critical care air transport team (CCATT) support is not available. The clinical operations section recommends clinical capabilities (task organized) required to be deployed forward to support corps personnel deployed to the division to provide direct support (corps slice).

(4) S4 for medical logistics support of critical Class VIII items required for patient care, to include medical supplies, pharmaceuticals, medical equipment, and blood. The clinical operations section monitors the blood distribution and reporting processes (Technical Manual [TM] 8-227-12) to determine the impact on clinical operations of shortages and delays. Further, they monitor the status of medical supplies, medical equipment, and medical equipment maintenance and repair to ensure that sufficient quantities are on hand and/or on order to sustain patient care activities within the command. They also work closely with the S4 in identifying and obtaining pharmaceuticals to treat diseases (to include BW agents) not usually present in US forces (such as for EPW). Advises the command on the management and disposition of captured enemy medical supplies and equipment.

(5) Communications-electronics section for information management, automation requirements, and CE support.

(6) Command judge advocate section for all medical-legal matters to include the determination of eligibility for medical care in US MTFs (Appendix A). Further, the CJA section provides guidance on the provisions of the Geneva Conventions as they affect medical personnel, equipment, evacuation platforms, and Class VIII supplies. He also provides guidance on any legal issues involving care to EPW, retained, and detained personnel.

(7) Unit ministry team on religious matters that affect HSS operations to include faith-based dietary restrictions and assistance in COSC programs and activities.

b. The chief, professional services exercises his technical supervision of all HSS clinical activities through his staff. As the senior physician in the command, he develops policies, procedures, and protocols for clinical activities within subordinate MTFs. Treatment protocols implemented in the command are developed in accordance with JRCAB standards and requirements, appropriate doctrinal publications (such as FM 4-02.283, FM 8-284, and FM 8-285), and sound medical practice. He ensures that IND protocols are followed (FM 8-284). He also monitors the use of chemoprophylaxis, pretreatments (FM 8-285), immunizations, and barrier creams (FM 8-285). He ensures credentialing policies are in place and are being adhered to. He further ensures that a quality assurance program is implemented. He monitors the medical evacuation/medical regulating activities to ensure necessary medical requirements and clearances for patients being evacuated are accomplished and develops patient preparation protocols for patients entering the USAF evacuation system, as required. He monitors the area support mission of assigned/ attached Level II MTFs to ensure adequate HSS to transient troop populations within the MEDBDE AO. He compiles and analyzes wounded in action (WIA) data to determine trends in wounding patterns, to forecast specialized care requirements, and to recommend protective measures as appropriate. He identifies medical issues which require medical research and development. (For an in-depth discussion of the duties and responsibilities of command surgeons refer to Chapter 1.) The duties and functions of his staff include the—

(1) Chief nurse who is the senior nurse in the command. He provides technical supervision of the MEDBDE subordinate MTFs nursing personnel (officer and enlisted). He establishes nursing policies and reviews and monitors nursing practices. He monitors staffing levels, personnel shortages, and advises the chief, professional services on the impact of nursing shortfalls on the capability to provide required patient care. He recommends to the chief, professional services priority of assignment for nursing care personnel. The chief nurse also ensures educational and training requirements are met and monitors in-service training activities of subordinate MTFs. The chief nurse monitors mass casualty planning of subordinate MTFs, provides consultation to subordinate MTF mass casualty coordinators during rehearsals of the mass casualty plan, and ensures that if training shortfalls are identified that appropriate refresher/ sustainment training is provided. He directs routine reporting requirements and establishes format and frequency of all formal nursing reports.

(2) Preventive medicine officer, ESO, and senior PVNTMED NCO monitor all PVNTMED activities and requirements of the command (FM 4-02.17 and FM 8-10-18). The PVNTMED officer establishes reporting requirements and frequency of reports (such as the weekly DNBI Report [Appendix E]). He consolidates subordinate unit DNBI Reports and analyzes the data submitted to identify trends and to compare incoming data with already established base-lines. If trends are identified, he recommends and develops effective medical countermeasures and disseminates this information to all subordinate, adjacent, and higher headquarters. The PVNTMED officer and ESO analyze the data for indicators of the potential exposure of US forces to enemy employment of BW and CW agents (increases in endemic disease rates in one specific geographic location or the appearance of diseases which can be weaponized and are not endemic to the AO) and to OEH hazards. He receives, monitors, reviews, and forwards supporting laboratory analysis of NBC samples/specimens and chain of custody actions for NBC samples/specimens (FM 4-02.7). He ensures that medical surveillance and OEH health surveillance activities are developed and implemented for the medical threats present in the AO. He monitors pest management, potable water inspection, and inspection of field feeding/dining facility sanitation activities, TIMs sources and hazards, and further ensures the procedures for the disposal of medical waste are being adhered to. The PVNTMED NCO ensures that field hygiene and sanitation training and unit field sanitation team training for subordinate

units and personnel is current and adequate. The veterinary NCO is responsible for monitoring the implementation of programs for the inspection of food and food sources for procurement, quality assurance, security, and sanitation. He also monitors animal medical care activities and identifies medical logistics shortfalls that will impact on animal medical care activities. The veterinary NCO also monitors veterinary PVNTMED activities. If additional veterinary expertise is required, he coordinates with the senior veterinary officer of the command (paragraph 4-16*c*[2] below). If a veterinary unit is not assigned to the MEDBDE, coordination for this support and expertise is accomplished with the MEDCOM.

(3) Behavioral science officer and MH NCO monitor all COSC activities and the treatment of MH and NP cases within subordinate MTFs. The behavioral science officer ensures that all treatment programs for combat operational stress are founded on proven principles of combat psychiatry and are established and administered in accordance with current doctrinal principles (FM 8-51). He monitors the stress level of subordinate unit medical personnel and provides consultation on critical event debriefing support to health care providers after mass casualty situations or other high stress events. He coordinates policies, procedures, and protocols for the treatment of MH and NP disorders with the senior subordinate unit psychiatrist (paragraph 4-16*c*[3] below) and provides consultation on the requirements for the medical evacuation of psychiatric patients.

(4) Dietitian and senior nutrition NCO monitor the status of medical diet supplement rations, hospital food service operations, and command health promotion program. The dietitian provides consultation to subordinate hospitals on special diet requirements and preparation. He further coordinates with the UMT on faith-based dietary restrictions. In humanitarian assistance operations, he provides consultation and advice on refeeding operations for malnourished children and adults, refugee or displaced person populations, and victims of man-made or natural disasters. He also provides consultation on special dietary requirements for patients being evacuated through the USAF evacuation system.

(5) The senior dental NCO monitors dental activities for the command. He receives reports from subordinate units and consolidates this data for forwarding to higher headquarters. He coordinates policies, procedures, and protocols for the treatment of dental conditions and preventive dentistry programs with the command dental surgeon (paragraph 4-16*c*[1] below).

c. Not all functional specialties are fully represented on the MEDBDE headquarters staff. Therefore the clinical operations section coordinates with subordinate medical units for expertise in the following areas—

(1) The senior subordinate dental officer serves as the command dental surgeon. He is the principle advisor to the chief, professional services on the dental health of command. He monitors preventive dentistry programs within the command and determines dental readiness rates. He develops policy, procedures, and protocols for dental treatment within the MEDBDE dental treatment facilities. He advises the chief, professional services when augmentation of oral and maxillofacial surgical resources is required. He provides consultation to MEDBDE MTFs on medical evacuation requirements for dental surgical patients entering the USAF evacuation system.

(2) If a veterinary unit is assigned to the MEDBDE, the senior subordinate veterinary officer serves as the principle advisor to the MEDBDE commander and chief, professional services on veterinary

support in the MEDBDE AO and forward deployed forces. The veterinary officer is responsible for the implementation of programs for the inspection of food and food sources for quality assurance and sanitation. Additionally, this senior veterinary officer is responsible for ensuring animal medical care activities are provided effectively and efficiently within the command. He is the principle advisor to the chief, professional services on veterinary PVNTMED activities and the transmission of zoonotic diseases to US forces. He coordinates with the PVNTMED officer and veterinary NCO to synchronize PVNTMED efforts within the command. He monitors the use of toxic plant and animal substances as contaminants of food crops and water supplies. In humanitarian assistance operations and other activities conducted during stability operations and support operations, he coordinates with other US government agencies/organizations (such as country team or United States Agency for International Development [USAID]), and NGOs for animal husbandry activities, as directed.

(3) The senior subordinate psychiatrist serves as the senior consultant to the MEDBDE commander on the treatment of NP and MH patients within the command. The MEDBDE behavioral science officer consults with this physician on matters beyond his level of expertise and coordinates policies, procedures, and protocols for the treatment of psychiatric patients.

(4) The senior subordinate medical laboratory officer serves as the principle consultant to the chief, professional services on all matters pertaining to clinical laboratory support. He monitors the performance of MEDBDE medical laboratories, to include area medical laboratory activities (including NBC sample/specimen processing and chain of custody requirements) and MTF clinical laboratory practices. He advises the chief, professional services on blood banking and storage capabilities of Level II and III MTFs within the command. He monitors Class VIII support as it impacts on medical laboratory capabilities and advises the chief, professional services of any shortfalls which adversely impact on the performance of laboratory procedures.

d. The clinical operations section coordinates with the higher and, when appropriate, adjacent medical headquarters any clinical issues which cannot be resolved at this level or that will adversely impact clinical operations in other adjacent or higher commands. The clinical operations section monitors medical specialty capabilities of subordinate hospitals and coordinates with its higher headquarters when medical specialty augmentation team support is required.

e. The clinical operations section coordinates with and provides consultation to the medical section of the military police internment and resettlement facilities established within the MEDBDE AO for the treatment and hospitalization of EPW, retained, and detained personnel.

f. To facilitate monitoring clinical operations of subordinate MTFs, the clinical operations section determines what reports are required, format to be used, and at what frequency the reports will be submitted (Appendix D). The S3 MRO section receives bed status reports and requests for medical regulating/ evacuation which should include the clinical operations section on distribution. The S4 receives medical supply status (MEDSUPSTAT) from all subordinate facilities which the clinical operations section must review to determine if the MEDSUPSTAT of subordinate facilities will adversely impact patient care. Additionally, he may develop a medical situation report (MEDSITREP) for the clinical aspects of subordinate MTF operations to remain apprised of daily/weekly operations. The clinical operations section also receives MEDSITREPs from forward deployed FSTs to determine if reconstitution/replacement/

reinforcement of these assets is required. This report also provides information on the types of surgical cases that will require follow-on surgery at subordinate MEDBDE hospitals.

CHAPTER 5

AREA MEDICAL LABORATORY

Section I. MISSION AND CAPABILITIES

5-1. General

a. The area medical laboratory (AML) (TOE 08668A000) is a new organization as a result of the Medical Reengineering Initiative (MRI). When fielded, it will replace the theater Army medical laboratory (TAML) (TOE 8657L000).

b. The AML functions independently of the individual patient care mission of deployed MTFs. This unit's focus is on rapid health-hazard identification (ID) and assessment within an AO. These operational health hazards include NBC threat agents, endemic diseases, and other medical threats associated with OEH hazards. The AML is capable of tailoring its deployable assets to meet specific operational objectives and split-based mission requirements. Outside the AO, established, nondeployable laboratory assets in the CONUS, OCONUS, and, when available, HN perform procedures that cannot be readily accomplished in the deployed environment, or do not provide critical, time-sensitive information.

5-2. Mission and Capabilities

a. The AML is modularly designed so that individual functional sections or sectional teams may deploy incrementally and independently from the parent base. The AML provides the operational commander with real-time or near-real-time health hazard assessment capability.

b. The ID and evaluation of health hazards in support of joint and combined military operations requires the use of sophisticated techniques and advanced technology. New applicable technologies are available from commercial, industrial, educational institutions, and military research and development facilities within or outside of the AO.

c. The application of AML NBC agent ID capabilities with current and evolving nonmedical detection systems enhances the integration, validity, and use of the Army's collective efforts to protect its troops from NBC threats.

d. The AML provides—

- Analytical, investigative, and consultative capabilities to identify NBC threat agents in biomedical specimens and other samples from the AO.

- Analytical, investigative, and consultative capabilities to assist in the ID of OEH hazards and endemic diseases.

- Special environmental control and containment to evaluate biomedical specimens for the presence of highly infectious or hazardous agents of operational concern.

- Data and data analysis to support medical analyses and operational decisions.

- Medical laboratory analysis to support the diagnosis of zoonotic and significant animal diseases that impact on military operations.

- Tailorable force projections to support full spectrum operations.

- Deployed modular sections or sectional teams will normally be deployed forward in the corps area. These teams interface with PVNTMED and/or veterinary teams, forward deployed medical units, Biological Integrated Detection System (BIDS) teams, and chemical company elements operating in the corps AO.

e. This unit performs unit maintenance on organic equipment, except medical, CE, and communications security (COMSEC) equipment that is provided by contractual services.

5-3. Limitations

The AML is dependent upon appropriate support elements in the EAC or corps for HSS, finance, religious, food service, legal, human resources and administration services, and supplementary transportation support. The assigned maintenance personnel augment the maintenance capability of the unit that performs maintenance on organic vehicles.

5-4. Mobility and Deployability

a. The AML is 10 percent mobile.

b. The AML is strategically and operationally deployable; organic vehicles are limited to required daily administrative, operational and logistical functions, and for movement of tailored, force projection teams to support health hazard assessment and investigative efforts.

c. The unit obtains its medical equipment through a lease or government-provided system which allows the equipment to be used in a table of distribution and allowances (TDA) organization until the unit is deployed. When the AML is deployed, the TDA organization releases the equipment to the AML for deployment.

5-5. Referral System

Nondeployable (fixed facility) organizations and special function laboratories provide a multidiscipline referral system to—

- Analyze samples/specimens and evaluate data provided by the AML.

- Aid in the discrimination between endemic (naturally occurring) agents from threat-delivered, bioengineered, and genetically modified organisms, toxins, and agents of biological origin.

- Augment the deployed capability to identify CW and radiological agents, industrial pollutants, and other hazardous materials that threaten the deployed force.

5-6. Epidemiological Assessment

The epidemiological assessment of medical threats is a collective effort of both deployable and fixed nondeployable laboratory resources. The cumulative effect of split-based resources and established referral facilities is to significantly expand the investigative and consultative potential available within the AO and to enhance the inherent deployability of the AML by minimizing the size of tailored laboratory support packages.

5-7. Modular Design

The modular design permits task-organization of AML personnel for limited functional capabilities without the deployment of the entire organization. Modules consist of functional increments that provide the necessary array of analytical, diagnostic, and investigative capabilities tailored for a specified mission or contingency operation. Likewise, the AML is capable of incrementally deploying its functional modules as the operational requirement for laboratory support increases. These characteristics enhance the total HSS system and better support split-based operations and rapid force projection without significantly degrading the capabilities of the parent unit.

Section II. ORGANIZATION, FUNCTIONS, AND EMPLOYMENT

5-8. Organization and Functions

a. *General*. The AML is organized with a headquarters section and three functional sections (Figure 5-1). It is assigned to a HHC, MEDCOM (EAC) (TOE 08611A000) or an HHC, MEDBDE (EAC) (TOE 08422A200) and further attached to other deployed HSS units. This unit is allocated on a basis of one unit per theater.

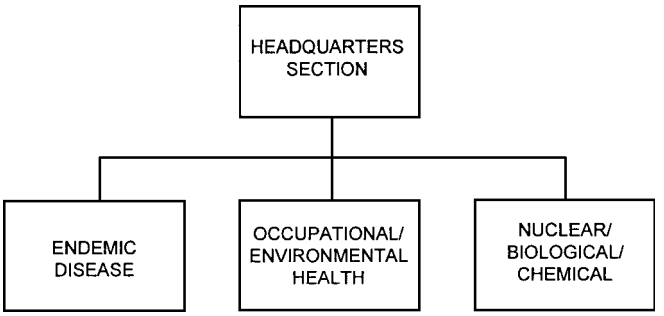

Figure 5-1. Area medical laboratory organization.

b. *Headquarters Section*. This section (Table 5-1) is staffed to—

- Provide C4I (to include coordinating for secure and nonsecure) capabilities, automation and computer analysis support requirements for the laboratory to facilitate split-based operations, and administrative and logistical support for the unit.

- Conduct staff planning activities and oversees the development and implementation of unit plans and orders.

- Liaise with supporting intelligence organizations to receive and disseminate information relating to threat identification functions of the laboratory.

- Perform unit administration activities.

- Plan for and execute unit movements.

- Identify unit training requirements and plan for and conduct unit training activities.

- Determine and submit requisitions for Class VIII supplies and equipment and general supply requirements.

- Identify requirements and supervise the use of contractual services for operator maintenance of all organic medical equipment.

Table 5-1. Headquarters Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
67B00	O6	COMMANDER	MS
71E67	O5	EXECUTIVE OFFICER	MS
70D67	O3	BIOMEDICAL INFORMATION MANAGEMENT OFFICER	MS
70H67	O3	MEDICAL OPERATIONS OFFICER	MS
91K50	E9	CHIEF MEDICAL LABORATORY NONCOMMISSIONED OFFICER	NC
91J20	E5	MEDICAL LOGISTICS SERGEANT	NC
42A10	E4	HUMAN RESOURCES SPECIALIST	
63B10	E4	WHEELED VEHICLE MECHANIC	
92G10	E3	COOK	

c. *Endemic Disease Section*. The endemic disease section (Table 5-2) is staffed to—

- Provide analytical, investigative, and consultative services on endemic diseases.

- Identify the endemic diseases that pose a potential threat to deployed forces (or other populations at risk) in the AO.

- Conduct diagnostics, field laboratory confirmation, and consultation on treatment and description of the natural history and transmission kinetics of infectious diseases.

- Conduct and direct the performance of microbiological procedures and investigate the characteristics of microorganisms.

- Provide risk assessment and advice on health hazards and disease trends.

- Determine the status of conditions that influence the health of personnel in an AO.

- Plan, implement, supervise, and consult in the field of veterinary pathology and perform anti- and postmortem examination of animal tissues to diagnose zoonotic and other diseases of military importance.

- Plan, direct, and conduct medical entomological studies and provide consultation and recommendations on control of pests and disease vectors.

- Conduct insecticide resistance testing on arthropods to ensure adequacy of control measures employed.

Table 5-2. Endemic Disease Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
60C00	O6	PREVENTIVE MEDICINE OFFICER	MC
61G00	O4	INFECTIOUS DISEASE OFFICER	MC
64D00	O4	VETERINARY PATHOLOGIST	VC
71A67	O4	MICROBIOLOGIST	MS
72B67	O4	ENTOMOLOGIST	MS
91K30	E6	MEDICAL LABORATORY NONCOMMISSIONED OFFICER	NC
91K20	E5	MEDICAL LABORATORY SERGEANT	NC
91S20	E5	PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER	NC
91K10	E4	MEDICAL LABORATORY SPECIALIST	
91S10	E4	PREVENTIVE MEDICINE SPECIALIST	
91K10	E3	MEDICAL LABORATORY SPECIALIST	

d. Occupational and Environmental Health Section. The OEH section (Table 3) is staffed to—

- Monitor and evaluate OEH hazards to deployed forces and provide medical assessment and consultation on associated hazards.

- Conduct and direct the performance of biochemical analysis and investigative protocols to determine OEH hazards.

- Provide consultation in areas related to biochemical analysis and data interpretation.

- Perform scientific work using sanitary/environmental engineering principles and practices to protect the health of deployed forces and the environment. Make recommendations to preserve and enhance health and environmental conditions, including air, water, noise, liquid and solid waste disposal, and institutional hygiene.

- Plan, implement, supervise, direct, and conduct various microbiological diagnostic procedures to diagnose zoonotic and animal diseases of military concern.

- Determine the status of conditions influencing the health of military personnel in an AO.

- Provide risk assessment and advise on health hazards and occupational disease trends.

- Formulate and recommend measures for health improvement as they relate to the performance of military duties in the operational environment.

- Perform analysis and investigations related to health physics, laser, microwave, directed energy (DE), and ionizing and nonionizing radiation biology associated with military operations.

- Supervise and perform biochemical analysis on OEH hazard specimens in the AO.

- Conduct PVNTMED inspections, surveys, and laboratory procedures relative to OEH.

- Perform analysis of radiologically contaminated samples.

- Assess, prepare, evaluate, and analyze food samples to determine food hygiene and safety.

Table 5-3. Occupational and Environmental Health Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
71B67	O5	BIOCHEMIST	MS
64E00	O4	VETERINARY MICROBIOLOGIST	VC
71B67	O4	BIOCHEMIST	MS
72D67	O4	ENVIRONMENTAL SCIENCE OFFICER	MS
72E67	O4	SANITARY ENGINEER	MS
71B67	O3	BIOCHEMIST	MS
72A67	O3	NUCLEAR MEDICAL SCIENCE OFFICER	MS
91K30	E6	MEDICAL LABORATORY NONCOMMISSIONED OFFICER	NC
91S30	E6	HEALTH PHYSICS NONCOMMISSIONED OFFICER	NC
91K20	E5	MEDICAL LABORATORY SERGEANT	NC
91R20	E5	FOOD INSPECTION SERGEANT	NC
91S20	E5	PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER	NC

Table 5-3. Occupational and Environmental Health Section (*Continued*)

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
91K10	E4	MEDICAL LABORATORY SPECIALIST	
91S10	E4	PREVENTIVE MEDICINE SPECIALIST	
91K10	E3	MEDICAL LABORATORY SPECIALIST	

e. Nuclear, Biological, and Chemical Section. The NBC section (Table 5-4) is staffed to—

- Provide analytical, investigative, and consultative services to assist in the ID of NBC threat agents in biomedical specimens and other samples.
- Perform field confirmation of suspected NBC threat agents.
- Conduct microbiological procedures and investigate microorganisms and their products (toxins) as a directed threat or weapon.
- Conduct biochemical analysis and investigative protocols to identify and evaluate CW agents.
- Perform scientific work related to health physics, laser, microwave, DE, and ionizing and nonionizing radiation biology that may be used as a weapons system.
- Perform elementary and advanced examinations of biomedical and environmental specimens to aid in determining the NBC threat directed against personnel or operations.
- Perform analysis of radiologically contaminated samples.

Table 5-4. Nuclear, Biological, and Chemical Section

AOC/MOS	GRADE	JOB DESCRIPTION	BRANCH
72A67	O5	NUCLEAR MEDICAL SCIENCE OFFICER	MS
71A67	O4	MICROBIOLOGIST	MS
71B67	O4	BIOCHEMIST	MS
91K30	E6	MEDICAL LABORATORY NONCOMMISSIONED OFFICER	NC
91K20	E5	MEDICAL LABORATORY SERGEANT	NC
91K10	E4	MEDICAL LABORATORY SPECIALIST	
91S10	E4	HEALTH PHYSICS SPECIALIST	
91K10	E3	MEDICAL LABORATORY SPECIALIST	

5-9. Employment

a. The MEDBDE or MEDCOM provides C4I and support to forward assigned sections of the AML or to the entire unit when deployed.

b. When operating in a split-based mode, the stay-behind headquarters element remains in CONUS or at EAC and conducts associated laboratory analysis, consultation, and referral of specimens to non-AML organizations, as appropriate.

c. The AML integrates its functional capabilities with other AMEDD and non-AMEDD assets to enhance the ID of medical threat agents; provides accurate field confirmation of suspect samples/specimens; and performs health hazard assessments across full spectrum operations.

(1) The AML, when operating in a split-based mode, employs both deployed and stay-behind elements to accomplish its operational requirements. Deployed assets will augment other deployed HSS units to assess and investigate health hazards within the AO. The nondeployed parent organization conducts associated analysis and consultation from the base and facilitates the referral of specimens to other organizations.

(2) Referral laboratory support integrates the diagnostic and analytical expertise of CONUS, OCONUS, and HN assets to expand its deployable capabilities. The shipment of specimens from the AO for a more definitive analysis, the mutual exchange of information, remote consultation through telemedicine services, and the use of sophisticated technologies and procedures not otherwise deployable will greatly enhance the functional capabilities of the AML. Referral laboratory support and consultation, as required, is obtained from the USACHPPM; US Army Medical Research Institute for Infectious Diseases (USAMRIID); US Army Medical Research Institute of Chemical Defense (USAMRICD); Walter Reed Army Institute of Research (WRAIR); US Army Research Institute of Environmental Medicine (USARIEM); US Army Institute of Surgical Research (USAISR); US Army Aeromedical Research Laboratory (USAARL); US Army Veterinary Laboratory Services; Armed Forces Institute of Pathology (AFIP); AFMIC; and other US Government and/or civilian reference laboratories. Similarly, OCONUS and forward-based facilities within the AO, or those facilities possessing certain unique analytical capabilities, may also be tasked to support the AML when appropriate.

(3) The AML coordinates extensively with other deployed HSS organizations to facilitate the acquisition, investigation, and analysis of medical threat information within the AO. The AML evaluates clinical information from MTFs to enhance its epidemiological assessment of operational health hazards and to identify early sentinels of disease/agent exposure. Further, the AML interfaces with PVNTMED assets to—

- Evaluate epidemiological data and provide entomological services (pesticide resistance studies and vector ID).
- Provide extended laboratory support to evaluate potential environmental health hazards.

- Assist in conducting medical and OEH surveillance within the AO.

(4) Deployed intelligence and chemical units play a critical role in the assessment and detection of NBC hazards in the AO. The integration of the AML's analytical capabilities with detection assets from chemical units expands the force commander's ability in assessing NBC use. The capability to rapidly exchange information and transfer specimens from geographically dispersed sites provides a more complete view of medical threat potential within the AO. Nonmedical assets, such as chemical detection teams, detect and collect samples following positive detection of NBC agents and transport appropriate samples to the AML for analysis, detection, and field confirmation. Similarly, information from intelligence units will clarify NBC threat potential, weaponization of agents, availability of delivery systems, and warning of actual attack.

(5) The AML capitalizes on the accessibility and expertise of other analytical facilities, such as commercial, industrial, academic, or other civilian laboratories, when appropriate.

5-10. Support to Military Operations

a. *Early Entry Operations*. In early entry operations, the ability to ID agents dispersed by the enemy and the capability to assess the potential release of NBC agents enhances the tactical commander's vision of the medical threat on the battlefield. Further, early ID of secondary release hazards allows the tactical commander to anticipate the NBC impact on operations and implement measures that better protect the force at risk. Rapid and accurate response is particularly critical during early entry operations when limited medical resources are deployed to treat endemic disease or casualties exposed to TIMs. The AML has the capability to deploy small, tailored assessment teams to aid the tactical commander in determining the health hazards in the AO.

b. *Combat Operations*. In combat operations, particularly aggressive high tempo operations, the force commander must have an accurate assessment of NBC use by the opposition. Continual evaluation and rapid ID of threat agents employed in a preemptive fashion will aid the implementation of appropriate preventive measures and medical treatment, and minimize operational impact on allied or coalition forces.

c. *Postconflict Operations*. Postconflict operations continue to focus on protecting and sustaining the health of the force. An accurate, comprehensive assessment of threat and endemic disease agent exposure will significantly enhance postdeployment diagnosis and treatment, as well as the long-term assessment of postconflict symptoms/syndromes secondary to operational exposures. These exposures include the medical effects of NBC agents, ionizing and nonionizing radiation, endemic diseases, OEH, and the cumulative effect of multiple hazards.

d. *Stability Operations and Support Operations*. The AML is tailored to support the laboratory requirements of contingency missions. During stability operations and support operations, the AML has the capability to deploy small assessment teams to support these operations. Thorough analysis and evaluation of endemic diseases, environmental health concerns, disease and surveillance, and unique medical threats to military, refugee, HN, and other populations at risk determines the specific laboratory capabilities that are required.

5-11. Sample or Specimen Collection and Transport of Suspect Nuclear, Biological, and Chemical Agents

a. Critical elements for accuracy in analysis of biological samples (nonhuman and nonanimal origin) and physiological specimens (human or animal origin) are correct collecting, packaging, handling, and transporting techniques. The quality of any analytical evaluation is directly related to the quality of the sample/specimen and the degree of postcollection degradation that occurs prior to testing. Health service support personnel collect and submit specimens for suspect NBC hazards/agents involving humans and animals. Chemical corps and other nonmedical units collect and submit environmental (air, plant, and soil) samples for suspect NBC hazards/agents. Preventive medicine personnel collect and submit water and ice samples for suspect NBC hazards and agents. Veterinary personnel collect and submit food samples, such as fruits and vegetables, and specimens from animals for suspect NBC hazards/agents. Specimens collected by clinical laboratory personnel from inpatients at an MTF that are suspect of being exposed to a BW agent are then forwarded to the supporting AML.

b. A strict chain of custody must be maintained for every sample/specimen collected. A DD Form 1911 or DA Form 4137 must be completed for each sample/specimen collected. The DA Form 4137 must accompany the sample/specimen during transport from the point of collection to the final receiving laboratory.

c. For detailed information on the collection, handling, and transport of samples/specimens, refer to FM 4-02.7.

APPENDIX A

ELIGIBILITY DETERMINATION FOR MEDICAL/DENTAL CARE

A-1. Eligibility for Care in a United States Army Medical Treatment Facility

a. During interagency and multinational operations, one of the most pressing questions is who is eligible for care in a US Army established MTF and the extent of care authorized. Numerous categories of personnel seek care in US facilities that are located in austere areas where the HN civilian medical infrastructure is not sufficient to provide adequate care. A determination of eligibility and whether reimbursement for services is required is made at the highest level possible and in conjunction with the supporting SJA. Additionally, Department of State and other military staff sections (such as the Assistant Chief of Staff, Civil Affairs [G5]) may also need to be involved in the determination process. Each operation is unique and the authorization for care is based on the appropriate US and international law, DODD and DODI, ARs, doctrine, and SOPs. Other factors impacting on the determination of eligibility are command guidance, practical humanitarian and medical ethics considerations, availability of US medical assets (in relationship to the threat faced by the force), and the potential training opportunities for medical forces. The sample format provided in paragraph A-2 is just one approach to delineate and disseminate this information to MTF personnel and may not be all inclusive based on specific scenarios.

NOTE

The examples for the authority to provide treatment are *only illustrative* in nature and should not be used as the basis for providing or denying medical care.

b. Basic documents required for determining eligibility of beneficiaries include AR 40-400; FM 27-10; relevant sections of Title 10, United States Code; relevant DODD and DODI; ISAs; Acquisition and Cross Servicing Agreements (ACSAs); orders from higher headquarters; interagency agreements (MOU and MOA); SOFA; and appropriate allied, coalition, or international agency guidance for the specific operation. If contractor personnel are present, a copy of the relevant sections of their contracts should be on file to delineate specific medical services to be rendered. Additionally, for contract personnel a point of contact (POC) for the contracting company and a POC for the administration of the contract should be maintained. Finally, the political-military environment of the AO must be taken into account as the medical C2 headquarters and its higher headquarters develop the eligibility matrix.

c. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name (see example in paragraph A-2). If individuals arrive at the emergency medical service (EMS) section of the MTF who are not included in the medical/dental support matrix, the MTF must always stabilize the individual first, then determine the patient's eligibility for continued care. The command POC for eligibility determination should be contacted immediately. Further, care will be provided in accordance with the SOP pending eligibility determination. (For example, a HN civilian presents himself at the gate and requests medical treatment. Although on the surface it may appear that he is not eligible for care, this determination can only be made after a medical assessment is completed by competent medical personnel. In some cases, the individual may have to be brought into the MTF to accomplish an adequate medical assessment. Conducting a medical assessment does not obligate the US

military to provide the full spectrum of medical care. Although it does obligate the MTF to provide immediate stabilization for life-, limb-, and eyesight-threatening medical conditions and to prepare the patient for evacuation to the appropriate civilian or national contingent MTF when the patient's medical condition permits.)

NOTE

Any individual requesting medical care should receive a timely medical assessment of his condition. Even though the individual is not eligible for treatment, life-, limb-, or eyesight-saving procedures warranted by the individual's medical condition are provided to stabilize the individual for transfer to the appropriate civilian or other nation MTF.

d. The MTF staff must be familiar with the medical care available in the AO from other sources. These sources could include allied, coalition, or HN military (tactical and strategic), NGO or international organizations (such as the UN), and local civilian resources. When appropriate, and by knowing the level and types of care available, the MTF staff can plan for the continued care of the patient after initial stabilization is provided in the US MTF and the patient can be transferred to another facility for continued care.

e. It is essential that eligibility for medical care guidance is disseminated and understood by the chain of command and all civilians and military members of the deployed force. The HSS commander must be able to articulate the basic concepts for medical eligibility determinations. This means that he will need to condense them into simple, easily understood instructions, and widely disseminate them through electronic means or other media (such as pocket-sized cards). As the chief planner for HSS operations, the HSS commander must ensure that this information is contained in appropriate OPLANs and OPORDs and briefed to the appropriate senior leadership of the command.

A-2. Sample Support Matrix for Eligibility for Care in a United States Army Medical Treatment Facility

ELIGIBILITY FOR MEDICAL/DENTAL CARE
SUPPORT MATRIX
(DATE)
(THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND/OR MODIFICATION)

CATEGORY	MEDICAL DENTAL	INFORMATION/AUTHORITY*
Allied military personnel	Yes[1]	The following nations have ACSAs and ISAs with the US which are administered by (*unified command*): *List nations.*
Coalition military personnel	Yes[1]	The following nations have ACSAs and ISAs with the US which are administered by (*unified command*): *List nations.*

CATEGORY	MEDICAL DENTAL	INFORMATION/AUTHORITY*
DOD civilian employees	Yes	Invitational travel orders (ITOs).
US Government employees (non-DOD)	Yes[2]	ITOs.
US embassy personnel	Yes	US citizens on official business.
US Congressional personnel	Yes	US citizens on official business.
Army and Air Force Exchange Service (AAFES) US citizen employees	Yes	ITOs.
AAFES Local national employees	Yes[3]	US law.
Nonappropriated fund instrumentality (NAFI) MWR US employees	Yes	ITOs.
NAFI (MWR) Local national employees	Yes[3]	US law.
Other persons on DOD ITOs	Yes	ITOs.
US Governmental Agency (such as USAID or the Drug Enforcement Agency [DEA]) US citizen employees	Yes	ITOs.
US Governmental Agency (such as USAID or DEA) Non-US citizen employees	Yes[3]	After stabilization, coordinate with the US Government Agency POC to evacuate the patient to his country of citizenship. AR 40-400 authorizes limited care. Contact Mr. Bannon, DSN XXX-XXXX.
Contractor employees who are US military retirees	Yes[4]	AR 40-400.
Contracted college instructors	Yes	ITOs.
United Nations personnel (includes all personnel employed by the UN and its agencies, such as the UN High Commissioner for Refugees [UNHCR])	Yes[3]	US law.
American National Red Cross	Yes[3]	DODD 1330.5.
Nongovernmental organi-zations personnel	Yes[3]	US law.

CATEGORY	MEDICAL DENTAL	INFORMATION/AUTHORITY*
Contractor #1 expatriate employees POC: Ms. Scott (XXX)XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes	Have copy of relevant contract.
Contractor #1 local national employees POC: Ms. Scott (XXX)XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[3]	Have copy of relevant contract. US law and SOFA.
Contractor #2 all employees POC: Mr. Franklin (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[3] No[5]	Contractor did not contract for the provision of medical care by military MTFs. Contractor stated in writing that they contracted with the HN medical infrastructure for the required care. Have copy of relevant contract. **NOTE:** A separate determination may be required for individual cases, as the individual may be eligible for care under a different provision. Contact Mr. Bannon, DSN XXX-XXXX if additional information is required.
Contractor #3 Communications Section POC: Ms. Jo Alce (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[3]	ITOs. **NOTE:** This entry for Contractor #3 does not include personnel assisting project XYZ. Those personnel are contracted by a different division of the contractor and are subject to separate contract terms. Contractor #3 in support of project XYZ has not submitted any information for determining eligibility for medical care and/or logistical support of these personnel.
Contractor #4 Mr. Edward Lee (company name classified) POC: Ms. Hannah (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes	Per Mr. Bannon, Mr. Lee is entitled to full medical and dental support without reimbursement. The terms of the contract and name of the contracting company are classified. Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required.
Contractor #5 Mr. Noah James (company name classified) POC: Ms. Hannah (XXX) XXX-XXXX ADMIN: Mr. Elliott DSN XXX-XXXX	Yes[6]	Per Mr. Bannon, Mr. James is entitled to full medical and dental support, however, this care is reimbursable. The terms of the contract and the name of the contracting company are classified. Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required.
Dependents of US active duty or retired military	Yes[4]	Only if space is available and appropriate medical services/care are available in the operational setting. AR 40-400. Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required.
Personnel in custody of US military forces	Yes	US and international law. This category includes personnel in protective custody, EPW, retained, or detained personnel. Extent of care rendered is the same as that provided to US military forces (FM 4-02 and FM 27-10*).*

CATEGORY	MEDICAL DENTAL	INFORMATION/AUTHORITY*
Individuals injured as a result of military operations	Yes	US and international law (FM 27-10), and SOFA. If the US military injures an individual (such as in an automobile accident involving a military vehicle), the US is responsible for providing immediate care (or paying for local care). Coordinate with Mr. Bannon, DSN XXX-XXXX, and LTC Brian, supporting SJA, DSN XXX-XXXX.

LEGEND:

* Illustrative in nature only.

1 Allied/coalition forces member nations are provided food, water, fuel, and medical treatment pursuant to reciprocal agreements. The amount of food, water, fuel, and medical care provided must be accounted for by the providing nation to the G5, multinational liaison. Logistical support is not permitted for those nations with whom the US does not have both an ACSA and ISA. However, the ACSA and ISA requirements may be waived for those nations whom the TF commander, in conjunction with the supporting SJA, feels are supporting the missions of the TF.

2 If not working for, contracted to, or on DOD ITO for logistical support, non-DOD US Government employees must pay for meals received at DOD dining facilities.

3 Emergency medical and dental care only. Emergency care is that care required to save life, limb, or eyesight.

4 Space available.

5 Routine.

6 Reimbursable.

APPENDIX B

MEDICAL MULTIFUNCTIONAL TASK FORCE

B-1. Task Organization

a. In many stability operations and support operations, medical assets must be task organized to support and successfully accomplish the mission. Medical troop ceilings, anticipated duration of the operation, and the type of mission to be performed dictate what medical resources may be deployed to the AO.

b. The HSS commander tasked with the mission must conduct a mission analysis to determine what resources are required. All ten functional areas must be considered and accommodated. In paragraph B-2, the functional area of medical laboratory services is not shown; it is embedded in the hospitalization and area support elements.

B-2. Force Structure of a Medical Multifunctional Task Force

a. No two MMTFs are alike in force structure. Each MMTF is developed to support a unique mission.

b. Typically, there are two types of C2 structures for an MMTF. These are—

(1) *Separate C2 headquarters*. This structure has a separate headquarters with the hospital and other medical units subordinate to it (Figure B-1).

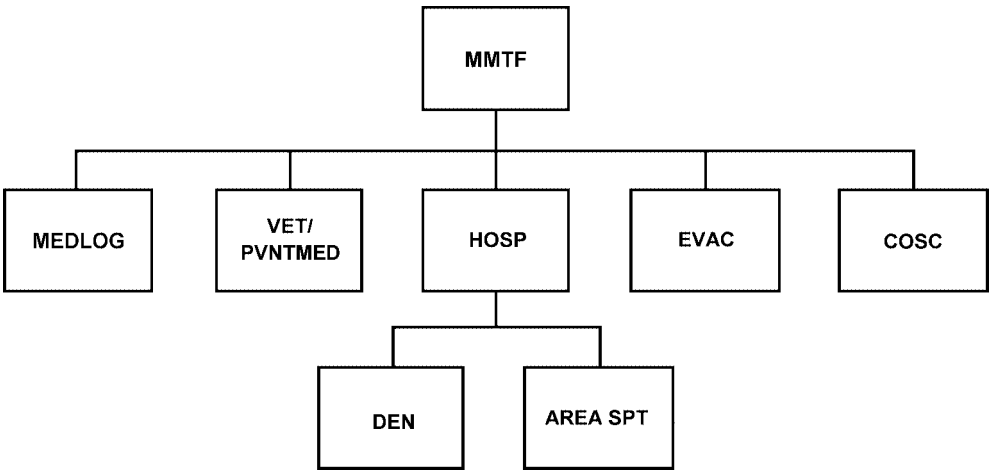

Figure B-1. Medical multifunctional task force separate command and control headquarters.

(2) *Parent unit headquarters*. This structure uses a base unit (parent unit) (Figure B-2) as the starting point for the organizational and personnel structure of the MMTF. The parent unit could be a hospital, area support medical battalion (ASMB), medical evacuation battalion, or other medical

C2 organization. The commander of the MMTF is also the commander of the parent unit. The other AMEDD functional area elements deployed are attached/assigned to the parent unit headquarters. This structure has both advantages and disadvantages. As the majority of the personnel comprising the MMTF come from the parent unit, the MMTF commander has already developed a working relationship with the staff. The greatest disadvantage of this structure is that the commander's focus is divided between the operational requirements of the MMTF and the operational requirements of the parent unit.

(3) *Lessons learned*. Lessons learned from the training centers and previous operations, demonstrate that the separate C2 structure is more effective than the parent unit structure. However, should a parent unit (such as a hospital) be tasked to form the MMTF, the commander should designate an individual (usually the Chief, Professional Services) to take over the planning and daily operations of the unit (hospital), thereby allowing the MMTF commander to focus on MMTF operations.

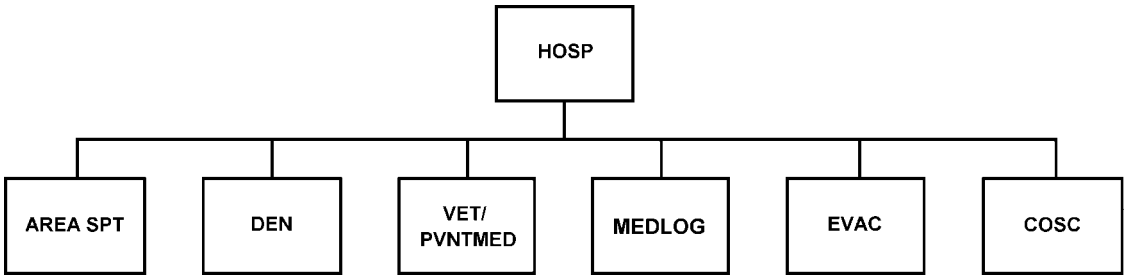

Figure B-2. Medical multifunctional task force parent unit command and control structure.

c. The MMTF commander determines what mix of clinical and operational personnel will be deployed. The staff must be balanced as both operational and clinical skills and orientation are essential to the accomplishment of the mission. Lessons learned from MMTF deployments demonstrate the critical balance which must be achieved. If an MMTF deploys without sufficient operational skills, clinical personnel must be diverted from their patient care duties to perform operational functions (such as, staffing the command post, establishing and manning communications systems, and developing and preparing OPLANs and OPORDs). Often times, the clinical staff does not have the training and experience to operate and sustain a deployed unit in the field. This most often results in the unit experiencing shortfalls or deficiencies in logistics, transportation, security, field services, operational planning, and unit training.

B-3. Equipment Requirements

In addition to determining what mix of personnel will comprise the MMTF, the commander must also determine what equipment and supplies will be deployed with the MMTF. During the planning process, a comprehensive listing of materiel should be developed and approved for use. This precludes expending

man hours on preparing equipment for deployment which, in fact, will not be deployed or is not needed to accomplish the mission.

B-4. Personnel Requirements

Once the commander determines the personnel requirements for the MMTF, he notifies higher headquarters of the positions (MOS/AOC) that cannot be accommodated from the base unit. The commander must continually monitor the status of these positions to ensure they are filled with sufficient time to allow for required orientation and training of these individuals as they are assigned.

B-5. Battalion Staff Plugs

a. An MMTF may deploy with a battalion-sized medical unit as the parent unit. Depending upon which battalion-sized medical unit is designated as the parent unit, the unit will require augmentation with the operational or clinical skills it is deficient in.

b. Tables B-1 through B-7 (pages B-3 through B-6) contain a comparison of the staff sections in the following five battalion-sized medical units:

- Headquarters and headquarters detachment, ASMB (TOE 08456A000).
- Headquarters and headquarters detachment, medical evacuation battalion (TOE 08446L000).
- Headquarters and headquarters detachment, medical logistics battalion (TOE 08496A000).
- Headquarters and headquarters detachment, combat support hospital (TOE 08956A000).
- Headquarters and headquarters detachment, veterinary support battalion (TOE 08416A000).

Table B-1. Unit Comparison—Command Section

ASMB	EVAC BN	MEDLOG BN	CSH	VET SPT BN
O5 CDR	O5 CDR	O5 CDR	O6 CDR	O5 CDR
O4 XO	O4 XO	O4 XO	*O6 CHIEF SURG	*O4 VET/PVNTMED
O4 S2/3	O4 S2/3	*O4 HLTH SVC MAT OFF	*O6 CHIEF NURSE	*W4 VET SVC TECH
O3 S1	*O4 FLT SURG	*O4 CE OFF	*O6 OP/ADMIN	E9 CSM
O3 S4	O3 S1	O3 S1	O5 S2/3	*E7 VET OP SGT
E9 CSM	O3 S4	O3 S2/3	*O4 CHAPLAIN	E4 ADMIN SPC
E3 DRIVER	*W4 AV SAFETY	O3 S4	O4 S1	E3 DRIVER
	*W4 AV STDZN	W4 BN MAINT OFF	O4 S4	
	E9 CSM	E9 CSM	*O3 FIELD MED ASST	
	E3 DRIVER	E3 DRIVER	E9 CSM	
			E5 ADMIN NCO	

*INDICATES SPECIALIZED PERSONNEL NOT COMMON TO EACH FUNCTIONAL BATTALION.

Table B-2. Unit Comparison—Detachment Headquarters

ASMB	EVAC BN	MEDLOG BN	CSH	VET SPT BN
O3 CDR	O2 CDR	O3 CDR	O3 CDR	O3 CDR
E7 DET SGT	E7 DET SGT	E7 DET SGT	E7 DET SGT	E7 DET SGT
E6 FOOD OP SGT	E5 SUPPLY SGT	E5 SUPPLY SGT	E5 SUPPLY SGT	E4 ARMORER
E5 FIRST COOK	E4 ADMIN SPC	E3 ADMIN CLERK	E4 ADMIN CLERK	
E4 COOK	E3 COOK			
E3 DRIVER				

Table B-3. Unit Comparison—S1 Sections

ASMB	EVAC BN	MEDLOG BN	CSH	VET SPT BN
E7 SR HR SGT	E7 SR HR SGT	E7 SR HR SGT	E7 SR HR SGT	E4 ADMIN SPC
E6 HR SGT	E4 LEGAL SPC	E4 LEGAL SPC	E5 LEGAL NCO	
E4 LEGAL SPC	E3 ADMIN SPC	E4 ADMIN SPC	E3 LEGAL SPC	
E4 ADMIN SPC	E3 ADMIN CLERK	E3 MAIL CLERK	E3 MAIL CLERK	
E3 MAIL CLERK			E3 ADMIN CLERK	

Table B-4. Unit Comparison—S2/3 Sections

ASMB	EVAC BN	MEDLOG BN	CSH	VET SPT BN
O3 MED OP OFF	O3 OP OFF	O2 HLTH SVC MAT OFF	O4 HLTH CARE ADMIN OFF	E5 NBC NCO
E8 OP SGT	O2 FIELD MED ASST	E8 OP SGT	E8 OP SGT	
E7 SECTION CHIEF	*W4 TAC OP OFF	E6 NBC NCO	*E7 INTEL SGT	
*E7 INTEL SGT	E8 OP SGT	E5 SR RADIO OPR	*E7 PLANS SGT	
*E7 PLANS SGT	E7 OP SGT	E4 RADIO OPR	E7 LIAISON NCO	
E6 NBC NCO	*E7 INTEL SGT	E4 TELECOM OPR	E6 NBC NCO	
E5 SR RADIO OPR	E7 MED NCO	E3 RADIO OPR	E5 SR RADIO OPR	
E4 RADIO OPR	*E7 PLANS NCO	E3 TELECOM OPR	E4 RADIO OPR	
E4 SIG INFO SPC	*E7 AV OP SGT		E4 ADMIN SPC	
E4 PNT ADMIN SPC	E6 NBC NCO		E3 RADIO OPR	
	E5 SR RADIO OPR		E3 ADMIN CLERK	
	E4 RADIO OPR			
	E4 SIG INFO SPC			
	E4 ADMIN SPC			
	E4 AV OP SPC			
	E3 RADIO OPR			
	E3 SIG SPT SPC			

*****INDICATES SPECIALIZED PERSONNEL NOT COMMON TO EACH FUNCTIONAL BATTALION.

Table B-5. Unit Comparison—S4 Sections

ASMB	EVAC BN	MEDLOG BN	CSH	VET SPT BN
O2 HLTH SVC MAT OFF	O3 HLTH SVC MAT OFF	E8 SR MAINT SUPV	O3 HLTH SVC MAT OFF	E5 SUPPLY SGT
E8 SR MAINT SUPV	*W4 AV MAT OFF	E7 SUPPLY SGT	W2 OP/MAINT TECH	
E7 SUPPLY SGT	*W3 AV LOG TECH	E6 MEDLOG SGT	W2 UNIT MAINT OFF	
E6 MEDLOG SGT	E8 SR MAINT SUPV	E5 PROP BOOK NCO	E7 SUPPLY SGT	
*E6 PHARMACY NCO	E7 FOOD OP SGT	E4 SUPPLY SPC	E5 PROP BOOK NCO	
E4 MED EQUIP REP	E7 SUPPLY SGT	E3 SUPPLY SPC	E5 SUPPLY SGT	
E4 MEDLOG SPC	E6 MEDLOG SGT		E4 SUPPLY SPC	
E4 SUPPLY ACCT SPC	E5 PROP BOOK NCO		E3 SUPPLY SPC	
E3 MED EQUIP REP	E4 SUPPLY SPC			
E3 SUPPLY ACCT SPC	E3 SUPPLY SPC			

*****INDICATES SPECIALIZED PERSONNEL NOT COMMON TO EACH FUNCTIONAL BATTALION.

Table B-6. Unit Comparison—Maintenance Sections

ASMB	EVAC BN	MEDLOG BN	CSH	VET SPT BN
W2 MAINT OFF	W2 MAINT OFF	W2 MAINT OFF		E5 EQUIP PARTS SGT
E6 MOTOR SGT	E6 MOTOR SGT	E6 MOTOR SGT		E4 LT WHL VEH MECH
E5 LT WHL VEH MECH	E5 LT WHL VEH MECH	E5 LT WHL VEH MECH		
E5 EQUIP PARTS SGT	E5 EQUIP PARTS SGT	E5 EQUIP PARTS SGT		
E4 GEN REP	E4 GEN REP	E4 GEN REP		
E4 REC VEH OPR	E4 REC VEH OPR	E4 REC VEH OPR		
E4 EQUIP PARTS SPC		E4 EQUIP PARTS SPC		
E3 LT WHL VEH MECH				

Table B-7. Unit Comparison—Specialty Sections

ASMB	EVAC BN	MEDLOG BN	CSH	VET SPT BN
*O4 PVNTMED OFF	*O3 FLIGHT SURG	*O3 PHARMACY OFF	*O3 S6	
*O3 ESO	*O3 PA	*O3 STK CONT OFF	*E7 S6 SEC CHIEF	
*E6 PVNTMED NCO	*E6 TRMT SQD LDR	*O3 HLTH SVC MAT OFF	*E4 SIG SVC SPC	
*E5 PVNTMED NCO	*E5 EMT SGT	*O2 BIOMED INFO OFF	*E4 FWD SIG SPT SPC	
*E4 PVNTMED SPC	*E4 MED SPC	*O2 SUPV MGT OFF	*O4 HLTH SVC SYS MGR	
*O3 OPT CHIEF	*E3 MED SPC	*E8 OP SGT	*E6 INFO SYS TM CHIEF	
*O3 OPT OFF		*E7 MED MAINT NCO	*E5 SR INFO SYS OPR	
*E5 OPT LAB SGT		*E7 MEDLOG SGT	*E4 INFO SYS OPR	
*E5 EYE SGT		*E5 MEDLOG SGT	*E3 INFO SYS OPR	
*E4 OPT LAB SPC		*E4 MEDLOG SPC	E5 LAUNDRY CHIEF	
*E4 EYE SPC		*E4 MEDLOG SPC	E4 LAUNDRY SPC	
*O4 PSYCHIATRIST			E3 LAUNDRY SPC	
*E4 MH SPC				
*E4 MH SPC				

*INDICATES SPECIALIZED PERSONNEL NOT COMMON TO EACH FUNCTIONAL BATTALION.

c. The MMTF commander must determine what his augmentation requirements will be based on METT-TC factors, anticipated duration of the operation, and any unique requirements based upon the scenario. To facilitate the process of determining and identifying requirements, Table B-8 provides a generic augmentation package for these small-scale operations. Tables B-9 through B-12 (pages B-7 through B-10) provide augmentation packages for specific battalion-sized functional battalions.

Table B-8. Medical Multifunctional Task Force Augmentation Package (*Generic*)

	PLANS/OPERATIONS TEAM	
O5	70H67	OPERATIONS OFFICER
O4	70H67	PLANS OFFICER
E8	91W40	OPERATIONS SERGEANT
	CLINICAL SERVICES TEAM	
O4	61J00	CLINICAL SERVICES OFFICER
E6	91W30	EMERGENCY TREATMENT SERGEANT
	PREVENTIVE MEDICINE TEAM	
O4	60C00	PREVENTIVE MEDICINE OFFICER
E6	91S30	PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER

Table B-8. Medical Multifunctional Task Force Augmentation Package (Generic) (Continued)

	MENTAL HEALTH TEAM	
O3	60W00	PSYCHIATRIST
E6	91X30	MENTAL HEALTH SERGEANT
	AVIATION OPERATIONS TEAM	
O4	67J20	AVIATION OPERATIONS OFFICER
E6	93P30	AVIATION OPERATIONS SERGEANT
	MEDICAL LOGISTICS TEAM	
O4	70K67	HEALTH SERVICES MATERIEL OFFICER
E6	91J30	MEDICAL LOGISTICS SERGEANT
	VETERINARY SERVICES TEAM	
O3	64B00	VETERINARIAN
E6	91T30	VETERINARY SERVICES NONCOMMISSIONED OFFICER

Table B-9. Medical Multifunctional Task Force Augmentation for the Area Support Medical Battalion

	CLINICAL SERVICES TEAM	
O3	61J00	SURGICAL SERVICE OFFICER
O3	66N00	NURSING SERVICE OFFICER
O3	61N00	FLIGHT SURGEON
E5	91W20	EMERGENCY MEDICAL TREATMENT SERGEANT
	VETERINARY SERVICES TEAM	
O3	64B00	VETERINARIAN
E5	91T20	VETERINARY SERVICES NONCOMMISSIONED OFFICER
	AVIATION OPERATIONS TEAM	
W4	153DB	AVIATION SAFETY OFFICER
W4	153DB	AVIATION STANDARDIZATION OFFICER
W3	151A0	AVIATION LOGISTICS OFFICER
E5	93P20	AVIATION OPERATIONS SERGEANT
	MEDICAL LOGISTICS TEAM	
O3	70K67	HEALTH SERVICES MATERIEL OFFICER
O3	67E00	PHARMACY OFFICER
E5	91A40	MEDICAL MAINTENANCE SERGEANT
E5	91J40	MEDICAL LOGISTICS SERGEANT

Table B-10. Medical Multifunctional Task Force Augmentation for the Medical Evacuation Battalion

	CLINICAL SERVICES TEAM	
O3	61J00	SURGICAL SERVICE OFFICER
O3	66N00	NURSING SERVICE OFFICER
O3	61N00	FLIGHT SURGEON
E5	91W20	EMERGENCY MEDICAL TREATMENT SERGEANT
	PREVENTIVE MEDICINE TEAM	
O3	60C00	PREVENTIVE MEDICINE OFFICER
E5	91S20	PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER
	OPTOMETRY TEAM	
O3	67F00	OPTOMETRY OFFICER
E5	91H20	OPTICAL LABORATORY SERGEANT
E5	91W20P3	EYE SERGEANT
	MENTAL HEALTH TEAM	
O3	60W00	PSYCHIATRIST
E5	91X20	MENTAL HEALTH SERGEANT
	VETERINARY SERVICES TEAM	
O3	64B00	VETERINARIAN
E5	91T20	VETERINARY SERVICES NONCOMMISSIONED OFFICER
	MEDICAL LOGISTICS TEAM	
O3	70K67	HEALTH SERVICES MATERIEL OFFICER
O3	67E00	PHARMACY OFFICER
E5	91A40	MEDICAL MAINTENANCE SERGEANT
E5	91J40	MEDICAL LOGISTICS SERGEANT

Table B-11. Medical Multifunctional Task Force Augmentation for the Medical Logistics Battalion

	PLANS/OPERATIONS TEAM	
O3	70H67	OPERATIONS OFFICER
O3	70H67	PLANS OFFICER
E6	91W30	INTELLIGENCE NONCOMMISSIONED OFFICER
E5	91W20	OPERATIONS SERGEANT
	AVIATION OPERATIONS TEAM	
W4	153DB	AVIATION SAFETY OFFICER
W4	153DB	AVIATION STANDARDIZATION OFFICER
W3	151A0	AVIATION LOGISTICS OFFICER
E5	93P20	AVIATION OPERATIONS SERGEANT

Table B-11. Medical Multifunctional Task Force Augmentation for the Medical Logistics Battalion (Continued)

	CLINICAL SERVICES TEAM	
O3	61J00	SURGICAL SERVICE OFFICER
O3	66N00	NURSING SERVICE OFFICER
O3	61N00	FLIGHT SURGEON
E5	91W20	EMERGENCY MEDICAL TREATMENT SERGEANT
	PREVENTIVE MEDICINE TEAM	
O3	60C00	PREVENTIVE MEDICINE OFFICER
E5	91S20	PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER
	OPTOMETRY TEAM	
O3	67F00	OPTOMETRY OFFICER
E5	91H20	OPTICAL LABORATORY SERGEANT
E5	91W20P3	EYE SERGEANT
	MENTAL HEALTH TEAM	
O3	60W00	PSYCHIATRIST
E5	91X20	MENTAL HEALTH SERGEANT
	VETERINARY SERVICES TEAM	
O3	64B00	VETERINARIAN
E5	91T20	VETERINARY SERVICES NONCOMMISSIONED OFFICER

Table B-12. Medical Multifunctional Task Force Augmentation for the Combat Support Hospital

	PREVENTIVE MEDICINE TEAM	
O3	60C00	PREVENTIVE MEDICINE OFFICER
E5	91S20	PREVENTIVE MEDICINE NONCOMMISSIONED OFFICER
	OPTOMETRY TEAM	
O3	67F00	OPTOMETRY OFFICER
E5	91H20	OPTICAL LABORATORY SERGEANT
E5	91W20P3	EYE SERGEANT
	MENTAL HEALTH TEAM	
O3	60W00	PSYCHIATRIST
E5	91X20	MENTAL HEALTH SERGEANT

Table B-12. Medical Multifunctional Task Force Augmentation for the Combat Support Hospital (*Continued*)

	VETERINARY SERVICES TEAM	
O3	64B00	VETERINARIAN
E5	91T20	VETERINARY SERVICES NONCOMMISSIONED OFFICER
	AVIATION OPERATIONS TEAM	
W4	153DB	AVIATION SAFETY OFFICER
W4	153DB	AVIATION STANDARDIZATION OFFICER
W3	151A0	AVIATION LOGISTICS OFFICER
E5	93P20	AVIATION OPERATIONS SERGEANT
	MEDICAL LOGISTICS TEAM	
O3	70K67	HEALTH SERVICES MATERIEL OFFICER
O3	67E00	PHARMACY OFFICER
E5	91A40	MEDICAL MAINTENANCE SERGEANT
E5	91J40	MEDICAL LOGISTICS SERGEANT

d. The most efficient MMTF organization is to build staff plugs based on existing cells within each of the functional HHDs. Once position requirements are identified, staffing of these positions should be task-organized from the supporting MEDBDE or MEDCOM.

B-6. Operational Requirements

For the MMTF to be successful, it must be capable of rapidly mobilizing, conducting predeployment activities, deploying, establishing and sustaining operations in the AO, and redeploying. For detailed information on the requirements and processes to accomplish these functions refer to FM 100-17.

B-7. Professional Filler System Personnel

a. Numerous positions on an MMTF are filled by PROFIS personnel. During the predeployment phase of the operation, the MMTF commander should immediately contact all identified PROFIS personnel to facilitate the integration of these personnel into the unit. The assigned/attached PROFIS personnel should be provided with information on—

- Reporting dates, times, and place.
- Types of uniforms and equipment they should bring.

- Training requirements.
- Credentialing requirements.

b. Once the PROFIS personnel arrive at the unit, they should be provided an orientation to the unit, medical threat in proposed AO, and if appropriate, cultural, social, ethnic, and religious considerations of the local populace.

APPENDIX C

MEDICAL UNITS WHICH MAY BE ASSIGNED OR ATTACHED TO A MEDICAL COMMAND OR MEDICAL BRIGADE

C-1. General

This appendix provides information on the TOE number, basis of allocation, and assignment of medical units which may be assigned or attached to a MEDCOM or MEDBDE. Some units are assigned or attached to subordinate units of the MEDCOM or MEDBDE. If the parent headquarters is not deployed, these units could be assigned or attached directly to the deployed MEDCOM or MEDBDE.

C-2. Medical Reengineering Initiative Units

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08416A000	*Headquarters and Headquarters Detachment (HHD), Veterinary Support Battalion	1 per 3 subordinate units, combination of Food Procurement Det, Animal Surgical Det, and Surveillance Det	Assigned to a MEDBDE or MEDCOM; may be attached to USN, USMC, USAF or other federal agencies in support of DOD veterinary mission, as directed	FM 8-10-18
08417A000	*Food Procurement Detachment	1 per 275,000 DOD personnel in theater	Assigned to Medical Battalion, Veterinary Support	FM 8-10-18
08418A000	*Animal Surgery Detachment	1 per 200 MWDs	Assigned to Medical Battalion, Veterinary Support	FM 8-10-18
08419A000	*Veterinary Service, Surveillance Detachment	1 per 100,000 DOD personnel in division and corps and 1 per 200,000 DOD personnel in the COMMZ	Assigned to Medical Battalion, Veterinary Support	FM 8-10-18
08429A000	Medical Detachment, Preventive Medicine	1 per 17,000 supported personnel in the corps and EAC	Assigned to MEDCOMs in corps and EAC. It may also be assigned to other CSS commands in the absence of a MEDCOM, or as required in support of individual units or joint/combined TF	FM 4-02.17
08453A000	Medical Company, Ground Ambulance	As required based on stated capabilities	Assigned to a Medical Battalion, Evacuation or a MEDBDE	FM 8-10-6
08456A000	Headquarters and Headquarters Detachment, Area Support Medical Battalion	1 per 15,000 nondivisional troops supported in the corps or COMMZ	Assigned to a MEDBDE	FM 4-02.24
08457A000	Medical Company, Area Support	1 per 15,000 nondivisional troops in corps and EAC	Assigned to an ASMB	FM 4-02.24
08463A000	Medical Detachment, Combat Stress Control	As required based on stated capability	Assigned to a MEDBDE or MEDCOM	FM 8-51

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08473A000	Dental Company, Area Support	1 per 20,000 supported US Army troops	MEDCOM in EAC or corps and MEDBDE	FM 4-02.19
08488A000	Medical Logistics Company	As required based on stated capability	Assigned to HHD, Medical Logistics Battalion	FM 4-02.1
08489A000	Blood Support Detachment	1 per 100,000 soldiers in the theater; 1 per 150,000 joint service population in the theater	Assigned to HHD, Medical Logistics Battalion	FM 4-02.1
08496A000	Headquarters and Headquarters Detachment, Medical Logistics Battalion	As required based on stated capability	Assigned to HHC, MEDCOM or HHC, MEDBDE	FM 4-02.1
08497A000	Logistics Support Company	As required by stated capability	Assigned to HHD, Medical Logistics Battalion	FM 4-02.1
08527AA00	Hospital Augmentation Team, Head and Neck	1 per 4 hospitals in corps	Assigned to a MEDBDE or MEDCOM and attached to a hospital	FM 4-02.10
08537AA00	Hospital Augmentation Team, Pathology	1 per theater	Assigned to a MEDBDE or MEDCOM and attached to a hospital	FM 4-02.10
08538AA00	Hospital Augmentation Team, Special Care	1 per theater	Assigned to a MEDBDE or MEDCOM and attached to a hospital or other MTF	FM 4-02.10
08539AA00	Medical Detachment, Telemedicine	1 per division-force equivalent (DFE) supported in the corps and 1 per 2 DFE in EAC	Assigned to a CSH and attached to the medical company of the forward support battalion, main support battalion, or ASMB	FM 4-02.10
08668A000	Area Medical Laboratory	1 per theater	Assigned to MEDCOM (TOE 08611A000) or MEDBDE (TOE 08422A200); may be further attached to other deployed medical units as needed	Chapter 5 of this manual and FM 4-02.17
08699A000	Medical Logistics Management Center	1 for the Army	Assigned to MEDCOM (TOE 08611A000)	FM 4-02.1
08753A000	Medical Detachment, Area Support	2 per corps	Assigned to a MEDBED; further attached to an ASMB	FM 4-02.24
08855A000	Combat Support Hospital (EAC) (Nonsplit Base)	Supports the requirement for all intensive care unit (ICU) and intermediate care ward (ICW) bed requirements (50 percent of total bed requirements). To support minimal care beds must be augmented by the Minimal Care Detachment.	Assigned to a MEDBDE or MEDCOM (EAC) or to a joint/ combined TF	FM 4-02.10

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08856A000	Headquarters and Headquarters Detachment, Combat Support Hospital (Nonsplit Base)	1 per CSH	Assigned to the CSH (TOE 08857A000)	FM 4-02.10
08857A000	Hospital Company (164 Beds) (Nonsplit Base)	1 per CSH (TOE 08856A000)	Assigned to the CSH (TOE 08856A00)	FM 4-02.10
08858A000	Hospital Company (84 Bed) (Nonsplit Base)	1 per CSH (TOE 08856A000)	Assigned to the CSH (TOE 08856A00)	FM 4-02.10
08949A000	Medical Detachment, Minimal Care	All CZ minimal care bed requirements (25%); all COMMZ minimal care bed requirements (50%); 2 per MTW to support EPW	Assigned to a MEDBDE and attached to a hospital	FM 4-02.10
08955A000	Combat Support Hospital (284 Bed) (Corps)	All intensive care and intermediate bed requirements (75%); to support the remaining minimal care beds (25%) a Minimal Care Detachment (TOE 08949A000) must augment the hospital	Assigned to a MEDBDE (TOE 08422A200) but may be assigned to a MEDCOM (TOE 08611A000)	FM 4-02.10
08956A000	Headquarters and Headquarters Detachment, Combat Support Hospital (Corps)	1 per CSH	Assigned to the CSH (TOE 08957A000)	FM 4-02.10
08957A000	Hospital Company (164 Bed) (Corps)	1 per CSH (TOE 08956A00)	Assigned to the CSH (TOE 08956A00)	FM 4-02.10
08958A000	Hospital Company (84 Bed) (Corps)	1 per CSH (TOE 08956A00)	Assigned to the CSH (TOE 08956A00)	FM 4-02.10

NOTE:

* The veterinary unit force structure is currently undergoing review and changes to organizational designs will be forthcoming.

C-3. Medical Force 2000 Units

The organizations listed below were initially designed under the Medical Force 2000 process. Some units were revised under MRI; however, these units retain the "L" designator. As MRI units are fielded, the Medical Force 2000 TOEs will transition to the new MRI TOEs. A brief description of the Medical Force 2000 C2 units (medical command, medical brigades, and medical group) are provided in Appendix E.

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08403L000	Medical Detachment, Veterinary Service Headquarters	1 per 4-11 Medical Det, Veterinary Service or Medical Det, Veterinary Medicine	Assigned to the MEDBDE	FM 8-10-18

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08413L000	Medical Detachment, Veterinary Service	1 per 70,000 troops in CZ; 1 per 140,000 troops in the COMMZ	Assigned to the MEDBDE or Veterinary Service Headquarters	FM 8-10-18
08422L100	Headquarters and Headquarters Company, Medical Brigade (Corps)	1 per corps	Corps Support Command (TOE 63431L000)	FM 8-55
08422L200	Headquarters and Headquarters Company, Medical Brigade (COMMZ)	1 per 3-7 medical battalions or battalion force equivalents	MEDCOM	FM 8-55
08432L000	Headquarters and Headquarters Company, Medical Group	3 per corps	Assigned to corps MEDBDE	FM 8-55
08433L000	Medical Detachment, Veterinary Service (Small)	1 per 10,000 troops in the CZ; 1 per 20,000 troops in the COMMZ; 1 per 20,000 joint service personnel	Assigned to MEDBDE, or Medical Det, Veterinary Service Headquarters, or Medical Det, Veterinary Services	FM 8-10-18
08443L100	Medical Company, Air Ambulance (UH-1)	1 per each division or DFE supported; .333 units per separate brigades or armored cavalry regiments (ACRs); 1 is in GS in the corps per 2 divisions; other, as determined by METT-TC or MTW	Assigned to a MEDBDE or Medical Group and further attached to a Medical Battalion, Evacuation	FM 8-10-26
08443L200	Medical Company, Air Ambulance (UH-60)	1 per each division or DFE supported; .333 units per separate brigades or ACRs; 1 is in GS in the corps per 2 divisions; other, as determined by METT-TC or MTW	Assigned to a MEDBDE or Medical Group and further attached to a Medical Battalion, Evacuation	FM 8-10-26
08446L000	Medical Battalion, Evacuation	1 per combination of 3-7 Medical Company, Air Ambulance and Medical Company, Ground Ambulance	Assigned to a MEDCOM (EAC) or MEDBDE (corps) and further assigned to a medical group	FM 8-10-6
08453L000	Medical Company, Ground Ambulance	1 per division supported and within EAC 1 per two divisions supported	Assigned or attached to the Medical Battalion, Evacuation	FM 8-10-6
08455L000	Medical Battalion, Area Support	.018 per 1,000 nondivisional troops in corps and EAC	Assigned to a MEDBE or Medical Group	FM 4-02.24
08456L000	Headquarters and Support Company, Area Support Medical Battalion	1 per ASMB	Assigned to an ASMB	FM 4-02.24
08457L000	Medical Company, Area Support	3 per ASMB	Assigned to an ASMB	FM 4-02.24
08458L000	Medical Company, Holding	1 per corps	Assigned to a MEDBDE and further attached to a Medical Group within the CZ	FM 8-55

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08463L000	Medical Detachment, Combat Stress Control	1 per division 1 per 2 to 3 separate brigade forces not otherwise provided CSC support	Assigned to a MEDCOM or MEDBDE and further attached to the Medical Company, CSC or supported Medical Company	FM 8-51
08467L000	Medical Company, Combat Stress Control	To the corps on a basis of .5 per division supported	Assigned to a MEDCOM or MEDBDE. It may be further assigned to a Medical Group	FM 8-51
08478L000	Medical Company, Dental Services	1 per each 20,000 troops supported	Assigned to a MEDCOM or MEDBDE	FM 4-02.19
08485L000	Medical Battalion, Logistics (Forward)	1 per corps or 3 division-equivalent force or 100,000 joint service population	Assigned to the corps MEDBDE	FM 8-10-9
08486L000	Headquarters and Headquarters Detachment, Medical Battalion, Logistics (Forward)	1 per Medical Battalion, Logistics (Forward)	Assigned to the Medical Battalion, Logistics (Forward)	FM 8-10-9
08487L000	Logistics Support Company, Medical Battalion, Logistics (Forward)	1 per Medical Battalion, Logistics (Forward)	Assigned to the Medical Battalion, Logistics (Forward)	FM 8-10-9
08488L000	Distribution Company, Medical Battalion, Logistics (Forward)	1 per Medical Battalion, Logistics (Forward)	Assigned to the Medical Battalion, Logistics (Forward)	FM 8-10-9
08498L000	Medical Detachment, Preventive Medicine, Sanitation	1 per 22,500 personnel and 1 per 50,000 EPWs	Assigned to a MEDBDE or Medical Group and further attached to an ASMB	FM 8-55 FM 4-02.17
08499L000	Medical Detachment, Preventive Medicine, Entomology	1 per 45,000 personnel and 1 per 100,000 EPWs	Assigned to a MEDBDE or Medical Group and further attached to an ASMB	FM 8-55 FM 4-02.17
08518LA00	*Medical Team, Forward Surgical	1 per division Maneuver Brigade (minus Air Assault and Airborne [ABN]), 2 per Air Assault Division, 1 per separate brigade, and 1 per heavy ACR	Assigned to a MEDBDE and attached to a CSH when not operationally employed and further attached for support to a Medical Company	FM 4-02.25
08518LB00	*Medical Team, Forward Surgical (Airborne)	1 per ABN brigade supported (2 per ABN division)	Assigned to a MEDBDE and attached to a CSH when not operationally employed and further attached for support to a Medical Company	FM 4-02.25
08527LA00	Medical Team, Head and Neck Surgery	.25 per CSH .25 per Field Hospital (FH) .25 per General Hospital (GH)	Assigned to a MEDCOM, MEDBDE, or Medical Group and further attached to a hospital	FM 8-55
08527LB00	Medical Team, Neurosurgery	.37 per CSH .37 per FH .37 per GH	Assigned to a MEDCOM, MEDBDE, or Medical Group and further attached to a hospital	FM 8-55

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08527LC00	Medical Team, Eye Surgery	.25 per CSH .25 per FH .25 per GH	Assigned to a MEDCOM, MEDBDE, or Medical Group and further attached to a hospital	FM 8-55
08537LA00	Medical Team, Pathology	1 per theater	Assigned to a MEDCOM, MEDBDE, or Medical Group and further attached to a hospital	FM 8-55
08537LB00	Medical Team, Renal Hemodialysis	1 per theater	Assigned to MEDCOM, MEDBDE, or Medical Group and further attached to a hospital	FM 4-02.10
08537LC00	Medical Team, Infectious Disease	1 per corps	Assigned to a MEDCOM, MEDBDE, or Medical Group and further attached to a hospital	FM 4-02.10
08657L000	Theater Army Medical Laboratory	1 per theater	Assigned to a MEDCOM or MEDBDE	FM 8-55
08695L000	Medical Battalion, Logistics (Rear)	1 per theater 1 per 250,000 joint service population	Assigned to EAC MEDCOM	FM 8-10-9
08696L000	Headquarters and Headquarters Detachment, Medical Battalion, Logistics (Rear)	1 per Medical Battalion, Logistics (Rear)	Assigned to Medical Battalion, Logistics (Rear)	FM 8-10-9
08697L000	Logistics Support Company, Medical Battalion, Logistics (Rear)	1 per Medical Battalion, Logistics (Rear)	Assigned to Medical Battalion, Logistics (Rear)	FM 8-10-9
08698L000	Distribution Company, Medical Battalion, Logistics (Rear)	1 per Medical Battalion, Logistics (Rear)	Assigned to Medical Battalion, Logistics (Rear)	FM 8-10-9
08705L000	Combat Support Hospital	2.4 hospitals per division	Assigned to corps MEDBDE and further attached to corps Medical Group	FM 8-10-14
08715L000	Field Hospital	2 per division supported for 1.462 per 1,000 admitted patients in EAC.	Assigned to the EAC MEDCOM and further attached to the EAC MEDBDE	FM 8-10-15
08725L000	General Hospital	2 GH per 3 divisions supported or 0.829 units per 1,000 patients admitted in EAC	Assigned to EAC MEDCOM and further attached to the EAC MEDBDE	FM 8-10-15
08736L100	Hospital Unit, Base (Combat Support Hospital)	1 per CSH	Organic to CSH	FM 8-10-14
08736L200	Hospital Unit, Base (Field Hospital)	1 per FH	Organic to FH	FM 8-10-15
08736L300	Hospital Unit, Base (General Hospital)	1 per GH	Organic to GH	FM 8-10-15
08737L000	Hospital Unit, Surgical	1 per CSH 1 per GH	Organic to a CSH and a GH	FM 8-10-14 FM 8-10-15

TOE NUMBER	NOMENCLATURE	BASIS OF ALLOCATION	ASSIGNMENT	REFERENCE
08738L000	Hospital Unit, Medical	1 per GH	Assigned to a GH	FM 8-10-14 FM 8-10-15
08739L000	Hospital Unit, Holding	1 per FH	Assigned to a FH	FM 8-10-14 FM 8-10-15
08863L000	**Mobile Army Surgical Hospital	1 per division	Assigned to a corps MEDBDE and further attached to a Medical Group	***FM 8-10-13
08903L000	Medical Logistics Support Detachment	1 per division or ACR not supported by a Medical Battalion, Logistics (Forward) 1 per 25,000 joint service population in the corps 1 per 50,000 joint service population in EAC 1 per Medical Battalion Logistics (Forward) supporting a 3 division corps	Assigned to Medical Battalion, Logistics (Forward or Rear)	FM 8-10-9

NOTE:

* This unit must be collocated with a CSH or a medical company for support. It is not a self-sufficient unit.

** This unit was replaced by the forward surgical team.

*** This publication was only published as an Approved Final Draft by the USAMEDDC&S. It is not available through the Reimer Digital Library.

C-4. Human Dimension Team

a. As stated in paragraph 3-2, the HDT conducts field research on soldier and unit cohesiveness, readiness, morale, and stressors affecting well-being and combat effectiveness. It also provides rapid feedback of results for use in the determination of operational and strategic policy. This team conducts surveys based on standard protocols. It receives focused guidance on human dimensions issues to be investigated through the corps MEDCOM commander, the Office of The Surgeon General, USAMRMC, and the DA staff. The HDT, supported by USAMRMC—

- Develops questionnaires and survey methodologies.
- Coordinates administration and collection of questionnaires within units.
- Conducts and supervises unit survey interviews of working sections at all levels.
- Analyzes data and transmits data to USAMRMC, USACHPPM, and other appropriate agencies for further analysis.

- Prepares reports and presentations of the findings.
- Gives briefings and disseminates results to user units.
- Publishes findings when appropriate.

b. The HDT has the capability to have two teams of an officer (research psychologist) and two enlisted personnel conducting mobile surveys in the field while one officer and NCO receive, analyze, and transmit data at the command headquarters. The HDT utilizes the COSC assets of the corps MEDCOM in collecting data and disseminating results.

APPENDIX D

COMMAND POST OPERATIONS AND JOINT MEDICAL OPERATIONS CENTER

Section I. COMMAND POST OPERATIONS

D-1. Command Post Elements

The MEDCOM and/or MEDBDE SOP establishes the MEDCOM/MEDBDE command post (CP) organization and composition. The CP consists of a main and alternate locations. The alternate locations are planned for in order to enhance the security and survivability of the main CP.

D-2. Main Command Post

a. The main CP consists of those elements of the command group, staff sections, and administrative support personnel required for C4I, staff supervision, personnel staff support, and life support. It also includes planning cells or liaison officers (LNOs) from higher and subordinate commands to synchronize HSS plans. The CP includes the life support and perimeter defense areas.

b. The CP configuration reflects broad specialized relationships, continuity of operations, and information flow among sections. The availability of existing facilities and terrain determines actual location of elements and supporting staff sections. The HHC commander plans the physical layout of the CP.

c. The life support area includes facilities for providing field feeding, billeting, and organizational supply and maintenance. The HHC commander coordinates these support activities as well as other essential support services, such as shower, laundry, and latrines. Life support services are incorporated within the base perimeter.

d. An alternate CP provides continuity of C4I in case of destruction or incapacitation of the main CP. The MEDCOM/MEDBDE Deputy Chief of Staff (Security, Plans, and Operations) (G3) selects alternate CP locations. The HHC commander is responsible for establishing the alternate CP.

D-3. Command Post Security

a. Command posts use several measures to improve the survivability of critical C4I elements. If a chemical/biological protected or nuclear hardened site is not available, CP dispersal enhances survivability, as does reducing the size and signature of the CP.

b. The HHC commander is responsible for coordinating internal security and local defense of the main CP. Command post security includes establishing—

- Prepared defensive positions and a warning system.

- Barrier systems and obstacles outside the perimeter.
- Manned guard posts.
- Sentries and guards for local internal security.
- Alternate and supplementary positions.
- Access control.

NOTE

The Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (GWS) does not itself prohibit the use of Article 24 personnel in perimeter defense of nonmedical units such as logistics support areas (LSAs) or base clusters under overall security defense plans, but the policy of the US Army is that Article 24 (GWS) personnel will not be used for this purpose. Adherence to this policy should avoid any issues regarding their status under the GWS due to a temporary change in their role from noncombatant to combatant. Medical personnel may guard their own unit without any concurrent loss of their protected status. For additional information on the medical aspects of the Geneva Conventions refer to FM 4-02.

c. Unless the main CP is within the perimeter of a larger secure base, the HHC commander controls access to the main CP. The MEDCOM/MEDBDE G3 operations branch is responsible for preparing and issuing passes. The HHC commander is responsible for employing alarm devices. The NBC officer designates the location of chemical detectors/alarms. The HHC commander establishes an airborne early warning network and implements an area alert system for ground and/or air attacks. He also notifies the supporting base cluster operations of attacks and immediately forwards requests for quick reaction forces through the MEDCOM/MEDBDE G3.

D-4. Reports

One means of maintaining SU is to receive situation and status reports from higher and subordinate HSS units. The C4I headquarters designates what reports are required, what format will be used, period covered by the report, frequency and submission times, and means of transmission. Figure D-1 depicts a sample Report Submission Schedule.

REPORT SUBMISSION SCHEDULE

REPORT	AS OF	ARRIVE NLT	PRECEDENCE	SENT TO
MEDICAL SPOT REPORT (MEDSPTREP)	AS NEEDED	IMMEDIATELY	PRIORITY	MEDCOM/ MEDBDE CDR
MEDICAL SITUATION REPORT (MEDSITREP)	0600	1000	ROUTINE	MEDCOM/ MEDBDE CDR
MEDICAL STATUS REPORT (MEDSTAT)	0600 DAILY	1000	ROUTINE	MEDCOM/ MEDBDE CDR
DISEASE AND NONBATTLE INJURY REPORT (DNBI)	2359 SAT WEEKLY	1200 MON WEEKLY	ROUTINE	MEDCOM/ MEDBDE PVNTMED OFFICER
BLOOD REPORT	0600 DAILY	1000 DAILY	ROUTINE	MEDCOM/ MEDBDE G4
MEDICAL SUPPLY STATUS (MEDSUPSTAT)	0600 DAILY	1000 DAILY	ROUTINE	MEDCOM/ MEDBDE G4
MEDICAL REGULATING REQUEST	0600 DAILY	1000 DAILY	ROUTINE	MEDCOM/ MEDBDE G3
FORWARD SURGICAL TEAM SITUATION REPORT	AS NEEDED	IMMEDIATELY	PRIORITY	MEDCOM/ MEDBDE CDR/ CMD SURGEON

NOTES:

1. DTG used for all reports will be ZULU (As of and Arrive NLT times are local).

2. Medical reports submitted will use the formats prescribed in these instructions. All reports will be transmitted to the MEDCOM/ MEDBDE surgeon/staff using the E-mail feature of the Global Command and Control System-Army (GCCS-A) except MEDSPTREPs which may be verbally transmitted over the telephone if the nature of the MEDSPTREP is such that immediate transmittal is warranted.

Figure D-1. Sample Report Submission Schedule.

NOTE

Report numbers depicted in Figures D-2 through D-5 are in accordance with FM 101-5-2.

a. *Medical SPOT Report* (*MEDSPTREP*). This format (Figure D-2) is used to report major medical incidents. Incidents to be reported include, but are not limited to, the following:

- Mass casualty situations (immediate MEDSPTREP required).
- Suspected or actual NBC exposure (in addition to required NBC reports).
- Loss or damage of MTF or other significant HSS assets to include personnel.
- Suspected or actual suicide or attempted suicide.
- Suspected or actual outbreaks of unusual diseases.
- Significant increase in DNBI rates.
- Hospitalization or injury of Army unit commanders or MEDCOM/MEDBDE key staff.
- United States military inflicted injuries to civilians or other adverse medical events with potential to generate media or political interest.
- Incidences of sabotage, subversion, terrorist attack, or other hostile activities of command interest.

MEDICAL SPOT REPORT (MEDSPTREP)
REPORT NUMBER M040

LINE 1	DATE AND TIME	DTG.
LINE 2	UNIT	UNIT MAKING REPORT.
LINE 3	INCIDENT	DTG OF INCIDENT.
LINE 4	LOCATION	UNIVERSAL TRANSVERSE MERCADOR (UTM) OR SIX-DIGIT GRID WITH GRID ZONE DESIGNATOR.
LINE 5	EMERGENCY	SPECIFIED MEDICAL EMERGENCY.
LINE 6	UNIT AFFECTED	AFFECTED FRIENDLY UNIT.
LINE 7	NARRATIVE	FREE TEXT FOR ADDITIONAL INFORMATION REQUIRED FOR CLARIFICATION OF REPORT.
LINE 8	AUTHENTICATION	REPORT AUTHENTICATION.

Figure D-2. Format for a Medical SPOT Report.

b. *Medical Situation Report* (*MEDSITREP*). This report (Figure D-3) is used to provide a quick, consolidated report of ongoing operations.

MEDICAL SITUATION REPORT (MEDSITREP)
REPORT NUMBER M035

LINE 1	DATE AND TIME	DTG.
LINE 2	UNIT	UNIT MAKING REPORT.
LINE 3	LOCATION	UTM OR SIX-DIGIT GRID WITH GRID ZONE DESIGNATOR.
LINE 4	STATUS	NUMBER OF OPERATIONAL BEDS AVAILABLE; NUMBER OF AVAILABLE COTS.
LINE 5	PATIENTS	NUMBER AND TYPES OF PATIENTS.
LINE 6	PROJECTED LOCATIONS	ANTICIPATED RELOCATION OF ELEMENTS WITH OPENING AND CLOSING DATA ON MTF.
LINE 7	MEDICAL LOGISTICS	NUMBER OF DAYS OF CLASS VIII ON HAND.
LINE 8	MEDICAL EVACUATION ASSETS	AVAILABILITY AND OPERATIONAL CAPACITY OF MEDICAL EVACUATION ASSETS (INCLUDE DS AND GS MISSIONS).
LINE 9	NARRATIVE	FREE TEXT FOR ADDITIONAL INFORMATION REQUIRED FOR CLARIFICATION OF REPORT.
LINE 10	AUTHENTICATION	REPORT AUTHENTICATION.

Figure D-3. Format for a Medical Situation Report.

c. *Medical Status Report* (*MEDSTAT*). This format (Figure D-4) is used to provide the status on hospitalization, incidence or occurrence of disease, and unresolved problems or items of significant interest having impact upon the overall medical capability or health of the command. The MEDSTAT must be repeated in its entirety to report the medical status of ashore and afloat units.

NOTE

An in-depth report on medical surveillance and OEH surveillance is compiled separately and reported in accordance with Chairman of the Joint Chiefs of Staff (CJCS) Memorandum MCM 0006-02, DODD 6490.2, DODI 6490.3, AR 40-5, and FM 4-02.17. The format for the DNBI Report is provided in Appendix F.

MEDICAL STATUS REPORT (MEDSTAT)
REPORT NUMBER M045

LINE 1	DATE AND TIME	DTG.
LINE 2	UNIT	UNIT MAKING REPORT.
LINE 3	TYPE	TYPE OF MEDICAL STATUS REPORT (ASHORE REPORT OR AFLOAT REPORT).
LINE 4	COMMAND	NAME OF DESIGNATOR OF REPORTING COMMAND OR FACILITY IF ASHORE; IF AFLOAT, SHIP NAME, TYPE, AND HULL NUMBER.
LINE 5	POC	NAME OF MEDICAL POC.
*LINE 6	AVAILABLE	NUMBER OF HOSPITAL BEDS AVAILABLE OR NUMBER OF COTS AVAILABLE.
*LINE 7	OCCUPIED	NUMBER OF HOSPITAL BEDS OCCUPIED OR NUMBER OF COTS OCCUPIED.
*LINE 8	OVERFLOW	NUMBER OF HOLDING BEDS/COTS OCCUPIED.
*LINE 9	FULL	NUMBER OF HOLDING BEDS/COTS OCCUPIED.
LINE 10	WAITING	NUMBER OF PATIENTS AWAITING EVACUATION OUT OF/FROM THE COMMAND'S AO SINCE LAST REPORT.
LINE 11	MEDICAL LOGISTICS	NUMBER OF DAYS OF CLASS VIII SUPPLIES ON HAND.
LINE 12	PROBLEMS	UNRESOLVED PROBLEMS AND ANTICIPATED PROBLEMS/ISSUES AFFECTING REPORTING COMMAND.
LINE 13	ASSESSMENT	COMMANDER'S ASSESSMENT OF OPERATIONAL CAPABILITIES AND ABILITY TO CONTINUE HSS (MANDATORY ENTRY).
LINE 14	NARRATIVE	FREE TEXT FOR ADDITIONAL INFORMATION REQUIRED FOR CLARIFICATION OF REPORT.
LINE 15	AUTHENTICATION	REPORT AUTHENTICATION.

NOTE: Report lines 3 to 14 as a group when reporting the medical status of more than one command and/or facility.

*These categories can be expanded to include the types of beds/patients reported on the medical regulating request (see paragraph D-4*g* below). If this level of detail is required, the codes used on the medical regulating request should be used on this report also.

Figure D-4. Format for a Medical Status Report.

d. Disease and Nonbattle Injury Report. This report summarizes the weekly DNBI rates and provides a baseline from which to identify disease trends. This is of particular importance when the threat of BW agents use is high, as the first indication may be a rise in naturally occurring endemic diseases and/or the occurrence of diseases not endemic to the AO. Refer to Appendix F for the DNBI Report format.

e. *Blood Reports*. Blood reports are required as specified by the Armed Services Blood Program Office (ASBPO). Message formats and voice message templates are provided in TM 8-227-12.

f. *Medical Supply Status* (*MEDSUPSTAT*) *Report*.

(1) The MEDSUPSTAT report (Figure D-5) provides the MEDCOM/MEDBDE commander with an evaluation of the current Class VIII medical supply and equipment status/situation. This report is also used to address any actual or projected critical shortages of Class VIII supplies and equipment. It also details concerns/problems in medical equipment maintenance and repair; supply distribution; medicinal gases, optical fabrication and repair; or any other medical areas that negatively impact on the ability of the command to provide timely and quality patient care.

MEDICAL SUPPLY STATUS REPORT

LINE 1: SUBJECT (ENTER MEDSUPSTAT)

LINE 2: AS OF: _____ (ENTER DTG OF REPORT).

LINE 3: STOCKED LINES: _____ (ENTER NUMBER OF STOCKED LINE ITEMS).

LINE 4: LINES DUE IN: (ENTER NUMBER OF SUPPLY LINES ORDERED THAT ARE DUE IN).

LINE 5: LINES DUE OUT: (ENTER NUMBER OF SUPPLY ITEMS REQUISITIONED THAT ARE VALID REQUISITIONS BUT NOT AVAILABLE TO BE SHIPPED).

LINE 6: LINES ZERO BALANCE: (ENTER NUMBER OF SUPPLY ITEMS REQUIRED TO BE STOCKED THAT ARE AT ZERO BALANCE ON HAND).

LINE 7: % LINES ZERO BALANCE: (ENTER PERCENTAGE OF TOTAL REQUIRED STOCKAGE ITEMS THAT ARE ZERO BALANCE ON HAND).

LINE 8: CRITICAL MEDICAL EQUIPMENT: NONMISSION CAPABLE (NMC) (LIST CRITICAL MEDICAL EQUIPMENT THAT IS NMC AND ESTIMATED NUMBER OF HOURS TO RENDER FULLY MISSION CAPABLE [FMC]):

CURRENT 24 HOURS 48 HOURS 72 HOURS 96 HOURS

STATUS:

NOTE: Status based on the following criteria:

Green—Status is greater than 90% demand satisfaction. Demand accommodation is greater than 80%. Zero balance of stock items is less than 10%. Days of supply are greater than 80% authorized. No significant medical materiel shortage.

Amber—Status is 80% - 90% demand satisfaction. Demand accommodation is greater than 70%. Zero balance is between 5% - 20%. Days of supply are greater than 60% of authorized. Experiencing moderate shortages of medical materiel or medical equipment inoperability.

Red—Status is at 65% - 80% demand accommodation is greater than 60%. Zero balance is between 20% - 40%. Days of supply are greater than 40% of authorized. Experiencing frequent wide shortages of selected medical materiel requiring considerable substitution of materiel and submission of high priority requisitions to CONUS.

Black—Status is at less than 65% demand satisfaction. Demand accommodation is less than 60%. Extensive substitution of available medical materiel within the command. Zero balance is greater than 40%. Extensive shortages of medical materiel resulting in patient deaths. Significant number of high priority requisitions to CONUS. Inability to treat patients due to selected medical equipment inoperability within the command.

Figure D-5. Format for a Medical Supply Status Report.

(2) The MEDSUPSTAT report will be consolidated by the division elements for all Level I and II MTFs and by the MEDBDEs for all Levels I through III medical facilities/units and submitted to the MEDCOM G4 daily as of 0600 local time to arrive NLT 1000 local.

g. *Medical Regulating Request*. Medical regulating is accomplished through the TRAC2ES system. Medical regulators use the formats prescribed by this system. However, should system interoperability issues occur a sample format for a medical regulating request is provided in Figure D-6. Liaison officers with the joint patient movement requirements center (JPMRC)/TPMRC should determine if additional information is required.

MEDICAL REGULATING REQUEST

CLINICAL CODES TO BE USED:

MC	PEDIATRICS	SO	ORTHOPEDICS
MM	MEDICAL	SS	SURGERY
MP	PSYCHIATRY	SSC	CARDIOVASCULAR/THORACIC SURGERY
SB	BURN	SSM	MAXILLOFACIAL SURGERY
SC	SPINAL CORD INJURY	SG	OB/GYN
SSN	NEUROSURGERY	SSU	UROLOGY
SSO	OPHTHALMOLOGY		

LINE 1: AS OF: (DTG OF THIS REQUEST).

LINE 2: REQUESTER: _____ (NAME OF REQUESTING ELEMENT WITH PATIENTS REQUIRING BEDS.)

LINE 3: LOCATION: _____ (LOCATION OF REQUESTING FACILITY USING GRID COORDINATES, UTM, OR PLACE NAME. REPORT ONLY ON FIRST REPORT OR UPON RELOCATION.)

LINE 4: TOTAL PATIENTS (ALL CATEGORIES): LITTER _____ AMBULATORY _____ TOTAL _____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL PATIENTS IN ALL MEDICAL SPECIALTY CATEGORIES REQUIRING BEDS.)

LINE 5: MEDICAL (MM): LITTER AMBULATORY TOTAL _____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL MEDICAL PATIENTS REQUIRING BEDS.)

LINE 6: PSYCHIATRIC (MP): LITTER AMBULATORY TOTAL _____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL PSYCHIATRIC PATIENTS REQUIRING BEDS.)

LINE 7: SURGERY (SS): LITTER AMBULATORY TOTAL _____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL GENERAL SURGERY PATIENTS REQUIRING BEDS.)

LINE 8: ORTHOPEDIC (SO): LITTER AMBULATORY TOTAL _____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL ORTHOPEDIC PATIENTS REQUIRING BEDS.)

LINE 9: BURN (SB): LITTER AMBULATORY TOTAL _____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL BURN PATIENTS REQUIRING BEDS.)

LINE 10: SPINAL CORD (SC): LITTER AMBULATORY TOTAL _____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL SPINAL CORD INJURY PATIENTS REQUIRING BEDS.)

Figure D-6. Format for a Medical Regulating Request.

MEDICAL REGULATING REQUEST (CONTINUED)

LINE 11: OB/GYN (SG): LITTER AMBULATORY TOTAL_____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL OB/GYN PATIENTS REQUIRING BEDS.)

LINE 12: PEDIATRIC (MC): LITTER AMBULATORY TOTAL_____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL PEDIATRIC PATIENTS REQUIRING BEDS.)

LINE 13: NEURO (SSN): LITTER AMBULATORY TOTAL_____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL NEUROSURGERY PATIENTS REQUIRING BEDS.)

LINE 14: MAXILLO (SSM): LITTER AMBULATORY TOTAL_____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL MAXILLOFACIAL PATIENTS REQUIRING BEDS.)

LINE 15: OPHTHAL (SSO): LITTER AMBULATORY TOTAL_____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL OPHTHALMOLOGY PATIENTS REQUIRING BEDS.)

LINE 16: THORACIC (SSC): LITTER AMBULATORY TOTAL_____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL CARDIOVASCULAR OR THORACIC SURGERY PATIENTS REQUIRING BEDS.)

LINE 17: UROLOGY (SSU): LITTER AMBULATORY TOTAL_____ (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL UROLOGY PATIENTS REQUIRING BEDS.)

LINE 18: SPECIAL CAT: LITTER AMBULATORY TOTAL (TOTAL NUMBER OF LITTER, AMBULATORY, AND ALL SPECIAL CATEGORY PATIENTS OTHER THAN ACTIVE DUTY US ARMED FORCES (LESS PEDIATRIC) REQUIRING BEDS.)

LINE 19: PICK-UP: (PATIENT PICKUP LOCATION USING GRID COORDINATES, UTM, OR PLACE NAME.)

LINE 20: ONLOAD: LITTER AMBULATORY TOTAL_____ (NUMBER OF LITTER, AMBULATORY, AND TOTAL NUMBER OF PATIENTS TO BE PICKED UP.)

LINE 21: TIME: (DTG WHEN PATIENTS WILL BE AVAILABLE FOR EVACUATION; USE ZULU TIME UNLESS OTHERWISE SPECIFIED.)

LINE 22: EQUIPMENT: (SPECIAL MEDICAL EQUIPMENT REQUIRED [PMI].)

LINE 23: NARRATIVE:

Figure D-6. Format for a Medical Regulating Request (*continued*).

h. Forward Surgical Team Situation Report. This report is used by the FST to report its current and projected capability. This report format is provided in FM 4-02.25. It is usually reported to the supporting command surgeon and the MEDBDE.

D-5. Planning Matrix and Informational Displays

a. Planning Matrix. This matrix provides a quick reference to unit locations and supported and supporting units. Whenever planning for HSS missions, all functional areas must be considered, even if

the units providing this support are not located in the immediate vicinity. Figure D-7 provides a sample format for a functional area planning matrix.

	UNITS	LOCATIONS	SUPPORTED UNITS	LOCATIONS	REMARKS
C4I					
EVACUATION					
GROUND AMBULANCE UNITS					
DIRECT SUPPORT					
GENERAL SUPPORT					
AIR AMBULANCE UNITS					
DIRECT SUPPORT					
GENERAL SUPPORT					
HOSPITALIZATION					
MEDICAL TREATMENT (AREA SUPPORT)					
PVNTMED					
COSC					
DENTAL					
MEDICAL LOGISTICS					
MED SUPPLY/EQUIPMENT					
BLOOD					
PATIENT MOVEMENT ITEMS					
VETERINARY					
MEDICAL LABORATORY					

Figure D-7. Sample format for a planning matrix (*functional areas*).

b. *Informational Display*. The commander may want information displayed graphically in order that a quick appraisal of the situation/status of key functions can be made. This information may be displayed using a bubble chart (Figure D-8). Each function is color-coded depending upon its readiness status (personnel, equipment, and training). The commander determines what numerical value each of the color-coded circles should have. For example: Green is fully functional (90-100%), Amber is partially functional but has some deficiencies which must be worked around (75-90%), and Red is essentially nonfunctional with major deficiencies in critical areas (below 75%). (See paragraph D-4*f* above for medical logistics criteria.)

	PREBATTLE	BATTLE	POSTBATTLE	RECONSTITUTION
C4I	0	0	0	0
EVACUATION	0	0	0	0
HOSPITALIZATION	0	0	0	0
MEDICAL TREATMENT (AREA SUPPORT)	0	0	0	0
PVNTMED	0	0	0	0
DENTAL	0	0	0	0
COSC	0	0	0	0
MEDICAL LOGISTICS	0	0	0	0
VETERINARY	0	0	0	0
MEDICAL LABORATORY	0	0	0	0

Figure D-8. Sample informational display format.

D-6. Synchronization Matrix

A synchronization matrix (Figure D-9) can be used to provide a highly visible, clear method of ensuring that planners address all functional areas when they are developing COA. The matrix clearly shows the relationships between activities, units, support functions, and key events.

	D-DAY	D+1	D+2	D+3	D+4	D+5	D+6	D+7	D+8
14 MEDCOM	ABLE								
5 MEDBDE	ABLE								
1 CSH	ABLE								
9 ASMB	ABLE								
15 ASMC	ABLE								
22 ASMC	OPCON TO JTF STAR								
34 ASMC	CAT				BART				
12 FST	*DOG			ABLE			*MOON		
36 FST	OPCON TO JTF STAR								
47 PVNTMED DET	ABLE								
47 PVNTMED DET (-)	RAY								
29 VET DET	ABLE								
58 MEDBDE	RAY								
91 CSH	RAY								
72 FST	*PET			RAY					
24 EVAC BN	RAY								
13 MED CO (AA)	RAY								
13 MED CO (AA) (-)	*PET			RAY					
13 MED CO (AA) (-)	*DOG						*MOON		
20 MED CO (AA)	ABLE								
68 MED CO (GND)	CAT				BART				
52 MED CO (GND)	OPCON TO JTF STAR								
35 MED CO (CSC)	CAT				BART				
35 MED CO (CSC) (-)	*PET						*MOON		
49 MED CO (DEN)	RAY								

NOTE:
Unit locations are in LSAs (such as LSA ABLE), unless otherwise indicated.
*Indicates unit is located in division support area (DSA) (such as DSA DOG)

Figure D-9. Sample corps synchronization matrix.

Section II. JOINT TASK FORCE SURGEON'S OFFICE AND JOINT MEDICAL OPERATIONS CENTER

D-7. Introduction

a. Joint operations planning at the JTF (operational) level links the tactical employment of forces to strategic objectives. The focus at the JTF level is on operational art—the use of military forces to achieve strategic objectives and end states through the design, organization, and execution of strategies, campaigns, major operations, and battles. Operational art determines when, where, and for what purpose major forces will be employed and should influence the enemy disposition before combat. It governs the deployment of those forces, their commitment to or withdrawal from battle, and the arrangement of battles and major operations to achieve operational and strategic objectives.

b. In some scenarios the corps may be the senior C4I unit within the theater. As such it would be designated as the ARFOR and may assume joint planning responsibilities when so designated. The corps MEDCOM and/or MEDBDE, being the senior medical C4I headquarters in theater, may also have to plan for and execute the joint HSS mission to include the SIMLM.

D-8. Organization and Functions of a Joint Task Force Surgeon's Office and a Joint Medical Operations Center

a. This paragraph discusses establishing and defining the roles and responsibilities of a JTF surgeon's office and a joint medical operations center (JMOC). This is only an example, the actual staffing, duties, and responsibilities of these activities are based on the JTF mission and size of the JTF. The JTF surgeon's office is normally built upon the Service staff of the JTF surgeon, augmented by medical planners and operations officers from the Service components. At the discretion of the JTF commander (CJTF), the JTF surgeon may be organized with the logistics directorate of a joint staff (J4). However, the JTF surgeon still retains direct coordination with the CJTF on all matters pertaining to the health of the command. In addition to the mission and size of the JTF, staffing levels may also be affected by the space available to establish the office (such as, limited space afloat versus buildings of opportunity ashore). Figure D-10 provides an example of a joint manning document. Other categories of information can include duty location, if different from the JTF surgeon's office location, unit of assignment, E-mail address, or other information as deemed appropriate.

b. Sample reports and report formats are provided in paragraph D-4. These reports can be adopted/modified for joint purposes.

c. Organization/Functions of the Joint Task Force Surgeon's Office.

(1) Joint task force surgeon.

(*a*) In establishing the JTF surgeon's office, it is essential to develop interoperability between Service component HSS elements and to understand the capabilities each Service has to offer.

This is accomplished by conducting component HSS capabilities briefings, developing SOPs (to include standardized reports and terminology) and checklists in consonance with established JTF headquarters SOPs, and ensuring proactive and frequent liaison with subordinate Service component surgeons. Additionally, the JTF surgeon needs to coordinate with other headquarters staff sections, liaison officers, and other agencies (such as other governmental agencies [for example, USAID], international agencies [UN], and NGOs). This facilitates establishing a battle rhythm early-on in the operation. A good-working relationship with the JTF headquarters staff ensures that synergy of HSS with combat operations occurs, facilitates the integration of HSS considerations into the OPLAN, and ensures that the JTF surgeon is apprised of changes in the OPLAN that will impact HSS COAs.

POS NO	POSITION	NAME/SSN	RANK	SERVICE COMPONENT	*MOS/ AOC	SEC CLR	DUTY PHONE
JTF4-021	JTF SURGEON		O-7	USA	00B00	TS/SCI	
JTF4-022	DEP SURGEON		O-6	USN	70H/60A	S	
JTF4-023	AIDE-DE-CAMP		O-2	USA	01A00	S	
JTF4-024	CHAUFFER		E-5	USA	88M20	S	
JTF4-025	CHIEF, JMOC		O-5	USA	70H67	S	
JTF4-026	AEROMED EVAC OFF		O-4	USA	67J00	S	
JTF4-027	MED PLANS OFF		O-4	USA	70H67	S	
JTF4-028	MED REG OFF		O-4	USAF	70E67	S	
JTF4-029	MED OP NCO		E-8	USN	91W50	S	
JTF4-030	PNT ADMIN NCO		E-6	USA	91G30	S	
JTF4-031	ENV SCI OFF		O-3	USAF	72D67	S	
JTF4-032	MED LOG OFF		O-4	USA	70K67	S	
JTF4-033	BLOOD OFF		O-3	USAF	71E8T	S	
JTF4-034	VET STAFF OFF		O-3	USA	64B00	S	

* ARMY

Figure D-10. Sample joint manning document for a joint task force surgeon's office.

(*b*) It is essential that the JTF surgeon's office has the right mix of professional expertise and skills on the staff. The JTF surgeon needs to analyze the mission from a joint perspective and determine what skills and from what Service components are required. Further, due to operational tempo (OPTEMPO) and rotation policies, the JTF surgeon must monitor the status of incoming and outgoing personnel for his staff and identify to the combatant command surgeon any deficiencies or shortfalls noted. He must also inform the combatant command surgeon when mission requirements exceed the capability of the JTF surgeon's office and augmentation is required. As duties, responsibilities, and relationships for specific skill sets differ across the Services, the JTF surgeon must ensure that they are clearly defined for each position on his staff.

(*c*) Another essential ingredient in successfully executing the JTF HSS mission is an understanding of and the application of joint doctrine, tactics, techniques, and procedures. The JTF surgeon must ensure that his staff is familiar with the Joint Operations Planning and Execution System (JOPES), force deployment issues, and C4I systems. The JTF surgeon should ensure appropriate training for his staff and should draw from the joint experience of the combatant command and his staff.

(*d*) As Director of Health Services, the JTF surgeon serves as the principle consultant to the CJTF on all HSS matters. The JTF surgeon is responsible for all medical assets in the joint task force operational area (JTFOA) and receives guidance and assistance from the combatant command surgeon. For additional information on the JTF surgeon's responsibilities refer to paragraph 1-8. The JTF surgeon—

- Determines JTF surgeon's office requirements, establishes and organizes the office, and prepares to conduct continuous (24 hours) operations from at least two locations.

- Establishes and maintains liaison with component surgeons.

- Establishes and oversees the operations of a JMOC, Area Joint Blood Program Office (AJBPO), JPMRC, Joint Medical Logistics Office (JMLO), Joint PVNTMED Office (JPMO), and other joint HSS offices/activities as required. The establishment of these functional offices is dependent upon the staffing level of the JTF surgeon's office. If the staffing is not sufficient or qualified personnel are not available to fully man these functional offices, the existing staff must still supervise and monitor the execution of these functions. For example, if a JPMRC is not established to provide management for both medical regulating and patient evacuation, direct liaison must be established with the TPMRC or GPMRC and Service patient movement components. (In order to delineate the requirements for the duties and responsibilities in these functional areas, each office will be discussed as though there is sufficient staffing to fully man the office.)

- Deploys and redeploys JTF surgeon's office as required.

- Exercises directive authority over all JTF HSS operations and elements.

- Establishes HSS procedures for operations in an NBC environment.

- Supervises operation of JTF surgeon's office.

- Sets priorities for actions within the surgeon's office and assigns responsibility to individual sections or individuals.

- Monitors medical regulating and patient movement activities of the JPMRC and ensures procedures are established to provide patient in-transit visibility information to the manpower and personnel directorate of the joint staff (J1).

- Advises the JTF commander and staff on the health of JTF forces, conservation of the fighting strength, and HSS aspects of the Geneva Conventions and the Law of Land Warfare.

- Provides limited patient status and clinical information on selected individual patients to commanders and authorized representatives as requested, based on level of capability for patient in-transit visibility.

- Supervises PVNTMED support and participates in the selection of bed-down locations.

- Advises CJTF of the results of medical analysis of the COAs and prepares the HSS estimate.

- Coordinates HN medical support requirements, in conjunction with the plans directorate of the joint staff (J5), with NGOs operating in the JTFOA.

(2) Depending upon the size of the JTF surgeon's office, the deputy JTF surgeon may also serve as the chief, JMOC. (Discussion of the duties and responsibilities of the JMOC is provided in paragraph D-8*d* below.) The deputy JTF surgeon—

- Performs duties and functions as directed by the JTF surgeon.

- Supervises operations and performs duties of the JTF surgeon at the JTF surgeon's office alternate location, if applicable.

- Supervises the development of HSS plans.

- Supervises integration and use of medical augmentation teams.

- Ensures appropriate health care delivery to all eligible beneficiaries (such as [but not limited to], DOD contractors, EPWs, personnel in US custody [retained/detained], and interagency personnel) in accordance with US and international law, regulations, and agreements. (Refer to Appendix A for an in-depth discussion of eligibility for care.)

- Develops mass casualty treatment and evacuation plans.

- Coordinates disaster relief and humanitarian assistance operations, as required.

- Coordinates provision of medical intelligence to JTF. Identifies CCIR, PIRs, and EEFI.

(3) Medical operations NCO—

- Controls deployment/redeployment of equipment and sets up office.
- Coordinates life support requirements, such as billeting, field feeding, and transportation for personnel assigned/attached to the office.
- Supervises enlisted personnel and establishes daily work assignments.
- Coordinates communications, automation, administrative, logistics, and other support requirements.
- Acts as POC for external enlisted personnel taskings.
- Controls the use and maintenance of assigned vehicles.
- Maintains control and accountability of incoming and outgoing reports, messages, and correspondence.
- Supervises daily staff journal operations and ensures all incoming and outgoing messages, correspondence, significant events, and actions are logged and maintained.
- Supervises message distribution and internal communications.

(4) Joint Patient Movement Requirements Center—

- Provides oversight of the TPMRC in their role of directing medical regulating activities within the JTFOA.
- Designate MTFs within the CJTF area of responsibility to receive patients based on medical regulating reports and requests.
- Informs the JTF surgeon on a daily basis of specialty bed availability within the command.
- Forwards patient movement requirements that cannot be satisfied with JTF resources to the combatant commander's surgeon's office.
- Determines tactical and strategic information requirements and points of contact.
- Maintains visibility of theater hospitals, TPMRC/GPMRC, subunified and component command headquarters, and transportation agencies to facilitate patient flow and optimum use of hospitals and medical evacuation assets.
- Develops/coordinates/disseminates patient movement bed lift plans and policies to Service component commands, activities, and agencies.

- Develops/disseminates standards/procedures for collection/presentation of patient movement statistical data and required reports.

- Coordinates patient movement issues with, and obtains required patient movement information from, the TPMRC/GPMRC.

- Coordinates with the TPMRC/GPMRC to obtain Levels IV and V (CONUS/ OCONUS) bed designations for patients who will not RTD within the theater evacuation policy.

- Provides the JTF surgeon and staff with information regarding patient movement activities, issues, and workload.

- Coordinates patient movement issues and PMI with the supporting TPMRC/GPMRC.

- Manages the movement of patients to and between MTFs within the JTFOA.

- Provides input to support medical analysis, estimates, and plans for medical regulating activities.

- Distributes approved standard operating procedures and guidance to subunified and component commands, medical C4I and medical regulating elements, and all theater MTFs.

(5) Administrative section and information management services. Depending upon the staffing levels, an administrative section may not be task-organized specifically for the JTF surgeon's office. If the JTF surgeon's office is task-organized under the J4, administrative support may be required from the J4 staff section. The sample joint manning document provided in Figure D-10, does not have an administrative staff included. The information provided below provides a brief description of administrative assistance which may be required.

- Administrative NCO supervises administrative section operations and assists medical operations NCO as required. Further, he—

  - Establishes a layered medical communications network among component medical units.

  - Establishes medical communications requirements with the JTF command, control, communications, and computer systems directorate of a joint staff (J6).

  - Inputs medical estimates into simulation models when conditions allow.

  - Determines the need for telemedicine capabilities that are not currently organic to component medical units.

- Assistant Administrative NCO ensures all equipment and supplies are packed/ unpacked and established per SOP. Establishes filing system and message processing section. Receives and reviews incoming messages and correspondence and directs appropriately.

- Administrative clerks perform assigned duties to include serving as drivers and mail clerks, and performing maintenance on assigned vehicles.

(6) Joint medical operations center is under the supervision of the deputy surgeon or chief, JMOC (depending upon staffing). Refer to paragraph D-8*d* below for additional information.

(7) Area Joint Blood Program Office—

- Establishes and manages Joint Blood Program for the JTF.

- Establishes policies, procedures, and guidance for blood management requirements.

- Establishes lines of communications with blood management offices of Service component commands and other agencies with blood product responsibilities.

- Obtains, consolidates, and disseminates current and projected estimates of need for blood and blood products.

- Develops/disseminates standards/protocols for the collection and presentation of blood management statistical data.

- Recommends to the JTF surgeon establishment of additional JBPOs to provide regional blood management are required.

- Supervises development/dissemination of plans, policies, and procedures for requesting blood and blood products.

- Directs distribution of blood products from blood transshipment centers in the JTFOA.

- Develops and implements handling, storage, and distribution systems in support of JTF blood support operations.

- Advises the JTF surgeon regarding management, policies, and procedures for handling blood and blood products.

- Receives blood situation reports and ensure blood shipment and requests are coordinated and processed.

(8) Joint Preventive Medicine Office—

- Plans, monitors, and supervises JTF PVNTMED operations.

- Advises the JTF surgeon regarding PVNTMED and medical threat issues.

- Maintains contact with Service component PVNTMED/public health sections/ services and personnel.

- Monitors status and availability of field sanitation materials and training.

- Advises commanders on PVNTMED and field sanitation programs for the protection of the health and well-being of their personnel.

- Monitors medical reports submitted to the JTF for the occurrence of diseases of military importance and ensures follow-up actions are taken as required.

- Provides oversight of veterinary PVNTMED, preventive dentistry, and the preventive aspects of combat operational stress control programs.

- Establishes predeployment guidance to include—

  - Conducting operational health risk assessment.

  - Establishing risk management and surveillance programs.

  - Conducing health screening.

  - Collecting serum specimens.

  - Providing medical threat briefing to include countermeasures, equipment, and supplies required.

  - Monitoring individual medical readiness requirements (such as immunizations, prophylaxis, and dental examinations).

  - Establishing individual health assessments (predeploying, deployment, and redeployment testing and monitoring).

- Establishes during deployment guidance to include—

  - Developing/establishing programs for health hazard surveillance, assessment, and prevention.

  - Establishing procedures for reporting DNBI, reportable medical events, and medical and OEH surveillance data.

  - Establishing an operational risk management program.

  - Conducting pest management operations.

  - Establishing and disseminating procedures for medical NBC defense operations.

- Establishing and disseminating procedures for communicating health risk to commanders at all levels.

- Establishing and monitoring procedures for documenting all NBC exposures (to include TIMs and radiological hazards).

- Establishes postdeployment guidance and documentation requirements, to include—

  - Conducting individual health assessment.

  - Providing medical debriefing for significant health events/exposures.

  - Accomplishing required medical procedures such as tuberculosis screening and specimen collection.

  - Providing follow-on health assessments.

  - Providing available health risk assessment information to redeployed personnel and their health care providers.

(9) Joint medical logistics office—

- Identifies required medical and dental supplies and sourcing, stockage levels, distribution, resupply, and maintenance requirements.

- Plans, monitors, and supervises JTF medical logistics (except blood) operations.

- Monitors SIMLM operations, if designated.

- Advises the JTF surgeon regarding medical logistics.

- Facilitates joint use of health care services and facilities.

- Coordinates contracts for HN support, when available.

- Develops medical logistics and policies for the JTF.

- Monitors PMI exchange/replacement activities.

- In coordination with the JPMO and J4, implements policies and procedures for removal of hazardous medical waste.

(10) Joint Veterinary Service Officer (JVSO)—

- Plans, monitors, and supervises veterinary operations in the JTF.

- Advises the JTF surgeon regarding veterinary services and support to include inspection of Class I and bottled water, inspection of local and regional food sources, food hygiene and safety, provision of animal medical care, and veterinary PVNTMED.

d. Joint Medical Operations Center. The JMOC is task-organized based on METT-TC and commander's guidance. The organization, duties, and responsibilities of the JMOC are:

(1) Chief, JMOC—

- Supervises the establishment and operations of the JTF surgeon's office and the daily operation of the JMOC.

- Establishes duty shifts and sets priorities for actions within each shift and assigns responsibility as required.

- Consolidates reports, monitors significant activities, and briefs these to the JTF surgeon/deputy surgeon for review at shift change.

- Acts as the releaser/approval authority for all outgoing messages and correspondence.

- Receives and evaluates all medical reports and other incoming messages and correspondence from subordinate and higher units, and determines if immediate action by the JMOC is required.

- Performs the necessary coordination to ensure urgent HSS problems/issues are addressed in a timely manner. If required, recalls key staff personnel to accomplish necessary coordination.

- Prepares, coordinates, and releases messages and correspondence required to implement actions.

- Ensures shift change briefings are conducted to include all significant activities during the last 12 hours and those expected in the next 12 hours.

- Supervises daily staff journal operations and ensures all incoming and outgoing messages, correspondence, and significant events and actions are logged.

- Ensures reports are posted on JMOC maps immediately and relayed to the appropriate JTF surgeon's staff.

- Checks situation maps in the joint operations center (JOC) as required and ensures changes are posted to the JMOC map.

- Ensures changes in the status/location of HSS units reported during the shift are posted in the JMOC.

- Coordinates with higher headquarters as required for information/support needed to accomplish the mission.
- Maintains contact with component surgeon's offices.
- Performs other duties and functions as directed by the JTF surgeon/deputy surgeon.
- Oversees the development and review of HSS policies and procedures for JTF surgeon/deputy surgeon approval.
- Conducts HSS crisis action planning.
- Supervises the development of current/ongoing and future HSS plans for the JTF.
- Supervises the preparation, staffing, coordination, and publication of Annex Q (Medical Services) to JTF operations plans/orders.
- Monitors deployment preparation and deployment of component HSS units.
- Monitors HSS situation on a continuous basis and provides centralized control and decentralized execution of HSS operations as directed by the JTF surgeon.
- Coordinates JTF HSS operations among and between the Services.
- Monitors JTF medical, dental, veterinary, PVNTMED, and medical logistics reports and operations.
- Monitors medical regulating and patient movement activities of the JPMRC/ TPMRC/GPMRC using TRAC2ES and ensures procedures are established to provide patient in-transit information to the J1.
- Recommends changes in priority for HSS to the JTF surgeon/deputy surgeon as required.
- Monitors and tracks hospitalization within the JTFOA. Upon activation of MTFs in JTFOA; each component will report bed availability and specialty mix.
- Directs, coordinates, and supervises realignment and relocation of HSS resources and augmentation/reinforcement/reconstitution of HSS unit and teams as required.
- Supervises the revision of HSS policies and procedures as required.
- Recommends HSS CCIR and PIRs to the intelligence directorate of a joint staff (J2).
- Coordinates HSS provided to or received from allied, coalition, or HN forces.

- Coordinates and provides liaison with NGOs conducting humanitarian assistance operations within the AO in conjunction with the JTF J5.

- Ensures the JTF surgeon/deputy surgeon are kept apprised of the current and potential HSS situation.

- Maintains SU and coordinates the preparation of daily and/or as required HSS briefings for the JTF surgeon/deputy surgeon.

- Monitors and coordinates operational activities of the AJBPO, JPMRC, JPMO, JMLO, JVSO, and other joint medical offices and/or activities established as required.

- Assists JTF J1 in producing patient estimates through use of the JOPES logistics planning exercise-medical (LPX-MED) module.

- Coordinates responses to JTF requests for information (RFIs) pertaining to HSS.

(2) Medical operations/plans officers—

- Identify and transport to the field all classified material/references required to support JTF operations.

- Act as JMOC watch officers.

- Receive and evaluate medical reports and other incoming messages and correspondence from subordinate and higher units and determine if referral to the chief, JMOC is required.

- Refer medical, blood management, and PVNTMED issues to the JMLO, AJBPO or JPMO for action.

- Develop and coordinate recommendations and present to JTF surgeon/deputy surgeon for approval, as required.

- Prepare and coordinate draft correspondence and messages required to implement chosen COAs and present to JTF surgeon/deputy surgeon for approval and release.

- Maintain contact with JTF surgeon's office and Service component surgeon's offices.

- Conduct medical forecasting and preparation of plans/annexes as required.

- Review plans/annexes prior to presentation to JTF surgeon/deputy surgeon for approval.

- Coordinate with J4, joint movement control center (JMCC), and the JOC to track corps HSS units, equipment, and supplies arriving in theater.

- Coordinate with the Air Force air operations center to maintain visibility of movement of transport aircraft into and out of the theater.

- Brief the chief, JMOC and other personnel as required at shift change.

- Attend JOC shift change briefings.

- Attend daily commander's update as required.

- Receive RFI's, contact appropriate JOC staff sections, and relay answers back to the JMOC.

- Obtain JTF task organization, force closure, proposed COAs, and planned future operations information needed to develop HSS scenarios from operations directorate of a joint staff (J3) or J5 as required.

- Act as POC for all JOC staff sections on HSS issues. Accept RFIs and either provide answers or relay RFI to JMOC for action. Receive answers from JMOC and relay to staff section.

- Prepare slides and present HSS portion of JTF commander's update and other briefings.

- Coordinate with specific Service components for HSS augmentation/reinforcement/ reconstitution.

- Perform other duties and functions as directed by the JTF surgeon, deputy surgeon, or chief, JMOC.

(3) Medical operations/plans NCOs—

- Set up equipment, maps, and informational displays for current and future operational planning.

- Maintain daily staff journal and ensure all incoming and outgoing messages, correspondence, significant events, and actions are logged.

- Receive medical reports, post information on JMOC map immediately, and relay to the JOC and JTF surgeon office for use in updating their maps.

- Maintain all JMOC maps, overlays, informational displays, and supplies. Monitor the tactical situation and post the changes to the JMOC maps as required.

- Through JOC and J4, monitor status of main supply routes (MSRs) and evacuation routes and post on JMOC maps.

- Assist medical operations officers with the collection and evaluation of medical reports and development and coordination of appropriate responses/actions.

- Does a face-to-face hand off to the on-coming medical operations/plans NCO of any significant activities that need to be followed up on or have any tasks that need to be completed.

- Perform other duties and functions as directed by the JTF surgeon, deputy surgeon, or chief, JMOC.

APPENDIX E

MEDICAL FORCE 2000 COMMAND AND CONTROL UNITS

E-1. General

a. Medical Force 2000 C2 units are being transitioned to MRI C2 units, however, there are still some Medical Force 2000 C2 units in the inventory. The redesign of C2 units during the MRI process was the first redesign of the medical C2 structure since the Korean Conflict. Under Medical Force 2000, the CZ had a medical group and a MEDBDE while the COMMZ had a MEDBDE and a MEDCOM. During Operations Desert Shield and Desert Storm, the mobility of medical C2 units was an issue as was modularity. Under the MRI design, the C2 units have increased mobility and are capable of task-organizing early entry elements for force projection operations. Further, the corps C2 organizations are aligned with the corps rather than with the COSCOM as was the case under Medical Force 2000.

b. This appendix provides information on the assignment, capabilities, and basis of allocation of the Medical Force 2000 C2 units.

E-2. Headquarters and Headquarters Company, Medical Command, TOE 08611L000

a. *Mission*. The mission of the HHC, MEDCOM is to provide C2, administrative assistance, technical supervision, and consultation services for assigned and attached units in the TO.

b. *Assignment*. This organization is assigned to the theater Army (TA) (current terminology for the TA is the ASCC).

c. *Capabilities*. This organization provides—

- Command and control of units providing HSS in the TO.
- Task organization for all theater HSS assets to meet the patient workload. Health service support assets are designed by duty functions and are interchangeable throughout the TO to meet workload requirements.
- Advice to senior commanders on the medical aspects of their operations.
- Command, control, staff planning, supervision of operations, and administration of the assigned and attached units. These functions include coordination for employment, patient evacuation, supply and equipment management, administrative services for the headquarters, and coordination between medical units operating in the MEDCOM AO.
- Medical regulating and evacuation scheduling for patient movement to and between assigned and attached MTFs. This includes coordination with the Level III MROs and the TPMRC in the TO. This office provides technical advice and assistance concerning patient statistics, patient movement, administrative support, and statistical data requirements.
- Consultation services and technical advice in PVNTMED (environmental health, medical entomology, epidemiology, radiological health, sanitary engineering), nursing, dentistry, veterinary services,

NP and social work, medicine and internal medicine, surgery, dietetics, optometry, and pharmacy to supported units.

- Preventive medicine consultative services include assessment of the medical threat, evaluation of theater PVNTMED program, technical advise on medical aspects of NBC and DE weapons, and staff coordination of theater PVNTMED services.

- Neuropsychiatry and social work services include the recommendations for regulating the combat stressed soldier, psychiatric consultation, alcohol and drug prevention/control programs, and providing advice on the coordination of operations of the medical companies, CSC in the MEDCOM AO.

- Dietary services and technical assistance include advice on nutrition in relation to health and fitness and medical food service consultation.

- Veterinary services and technical advice include status of approved sources of food for local procurement, food in storage, incidence or prevalence of zoonotic diseases, and food wholesomeness, hygiene, safety, and quality assurance standards. Veterinary services also include inspection of food suspected of NBC contamination for wholesomeness before it is consumed by troops.

- Advice and assistance in facility site selection and preparation.

- Supervision of Class VIII and general supply usage and resupply movement.

- Unit-level vehicle, communications, weapons, and power generation equipment maintenance advice and management.

- Food service personnel for dining facility support for the HHC, MEDCOM.

d. *Basis of Allocation*. One MEDCOM is allocated per TA.

E-3. Headquarters and Headquarters Company, Medical Brigade (Corps, TOE 08422L100 or Communications Zone, TOE 08422L200)

Medical brigade commanders have the ability to task organize HSS assets to meet the patient workload. The HSS assets are modularly designed by duty functions and are replicated throughout the TO to meet these requirements.

a. *Mission*. The mission of the unit is to provide C2, administrative assistance, and technical supervision of assigned and attached medical units.

b. *Assignment*. This company is assigned to—

- Corps support command, TOE 63431L000, when organized under TOE 08422L100.

- Medical command, TOE 08611L000, when organized under TOE 08422L200.

c. *Capabilities*. At full strength, this unit provides—

- Command and control of all medical units in its AO.

- Task organization of HSS assets to meet the patient workload demands. Health service support assets are modularly designed by function and replicated throughout the TO.

- Advice to senior commanders on the medical aspects of their operations.

- Medical regulation of patient movements to and between assigned and attached MTFs.

- Coordination with MEDCOM and/or TPMRC for all medical regulating for evacuation from the MEDBDE facilities to supporting MTFs in the COMMZ and CONUS when organized as TOE 08422L200.

- Consultation services and technical advice in PVNTMED (environmental health, medical entomology, radiological health, sanitary engineering), nursing, dentistry, veterinary services, and NP and social work to supported units.

- Advice and assistance in facility site selection and preparation.

- Control and supervision of Class VIII supply and resupply movement.

d. *Basis of Allocation*. This unit is allocated as follows:

- Headquarters and headquarters company, medical brigade (corps), TOE 08422L100—one per corps.

- Generally, there is one HHC, medical brigade (COMMZ), TOE 08422L200, allocated per three to seven medical battalions or battalion force-equivalent organizations.

E-4. Medical Group, TOE 08432L000

a. *Mission*. The mission of the medical group is to provide C2, and administrative supervision of assigned and attached corps medical units.

b. *Assignment and Basis of Allocation*. The medical group is assigned to the MEDBDE. As a general rule of thumb, there are three medical groups per corps. As in the MEDBDE, the commander of the medical group can task organize his medical assets to meet patient workloads.

c. *Capabilities*. The capabilities of this unit include—

- The C2, staff planning, supervision of operations, and administration of the assigned and attached units which may include ASMBs, hospitals, evacuation battalions, CSC companies, dental

battalions, and PVNTMED detachments. The command of the assigned medical units includes coordination for employment, patient evacuation, supply and equipment management, and various other headquarters requirements. Units of the medical group may be task organized to support close, deep, and rear operations.

- Medical regulating for evacuation and the scheduling of medical group facilities in coordination with the brigade MRO to hospitals assigned to other MEDBDEs. This includes coordination with the division medical operations center (DMOC) in those divisions organized under the forward support battalion (FSB) and main support battalion (MSB) concept to regulate the patient evacuation from the division AO. It also coordinates with the MEDBDE all medical regulating for further evacuation from the medical group facilities to the supporting MTFs in the COMMZ.

- Consultation services and technical advise in PVNTMED (environmental health and sanitary engineering), nursing, MH, and facility site selection and preparation to supported units. Preventive medicine consultative services include—

    - Assessment of the medical threat.
    - Evaluation of theater PVNTMED programs.
    - Technical advise on medical aspects of NBC and DE weapons.
    - Staff coordination on employment of theater PVNTMED assets.
    - Supervision of Class VIII and general supply usage, and resupply movement.

d. *Basis of Allocation*. Generally, this unit is allocated on the basis of one per three to seven medical battalions or battalion-equivalent organizations.

APPENDIX F

DISEASE AND NONBATTLE INJURY REPORT

F-1. Disease and Nonbattle Injury Rates—The Vital Signs of the Unit

a. Disease and nonbattle injury rates are an important tool at the unit level. The DNBI Report summarizes the weekly DNBI data rates and provides baseline rates for comparison. Abnormal rates indicate a problem exists which could negatively impact readiness and indicate preventive medicine measures need to be implemented. Unit data must be reported weekly (ending Saturday 2359 hours local) via command channels to the MEDCOM/MEDBDE commander. Additionally, DNBI data must be simultaneously reported to the Service Surveillance Centers for further analysis and to the Defense Medical Surveillance System (DMSS) for repository purposes. United States Army Centers for Health Promotion and Preventive Medicine further analyzes DNBI data, identifying adverse trends, and reporting, through appropriate channels, medical threat anomalies to the MEDCOM/MEDBDE commander.

b. The DNBI Report is based on unit logs which must record at a minimum the following information on every patient encounter. Some information required for record as part of the DNBI data collection (such as name, SSN, gender, or unit) is not required for completion of the weekly DNBI Report. The purpose of collecting this information is to allow local medical authorities to quickly review pertinent data that describes the occurrence of medical events. This is particularly useful for investigation of outbreaks or other medical problems which may occur during the deployment. Information sources for the DNBI Report include the Daily Disposition Log (DDL)/Sick Call Log (FM 4-02.4), electronic patient record, hospital admissions, and accident reports:

- Patient's name, SSN, gender, unit, unit identification code (UIC), and duty location.
- Type of visit—new, follow-up, or administrative.
- Primary complaint.
- Final diagnosis.
- Injuries, a classification into recreation/sports, motor vehicle accident (MVA), work/training, or other.
- Final disposition into one of the following categories:
  - Full duty.
  - Light duty (number of days).
  - Sick in quarters (number of days).
  - Hospital inpatient admissions (number of days).
- Disease and nonbattle injury (case definitions provided in paragraph F-3).

c. Daily Disposition Logs, electronic patient records, and other records of raw data compiled to create the DNBI Report must be retained by the medical unit at the conclusion of the deployment for at least one-year. Medical units will forward copies of all deployment DDLs annually to DMSS for archiving.

F-2. Disease and Nonbattle Injury Report Instructions

a. Record the administrative data in the spaces provided at the top of the weekly DNBI Report format (Figure F-1) and the Tri-Service Reportable Medical Event List (Figure F-2). Obtain average troop strength for the reporting period from the S1/G1/J1.

WEEKLY DNBI REPORT

UNIT/COMMAND: _____ TROOP STRENGTH: _____
DATES COVERED: _____ (SUNDAY 0001) THROUGH _____ (SATURDAY 2359)
INDIVIDUAL PREPARING REPORT: _____
PHONE: _____ E-MAIL: _____

CATEGORY	INITIAL VISITS	RATE	SUGGESTED REFERENCE RATE	DAYS OF LIGHT DUTY	LOST WORK DAYS	ADMITS
COMBAT/OPERATIONAL STRESS REACTIONS			0.1%			
DERMATOLOGIC			0.5%			
GI, INFECTIOUS			0.5%			
GYNECOLOGIC			0.5%			
HEAT/COLD			0.5%			
INJURY, RECREATIONAL/SPORTS			1.0%			
INJURY, MVA			1.0%			
INJURY, WORK/TRAINING			1.0%			
INJURY, OTHER			1.0%			
OPHTHALMOLOGICAL			0.1%			
PSYCHIATRIC, MENTAL DISORDERS			0.1%			
RESPIRATORY			0.4%			
STDs			0.5%			
FEVER, UNEXPLAINED			0.0%			
ALL OTHER, MEDICAL/SURGICAL						
TOTAL DNBI						
DENTAL		XXXXXX				
MISC/ADMIN/ FOLLOW-UP		XXXXXX				
DEFINABLE						
DEFINABLE						

PROBLEMS IDENTIFIED: _____ CORRECTIVE ACTIONS: _____

Figure F-1. Weekly Disease and Nonbattle Injury Report format.

TRI-SERVICE REPORTABLE MEDICAL EVENT LIST

	CONDITION	ICD–9 CODE
1.	AMEBIASIS	006
2.	ANTHRAX	022
3.	BIOLOGICAL WARFARE AGENT EXPOSURE	E997.1
4.	BOTULISM	005.1
5.	BRUCELLOSIS	023
6.	CAMPYLOBACTER	008.43
7.	CARBON MONOXIDE POISONING	986
8.	CHEMICAL AGENT EXPOSURE	989
9.	CHLAMYDIA	099.41
10.	CHOLERA	001
11.	COCCIDIOIDOMYCOSIS	114
12.	COLD WEATHER INJURY (ALL)	
	A) CWI, FROSTBITE	991.3
	B) CWI, HYPOTHERMIA	991.6
	C) CWI, IMMERSION TYPE	991.4
	D) CWI, UNSPECIFIED	991.9
13.	CRYPTOSPORIDIOSIS	007.4
14.	CYCLOSPORA	136.8
15.	DENGUE FEVER	061
16.	DIPHTHERIA	032
17.	E. COLI 0157:H7	008.04
18.	EHRLICHIOSIS	083.8
19.	ENCEPHALITIS	062
20.	FILARIASIS	125
21.	GIARDIASIS	007.1
22.	GONORRHEA	098
23.	H. INFLUENZAE, INVASIVE	038.41
24.	HANTAVIRUS INFECTION	079.81
25.	HEAT INJURIES	
	A) HEAT EXHAUSTION	992.3
	B) HEAT STROKE	992.0
26.	HEMORRHAGIC FEVER	065
27.	HEPATITIS A	070.1
28.	HEPATITIS B	070.3
29.	HEPATITIS C	070.51
30.	INFLUENZA	487
31.	LEAD POISONING	984
32.	LEGIONELLOSIS	482.8
33.	LEISHMANIASIS (ALL)	
	A) LEISHMANIASIS, CUTANEOUS	085.4
	B) LEISHMANIASIS, MUCOCUTANEOUS	085.5
	C) LEISHMANIASIS, UNSPECIFIED	085.9
	D) LEISHMANIASIS, VISCERAL	085.0
34.	LEPROSY	030
35.	LEPTOSPIROSIS	100
36.	LISTERIOSIS	027.0
37.	LYME DISEASE	088.81
38.	MALARIA (ALL)	
	A) MALARIA, FALCIPARUM	084.0
	B) MALARIA, MALARIAE	084.2
	C) MALARIA, OVALE	084.3
	D) MALARIA, UNSPECIFIED	084.6
	E) MALARIA, VIVAX	084.1
39.	MEASLES	055
40.	MENINGOCOCCAL DISEASE	
	A) MENINGITIS	036.0
	B) SEPTICEMIA	036.2
41.	MUMPS	072
42.	PERTUSSIS	033
43.	PLAGUE	020
44.	PNEUMOCOCCAL PNEUMONIA	481
45.	POLIOMYELITIS	045
46.	Q FEVER	083.0
47.	RABIES, HUMAN	071
48.	RELAPSING FEVER	087
49.	RHEUMATIC FEVER, ACUTE	390
50.	RIFT VALLEY FEVER	066.3
51.	ROCKY MOUNTAIN SPOTTED FEVER	082.0
52.	RUBELLA	056
53.	SALMONELLOSIS	003
54.	SCHISTOSOMIASIS	120
55.	SHIGELLOSIS	004
56.	SMALLPOX	050
57.	STREPTOCOCCUS, GROUP A, INVASIVE	038.0
58.	SYPHILIS (ALL)	
	A) SYPHILIS, CONGENITAL	090
	B) SYPHILIS, LATENT	096
	C) SYPHILIS, PRIMARY/SECONDARY	091
	D) SYPHILIS, TERTIARY	095
59.	TETANUS	037
60.	TOXIC SHOCK SYNDROME	785.59
61.	TRICHINOSIS	124
62.	TRYPANOSOMIASIS	086
63.	TUBERCULOSIS, PULMONARY	011
64.	TULAREMIA	021
65.	TYPHOID FEVER	002
66.	TYPHUS FEVER	080
67.	URETHRITIS, NON-GONOCOCCAL	099.40
68.	VACCINE, ADVERSE EVENT	979.9
69.	VARICELLA, ACTIVE DUTY ONLY	052
70.	YELLOW FEVER	060

NOTES: 1) This list represents minimum reportable events and can be supplemented by the Combatant Command, as necessary.
2) Tri-Service Reportable Events Guidelines and Case Definitions are available at: http://amsa.army.mil under "Documents" heading.

Figure F-2. Tri-Service Reportable Medical Event List.

b. Review the DDL and/or other record and add up the total number of new cases (excluding follow-ups) seen during the week in each DNBI category. Fill in the appropriate block. Add up the total DNBI and record the number in the space provided.

c. To calculate DNBI rates, divide the total number of patients seen in each category by the average troop strength, and multiply by 100. For the gynecologic category, the female troop strength must be used to calculate the rate, not the total troop strength. Remember to calculate an overall DNBI total rate. Example: If there were 20 dermatological (derm) cases this week in 500 troops, the DNBI rate (percent) for dermatological cases would be calculated as follows:

$$\text{DNBI (\%)} = \frac{\text{number of patients}}{\text{number of troops}} \times 100$$

$$\text{DNBI}_{\text{derm}}(\%) = \frac{20}{500} \times 100$$

$$\text{DNBI}_{\text{derm}}(\%) = (0.04) \times 100$$

$$\text{DNBI}_{\text{derm}}(\%) = 4\%$$

d. Next, add up the total number of estimated light duty days, lost workdays (total of sick-in-quarters days plus inpatient admission days), and MTF inpatient admissions in each category, and fill in the appropriate block.

e. Compare calculated rates for each category with the suggested reference rate for that category (comment is required under the section *Problems Identified—Corrective Actions* for all categories where rates are above the suggested reference rate). When comparing rates, keep the following information in mind:

- The suggested reference rates are only approximate and should be used as a rough guide only. The MEDCOM/MEDBDE commander may modify the *Suggested Reference Rates* based upon theater/deployment specific trends. Establishing statistical confidence levels of 2 and 3 standard deviations is desirable when sufficient DNBI data has been collected.

- Exceeding a rate by 0.1 percent is not necessarily an indication of a significant problem. Rates between 2 and 3 standard deviations should heighten surveillance. Rates exceeding 3 standard deviations indicate that there is a health problem requiring urgent attention, possible intervention, and reporting to the MEDCOM/MEDBDE commander.

- The individual suggested reference rates are not intended to add up to the total DNBI suggested reference rate. An individual category could have a high rate without causing the total rate to exceed the reference rate—attention to the individual category is appropriate and necessary in this situation. Alternatively, the total DNBI rate could be high without causing individual categories to exceed their

reference rates—attention to systemic problems causing general sick call visits to rise is appropriate and necessary in this situation.

- Use common sense in interpreting the DNBI rates. Track DNBI rates over time and compare current DNBI rates with your unit's past DNBI rates for comparable situations.

- Report weekly DNBI data to the unit commander and to medical personnel at higher echelons as directed. The MEDCOM/MEDBDE commander is the releasing authority for all reportable DNBI outcomes. Should an adverse disease incident occur, the MEDCOM/MEDBDE commander requests augmentation of organic PVNTMED resources, if necessary, to investigate the source of the adverse disease incident.

F-3. Case Definitions

a. This paragraph provides a discussion of the case definitions used in this report. When completing this report count only the initial visit. Do not count follow-up visits. All initial sick call visits should be placed in a category. Some patients with multiple ailments may need to be counted in multiple categories. If in doubt about which category, make the best selection. Estimate days of light duty, lost workdays, or admissions resulting from initial visits.

b. Use the following case definitions:

- Combat Operational Stress Reactions—acute debilitating mental, behavioral, or somatic symptoms thought to be caused by operational or combat stressors, that are not adequately explained by physical disease, injury, or a preexisting mental disorder, and that can be managed with reassurance, rest, physical replenishment, and activities that restore confidence.

- Dermatological—diseases of the skin and subcutaneous tissue, including heat rash, fungal infection, cellulitis, impetigo, contact dermatitis, blisters, ingrown toenails, unspecified dermatitis, and such. This category also includes sunburn.

- Gastrointestinal, Infectious—all diagnoses consistent with infection of the intestinal tract. This category includes any type of diarrhea, gastroenteritis, stomach flu, nausea/vomiting, and hepatitis. This category does not include noninfectious intestinal diagnoses such as hemorrhoids, ulcers, or other such conditions.

- Gynecological Conditions—menstrual abnormalities, vaginitis, pelvic inflammatory disease, or other conditions related to the female reproductive system. This category does not include pregnancy.

- Heat/Cold Injuries—climatic injuries, including heat stroke, heat exhaustion, heat cramps, dehydration, hypothermia, frostbite, trench foot, immersion foot, and chilblain.

- Injuries, Recreational/Sports—any injury occurring as a direct consequence of the pursuit of personal and/or group fitness, excluding formal training.

- Injuries, Motor Vehicle Accidents—any injury occurring as a direct consequence of an MVA.

- Injury, Work/Training—any injury occurring as a direct consequence of military operations/duties or of an activity carried out as part of formal military training, to include organized runs and physical fitness programs.

- Injury, Other—any injury not included in the previously defined injury categories.

- Ophthalmologic—any acute diagnosis involving the eye, including pinkeye, conjunctivitis, sty, corneal abrasion, foreign body, and vision problems. This category does not include routine referral for glasses (non-acute).

- Psychiatric, Mental Disorders—debilitating mental, behavioral, or somatic symptoms that meet diagnostic criteria for or have been previously diagnosed as a psychiatric/mental disorder. This category does not include symptoms due to identified physical disease or injury, or symptoms better explained as a transient combat operational stress reaction.

- Respiratory—any diagnosis of the: lower respiratory tract, such as bronchitis, pneumonia, emphysema, reactive airway disease, and pleurisy; or the upper respiratory tract, such as the common cold, laryngitis, tonsillitis, tracheitis, otitis and sinusitis.

- Sexually Transmitted Diseases—all sexually transmitted infections including chlamydia, human immunodeficiency virus, gonorrhea, syphilis, herpes, chancroid, and venereal warts.

- Fever, Unexplained—Temperature of 100.5°F or greater for 24 hours, or history of chills and fever without a clear diagnosis (this is a screening category for many tropical diseases such as malaria, dengue fever, and typhoid fever). Such fever cannot be explained by other inflammatory/infectious processes such as respiratory infections, heat, and overexertion.

- All Other, Medical/Surgical—any medical or surgical condition not fitting into any category above.

- Dental—any disease of the teeth and oral cavity, such as periodontal and gingival disorders, caries, and mandible anomalies.

- Miscellaneous/Administration/Follow-up—all other visits to the treatment facility not fitting one of the above categories, such as profile renewals, pregnancy, immunizations, prescription refills, and physical exams or laboratory tests for administrative purposes.

- Definable—an additional category established for a specific deployment based upon public health concerns (such as, malaria, dengue, or airborne/high-altitude, low opening [HALO] injuries).

GLOSSARY

ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

A2C2 Army airspace command and control
AA air ambulance
AAFES Army and Air Force Exchange Service
ABCA American, British, Canadian, and Australian
abn airborne
acct account
ACFT aircraft
ACofS/ACS Assistant Chief of Staff
ACR armored cavalry regiment
ACSA Acquisition and Cross Servicing Agreement
admin administrative/administration
advanced trauma management Resuscitative and stabilizing medical or surgical treatment provided to patients to save life or limb and to prepare them for further evacuation without jeopardizing their well-being or prolonging the state of their condition.
AEROMED aeromedical
AFIP Armed Forces Institute of Pathology
AFMIC Armed Forces Medical Intelligence Center
AG Adjutant General
AJBPO Area Joint Blood Program Office
AMEDD Army Medical Department
AMEDDC&S Army Medical Department Center and School
AML area medical laboratory
AN Army Nurse Corps
AO *See* area of operations
AOC area of concentration
AR Army regulation
area of operations That portion of an area of conflict necessary for military operations. Areas of operations are geographical areas assigned to commanders for which they have responsibility and in which they have authority to conduct military operations.
area support (medical) Medical support delineated by a specific geographical area of responsibility. It includes provision of health service support for organizations (and individuals) located within this area without their own organic health service support capability.
ARFOR Army forces
ARSOF Army Special Operations Forces
ASBPO Armed Services Blood Program Office
ASCC Army Service Component Command
ASMB area support medical battalion
ASMC area support medical company
assign To place units or personnel in an organization where such placement is relatively permanent, and/or where such organization controls, administers, and provides logistical support to units or personnel for the primary function or a greater portion of the functions of the unit or personnel.
asst assistant
ATM *See* advanced trauma management
attach The temporary placement of units or personnel in an organization. Subject to limitations imposed by the attachment order, the commander of the formation, unit or organization receiving the

attachment will exercise the same degree of command and control as he does over units and personnel organic to his command. However, the responsibility for transfer and promotion of personnel will normally be retained by the parent formation, unit, or organization.

attn attention

augmentation (1) The addition of specialized personnel and/or equipment to a unit, aircraft, or ship to supplement the medical evacuation mission. (2) The provision of personnel to accomplish a task/mission that organic personnel cannot accomplish in addition to their primary mission (example: nonmedical personnel detailed to a medical treatment facility to perform patient decontamination).

AV aviation

BAS battalion aid station

BG brigadier general

BIDS Biological Integrated Detection System

biological warfare agent A biological warfare agent is a pathogen (microorganism capable of causing disease) or toxin derived from a living organism that is deliberately used to produce disease or death in humans, animals, or plants.

BIOMED biomedical

bn battalion

BSMC brigade support medical company

BW biological warfare

C2 *See* command and control

C4I command, control, communications, computers, and intelligence

CA *See* civil affairs

CAPT captain (Navy)

CAT category

CCAT critical care air transport

CCIR commander's critical information requirements

CDC Centers for Disease Control and Prevention

CDR commander

CE communications-electronics

CH Chaplain/chief

chain of command The succession of commanding officers from a superior to a subordinate through which command is exercised.

CHEM chemical

chemical warfare agent A chemical substance which, because of its physiological, psychological, or pharmacological effects, is intended for use in military operations to kill, seriously injure, or incapacitate humans (or animals) through its toxicological effects. Excluded are riot control agents, chemical herbicides, and smoke and flame materials. Chemical agents are nerve agents, incapacitating agents, blister agents (vesicants), lung-damaging agents, blood agents, and vomiting agents.

chemoprophylaxis (1) The administration of an antibiotic agent to prevent an infection, or to prevent an incubating infection from progressing to disease, or to eliminate a carrier state to prevent transmission and disease in others. (2) The use of a chemical to prevent the development and transmission of an infectious disease or other health threats. (3) Administration of a chemical to prevent the development of an infection or the progression of an infection to actively manifest disease.

CHL combat health logistics
CHS combat health support
civil affairs Those phases of the activities of a commander which embrace the relationship between the military forces and civil authorities and people in a friendly country or area or occupied country or area when military forces are present.
CJA command judge advocate
CJCS Chairman, Joint Chiefs of Staff
CJTF commander, joint task force
CLR clearance
CLS *See* combat lifesaver
CM Chemical Corps
CMO civil-military operations
COA courses of action
CO company
CofS chief of staff
combat lifesaver Is a nonmedical soldier trained to provide enhanced first aid as a secondary mission. Enhanced first aid procedures include, but are not limited to, initiating an intravenous infusion, administering additional nerve agent antidote, and inserting an oropharyngeal airway. Normally, one member of each squad, team, or crew is trained.
combat operational stress The expected, predictable, emotional, intellectual, physical and/or behavioral reactions of service members who have been exposed to stressful events in combat or military operations other than war. Combat stress reactions vary in quality and severity as a function of operational conditions, such as intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission. Terms for combat and operational stress historically included nostalgia, soldier's heart, war neurosis, combat neurosis, combat fatigue, combat exhaustion, and battle fatigue.
combat service support (1) The support provided to sustain combat forces, primarily in the fields of administration and logistics. It may include personnel support, religious support, finance support, legal service and support, civil affairs, food service, maintenance, HSS, military police, supply, transportation, and other logistical services. The basic mission of combat service support is to maintain and support our soldiers and their weapon systems. (2) The assistance provided to sustain combat forces, primarily in the fields of administration and logistics. It includes administrative services, chaplain services, civil affairs, food service, finance, legal services, maintenance, health service support, supply, transportation, and other logistical services. (3) The essential capabilities, functions, activities, and tasks necessary to sustain all elements of operating forces in theater at all levels of war. Within the national and theater logistic systems, it includes but is not limited to the support rendered by Service forces in ensuring the aspects of supply, maintenance, transportation, health services, and other services required by aviation and ground combat troops to permit those units to accomplish their missions in combat. Combat service support encompasses those activities at all levels of war that produce sustainment to all operating forces on the battlefield.
combat support Fire support and operational assistance provided to combat elements. May include artillery, aviation, military police, signal, and electronic warfare.
combat zone (1) That area required by combat forces for the conduct of operations. It is the territory forward of the Army rear area boundary. (2) That area required by combat forces for the conduct of operations.

command and control The exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. Command and control functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations in the accomplishment of the mission.

command and staff channels These channels clearly identify the official relationship of commands and staffs and the flow of information as commander to commander, staff to staff, and technical activity to technical activity.

command channel This channel is the direct, official link between headquarters and commanders. All others and instructions to subordinate units pass through this channel. Within your authority, you use command channels when acting in the commander's name.

communications zone Rear part of a theater of operations (behind but contiguous to the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces.

COMMZ *See* communications zone
COMSEC communications security
CONOPS continuous operations
cont control
CONUS continental United States
COSC combat operational stress control
COSCOM corps support command
CP command post
CPO chief petty officer (Navy)
CPT captain
CS *See* combat support
CSC combat stress control
CSH combat support hospital
CSS *See* combat service support
CW chemical warfare
CZ *See* combat zone

DA Department of the Army
DACMC division air cavalry medical company
DC Dental Corps
DCS Deputy Chief of Staff
DCSCA Deputy Chief of Staff, Civil Affairs
DCSIM Deputy Chief of Staff, Information Management
DCSLOG Deputy Chief of Staff, Logistics
DCSMED Deputy Chief of Staff, Medicine
DCSPER Deputy Chief of Staff, Personnel
DCS SPO Deputy Chief of Staff, Security/Plans/Operations
DD/DOD Department of Defense
DDL Daily Disposition Log
DE directed energy
DEA Drug Enforcement Agency

DEN dental
dep deputy
DEPMEDS Deployable Medical System
det detachment
DFE division force equivalent
DIA Defense Intelligence Agency
direct support A direct support unit gives priority of support to a specific unit or force. The supporting unit takes support requests directly from the unit or force in need of support. The supporting unit normally establishes liaison and communications; it also provides advice to the supported unit. A unit in direct support has no command relationship with the supported unit or force.
DLA Defense Logistics Agency
DMC distribution management center
DMOC division medical operations center
DMSS Defense Medical Surveillance System
DNBI disease and nonbattle injury
DODD Department of Defense Directive
DODI Department of Defense Instruction
DS *See* direct support
DSA division support area
DSMC division support medical company
DSO domestic support operations
DTG date/time group

EAC *See* echelons above corps
echelons above corps Army headquarters and organizations that provide the interface between the theater commander (joint or combined) and the corps for operational matters, and between the continental United States/host nation and the deployed corps for combat service support. Operational echelons above corps may be United States only or allied headquarters, while echelons above corps for combat service support will normally be United States national organizations.
EEFI *See* essential elements of friendly information
emergency medical treatment The immediate application of medical procedures to the wounded, injured, or sick by specially trained medical personnel.
EMS emergency medical service
EMT *See* emergency medical treatment
ENG engineer
env environmental
EPW enemy prisoners of war
equip equipment
ESO environmental science officer
essential elements of friendly information The critical aspects of a friendly operation that, if known by the enemy, would subsequently compromise, lead to failure, or limit success of the operation and, therefore, must be protected from enemy detection.
evac evacuation
exec executive

1LT first lieutenant
1SG first sergeant
F Fahrenheit
FDA Food and Drug Administration
FFIR friendly forces information requirements
FH field hospital
fin finance
first aid (self-aid/buddy aid) Urgent and immediate lifesaving and other measures which can be performed for casualties (or performed by the victim himself) by nonmedical personnel when medical personnel are not immediately available.
fld field
flt flight
FM field manual
FMC fully mission capable
FSB forward support battalion
FSMC forward support medical company
FST forward surgical team
fwd forward

G1 Assistant/Deputy Chief of Staff, Personnel
G2 Assistant/Deputy Chief of Staff, Intelligence
G3 Assistant/Deputy Chief of Staff, Security/Plans/Operations
G4 Assistant/Deputy Chief of Staff, Logistics
G5 Assistant/Deputy Chief of Staff, Civil Affairs
G6 Assistant/Deputy Chief of Staff, Information Management
GCCS-A Global Command and Control System—Army
gen generator
general support A general support unit provides support to the total force, not to any particular subdivision. Therefore, subdivisions may not directly request support from the general support unit. Only the supported force headquarters may determine priorities and assign missions or tasks to the general support unit. A general support unit has no command relationship with the supported unit or force.
GH general hospital
Global Patient Movement Requirements Center (1) A joint activity reporting directly to the Commander, US Transportation Command, the Department of Defense single manager for the regulation of movement of uniformed services patients. The GPMRC authorizes transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs and coordinates intertheater and inside continental United States patient movement requirements with the appropriate transportation component commands of United States Transportation Command. (2) The GPMRC is a joint agency located in the continental United States and established by the US Transportation Command. The GPMRC receives requests from the TPMRC. The primary role of the GPMRC is to apportion intertheater assets to the TPMRCs, collaborate and integrate proposed TPMRC intertheater plans and schedules, and communicate lift and bed requirements. The destination hospital is determined based on the patient's medical needs and the available transportation resources.
gnd ground
GO general officer

GPMRC *See* Global Patient Movement Requirements Center
GS *See* general support
GWS *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*, 12 August 1949

HALO high-altitude, low opening
HDT human dimensions team
health threat Refers to an individual soldier's health. The term can include hereditary conditions which manifest themselves in adulthood, individual exposure to an industrial chemical or toxin where others are not exposed, or other injuries and traumas which affect an individuals health rather than the health of the unit. A *health threat* may be more individualized in nature and may not be of military significance. *See also* medical threat.
HHC headquarters and headquarters company
HHD headquarters and headquarters detachment
hlth health
HN *See* host nation
hosp hospital
host nation A nation which receives the forces and/or supplies of allied nations and/or NATO to be located on, or to operate in, or to transit through its territory.
host-nation support (1) Civil and military assistance rendered in peacetime and in wartime to allied forces and organizations located in the host nation's territory. The bases of such assistance are commitments arising from national agreements concluded among host nation(s), international organizations, and nation(s) having forces operating in the host nation's territory. (2) Civil and/or military assistance rendered by a nation to foreign forces within its territory during peacetime, crisis or emergencies, or war based upon agreements mutually concluded between nations.
HR human resources
HSL health service logistics
HSS health service support

ICU intensive care unit
ICW intermediate care ward
ID identification
IG Inspector General
IMM immaterial
IND investigational new drug
info information
INT internal
intel intelligence
interagency operations Any action that combines the human and material resources of two or more independent organizations, whether they are governmental, international, or private, in the prosecution of a common objective.
interoperability The ability of systems, units, or forces to provide services to and accept services from other systems, units, or forces and to use the services so exchanged to enable them to operate effectively together.
ISA international standardization agreement

ITO invitational travel order
IV intravenous

J1 manpower and personnel directorate of a joint staff
J2 intelligence directorate of a joint staff
J3 operations directorate of a joint staff
J4 logistics directorate of a joint staff
J5 plans directorate of a joint staff
J6 command, control, communications, and computer systems directorate of a joint staff
JA Judge Advocate General Corps
JBPO Joint Blood Program Office
JFC *See* joint force commander
JFS *See* joint force surgeon
JMCC joint movement control center
JMLO Joint Medical Logistics Office
JMOC joint medical operations center
JOA joint operational area
JOC joint operations center
joint force A general term applied to a force composed of significant elements, assigned or attached, of two or more Military Departments, operating under a single joint force commander.
joint force commander A general term applied to a combatant commander, subunified commander, or joint task force commander authorized to exercise combatant command (command authority) or operational control over a joint force.
joint force surgeon A general term applied to an individual appointed by the joint force commander to serve as the theater or joint task force special staff officer responsible for establishing, monitoring, or evaluating joint force health service support.
JOPES Joint Operations Planning and Execution System
JPMO Joint Preventive Medicine Office
JPMRC joint patient movement requirements center
JRCAB Joint Readiness Clinical Advisory Board
JTF joint task force
JTFOA joint task force operational area
JVSO Joint Veterinary Service Officer

LAB laboratory
ldr leader
LNO liaison officer
log logistics
LPX-MED logistics planning exercise—medical
LSA logistics support area
lt light

maint maintainer/maintenance
MAJ/Maj major (Army/Marine Corps)

mass casualty Any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack, that exceeds local logistical support capabilities.
mat materiel
MAXILLO maxillofacial
MC Medical Corps
MCA movement control agency
mech mechanic
med medical
MEDBDE medical brigade
MEDCOM medical command
medical equipment set A chest containing medical instruments and supplies designed for specific table of organization and equipment units or specific missions.
medical intelligence That category of intelligence resulting from collection, evaluation, analysis, and interpretation of foreign medical, bioscientific, and environmental information which is of interest to strategic planning and to military medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors.
medical regulating The actions and coordination necessary to arrange for the movement of patients through the echelons of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities, and it also ensures that bed space is available.
medical surveillance The ongoing, systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know.
medical threat (1) A collective term used to designate all potential or continuing enemy actions and environmental situations that could possibly adversely affect the combat effectiveness of friendly forces, to include wounding, injuries, or sickness incurred while engaged in a joint operation. (2) A composite of all ongoing potential enemy actions and environmental conditions (diseases and nonbattle injuries) that may render a soldier combat ineffective.
medical treatment facility (1) Any facility established for the purpose of providing medical treatment. This includes battalion aid stations, division clearing stations, dispensaries, clinics, and hospitals. (2) A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. (3) Denotes a facility established for the purpose of providing health services to authorized personnel.
MEDLOG medical logistics
MEDSITREP Medical Situation Report
MEDSPTREP Medical SPOT Report
MEDSTAT Medical Status Report
MEDSUPSTAT Medical Supply Status Report
MES *See* medical equipment set
METL mission essential task list
METT-TC mission, enemy, terrain and weather, troops and support available, time available, civil considerations
MGMT/mgt management
mgr manager

MH mental health
MLMC medical logistics management center
MMTF medical multifunctional task force
MNT maintenance
MOA memorandum of agreement
Mon Monday
MOS military occupational specialty
MOU memorandum of understanding
MRI Medical Reengineering Initiative
MRO medical regulating office
MS Medical Service Corps
MSB main support battalion
MSMC main support medical company
MSR main supply route
MTF *See* medical treatment facility
MTW major theater war
MVA motor vehicle accident
MWD military working dog
MWR morale, welfare, and recreation

NAFI nonappropriated fund instrumentality
NATO North Atlantic Treaty Organization
NBC nuclear, biological, and chemical
NC noncommissioned
NCO noncommissioned officer
NDMS National Disaster Medical System
NEURO neurological
NGO nongovernmental organization
NLT not later than
NMC nonmission capable
no number
NP neuropsychiatric

OB/GYN obstetrical/gynecological
occupational and environmental health threats Threats to the health of military personnel and to military readiness created by exposure to hazardous agents, as well as exposure to environmental contamination or toxic industrial materials.
OCONUS outside the continental United States
OEH occupational and environmental health
off officer
op operations/operational
OPCON operational control
operation order A directive issued by a commander to subordinate commanders for effecting the coordinated execution of an operation, including tactical movement orders. (*See also* operation plan.)

operation plan A plan for a military operation. It covers a single operation or series of connected operations to be carried out simultaneously or in succession. It implements operations derived from the campaign plan. When the time and/or conditions under which the plan is to be placed in effect occur, the plan becomes an operations order. (*See also* operation order.)
OPHTHAL ophthalmic
OPLAN *See* operation plan
OPORD *See* operation order
opr operator
OPR-MNT operator-maintainer
OPSEC operations security
opt optometry
OPTEMPO operational tempo
OR operating room

PA public affairs/physician assistant
PAHO Pan-American Health Organization
PAO public affairs officer
patient estimates Are derived from the casualty estimate (prepared by the S1/G1) by the combat health support planner. Not all classifications of casualties are *medical casualties* (such as killed in action, absent without leave, or detained persons). Patient estimates only encompass *medical casualties*.
PER personnel
PIR priority intelligence requirement
PMI patient movement items
PMM preventive medicine measures
pnt patient
POC point of contact
POS position
preventive medicine The anticipation, prediction, identification, prevention, and control of communicable diseases (including vector-, food-, and waterborne diseases), illnesses, injuries and diseases due to exposure to occupational and environmental threats, including nonbattle injury threats, combat stress responses, and other threats to the health and readiness of military personnel and military units.
PROF professional
PROFIS Professional Filler System
prop property
pub publication
PVNTMED *See* preventive medicine

QAP Quadripartite Advisory Publication
QSTAG *See* Quadripartite Standardization Agreement
Quadripartite Standardization Agreement The ABCA organization's standardization agreements. The ABCA member nations are allied together for military interoperability in both equipment and methods of operations. As each QSTAG is adopted, it becomes part of each nation's unilateral procedures and is incorporated into national doctrinal and procedural publications.

rationalization Any action that increases the effectiveness of allied forces through more efficient or effective use of defense resources committed to the alliance. Rationalization includes consolidation, reassignment of national priorities to higher alliance needs, standardization, specialization, mutual support or improved interoperability, and greater cooperation. Rationalization applies to both weapons/materiel resources and nonweapons military matters.
REC/rec recovery/records
reg regulating
rep repairer
req request
RETRANS retransmission
return to duty A patient disposition which, after medical evaluation and treatment when necessary, returns a soldier for duty in his unit.
RFI request for information
RSI rationalization, standardization, and interoperability
RSO&I reception, staging, onward movement, and integration
RTD *See* return to duty

S secret
S1 Adjutant, US Army
S2 Intelligence Officer, US Army
S3 Operations and Training Officer, US Army
S4 Logistics Officer, US Army
S6 Communications-Electronic Officer
sample Material collected from a source other than an animal or man for laboratory analysis (such as water sample or soil sample).
Sat Saturday
SC Signal Corps
SCI science/sensitive compartmented information
SCTY security
sec section
SECY secretary
SGT sergeant
sig signal
SIMLM *See* single integrated medical logistics manager
single integrated medical logistics manager When two or more Services are operating within the combatant commander's area of responsibility a Service may be designated as the SIMLM. The SIMLM system encompasses the provision of medical supplies, medical equipment maintenance and repair, blood management, and optical fabrication to all joint forces within the theater of operations.
SJA staff judge advocate
SOFA Status of Forces Agreement
SOP standing operating procedure
SP Army Medical Specialist Corps
SPC specialist
specimen Material collected from a man or animal for laboratory analysis (such as tissue or blood specimen).
spt support

sqd squad
Sr senior
SSG staff sergeant
SSN social security number
staff channel This channel is the staff-to-staff link between headquarters. It is for coordination and transmission of information.
STANAG *See* standardization agreement
standardization The process of developing concepts, doctrines, procedures, and designs to achieve and maintain the most effective levels of compatibility, interoperability, interchangeability, and commonality in the fields of operations, administration, and materiel.
standardization agreement The NATO standardization agreement. The NATO consists of 15 member nations allied together for military interoperability in both equipment and methods of operations. As each STANAG is adopted, it becomes part of each nation's unilateral procedures and is incorporated into national doctrinal and procedural publications.
stdzn standardization
stk stock
SU situational understanding
supv supervisor
surg surgeon
SVC services
sys system

TA theater Army
tac tactical
TAML theater Army medical laboratory
task organization Is a temporary grouping of forces designed to accomplish a particular mission. Task organization involves the allocation or distribution of available forces to a subordinate headquarters by placing these forces either attached, under operational control to, or in direct support of the subordinate headquarters. Staff planners must distinguish between that support and augmentation which is provided to any or all the division(s), and additional support or augmentation which may be required by the heavy or light division when conducting heavy-light operations.
TC Transportation Corps
TDA table of distribution and allowances
tech technician
technical channel Commanders and staffs use this channel to send technical instructions between commands. Technical changes and decisions may affect the mission's accomplishment; therefore, you must inform your commander of any technical change. He can then accurately assess the impact of these changes and take appropriate action.
telecom telecommunications
TELEMED *See* telemedicine
telemedicine The use of electronic communications and information technologies to provide or support medical/clinical care at a distance.
TF task force
theater evacuation policy A command decision indicating the length in days of the maximum period of noneffectiveness that patients may be held within the command for treatment. Patients who, in the

opinion of responsible medical officers, cannot be returned to duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities.

theater of operations That portion of an area of conflict necessary for the conduct of military operations, either offensive or defensive, to include administration and logistical support.

Theater Patient Movement Requirements Center The TPMRC is a joint agency normally located at or near the unified theater headquarters. The theater surgeon supervises the functions of this office. The functions of this officer are: maintaining direct liaison with the GPMRC, the medical regulating officers of component Services, and the transportation agencies which furnish the means of evacuation; obtaining periodic reports of available beds from the Service medical regulating officers; and selecting hospitals based on the reported bed availability to receive patients within echelons above corps.

TIM *See* toxic industrial material

TM team/Technical Manual

TO *See* theater of operations

TOE table of organization and equipment

toxic industrial material Materials such as chemicals and radioactive material from industrial processes that pose hazards to individuals.

TPMRC *See* theater patient movement requirements center

TRAC2ES United States Transportation Command Regulating Command and Control Evacuation System

trmt treatment

TS top secret

TSC theater support command

UIC unit identification code

UMT unit ministry team

UN United Nations

UNHCR United Nations High Commission on Refugees

UO urban operations

US United States

USA United States Army

USAARL United States Army Aeromedical Research Laboratory

USACHPPM United States Army Center for Health Promotion and Preventive Medicine

USAF United States Air Force

USAID United States Agency for International Development

USAISR United States Army Institute of Surgical Research

USAMEDCOM United States Army Medical Command

USAMRICD United States Army Medical Research Institute of Chemical Defense

USAMRIID United States Army Medical Research Institute of Infectious Diseases

USAMRMC United States Army Medical Research and Materiel Command

USARIEM United States Army Research Institute of Environmental Medicine

USMC United States Marine Corps

USN United States Navy

UTM Universal Transverse Mercador

VC Veterinary Corps

veh vehicle

vet veterinary

WHL wheel/wheeled
WHO World Health Organization
WIA wounded in action
WMD weapons of mass destruction
WO warrant officer
WRAIR Walter Reed Army Institute of Research

XO executive officer

REFERENCES

NATO

NATO Emergency War Surgery Handbook. 1988.

NATO Standardization Agreements

These agreements are available on request (using DD Form 1425) from Standardization Documents Order Desk, 700 Robbins Avenue, Building 4, Section D, Philadelphia, Pennsylvania 19111-5094.

2002. *Warning Signs for the Marking of Contaminated or Dangerous Land Areas, Complete Equipments, Supplies and Stores*. 26 January 1999. (Latest Amendment, June 1992.)
2040. *Stretchers, Bearing Brackets and Attachment Supports*. *Edition 5*. 23 September 1982. (Latest Amendment, 30 May 1986.)
2060. *Identification of Medical Materiel for Field Medical Installations*. *Edition 2*. 22 October 1984. (Latest Amendment, 27 May 1994.)
2061. *Procedures for Disposition of Allied Patients by Medical Installation*. *Edition 4*. 30 June 1988. (Latest Amendment, 27 May 1994.)
2068. *Emergency War Surgery*. *Edition 4*. 28 October 1986. (Latest Amendment, 17 October 1991.)
2087. *Medical Employment of Air Transport in the Forward Area*. *Edition 5*. 9 September 1997. (Latest Amendment, 10 September 1999.)
2105. *NATO Table of Medical Equivalents—AMedP-1(E)*. *Edition 6*. 1 December 1998.
2128. *Medical and Dental Supply Procedures*. *Edition 4*. 21 November 1991.
2131. *Multilingual Phrase Book for use by the NATO Medical Services—AMedP-5(B)*. *Edition 4*. 2 March 2000.
2132. *Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients*. *Edition 2*. 7 August 1974. (Latest Amendment, 15 September 1986.)
2350. *Morphia Dosage and Casualty Marking*. *Edition 2*. 27 April 1994.
2358. *First Aid and Hygiene Training in NBC Operations*. *Edition 3*. 12 June 1996.
2454. *Regulations and Procedures for Road Movements and Identification of Movement Control and Traffic Control Personnel and Agencies—AMovP-1*. *Edition 1*. 6 July 1998. (Latest Amendment, 17 October 2000.)
2500. *NATO Handbook on the Medical Aspects of NBC Defensive Operations—AMedP-6(B)*. *Edition 4*. 11 February 1997.
2871. *First Aid Materiel for Chemical Injuries*. *Edition 3*. 8 March 1989. (Latest Amendment, 24 July 1995.)
2873. *Concepts of Operations of Medical Support in Nuclear, Biological, and Chemical Environments—AMedP-7(A)*. *Edition 3*. 16 October 1996.
2874. *Planning Guide for the Estimation of Battle Casualties (Nuclear)—AMedP-8*. *Edition 2*. 27 November 1981. (Latest Amendment, 26 April 1994.)
2879. *Principles of Medical Policy in the Management of a Mass Casualty Situation*. *Edition 3*. 7 September 1998.
2931. *Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations*. *Edition 2*. 19 January 1998. (Latest Amendment, 3 April 1998.)
2939. *Medical Requirements for Blood, Blood Donors, and Associated Equipment*. *Edition 4*. 24 January 2000.

3204. *Aeromedical Evacuation. Edition 6.* 15 July 1999. (Latest Amendment, 4 October 2000.)

ABCA Quadripartite Advisory Publication

82. *ABCA Armies' Medical Interoperability Handbook.* March 1998.

ABCA Quadripartite Standardization Agreements

These agreements are available on request (using DD Form 1425) from Standardization Documents Order Desk, 700 Robbins Avenue, Building 4, Section D, Philadelphia, Pennsylvania 19111-5094.

230. *Morphia Dosage Agreement. Edition 2.* 23 January 1985. (Latest Amendment, 27 February 1990.)
236. *Medical Gas Cylinders. Edition 1.* 8 April 1971. (Latest Amendment, 14 August 1989.)
245. *Minimum Requirements for Water Potability (Short and Long Term Use). Edition 2.* 10 September 1985.
248. *Identification of Medical Materiel to Meet Urgent Needs. Edition 2.* 27 September 1988.
288. *Intravenous Replacement Fluids. Edition 1.* 13 August 1980. (Latest Amendment, 1 August 1988.)
289. *Minimum Essential Characteristics of Blood Products Shipping Containers. Edition 3.* 12 August 1991.
290. *Minimum Requirements for Controlled Temperature Storage and Transport of Medical Materiel. Edition 2.* 16 February 1989. (Latest Amendment, 7 August 1989.)
291. *Interface of Medical Materiel Procedures. Edition 1.* 5 June 1974. (Latest Amendment, 14 August 1989.)
292. *Vaccination of Armed Forces. Edition 2.* 6 August 1984. (Latest Amendment, 14 August 1989.)
322. *Emergency War Surgery. Edition 1.* 19 December 1986. (Latest Amendment, 8 August 1988.)
423. *Levels of Medical Support. Edition 2.* 12 August 1991.
470. *Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients. Edition 1.* 23 February 1979. (Latest Amendment, 14 August 1989.)
519. *Common Standards on Stretchers to be Used in Both Air and Land Evacuation Ambulances. Edition 1.* 20 November 1985. (Latest Amendment, 13 September 1990.)
529. *Medical Employment of Air Transport in the Forward Area. Edition 1.* 24 March 1980. (Latest Amendment, 14 August 1989.)
535. *Medical Training in First Aid, Basic Hygiene, and Emergency Care. Edition 1.* 12 November 1979. (Latest Amendment, 27 February 1990.)
536. *Medical, Surgical, and Dental Instruments, Equipment, and Supplies.* 27 February 1990.
623. *Standard Method of Writing Prescriptions for Spectacles. Edition 1.* 9 August 1979. (Latest Amendment, 27 February 1990.)
624. *Medical Design Requirements for Military Pattern Ground Ambulances. Edition 1.* 23 August 1984. (Latest Amendment, 12 December 1996.)
677. *Resuscitation Materiel for Field Use. Edition 2.* 12 August 1991.
815. *Blood Supply in the Area of Operations. Edition 1.* 21 October 1991.
816. *Medical Aspects of Mass Casualty Situations. Edition 1.* 25 June 1987. (Latest Amendment, August 1990.)

850. *Blood, Blood Donor, and Transfusion Equipment Requirements. Edition 3.* 27 February 1990. (Latest Amendment, 20 June 2001.)
889. *Essential Field Sanitary Requirements. Edition 1.* 27 September 1988. (Latest Amendment, 27 February 1990.)
892. *Prevention of Cold Injuries. Edition 1.* 21 October 1991.
893. *Patient Management in a Cold Climate. Edition 1.* 21 October 1994.
908. *Medical Warning Tag.* Edition 1. 16 February 1989. (Latest Amendment, 25 September 1990.)
909. *Principles of Prevention of Combat Stress Reaction. Edition 1.* 21 October 1991.

Code of Federal Regulations

United States Code: *Title 10. Armed Forces.*

Federal Emergency Management Agency

FEMA 229. *Federal Response Plan.* 7 February 1997.

Joint and Multiservice Publications

DODD 1330.5. *American National Red Cross.* 16 August 1969. (Change 4, 20 December 1991.)
DODD 2205.2. *Humanitarian and Civic Assistance (HCA) Provided in Conjunction with Military Operations.* 6 October 1994.
DODD 2310.1. *DOD Program for Enemy Prisoners of War (EPOW) and Other Detainees.* 18 August 1994.
DODD 3025.15. *Military Assistance to Civil Authorities.* 18 February 1997.
DODD 5100.77. *DOD Law of War Program.* 9 December 1998.
DODD 5160.54. *Critical Asset Assurance Program (CAAP).* 20 January 1998.
DODD 6000.12. *Health Services Operations and Readiness.* 29 April 1996. (Change 1, 20 January 1998.)
DODD 6420.1. *Armed Forces Medical Intelligence Center (AFMIC).* 30 September 1996.
DODD 6490.2. *Joint Medical Surveillance.* 30 August 1997.
DODI 2205.3. *Implementing Procedures for the Humanitarian and Civic Assistance (HCA) Program.* 27 January 1995.
DODI 6430.2. *DOD Medical Standardization Board (DSMB).* 17 March 1997.
DODI 6490.3. *Implementation and Application of Joint Medical Surveillance for Deployments.* 7 August 1997.
Joint Chiefs of Staff Memorandum MCM 0006-02. *Updated Procedures for Deployment Health Surveillance and Readiness.* 1 February 2002.
Joint Pub 1-02. *Department of Defense Dictionary of Military and Associated Terms.* 12 April 2001.
Joint Pub 3-0. *Doctrine for Joint Operations.* 10 September 2001.
Joint Pub 3-07. *Joint Doctrine for Military Operations Other Than War.* 16 June 1995.
Joint Pub 3-07.1. *Joint Tactics, Techniques, and Procedures for Foreign Internal Defense.* 26 June 1996.

Joint Pub 3-07.2. *Joint Tactics, Techniques, and Procedures for Antiterrorism*. 17 March 1998.
Joint Pub 3-07.3. *Joint Tactics, Techniques, and Procedures for Peace Operations*. 12 February 1999.
Joint Pub 3-07.4. *Joint Counterdrug Operations*. 17 February 1998.
Joint Pub 4-02. *Doctrine for Health Service Support in Joint Operations*. 30 July 2001.
Joint Pub 4-02.1. *Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations*. 6 October 1997.
Joint Pub 4-02.2. *Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations*. 30 December 1996.
AR 40-70. *Department of Defense Veterinary/Medical Laboratory Food Safety and Quality Assurance Program*. NAVSUPINST 4355.6A; MCO 10110.44A. 1 February 1995.
AR 40-535. *Worldwide Aeromedical Evacuation*. AFR 164-5; OPNAVINST 4630.9C; MCO P4630-9A. 1 December 1975. (Reprinted with basic including Change 1, 10 May 1979.)
AR 40-562. *Immunizations and Chemoprophylaxis*. AFJI 48-110; BUMEDINST 6230-15; CG COMDTINST M6230-4E. 1 November 1995.
AR 40-656. *Veterinary Surveillance Inspection of Subsistence*. NAVSUPINST 4355.10; MCO 10110.45. 15 October 1986.
AR 40-657. *Veterinary/Medical Food Inspection and Laboratory Service*. NAVSUPINST 4355.4F; MCO P10110.31G. 6 November 1997.
AR 40-905. *Veterinary Health Services*. SECNAVINST 6401.A; AFI 48-135. 16 August 1994.
AR 190-8. *Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees*. OPNAVINST 3461.6; AFJI 31-304; MCO 3461.1. 1 October 1997.
AR 500-4. *Military Assistance to Safety and Traffic* (*MAST*). AFR 64-1. 15 January 1982.
DA Pamphlet 40-3. *Medical Service Multilingual Phrase Book*. NAVMED P-5104; AFP 160-28. 31 May 1971.
FM 3-3. *Chemical and Biological Contamination Avoidance*. FMFM 11-17. 16 November 1992. (Change 1, 29 September 1994.)
FM 3-4. *NBC Protection*. FMFM 11-9. 29 May 1992. (Reprinted with basic including Change 1, 28 October 1992; Change 2, 21 February 1996.)
FM 3-5. *NBC Decontamination*. MCWP 3-37.3. 28 July 2000. (Change 1, 31 January 2002.)
FM 3-11. *Multiservice Tactics, Techniques, and Procedures for Nuclear, Biological, and Chemical Defense Operations*. *MCWP 3-37.1; NWP 3-11; AFTTP(I) 3-2.42*. 10 March 2003.
FM 3-11.21. *Multiservice Tactics, Techniques, and Procedures for Nuclear, Biological, and Chemical Aspects of Consequence Management*. MCRP 3-37.2C; NTTP 3-11.24: AFTTP(I) 3-2.37. 12 December 2001.
FM 3-100.4. *Environmental Considerations in Military Operations*. MCRP 4-11B. 15 June 2000. (Change 1, 11 May 2001.)
FM 4-02.33. *Control of Communicable Diseases Manual. 17th Edition*. NAVMED P-5038. 31 December 1999.
FM 4-02.283. *Treatment of Nuclear and Radiological Casualties*. NTRP 4-02.21; AFMAN 44-161(I); MCRP 4-11.1B. 20 December 2001.
FM 4-25.11. *First Aid*. NTRP 4-02.1; AFMAN 44-163(I). 23 December 2002.
FM 6-22.5. *Combat Stress*. MCRP 6-11C; NTTP 1-15M. 23 June 2000.
FM 8-9. *NATO Handbook on the Medical Aspects of NBC Defensive Operations AMedP-6*(*B*), *Part I—Nuclear, Part II—Biological, Part III—Chemical*. NAVMED P-5059; AFJMAN 44-151V1V2V3. 1 February 1996.

FM 8-70. *Standards for Blood Banks and Transfusion Services*. NAVMED P-5120; AFMAN 41-111. 1 August 2000.
FM 8-284. *Treatment of Biological Warfare Agent Casualties*. NTRP 4-02.23; AFMAN (I) 44-156; MRCP 4-11.1C. 17 July 2000. (Change 1, 8 July 2002.)
FM 8-285. *Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries*. NAVMED P-5041; AFJMAN 44-149; FMFM 11-11. 22 December 1995.
FM 21-10. *Field Hygiene and Sanitation*. MCRP 4-11.1D. 21 June 2000.
FM 90-3. *Desert Operations*. FMFM 7-27. 24 August 1993.
FM 90-13. *River Crossing Operations*. MCWP 3-17.1. 26 January 1998.
TM 5-632. *Military Entomology Operational Handbook*. NAVFAC MO-310; AFM 9-16. 1 December 1971. (Reprinted with basic including Changes 1—2, January 1976.)
TM 8-227-3. *The Technical Manual of the American Association of Blood Banks*. NAVMED P-5101; AFMAN(I) 41-119. 1 June 2002.
TM 8-227-11. *Operational Procedures for the Armed Services Blood Program Elements*. NAVMED P-5123; AFI 44-118. 1 September 1995.
TM 8-227-12. *Armed Services Blood Program Joint Blood Program Handbook*. NAVMED P-6530; AFH 44-152. 21 January 1998.

Army Publications

AR 25-1. *Army Information Management*. 31 May 2002.
AR 40-3. *Medical, Dental, and Veterinary Care*. 12 November 2002.
AR 40-5. *Preventive Medicine*. 15 October 1990.
AR 40-66. *Medical Records Administration and Health Care Documentation*. 10 March 2003.
AR 40-400. *Patient Administration*. 12 March 2001.
AR 350-1. *Army Training and Education*. 9 April 2003.
AR 600-20. *Army Command Policy*. 13 May 2002.
DA Pamphlet 27-1. *Treaties Governing Land Warfare*. 7 December 1956.
FM 1-120. *Army Air Traffic Services Contingency and Combat Zone Operations*. 22 May 1995.
FM 3-0. *Operations*. 14 June 2001.
FM 3-05.20. *Special Forces Operations*. 26 June 2001.
FM 3-05.70. *Survival*. May 2002.
FM 3-06. *Urban Operations*. 1 June 2003.
FM 3-06.11. *Combined Arms Operations in Urban Terrain*. 28 February 2002.
FM 3-07. *Stability Operations and Support Operations*. 20 February 2003.
FM 3-19.30. *Physical Security*. 8 January 2001.
FM 3-19.40. *Military Police Internment/Resettlement Operations*. 1 August 2001.
FM 3-52. *Army Airspace Command and Control in a Combat Zone*. 1 August 2002.
FM 3-90. *Tactics*. 4 July 2001.
FM 3-100.21. *Contractors on the Battlefield*. 3 January 2003.
FM 4-0. *Combat Service Support*. 29 August 2003.
FM 4-02. *Force Health Protection in a Global Environment*. 13 February 2003.
FM 4-02.1. *Combat Health Logistics*. 28 September 2001.
FM 4-02.4. *Medical Platoon Leaders' Handbook—Tactics, Techniques, and Procedures*. 24 August 2001.

FM 4-02.6. *The Medical Company—Tactics, Techniques, and Procedures*. 1 August 2002.
FM 4-02.7. *Health Service Support in a Nuclear, Biological, and Chemical Environment*. 1 October 2002.
FM 4-02.10. *Theater Hospitalization*. 29 December 2000.
FM 4-02.16. *Army Medical Information Operations—Tactics, Techniques, and Procedures*. 22 August 2003.
FM 4-02.17. *Preventive Medicine Services*. 28 August 2000.
FM 4-02.19. *Dental Service Support in a Theater of Operations*. 1 March 2001.
FM 4-02.21. *Division and Brigade Surgeons' Handbook (Digitized)—Tactics, Techniques, and Procedures*. 15 November 2000.
FM 4-02.24. *Area Support Medical Battalion—Tactics, Techniques, and Procedures*. 28 August 2000.
FM 4-02.25. *Employment of Forward Surgical Teams—Tactics, Techniques, and Procedures*. 28 March 2003.
FM 4-02.56. *Army Medical Field Feeding Operations*. 29 April 2003.
FM 4-25.12. *Unit Field Sanitation Team*. 25 January 2002.
FM 4-93.4. *Theater Support Command*. 15 April 2003.
FM 8-10-3. *Division Medical Operations Center—Tactics, Techniques, and Procedures*. 12 November 1996.
FM 8-10-5. *Brigade and Division Surgeons' Handbook—Tactics, Techniques, and Procedures*. 10 June 1991.
FM 8-10-6. *Medical Evacuation in a Theater of Operations—Tactics, Techniques, and Procedures*. 14 April 2000.
FM 8-10-9. *Combat Health Logistics in a Theater of Operations—Tactics, Techniques, and Procedures*. 3 October 1995.
FM 8-10-13. *Employment of the Mobile Army Surgical Hospital—Tactics, Techniques, and Procedures*. Final Approved Draft, 4 June 1993. (Not available on the Reimer Digital Library.)
FM 8-10-14. *Employment of the Combat Support Hospital—Tactics, Techniques, and Procedures*. 29 December 1994.
FM 8-10-15. *Employment of the Field and General Hospitals—Tactics, Techniques, and Procedures*. 26 March 1997.
FM 8-10-18. *Veterinary Service—Tactics, Techniques, and Procedures*. 22 August 1997.
FM 8-10-26. *Employment of the Medical Company (Air Ambulance)*. 16 February 1999. (Change 1, 30 May 2002.)
FM 8-42. *Combat Health Support in Stability Operations and Support Operations*. 27 October 1997.
FM 8-43. *Combat Health Support for Army Special Operations Forces*. 21 June 2000.
FM 8-51. *Combat Stress Control in a Theater of Operations—Tactics, Techniques, and Procedures*. 29 September 1994. (Change 1, 30 January 1998.)
FM 8-55. *Planning for Health Service Support*. 9 September 1994.
FM 8-250. *Preventive Medicine Specialist*. 27 January 1986. (Reprinted with basic including Change 1, 12 September 1986.)
FM 10-52. *Water Supply in Theaters of Operations*. 11 July 1990.
FM 12-6. *Personnel Doctrine*. 9 September 1994.
FM 19-15. *Civil Disturbances*. 25 November 1985.
FM 22-51. *Leaders' Manual for Combat Stress Control*. 29 September 1994.
FM 27-2. *Your Conduct in Combat Under the Law of War*. 23 November 1984.

FM 27-10. *The Law of Land Warfare*. 18 July 1956. (Reprinted with basic including Change 1, 15 July 1976.)
FM 41-10. *Civil Affairs Operations*. 14 February 2000.
FM 90-5. *Jungle Operations*. 16 August 1982.
FM 90-8. *Counterguerrilla Operations*. 29 August 1986.
FM 100-6. *Information Operations*. 27 August 1996.
FM 100-7. *Decisive Force: The Army in Theater Operations*. 31 May 1995.
FM 100-14. *Risk Management*. 23 April 1998.
FM 100-15. *Corps Operations*. 29 October 1996.
FM 100-17. *Mobilization, Deployment, Redeployment, and Demobilization*. 28 October 1992.
FM 100-17-1. *Army Pre-Positioned Afloat Operations*. 27 July 1996.
FM 100-17-3. *Reception, Staging, Onward Movement, and Integration*. 17 March 1999.
FM 101-5 (5-0). *Staff Organization and Operations*. 31 May 1997.
FM 101-5-2. *US Army Report and Message Formats*. 29 June 1999.
TB Med 577. *Occupational and Environmental Health: Sanitary Control and Surveillance of Field Water Supplies*. 7 March 1986. (Currently under revision.)
TC 3-34.489. *The Soldier and the Environment*. 8 May 2001. (Change 1, 26 October 2001.)

DEPARTMENT OF DEFENSE FORMS

DD Form 2A (ACT). *Active Duty Military ID Card*. July 1974.
DD Form 600. *Patient's Baggage Tag*. 1 July 1973.
DD Form 601. *Patient Evacuation Manifest*. 1 October 1951.
DD Form 602. *Patient Evacuation Tag*. 1 February 1963.
DD Form 1911. *Materiel Courier Receipt*. May 1982.
DD Form 1380. *United States Field Medical Card*. December 1991.
DD Form 1425. *Specifications and Standards Requisition*. March 1986.
DD Form 1934. *Geneva Conventions Identity Card for Medical and Religious Personnel Who Serve in or Accompany the Armed Forces*. July 1974.

DEPARTMENT OF ARMY FORM

DA Form 4137. *Evidence/Property Custody Document*. 1 July 1976.

UNNUMBERED PUBLICATIONS

Executive Order 13139. *Improving Health Protection of Military Personnel Participating in Particular Military Operations*. 30 September 1999.
Force Health Protection Capstone Document. (Available at website: http://www.ha.osd.mil/forcehealth\library\docs\FHP_capstone1.doc)
Joint Readiness Clinical Advisory Board. Deployable Medical System (DEPMEDS) Administrative Procedures, Clinical and Support Guidelines, and Patient Treatment Briefs. (Available at website: http://www.armymedicine.army.mil/jrcab/d-prod.htm.)

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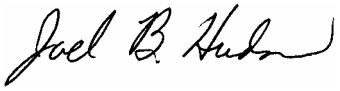

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