

FM 8-10-15

**EMPLOYMENT OF THE
FIELD AND GENERAL
HOSPITALS**

TACTICS, TECHNIQUES, AND PROCEDURES

HEADQUARTERS, DEPARTMENT OF THE ARMY

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PREFACE

The purpose of this publication is to describe the functions and employment of the field hospital (FH) and the general hospital (GH). This publication is designed for hospital commanders, their staffs, and assigned personnel. It embodies doctrine based on Medical Force 2000 and the L-edition Tables of Organization and Equipment (TOE) 08715L000 and 08725L000, respectively. The structural layout of the hospitals is flexible and situationally determined (for example, mission requirements, commander's guidance, and terrain features). Intensive prior planning and training of all personnel is required to establish these facilities. The staffing and organizational structures presented in this publication reflect those established in their respective L-edition TOE. However, such staffing is subject to change to comply with Manpower Requirements Criteria outlined in Army Regulation (AR) 570-2 and can be subsequently modified by the modification TOE (MTOE).

This publication is in concert with Field Manual (FM) 8-10, FM 8-55, and Training Circular (TC) 8-13. Other FM 8-Series publications will be referenced in this manual. Users should be familiar with FM 100-5 and FM 100-10.

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA) Form 2028 directly to **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 E. Grayson Street, Fort Sam Houston, Texas 78234-6175.**

This publication implements the following North Atlantic Treaty Organization (NATO) International Standardization Agreements (STANAGs):

STANAG	TITLE
2068 Med 2931	Emergency War Surgery (Edition 4) (Amendment 3) Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations

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

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

CHAPTER 1

HOSPITALIZATION SYSTEM IN A THEATER OF OPERATIONS**1-1. Combat Health Support in a Theater of Operations**

a. A theater of operations (TO) is that portion of an area of war necessary for military operations and for the administration of such operations. The scenario depicts the size of the TO and the US forces to be deployed. The theater is normally divided into a combat zone (CZ) and a communications zone (COMMZ). The CZ begins at the Army/corps rear boundary and extends forward to the extent of the commander's area of influence. The COMMZ begins at the corps rear boundary and extends rearward to include the area(s) needed to provide support to the forces in the CZ. In some instances, the COMMZ may be outside the TO and located in offshore support facilities, third country support bases, or in the continental United States (CONUS).

b. Combat health support (CHS) for the Army component in a TO is the theater Army (TA) commander's responsibility. A TA surgeon is on the TA commander's special staff.

c. Normally, the medical command (MEDCOM) commander or the senior medical commander in the COMMZ functions as the TA surgeon. As the TA surgeon, he provides information, recommendations, and professional medical advice to the general and special staffs. He also maintains current data regarding the status, capabilities, and requirements of the TA's CHS. As the medical staff adviser, he is responsible to the TA commander for staff planning, coordinating, and developing policies for TA forces' CHS.

d. The mission of the Army Medical Department (AMEDD) is to conserve the fighting strength. This mission of CHS is a continuous and integrated function throughout the TO. It extends from the CZ back through the COMMZ and ends in CONUS. Combat health support maximizes the system's ability to maintain presence with the supported soldier, to return injured, sick, and wounded soldiers to duty, and to clear the battlefield of soldiers who cannot return to duty (RTD). Patients are examined, treated, and identified as RTD or nonreturn to duty (NRTD) as far forward as is medically possible. Early identification is performed by the treating primary care provider and continues in the evacuation chain with constant reassessment. Patients requiring evacuation out of the division who are expected to RTD within the theater evacuation policy are evacuated to a corps and/or COMMZ hospital. Those patients classified as NRTD follow the evacuation chain for evacuation out of the theater.

1-2. Echelons of Combat Health Support

The CHS system is organized into five echelons of support. The TO is normally organized into four echelons of support which extend rearward throughout the theater. The fifth echelon is located in CONUS (see Figure 1-1). In the TO, CHS is tailored and phased to enhance patient acquisition, treatment, evacuation, and RTD as far forward as the tactical situation will permit. Hospital resources located at Echelons III and IV will be employed on an area basis to provide the utmost benefit to the maximum number of personnel in the area of operations (AO). Each echelon reflects an increase in capability, with the function of each lower echelon being contained within the capabilities of the higher echelon. Wounded, sick, or injured soldiers will normally be treated, returned to duty, and/or evacuated to CONUS (Echelon V) through the theater's four echelons:

a. Echelon I. Care is provided by designated individuals or elements organic to combat and combat support (CS) units and elements of the area support medical battalion (ASMB). Major emphasis is placed on those measures necessary to stabilize the patient (maintain airway, stop bleeding, prevent shock) and allow for evacuation to the next echelon of care.

(1) *Combat medic.* This is the first individual in the CHS chain who makes medically substantiated decisions based on medical military occupational specialty (MOS)-specific training. The combat medic is supported by first-aid providers in the form of self-aid and buddy aid and the combat lifesaver.

(a) *Self-aid and buddy aid.* The individual soldier is trained to be proficient in a variety of specific first-aid procedures with particular emphasis on lifesaving tasks. This training enables the soldier, or a buddy, to apply immediate care to alleviate a life-threatening situation.

(b) *Combat lifesaver.* Enhanced first-aid training is provided to selected individuals who are called combat lifesavers. These individuals are nonmedical unit members selected by their commander for additional training to be proficient in a variety of first-aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit is trained. All combat units and some CS and combat service support (CSS) units have combat lifesavers. The primary duty of these individuals does not change. The additional duties of combat lifesavers are performed when the tactical situation permits. These individuals provide enhanced first-aid care for injuries prior to treatment by the combat medic. The training is normally provided by medical personnel assigned or attached to the unit. The training program is managed by a senior medical person designated by the commander.

(2) *Treatment squad.* The treatment squad consists of a field surgeon, a physician assistant (PA), two noncommissioned officers (NCOs), and four medical specialists. The personnel are trained and equipped to provide advanced trauma management (ATM) to the battlefield casualty. Advanced trauma management is emergency care designed to resuscitate and stabilize the patient for evacuation to the next echelon of care. Each squad can split into two trauma treatment teams. These squads are organic to medical platoons/sections in maneuver battalions and designated CS units and medical companies of separate brigades, divisions, and echelons above division in the ASMB. Treatment squads (treatment teams) may be employed anywhere on the battlefield. When not engaged in ATM, these elements provide routine sick call services on an area basis. Echelon I care for units not having organic Echelon I capability is provided on an area basis by the organization responsible in the sector.

b. Echelon II. Care at this echelon is rendered at the clearing station (division or corps) and the forward surgical team (FST).

(1) At the clearing station the casualty is examined and his wounds and general status are evaluated to determine his treatment and evacuation precedences, as a single casualty among other casualties. Those patients who can RTD within 1 to 3 days are held for treatment. Emergency medical treatment (EMT) (including beginning resuscitation) is continued and, if necessary, additional emergency measures are instituted; but they do not go beyond the measures dictated by the immediate necessities. The division clearing station has blood replacement capability, limited x-ray and laboratory services, patient-holding capability, and emergency dental care. Clearing stations provide Echelon I CHS functions on an area basis to those units without organic medical elements.

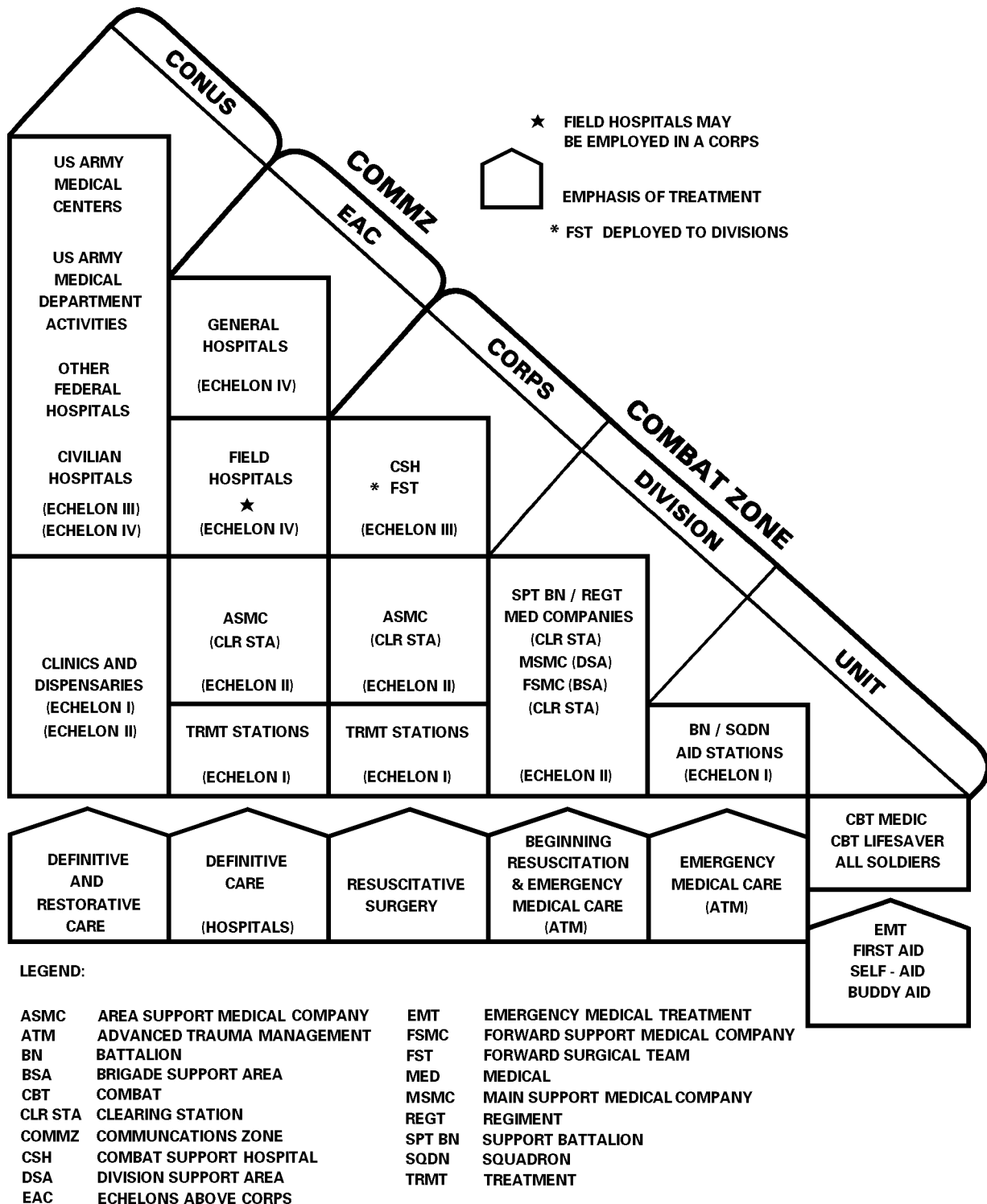


Figure 1-1. Echelons of combat health support.

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(2) The FST is a corps augmentation for divisional and nondivisional medical companies. The FST provides emergency/urgent initial surgery and nursing care after surgery for the critically wounded/injured patient until sufficiently stable for evacuation to a corps hospital. The FSTs not organic to divisions and regiments will be assigned to a medical brigade or group and normally attached to a corps hospital when not operationally employed. The FST will be further attached for support to a divisional/nondivisional medical unit.

(3) Division-level CHS also includes preventive medicine (PVNTMED) activities and combat stress control (CSC). These functions are performed typically by company-sized medical units organic to brigades, divisions, and ASMBs.

c. Echelon III. The first hospital facility, the combat support hospital (CSH), is located at this echelon. The CSH is staffed and equipped to provide resuscitation, initial wound surgery, and postoperative treatment. Patients are stabilized for continued evacuation or returned to duty. Those patients who are expected to RTD within the theater evacuation policy are regulated to a facility that has the capability for reconditioning and rehabilitating.

d. Echelon IV. At this echelon, the patient may be treated at the FH or the GH. These hospitals are staffed and equipped for general and specialized medical and surgical care. Those patients not expected to RTD within the theater evacuation policy are stabilized and evacuated to CONUS. At the FH, reconditioning and rehabilitating services are provided for those patients who will be RTD within the theater evacuation policy.

e. Echelon V. This echelon of care is provided in CONUS. Hospitalization is provided by DOD hospitals (military hospitals of the triservices) and Department of Veterans Affairs (DVA) hospitals. Under the National Disaster Medical System, patients overflowing DOD and DVA hospitals will be cared for in designated civilian hospitals.

1-3. Theater Hospital System

a. This system consists of three hospitals, a medical company, holding, and six medical/surgical teams. The corps hospital is the CSH. The two COMMZ hospitals are the FH and the GH. In addition to these hospitals, the medical company, holding provides a 1200-bed convalescent capability. For a detailed discussion on the Medical Force 2000 hospital system, refer to FM 8-10.

(1) *Combat support hospital.* This hospital's mission is to stabilize patients for further evacuation and to RTD those soldiers who fall within the corps evacuation policy. It is capable of handling all types of patients and will normally be employed in the corps area. The CSH provides hospitalization for up to 296 patients; surgical capacity with eight operating room (OR) tables; consultation services for patients referred from other medical treatment facilities (MTFs); pharmacy, clinical laboratory, blood banking, radiology, and nutrition care services; and physical therapy support for patients. For a detailed discussion on the CSH, refer to FM 8-10-14.

(2) *Field hospital.* This hospital is addressed in detail in Chapter 2 and other chapters of this publication.

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(3) *General hospital.* This hospital is addressed in detail in Chapter 3 and other chapters of this publication.

(4) *Medical company, holding.* The mission of the medical company, holding is to provide a holding capability within the CZ for up to 1200 minimal care patients and minor medical treatment and rehabilitation for patients being held. This unit is assigned to a medical brigade. Its capabilities include—

- Providing five holding platoons, each capable of operating a holding facility with 240 supplemental cots for minimal care patients. The platoons have six holding squads (each having a capacity of 40 patients) and one treatment squad.
- Employing platoons to expand hospital minimal care ward facilities.
- Employing platoons, in conjunction with CSC assets, to hold battle fatigue casualties (BFCs).
- Employing platoons to augment United States Air Force (USAF) mobile aeromedical staging facilities (MASFs).
- Performing limited CHS on an area basis.

(5) *Surgical service teams.* The mission of these teams is to provide surgical augmentation to CZ and COMMZ hospitals. These teams are assigned to a MEDCOM or a medical brigade or group and further attached to subordinate hospitals. (For information on the basis of allocation for these teams, refer to FM 8-10.) These teams include—

- Medical team, head and neck surgery. This team provides initial and secondary maxillofacial and ear, nose, and throat (ENT) surgery.
- Medical team, neurosurgery. This team provides initial and secondary neurosurgery.
- Medical team, eye surgery. This team provides initial and secondary ophthalmologic surgery.

(6) *Medical service teams.* The mission of these medical service teams is to provide medical augmentation to CZ and COMMZ hospitals. (For information on the basis of allocation for these teams, refer to FM 8-10.) These teams include—

- Medical team, pathology. This team provides investigative pathology support.
- Medical team, renal dialysis. This team provides renal hemodialysis care for patients with acute renal failure and consultative services on an area basis.
- Medical team, infectious disease. This team provides infectious disease investigative and consultative services.

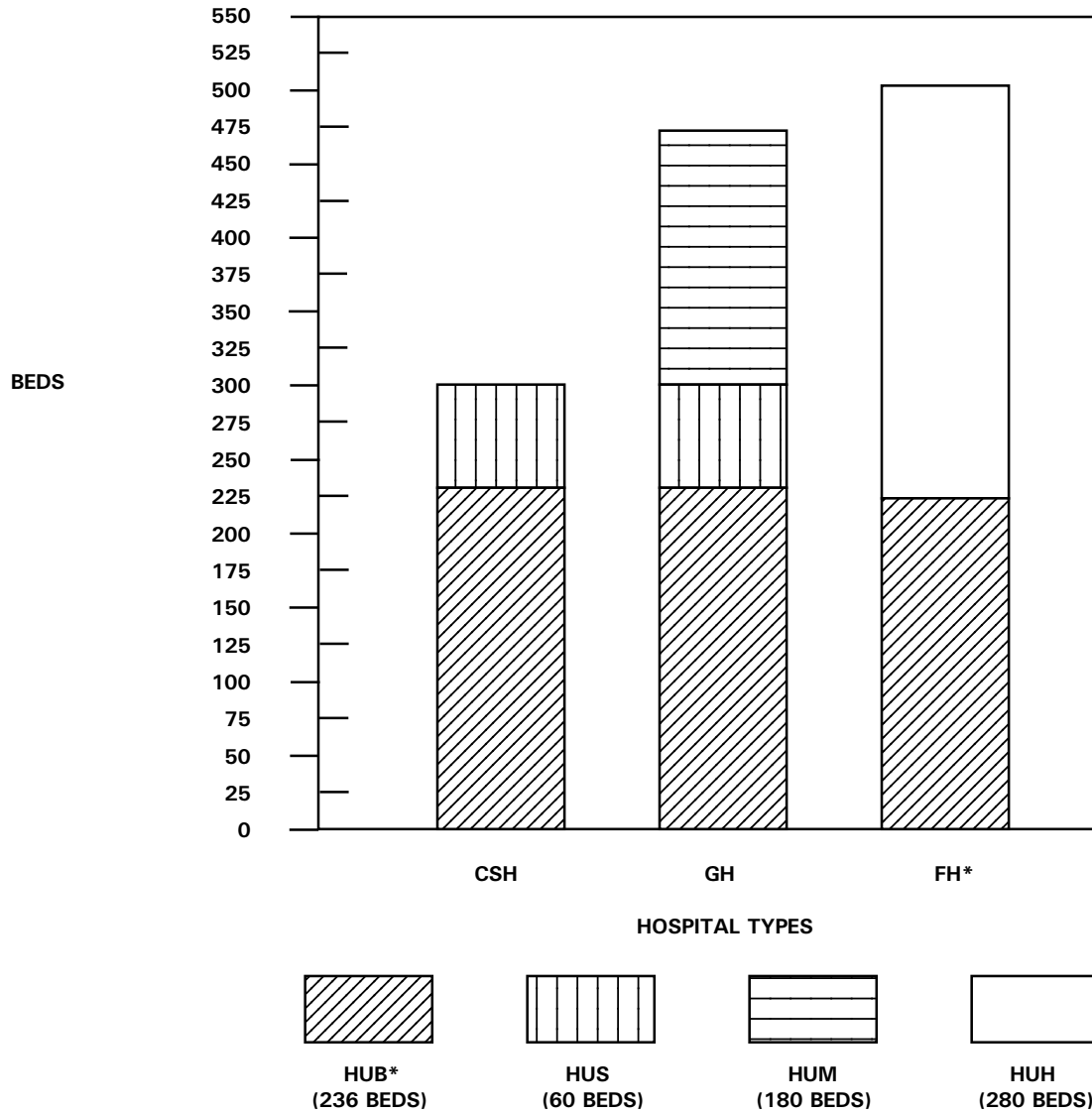
b. The CSH, FH, and GH are modular designed. They consist of a base component (hospital unit, base [HUB]) which is clinically similar in all the facilities. This unit is augmented by one or more mission-adaptive components to meet work load requirements. These separate hospital components promote the CHS planner's ability to task organize and reconstitute the hospital as operational needs dictate. These components are assigned separate TOE to facilitate training, cohesiveness, and response capabilities. These components (Figure 1-2) include the—

(1) *Hospital unit, base.* The HUB is the foundation for the hospital. It is an independent organization which includes all hospital services. Normally, it is employed with one or more mission-adaptive components but is capable of stand-alone operations. The capabilities of the HUB are—

- Hospitalization for up to 236 patients, consisting of 36 intensive, 140 intermediate, 40 minimal, and 20 neuropsychiatric (NP) care beds. Note Figure 1-2.
- Surgical capability for the CSH and GH is based on two OR modules, one surgical and the other orthopedic, which are staffed to provide a total of 72 OR table hours per day. Surgical capability for the FH is based on one OR module.
- Consultation services for outpatients referred from other MTFs.
- Unit-level CHS for organic personnel only.
- Pharmacy, clinical laboratory, blood banking, radiology, and nutrition care services.
- Physical therapy support to patients.
- Medical administrative and logistical services to support patient work loads.
- Dental treatment for staff and patients and oral surgery support for military personnel in the immediate area, plus patients referred by the area CHS units.
- Occupational therapy support.
- Attachment of specialty surgical teams.

(2) *Hospital unit, surgical (HUS).* The HUS provides an increased surgical capability to a HUB. It is organic to a CSH and a GH. As a component of the CSH or the GH, this unit provides—

- Hospitalization for up to 60 patients consisting of five wards providing intensive care nursing.
- Surgical capability based on two ORs for a surgical capacity of 72 OR table hours per day.
- Unit-level CHS, less dental, for organic personnel.



* ALTHOUGH THE HUB HAS 236 BEDS, WHEN IT IS USED AS THE BASE COMPONENT FOR THE FH, IT IS ONLY STAFFED TO PROVIDE HOSPITALIZATION FOR 224 PATIENTS. IN THE FH CONFIGURATION, THE HUB HAS TWO INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 24 PATIENTS. BY CONTRAST, IN THE CSH AND GH CONFIGURATIONS, THE HUB HAS THREE INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 36 PATIENTS. THIS IS THE REASON FOR THE 12-PATIENT DIFFERENCE IN THE FH CONFIGURATION.

Figure 1-2. Component hospital system.

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- Radiology augmentation services for up to 60 patients.
- Medical administrative services.

NOTE

When the HUB and the HUS are employed to form the GH, half of the OR tables are staffed for two 12-hour shifts with the other half only staffed for one 12-hour shift per day.

(3) *Hospital unit, medical (HUM)*. The HUM provides medical augmentation to a HUB. It is assigned to a GH. As a component of the GH, this unit provides—

- Hospitalization for up to 180 patients, consisting of nine wards providing intermediate care nursing.
- Consultation services for outpatients referred from other MTFs.
- Pharmacy, clinical laboratory, and radiology augmentation services for up to 180 patients.
- Physical and occupational therapy augmentation support.

(4) *Hospital unit, holding (HUH)*. The HUH provides hospitalization for patients returning to duty within the prescribed theater evacuation policy. It is assigned to a FH. As a component of the FH, this unit provides—

- Hospitalization for up to 280 patients, consisting of seven patient support sections providing convalescent care.
- Unit-level CHS, less dental, for organic personnel.
- Physical and occupational therapy support to patients.
- Medical administrative and logistical services.

1-4. Hospital Support Requirements

a. In deployment and sustainment of operations, these hospitals are dependent upon appropriate elements of the theater for—

- Personnel administrative services.

- Finance.
 - Mortuary affairs and legal services.
 - Transportation services (the FH is 20 percent mobile and the GH is 10 percent mobile with organic assets).
 - Bath and laundry services.
 - Security and enemy prisoner of war (EPW) security during processing and evacuation.
 - Transportation for discharged patients.
 - Transportation and reequipping (to include individual clothing and equipment, seasonal outer garments, and protection garments) for discharged patients.
 - Class I supplies (rations), to include the Medical B Rations required for patient feeding.
- b.* During deployment and sustainment of operations, engineer support is required for establishment or modification of the FH or GH site and to construct or modify waste disposal areas.
- c.* During sustainment of operations—
- Coordination with and assistance from veterinary service units may be required for zoonotic disease control and investigation; inspection of medical and nonmedical rations, to include suspected contaminated rations and disposition recommendations; inspection and procurement of bottled water for consumption by US forces; and animal bites.
 - Coordination with and assistance from PVNTMED units may be required for food facility inspection, vector control, water production and distribution, field sanitation, wet bulb globe temperatures, and control of medical and nonmedical waste.

1-5. Medical Evacuation and Medical Regulating

a. Definition.

(1) Medical evacuation is the timely, efficient movement and en route care provided by medical personnel of wounded, injured, and ill soldiers from the battlefield or other locations within the TO. Evacuation begins when medical personnel receive the injured or ill soldier and continues as far rearward as the patient's medical condition warrants or the tactical situation allows. The higher echelon is responsible for arranging for the evacuation of patients from the lower echelon of care.

(2) Medical regulating entails identifying the patients awaiting evacuation, locating the available beds, and coordinating the transportation means for movement. Careful control of patient evacuation to appropriate hospitals is necessary to—

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- Effect an even distribution of cases.
- Ensure adequate beds are available for current and anticipated needs.
- Route patients requiring specialized treatment to the appropriate MTF.

b. Theater Evacuation Policy.

(1) The theater evacuation policy is established by the Secretary of Defense with the advice of the Joint Chiefs of Staff and upon the recommendation of the theater commander. The policy establishes, in the number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the TO for treatment. This policy does not mean that a patient is held in the TO for the entire period of noneffectiveness. A patient who is not expected to be ready to RTD within the number of days established in the theater evacuation policy is evacuated to CONUS or some other safe haven. This is done providing that the treating physician determines that such evacuation will not aggravate the patient's disabilities or medical condition.

(2) To the degree that an increase in patients occur which is not planned for (due perhaps to an epidemic or heavy combat casualties), a temporary reduction in the policy may be necessary. This reduction is used to adjust the volume of patients to be held in the TO hospital system. A reduction in the evacuation policy increases the number of patients requiring evacuation out-of-theater, and it increases the requirement for evacuation assets. This action is necessary to relieve the congestion caused by the patient increases. A decrease in the theater evacuation policy decreases the hospitalization requirements.

(3) The time period established in the theater evacuation policy starts on the date the patient is admitted to the first hospital (CZ or COMMZ). The total time a patient is hospitalized in the TO (including transit time between MTFs) for a single, uninterrupted episode of illness or injury should not exceed the number of days stated in the theater evacuation policy. Though guided by the evacuation policy, the actual selection of a patient for evacuation is based on clinical judgement as to the patient's ability to tolerate and survive the movement to the next level of CHS.

1-6. Principles of Combat Health Support

a. Conformity. Conformity with the theater plan is the most fundamental element for effectively providing CHS. Only by participating in the development of this operation plan (OPLAN) can the medical planner ensure adequate CHS at the right time and at the right place.

b. Continuity. Combat health support must be continuous since an interruption of treatment may cause an increase in morbidity and mortality. Procedures are standardized at each organizational level to ensure that all required medical treatment is accomplished. No patient is evacuated any farther to the rear than his physical condition or the military situation requires. In the COMMZ, patients are not evacuated to the CONUS support base if they can be returned to duty within the provisions of the theater evacuation policy.

c. Control. Control of medical resources must rest with the medical commander. Combat health support staff officers must be proactive and keep their commanders apprised of the impact of future operations on CHS assets. The medical commander must ensure that the CHS system is responsive to the requirements of the theater. He must be able to tailor his CHS resources and direct them to focal points of demand throughout the AO. Since CHS resources are limited, it is essential that their control be retained at the highest CHS level consistent with the tactical situation.

d. Proximity. In the CZ, the location of CHS assets in support of combat operations is dictated by the tactical situation (mission, enemy, terrain, troops, and time available [METT-T] factors) and the availability of evacuation resources. In the COMMZ, the hospitals should be located to facilitate access to medical evacuation resources (Army, USAF, and Navy, if available), host-nation (HN) rehabilitation resources (if applicable), and command and control (C2) facilities.

e. Flexibility. A change in tactical plans or operations may require redistribution or relocation of medical resources. No more medical resources should be committed nor MTFs established than are required to support the expected patient densities.

f. Mobility. In the CZ, since contact with supported units must be maintained, CHS elements must have mobility comparable to that of the units they support. Mobility is measured by the extent to which a unit can move its personnel and equipment with organic transportation. When totally committed to patient care, a CHS unit can retain its limited mobility only by immediate patient evacuation. The mobility of the FH and the GH severely limits their ability to relocate assigned personnel and equipment. Transportation support organizations should recognize the relocation requirements for these facilities. The FH and the GH must have contingency plans to affect a move should one be required; they should routinely do those administrative measures that will enhance the facilities' ability to move. For example, all assigned personnel should be up-to-date on required immunizations; load plans are developed, maintained, and updated as necessary to ensure that all necessary equipment and supplies will be included in the move.

1-7. The Medical Threat and Medical Intelligence

a. The medical threat is derived from a variety of informational sources outside the military as well as through formal intelligence channels. In most cases, the incidence and exposure to endemic disease is greater in developing nations. The medical threat is a composite of all ongoing or potential enemy actions and environmental conditions that may render a soldier combat ineffective. The soldier's reduced effectiveness results from sustained wounds and disease and nonbattle injuries (DNBI). Prior to deployment, units should receive a medical threat briefing from PVNTMED personnel outlining the medical threat and appropriate countermeasures. Units should ensure that the field sanitation team is trained, has a copy of the medical threat brief and countermeasures, and has adequate supplies. The elements of the medical threat include, but are not limited to—

- Diseases endemic to the AO (arthropodborne, rodentborne, waterborne, foodborne, and respiratory diseases).
- Environmental factors (heat, cold, humidity, and significant elevations above sea level).

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- Battle injuries from conventional, directed-energy (DE), and nuclear, biological, and chemical (NBC) weapons.

b. In order to develop the CHS estimate and plan, the medical planner obtains updated medical intelligence through intelligence, PVNTMED, and other channels. Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. In the normal course of duty, medical personnel at all echelons obtain medical intelligence information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or AOs and is significant to military planning. Such information should be reported quickly to the supporting intelligence element. Until medical information is appropriately processed (ordinarily on the national level by the Armed Forces Medical Intelligence Center [AFMIC] at Fort Detrick, Maryland), it is not considered to be technical intelligence.

c. For additional information on the medical threat and medical intelligence, refer to FM 8-10, FM 8-10-8, and FM 8-42. The medical planner must utilize the PVNTMED estimate to identify the impact of the medical threat on the deploying force. For information on medical threat countermeasures, contact the US Army Center for Health Promotion and Preventive Medicine (USACHPPM) and refer to FM 8-33, FM 21-10, and FM 21-10-1.

1-8. Planning for Combat Health Support

a. The emerging world situation has resulted in an evolution from a forward deployed army to one capable of projecting combat power worldwide. Our Army is becoming smaller and primarily CONUS-based. For the Army to accomplish the assigned mission, it must rely on its ability to mobilize, deploy, sustain, reconstitute, and redeploy a crisis response force and reinforcing forces, if required. It must be able to project power from CONUS or forward presence locations in response to requirements from the National Command Authorities. To meet the challenge, the AMEDD must be proactive in projecting CHS. Once the mission is assigned, the commander and his staff use the planning process to determine the most effective means to accomplish the mission. This process enables the commander to estimate, analyze, and determine the courses of action to be undertaken. These courses of action are designed to maximize the accomplishment of the mission.

b. Planning at the FH and the GH levels entails preparing plans for a variety of situations, such as—

- Activities to be conducted at the various defense readiness condition (DEFCON) postures.
- Hospital operations conducted in an NBC environment.
- Joint and multinational deployments.
- Relocation of the hospital complex, to include patient disposition.
- Contingency missions (such as humanitarian assistance or disaster relief).

- Mass casualty situations.
- Rear AO support.
- Reinforcement or reconstitution support for forward medical elements.
- Combating terrorism activities.

For a detailed discussion of the planning process for CHS, refer to the remainder of this manual and FM 8-55.

c. To be complete, CHS planning must consider all functional areas within the AMEDD. These functional areas are—

- Patient evacuation and medical regulating. Refer FMs 8-10-6 and 8-55.
- Hospitalization. In addition to this publication, refer to FMs 8-10-14 and 8-55.
- Combat health logistics/blood management. Refer to FMs 8-10-9 and 8-55.
- Medical laboratory services. Refer to FM 8-55.
- Dental services. Refer to FMs 8-10-19 and 8-55.
- Veterinary services. Refer to FMs 8-27 and 8-55.
- Preventive medicine services. Refer to FMs 8-55, 21-10, and 21-10-1.
- Combat stress control. Refer to FMs 8-51, 8-55 and 22-51.
- Area medical support. Refer to FMs 8-10-24 and 8-55.
- Command, control, communications, computers, and intelligence (C4I). In addition to this manual, refer to FMs 8-55 and 11-55.

CHAPTER 2

THE FIELD HOSPITAL**2-1. Mission and Allocation**

The primary mission of this hospital is to provide reconditioning and rehabilitation for those patients who will be able to RTD within the prescribed theater evacuation policy. The FH will normally be located in the COMMZ but could be used in the corps when geographical operations constraints dictate. It has a basis of allocation of two FHs per division supported or 1.462 per 1,000 admitted patients in the COMMZ.

2-2. Assignment and Capabilities

a. The FH is assigned to the Headquarters and Headquarters Company (HHC), MEDCOM, TOE 08611L000. The hospital may be further attached to the HHC, Medical Brigade, TOE 08422L000.

b. This facility provides hospitalization for up to 504 patients. The majority of patients within this facility will be in the convalescent care category. Patients will be received from the CZ (by theater evacuation assets), the COMMZ, and other MTFs within the COMMZ.

c. Surgical capacity is based on one OR (two operating tables) for a surgical capacity of 24 OR table hours per day.

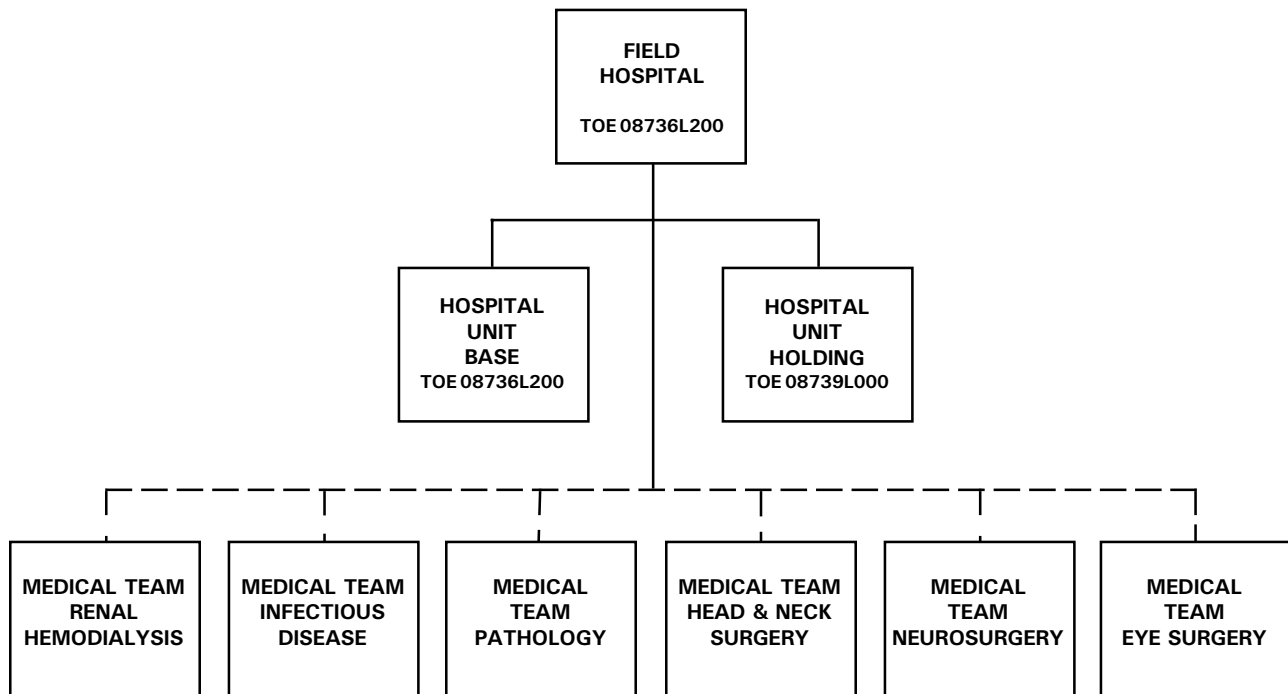
d. Other capabilities include—

- Consultation services for patients referred from other MTFs.
- Unit-level CHS for organic personnel only.
- Pharmacy, clinical laboratory, blood banking, radiology, and nutrition care services.
- Physical and occupational therapy support to patients.
- Medical administrative and logistical services to support work loads.
- Dental treatment to staff and patients and oral surgery support for military personnel in the immediate area, plus patients referred by area CHS units.
- Augmentation and reconstitution of other hospitals.

2-3. Hospital Organization and Functions

The hospital includes a 224-bed HUB and a 280-bed HUH. Collectively, this modular-designed hospital has two wards providing intensive nursing care for up to 24 patients, seven wards providing intermediate nursing care for up to 140 patients, one ward providing NP care for up to 20 patients, two wards providing minimal nursing care for up to 40 patients, and seven patient support sections providing convalescent care for up to

280 patients. The FH is not a surgical-intensive facility. It has one OR in the HUB instead of the four ORs organic to the GH. This hospital is more of a convalescent facility for those RTD patients within the theater. Figures 2-1, 2-2, and 2-3 show the FH organization.



NOTE: DEPENDING UPON OPERATIONAL REQUIREMENTS, THE MEDICAL AND SURGICAL TEAMS MAY OR MAY NOT BE ATTACHED TO THE INDIVIDUAL CLINICAL ELEMENT OF THE FH.

Figure 2-1. Field hospital organization (TOE 08715L000).

2-4. The Hospital Unit, Base

The HUB is an independent organization which includes all hospital services. It provides a solid infrastructure for FH operations. The HUB contains the following sections:

a. *Hospital Headquarters Section.* This section provides internal C2 and management of all hospital services. Personnel of this section supervise and coordinate the surgical, nursing, medical, pastoral, and administrative services. Staffing includes the HUB commander, a chief nurse, a chaplain, chiefs of surgery and medicine, an executive officer (XO), a command sergeant major (CSM), and an administrative specialist (Table 2-1, page 2-4). When the HUB and the HUH join to function as a FH, the HUB commander is the FH commander unless otherwise designated.

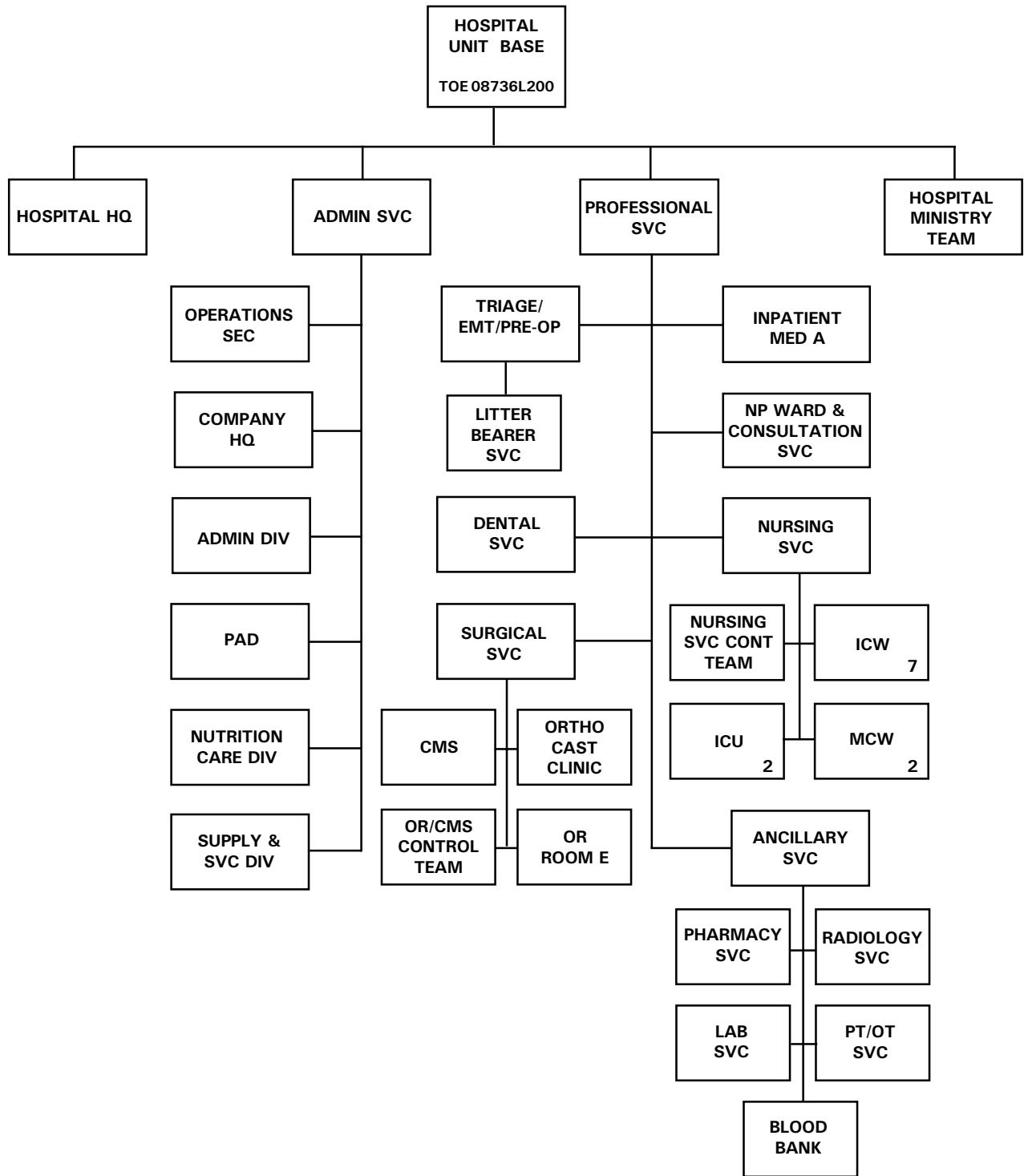


Figure 2-2. Hospital unit, base (TOE 08736L200).

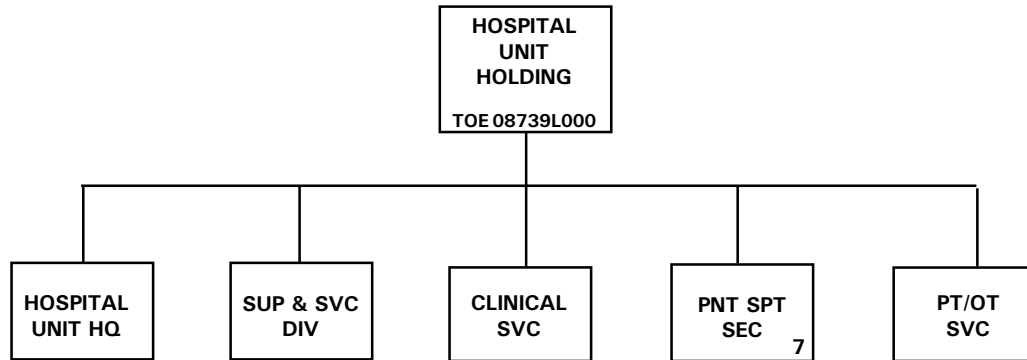


Figure 2-3. Hospital unit, holding (TOE 08739L000).

Table 2-1. Hospital Headquarters Organization

HOSPITAL HEADQUARTERS			
HOSPITAL COMMANDER	COL	60A00	MC
CHIEF, NURSING SERVICE	COL	66N00	AN
HOSPITAL CHAPLAIN	LTC	56A00	CH
CHIEF, MEDICAL SERVICE	LTC	61F00	MC
CHIEF, SURGICAL SERVICE	LTC	61J00	MC
EXECUTIVE OFFICER	LTC	67A00	MS
COMMAND SERGEANT MAJOR	CSM	00Z50	NC
ADMINISTRATIVE SPECIALIST	SGT	71L20	NC

(1) *Hospital commander (60A00)*. Command and control is the process through which the activities of the hospital are directed, coordinated, and controlled to accomplish the mission. This process begins and ends with the commander. An effective commander must have a thorough knowledge and understanding of planning and implementing CHS (FM 8-55). He is decisive and provides specific guidance to his staff in the execution of the mission. The successful commander delegates authority and fosters an organizational climate of mutual trust, cooperation, and teamwork. He has the overall responsibility for coordination of CHS within the hospital's AO. Additionally, he is responsible for the structural layout of the hospital. He establishes and promotes safety, preventive medicine, and occupational health directives and policies to protect personnel and equipment under his command. The hospital commander will designate personnel for staffing functions not identified in the TOE. These staffing positions include but are not limited to the following: Chief, Professional Services and Chief, Ancillary Services.

(2) *Chief, nursing service (66N00)*. The chief nurse is the principal adviser to the hospital commander for nursing activities. This officer plans, organizes, supervises, and directs nursing care practices and activities of the hospital. This officer is also responsible for the orientation and professional development programs for the nursing staff.

(3) *Hospital chaplain (56A00)*. The chaplain functions as the staff officer for all matters in which religion impacts on command programs, personnel, policy, and procedures. He provides for the spiritual well-being and morale of patients and hospital personnel. He also provides religious services and pastoral counseling to soldiers in the AO.

(4) *Chief, medical service (61F00)*. This officer is responsible for the examination, diagnosis, and treatment, or recommended course of management for patients with medical illnesses. He controls the length of patient stay through continuous patient evaluation, early determination of disposition, or evacuation to the next echelon of care.

(5) *Chief, surgical service (61J00)*. The chief surgeon is the principal adviser to the hospital commander for surgical activities. He provides supervision and control over the surgical service to include the ORs. He prescribes courses of treatment and surgery for patients having injuries or disorders with surgical conditions and participates in surgical procedures as required. He coordinates and is responsible for all matters pertaining to the evaluation, management, and disposition of patients received by the section. He is responsible for the evaluation and training programs for his professional staff. He also functions as the Deputy Commander for Professional Services.

(6) *Executive officer (67A00)*. The hospital XO advises the commander on matters pertaining to health care delivery. He plans, directs, and coordinates administrative activities for the hospital. He provides guidance to the tactical operations center (TOC) staff in planning for future operations. He also functions as the Chief, Administrative Service.

(7) *Command sergeant major (00Z50)*. The CSM is the principal enlisted representative to the commander. He advises the commander and his staff on all matters pertaining to the welfare and morale of enlisted personnel in terms of assignment, reassignment, promotion, and discipline. The CSM provides counsel and guidance to NCOs and other enlisted personnel of the hospital. He is also responsible for the reception of newly assigned enlisted personnel into the unit. The CSM evaluates the implementation of individual soldier training on common soldier tasks and supervises the hospital's NCO professional development.

(8) *Administrative specialist (71L20)*. The administrative specialist performs typing, clerical, and administrative duties for the hospital headquarters. He proofreads correspondence for proper spelling, grammar, punctuation, format, and content accuracy. He establishes and maintains files, logs, and other statistical information for the command. He is the light-vehicle driver and radio operator for the command section.

b. Hospital Operations Section. This section is responsible for security, plans and operations, deployment, and relocation of the hospital. This section is also responsible for coordinating communication

support requirements with the supporting signal element. The staff is composed of an operations officer, a plans officer, an operations NCO, an NBC NCO, and appropriate communications MOSs (Table 2-2).

Table 2-2. Hospital Operations Section Organization

HOSPITAL OPERATIONS SECTION			
MEDICAL OPERATIONS OFFICER	MAJ	70H67	MS
FIELD MEDICAL ASSISTANT	CPT	70B67	MS
SECTION CHIEF	SFC	31U40	NC
OPERATIONS SERGEANT	SFC	91B40	NC
NUCLEAR, BIOLOGICAL, AND CHEMICAL NCO	SFC	54B40	NC
SENIOR RADIO OPERATOR	SGT	31C20	NC
SENIOR SWITCH SYSTEMS OPERATOR/MAINTAINER	SGT	31F20	NC
SINGLE-CHANNEL RADIO OPERATOR	SPC	31C10	
SWITCH SYSTEMS OPERATOR/MAINTAINER	SPC	31F10	
SIGNAL INFORMATION SERVICE SPECIALIST	SPC	31U10	
ADMINISTRATIVE SPECIALIST	SPC	71L10	
SINGLE-CHANNEL RADIO OPERATOR	PFC	31C10	
SWITCH SYSTEMS OPERATOR/MAINTAINER	PFC	31F10	
SIGNAL SUPPORT SYSTEMS SPECIALIST	PFC	31U10	

(1) *Medical operations officer (70H67)*. This officer is responsible to the XO for the Intelligence Officer (US Army) (S2)/Operations and Training Officer (US Army) (S3) functions of the hospital. He supervises all tactical operations conducted by the hospital, to include planning and relocation. He coordinates with the chief wardmaster and the utility operations and maintenance technician in the development of the hospital layout and submits recommendations to the hospital commander for approval. He is responsible for the formulation of the tactical standing operating procedure (TSOP) and the hospital planning factors (refer to Appendix A for an example of a TSOP format and Appendix B for an estimate of hospital planning factors).

(2) *Field medical assistant (70B67)*. This officer is responsible to the medical operations officer for planning and coordinating site selection and convoy operations during hospital deployment and

relocation. He also functions as the operations security (OPSEC) and communications security (COMSEC) officer for the hospital. This position is accounted for by the field medical assistant (CPT, 70B67) in the HUH unit headquarters (paragraph 2-5a[3]) and is not included in the total authorizations for the hospital operations section. The HUH officer becomes the plans officer for the hospital operations section when the HUB and the HUH join to function as a FH.

(3) *Section chief (3IU40)*. This NCO serves as the principal signal adviser to the hospital commander and medical operations officer on all communications matters. He is responsible to the medical operations officer and the field medical assistant for planning, supervising, coordinating, and providing technical assistance in the installation, operation, management, and operator-level maintenance of radio, field wire, and switchboard communications systems. He supervises all subordinate communications personnel.

(4) *Operations sergeant (9IB40)*. The operations sergeant is responsible to the medical operations officer for physical security, to include the hospital defense plan; preparation of unit plans, operation orders (OPORDs), and map overlays; and intelligence information and records. He also supervises the subordinate staff.

(5) *Nuclear, biological, and chemical noncommissioned officer (54B40)*. This NCO is the technical adviser to the hospital commander and operations officer on matters pertaining to NBC operations. He is responsible to the medical operations officer for planning, training, NBC decontamination (less patient), and other aspects of hospital NBC defensive operations.

(6) *Senior radio operator/maintainer (3IC20)*. This individual is responsible to the section chief for the installation and operation of unit wire systems, associated equipment, and frequency-modulated (FM) radios.

(7) *Senior switch systems operator/maintainer (3IF20)*. This individual is responsible to the section chief for the installation, operation, and unit-level maintenance of switchboards and switching systems.

(8) *Radio operator/maintainer (3IC10)*. These radio operators are responsible to the senior radio operator/maintainer for the installation, operation, and unit-level maintenance on single-channel radios, radio teletypewriters, and associated equipment.

(9) *Switch systems operator/maintainer (3IF10)*. These operators are responsible to the senior switch systems operator/maintainer for the installation, operation, and unit-level maintenance on switchboards, switching assemblages, and associated communications equipment.

(10) *Signal support system specialist (3IU10)*. This individual is responsible to the signal section chief for troubleshooting and assisting in the installation of wire for field telephones. He also provides technical assistance to the operators of the hospital FM radios and performs unit-level maintenance on this equipment. He is the designated light-vehicle driver for the section.

(11) *Administrative specialist (7IL10)*. This individual is responsible to the operations sergeant for general typing and administrative functions for the section.

(12) *Signal support systems specialist (3IU10)*. This individual is responsible to the signal section chief for installing wire for field telephones and assisting in the operation of the hospital FM radios.

c. *Company Headquarters*. This section is responsible for company-level command, duty rosters, weapons control, and general supply support. Staffing includes the company headquarters commander, the first sergeant, an armorer, and an administrative clerk (Table 2-3).

Table 2-3. *Company Headquarters Organization*

COMPANY HEADQUARTERS			
COMPANY COMMANDER	CPT	70B67	MS
FIRST SERGEANT	MSG	91B5M	NC
ARMORER	SPC	92Y10	
ADMINISTRATIVE CLERK	SPC	71L10	

(1) *Company commander (70B67)*. The company commander is responsible to the hospital commander for all activities in the company headquarters. He administers Uniform Code of Military Justice (UCMJ) actions for enlisted personnel. Additionally, he is responsible for planning and conducting common task training. When the HUB and the HUH join to function as a FH, this officer functions as the commander of the medical holding detachment.

(2) *First sergeant (91B5M)*. The first sergeant is responsible to the company commander for enlisted matters. He also assists in supervising company administration and training activities. He provides guidance to the enlisted members of the company and represents them to the company commander. He also functions as the retention NCO.

(3) *Armorer (92Y10)*. The armorer’s primary duty is that of maintaining the weapons storage area, issuing and receiving small arms and ammunition, and performing small arms unit maintenance.

(4) *Administrative clerk (71L10)*. The administrative clerk is responsible to the first sergeant for providing personnel and unit administration support for the company headquarters. His duties consist of general administration and personnel actions.

d. *Administrative Division*. This division provides overall administrative services for the hospital, to include personnel administration, mail distribution, awards and decorations, leaves, and typing support. The staff is composed of the hospital adjutant, a personnel sergeant, legal specialists, an administrative specialist, personnel administrative specialists, mail delivery clerks, an administrative clerk, and a personnel administrative clerk (Table 2-4). This section coordinates with elements of Theater Army Area Command (TAACOM) for finance, personnel, and administrative services.

Table 2-4. Administrative Division Organization

ADMINISTRATIVE DIVISION			
HOSPITAL ADJUTANT	CPT	70F67	MS
PERSONNEL SERGEANT	SFC	75Z40	NC
LEGAL SPECIALIST	SPC	71D10	(2)
ADMINISTRATIVE SPECIALIST	SPC	71L10	
PERSONNEL ADMINISTRATIVE SPECIALIST	SPC	75B10	(2)
MAIL DELIVERY CLERK	PFC	71L10	(3)
ADMINISTRATIVE CLERK	PFC	71L10	
PERSONNEL ADMINISTRATIVE CLERK	PFC	75B10	

(1) *Hospital adjutant (70F67)*. This officer is responsible to the Chief, Administrative Service for the adjutant functions within the hospital. He also advises the commander and his staff in the area of personnel management for patients and staff.

(2) *Personnel sergeant (75Z40)*. The personnel sergeant is responsible to the adjutant for specific personnel functions which include personnel management, records, actions, and preparation of Standard Installation/Division Personnel System (SIDPERS) changes. He ensures coordination between the MEDCOM and/or medical brigade Personnel and Administration Center (PAC) and the hospital. He advises the hospital commander, adjutant, and other staff members on personnel administrative matters. He also supervises the activities of subordinate personnel.

(3) *Legal specialists (71D10)*. These specialists perform duties associated with court-martial proceedings, line-of-duty investigations, board proceedings, claims investigation, and other military justice and legal assistance matters for the hospital.

(4) *Administrative specialist (71L10)*. This specialist is responsible to the personnel sergeant for general typing and administrative functions for the division.

(5) *Personnel administrative specialists (75B10)*. These individuals are responsible to the personnel sergeant for personnel and administrative functions for the hospital. They prepare all SIDPERS transactions and associated reports.

(6) *Mail delivery clerks (71L10)*. These mail delivery clerks are responsible to the personnel sergeant for establishing and operating the unit mail room. They also assist the personnel sergeant with personnel and clerical duties. They are the designated light-vehicle operators for the division.

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(7) *Administrative clerk (71L10)*. This clerk is responsible to the personnel sergeant for general typing and administrative functions for the division. He maintains the functional files for the division.

(8) *Personnel administrative clerk (75B10)*. This individual works in unison with the personnel administrative specialists.

e. Patient Administration Division. This division is responsible for patient accountability, medical records management, release of medical information, security of patient baggage and valuables, medical regulation, patient evacuation, decedent affairs, operation of Theater Army Medical Management Information System (TAMMIS) for the Medical Patient Accounting and Reporting (MEDPAR) System and for the Medical Regulating (MEDREG) System, and medical statistical reporting. The staff is composed of the patient administration officer, NCOs, and specialists (Table 2-5).

Table 2-5. Patient Administration Division Organization

PATIENT ADMINISTRATION DIVISION			
PATIENT ADMINISTRATION OFFICER	CPT	70E67	MS
PATIENT ADMINISTRATION NCO	SSG	71G30	NC
PATIENT ADMINISTRATION NCO	SGT	71G20	NC
PATIENT ADMINISTRATION SPECIALIST	SPC	71G10	
PATIENT ADMINISTRATION SPECIALIST	PFC	71G10	

(1) *Patient administration officer (70E67)*. This officer is responsible to the hospital XO for planning, organizing, directing, and controlling the patient administration aspects of the hospital. He advises the commander on patient administration matters. He maintains close liaison with the chiefs of services, attending physicians, and chiefs of administrative sections and offices to ensure timely decisions on patient administration matters.

(2) *Patient administration noncommissioned officer (71G30)*. This NCO is responsible to the patient administration officer for patient administration and disposition procedures, inpatient records, and security of patients' personal effects. He works in concert with the supply sergeant to coordinate the return of the soldier to the replacement company. He also supervises the application of the TAMMIS for the MEDPAR System and for the MEDREG System.

(3) *Patient administration noncommissioned officer (71G20)*. This NCO is responsible to the patient administration NCO for implementing the TAMMIS-MEDPAR and TAMMIS-MEDREG for the hospital. He processes correspondence received for admissions and dispositions, medical regulating, decedent affairs, and medical information. This NCO also assists in supervising subordinate specialists.

(4) *Patient administration specialists (71G10)*. These specialists are responsible for processing all admissions and dispositions, operating TAMMIS equipment, managing medical records, preparing statistical reports, conducting decedent operations, securing patient baggage and valuables, and preparing patients for evacuation.

f. *Nutrition Care Division*. This division is responsible for providing hospital nutrition services; meal preparation and distribution to patients and staff; dietetic planning; and supervision and control of overall operations. The hospital staff will be fed in accordance with (IAW) the theater ration policy. The field medical feeding standard for hospitals is to prepare three hot meals per day plus nourishments and supplemental fluids using Medical B, A, or T Rations. Meals, ready to eat (MRE) are not authorized for patient use. Rations will be obtained from the supporting TAACOM element. Patient meals, nourishments, and forced fluids will be distributed to the wards three times per day; tube feedings are provided intermittently as patient’s nutritional needs require. (Refer to FM 8-505, Technical Manual [TM] 8-500, and Appendix B of this manual.) The staff is composed of dietitians, hospital food service NCOs, and hospital food service specialists (Table 2-6).

Table 2-6. *Nutrition Care Division Organization*

NUTRITION CARE DIVISION			
CHIEF, NUTRITION CARE DIVISION	MAJ	65C00	SP
DIETITIAN	CPT	65C00	SP
HOSPITAL FOOD SERVICE NCO	SFC	91M40	NC
HOSPITAL FOOD SERVICE NCO	SSG	91M30	NC
HOSPITAL FOOD SERVICE NCO	SGT	91M20	NC (6)
HOSPITAL FOOD SERVICE SPECIALIST	SPC	91M10	(10)
HOSPITAL FOOD SERVICE SPECIALIST	PFC	91M10	(10)

(1) *Chief, Nutrition Care Division (65C00, ASI 8I)*. This officer is responsible to the Chief, Administrative Service for the operation of this division. He directs and supervises the operation of nutrition care services. This officer holds the ASI 8I, clinical nutrition specialist.

(2) *Dietitian (65C00, ASI 8I)*. This officer is responsible to the Chief, Nutrition Care Division for formulating policies, developing procedures, and assisting in supervising the operation of nutrition care. This officer also assists physicians in dietary management of patients. This officer holds the ASI 8I, clinical nutrition specialist.

(3) *Hospital food service noncommissioned officer (91M40)*. This NCO serves as the principal NCO for the Nutrition Care Division. He is responsible to the chief of the division for the implementation of policies and procedures and for supervision and training of subordinate personnel.

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(4) *Hospital food service noncommissioned officer (91M30)*. This NCO is responsible to and serves as an assistant to the principal NCO in nutrition care operations. He implements and directs contingency and combat feeding plans.

(5) *Hospital food service noncommissioned officers (91M20)*. These sergeants are responsible to the principal NCO and assist with the clinical and administrative management of nutritional care programs.

(6) *Hospital food service specialists (91M10)*. These hospital food service specialists are responsible to the hospital food service NCOs for performing basic clinical dietetic functions in the dietary management and treatment of patients. They prepare, cook, and serve regular and modified food. They also perform light-vehicle operator/driver duties for the division, to include operator maintenance.

g. Supply and Service Division. This division provides logistics functions throughout the hospital, to include general and medical supplies and maintenance; blood management (see Appendix B); utilities such as water distribution, waste disposal, and environmental control of patient treatment areas; power and vehicle maintenance; equipment records and repair parts; fuel distribution; and transportation, to include ground and the coordination of air movement operations. The supply and services division requests resupply from the supporting medical logistics (MEDLOG) battalion (rear) and TAACOM area support groups (ASGs) using whatever communication links are available and compatible with the TAMMIS-Medical Supply (MEDSUP). Medical logistics and medical maintenance will be managed utilizing TAMMIS-MEDSUP and TAMMIS-Medical Maintenance (MEDMNT). This division coordinates with TAACOM elements for materiel handling equipment (MHE) capable of moving Deployable Medical Systems (DEPMEDS) equipment, environmental control units, and power-distribution equipment for the hospital. This section coordinates with elements of the TAACOM ASGs and Theater Army Movement Control Agency (TAMCA) for movement control, nonmedical supplies and equipment, and field services. This section will ensure each RTD soldier has or is issued one basic serviceable uniform and will also coordinate with the TAACOM and Theater Army Personnel Command (PERSCOM) for the transportation of these soldiers to the replacement companies. Table 2-7 lists the staffing for this division.

Table 2-7. Supply and Service Division Organization

SUPPLY AND SERVICE DIVISION			
HEALTH SERVICE MATERIEL OFFICER	MAJ	70K67	MS
HEALTH SERVICE MATERIEL OFFICER	CPT	70K67	MS
UTILITY OPERATIONS AND MAINTENANCE TECHNICIAN	W2	210A0	WO
UNIT MAINTENANCE OFFICER	W2	670A0	WO
MEDICAL SUPPLY SERGEANT	MSG	76J50	NC

Table 2-7. Supply and Service Division Organization (Continued)

SUPPLY AND SERVICE DIVISION				
MOTOR SERGEANT	SFC	63B40	NC	
SENIOR UTILITIES EQUIPMENT REPAIRER	SSG	52C30	NC	
STOCK CONTROL SUPERVISOR	SSG	76J30	NC	
MEDICAL STORAGE SUPERVISOR	SSG	76J30	NC	
SUPPLY SERGEANT	SSG	92Y30	NC	
UTILITIES EQUIPMENT REPAIRER	SGT	52C20	NC	
LIGHT-WHEELED VEHICLE MECHANIC	SGT	63B20	NC	
MEDICAL SUPPLY SERGEANT	SGT	76J20	NC	(3)
MEDICAL EQUIPMENT REPAIRER SERGEANT	SGT	91A20	NC	
EQUIPMENT RECEIVER/PARTS SPECIALIST	SGT	92A20	NC	
UTILITIES EQUIPMENT REPAIRER	SPC	52C10		
POWER-GENERATOR EQUIPMENT REPAIRER	SPC	52D10		
LIGHT-WHEELED VEHICLE MECHANIC	SPC	63B10		
QUARTERMASTER AND CHEMICAL EQUIPMENT REPAIRER	SPC	63J10		
MEDICAL SUPPLY SPECIALIST	SPC	76J10		(7)
PETROLEUM LIGHT-VEHICLE OPERATOR	SPC	77F10		
MEDICAL EQUIPMENT REPAIRER	SPC	91A10		
SUPPLY SPECIALIST	SPC	92Y10		
UTILITIES EQUIPMENT REPAIRER	PFC	52C10		(2)
POWER-GENERATOR EQUIPMENT REPAIRER	PFC	52D10		
LIGHT-WHEELED VEHICLE MECHANIC	PFC	63B10		
MEDICAL SUPPLY SPECIALIST	PFC	76J10		(7)
PETROLEUM LIGHT-VEHICLE OPERATOR	PFC	77F10		(2)
EQUIPMENT RECEIVER/PARTS SPECIALIST	PFC	92A10		
SUPPLY SPECIALIST	PFC	92Y10		

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(1) *Health service materiel officer (70K67)*. This officer is responsible to the XO. He plans, coordinates, and manages the entire logistics system for the hospital. Additionally, he controls and manages the budget for the hospital commander. He is also responsible for hospital field waste and safety procedures (refer to Appendixes C and D for examples of programs). He functions as the Chief, Supply and Service Division.

(2) *Health service materiel officer (70K67)*. This officer is responsible to the Chief, Supply and Service Division. He has primary responsibility for the medical supply area and functions as the supply officer for the hospital. This officer is also responsible for managing the controlled substances stored by the medical supply section.

(3) *Utility operations and maintenance technician (210A0)*. This warrant officer is responsible to the Chief, Supply and Service Division. He advises the command on the status, maintenance, and repairs of power-generator equipment. He supervises organizational maintenance of wheeled vehicles, associated support equipment, and power-generation equipment. He is responsible for the preparation of log books, maintenance records, and associated reports. He coordinates with the Hospital Operations Section in the planning of the hospital layout.

(4) *Unit maintenance officer (670A0)*. This warrant officer is responsible to the Chief, Supply and Service Division. He supervises and assists in the installation and maintenance of hospital equipment. He serves as the technical consultant to all members of the hospital staff on medical maintenance matters. He also performs scheduled (preventive maintenance) and unscheduled (repair) services on medical and related equipment within his scope of responsibility. He supervises the operation of TAMMIS-MEDMNT.

(5) *Medical supply sergeant (76J50)*. This NCO assists the Chief, Supply and Service Division in the supervision of personnel, to include medical supply operations, stock control, and medical assemblage management. He is responsible for the development and preparation of plans, maps, overlays, sketches, and other administrative procedures related to employment of the Supply and Service Division.

(6) *Motor sergeant (63B40)*. This NCO is responsible to the utility operations and maintenance technician for unit maintenance on wheeled vehicles and MHE and the upkeep of hand and power tools. He supervises, trains, advises, and inspects subordinate personnel in the use of The Army Maintenance Management System (TAMMS), prescribed load list (PLL), and automated systems output. He is also responsible for supervising the training and licensing of vehicle and equipment operators and ensuring their skills qualification.

(7) *Senior utilities equipment repairer (52C30)*. This NCO is responsible to the utility operations and maintenance officer for supervising and performing unit maintenance of utility equipment. He inspects the installation and condition of power-generation and distribution equipment systems.

(8) *Stock control supervisor (76J30)*. This NCO is responsible to the health service materiel officer (Captain [CPT]) for stock and inventory management of Class VIII supplies. He conducts periodic

and special inventories, updating inventory records accordingly. He operates the TMMIS-MEDSUP for the hospital. He supervises the medical supply sergeants (76J20) and medical supply specialists (76J10) as assigned to him by the health service materiel officer of his duty section.

(9) *Medical storage supervisor (76J30)*. This NCO is responsible to the health service materiel officer (CPT) for supervising and planning hospital storage activities. He prepares and updates the warehouse planographs. He supervises the medical supply sergeants (76J20) and medical supply specialists (76J10) as assigned to him by the health service materiel officer of his duty section.

(10) *Supply sergeant (92Y30)*. The supply sergeant is responsible to the health service materiel officer (CPT) for the requisitioning, accountability, and issuing of general supplies and equipment for the hospital. He keeps the property book for the hospital on the Tactical Army CSS Computer System (TACCS), using the Standard Property Book System-Revised (SPBS-R). He works in concert with the Patient Administration Division (PAD) and requests those minimum essential uniform items required (to include mission-oriented protective posture [MOPP] gear, if required) for RTD soldiers while in transit to the replacement company. He coordinates through PAD to the replacement company for transportation of RTD soldiers. The supply sergeant supervises the activities of the supply specialists (92Y10).

(11) *Utilities equipment repairer (52C20)*. This NCO is responsible to the senior utilities equipment repairer for repair and maintenance of utilities-type equipment. He installs heating, refrigeration, and air-conditioning equipment. He is also a light-vehicle operator for the section.

(12) *Light-wheeled vehicle mechanic (63B20)*. This mechanic is responsible to the motor sergeant for those mechanical duties within his scope of responsibility. He also performs driver/operator duties.

(13) *Medical supply sergeant (76J20)*. These NCOs perform medical supply duties and are responsible to section medical supply sergeant (76J30) to which they are assigned. These NCOs assist their section sergeant in supervising the lower grade medical supply specialists.

(14) *Medical equipment repairer sergeant (91A20)*. This NCO is responsible to the unit maintenance officer for performing and supervising hospital medical maintenance operations. He is responsible for interpreting technical publications that apply to inspection, troubleshooting, maintenance, repair, calibration, and testing of medical equipment. He supervises subordinate medical equipment repairers.

(15) *Equipment receiver/parts specialist (92A20)*. This soldier is responsible to the utility operations and maintenance technician for maintaining equipment records and repair parts lists and for performing maintenance control duties. He also performs driver/operator duties.

(16) *Utilities equipment repairers (52C10)*. These repairers are responsible to the senior utilities equipment repairer for unit maintenance of refrigeration equipment, air-conditioning units, and gasoline engines used as prime movers of refrigeration units. They also perform vehicle operator duties.

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(17) *Power-generator equipment repairer (52D10)*. This specialist is responsible to the senior utilities equipment repairer for performing unit-level maintenance functions on power-generation equipment and associated items. He also supervises the subordinate power-generator equipment repairer.

(18) *Light-wheeled vehicle mechanic (63B10)*. This specialist is responsible to the light-wheeled vehicle mechanic NCO for performing his designated duties.

(19) *Quartermaster and chemical equipment repairer (63J10)*. This specialist is responsible to the senior utilities equipment repairer for troubleshooting and repairing quartermaster and chemical equipment malfunctions.

(20) *Medical supply specialists (76J10)*. These specialists are responsible to the section NCO (76J30) to which they are assigned. Assignment of these medical supply specialists to the stock control or medical storage section will be as determined by the Chief, Supply and Service Division and the medical supply sergeant (76J50). These medical supply specialists also perform vehicle operator duties.

(21) *Petroleum light-vehicle operator (77F10)*. This petroleum light-vehicle operator is responsible to the motor sergeant. He receives, stores, accounts and cares for, dispenses, issues, and ships bulk and packaged petroleum, oil, and lubricant (POL) supplies. He also operates and maintains the petroleum vehicle.

(22) *Medical equipment repairer (91A10)*. This repairer is responsible to the medical equipment repairer/supervisor for performing unit-level maintenance on assigned medical equipment. He also assists in training equipment operators in the performance of operator-level preventive maintenance checks and services (PMCS).

(23) *Supply specialist (92Y10)*. This supply specialist assists the supply sergeant in the accomplishment of his duties.

(24) *Utilities equipment repairers (52C10)*. These repairers are responsible to the senior utilities equipment repairer for unit maintenance of refrigeration equipment, air-conditioning units, and gasoline engines used as prime movers of refrigeration units. They also perform vehicle operator duties.

(25) *Power-generator equipment repairer (52D10)*. This equipment repairer is responsible to the power-generator equipment repairer NCO for operator and unit maintenance of tactical-utility and power-generation equipment and associated items.

(26) *Light-wheeled vehicle mechanic (63B10)*. This specialist is responsible to the motor sergeant for performing his designated duties. He also performs vehicle operator duties.

(27) *Petroleum light-vehicle operators (77F10)*. These petroleum specialists are responsible to the motor sergeant. They receive, store, account and care for, dispense, issue, and ship bulk and packaged POL supplies. They also operate and maintain the petroleum vehicles.

(28) *Equipment receiver/parts specialist (92A10)*. This specialist is responsible to the senior utilities equipment repairer for maintaining equipment records and repair parts lists and for performing maintenance control duties.

(29) *Supply specialist (92Y10)*. This supply specialist assists the supply sergeant in the accomplishment of his duties.

h. Nursing Service Control Team. This team is responsible to the Chief, Nursing Service for supervision of all nursing service personnel regardless of organizational placement. This team also provides daily patient reports to the chief nurse and PAD and is responsible for the standards of nursing practice and nursing care throughout the facility. The staff to provide this control are the assistant chief nurse, chief and assistant chief wardmasters, and a respiratory NCO (Table 2-8).

Table 2-8. *Nursing Service Control Team Organization*

NURSING SERVICE CONTROL TEAM			
ASSISTANT CHIEF NURSE	LTC	66N00	AN
CHIEF WARDMASTER	MSG	91C50	NC
ASSISTANT CHIEF WARDMASTER	SFC	91C40	NC (2)
RESPIRATORY NCO	SFC	91V40	NC

(1) *Assistant chief nurse (66N00)*. The assistant chief nurse works in concert with the Chief, Nursing Service. This nurse plans, organizes, executes, and directs nursing care practices for the hospital.

(2) *Chief wardmaster (91C50)*. This master sergeant (MSG) manages and supervises enlisted personnel and assists in the planning and operation of the nursing service. He coordinates with the operations section in planning the hospital layout. He is responsible to the chief nurse for the erection of the hospital clinical facilities.

(3) *Assistant chief wardmasters (91C40)*. These NCOs assist the chief wardmaster in supervising enlisted personnel and in the operation of the nursing service.

(4) *Respiratory noncommissioned officer (91V40)*. Under the technical guidance of a physician, this NCO supervises respiratory activities within the nursing service.

i. Triage/Preoperative/Emergency Medical Treatment Section. This section provides for the receiving, triaging, and stabilizing of incoming patients. The staff will receive patients, assess their medical condition, provide EMT, and transfer them to the appropriate areas of the hospital. The staff monitors

patient conditions and prepares those requiring immediate surgery for the OR. Sick call for organic staff is conducted by this section. Table 2-9 lists the staffing for this section.

Table 2-9. Triage/Preoperative/Emergency Medical Treatment Section Organization

TRIAGE/PREOPERATIVE/EMERGENCY MEDICAL TREATMENT			
EMERGENCY PHYSICIAN	MAJ	62A00	MC
HEAD NURSE	MAJ	66H00	AN
PRIMARY CARE PHYSICIAN	CPT	61H00	MC
EMERGENCY PHYSICIAN	CPT	62A00	MC
MEDICAL-SURGICAL NURSE	CPT	66H00	AN (2)
MEDICAL-SURGICAL NURSE	LT	66H00	AN
EMERGENCY TREATMENT NCO	SFC	91B40	NC
EMERGENCY TREATMENT NCO	SSG	91B30	NC (2)
EMERGENCY TREATMENT NCO	SGT	91B20	NC (3)
MEDICAL SPECIALIST	SGT	91B20	NC
MEDICAL SPECIALIST	SPC	91B10	(2)
MEDICAL SPECIALIST	PFC	91B10	(3)

(1) *Emergency physician (62A00)*. This physician is responsible to the Chief, Professional Services (or the designated chief of emergency medical services) for management and operations of this section. He examines, diagnoses, and treats or prescribes courses of treatment for the initial phase of diseases and injuries. This officer is the physician primarily responsible for triage.

(2) *Head nurse (66H00)*. This nurse manages the operations of the triage/preoperative/EMT section, to include staffing and supervising nursing personnel and developing nursing policies and procedures. He is also responsible for the standard of nursing care provided and assists in providing patient care.

(3) *Primary care physician (61H00)*. This physician provides care to patients in the areas of general medicine, obstetrics/gynecology (OB/GYN), psychiatry, PVNTMED, pediatrics, and orthopedics. When the EMT/surgical patient load is heavy, this officer can assume the duties of triage and preoperative evaluation/care. This physician is advanced trauma life support trained.

(4) *Emergency physician (62A00)*. This physician examines, diagnoses, and treats or prescribes course of treatment for the initial phase of disease and for injuries.

(5) *Medical-surgical nurses (66H00)*. These nurses plan and implement nursing care under the supervision of the head nurse. They provide direct supervision to subordinate nursing service personnel.

(6) *Emergency treatment noncommissioned officer (91B40)*. This NCO is responsible to the senior nurse. He manages and supervises the enlisted nursing staff. He is also responsible for supplies and equipment.

(7) *Emergency treatment noncommissioned officers (91B30/91B20)*. These NCOs are supervised by the principal NCO. They perform direct patient care within their scope of practice and under professional supervision. They supervise subordinate enlisted nursing staff. The emergency treatment NCO (91B30) also performs radio operator duties for the section.

(8) *Medical specialists (91B20/91B10)*. Under professional supervision, these specialists are responsible for providing nursing care within their scope of practice.

j. *Operating Room/Central Materiel Service Control Team*. This team provides supervision of the OR and central materiel service (CMS). It is responsible for the scheduling of the nursing staff, preparing and maintaining the OR and CMS, and the maintaining of surgical, anesthetic, and nursing standards within these areas. The OR/CMS control team is composed of an anesthesiologist, an OR clinical head nurse, a senior CMS NCO, and a senior OR NCO (Table 2-10).

Table 2-10. *Operating Room/CMS Control Team Organization*

OPERATING ROOM/CMS CONTROL TEAM			
ANESTHESIOLOGIST	MAJ	60N00	MC
CLINICAL HEAD NURSE OR	MAJ	66E00	AN
SENIOR CMS NCO	SFC	91D40	NC
SENIOR OR NCO	SFC	91D40	NC

(1) *Anesthesiologist (60N00)*. This physician is responsible to the Chief, Surgical Service and supervises the OR/CMS control team members. He establishes the hospital's anesthesiology program. He administers or supervises administration of anesthetics to patients in the OR.

(2) *Clinical head nurse operating room (66E00, ASI 8J)*. This officer is responsible to the chief nurse for the management of daily operations of the OR and CMS, to include scheduling and supervising the nursing staff. He coordinates with the Chief, Surgical Service, anesthesiologist, and clinical head nurse in scheduling and assigning surgical cases. He is responsible for the quality of nursing care provided. This officer holds ASI 8J as an infection control officer.

(3) *Senior central materiel service noncommissioned officer (91D40)*. This NCO is responsible to the clinical head nurse for the supervision and management of enlisted CMS staff. He assists in the daily operations of CMS and is responsible for supplies and equipment maintenance in CMS.

(4) *Senior operating room noncommissioned officer (91D40)*. This NCO is responsible to the head nurse for the supervision and management of the enlisted OR nursing staff. He also manages supplies and equipment.

k. *Operating Room E*. This section provides general surgical services with two OR tables for a total of 24 hours of table time per day. The staff is composed of a general surgeon, an orthopedic surgeon, OR nurses, clinical nurse anesthetists, an OR NCO, and OR specialists (Table 2-11).

Table 2-11. Operating Room E Organization

OPERATING ROOM E			
GENERAL SURGEON	MAJ	61J00	MC
ORTHOPEDIC SURGEON	MAJ	61M00	MC
OPERATING ROOM NURSE	CPT	66E00	AN (2)
CLINICAL NURSE, ANESTHETIST	CPT	66F00	AN (2)
OPERATING ROOM NCO	SSG	91D30	NC
OPERATING ROOM SPECIALIST	SGT	91D20	NC
OPERATING ROOM SPECIALIST	SPC	91D10	
OPERATING ROOM SPECIALIST	PFC	91D10	

(1) *General surgeon (61J00)*. This physician is responsible to the Chief, Surgical Service for Operating Room E. He examines, diagnoses, and treats or prescribes courses of treatment and surgery for patients having injuries or disorders with surgical conditions.

(2) *Orthopedic surgeon (61M00)*. He examines, diagnoses, and treats or prescribes courses of treatment and surgery for patients having disorders, malfunctions, diseases, and/or injuries of the musculoskeletal system.

(3) *Operating room nurses (66E00)*. The senior nurse is responsible to the clinical head nurse, OR/CMS control team, for all nursing activities of this section. The senior nurse is also responsible for the supervision of the enlisted OR staff. These OR nurses perform nursing duties in any phase of the operative process for patients undergoing surgery and ensure safe supplies and equipment are available for operative services.

(4) *Clinical nurses, anesthetist (66F00)*. These two anesthetists perform (in consultation with an anesthesiologist or other physicians) nursing duties for patients requiring anesthesia for surgical or diagnostic procedures, respiratory care, cardiopulmonary resuscitation, and/or fluid therapy. Provides preanesthetic evaluation/therapy, administers all types of anesthetic techniques and performs postanesthetic evaluation/therapy.

(5) *Operating room noncommissioned officer (91D30)*. This NCO is responsible to the chief, OR nurse for supplies, equipment maintenance, and supervision of the enlisted nursing staff.

(6) *Operating room noncommissioned officer (91D20)*. This NCO assists the OR NCO in supervising the enlisted staff. Under professional supervision, he provides patient care within his scope of practice.

(7) *Operating room specialists (91D10)*. These specialists provide patient care, under professional supervision, within their scope of practice.

l. Orthopedic Cast Clinic. This section is responsible to the orthopedic surgeon for casting, splinting, and traction services for the hospital. The staffing is composed of an orthopedic NCO and an orthopedic specialist (Table 2-12). The orthopedic NCO and specialist hold the ASI P1, orthopedic specialty.

Table 2-12. *Orthopedic Cast Clinic Organization*

ORTHOPEDIC CAST CLINIC			
ORTHOPEDIC NCO	SSG	91B30	NC
ORTHOPEDIC SPECIALIST	SPC	91B10	

(1) *Orthopedic noncommissioned officer (91B30, ASI P1)*. This NCO is responsible to the orthopedic surgeon for the operation of this clinic. He supervises the orthopedic specialist.

(2) *Orthopedic specialist (91B10, ASI P1)*. Under professional supervision, this specialist provides patient care within his scope of practice.

m. Central Materiel Service. This section provides sterilization of OR equipment, surgical instruments, and supplies, as well as sterile supplies for other patient care areas. The staff is composed of a CMS NCO, a CMS sergeant, and two CMS specialists (Table 2-13).

(1) *Central materiel service noncommissioned officer (91D30)*. This NCO works under the supervision of the CMS NCO of the OR/CMS control team. He supervises the activities of the CMS sergeant and specialists. He ensures that sterilization techniques and procedures are applied; he further ensures that safe sterile supplies are provided to users on a timely basis. He also supervises operator-level maintenance of CMS equipment.

Table 2-13. Central Materiel Service Organization

CENTRAL MATERIEL SERVICE			
CMS NCO	SSG	91D30	NC
CMS SERGEANT	SGT	91D20	NC
CMS SPECIALIST	SPC	91D10	
CMS SPECIALIST	PFC	91D10	

(2) *Central materiel service sergeant/specialists (91D20/91D10)*. The CMS sergeant and specialists are responsible to the CMS section NCO. They perform CMS functions within their scope of responsibility.

n. *Dental Services*. This section provides dental services and consultation for patients and staff. During mass casualty situations, the dentists assist in the delivery of ATM. The oral surgeon uses the OR B or the dental operatory to perform oral and maxillofacial surgery. The staff is composed of an oral and maxillofacial surgeon, a comprehensive dental officer, a preventive dentistry specialist NCO, and a dental specialist (Table 2-14).

Table 2-14. Dental Services Organization

DENTAL SERVICES			
ORAL AND MAXILLOFACIAL SURGEON	MAJ	63N00	DC
COMPREHENSIVE DENTAL OFFICER	CPT	63B00	DC
PREVENTIVE DENTISTRY SPECIALIST NCO	SGT	91E20	NC
DENTAL SPECIALIST	SPC	91E10	

(1) *Oral and maxillofacial surgeon (63N00)*. This officer examines, diagnoses, and treats or prescribes courses of treatment for conditions which involve the oral and maxillofacial structures, to include oral and maxillofacial injuries, wounds, and infections. Additionally, he provides treatment to patients referred by other dental and medical facilities when required oral and maxillofacial care is beyond the capability of the referring facility. This officer is responsible to the Chief, Professional Services for the technical and administrative management of the section.

(2) *Comprehensive dental officer (63B00)*. This officer provides emergency care to inpatients and staff. When work load permits, this officer provides maintaining-level dental care to the same population and to patients referred from other dental and medical facilities when the required dental treatment is beyond

the capability of the referring facility. In addition, he provides OR assistance and support to the oral and maxillofacial surgeon, when requested. He also augments the ATM capability of the hospital, particularly during mass casualty situations.

(3) *Preventive dentistry specialist noncommissioned officer (91E20, ASI X2)*. This NCO assists the dental officers in prevention, examination, and treatment of diseases of teeth and oral region. He also performs those administrative tasks as directed by the oral surgeon. He supervises operator-level maintenance of the dental equipment. This NCO holds the ASI X2, designating formal preventive dentistry specialist training.

(4) *Dental specialist (91E10)*. This specialist is responsible to the preventive dentistry specialist NCO. He assists in the prevention, examination, and treatment of diseases of teeth and oral region. He performs operator-level maintenance of dental equipment.

o. Inpatient Medicine A. This section provides medical services such as consultations, as requested; evaluation and treatment of infectious disease and internal medicine disorders; evaluation and treatment of skin disorders; and treatment of patients with gynecological disease, injury, or disorders. Staffing includes an obstetrician/gynecologist, internists, and primary care physicians (Table 2-15).

Table 2-15. *Inpatient Medicine A Organization*

INPATIENT MEDICINE A			
OBSTETRICIAN AND GYNECOLOGIST	MAJ	60J00	MC
INTERNIST	MAJ	61F00	MC (2)
PRIMARY CARE PHYSICIAN	CPT	61H00	MC (2)

(1) *Obstetrician/gynecologist (60J00)*. This physician provides medical care during pregnancy, performs obstetric deliveries, and examines, diagnoses, and treats or prescribes courses of treatment for patients who have gynecological disease, injury, or disorders. He is responsible to the Chief, Professional Services for the technical and administrative management of this section.

(2) *Internists (61F00)*. These internists examine, diagnose, and treat patients with medical illnesses and recommend courses of management for those illnesses.

(3) *Primary care physicians (61H00)*. These physicians provide comprehensive health care to patients in the areas of general medicine, OB/GYN, psychiatry, PVNTMED, pediatrics, and orthopedics in both inpatient and outpatient care. They may be used to augment surgical specialties in triage and preoperative care.

p. Intensive Care Unit Wards. These two 12-bed intensive care units (ICUs) provide for critically injured or ill patients. This section is under the supervision of the nursing service control team. Nursing

care is performed for those patients who require close observation and vital sign monitoring, complex nursing care, and mechanical respiratory assistance. The ICU is also used as a postanesthesia recovery area for patients after surgery. Intensive care is provided by a staff of clinical head nurses, clinical nurses, wardmasters, practical nurses, respiratory NCOs, respiratory sergeants, and medical specialists (Table 2-16).

Table 2-16. Intensive Care Ward Organization

INTENSIVE CARE WARD (2)			
CLINICAL HEAD NURSE, INTENSIVE CARE UNIT	MAJ	66H00	AN (2)
CLINICAL NURSE, INTENSIVE CARE UNIT	CPT	66H00	AN (6)
CLINICAL NURSE, INTENSIVE CARE UNIT	LT	66H00	AN (4)
WARDMASTER	SFC	91C40	NC (2)
PRACTICAL NURSE	SSG	91C30	NC (6)
RESPIRATORY NCO	SSG	91V30	NC (2)
PRACTICAL NURSE	SGT	91C20	NC (6)
RESPIRATORY SERGEANT	SGT	91V20	NC (2)
MEDICAL SPECIALIST	SPC	91B10	(4)

(1) *Clinical head nurses, intensive care unit (66H00, ASI 8A).* These officers are responsible to the nursing service control team for managing the operations of the ICU, to include developing nursing policies and procedures and scheduling and supervising the nursing staff. They are responsible for the quality of nursing care. They supervise all other ICU nursing personnel. These clinical head nurses hold an ASI of 8A, intensive care.

(2) *Clinical nurses, intensive care unit (66H00, ASI 8A).* These clinical nurses are responsible to the clinical head nurse for planning and providing nursing care of a specialized and technical nature for critically injured or ill and postanesthesia patients. They supervise enlisted nursing personnel. Only three of five officers (CPT, 66H) will hold the ASI 8A on any ICU.

(3) *Wardmasters (91C40).* These NCOs work under the supervision of the ICU head nurses. They also work in concert with the chief wardmaster of the nursing control team. They manage and supervise the enlisted nursing personnel and assist in the planning and operation of the ICU.

(4) *Practical nurses (91C30).* These practical nurses are responsible to the wardmasters. They provide direct patient care, under professional supervision, within their scope of practice. They also assist in supervising the subordinate enlisted nursing staff.

(5) *Respiratory noncommissioned officers (91V30)*. These NCOs provide technical guidance to and training of subordinate personnel. They manage the respiratory care functions under the supervision of a physician or the respiratory NCO (SFC, 91V40 [see Table 2-8, Nursing Service Control Team]).

(6) *Practical nurses (91C20)*. These practical nurses perform preventive, therapeutic, and emergency nursing care procedures, under professional supervision, within their scope of practice.

(7) *Respiratory sergeants (91V20)*. Under the supervision of a physician or the respiratory NCOs, these respiratory sergeants provide treatment for patients with cardiopulmonary problems. Included is emergency care in cases of heart failure, shock, treatment of acute respiratory symptoms in cases of head injuries, and respiratory complications in patients having thoracic or abdominal surgery.

(8) *Medical specialists (91B10)*. Under the supervision of a clinical or practical nurse, these specialists provide direct patient care within their scope of practice. They are designated vehicle operators for the section.

q. Intermediate Care Wards. These seven intermediate care wards (ICWs) with 20 beds per ward are identical in personnel and equipment. They are under the supervision of the nursing service control team. These wards provide care for patients whose conditions vary from acute to moderate. The nursing care staff consists of clinical head nurses, clinical nurses, wardmasters, practical nurses, and medical specialists (Table 2-17). The responsibilities and functions of the clinical head nurses, clinical nurses (66H00), wardmasters, practical nurses, and medical specialists are the same as those identified in paragraph 2-4*p* above. The lowest-grade medical specialist is the designated vehicle operator for the section.

Table 2-17. *Intermediate Care Ward Organization*

INTERMEDIATE CARE WARD (7)			
CLINICAL HEAD NURSE	MAJ	66H00	AN (3)
CLINICAL NURSE	CPT	66H00	AN (7)
CLINICAL NURSE	LT	66H00	AN (14)
WARDMASTER	SFC	91C40	NC (7)
PRACTICAL NURSE	SSG	91C30	NC (14)
PRACTICAL NURSE	SGT	91C20	NC (35)
MEDICAL SPECIALISTS	SPC	91B10	(7)
MEDICAL SPECIALISTS	PFC	91B10	(7)

r. *Neuropsychiatric Ward and Consultation Service.* This section provides NP diagnosis and consultation to all areas of the hospital; it staffs a 20-bed ward for inpatient stabilization of NP patients. The staff for this section consists of a psychiatrist, psychiatric/mental health nurses, a social work officer, a clinical nurse, mental health NCOs, a mental health wardmaster, an occupational therapy NCO, and mental health specialists (Table 2-18). To the extent possible, the FH's NP ward should receive only those NP and/or stress casualties who are too disturbed to receive restoration treatment at Echelon IV MTFs or who have not improved sufficiently after reconditioning treatment at Echelon III, but who are judged to have RTD potential. These soldiers are reevaluated to determine whether they should continue in Echelon IV reconditioning, be discharged for administrative action, or be evacuated to CONUS. The CSC Echelon IV reconditioning center may be attached to the FH. The CSC center will maintain its separate, nonhospital identity, but will closely coordinate with the FH's NP service. The CSC reconditioning center, if attached to the FH, will require administrative and logistical support. If no CSC unit teams have been allocated to provide Echelon IV support, the NP service of the FH, assisted by the psychology and occupational therapy personnel of the FH, will staff and conduct the reconditioning program IAW FM 8-51.

Table 2-18. *Neuropsychiatric Ward and Consultation Service Organization*

NEUROPSYCHIATRIC WARD AND CONSULTATION SERVICE			
PSYCHIATRIST	MAJ	60W00	MC
PSYCHIATRIC/MENTAL HEALTH NURSE	MAJ	66C00	AN
PSYCHIATRIC/MENTAL HEALTH NURSE	CPT	66C00	AN (2)
SOCIAL WORK OFFICER	CPT	73A67	MS
CLINICAL NURSE	LT	66H00	AN
MENTAL HEALTH NCO	SSG	91X30	NC
MENTAL HEALTH WARDMASTER	SSG	91X30	NC
OCCUPATIONAL THERAPY NCO	SGT	91B20	NC
MENTAL HEALTH NCO	SGT	91X20	NC (3)
MENTAL HEALTH NCO	SGT	91X20	NC
MENTAL HEALTH SPECIALIST	SPC	91X10	(2)
MENTAL HEALTH SPECIALIST	PFC	91X10	

(1) *Psychiatrist (60W00).* This officer is responsible to the Chief, Professional Services for the technical and administrative management of this section. He supervises the NP service staff, advises the hospital commander, and provides technical supervision of NP/mental health activities throughout the hospital. He examines, diagnoses, treats and/or prescribes treatment, and recommends disposition for patients and staff with NP and stress disorders.

(2) *Psychiatric/mental health nurse (66C00)*. This officer is responsible for the technical and professional management of the NP ward nursing staff. He provides psychiatric nursing consultation to all other wards of the FH. He provides specialized nursing services for patients with psychiatric and emotional problems and promotes mental health within the hospital and support area. This nurse performs liaison, consultative, and training functions throughout the FH to enhance the continuity and quality of patient care.

(3) *Psychiatric/mental health nurses (66C00)*. These officers are responsible to the psychiatrist and head nurse for operation of the ward and consultation throughout the hospital. They develop and carry out nursing care plans for each NP ward patient. These nurses also assist in the training, supervising, and technical management of subordinate NP ward staff, including the nonpsychiatrically trained nurses and augmenting technicians.

(4) *Social work officer (73A67)*. This officer is responsible to the psychiatrist. He provides stress control prevention and treatment throughout the hospital and especially to the minimum care (RTD-oriented) wards. He supports the NP ward by evaluating the RTD potential of patients, based on interviews with the soldier, plus data from the soldier's unit. He coordinates RTD, administrative disposition, or transfer to the CSC reconditioning center. The social work officer also assures effective use of social service support agencies for patients and FH staff members.

(5) *Clinical nurse (66H00)*. This clinical nurse is responsible to the head nurse for direct and surgical nursing care to patients on the ward. He is cross-trained in stress control techniques and procedures.

(6) *Mental health noncommissioned officer (91X30)*. This NCO assists the wardmaster in the performance of his duties. He provides psychiatric nursing care duties within his scope of practice.

(7) *Mental health wardmaster (91X30)*. This NCO assists the psychiatrist and nursing staff with the management and administrative functions of the ward. He provides psychiatric nursing care duties within his scope of practice.

(8) *Occupational therapy noncommissioned officer (91B20, ASI N3)*. This NCO is responsible to the head nurse for establishing and conducting the work therapy and recreational programs throughout the FH and especially the minimal care wards. Under professional supervision, he provides occupational therapy within his scope of practice. He holds the ASI N3, occupational therapy.

(9) *Mental health noncommissioned officers (91X20)*. Under professional supervision, these NCOs provide psychiatric nursing care within their scope of practice.

(10) *Mental health noncommissioned officer (91X20)*. Under professional supervision, this NCO provides mental health assessment and care within his scope of practice.

(11) *Mental health specialists (91X10)*. These specialists are responsible to the mental health NCOs. Under professional supervision, they provide care and treatment for psychiatric, drug, and alcohol patients within their scope of practice.

s. *Minimal Care Wards.* These two minimal care wards of 20 beds each provide care for patients whose conditions vary from moderate to minimal. These are convalescent patients with minimal requirements for nursing and medical treatment. Staffing is composed of clinical nurses, a wardmaster, a practical nurse, and medical specialists (Table 2-19).

Table 2-19. *Minimal Care Ward Organization*

MINIMAL CARE WARD (2)			
CLINICAL NURSE	LT	66H00	AN (2)
WARDMASTER	SSG	91C30	NC
PRACTICAL NURSE	SGT	91C20	NC
MEDICAL SPECIALISTS	SPC	91B10	(2)
MEDICAL SPECIALISTS	PFC	91B10	(2)

(1) *Clinical nurses (66H00).* These nurses are responsible to the nursing service control team for management and operations of the ward. They supervise the enlisted nursing staff and perform appropriate nursing duties.

(2) *Wardmaster (91C30).* This NCO assists the clinical nurses in ward management. He provides nursing care leadership and supervises subordinate staff. This NCO also works in concert with the chief wardmaster of the nursing service control team.

(3) *Practical nurse (91C20).* This practical nurse is responsible to the wardmaster and, under professional supervision, performs nursing care duties within his scope of practice.

(4) *Medical specialists (91B10).* Under professional supervision, these specialists provide medical treatment to patients within their scope of practice.

t. *Pharmacy Services.* The pharmacy is responsible for quality control of pharmaceuticals, distribution of bulk drugs, maintenance and publication of the hospital formulary, and the intravenous (IV)-additive program. This section maintains a registry for controlled drugs. The pharmacy provides discharge medications for the required number of days to complete therapy and/or a 5-day supply of medications required for air evacuation out of theater. The pharmacy requisitions required supplies through the logistics section to the supporting MEDLOG battalion (rear). The staff is composed of pharmacy officers, NCOs, and specialists (Table 2-20). Three of the enlisted staff hold the ASI Y7 (sterile pharmacy specialty) for the IV-additive program.

(1) *Chief, pharmacy services (67E00).* This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services). He directs, plans, and participates in all hospital

pharmaceutical activities. He is responsible for and maintains security within the pharmacy area and monitors the storage, security, and control, to include inventories and audit trails, of controlled substances. He also acts as a liaison between the professional staff and the logistics office for requisition of pharmaceutical items.

Table 2-20. Pharmacy Services Organization

PHARMACY SERVICES			
CHIEF, PHARMACY SERVICES	MAJ	67E00	MS
PHARMACY OFFICER	CPT	67E00	MS
PHARMACY NCO	SFC	91Q40	NC
PHARMACY NCO	SSG	91Q30	NC
STERILE PHARMACY NCO	SGT	91Q20	NC
PHARMACY SPECIALIST	SPC	91Q10	
STERILE PHARMACY SPECIALIST	SPC	91Q10	
PHARMACY SPECIALISTS	PFC	91Q10	
STERILE PHARMACY SPECIALIST	PFC	91Q10	

(2) *Pharmacy officer (67E00)*. This officer assists the Chief, Pharmacy Services in the performance of his duties. He supervises other pharmaceutical staff and collects data for required reports.

(3) *Pharmacy noncommissioned officer (91Q40)*. This NCO serves as the noncommissioned officer in charge (NCOIC) of pharmacy services. He is responsible for the work schedule of subordinate pharmacy NCOs and specialists; he is also responsible for ensuring adequate training for all subordinate specialists. Under the supervision of a pharmacist, he prepares, controls, and issues pharmaceutical products. He also assists with the supervision of the section, providing technical guidance to subordinate personnel.

(4) *Pharmacy noncommissioned officer (91Q30)*. This NCO assist the pharmacy officer and the pharmacy NCO in their duty performance. He prepares, controls, and issues pharmaceutical products, ensuring compliance with Army and Federal rules, laws, and regulations relative to pharmacy operations.

(5) *Sterile pharmacy noncommissioned officer (91Q20)*. This NCO serves as the NCOIC of the sterile products service. He performs sterile technique procedures in the preparation of items such as IV-additives which are used to combat infection and to restore and maintain electrolyte and nutritional balance. He holds the ASI Y7, sterile pharmacy specialty.

(6) *Pharmacy/sterile pharmacy specialists (91Q10)*. Under professional supervision, these specialists perform pharmaceutical duties within their scope of practice. The two sterile pharmacy specialists

hold the ASI Y7. Their duties as sterile pharmacy specialists will be the same as those identified in paragraph (5) above.

u. Laboratory Services. This section performs a general, but limited, array of analytical procedures in hematology, urinalysis, clinical chemistry, microbiology, and serology. This section also prepares biological specimens, to include those suspected of exposure to biological weapons, for shipment to reference laboratories, such as the Theater Army Medical Laboratory (TAML). The staff is composed of a clinical laboratory officer, medical laboratory NCOs, and medical laboratory specialists (Table 2-21).

Table 2-21. Laboratory Services Organization

LABORATORY SERVICES			
CLINICAL LABORATORY OFFICER	CPT	71E67	MS
MEDICAL LABORATORY NCO	SFC	91K40	NC
MEDICAL LABORATORY NCO	SSG	91K30	NC
MEDICAL LABORATORY NCO	SGT	91K20	NC (2)
MEDICAL LABORATORY SPECIALIST	SPC	91K10	(3)
MEDICAL LABORATORY SPECIALIST	PFC	91K10	(5)

(1) *Clinical laboratory officer (71E67).* This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services) for management and supervision of the laboratory section and blood bank/donor center, including technical supervision and overall quality assurance of laboratory procedures performed in the hospital. He directs the performance of laboratory procedures used in the detection, diagnosis, treatment, and prevention of disease. He coordinates with other military or civilian agencies and treatment facilities for enhanced support, reference laboratory support, and blood support. He also coordinates with appropriate military agencies for evaluation and shipment of biomedical specimens suspected of exposure to chemical or biological warfare agents or other hazardous substances.

(2) *Medical laboratory noncommissioned officer (91K40).* This senior laboratory NCO functions as the laboratory NCOIC. He advises and assists the laboratory officer in laboratory operations, supply economy and inventory management, advanced technical procedures, and administrative requirements. He provides technical guidance to the subordinate staff.

(3) *Medical laboratory noncommissioned officer (91K30).* This laboratory NCO is responsible to the senior laboratory NCO for laboratory operations. He supervises the subordinate medical laboratory specialists. He also performs elementary and advanced examinations of patient-derived specimens (including suspect biological warfare specimens) to aid in the diagnosis, treatment, and prevention of disease.

(4) *Medical laboratory noncommissioned officers (91K20)*. These NCOs are responsible to medical laboratory NCO (91K30) for clinical laboratory operations. They also assist in the supervision of subordinate medical laboratory specialists.

(5) *Medical laboratory specialists (91K10)*. Under the supervision of laboratory NCOs, these specialists perform elementary clinical laboratory procedures.

v. *Blood Bank*. This section provides all routine blood grouping and typing, abbreviated crossmatching procedures, emergency blood collection, and blood inventory management. It has the capacity to store and issue liquid blood components and fresh frozen plasma. Staffing for this section includes a medical laboratory NCO and blood donor center operations NCOs and specialists (Table 2-22). All blood donor center operations personnel hold the ASI M4, blood donor center operations.

Table 2-22. *Blood Bank Organization*

BLOOD BANK			
MEDICAL LABORATORY NONCOMMISSIONED OFFICER	SSG	91K30	NC
BLOOD DONOR CENTER OPERATIONS NCO	SSG	91K30	NC
BLOOD DONOR CENTER OPERATIONS NCO	SGT	91K20	NC
BLOOD DONOR CENTER OPERATIONS SPECIALIST	SPC	91K10	(2)
BLOOD DONOR CENTER OPERATIONS SPECIALIST	PFC	91K10	(2)

(1) *Medical laboratory noncommissioned officer (91K30)*. This NCO is responsible to the clinical laboratory officer of laboratory services for the management and operation of this section. He performs advanced procedures in all phases of blood banking.

(2) *Blood donor center operations noncommissioned officer (91K30, ASI M4)*. This NCO is responsible to the blood bank NCO for the management and operation of blood donor center operations. He performs advanced procedures in all phases of blood donor center operations. He supervises subordinate blood donor center personnel in the performance of their duties.

(3) *Blood donor operations specialists (91K20/91K10, ASI M4)*. The duties and functions of the remaining staff are the same as the corresponding staff in paragraph 2-24u(5).

w. *Radiology Service*. This section provides radiological services to all areas of the hospital and operates on a 24-hour basis. Staffing includes a diagnostic radiologist, a senior radiology NCO, radiology NCO, and radiology specialists (Table 2-23).

Table 2-23. Radiology Service Organization

RADIOLOGY SERVICE			
DIAGNOSTIC RADIOLOGIST	MAJ	61R00	MC
SENIOR RADIOLOGY NCO	SFC	91P40	NC
RADIOLOGY NCO	SSG	91P30	NC
RADIOLOGY SERGEANT	SGT	91P20	NC
RADIOLOGY SPECIALIST	SPC	91P10	(3)
RADIOLOGY SPECIALIST	PFC	91P10	(2)

(1) *Diagnostic radiologist (61R00)*. This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services) for the management and operation of this section. He performs and interprets all diagnostic radiological and fluoroscopic procedures, including special vascular studies and imaging, on patients referred by other physicians.

(2) *Senior radiology noncommissioned officer (91P40)*. This NCO assists the radiologist in the supervision of subordinate personnel and administrative management of this section. Under the supervision of the radiologist, he performs radiological duties within his scope of training.

(3) *Radiology noncommissioned officer (91P30)*. This NCO assists the radiology NCO in the supervision of subordinate personnel and administrative management of this section. Under the supervision of the radiologist, he performs radiological duties within his scope of training.

(4) *Radiology sergeant and specialists (91P20/91P10)*. Under the supervision of the radiology NCO, these individuals perform duties within their scope of training. They also perform vehicle operator duties for the section.

x. *Physical/Occupational Therapy Service*. This section provides inpatient physical/occupational therapy services and consultation for patients. The primary role of this section is evaluating and treating neuromusculoskeletal conditions and providing burn/wound care to patients with potential for RTD within the theater evacuation policy. During mass casualty situations, physical therapy personnel may be utilized in managing minimal or delayed patients, or augmenting the orthopedic staff. The staff is composed of a physical therapist and a physical therapy NCO (Table 2-24).

Table 2-24. Physical/Occupational Therapy Service Organization

PHYSICAL/OCCUPATIONAL THERAPY SERVICE			
PHYSICAL THERAPIST	CPT	65B00	SP
PHYSICAL THERAPY NCO	SSG	91B30	NC

(1) *Physical therapist (65B00)*. This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services) for the management and supervision of physical therapy services. The physical therapist plans and supervises physical therapy programs upon referral from medical officers. This officer also provides guidance in the areas of physical fitness, physical training, and injury prevention.

(2) *Physical therapy noncommissioned officer (91B30, ASI N9)*. This physical therapy NCO is responsible to the physical therapist. He provides physical therapy treatment to patients within his scope of practice. He holds the ASI N9, physical therapy specialty.

y. *Hospital Ministry Team*. This section is composed of a chaplain, a unit ministry team (UMT) NCO, and a chaplain’s assistant to provide religious support and pastoral care ministry for assigned staff and patients (Table 2-25).

Table 2-25. *Hospital Ministry Team Organization*

HOSPITAL MINISTRY TEAM			
HOSPITAL CHAPLAIN	CPT	56A00	CH
UNIT MINISTRY TEAM NCO	SGT	71M20	NC
CHAPLAIN’S ASSISTANT	PFC	71M10	

(1) *Hospital chaplain (56A00, ASI 7R)*. This chaplain, supervised by the hospital headquarters chaplain, coordinates the program of religious ministries, including workshops, pastoral counseling, and religious education, for the hospital. He supervises the activities of the other ministry team staff.

(2) *Unit ministry team noncommissioned officer (71M20)*. This UMT NCO is responsible to the hospital chaplain and assists him in his duties. He also supervises the activities of the chaplain’s assistant.

(3) *Chaplain’s assistant (71M10)*. This assistant is responsible to the UMT NCO. He prepares the chapel for worship and prepares sacraments of Protestant, Catholic, Orthodox, and Jewish faiths.

2-5. The Hospital Unit, Holding

The HUH is organized with 63 personnel. It provides hospitalization for patients in the COMMZ and for patients who require reconditioning and rehabilitation to facilitate their RTD within the prescribed theater evacuation policy. The HUH provides the convalescent care capability for the hospital. It is composed of the following sections:

a. *Unit Headquarters.* This section provides augmentation to the HUB for unit-level command, communications, security, plans and operations, duty rosters, weapons control, administration, general support supplies, and patient administrative support. The staff is composed of the HUH commander, an assistant chief nurse, a field medical assistant, and a first sergeant (holding company) (Table 2-26).

Table 2-26. *Hospital Unit, Holding, Unit Headquarters Organization*

UNIT HEADQUARTERS			
COMMANDER	LTC	61H00	MC
ASSISTANT CHIEF NURSE	MAJ	66H00	AN
FIELD MEDICAL ASSISTANT	CPT	70B67	MS
FIRST SERGEANT (HOLDING COMPANY)	MSG	91B50	NC

(1) *Hospital unit, holding commander (61H00).* This officer, in his capacity as the HUH commander, ensures a smooth and functional integration of unity of the HUH with the HUB. Once the two units are combined to form a FH, this officer performs the duties of a primary care physician in the clinical services section (see paragraph 2-5c).

(2) *Assistant chief nurse (66H00).* This officer functions in unison with the chief nurse of the HUB in providing the necessary planning, execution, and direction for the HUH.

(3) *Field medical assistant (70B67).* This officer assists the HUH commander in the areas of organizational administration, supply, training, operation, transportation, and patient evacuation. He augments the HUB operations section.

(4) *First sergeant (holding company) (91B50).* This NCO functions as the first sergeant of the medical holding company. When the HUB and the HUH unite to form the FH, he will be supervised by the HUB company headquarters commander who functions as the commander, medical holding company. This NCO is also the principal enlisted assistant to the HUH commander. He maintains liaison between the HUH commander and assigned NCOs. He provides guidance to enlisted members of the HUH and represents them to the commander.

b. *Supply and Service Division (Augmentation).* Because of the increased work load associated with the HUH, this section augments the Supply and Service Division of the HUB. Staffing includes a medical supply sergeant, a supply sergeant, medical supply specialists, and supply specialists (Table 2-27).

(1) *Medical supply sergeant (76J20).* This NCO is responsible to the medical supply NCO (HUB) for medical supply operations, stock control, and medical assemblage management. He is responsible for the development and preparation of plans, maps, overlays, sketches, and other administrative procedures related to employment of the HUH Supply and Service Division.

Table 2-27. *Supply and Service Division Organization*

SUPPLY AND SERVICE DIVISION			
MEDICAL SUPPLY SERGEANT	SGT	76J20	NC
SUPPLY SERGEANT	SGT	92Y20	NC
MEDICAL SUPPLY SPECIALIST	SPC	76J10	
SUPPLY SPECIALIST	SPC	92Y10	
MEDICAL SUPPLY SPECIALIST	PFC	76J10	
SUPPLY SPECIALIST	PFC	92Y10	

(2) *Supply sergeant (92Y20)*. This NCO is responsible for general supply operations, to include supervision of the supply specialists. He maintains accountability for all equipment organic to the HUH.

(3) *Medical supply specialists (76J10)*. These specialists are responsible to the medical supply sergeant for performing designated medical supply and equipment functions.

(4) *Supply specialists (92Y10)*. These supply specialists assist the supply sergeant in his duty performance. They request, receive, inspect, load, unload, segregate, store, issue, and turn in organizational supplies and equipment. One of the specialists will function as the armorer. The armorer maintains the weapons storage area, issues and receives small arms and ammunitions, and performs small arms unit maintenance.

c. Clinical Services. This section provides specialty services and the overall medical treatment plan and implementation for the HUH. Staffing includes primary care physicians, a dermatologist, a clinical psychologist, a podiatrist, a microbiologist, medical-surgical nurses, emergency treatment NCOs, medical specialists, and a mental health NCO (Table 2-28).

(1) *Primary care physicians (61H00)*. These physicians provide comprehensive care to patients in the areas of general medicine, OB/GYN, psychiatry, PVNTMED, and orthopedics. They can be used to augment surgical specialties in triage and preoperative care. The Lieutenant Colonel (LTC) position is accounted for in the unit headquarters (paragraph 2-5a[1]) and is not included in the total authorizations for clinical services. This officer will function as the Chief, Clinical Services. He will be responsible to the Chief, Professional Services (HUB) for the management and supervision of this section.

(2) *Dermatologist (60L00)*. This physician examines, diagnoses, and treats or prescribes course of treatment for patients having diseases of the skin.

(3) *Clinical psychologist (73B67)*. This officer applies psychological principles, theories, methods, and techniques through direct patient service or consultation. He provides preventive interventions

and treatment throughout the hospital, especially on the minimum care wards. He performs psychological and neuropsychological testing to determine diagnosis and RTD potential.

Table 2-28. *Clinical Services Organization*

CLINICAL SERVICES			
PRIMARY CARE PHYSICIAN	LTC	61H00	MC*
DERMATOLOGIST	MAJ	60L00	MC
CLINICAL PSYCHOLOGIST	MAJ	73B67	MS
PRIMARY CARE PHYSICIAN	CPT	61H00	MC
PODIATRIST	CPT	67G00	MS
MICROBIOLOGIST	CPT	71A67	MS
MEDICAL-SURGICAL NURSE	LT	66H00	AN (3)
EMERGENCY TREATMENT NCO	SSG	91B30	NC
EMERGENCY TREATMENT NCO	SGT	91B20	NC
MEDICAL SPECIALIST	SGT	91B20	NC
MENTAL HEALTH NCO	SGT	91X20	NC
MEDICAL SPECIALIST	SPC	91B10	(2)
MEDICAL SPECIALIST	PFC	91B10	

*THE HUH COMMANDER ALSO FUNCTIONS AS A PRIMARY CARE PHYSICIAN IN CLINICAL SERVICES.

(4) *Podiatrist (67G00)*. This officer examines, diagnoses, and treats soldiers suffering from foot diseases, disorders, and/or injuries. His duties include inpatient and outpatient surgical and nonsurgical treatment and consultative services. He performs surgery under the supervision of an orthopedic or general surgeon.

(5) *Microbiologist (71A67)*. This officer conducts and directs the performance of more complex microbiology procedures provided in the microbiology augmentation set. He provides technical consultation to the primary care provider and others in the AO and coordinates with supporting organizations (such as the TAML) for the evaluation of biomedical specimens for exposure to biological warfare agents.

(6) *Medical-surgical nurses (66H00)*. These nurses are responsible to the assistant chief nurse for planning and providing professional nursing care of a generalized, specialized, and/or technical nature in the care and treatment of medical-surgical patients.

(7) *Emergency treatment noncommissioned officers (91B30/91B20)*. These NCOs assist with technical and administrative management of clinical medical facilities under the supervision of a physician or nurse. They supervise the subordinate medical specialists.

(8) *Mental health noncommissioned officer (91X20)*. This NCO collects and records social and psychological data and counsels personnel with personal, behavioral, or psychological problems. He is supervised by the clinical psychologist.

(9) *Medical specialists (91B20/91B10)*. These specialists assist with inpatient and outpatient care and treatment. They are supervised by the emergency treatment NCOs.

d. *Patient Support Section*. This section consists of seven convalescent care wards of 40 beds per ward for self-care patients. The wards are identical in personnel and equipment. They are under the supervision of the HUB nursing service control team. The nursing care staff of each ward consists of a wardmaster, a practical nurse, and medical specialists (Table 2-29).

Table 2-29. *Patient Support Section Organization*

PATIENT SUPPORT SECTION (7)			
WARDMASTER	SSG	91C30	NC (7)
PRACTICAL NURSE	SGT	91C20	NC (7)
MEDICAL SPECIALISTS	SPC	91B10	(7)
MEDICAL SPECIALISTS	PFC	91B10	(7)

(1) *Wardmasters (91C30)*. These NCOs are responsible for section management. They provide nursing care leadership and supervise subordinate staff. These NCOs are supervised by and work in concert with the chief wardmaster of the nursing service control team.

(2) *Practical nurses (91C20)*. These practical nurses are responsible to their respective wardmaster and, under professional supervision, perform nursing care duties within their scope of practice.

(3) *Medical specialists (91B10)*. Under professional supervision, these specialists provide medical treatment to patients within their scope of practice.

e. *Physical/Occupational Therapy Service*. This section provides inpatient physical/occupational therapy services and consultation for patients. The primary role of physical therapy services is to provide evaluation and treatment of patients with neuromusculoskeletal conditions and provide burn/wound care to patients with the potential to RTD within the theater evacuation policy. The primary wartime role of occupational therapy services is to provide upper extremity neuromusculoskeletal skills evaluation and treatment; prevention and treatment of combat stress and battle fatigue; and reconditioning and treatment to

increase physical fitness, duty-related skills, and work performance to patients with the potential to RTD within the theater evacuation policy. During mass casualty situations, physical/occupational therapy personnel may be utilized in managing minimal or delayed patients or augmenting the orthopedic staff. The occupational and physical therapy enlisted staff hold an ASI of N3 and N9, respectively. The staff is composed of physical therapists, occupational therapists, and occupational and physical therapy NCOs and specialists (Table 2-30).

Table 2-30. *Physical/Occupational Therapy Service Organization*

PHYSICAL/OCCUPATIONAL THERAPY SERVICE			
PHYSICAL THERAPIST	MAJ	65B00	SP
OCCUPATIONAL THERAPIST	CPT	65A00	SP
OCCUPATIONAL THERAPIST	LT	65A00	SP
PHYSICAL THERAPIST	LT	65B00	SP
OCCUPATIONAL THERAPY NCO	SSG	91B30	NC
PHYSICAL THERAPY SERGEANT	SGT	91B20	NC
OCCUPATIONAL THERAPY SERGEANT	SGT	91B20	NC
OCCUPATIONAL THERAPY SPECIALIST	SPC	91B10	
PHYSICAL THERAPY SPECIALIST	SPC	91B20	(2)

(1) *Physical therapists (65B00)*. The senior officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services) for the management and supervision of this section. He develops and plans physical therapy programs upon referral from medical officers. Each physical therapist provides guidance to the subordinate staff for patient treatment in the areas of physical fitness, physical training, and injury prevention.

(2) *Occupational therapists (65A00)*. The senior officer is responsible for developing and planning policies and activities for the overall occupational therapy program. He coordinates patient referrals with the subordinate staff and provides reports to the appropriate professional staff. Each occupational therapist provides patient treatment and guidance to the subordinate staff for patient treatment.

(3) *Occupational therapy noncommissioned officers (91B30/91B20, ASI N3)*. The senior occupational therapy NCO is responsible to the senior occupational therapist for supervision of subordinate staff. Each NCO provides occupational therapy treatment to patients within their scope of practice. They hold the ASI N3, occupational therapy specialty.

(4) *Physical therapy noncommissioned officer (91B20, ASI N9)*. This physical therapy sergeant is responsible to the senior physical therapist for supervision of subordinate staff. He provides

physical therapy treatment to patients within his scope of practice. He holds the ASI N9, physical therapy specialty.

(5) *Occupational therapy specialist (91B10, ASI N3)*. This specialist provides patient treatment within his scope of practice. He holds the ASI N3, occupational therapy specialty.

(6) *Physical therapy specialists (91B10, ASI N9)*. These specialist provide patient treatment within their scope of practice. They hold the ASI N9, physical therapy specialty.

CHAPTER 3

THE GENERAL HOSPITAL**3-1. Mission and Allocation**

The mission of this hospital is to provide stabilization and hospitalization for patients who require further evacuation out of the TO or who can RTD within the theater evacuation policy. The GH will normally be located in the COMMZ. The majority of patients will be received from the CZ by theater evacuation assets. It has a basis of allocation of 0.829 units per 1,000 admitted patients in the COMMZ. (Rule of thumb is two GHs per three divisions supported.)

3-2. Assignment and Capabilities

a. The GH is assigned to the HHC, MEDCOM, TOE 08611L000. The hospital may be further attached to the HHC, Medical Brigade, TOE 08422L000.

b. This facility provides hospitalization for up to 476 patients. It can be augmented with specialty surgical/medical teams to increase its capabilities. It may become a designated specialty center as the work load or mission dictates.

c. Surgical capacity is based on four ORs (eight operating tables) for a surgical capacity of 144 OR table hours per day.

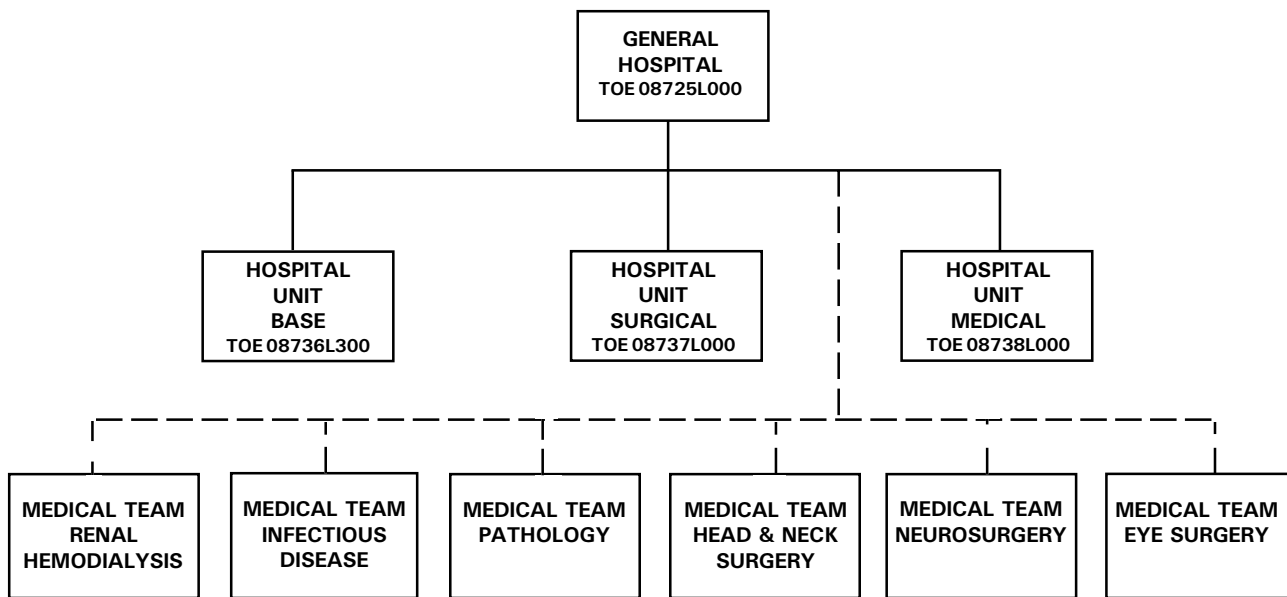
d. Other capabilities include—

- Consultation services for patients referred from other MTFs.
- Unit-level CHS for organic personnel only.
- Pharmacy, clinical laboratory, blood banking, radiology, and nutrition care services.
- Physical and occupational therapy support to patients.
- Medical administrative and logistical services to support work loads.
- Dental treatment to staff and patients and oral and maxillofacial surgery support for military personnel in the immediate area, plus patients referred by area CHS units.
- Augmentation and reconstitution of other hospitals.

3-3. Hospital Organization and Functions

The hospital includes a 236-bed HUB, 60-bed HUS, and a 180-bed HUM. Collectively, this modular-designed hospital has 8 wards providing intensive nursing care for up to 96 patients, 16 wards providing

intermediate nursing care for up to 320 patients, 1 ward providing NP care for up to 20 patients, and 2 wards providing minimal nursing care for up to 40 patients. Figures 3-1, 3-2, 3-3, and 3-4 (page 3-5) show the GH organization.



NOTE: DEPENDING UPON OPERATIONAL REQUIREMENTS, THE MEDICAL AND SURGICAL TEAMS MAY OR MAY NOT BE ATTACHED TO THE INDIVIDUAL CLINICAL ELEMENT OF THE GH.

Figure 3-1. General hospital organization (TOE 08725L000).

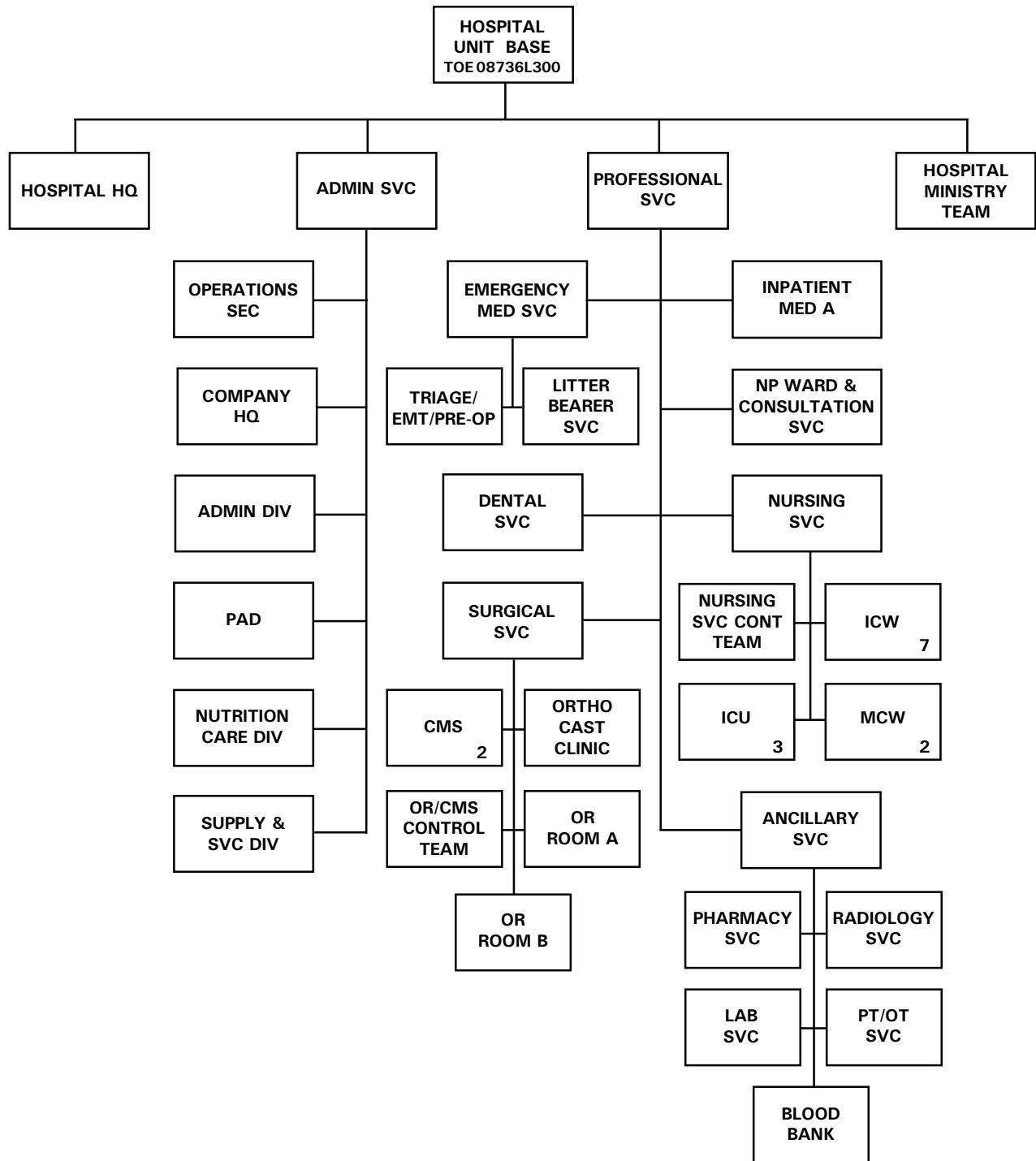


Figure 3-2. Hospital unit, base (TOE 08736L300).

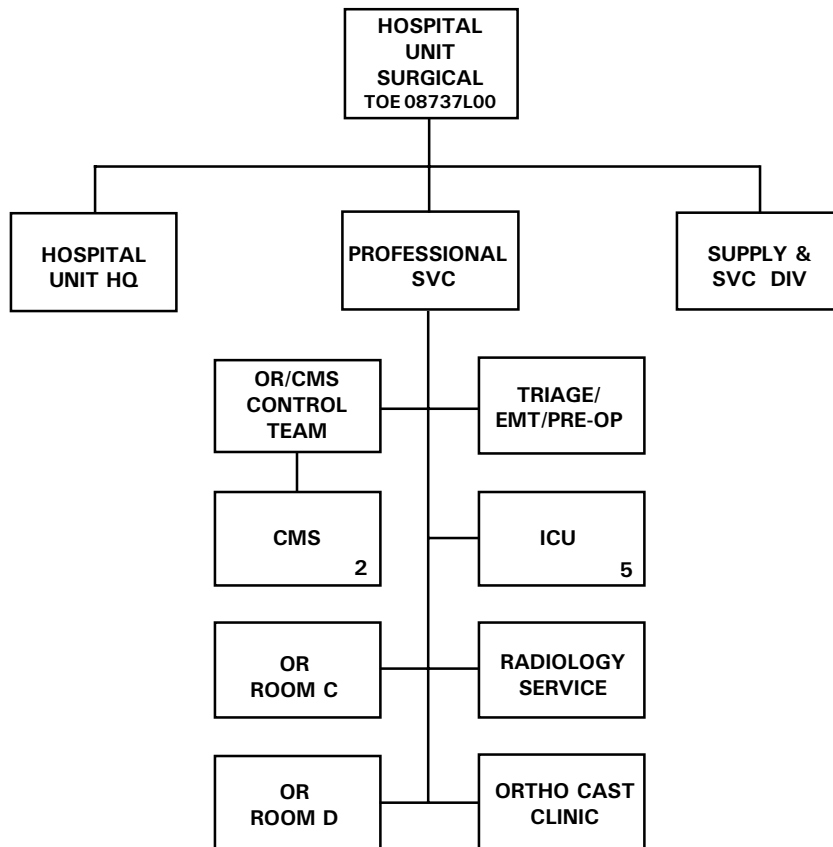


Figure 3-3. Hospital unit, surgical (TOE 08737L000).

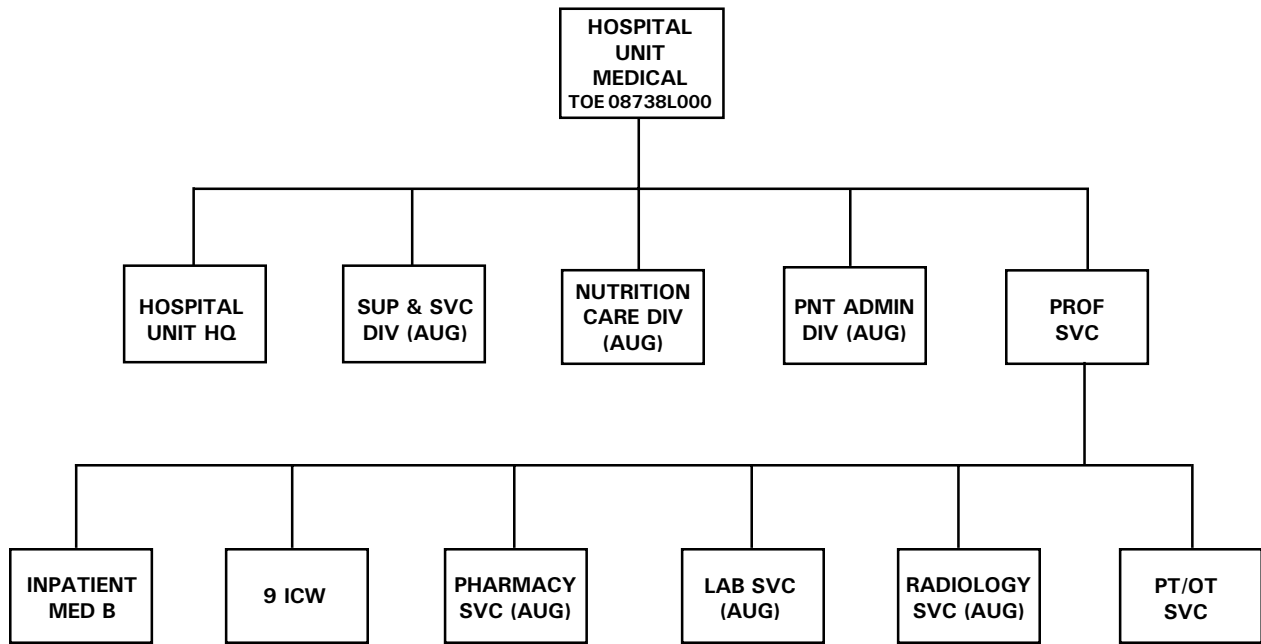


Figure 3-4. Hospital unit, medical (TOE 08738L000).

3-4. The Hospital Unit, Base

The HUB is an independent organization which includes all hospital services. It provides a solid infrastructure for the GH's operations. The HUB contains the following sections:

a. Hospital Headquarters Section. This section provides internal C2 and management of all hospital services. Personnel of this section supervise and coordinate the surgical, nursing, medical, pastoral, and administrative services. Staffing includes the HUB commander, the chiefs of surgery, nursing, and medicine, an XO, a chaplain, a CSM, and an administrative specialist (Table 3-1). When the HUB, the HUS, and the HUM join to function as a GH, the HUB commander is the GH commander unless otherwise designated.

Table 3-1. Hospital Headquarters Organization

HOSPITAL HEADQUARTERS			
HOSPITAL COMMANDER	COL	60A00	MC
CHIEF, SURGICAL SERVICE	COL	61J00	MC
CHIEF, NURSING SERVICE	COL	66N00	AN
CHIEF, MEDICAL SERVICE	COL	61F00	MC
EXECUTIVE OFFICER	COL	67A00	MS
HOSPITAL CHAPLAIN	LTC	56A00	CH
COMMAND SERGEANT MAJOR	CSM	00Z50	NC
ADMINISTRATIVE SPECIALIST	SGT	71L20	NC

(1) *Hospital commander (60A00)*. Command and control is the process through which the activities of the hospital are directed, coordinated, and controlled to accomplish the mission. This process begins and ends with the commander. An effective commander must have a thorough knowledge and understanding of planning and implementing CHS (FM 8-55). He is decisive and provides specific guidance to his staff in the execution of the mission. The successful commander delegates authority and fosters an organizational climate of mutual trust, cooperation, and teamwork. He has the overall responsibility for coordination of CHS within the hospital's AO. Additionally, he is responsible for the structural layout of the hospital. He establishes and promotes safety, PVNTMED, and occupational health directives and policies to protect personnel and equipment under his command.

(2) *Chief, surgical service (61J00)*. The chief surgeon is the principal adviser to the hospital commander for surgical activities. He provides supervision and control over the surgical service to include the ORs. He prescribes courses of treatment and surgery for patients having injuries or disorders with surgical conditions and participates in surgical procedures as required. He coordinates and is responsible for all matters pertaining to the evaluation, management, and disposition of patients received by the section. He is responsible for the evaluation and training programs for his professional staff. He also functions as the Deputy Commander for Professional Services.

(3) *Chief, nursing service (66N00)*. The chief nurse is the principal adviser to the hospital commander for nursing activities. This officer plans, organizes, supervises, and directs nursing care practices and activities of the hospital. This officer is also responsible for the orientation and professional development programs for the nursing staff.

(4) *Chief, medical service (61F00)*. This officer is responsible for the examination, diagnoses, and treatment, or recommended course of management, for patients with medical illnesses. He controls the length of patient stay through continuous patient evaluation, early determination of disposition, or evacuation to the next echelon of care.

(5) *Executive officer (67A00)*. The hospital XO advises the commander on matters pertaining to health care delivery. He plans, directs, and coordinates administrative activities for the hospital. He provides guidance to the TOC staff in planning for future operations. He also functions as the Chief, Administrative Service.

(6) *Hospital chaplain (56A00)*. The chaplain functions as the staff officer for all matters in which religion impacts on command programs, personnel, policy, and procedures. He provides for the spiritual well-being and morale of patients and hospital personnel. He also provides religious services and pastoral counseling to soldiers in the AO.

(7) *Command sergeant major (00Z50)*. The CSM is the principal enlisted representative to the commander. He advises the commander and his staff on all matters pertaining to the welfare and morale of enlisted personnel in terms of assignment, reassignment, promotion, and discipline. The CSM provides counsel and guidance to NCOs and other enlisted personnel of the hospital. He is also responsible for the reception of newly assigned enlisted personnel into the unit. The CSM evaluates the implementation of individual soldier training on common soldier tasks and supervises the hospital's NCO professional development.

(8) *Administrative specialist (71L20)*. The administrative specialist performs typing, clerical, and administrative duties for the hospital headquarters. He proofreads correspondence for proper spelling, grammar, punctuation, format, and content accuracy. He establishes and maintains files, logs, and other statistical information for the command. He is the light-vehicle driver and radio operator for the command section.

b. Hospital Operations Section. This section is responsible for security, plans and operations, deployment, and relocation of the hospital. This section is also responsible for coordinating communication support requirements with the supporting signal element. The staff is composed of an operations officer, a plans officer, an operations NCO, an NBC NCO, and appropriate communications specialists (Table 3-2).

(1) *Medical operations officer (70H67)*. This officer is responsible to the XO for the S2/S3 functions of the hospital. He supervises all tactical operations conducted by the hospital, to include planning and relocation. He coordinates with the chief wardmaster and the utility operations and maintenance technician in the development of the hospital layout and submits recommendations to the hospital commander for approval. He is responsible for the formulation of the TSOP and the hospital planning factors (refer to Appendix A for an example TSOP format and Appendix B for an estimate of hospital planning factors).

(2) *Field medical assistant (70B67)*. This officer is responsible to the medical operations officer for planning and coordinating site selection and convoy operations during hospital deployment and relocation. He also functions as the OPSEC and COMSEC officer for the hospital. This position is accounted for by the field medical assistant (CPT, 70B67) in the HUS unit headquarters (paragraph 3-5a[3]) and is not included in the total authorizations for the hospital operations section. This HUS officer becomes the plans officer for the hospital operations section when the HUB, HUS, and HUM join to function as a GH.

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(3) *Section chief (31U40)*. This NCO serves as the principal signal adviser to the hospital commander and medical operations officer on all communications matters. He is responsible to the medical operations officer and the field medical assistant for planning, supervising, coordinating, and providing technical assistance in the installation, operation, management, and operator-level maintenance of radio, field wire, and switchboard communications systems. He supervises all subordinate communications personnel.

(4) *Operations sergeant (91B40)*. The operations sergeant is responsible to the medical operations officer for physical security, to include the hospital defense plan; preparation of unit plans, OPOORDs, and map overlays; and intelligence information and records. He also supervises the subordinate staff.

(5) *Nuclear, biological, and chemical noncommissioned officer (54B40)*. This NCO is the technical adviser to the hospital commander and operations officer on matters pertaining to NBC operations. He is responsible to the medical operations officer for planning, training, NBC decontamination (less patient), and other aspects of hospital NBC defensive operations.

(6) *Senior radio operator/maintainer (31C20)*. This individual is responsible to the section chief for the installation and operation of unit wire systems, associated equipment, and FM radios.

(7) *Senior switch systems operator/maintainer (31F20)*. This individual is responsible to the section chief for the installation, operation, and unit-level maintenance of switchboards and switching systems.

(8) *Radio operator/maintainer (31C10)*. These radio operators are responsible to the senior radio operator/maintainer for the installation, operation, and unit-level maintenance on single-channel radios, radio teletypewriters, and associated equipment.

(9) *Switch systems operator/maintainer (31F10)*. These operators are responsible to the senior switch systems operator/maintainer for the installation, operation, and unit-level maintenance on switchboards, switching assemblages, and associated communications equipment.

(10) *Signal support system specialist (31U10)*. This individual is responsible to the signal section chief for troubleshooting and assisting in wire installation for field telephones. He also provides technical assistance in the operation of the hospital FM radios and provides unit-level maintenance on the radios. He is the designated light-vehicle driver for the section.

(11) *Administrative specialist (71L10)*. This individual is responsible to the operations sergeant for general typing and administrative functions for the section.

(12) *Signal support systems specialist (31U10)*. This individual is responsible to the section chief for installing wire for field telephones and assisting in the operation of the hospital FM radios.

Table 3-2. Hospital Operations Section Organization

HOSPITAL OPERATIONS SECTION			
MEDICAL OPERATIONS OFFICER	MAJ	70H67	MS
FIELD MEDICAL ASSISTANT	CPT	70B67	MS
SECTION CHIEF	SFC	31U40	NC
OPERATIONS SERGEANT	SFC	91B40	NC
NUCLEAR, BIOLOGICAL, AND CHEMICAL NCO	SFC	54B40	NC
SENIOR RADIO OPERATOR/MAINTAINER	SGT	31C20	NC
SENIOR SWITCH SYSTEMS OPERATOR/MAINTAINER	SGT	31F20	NC
RADIO OPERATOR/MAINTAINER	SPC	31C10	
SWITCH SYSTEMS OPERATOR/ MAINTAINER	SPC	31F10	
SIGNAL SUPPORT SYSTEMS SPECIALIST	SPC	31U10	
ADMINISTRATIVE SPECIALIST	SPC	71L10	
RADIO OPERATOR/MAINTAINER	PFC	31C10	
SWITCH SYSTEMS OPERATOR/ MAINTAINER	PFC	31F10	
SIGNAL SUPPORT SYSTEMS SPECIALIST	PFC	31U10	

c. *Company Headquarters.* This section is responsible for company-level command, duty rosters, weapons control, and general supply support. Staffing includes the company headquarters commander, the first sergeant, an armorer, and an administrative clerk (Table 3-3).

Table 3-3. Company Headquarters Organization

COMPANY HEADQUARTERS			
COMPANY COMMANDER	CPT	70B67	MS
FIRST SERGEANT	MSG	91B5M	NC
ARMORER	SPC	92Y10	
ADMINISTRATIVE CLERK	SPC	71L10	

(1) *Company commander (70B67)*. The company commander is responsible to the hospital commander for all activities in the company headquarters. He administers UCMJ actions for enlisted personnel. Additionally, he is responsible for planning and conducting common task training. When the HUB and HUS join to function as a GH, this officer functions as the commander of the medical holding detachment.

(2) *First sergeant (91B5M)*. The first sergeant is responsible to the company commander for enlisted matters. He also assists in supervising company administration and training activities. He provides guidance to the enlisted members of the company and represents them to the company commander. He also functions as the retention NCO.

(3) *Armorer (92Y10)*. The armorer’s primary duty is that of maintaining the weapons storage area, issuing and receiving small arms and ammunition, and performing small arms unit maintenance.

(4) *Administrative clerk (71L10)*. The administrative clerk is responsible to the first sergeant for providing the personnel and unit administration support for the company headquarters. His duties consist of general administration and personnel actions.

d. *Administrative Division*. This division provides overall administrative services for the hospital, to include personnel administration, mail distribution, awards and decorations, leaves, and typing support. The staff is composed of the hospital adjutant, personnel sergeant, personnel administrative sergeant, an administrative specialist, mail delivery clerks, and an administrative clerk (Table 3-4). This section coordinates with elements of TAACOM for finance, personnel, and administrative services.

Table 3-4. *Administrative Division Organization*

ADMINISTRATIVE DIVISION			
HOSPITAL ADJUTANT	CPT	70F67	MS
PERSONNEL SERGEANT	SFC	75Z40	NC
PERSONNEL ADMINISTRATIVE SERGEANT	SGT	75B20	NC
ADMINISTRATIVE SPECIALIST	SPC	71L10	
MAIL DELIVERY CLERK	PFC	71L10	(3)
ADMINISTRATIVE CLERK	PFC	71L10	

(1) *Hospital adjutant (70F67)*. This officer is responsible to the Chief, Administrative Service for the adjutant functions within the hospital. He also advises the commander and his staff in the area of personnel management for patients and staff.

(2) *Personnel sergeant (75Z40)*. The personnel sergeant is responsible to the adjutant for specific personnel functions which include personnel management, records, actions, and preparation of SIDPERS changes. He ensures coordination between the MEDCOM and/or medical brigade PAC and the hospital. He advises the hospital commander, adjutant, and other staff members on personnel administrative matters. He also supervises the activities of subordinate personnel.

(3) *Personnel administrative sergeant (75B20)*. This individual is responsible to the personnel sergeant for personnel and administrative functions for the hospital.

(4) *Administrative specialists (71L10)*. These specialists are responsible to the personnel sergeant for general typing and administrative functions for the division.

(5) *Mail delivery clerks (71L10)*. These mail delivery clerks are responsible to the personnel sergeant for establishing and operating the unit mail room. They also assist the personnel sergeant with personnel and clerical duties. They are the designated light-vehicle operators for the division.

e. Patient Administration Division. This division is responsible for patient accountability, medical records management, release of medical information, security of patient baggage and valuables, medical regulation, patient evacuation, decedent affairs, operation of TAMMIS for MEDPAR and MEDREG, and medical statistical reporting. The staff is composed of the patient administration officers, NCOs, and specialists (Table 3-5).

Table 3-5. *Patient Administration Division Organization*

PATIENT ADMINISTRATION DIVISION			
PATIENT ADMINISTRATION OFFICER	LTC	70E67	MS
PATIENT ADMINISTRATION OFFICER	CPT	70E67	MS
PATIENT ADMINISTRATION NCO	SFC	71G40	NC
PATIENT ADMINISTRATION NCO	SGT	71G20	NC (3)
PATIENT ADMINISTRATION SPECIALIST	SPC	71G10	(3)
PATIENT ADMINISTRATION SPECIALIST	PFC	71G10	(3)

(1) *Patient administration officer (70E67)*. As chief of the PAD, this officer is responsible to the hospital XO for planning, organizing, directing, and controlling the patient administration aspects of the hospital. He advises the commander on patient administration matters. He maintains close liaison with the chiefs of services, attending physicians, and chiefs of administrative sections and offices to ensure timely decisions on patient administration matters.

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(2) *Patient administration officer (70E67)*. This officer assists the chief, PAD, in developing plans and procedures for patient administration support, to include patient statistical reports and medical regulation of patient dispositions (refer to FM 8-10-6).

(3) *Patient administration noncommissioned officer (71G40)*. This NCO is responsible to the patient administration officer for patient administration and disposition procedures, inpatient records, and security of patients' personal effects. He works in concert with the supply sergeant to coordinate the return of the soldier to the replacement company. He also supervises the application of the TAMMIS for the MEDPAR System and for the MEDREG System.

(4) *Patient administration noncommissioned officers (71G20)*. These NCOs are responsible to the patient administration NCO for implementing the TAMMIS-MEDPAR and TAMMIS-MEDREG for the hospital. They process correspondence received for admissions and dispositions, medical regulating, decedent affairs, and medical information. These NCOs also assist in supervising subordinate specialists.

(5) *Patient administration specialists (71G10)*. These specialists are responsible for processing all admissions and dispositions, operating TAMMIS equipment, managing medical records, preparing statistical reports, conducting decedent operations, securing patient baggage and valuables, and preparing patients for evacuation.

f. Nutrition Care Division. This division is responsible for providing hospital nutrition services; meal preparation and distribution to patients and staff; dietetic planning; and supervision and control of overall operations. The hospital staff will be fed IAW the theater ration policy. The field medical feeding standard for hospitals is to prepare three hot meals per day plus nourishments and forced fluids using Medical B (or A) Rations. Meals, ready to eat are not authorized for patient use. Rations will be obtained from the supporting TAACOM element. Patient meals, nourishments, and forced fluids will be distributed to the wards three times per day; tube feedings are provided intermittently as patient's nutritional needs require. (Refer to FM 8-505, TM 8-500, and Appendix B of this manual.) The staff is composed of dietitians, hospital food service NCOs, and hospital food service specialists (Table 3-6).

Table 3-6. Nutrition Care Division Organization

NUTRITION CARE DIVISION			
CHIEF, NUTRITION CARE DIVISION	LTC	65C00	SP
DIETITIAN	LT	65C00	SP
HOSPITAL FOOD SERVICE NCO	MSG	91M50	NC
HOSPITAL FOOD SERVICE NCO	SSG	91M30	NC
HOSPITAL FOOD SERVICE NCO	SGT	91M20	NC (5)
HOSPITAL FOOD SERVICE SPECIALIST	SPC	91M10	(10)
HOSPITAL FOOD SERVICE SPECIALIST	PFC	91M10	(9)

(1) *Chief, Nutrition Care Division (65C00, ASI 8I)*. This officer is responsible to the Chief, Administrative Service for the operation of this division. He directs and supervises the operation of nutrition care services.

(2) *Dietitian (65C00, ASI 8I)*. This officer is responsible to the Chief, Nutrition Care Division for formulating policies, developing procedures, and assisting in supervising the operation of nutrition care. This officer also assists physicians in dietary management of patients.

(3) *Hospital food service noncommissioned officer (91M50)*. This NCO serves as the principal NCO for the Nutrition Care Division. He is responsible to the chief of the division for the implementation of policies and procedures and for supervision of subordinate personnel.

(4) *Hospital food service noncommissioned officer (91M30)*. This NCO is responsible to and serves as an assistant to the principal NCO in nutrition care operations. He implements and directs contingency and combat feeding plans.

(5) *Hospital food service noncommissioned officers (91M20)*. These sergeants are responsible to the principal NCO and assist with the clinical and administrative management of nutritional care programs.

(6) *Hospital food service specialists (91M10)*. These hospital food service specialists are responsible to the hospital food service NCOs for performing basic clinical dietetic functions in the dietary management and treatment of patients. They prepare, cook, and serve regular and modified food. They also perform light-vehicle operator/driver duties for the division, to include operator maintenance.

g. Supply and Service Division. This division provides logistics functions throughout the hospital, to include general and medical supplies and maintenance; blood management (see Appendix B, paragraph B-3f [this manual]); utilities such as water distribution, waste disposal, and environmental control of patient treatment areas; power and vehicle maintenance; equipment records and repair parts; fuel distribution; and transportation, to include ground and the coordination of air movement operations. The supply and services division requests resupply from the supporting MEDLOG battalion (rear) and TAACOM ASGs using whatever communication links are available and compatible with the TAMMIS-MEDSUP. Medical logistics and medical maintenance will be managed utilizing TAMMIS-MEDSUP and TAMMIS-MEDMNT. This division coordinates with TAACOM elements for MHE capable of moving DEPMEDS equipment, environmental control units, and power-distribution equipment for the hospital. This section coordinates with elements of the TAACOM ASGs and TAMCA for movement control, nonmedical supplies and equipment, and field services. This section will ensure each RTD soldier has or is issued one basic serviceable uniform and will also coordinate with the TAACOM and TA PERSCOM for the transportation of these soldiers to the replacement companies. Table 3-7 lists the staffing for this division.

(1) *Health service materiel officer (70K67)*. This officer is responsible to the XO. He plans, coordinates, and manages the entire logistics system for the hospital. Additionally, he controls and manages the budget for the hospital commander. He is also responsible for hospital field waste and safety procedures (refer to Appendixes C and D for examples of programs).

(2) *Health service materiel officer (70K67)*. This officer is responsible to the Chief, Supply and Service Division. He has primary responsibility for the medical supply area and functions as the supply officer for the hospital. This officer is also responsible for managing the controlled substances stored by the medical supply section.

Table 3-7. *Supply and Service Division Organization*

SUPPLY AND SERVICE DIVISION				
HEALTH SERVICE MATERIEL OFFICER	LTC	70K67	MS	
HEALTH SERVICE MATERIEL OFFICER	MAJ	70K67	MS	
UNIT MAINTENANCE OFFICER	W3	670A0	WO	
UTILITY OPERATIONS AND MAINTENANCE TECHNICIAN	W2	210A0	WO	
MEDICAL SUPPLY SERGEANT	MSG	76J50	NC	
MOTOR SERGEANT	SFC	63B40	NC	
SENIOR UTILITIES EQUIPMENT REPAIRER	SSG	52C30	NC	
STOCK CONTROL SUPERVISOR	SSG	76J30	NC	
MEDICAL STORAGE SUPERVISOR	SSG	76J30	NC	
SUPPLY SERGEANT	SSG	92Y30	NC	
UTILITIES EQUIPMENT REPAIRER	SGT	52C20	NC	(2)
POWER-GENERATOR EQUIPMENT REPAIRER	SGT	52D20	NC	
LIGHT-WHEELED VEHICLE MECHANIC	SGT	63B20	NC	
QUARTERMASTER AND CHEMICAL EQUIPMENT REPAIRER	SGT	63J20	NC	
MEDICAL SUPPLY SERGEANT	SGT	76J20	NC	
MEDICAL EQUIPMENT REPAIRER SERGEANT	SGT	91A20	NC	
EQUIPMENT RECEIVER/PARTS SPECIALIST	SGT	92A20	NC	
POWER-GENERATOR EQUIPMENT REPAIRER	SP	52D10		
UTILITIES EQUIPMENT REPAIRER	SPC	52C10		(2)
LIGHT-WHEELED VEHICLE MECHANIC	SPC	63B10		
MEDICAL SUPPLY SPECIALIST	SPC	76J10		(5)
PETROLEUM LIGHT VEHICLE OPERATOR	SPC	77F10		
MEDICAL EQUIPMENT REPAIRER	SPC	91A10		
SUPPLY SPECIALIST	SPC	92Y10		
UTILITIES EQUIPMENT REPAIRER	PFC	52C10		(3)
POWER-GENERATOR EQUIPMENT REPAIRER	PFC	52D10		
LIGHT-WHEELED VEHICLE MECHANIC	PFC	63B10		(2)
QUARTERMASTER AND CHEMICAL EQUIPMENT REPAIRER	PFC	63J10		
MEDICAL SUPPLY SPECIALIST	PFC	76J10		(6)
PETROLEUM LIGHT VEHICLE OPERATOR	PFC	77F10		(2)
MEDICAL EQUIPMENT REPAIRER	PFC	91A10		
EQUIPMENT RECEIVER/PARTS SPECIALIST	PFC	92A10		
SUPPLY SPECIALIST	PFC	92Y10		

(3) *Utility operations and maintenance technician (210A0)*. This warrant officer is responsible to the Chief, Supply and Service Division. He advises the command on the status, maintenance, and repairs of power-generator equipment. He supervises organizational maintenance of wheeled vehicles, associated support equipment, and power-generation equipment. He is responsible for the preparation of log books, maintenance records, and associated reports. He coordinates with the hospital operations section in the planning of the hospital layout.

(4) *Unit maintenance officer (670A0)*. This warrant officer is responsible to the Chief, Supply and Service Division. He supervises and assists in the installation and maintenance of hospital equipment. He serves as the technical consultant to all members of the hospital staff on medical maintenance matters. He also performs scheduled (preventive maintenance) and unscheduled (repair) services on medical and related equipment within his scope of responsibility. In addition, he supervises the operation of the TAMMIS-MEDMNT.

(5) *Medical supply sergeant (76J50)*. This NCO assists the division chief in the supervision of the Supply and Service Division, to include medical supply operations, stock control, and medical assemblage management. He is responsible for the development and preparation of plans, maps, overlays, sketches, and other administrative procedures related to employment of the Supply and Service Division.

(6) *Motor sergeant (63B40)*. This NCO is responsible to the utility operations and maintenance technician for unit maintenance on wheeled vehicles and MHE and the upkeep of hand and power tools. He supervises, trains, advises, and inspects subordinate personnel in the use of TAMMS, PLL, and automated systems output. He is also responsible for supervising the training and licensing of vehicle and equipment operators and ensuring their skills qualification.

(7) *Senior utilities equipment repairer (52C30)*. This NCO is responsible to the utility operations and maintenance technician for supervising and performing unit maintenance of utility equipment. He inspects the installation and condition of power-generation and distribution equipment systems.

(8) *Stock control supervisor (76J30)*. This NCO is responsible to the health service materiel officer (CPT) for stock and inventory management of Class VIII supplies. He conducts periodic and special inventories, updating inventory records accordingly. He operates the TAMMIS-MEDSUP for the hospital.

(9) *Medical storage supervisor (76J30)*. This NCO is responsible to the health service materiel officer (CPT) for supervising and planning hospital storage activities. He prepares and updates the warehouse planographs.

(10) *Supply sergeant (92Y30)*. The supply sergeant is responsible to the health service materiel officer (CPT) for the requisitioning, accountability, and issuing of general supplies and equipment for the hospital. He keeps the property book for the hospital on the TACCS, using the SPBS-R. He works in concert with the PAD and requests those minimum essential uniform items required (to include MOPP gear, if required) for RTD soldiers while in transit to the replacement company. He coordinates through PAD to the replacement company for transportation of RTD soldiers. The supply sergeant supervises the activities of the supply specialists (92Y10).

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(11) *Utilities equipment repairers (52C20)*. These NCOs are responsible to the senior utilities equipment repairer for repair and maintenance of utilities-type equipment. They install heating, refrigeration, and air-conditioning equipment. They are also the light-vehicle operators for the section.

(12) *Power-generator equipment repairer (52D20)*. This NCO is responsible to the utility operations and maintenance technician for performing unit-level maintenance functions on power-generation equipment and associated items. He also supervises the subordinate power-generator equipment repairer.

(13) *Light-wheeled vehicle mechanic (63B20)*. This mechanic is responsible to the motor sergeant for those mechanical duties within his scope of responsibility. He also performs driver/operator duties.

(14) *Quartermaster and chemical equipment repairer (63J20)*. This NCO is responsible to the utility operations and maintenance technician for troubleshooting and repairing quartermaster and chemical equipment malfunctions.

(15) *Medical supply sergeant (76J20)*. This NCO performs medical supply duties and is responsible to the stock control supervisor. Also, he supervises the medical supply specialists assigned to his section.

(16) *Medical equipment repairer sergeant (91A20)*. This NCO is responsible to the unit maintenance officer for performing and supervising hospital medical maintenance operations. He is responsible for interpreting technical publications that apply to inspection, troubleshooting, maintenance, repair, calibration, and testing of medical equipment. He supervises subordinate medical equipment repairers.

(17) *Equipment receiver/parts specialist (92A20)*. This soldier is responsible to the utility operations and maintenance technician for maintaining equipment records and repair parts list and performing maintenance control duties. He also performs driver/operator duties.

(18) *Utilities equipment repairers (52C10)*. These repairers are responsible to the senior utilities equipment repairer for unit maintenance of refrigeration equipment, air-conditioning units, and gasoline engines used as prime movers of refrigeration units. They also perform vehicle operator duties.

(19) *Power-generator equipment repairer (52D10)*. This equipment repairer is responsible to the power-generator equipment repairer NCO for operator and unit maintenance of tactical utility and power-generation equipment and associated items.

(20) *Light-wheeled vehicle mechanic (63B10)*. These mechanics are responsible to the light-wheeled vehicle mechanic NCO for performing their designated duties.

(21) *Medical supply specialists (76J10)*. These specialists are responsible to the section NCO to which they are assigned. Assignment of these medical supply specialists to the stock control or medical storage sections will be as determined by the health service materiel officer (MAJ) and the medical supply sergeant (76J50). These supply specialists also perform vehicle operator duties.

(22) *Petroleum light-vehicle operator (77F10)*. These petroleum light-vehicle operators are responsible to the motor sergeant. They receive, store, account and care for, dispense, issue, and ship bulk and packaged POL supplies. They also operate and maintain the petroleum vehicle.

(23) *Medical equipment repairer (91A10)*. This repairer is responsible to the medical equipment repairer/supervisor for performing unit-level maintenance on assigned medical equipment. He also assists in training equipment operators in the performance of operator-level PMCS.

(24) *Supply specialist (92Y10)*. These supply specialists assist the supply sergeant in the accomplishment of his duties.

(25) *Utilities equipment repairers (52C10)*. These repairers are responsible to the senior utilities equipment repairer for unit maintenance of refrigeration equipment, air-conditioning units, and gasoline engines used as prime movers of refrigeration units. They also perform vehicle operator duties.

(26) *Power-generator equipment repairer (52D10)*. This equipment repairer is responsible to the power-generator equipment repairer NCO for operator and unit maintenance of tactical-utility and power-generation equipment and associated items.

(27) *Quartermaster and chemical equipment repairer (63J10)*. This equipment repairer is responsible to the quartermaster and chemical equipment repairer NCO for unit maintenance on quartermaster and chemical equipment.

(28) *Medical equipment repairer (91A10)*. This repairer is responsible to the medical equipment repairer sergeant for performing unit-level maintenance on assigned medical equipment. He also assists in training equipment operators in the performance of operator-level PMCS.

(29) *Equipment receiver/parts specialist (92A10)*. This specialist is responsible to the equipment receiver/parts NCO for maintaining equipment records and repair parts lists and performing maintenance control duties.

h. Nursing Service Control Team. This team is responsible to the Chief, Nursing Service for supervision of all nursing service personnel regardless of organizational placement. This team also provides daily patient reports to the chief nurse and PAD and is responsible for the standards of nursing practice and nursing care throughout the facility. The staff to provide this control is the assistant chief nurse, chiefs of the medical and surgical nursing services, chief and assistant chief wardmasters, and a respiratory NCO (Table 3-8).

(1) *Assistant chief nurse (66N00)*. The assistant chief nurse works in concert with the Chief, Nursing Service. This nurse plans, organizes, executes, and directs nursing care practices for the hospital.

(2) *Chiefs medical/surgical nursing service (66H00)*. These nurses are responsible to the head nurse for planning and implementing nursing care and treatment of medical-surgical patients. They provide direct supervision to subordinate nursing service personnel.

Table 3-8. Nursing Service Control Team Organization

NURSING SERVICE CONTROL TEAM			
ASSISTANT CHIEF NURSE	LTC	66N00	AN
CHIEF, MEDICAL NURSING SVC	LTC	66H00	AN
CHIEF, SURGICAL NURSING SVC	LTC	66H00	AN
CHIEF WARDMASTER	MSG	91C50	NC
ASSISTANT CHIEF WARDMASTER	MSG	91C50	NC
RESPIRATORY NCO	SFC	91V40	NC

(3) *Chief wardmaster (91C50)*. This master sergeant (MSG) manages and supervises enlisted personnel and assists in the planning and operation of nursing service. He coordinates with the operations section in planning the hospital layout. He is responsible to the chief nurse for the erection of the hospital clinical facilities.

(4) *Assistant chief wardmaster (91C50)*. This NCO assists the chief wardmaster in supervising enlisted personnel and in the operation of the nursing service.

(5) *Respiratory noncommissioned officer (91V40)*. Under the technical guidance of a physician, this NCO supervises respiratory activities within the nursing service.

i. Triage/Preoperative/Emergency Medical Treatment. This section provides for the receiving, triaging, and stabilizing of incoming patients. The staff will receive patients, assess their medical condition, provide EMT, and transfer them to the appropriate areas of the hospital. The staff monitors patient conditions and prepares those requiring immediate surgery for the OR. Sick call for organic staff is conducted by this section. Table 3-9 lists the staffing for this section.

(1) *Emergency physician (62A00)*. This physician is responsible to the Chief, Professional Services (or the designated chief of emergency medical services) for management and operations of this section. He examines, diagnoses, and treats or prescribes courses of treatment for the initial phase of diseases and injuries. This officer is the physician primarily responsible for triage.

(2) *Head nurse (66H00)*. This nurse manages the operations of the triage/preoperative/EMT section, to include staffing and supervising nursing personnel and developing nursing policies and procedures. He is also responsible for the standard of nursing care provided and assists in providing patient care.

(3) *Primary care physician (61H00)*. This physician provides care to patients in the areas of general medicine, OB/GYN, psychiatry, PVNTMED, pediatrics, and orthopedics. When the EMT/surgical patient load is heavy, this officer can assume the duties of triage and preoperative evaluation/care. This physician is advanced trauma life support trained.

Table 3-9. Triage/Preoperative/Emergency Medical Treatment Section Organization

TRIAGE/PREOPERATIVE/EMERGENCY MEDICAL TREATMENT			
EMERGENCY PHYSICIAN	MAJ	62A00	MC
HEAD NURSE	MAJ	66H00	AN
PRIMARY CARE PHYSICIAN	CPT	61H00	MC
EMERGENCY PHYSICIAN	CPT	62A00	MC
MEDICAL-SURGICAL NURSE	CPT	66H00	AN (2)
MEDICAL-SURGICAL NURSE	LT	66H00	AN
EMERGENCY TREATMENT NCO	SFC	91B40	NC
EMERGENCY TREATMENT NCO	SSG	91B30	NC (2)
EMERGENCY TREATMENT NCO	SGT	91B20	NC (3)
MEDICAL SPECIALIST	SGT	91B20	NC
MEDICAL SPECIALIST	SPC	91B10	(2)
MEDICAL SPECIALIST	PFC	91B10	(3)

(4) *Emergency physician (62A00)*. This physician examines, diagnoses, and treats or prescribes course of treatment for the initial phase of disease and for injuries.

(5) *Medical-surgical nurses (66H00)*. These nurses plan and implement nursing care under the supervision of the head nurse. They provide direct supervision to subordinate nursing service personnel.

(6) *Emergency treatment noncommissioned officer (91B40)*. This NCO is responsible to the senior nurse. He manages and supervises the enlisted nursing staff. He is also responsible for supplies and equipment.

(7) *Emergency treatment noncommissioned officers (91B30/91B20)*. These NCOs are supervised by the principal NCO. They perform direct patient care within their scope of practice and under professional supervision. They supervise subordinate enlisted nursing staff. The emergency treatment NCO (91B30) also performs radio operator duties for the section.

(8) *Medical specialists (91B10)*. Under professional supervision, these specialists are responsible for providing nursing care within their scope of practice.

j. Operating Room/Central Materiel Service Control Team. This team provides supervision of the OR and CMS. It is responsible for the scheduling of the nursing staff; preparing and maintaining the OR

and CMS; and maintaining surgical, anesthetic, and nursing standards within these areas. The OR/CMS control team is composed of an anesthesiologist, an OR clinical head nurse, an OR NCO, and a CMS specialist (Table 3-10).

Table 3-10. Operating Room/CMS Control Team Organization

OPERATING ROOM/CMS CONTROL TEAM			
ANESTHESIOLOGIST	LTC	60N00	MC
CLINICAL HEAD NURSE OR	LTC	66E00	AN
CHIEF OR NCO	SFC	91D40	NC
CMS SPECIALIST	SPC	91D10	

(1) *Anesthesiologist (60N00)*. This physician supervises team members and is responsible to the Chief, Surgical Service. He establishes the hospital’s anesthesiology program. He administers or supervises administration of anesthetics to patients in the multiple ORs.

(2) *Clinical head nurse operating room (66E00, ASI 8J)*. This officer is responsible to the chief nurse for the management of daily operations of the OR and CMS, to include scheduling and supervising the nursing staff. He coordinates with the Chief, Surgical Service in scheduling patient cases. He is responsible for the quality of nursing care provided. This officer holds ASI 8J as an infection control officer.

(3) *Chief operating room noncommissioned officer (91D40)*. This NCO is responsible to the head nurse for the supervision and management of the enlisted OR nursing staff. He also manages supplies and equipment.

(4) *Central materiel service specialist (91D10)*. This specialist is responsible to the clinical head nurse for supplies and equipment maintenance.

k. *Operating Room A*. This section provides general surgical services with two OR tables for a total of 36 hours of table time per day. The staff is composed of an otolaryngologist, general surgeons, OR nurses, nurse anesthetists, ENT NCO, OR NCO, and OR specialists (Table 3-11).

(1) *Otolaryngologist (60T00)*. This physician is responsible to the Chief, Surgical Service for Operating Room A. He examines, diagnoses, and treats or prescribes course of treatment for personnel suffering from diseases, injuries, or disorders of ENT. He performs surgery when required.

(2) *General surgeon (61J00)*. These physicians examine, diagnose, and treat or prescribe courses of treatment and surgery for patients having injuries or disorders with surgical conditions.

Table 3-II. Operating Room A Organization

OPERATING ROOM A			
OTOLARYNGOLOGIST	MAJ	60T00	MC
GENERAL SURGEON	MAJ	61J00	MC (2)
OPERATING ROOM NURSE	MAJ	66E00	AN
OPERATING ROOM NURSE	CPT	66E00	AN
CLINICAL NURSE, ANESTHETIST	CPT	66F00	AN (2)
ENT NCO	SSG	91B30	NC
OPERATING ROOM NCO	SSG	91D30	NC
OPERATING ROOM SPECIALIST	SGT	91D20	NC
OPERATING ROOM SPECIALIST	SPC	91D10	
OPERATING ROOM SPECIALIST	PFC	91D10	

(3) *Operating room nurses (66E00)*. The senior nurse is responsible to the clinical head nurse, OR, for all nursing activities of this section. The senior nurse is also responsible for the supervision of the enlisted OR staff. These two OR nurses perform nursing duties in any phase of the operative process for patients undergoing surgery. They ensure safe supplies and equipment are available for all operative services.

(4) *Clinical nurses, anesthetist (66F00)*. These two anesthetists perform, in consultation with an anesthesiologist or other physician anesthesia, nursing duties for patients requiring anesthesia for surgical or diagnostic procedures, respiratory care, cardiopulmonary resuscitation, and/or fluid therapy. They provide preanesthetic evaluation/therapy, administers all types of anesthetic techniques, to include monitored anesthesia care, local, regional, and general anesthesia, and perform postanesthesia evaluation/therapy.

(5) *Ear, nose, and throat noncommissioned officer (91B30, ASI P2)*. This NCO works under the supervision of the otolaryngologist. He provides treatment to ENT patients as directed. He holds ASI P2, ENT specialty.

(6) *Operating room noncommissioned officer (91D30)*. This NCO is responsible to the chief, OR nurse for supplies, equipment maintenance, and supervision of enlisted nursing staff.

(7) *Operating room specialists (91D20/91D10)*. These specialists provide patient care within their scope of practice under professional supervision.

l. Operating Room B. This section provides orthopedic surgical service with two OR tables for a total of 36 hours of table time per day. The staff is composed of orthopedic surgeons, OR nurses, nurse anesthetists, an OR NCO, and OR specialists (Table 3-12). This OR may be used by the oral surgeon in performing oral and maxillofacial surgery.

Table 3-12. Operating Room B Organization

OPERATING ROOM B			
ORTHOPEDIC SURGEON	MAJ	61M00	MC (2)
OPERATING ROOM NURSE	CPT	66E00	AN (2)
CLINICAL NURSE, ANESTHETIST	CPT	66F00	AN (2)
OPERATING ROOM NCO	SSG	91D30	NC
OPERATING ROOM SPECIALIST	SGT	91D20	NC
OPERATING ROOM SPECIALIST	SPC	91D10	
OPERATING ROOM SPECIALIST	PFC	91D10	

(1) *Orthopedic surgeons (61M00).* The senior physician is responsible to the Chief, Surgical Service for operation of the OR. The physicians examine, diagnose, and treat or prescribe courses of treatment and surgery for patients having disorders, malfunctions, diseases, and/or injuries of the musculoskeletal system.

(2) *Remaining staff.* The duties and responsibilities of the remaining OR B staff are the same as the corresponding staff identified in paragraph 3-4k. The OR specialist (91D10) is the designated vehicle operator for this section.

m. Orthopedic Cast Clinic. This section is responsible to the senior orthopedic surgeon for casting, splinting, and traction services for the hospital. The staffing is composed of an orthopedic NCO, an orthopedic sergeant, and an orthopedic specialist (Table 3-13). Each staff member holds the ASI P1, orthopedic specialty.

Table 3-13. Orthopedic Cast Clinic Organization

ORTHOPEDIC CAST CLINIC			
ORTHOPEDIC NCO	SSG	91B30	NC
ORTHOPEDIC SERGEANT	SGT	91B20	NC
ORTHOPEDIC SPECIALIST	SPC	91B10	

(1) *Orthopedic noncommissioned officer (91B30)*. This NCO is responsible to the senior orthopedic surgeon for the operation of this clinic. He supervises the other assigned cast clinic personnel.

(2) *Orthopedic sergeant/specialist (91B20/91B10)*. Under professional supervision, this sergeant and specialist provide patient care within their scope of practice.

n. *Central Materiel Service*. This section operates two CMS units which provide sterilization of OR equipment, surgical instruments, and supplies, as well as sterile supplies for other patient care areas. The staff is composed of two CMS NCOs, two CMS sergeants, and four CMS specialists (Table 3-14).

Table 3-14. *Central Materiel Service Organization*

CENTRAL MATERIEL SERVICE (2)			
CMS NCO	SSG	91D30	NC (2)
CMS SERGEANT	SGT	91D20	NC (2)
CMS SPECIALIST	SPC	91D10	(2)
CMS SPECIALIST	PFC	91D10	(2)

(1) *Central materiel service noncommissioned officers (91D30)*. These NCOs work under the supervision of the chief medical NCO of the OR/CMS control team. They supervise the activities of the CMS sergeants and specialists. They ensure that sterilization techniques and procedures are applied; they further ensure that safe sterile supplies are provided to users on a timely basis. They also supervise operator-level maintenance of CMS equipment.

(2) *Central materiel service sergeants/specialists (91D20/91D10)*. These CMS sergeants and specialists are responsible to the CMS section NCOs. They perform CMS functions within their scope of responsibility.

o. *Dental Services*. This section provides dental services and consultation for patients and staff. During mass casualty situations, the dentists assist in the delivery of ATM. The oral surgeon uses the OR B or the dental operatory to perform oral and maxillofacial surgery. The staff is composed of an oral and maxillofacial surgeon, a comprehensive dental officer, a preventive dentistry specialist NCO, and a dental specialist (Table 3-15).

(1) *Oral and maxillofacial surgeon (63N00)*. This officer examines, diagnoses, and treats or prescribes courses of treatment for conditions which involve the oral and maxillofacial structures, to include wounds and infections. Additionally, he provides treatment to patients referred by other dental and medical facilities when required oral and maxillofacial care is beyond the capability of the referring facility. This officer is responsible to the Chief, Professional Services for the technical and administrative management of the section.

Table 3-15. Dental Services Organization

DENTAL SERVICES			
ORAL AND MAXILLOFACIAL SURGEON	MAJ	63N00	DC
COMPREHENSIVE DENTAL OFFICER	CPT	63B00	DC
PREVENTIVE DENTISTRY SPECIALIST NCO	SGT	91E20	NC
DENTAL SPECIALIST	SPC	91E10	

(2) *Comprehensive dental officer (63B00)*. This officer provides emergency care to staff and in-patients. When work load permits, this officer provides maintaining-level dental care to the same population and to patients referred from other dental and medical facilities when the required dental treatment is beyond the capability of the referring facility. In addition, he provides OR assistance and support to the oral and maxillofacial surgeon, when requested. He also augments the ATM capability of the hospital, particularly during mass casualty situations.

(3) *Preventive dentistry specialist noncommissioned officer (91E20, ASI X2)*. This NCO assists the dental officers in prevention, examination, and treatment of diseases of teeth and oral region. He also performs those administrative tasks as directed by the oral surgeon. He supervises operator-level maintenance of the dental equipment. This NCO holds the ASI X2, designating formal preventive dentistry specialist training.

(4) *Dental specialist (91E10)*. This specialist is responsible to the preventive dental NCO. He assists in the prevention, examination, and treatment of diseases of teeth and oral region. He performs operator-level maintenance of dental equipment.

p. Inpatient Medicine A. This section provides medical services such as consultations, as requested; evaluation and treatment of infectious disease and internal medicine disorders; evaluation and treatment of skin disorders; and treatment of patients with gynecological disease, injury, or disorders. Staffing includes an obstetrician/gynecologist, internists, and primary care physicians (Table 3-16).

(1) *Obstetrician/gynecologist (60J00)*. This physician provides medical care during pregnancy, performs obstetric deliveries, and examines, diagnoses, and treats or prescribes courses of treatment for patients who have gynecological disease, injury, or disorders. He is responsible to the Chief, Professional Services for the technical and administrative management of this section.

(2) *Internists (61F00)*. These physicians examine, diagnose, and treat patients with medical illnesses and recommend courses of management for those illnesses.

(3) *Primary care physicians (61H00)*. These physicians provide comprehensive health care to patients in the areas of general medicine, OB/GYN, psychiatry, PVNTMED, pediatrics, and orthopedics

in both inpatient and outpatient care. They may be used to augment surgical specialties in triage and preoperative care.

Table 3-16. *Inpatient Medicine A Organization*

INPATIENT MEDICINE A			
OBSTETRICIAN AND GYNECOLOGIST	MAJ	60J00	MC
INTERNIST	MAJ	61F00	MC (2)
PRIMARY CARE PHYSICIAN	CPT	61H00	MC (2)

q. Intensive Care Unit Wards. These three 12-bed ICUs provide for critically injured or ill patients. This section is under the supervision of the nursing service control team. Nursing care is performed for those patients who require close observation and vital sign monitoring, complex nursing care, and mechanical respiratory assistance. The ICU is also used as a postanesthesia recovery area for patients after surgery. Intensive care is provided by a staff of clinical head nurses, clinical nurses (only three of five CPTs, 66H, will hold the ASI 8A), wardmasters, practical nurses, respiratory NCOs, respiratory sergeants, and medical specialists (Table 3-17).

Table 3-17. *Intensive Care Ward Organization*

INTENSIVE CARE WARD (3)			
CLINICAL HEAD NURSE, INTENSIVE CARE UNIT	MAJ	66H00	AN (3)
CLINICAL NURSE, INTENSIVE CARE UNIT	CPT	66H00	AN (9)
CLINICAL NURSE, INTENSIVE CARE UNIT	LT	66H00	AN (6)
WARDMASTER	SFC	91C40	NC (3)
PRACTICAL NURSE	SSG	91C30	NC (9)
RESPIRATORY NCO	SSG	91V30	NC (3)
PRACTICAL NURSE	SGT	91C20	NC (9)
RESPIRATORY SERGEANT	SGT	91V20	NC (3)
MEDICAL SPECIALIST	SPC	91B10	(6)

(1) *Clinical head nurses, intensive care unit (66H00, ASI 8A)*. These officers are responsible to the nursing service control team for managing the operations of the ICU, to include the development of nursing policies and procedures and the scheduling and supervision of nursing staff. They are responsible for the quality of nursing care. They supervise all other ICU nursing personnel. These clinical head nurses hold an ASI of 8A, intensive care.

(2) *Clinical nurses, intensive care unit (66H00, ASI 8A)*. These clinical nurses are responsible to the clinical head nurse for planning and providing nursing care of a specialized and technical nature for critically injured or ill and postanesthesia patients. They supervise enlisted nursing personnel. As noted above, only three of five of the clinical nurses (CPTs) hold an ASI of 8A on any ICU.

(3) *Wardmasters (91C40)*. These NCOs work under the supervision of the ICU head nurses. They also work in concert with the chief wardmaster of the nursing control team. They manage and supervise enlisted personnel and assist in the planning and operation of the ICU.

(4) *Practical nurses (91C30)*. These practical nurses are responsible to the wardmasters. They provide direct patient care under professional supervision within their scope of practice. They also assist in supervising the subordinate enlisted nursing staff.

(5) *Respiratory noncommissioned officers (91V30)*. These NCOs provide technical guidance and training of subordinate personnel. They manage the respiratory care functions under the supervision of a physician or the respiratory NCO (SFC, 91V40 [see Table 3-8, Nursing Service Control Team]).

(6) *Practical nurses (91C20)*. These practical nurses perform preventive, therapeutic, and emergency nursing care procedures under professional supervision within their scope of practice.

(7) *Respiratory sergeants (91V20)*. Under the supervision of a physician or respiratory noncommissioned officer, these respiratory sergeants provide treatment for patients with cardiopulmonary problems. Included is emergency care in cases of heart failure, shock, treatment of acute respiratory symptoms in cases of head injuries, and respiratory complications in patients having thoracic or abdominal surgery.

(8) *Medical specialists (91B10)*. Under the supervision of a clinical or practical nurse, these specialists provide direct patient care within their scope of practice. They are designated vehicle operators for the section.

r. Intermediate Care Wards. These seven ICWs with 20 beds per ward are identical in personnel and equipment. They are under the supervision of the nursing service control team. These wards provide care for patients whose conditions vary from acute to moderate. The nursing care staff consists of clinical head nurses, clinical nurses, wardmasters, practical nurses, and medical specialists (Table 3-18). The responsibilities and functions of the clinical head nurses, clinical nurses (66H00), wardmasters, practical nurses, and medical specialists are the same as those identified in paragraph 3-4*q* above. The clinical nurses (66H00) assist the physicians and more senior clinical nurses in their duty performance. They perform first-level nursing care duties within their scope of clinical nursing activities. The lowest-grade medical specialist is the designated vehicle operator for the section.

Table 3-18. Intermediate Care Ward Organization

INTERMEDIATE CARE WARD (7)				
CLINICAL HEAD NURSE	MAJ	66H00	AN	(3)
CLINICAL NURSE	CPT	66H00	AN	(7)
CLINICAL NURSE	LT	66H00	AN	(7)
CLINICAL NURSE	LT	66H00	AN	(7)
WARDMASTER	SFC	91C40	NC	(4)
PRACTICAL NURSE	SSG	91C30	NC	(14)
WARDMASTER	SSG	91C30	NC	(3)
PRACTICAL NURSE	SGT	91C20	NC	(35)
MEDICAL SPECIALISTS	SPC	91B10		(7)
MEDICAL SPECIALISTS	PFC	91B10		(7)

s. *Neuropsychiatric Ward and Consultation Service.* This section provides NP diagnosis and consultation to all areas of the hospital; it staffs a 20-bed ward for inpatient stabilization of NP patients. The staff for this section consists of a psychiatrist, psychiatric nurses, a social worker, a clinical nurse, psychiatric NCOs, a psychiatric wardmaster, an occupational therapy NCO, a behavioral science NCO, and psychiatric specialists (Table 3-19). Medical command and brigade headquarters integrate the GH's NP section's operations with those of the ASMB mental health section and with the CSC units in the area. To the extent possible, the GH's NP ward should receive only those NP and/or stress casualties who are too disturbed to receive reconditioning treatment at Echelon III or IV CSC company reconditioning centers or at Echelon IV FHs. These casualties include—

- Cases of psychosis, paranoia, mania, and suicidal depression.
- Substance overdose or withdrawal requiring detoxification.
- Mental or bodily symptoms which require the GH laboratory and x-ray capability to rule out life- or limb- threatening organic causes.

The mission of the NP ward is to provide brief (2 to 4 days) stabilization. The patients are then reevaluated to determine if they should be—

- Evacuated to CONUS for further stabilization and evacuation, definitive treatment, or administrative discharge.

- Transferred to a FH or CSC company in the COMMZ for RTD after 14 to 28 days of further reconditioning (depending on the theater evacuation policy).
- Detoxified for substance abuse/dependence, and returned to duty in the COMMZ for administrative disposition.

Table 3-19. Neuropsychiatric Ward and Consultation Service Organization

NEUROPSYCHIATRIC WARD AND CONSULTATION SERVICE			
PSYCHIATRIST	MAJ	60W00	MC
PSYCHIATRIC/MENTAL HEALTH NURSE	MAJ	66C00	AN
PSYCHIATRIC/MENTAL HEALTH NURSE	CPT	66C00	AN (2)
SOCIAL WORK OFFICER	CPT	73A67	MS
CLINICAL NURSE	LT	66H00	AN
MENTAL HEALTH NCO	SSG	91X30	NC
MENTAL HEALTH WARDMASTER	SSG	91X30	NC
OCCUPATIONAL THERAPY NCO	SGT	91B20	NC
MENTAL HEALTH NCO	SGT	91X20	NC (3)
MENTAL HEALTH NCO	SGT	91X20	NC
MENTAL HEALTH SPECIALIST	SPC	91X10	(2)
MENTAL HEALTH SPECIALIST	PFC	91X10	

(1) *Psychiatrist (60W00)*. This officer is responsible to the Chief, Professional Services for the technical and administrative management of this section. He supervises the NP service staff, advises the hospital commander, and provides technical supervision of NP/mental health activities throughout the hospital. He examines, diagnoses, treats and/or prescribes treatment, and recommends disposition for patients and staff with NP and stress disorders.

(2) *Psychiatric/mental health nurse (66C00)*. This officer is responsible for the technical and professional management of the NP ward nursing staff. He provides psychiatric nursing consultation to all other wards of the GH. He provides specialized nursing services for patients with psychiatric and emotional problems and promotes mental health within the hospital and support area. This nurse performs liaison, consultative, and training functions throughout the GH to enhance the continuity and quality of patient care.

(3) *Psychiatric/mental health nurses (66C00)*. These officers are responsible to the psychiatrist and head nurse for operation of the ward and consultation throughout the hospital. They develop and carry out nursing care plans for each NP ward patient. These nurses also assist in the training, supervising, and technical management of subordinate NP ward staff, including the nonpsychiatrically trained nurses and augmenting technicians.

(4) *Social work officer (73A67)*. This officer is responsible to the psychiatrist. He provides stress control prevention and treatment throughout the hospital and especially to the minimum care (RTD-oriented) wards. He supports the NP ward by evaluating the RTD potential of patients, based on interviews with the soldier, plus data from the soldier's unit. He coordinates RTD, administrative disposition, or transfer to the CSC reconditioning center. The social work officer also ensures effective use of social service support agencies for patients and GH staff members.

(5) *Clinical nurse (66H00)*. This clinical nurse is responsible to the head nurse for direct and surgical nursing care to patients on the ward. He is cross-trained in stress control techniques and procedures.

(6) *Mental health noncommissioned officer (91X30)*. This NCO assists the wardmaster in the performance of his duties. He provides psychiatric nursing care duties within his scope of practice.

(7) *Mental health wardmaster (91X30)*. This NCO assists the psychiatrist and nursing staff with the management and administrative functions of the ward. He provides psychiatric nursing care duties within his scope of practice.

(8) *Mental health noncommissioned officers (91X20)*. Under professional supervision, these NCOs provide psychiatric nursing care within their scope of practice.

(9) *Mental health noncommissioned officer (91X20)*. Under professional supervision, this NCO provides mental health assessment and care within his scope of practice.

(10) *Occupational therapy noncommissioned officer (91B20, ASI N3)*. This NCO is responsible to the head nurse for establishing and conducting the work therapy and recreational programs throughout the GH and especially the minimal care wards. Under professional supervision, he provides occupational therapy within his scope of practice. He holds the ASI N3, occupational therapy. If additional clinical guidance is required for planning and implementing occupational therapy programs, occupational therapists (65A) are assigned to CSC companies and detachments, FHs, and GHs.

(11) *Mental health specialists (91X10)*. These specialists are responsible to the psychiatric NCOs. Under professional supervision, they provide care and treatment for psychiatric, drug, and alcohol patients within their scope of practice.

t. Minimal Care Wards. These two minimal care wards of 20 beds each provide care for patients whose conditions vary from moderate to minimal. These are convalescent patients with minimal requirements for nursing and medical treatment. Staffing is composed of clinical nurses, a wardmaster, a practical nurse, and medical specialists (Table 3-20).

Table 3-20. Minimal Care Ward Organization

MINIMAL CARE WARD (2)			
CLINICAL NURSE	LT	66H00	AN (2)
WARDMASTER	SSG	91C30	NC
PRACTICAL NURSE	SGT	91C20	NC
MEDICAL SPECIALISTS	SPC	91B10	(2)
MEDICAL SPECIALISTS	PFC	91B10	(2)

(1) *Clinical nurses (66H00)*. These nurses are responsible to the nursing service control team for management and operations of the ward. They supervise the enlisted nursing staff and perform appropriate nursing duties.

(2) *Wardmaster (91C30)*. This NCO assists the clinical nurses in ward management. He provides nursing care leadership and supervises subordinate staff. This NCO also works in concert with the chief wardmaster of the nursing service control team.

(3) *Practical nurse (91C20)*. This practical nurse is responsible to the wardmaster and, under professional supervision, performs nursing care duties within his scope of practice.

(4) *Medical specialists (91B10)*. Under professional supervision, these specialists provide medical treatment to patients within their scope of practice.

u. Pharmacy Services. The pharmacy is responsible for quality control of pharmaceuticals, distribution of bulk drugs, maintenance and publication of the hospital formulary, and the IV-additive program. This section maintains a registry for controlled drugs. The pharmacy provides discharge medications for the required number of days to complete therapy and/or a 5-day supply of medications required for air evacuation out of theater. The pharmacy requisitions required supplies through the logistics section to the supporting MEDLOG battalion (rear). The staff is composed of pharmacy officers, NCOs, and specialists (Table 3-21). Three of the enlisted staff hold the ASI Y7 (sterile pharmacy specialty) for the IV-additive program.

(1) *Chief, pharmacy services (67E00)*. This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services). He directs, plans, and participates in all hospital pharmaceutical activities. He is responsible for and maintains security within the pharmacy area and monitors the storage, security, and control, to include inventories and audit trails, of controlled substances. He also acts as a liaison between the professional staff and the logistics office for requisition of pharmaceutical items.

(2) *Pharmacy officer (67E00)*. This officer assists the Chief, Pharmacy Services in the performance of his duties. He supervises other pharmaceutical staff and collects data for required reports.

Table 3-21. Pharmacy Services Organization

PHARMACY SERVICES			
CHIEF, PHARMACY SERVICES	MAJ	67E00	MS
PHARMACY OFFICER	CPT	67E00	MS
SENIOR PHARMACY NCO	MSG	91Q50	NC
PHARMACY NCO	SSG	91Q30	NC
STERILE PHARMACY NCO	SSG	91Q30	NC
PHARMACY SPECIALIST	SPC	91Q10	
STERILE PHARMACY SPECIALIST	SPC	91Q10	
PHARMACY SPECIALISTS	PFC	91Q10	
STERILE PHARMACY SPECIALIST	PFC	91Q10	

(3) *Senior pharmacy noncommissioned officer (91Q50)*. This NCO serves as the NCOIC of pharmacy services. He is responsible for the work schedule of subordinate specialists; he is also responsible for ensuring adequate training for all subordinate specialists. Under the supervision of a pharmacist, he prepares, controls, and issues pharmaceutical products. He also assists with the supervision of the section, providing technical guidance to subordinate personnel.

(4) *Pharmacy and sterile pharmacy noncommissioned officers (91Q30)*. These NCOs assist the pharmacy officer and the pharmacy NCO in their duty performance. They prepare, control, and issue pharmaceutical products, ensuring compliance with Army and Federal rules, laws, and regulations relative to pharmacy operations. The sterile pharmacy NCO holds the ASI Y7, sterile pharmacy specialty. This specialist serves as the NCOIC of the sterile products service. He performs sterile technique procedures in the preparation of items such as IV-additives which are used to combat infection and to restore and maintain electrolyte and nutritional balance.

(5) *Pharmacy/sterile pharmacy specialists (91Q10)*. Under professional supervision, these specialists perform pharmaceutical duties within their scope of duties. The two sterile pharmacy specialists hold the ASI Y7. Their duties as sterile pharmacy specialists will be the same as those identified in paragraph (4) above.

v. *Laboratory Services*. This section performs a general, but limited, array of analytical procedures in hematology, urinalysis, chemistry, microbiology, serology, and blood bank. Laboratory capabilities may be tailored to meet the mission needs of a specific geographic region. The staff is composed of a clinical laboratory officer, medical laboratory NCOs, and medical laboratory specialists (Table 3-22).

Table 3-22. Laboratory Services Organization

LABORATORY SERVICES			
CLINICAL LABORATORY OFFICER	MAJ	71E67	MS
MEDICAL LABORATORY NCO	MSG	91K50	NC
MEDICAL LABORATORY NCO	SFC	91K40	NC
MEDICAL LABORATORY NCO	SSG	91K30	NC (3)
MEDICAL LABORATORY SPECIALIST	SSG	91K20	NC (2)
MEDICAL LABORATORY SPECIALIST	SPC	91K10	(2)
MEDICAL LABORATORY SPECIALIST	PFC	91K10	(3)

(1) *Clinical laboratory officer (71E67)*. This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services) for management and operation of the laboratory section. He directs the performance of laboratory procedures used in the detection, diagnosis, treatment, and prevention of disease. He establishes and supervises an appropriate laboratory quality control program. He also supervises the blood bank activities.

(2) *Medical laboratory noncommissioned officer (91K50)*. This senior laboratory NCO functions as the laboratory NCOIC. He advises and assists the laboratory officer in laboratory operations, supply economy and inventory management, advanced technical procedures, and administrative requirements. He provides technical guidance to the subordinate staff.

(3) *Medical laboratory noncommissioned officer (91K40)*. This laboratory NCO is responsible to the senior laboratory NCO for laboratory operations and for supervision of the subordinate staff. He performs the full array of laboratory procedures.

(4) *Medical laboratory noncommissioned officers (91K30)*. These NCOs perform elementary and advanced examinations of patient-derived specimens (including suspect biological warfare specimens) to aid in the diagnosis, treatment, and prevention of disease.

(5) *Medical laboratory specialists (91K20)*. These laboratory specialists perform clinical laboratory procedures in hematology, biochemistry, serology, bacteriology, parasitology, and urinalysis.

(6) *Medical laboratory specialists (91K10)*. Under the supervision of the laboratory NCO, these specialists perform elementary clinical laboratory procedures.

w. *Blood Bank*. This section provides all routine blood grouping and typing, crossmatch testing, and issue of blood products, emergency blood collection, shipment of blood donor samples for infectious disease screening, blood storage, and inventory management. It has the capacity to store and utilize frozen

plasma. Staffing for this section includes blood donor center operations NCOs and specialists (Table 3-23). All blood bank personnel hold the ASI M4, blood donor center operations.

Table 3-23. Blood Bank Organization

BLOOD BANK			
BLOOD DONOR CENTER OPERATIONS NCO	SSG	91K30	NC (2)
BLOOD DONOR CENTER OPERATIONS NCO	SGT	91K20	NC
BLOOD DONOR CENTER OPERATIONS SPECIALIST	SPC	91K10	(2)
BLOOD DONOR CENTER OPERATIONS SPECIALIST	PFC	91K10	(2)

(1) *Blood donor center operations noncommissioned officers (91K30).* These NCOs are responsible to the Chief, Professional Services (or the designated chief of ancillary services) for the management and operation of this section. They perform advanced procedures in all phases of blood banking. They supervise subordinate specialists in the performance of their duties.

(2) *Blood donor operations specialists (91K20/91K10, ASI M4).* These specialists work under the supervision of the blood donor center operations NCO in the performance of the full array of clinical laboratory and blood banking procedures. They provide direct support to the blood bank section and backup support to the other laboratory sections.

x. *Radiology Service.* This section provides radiological services to all areas of the hospital and operates on a 24-hour basis. Staffing includes a diagnostic radiologist, a chief radiology NCO, a senior radiology NCO, radiology sergeants, and radiology specialists (Table 3-24).

Table 3-24. Radiology Service Organization

RADIOLOGY SERVICE			
DIAGNOSTIC RADIOLOGIST	MAJ	61R00	MC
CHIEF RADIOLOGY NONCOMMISSIONED OFFICER	MSG	91P50	NC
SENIOR RADIOLOGY NONCOMMISSIONED OFFICER	SFC	91P40	NC
RADIOLOGY SERGEANT	SGT	91P20	NC (3)
RADIOLOGY SPECIALIST	SPC	91P10	(2)

(1) *Diagnostic radiologist (61R00)*. This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services) for the management and operation of this section. He performs and interprets all diagnostic radiological and fluoroscopic procedures, including special vascular studies and imaging, on patients referred by other physicians.

(2) *Chief radiology noncommissioned officer (91P50)*. This NCO assists the radiologist in the performance of his duties, to include technical guidance to subordinate personnel. He assists in the technical and administrative management of this section.

(3) *Senior radiology noncommissioned officer (91P40)*. This NCO assists the chief NCO in the supervision of subordinate personnel and administrative management of this section. Under the supervision of the radiologist, he performs radiological duties within his scope of training.

(4) *Radiology sergeants and specialists (91P20/91P10)*. Under the supervision of the radiology NCO, these individuals perform duties within their scope of training. They also perform vehicle operator duties for the section.

y. *Physical/Occupational Therapy Service*. This section provides inpatient physical/occupational therapy services and consultation for patients. The primary wartime role of this section is evaluating and treating neuromusculoskeletal conditions and providing burn/wound care to patients with potential for RTD within the theater evacuation policy. During mass casualty situations, physical therapy personnel may be utilized in managing minimal or delayed patients or augmenting the orthopedic staff. The staff is composed of a physical therapist and a physical therapy sergeant (Table 3-25).

Table 3-25. *Physical/Occupational Therapy Service Organization*

PHYSICAL/OCCUPATIONAL THERAPY SERVICE			
PHYSICAL THERAPIST	CPT	65B00	SP
PHYSICAL THERAPY SERGEANT	SSG	91B30	NC

(1) *Physical therapist (65B00)*. This officer is responsible to the Chief, Professional Services (or the designated chief of ancillary services) for the management and supervision of physical therapy services. The physical therapist plans and supervises physical therapy programs upon referral from medical officers. This officer also provides guidance in the areas of physical fitness, physical training, and injury prevention.

(2) *Physical therapy sergeant (91B30, ASI N9)*. This physical therapy sergeant is responsible to the physical therapist. He provides physical therapy treatment to patients within his scope of practice. He holds the ASI N9, physical therapy specialty.

z. *Hospital Ministry Team.* This section is composed of a chaplain, a senior chaplain’s assistant, and a chaplain’s assistant to provide religious support and pastoral care ministry for assigned staff and patients (Table 3-26).

Table 3-26. *Hospital Ministry Team Organization*

HOSPITAL MINISTRY TEAM			
HOSPITAL CHAPLAIN	CPT	56A00	CH
SENIOR CHAPLAIN’S ASSISTANT	SGT	71M20	NC
CHAPLAIN’S ASSISTANT	PFC	71M10	

(1) *Hospital chaplain (56A00, ASI 7R).* This chaplain, supervised by the hospital headquarters chaplain, coordinates the program of religious ministries, including workshops, pastoral counseling, and religious education, for the hospital. He supervises the activities of the other ministry team staff.

(2) *Senior chaplain’s assistant (71M20).* This senior chaplain’s assistant is responsible to the hospital chaplain and assists him in his duties. He also supervises the activities of the chaplain’s assistant.

(3) *Chaplain’s assistant (71M10).* This assistant is responsible to the senior chaplain’s assistant. He prepares the chapel for worship and prepares sacraments of Protestant, Catholic, Orthodox, and Jewish faiths.

3-5. The Hospital Unit, Surgical

The HUS augments the HUB to form the GH. The HUS is composed of the following sections:

a. *Unit Headquarters.* This section provides augmentation to the HUB to assist in nursing supervision, hospital operation, and company headquarters operation. The staff is composed of the HUS commander, an assistant chief nurse, a field medical assistant, a detachment NCO, and a patient administration specialist (Table 3-27).

(1) *Hospital commander (61J00).* This officer, in his capacity as the HUS commander, ensures a smooth and functional integration of unity of the HUS with the HUB. Once the two units are combined to form a GH, this officer performs the duties of a general surgeon in OR C.

(2) *Assistant chief nursing service (66N00).* This officer functions in unison with the chief nurse of the HUB in providing the necessary planning, execution, and direction for the HUS.

(3) *Field medical assistant (70B67).* This officer assists the HUS commander in the areas of organizational administration, supply, training, operation, transportation, and patient evacuation. He augments the HUB operations section and functions as a hospital plans officer.

Table 3-27. Hospital Unit, Surgical Headquarters Organization

UNIT HEADQUARTERS			
COMMANDER	LTC	61J00	MC
ASSISTANT CHIEF NURSING SERVICE	LTC	66N00	AN
FIELD MEDICAL ASSISTANT	CPT	70B67	MS
DETACHMENT NCO	SFC	91B40	NC
PATIENT ADMINISTRATION SPECIALIST	SPC	71G10	

(4) *Detachment noncommissioned officer (91B40)*. The detachment NCO is the principal enlisted assistant to the HUS commander. He maintains liaison between the HUS commander and assigned NCOs, provides guidance to enlisted members of the HUS, and represents them to the commander. When the HUB and HUS unite to form a GH, he also functions as the first sergeant of the medical holding detachment. As such, he is supervised by the HUB company headquarters commander who functions as the commander, medical holding detachment.

(5) *Patient administration specialist (71G10)*. This specialist works in concert with the PAD of the HUB in preparing and maintaining patient records, to include statistical data for required reports.

b. Supply and Service Division (Augmentation). Because of the increased work load associated with the HUS, this section augments the Supply and Service Division of the HUB. Staffing includes a medical supply sergeant, a supply sergeant, medical supply specialists, and supply specialists (Table 3-28).

Table 3-28. Supply and Service Division Organization

SUPPLY AND SERVICE DIVISION			
MEDICAL SUPPLY SERGEANT	SGT	76J20	NC
SUPPLY SERGEANT	SGT	92Y20	NC
MEDICAL SUPPLY SPECIALIST	SPC	76J10	
SUPPLY SPECIALIST	SPC	92Y10	
MEDICAL SUPPLY SPECIALIST	PFC	76J10	
SUPPLY SPECIALIST	PFC	92Y10	

(1) *Medical supply sergeant (76J20)*. This NCO is responsible to the medical supply NCO (HUB) for medical supply operations, stock control, and medical assemblage management. He is responsible for the development and preparation of plans, maps, overlays, sketches, and other administrative procedures related to employment of the HUS Supply and Service Division.

(2) *Supply sergeant (92Y20)*. This NCO is responsible for general supply operations, to include supervision of the supply specialists. He maintains accountability for all equipment organic to the HUS.

(3) *Medical supply specialists (76J10)*. These specialists are responsible to the medical supply sergeant for performing designated medical supply and equipment functions.

(4) *Supply specialists (92Y10)*. These supply specialists assist the supply sergeant in his duty performance. They request, receive, inspect, load, unload, segregate, store, issue, and turn in organizational supplies and equipment. One of the specialists will function as the armorer. The armorer maintains the weapons storage area, issues and receives small arms and ammunitions, and performs small arms unit maintenance.

c. *Operating Room/Central Materiel Service Control Team*. This team provides augmentation to the HUB to assist in supervising and scheduling the nursing staff and in preparing and maintaining the ORs/CMSs. The ranks and titles of the personnel (Table 3-29) are designed to interface with the HUB OR/CMS control team (Table 3-10) to provide support without duplicating duties and responsibilities.

Table 3-29. *Operating Room/Central Materiel Service Control Team Organization*

OPERATING ROOM/CENTRAL MATERIEL SERVICE CONTROL TEAM			
ANESTHESIOLOGIST	LTC	60N00	MC
CLINICAL HEAD NURSE, ANESTHETIST	LTC	66F00	AN
ANESTHESIOLOGIST	MAJ	60N00	MC
ASSISTANT CLINICAL HEAD NURSE, OPERATING ROOM	MAJ	66E00	AN

(1) *Anesthesiologists (60N00)*. These physicians administer or supervise administration of anesthetics to patients.

(2) *Clinical head nurse, anesthetist (66F00)*. This officer is responsible to the chief nurse for the management of daily operations of the anesthesia nursing section, to include scheduling and supervising the anesthesia nursing staff, coordinating logistical operations of the anesthesia service, and total quality management issues. He coordinates with the Chief, Surgical Service, anesthesiologist and clinical head nurse in the scheduling and assignment of surgical cases. He also serves as nurse anesthetist in clinical functions.

(3) *Assistant clinical head nurse, operating room (66E00).* This assistant clinical head nurse performs nursing duties in any phase of the operative process for patients undergoing all types of surgery and provides safe supplies and equipment for operative services.

d. *Triage/Preoperative/Emergency Medical Treatment Section.* This section provides for the receiving, triaging, and stabilizing of incoming patients. The staff receives patients, assesses their medical condition, provides EMT, and triages them to the appropriate nursing unit or health service. The staff monitors patient conditions and prepares those requiring immediate surgery for the OR. This section works in conjunction with the triage/preoperative/EMT section, HUB, to handle the overall work load for the hospital. This section gives the hospital commander several options:

- Personnel can be used to supplement the HUB EMT section with its equipment remaining loaded for use as a jump or movement echelon or reconstitution of other theater medical organizations.
- Part of the equipment and staff can be used to have a sick call or minor injury area with all major trauma sent to the main EMT section.
- The hospital can have two fully operational EMT sections. This would require the headquarters to carefully monitor and evaluate the admissions and OR requirements of these two sections if both were treating major trauma patients.

The staffing of this section is identical to that of the HUB’s EMT section (Table 3-9). The duties and responsibilities are the same for the corresponding positions as identified in paragraphs 3-4i(1)—(8).

e. *Operating Room C.* This section provides general and ENT surgical services with two OR tables for a total of 36 hours of table time per day. The staff for this section includes general surgeons, clinical and OR nurses, an OR NCO, and OR specialists (Table 3-30).

Table 3-30. *Operating Room C Organization*

OPERATING ROOM C				
GENERAL SURGEON	LTC	61J00	MC*	
GENERAL SURGEON	MAJ	61J00	MC	(3)
OPERATING ROOM NURSE	CPT	66E00	AN	(5)
CLINICAL NURSE, ANESTHETIST	CPT	66F00	AN	(5)
OPERATING ROOM NCO	SSG	91D30	NC	
OPERATING ROOM SERGEANT	SGT	91D20	NC	
OPERATING ROOM SPECIALIST	SPC	91D10		
OPERATING ROOM SPECIALIST	PFC	91D10		(3)

*HUS COMMANDER ALSO FUNCTIONS AS GENERAL SURGEON IN OPERATING ROOM C.

(1) *General surgeons (61J00)*. These surgeons examine, diagnose, treat or prescribe courses of treatment and surgery for patients having injuries or disorders with surgical conditions, and perform required surgery. As noted in Table 3-30, the HUS commander also functions as a general surgeon in OR C. This requirement is accounted for in the unit headquarters and is not included in the total authorizations for the OR.

(2) *Other assigned personnel*. The duties and responsibilities of the OR nurses, clinical nurses (anesthetist), OR NCOs, and OR specialists are the same as identified in paragraphs 3-4k(3)—(4) and (6)—(7).

f. *Operating Room D*. This section provides primarily orthopedic, thoracic, and urological surgical services with two OR tables for a total of 36 hours of table time per day. Staffing for this section includes a thoracic surgeon, a urologist, orthopedic surgeons, clinical nurse (anesthetists), OR nurses, an OR NCO, and OR specialists (Table 3-31).

Table 3-31. *Operating Room D Organization*

OPERATING ROOM D			
UROLOGIST	MAJ	60K00	MC
THORACIC SURGEON	MAJ	61K00	MC
ORTHOPEDIC SURGEON	MAJ	61M00	MC (3)
CLINICAL NURSE, ANESTHETIST	MAJ	66F00	AN
OPERATING ROOM NURSE	CPT	66E00	AN (5)
CLINICAL NURSE, ANESTHETIST	CPT	66F00	AN (4)
OPERATING ROOM NCO	SSG	91D30	NC
OPERATING ROOM SPECIALIST	SGT	91D20	NC
OPERATING ROOM SPECIALIST	SPC	91D10	(2)
OPERATING ROOM SPECIALIST	PFC	91D10	(3)

(1) *Urologist (60K00)*. The urologist examines, diagnoses, and treats or prescribes courses of treatment or surgery for patients having diseases, injuries, or disorders of the genitourinary tract. He performs required surgery.

(2) *Thoracic surgeon (61K00)*. This physician examines, diagnoses, and treats or prescribes courses of treatment and surgery for patients having surgical diseases or injuries of the thorax and vascular system. He performs required surgery.

(3) *Orthopedic surgeons (61M00)*. These surgeons examine, diagnose, and treat or prescribe courses of treatment and surgery for patients having disorders, malformations, diseases, or injuries of the musculoskeletal systems. They perform surgical operations as required.

(4) *Clinical nurse, anesthetists (66F00)*. These clinical nurses perform in consultation with an anesthesiologist or a physician. They provide nursing services for patients requiring anesthesia for surgical or diagnostic procedures, respiratory care, cardiopulmonary resuscitation, and/or fluid therapy. They also provide preanesthetic evaluation/therapy; administer all types of anesthetic techniques, to include monitored anesthesia care, local, regional, and general anesthesia; and performs postanesthetic evaluation/therapy. Also, they assist the clinical nurse anesthetist (MAJ) in administrative functions.

(5) *Operating room nurses (66E00)*. These nurses perform nursing duties in any phase of the operative process for patients undergoing surgery. They also provide safe supplies and equipment for operative services.

(6) *Other assigned personnel*. The duties and responsibilities of the remaining OR D staff will be the same as the corresponding staff in paragraph 3-4k (6)—(7), with one exception. The OR specialist, 91D10, is the designated vehicle operator for this section.

g. Orthopedic Cast Clinic. This section augments the orthopedic cast clinic of the HUB to provide casting, splinting, and traction services throughout the hospital. As with the multiple triage, preoperative, and EMT sections, this second orthopedic and cast clinic gives the hospital commander various employment options. The staffing and duties of this clinic is the same as that identified in paragraph 3-4m(1)—(2) and Table 3-13.

h. Central Materiel Service. This section operates two CMS units which provide for the sterilization of OR equipment, surgical instruments, and supplies, as well as for sterile supplies for other patient care areas. This section operates in conjunction with the CMS section of the HUB under the control of the OR/CMS control team. Normally, each CMS would function primarily to support the activities of its associated OR and wards. The staffing, duties, and responsibilities are identical to those identified in Table 3-14 and paragraphs 3-4n(1) and (2).

i. Intensive Care Ward. These nursing units provide five ICUs of 12 beds each for critically injured or ill patients. The clinical head nurses and only three of the five clinical nurses (CPTs) hold an ASI of 8A as ICU nurses. When functioning as a GH, this section is under the supervision of the nursing service control team (HUB). The staff performs recovery room nursing care for those patients who require close observation, vital sign monitoring, IV fluid replacement, and respiratory assistance. The staff consists of a clinical head nurse, clinical nurses, a wardmaster, practical nurses, respiratory NCOs, respiratory sergeants, and medical specialists (Table 3-32). The duties and responsibilities are the same as the corresponding positions identified in paragraphs 3-4q(1)—(8).

Table 3-32. Intensive Care Ward Organization

INTENSIVE CARE WARD (5)				
CLINICAL HEAD NURSE, ICU	MAJ	66H00	AN	(5)
CLINICAL NURSE, ICU	CPT	66H00	AN	(15)
CLINICAL NURSE, ICU	LT	66H00	AN	(10)
WARDMASTER	SFC	91C40	NC	(5)
PRACTICAL NURSE	SSG	91C30	NC	(15)
RESPIRATORY NCO	SSG	91V30	NC	(5)
PRACTICAL NURSE	SGT	91C20	NC	(15)
RESPIRATORY SERGEANT	SGT	91V20	NC	(5)
MEDICAL SPECIALIST	SPC	91B10		(10)

j. *Radiology Service.* This section provides augmentation to the radiology section of the HUB. Staffing consists of a radiologist, radiology NCOs, and radiology specialists (Table 3-33).

Table 3-33. Radiology Service Organization

RADIOLOGY SERVICE				
DIAGNOSTIC RADIOLOGIST	MAJ	61R00	MC	
RADIOLOGY NCO	SSG	91P30	NC	(2)
RADIOLOGY SERGEANT	SGT	91P20	NC	
RADIOLOGY SPECIALIST	SPC	91P10		(2)
RADIOLOGY SPECIALIST	PFC	91P10		

(1) *Diagnostic radiologist (61R00).* This officer conducts, interprets, and directs x-ray and fluoroscopy examinations, to include administration of ionizing radiation and patient care. He assists the radiologist, radiology service, HUB with the management of the section. He also provides technical supervision to the subordinate staff.

(2) *Other assigned personnel.* The duties and responsibilities of the remaining staff are the same as those identified in paragraphs 3-5x(3)—(4).

3-6. The Hospital Unit, Medical

The HUM provides increased medical capability to the HUB. The HUM is composed of the following sections:

a. Unit Headquarters. This section provides augmentation to assist in the supervision for all personnel assigned in this module and to provide daily reports to the hospital commander and related divisions. The staff is composed of the HUM commander, a field medical assistant, and a detachment NCO (Table 3-34).

Table 3-34. Unit Headquarters Organization

UNIT HEADQUARTERS			
COMMANDER	LTC	61F00	MC
FIELD MEDICAL ASSISTANT	CPT	70B67	MS
DETACHMENT NCO	SFC	91B40	NC

(1) *Unit commander (61F00).* This officer works in concert with the hospital commander to ensure a smooth and functional integration of the HUM with the other GH modules. As a subordinate staff member of the GH, he functions as an internist in the Inpatient Medicine B section.

(2) *Field medical assistant (70B67).* This officer performs the plans and operations functions for this module. He augments the hospital operations section (HUB) and works in unison with the hospital plans officer.

(3) *Detachment noncommissioned officer (91B40).* This NCO performs those duties required of a first sergeant for this module. He augments the company headquarters (HUB) and works in concert with the first sergeant.

b. Supply and Service Division (Augmentation). Because of the increased work load associated with the HUM, this section augments the Supply and Service Division of the HUB. Staffing and staffing responsibilities are the same as those identified in Table 3-28, paragraphs 3-5*b*(1)–(4).

c. Inpatient Medical B. This section provides medical services such as consultations, as requested; evaluation and treatment of infectious disease and internal medicine disorders; and evaluation and treatment of skin disorders. Staffing includes internists, a neurologist, an infectious disease officer, an audiologist, and a medical specialist (Table 3-35).

Table 3-35. *Inpatient Medicine A Organization*

INPATIENT MEDICINE B			
INTERNIST	LTC	61F00	MC
NEUROLOGIST	MAJ	60V00	MC
INTERNIST	MAJ	61F00	MC (2)
INFECTIOUS DISEASE OFFICER	MAJ	61G00	MC
AUDIOLOGIST	CPT	72C67	MS
MEDICAL SPECIALIST	SPC	91B10	

(1) *Internist (61F00)*. This physician is responsible to the Chief, Professional Services (HUB) for the technical and administrative management of this section. He also functions as the HUM commander. His position is accounted for in the HUM unit headquarters and is not included in the total authorizations for the Inpatient Medical B Section. His medical duties are the same as the other internists assigned to this section.

(2) *Neurologist (60V00)*. This physician examines, diagnoses, and treats and/or directs management of patients suffering from organic disorders, injuries, and diseases of the central and peripheral nervous system.

(3) *Internists (61F00)*. These internists examine, diagnose, and treat patients with medical illnesses and/or recommend courses of management for those illnesses.

(4) *Infectious disease officer (61G00)*. This physician is responsible for diagnosis, laboratory confirmation, treatment, control and/or description of natural history, and transmission kinetics of infectious diseases.

(5) *Audiologist (72C67)*. This officer conducts quantitative and qualitative examinations of auditory pathway; prescribes and implements nonmedical treatment to conserve or improve communication ability; designs, develops, and maintains hearing conservation programs.

(6) *Medical specialist (91B10)*. This specialist works under supervision of the section staff. He assists with EMT to casualties; assists with outpatient care and treatment; or assists with inpatient care and treatment.

d. Intermediate Care Wards. These nine ICWs with 20 beds per ward are identical in personnel and equipment. They are under the supervision of the HUB nursing service control team. These wards provide care for patients whose conditions vary from acute to moderate. The nursing care staff consists of a clinical head nurse, clinical nurses, a wardmaster, practical nurses, and medical specialists (Table 3-36).

The responsibilities and functions of the clinical head nurses, clinical nurses (66H00), wardmasters, practical nurses, and medical specialists are the same as those identified in paragraph 3-4r. The clinical nurses (66J00) assist the physicians and more senior clinical nurses in their duty performance. They perform first-level nursing care duties within their scope of clinical nursing activities. The lowest-grade medical specialist is the designated vehicle operator for the section.

Table 3-36. Intermediate Care Ward Organization

INTERMEDIATE CARE WARD (9)				
CLINICAL HEAD NURSE	MAJ	66H00	AN	(4)
CLINICAL NURSE	CPT	66H00	AN	(9)
CLINICAL NURSE	LT	66H00	AN	(9)
CLINICAL NURSE	LT	66J00	AN	(9)
WARDMASTER	SFC	91C40	NC	(5)
PRACTICAL NURSE	SSG	91C30	NC	(9)
WARDMASTER	SSG	91C30	NC	(4)
PRACTICAL NURSE	SGT	91C20	NC	(45)
MEDICAL SPECIALISTS	SPC	91B10		(9)
MEDICAL SPECIALISTS	PFC	91B10		(9)

e. *Nutrition Care Division (Augmentation).* This section augments the HUB Nutrition Care Division (paragraph 3-4f). The staff is composed of a dietitian, a hospital food service NCO, a hospital food service sergeant, and hospital food service specialists (Table 3-37).

Table 3-37. Nutrition Care Division Organization

NUTRITION CARE DIVISION				
CHIEF, NUTRITION CARE DIVISION	MAJ	65C00	SP	
HOSPITAL FOOD SERVICE NCO	SFC	91M40	NC	
HOSPITAL FOOD SERVICE NCO	SGT	91M20	NC	
HOSPITAL FOOD SERVICE SPECIALIST	SPC	91M10		(3)
HOSPITAL FOOD SERVICE SPECIALIST	PFC	91M10		(4)

(1) *Chief, Nutrition Care Division (65C00, ASI 8I)*. This officer is responsible to the Chief, Nutrition Care Division (HUB). He assists in formulating policies, developing procedures, and supervising the operation of nutrition care.

(2) *Hospital food service noncommissioned officer (91M40)*. This NCO serves as the principal NCO for the Nutrition Care Division (Augmentation). He is responsible to the hospital food service NCO (HUB) for the implementation of policies and procedures and for supervision of subordinate personnel.

(3) *Hospital food service sergeant (91M20)*. This sergeant is responsible to the principal NCO and assists with the clinical and administrative management of nutritional care programs.

(4) *Hospital food service specialists (91M10)*. These hospital food service specialists are responsible to the hospital food service sergeant for performing basic clinical dietetic functions in the dietary management and treatment of patients. They prepare, cook, and serve regular and modified food. They also perform light-vehicle operator/driver duties for the division, to include operator maintenance.

f. *Pharmacy Services*. This section augments the pharmacy services (HUB). The staff is composed of a pharmacy officer, a pharmacy NCO, a pharmacy sergeant, and pharmacy specialists (Table 3-38).

Table 3-38. *Pharmacy Services Organization*

PHARMACY SERVICES			
PHARMACY OFFICER	LT	67E00	MS
PHARMACY NCO	SSG	91Q30	NC
PHARMACY SERGEANT	SGT	91Q20	NC
PHARMACY SPECIALIST	SPC	91Q10	(2)
PHARMACY SPECIALIST	PFC	91Q10	(2)

(1) *Pharmacy officer (67E00)*. This officer assists the Chief, Pharmacy Services (HUB) in the performance of his duties. He supervises other pharmaceutical staff and collects data for required reports.

(2) *Pharmacy noncommissioned officer (91Q30)*. This NCO assists the pharmacy officer in his duty performance. He prepares, controls, and issues pharmaceutical products, ensuring compliance with Army and Federal rules, laws, and regulations relative to pharmacy operations. He assists in the supervision of subordinate personnel.

(3) *Pharmacy sergeant (91Q20)*. This pharmacy sergeant prepares, controls, and issues pharmaceutical products as directed by the pharmacy officer and NCO. He assists in preparing reports and other administrative functions.

(4) *Pharmacy specialists (91Q10)*. Under professional supervision, these specialists perform pharmaceutical duties within their scope of duties.

g. *Laboratory Services*. This section augments the laboratory services (HUB) and assists in all laboratory functions, except pathology, for all hospital areas. The staff is composed of a microbiologist, a biochemist, and medical laboratory specialists (Table 3-39).

Table 3-39. *Laboratory Services Organization*

LABORATORY SERVICES			
MICROBIOLOGIST	CPT	71A67	MS
BIOCHEMIST	CPT	71B67	MS
MEDICAL LABORATORY SPECIALIST	SGT	91K20	NC
MEDICAL LABORATORY SPECIALIST	SPC	91K10	(2)
MEDICAL LABORATORY SPECIALIST	PFC	91K10	(3)

(1) *Microbiologist (71A67)*. This officer is responsible to the Chief, Laboratory Services, HUB. He conducts and directs the performance of more extensive, highly complex microbiology procedures in the augmented laboratory. He provides technical consultation to the primary care provider and others in the AO and coordinates with supporting organizations such as TAML for the evaluation of biomedical specimens for exposure to biological warfare agents.

(2) *Biochemist (71B67)*. This officer is responsible to the Chief, Laboratory Services, HUB. He conducts and directs the performance of highly complex clinical chemistry tests in the augmented laboratory. He provides technical consultation to the primary care provider and others in the AO and coordinates with supporting organizations such as the TAML for the evaluation of biomedical specimens and environmental specimens for the exposure to chemical/biological warfare agents and for clinical diagnosis.

(3) *Medical laboratory specialist (91K20/10)*. These laboratory specialists work under the supervision of the medical laboratory NCO (91K30), HUB. These specialists perform the full array of clinical laboratory procedures and assists the biochemist in the performance of more complex clinical chemistry tests in the augmented laboratory.

h. *Radiology Service*. This section augments the radiology service (HUB) (paragraph 3-4x, Table 3-33) and assists in the 24-hour operation of that section. Staffing includes radiology specialists (Table 3-40). These specialists perform duties within their scope of training under the supervision of the radiology NCOs.

Table 3-40. Radiology Service Organization

RADIOLOGY SERVICE		
RADIOLOGY SPECIALIST	SPC	91P10
RADIOLOGY SPECIALIST	PFC	91P10

i. *Patient Administration Division.* This section provides patient administrative services to augment the PAD (HUB) (paragraph 3-4e, Table 3-5). The staff is composed of the patient administration NCOs and specialists (Table 3-41).

Table 3-41. Patient Administration Division Organization

PATIENT ADMINISTRATION DIVISION			
PATIENT ADMINISTRATION NCO	SSG	71G30	NC
PATIENT ADMINISTRATION NCO	SGT	71G20	NC (5)
PATIENT ADMINISTRATION SPECIALIST	SPC	71G10	(6)
PATIENT ADMINISTRATION SPECIALIST	PFC	71G10	(5)

(1) *Patient administration noncommissioned officer (71G30).* This NCO is responsible to the patient administration NCO for patient administration and disposition procedures, inpatient records, and security of patients' personal effects. He works in concert with the supply sergeant (company headquarters) on reequipping the RTD soldier. He also supervises the application of the TAMMIS for the MEDPAR System and for the MEDREG System.

(2) *Patient administration noncommissioned officers (71G20).* These NCOs are responsible to the patient administration NCO for implementing the TAMMIS-MEDPAR and TAMMIS-MEDREG for the hospital. They process correspondence received for admissions and dispositions, medical regulating, decedent affairs, and medical information. These NCOs also assist in supervising subordinate specialists.

(3) *Patient administration specialists (71G10).* These specialists are responsible for processing all admissions and dispositions, operating TAMMIS equipment, managing medical records, preparing statistical reports, conducting decedent operations, securing patient baggage and valuables, and preparing patients for evacuation.

j. Physical Therapy/Occupational Therapy Service. This section provides inpatient physical therapy/occupational therapy services and consultation for patients. The primary wartime role of this section is evaluating and treating neuromusculoskeletal conditions and providing burn/wound care to patients with potential for RTD within the theater evacuation policy. During mass casualty situations, physical therapy/occupational therapy personnel may be utilized in managing minimal or delayed patients, or augmenting the orthopedic staff. The staff is composed of an occupational therapist, a physical therapist, and occupational and physical therapy NCOs (Table 3-42).

Table 3-42. *Physical Therapy/Occupational Therapy Service Organization*

PHYSICAL THERAPY/OCCUPATIONAL THERAPY SERVICE			
OCCUPATIONAL THERAPIST	CPT	65A00	SP
PHYSICAL THERAPIST	CPT	65B00	SP
OCCUPATIONAL THERAPY SERGEANT	SGT	91B20	NC
PHYSICAL THERAPY SERGEANT	SGT	91B20	NC

(1) *Occupational therapist (65A00).* This officer is responsible to the designated physical therapy/occupational therapy section chief. He plans, implements, and supervises occupational therapy programs upon referral from medical officers in the hospital and other MTFs. The primary wartime role is upper extremity neuromusculoskeletal skills evaluation and treatment; prevention and treatment of combat stress and battle fatigue; and reconditioning and treatment to increase physical fitness, duty-related skills, and work performance to minimize RTD time.

(2) *Physical therapist (65B00).* This officer is responsible to the designated physical therapy/occupational therapy section chief. He implements the physical therapist’s plans and supervises physical therapy programs upon referral from medical officers in the hospital and other MTFs. His primary wartime role is to provide burn and wound care and evaluation and treatment of patients with neuromusculoskeletal conditions to minimize RTD time.

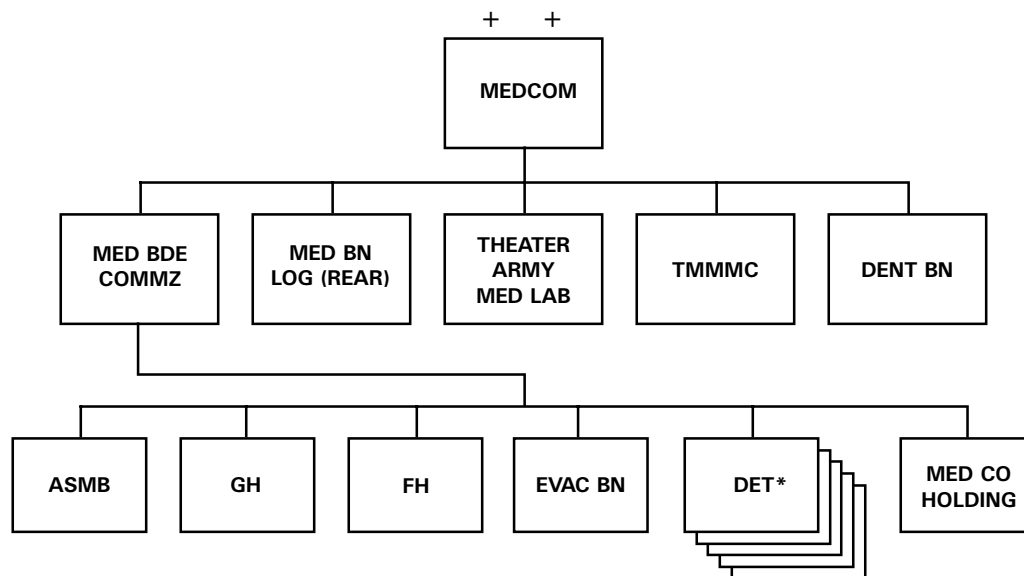
(3) *Occupational therapy/physical therapy sergeants (91B20).* These sergeants are responsible to the section NCO. They provide occupational/physical therapy treatment to patients within their scope of practice. These NCOs hold the respective ASIs N3 (occupational therapy specialty) and N9 (physical therapy specialty).

CHAPTER 4

COMMAND, CONTROL, AND COMMUNICATIONS OF THE FIELD AND THE GENERAL HOSPITALS

4-1. Command and Control

The major echelon above corps (EAC) C2 units are the MEDCOM and the medical brigades. The MEDCOM's mission is to command, control, and supervise assigned and attached units in the TA COMMZ. The MEDCOM is assigned on the basis of one per TA. The types and number of CHS units assigned to the MEDCOM depend on various factors such as size, composition, and location of supported forces; types of operations conducted; anticipated work load; and theater evacuation policy. An example of an EAC medical force structure in a mature theater is shown in Figure 4-1. The medical brigade commands, controls, and provides administrative and technical supervision for assigned and attached medical units in its AO. The medical brigade is assigned to the MEDCOM in the COMMZ or the corps support command (COSCOM) in the corps. The medical brigade is assigned to the COMMZ on the basis of one per three to seven battalion-sized units. The MEDCOM controls the majority of its EAC assigned units through subordinate COMMZ medical brigades.



* MAY INCLUDE ASSIGNED OR ATTACHED VETERINARY, SURGICAL, DENTAL, PREVENTIVE MEDICINE, AND PROFESSIONAL SERVICES DETACHMENTS.

Figure 4-1. Example of a medical command organization.

4-2. Communications

Management and control of CHS operations is dependent on the hospital headquarters' ability to communicate with its staff, the MEDCOM, the medical brigade, elements of the medical evacuation battalion, and other CSS units. Hospital communications assets include amplitude-modulated (AM) and FM radios and mobile subscriber equipment (MSE). The MSE is applicable to echelon corps level and below. See Appendix E, Communications, Automation, and Position/Navigation (POS/NAV) Systems.

a. Communications Planning. A HN commercial communications system may be available. The area common user network interfaces with existing combined communications systems and any existing local telephone and telegraph systems. This is accomplished as outlined in applicable STANAGs and HN support agreements. It should be noted that military, civilian agency, and civilian law enforcement communications systems may not be compatible. Extensive communications planning is required for joint military-civilian stability and support operations (SASO). The hospital operations section must plan for communications requirements and usage for each phase of military operation—predeployment, deployment, sustainment operations, and redeployment.

b. Communications Support. Communications support for organizations within a TO is based upon a unit's level of operations. Signal support for a COMMZ unit is provided by the theater signal brigade through the theater Deputy Chief of Staff for Operations and the Deputy Chief of Staff for Information Management. Units assigned to a corps will request signal support through the corps Assistant Chief of Staff, G3 (Operations and Plans) and will be supported by the corps signal brigade.

c. Staff Responsibilities. Each staff element of the hospital is responsible for adhering to signal support policies, procedures, and standards in their daily operations. The hospital operations sections' section chief coordinates telecommunications support and interface requirements with higher headquarters and with the supporting signal unit.

d. Area Common-User System.

(1) The area common-user system (ACUS) is the primary means of communications. The interface between triservice tactical communications (TRI-TAC) at EAC (Figure 4-2, sample ACUS access at EAC via switching nodes) and MSE at corps and division areas (Figure 4-3, sample of typical division small extension node deployment) provides an integrated communications network. Each MSE corps network includes at least two gateway connections to the EAC TRI-TAC network and adjacent corps. The TRI-TAC switch is programmed in the same way for the MSE gateway access into the corps network. This network provides voice and digital data transmission capabilities for C2, operations/intelligence, administration, and logistics functions. It should be noted that both the FH and the GH will normally be located in the COMMZ. The FH may be employed in the corps area when the situation dictates.

(2) The ACUS provides a secure mobile, survivable communications system capable of passing voice, data, and facsimile (FAX) at EAC and below. Additionally, it provides a direct interface to other Services, NATO, combat net radio (CNR), and commercial communications systems.

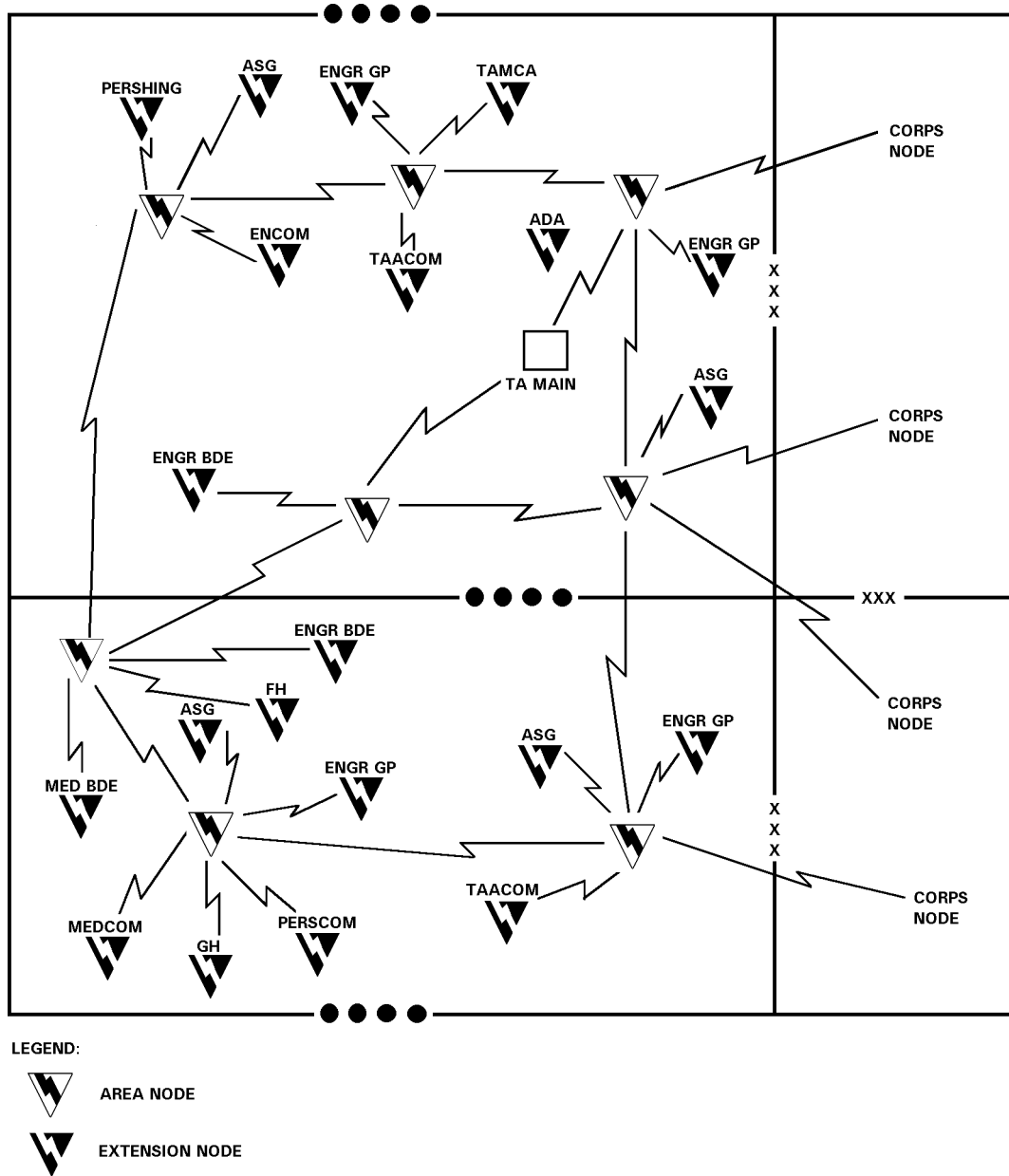


Figure 4-2. Sample area common-user system access at echelons above corps via switching nodes.

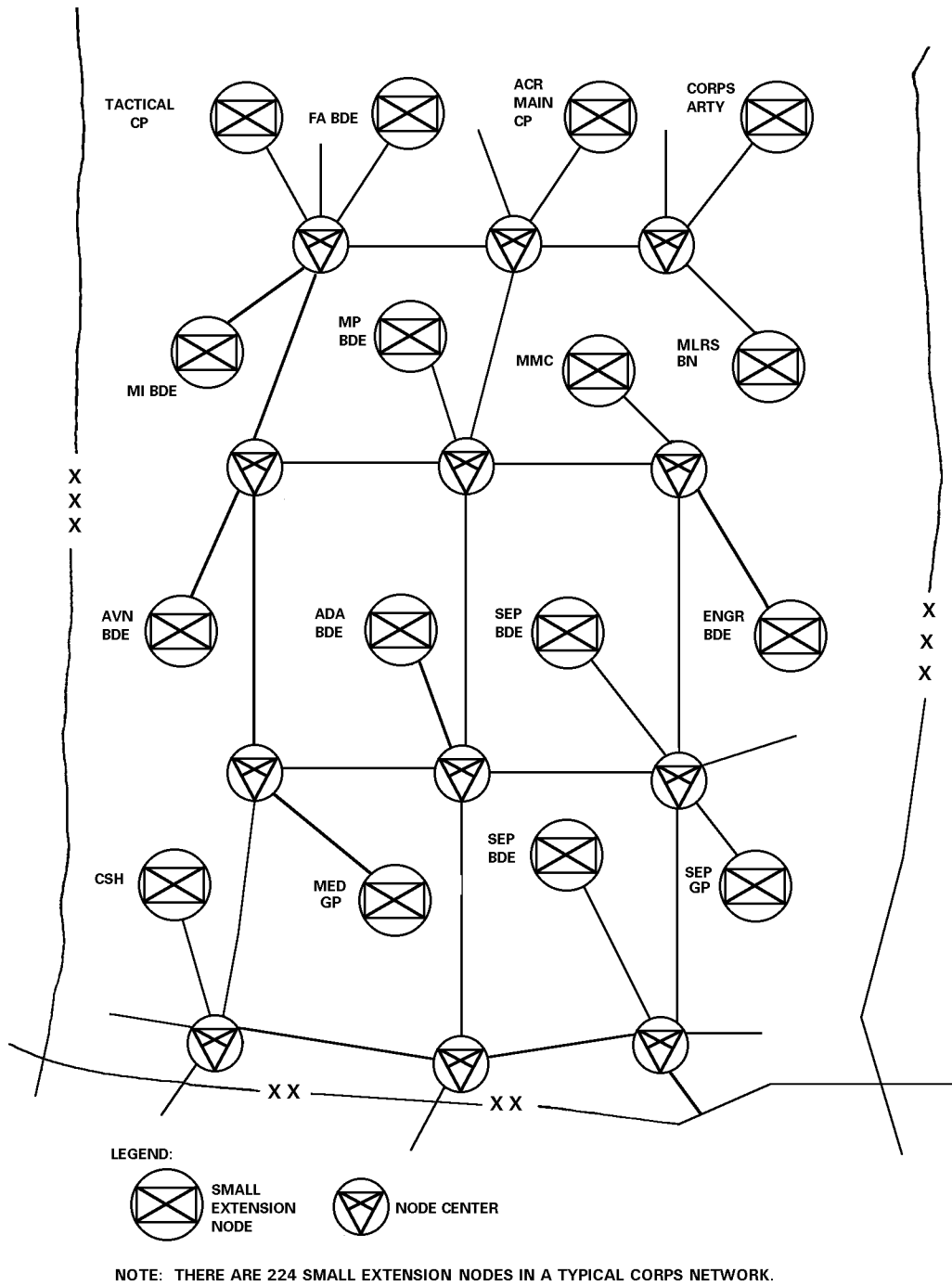


Figure 4-3. Typical division small extension node deployment.

(3) The ACUS is composed of multiple communications nodes with network features which automatically bypass and reroute communications around damaged or jammed nodes. It integrates the functions of transmission, switching, control, and terminal equipment (voice and data) into one system and provides the user with a switched telecommunications system extended by mobile subscriber radiotelephones. Nodes are deployed from the EAC rear boundary forward to the maneuver brigade rear area based on geographical and subscriber density factors. Node centers (NCs) make up the system's assemblage. Extension switches permit wire-line terminal subscribers (telephone, FAX, and data) to enter into the total area communications system.

(4) Radio access units (RAUs) let the users of mobile subscriber radiotelephone terminals (MSRTs) communicate with other mobile and wire telephone users throughout the corps area. The system control centers (SCCs) provide the processing capability to assist in overall network management. At echelons corps and below, the MSE system lets subscribers communicate with each other using fixed directory numbers regardless of a subscriber's battlefield location. (The small extension node and large extension node operate at echelons corps and below to support the TA-954 and TA-1042 which are authorized for the GH and are not part of the MSE.) The MSE system is comprised of the following five functional areas:

- Area coverage.
- Subscriber terminals.
- Wire subscriber access.
- Mobile subscriber access.
- System control.

The FH will participate in the first four of the above functional areas; the GH will participate in the first three. Figure 4-4 (typical mobile subscriber connectivity) shows how the system integrates the functions of transmission, switching, control, and terminal equipment.

(a) *Area coverage.* Area coverage means that MSE provides common-user support to a geographic area, as opposed to dedicated support to a specific unit or customer. Node centers are under the control of the supporting signal officer. This functional area is applicable to the FH/GH.

(b) *Subscriber terminal (fixed).* The MSE telephone, mobile radiotelephone, FAXs, and data terminal, as part of the ACUS, are user-owned and operated. The hospital's operations section is responsible for running wire to the designated junction boxes. These boxes tie the hospital MSE telephones into the extension switches which access the system. The subscriber terminals used by the hospital are digital, four-wire voice, as well as data ports for interfacing the AN/UXC-7 FAX, the TACCS, and the medical transportable computer unit (MEDTCU), as depicted in Figure 4-5 (sample of fixed subscriber terminals). This functional area is applicable to the FH/GH.

(c) *Wire subscriber access.* Wire subscriber access points provide the entry points (interface) between fixed subscriber terminal equipment owned and operated by users and the TRI-TAC and

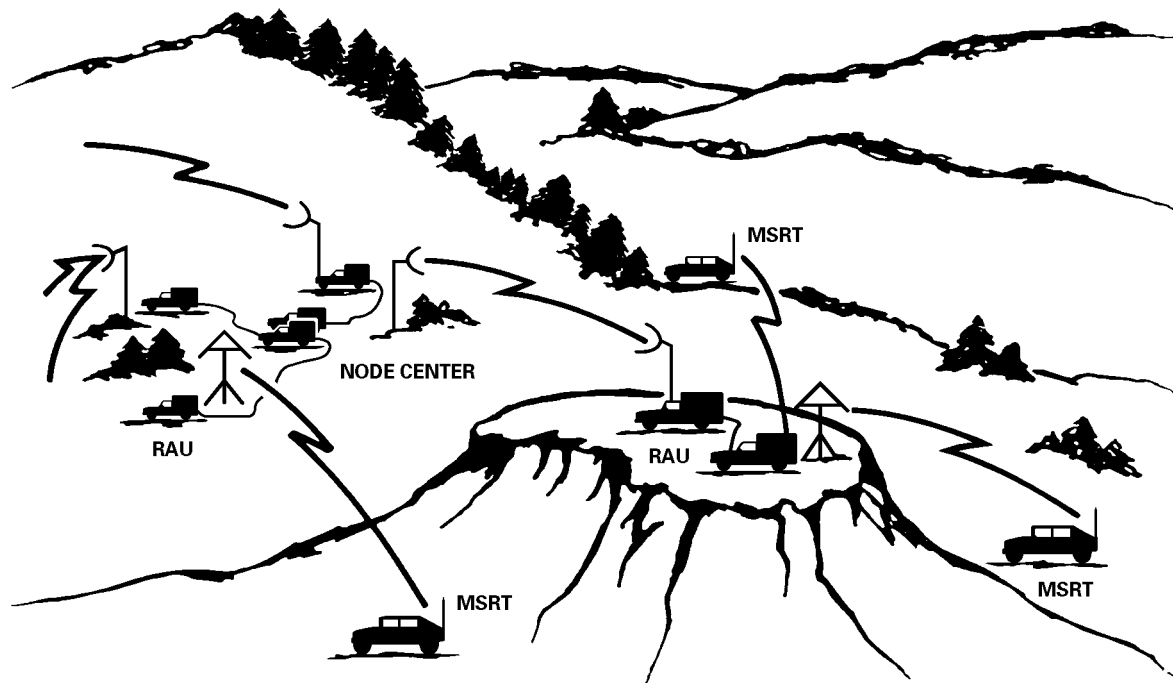


Figure 4-4. Typical mobile subscriber connectivity.

MSE area system operated by the supporting signal unit. The hospitals' switchboards may tie into the area system. The two types of interface equipment are—

- The signal distribution panel (junction box) J-1077. Each panel provides up to 13 subscriber access points.
- Remote multiplexer combiners which provide access for 8 subscriber access points.

See FM 11-55 for definitive information pertaining to an MSE area communications system. Figures 4-6 through 4-12 depict examples of the hospitals' wire net diagram. The hospital commanders will designate the hospital's wire net system based on the mission. This functional area is applicable to the FH/GH.

(d) *Mobile subscriber access.* The MSE terminal is the AN/VRC-97 MSRT. The MSRT is authorized for the FH. It consists of a very high-frequency radio and a digital secure voice terminal. The MSRT can be installed in one of nine US Army vehicles or used in a stand-alone configuration. It interfaces with the MSE system through an RAU. The primary use of the MSRT is to provide mobile subscriber access to the MSE area network. The MSRTs also operate in command posts to allow access to staff and functional personnel. The operational planning range is 15 kilometers from any RAU. Figure 4-13 depicts a typical MSRT interface into the area system.

e. Combat Net Radio System. The CNR equipment is authorized for both the FH and the GH. The CNR equipment includes both the improved high-frequency radio (IHFR) system and the single-channel ground and airborne radio system (SINCGARS). These radios provide the primary means for voice transmission of C2 information. They provide a secondary means for transmission of administrative/logistics data. Data transmission will be required when data transfer requirements cannot be met by using the TRI-TAC and MSE systems. The improved high-frequency AM radio series provide mid-to-far-range communications capability. They interface with other AM high-frequency radios and have push-button frequency selection. The SINCGARS series' FM radios are designed for simple and quick operation using a 16-element keypad for push-button tuning. They are capable of short-range operation for voice or digital data communications and interfacing with the AN/VRC-12 series of FM radios. They also can operate in a jam-resistant, frequency-hopping mode.

f. Hospital Radio Nets. The FH/GH and their staffs depend on both AM and FM radios and area communications systems to operate. The hospitals' FM radio nets are shown in Figures 4-14 and 4-15 (also see Appendix E). The hospitals monitor the following FM nets:

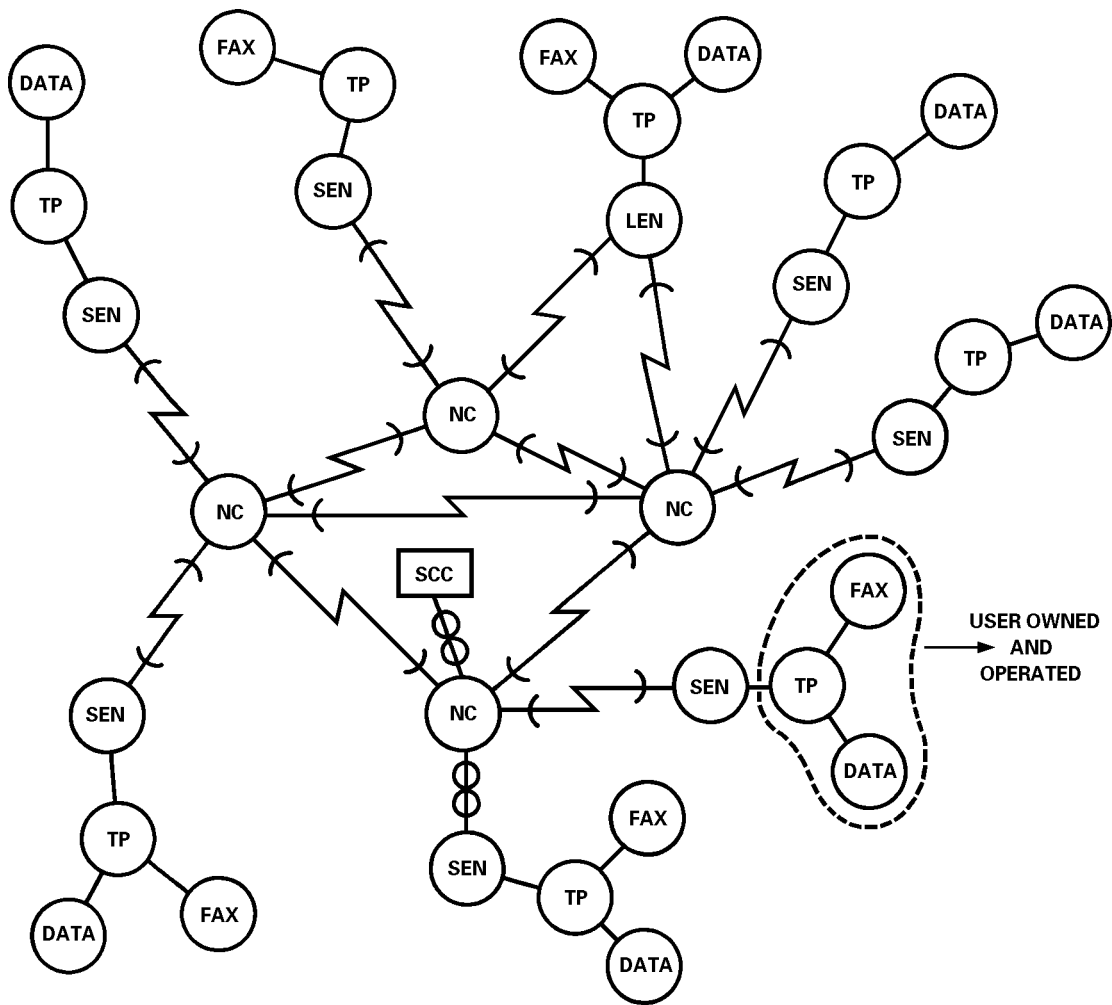
- Field hospital commander—MEDCOM, medical brigade/group command net.
- Field hospital and GH S2/S3—MEDCOM, medical brigade/group command net.
- Supported CSS FM nets.
- Field hospital and GH triage/preoperative/ EMT—used to control operation of the medical evacuation and heliport operations.
- Commander, HUS—hospital command net.

g. Hospital Operations Net—AM-IHFR. The FH/GH operations net (Figure 4-16, hospital net—AM-IHFR) uses an AN/GRC-193A radio. This net is used to facilitate patient management, air and ground evacuation, and medical regulation of patients. This net links the hospitals with the MEDCOM and/or medical brigade which is the net control station (NCS) for the CHS operations net.

h. Signal Security. As part of the overall security program, all hospital elements must practice signal security (SIGSEC). The hospital operations section is responsible for SIGSEC and COMSEC. Some considerations include—

- Using terrain features, such as hills, vegetation, and buildings, to mask transmissions.
- Maintaining radio and radio-listening silence; using the radio only when absolutely necessary.
- Distributing codes on a need-to-know basis.
- Using only authorized call signs and brevity codes.

- Using authentication and encryption codes specified in the current signal operation instructions (SOI).
- Keeping transmissions short (less than 20 seconds if possible).
- Reporting all COMSEC discrepancies to appropriate authorities.



LEGEND:

DATA	TACTICAL ARMY CSS COMPUTER SYSTEM / ARMY TACTICAL C2 SYSTEM / MEDTCU	NC	NODE CENTER
FAX	AN UXC-7 FACSIMILE	SCC	SYSTEM CONTROL CENTER
LEN	LARGE EXTENSION NODE (SWITCHBOARD)	SEN	SMALL EXTENSION NODE (SWITCHBOARD)
		TP	DIGITAL NONSECURE VOICE TELEPHONE (DNVT-TA1035 U)

Figure 4-5. Example of fixed subscriber terminals.

WIRE NET DIAGRAM

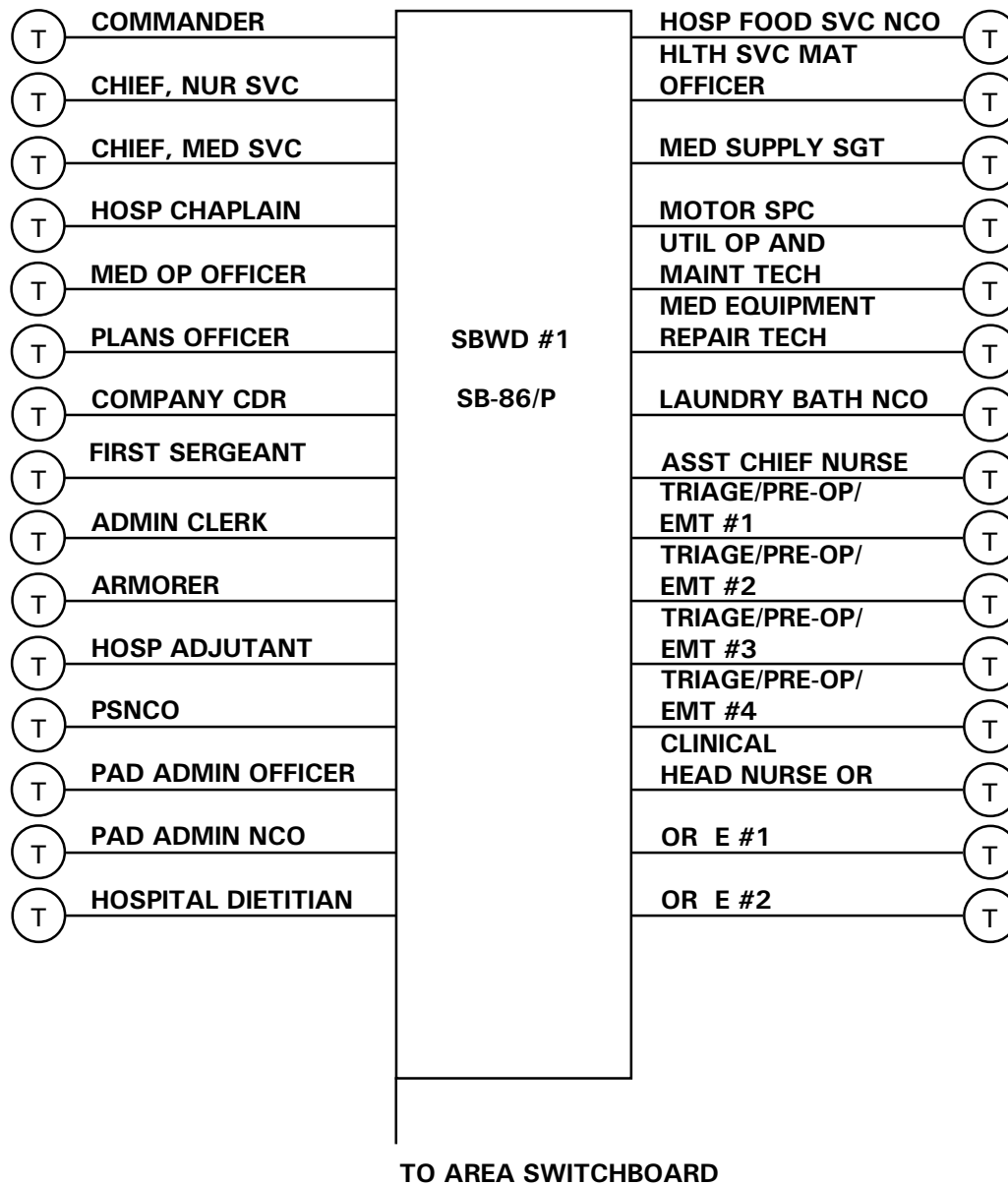


Figure 4-6. Wire net diagram, FH, HUB, switchboard 1.

WIRE NET DIAGRAM

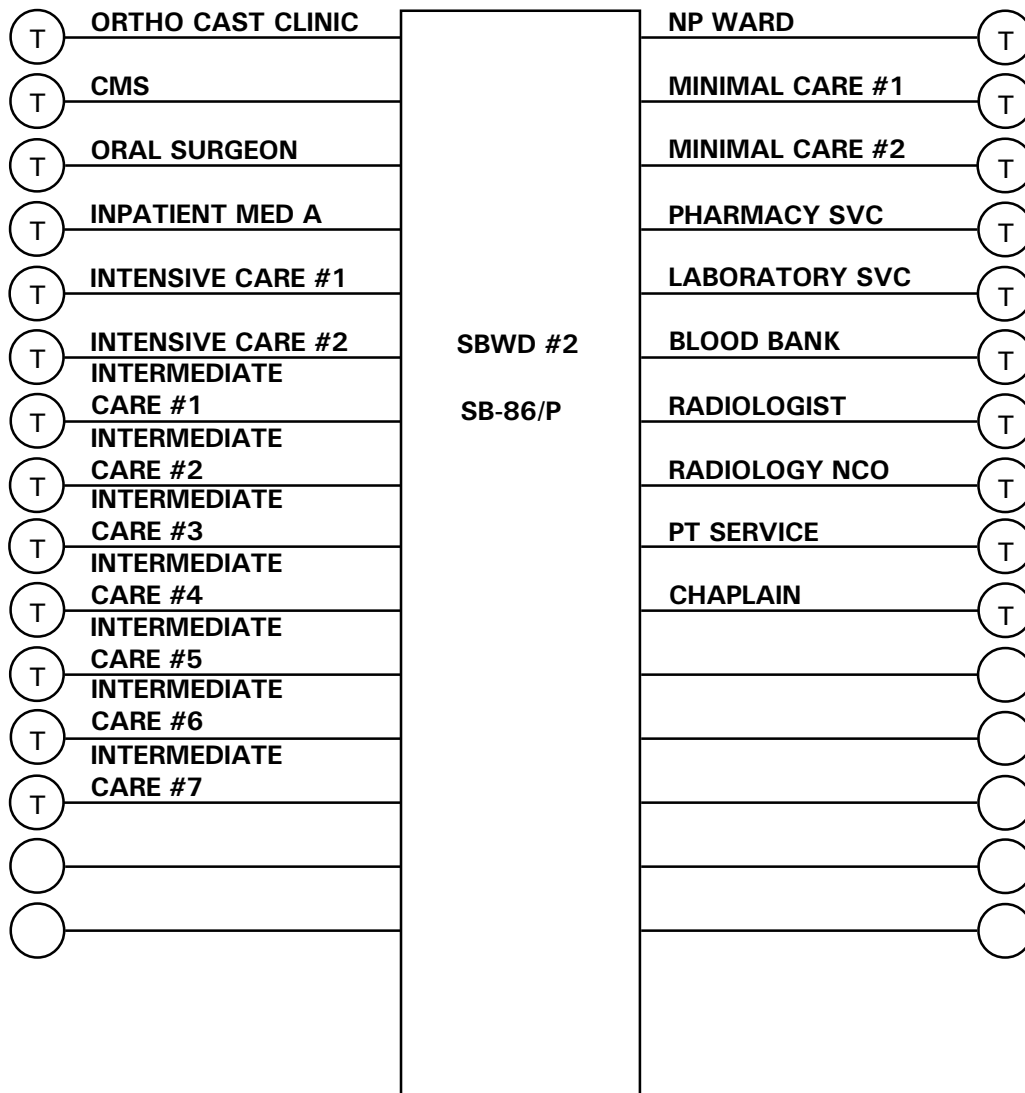
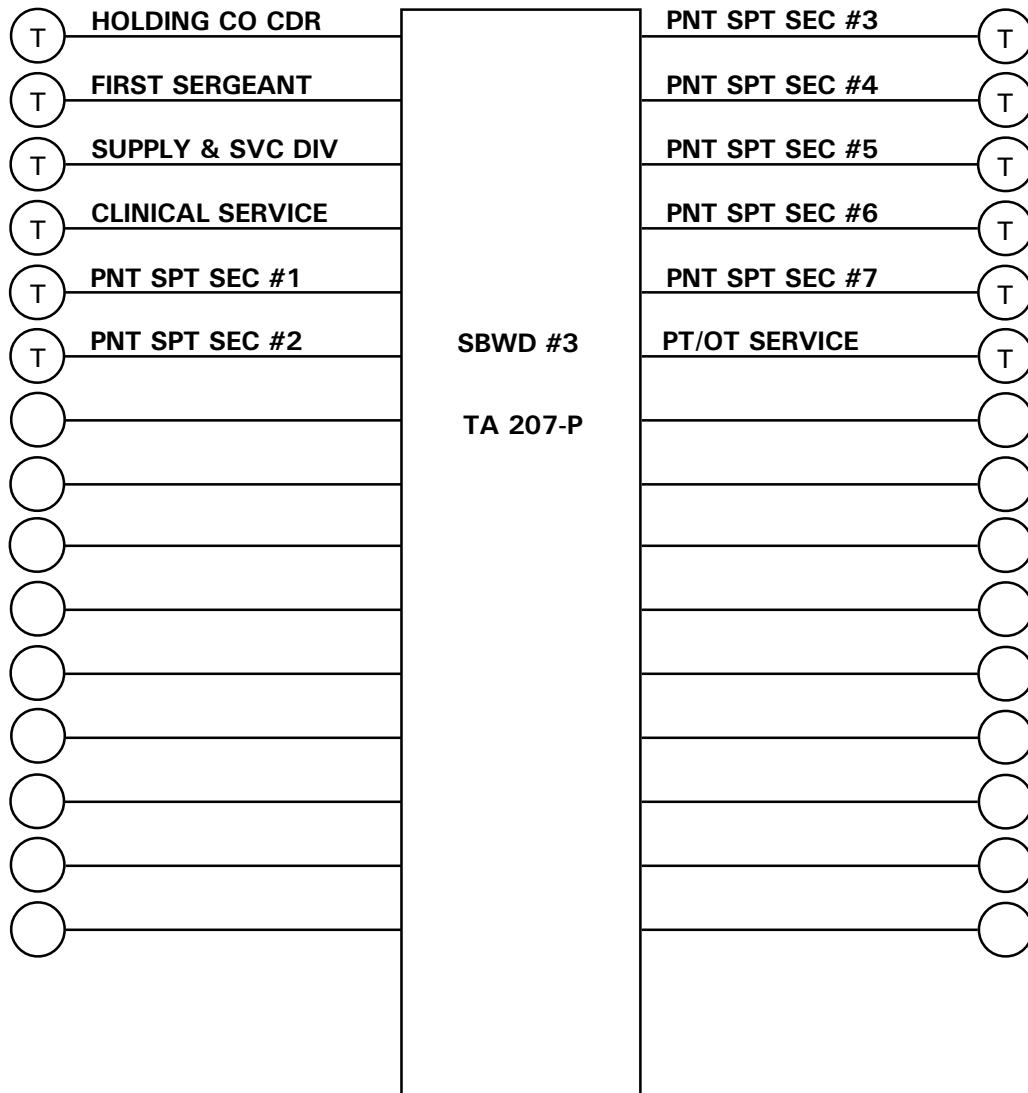


Figure 4-7. Wire net diagram, FH, HUB, switchboard 2.

WIRE NET DIAGRAM



NOTE: ONE OF THE SB-86/Ps IS AUGMENTED WITH A TA 207-P (SIGNAL ASSEMBLY SWITCHBOARD) TO PROVIDE 30 ADDITIONAL SWITCHBOARD LINES.

Figure 4-8. Wire net diagram, FH, HUH, switchboard 3.

WIRE NET DIAGRAM

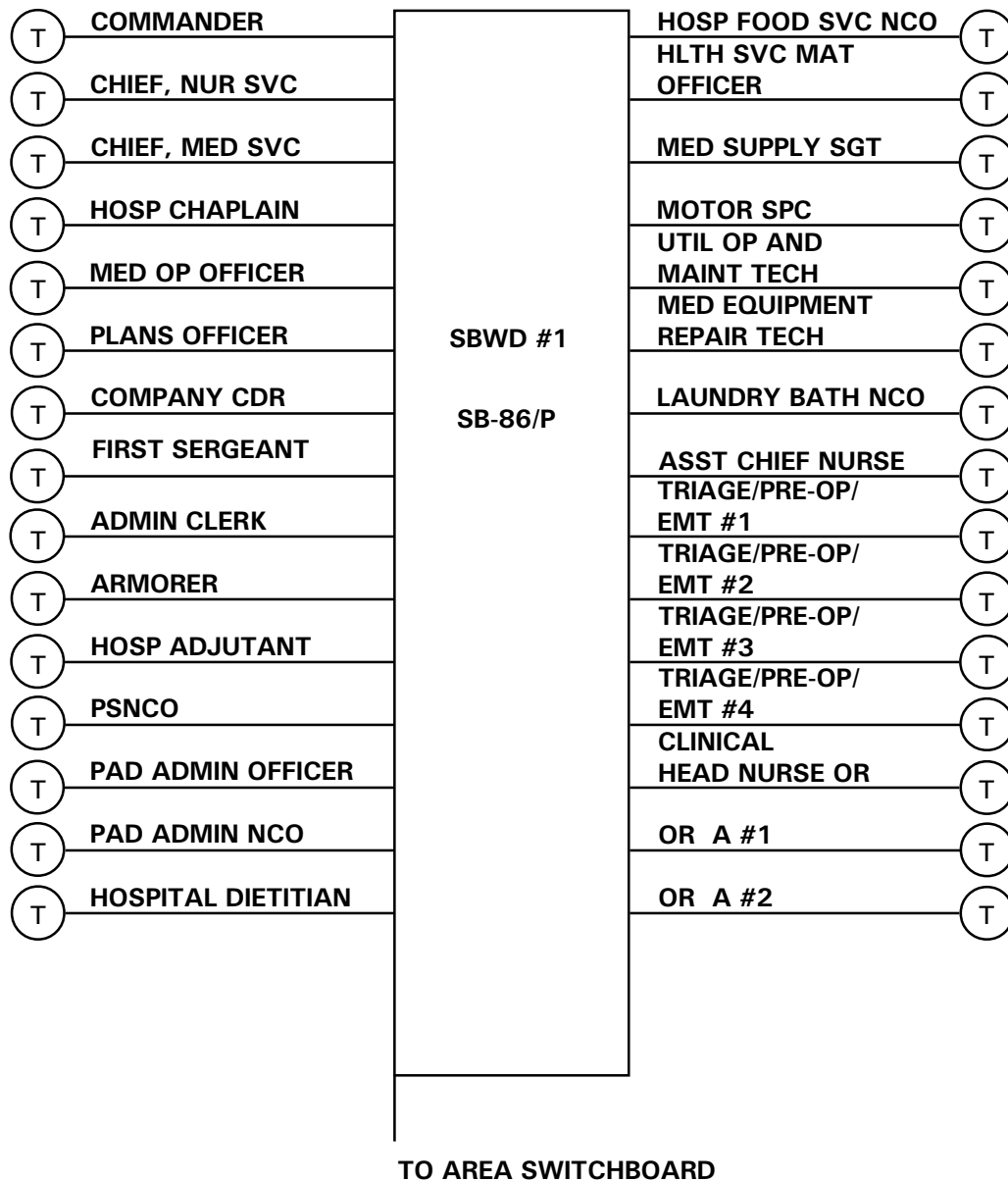


Figure 4-9. Wire net diagram, GH, HUB, switchboard 1.

WIRE NET DIAGRAM

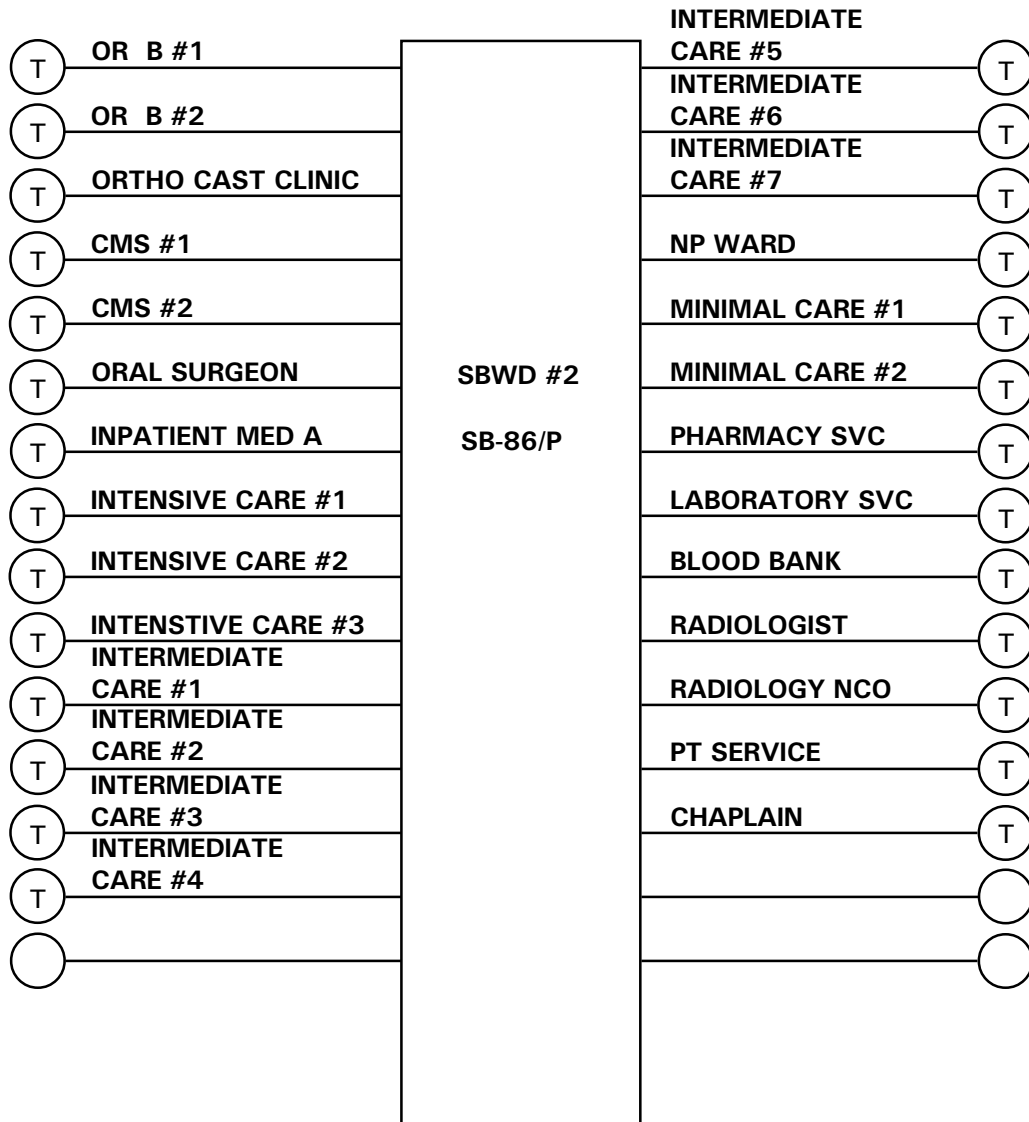
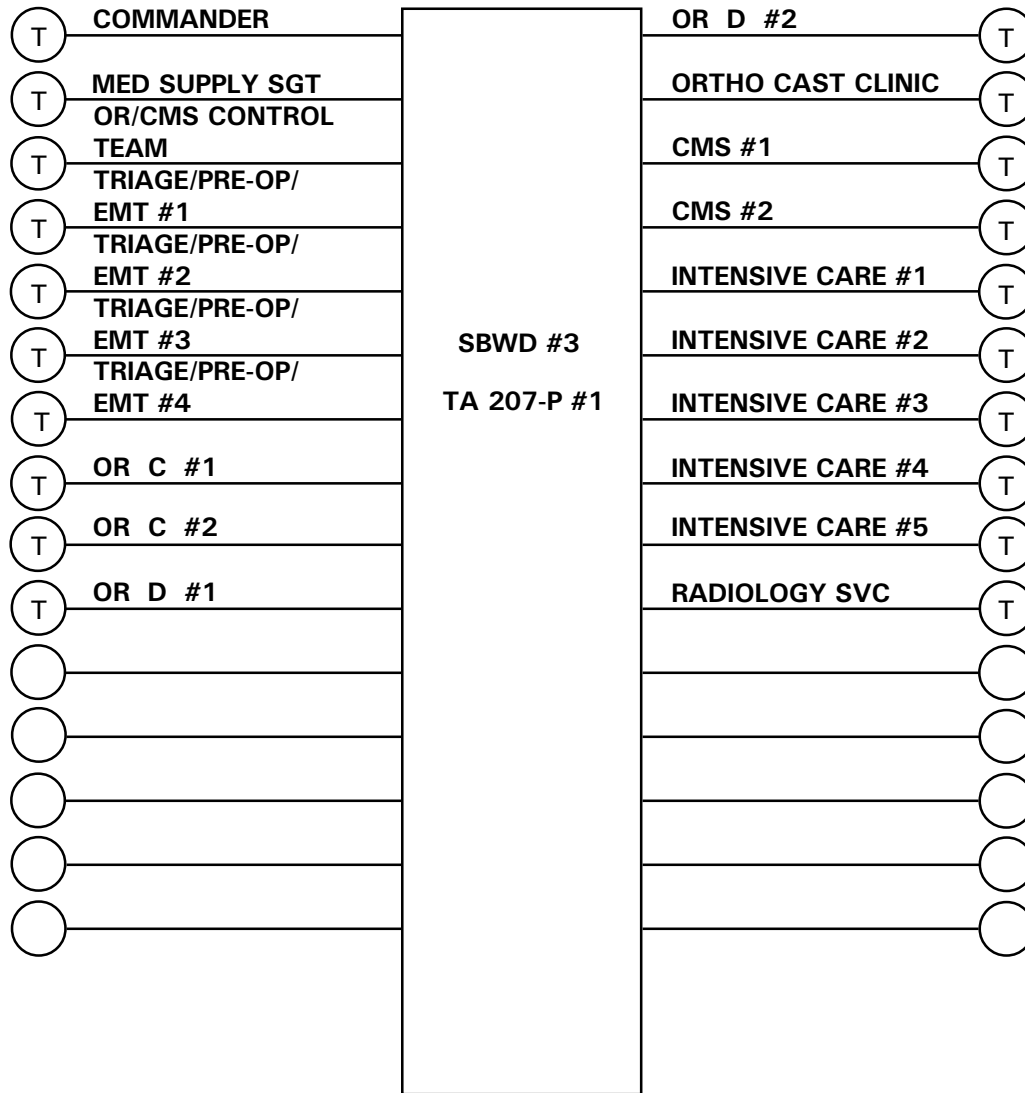


Figure 4-10. Wire net diagram, GH, HUB, switchboard 2.

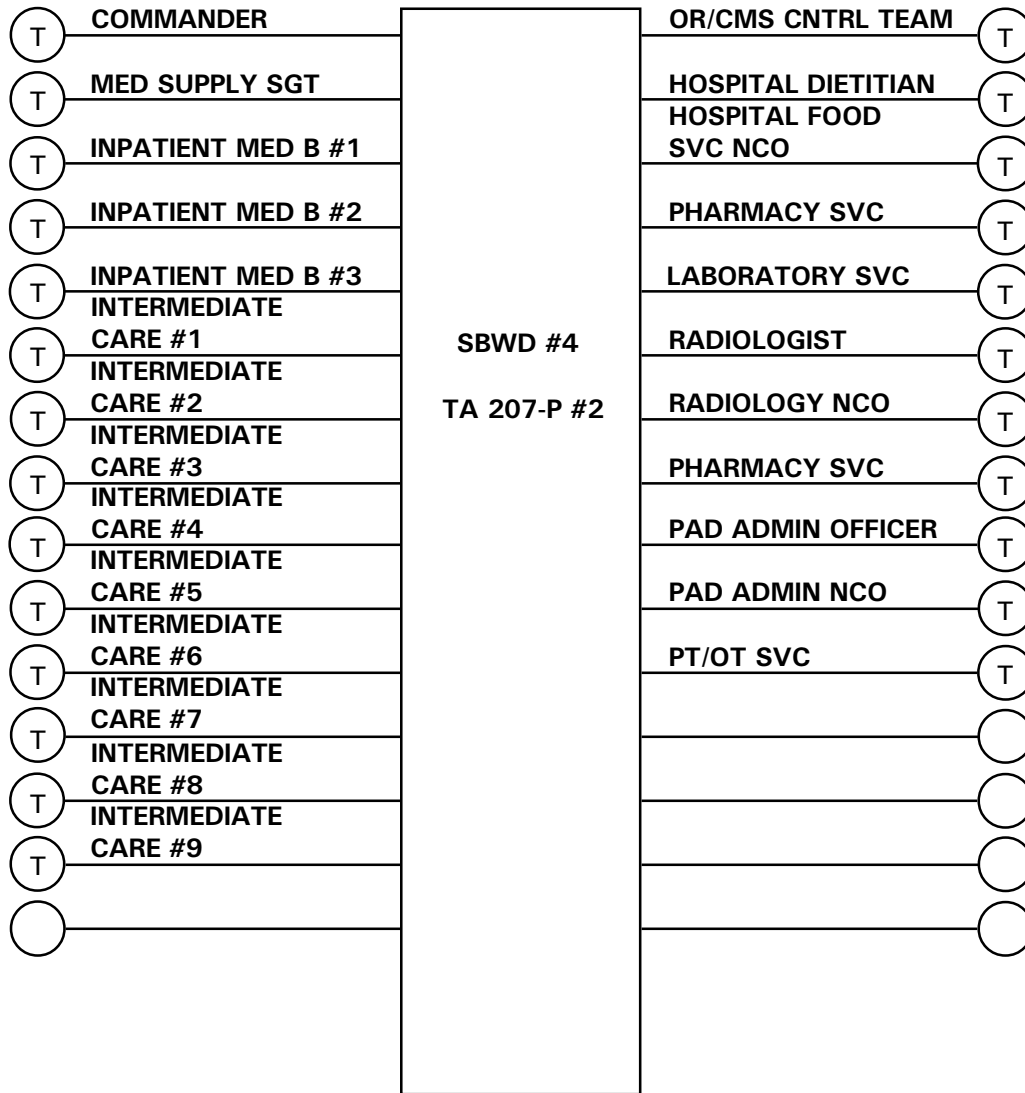
WIRE NET DIAGRAM



NOTE: ONE OF THE SB-86/Ps IS AUGMENTED WITH A TA 207-P (SIGNAL ASSEMBLY SWITCHBOARD) TO PROVIDE 30 ADDITIONAL SWITCHBOARD LINES.

Figure 4-11. Wire net diagram, GH, HUS, switchboard 3.

WIRE NET DIAGRAM



NOTE: ONE OF THE SB-86/Ps IS AUGMENTED WITH A TA 207-P (SIGNAL ASSEMBLY SWITCHBOARD) TO PROVIDE 30 ADDITIONAL SWITCHBOARD LINES.

Figure 4-12. Wire net diagram, GH, HUM, switchboard 4.

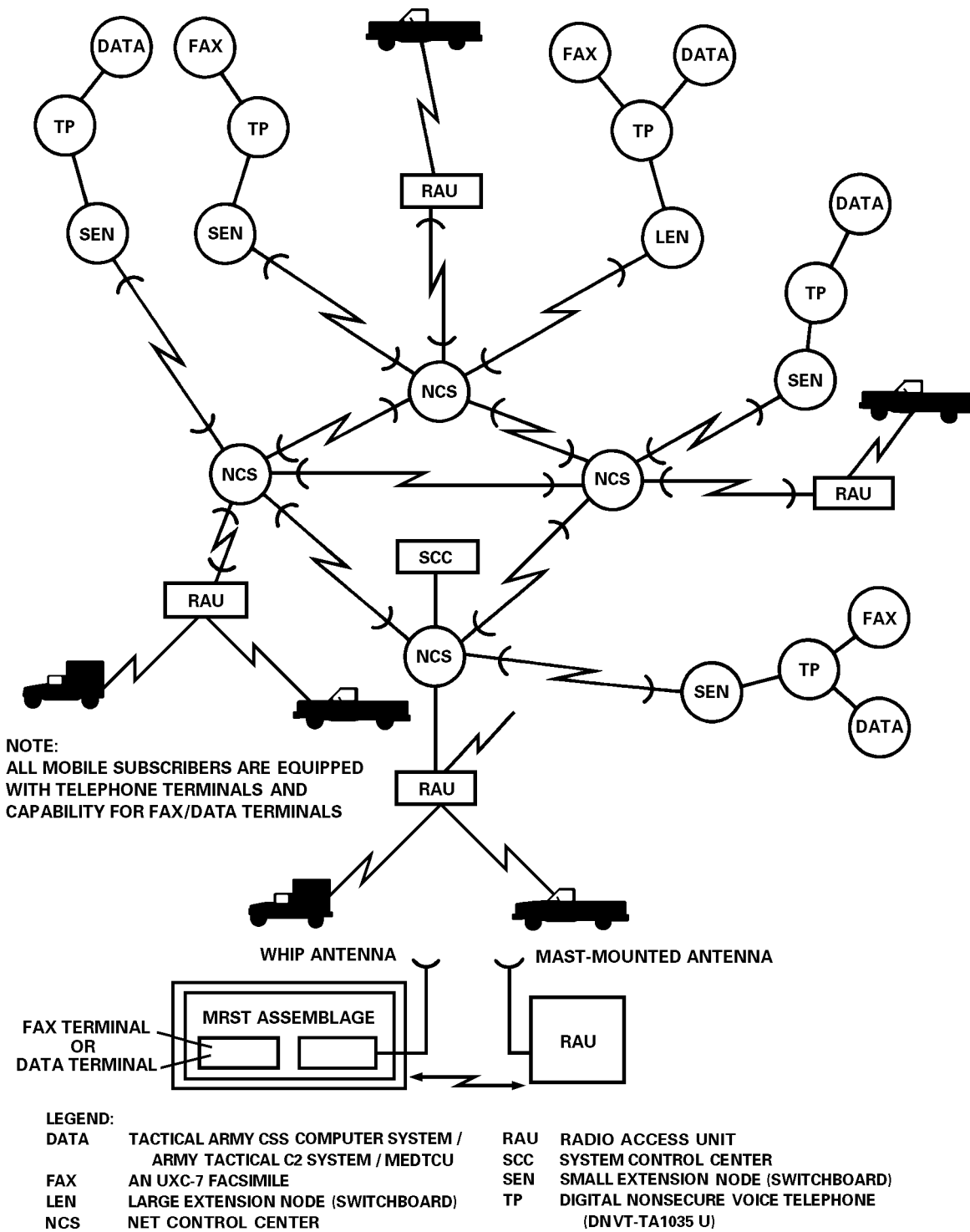


Figure 4-13. Mobile subscriber interface.

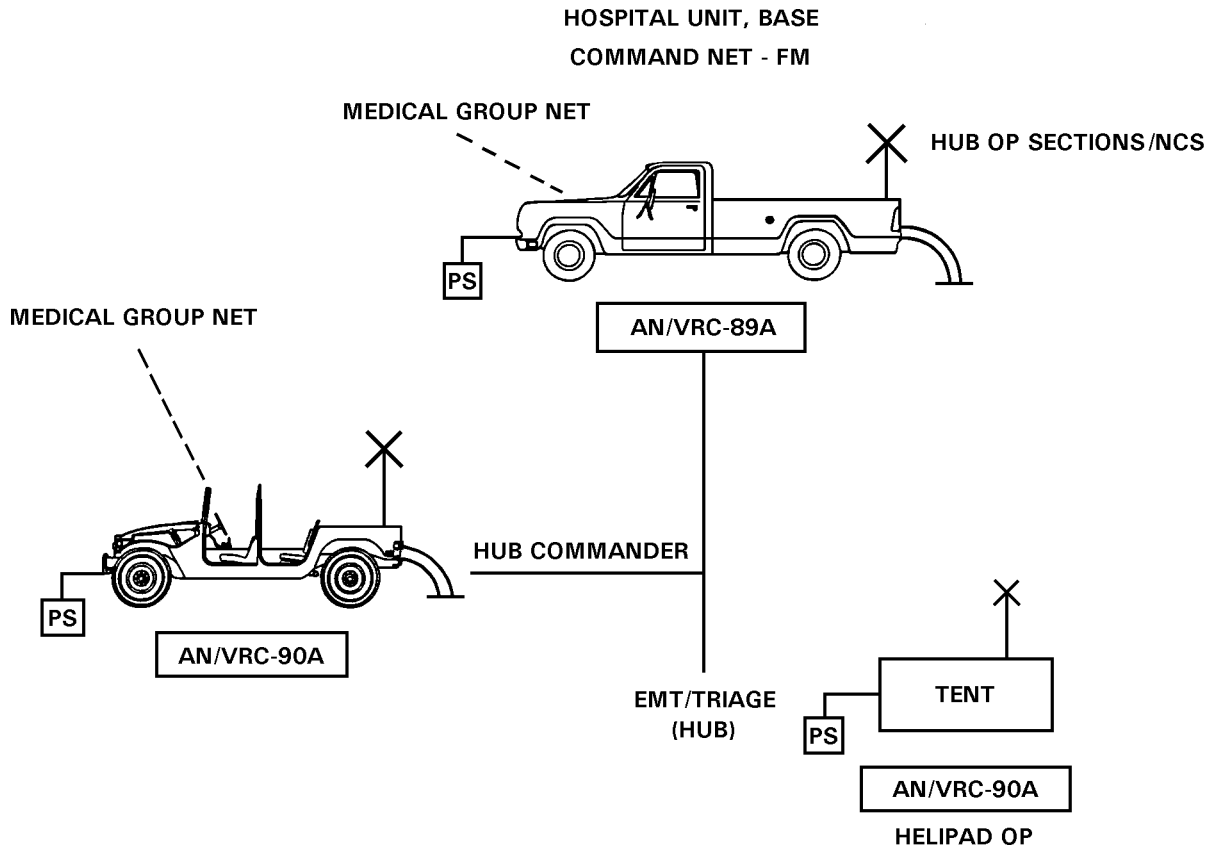


Figure 4-14. Field hospital net—FM.

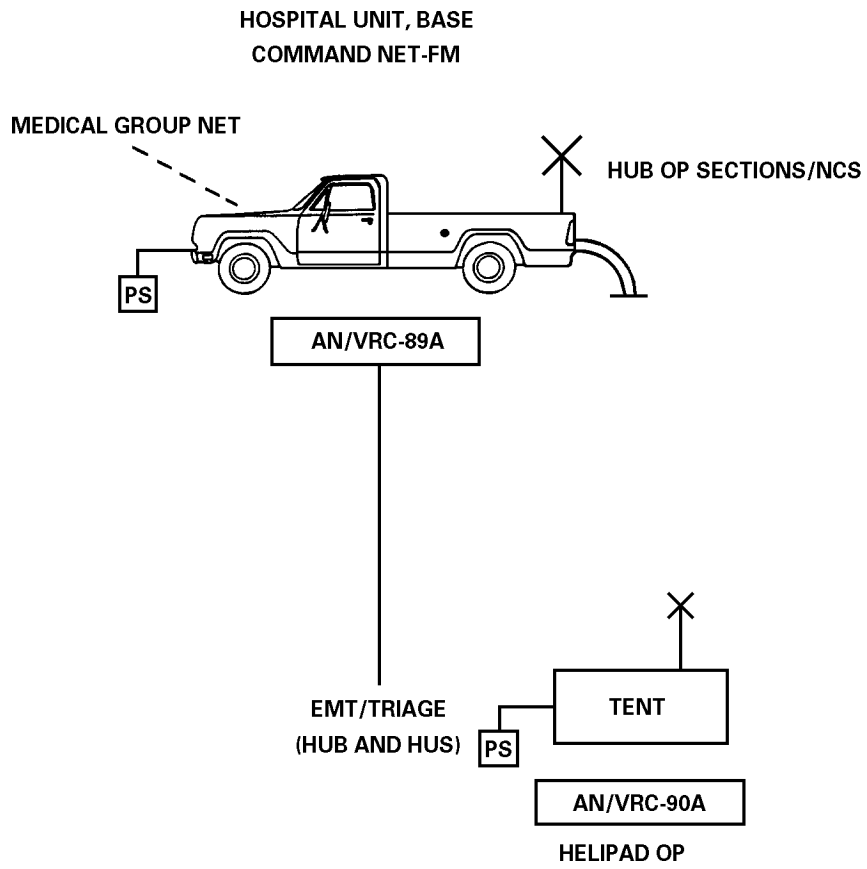


Figure 4-15. General hospital net—FM.

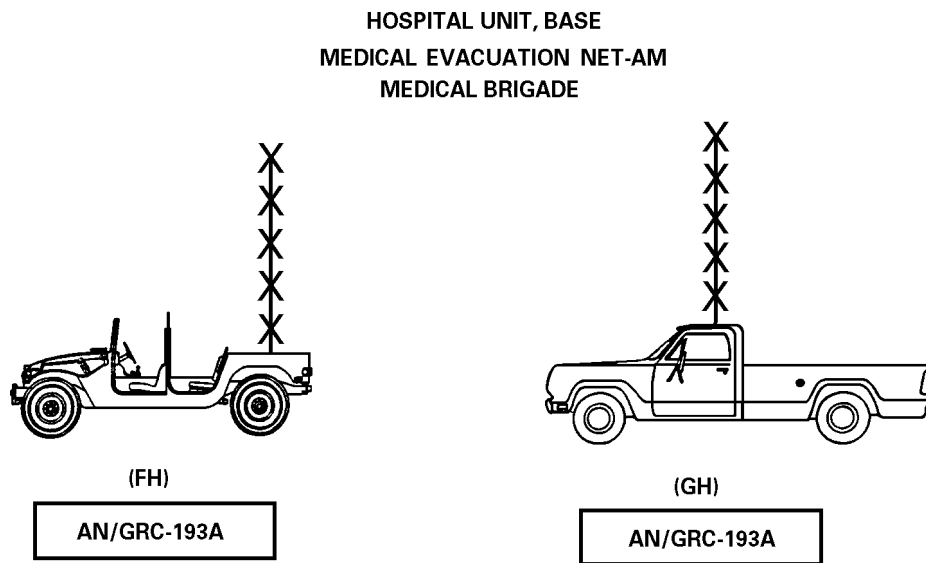


Figure 4-16. Field and general hospitals net—AM-IHFR.

CHAPTER 5

**DEPLOYMENT AND EMPLOYMENT
OF THE FIELD AND GENERAL HOSPITALS****5-1. Threat**

a. The military threat facing the US Armed Forces is massive. For years, the Communist military forces were considered to be our major adversary. Not only must we remain cognizant of the potential threat of major global powers, we must also maintain an awareness of the various threats and trouble spots of Third World countries. Once considered not to be a major threat, the Third World regional powers pose a threat to US security and interests worldwide. These countries now have the capability of conducting hostile activities, and during wartime or periods of crisis, of supporting espionage, subversion, and sabotage operations. Highly destructive regional wars remain a danger. Potential aggressors will be well-armed with modern aircraft and armored forces. They will likely be equipped with highly sophisticated and state-of-the-art weaponry systems. The proliferation and use of NBC weapons by developing nations will continue to pose a threat. They could attack using NBC weapons, powerful conventional weapons, or an assortment of both. The US Army will most likely face regional threats attempting to expand their sphere of influence by force.

b. Another major threat to US forces deployed outside continental United States (OCONUS) is that of a medical threat. Elements of the medical threat include naturally occurring infectious diseases (also referred to as endemic diseases), environmental extremes, and combat stress. For a detailed discussion of medical threat elements, see FM 8-10.

5-2. Planning Combat Health Support Operations

Combat health support is an integral part of the force structure and is vital to all contingencies for the sustainment of forces. Planning CHS is a continuous and demanding process. The hospital commanders and their staffs must constantly assess new information for its impact on current and future support requirements. Hospital commanders must understand how their actions should complement their higher headquarters plan. Misinterpretations can lead to counterproductive actions and potentially disastrous results. Two primary factors hospital planners must be knowledgeable of are the higher commander's intent and the METT-T. The planning process for future missions should not be isolated from current support actions. The planning process should be flexible and adaptive to the situation and the hospitals' mission. Combat health support elements should be deployed in the appropriate mix, in a logical sequence, based on the supported forces.

5-3. Mobilization*a. Concept of Operations.*

(1) In the event of contingencies in support of war, peace, or conflict, the DOD initiates appropriate action for the deployment of forces in response to the scenario. Based on the situation, selected Active Component (AC) and Reserve Component (RC) hospitals and other units are alerted through command channels. For those units located in CONUS, the United States Army Forces Command (FORSCOM) uses

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the Time-Phased Force Deployment Data List (TPFDDL) based on the theater commander's requirements, and the air and sea resources available. For deployable AC hospitals, an increase in readiness posture (DEFCON) is directed by the post or installation commander, or by higher headquarters. For RC hospitals, mobilization notification constitutes an increase in readiness posture.

(2) Deployment operations for hospital readiness validation are controlled through the post or installation emergency operations center (EOC) according to established plans and regulations. The EOC plans and coordinates all deployment preparation support for the deploying hospital and monitors and controls all facets of the deployment operation, to include reporting to higher headquarters.

(3) The hospitals may deploy by land, sea, or air (or a combination of these modes) from locations designated by higher headquarters. Priority of effort is given to those modes of movement outlined in current plans.

(4) Active Component hospitals maintain the capability for emergency deployment on short notice to execute assigned missions.

(5) Mobilizing RC hospitals must attain and maintain the capability for mobilizing on short notice and arriving at their designated mobilization site according to unit mobilization plans.

(6) Once mobilization is validated, hospitals prepare for deployment on short notice (72 hours or less). During validation, appropriate status reports are submitted to higher headquarters.

b. Conduct of Operations.

(1) Commanders of deploying hospitals develop movement plans and TSOPs to accomplish the necessary preparations for deployment. Provisions for accomplishing all required training and other requirements to be accomplished during all phases of the deployment are identified. The checklists contained in Appendix F can be used as a guide for developing deployment operation procedures in support of movement by air and surface modes, or a combination thereof. The checklists are applicable to both AC and RC units. **The checklists are detailed only as a guide for commanders.** Installation mobilization stations and/or higher headquarters may prescribe different procedures for your unit.

(2) Active Component hospitals maintain the capability necessary to achieve a deployment posture in the time required by any alert warning order or deployment instructions received. For planning purposes, the readiness posture maintained is consistent with the shortest notification period presented in the mobilization plan.

(3) Reserve Component hospitals maintain the readiness posture necessary to meet planned deployment dates contained in current FORSCOM and mobilization documents. Upon arrival at the designated mobilization site, hospitals are placed in an increased or advanced deployability posture based on the published priorities of plans for which the hospitals are listed. The hospitals are managed through the RC chain of command, with input by the mobilization installation commander during the premobilization period.

(4) All hospitals are scheduled for deployment validation by unit line number based on the published validation schedule. Hospitals can be expected to deploy within 72 hours following validation. Actual deployment date and times are as directed by higher headquarters.

5-4. Deployment

a. When directed by higher headquarters through the port call or airlift message, the FH/GH will move to the port of embarkation (POE) for deployment. Deployment from the POE will be as directed by the United States Transportation Command. Upon arrival at the theater point of entry, it is essential that contact with the assigned MEDCOM or medical brigade be made immediately. Normally, the MEDCOM or medical brigade has liaison personnel to meet and assist the hospital staff with coordination and movement to its AO. As equipment and supplies are off-loaded, they are moved to a designated receiving area for consolidation and movement. An inventory for accountability and damage assessment is conducted. Vehicles are serviced and necessary repairs are made, or coordination is made with the supporting maintenance element for the repairs. Documentation for replacement of unusable supplies or equipment damaged beyond repair is initiated through the MEDCOM or medical brigade headquarters element. Vehicle loads are adjusted for convoy operations. For equipment that was transported separately from the hospital, coordination is made for receiving and transporting it upon arrival. Once the hospital has moved to its AO, the MEDCOM or medical brigade staff elements conduct formal personnel in-processing and an orientation on current operating policies and procedures. The orientation includes information on the following:

- Mission update, to include geographical support area.
- Combat health support issues.
- Host-nation support.
- Local laws and customs.
- Threat update.
- Security requirements.
- Personnel restrictions.
- Personnel replacements.
- Uniform requirements.
- Emergency warning signals.
- Religious support.

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- Vehicle and unit movement requirements.
- Geneva Conventions (see Appendix G).
- Supply support activities and procedures (all classes).

b. In a force projection Army, METT-T will drive the amount of supplies required to support the force. For planning purposes, the hospitals normally deploy with 10 days of medical supplies; the medical assemblage for each work area contains a basic load of 3 days of supply; the medical supply set maintained by the supply and service division contains a 7-day basic load for the entire hospital. In a maturing theater, medical resupply is accomplished by preconfigured resupply packages until the MEDLOG battalion (rear) has been established. These “push packages” are throughput directly to the hospital via the transportation system. These packages may be pre-positioned “mobilization stocks,” or may be built and shipped from the Defense Logistics Agency (DLA) depot system. Hospital logistics personnel coordinate with their next higher command headquarters for all logistical support to include resupply. Early deploying hospitals that arrive prior to their higher medical C2 headquarters must coordinate with port transportation personnel for shipment and receipt of supplies and equipment. Once the MEDLOG battalion (rear) has been established, hospital logistics personnel coordinate directly with the MEDLOG battalion for resupply of Class VIII materiel. (For a detailed discussion on Class VIII resupply, see FM 8-10-9.) All other resupply is requisitioned through higher headquarters with the appropriate supporting organization. Effective coordination is the key to responsible logistical support. To be effective it must be early and it must be often.

c. For maximum use of the FH/GH, the entire hospital should deploy together. However, due to their limited mobility and the availability of transportation support requirements, it may be necessary to deploy by echelons. If required to move by echelons, the number and composition of each echelon is a command decision. The following is a recommended sequence:

(1) *Field hospital.*

(a) *First echelon.* Advanced/quartermaster party.

(b) *Second echelon.* This echelon should include—

- | | |
|-----------------------------------|-----|
| • Hospital Headquarters | HUB |
| • Triage/Preoperative/EMT | HUB |
| • Operating Room/CMS Control Team | HUB |
| • Operating Room E Module | HUB |
| • One ICU Ward | HUB |
| • Two ICWs | HUB |

- Laboratory HUB
- Blood Bank HUB
- X-Ray HUB
- Pharmacy HUB
- CMS HUB
- Ortho Cast Clinic HUB

Elements of the following should also be included to provide necessary support: company headquarters (HUB), supply and service division (HUB), PAD, and nutrition care division. It is critical to the operation of the hospital that the first echelon include a heavy complement of utilities personnel and equipment.

(c) *Third echelon.* This echelon should include—

- Neuropsychiatric Service and Ward HUB
- Inpatient Medicine—Module A HUB
- One ICU Ward HUB
- Two ICWs HUB
- Two Minimal Care Wards HUB
- Three Patient Support Sections HUH
- Physical Therapy/Occupational
Therapy Service HUB
- Dental Service HUB

Elements of the following should be included in this echelon: company headquarters (HUB), supply and service division (HUB), and PAD.

(d) *Fourth echelon.* All remaining elements of the hospital.

(2) *General hospital.*

(a) *First echelon.* Advanced/quartering party.

(b) *Second echelon.* This echelon should include—

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- Hospital Headquarters HUB
- Supply and Service Division HUS
- Triage/Preoperative/EMT HUS
- Operating Room/CMS Control Team HUS
- Operating Room A/B Module HUB
- Inpatient Medicine—Module A HUB
- Three ICU Wards HUB
- Four ICWs HUB
- Laboratory HUB
- Blood Bank HUB
- X-Ray HUB
- Pharmacy HUB
- Two CMSs HUS
- Ortho Cast Clinic HUS
- Litter Bearer Section HUB

Elements of the following should also be included to provide necessary support: company headquarters (HUB), supply and service division (HUB), PAD (HUB), and nutrition care division (HUB). It is critical to the operation of the hospital that the first echelon include a heavy complement of utilities personnel and equipment.

(c) *Third echelon.* This echelon should include—

- Neuropsychiatric Service and Ward HUB
- Operating Room C/D Module HUS
- Inpatient Medicine—Module B HUM
- Two ICU Wards HUS

- Two ICWs HUB
- Four ICWs HUM
- Two Minimal Care Wards HUB
- Two CMSs HUB

Elements of the following should be included in this echelon: company headquarters (HUS), supply and service division (HUB/HUS), and PAD (HUB/HUM).

(d) *Fourth echelon.* All remaining elements of the hospital.

5-5. Employment

a. The FH/GH are employed in the COMMZ (with exception of the FH as noted in Chapter 2). A COMMZ is defined as the rear part of the TO (behind but contiguous to the CZ) that contains the logistics routes (lines of communication [LOC]) established for supply and evacuation and other agencies required to immediately support and maintain the field forces.

b. The FH/GH provide hospitalization for patients originating in the COMMZ and for those received from the CZ. Patients are received by air and ground ambulance. The patients are triaged, treated, and RTD or stabilized for further evacuation. Patients who cannot RTD within the theater evacuation policy are normally stabilized at the GH for evacuation to CONUS. Those patients identified as RTD are hospitalized and receive rehabilitative care at the FH.

c. The hospitals should be located where they can best acquire patients from the CZ and COMMZ. By virtue of their dependency on COMMZ support units, their location should be in an area where they can be easily supported by elements of the TAACOM ASGs, the theater signal brigade, the district contingency engineer manager, and the TAMCA and its associated regional movement control battalions and movement control teams (MCTs). If the FH is deployed in the corps area, it should be located where it can be readily supported by elements of the corps support group, the corps signal brigade, the corps contingency engineer manager, and the COSCOM movement control center (MCC). Each hospital will require a large area to establish and operate (see Appendix B). The total area is dependent upon the hospital's mission and the terrain features.

d. Appendix H depicts an example of a functional layout for each hospital using the DEPMEDS tent, extendable, modular, personnel (TEMPER) and international organization for standardization (ISO) system. See TC 8-13 for a recommended design of these systems for hospital operations. When possible, these hospitals should use existing buildings in the area. Because of their size and support requirements, relocating these hospitals should be limited.

e. The size and composition of health services in support of military operations will be tailored based on—

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- Mission.
- Size of force being supported.
- Projected patient work loads.
- Anticipated civic action programs.
- Availability of evacuation assets.
- Evacuation policy.

f. During the initial stages of military operations, CHS to the US forces will be austere and limited to the unit's organic medical capabilities. A short theater evacuation policy is normally established; tailored hospital support is required. Projected patient work loads will dictate the composition of these hospitals. The modular design of these hospitals allow augmentation as needed.

5-6. Hospital Displacement

a. Concept of Operations.

(1) The MEDCOM or medical brigade commander moves the FH/GH in support of sustainment operations. Hospital displacement may be in response to forward moves in support of tactical operations, or rearward moves during a retrograde operation. The MEDCOM or medical brigade normally issues orders, either verbally or in writing, to the hospital commander. Frequently, the time to respond to orders may be short; therefore, the hospital commander must disseminate his guidance to his staff in the most expedient method. Upon receiving the commander's guidance, the hospital staff conducts the mission analysis, incorporating changes based on new information or situation. The hospital saves time by rehearsing moves, using knowledge from past experience, and maintaining a detailed TSOP.

(2) The hospital operations section develops the OPORD IAW the MEDCOM's or medical brigade's plan, FM 101-5, FM 8-55, and the TSOP. The hospital commander, in consultation with the hospital XO, approves the OPORD. The hospital commander ensures that the move is coordinated with higher headquarters and all supported elements. All supported elements must be aware of when medical operations at the current location will be curtailed and the date and time of opening of the operation at the new site. Hospital displacement necessitates the transfer of patients and medical operations to other MTFs. To minimize hospital operations disruption, the hospital should move in echelons. Displacement by echelons is contingent upon the higher commander's intent, the tactical situation, and the availability of support requirements.

b. Conduct of Operations.

- (1) *Warning order.*

(a) A move is usually initiated by a warning order issued by the MEDCOM or brigade headquarters. The warning order serves notice of a contemplated action or order that is to follow. The amount of detail included in a warning order depends on the time available, the means of communications, and the information necessary for the hospital commander. Warning orders are brief oral or written orders.

(b) Upon receiving the warning order, the hospital commander analyzes the mission and provides planning guidance to his staff. Using the MEDCOM's or medical brigade's service support annex, status reports, and other appropriate documents, the hospital staff formulates the hospital service support estimate for the commander's approval. (Field Manual 8-55 discusses staff estimates and functions in greater detail.) With the acceptance and approval of the staff estimates, the hospital commander provides his decision and concept of operations. Concurrently with the staff estimate sequence, other hospital personnel conduct preliminary equipment checks and equipment loading procedures. Based on the commander's decision, the PAD coordinates with the MEDCOM or medical brigade to effect the transfer of patients to other MTFs.

(c) In preparation for displacement, the hospital commander should organize the hospital into manageable echelons, preserving hospital integrity as much as possible. Preparation for displacement requires—

- Identifying external support requirements; for example, MHE.
- Phasing down and transferring hospital operations.
- Performing map, ground, and/or air reconnaissance of the routes, and selecting the new site when possible.
- Selecting routes (coordinate with local MCT).
- Designating start points (SPs) and release points (RPs).
- Reconnoitering the route to the SP.
- Providing for security, maintenance, supply, and evacuation.
- Determining the march order (echelons), rate of march, maximum speed of vehicles, and distance between vehicles.
- Establishing checkpoints and halts.
- Establishing COMSEC procedures.
- Issuing strip maps.
- Dispatching reconnaissance and advanced parties.

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- Controlling traffic.
- Issuing orders.

(2) *Operation orders.*

(a) The operations officer has staff responsibility for formulating, publishing, and obtaining the commander's approval of and distributing the OPORD. The OPORD provides hospital staff and personnel the information needed to carry out an operation. Preparation of this order normally follows the completion of area reconnaissance and an estimate of the situation. When time is available and the existing tactical situation conditions prevent detailed planning or area reconnaissance, the MEDCOM or brigade conducts coordination and prepares an initial march plan and issues fragmentary orders (FRAGOs) to modify these plans as needed. If conditions and time permit, information in the OPORD includes—

- Destination and routes.
- Rate of march, maximum speeds, and order of march.
- Start points and SP times.
- Scheduled halts, vehicle distances, and RPs.
- Required communications.
- Strip maps.

(Appendix I provides a sample OPORD with annexes; FM 8-55 and FM 101-5 contain more detailed OPORD information.)

(b) Each hospital division or section reports its supply, vehicle, equipment, work load, and maintenance status to the operations officer. This information is used in coordination with higher headquarters to finalize the convoy organization, compute additional transportation and external support requirements, and perform march computations. (For additional information on march computations, see FM 55-30.)

(3) *Area reconnaissance.*

(a) The MEDCOM or medical brigade headquarters normally coordinates unit movement with adjacent maneuver forces and prescribes the reconnaissance route. The hospital operations section uses a map reconnaissance in such cases to confirm checkpoints, identify problem areas, and begin planning positions of the hospital in the new area. If the route is not prescribed and the hospital reconnaissance team is not included as part of a reconnaissance party with other units, the operations section briefs the reconnaissance team on the displacement plan. The operations section provides the team with a map with graphic control measures, radio frequencies of adjacent units for coordination, and the designated

MOPP level and then notifies higher headquarters of the route selected. The composition of the reconnaissance team is directed by the hospital commander.

(b) The reconnaissance party wears the designated MOPP gear and monitors all radiological and chemical detection devices. It performs duties to—

- Verify map information.
- Note capabilities of road networks.
- List significant terrain features and potential problem areas.
- Verify travel times and distances.
- Draw/design a power configuration plan to the proposed layout of the hospital complex which will identify the power generation equipment, routes of electrical power dispersion, and fuel requirements to meet necessary electrical demands to various portions of the DEPMEDS hospital.
- Estimate hospital site preparation. (See TC 8-13 for a detailed discussion on site selection, layout, and support requirements.)

(4) *Advanced party.* The advanced party moves before the main body and is dispatched as directed by the hospital commander. Its composition is recommended by the medical operations officer and approved by the hospital commander. The advanced party normally consists of representatives from Echelon II of the convoy organization (see paragraph 5-4c[1] and [2]). It prepares the new site for arrival of the main body. The advanced party performs duties to—

- Conduct a security sweep of the new site to ensure the area is free of enemy activity. This is normally done by security support forces.
- Position chemical alarms.
- Establish communications with higher headquarters and old location.
- Designate boundaries of hospital elements based on unit defense plan and consistency with types of weapons and personnel availability.
- Increase security by manning key points along the perimeter.
- Establish a command post.
- Complete hospital site preparation layout (see TC 8-13).
- Establish land-line communications for critical areas.

- Ensure personnel follow dispersion and other measures.
- Position personnel to guide main body from the RP to designated locations.

(5) *Main body.* The main body moves as directed in the OPORD. The last echelon normally closes out any remaining operations, ensuring the old site is clear of evidence of intelligence valuable to the enemy, and moves to the new site. This echelon includes maintenance elements to deal with disabled vehicles from the rest of the convoy. It also picks up guides and markers along the route. As the main body arrives at the new site, it is met by the advanced party and guided to designated positions. Erection of the hospital and the establishment of hospital operations follows the priorities set by the commander.

(6) *Crossing a nuclear, biological, and/or chemical contaminated area.* When the hospital commander is directed by higher headquarters, or when the tactical situation dictates, the hospital may have to cross a contaminated area or an area designated as a contaminated area. Should this situation occur, the following are recommended procedures:

(a) *Operations section.*

- The operations officer conducts a map reconnaissance of the area and briefs the commander on the best possible route.
- Based on the commander's approval, a route reconnaissance is conducted prior to moving the convoy through the contaminated area.
- The reconnaissance team wears the appropriate MOPP level and carries monitoring equipment.
- The route selected should minimize hospital exposure when crossing the area.

NOTE

In a nuclear environment, the turn-back dose rate will be identified.

(b) *Convoy operations.*

- The convoy travels at a maximum safe speed with no scheduled stops within the contaminated area.
- Prior to convoy operations, the commander designates the MOPP level.
- The lead vehicle of each serial of the convoy has monitoring capabilities and survey instruments, with a map indicating areas of contamination. The map includes data from the reconnaissance party report. Continuous monitoring is conducted through the contaminated area.

- Spacing of vehicles should take into consideration dust generated by the next forward vehicle.

- Disabled vehicles will be collected IAW the maintenance collection plan (like vehicles can tow like vehicles). Coordination must be made with the unit providing recovery support.

(c) *Decontamination.*

- Immediately upon completion of the move, personnel and equipment are decontaminated. The hospital is responsible for decontaminating its personnel and equipment (see FM 3-5). Decontamination beyond the capability of the hospital will be requested from the supporting chemical company.

- The decontamination site is annotated on the map.

(d) *Reports.* Upon completion of the move, the operations officer reports immediately to the hospital commander and higher headquarters any contamination acquired during the move. Other required reports are also included.

5-7. Emergency Displacement

When confronted with an adverse tactical situation and/or when directed by higher headquarters, the hospital may be required to relocate expeditiously. Movement procedures identified above may be modified to accommodate the situation. As soon as the threat appears inevitable, all available means are used for evacuation of casualties, hospital personnel, and equipment. Wounded soldiers have priority on transportation assets. The critically wounded who cannot be moved are left behind with medical personnel, supplies, and equipment. The decision to leave patients behind is made by the tactical commander. Medical supplies and equipment are not intentionally destroyed, even to prevent them from falling into enemy hands. Paragraph 5 of Article 12, Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, provides that if we must abandon wounded or sick, we have a moral obligation to, “as far as military considerations permit,” leave medical supplies and personnel to assist in their care.

5-8. Nuclear, Biological, and Chemical Operations

As stated earlier in the threat, the corps' and division's sustainment capabilities are prime targets for the enemy's NBC weapons. Although the hospital may not be specifically targeted, locating it close to other CS and CSS units, major airfields, and road junctions makes it vulnerable to NBC weapons. The hospital's TEMPERs are relatively permeable. Without increased protection, hospital assets can be expected to experience a significant amount of contamination and damage when exposed to NBC strikes. The distance of the hospital from other support units and interposed terrain features as protective factors must be balanced against accessibility and time required for patient transport. Prompt notification of, and reaction to, downwind messages in the event of NBC employment will enhance hospital operations and patient and

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individual protective measures. However, NBC defense includes all measures to minimize casualties and enhance the effectiveness of hospital operations under NBC conditions. These measures may be proactive or reactive in nature. They include contamination avoidance and control, protection, and decontamination. For a comprehensive discussion on hospital operations in a NBC environment, see FM 8-10-7 and FM 8-285.

CHAPTER 6

**THEATER ARMY MEDICAL MANAGEMENT
INFORMATION SYSTEM****6-1. Theater Army Medical Management Information Support**

a. The TMMIS supports the information management requirements of field medical units in war, peace, and conflict. It is an automated, on-line, interactive microcomputer system designed to assist commanders and their staffs by providing timely, accurate, and relevant medical information in the following areas:

- Medical assemblage management (MEDASM).
- Medical maintenance.
- Medical patient accounting and reporting.
- Medical regulating.
- Medical supply.

b. Controlled accessibility is a TMMIS feature included both to simplify the system and to increase security. During system setup, the local manager establishes each user's accessibility to each part of the system through system setup files; the user will review only the portion of the system that pertains to his job responsibilities. The local manager can also adjust his unit's system to accommodate local requirements and the operating environment.

c. The TMMIS has flexible communication capabilities and can relay information between units in various ways. The preferred medium is through direct communication between computers through a local area network (LAN) or MSE. (When direct electronic communications links are not available, an alternative means is via modem or International Maritime Satellite (INMARSAT).

d. In this chapter only those systems which support the FH's and GH's mission in the TO are addressed. Medical regulating and MEDPAR C2 will not be addressed. See FM 8-55 for information on medical regulating.

6-2. Medical Assemblage Management

a. The TMMIS-MEDASM automates the management of medical assemblages for facility commanders. The system provides the commander with the capability to track overages, shortages, quality control information, and locations for each assemblage. The system operates within the corps and COMMZ. Medical assemblage management information will enhance the commander's ability to determine the readiness status of his medical assemblages.

b. The TAMMIS-MEDASM provides the user with automated capabilities in the following areas:

(1) *Assemblage management process.* The system provides a grouping of individual processes which are used for item, allowance, and quality control management. Collectively, these individual processes allow accurate predictions of hospital readiness based on asset availability.

(2) *Request, receipt, due-in management.* The system includes separate processes which expedite ordering of shortage items, recording receipts, and managing aged orders for required items.

(3) *System setup procedures.* This system includes a group of processes which define the operating environment to the medical assemblages. These procedures describe the parent department/section, its supported assemblages, sources of supply support, and ordering processes.

(4) *User designed reports.* This process allows the user to create, modify, delete, and print reports of his own design. This will enhance the standardization of readiness reporting and tracking of medical assemblages. The TAMMIS-MEDASM will also provide the user with the capability to prepare reports listing sub-hand receipt durable items and nonexpendable pieces of equipment within assemblages.

6-3. The Medical Maintenance System

a. The TAMMIS-MEDMNT supports the scheduled maintenance and repair of medical equipment essential for treating patients. The system is designed to operate at the division medical supply office (DMSO) within the US Army divisions, at the MEDLOG battalions (forward and rear), and at TOE hospitals within the corps and COMMZ. The system is used at each of these locations to manage equipment maintenance and repair for equipment owned by the supporting and supported units. In the MEDLOG battalions (forward and rear), the TAMMIS-MEDMNT will operate on the Corps/Theater Automated Support Center Phase II (CTASC II) computer. In all other locations (DMSO and TOE hospitals), the TAMMIS-MEDMNT will operate on the MEDTCU.

b. The TAMMIS-MEDMNT provides the user with automated capabilities in the following areas:

(1) *Work order processing.* Allows the scheduling, assigning, tracking, and reporting of medical equipment maintenance work orders. It also allows the user to identify and track the status of equipment directly supported by local medical maintenance personnel.

(2) *Supply management.* Allows the unit to maintain information on stockage of items required to support the medical maintenance mission. It also allows the maintenance unit to interface with the supply system through the unit-level logistics system to requisition nonmedical repair parts.

(3) *Periodic processing and reporting.* Generates a monthly performance report that provides scheduled and unscheduled maintenance service information to be used by local management or higher commands. A C2 report provides the commander with up-to-the-minute status of all readiness-significant items of medical equipment. It also provides a Materiel Condition Status Report (DA Form 2406) which passes unit readiness information through the command.

(4) *Maintenance system setup procedures.* Defines the local environment used to control system processing by identifying supporting activities and supported customer and by processing default data.

(5) *User designed reports.* This process allows the user to create, modify, delete, and print reports of their own design.

6-4. Medical Patient Accounting and Reporting

a. The TAMMIS-MEDPAR supports facility commanders in the management of patients and resources. The system tracks patients for casualty reporting and personnel strength accounting. The system operates within the corps and COMMZ. Individual patient data and medical information are accumulated to determine the availability of medical resources and to support the personnel and casualty reporting systems.

b. The TAMMIS-MEDPAR provides the user with automated capabilities in the following areas:

(1) *Patient admission and disposition.* Medical patient accounting and reporting enables personnel to quickly collect and maintain patient demographics for all patients admitted to a facility. This information may be collected through a data entry screen, the individually carried record (ICR), or the MEDTCU, and is used for tracking patients and managing facility resources. The system prompts users for information specific to the type of admission being performed. The system will accept information for patients being transferred from another MTF. Medical patient accounting and reporting also enables personnel to quickly collect and maintain discharge data and prompts the user for the information specific to the type of discharge (RTD, transfer, absent without leave [AWOL], death, discharge from hospital, retired/separated from service). Upon discharge, MEDPAR releases resources to send transfer data for patients transferred to another MTF. Medical patient accounting and reporting also interfaces with the Standard Installation/Division Personnel System-3 in order to transmit data concerning hospitalized soldiers.

(2) *Patient record management.* Medical patient accounting and reporting enables users to produce a hard copy of the Inpatient Treatment Record Cover Sheet, sets of patient labels, and a hard copy of the patient record including any transactions that occurred during the patient's stay in the MTF. Using MEDPAR, personnel have the ability to archive and maintain the patient's record after the patient has been discharged from the facility.

(3) *Patient status management.* Medical patient accounting and reporting allows users to update information concerning the patient's condition, acuity level, stability, location within the facility, casualty status, and evacuation status, as well as the patient's activity in and out of the facility. The system uses this information to generate Patient Evacuation Requests and Patient Manifests.

(4) *Patient accounting reports.* Medical patient accounting and reporting enables users to produce a Ward Report, Admissions and Dispositions (AAD) Report, Allied Admissions and Dispositions Report, Very Serious Ill (VSI)/Seriously Ill (SI)/Special Category (SC) Roster, Patient Alpha Roster, Patient Roster by Unit, and a Reportable Conditions (MED-16) Roster. The system also allows users to make AAD corrections to previous AAD Reports, reflecting the changes on the next AAD Report produced.

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(5) *Facility management reports.* Medical patient accounting and reporting enables users to produce a Command Interest Roster, Patient Evacuation Roster, Expected Dispositions Report, Bed Status Report, Register Number Listing, Pre-Admission Report, Medical Summary Report Worksheet, and Medical Summary Report. The system also allows users to print reports received from the MEDREG system and send the Bed Status Report to the MEDREG system via floppy diskette, tape, or modem.

(6) *Individually carried record.* Medical patient accounting and reporting enables users to read and update the ICR. The ICR was designed to store data pertaining to the individual soldier on a tag or other similar device. Data can be read or downloaded from the tag into MEDPAR through the use of an interface device. The system allows users to enter and update the administrative data file, medically significant data file, medical readiness data file, and the combat treatment file after reading the ICR. This function is currently disabled.

(7) *Command interest roll-up reports.* Medical patient accounting and reporting allows users to send Recapitulation Reports, Bed Status Reports, Reportable Condition Reports, and Comment Reports to the next higher headquarters by floppy diskette, tape, or modem.

(8) *Medical patient accounting and reporting system maintenance.* The system enables the MEDPAR system administrator to maintain the MEDPAR system files, the archive log, and the select tables. The MEDPAR system administrator can modify specific report parameters for the Command Interest Report and the environmental information that describes the facility, location of the facility, and the number of OR suites in the facility. This gives the system administrator flexibility in meeting changing battlefield requirements. The system administrator can also modify a patient register number, ensuring the integrity of the MEDPAR database. The system administrator can also reconcile the facility bed status. This useful function should be run when the system fails while a patient activity is being recorded. The system allows users to correct previous Medical Summary Report Worksheets. These changes are reflected in the monthly Medical Summary Report.

(9) *User designed reports.* Medical patient accounting and reporting allows users to browse through the Ad Hoc Report file and create, modify, delete, and print reports.

6-5. The Medical Supply System

a. The TAMMIS-MEDSUP automates the comprehensive management and requisitioning of medical materiel required to support medical units. It is designed to operate at the DMSO within US Army divisions; at the MEDLOG battalions (forward and rear); and at TOE hospitals within the corps and COMMZ. At the MEDLOG battalions, TAMMIS will operate on the CTASC II computer which is a mini-mainframe computer. At all other locations (such as DMSO and the TOE hospitals), TAMMIS will run on the MEDTCU. The TAMMIS-MEDSUP interfaces with the Standard Army Management Information System, specifically the Department of the Army Movement Management System-Redesigned (DAMMS-R), Combat Service Support Control System (CSSCS), Standard Army Retail Supply System (SARSS), and SPBS-R.

- b. The TAMMIS-MEDSUP provides the user with automated capabilities in the following areas:
- (1) *Customer processing.* Enables the user to—
 - Enter routine and emergency customer requests for medical materiel.
 - Enter, approve, reject, or receive customer turn-ins.
 - Maintain a customer request file where requests can be reviewed, modified, or canceled, and supply status can be provided to the customer.
 - Build and maintain an automated customer reorder list.
 - Produce various customer supply and financial reports.
 - Prepare files for customers.
 - Load and process files from customers.
 - (2) *Supply requisitioning and receiving and dues-in.* Allows the user to—
 - Generate, review, and enter replenishment requisitions.
 - Review, modify, or cancel due-in records.
 - Generate follow-up requests and print the due-in items report.
 - Enter, process, review, and reverse receipts.
 - Prepare files for the supplier.
 - Load and process files from the supplier.
 - (3) *Local stock maintenance, quality control, and reports.*
 - (a) Enables the user to—
 - Maintain local stock records and levels by adding or changing stock record files and processing stock number changes.
 - Review the item request history for stockage of an item.
 - Recompute the requisitioning objective or reorder point (ROP) for stocked items.
 - Review contingency versus active stocks.

(b) Allows the user to—

- Maintain a stock location file.
- Produce location reports.
- Conduct more efficient physical inventories.
- Perform inventory adjustments.
- Produce inventory reports.

(c) Allows the user to perform quality controls and destruction actions by—

- Processing quality control alert messages.
- Scheduling quality control surveillance inspections.
- Entering quality control data for materiel received.
- Entering or updating destruction records.
- Adjusting the stock record file for destruction.
- Printing quality control and destruction reports.

(d) Enables the user to—

- Obtain information for current stock status and process catalog changes.
- Perform monthly summary purge and create the Standard Financial System (STANFINS) file.
- Perform periodic and special purpose reporting, such as C2 and numerous supply management reports.
- Perform excess stock management and reporting.

(4) *Query by the national stock number (NSN), due in or due out, or transaction history.*
Allows the user to—

- View current stock status, due-in or out transaction history, and demand history on the screen.
- Modify or cancel customer requests.
- Review, modify, or cancel due-in records.

(5) *Setting up and maintaining system procedures.* Enables the user at initial system setup or during normal system operation to—

- Build or update the supported customer file.
- Build or update the supporting activity file.
- Build or update the environmental data file by entering and updating local destruction date, financial description data, requisitioning objective or ROP calculation data, processing default data, and control data.
- Update month and cut-off dates.
- Update reporting, printing, and display options.
- Perform file archiving.
- Build an updated cost file.
- Update the elements of expense file.

(6) *Reviewing exceptions referred to manager.* Allows the user to review and process exception records from the due-in exception file, customer demand exception file, receipt exception file, and replenishment exception file.

(7) *User-designed reports.* Allows the user to create, modify, delete, and print user-designed temporary reports.

APPENDIX A

**TACTICAL STANDING OPERATING PROCEDURE
FOR HOSPITAL OPERATIONS****A-1. Tactical Standing Operating Procedure**

This appendix provides a sample TSOP which may be modified for a FH/GH. It provides the tactics, techniques, and procedures for hospital operations; however, it should not be considered as all-inclusive. It may be supplemented with information and procedures required for operating within a specific command, contingency, or environment.

A-2. Purpose of the Tactical Standing Operating Procedure

The TSOP prescribes policy, guidance, and procedures for the routine tactical operations of a specific unit. It should cover broad areas of unit operations and be sufficiently detailed to provide newly assigned personnel the guidance required for them to perform their mission. A TSOP may be modified by TSOPs and OPLANs/OPORDs of higher headquarters. It applies to a specific unit and all subordinate units assigned and attached. Should a TSOP not be in conformity with the TSOP of the higher headquarters, the higher headquarters' TSOP governs. The TSOP is periodically reviewed and updated annually.

A-3. Format for the Tactical Standing Operating Procedure

a. There is not a standard format for all TSOPs; however, it is recommended that a unit TSOP follow the format used by its higher headquarters. The TSOP can be divided into sections (specific functional areas or major operational areas). The TSOP may contain one or more annexes, each of which may have one or more appendixes. The appendixes may each have one or more tabs. Appendixes can be used to provide detailed information on major subdivisions of the annex, and tabs can be used to provide additional information (such as report formats or area layouts) addressed in the appendix(es).

b. Regardless of the format used, the TSOP follows a logical sequence in the presentation of material. It should discuss the chain of command, major functions and staff sections of the unit, operational requirements, required reports, necessary coordination with higher and subordinate elements for mission accomplishment, programs (such as command information, PVNTMED measures, and CSC), and other relevant topics.

c. Pagination of the TSOP can be accomplished by starting with page 1 and numbering the remaining pages sequentially. If the TSOP is subdivided into sections, annexes, appendixes, and tabs, a numbering system that clearly identifies the location of the page within the document should be used. Annexes are identified by letters and are listed alphabetically. Appendixes are identified by numbers and arranged sequentially within a specific annex. Tabs are identified by a letter and are listed alphabetically within a specific appendix. After numbering the initial sections using the standard numbering system (sequentially starting with page 1 through to the end of the sections), number the annexes and their subdivisions. They are numbered as the letter of the annex, the number of the appendix, the letter of the tab, and the page number. For example, page 4 of Annex D is written as "D-4"; page 2 of Appendix 3 to

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Annex D is written as “D-3-2”; page 5 of Tab A to Appendix 3 of Annex D is written as “D-3-A-5.” This system of numbering makes the pages readily identifiable as to their place within the document.

d. In addition to using a numbering system to identify specific pages within the TSOP, descriptive heading should be used on all pages to identify the subordinate elements of the TSOP.

(1) The first page of the TSOP should be prepared on the unit’s letterhead. The remaining pages of the sections should include the unit identification in the upper right hand corner of the paper (for example: “XXX Combat Support Hospital”).

(2) A sample heading for an annex is: “Annex Q (Nursing Service) to XXX Combat Support Hospital.”

(3) A sample heading for an appendix to Annex Q is: “Appendix 4 (Patient Food Service) to Annex Q (Nursing Service) to XXX Combat Support Hospital.”

(4) A sample heading for a tab to Appendix 4 to Annex Q is: “Tab C (Diet Roster) to Appendix 4 (Patient Food Service) to Annex Q (Nursing Service) to XXX Combat Support Hospital.”

e. As the TSOP is developed there may be an overlap of material from one annex to another. This is due in part to similar functions that are common to two or more staff sections. Where overlaps occur, the material presented should not be contradictory. All discrepancies will be resolved prior to the authentication and publication of the TSOP. The TSOP will be authenticated by the hospital commander.

f. Tactical standing operating procedure writers should review the appropriate mission training program (MTP) to ensure the TSOP is thorough and doctrinally correct. See Army Training and Evaluation Program (ARTEP) 8-715-MTP for FHs and ARTEP 8-725-MTP for GHs.

A-4. Sample Tactical Standing Operating Procedure (Sections)

The information contained in this paragraph can be supplemented. It is not intended to be an all-inclusive listing. Different commands will have unique requirements that need to be included.

a. The first section of the TSOP identifies the specific unit/headquarters that developed the TSOP.

(1) *Scope.* This paragraph establishes and prescribes procedures to be followed by the hospital and its assigned, attached, or operational control (OPCON) units/elements.

(2) *Purpose.* This paragraph provides policy and guidance for routine tactical operations of the headquarters and its assigned, attached, or OPCON units.

(3) *Applicability.* Except when modified by TSOPs and OPLANs/OPORDs of higher headquarters, this paragraph applies to the hospital and to all units assigned, attached, or OPCON for

combat operations. These orders, however, do not replace judgment and common sense. In cases of nonconformity, the document of the higher headquarters governs. Each subordinate element will prepare a unit TSOP, conforming to the guidance herein.

(4) *General information.* This paragraph discusses the required state of readiness of the unit; primary, secondary, and contingency missions; procedures for operating within another command's AO; and procedures for resolution of conflicts with governing regulations, policies, and procedures.

(5) *References.* This paragraph can include any pertinent regulations, policy letters, higher headquarters TSOP, or other appropriate documents.

b. The second section of the TSOP discusses the hospital organization.

(1) *Organization.* The unit is organized and equipped IAW the applicable MTOE and/or other staffing documentation. The applicable MTOE and other staffing documentation should be listed in this paragraph.

(2) *Succession of command.* The guidance for determining the succession of command is discussed.

(3) *Task organization.* Task organization is contingent on the mission and will be approved by the headquarters ordering deployment.

(4) *Organizational charts.* Contained in Annex A.

c. The third section of the TSOP discusses hospital functions. It will supplement the hospital organizational chart(s). The functions of the various hospital divisions/sections, to include personnel and some of their responsibilities, are provided in Chapter 2 of this publication. For a more detail description of personnel duties, see FM 101-5, AR 611-201, and AR 611-101.

d. The fourth section of the TSOP pertains to division/section operations and is subdivided into annexes.

A-5. Sample Tactical Standing Operating Procedure (Annexes)

Annexes are used to provide detailed information on a particular function or area of responsibility. The commander determines the level of specificity required for the TSOP. Depending upon the complexity of the material to be presented, the annex may be further subdivided into appendixes and tabs. If the annex contains broad guidance or does not provide formats for required reports, paragraphs may be used. The annex should not require further subdivision. However, as the material presented becomes more complex, prescribes formats, or contains graphic materials, the annex will require additional subdivision. Applicable references, such as ARs, FMs, and TMs, should be provided in each annex. The number of annexes and their subdivisions should be based on command/contingency requirements. Each annex should contain

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information relating to mission, organization, duties and/or responsibilities, and procedures. The following sample annexes are provided as a guide and are not considered all-inclusive.

a. Annex B, Hospital Headquarters. This annex discusses the hospital commander and his responsibilities. The hospital commander is the senior MC officer assigned or as appointed by higher headquarters. The hospital commander, assisted by the chiefs of surgery, nursing, and medicine, XO, chaplain, and CSM, provides the C2 necessary to accomplish the mission. The day-to-day operations shall include a review of hospital activities occurring during the preceding shift and the implementation of directives received from higher headquarters.

(1) The daily assessment of hospital operations is accomplished via a report(s) on admissions, dispositions, bed census (by type), unusual occurrences, and significant SI patients. The chief of professional services reports on bed availability by type bed and service capabilities that can be provided. This information must also be provided daily to the PAD for medical evacuation and patient regulating operations.

(2) The commander and his staff, in the conduct of daily operations, can use personal and telephonic contact to become aware of personnel, logistical, and administrative problems which may affect the overall hospital operations.

(3) Regularly scheduled meetings and review of reports and programs can be used to monitor the effectiveness and efficiency of hospital operations.

(4) The hospital commander, during command visits or contacts with the medical group, can be apprised of the tactical situation. The hospital commander provides higher headquarters the hospital's overall status, to include patient work load, hospital capability, personnel status, logistical requirements, and other information as he deems appropriate. The hospital commander maintains liaison with the MEDLOG battalion, the medical evacuation battalion, and corps support organizations.

(5) The hospital commander may activate the TOC based on the tactical situation. (See Annex D for a discussion on TOC operations.)

(6) This annex should also address the hospital hours of operation, to include the hospital staff and personnel shifts.

b. Annex C, Company Headquarters. This annex discusses the C2 structure for all assigned or attached officers and enlisted personnel of the hospital. The annex outlines procedural guidance for, but not limited to, the following:

- Unit-level administration.
- Reenlistment and extension programs.
- Billeting, to include fire safety, sanitation (including field sanitation), and key control.
- Security, assignment, accountability, and maintenance of weapons.

- Perimeter security.
- Life support and site improvement.
- Welfare and recreational activities.
- Unit supply.
- Duty rosters.
- Physical fitness.
- Training.
- Uniform Code of Military Justice actions.

c. *Annex D, Tactical Operations Center.* Areas covered by this annex include—

(1) *Definition.* The TOC is the command element of the hospital containing communications and personnel required to command, control, and coordinate hospital and CHS operations.

(2) *Purpose.* The purpose of the TOC is to provide a secure area where the commander and key staff can assemble to estimate the situation, assess the requirements, and react to varying problems such as area defense, NBC operations, mass casualty situations, and CHS operations.

(3) *Responsibilities.* The hospital commander has overall supervision and control over the TOC. The hospital XO has primary staff responsibility in the absence of the commander. Daily operations of the TOC are the responsibility of the operations section.

(4) *Operations.* The TOC operates on a 24-hour basis. It is principally staffed by each primary staff section furnishing necessary manpower as required. The TOC will be adjacent to the communications facility, as well as in proximity to the emergency room and triage areas. The TOC should be of sufficient size to allow for establishment of maps, storage of individual weapons and chemical defense equipment, and facilitate communications among the staff. Telephone communications connect the TOC to other staff sections within the hospital, higher headquarters, and other appropriate units. The CNR will also provide the appropriate communications for CHS. Access to the TOC is strictly controlled by means of an access roster and, if available, security badges. Only essential personnel and authorized visitors are allowed to enter. Each hospital element maintains a TSOP on the organization and operation of its section. All elements within the TOC maintain, when appropriate, a current situational map of their specific operations. Discussion and portrayal of tactical plans outside of the security area are prohibited.

(5) *Composition of the tactical operations center.* This is a listing of those personnel comprising the TOC. It normally includes the commander, XO, CSM, principal staff members, and other specific staff members as required.

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(6) *Tactical operations center configuration.* This is a schematic representation of the physical layout of the TOC. It can be included as an appendix to the annex.

(7) *Message center.* This paragraph establishes procedures for the handling of classified messages; provides delivery and service of IMMEDIATE and FLASH messages to the appropriate staff section; provides procedures for preparing outgoing messages and delivery service to the servicing message center for the transmission of outgoing messages.

(8) *Appendixes.* The addition of appendixes to this annex is permissible and may cover topics such as—

- Schematics of the physical layout.
- Change of shift procedures.
- Security requirements, to include guard duties and identification badges.
- Briefing requirements.
- Overlay preparation.

(9) *Camouflage.* This paragraph discusses what camouflage procedures are required, to include type and amount of required camouflage materials (such as nets and terrain features); display of the Geneva Conventions' distinctive emblem on facilities and vehicles; and other pertinent information. See FM 8-10 for information concerning the camouflaging of medical units.

d. Annex E, Operations. This annex establishes procedures for the operations section within the hospital and provides a basis for standardization of CHS operations in a tactical environment. It is essential that these procedures be standardized to ensure common understanding, facilitate control and responsiveness, and enhance mission accomplishment. Although intelligence and hospital defense are functions of the hospital operations section, they may be addressed in separate annexes. For simplicity and coherency, these areas are discussed in paragraphs *e* and *f*, respectively. Commanders may elect to consolidate the S2/S3 functions into a single annex. Appendixes to this annex should include the following areas:

(1) *Operational situation report.* Requirements for format, preparation, and submission of this report are discussed in this appendix.

(2) *Operations security.* This appendix provides the guidance and procedures for secure planning and conduct of combat operations.

(a) *Responsibilities.* The commander is ultimately responsible for denying information to the enemy. The operations officer is responsible to the commander for the overall planning and execution of operations. He has the principle staff interest in assuming the required degree of OPSEC and has the primary staff responsibility for coordinating the efforts of all other staff elements in this regard. The operations officer is responsible for the preparation of the essential elements of friendly information (EEFI)

and for providing classification guidance. Additionally, the OPSEC officer identifies the priorities for OPSEC analysis and develops OPSEC countermeasures. Coordination is effected with higher headquarters in planning an OPSEC analysis of operations and analyzing EEFI.

(b) *Classified and sensitive information.* Document classification, downgrading, and declassification is the responsibility of the operations section. Classified and sensitive information, such as the status of the forces, readiness condition, equipment status, and other information relative to the hospital's ability to perform its mission, will be limited to those individuals with a security clearance and the need to know.

(3) *Hospital relocation.* This appendix provides the procedures for hospital relocation. Because of the hospital's limited mobility, transportation support and other site preparation are required from COSCOM assets. The operations officer, in conjunction with the supply and service division, plans and coordinates hospital movement. Considerations should include, but not be limited to, the following:

- Coordination with higher headquarters.
- Patient relocation.
- Tactical situation.
- Transportation requirements availability.
- Convoy operations (to include clearance and security).
- Terrain analysis and site selection, to include PVNTMED considerations (insect breeding sites, waste disposal considerations, and proximity to water supplies).
- Availability of required support (engineer, communications, and supply).

(4) *Communications-electronics.* This appendix establishes communications policies, procedures, and responsibilities for the installation, operation, and maintenance of communications-electronics (CE) equipment. Responsibilities of the CE NCO include—

- Advising the hospital commander and operations officer on CE matters.
- Determining requirements for communications support.
- Radio communications.
- Radio teletypewriter communications.
- Message and communications center service.
- Message handling procedures.

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- Wire communications.
- Switchboard operations.
- Communications security and operations.
- Security violations. This prescribes procedures for reporting any event or action which may jeopardize COMSEC.
- Daily shift inventory.
- Physical security of communications equipment.
- Transmission security.
- Security areas. This discusses access procedures and rosters, access approval requirements, and prohibited items.
- Communications security officers and custodians. The appointment procedures, orders requirements, and duties of personnel are described.
- Safety. This discusses requirements for the grounding of, handling, and storage of COMSEC equipment.
- Power units.
- Emergency destruction of classified operating instructions and associated materials.

e. Annex F, Intelligence and Security. This annex pertains to intelligence requirements and procedures and operational security considerations. Appendixes to this annex may include the following subjects:

(1) *Intelligence.* The operations section has the responsibility of collecting information to assist the commander in reaching logical decisions as to the best courses of action to pursue. Priority intelligence requirements (PIR) include, but are not limited to, the location, type, and strength of the enemy threat; location of area of casualty concentration; known or suspected NBC activity; and issues which the commander considers to be PIR.

(2) *Intelligence reports.* The operations section is responsible for disseminating all applicable estimates, analyses, periodic intelligence reports, and intelligence summaries generated within the hospital or received from higher headquarters. Information on submission of reports and suspenses on intelligence products and reports should also be addressed in this appendix.

(3) *Counterintelligence.*

- *Camouflage.* When ordered or directed by the tactical commander, all units will initiate and continually strive to improve camouflage of positions, vehicles, and equipment. Noise and light discipline is emphasized at all times.

- *Communications security.* These measures are enforced at all times. Specific requirements and considerations are included.

- *Signs and countersigns.* This paragraph outlines procedures for establishing signs and countersigns to be used during hours of darkness. It also includes reporting requirements and procedures if the sign/countersign is lost or compromised.

- *Document security.* This paragraph discusses the procedures for inventorying, marking, safeguarding, and destroying classified material, both work documents and completed documents. Reporting requirements in the event of compromise are also included.

(4) *Captured personnel, equipment, supplies, and documents.* This appendix provides specific guidance on the handling of captured personnel, equipment, supplies, and documents. The disposition of captured medical equipment and supplies is governed by the Geneva Conventions and is protected against intentional destruction.

(5) *Security.* This appendix discusses weapons security, SOI (communications) security, TOC security, and Sensitive Item Status Report policies, guidance, or procedures.

f. Annex G, Hospital Defense. This annex describes procedures for security of the hospital in a wartime environment. Security should be a part of an integrated defense plan (base cluster commander and HN base defense plan). Within the theater area, the base cluster and base commanders are appointed by the area commander. These commanders have the overall responsibility for the base cluster defense and base defense organizations and plans. The hospital should be included as a part of the base cluster/base plan as established by the base cluster/defense commander. This annex addresses, as a minimum, the following:

- Sustainment operations.
- Defense reaction force(s).
- Hospital movement.
- Terrain management.
- Medical unit self-defense according to the Law of Land Warfare (see Appendix G). For a comprehensive discussion on the Law of Land Warfare, see FM 8-10 and FM 27-10.

g. Annex H, Administration and Personnel. This annex outlines procedures relating to administrative and personnel matters and associated activities. The theater surgeon has assignment, reassignment, and career management authority for all AMEDD officer and warrant officer personnel arriving into or within the theater during mobilization and wartime. Request for personnel and administrative

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support will be submitted through the medical group (S1 [Adjutant, US Army]) to the appropriate supporting regional personnel center. Paragraphs of the annex or attached appendixes should discuss the following:

(1) *Personnel loss estimate.* Initially, FM 101-10-1/1 and FM 101-10-1/2 will be used as a basis for the computation of gross and special personnel loss estimates. Factors and loss rate tables in the FMs may not accurately reflect current situations and should be modified as actual experience factors are developed.

(2) *Emergency personnel replacements.* A request for hospital personnel replacement is submitted to the medical group S1 when there are unexpected losses for which no replacements are allocated.

(3) *Personnel daily summary (PDS).* This paragraph provides the procedures for filling out and submitting a daily personnel status report. The instructions may include requirements for encrypting the report prior to transmission, specific guidance on time of submission, corrections, or other administrative requirements.

(4) *Casualty reports.* This paragraph applies to all US military personnel who are serving within the hospital's area of support and become casualties in areas under US control. It is also applicable to EPWs and civilian internees who become casualties while under control of US units.

- *Casualty feeder report.* This report is submitted on DA Form 1156. Instructions for completing the form and submission requirements are included.

- *Witness statements on individuals.* This statement is completed on DA Form 1155 only when the recovery of a body is not possible, or when a body cannot be identified. This form is to be submitted to the S1 within 24 hours of the incident. The paragraph should contain information on obtaining the form, instructions for completing it, and other relevant information or procedures.

- *Other reports.* This section may also include other reports required by the command.

(5) *Personnel management.*

- *Replacements.* Individual replacements will not be readily available during the initial phases of operations. The administrative division will automatically initiate replacement requests for personnel who are reported on the PDS report as wounded in action (WIA), missing in action, or killed in action.

- *Assignments and reassignments.* This paragraph will address the actions required for patients and permanent party personnel.

- *Leaves.* Ordinary and emergency leave procedures are outlined in AR 630-5. Policies established by the theater will take precedence.

- *Personnel actions.* All personnel actions are channeled through the administrative division. Division/section chiefs and NCOICs are the hospital points of contact. Actions will be handled expeditiously and meet suspense dates (tactical situation permitting).

- *Efficiency reports.* This paragraph describes the pertinent information needed for the completion and submission of these reports.

- *Award recommendations.* This paragraph delineates the responsibilities and guidance for submitting recommendations for awards and for scheduling and conducting award ceremonies.

- *Promotions.* This paragraph discusses the procedures for submitting recommendations for promotion and for scheduling and conducting promotion ceremonies.

- *Correspondence.* All correspondence addressed to higher headquarters is submitted through the administrative division. Requirements for submission, preparation, and approval are also provided.

- *Personnel records.* This paragraph discusses requirements for coordination of this support. It also discusses the procedures for having correspondence included in the official military personnel records of personnel assigned and attached.

(6) *Personnel services.* Personnel services are those activities pertaining to soldiers as individuals. Unless prohibited by the tactical situation, the services listed below will be available to all assigned and attached units.

- *Family care plans.* An individual soldier's plan is reviewed and updated in order to provide for his family during his absence.

- *Sporting activities and morale and welfare activities.*

- *American Red Cross.*

- *Finance.* This service includes disbursements and currency control, payday activities, currency conversion, check cashing, and the appointment of Class A agents.

- *Legal services.* Information and specific guidance on administrative boards, court-martial authority and jurisdiction, legal assistance, and general services should be provided.

- *Religious activities.* Religious activities include chaplain support, services available for different faiths, schedule of services, and hospital visitations.

- *Postal services.* This includes hours of operation and services available. Emergency destruction, prisoner of war mail, and mail restriction policies will be outlined. Postal services should be addressed in an appendix to this annex.

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- *Post exchange services.* This includes hours of operation and availability.
- *Distribution.* Pick up and delivery schedules and any command-specific issues and procedures are provided.

(7) *Mortuary affairs.* Commanders at all levels are responsible for unit mortuary affairs (MA) and the search, recovery, and evacuation of remains to collection points. Selected hospital personnel should be trained on MA tasks to ensure proper handling of remains and the deceased's personal effects.

- *Responsibilities.* This paragraph discusses hospital responsibilities and the relationship with the medical group and supporting MA activity.
- *Disposition.* Specific guidance on procedures, MA collection points, transportation requirements, and handling of remains is provided.
- *Hasty burials.* Specific requirements for conducting hasty burials, and marking and reporting of grave sites are included.
- *Personal effects.* Guidance on accounting for personal effects and requirements for burial should a hasty burial be required is contained in this paragraph.
- *Disposition of civilian and EPW remains.* The local civilian government is responsible for the burial of remains of its citizens. The remains of EPWs are buried in separate cemeteries from US and allied personnel. If this is not possible, a separate section of the same cemetery is used and will be properly marked.
- *Contaminated remains.* This paragraph discusses handling and disposition requirements (to include protective clothing), procedures, and marking and reporting of burial site.

(8) *Public information.* This appendix contains procedures for obtaining approval on the public release of information to include the hometown news release programs.

(9) *Maintenance of law, order, and discipline.* This appendix should provide applicable regulations, policy, and command guidance on topics such as serious incident reports, notifications and submission formats, straggler control, confinement of military prisoners, and EPWs (also discussed in [10] below).

(10) *Enemy prisoners of war.* This appendix discusses the unit responsibility for EPWs captured by or surrendered to the unit. These procedures do not pertain to EPW patients captured by other units. Medical personnel do not guard, search, or interrogate EPWs while in the CHS system; guards are provided by nonmedical personnel designated by the tactical commander for these duties. Until EPW personnel can be evacuated to an EPW collection point, medical personnel should remember and enforce the basic skills: segregate, safeguard, silence, secure, speed, and tag. (The speed portion of evacuating EPWs to designated collection points is of paramount importance to medical units.)

NOTE

The treatment of EPWs is governed by international and US law and the provisions of the Geneva Conventions. Personnel should be aware of these requirements and have ready access to the applicable regulations and policy guidance (see FM 8-10 and AR 190-8).

(11) *Records disposal procedures.* The emergency disposal of files, when hostile action is imminent and if retention is prejudicial to the interest of the US, will be outlined. Nonemergency disposal, to include lost or destroyed files, will be included.

(12) *Appendixes.* The following appendixes should be developed as part of this annex:

- Human relations and equal opportunity.
- Civilian personnel.
- Provost marshal.
- Safety (see Appendix D).
- Postal operations.
- Command message center.

h. Annex I, Chaplain. This annex outlines the duties and responsibilities of the hospital chaplain and the hospital ministry team. Although the chaplain reports directly to the hospital commander, his activities will be coordinated with the hospital adjutant.

(1) *Chaplain support and coverage.* This paragraph will address the following:

- Normal and emergency chaplain duties.
- Religious services.
- Visitation.
- The SI patient.
- Death.
- Burial services.
- Reports.

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(2) *Chaplain funds.* Procedures will be outline for the establishment of a nonappropriated chaplain's fund upon mobilization.

i. Annex J, Nuclear, Biological, and Chemical Defense. This annex provides general guidance regarding unit and individual defense against NBC attacks, decontamination procedures, and care of NBC casualties.

(1) The NBC NCO is the technical adviser to the hospital commander and the operations officer on all matters pertaining to NBC operations. Procedures should be developed for—

- Organizing and training the required NBC teams.
- Establishing a warning and alarm system. The system will include vocal, visual, and sound.
- Training hospital personnel on MOPP and other NBC defensive measures.
- Advising the hospital commander on activation of the appropriate MOPP level, to include masking and unmasking procedures, based on the tactical situation.
- Maintaining NBC records and submitting the required reports.
- Establishing collective shelters. The operations section will determine the requirements for NBC collective shelters. The responsibility for establishing and maintaining NBC shelters rest with the section being hardened.
- Publishing radiation exposure guidance. This includes methods to minimize exposure and protect against electromagnetic pulses.
- Maintaining and distributing unit NBC defense equipment.
- Maintaining accountability and proper stockage of NBC defense equipment and PLL items.

(2) This annex should include the following appendixes:

- Appendix 1—NBC Teams.
- Appendix 2—Decontamination Procedures.
- Appendix 3—Operating in an NBC Environment.
- Appendix 4—Individual and Collective Protective Plan.
- Appendix 5—Handling and Patient Care of NBC Patients.

- the area).
- Appendix 6—Handling Contaminated Patients.
 - Appendix 7—Establishing Decontamination Sites.
 - Appendix 8—Locating Contaminated Areas (to include traffic control in and out of
 - Appendix 9—NBC Warning and Reporting.
 - Appendix 10—Hospital Recovery.
 - Appendix 11—Radiation Exposure Guidance.
 - Appendix 12—NBC Equipment and Supply Logistical Requirements.
 - Appendix 13—References.

j. Annex K, Nutrition Care. This annex outlines procedures relating to patient nutrition management and Army medical field feeding operations. The annex addresses the nutrition care division's organization and staff responsibilities. The organization and a detailed discussion of the following specific areas should be included as appendixes:

- Organization.
- Medical rations.
- Patient meal delivery.
- Staff and ambulatory patient feeding.
- Safety.
- Sanitation.
- Nutritional support.
- Nourishments, to include forced fluids.
- Ration accountability.
- Ration procurement.
- Equipment maintenance.
- Training.

- References.

k. Annex L, Logistics. This annex outlines sources, procedures, requirements, responsibilities, and planning guidance for logistical support for a hospital.

(1) Areas addressed. Specific areas which are addressed are listed below. The discussion to the areas should be provided in appendixes with the inclusion of tabs, if appropriate.

- Supply and services.
- Medical supply.
- General supply.
- Maintenance (less medical).
- Medical equipment maintenance.
- Waste disposal.
- Linen.
- Interface with the supporting MEDLOG battalion.
- Transportation and mobility.
- Supply and distribution.
- Engineer support.
- Quartermaster support.
- Hospital safety.
- Blood component resupply.

Logistics applications of automated marking and reading symbols (LOGMARS), TACCS, MEDTCU, and test, measurement, and diagnostic equipment are included in the discussions when appropriate.

(2) Transportation and movement requirements. This appendix covers the following areas: applicability; responsibilities; policies on speed, vehicle markings, transporting flammable materials, transporting ammunition and weapons; convoy procedures; safety; and accident reporting.

(3) Fire prevention and protection. Guidance on the use of flammable materials, use of cigarettes, matches, and lighters, electrical wiring and appliances, safety of tents and occupants, spacing of tents, stoves and ranges, and fire-fighting equipment and procedures are presented in this appendix.

(4) Field hygiene and sanitation. This appendix provides uniform guidance and procedures for the performance of functions related to field hygiene and sanitation. It includes policies, communicable disease control, field water supply (water trailers, cans, and fabric water storage containers), food sanitation, latrines, liquid waste disposal, garbage and rubbish disposal, personal hygiene, arthropod and rodent control and protection, medical waste disposal, hearing protection, site selection, and garbage. For additional information on field hygiene and sanitation, see FMs 21-10 and 21-10-1.

(5) Conventional ammunition down/upload procedures. This appendix delineates responsibilities and provides guidance and procedures for the requisition, storage, and distribution of ammunition and weapons, reporting requirements, and safety.

(6) Petroleum, oils, and lubricants accounting.

(7) Combat health logistics support. The combat health logistics concept of operations, requisition, and distribution procedures, accountability, and reports are provided in this appendix.

l. Annex M, Laboratory. This annex prescribes laboratory policies and procedures in support of the hospital. Procedural guidance will include, but not be limited to—

- Hematology and urinalysis.
 - Performing white blood cell (WBC) count.
 - Performing complete blood count (red blood cell [RBC], WBC, hemoglobin [Hgb], and hematocrit [Hct]).
 - Determining Hct.
 - Determining WBC differential.
 - Determining prothrombin time.
 - Determining partial thromboplastin time.
 - Performing cerebrospinal fluid (CSF) cell count and differential.
 - Performing urinalysis (dipstick).
 - Performing urinalysis (microscopic).
 - Performing platelet estimate.
 - Performing platelet count.
 - Determining fibrinogen level.

- Determining fibrin degradation products.
- Biochemistry.
 - Performing blood gas analysis.
 - Performing electrolyte levels (Na, K, Cl, and CO₂).
 - Determining total serum protein.
 - Determining serum creatinine.
 - Determining serum amylase.
 - Determining serum AST activity.
 - Determining serum ALT activity.
 - Determining serum CK activity.
 - Determining serum glucose.
 - Determining serum T. bilirubin.
 - Determining serum calcium.
 - Determining CSF glucose.
 - Determining CSF protein
 - Determining urine protein.
 - Determining urine glucose.
- Microbiology and serology.
 - Performing occult blood test.
 - Performing thick and thin smears for malaria.
 - Performing gram stains.
 - Performing RPR test (syphilis).
 - Performing IM (infectious mononucleosis) tests.

- Examining feces for ova, cysts, and parasites.
- Performing potassium hydroxide (KOH) preps.
- Performing pregnancy tests.
- Microbiology (capabilities available with specific augmentation).
 - Performing urine cultures (colony counts and sensitivity).
 - Performing wound culture and sensitivity.
 - Performing culture and sensitivity for gonorrhea.
 - Performing throat cultures.
- Quality control procedures.
- Reports.
- Infectious, chemical, hazardous, and solid waste disposal.
- Safety.

m. Annex N, Blood Bank Services. This annex prescribes hospital blood bank policies and procedures. It addresses procedures for—

- Storing, collecting, and administering blood and blood products.
- Performing blood group and type (ABO, Rh).
- Performing abbreviated blood crossmatching procedures.
- Thawing and issuing fresh frozen plasma.
- Blood planning factors.
- Reports.
- Automated blood management system.

n. Annex O, Dental Services. This annex outlines policies and procedures for dental clinic operations in a hospital. Procedures include—

- Priority of treatment.

- Dental records.
- Narcotics and drug control.
- Dental supply and maintenance operations.
- Precious metal control.
- Mercury hygiene and syringe and needle security.
- Sterilization and infection control.
- Safety.

o. Annex P, Pharmacy Service. The pharmacy operation is centered around an inpatient and outpatient system, distribution of bulk drugs, and the IV-additive program. This annex addresses the following procedures:

- Storing, safeguarding, labeling, and dispensing pharmaceutical and drug products.
- Operating an IV-additive program.
- Controlling drugs (Q and R).
- Preparing signature cards.
- Accessing letters.
- Rotating stockage of drugs and medication.
- Requisitioning drugs and supplies.
- Preparing reports.

p. Annex Q, Patient Administration Division. This annex outlines the general functions for the PAD. Procedural guidance is identified for the following:

- Maintenance and accountability for clinical records.
- Admitting, discharging, and transferring patients (surface and air movement).
- Processing and disposing of weapons, ammunition, maps, and classified and sensitive documents taken from patients admitted to the hospital.
- Medical statistics and reports.

- Claims.
- Processing hospital deaths.
- Theater Army Medical Management Information System-MEDPAR and TAMMIS-MEDREG.
- Patient evacuation and medical regulating.
- Mass casualty operations.

q. Annex R, Nursing Service. This annex provides administrative and operational guidance for all nursing service personnel throughout the hospital. It provides nursing care standards, policies, and procedures which are applicable to all wards, to include ORs and the triage, EMT, and preoperative treatment sections. Areas addressed should include, but not be limited to, the following:

- Nursing documentation.
- Scope of nursing practices.
- Standards of nursing practice.
- Standards of patient care.
- Assignment of personnel.
- Infection control.
- Special category patients.
- Procedures available in radiology.
- Procedures available in laboratory.
- Admission and discharge.
- Procedures for cardiopulmonary resuscitation.
- Cardiac arrest and trauma resuscitation procedures.
- Preparation of patient for medical evacuation.
- Management of controlled substances.
- Mass casualty plan.

- Preoperative care of the patient.
- Postoperative care of the patient.
- Care of patient with indwelling catheters.
- Care of patient with central IV lines.
- Care of patient with tracheostomy.
- Care of patient with chest tube.
- Death procedures.
- Hazardous and medical waste disposal.
- Bedpan and urinal washing and disinfecting procedures.

r. *Annex S, Radiological Services.* This annex establishes policies and procedures for requesting radiological services, preparation of patients, and use of x-ray films.

(1) Request for diagnostic procedures is outlined for the following examinations:

- Routine.
- Emergency.
- Bedside.
- Special (upper gastrointestinal series, gallbladder).
- Urological.
- Preoperative chest x-rays.

(2) Appendixes to the annex may include other information to assist daily operations. Suggested areas are—

- Radiation safety.
- Radiation protection.
- Equipment records.
- Radiographic film security.

- Filing procedures.

s. *Annex T, Medical Services.* This annex prescribes the duties and procedures for medical services in the treatment of all patients admitted to the hospital. Areas to be addressed include, but are not limited to—

- Treatment protocols.
- Examination procedures.
- Evaluation and treatment of infectious diseases.
- Evaluation and treatment of internal medicine disorders.
- Evaluation and treatment of skin disorders.
- Treatment of patients with gynecological diseases, injuries, or disorders.
- Medical supply and resupply procedures.
- Consultation services.
- Infection control (procedures to be followed to reduce the threat of infection in an austere environment).
- Fire evacuation plan.
- Reports.

t. *Annex U, Surgical Services.* This annex outlines diagnostic and surgical treatment procedures for the hospital. It should include, but not be limited to, the following:

- Scheduling procedures, to include after-hours and emergency cases.
- Aseptic (sterile) techniques.
- Maintenance of registry.
- Scrub attire and surgical hand-scrub procedures.
- Environmental safety.
- Electrosurgical unit safety.
- Operating room environmental sanitation.

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- Counts of sponges and sharps.
- Bullet removal evidence and property custody document.
- Death procedures.
 - Notifications.
 - Autopsy, to include coordination with HN health officials or compliance with valid agreements.
 - Disposition.
- Cardiac arrest procedures.
- Traffic patterns.
 - Transportation of patients to and from the OR.
 - Transportation of sterile, clean, and dirty equipment.
 - Evacuation of personnel and patients during contingencies.
- Handling contaminated needles and syringes.

u. Annex V, Operating Room/Central Materiel Service Control Team. This annex outlines the functional procedures of the OR, CMS, and anesthesia services, and the preparation and maintenance of OR-related equipment. With exception of CMS, the OR and anesthetists are not a separate paragraph in the L-edition series TOE. As an entity, these elements are under the supervision of the senior anesthesiologist or the officer appointed by the hospital commander. (Because of the dual relationship, the OR and CMS staff report to the chief surgeon and the chief nurse. The chief nurse is usually the rater of the OR/CMS head nurse and the senior rater is the chief surgeon. The chief surgeon is usually the rater of the senior anesthesiologist and the senior rater is the hospital commander.) The operational guidance includes, but is not limited to—

(1) *Operating room service.*

- Verifying personnel qualifications for assigned duties.
- Scheduling nursing staff.
- Providing immediate postoperative care of surgical patients (recovery room/ICUs).
- Availability of ORs.

- Operating room space utilization.
- Medical resupply, to include time lines.
- Medical maintenance, to include organic and depot.

(2) *Anesthesia services.*

- Standards.
- Duty roster and on-call requirements.
- Master list of clinical procedures.
- Equipment checklists.
- Classification of patients.
- Narcotics control.
- Infection control in work area.
- Anesthesia carts.
- Disposition of hazardous or infectious waste.
- Storage of combustibles and cleaning schedule.
- Quality control procedures for equipment.
- Verifying personnel qualifications for assigned duties.

(3) *Central materiel supply.*

- Loading and unloading the steam sterilizer.
- Monitoring the sterilization process.
- Labeling and monitoring shelf life of sterile items.
- Providing tray setup and wrapping procedures, to include cleaning and preparing equipment and supplies for sterilization.

v. *Annex W, Emergency Medical Services.* This annex outlines the procedures for receiving patients, performing patient assessments, providing EMT, and transporting patients to the appropriate element of the hospital. Procedures include—

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- Continuous 24-hour emergency treatment service.
- Verification of personnel qualification.
- A 24-hour physician and nursing service coverage plan.
- Patient registration ledger.
- Triage.
- Scope of practice of MOS 91B personnel.
- Routine patient care management.
- Emergency patient care management.
- Care of HN military and dependents (as required).
- Care of HN contract civilian and other HN medical care requirements.
- Admission and transfer of patients.
- Mass casualty operations.
- Medical treatment for chemical and biological agent patients.
- Medical evacuation.
- Utilization of the hospital litter team.
- Medical resupply and maintenance.
- Care of refugees and displaced persons.
- Assessment and emergency treatment of patients undergoing and awaiting NBC decontamination.

w. *Annex X, Neuropsychiatric Service and Ward.* This annex outlines procedures for hospital NP service including diagnosis and consultation to all areas within the hospital and to others as may be directed by the command. Procedures include, but are not limited to—

- Screening of patients by a psychiatrist.
- Ward support for nonambulatory or secluded patients.

- Patient ledger and transfer coordination.
- Patient restraining.
- Enemy prisoner of war patient support augmentation.
- Records and administration.
- Drug control.
- Identifying and monitoring suicidal and homicidal patients.
- Neuropsychiatric and combat fatigue-related casualties.
- Medical supplies and maintenance.
- Stress control to patients and staff of other wards.

x. *Annex Y, Physical Therapy.* This annex outlines procedures for the utilization and support of physical therapy services. Areas to be addressed include, but are not limited to, the following:

- Verification of personnel qualification.
- Scope of practice of physical therapy personnel.
- Assignment of physical therapy personnel.
- Services provided.
- Referral procedures.
- Mass casualty role.
- Utilization of radiology and pharmacy services.
- Injury prevention programs.
- Logistical support.

y. *Annex Z, Mass Casualty.* This annex outlines procedures to enable the hospital to respond effectively to a variety of emergency, external, and internal disaster situations. In any situation, the hospital must be prepared to receive, triage, treat, and hospitalize large numbers of casualties within a short period of time. The development of this plan is the responsibility of the operations section, or as directed by the hospital commander. Procedures include—

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- Planning and training requirements.
- Medical cadre positions.
- Nonmedical personnel positions and duties, including litter teams, perimeter guard, crowd control, and information personnel.
- Location of services, to include triage, delayed care, immediate care, minimal care, and expectant care areas.
 - Support requirements beyond hospital capability.
 - Evacuation.
 - Discharge of patients.
 - Records and reports.

z. *Annex AA, Civil-Military Operations.* This annex discusses participation in civil-military operations (CMO). Medical elements are often involved in CMO, humanitarian assistance, and disaster relief operations. The activities which may be covered include providing medical treatment within the capabilities of the hospital and providing training to a HN's medical infrastructure. The responsibility for this annex is the operations officer, or as directed by the hospital commander.

APPENDIX B

HOSPITAL PLANNING FACTORS

This appendix provides information for the FH/GH commanders, their staffs, and assigned personnel. It contains planning factors for personnel, transportation and movement, supply, personnel service support, CHS planning for hospitalization, and engineer requirements effective as of the date of this publication. **The data is an estimate and is not intended to be all-inclusive.** Fluctuations and changes in the data presented are contingent upon modifications to the TOE, its mission, and the scenario. Sections I and II contain planning factors for the respective FH and GH.

Section I. FIELD HOSPITAL PLANNING FACTORS

B-1. Personnel and Equipment Deployable Planning Factors

a. Personnel.

Officer	102
Warrant Officer	2
Enlisted	324
TOTAL	428

b. Weight and Cube—Personnel and Equipment.

Personnel-weight (combat equipped, includes 15 lb hand-carry bag)	190 lb/man (215)	40,850 lbs
Personnel-weight (with M-16)	200 lb/man (193)	38,600 lbs
Personnel-weight (with 9 MM)	195 lb/man (20)	3,900 lbs
Personnel-cube	11 cu ft/man	4,708 cu ft
Mobilization bag-weight	25 lb/man	10,700 lbs
Mobilization bag-cube	1 cu ft/man	428 cu ft
Check-in baggage-weight	70 lb/man	29,960 lbs
Check-in baggage-cube	3 cu ft/man	1,284 cu ft
TOTAL		
Personnel-weight and cube with all gear	124,010 lbs	6,420 cu ft
Weight and cube TOE equipment	1,110,854 lbs	142,279 cu ft
Weight and cube, CTA deployable equipment	225,992 lbs	24,791 cu ft
Weight and cube of personnel, equipment, and CTA deployable equipment	1,460,856 lbs	173,490 cu ft

c. *Transportation Reference Data.*

(1) *Railcar transportation requirements.*

Railcar = 80 ft 28 each

(2) *Tactical aircraft airlift requirements.*

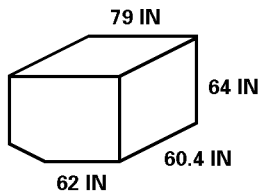
Cargo compartment data:	C-141	vs	C-5A
Length (inches)	840		1,454
Width (inches)	123		228
Height (inches)	109		162
Allowable cargo load (pounds)	50,000		150,000
Troop seats	102		20/73
Aircraft requirement strategic deployment	14		5

(3) *Commercial cargo capacities and configurations.*

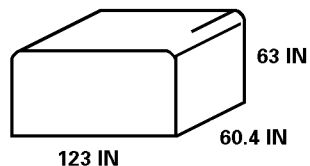
Cargo Capacity (cu ft)	Bulk Bin (cu ft)	Number of Containers	Maximum Capacity Cargo Bins (lbs)	Cargo Door Sizes (inches)		
TRISTAR L-1011-250						
2,385	700	16 (LD-3)	53,650	FWD	70W	68H
				AFT	70W	68H
				Bulk compartment	44W	48H
TRISTAR L-1011-500						
2,831	435	19 (LD-3)	61,500	FWD	104W	68H
				AFT	70W	68H
				Bulk compartment	44W	48H
BOEING 767-200						
2,508	430	22 (LD-2)	46,050	FWD	70W	69H
				AFT	70W	69H
				Bulk compartment	38W	48H

Cargo Capacity (cu ft)	Bulk Bin (cu ft)	Number of Containers	Maximum Capacity Cargo Bins (lbs)	Cargo Door Sizes (inches)		
BOEING 767-300						
4,770	430	30 (LD-2)	69,850	FWD	70W	69H
				AFT	70W	69H
				Bulk compartment	38W	48H
BOEING 757-200						
1,728			25,700	FWD	55W	42H
				AFT	55W	44H
BOEING 727-200						
1,454			19,000	FWD	55W	42H
				AFT	55W	44H
				Rear compartment	48W	30H
MD-88						
1,253			21,855	Three cargo bin doors		44H
					53W	29H
BOEING 737-200						
850			12,985	FWD	48W	34H
				AFT	48W	35H
BOEING 737-300						
1,068			12,634	FWD	48W	34H
				AFT	48W	35H
DOUGLAS DC-9-32						
750			11,150	FWD	53W	31H
				AFT	36W	30H

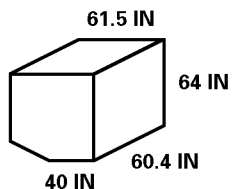
COMMERCIAL CONTAINER DESCRIPTION



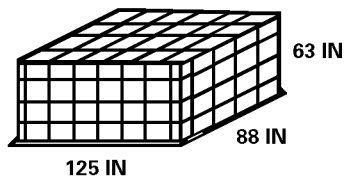
LD-3
CARRIER OWNED
155 CUBIC FEET
3,500 LBS MAXIMUM GROSS WEIGHT
CARRIED ON L-1011 AIRCRAFT
(TYPE 8 - WHEN USING INTERNATIONALLY)



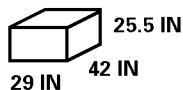
LD-11
CARRIER OWNED
260 CUBIC FEET
7,000 LBS MAXIMUM GROSS WEIGHT
CARRIED ON L-1011 AIRCRAFT



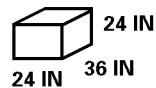
LD-2
CARRIER OWNED
124 CUBIC FEET
2,700 LBS MAXIMUM GROSS WEIGHT
CARRIED ON 767 AIRCRAFT



L-7
PALLET
9,500 LBS MAXIMUM GROSS WEIGHT
(TYPE 5 FOR INTERNATIONAL USE ONLY)
CARRIED ON L-1011 500 AIRCRAFT



E
SHIPPER OWNED
18 CUBIC FEET
500 LBS MAXIMUM GROSS WEIGHT



EH
SHIPPER OWNED
12 CUBIC FEET
250 LBS MAXIMUM GROSS WEIGHT
CARRIED ON ALL DELTA AIRCRAFT

(4) *Sealift planning factors.*

Ship Type

Square Foot Capacity

- Fast-sealift ship
- Roll-on/roll-off
- Break-bulk
- Container ship

- 150,000 sq ft
- 100,000 sq ft
- 40,000 sq ft
- 600 containers

B-2. Hospital Operational Space Requirements

It is estimated that the hospital will require approximately 375 meters X 375 meters for its full complement of personnel and equipment.

B-3. Logistics Planning Factors (Classes I, II, III, IV, VI, VIII)

a. Classes of Supply Planning Factor Rates.

Class of Supply	Planning Factor
-----------------	-----------------

Class I—Information on available operational rations and menu planning in a TO is available in FM 10-23. The DLA C-8900-SL Federal Supply Classification (FSC) Stock List Group 89, Subsistence, lists the NSNs, item information, and weight and cube information for all operational rations. Menu planning should be coordinated with the theater Class I manager to ensure the availability of the ration mix needed to support medical requirements.

Class II	SWA NEA ARC	2.091 3.367 1.539	PMD PMD PMD
Class III	(Packaged)	0.510	PMD
Class IV		8.500	PMD (includes 4.0 barrier materiel and 4.5 base construction)

Class VI—(personal demand items) All soldiers should deploy with at least 30 days supply of personal demand items. If exchange support is not readily available or cannot be established, health and comfort items are packaged and issued as a Health and Comfort Pack (HCP). The DLA C-8900-SL FSC Stock List Group 89, Subsistence, lists the NSNs, and weight and cube information for the HCP Types I (all soldiers) and II (female only). Army Regulation 710-2 provides guidance on planning and requisition of these items. Adjustments in quantity or selection of items in the HCP should be submitted to the theater Class I manager. The issue of HCPs will cease when exchange facilities are available.

Class VIII—(PMD planning factors are based on total Army analysis [TAA] 03 NATO scenario)

Echelons 1 & 2 (Division)	1.47 1.10	PMD PMD	MRC-E MRC-W
Echelons 1, 2, & 3 (Combat Zone)	0.88 0.79	PMD PMD	MRC-E MRC-W
Theater (Army)	0.72 0.80	PMD PMD	MRC-E MRC-W
Theater (Joint)	0.59 0.84	PMD PMD	MRC-E MRC-W

Legend: MRC-E—Major Regional Conflict-East
MRC-W—Major Regional Conflict-West
PMD—Pounds Per Man Per Day

b. Army Medical Field Feeding Policy. The Army medical field feeding policy for hospitalized patients is three hot meals daily. The meals will consist of B Rations and Medical B Rations. A Ration meals or components will be used when the tactical and logistical situation permits. A and B Rations will be supported through the use of the Unitized Group Ration unless not available. Meals, ready to eat and Heat and Serve (H&S) Rations are **NOT AUTHORIZED** for feeding hospitalized patients **EXCEPT IN EMERGENCIES** when other rations are not available. The current Surgeon General's policy allows MREs to be consumed as the sole source of subsistence for up to 21 days. When available, bread, fruit, and milk as enhancements to the MRE are recommended.

c. Army Medical Field Feeding Inpatient Census and Accounting.

(1) Inpatient census is obtained from the Recapitulation Table of the Admissions and Disposition Report, which is prepared daily by the hospital PAD. Inpatient figures reflect the number of hospital beds occupied as of 2400 the previous day.

(2) Inpatient (accounting) strength will be recorded in the Remarks Section of DA Form 5913-R (Strength and Feeder Report) for information purposes. Patient strength will not be included in the Present-for-Duty Section of DA Form 5913-R.

d. Standard Medical B Ration Purpose/Policy.

(1) Standard Medical B Ration is planned for subsisting patients in Armed Forces MTFs when semiperishable food is required.

(2) Patients are exempt from theater ration policy and will receive three hot prepared meals per day.

(3) The staff assigned to medical units will be fed according to the service theater ration policy. To simplify procurement, menu preparation, and service when hot meals are served to medical personnel, they will be served the regular diet from the Medical B Ration.

(4) In unusual circumstances (for example, facility relocation/movement), MREs may be required for the staff (not to exceed 21 days).

e. Standard Medical B Ration Meals. To support 24-hour patient care, the hospital must prepare four meals per day: breakfast, lunch, dinner, and a night meal. The night meal may utilize a breakfast or lunch/dinner menu according to local procedures.

f. Management and Planning Blood Requirements.

(1) The management and distribution of blood in the TO is a function of combat health logistics. In the long term, theater blood management is based on resupply from the CONUS blood donor base, using a combination of liquid and frozen blood products. In the mature theater, blood management is based on resupply of needs from the CONUS donor base, using a combination of liquid and frozen products. Each FH stores liquid blood and a combination of liquid and frozen blood products of various groups and types.

(2) Liquid blood products enter the theater through the USAF Blood Transshipment Centers (BTCs) for further distribution to the Army blood bank platoon, located in the MEDLOG battalion (rear) and issued to the hospital when it is located in the COMMZ. When the FH is located in the corps area, it will receive blood from the MEDLOG battalion (forward). The blood bank platoon assigned to the MEDLOG battalion (rear/forward) is resupplied from a supporting USAF BTC. The platoon leader of the deployed MEDLOG battalion may also serve as the TA blood manager until the Theater Medical Materiel Management Center (TMMMC) is operational.

(3) Blood collection in the theater is governed by theater policy, but normally is done to provide platelets for emergency situations. Limited testing of blood drawn in the theater is done to minimize danger to recipients.

(4) Blood shipped into the AO will be packed RBCs only. Fresh frozen plasma and frozen platelets are also available. Subject to availability, RBCs shipped from CONUS are packed with the following unit group and type distribution:

Blood Group/Type	Distribution
O Rh Positive	40%
O Rh Negative	10%
A Rh Positive	35%
A Rh Negative	5%
B Rh Positive	8%
B Rh Negative	2%

(5) Blood planning factors.

Blood Component	Planning Factor
Red Blood Cells	*4 units for each WIA and nonbattle injury (NBI) casualty initially admitted to a hospital
Fresh Frozen Plasma	0.08 units for each hospitalized WIA or NBI
Frozen Platelet Concentrate	0.04 units for each hospitalized WIA or NBI

* For blood planning purposes, only count the WIA or NBI once in the system, not each time the patient is seen or admitted.

(6) The expected admission rates per day are critical in computing initial blood requirements. These rates, along with the above blood planning factors, provide the planner with an initial estimate of daily blood requirements.

Sample Calculations for Initial Blood Requirements

Expected Initial Admission Rate for WIA and NBI = 8 Per 1,000 Per Day

Total Personnel = 10,000

RBC Planning Factor = 4 Units

Formula:

$$\text{(Total Personnel/1,000) X Admission Rate Per Day X Factor = Blood or Blood Component Per Day}$$

$$\text{Example: (10,000/1,000) X 8 X 4 = 320 Units of RBCs Per Day}$$

(For additional information on blood requirements and calculations, see FM 8-55.)

g. *Estimated Oxygen Planning Factors and Requirements.*

(1) *Estimated planning factors.*

OR Table: 2.8 liter/min during operational time.

ICU Beds: 4.5 liter/min for 17 percent of the total ICU beds (patients on resuscitator/ventilator).

ICU Beds: 3.1 liter/min for 17 percent of the total ICU beds (patients on nasal cannula/mask).

Miscellaneous

Requirements: An additional factor of 10 percent is applied to the total of OR and ICU requirements to account for oxygen requirements in other areas of the hospital.

(2) *Oxygen conversion factors.*

1 gallon (gaseous oxygen)	=	0.1333	cu ft
95 gallon "D" cylinder	=	12.7	cu ft
1650 gallon "H" cylinder	=	220.0	cu ft
1 cu ft (gaseous oxygen)	=	28.317	liters
95 gallon "D" cylinder	=	359.63	liters
1650 gallon "H" cylinder	=	6229.74	liters

(3) *Estimated FH oxygen requirements.*

OR Table Hours (HUB)	96,768	liters/day
HUH (No Gas Required)		
ICU Beds on Vent (HUB)	191,601	liters/day
EMT and other Oxygen Requirements	77,760	liters/day
Pneumatic Instruments	699	liters/day
TOTAL daily required	366,828	liters/day

h. Class VIII Planning Factor.

(1) *Class VIII composition.*

FSC	Item	Percentage of PMD
6505	Drugs/biologicals and other official reagents	77.1
6510	Surgical dressings	6.8
6515	Medical/surgical supplies	8.0
Other FSCs	X-ray film/development laboratory reagents, test kits, patient care accessories	8.1

(2) *Supply requisitions:*

FH—17,181 per month.

(3) *Class VIII weight and cube (Codes P, G, W, and Q and R).*

	Weight	Cube
Code P (potency period/expiration date)	22,368.07 lbs	767.302 cu ft
Code G (between 35 to 46 degrees Fahrenheit)	1,065.96 lbs	48.765 cu ft
Code W (must be frozen for preservation)	0.04 lbs	0.003 cu ft
Code Q/Code R (controlled/vault storage)	455.12 lbs	25.478 cu ft

i. Estimated Field Hospital Fuel Consumption.

(1) *Fuel consumption:*

	Gal/Day	Weight	Cube
Gasoline	713.78	4,425.49 lbs	95.647 cu ft
Diesel	997.28	7,010.87 lbs	133.635 cu ft
TOTAL	1,711.06	11,436.36 lbs	229.282 cu ft

(2) *Petroleum storage capability (based on hospital TOE):*

LIN/Nomenclature	Quantity	Gallons
V12141 Tank and pump unit 1,200 gal	1	1,200
V15086 Tank, fabric, collapsible 3,000 gal	1	3,000
TOTAL storage capability (gal):		4,200

j. *Water Planning Factors (Gallons of Water Per Day).*

- (1) Total patients (beds) X 17.25 gallons = _____
- Surgical cases X 19.0 gallons = _____
- Staff X 10.25 gallons = _____
- Bed patients X 22.0 gallons = _____
- Minimal care patients X 10.0 gallons = _____
- Staff X 9.4 gallons = _____
- Decontamination
 - 7 gallons per individual
 - 380 gallons per major end item
- Vehicle maintenance
 - ~ gallon per vehicle (temperate)
 - 1 gallon per vehicle (hot climate)
- Loss/waste factor = 10 percent of total requirement

(2) Hospital water requirement (consumptive factors).

Staff	Water Requirement
Drinking	1.5 gal/man/day
Hygiene	1.7 gal/man/day
Food prep	1.75 gal/man/day
Extra showers	5.3 gal/man/day
Unit wastewater generation	7.0 gal/man/day

Patient Care	Water Requirement
Cleanup	1.0 gal/bed/day
Heat treatment	0.2 gal/bed/day
Bed bath	5.0 gal/bed/day
Hygiene	1.7 gal/bed/day
Bed pan wash	1.5 gal/bed/day
Laboratory	0.2 gal/bed/day
Sterilizer	0.2 gal/bed/day
X-ray 0.2	gal/bed/day
Handwashing	2.0 gal/bed/day
Cleanup	1.0 gal/bed/day
Unit wastewater generation	12.0 gal/bed/day

Surgical	Water Requirement
Scrub	10.0 gal/case/day
Instrument wash	4.0 gal/case/day
OR cleanup	5.0 gal/case/day
Unit wastewater generation	19.0 gal/case/day

Hospital Laundry	Water Requirement
Bed patients	22.0 gal/bed/day
Ambulatory patients	10.0 gal/bed/day
Staff smocks	9.4 gal/bed/day
Unit wastewater generation	41.4 gal/bed/day
Decontamination	Water Requirement
Individual	7 gal/decon
Major end item	380 gal/decon
Vehicle	450 gal/decon
Wastewater generation	To be determined

(3) Water usage table for food and beverage preparation patient menu (gallons per meal per 100 portions).

	Menu				Alternate Menu			
	B	L	D	Total	B	L	D	Total
Day 1	52	29	32	113	45	28	35	108
Day 2	50	40	39	129	44	35	33	112
Day 3	48	34	32	114	23	29	18	70
Day 4	56	40	37	133	45	34	34	113
Day 5	49	42	35	126	48	37	34	119
Day 6	53	34	35	122	35	34	31	100
Day 7	51	35	36	122	45	38	33	116
Day 8	44	38	36	118	41	35	31	107
Day 9	51	35	36	122	44	33	37	114
Day 10	52	36	39	127	46	31	31	108
TOTAL				1226				1067

Note: For every 100 patients, an additional 30 gallons of water per meal is required to preheat insulated food and beverage containers for decentralized ward service.

(4) Water usage table for food and beverage preparation staff menu (gallons per meal per 100 portions).

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	Menu				Alternate Menu			
	B	L	D	Total	B	L	D	Total
Day 1	36	27	28	91	30	25	32	87
Day 2	35	39	38	112	29	33	30	92
Day 3	31	32	30	93	25	37	33	95
Day 4	42	39	35	116	30	32	31	93
Day 5	32	44	32	108	31	37	31	99
Day 6	42	31	34	107	36	31	31	98
Day 7	35	34	34	103	29	38	30	97
Day 8	25	38	35	98	24	33	29	86
Day 9	35	32	33	100	29	30	34	93
Day 10	36	33	38	107	30	28	30	88
TOTAL				1035				928

Daily water consumption (patient and staff): 13,730 gal/day.
 Laundry daily water consumption (patient and staff): 13,660 gal/day.
 TOTAL water consumption: 27,390 gal/day.

(5) Estimated water consumptive factors (under chemical environment, 72-hour scenario).

Staff	
Drinking (1.5 gal/man/day)	642
Hygiene (1.0 gal/man/day)	428
Feeding (0.25 gal/man/day)	107
Patient Care (4 gal/patient/bed/day)	2,016
Surgical (3 gal/case/day)	12
TOTAL daily water requirement (gal):	3,205

(6) Water storage capability (based on hospital TOE):

LIN/Nomenclature	Quantity	Gallons
G68998		
Drum, fabric, collapsible, 250 gal	4	1,000
V15018		
Tank, fabric, collapsible, 3,000 gal	4	12,000
W98825		
Trailer tank, 1 ~ ton, 2 wheel, 400 gal	2	800
X58367		
Truck tank, water, 1,000 gal	2	2,000
TOTAL storage capability (gal):		15,800

k. Laundry.

(1) The Surgeon General's policy statement (theater hospital laundry support) states that hospitals operating in the COMMZ will use area support facilities for laundry. Planning for establishing hospitals in the COMMZ normally will include the provision of shower facilities for patients. Clothing exchange functions will be a responsibility of the medical holding element.

(2) Basic formulas for determining laundry requirements for permanent party hospital personnel are—

- Formula 1: 42 lbs (6 lbs clothing per person per day X 7 days) X 75 percent of assigned personnel = weekly laundry requirement for patient care personnel.

- Formula 2: 6 lbs clothing per person per week X 25 percent of assigned personnel = weekly laundry requirement for hospital support personnel.

- Weekly laundry requirement (Formula 1 + Formula 2) divided by number of assigned personnel = average laundry requirement per person per week.

l. Showers. Minimum frequency for showering and laundering from a health maintenance perspective is deemed to be once weekly regardless of location, season, or level of combat activity. (Source: Office of The Surgeon General, Department of the Army, 31 January 1983.)

m. Solid Waste Factors.

(1) Solid waste calculation (estimated):

Total patients (beds) X 15 lbs = total patient solid waste
 Staff X 12.5 lbs = total staff solid waste

(2) Hospital infectious waste planning factors (estimated):

3 lbs per cu ft of infectious waste
 3 lbs of infectious waste generated per bed per day

(3) Hospital infectious waste:

1,512 lbs per day 504 cu ft per day

n. *Wastewater Planning Factors.*

Wastewater calculations (estimated):

Total wastewater—22,356 gal per day (estimated).

Assume that 80 percent of patient care and staff water requirements become wastewater and all of laundry water requirements become wastewater.

o. *Power Requirements.* It is estimated that 1,384.295 kilowatts of power will be required on a daily basis.

Section II. GENERAL HOSPITAL PLANNING FACTORS

B-4. Personnel and Equipment Deployable Planning Factors

a. *General Hospital Personnel.*

Officer	220
Warrant Officer ²	
Enlisted	534
TOTAL	756

b. *Weight and Cube—Personnel and Equipment.*

Personnel-weight (combat equipped, includes 15 lb hand-carry bag)	190 lb/man (376)	71,440 lbs
Personnel-weight (with M-16)	200 lb/man (347)	69,400 lbs
Personnel-weight (with 9 MM)	195 lb/man (33)	6,435 lbs
Personnel-cube	11 cu ft/man	8,316 cu ft
Mobilization bag-weight	25 lb/man	18,900 lbs
Mobilization bag-cube	1 cu ft/man	756 cu ft
Check-in baggage-weight	70 lb/man	52,920 lbs
Check-in baggage-cube	3 cu ft/man	2,268 cu ft
TOTAL		
Personnel-weight and cube with all gear	219,095 lbs	11,340 cu ft
Weight and cube TOE equipment	1,743,072 lbs	258,536 cu ft
Weight and cube, CTA deployable equipment	288,670 lbs	30,743 cu ft
Weight and cube of personnel, equipment, and CTA deployable equipment	2,250,837 lbs	300,619 cu ft

c. *Transportation Reference Data.*

(1) *Semitrailer requirements.*

M872 semitrailer, platform, break-bulk, 30 each
 container transporter, 22" ton
 length = 29.8 ft; width = 8 ft, height = 4.6 ft

(2) *Railcar transportation requirements.*

Railcar = 80 ft 46 each

(3) *Tactical aircraft airlift requirements.*

Cargo compartment data:	C-141	vs	C-5A
Length (inches)	840		1,454
Width (inches)	123		228
Height (inches)	109		162
Allowable cargo load (pounds)	50,000		150,000
Troop seats	102		20/73
Aircraft requirement strategic deployment	29		7

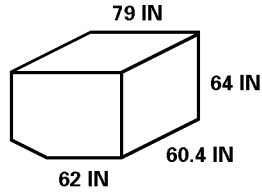
(4) *Commercial cargo capacities and configurations.*

Cargo Capacity (cu ft)	Bulk Bin (cu ft)	Number of Containers	Maximum Capacity Cargo Bins (lbs)	Cargo Door Sizes (inches)		
TRISTAR L-1011-250						
2,385	700	16 (LD-3)	53,650	FWD	70W	68H
				AFT	70W	68H
				Bulk compartment	44W	48H
TRISTAR L-1011-500						
2,831	435	19 (LD-3)	61,500	FWD	104W	68H
				AFT	70W	68H
				Bulk compartment	44W	48H

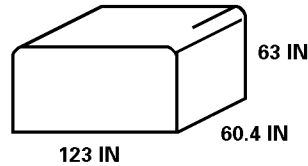
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Cargo Capacity (cu ft)	Bulk Bin (cu ft)	Number of Containers	Maximum Capacity Cargo Bins (lbs)	Cargo Door Sizes (inches)		
BOEING 767-200						
2,508	430	22 (LD-2)	46,050	FWD	70W	69H
				AFT	70W	69H
				Bulk compartment	38W	48H
BOEING 767-300						
4,770	430	30 (LD-2)	69,850	FWD	70W	69H
				AFT	70W	69H
				Bulk compartment	38W	48H
BOEING 757-200						
1,728			25,700	FWD	55W	42H
				AFT	55W	44H
BOEING 727-200						
1,454			19,000	FWD	55W	42H
				AFT	55W	44H
				Rear compartment	48W	30H
MD-88						
1,253			21,855	Three cargo bin doors		44H
					53W	29H
BOEING 737-200						
850			12,985	FWD	48W	34H
				AFT	48W	35H
BOEING 737-300						
1,068			12,634	FWD	48W	34H
				AFT	48W	35H
DOUGLAS DC-9-32						
750			11,150	FWD	53W	31H
				AFT	36W	30H

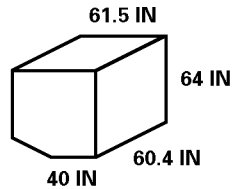
COMMERCIAL CONTAINER DESCRIPTION



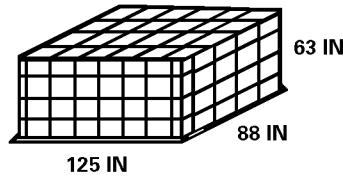
LD-3
CARRIER OWNED
155 CUBIC FEET
3,500 LBS MAXIMUM GROSS WEIGHT
CARRIED ON L-1011 AIRCRAFT
(TYPE 8 - WHEN USING INTERNATIONALLY)



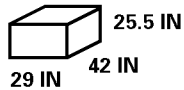
LD-11
CARRIER OWNED
260 CUBIC FEET
7,000 LBS MAXIMUM GROSS WEIGHT
CARRIED ON L-1011 AIRCRAFT



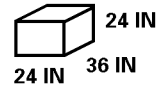
LD-2
CARRIER OWNED
124 CUBIC FEET
2,700 LBS MAXIMUM GROSS WEIGHT
CARRIED ON 767 AIRCRAFT



L-7
PALLET
9,500 LBS MAXIMUM GROSS WEIGHT
(TYPE 5 FOR INTERNATIONAL USE ONLY)
CARRIED ON L-1011 500 AIRCRAFT



E
SHIPPER OWNED
18 CUBIC FEET
500 LBS MAXIMUM GROSS WEIGHT



EH
SHIPPER OWNED
12 CUBIC FEET
250 LBS MAXIMUM GROSS WEIGHT
CARRIED ON ALL DELTA AIRCRAFT

(5) *Sealift planning factors.*

Ship Type	Square Foot Capacity
Fast-sealift ship	150,000 sq ft
Roll-on/roll-off	100,000 sq ft
Break-bulk	40,000 sq ft
Container ship	600 containers

B-5. Hospital Operational Space Requirements

It is estimated that the hospital will require an area approximately 400 meters X 400 meters for its full complement of personnel and equipment.

B-6. Logistics Planning Factors (Classes I, II, III, IV, VI, VIII)

a. Classes of Supply Planning Factor Rates.

Class of Supply	Planning Factor
-----------------	-----------------

Class I—Information on available operational rations and menu planning in a TO is available in FM 10-23. The DLA C-8900-SL FSC Stock List Group 89, Subsistence, lists the NSNs, item information, and weight and cube information for all operational rations. Menu planning should be coordinated with the theater Class I manager to ensure the availability of the ration mix needed to support medical requirements.

Class II	SWA NEA ARC	2.091 3.367 1.539	PMD PMD PMD
Class III	(Packaged)	0.510	PMD
Class IV		8.500	PMD (includes 4.0 barrier materiel and 4.5 base construction)

Class VI—(personal demand items) All soldiers should deploy with at least 30 days supply of personal demand items. If exchange support is not readily available or cannot be established, health and comfort items are packaged and issued as a HCP. The DLA C-8900-SL FSC Stock List Group 89, Subsistence, lists the NSNs, and weight and cube information for the HCP Types I (all soldiers) and II (female only). Army Regulation 710-2 provides guidance on planning and requisition of these items. Adjustments in quantity or selection of items in the HCP should be submitted to the theater Class I manager. The issue of HCPs will cease when exchange facilities are available.

Class VIII—(PMD planning factors are based on TAA 03 NATO scenario)

Echelon 1 & 2 (Division)	1.47 1.10	PMD PMD	MRC-E MRC-W
Echelon 1, 2, & 3 (Combat Zone)	0.88 0.79	PMD PMD	MRC-E MRC-W
Theater (Army)	0.72 0.80	PMD PMD	MRC-E MRC-W
Theater (Joint)	0.59 0.84	PMD PMD	MRC-E MRC-W

Legend: MRC-E—Major Regional Conflict-East
MRC-W—Major Regional Conflict-West
PMD—Pounds Per Man Per Day

b. Army Medical Field Feeding Policy. The Army medical field feeding policy for hospitalized patients is three hot meals daily. The meals will consist of B Rations and Medical B Rations. A Ration meals or components will be used when the tactical and logistical situation permits. A and B Rations will be supported through the use of the Unitized Group Ration unless not available. Meals, ready to eat and H&S Rations are **NOT AUTHORIZED** for feeding hospitalized patients **EXCEPT IN EMERGENCIES** when other rations are not available. The current Surgeon General's policy allows MREs to be consumed as the sole source of subsistence for up to 21 days. When available, bread, fruit, and milk as enhancements to the MRE are recommended.

c. Army Medical Field Feeding Inpatient Census and Accounting.

(1) Inpatient census is obtained from the Recapitulation Table of the Admissions and Disposition Report, which is prepared daily by the hospital PAD. Inpatient figures reflect the number of hospital beds occupied as of 2400 the previous day.

(2) Inpatient (accounting) strength will be recorded in the Remarks Section of DA Form 5913-R (Strength and Feeder Report) for information purposes. Patient strength will not be included in the Present-for-Duty Section of DA Form 5913-R.

d. Standard Medical B Ration Purpose/Policy.

(1) Standard Medical B Ration is planned for subsisting patients in Armed Forces MTFs when semiperishable food is required.

(2) Patients are exempt from theater ration policy and will receive three hot prepared meals per day.

(3) The staff assigned to medical units will be fed according to the service theater ration policy. To simplify procurement, menu preparation, and service when hot meals are served to medical personnel, they will be served the regular diet from the Medical B Ration.

(4) In unusual circumstances (for example, facility relocation/movement), MREs may be required for the staff (not to exceed 21 days).

e. Standard Medical B Ration Meals.

(1) To support 24-hour patient care, the hospital must prepare four meals per day: breakfast, lunch, dinner, and a night meal. The night meal may utilize a breakfast or lunch/dinner menu according to local procedures.

(2) Late meals will be served in accordance with dietary constraints, local procedures, and PVNTMED sanitation guidelines.

f. Management and Planning Blood Requirements.

(1) The management and distribution of resuscitative fluids in the TO, including blood and blood products, are functions of combat health logistics. In the mature theater, blood management is based

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on resupply of needs from the CONUS donor base. In a developing theater during the buildup period, immediate blood requirements may be provided by pre-positioned frozen blood. These pre-positioned stocks are designed to meet initial blood requirements until the logistical system can deliver liquid blood to the TO.

(2) Blood and blood products enter the theater through the USAF BTCs for further distribution to the Army blood bank platoon, located in the MEDLOG battalion (forward or rear). The GH is supplied with blood and blood products by a blood bank platoon assigned to the MEDLOG battalion (rear).

(3) Blood shipped into the AO will be packed RBCs only. Frozen plasma and platelets are also available. Subject to availability, RBCs shipped from CONUS are packed with the following unit group and type distribution:

Blood Group/Type	Distribution
O Rh Positive	40%
O Rh Negative	10%
A Rh Positive	35%
A Rh Negative	5%
B Rh Positive	8%
B Rh Negative	2%

(4) Blood planning factors.

Blood Component	Planning Factor
Red Blood Cells	*4 units for each WIA and NBI casualty initially admitted to a hospital
Frozen Plasma	0.08 units for each hospitalized WIA or NBI
Frozen Platelet Concentrate	0.04 units for each hospitalized WIA or NBI

* For blood planning purposes, only count the WIA or NBI once in the system, not each time the patient is seen or admitted.

(5) The expected admission rates per day are critical in computing initial blood requirements. These rates, along with the above blood planning factors, provide the planner with an initial estimate of daily blood requirements.

Sample Calculations for Initial Blood Requirements

Expected Initial Admission Rate for WIA and NBI = 8 Per 1,000 Per Day

Total Personnel = 10,000

RBC Planning Factor = 4 Units

Formula:

$$(\text{Total Personnel}/1,000) \times \text{Admission Rate Per Day} \times \text{Factor} = \text{Blood or Blood Component Per Day}$$

$$\text{Example: } (10,000/1,000) \times 8 \times 4 = 320 \text{ Units of RBCs Per Day}$$

(6) It is estimated that the GH will require 130 units of blood per day. It has the capability to store 160 units. It stores RBCs of various groups and types. The GH has emergency blood collection capability but does not have the capability to perform serological testing of the donor units (for example, hepatitis, human immunodeficiency virus, and syphilis testing). Blood collection in the theater is governed by theater policy, but normally is done to provide platelets for emergency situations. Limited testing of blood drawn in the theater is done to minimize danger to recipients.

g. Estimated Oxygen Planning Factors and Requirements.

(1) *Estimated planning factors.*

OR Table: 2.8 liter/min during operational time.

ICU Beds: 4.5 liter/min for 17 percent of the total ICU beds (patients on resuscitator/ventilator).

ICU Beds: 3.1 liter/min for 17 percent of the total ICU beds (patients on nasal cannula/mask).

Miscellaneous

Requirements: An additional factor of 10 percent is applied to the total of OR and ICU requirements to account for oxygen requirements in other areas of the hospital.

(2) *Oxygen conversion factors.*

1 gallon (gaseous oxygen)	=	0.1333	cu ft
95 gallon "D" cylinder	=	12.7	cu ft
1650 gallon "H" cylinder	=	220.0	cu ft
1 cu ft (gaseous oxygen)	=	28.317	liters
95 gallon "D" cylinder	=	359.63	liters
1650 gallon "H" cylinder	=	6229.74	liters

(3) *Estimated oxygen requirements.*

OR Table Hours (HUB)	96,768	liters/day
OR Table Hours (HUS)	193,536	liters/day
ICU Beds On Vent (HUB)	191,601	liters/day
ICU Beds on Vent (HUS)	266,112	liters/day
EMT and other Oxygen Requirements	77,760	liters/day
Pneumatic Instruments	3,143	liters/day
TOTAL daily required	828,920	liters/day

h. Class VIII Planning Factor.

(1) *Class VIII composition.*

FSC	Item	Percentage of PMD
6505	Drugs/biologicals and other official reagents	77.1
6510	Surgical dressings	6.8
6515	Medical/surgical supplies	8.0
Other FSCs	X-ray film/development laboratory reagents, test kits, patient care accessories	8.1

(2) *Supply requisitions:*

565 per day	28,098 per month
-------------	------------------

(3) *Class VIII weight and cube (Codes P, G, W, and Q and R).*

	Weight	Cube
Code P (potency period/expiration date)	31,218.00 lbs	1,083.889 cu ft
Code G (between 35 to 46 degrees Fahrenheit)	1,796.28 lbs	82.518 cu ft
Code W (must be frozen for preservation)	0.04 lbs	0.003 cu ft
Code Q/Code R (controlled/vault storage)	575.54 lbs	32.183 cu ft

i. Estimated General Hospital Petroleum, Oils, and Lubricants/Fuel Consumption.

(1) *Fuel consumption:*

	Gal/Day	Weight	Cube
Gasoline	1,124.02	6,968.92 lbs	150.618 cu ft
Diesel	1,624.20	11,418.12 lbs	217.642 cu ft
TOTAL	2,748.22	18,387.04 lbs	368.260 cu ft

(2) *Petroleum storage capability (based on hospital TOE):*

LIN/Nomenclature	Quantity	Gallons
V15086 Tank, fabric, collapsible, 3,000 gallons	1	3,000

j. *Water Planning Factors (Gallons of Water Per Day).*

- (1) Total patients (beds) X 17.25 gallons = _____
- Surgical cases X 19.0 gallons = _____
- Staff X 10.25 gallons = _____
- Bed patients X 22.0 gallons = _____
- Minimal care patients X 10.0 gallons = _____
- Staff X 9.4 gallons = _____
- Decontamination
 - 7 gallons per individual
 - 380 gallons per major end item
- Vehicle maintenance
 - ~ gallon per vehicle (temperate)
 - 1 gallon per vehicle (hot climate)
- Loss/waste factor = 10 percent of total requirement

(2) Hospital water requirement (consumptive factors).

Staff	Water Requirement
Drinking	1.5 gal/man/day
Hygiene	1.7 gal/man/day
Food prep	1.75 gal/man/day
Extra showers	5.3 gal/man/day
Unit wastewater generation	7.0 gal/man/day
Patient Care	
Cleanup	1.0 gal/bed/day
Heat treatment	0.2 gal/bed/day
Bed bath	5.0 gal/bed/day
Hygiene	1.7 gal/bed/day
Bed pan wash	1.5 gal/bed/day
Laboratory	0.2 gal/bed/day
Sterilizer	0.2 gal/bed/day
X-ray 0.2	gal/bed/day
Handwashing	2.0 gal/bed/day
Cleanup	1.0 gal/bed/day
Unit wastewater generation	12.0 gal/bed/day
Surgical	
Scrub	10.0 gal/case/day
Instrument wash	4.0 gal/case/day
OR cleanup	5.0 gal/case/day
Unit wastewater generation	19.0 gal/case/day

Hospital Laundry	Water Requirement
Bed patients	22.0 gal/bed/day
Ambulatory patients	10.0 gal/bed/day
Staff smocks	9.4 gal/bed/day
Unit wastewater generation	41.4 gal/bed/day
Decontamination	Water Requirement
Individual	7.0 gal/decon
Major end item	380.0 gal/decon
Vehicle	450.0 gal/decon
Wastewater generation	To be determined

(3) Water usage table for food and beverage preparation patient menu (gallons per meal per 100 portions).

	Menu				Alternate Menu			
	B	L	D	Total	B	L	D	Total
Day 1	52	29	32	113	45	28	35	108
Day 2	50	40	39	129	44	35	33	112
Day 3	48	34	32	114	23	29	18	70
Day 4	56	40	37	133	45	34	34	113
Day 5	49	42	35	126	48	37	34	119
Day 6	53	34	35	122	35	34	31	100
Day 7	51	35	36	122	45	38	33	116
Day 8	44	38	36	118	41	35	31	107
Day 9	51	35	36	122	44	33	37	114
Day 10	52	36	39	127	46	31	31	108
TOTAL				1226				1067

Note: For every 100 patients, an additional 30 gallons of water per meal is required to preheat insulated food and beverage containers for decentralized ward service.

(4) Water usage table for food and beverage preparation staff menu (gallons per meal per 100 portions).

	Menu				Alternate Menu			
	B	L	D	Total	B	L	D	Total
Day 1	36	27	28	91	30	25	32	87
Day 2	35	39	38	112	29	33	30	92
Day 3	31	32	30	93	25	37	33	95
Day 4	42	39	35	116	30	32	31	93
Day 5	32	44	32	108	31	37	31	99
Day 6	42	31	34	107	36	31	31	98
Day 7	35	34	34	103	29	38	30	97
Day 8	25	38	35	98	24	33	29	86
Day 9	35	32	33	100	29	30	34	93
Day 10	36	33	38	107	30	28	30	88
TOTAL				1035				928

Daily water consumption (patient and staff): 16,750 gal/day.

Laundry daily water consumption (patient and staff): 16,720 gal/day.

TOTAL water consumption: 33,470 gal/day.

- (5) Estimated water consumptive factors (under chemical environment, 72-hour scenario).

Staff	
Drinking (1.5 gal/man/day)	1,134
Hygiene (1.0 gal/man/day)	756
Feeding (0.25 gal/man/day)	189
Patient Care (4 gal/patient/bed/day)	1,904
Surgical (3 gal/case/day)	36
TOTAL daily water requirement (gal):	4,019

- (6) Water storage capability (based on hospital TOE):

LIN/Nomenclature	Quantity	Gallons
G68998		
Drum, fabric, collapsible, 250 gal	4	1,000
V15018		
Tank, fabric, collapsible, 3,000 gal	4	12,000
W98825		
Trailer tank, 1" ton, 2 wheel, 400 gal	3	1,200
X58367		
Truck tank, water, 1,000 gal	2	2,000
TOTAL storage capability (gal):		16,200

k. Laundry.

(1) The Surgeon General's policy statement (theater hospital laundry support) states that hospitals operating in the COMMZ will use area support facilities for laundry. Planning for establishing hospitals in the COMMZ normally will include the provision of shower facilities for patients. Clothing exchange functions will be a responsibility of the medical holding element.

(2) Basic formulas for determining laundry requirements for permanent party hospital personnel are—

- Formula 1: 42 lbs (6 lbs clothing per person per day X 7 days) X 75 percent of assigned personnel = weekly laundry requirement for patient care personnel.

- Formula 2: 6 lbs clothing per person per week X 25 percent of assigned personnel = weekly laundry requirement for hospital support personnel.

- Weekly laundry requirement (Formula 1 + Formula 2) divided by number of assigned personnel = average laundry requirement per person per week.

l. Showers. Minimum frequency for showering and laundering from a health maintenance perspective is deemed to be once weekly regardless of location, season, or level of combat activity. (Source: Office of The Surgeon General, Department of the Army, 31 January 1983.)

m. Solid Waste Factors.

(1) Solid waste calculation (estimated):

Total patients (beds) X 15 lbs = total patient solid waste
Staff X 12.5 lbs = total staff solid waste

(2) Hospital infectious waste planning factors (estimated):

3 lbs per cu ft of infectious waste
3 lbs of infectious waste generated per bed per day

(3) Hospital infectious waste:

1,428 lbs per day 476 cu ft per day

n. Wastewater Planning Factors.

Wastewater calculations (estimated):

Total wastewater—30,120 gal per day (estimated).

Assume that 80 percent of patient care and staff water requirements become wastewater and all of laundry water requirements become wastewater.

o. Power Requirements. It is estimated that 1,951.2299 kilowatts of power will be required on a daily basis.

APPENDIX C

FIELD WASTE

The accumulation and disposal of waste of all types is a major concern on the modern battlefield. Improper handling and disposal of field wastes can adversely impact military operations by leaving an operational footprint, causing health and sanitation problems to include serving as breeding grounds for rodents and arthropods that cause disease. Further, the accumulation of waste contributes to environmental contamination.

Section I. OVERVIEW**C-1. General**

Army policy is that all solid and hazardous waste will be disposed of in an environmentally acceptable manner consistent with good sanitary engineering principles and the accomplishment of unit mission. While operating OCONUS, either in training or actual contingency operations, the theater commander will determine the applicability of both US and host-country policies.

C-2. Responsibility for Disposal of Waste

a. Depending on the nature and volume of waste created, units generating the waste are normally responsible for its collection and disposal.

b. Certain types of waste require special handling that may be beyond the capability of the unit or facility. Units generating larger amounts of waste, such as hospitals, may not have the resources or equipment to properly dispose of solid waste. In these cases, supporting engineer units should be contacted to provide waste disposal support.

C-3. Categories of Waste

Waste can be subdivided into five distinct categories: general waste (including solid waste), hazardous waste, medical waste, human waste, and wastewater. Nonmedical solid waste (general and hazardous waste) can be generated by any military unit. Medical waste is only generated by medical elements, such as treatment, research, and laboratory. Supporting engineer and PVNTMED personnel can provide guidance and assistance on the handling, processing, and disposing of waste.

a. General Waste. This category includes all waste not specifically classified as medical waste or hazardous waste. It includes such items as—

- Paper and plastic products (which are by far the most abundant solid waste generated in a field environment).

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- Garbage (generated by dining facilities).
- Scrap material (wood, metal, and so forth).

b. Hazardous Waste. This includes waste which is either ignitable, corrosive, reactive, or toxic, especially POL and some chemicals. Hazardous waste usually requires special handling, transportation, disposal, and documentation, or treatment to render it nonhazardous.

c. Medical Waste. There are two types of medical wastes; nonregulated and regulated. Nonregulated medical waste is defined as solid material generated from the direct result of patient diagnosis, treatment, or therapy which requires no further treatment and can be disposed of as general waste. An example of this type of medical waste includes soiled dressings, bandages, disposable catheters, swabs, used disposable drapes, gowns, masks, gloves, empty used specimen cups, and gauze or cotton rolls, to include saliva soaked and blood-tinged gauze. Regulated medical waste (RMW) is defined as medical or laboratory wastes which is potentially capable of causing disease in people and may pose a risk to individuals or public health if not handled or treated properly.

d. Human Waste. This waste is comprised of feces and urine.

e. Waste Water. This includes liquid waste generated by laundry, shower, food service, and routine MTF operations.

Section II. GENERAL AND HAZARDOUS WASTE

C-4. General

General and hazardous waste are produced by all military units. Control and disposal of these types of waste requires planning and the development of the unit's standing operating procedures.

C-5. Sources of General and Hazardous Waste

- a.* The primary sources of general and hazardous waste are—
- Routine troop support operations.
 - Maintenance and motor pool operations.
 - Administrative functions.
 - Dining facility operations.

- Medical treatment facilities.

b. In all of these operations or functions, a major effort must be made to reduce the amounts of waste generated and, thus, to lessen the burden on the disposal system.

C-6. Disposal of General and Hazardous Waste

Most general waste is buried or burned by the generating element. It can be transported in organic vehicles to a waste disposal point (sanitary landfill). It is important to remember that vehicles used to transport waste must be properly cleaned and sanitized before being used for ration or patient transportation operations. During training exercises, supporting engineers are responsible for the construction and operation of the landfills.

a. Putrescible waste from dining facilities, while not hazardous or infectious in and of itself, can become both a serious aesthetic problem, as well as a breeding site for disease-carrying rodents and arthropods. This class of solid waste must be removed and disposed of after every meal. Burial of this type waste should be at least 30 yards (or meters) from the food service facility. Normally, one garbage pit is required per 100 soldiers per day (FM 21-10-1).

b. Used oil and POL products are classified as hazardous wastes. Disposal methods for this waste must comply with federal, state, local, and HN regulations. Military engineer and PVNTMED support elements can advise on required disposal procedures.

Section III. MEDICAL WASTE

C-7. General

Regulated medical waste is the category of medical waste which requires special handling, treatment, and/or disposal. Classes of RMW are as follows:

a. Class 1—Culture Stocks and Vaccines. Cultures and stocks of infectious agents and associated biologicals, including cultures from medical and pathological laboratories, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures. (All other laboratory waste except Class 2 and Class 3 is considered general waste.)

b. Class 2—Pathological Waste. Human pathological wastes, including tissues, organs, body parts, extracted human teeth, and body fluids removed during surgery or autopsy and during other medical procedures as well as specimens of body fluids.

c. Class 3—Blood and Blood Products.

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(1) Free-flowing human blood, plasma, serum, and other blood derivatives that are wastes (for example, blood in blood bags, blood and/or body drainage in suction containers).

(2) Items such as gauze or bandages, saturated or dripping with human blood, including items produced in dental procedures, such as gauze or cotton rolls saturated or dripping with saliva.

NOTE

The following items saturated or dripping with blood are not subject to the requirements of this regulation: Products used for personal hygiene, such as diapers, facial tissues, and sanitary napkins.

d. Class 4 and 7—All Used and Unused Sharps. Sharps used in animal or patient care or treatment in medical, research, or support laboratories (including hypodermic needles, syringes (with or without the attached needle), Pasteur pipettes, scalpel blades, blood collection tubes and vials, test tubes, needles attached to tubing, and culture dishes [regardless of presence of infectious agents]). Other types of broken or unbroken glassware that were in contact with infectious agents (that is, used slides and cover slips).

e. Class 5—Animal Waste. Animal carcasses, body parts, bedding contaminated or suspected of contamination with infectious agents. Road kills, euthanatized animals, and animals dying of natural causes are not considered Class 5 (Animal Waste).

f. Class 6—Isolation Centers for Disease Control (CDC) Risk Group IV Waste. Biological waste and discarded materials contaminated with blood, excreta, or secretions from humans or animals isolated to protect others from highly communicable diseases. Disease agents classified in CDC Risk Group IV are considered highly communicable.

C-8. Responsibility for Disposal of Medical Waste

a. The hospital commander is responsible for implementing policies for medical waste management to include—

- Identification.
- Segregation.
- Handling.
- Storage.
- Disposal.
- Transportation.

b. The hospital commander will normally designate a member of his staff to serve as the Infectious Disease Control Officer. This officer assists the hospital commander in establishing infectious disease control procedures. Infectious disease control procedures are established to preclude the spread of infection within the hospital and to prevent the spread of infectious disease outside the facility.

c. The PVNTMED adviser is responsible for providing the commander with technical guidance on properly managing medical waste.

d. Medical treatment personnel are responsible for the proper identification, segregation, and handling of medical waste generated during patient care.

e. Supply and Service Division is responsible for the handling, transportation, and disposal of the medical waste.

C-9. Source of Medical Waste

The major source of medical waste is patient care areas, especially the emergency room or EMT/triage areas, ORs, and ICUs. Medical wards and laboratories are also medical waste generators. The actual amount of medical waste generated is dependent on the intensity and nature of medical operations.

C-10. Handling and Transporting Medical Waste

a. Proper handling is the key to an effective hospital waste program. Segregation of RMW from general waste at the point of generation is a must. Procedures for handling medical waste are as follows:

- Personnel who transport and dispose of RMW wear a disposable mask, butyl rubber apron, and gloves.

- Regulated medical waste is collected in double-lined impervious containers lined with leak-resistant bags; otherwise, double plastic bags are used. The containers are clearly marked as RMW. All bags are sealed after being filled to only two-thirds capacity, then sealed by lapping the gathered open end and binding it with tape or a closure device. This ensures that liquid waste cannot leak. A method of segregating RMW from general waste is the use of distinctly colored bags (red) for RMW, if available (AR 40-5).

- Sharps are placed in a rigid, puncture-resistant container, clearly marked with the universal biohazard symbol.

NOTE

Needle/syringe clippers are not authorized for use.

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- Blood, blood products, and semisolid waste are placed in unbreakable capped or stoppered containers.
- Medical waste is stored in designated areas, either secured or under direct physical control.
- Regulated medical waste is removed from the point of generation and is disposed of at least every 24 hours.

b. The transportation of medical waste within the hospital is in rigid, leakproof containers, marked and used exclusively for its transport. Vehicles used to transport medical waste to disposal sites must not be used to transport rations, clean laundry, or medical supplies, or used for other purposes until after they have been thoroughly cleaned and sanitized using a 5 percent chlorine solution (48 ounces of chlorine granules in 5 gallons of water).

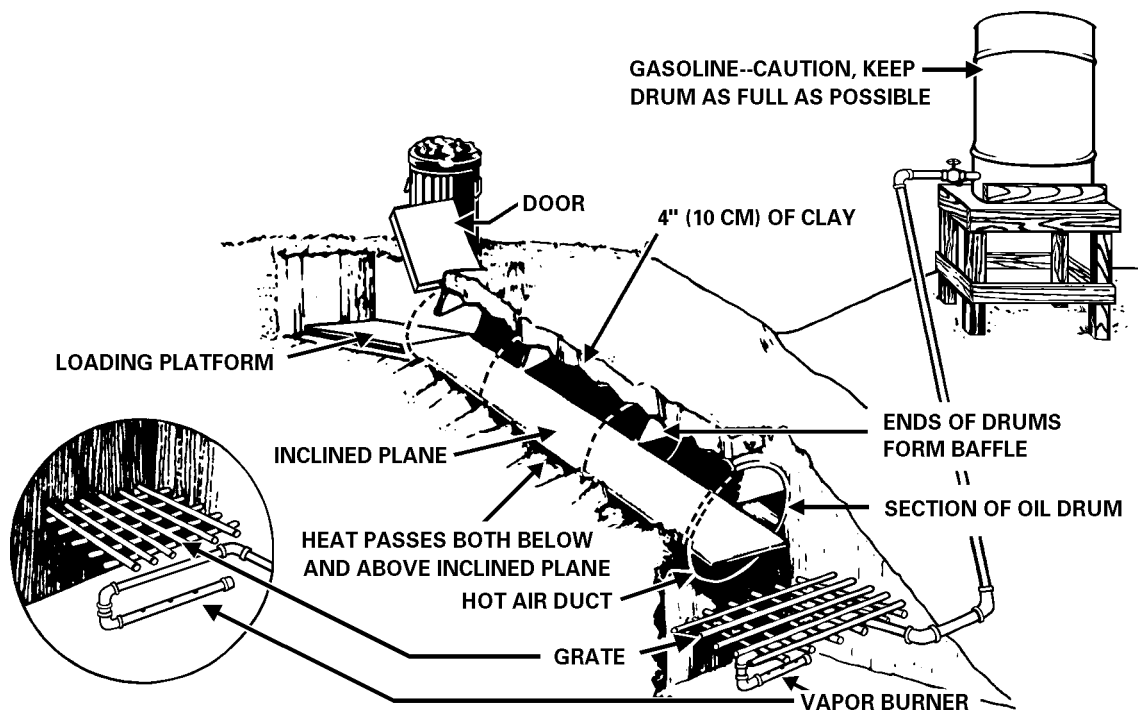
C-11. Disposal of Medical Waste

The purpose of properly treating and disposing of medical waste is to render it nonpathogenic, unrecognizable, and to make it unusable (sharps). Depending on the quantity and type of waste, command policies, and availability of disposal facilities and engineer support, a variety of options exists. Every effort should be made to use the safest and most complete method of disposing of this waste.

a. Training and Tactical Deployment. During training deployment in CONUS and training/tactical deployment in many OCONUS locations (such as European), the HN environmental regulations are such that disposal of medical waste via field expedient methods is not permitted. Furthermore, the quantities and types of medical waste generated during training are relatively limited due to the limited amount of actual patient care. As such, the option of choice is to haul the medical waste, via military vehicle or contract services, to fixed installations (preferably large fixed medical facilities) for treatment and disposal according to command policies. While proper field medical waste techniques are difficult or against regulation to train in the field, it is still important to plan for during operations. The requirements for segregating and handling waste are critical and remain an essential part of training.

b. Steam Sterilization. Some types of medical waste, especially in small quantities, can be rendered nonpathogenic by autoclave (steam sterilization). This technique or system is particularly appropriate for small amounts of waste generated in EMT areas and the laboratory element (for example, contaminated dressings, needles, syringes, cultures, culture plates, pipettes, and blood tubes). To ensure complete disinfection, the steam sterilizer must operate at a minimum of 250 degrees Fahrenheit (121 degrees centigrade), under 15-17 pounds of pressure per square inch, for 45 minutes. Two factors must be kept in mind when using the autoclave—the size of the load placed in the chamber and the exposure time. There are a number of different types of autoclaves; therefore, for detailed information on the operation of a specific autoclave, refer to the manufacturer's instructions or TM. DO NOT autoclave waste in a sterilizer that is used to prepare sterile packs or instruments for medical uses. Also, some plastics (red bags) and sharps containers may melt during an autoclave cycle, causing uncontained waste to stick to the autoclave. It may be necessary to use autoclave bags that can withstand the physical conditions produced by the sterilizer.

c. *Controlled Incineration.* Incineration is the method of choice for most types of medical waste, but it must be controlled. Burning medical waste requires incinerators specifically designed for the various types of medical waste. During OCONUS mobilization deployment, an inclined plane incinerator (Figure C-1) is a field expedient method when no other option is available. For the hospital to build and use this incinerator, there should be no immediate plans to relocate the hospital. This field expedient incinerator is a controlled open air burning method that can be used for burning small amounts of medical waste; however, command approval must be given prior to its use. Thorough consideration must be given to all available options before deciding to implement the open air burning method.



THIS INCINERATOR WILL DISPOSE OF TRASH AND MEDICAL WASTE FROM A FH/GH OR A SMALLER-SIZED MTF. THE COMBUSTION ACHIEVED BY THIS INCINERATOR AND THE FACT THAT IT IS NOT AFFECTED BY LIGHT RAIN OR WIND MAKES IT AN EXCELLENT IMPROVED DEVICE. TIME AND SKILL, HOWEVER, ARE REQUIRED IN BUILDING IT. A SHEET METAL PLANE IS INSERTED THROUGH TELESCOPED OIL DRUMS FROM WHICH THE ENDS HAVE BEEN REMOVED. A LOADING OR STOKING PLATFORM IS BUILT; THEN ONE END OF THE PLANE DRUM DEVICE IS FASTENED TO IT, THUS CREATING AN INCLINED PLANE (FM 21-10-1). A GRATE IS POSITIONED AT THE LOWER END OF THE PLANE, AND A WOOD OR FUEL OIL FIRE IS BUILT UNDER THE GRATE. AFTER THE INCINERATOR BECOMES HOT, DRAINED WASTE MATERIAL IS PLACED ON THE STOKING PLATFORM. AS THE WASTE DRIES, IT IS PUSHED DOWN THE INCLINE IN SMALL AMOUNTS TO BURN. FINAL COMBUSTION TAKES PLACE ON THE GRATE. THE OPERATOR OF THIS DEVICE MUST WEAR GLOVES, A BUTYL RUBBER APRON, AND A DISPOSABLE MASK.

Figure C-1. Improvised inclined plane incinerator.

NOTE

In all cases, ash from waste incineration must be buried.

d. Disposal by Burying. As a last resort, and with command approval, medical waste can be buried. Engineer support is required for construction of the waste disposal site. The waste must be covered immediately with refuse (trash) then sealed to ensure the waste is not accessible to scavenging. All previous options are considered before accepting burial as the final option. Close coordination with PVNTMED personnel and HN authorities are essential.

Section IV. HUMAN WASTE

C-12. General

Correct human waste (feces and urine) disposal is essential to prevent the spread of diseases caused by direct contact, contamination of water supplies, or dissemination by rodents or arthropods. It is even more critical in a hospital environment because patients are more susceptible to diseases transmitted through fecal contact. All human waste must be disposed of in a manner consistent with command policy and good sanitary engineering practices.

C-13. Responsibility for Disposal of Human Waste

The hospital commander is responsible to provide human waste disposal facilities. This may require the supporting engineer element to assist in the construction of latrine facilities.

a. Field Medical Treatment Facilities. In some locations, construction and use of actual field expedient waste facilities may be prohibited. In this case, one option is to obtain engineer support. The option of choice is to establish the hospital in an area with permanent or semipermanent latrine facilities already constructed and connected to an established sanitary sewer system. However, this may only be possible in areas designated as deployment sites. In many instances, it may be possible for hospitals to contract waste removal or latrine facilities through a HN support contract. Procedures will vary depending on the command policy and local (HN) agreements, but waste will still have to be separated into types by the unit. The use of chemical or self-contained toilets is another option instead of constructing field expedient latrines. In all types of arrangements, the hospital field sanitation team and PVNTMED personnel are responsible for monitoring the achievement of field sanitation requirements (FM 21-10-1).

b. Field Expedient Facilities.

(1) *Type selection.*

(a) The type of field latrine selected for a given situation depends on a variety of factors, such as—

- Number of personnel (staff and patients).
- Duration of stay at the site.
- Geological and climatic conditions.

(b) Supporting PVNTMED personnel and the hospital's field sanitation team can assist the commander in determining the appropriate type of latrines, their locations, and size.

(c) Specific guidance on selection criteria is provided in FMs 21-10 and 21-10-1.

(2) *Location.* Latrines should be located in a manner which prevents the contamination of food and water. Hospital latrines are located at least 100 yards (90 meters) downwind (prevailing wind) from the hospital food service facility, at least 100 feet (30 meters) from any ground water source, and at least 30 yards from the hospital perimeter but within reasonable distance for easy access (FM 21-10-1). For the FH/GH, multiple latrine sites are required due to the size of hospital layout and distances between patient care, administrative, and sleeping areas.

(3) *Maintenance.* Sanitation and maintenance of the hospital's latrine facilities are critical to prevent disease transmission. Handwashing facilities must be placed at each latrine.

d. Closing and Marking. Closing and marking of latrines will be IAW command policy and good field sanitation practice as stated in FMs 21-10 and 21-10-1.

C-14. Patient Facilities

a. Ambulatory patients will use the same latrines as the staff. The number of latrines established will be based on both the number of staff and the anticipated patient load. However, male and female latrines are required. Latrines need to be close enough to the ward areas for convenience of access while maintaining distances from dining facilities, water sources, and the like.

b. Nonambulatory patients require the use of bedpans and urinals. Disposal of fecal matter and urine and the sanitation of bedpans and urinals are major concerns. The sinks within the hospital will not be used for disposal of waste or for washing bedpans and urinals. One or more of the hospital latrines should be designated for emptying bedpans and urinals. Once the bedpans and urinals are emptied, they are washed (using a brush) with the wastewater disposed of in the latrine or designated area. An area should be established similar to that of a mess kit laundry line using metal garbage cans and immersion heaters. One can must have warm soapy water and the other can must have clear boiling water. These cans must be clearly marked for use in washing bedpans and urinals only. The bedpans are then sanitized by submerging into boiling water for 30 seconds.

WARNING

A hook or some device should be used to prevent contact with the boiling water and hot bedpans or urinals.

The bedpans and urinals are then placed on tent pegs or some hanging device to air dry.

NOTE

Personnel working with immersion heaters should be aware of the safety precautions and be trained in immersion heater lighting and operation.

An alternative consideration is the use of plastic bedpan liners. If plastic liners are used, they will reduce the requirement for cleaning and sanitizing the bedpan. The plastic liners will then be managed as solid waste.

Section V. WASTEWATER

C-15. General

Water usage generally results in the production of wastewater which requires disposal. Depending on the source, wastewater may contain suspended solids and particulate matter, organic material, grease, dissolved salts, biological, pathological, and pathogenic organisms, and toxic elements. Just the volume of wastewater alone, without consideration of the various contaminants, can cause substantial operational and health related issues if not properly managed and disposed.

C-16. Requirement for Disposal

a. All wastewater and waterborne wastes generated in a field environment must be collected and disposed of in a manner that—

- Protects water resources from contamination.
- Preserves public health while minimizing mission impairment or adversely impacting on the readiness of the force.

- Protects the local environment from harm.

b. When operating OCONUS, units may have to comply with applicable HN laws and procedures; this is determined by the theater commander. In an actual contingency operation, the theater commander (with input from the command surgeon) determines the applicability of local environmental laws in the AO. Irrespective of laws and regulations, proper disposal of wastewater is essential to protect the health of the force by precluding contamination of water supplies and development of rodent and arthropod breeding sites.

C-17. Responsibility for Disposal

Units generating wastewater in the field are responsible for their own wastewater collection and disposal. Large volume wastewater generators, such as hospitals, may require engineer support. Theater combat engineers will provide support during OCONUS deployments or contingency operations. In any case, the hospital commander has the final responsibility for coordinating disposal of his unit's wastewater.

C-18. Wastewater Sources and Collection

Hospitals generate a significant volume of wastewater corresponding to the volume of water consumed. A conservative estimate of wastewater volume for planning purposes is that 80 percent of all water used (other than human consumption) will end up as wastewater. The largest volumes of wastewater are generated by support operations of the hospitals such as laundry, shower, and food service operations. While this type of wastewater is not unique to a hospital, it contributes to an enormous volume requiring collection and disposal. However, wastewater generated from direct patient care functions is unique to the hospitals and may be contaminated with blood, other body fluids, particulate matter, and potentially infectious organisms. In addition to the quantity of wastewater, an added problem is the multiplicity of sources within the hospital that contribute to the complexity of collection.

a. Field Sinks. Field sinks are a primary source of wastewater from staff handwashing, patient hygiene, instrument cleaning, and the like. This liquid waste is generated intermittently and the volume is highly variable depending on the functional area and patient work load. The sinks can operate with the drain line placed in an empty 5-gallon water can. This can must be periodically emptied into a disposal system.

NOTE

Extreme care must be taken to ensure that 5-gallon cans used for wastewater are not mistaken or confused with 5-gallon cans used for potable water; clear labeling is critically essential.

If wastewater collection cans or the DEPMEDS wastewater collection system are not used, the sinks will drain to the immediate exterior of the hospital shelter, resulting in an unacceptable pooling of wastewater throughout the hospital area.

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b. Medical Treatment Facility Sources. Sources of wastewater other than the sinks are limited and will generate relatively small volumes of waste liquids. In most cases, this wastewater can be collected and discharged into a nearby sink. An exception may be the water used for facility and major equipment sanitation; for example, wastewater from washing OR tables, OR floors, litters, ambulances, and other medical materiel.

c. Field Showers.

(1) While not an actual part of the hospital system, quartermaster field showers may collocate or be near the hospital to support both patient and staff. These showers may also support personnel of other units within the area. The quartermaster personnel operating field showers are responsible for wastewater collection and disposal. In some situations, the disposal of this wastewater may be in conjunction with that of the hospital.

(2) If quartermaster support is not available, hospital personnel must provide their own showers (FMs 21-10 and 21-10-1). The hospital is responsible for the collection and disposal of this wastewater.

d. Field Laundries. The field laundry is one of the largest generators of wastewater. Field laundries may be collocated with or near hospitals to provide support and can present an inordinate wastewater disposal problem. It is estimated that the hospital patient laundry supply requirements will be 77 pounds per patient per week. Laundry support requirements for each soldier is estimated to be 15 pounds per week. Like the showers, quartermaster personnel operating laundries are responsible for wastewater collection and disposal. Because of the large volume of water required for laundry operations, the facility may have to be located away from a hospital and closer to a water source. In effect, this location would reduce or remove what may be a wastewater disposal problem from the immediate area of the hospital. (Preventive medicine personnel must ensure that laundry personnel are trained in and properly implementing procedures for handling contaminated linens.)

e. Field Kitchen. Army field kitchens are also significant sources of wastewater. In addition to the volume, the greases and particulate matter in wastewater from a field kitchen must be dealt with in a much more deliberate manner. For instance, grease traps must be constructed to remove food particles and grease from the kitchen wastewater before disposal. Information for the construction and operation of the filter and baffle grease traps is provided in FM 21-10 and FM 21-10-1. Also, hospital commanders may obtain technical assistance from the supporting PVNTMED element.

C-19. Disposal of Wastewater

a. In disposing of wastewater, a number of factors should be considered. These include—

- Volume and characteristics of the wastewater.
- Operational considerations (for example, duration of stay in a given location and the intensity of combat operations).

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- Geological conditions (for example, type of terrain and soil characteristics, or depth of the water table).
- Climatic conditions.
- Availability of engineer support.
- Accessibility of established sewage collection, treatment, and disposal systems.
- Applicability of command environmental programs.

b. In light of the above factors, there are a number of wastewater disposal alternatives that a hospital commander may select. These include—

- Connection to established sanitary sewer system.
- Collection and holding wastewater for engineer or HN agency removal to a fixed treatment facility.
- An engineer-constructed, semipermanent wastewater collection and disposal system.
- A unit-constructed field expedient wastewater disposal system (FM 21-10-1).

c. In many OCONUS noncombat operations, especially in the more developed countries, use of existing installation disposal facilities should be the method of choice. Even in some contingency operations, preplanned siting of hospitals can take advantage of preestablished connections to the existing sewer system. Coordinate with the local waste disposal facility prior to connecting to the sewer system or dumping waste into the system to ensure the facility can handle the extra waste and for compliance with environmental laws. Assistance from supporting engineers is required to establish the necessary connections and access to the sewer system. However, grease traps or filters may still have to be used in some areas, such as the dining facility's wastewater stream. Traps and filters will be required to remove grease and particulate matter that would adversely affect the operation of the wastewater pumps.

d. If use of a HN sewer is possible, but direct connection is not readily available, an alternate approach is to consolidate and collect wastewater in containers for eventual removal to a sewage treatment plant or a sanitary sewer access by supporting engineers or HN agency. As these storage containers are not part of the hospital's TOE and the wastewater tank trucks and pumping equipment are not standard engineer equipment, this option requires extensive prior planning and coordination.

e. All AMEDD personnel are required to know how to construct and operate field expedient waste facilities. For the hospital, some engineer support in the form of excavation equipment is almost always required. This requirement will be due, in part, to the inordinate volumes of wastewater generated by the hospital and its associated (kitchen, shower, and laundry) facilities. Engineer support must be coordinated and included in the site preparation planning.

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f. Traditional field expedient methods of wastewater disposal consist of soakage pits, soakage trenches, and/or evaporation beds. The effectiveness of these methods depends on the geological conditions and the climate. While these disposal devices, especially soakage pits, are generally constructed for small volumes of wastewater, with proper design and operation they can be effective for larger volumes. Because these methods result in final disposal, it is necessary to remove grease, particulate matter, and other such organic material that could reduce the effectiveness of the process. Guidance on designs and construction of these devices is available in FMs 21-10 and 21-10-1 and from supporting engineer and PVNTMED personnel.

g. In arctic environments, or when geological or climatic conditions are to such extreme that soakage or evaporation is not possible, the only alternative may be to collect the wastewater in containers and coordinate removal with Army engineers or use HN operators.

APPENDIX D

SAFETY**Section I. INTRODUCTION****D-1. Safety Policy and Program**

An effective safety program is essential to any unit. Leaders must stress the importance of constant vigilance to detect potential hazards and reduce or eliminate these hazards.

a. Policy. The safety policy of the Army is to reduce and keep to a minimum accident man-power (and monetary) losses, thus providing more efficient use of resources and advancing combat effectiveness.

b. Program. The unit safety program should be designed to cover all operations and take into consideration all conditions peculiar to the specific operation of the unit. Implementation of the program includes the establishment of a safety organization consisting of a unit safety officer responsible for the supervision and coordination of all unit safety activities and other personnel as required to assist him (see AR 385-10).

D-2. Responsibility for Accident Prevention

a. Commander. The hospital commander must establish and promote safety and occupational health directives and policies to protect personnel and equipment under his command. He must coordinate and integrate these directives and policies with those of higher headquarters and other commands and Services. The hospital commander appoints a qualified individual as the hospital safety officer (see AR 385-10).

b. Hospital Safety Officer. The hospital safety officer serves as a principal adviser to the commander. He manages the safety program by integrating safety into all functions conducted within the hospital. He must continuously monitor the safety program for effectiveness and identify new methods for accident prevention.

c. Supervisors. Supervisors enforce command safety directives and policies through specific training programs, routine inspections of work areas, accident investigations, and prompt evaluation and action to eliminate or minimize potential hazards identified by personnel.

d. Individuals. All personnel should be made to realize that safety rules have been established for their protection. It is their responsibility to report all unsafe conditions/acts, accidents, and near misses to their immediate supervisor; to follow all instructions; and to properly use all personal protective equipment and safeguards.

D-3. Principles of Accident Prevention

An effective safety program depends on the proper application of the following principles of accident prevention:

a. Stimulation of Interest. Emphasis on safety must be vigorous and continuous, and it must originate with the hospital commander. Group discussions, safety meetings, bulletin board notices, posters, and recognition of individuals for participation create interest in the safety program.

b. Applicability. Practical safety controls should be provided in all planning, training, tactical operations, professional activities, and off-duty activities.

c. Fact Finding. This refers to the assembly of information bearing upon the occurrence and prevention of accidents. For each accident, the following facts should be determined:

- (1) Who was injured, and what was damaged.
- (2) The time and place where the accident or injury occurred.
- (3) The severity and cost of the accident or injury.
- (4) The nature of the accident or injury.
- (5) Measures that can be instituted to guard against future recurrences.

d. Corrective Action Based on Facts. Any corrective action that is adopted should be based on available and pertinent facts surrounding the accident or injury. Near accidents also should be reported with all available information so that hazards and unsafe procedures or conditions can be eliminated. Similarly, any procedure or condition which might be dangerous should be reported so that remedial action can be instituted.

e. Safety Education and Training. The objectives of safety education and training are to develop the individual's safety awareness so he performs his tasks with minimal risk to himself and to others.

f. Inspections. The purpose of safety inspections is to eliminate the cause of accidents through specific, methodical procedures.

D-4. Safety Plan

Many items that can be included in any safety plan are listed below, but the list is neither all-inclusive nor restrictive. Certain conditions or geographical areas may require guidance to conform with those needs. Precautions for certain medical/dental procedures or equipment are included here.

a. Accident Reporting. Basic to any safety plan is accident reporting. A definite procedure should be established that emphasizes prompt and complete reporting of all accidents or injuries (AR 385-40).

Supervisors must investigate all accidents and injuries, and when needed, seek the assistance of the safety officer to determine the cause(s) and take corrective action to prevent their recurrence. Any accident resulting in damage to equipment should be reported immediately. Continued operation of damaged equipment can subsequently result in injuries to personnel.

b. Safety Color Code Markings and Signs. The safety color code prescribes the use of color combinations that are effective in preventing accidents and in improving production, visual perception, and housekeeping. The code defines the application of colors for such specific purposes as the uniform markings of physical hazards, showing the location of safety equipment, identifying fire-fighting equipment, and designating colors to be used if local conditions warrant the use of color coding (AR 385-30).

c. Fire Prevention.

(1) A hospital fire plan or a fire standing operating procedure (SOP) should be included in the safety program. It should contain fire prevention guidance and information on what to do if a fire occurs.

(2) **NO SMOKING** signs should be posted wherever fire hazards exist, such as oxygen administration and flammable materials storage areas. Smoking should be permitted only in designated safety areas. Fire-fighting equipment should be available, and all personnel should be familiar with its location and operation. This equipment should be inspected frequently to determine if it is serviceable and operative. Fire drills should be conducted often enough for all personnel to be familiar with the procedures. Guard personnel should be alert to fire hazards at night. Gasoline, oil, paint, and other flammables should be stored in approved locations and in authorized containers. Oxygen and acetylene tanks must be stored separately and apart from other flammables. Electrical power cables should not be exposed to vehicular and/or foot traffic.

d. Generators. Generators in the field produce the same potential electrical hazards that are found with electricity at permanent installations and demand the same precautions. Only those personnel who have been properly trained and certified on the use of power generation equipment should handle or work with this equipment. Personnel working around generators or electrical wiring should remove rings and watches. Generators should be grounded and not refueled while they are in operation. Generators used for patient treatment areas should be located to reduce, as much as possible, their noise in the operative area (military-owned demountable containers [MILVANs] strategically placed in proximity to generators serve as excellent noise buffers).

e. Housekeeping. Professional and administrative areas must be kept clean and orderly at all times. Hazards to personnel and equipment can be eliminated or controlled by enforcing high housekeeping standards.

f. Heaters. When heaters are used, they should be watched closely for a potential tent fire. Spark arresters or flue guards on stove exhaust pipes and metal shields in stovepipe openings in tents should be used when heaters are in operation. Fire guards are required when stoves are in use to monitor stoves for correct operations and alert others of any potential fire hazards.

g. M-2 Burners. The M-2 burner unit is a heat source used in the nutrition care division and CMS. These units require safety precautions and trained operators who know what to do if the burners malfunction or a fire starts. The commander may require a licensed operator to operate the burners. The burner units have a U-shaped tank containing fuel under pressure. When burners are used, they should be closely monitored because of potential fire and safety hazards. Burners must be used in well-ventilated areas because of the buildup of carbon monoxide gas produced.

h. Vehicle Operation. Army Regulation 385-55 contains guidance on government vehicle operation.

i. Weapons and Ammunition. Continual command emphasis should be directed toward training each individual in the hospital in the handling of weapons and ammunition. Training should begin when an individual joins the hospital. Commanders should ensure that all personnel are briefed on the handling of weapons which accompany patients to the treatment facility. Weapons of hospital personnel should be cleared and placed on safety until required otherwise. Army Regulation 190-11 and FM 19-30 provide guidance on the physical security of weapons and ammunition.

D-5. Accident Investigation and Reporting

a. Investigations. Accident investigation is necessary for accident prevention. Investigation seeks to determine the cause of accidents by finding the elements and sources from which accidents develop. Corrective measures may then be instituted.

b. Reporting. In accordance with AR 385-40, the Army accident reporting system provides for the initial reporting of accidents at unit level. This is done to notify the higher echelon of the command that a mishap has occurred; to record information that will identify causes and corrective actions, indicate trends, and provide a basis for formulating future plans; and to evaluate progress in accident prevention.

Section II. DEPLOYED MEDICAL UNIT SAFETY CONSIDERATIONS

D-6. X-Ray Protective Measures and Standards

a. General. Every possible safety precaution must be used when operating radiographic equipment. If all safety rules are strictly adhered to, medical personnel should receive virtually no radiation dose and the patient's exposure will be minimized.

b. Medical Personnel Protection and Standards.

(1) *Radiation monitoring.* Army Regulation 40-14 prescribes monitoring practices for Army personnel. It requires each person who is occupationally exposed to ionizing radiation and who may receive an accumulated dose equivalent in excess of 10 percent of the stochastic limit of 5 rems/year total effective

dose equivalent; or 10 percent of the nonstochastic limit of 50 rems/year total effective dose equivalent to any individual organ or tissue other than the lens of the eye to wear a dosimeter. The unit's medical supply personnel should coordinate dosimeter support through the US Army Ionizing Radiation Dosimetry Center, ATTN: AMSMI-TMDE-SR-D, Redstone Arsenal, AL 35898-5400, Defense Switched Network (DSN) 746-7634/7674 or commercial 205-876-7634/7674 or issue the IM-9 pocket dosimeters. The dosimeter monitors the amount of radiation received by the individual. If worn, the whole body dosimeter will be worn below the shoulders and above the hips on the outside of the clothing and the lead apron. The results are recorded on an automated dosimetry record by the US Army Ionizing Dosimetry Center. The automated dosimetry record will be reviewed by the hospital radiologist quarterly and then the record is kept permanently as part of the individual's health record.

(2) *Care and handling of dosimeter.* When not being used, dosimeters will be stored in a radiation protection officer-approved area which is close to the area in which occupationally exposed individuals work, yet outside the areas where the radiation -source devices are actually used or located. The storage area must be adequately shielded and contain a control dosimeter. Dosimeters should be marked to preclude personnel using each other's dosimeters.

(3) *Radiation standards.* For the personnel operating radiographic equipment, an accumulated whole body dose, in rems, must not exceed the stochastic limit of a total effective dose equivalent of 5 rems/year. The nonstochastic limit of a total effective dose equivalent of 50 rems/year to any individual organ or tissue other than the lens of the eye; an eye-lens dose equivalent of 15 rems/year; and a limit of 50 rems to the skin or to any extremity.

(4) *Protective shielding.* Fixed facilities use lead shielding to protect those working in the area where X rays are taken. However, the potential of finding lead-lined facilities in a deployed environment is limited. When deployed hospitals use buildings of opportunity, the following should be considered:

- When using field x-ray apparatus in a building of opportunity, a major consideration is the location of a room or an isolated area where access can be easily controlled. This area should have at least one, preferably two, walls common to the building exterior. Adjoining rooms should be unoccupied.
- The upright chest bucky should be oriented towards the outside wall and away from the operator.
- The x-ray apparatus should be positioned to maximize the distance from the back of the x-ray tube head to the operator. The apparatus should be positioned so that the x-ray beam will not routinely be directed toward occupied space or heavily traveled passageways.
- The operator should wear a lead apron or stand behind a lead-lined protective barrier when the apparatus is used.
- The unoccupied area outside the building should be cleared of personnel and properly marked off for at least 50 feet from the x-ray head. This exclusion area should include all potential areas toward which the x-ray beam may be directed. The 50-foot exclusion area fulfills the requirements of Technical Bulletin Medical (TB MED) 521 for all ionizing radiation-producing equipment and is meant to control the continuous occupancy of this area.

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(5) *Patient protection.* Use all means available to reduce the patient's exposure to ionizing radiation. The following practices will help:

- Take only those X rays that are required for diagnosis and treatment.
- Avoid improper positioning, improper exposure techniques, and faulty film processing techniques.
- Use a lead apron or gonadal shielding, if practical, to protect portions of the patient's body which are not in the direct x-ray beam.
- Check the patient's medical history.
- Use the most sensitive emulsion film available.
- Use proper collimation. Image size should be as small as possible but still include all the area of interest.

(6) *X-ray processing.* When working with the film-processing chemicals, personnel will use protective eyewear, gloves, and aprons.

D-7. Hearing Conservation

a. Department of the Army Pamphlet 40-501 provides the guidance on unit hearing conservation programs.

b. Units should contact the PVNTMED activity of the area medical support activity for identification of noise hazardous equipment, job sites, and exposed personnel. This is to be accomplished by conducting sound level surveys on field equipment (that is, compressors, generators, medical and dental handpieces, field laboratory equipment, and military vehicles). These data are used to identify individuals who will require hearing protection fitting, medical surveillance, and health education.

c. Personnel identified in this survey are entered in the hearing conservation program and monitored by the medical unit for response to noise exposure and adequacy of hearing-protective devices by the periodic testing of hearing levels. Audiograms are conducted annually, as a minimum.

d. Hearing protectors are issued to all unit personnel. Their use will be required when operating or in proximity to noise hazardous equipment such as (but not limited to) generators, compressors, field laboratory equipment, and tactical vehicles, 2" tons and larger. Areas around this equipment should be identified by placing **NOISE HAZARDOUS AREA, HEARING PROTECTION REQUIRED** signs as directed in the hospital's TSOP.

e. Noise hazardous equipment such as generators and compressors should be sandbagged as directed by the hospital's TSOP to reduce the noise hazard and noise signature.

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D-8. Compressed Gas Cylinders

All compressed gas cylinders should be considered full for handling purposes. They should never be dropped or struck by any object. While cylinders are being transported in vehicles, they should be restrained to prevent them from falling. Cylinders must be protected from dampness and excessive temperatures. Smoking is prohibited near a cylinder. Valve protection caps must be installed on each cylinder. Oxygen should be stored in areas separated from other gases by at least 50 feet. Oxygen should be separated from acetylene by at least 100 feet. Gases used in laboratory procedures require caution in handling. All compressed gas cylinders should be labeled and tagged with the contents of the container to avoid confusion of what material is in each cylinder.

D-9. Flammable, Explosive, or Corrosive Materials

These materials must be kept in approved safety containers and away from any potential source of ignition. Acids used in laboratory procedures should be stored in noncorrosive containers and cabinets designed to hold caustic/corrosive material.

D-10. Special Equipment

Individuals using high-speed medical/dental units and those working in the laboratory should use plano cylinder or prescription safety eyewear to prevent injuries to their eyes.

D-11. Department of Defense Federal Hazard Communication Training Program

Department of Defense Instruction 6050.5 directed the elements of DOD to develop a training program to meet the requirements of the Occupational Safety and Health Act (OSHA) Hazard Communication Standard (29 CFR 1910.1200). The OSHA issued this standard to ensure everyone's right to work in a safe environment. It requires that everyone understand the hazards of the materials they work with and know how to minimize these hazards. It requires supervisors to develop and maintain current listings of all hazardous materials used at a work site and the specific hazards of each material. Material Safety Data Sheets must be maintained at each work location, and personnel should be trained in the hazards of their occupation.

D-12. United States Army Center for Health Promotion and Preventive Medicine

There are PVNTMED assets located within each division and at corps level. These units have subject matter experts in most areas of environmental health, sanitation, industrial hygiene, and occupational health. The mission of PVNTMED is to provide guidance to unit commanders on compliance with DA and Federal requirements in these areas. Additionally, the USACHPPM has the mission of looking out for the soldiers' welfare worldwide. The USACHPPM is an excellent source for advice and assistance in areas related to environmental quality or occupational health. Any Army official safety representative (for

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example, unit safety officer) can request assistance from this organization. Potential areas for assistance include, but are not limited to—

- Technical assistance on monitoring the use of ionizing radiation, telephone: DSN 584-3548/3502.
- Hospital hazardous waste management on-site CONUS/OCONUS visits, DSN 584-3651.
- Hospital safety program on-site visits, CONUS/OCONUS, DSN 584-3040.

The USACHPPM also provides document review services which may be of assistance in evaluating unit safety, PVNTMED, and field sanitation programs. Requests for on-site visits should be coordinated in advanced with higher headquarters, particularly for OCONUS locations.

D-13. Infection Control

Special precautions must be taken during patient treatment procedures to avoid the transmission of infections. Infection control, to include medical waste disposal, is covered in Appendix C. Detailed guidance on infection control will be provided in the department's, division's, and section's TSOP.

APPENDIX E

COMMUNICATIONS, AUTOMATION, AND POSITION/NAVIGATION SYSTEMS

E-1. Operational Facility Rules and Equipment

a. The ability to communicate is essential to C2 and the accomplishment of the assigned mission. To ensure effective communications, a system has evolved which authorizes specific types and numbers of radios for a unit or element. This appendix contains those operational facility (OPFAC) rules applicable to the FH and the GH.

b. The OPFAC rule is the tool used to determine where, type, and numbers of communication devices are needed. The OPFAC rule identifies the smallest element of a TOE to which a piece of communications equipment is assigned (such as the commander, staff officer, or section or platoon).

c. The OPFAC rules are the basis for documenting C2, communications, and computer equipment in the basis of issue plans (BOIPs) and TOEs. These determine the correct type and distribution of radios, MSE, POS/NAV devices, and tactical computers for each TOE. The OPFAC rule system is an ongoing validation. *These rules are subject to change.* The rules discussed here are current as of the date of this publication. Tables E-1, E-2, and E-3 depicts the OPFAC and the distribution of equipment for the FH and the GH.

Table E-1. TOE 08736L200, HUB, Field Hospital

PARA	USER/ POSITION	OPFAC RULE #	FM RADIO	AM RADIO	MSE	FAX	POS/NAV EQUIPMENT	ADP EQUIPMENT	ADP USE	COMM TERMINAL
01.01	HOSPITAL COMMANDER	D8201	90A		TA-1035, MSRT		PLGR			
01.03	HOSPITAL XO	D8210			TA-1035		PLGR			
01.06	HOSPITAL CHAPLAIN	D0640			TA-1035					
02.00	HOSPITAL OPERATIONS SECTION	D8811	89A	193A	TA-1035 (2)	FAX	PLGR		ADMIN	
04.00	ADMIN DIVISION	D8802			TA-1035 (2)			TACCS	SIDPERS	
05.00	PAD SECTION	D1204			TA-1035 (2)			MEDTCU	MEDPAR MEDREG	
07.00	SUPPLY & SVC DIV	DH920			TA-1035 (2)			MEDTCU MEDTCU TACCS	MEDSUP MEDMNT SPBS-R	RKVDU
09.00	TRIAGE/EMT	DH203	90A		TA-1035					
24.00	BLOOD BANK	DHKPO			TA-1035			DBSS	MEDBLD	

Table E-2. TOE 08736L300, HUB, General Hospital

PARA	USER/ POSITION	OPFAC RULE #	FM RADIO	AM RADIO	MSE	FAX	POS/NAV EQUIPMENT	ADP EQUIPMENT	ADP USE	COMM TERMINAL
01.01	HOSPITAL COMMANDER	D8203			TA-954					
01.03	HOSPITAL XO	D8213			TA-954					
01.06	HOSPITAL CHAPLAIN	D0641			TA-954					
02.00	HOSPITAL OPERATIONS SECTION	D8810	89A	193A	TA-954 TA-1042	FAX	PLGR		ADMIN	
04.00	ADMIN DIVISION	D8805			TA-954 (2)			TACCS	SIDPERS	
05.00	PAD SECTION	D1208			TA-954 (2)			MEDTCU	MEDPAR MEDREG	
07.00	SUPPLY & SVC DIV	DH922			TA-954 (2)			MEDTCU TACCS	MEDSUP MEDMNT MEDASM SPBS-R	RKVDU
09.00	TRIAGE/EMT	DH205	90A		TA-954					
24.00	BLOOD BANK	DHKP1			TA-954			DBSS	MEDBLD	

Table E-3. TOE 08737L000, HUS, General Hospital

PARA	USER/ POSITION	OPFAC RULE #	FM RADIO	AM RADIO	MSE	FAX	POS/NAV EQUIPMENT	ADP EQUIPMENT	ADP USE	COMM TERMINAL
01.01	HOSPITAL UNIT COMMANDER	D8203			TA-954					
04.00	TRIAGE/EMT	DH205	90A		TA-954					

E-2. Communications Equipment

The OPFAC rules expressly impact on four types of communications equipment:

a. Radios. Frequency modulated and AM radios comprise the family of radios discussed in this appendix as CNRs. When dealing with OPFAC rules, the SINCGARS radios constitute the FM slice and the IHFR constitutes the AM component. The Alpha series of the FM SINCGARS radios have built-in capabilities for encrypting/decrypting voice traffic. The AM radios have secure voice capability when used with the KY-99 minterm (Figure E-1). For the purposes of this manual, the discussion of radios will be restricted to those authorized for the FH and the GH—the AN/VRC-89A, the AN/VRC-90A, and the AN/GRC-193A.

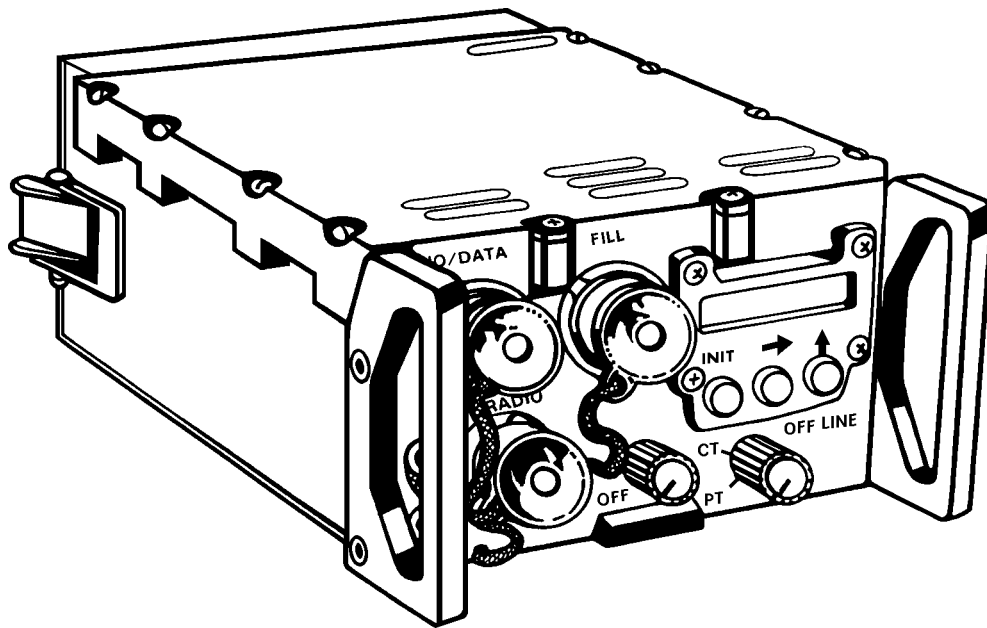


Figure E-1. KY-99 minterm.

(1) *Single channel airborne radio system.* The SINCGARS radios, AN/VRC-89A and AN/VRC-90A, operate in the 30- to 88-megahertz (MHz) frequency range in 25-kilohertz (kHz) steps for a total of 2,320 channels. They can operate in either a single-channel or frequency-hopping mode.

(a) AN/VRC-89A. The AN/VRC-89A radio is a vehicular-mounted, dual-configuration radio consisting of two short-range (approximately 8 kilometers [km]), solid state, securable transceivers mounted in a single vehicular mount. Included is a power amplifier (Figure E-2) that provides one of the radios with long-range communications capability (up to 35 km). This radio is authorized for the FH and GH (see Tables E-1 and E-2).

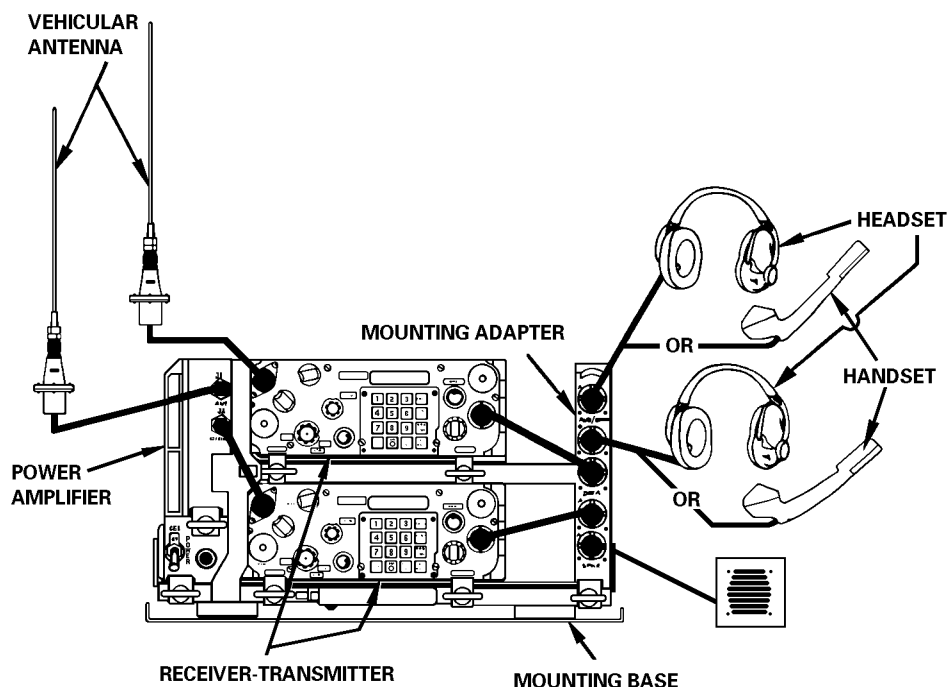


Figure E-2. Vehicular long-range/short-range radio, AN/VRC-89A.

(b) AN/VRC-90A. The AN/VRC-90A radio is an AN/VRC-87A with a power amplifier added for long-range capability. It is used for long-range communications (up to 35 km) (Figure E-3). This radio set is authorized for the FH and GH (see Tables E-1, E-2 and E-3).

(2) Improved high-frequency, amplitude-modulated radio.

(a) The AN/GRC-193A is the AM radio that is designed to provide reliable, long-range, high-frequency voice and data communications for both mobile and fixed stations (Figure E-4). This radio is authorized for the FH and GH (see Tables E-1 and E-2). This radio is used to facilitate hospital net operations. It links the hospital with higher headquarters and the CHS operations net.

(b) The KY-99 minterm is designed to provide half-duplex, narrow-band secure voice and data communications for a variety of military applications. One KY-99 minterm is required for each AN/GRC-193A subscriber radio terminals.

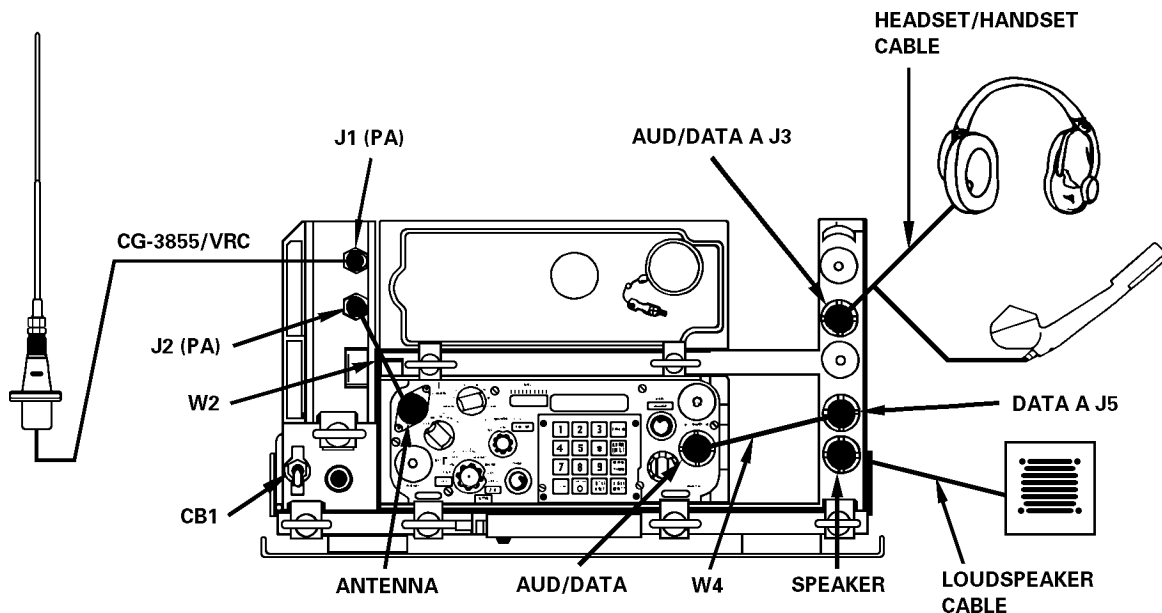


Figure E-3. Vehicular long-range radio, AN/VRC-90A.

b. Mobile Subscriber Equipment.

(1) *Digital nonsecure voice telephone (DNVT): TA-1035/U.* The DNVT TA-1035/U (Figure E-5) is a prime subscriber terminal that provides full-duplex digital voice communications and voltage reference signal for data subscribers in the MSE system. It is also equipped with a data port that allows users of the lightweight digital facsimile (LDF) AN/UXC-7 to access the MSE network. The TA-1035/U is found in the FH (see Table E-1).

(2) *Digital nonsecure voice telephone without data port: TA-954.* The DNVT TA-954 (Figure E-6) is a fixed/hard wire digital telephone designed for use at EAC in applications where a data port is not required. It provides a digital communications interface with TRI-TAC and MSE circuit switches. The TA-954 is found in the GH (see Tables E-2 and E-3).

(3) *Digital nonsecure voice telephone with data port: TA-1042.* The DNVT TA-1042 (Figure E-7) is a fixed/hard wire telephone designed for use at EAC where a data port is required for interface to either a FAX or computer. The TA-1042 is found in the GH (see Table E-2).

(4) *Tactical lightweight digital facsimile: AN/UXC-7.* The tactical LDF AN/UXC-7 (Figure E-8) is a prime subscriber terminal that provides full-duplex digital communications and voltage reference signal for data subscribers in the MSE system. It is also equipped with a data port that allows its users to access the MSE network. The AN/UXC-7 enables subminute transmission/reception of typed or handwritten

copy, sketches, or overlays up to 8" by 11 inches in black and white format (two shades of gray). The LDF operates directly into the TA-1035/U data port for MSE network access. It will also operate over radios and wire circuits and has full digital or analog data/voice capability. The AN/UXC-7's brief transmission (burst) reduces the chance of detection by the enemy. The critical advantages are made possible by the LDF set's ability to store data in memory and then send in short, high-speed transmission, requiring 7 to 15 seconds to transmit a full page. It is used to send and receive hard-copy data for supporting CHS at echelons above brigade. The AN/UXC-7 is found in the FH and GH (see Tables E-1 and E-2).

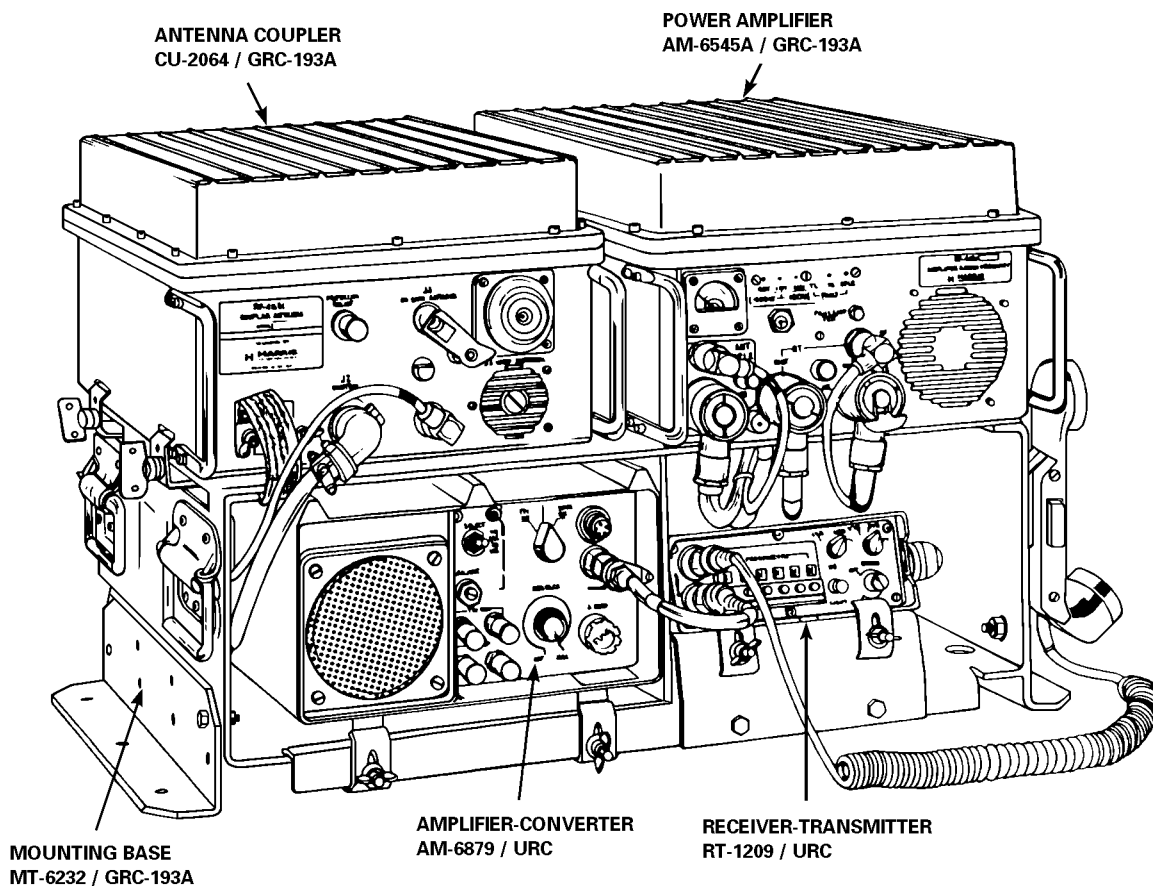


Figure E-4. Improved high-frequency radio.



Figure E-5. Digital nonsecure voice telephone, TA-1035/U.

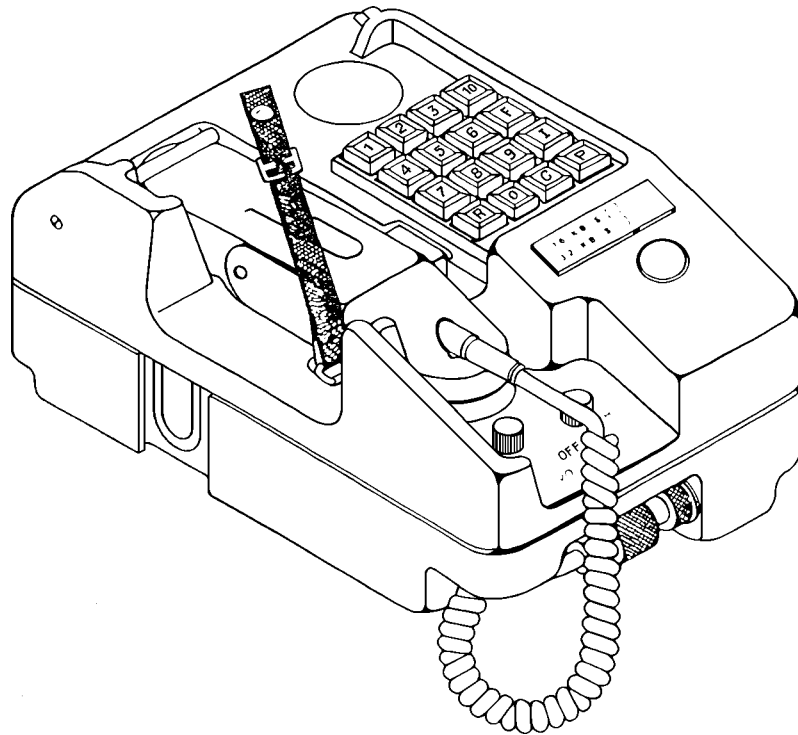


Figure E-6. Digital nonsecure voice telephone without data port, TA-954.

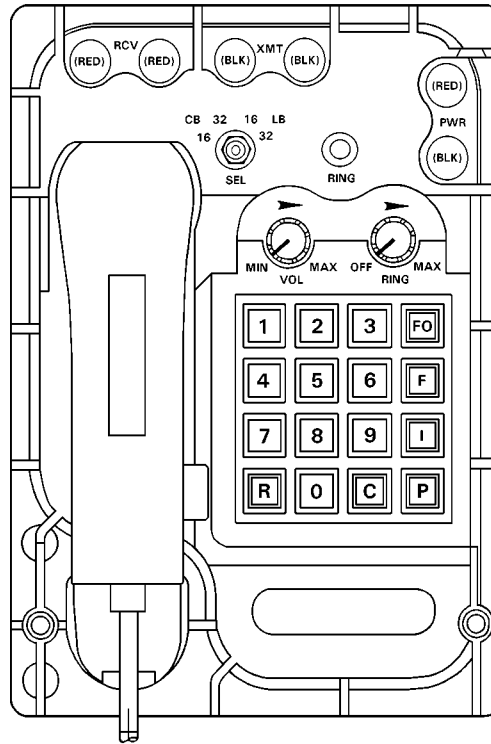


Figure E-7. Digital nonsecure voice telephone with data port, TA-1042.

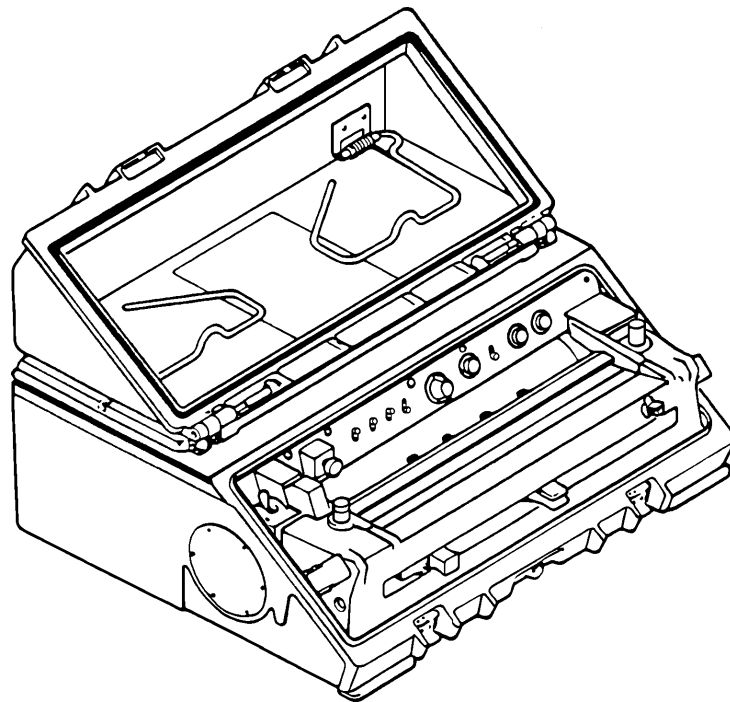


Figure E-8. Tactical lightweight digital facsimile, AN/UXC-7.

c. *Tactical Computers.*

(1) *Medical transportable computer unit.* The MEDTCU is the specific computer hardware system configured to perform the TAMMIS software applications of MEDASM, MEDMNT, MEDPAR, MEDREG and MEDSUP. The TACCS is also a computer hardware system configured to perform the TAMMIS software applications; it will be replaced by the MEDTCU. The MEDTCU may be a commercial off-the-shelf (COTS) system; see paragraph (a) below. The MEDTCU is used in the PAD and supply and service sections of the FH and GH (see Tables E-1 and E-2). The MEDTCU is comprised of a transportable computer unit, color monitor device, printer unit, and an archives device (Figure E-9).

NOTE

There is no TAMMIS software application for medical blood. The Defense Blood Standard System (DBSS) is under development and should be the automated information system to support Armed Services Blood Program in SASO and war. The DBSS will most likely be fielded on a COTS system.

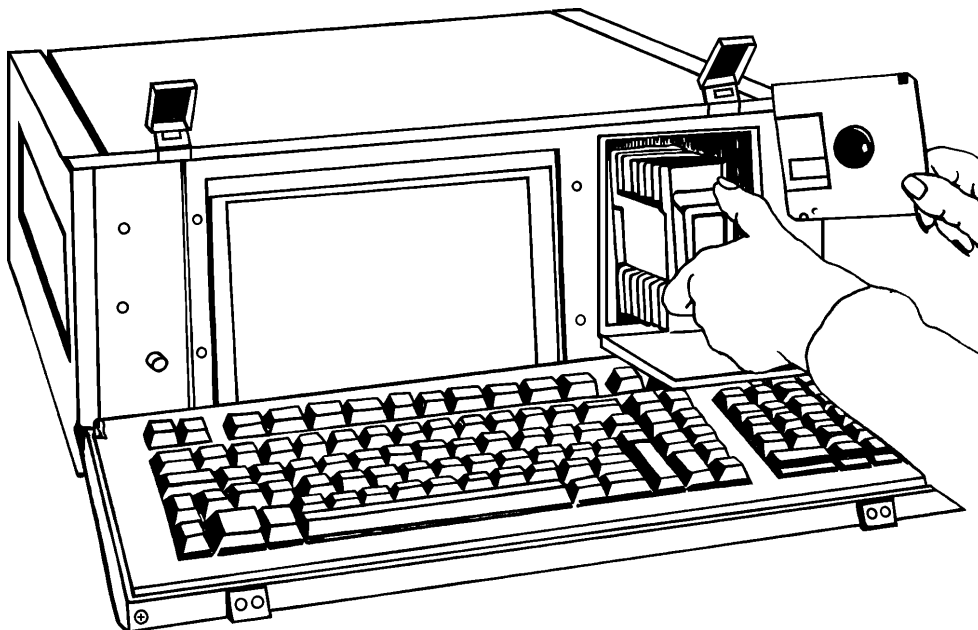
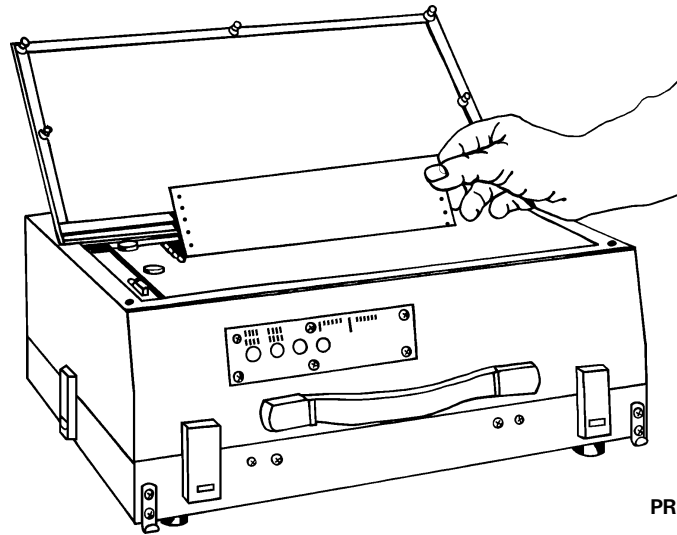
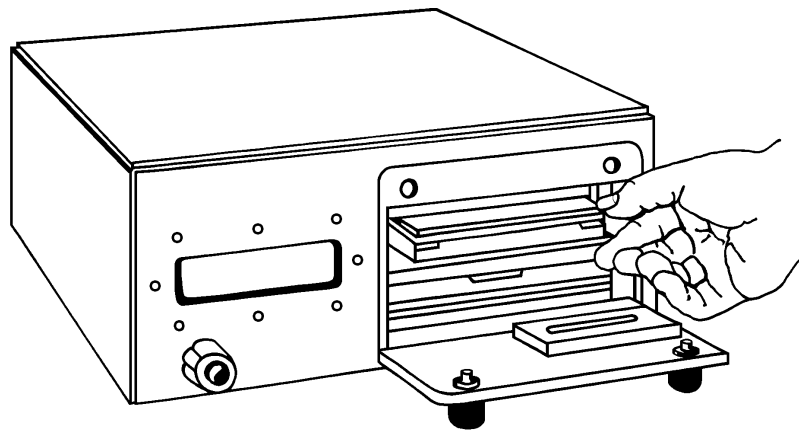


Figure E-9. Medical transportable computer unit.



PRINTER UNIT



ARCHIVE DEVICE

Figure E-9. Medical transportable computer unit (continued).

(a) *Transportable computer unit.* This unit connects with the archive device and printer unit and provides multitasking software resources for computational and graphic capability, word processing, and data base management. It operates from standard 115 or 230 volt alternating current (AC). The unit comes with a full-size, hinged/detachable keyboard that can be detached and relocated up to 24 inches from the computer unit.

(b) *Color monitor device.* This monitor device has four to eight color planes and is driven by a video card installed in the host computer.

(c) *Printer.* This unit is a rugged printer designed to satisfy 80-column printer applications in an adverse environment where size, weight, and power consumption are prime considerations. The printer unit is a portable device. It employs solid state, dot matrix, printing technology.

(d) *Archive device.* The archive device is a rugged L-inch (disk drive) streaming magnetic tape cartridge system intended to provide backup or archiving. The capacity of each cartridge is 67 megabytes. The archive device tape system is supported on the transportable computer unit.

(2) *Commercial off-the-shelf system.* The COTS system is the computer system designed to support the TAMMIS software applications of MEDASM, MEDMNT, MEDPAR, MEDREG and MEDSUP. (For additional information on TAMMIS, see Chapter 6.) The COTS system is comprised of a 486 Everex Tower central processing unit (CPU), color monitor, printer, dumb terminals, and an uninterruptible power supply (UPS).

(a) *Central processing unit.* The CPU connects the monitor, printer, modem, terminals, and UPS and provides multitasking software resources for both TAMMIS and disk operating systems (DOS) (word processing, graphics, spreadsheets, and data base management) applications. The CPU operates from standard 110 and 220 volt AC. The CPU has an internal streaming magnetic tape drive cartridge system intended to provide data backup and archiving. The capacity of each tape cartridge is 250 megabytes. Some systems also have a compact disk-read only memory (CD-ROM) drive.

(b) *Color monitor.* The monitor is a super video graphics applications (SVGA) monitor with a 14-inch screen and is driven by a video card installed in the CPU.

(c) *Printer.* The printer is a lightweight, small footprint printer designed to support 80-132 column dot matrix printer applications.

(d) *Modem.* The modem is an external 9600 baud modem designed to provide data telecommunication support over commercial telephone lines.

(e) *Terminals.* The COTS system can support 8 to 32 additional dumb terminals (depending on the system).

(f) *Uninterruptible power supply.* The UPS protects the COTS system hardware from power fluctuations and provides temporary power when the primary power supply is lost.

(3) *Tactical Army Combat Service Support Computer System.* The TACCS is the tactical hardware which operates the SIDPERS and the SPBS-R (Figure E-10). This system is used in the FH and GH (see Tables E-1 and E-2).

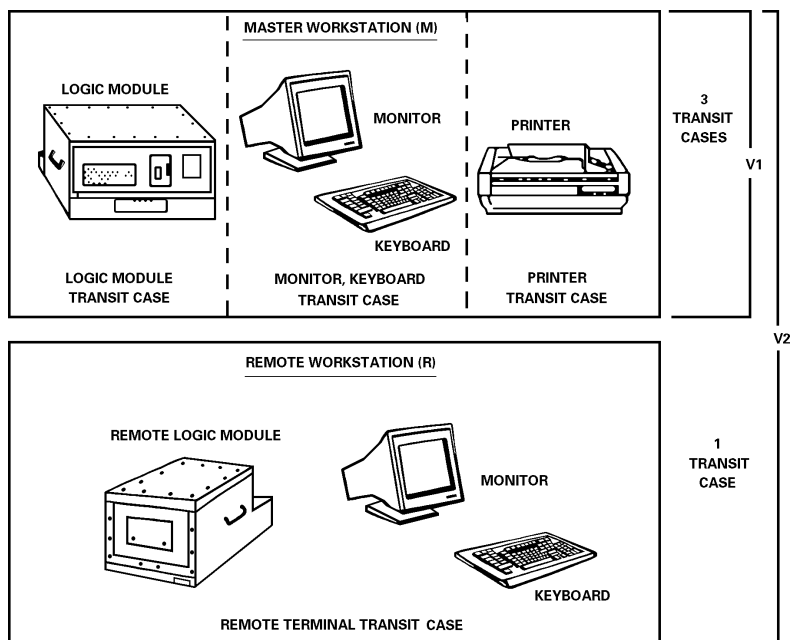


Figure E-10. Tactical Army Combat Service Support Computer System

(4) *Remote keyboard visual display unit.* This unit is a remote (COMM terminal) monitor and keyboard designed for use with the TACCS equipment. It provides the capability for data to be retrieved or entered by more than one operator simultaneously. The remote keyboard visual display unit is used in the FH and GH supply and service divisions.

d. *Position Location/Navigation Device.* The precision lightweight global positioning system (GPS) receiver (Figure E-11) is a hand-held, battery-powered POS/NAV set that receives its signal from GPS satellites. The device provides a very accurate position location capability for determining and/or reporting self-location; however, it is *not* a communications device. The GPS is authorized for selected sections of the FH and the GH (see Tables E-1 and E-2). The device is designed for individual or vehicle use.

e. *Mobile Subscriber Radiotelephone.* This telephone is issued with MSE for primary use in vehicles. It is allocated to the FH commander (see Figure E-12 and Table E-1).

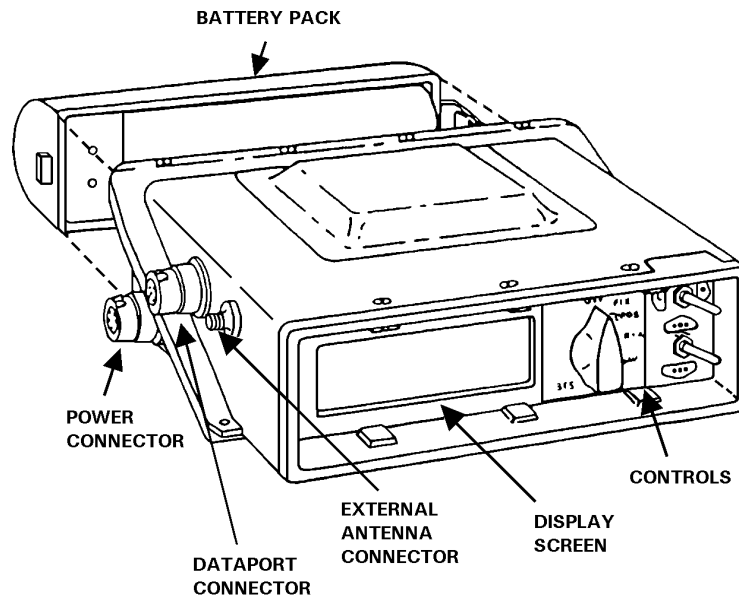


Figure E-11. Precision lightweight global positioning system receiver.

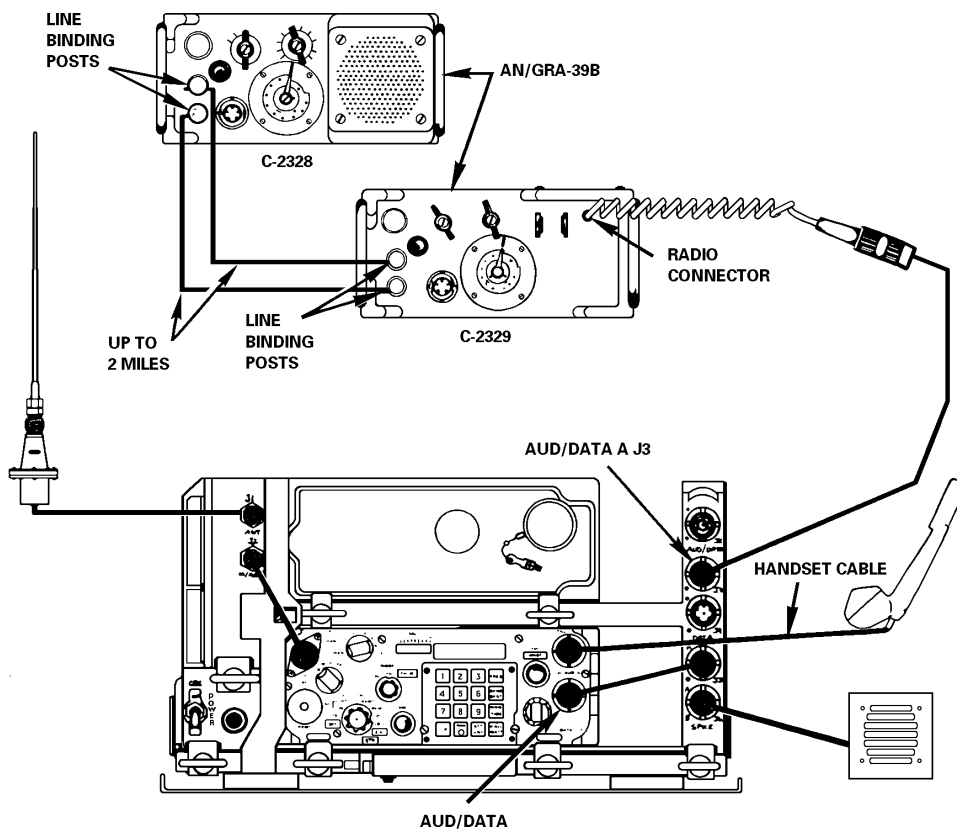


Figure E-12. Typical mobile subscriber radiotelephone installation.

APPENDIX F

COMMANDERS' CHECKLIST**Section I. PERSONNEL CHECKLIST—MOBILIZATION****F-1. Personnel and Administration**

- a.* Maintain individual records alphabetically by last name. If records are maintained by an activity separate from the hospital, provide that activity an updated personnel roster as of the 15th of each month to arrive not later than (NLT) the 20th. Reserve Component hospitals use the most current DA Form 1379.
- b.* Identify nondeployable personnel and initiate procedures for reassignment and/or separation.
- c.* Identify and color code all reference publications to be taken with the hospital upon deployment.
- d.* Maintain personnel readiness folders and review them quarterly.
- e.* Ensure that hospital members' (to include professional officer filler system [PROFIS]) identification tags and Geneva Conventions cards are on hand and are in serviceable condition.
- f.* Identify files to accompany the hospital in case of deployment, as well as those to be destroyed.
- g.* Maintain a 60-day supply of blank forms for deployment.
- h.* Maintain a deployment set of DA Form 3955 on all assigned personnel in alphabetical order.
- i.* Appoint a (unit) family member's assistance officer.
- j.* Conduct personal affairs briefing according to AR 220-10.
- k.* Identify personnel shortages by grade and MOS.
- l.* Submit requisition for personnel shortages.
- m.* Ensure that assigned personnel have enrolled their dependents in defense eligibility enrollment system (DEERS).
- n.* Ensure that dependent care plans are on file and adequate for service members and PROFIS personnel who are sole-parents, or are married to another service member and have children.
- o.* Appoint unit mail clerk.
- p.* Requisition and maintain recreational equipment and supplies.

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- q.* Appoint a unit safety officer and NCO.
- r.* Maintain in a current status the personnel data cards (PDCs) for all personnel assigned, to include designated PROFIS personnel.
- s.* Appoint a unit records management coordinator to pick up and transport the hospital's individual records (personnel, medical, dental, and finance) in case of a deployment.
- t.* Ensure assigned personnel maintain current MOS evaluation scores; if personnel have failed to verify their MOS, conduct training in deficient tasks.
- u.* Establish procedures to recall personnel absent from the unit in the event of increased readiness conditions.
- v.* Obtain sufficient boxes to carry unit files and personnel, dental, and medical records.
- w.* Maintain records (PDC files) on PROFIS personnel.
- x.* Appoint rear detachment commander.
- y.* Check to ensure military drivers license are current and schedule driver's training/testing to ensure sufficient number of drivers are available for movement of unit's assigned vehicles.

F-2. Finance

- a.* Maintain a current roster of all assigned and PROFIS personnel.
- b.* Ensure that orders for purchasing officer and Class A agent are current and that each individual is thoroughly briefed on his duties.
- c.* Upon mobilization, ensure that the Class A agent contacts the mobilization station finance and accounting office (FAO) and identifies any immediate finance requirements.
- d.* Establish contact with FAO upon arrival at the mobilization station to enhance personnel processing.
- e.* Arrange for emergency financial assistance, as required.
- f.* Advise personnel to adjust or initiate allotments for dependents, as appropriate.
- g.* Upon mobilization and deployment notification, advise personnel of the amount of cash and/or credit cards they should bring.

F-3. Medical

a. Ensure that the home station medical and dental treatment facilities (supporting mobilization/deployment operations) record the deploying soldier's essential health- and dental-care information on DA Form 8007, Individual Medical History. The health record (DA Form 3444 or DA Form 8005-series [Medical and Dental Treatment Record]) folders of deploying soldiers will not accompany them to combat areas. For additional information, see AR 40-66.

(1) The preparation and use of DA Form 8007 is applicable to deploying military personnel as well as civilian employees who may accompany the unit.

(2) If the health record is not available, DA Form 8007 will be completed based on soldier interviews and any other locally available data. A health record may not be available for Individual Ready Reserves, Individual Mobilization Augmentees, and retired personnel because their health records may be on file at the US Army Reserve Personnel Center.

(3) The FH/GH will maintain the DA Form 8007 in an outpatient field file for reference as needed. The field file will consist of, in part, DA Form 8007, and possibly, Standard Form (SF) 600 (Health Record—Chronological Record of Medical Care), SF 558 (Emergency Care Treatment), SF 603 (Health Record—Dental), or Department of Defense (DD) Form 1380 (US Field Medical Card).

- b.* Ensure that immunizations for unit personnel are current.
- c.* Verify temporary physical profiles every 3 months.
- d.* Maintain a record copy of all permanent physical profiles.
- e.* Ensure all personnel requiring spectacles have at least two pairs, as well as optical inserts for their protective mask.
- f.* Ensure that each individual has a duplicate panoramic dental X ray on file and that a deoxyribonucleic acid (DNA) specimen is on file with the DOD DNA Registry and Repository.
- g.* Requisition and maintain medical supplies based upon MTOE, mission(s), and contingency plans.
- h.* Ensure that each individual has an ample supply of all personal medications and other personal supplies.
- i.* Ensure that the correct blood type is posted to individual records.
- j.* Ensure all soldiers have their annual hearing exam and have medically fitted hearing protection.
- k.* Request information on the medical threat and countermeasures in the AO.

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l. Ensure all field sanitation team supplies are on hand and all field sanitation equipment is mission capable.

m. Ensure all personnel have a current human immunodeficiency virus (HIV) test according to requirements of AR 600-110.

F-4. Discipline, Law, and Order

a. Prepare plans for security of unit equipment, weapons, and ammunition.

b. Designate unit physical security officer.

c. Brief unit personnel on the policy which prohibits bringing privately owned firearms to the mobilization station.

d. Conduct a shakedown inspection for contraband prior to movement to mobilization station.

e. Dispose of privately owned vehicles (POVs), firearms, pets, and other personal property.

F-5. Religion

a. Ensure that religious services are available.

b. Provide necessary training for chapel activity specialists.

c. Obtain appropriate religious equipment and supplies.

F-6. Legal

a. Seek assistance from the Staff Judge Advocate in preparing unit for deployment.

b. Ensure that personnel have access to an attorney to have a Power of Attorney prepared and executed.

c. Ensure that personnel see an attorney to have a Last Will and Testament prepared and executed. Advise personnel of the importance of a Will.

d. Dispose of all disciplinary actions pending against personnel; for example, take action or forward to higher commander for action.

e. Ascertain from the convening authority which personnel will remain at the mobilization site because of pending investigations or courts-martial.

- f.* Arrange for the release of individuals from pretrial confinement, if appropriate.
- g.* Dispose of claims and military justice cases.

F-7. Public Affairs

- a.* Make provisions to recall unit personnel through the use of electronic media outlets; that is, radio and television stations.
- b.* Brief personnel on the nature and background of the emergency which has required the mobilization.
- c.* Brief unit personnel on the history, geography, religion, language, and customs of the country or area of eventual military operations.
- d.* Make sure assigned personnel are aware of required actions to take if contacted by members of the news media.
- e.* Inform personnel of actions to take and agencies available to support their family members after mobilization; for example, legal assistance, health care, financial arrangements, and so forth.
- f.* Advise personnel not to discuss sensitive information outside of the unit; for example, movement dates, times, departure points, troop lists, means of transportation, special training, special equipment, status of morale, and so forth.

Section II. OPERATIONS CHECKLIST—MOBILIZATION

F-8. Operations

- a.* Maintain current alert notification rosters (both telephonic and nontelephonic); update monthly and conduct exercises periodically.
- b.* Brief key personnel on contingency plans and exercise requirements.
- c.* Report attainment of deployability posture according to FORSCOM alert and deployment procedures and plans and policies of the mobilization site.
- d.* Monitor unit preparation for oversea movement (POM) operations and request guidance and assistance as required.
- e.* Provide current access roster to the EOC and update as needed.

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- f.* Prepare hospital movement plans.
- g.* Establish liaison and communications with the EOC.
- h.* Obtain mission briefing and plans required for execution of deployment mission.

F-9. Security and Intelligence

a. The S2 officer accomplishes all duties related to security and intelligence matters. The commander is briefed as required.

b. Review the personnel security status of the unit and request, in order of priority, interim security clearances to ensure the correct personnel have proper clearance consistent with mission requirements, to include classified material escort responsibilities.

c. Ensure appropriate hospital personnel are familiar with duties and responsibilities in conjunction with movement and shipment of classified material, protection of movement data, and execution of classified moves, as applicable.

d. Prepare to enforce the primary Wartime Information Security Program.

- (1) Appoint primary censors (one for every 100 personnel).
- (2) Prepare requisition for censorship stamp.
- (3) Initiate censorship education program.

e. Conduct OPSEC training according to AR 530-1 and local supplements.

f. Prepare briefing for hospital personnel to be conducted when movement is imminent. Include the following:

- (1) Subversion and Espionage Directed Against US Army according to AR 381-12.
- (2) Procedures for classified moves.

g. Ensure access rosters are current; prepare and submit access rosters to the appropriate mobilization site staff and higher headquarters, if appropriate.

h. Expedite processing of pending security clearance actions.

i. Ensure all personnel, including fillers, are briefed on OPSEC practices.

j. Brief command and staff personnel on the nature of the threat of electronic warfare (EW) and signal intelligence.

- k.* Ensure personnel are aware of intelligence acquisition tasks, responsibilities, techniques, and reporting procedures.
- l.* If sealed-off staging areas are used—
 - (1) Conduct mission briefings at the latest possible time prior to out-loading.
 - (2) Restrict briefed personnel to sealed-off area.
 - (3) Establish and enforce controlled pass procedures.
 - (4) Monitor and control telephone use.
- m.* Identify classified documents which will not accompany the hospital.
- n.* Review plans for the conduct of a counterintelligence (CI) inspection of the hospital area upon departure.
- o.* Ensure timely transfer or destruction of classified material not to accompany the hospital.
- p.* Request assistance for security briefings.
- q.* Ensure all plans contain OPSEC and CE security planning considerations.
- r.* Maintain a list of map requirements and prestock. Submit requirements to the appropriate staff section at the mobilization site.
- s.* Ensure SIGSEC plans include—
 - (1) Nature and amount of information to be transmitted or protected.
 - (2) Communications system capabilities and limitations.
 - (3) Selection of available SIGSEC kits and instructions for use.
 - (4) Basic load, source, and manner of resupply for key cards, authentication codes, and other security-related codes.
 - (5) Operating procedures to include command and control warfare (C2W) techniques and any special requirements.
 - (6) Emergency destruction of classified operating instructions and associated materials.
- t.* Identify all intelligence requirements and submit to the appropriate security staff at the mobilization site.

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- u.* Identify all linguist-qualified personnel and potential translator needs based upon mission(s) and contingency plans.
- v.* Review plans for the conduct of a classified move according to AR 380-5 and AR 220-10.
- w.* If deployment is from a civilian port, make a request for port security to Intelligence and Security Command (INSCOM) through the appropriate staff at the mobilization site or home station.
- x.* Coordinate with the appropriate staff for any unique unit requirements.

F-10. Training

- a.* Train field sanitation teams (FM 21-10-1).
- b.* Conduct training in air and rail movement.
- c.* Conduct MOS training as required.
- d.* Conduct PVNTMED refresher training (FM 21-11). Training should include—
 - The transmission and countermeasure information for endemic and epidemic diseases prevalent in the AO.
 - Heat and cold weather injury prevention.
 - Poisonous plant, wild animals, and reptiles (land and water).
 - Pest management.
- e.* Conduct weapons qualification and NBC training.
- f.* Conduct training for potential civic action programs which include medical operations (FM 8-42).
- g.* Conduct defense team training.

Section III. LOGISTICS CHECKLIST—MOBILIZATION

F-11. Subsistence

- a.* Complete basic load of Class I (DA Form 3161) and forward to troop issue subsistence officer.

- b.* Complete ration requirements for air deployment: 3 days subsistence for pre-positioning of materiel configured to unit sets (POMCUS) hospitals and 5 days for non-POMCUS hospitals.
- c.* Identify rations required for personnel to accompany sea-deploying equipment.
- d.* For hospitals operating their own dining facility—
 - (1) Coordinate with the appropriate staff section to close accounts and turn in or transfer dining facility supplies and equipment.
 - (2) Coordinate for subsistence support of hospital personnel during the period between the closure of the hospital's dining facility and hospital deployment.
- e.* For FHs/GHs currently subsisting in another organization's dining facility—
 - (1) Coordinate with the supporting dining facility manager to withdraw hospital food service personnel during deployment preparations.
 - (2) Prepare plans to collect and turn in meal cards to the supporting facility prior to unit deployment.
 - (3) Prepare a roster of all deployable and nondeployable personnel receiving basic allowance for subsistence; for example, separate rations. For deployable personnel, establish a termination date for the basic allowance for subsistence and coordinate with the supporting dining facility and the finance officer.
- f.* Ensure ration requirements for patient feeding in the AO have been planned for and are available. Planning for a basic load of unique patient-feeding items may be needed until the TO can support these items.

F-12. Supplies and Equipment

- a.* Ensure assigned personnel have all required individual clothing and supplies, to include permethrin, DEET, and personal hygiene items. Cover shortages by requisition, cash collection voucher, or scheduled individual purchase.
- b.* Ensure personnel have all required organizational clothing and equipment and that items are marked, as required. Cover shortages by requisition, cash collection vouchers, or individual purchases.
- c.* Expendable supplies.
 - (1) Prepare a list of expendable supplies required for 15-day usage.
 - (2) Ensure all expendable supplies required are on hand, requisitioned, or readily available through the self-service supply center (SSSC).

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(3) Ensure hospital draft loading plan makes provisions for carrying the 15-day supply of expendables to accompany troops (TAT) baggage.

d. Medical sets, kits, and outfits and tools.

(1) Have all sets, kits, and outfits on hand or on order, follow up with status card or upgrade the priority.

(2) Prepare shortage annexes for all sets, kits, and outfits on hand.

(3) Document all shortages by shortage annex, report of survey, statement of charges, or cash collection voucher.

(4) Place all shortages on requisition.

(5) Ensure all supply catalogs are on hand and current.

e. Identify all station property and coordinate to ensure turn in during deployment preparation.

f. Ensure supply personnel are familiar with procedures to close out SSSC and other accounts.

F-13. Petroleum, Oils, and Lubricants

a. Determine requirements for packaged products for deployment. Ensure necessary items are on hand, requisitioned, or readily available through the SSSC.

b. Bulk POL.

(1) Have required 5-gallon fuel cans on hand or on requisition.

(2) Have bulk POL containers serviceable, or initiate appropriate repair or replacement action.

(3) Coordinate with the appropriate staff element for the purging of bulk containers prior to deployment. Have replacement filters on hand or on requisition for this equipment.

F-14. Ammunition

a. Compute unit basic load and have computations verified by the appropriate staff element at the mobilization site/home station.

b. Prepare and submit DA Form 581 for basic load.

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- c.* If appropriate, include that portion of the basic load in hospital TAT load plans.
- d.* Identify requirements for guard ammunition for equipment and classified material escorts.

F-15. Major End Items

- a.* Ensure all TOE/MTOE-required items are on hand or on requisition.
- b.* Have all excesses identified and turned in prior to deployment.
- c.* Have all requisitions for shortages screened for status, proper unit movement data (UMD), and priority.
- d.* Identify impact of shortages to the appropriate headquarters and in unit readiness report.
- e.* Ensure that major training sets, such as the DEPMEDS medical equipment training sets, are either turned in or prepared for shipment to the mobilization site or port of embarkation.

F-16. Medical Supplies and Equipment

- a.* Have all required medical supplies and equipment items on hand or requisitioned through the supporting Class VIII organization.
- b.* Have requisitions for shortages validated and obtain latest status.
- c.* Address the effect of shortages to the appropriate headquarters and in the unit readiness report.
- d.* Ensure that enough refrigerated and heated storage is available for the temperature-controlled items for shipment.
- e.* Ensure that medical supplies (such as cylinders containing oxygen and anesthesia gases, Code R items, and other hazardous materials) requiring special handling are identified and on hand or on requisition.

F-17. Prescribed Load List

- a.* Review hospital's PLL on all equipment.
- b.* Provide PLL to the appropriate supporting staff.
- c.* Have all PLL items on hand or on requisition.

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- d.* Include PLL in hospital loading plans.
- e.* Include the blocking, bracing, packing, crating, and tie-down (BBPCT) requirements necessary to protect PLL in the hospital's BBPCT forecast.
- f.* Adjust PLL to reflect continuous equipment operations.
- g.* Provide list of PLL shortages having or anticipated to have an impact on unit readiness to the appropriate staff element or higher headquarters.

F-18. Maintenance

- a.* Initiate equipment records for all newly received items IAW DA Pamphlet (Pam) 738-750.
- b.* Identify all excess equipment and coordinate with the support activity for turn in.
- c.* Have all items requiring direct support- or general support-level maintenance, to include equipment to be purged, job-ordered to the appropriate support activity.
- d.* Ensure calibration of equipment is completed, or scheduled for completion.
- e.* Upgrade job order priorities to reflect anticipated deployment dates.
- f.* Notify the EOC or higher headquarters of any conflict or shortfalls between the estimated completion date of equipment repairs and the required-to-load date for deployment.
- g.* Request maintenance assistance in conducting final inspection of major equipment prior to movement and loading.

F-19. Laundry

- a.* Review procedures necessary to close out laundry account; prepare and submit paperwork as necessary.
- b.* Notify laundry manager of anticipated deployment date.

F-20. Transportation

- a.* Keep the hospital's automated unit equipment list and computerized movement and status system reports current. Coordinate with local MCT for additional transportation assets.

F-12

b. Train hospital personnel in the following areas:

(1) How to load unit equipment on aircraft, trucks, and railcars for deployment, including hazardous materials certification.

(2) Preparation of packing lists.

(3) Marking of containers.

(4) Preparation of the transportation control and movement document (TCMD) (DD Form 1384).

(5) Preparation of personnel manifests as required by the Air Mobility Command (AMC).

(6) Blocking, bracing, packing, crating, and tie-down.

(a) Computation of hospital BBPCT requirements for both air and sea deployment. Have requirements validated by the transportation support activity and place a job order for BBPCT.

(b) Computation of supplemental packing and crating requirements and, if required, submit appropriate request to the USAF for those requirements which cannot be met. This request should be for fabrication of supplemental packing and crating for—

(1) Air deployment.

(2) Rail deployment.

(3) Surface (sea) deployment.

(c) Maintaining supplemental packing and crating items.

(7) Determining center of gravity and marking vehicle and cargo loads.

(8) Loading vehicles for both air and/or sea deployment as appropriate.

(9) Preparation of movement documents for items requiring special handling and packing and hazardous materials certification.

c. Review with the Installation Transportation Officer, Port Support Activity, or Arrival/Departure Airfield Control Group the support requirements for the following areas:

(1) Preparing, packing, and marking loads.

(2) Augmenting vehicle requirements to support movement to POE and other transportation requirements.

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- (3) Providing MHE support to assist in loading.
 - (4) Load team and driver team requirements.
 - (5) Application of LOGMARS labels.
 - (6) Operation of marshaling area at POE.
- d.* Prepare hospital movement plans to include—
- (1) Convoy or move to POE.
 - (2) Logistical support of hospital elements at POE.
 - (3) Guard personnel and equipment at POE.
 - (4) Handling of hazardous and special cargo and preparation of necessary certificates.
 - (5) Preparation of equipment and items which use or store combustibles; that is, generators, water heaters, and so forth for shipment.

F-21. Miscellaneous Logistics

- a.* Establish guidance and plans for the establishment of a rear detachment, to include transfer of property and signature cards (DA Form 1687).
- b.* Establish procedures to terminate all signature cards and authorizations on departure of the last hospital element.
- c.* Personal property.
- (1) Dispose of all civilian clothing and personal property.
 - (2) Have on hand or on order sufficient C-boxes and inventory forms for packing and storing of personal items which cannot be disposed of by the individual.
 - (3) Train supply personnel in inventorying, packing, marking, and transferring personal property.
- d.* Billeting.
- (1) Advise personnel who reside in bachelor officer quarters (BOQ), bachelor enlisted quarters (BEQ), and off-post housing of necessary termination and clearance procedures on notification of deployment.

(2) Prepare a listing of personnel who will have their basic allowance for quarters (BAQ) terminated upon deployment.

e. Provide personnel with a list of personal comfort items that should be obtained and a list of prohibited items based upon projected deployment locations, local customs and religion, and PVNTMED guidance.

f. Establish a list of personal support items to be obtained based upon projected deployment locations, such as lip balm, bug repellent, sunscreen, and mosquito netting.

g. Real property facilities.

(1) Maintain a current roster of real property facilities (RPF) managers for all RPF assigned to the hospital.

(2) Identify interim RPF managers who will not deploy and will assume accountability for assigned RPF.

F-22. Contracting

Notify the contracting activity of the anticipated termination date of any supply or service support provided by civilian contractors.

Section IV. PERSONNEL CHECKLIST—DEPLOYMENT

F-23. Personnel and Administration

a. Upon notification of deployment, recall all personnel, including those on leave, special duty, and temporary duty (except MOS-producing schools).

b. Coordinate with higher headquarters for PROFIS personnel. The PROFIS is met primarily through the designation of officers within the MEDCOM to meet AMEDD professional filler requirements (see AR 601-142).

c. Submit personnel status report.

d. Conduct final preparation of replacements for oversea movement (POR) qualification. Identify nondeployable personnel and initiate procedures for reassignment and/or separation.

e. Have unit records management coordinator assist the officer in charge at the POR processing site.

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f. Clear nondeployable personnel from the hospital after final POR. Return their records and update the personnel roster.

g. Following final POR, receipt for medical and dental records. Pack them in boxes to accompany the hospital. Personnel records will remain at the installation for 90 days pending determination of where to ship them. Dental records (necessary for identification of remains) will not be transported on the same vessel or airplane as service members.

h. Ensure that a set of DA Form 3955 accompanies the hospital for filing at the postal activity in the AO.

i. If not initiated, submit DA Form 17 for publications and blank forms.

j. Pack files, publications, and blank forms which will accompany the hospital. Retire or destroy remaining files. Turn in excess publications and blank forms.

k. Carry copies of the movement orders with the hospital.

l. Carry a copy of the current enlisted promotion list with the hospital.

m. Ensure that personnel are cleared of post activities; follow-up on discrepancies.

n. Conduct safety orientation for all unit personnel regarding the deployment operation.

o. Orient personnel on the Status of Forces Agreement in the AO.

p. Conduct personal affairs briefing IAW AR 220-10.

q. Close unit Morale Support Fund account and dispose of fund property.

r. Arrange for emergency financial assistance of hospital personnel, as needed, with Army Emergency Relief and Red Cross, or other appropriate agencies.

s. Inform the installation postal officer, in writing, of the day and time of the last postal pick up; provide the postal officer a copy of the movement orders.

t. Initiate action to terminate separate rations as of the day the hospital departs the installation.

u. Turn in recreational services clothing and equipment except for items accompanying the hospital.

F-24. Medical

a. Ensure convoy and serial commanders know the sources and methods of obtaining emergency medical support while en route and at the POEs.

F-16

b. Identify medical personnel to provide EMT during convoy and stationary operations. Ensure that enough air bags, litters, and other equipment are set aside for their support.

c. Identify evacuation and medical treatment support (usually on an area basis) for each stage of deployment and movement.

F-25. Discipline, Law, and Order

a. Have service members' POVs placed in temporary storage or ensure that other suitable arrangements have been made for disposal or upkeep. For POVs temporarily stored on the installation, have service member provide Power of Attorney authorization to a responsible individual to pick up the vehicle, or have the service member arrange for long-term commercial storage at his own expense.

b. Report assigned personnel who are absent without leave.

c. Prepare for disposition of privately owned weapons stored in the unit arms room.

d. Dispose of weapons, pets, and other personal property.

F-26. Religion

Ensure that religious services are available to all personnel.

F-27. Legal

a. Have hospital personnel provide their dependents with a Power of Attorney which permits acceptance and termination of government quarters.

b. Dispose of claims and military justice cases.

c. Orient personnel on Status of Forces Agreement.

d. Advise personnel on importance of a Power of Attorney and having a Will.

F-28. Public Affairs

a. Keep hospital personnel apprised of the current overall emergency situation requiring the mobilization and deployment.

b. Brief hospital personnel on such topics as Standard of Conduct, Code of Conduct, Hague and Geneva Conventions, and the Law of Land Warfare.

- c.* Apprise personnel of any operational changes to the hospital's mission.
- d.* Brief personnel on their eventual AO.
- e.* Use the hometown news release program, if warranted.
- f.* Continue coordination with installation.
- g.* Continue command information program throughout the period of mobilization and deployment.

Section V. OPERATIONS CHECKLIST – DEPLOYMENT

F-29. Operations

- a.* Conduct overseas orientation IAW AR 220-10.
- b.* Report attainment of deployability posture IAW FORSCOM emergency action procedures and installation EOC policies and procedures.
- c.* Monitor hospital POM operations, and provide guidance and assistance, as required.
- d.* Prepare appropriate plans and orders.
- e.* Coordinate hospital movement.
- f.* With the approval of the hospital commander, appoint an officer or NCO as rear detachment commander.

F-30. Security and Intelligence

- a.* Review the personnel security status to ensure sufficient numbers of personnel are properly cleared consistent with mission requirements to include classified material escort responsibilities.
- b.* Ensure appropriate personnel are familiar with the duties and responsibilities in conjunction with classified movement and shipment, if applicable.
- c.* Initiate censorship education program.
- d.* Conduct OPSEC program.

e. Prepare briefing for unit personnel to be conducted when movement is imminent. Briefing will include, but not be limited to, the following:

- (1) Dissemination of movement data on a need-to-know basis.
- (2) Procedure for handling movement documents.
- (3) Procedures for handling classified material in transit.
- (4) Subversion and Espionage Directed Against US Army.
- (5) Procedures for classified moves.

f. Ensure all personnel, including fillers, are briefed on OPSEC practices.

g. Brief command and staff personnel on the nature of the threat's EW/signals intelligence capabilities.

h. If sealed-off staging areas are used—

- (1) Establish strict security.
- (2) Enforce blackout camouflage.
- (3) Conduct mission briefings at the latest possible time prior to out-loading.
- (4) Restrict briefed personnel to sealed-off area.
- (5) Establish and enforce controlled pass procedures.
- (6) Monitor and control telephone use.

(7) Ensure personnel hospitalized or confined during staging are isolated until public announcement of the operation.

(8) Collect letters and other personal mail and place in sealed mail bags until public announcement of the operation.

i. Identify classified documents which will not accompany the hospital.

j. Ensure timely transfer or destruction of classified material not to accompany the hospital.

k. Review plans for the conduct of a CI inspection of the area upon departure.

l. Review plans for the return of cryptographic material, not accompanying the hospital, to the office of record or issue; transfer as appropriate.

- m.* Ensure all plans contain OPSEC, communications, and electronic security planning considerations.
- n.* Plan for the distribution of maps and related topographical materials.
- o.* If deploying from a civilian port, forward request for port security to INSCOM through appropriate channels.

Section VI. LOGISTICS CHECKLIST—DEPLOYMENT

F-31. Subsistence

- a.* Draw unit basic load of rations and store with TAT cargo.
- b.* Draw rations to support deployment (3 days for POMCUS units, 5 days for non-POMCUS units) and load in a readily accessible manner.
- c.* Arrange subsistence support to any portion of the unit that will not accompany the main body.
- d.* For hospitals operating their own dining facility—
 - (1) Close out all accounts and hand receipts.
 - (2) Turn in or transfer all unused rations and condiments.
 - (3) Make arrangements to subsist assigned personnel at another activity from the closure of the dining facility until deployment.
- e.* For hospitals supported at another activity's dining facility—
 - (1) Make arrangements with the supporting facility for final turn in of meal cards.
 - (2) Coordinate with supporting dining facility for the release of deploying food service personnel.
- f.* Submit the necessary paperwork to the finance office to terminate basic allowance for subsistence for any personnel receiving it; arrange to subsist personnel on the termination of their basic allowance for subsistence.

F-32. Supplies

- a.* Pack the hospital's 15-day supply of expendables with TAT cargo.
- b.* Report significant shortfalls in expendable supplies to the supporting element.

- c.* Report shortfalls in individual clothing items to the supporting element.
- d.* Report shortfalls in organizational clothing and equipment to the supporting element.
- e.* Report shortfalls in tools and/or test equipment to the supporting element.
- f.* Close out all station property accounts.
- g.* Close out SSSC account, and complete credit and turn in.

F-33. Ammunition

- a.* Draw basic load of ammunition; include in the TAT cargo load plans.
- b.* Draw necessary ammunition to guard equipment during deployment.

F-34. Major End Items

- a.* Turn in all excess items and other equipment not accompanying the hospital.
- b.* Pick up all incoming items of equipment on the property records.
- c.* Report shortages to the EOC and the supporting element.

F-35. Medical Items

- a.* Ensure all medical items and supplies are received and included in the loading plans.
- b.* Report shortages to the EOC and the supporting element.
- c.* Ensure that all medical supplies requiring special handling (paragraph F-16*d* and *e*) are on hand and included in the loading plans.

F-36. Repair Parts

- a.* Adjust PLL to reflect any equipment increases and expected increased utilization; have PLL at 100 percent fill; if not, report critical shortage to the supporting element.
- b.* Prepare loading plans which place the PLL in a readily available location.

F-37. Maintenance

- a.* Complete calibration.
- b.* Close out direct support and general support job orders at the maintenance support facility.
- c.* Conduct inspection of vehicles and other major end items to ensure that they are ready for deployment. Take corrective action as required.
- d.* Complete equipment records for newly received equipment according to DA Pam 738-750.
- e.* Have unit mechanics available to support convoy moves to the POE. Arrange for tool boxes.
- f.* Arrange for recovery support, both internal and external, and address in the movement plans.
- g.* Maintain floats for those that cannot be taken out of support maintenance.

F-38. Transportation

Transportation planning and requirements represent the most detailed and transient elements of the deployment process. As a result, a complete checklist of all possible requirements would be too bulky for meaningful use by the commander. Therefore, the commander and the unit movement coordinator must be thoroughly familiar with FORSCOM and installation mobilization requirements. Presented below are major topics that are common to the various modes of deployment.

- a. General.*
 - (1) Configure unit vehicle loads for air and/or sea deployment, as appropriate.
 - (2) Mark all vehicles, crates, and pallets as required.
 - (3) Have all vehicles clean and free from leaks and seeps.
 - (4) Have fuel pods and bladders prepared and certified.
 - (5) Mark all TAT cargo with 3-inch red or yellow disk and stencil "TAT" on the disk.
 - (6) Prepare packing lists (DD Form 1750).
 - (7) Designate armed guards for classified and sensitive cargo.
- b. Blocking, Bracing, Packing, Crating, and Tie-Down.*
 - (1) Determine, in coordination with the appropriate office, specific BBPCT requirements for deployment based on actual personnel and equipment for movement; actual method of movement; equipment for movement; and POE.

- (2) Request any necessary BBPCT support from the USAF. The request should identify—
 - (a) The location of the POE at which the support is required.
 - (b) The date and time which hospital personnel will report to the POE, and the date and time they will depart (deploy).
- (3) Request any packing and crating support necessary to supplement organic assets for sealing previously fabricated supplemental packing items.
- (4) Provide space in the unit area for packing and crating operations.
- (5) Deliver equipment and supplies to the designated packing and crating base of operations.
- (6) Maintain a packing list for each box packed.
- (7) Provide sufficient trained teams to execute rail, air, and sea loading operations. Type team is dependent upon specified method of deployment.

c. Convoy Operations.

- (1) Submit road clearances (DD Form 1265) and oversized cargo clearance (DD Form 1266) to the supporting transportation element for unit moves to POE.
- (2) For movement to seaport POE—
 - (a) Provide convoy and serial commanders with strip maps, EMT and emergency maintenance instructions, and points of contact.
 - (b) Coordinate and finalize billeting and messing arrangements for drivers.
 - (c) Ensure priority for unit recovery capability is given to POE convoy.
- (3) Allocate maintenance personnel to each convoy to assist in final preparation of vehicles for loading.
- (4) Brief each serial commander on refueling and defueling requirements.
- (5) Arrange, as required, for civilian or military escort.

d. Forms.

- (1) Have TCMDs (DD Form 1384) completed; one form for each vehicle or other exterior container.

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- (2) Have load plans completed for each vehicle; load plans will reflect necessary last minute adjustments.
- (3) Submit request to AMC for personnel being air transported.
- (4) Prepare DD Form 1387-2 for hazardous cargo to be airlifted.
- (5) Prepare DA Form 2940-R for vehicles, trailers, MILVANS, pallet loads, or other exterior shipping containers.
- (6) Prepare aircraft load plans as required by Military Airlift Command.

F-39. Miscellaneous Logistics

- a.* Finalize support arrangements for rear detachment, if required.
- b.* Have all supply and maintenance accounts closed out and signature cards canceled.
- c.* Notify the appropriate activity, in writing, of the termination date of any contract that provides supplies or services.
- d.* Billeting.
 - (1) All personnel in BOQ or BEQ will clear quarters.
 - (2) Notify finance of the cutoff date for BAQ (quarters allowance) for all single personnel.
 - (3) Brief dependent families on family quarters policies and procedures.
 - (4) All personnel residing off-post will either terminate their leases or make other suitable arrangements.
- e.* Secure personal property.
 - (1) Inventory and pack personal property.
 - (2) Provide service members with a copy of the personal property inventory.
 - (3) Transfer all personal property to the supporting transportation element.
- f.* Real Property Facilities.
 - (1) Request termination of assigned RPF.
 - (2) Request designation of interim RPF manager through command channels.
 - (3) Transfer accountability for RPF to the interim RPF manager prior to deployment.

APPENDIX G

THE GENEVA CONVENTIONS**G-1. Law of Land Warfare***a. Sources of the Law of Land Warfare.*

(1) The Law of Land Warfare is drawn from two sources:

(a) The first is treaty law. Treaties are formally enacted under procedures set out in the US Constitution. They are laws of the highest order and statutes and regulations must comply with them. They govern all US soldiers and civilians.

(b) The second source of Law of Land Warfare is customary international law. Once a practice is internationally accepted, either by widespread treaty enactment or other agreement, it becomes customary international law. Once this occurs, it regulates even countries which do not agree with the concept concerned.

(2) In the area of CHS, the principal treaties are the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (12 August 1949) and the Hague Resolutions. These are found in DA Pam 27-1. For the commander, FM 27-10 is a handbook reference which will provide the answers to questions concerning the law of war.

b. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces. This Convention provides for the protection of Armed Forces members and other persons who are wounded and sick on the battlefield. It provides for members of the conflict to take all possible measures to search for and collect the wounded and sick; to protect them against pillage and ill treatment; to ensure their adequate care; and to search for the dead and prevent their being despoiled. It further provides for the protection afforded AMEDD personnel.

G-2. Medical Implications of Geneva Conventions

a. Provisions for Collection of Wounded and Sick. Provisions must be made for the collection and treatment of wounded and sick personnel, whether friend or foe, military or civilian, regardless of legal status. Only urgent medical reasons will determine priority in the order of treatment to be administered. This means that wounded enemy soldiers may be treated before wounded Americans or allies. For enemy personnel wounded as a result of military operations, dual responsibilities must be carried out—custodial and medical. The custodial activity of guarding the wounded EPW should be carried out by assets other than AMEDD personnel. The echelon commander will designate nonmedical units to act as guards when EPW are in medical channels.

b. Accountability and Custody of Enemy Prisoners of War (Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949). Enemy prisoners of war evacuated through medical channels must be identified and their accountability established prior to evacuation per appropriate TSOP. Sick, injured, and wounded prisoners may be evacuated through normal medical channels, but they are

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segregated from US and allied personnel. They may also be evacuated through dedicated or task organized evacuation assets, particularly in rear areas where they are likely to be moved in a group.

c. Responsibility and Handling of Prisoners of War. The US Army is responsible for the care and treatment of EPW from the moment of capture. Below brigade level, these prisoners are handled by combat troops who bring them to the forward or brigade collecting points. Enemy prisoner of war patients will be evacuated from the CZ as soon as possible. Only those sick or wounded prisoners who would run a greater health risk by being immediately evacuated may be temporarily kept in the CZ. When intelligence sources indicate that large numbers of enemy prisoners may result from an operation, medical units may require reinforcement to support the additional EPW patient work load. In this case, the care of the EPW wounded becomes a joint matter between the ground combat commander and the medical commander. Procedures for estimating the medical work load involved in the treatment and care of enemy prisoners is described in FM 8-55. For a more detailed discussion on the administration, handling, treatment, and identification of EPW, see AR 190-8, FM 8-10, and FM 19-40.

d. Identification and Protection of Medical Personnel.

(1) Personnel exclusively engaged in the performance of medical duties in connection with the sick or wounded in medical units or establishments shall wear, affixed to the left arm, a water-resistant brassard/arm band bearing the distinctive emblem (the red cross on a white background) prescribed by the Geneva Conventions. The wearing of brassards/armbands will be at the discretion of the tactical commander in far forward areas.

(2) Medical personnel are to carry a special identity card, DD Form 1934 (Geneva Conventions Identity Card for Medical and Religious Personnel Who Serve in or Accompany the Armed Forces), issued to all persons qualifying as protected medical personnel (see AR 640-3). It will be carried in addition to their regular identification card.

(3) Enemy military medical personnel who are captured are considered retained personnel and not prisoners of war. They will receive the benefits and protection of the Geneva Conventions and may be required to treat prisoners of war. United States medical personnel or medical units that are captured would do likewise, continuing to provide medical support behind enemy lines. In such a situation, this would probably be a primary source of treatment for US prisoners of war, although enemy wounded could be treated also.

(4) Enemy civilian medical personnel who are physicians, surgeons, dentists, nurses, or medical orderlies may also be required to use their medical knowledge in the interest of prisoners of war. These medical personnel are considered protected (under the Conventions) and receive the same treatment as retained military medical personnel.

(5) Personnel protected as medical personnel under the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field must be *exclusively engaged* in medical duties or administration of medical units. This includes all members of a medical unit, even cooks, mechanics, drivers, or administration personnel. However, this protection is given only if the soldier is exclusively engaged in medical duties. Performance of any nonmedical duty removes the protection, and

the DD 1934 must be withdrawn. For example, if an ambulance driver is tasked with driving an unmarked vehicle forward with ammunition prior to evacuating casualties rearward, he would not be exclusively engaged in medical duties and could not be considered or credentialed as “medical personnel.”

e. Self-Defense.

(1) Medical personnel may carry arms for defense of themselves and their patients. This does not mean that they may resist capture or fire on the advancing enemy. It means that, if the enemy is attacking and ignoring the marked medical status of the medic or the medical unit, the medic may provide self-protection. If the enemy merely seeks to assume control of a medical facility or a vehicle without firing on it, the facility or vehicle may be occupied. Of course, it is preferable and proper to attempt to avoid capture by withdrawal.

(2) The arms that medics may use are only defensive arms. By AR these are defined as service rifles (M-16s) and pistols. Other US services restrict arms to pistols alone.

(3) An overall defense plan may not require medical units to take offensive action against enemy troops at any time. If a medical force is part of a defensive area containing nonmedical units, the medical unit’s personnel (that is, all personnel assigned or attached to that unit) may not be responsible for manning part of the overall perimeter. If located in isolation, the medical unit may provide its own security if other support is not available. However, a medical unit may not be defended from capture even if military police or other soldiers are acting as pickets.

(4) If medical personnel fire on enemy troops or otherwise abuse their protected status, they may lose their special status under the Law of Land Warfare. It is also possible that such a violation could result in a war crimes trial by the capturing force. For instance, if an enemy force was advancing on a marked medical facility but was not firing on it and medical personnel then took advantage of the situation and fired on the enemy, this would be an offense. Under the Law of Land Warfare, this action would constitute an act of perfidy or treason. It would be akin to firing on soldiers exposed under a flag of truce.

This paragraph implements STANAG 2931.

f. Marking of Medical Units/Facilities and Ambulances.

(1) *Medical units and facilities.*

(a) The distinctive flag (red cross on a white background) of the Conventions shall be hoisted only over such medical units and facilities (except veterinary) as are entitled to be respected under the Conventions and only with the consent of the tactical commander of a brigade-size or larger unit. The marking of facilities and the use of camouflage are incompatible and should not be attempted concurrently. Use of the red cross is authorized. The camouflage of medical units is regulated by ARs and also, in the

European theater, by NATO STANAG 2931. It is not envisioned that fixed, large medical facilities would be camouflaged. The commander must be aware of who has the authority to order camouflage and for what period it may last. The camouflage of medical facilities is one of the more difficult ones to reconcile with operational necessities. The problem has been present in past wars but is now more critical due to the ability of intelligence assets to see deep into the rear AO. If the failure to camouflage endangers or compromises the tactical operations, the camouflage of medical facilities may be ordered by a NATO commander of at least brigade level or equivalent. Such an order is to be temporary and local in nature and is countermanded as soon as circumstances permit.

(b) The camouflage of a medical unit does not deprive it of protection. However, the enemy is not required to respect a camouflaged facility until he recognizes it as such, so the protection is illusory to a point, especially where indirect fire weapons are involved. The use of defensive arms by medical personnel at a camouflaged site attacked by ground maneuver forces poses a dilemma. The medics should attempt to make the attackers aware of their status rather than fighting back. However, that may be difficult to do on the modern battlefield.

(c) If medical facilities are used to commit acts harmful to the enemy, the protection of those facilities may be withdrawn if the acts are not stopped after warning. This might be the case where a facility is used as an observation post or if combat information was reported or relayed through the facility.

(2) *Ambulances.*

(a) Air and ground ambulances will be marked with the distinctive red cross emblem. There is no legal reason why the ambulances could not have the red cross removed and then be used for nonmedical roles. It should be remembered that the aviators and drivers may not do nonmedical tasks without losing their medical status. As such, the policy that benefits the mission to the greatest degree is to use ambulances exclusively for medical tasks.

(b) The US policy is that crew-served weapons may not be mounted on armored ambulances or air ambulances, even if mounting brackets are present.

(c) Vehicles other than ambulances may be used in a dual role, moving wounded to the rear under removable red crosses. However, the red crosses must be removed before nonmedical tasks are attempted, and care must be taken so that the protection provided by the red cross is not abused.

g. *Civilians—Wounded and Sick (Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949).* Civilians who are wounded or become sick as a result of military operations will be collected and provided initial medical treatment in accordance with theater policies and transferred to appropriate civil authorities as soon as possible. All those wounded and sick as a result of an armed conflict will be collected and cared for. The echelon commander and medical unit commanders jointly exercise responsibilities for custody and treatment of the sick, injured, or wounded and detained civilian personnel.

h. *Captured Medical Supplies and Equipment.* Because medical supplies and equipment captured from the enemy are considered neutral and protected, they are not to be intentionally destroyed. If these

items are considered unfit for use, or if they are not needed for US and allied forces, noncombatants, or EPW patients, they may be abandoned for enemy use. Since captured medical personnel are familiar with their medical supplies and equipment, the captured items are especially valuable in the treatment of EPW. Use of these captured items for EPW and the indigenous population helps to conserve other medical supplies and equipment. When the capture of US medical supplies and equipment by enemy forces is imminent, these items are not to be purposely destroyed. Every attempt must be made to evacuate them. Those items which cannot be evacuated should be abandoned; however, such abandonment is a command decision.

G-3. Compliance with the Geneva Conventions

a. As the US is a signatory to the Geneva Conventions, all medical personnel should thoroughly understand the provisions that apply to CHS activities. Violation of these Conventions can result in the loss of the protection afforded by them. Medical personnel should inform the tactical commander of the consequences of violating the provisions of these Conventions.

b. Outright violations of the Geneva Conventions result when—

- Medical personnel are used to man or help man the perimeter of nonmedical facilities, such as unit trains, logistics areas, or base clusters.
- Medical personnel are used to man any offensive-type weapons or weapons systems.
- Medical personnel are ordered to engage enemy forces other than in self-defense or in the defense of patients and MTFs.
- Crew-served weapons are mounted on a medical vehicle.
- Mines or booby traps are placed in and around medical units and facilities.
- Hand grenades, light antitank weapons, grenade launchers, or any weapons other than rifles and pistols are issued to a medical unit or its personnel.
- The site of a medical unit is used as an observation post, a fuel dump, or an ammunition storage site.

c. Possible consequences of violations described in *b* above are—

- Loss of protected status for the medical unit and personnel.
- Medical facilities attacked and destroyed by the enemy.
- Medical personnel being considered prisoners of war rather than retained persons when captured.

FM 8-10-15

- Combat health support capabilities are decremented.
- d.* Other examples of violations of the Geneva Conventions include—
- Making medical treatment decisions for the wounded and sick on any basis other than medical priority, urgency, or severity of wounds.
 - Allowing the interrogation of enemy wounded or sick even though medically contraindicated.
 - Allowing anyone to kill, torture, mistreat, or in anyway harm a wounded or sick enemy soldier.
 - Marking nonmedical unit facilities and vehicles with the distinctive emblem or making any other unlawful use of this emblem.
 - Using medical vehicles marked with distinctive Geneva emblem for transporting nonmedical troops, equipment, and supplies.
 - Using a medical vehicle as a TOC.
- e.* Possible consequences of violations described in *d* above are—
- Criminal prosecution for war crimes.
 - Reprisals taken against our wounded in the hands of the enemy.
 - Medical facilities attacked and destroyed by the enemy.
 - Medical personnel being considered prisoners of war rather than retained persons when captured.

APPENDIX H

SAMPLES OF HOSPITAL LAYOUT

A sample of a FH layout and a GH layout without a chemical and biological protected shelter system is shown in Figure H-1 and Figure H-2. The patient decontamination area shown is applicable for the hospital with or without collective protection. The patient decontamination area should be at least 30 to 50 yards downwind of the hospital. The actual layout of the hospital is contingent upon the METT-T factors and guidance provided by the hospital commander.

A layout for a FH/GH (HUB) with chemical and biological protected shelter system is shown in Figure H-3.

LEGEND:

- | | |
|-------------------------------|-----------------------------------|
| 1. BLOOD BANK | 23. FLUSH LATRINE AND BEDPAN WASH |
| 2. CMS | 24. BAG SEAL LATRINE |
| 3. DENTAL | 25. ADMINISTRATIVE |
| 4. ENT | 26. BEDPAN LAUNDRY |
| 5. EMT/TRIAGE/SURG | 27. CO HQ |
| 6. INTENSIVE CARE UNIT | 28. DINING HALL |
| 7. INTERCHANGE | 29. HOSPITAL HQ CMD |
| 8. INTERMEDIATE CARE WARD | 30. HOSPITAL OP |
| 9. LAB (GEN) | 31. KITCHEN |
| 10. MED MAINT | 32. LOG DIV |
| 11. MED SVC | 33. MAINTENANCE TENT |
| 12. NEUROPSYCHIATRIC | 34. MINIMAL CARE WARD |
| 13. OB/GYN | 35. PAD |
| 14. OPERATING ROOM | 36. PATIENT LATRINE |
| 15. ORTHOPEDIC | 37. RATION STORAGE |
| 16. PHARMACY | 38. SANITATION CENTER |
| 17. PRE-OP SURG | 39. SUPPLY |
| 18. PHYSICAL THERAPY/OT | 40. CHAPLAIN |
| 19. X-RAY | 41. ORTHO CAST |
| 20. PATIENT PROCESSING CENTER | 42. INPATIENT MED A |
| 21. WATER SUPPLY | 43. NURSING SERVICES |
| 22. RESUPPLY AIR LOCK | 44. CONVALESCENT CARE WARD |

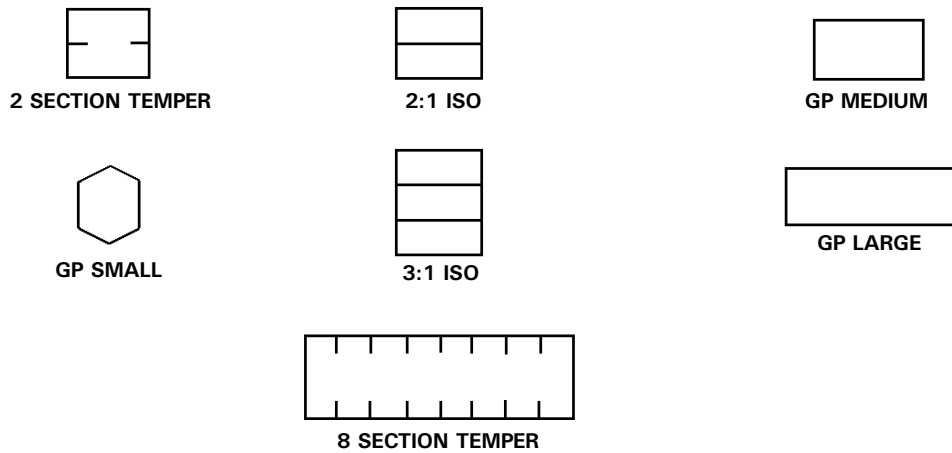


Figure H-1. Sample of a field hospital layout (continued).

LEGEND:

- | | |
|-------------------------------|-----------------------------------|
| 1. BLOOD BANK | 23. FLUSH LATRINE AND BEDPAN WASH |
| 2. CMS | 24. BAG SEAL LATRINE |
| 3. DENTAL | 25. ADMINISTRATIVE |
| 4. ENT | 26. BEDPAN LAUNDRY |
| 5. EMT/TRIAGE/SURG | 27. CO HQ |
| 6. INTENSIVE CARE UNIT | 28. DINING HALL |
| 7. INTERCHANGE | 29. HOSPITAL HQ CMD |
| 8. INTERMEDIATE CARE WARD | 30. HOSPITAL OP |
| 9. LAB (GEN) | 31. KITCHEN |
| 10. MED MAINT | 32. LOG DIV |
| 11. MED SVC | 33. MAINTENANCE TENT |
| 12. NEUROPSYCHIATRIC | 34. MINIMAL CARE WARD |
| 13. OB/GYN | 35. PAD |
| 14. OPERATING ROOM | 36. PATIENT LATRINE |
| 15. ORTHOPEDIC | 37. RATION STORAGE |
| 16. PHARMACY | 38. SANITATION CENTER |
| 17. PRE-OP SURG | 39. SUPPLY |
| 18. PHYSICAL THERAPY/OT | 40. CHAPLAIN |
| 19. X-RAY | 41. ORTHO CAST |
| 20. PATIENT PROCESSING CENTER | 42. INPATIENT MED A & B |
| 21. WATER SUPPLY | 43. NURSING SERVICES |
| 22. RESUPPLY AIR LOCK | 44. CONVALESCENT CARE WARD |

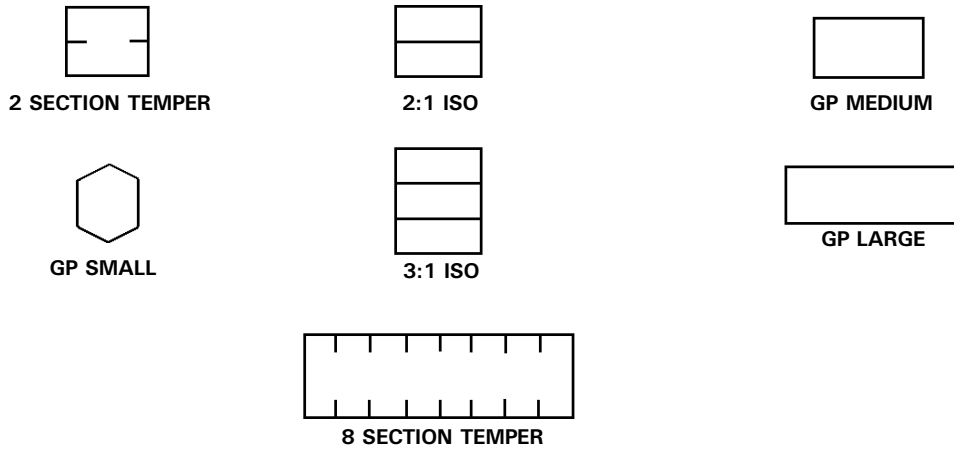


Figure H-2. Sample of a general hospital layout (continued).

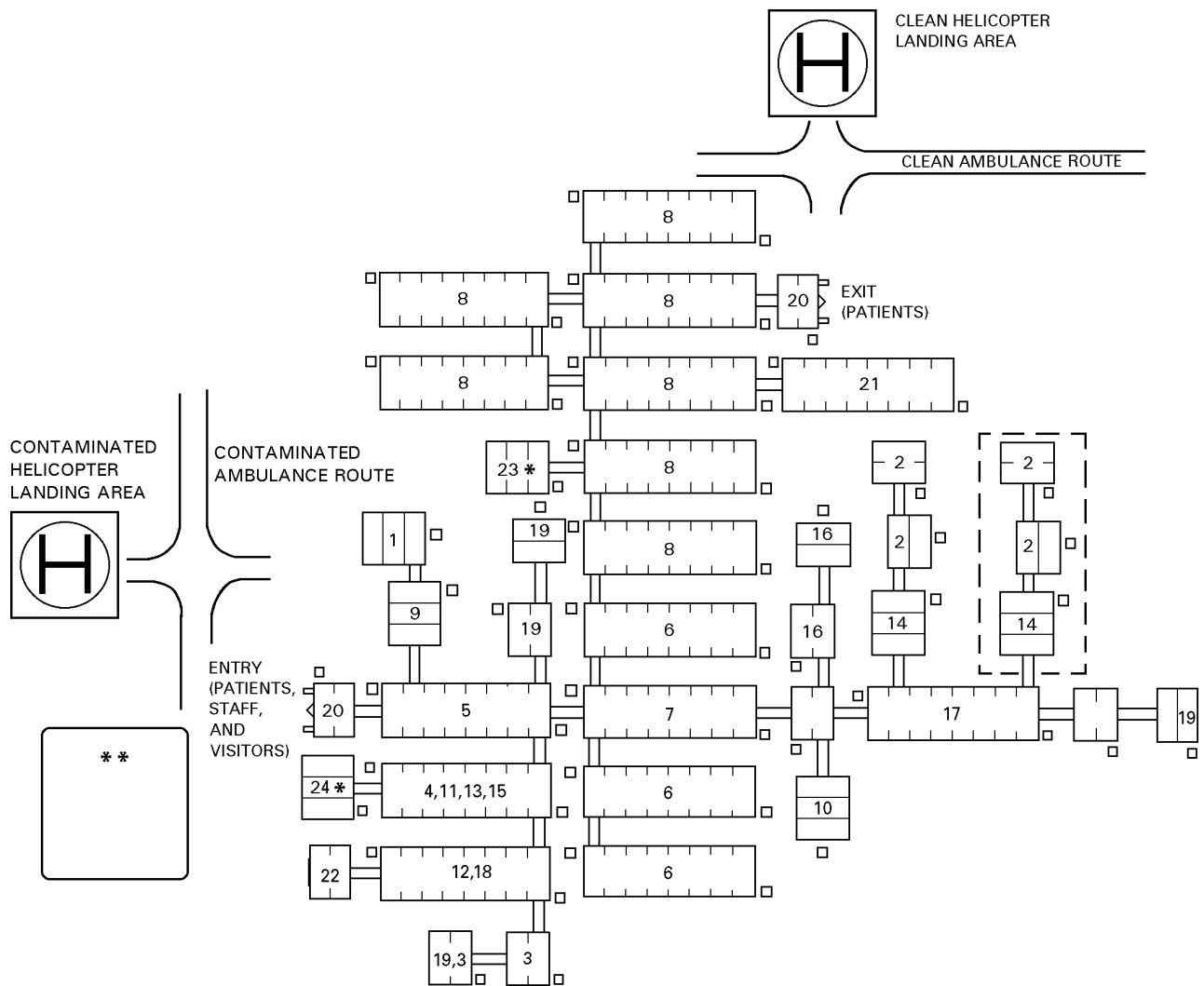


Figure H-3. Sample of a chemical and biological protected field/general hospital (HUB) layout.

LEGEND:

- | | |
|---------------------------|------------------------------------|
| 1. BLOOD BANK | 13. OB/GYN |
| 2. CMS | 14. OPERATING ROOM |
| 3. DENTAL | 15. ORTHOPEDIC |
| 4. ENT | 16. PHARMACY |
| 5. EMT/TRIAGE/SURG | 17. PRE-OP SURG |
| 6. INTENSIVE CARE UNIT | 18. PHYSICAL THERAPY/OT |
| 7. INTERCHANGE | 19. X-RAY |
| 8. INTERMEDIATE CARE WARD | 20. PATIENT PROCESSING CENTER |
| 9. LAB (GEN) | 21. WATER SUPPLY |
| 10. MED MAINT | 22. RESUPPLY AIR LOCK |
| 11. MED SVC | *23. FLUSH LATRINE AND BEDPAN WASH |
| 12. NEUROPSYCHIATRIC | *24. BAG SEAL LATRINE |

* CURRENTLY UNDER DEVELOPMENT AND TESTING. THE TYPE LATRINE SHOWN MAY OR MAY NOT BE FIELDIED.

** PATIENT DECONTAMINATION AREA. (SEE FM 8-10-7, HEALTH SERVICE SUPPORT IN A NUCLEAR, BIOLOGICAL, AND CHEMICAL ENVIRONMENT.)

— — — APPLICABLE TO A FIELD HOSPITAL ONLY.

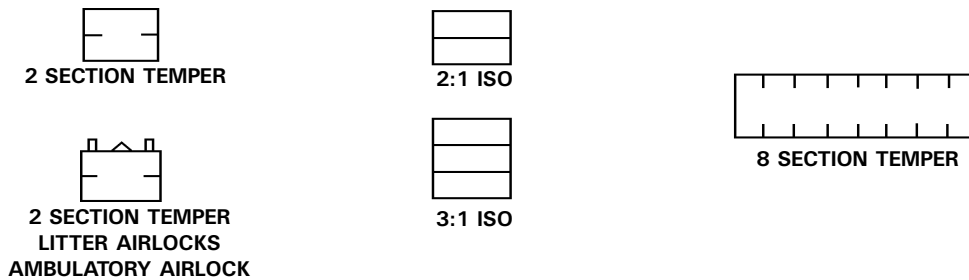


Figure H-3. Sample of a chemical and biological protected field/general hospital (HUB) layout (continued).

APPENDIX I

SAMPLE OPERATION ORDER WITH ANNEXES

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OPLAN 1234

References:

- a. Map series 1501, sheets NM 32-5 (FRANKFURT), edition 2, NM 32-8 (MANNHEIM), edition 3, 1:250000 scale.
- b. _____ General Hospital TSOP.
- c. Medical Command/Medical Brigade (Med Cmd/Med Bde) OPLAN 2987.
- d. _____ TA OPLAN 222.

Time Zone Used Throughout the Plan: ZULU

Task Organization: General Hospital
 Medical Service, Medical Teams
 Medical Service, Surgical Teams

1. SITUATION.

a. *Enemy Forces.*

(1) The _____ TA is opposed by two corps estimated to be approximately 95 percent strength. These ground forces are supported by a helicopter company and an artillery battery which is capable of mass artillery barrages within a 10-mile radius and attack helicopter strikes within 20 miles. Intelligence indicates that the full range of radio electronic combat elements will be employed to gather intelligence and to degrade the effectiveness of friendly C2 nets through the use of electronic warfare. The threat has the ability to deliver nuclear weapons and/or chemical agents into the TAACOM. Intelligence also indicates that threat will employ tactical air (TACAIR), airborne/airmobile regular army units and local guerilla units in the TAACOM and theater to disrupt/destroy CSS operations.

(Classification)

(Classification)

OPLAN 1234- _____ GH

(2) See current intelligence summary.

b. Friendly Forces.

(1) Theater Army attack 120500 June through elements of the 1st and 2nd Threat Corps with two corps abreast. 1st Corps on the left (east) conducts main attack; 2nd Corps on the right (west) conducts supporting attack. 3rd Corps follows in zone of 1st Corps secures FREISING (QU0364) and MOOSBURG (QU1773) and prepares to continue attack on to S and SW.

(2) Provide hospitalization support to TA units on area basis. Defend the hospital area within the base cluster defense when attacked.

c. Attachments and Detachments.

d. Assumptions.

(1) The GH with assigned and attached elements will be in place and prepared to support TA.

(2) There will be air parity.

(3) Both threat and friendly forces possess the capability to initiate nuclear or chemical warfare, limited or full scale, in any combination.

(4) Med Cmd/Med Bde OPLAN 2987 has been implemented.

2. MISSION. Provide hospitalization support to the TA.

3. EXECUTION.

a. General Hospital. Provide hospitalization support for TA tactical operations. Render resuscitative care and medical treatment of critically injured or ill patients requiring highly specialized care and surgical and medical services for patients held for definitive treatment. Patients identified as NRTD will be prepared for evacuation to CONUS.

b. Boundaries. Annex B (Operations Overlay), TA OPLAN 222.

c. Coordinating Instructions.

(Classification)

(Classification)

OPLAN 1234- _____ GH

- (1) This OPLAN is effective for planning upon receipt; executing on order.
 - (2) All elements provide closing notification upon arrival at designated operating locations with projected operational capability attainment until fully mission capable.
 - (3) Units located in TAACOM will comply with defense and area damage control procedures established by the TAACOM commander.
 - (4) Chemical MOPP 1 is in effect. Be prepared to increase MOPP on short notice.
 - (5) Operation Security. Annex K, Med Cmd/Med Bde OPLAN 2987 and Annex L, TA OPLAN 222.
 - (6) Movement Annex for TAACOM units to be prepared separately.
4. SERVICE SUPPORT. See Annex B (Service Support).
 5. COMMAND AND SIGNAL.
 - a. *Command.* General Hospital located at VIC MA779705.
 - b. *Signal.*
 - (1) Current SOI in effect.
 - (2) Minimize is in effect for FM radio traffic until lifted by GH commander.

Acknowledge.

CDR
COL

OFFICIAL:
/s/

Annexes:

- A. Operational Overlay
- B. Road Movement
- C. Service Support
- D. Rear Operations

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ANNEX A (OPERATIONAL OVERLAY) TO OPLAN 1234- _____ GH

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ANNEX B (ROAD MOVEMENT) TO OPLAN 1234- _____ GH

References:

- a. Map series 1501, sheets NM 35-2 (FRANKFURT), edition 2, NM 32-8, edition 3, 1:250000 scale.
- b. _____ General Hospital TSOP.

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ANNEX B (ROAD MOVEMENT) TO OPLAN 1234- _____ GH

- c. Med Cmd/Med Bde OPLAN 2987.
- d. Theater Army OPLAN 222.

Time Zone Used Throughout the Plan: ZULU

1. SITUATION.

a. Enemy Forces. The enemy capability to conduct road interdiction through mining and demolition generally along the route is acknowledged. However, it is anticipated that the enemy will limit their interdictions to the intent consistent with meeting specific military objectives in ambush attack operations. The enemy capability to conduct simultaneous and multiple convoy ambush operations at critical areas exists. However, this is unlikely because of the restriction on convoy movement within the TAACOM.

b. Friendly Forces.

(1) Theater Army Area Command units move night of 21-22 June 19XX to assembly area VIC GRAFTON (UV 6302).

(2) Aerial observation and close air support is provided by the USAF.

(3) Battery B, 317th Artillery provides artillery support, as required.

(4) Medical support will be provided by _____.

(5) The 504th Main Support Battalion (Rear) provides transportation support, as required.

2. MISSION. General hospital move commencing 210300 June 19XX to an AO to support _____ TA tactical mission.

3. EXECUTION.

a. Concept of Operations. General hospital conducts a tactical road march in four echelons over two routes to a new AO. First echelon crossing SP 210300 June and last echelon crossing RP 220546 June.

b. Convoy Organization.

 (Classification)

(Classification)

ANNEX B (ROAD MOVEMENT) TO OPLAN 1234- _____ GH

(1) Echelon 1: Advance/Quartering Party

(2) Echelon 2.

Hospital Headquarters	HUB
Supply and Service Division	HUS
Triage/Preoperative/EMT	HUS
Operating Room/CMS Control Team	HUS
Operating Room A/B	HUB
Inpatient Medicine A	HUB
Three ICU Wards	HUB
Four ICWs	HUB
Laboratory	HUB
Blood Bank	HUB
X-Ray	HUB
Pharmacy	HUB
Two CMSs	HUS
Orthopedic Cast Clinic	HUS
Litter Bearer Section	HUB

(3) Echelon 3.

Neuropsychiatric Service and Ward	HUB
Operating Room C/D	HUS
Inpatient Medicine B	HUM
Two ICU Wards	HUS
Two ICWs	HUB
Four ICWs	HUM
Two Minimal Care Wards	HUB
Two CMSs	HUB

(4) Echelon 4. All remaining elements of the hospital.

c. *Tasks to Subordinate Elements.* Supply and Service Division will provide recovery support along the route.

d. *Checkpoints.* Checkpoints are listed below:

(Classification)

(Classification)

ANNEX B (ROAD MOVEMENT) TO OPLAN 1234- _____ GH

CHECKPOINTS	COORDINATES	KILOMETERS BETWEEN CHECKPOINTS
SP	721624	19.8
40	711121	12.4
12	701243	22.3
93	693240	12.1
77	695179	12.1
RP	711234	11.9

e. Coordinating Instructions.

- (1) Advance/quartermen party assemble at GH dismount point 210200 June.
- (2) Formation: Close Column.
- (3) Time Gap: 8 hours between echelons
- (4) Appendix 1, Road Movement Table.
- (5) Appendix 2, Route Overlay.

4. SERVICE SUPPORT. Traffic control (TC).

a. Quartermen Party will drop two-man TC teams at Critical Points 1, 2, and 4. Military police will be responsible for traffic control points (TCP) at Blue River and in the town of Manly.

b. Recovery.

- (1) Units will recover organic vehicles that breakdown along the route.
- (2) Ordnance (heavy equipment maintenance) company, general support, trail echelon will recover all vehicles beyond self recovery capability.

c. Medical.

- (1) Emergency medical treatment/triage/preoperative will provide treatment services.

(Classification)

(Classification)

ANNEX B (ROAD MOVEMENT) TO OPLAN 1234- _____ GH

(2) Aeromedical evacuation procedures (Medical Annex, TSOP).

5. COMMAND AND SIGNAL.

a. Command.

(1) Command post (CP) and command group with Echelon 2.

(2) Command post opening, closing times, and locations to be announced.

b. Signal

(1) Signal operation instructions Index 1—12 in effect.

(2) Listening silence effective 211300 June.

Acknowledge.

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Appendixes:

1. Road Movement Table
2. Route Overlay

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APPENDIX 1 (ROAD MOVEMENT TABLE) TO ANNEX B (ROAD MOVEMENT), OPLAN 1234- ____ GH

Map Reference: Map series 1501, sheets NM 35-2 (FRANKFURT), edition 2, NM 32-8, edition 3, 1:250000 scale.

Time Zone Used Throughout the Order: ZULU

General Data:

1. Average speed:
2. Traffic density:
3. Halts:
4. Critical points:
 - a. Starting point:
 - b. Release point:
 - c. Other critical points:
 - d. Route classification:
 - e. Route restrictions:
5. Main route to SP:
6. Main route to RP:

(Classification)

(Classification)

APPENDIX 1 (ROAD MOVEMENT TABLE) TO ANNEX B (ROAD MOVEMENT), OPLAN 1234- __ GH

March Unit Date	Number of Unit Vehicles	Class of Heaviest Vehicles	From	To	Route	Critical Points

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APPENDIX 2 (ROUTE OVERLAY) TO ANNEX B (ROAD MOVEMENT), OPOD 1234- _____ GH

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ANNEX C (SERVICE SUPPORT) TO OPLAN 1234- _____ GH

1. GENERAL. This annex provides the support plan for _____ TA. Combat service support will be provided/coordinated through the GH staff and the Med Cmd/Med Bde Deputy Chief of Staff for Logistics (DCSLOG).

(Classification)

(Classification)

ANNEX C (SERVICE SUPPORT) TO OPLAN 1234- _____ GH

2. MATERIAL AND SERVICES.

a. Supply.

(1) Class I. The TA support command will operate ration supply points for Med Cmd/Med Bde and its supporting units.

(2) Water. The 504th Main Support Battalion (Rear) will operate the water points. Water requirements will be coordinated through the Med Cmd/Med Bde DCS, Security, Plans, and Operations (SPO) and may be located in the TAACOM.

(3) Class II, III (package & bulk).

(a) Class II, III (package).

1. Supply point distribution from main support battalion (rear), TA support group.

2. Request will be submitted to GH operations section.

(b) Class III (bulk).

1. Supply point distribution from any Class III supply point.

2. Allocations will be provided by the Med Cmd/Med Bde, DCSLOG, when required.

(4) Class IV.

(a) Supply point distribution. Selected Class IV materials issued by the main support battalion (rear), TA support group.

(b) Class IV priorities assigned by the TA support group.

(c) The following controlled items will be requisitioned through command channels.

1. Culvert nestable, 60 feet.

(Classification)

 (Classification)

ANNEX C (SERVICE SUPPORT) TO OPLAN 1234- _____ GH

2. Lumber, softwood, 2X4, random length.

(5) Class V.

(a) Ammunition transfer point (ATP) will be operated by the main support battalion (rear), TA support group.

(b) Controlled supply rate (CSR) for items in critical shortage will be listed in this paragraph.

(c) Units will maintain basic loads.

(6) Class VII.

(a) Selected Class VII will be stocked by the ordnance (light equipment maintenance) company, general support.

(b) Requests to fill TOE shortages will be submitted to Med Cmd/Med Bde DCSLOG citing TOE authority. Battle loss replacement will be requested by submitting Daily Battle Loss Reports in accordance with field SOP. The Med Cmd/Med Bde DCSLOG will forward request to TA support group Assistant Chief of Staff, G4 (Logistics).

(7) Class VIII. Medical logistical battalion (rear) provides Class VIII support on a supply point distribution basis.

(8) Class IX.

(a) Ordnance (light equipment maintenance) company, general support, provides repair parts support.

(b) Stockage objectives. Direct support: 15 days of authorized stockage list items.

(c) Major critical shortages exists for the following items:

1. Monitor - Recorder M79195, electrocardiogram (ECG).

2. Light, Surgical Field L65295, 110-volt AC or 24-volt direct current (DC).

 (Classification)

(Classification)

ANNEX C (SERVICE SUPPORT) TO OPLAN 1234- _____ GH

(d) Cannibalization. Unserviceable end items and major assemblies will be evacuated to the ordnance (light equipment maintenance) company, general support, ordnance (maintenance) battalion TAACOM collection points. Controlled exchange may be performed at the discretion of the hospital commander.

(9) Class X. Civil relief supply requirements will be approved by Med Cmd/Med Bde and coordinated through the DCSSPO.

(10) Maps are provided by the Med Cmd/Med Bde DCSLOG.

(11) Captured enemy materials.

(a) Will be reported to Med Cmd/Med Bde DCSSPO for disposition instructions.

(b) Enemy rations and medical supplies will not be utilized or consumed by Med Cmd/Med Bde DCS Personnel (PER).

(12) Excess supplies. All elements will report excess supplies through supply channels to Med Cmd/Med Bde DCSLOG for disposition instructions.

b. Transportation.

(1) All main supply routes (MSRs) are two-way.

(2) Ten or more vehicles dispatched to the same destination from one point of origin constitutes a convoy.

(3) Elements coordinate convoy movements with the Med Cmd/Med Bde DCSSPO.

(4) Emergency resupply requirements will be submitted through command channels.

c. Services.

(1) Construction efforts will be limited to the minimum essential required.

(2) Theater Army units will evacuate remains to the nearest TAACOM graves registration (GRREG) collection point. Collection points will be operated by the TAACOM GRREG battalion.

(Classification)

(Classification)

ANNEX C (SERVICE SUPPORT) TO OPLAN 1234- _____ GH

(3) Clothing exchange and bath services will be coordinated by Med Cmd/Med Bde DCSLOG.

d. Maintenance.

(1) Maintenance collection points will be established in the TAACOM by the TA ASG.

(2) Priority of maintenance is to the 1st Corps.

(3) Repair time limits: 48 hours. If an item will be deadlined in excess of 24 hours and otherwise qualifies for float, it may be exchanged for a serviceable like item at the discretion of the GH commander in coordination with Med Cmd/Med Bde commander.

3. MEDICAL EVACUATION AND HOSPITALIZATION.

a. Evacuation.

(1) Theater evacuation policy is 30 days.

(2) Primary means of evacuation is ground ambulance.

(3) Preferred means of evacuation is air ambulance.

b. Hospitalization.

(1) Medical facilities forward of division boundaries will camouflage.

(2) Hospitalization will be provided by the _____ Hospital.

4. PERSONNEL.

a. Maintenance of Unit Strength. Replacements will be assigned to units based upon priority of the commander.

b. Personnel Management.

(1) Enemy prisoners of war and civilian internees. Med Cmd/Med Bde evacuates EPW to TA collection points. Enemy prisoners of war from a chemical, biological, or nuclear unit will be reported immediately to the Med Cmd/Med Bde command channel.

(Classification)

(Classification)

ANNEX C (SERVICE SUPPORT) TO OPLAN 1234- _____ GH

(2) Military prisoners. Theater Army headquarters will retain military prisoners until sentences are approved.

c. Development and Maintenance of Morale.

(1) Morale and personnel services.

(a) Postal, personnel/administrative, and financial services provided to Med Cmd/Med Bde by TA PERSCOM contact teams.

(b) Legal services will be requested from Med Cmd/Med Bde through the DCSPER.

(2) Graves registration.

(a) Army cemeteries will not be established.

(b) Concurrent return program is in effect.

(c) Isolated or mass burials are not authorized unless approved by the TA commander. In emergencies, commanders may request such burials through TOC channels. When authorized, report number of remains, identify (by nationality, sex, age grouping, and name, if possible) cause of deaths to the Med Cmd/Med Bde Headquarters, ATTN: DCSPER, within 48 hours of burial.

(3) Maintenance of discipline, law, and order.

(a) Commanders will give special attention to the problems of illegal sale and bartering of military supplies and equipment. Incidents will be reported to appropriate criminal investigation or military police unit.

(b) Claims by indigenous personnel will be reported to the Med Cmd/Med Bde DCSSPO.

5. CIVIL-MILITARY OPERATIONS.

a. The TA Civil Affairs Brigade's Assistant Chief of Staff, G5 (Civil Affairs) provides civil affairs support.

b. 288th Psychological Operations Company provides psychological operation support.

(Classification)

(Classification)

ANNEX C (SERVICE SUPPORT) TO OPLAN 1234- _____ GH

c. All civil affairs/psychological operations-related activities will be coordinated through Med Cmd/Med Bde CMO.

6. MISCELLANEOUS.

a. Hospital elements submit a Daily Battle Loss Report twice each day to the Med Cmd/Med Bde and GH. Reporting periods are 0001 to 1200, due NLT 1400; 1201 to 2400, due NLT 0400 the following day.

b. See Reports TSOP.

Acknowledge.

CDR
COL

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Copy No. _____ of _____ Copies
GH, MED CMD/MED BDE _____ TA
Anywhere, USA
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ANNEX D (REAR BATTLE OPERATIONS) TO OPLAN 1234- _____ GH

1. SITUATION. OPLAN 1234- _____ GH.
2. MISSION. The GH provides hospitalization support within the corps support area.
3. EXECUTION.

a. Concept of Operations. With rear security operations as a primary consideration, units in the TAACOM will establish individual bases for rear security. The base cluster will have an appointed commander who will form and operate the base defense operations center on a 24-hour basis. Base commanders are responsible for their own base defense and base damage control. Base cluster commander will coordinate and supervise base defense within cluster. Under direction Med Cmd/Med Bde DCSSPOs, supporting military police will respond to bases under attack by threat forces. The Med Cmd/Med Bde DCSSPO will request commitment of TA reserve forces should a threat attack occur in the TAACOM. Base commanders will request support from the TAACOM base cluster operations center. Any rear operations liaison or technical support provided by the TAACOM will be collocated with Med Cmd/Med Bde headquarters.

b. Base Cluster Operations Center/Tactical Operations Center.

- (1) Provide protection.
- (2) Request support.
- (3) Request area damage control support.

c. Med Cmd/Med Bde Deputy Chief of Staff, Signal Property Office.

- (1) Disseminate tactical information to GH CP.
- (2) Forward request for assistance from GH.
- (3) Forward priority communications from GH.
- (4) Monitor base defense preparedness.

(Classification)

(Classification)

ANNEX D (REAR BATTLE OPERATIONS) TO OPLAN 1234- _____ GH

d. Coordinating Instructions.

(1) Reporting enemy activities. Individual units within a base defense cluster will report all observed enemy acts and any locally gathered intelligence data to the base defense operations center and next higher headquarters.

(2) Barrier and denial. No barrier and denial operations will be conducted without approval of the headquarters.

4. SERVICE SUPPORT. Annex C.

5. COMMAND AND SIGNAL.

a. Command. Command of rear operations in the TAACOM as directed by corps support area base defense operations center (MA676988).

b. Signal. Current SOI/signal standing instructions in effect.

Acknowledge.

CDR
COL

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GLOSSARY

ABBREVIATIONS AND ACRONYMS

AAD admissions and dispositions

ABO blood type/group

AC Active Component; alternating current

ACR armored cavalry regiment

ACUS area common-user system

ADA air defense artillery

admin administration/administrative

AFMIC Armed Forces Medical Intelligence Center

ALT alanine aminotransferase

AM amplitude modulated

AMC Air Mobility Command

AMEDD Army Medical Department

AMEDDC&S Army Medical Department Center and School

AN Army Nurse Corps

AO area of operations

AR Army Regulation

ARC Arctic

ARTEP Army Training and Evaluation Program

arty artillery

ASG area support group

ASI additional skill identifier

ASMB area support medical battalion

FM 8-10-15

asst assistant

AST aspartate aminotransferase

ATM advance trauma management

ATP ammunition transfer point

ATTN attention

aug augmentation

avn aviation

AWOL absent without leave

BAQ basic allowance for quarters

BBPCT blocking, bracing, packing, crating, and tie-down

bde brigade

BEQ bachelor enlisted quarters

BFC battle fatigue casualty

bn battalion

BOIP basis of issue plan

BOQ bachelor officer quarters

BTC Blood Transshipment Center

C2 command and control

C2W command and control warfare

C4I command, control, communications, computers, and intelligence

CA Civil Affairs

CDC Centers for Disease Control

CDR commander

Glossary-2

CD-ROM compact disk-read only memory

CE communications-electronics

CH chaplain

CHS combat health support

CI counterintelligence

CK creatine kinase

Cl chlorine

cm centimeter

CMD command

CMO civil-military operations

CMS central materiel service

CNR combat net radio

cntrl control

co company

CO₂ carbon dioxide

COL colonel

comm communications

COMMZ communications zone

COMSEC communications security

cont control

CONUS continental United States

COSCOM corps support command

COTS commercial off-the-shelf

FM 8-10-15

CP command post

CPT captain

CPU central processing unit

CS combat support

CSC combat stress control

CSF cerebrospinal fluid

CSH combat support hospital

CSM command sergeant major

CSR controlled supply rate

CSS combat service support

CSSCS Combat Service Support Control System

CTA common table of allowances

CTASC II Corps/Theater Automated Support Center Phase II

cu cubic

CZ combat zone

DA Department of the Army

DAMMS-R Department of the Army Movement Management System-Redesigned

DBSS Defense Blood Standard System

DC Dental Corps; direct current

DCS Deputy Chief of Staff

DCSLOG Deputy Chief of Staff for Logistics

DCSPER Deputy Chief of Staff for Personnel

DD Department of Defense

Glossary-4

DE directed energy

decon decontamination

DEERS defense eligibility enrollment system

DEFCON defense readiness condition

deg degree

dent dental

DEPMEDS Deployable Medical Systems

det detachment

div division

DLA Defense Logistics Agency

DMSO division medical supply office

DNA deoxyribonucleic acid

DNBI disease and nonbattle injury

DNVT digital nonsecure voice telephone

DOD Department of Defense

DOS disk operating system

DSN Defense Switched Network

DVA Department of Veterans Affairs

EAC echelon above corps

ECG electrocardiogram

EEFI essential elements of friendly information

EMT emergency medical treatment

ENCOM Engineer Command

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enr engineer

ENT ear, nose, and throat

EOC emergency operations center

EPW enemy prisoner(s) of war

evac evacuation

EW electronic warfare

FA field artillery

FAO finance and accounting office

FAX facsimile

FH field hospital

FM frequency modulated; field manual (when used with a number)

FORSCOM United States Army Forces Command

FRAGO fragmentary orders

FSC Federal supply classification

FSN Federal stock number

FST forward surgical team

ft feet/foot

FWD forward

G3 Assistant Chief of Staff (Operations and Plans)

G5 Assistant Chief of Staff (Civil Affairs)

gal gallon(s)

GH general hospital

gp group

Glossary-6

GPS global positioning system
grp group
GRREG graves registration
H&S heat and serve
HCP health and comfort pack
Hct hematocrit
Hgb hemoglobin
HHC Headquarters and Headquarters Company
HIV human immunodeficiency virus
hlth health
HN host nation
hosp hospital
HQ Headquarters
HUB hospital unit, base
HUH hospital unit, holding
HUM hospital unit, medical
HUS hospital unit, surgical
IAW in accordance with
ICR individually carried record
ICU intensive care unit
ICW intermediate care ward
IHFR improved high-frequency radio
IM infectious mononucleosis

FM 8-10-15

INMARSAT International Maritime Satellite

INSCOM Intelligence and Security Command

ISO International Organization for Standardization

IV intravenous

K potassium

kHz kilohertz

km kilometer

KOH potassium hydroxide

kw kilowatt

LAB laboratory

LAN local area network

lbs pounds

LDF lightweight digital facsimile

LIN line item number

LOC lines of communications (logistics routes)

LOG logistics

LOGMARS logistics applications of automated marking and reading symbols

LT lieutenant

LTC lieutenant colonel

MA mortuary affairs

maint maintenance

MAJ major

MASF mobile aeromedical staging facilities

Glossary-8

mat materiel

MC Medical Corps

MCC movement control center

MCT movement control team

MCW minimal care ward

med medical/medicine

MEDASM medical assemblage management

MEDCOM medical command

MEDLOG medical logistics

MEDMNT medical maintenance

MEDPAR medical patient accounting and reporting

MEDREG medical regulating

MEDSUP medical supply

MEDTCU medical transportable computer unit

METT-T mission, enemy, terrain, troops, and time available

MHE materiel handling equipment

MHz megahertz

MI military intelligence

MILVAN military-owned demountable container

min minute

MLRS Multiple Launch Rocket System

mm millimeter

MMC Materiel Management Center

FM 8-10-15

MOPP mission-oriented protective posture

MOS military occupational specialty

MP military police

MRC-E Major Regional Conflict-East

MRC-W Major Regional Conflict-West

MRE meal(s), ready to eat

MS Medical Service Corps

MSE mobile subscriber equipment

MSG master sergeant

MSR main supply route

MSRT mobile subscriber radiotelephone terminal

MTF medical treatment facility

MTOE modification tables(s) of organization and equipment

MTP mission training plan

Na sodium

NATO North Atlantic Treaty Organization

NBC nuclear, biological, and chemical

NBI nonbattle injury

NC node center/noncommissioned

NCO noncommissioned officer

NCOIC noncommissioned officer in charge

NCS net control station

NEA Northeast Asia

Glossary-10

NLT not later than

NP neuropsychiatric

NRTD nonreturn to duty

NSN national stock number

nur nursing

OB/GYN obstetrics/gynecology

OCONUS outside continental United States

OP/op operation(s); operator

OPCON operational control

OPFAC operational facility

OPLAN operation plan

OPORD operation order

OPSEC operations security

OR operating room

ortho orthopedic

OSHA Occupational Safety and Health Act

OT occupational therapy

oz ounce

PA physician assistant

PAC Personnel and Administration Center

PAD Patient Administration Division

Pam pamphlet

para paragraph

FM 8-10-15

PDC personnel data card

PDS personnel daily summary

PERSCOM personnel command

PFC private first class

PIR priority intelligence requirements

PLL prescribed load list

PMCS preventive maintenance checks and services

PMD pounds per man per day

pnt patient

POE port of embarkation

POL petroleum, oils, and lubricants

POM preparation for oversea movement

POMCUS pre-positioning of materiel configured to unit sets

POR preparation of replacements for oversea movement

POS/NAV position/navigation

POV privately owned vehicle

PRE-OP preoperative

PROFIS professional officer filler system

PSNCO personnel staff noncommissioned officer

PT preventive medicine

PVNTMED preventive medicine

RAU radio access unit

RBC red blood cell

Glossary-12

RC Reserve Component

rem roentgen equivalent man

Rh rhesus factor

RMW regulated medical waste

ROP reorder point

RP release point

RPF real property facility

RPR rapid plasma reagin

RTD return to duty

S1 Adjutant (US Army)

S2 Intelligence Officer (US Army)

S3 Operations and Training Officer (US Army)

SARSS Standard Army Retail Supply System

SB supply bulletin

SC special category

SCC system control center

sec section

sep separate

SF standard form

SFC sergeant first class

SGT sergeant

SI seriously ill

SIDPERS Standard Installation/Division Personnel System

FM 8-10-15

SIGSEC signal security

SINGARS single-channel ground and airborne radio system

SOI signal operation instructions

SOP standing operating procedure

SP Specialist Corps/start point

SPBS-R Standard Property Book System-Revised

SPC/SPEC specialist

SPO security, plans, and operations

spt support

sq square

SSG staff sergeant

SSSC self-service supply center

STANAG Standardization Agreement

STANFINS Standard Financial System

sup supply

SVC service(s)

SVGA super video graphics applications

SWA Southwest Asia

TA theater Army

TAA total Army analysis

TAACOM Theater Army Area Command

TACAIR tactical air

TACCS Tactical Army CSS Computer System

TAMCA Theater Army Movement Control Agency
TAML Theater Army Medical Laboratory
TAMMIS Theater Army Medical Management Information System
TAMMS The Army Maintenance Management System
TASG Theater Army Support Group
TAT to accompany troops
TB MED technical bulletin medical
TC traffic control; training circular (when used with a number)
TCMD transportation control and movement document
TCP traffic control point
tech technician
TEMPER tent, extendable, modular, personnel
TM technical manual
TMMMC Theater Medical Materiel Management Center
TO theater of operations
TOC tactical operations center
TOE table(s) of organization and equipment
TPFDDL Time-Phased Force Deployment Data List
TRI-TAC triservice tactical communications
TSOP tactical standing operating procedure
UCMJ Uniform Code of Military Justice
UMD unit movement data
UMT unit ministry team

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UPS uninterruptible power supply

US United States

USACHPPM US Army Center for Health Promotion and Preventive Medicine

USAF United States Air Force

util utility

vs versus

VSI very seriously ill

W2 warrant officer, second grade

W3 warrant officer, third grade

WBC white blood cell

WIA wounded in action

WO warrant officer

XO executive officer

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