FM 8-10-3

DIVISION MEDICAL OPERATIONS CENTER

TACTICS, TECHNIQUES, AND PROCEDURES

HEADQUARTERS, DEPARTMENT OF THE ARMY

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DIVISION MEDICAL OPERATIONS CENTER TACTICS, TECHNIQUES, AND PROCEDURES

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Table 1-2. Interface Between DMOC and Division Staff Section

SUBJECT	DIVISION STAFF SECTION
CASUALTY ESTIMATES	G1
ARMY AIRSPACE COMMAND AND CONTROL	G3-AIR
HEALTH CARE POLICY	G1/G3
CIVIL AFFAIRS AND HOST-NATION SUPPORT	G5
FOOD SERVICE AND PREVENTIVE MEDICINE ISSUES	G4
CLASS VIII PLANNING FACTORS	G4

Table 1-3. Areas of Mutual Interest for DMOC and Division Staff

SUBJECT	DIVISION STAFF SECTION
MEDICAL INTELLIGENCE	G2
COMBAT HEALTH SUPPORT	G1/G3
CONTINGENCY OPERATIONS	G3
REPLACEMENT AND RECONSTITUTION OPERATIONS	G1/G3/G4
PREVENTIVE MEDICINE	G1/G2/G3/G4
CIVIL AFFAIRS/HOST-NATION SUPPORT	G5/G3/G4
ENEMY PRISONER OF WAR OPERATIONS	G1/G2/G3
MASS CASUALTY PLAN	G1/G2/G3/G4
NUCLEAR, BIOLOGICAL, CHEMICAL DEFENSE	G1/G2/G3/G4

1-12. Interface with the Major Commands of the Division

a. Combat Brigades. Interface with each of the combat brigades is accomplished with the S2 and S3 sections. This interface will focus on CHL and CHS requirements for the brigades. It also includes coordination for A2C2 information for air evacuation assets supporting maneuver elements.

b. Aviation Brigade. Interactions between the aviation brigade and the DMOC may include—

- Coordination for area medical support.
- Coordination for evacuation of patients using helicopters with heavy lift capabilities (CH 47).
- Coordination for air delivery of Class VIII emergency resupply.
- Coordination for appropriate aviation plans and overlays supporting division operations.
- Coordination for aviation logistics support (aviation fuel maintenance and spare parts) to support air ambulances, when required.
- Coordination for aviation weather information from the USAF WX detachment in the aviation brigade.

1-13. Interface with the Main Support Battalion

Information pertaining to the structure and operations of the MSB is provided in FM 63-21. The DMOC will interface with elements of the MSB, as required and approved by the DISCOM commander. The DMOC may interface with elements of the MSB through the DISCOM support operations section. The interactions and coordination between the DMOC and the MSB are driven by CHS requirements of the division and changes with the tactical situation. These interactions are conducted through two different channels of communications-the command channel and the technical medical channel. Communications which take place through the technical channel pertain to CHS operations, coordination activities, patient evacuation, medical resupply, and medical personnel and equipment status reports. This technical channel of communications is designed to enhance reaction time of MSB elements to CHS operations requirements. The chief, DMOC, and the MSB commander must develop policies and procedures which clearly delineate responsibilities and coordination requirements' for an effective working relationship. Tasking of the MSMC elements by the DISCOM will be through command channels.

a. The MSB S2/S3 is the focal point for internal operations for the battalion. It supervises technical and military intelligence gathering as well as formulates plans specifically geared to the battalion's mission. The S2/S3 and DMOC interface pertains to the following subject areas:

- Position of MSMC within the MSB's area of operations (AO).
- Status reports on tactical situation and conditions along main supply routes (MSRs).

b. Support operations section of the MSB is responsible for the supervision of logistical activities that are the primary mission of the battalion. The DMOC interfaces with the health service support officer (HSSO) assigned to this section concerning—

- Combat health support planning.

- Main support battalion medical elements tasking, to include reinforcement and reconstitution requirements throughout the division.
- Class VIII resupply.
- Evacuation of patients using nonmedical vehicles.
- Corps CHS elements/units attached to the MSB.

c. The MSMC provides division- and unit-level CHS and medical staff advice and assistance on an area basis to units operating in the DSA. Combat health support operations are coordinated by the DISCOM DMOC medical operations branch through technical channels. The DISCOM will task elements of the MSMC through command channels to provide division-level CHS. The interface between the MSMC and the DMOC is essential for providing required division CHS. The interaction and information exchange which is conducted through the technical medical channel is shown in Table 1-4.

Table 1-4. DMOC Interface with the Main Support Battalion

SUBJECT AREA	MSB	DMOC
COMBAT HEALTH SUPPORT	SPT OPS/HSSO, MSMC HQ	MED OPS BR
THREAT UPDATE/INFORMATION	S2/S3 SEC, MSMC HQ	MED OPS BR
OPERATIONS/PLANNING	SPT OPS/HSSO, MSMC HQ	MED OPS BR
AREA MEDICAL/DENTAL SUPPORT	SPT OPS/HSSO, MSMC HQ TREATMENT PLT HQ	MED OPS BR MED OPS BR PNT DISP/RPTS BR
EVACUATION OPERATIONS	SPT OPS/HSSO, MSMC HQ MSMC HQ MSMC AMBULANCE PLT	MED OPS BR MED OPS BR MED OPS BR
COMBAT HEALTH LOGISTICS	SPT OPS/HSSO MSMC HQ DMSO	MED OPS BR MED OPS BR MED MAT MGT BR
DIVISION PVNTMED PROGRAM	SPT OPS/HSSO MSMC HQ PVNTMED SECTION	MED OPS BR MED OPS BR
DIVISION MENTAL HEALTH PROGRAM	MSMC HQ	MED OPS BR
COMBAT STRESS CONTROL	MENTAL HEALTH SECTION SPT OPS/HSSO	MED OPS BR
DIVISION PSYCHIATRIC SERVICE	MENTAL HEALTH SECTION	MED OPS BR

Table 1-4. DMOC Interface with the Main Support Battalion (Continued)

SUBJECT AREA	MSB	DMOC
COMMUNICATIONS	MSMC HQ	MED OPS BR COMM BR
OPTOMETRY SERVICE	MSMC HQ OPTOMETRY SECTION DMSO	MED MAT MGT BR
REINFORCEMENT/RECONSTITUTION OF FORWARD MEDICAL ELEMENTS	SPT OPS/HSSO MSMC HQ TREATMENT PLT AMBULANCE PLT DMSO MENTAL HEALTH SECTION PVNTMED SECTION	MED OPS BR
CORPS MEDICAL ELEMENTS ATTACHED TO MSB	S3/SPT OPS/HSSO MSMC HQ	MED OPS BR MED OPS BR
RECORDS/REPORTS	MSMC TREATMENT PLT	PNT DISP/RPTS BR

1-14. Interface with the Forward Support Battalions

The DMOC will interface with elements of the FSB as required and approved by the DISCOM commander. The DMOC may interface with elements of the FSB through the DISCOM support operations section. This interface between the DMOC and elements of the FSB is driven by CHS requirements in the forward areas. This information will assist the DMOC in planning, coordinating, and managing division medical elements and resources in support of the battle. Communications and coordination between elements of the DMOC and the FSBs are essential for successful accomplishment of the DMOC's and FSB's CHS mission. The DMOC interface may involve the following FSB elements:

a. S2/S3. The S2 or S3 advises and assists the FSB commander in planning, coordinating, and supervising the communications, operations, training, security, and intelligence functions of the battalion. Interface is not limited to but will include the subject areas identified in Table 1-5.

b. Support Operations Section. The support operations section's mission includes DS supply, field services, DS maintenance, CHS, and limited transportation functions. The section must ensure that logistical and CHS to the supported units remain at a level consistent with the type of tactical operations being conducted. Interface between the support operations section and the DMOC maybe director indirect. This interface is accomplished through the HSSO and is not limited to but will include the subject areas identified in Table 1-5.

Table 1-5. DMOC Interface with the Forward Support Battalion

SUBJECT AREA	FSB	DMOC
TACTICAL OPERATIONS	SPT OPS SEC/HSSO	MED OPS BR
INTENSITY OF BATTLE	SPT OPS SEC/HSSO	MED OPS BR
THREAT UPDATE/INFORMATION	S2/S3 SEC SPT OPS BR/HSSO	MED OPS BR
CAPTURED MEDICAL SUPPLIES	S2/S3 SEC	
STATUS OF MEDICAL ELEMENTS	SPT OPS SEC/HSSO MED CO HQ	MED OPS BR
LOCATIONS OF UNITS	SPT OPS SEC/HSSO	MED OPS BR
ARMY AIRSPACE C2 PLANNING FOR THE BRIGADE	SPT OPS SEC/HSSO	MED OPS BR
AMBULANCE EXCHANGE POINTS	SPT OPS SEC/HSSO MED CO HQ	MED OPS BR
EMERGENCY CLASS VIII RESUPPLY & MEDICAL EQUIPMENT REPLACEMENT	MED CO HQ	MED MAT MGT BR
COMBAT HEALTH SUPPORT	MED CO HQ	MED OPS BR
OPERATIONS/PLANNING	MED CO HQ	MED OPS BR
AREA MEDICAL/DENTAL SUPPORT	MED CO HQ TREATMENT PLT HQ	MED OPS BR PNT DISP/RPTS BR
EVACUATION OPERATIONS	MED CO HQ AMBULANCE PLT	MED OPS BR MED OPS BR
COMBAT HEALTH LOGISTICS	MED CO HQ	MED OPS BR MED MAT MGT BR
DIVISION PVNTMED PROGRAM	MED CO HQ	MED OPS BR
DIVISION MENTAL HEALTH PROGRAM	MED CO HQ	MED OPS BR
COMBAT STRESS CONTROL	MED CO HQ	MED OPS BR
DIVISION PSYCHIATRIC SERVICE		MED OPS BR
COMMUNICATIONS	SPT OPS SEC MED CO HQ	MED OPS BR COMM BR

Table 1-5. DMOC Interface with the Forward Support Battalion (Continued)

SUBJECT AREA	FSB	DMOC
OPTOMETRY SERVICE	MED CO HQ	MED OPS BR
REINFORCEMENT/RECONSTITUTION OF FORWARD MEDICAL ELEMENTS	SPT OPS SEC/HSSO MED CO HQ TREATMENT PLT AMBULANCE PLT	MED OPS BR MED MAT MGT BR
CORPS MEDICAL ELEMENTS ATTACHED TO FSB	MED CO HQ SPT OPS SEC/HSSO	MED OPS BR
RECORDS/REPORTS	MED CO HQ TREATMENT PLT	PNT DISP/ RPTS BR

c. Forward Support Medical Company. The FSMC provides CHS for the brigade as well as area medical support for the BSA. Combat health support operations are coordinated by the DMOC medical operations branch through technical medical channels. The DISCOM tasks elements of the FSMC through command charnels to provide division-level CHS. The FSMC commander has a dual role as the brigade surgeon and as the principal manager of CHS assets assigned or attached to the brigade. He provides assistance to the support operations section in planning CHS. This interface is not limited to, but will include, the subject areas identified in Table 1-5.

1-15. Interface with Corps Medical Units

Interface with corps medical units is accomplished through the corps medical brigade/group. Interface may also occur with those medical units providing support to the division. The medical brigade/group may provide subordinate units to support the division by establishing a command relationship of OPCON or attached. The medical brigade/group may also choose to maintain only a support relationship of DS or GS to support the division. The DMOC interfaces with corps medical units according to the medical brigade/group TSOP. The DMOC and other DISCOM staff elements must be prepared to integrate corps-level medical units/elements into the medical as well as the logistical support structure. Information concerning the organization, functions, and responsibilities of the corps medical brigade/group is found in FM 8-10.

a. The corps medical brigade provides C2, including—

- Staff planning.
- Supervision of operations.
- Administration of the assigned and attached units, to include the corps medical group.

(1) The following areas are subjects of mutual concern for division and corps medical staff elements:

- Medical regulating.
- Division CHS requirements.
- Ground and air ambulance support and maintenance.

- Class VIII resupply and maintenance.
- Blood management.
- Status of corps medical elements attached, or OPCON, to the division.
- Medical threat and intelligence estimates.
- Captured medical supplies and equipment.
- Reinforcement and reconstitution of CHS elements.
- Civil affairs and host-nation support.
- Communications.
- Locations of medical elements in support of the division.
- Preventive medicine. mental health, dental, or' veterinary assistance.

(2) Logistical support requirements for corps medical elements operating in the division must be identified and coordinated with the corps support battalion (forward). When division support is not available, this support is normally provided by the corps support battalion (forward). Coordination may be required for—

- Class I. Subsistence items and gratuitous issue health and welfare items.
- Class II. Items of equipment other than principal items which are prescribed in authorization and allowance tables: individual equipment, clothing items, tentage, tool sets, and administrative and housekeeping supplies.
- Class III. Petroleum, oils, and lubricants (POL): petroleum fuels, hydraulic and insulating oils, chemical products, antifreeze compounds, compressed gases, coal.
- Class IV. Construction and barrier materials, lumber, sandbags, barbed wire.
- Class V. Ammunition.
- Class VII. Major end items: final combination of items which are ready (assembled) for intended use.
- Class IX. Repair parts.
- Field services (billeting, showers, and services).
- Personnel replacements (corps supported).

b. The MEDLOG battalion (forward) is organic to the corps medical brigade. The MEDLOG battalion (forward) provides CHL support to medical units supported in the corps. This support includes Class VIII resupply, medical equipment maintenance, blood and blood products, and single-vision optical fabrication. Division medical operations center interface with the MEDLOG battalion (forward) may be required for—

- Emergency Class VIII resupply.

- Repair of medical equipment.
- Blood management,
- Optical fabrication requirements.
- Management of captured medical materiel.
- Storage and decontamination techniques to minimize NBC contamination of Class VIII supplies.

c. The headquarters and headquarters detachment medical evacuation battalion serves as the central manager of ground and air evacuation assets in the corps. Its mission is to provide C2 of ground and air medical evacuation units within its AO. Information pertaining to the organization, functions, and capabilities of this unit is discussed in FM 8-10-6. The DMOC interfaces with the medical evacuation battalion or subordinate units concerning—

- Air and ground movement liaison within the division AO.
- Reinforcement of division CHS assets.
- Mass casualty evacuation plans.
- Evacuation of patients from division to supporting corps hospitals.
- Emergency movement of medical personnel, supplies, and blood.
- Ambulance shuttle operations to include ambulance exchange points (AXPs) and patient collecting points.
- Status of medical evacuation battalion elements operating in the division.
- Management and decontamination of ground/air evacuation assets.
- Support requirements for forward deployed medical evacuation battalion assets.
- Location of medical evacuation battalion assets.
- Location of division medical elements.
- Tactical situation and threat updates.
- Delivery of blood and blood products.
- Reinforcement of covering force and deep operations evacuation assets.
- Road and movement clearances.
- Maintenance support, to include aviation intermediate maintenance (AVIM).
- Emergency resupply of medical and nonmedical items (if required).
- Communications requirements and signal operation instructions (SOI).
- Updated tactical maps and evacuation overlays.

- Terrain considerations and barrier plans for ambulances.
- Evacuation destination (MRO functions).
- Division and brigade A2C2 requirements.
- Combat search and rescue mission.

(1) Within the division area, the air ambulance company provides aeromedical evacuation on a DS basis. This company may be attached for support (less OPCON) to the division aviation brigade. Air ambulances may operate from the DSA and BSAs providing 24-hour immediate response medical evacuation capability. Successful aeromedical evacuation support to the division requires current and accurate operational information. This information includes A2C2, current intelligence, friendly situation, air traffic service procedures, weather, CSS, and aviation safety and standardization data. To enhance the safety and effectiveness of aeromedical operations, operations information should flow between air ambulance units and the GS aviation battalion or assault helicopter battalion of the respective aviation brigade. Information is exchanged by various methods including on-site coordination or communications systems. The air ambulance company can obtain information through various sources such as the DMOC and maneuver brigade tactical operations centers (TOCs). However, during the planning and execution phases of operations, the medical evacuation battalion and the aviation unit to which the air ambulance company is attached are the primary sources for providing this information. The DMOC also provides A2C2 planning information to the air ambulance company. This information includes, but is not limited to, the following:

- Location of medical units.
- Locations of forward area rearm/refueling points (FARPs).
- Liaison requirements with supported units.
- Recommended evacuation corridors.

The air ambulance company, in turn, continually provides the medical evacuation battalion, aviation brigade, and DMOC with updated information about its current and planned operations. The company also provides pertinent combat information obtained during missions. This information includes enemy disposition, downed aircraft, weather, and other factors obtained by air ambulance crews during the performance of their duty. All medical evacuation crews communicate directly with the division air traffic service and execute A2C2 while operating behind brigade boundaries.

(2) Air ambulances, collocated with the MSB, coordinate air ambulance evacuation missions in the DSA through the MSB HSSO. The HSSO is located in the support operations cell of the MSB. The HSSO provides real-time tactical information to the air ambulance crew about evacuation missions from the requesting unit. When air ambulances operate in the DSA, they execute the A2C2 plan through and communicate directly with the division air traffic service. Emergency requests for aeromedical evacuation may be relayed from the DMOC to the HSSO who coordinates with air ambulances elements for the mission. When air ambulances are positioned at other locations in the DSA, the HSSO submits aeromedical evacuation requests through the DMOC to the supporting air ambulance element.

(3) Air ambulances deployed forward into the BSA may collocate with the FSB or aviation task force. When deployed forward to the BSA, the air ambulance team's evacuation missions

are coordinated through the HSSO. The HSSO is located in the support operations cell of the FSB. The HSSO provides real-time tactical information to the air ambulance crew about evacuation missions from the maneuver battalion/company to the brigade rear area. When air ambulances operate forward of the BSA, they will execute the A2C2 plan through the maneuver brigade S3. The FSB support operations branch provides planning and coordination between aeromedical evacuation and the supported maneuver brigade. The brigade S3 provides the A2C2 plan which includes the air corridors, air control points, and communications checkpoints. The brigade S3 will provide updates as required.

(4) The medical evacuation battalion communications link to the air ambulance company is accomplished by a combination of wire, FM voice, and MSE. To enable air-to-air communications between medical evacuation aircraft and aviation brigade aircraft during the conduct of missions, air ambulance companies obtain aviation unit call signs, frequencies, and cryptonet variables.

(5) Corps aeromedical elements may operate from the DSAs and BSAs providing around-the-clock immediate response evacuation aircraft. To accomplish this, elements must maintain a close tie with the A2C2 system in the division. The division A2C2 element provides an airspace plan through the division operation order (OPORD)/operation plan (OPLAN) A2C2 annex. The aircrew must also be familiar with the daily airspace control order (ACO) and the airspace control plan (ACP). These documents contain all airspace control measures (ACM) to include free fire areas, no fly/fire areas, restricted operations zones (ROZ), established and standard Army aircraft flight routes (SAAFRs). These routes and ACMs change on a daily basis and cannot be integrated into the division OPORD. The DMOC will ensure all A2C2 information is provided to corps aeromedical elements. The DMOC does not generate A2C2 information, but does provide A2C2 planning information to division A2C2 elements. This information includes, but is not limited to, the following:

- Locations of medical air elements and number of aircraft at each location.
- Locations of medical aviation and medical units.
- Locations of FARPs.
- Locations of supported units and liaison requirements.
- Locations of evacuation corridors and recommendations on usage.

(6) All medical air-flight crews will communicate directly with the division air traffic service and execute division A2C2 while operating behind brigade boundaries. The medical evacuation battalion may deploy air ambulance elements to the division. These elements may include an air ambulance company or a selected element of the company. When the air ambulance company is deployed to the division, it collocates with the aviation brigade or according to the division TSOP. Air ambulance companies will obtain A2C2 information from the division A2C2 section and coordinate with the DMOC (see Figure 1-2, page 1-23). Air ambulance teams may be deployed forward into the BSA and collocate with the FSB. When deployed forward, the air ambulance team is dependent on the FSB for communications support. When air ambulance elements operate forward of the brigade rear boundary, they will execute the A2C2 plan through the brigade S3. The FSB support operations branch provides planning and coordination between air evacuation elements and the maneuver brigade S3. Information provided to the maneuver brigade S3 should include, but not be limited to, the following:

- Location of MTFs and AXPs.
- Location and number of aircraft in sections.
- Location of FARPs.
- Locations of supported units and liaison requirements.
- Locations of evacuation corridors and recommendations on usage.

(7) The brigade S3 provides the A2C2 plan which includes the air corridors, air control points, and communications checkpoints. The brigade S3 will provide updates as required. Figure 1-2 depicts the medical A2C2 information flow.

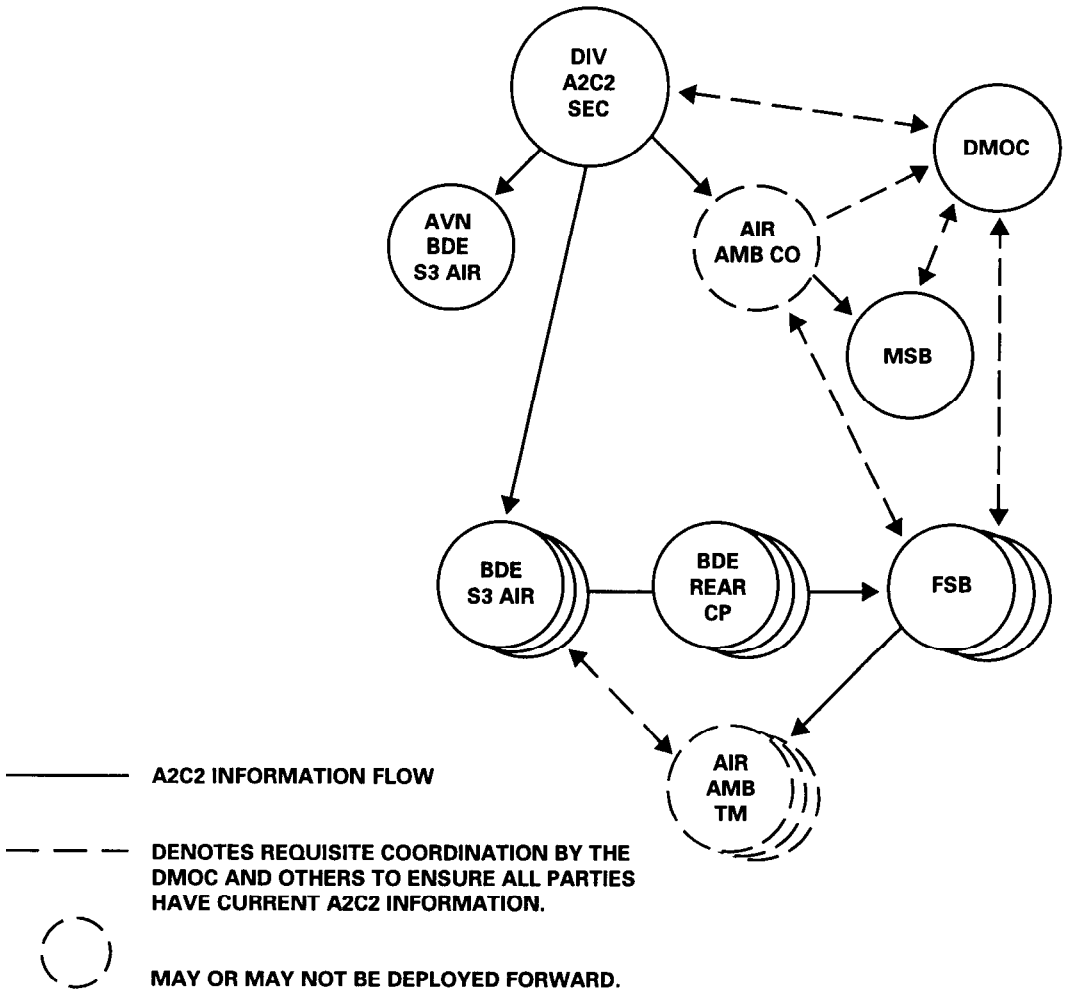


Figure 1-2. Medical Army airspace command and control information flow.

CHAPTER 2

ESTABLISHMENT OF THE DIVISION MEDICAL OPERATIONS CENTER

Section I. COMMAND POST SETUP

2-1. Command Post, Division Support Command

The DISCOM command post (CP) normally collocates with the division rear CP.

a. Command posts may be organized in many different ways to accomplish their missions. Figure 2-1 provides a sample layout of the DISCOM CP in a heavy division and Figure 2-2 provides a sample layout of the DISCOM Level II CP for light divisions. The three primary cells consist of the S2/S3 and plans intelligence branch, the division materiel management office, and the DMOC. Additionally, a separate commander's briefing area provides a workplace for the command section in the CP area. For definitive information on the DISCOM CP, see FMs 63-2 and 63-2-1.

b. The DMOC area of the CP is setup according to DISCOM TSOP. This setup is normally one that establishes only the necessary operations and communications equipment which supports the C2 operations requirement. An alternate area should be selected for placement of equipment not in use. This setup facilitates a timely and organized displacement without disruption of C2 operations capabilities. When the CP does move, it displaces by echelons. Once an interim operations capability is established at the new location, the remainder of the CP elements move. The jump DMOC as part of the jump DISCOM performs quartering party activities. (They select a site within the designated area, then select an alternate location. The selection of the alternate location is based on the enemy situation, terrain, and command guidance. Combat health support operations should not be disrupted as a result of relocating the DISCOM CP.)

2-2. Communications

Effective management and control of division CHS operations are dependent on the DMOC's ability to communicate with DISCOM and corps elements. Communications assets available to the DMOC include radios (AM and FM), and MSE. Communications support for the DISCOM HHC (DMOC) is provided by elements of the division signal battalion. For information on radio nets within the DISCOM, see FMs 63-2 and 63-2-1.

a. The DMOC maintains continual communications with division medical elements through its FM medical net or its AM medical operations net. Single-channel ground and airborne radio system (SINCGARS) components (see FM 24-24) provide the DMOC with an AN/VRC 89 (FM) which has a receiver/transmitter capable of using two FM nets for reception and transmission. This permits the DMOC to operate the medical net (FM). The medical operations net (AM-IHFR) uses an AN/GRC 213 radio. Division medical operations networks (technical and command) are depicted in Figure 2-3.

b. Mobile subscriber equipment is a part of the area common-user system (ACUS) and goes from the corps rear boundary forward to the division maneuver battalion's rear area. This system will allow the DMOC to communicate throughout the battlefield in either a mobile or static situation. The mobile subscriber system is managed by the organic MSE signal battalion which consists of an HHC, one or two area signal companies, and a signal support company. The signal support company normally provides subscriber services to the DISCOM CP/division rear. Additional information pertaining to MSE maybe found in FM 11-30 and FM 63-2.

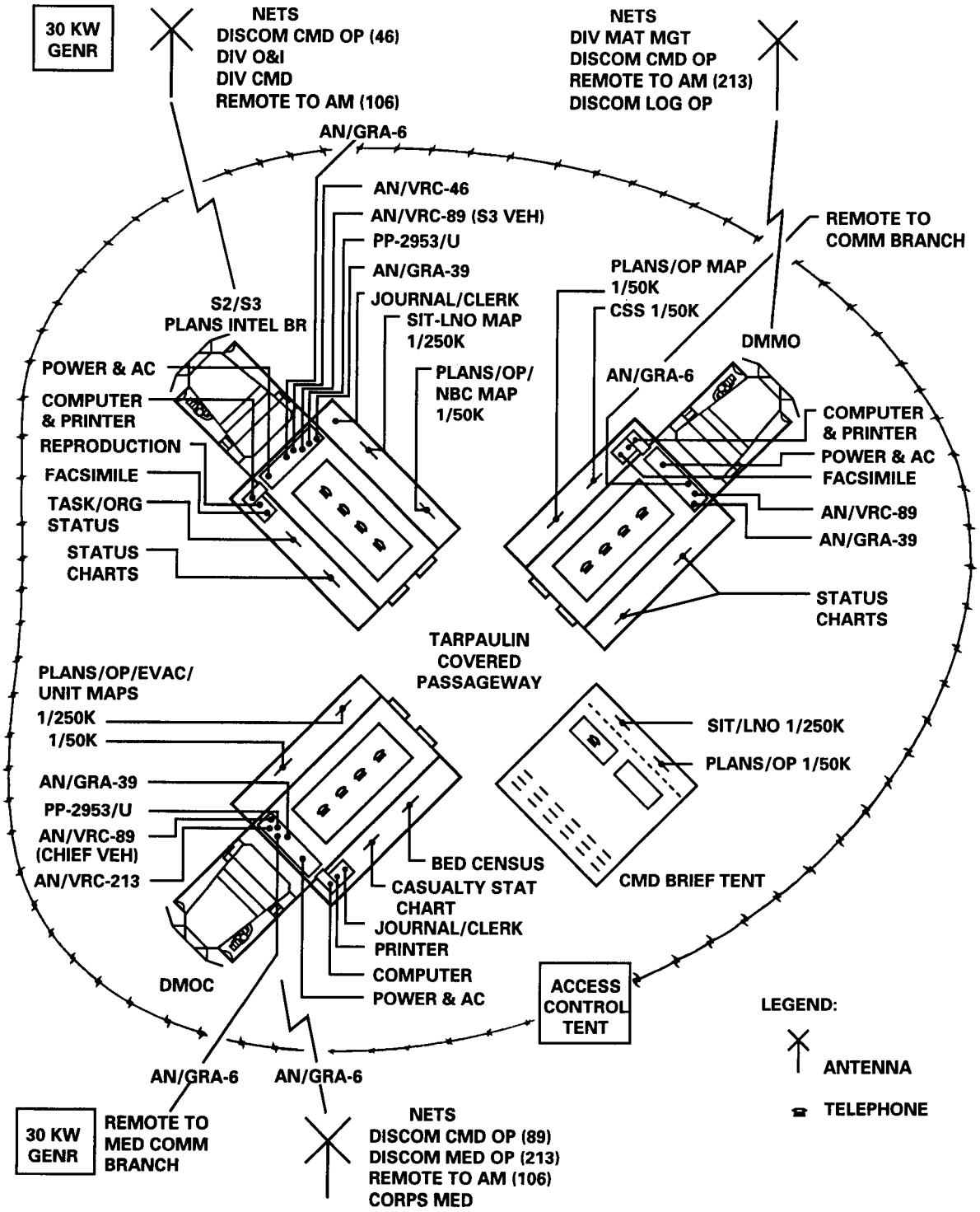


Figure 2-1. DISCOM command post, heavy.

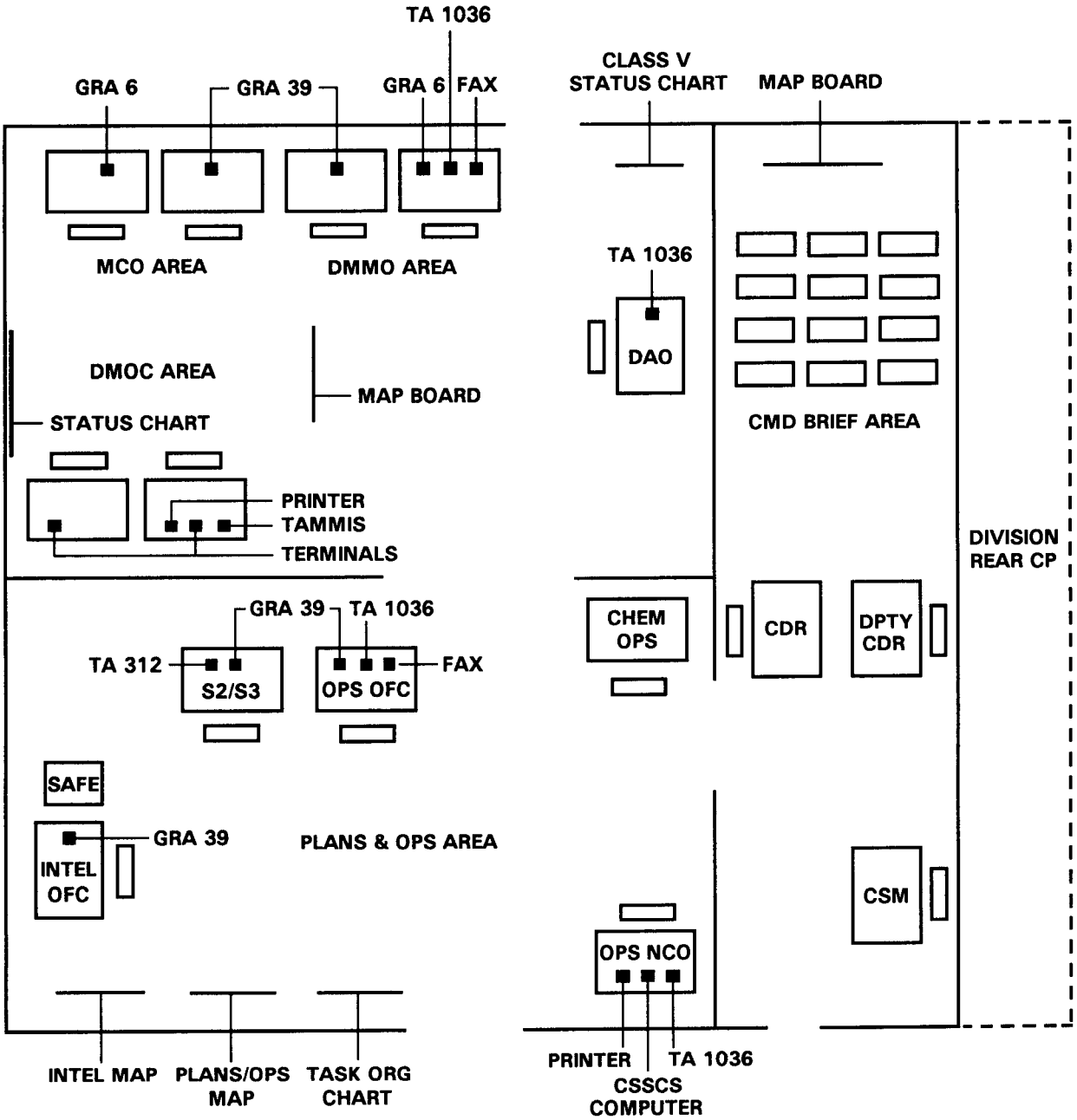


Figure 2-2. DISCOM command post, light.

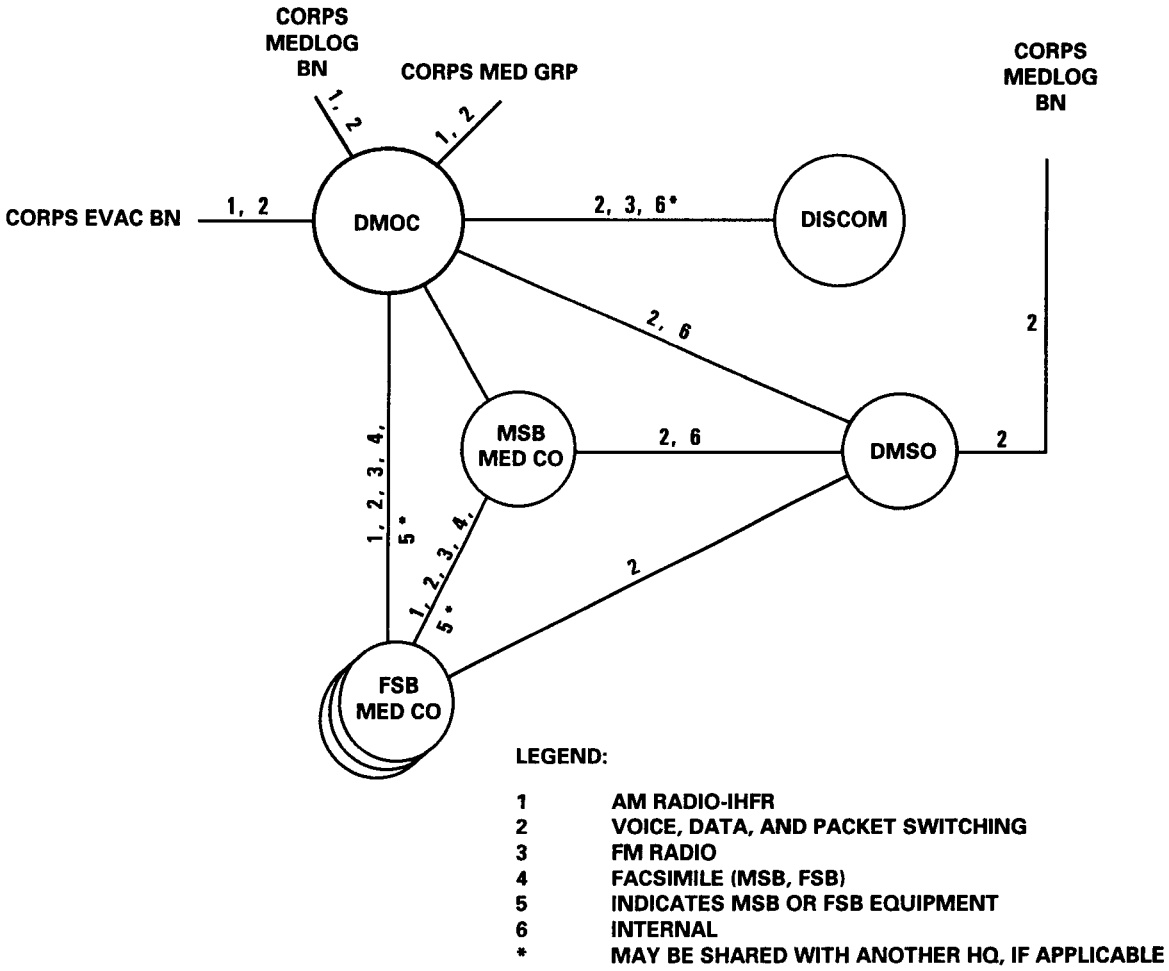


Figure 2-3. Division medical operations networks (technical and command).

(1) *Subscriber terminal fixed).* The MSE telephones, mobile subscriber radiotelephone terminals (MSRTs), facsimiles (FAXs), data terminals, and computer systems, as part of the ACUS, are user-owned and operated. The DMOC is responsible for running wire to the designated junction boxes. These boxes tie the DMOC MSE telephones into the extension switches which access the system. The subscriber terminals used by the units are digital nonsecure voice telephones. These provide full duplex digital, four-wire voice, as well as data ports, for interfacing the AN/UXC-7 FAX, the TACCS computer, and the unit-level computer (ULC). See FM 11-43 for information on how to connect terminals to communications systems,

(2) *Wire subscriber access.* Wire subscriber access points provide the entry points (interface) between fixed subscriber terminal equipment owned and operated by users and the MSE area system operated by signal units. See FM 63-2 for information pertaining to fixed subscriber terminal equipment assignments for the DMOC.

(3) *Mobile subscriber terminal access.* The MSE mobile subscriber terminal is the AN/VRC-97 MSRT terminal. This MSRT, which consists of a very high frequency radio and a digital *secure voice* terminal, is a vehicle-mounted assembly. It interfaces with the MSE system through a radio access unit. The primary use of the MSRT terminal is to provide mobile subscribers access to the MSE area network. See FM 11-43 for MSRT terminal interface into the area system. Radio access units are deployed to maximize area coverage and MSRT terminal concentrations. Mobile subscriber radiotelephone terminals can also operate in CPs to allow access to staff and functional personnel. Local standing operating procedures (SOP) will determine use of MSRTs in CP areas based on the possibility of interference with SINCGARS radios operating in the immediate area. As the Army continues to digitize the battlefield and modernize the force, the use of automation continues to develop. Mobile subscriber equipment Packet Switching Network gives units the ability to connect to division and corps Local Area Networks (LANs). This allows units/CPs to connect computer systems to an ethernet cable (coaxial) and send and receive information in an extremely efficient manner. Packet switching does not utilize or take up existing telephone lines. Instead, telephone lines are freed up even more because information is being sent over a network on data packets.

c. Using the Army Tactical Command and Control System (ATCCS), common hardware/software facilitates the interface and exchange of information between the DMOC, corps, and division medical elements. See FM 63-2 for information concerning automatic data processing (ADP) continuity of the operations plan.

2-3. Patient Disposition and Reporting Procedures

Patient accountability within the medical treatment chain must be maintained at all times. Prompt reporting of patients and their health status to the next higher headquarters and servicing personnel service detachment (PSD) is necessary for the maintenance of a responsive personnel replacement system and the Army Casualty System. Patient accountability and status reporting is a requirement for—

- Providing the commander with an accurate account of casualties in the medical treatment chain.
- Verifying personnel replacement requirements.
- Quantifying and prioritizing division evacuation demands.
- Assisting the command surgeon in the preparation of the medical estimate.

- Alerting PVNTMED officers and the intelligence community to probable environmental health hazards and probable enemy use of exotic munitions.

a. Employment of patient accountability and status reporting is accomplished as shown in Figure 2-4.

(1) The Daily Disposition Log (DDL) (see Appendix B for sample format) is maintained by Echelon I (unit-level) and Echelon II (division-level) MTFs. The information from this log is extracted, when required, and provided to the S 1 and G1 or supported unit requesting such information. The DDL is also the primary source for the information needed in the Patient Evacuation and Mortality Report (PE&MR).

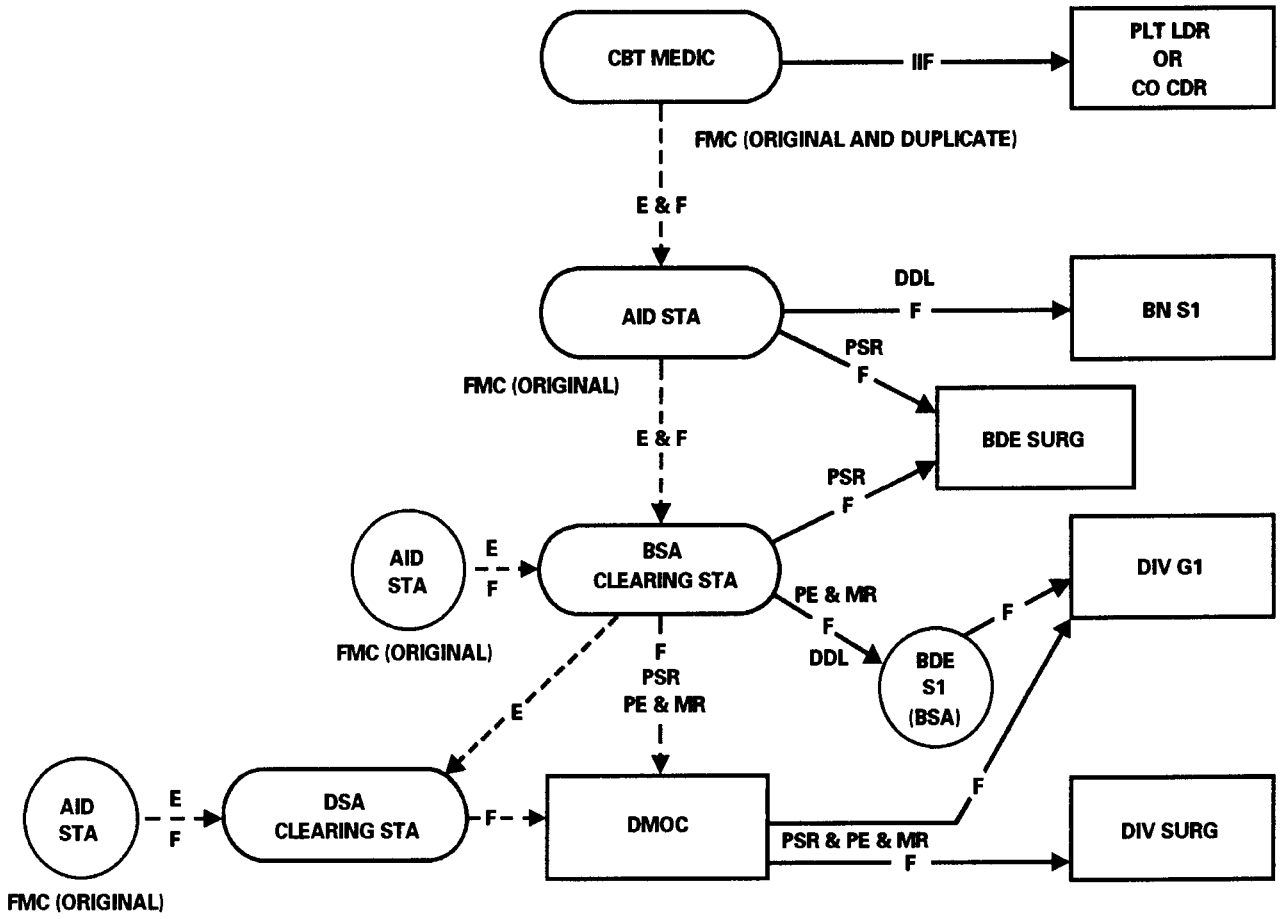
(2) The PE&MR (see Appendix B for sample format) is prepared by Echelon III (corps-level) and Echelon II MTFs and disseminated as shown in Figure 2-4. The PE&MR primarily serves as a "medical spot report. " The frequency of this report is established by the command surgeon.

(3) The Patient Summary Report (PSR) is a weekly report (see Appendix B for sample format). It is prepared by Echelon I through Echelon III MTFs and is submitted to respective surgeons as shown in Figure 2-4.

(4) The Admission and Disposition (AAD) Report is prepared and distributed by the patient administration element of the MTF (see AR 40-66).

b. The DMOC patient disposition and reporting procedures involve consolidating all patient and disposition reports that originate within the division. The DMOC will consolidate these reports and forward them to the division and corps headquarters according to the TSOP.

c. Reporting procedures for allied, host nation, and third country citizens are accomplished according to commanders guidance, standardization agreements, memorandum of understanding, or other appropriate regulatory guidance.



LEGEND:

DDL	DAILY DISPOSITION LOG	IIF	INFORMAL INFORMATION FLOW
E	PATIENT EVAC FLOW	PE & MR	PATIENT EVAC AND MORTALITY REPORT
F	FORMAL INFORMATION FLOW	PSR	PATIENT SUMMARY REPORT
FMC	FIELD MEDICAL CARD		

NOTE: – – – PATIENT FLOW AND INFORMATION
——— INFORMATION ONLY

Figure 2-4. Patient accountability and status reporting.

Section II. MONITORING AND MANAGING ACTIVITIES FOR ECHELON II COMBAT HEALTH SUPPORT ELEMENTS IN THE DIVISION

2-4. Medical Regulating from the Division

a. Medical regulating in and from the division is the responsibility of the patient disposition and reports branch of the DMOC, Medical regulating in the division is an informal system. It is procedurally operated to prevent sole dependence on communications. The patient disposition and reports branch is concerned with—

- Tracking the movement of patients throughout the division and into the corps.
- Monitoring the use of ambulance elements.
- Coordinating with the corps medical evacuation battalion.
- Maintaining communications with corps air and ground ambulance elements in support of the division.

b. Various techniques for regulating patients may be employed, depending on mission and operational constraints. The technique provided below is one of the many ways to accomplish medical regulating. Provided in the technique are medical regulating requirements for the division and corps areas.

(1) *Division area.* In this technique, corps hospital destinations are predetermined when corps medical evacuation elements deploy forward. The DMOC and the medical brigade/group MRO will coordinate patient evacuation to corps hospitals. The number and types of patients a supporting corps hospital can accept during a particular period of time is established. Blocks of beds will be provided to corps ambulance elements by the corps MRO. This is accomplished through the DMOC and supporting medical companies prior to calling for a medical evacuation mission. Upon departure of ambulances from pickup sites, the originating MTF contacts the DMOC patient disposition and reports branch. Patient evacuation information is provided to the patient disposition and reports branch. This information includes—

- Patient numbers by category and precedence.
- Departure times.
- Modes of transportation.
- Destination facilities.
- Any other information established by TSOP.

(2) *Corps area.*

(a) The DMOC notifies the medical brigade/group MRO and provides the information collected in (1) above via the medical operations (AM) net. This net should be monitored by corps hospitals. Since corps ground ambulances currently are without on-board communications and corps air ambulances are without AM-high frequency (HF) capabilities, all patient information must be passed to gaining facilities via the patient administration net from division to corps. The corps MRO must constantly search for methods which will reduce ground ambulance turnaround time and expedite the evacuation of seriously injured or seriously ill patients. Factors which will influence or alter the medical regulating of patients include—

- Time and distance.
- Weather.
- Available ambulance assets.
- Flight time for air ambulances (amount of time before required maintenance).
- Threat.
- Number of patients requiring medical evacuation.

(b) The corps MRO, DMOC, and evacuation battalion must be prepared to initiate procedures which will compensate or maintain acceptable levels of medical evacuation support as a result of the factors identified in *(a)* above. Some of their options include—

- Using air ambulances to support units on the move.
- Limiting the use of air ambulances to only those patients assigned an URGENT, URGENT SURG, or PRIORITY category.
- Directing ground ambulances to the nearest combat support hospitals (CSHs).
- Using AXPs.
- Redirecting ground ambulances when routes to designated hospitals are blocked by the enemy.
- Coordinating the use of nonmedical vehicles for evacuating patients.

c. Patient regulating from the FSMCs to the mobile army surgical hospital (MASH) is coordinated by the DMOC. This coordination involves the MASH patient administration and disposition (PAD) section and the patient disposition and reports branch of the DMOC. The DMOC updates the brigade/group MRO when patients are evacuated from the division to the MASH.

d. Medical evacuation can be accomplished under conditions of communications silence by ensuring SOPS include—

- Establishing work load planning data.
- Completing casualty estimates.
- Prioritizing and task-organizing ambulance support.
- Assigning blocks of hospital bed designations.
- Following a predetermined route and schedule to collect patients.

2-5. Division Medical Supply Office

a. Responsibilities. The DMSO is assigned to the MSMC. It is responsible for providing medical supply and unit-level medical maintenance support to the medical treatment

elements within the division. The HSMO of the DMSO manages Class VIII supplies and equipment; he also executes the CHL plan. The HSMO of the DMOC monitors and provides technical staff supervision for DMSO operations.

b. Functions.

(1) The functions of the DMSO include—

- Developing and maintaining prescribed loads of contingency medical supplies for division medical elements.
- Managing the medical quality control program.
- Supervising unit (organizational) medical maintenance support,
- Monitoring the division medical assemblage management program.
- Coordinating the CHL requirements for preconfigured Class VIII packages with the DMOC MMMB and the corps MEDLOG battalion (forward).

(2) The DMSO will use the TAMMIS-medical supply (MEDSUP). This system will interface with the MEDLOG battalion (forward) using the Army Tactical Command and Control System—Common Hardware/Software (ATCCS-CHS) computers, TAMMIS, and commercial off-the-shelf software systems.

(3) This office is also involved in the logistical aspects of the division blood management program and optical fabrication and repair.

c. *Medical Resupply*. The DMSO normally performs its mission by operating under the supply point distribution system. While each medical unit maintains its own basic load (2 days of supply) of medical supplies, the DMSO carries the division operating stocks. The DMSO normally stocks 5-to 15-day levels of selected medical supply items. The number of days of supply and any additional items maintained by the DMSO are determined by the division's mission, its location, and guidance from the division surgeon and the DMOC medical materiel manager.

(1) During the initial employment phase, each FSMC receives a preconfigured medical resupply push-package every 48 hours from the DMSO until appropriate elements of the corps MEDLOG battalion (forward) are established.

(2) During deployment, lodgment, and early buildup phases, medical units operate from planned, prescribed loads and from existing pre-positioned war reserve stockpiles identified in applicable contingency plans.

(3) Initial resupply efforts may consist of preconfigured medical supply packages tailored to meet specific mission requirements. Resupply by preconfigured packages will normally be shipped directly (push-packages) to the division until replenishment line item requisitioning is established with the supporting MEDLOG battalion (forward). While resupply by preconfigured packages is intended to provide support during the initial phase, continuation on an exception basis may be dictated by operational needs. Planning for such a contingency must be directly coordinated with the DMSO who will coordinate further Class VIII requirements with the supporting MEDLOG battalion (forward). Shipment of medical materiel from the DSA is coordinated with the division support operations branch, or is achieved through

use of the backhaul method using returning medical evacuation resources when possible.

d. Medical Resupply Operations.

NOTE

In contrast to the formal procedures normally associated with support between the combat zone MEDLOG battalion (forward) and the DMSO, requests submitted to the DMSO from the division MTFs may be informal. Request may come by message with returning ground or air ambulances, by land lines, or through FM command nets within the division.

(1) *From requesting units.*

(a) Routine. The DMSO receives requests from supported units using the Customer Reorder List (resupply requisition format submitted through command channels). If requested items are available for issue, a Materiel Release Order is printed and stock issued to the unit. For items not available for issue, the requests are passed to the next higher level of supply.

(b) Emergency. All emergency requests are immediately processed by the DMSO and issued to requesting unit. The medical materiel branch of the DMOC has the responsibility of monitoring all emergency requirements not immediately filled by the DMSO. The medical materiel branch (DMOC) coordinates with the DISCOM's support operations branch for the transportation of emergency medical supplies, if required.

(2) *From source of supply.*

(a) Routine. The DMSO requests all supplies according to TAMMIS users manual (MEDLOG). All supplies are forwarded using supply point distribution.

(b) Emergency. The DMSO immediately forwards all emergency requests not filled to the next source of supply. The medical materiel branch (DMOC) coordinates, as required, with the DISCOM's support operations branch to meet shortfalls in the supply point distribution system by updating priorities with the MEDLOG battalion (forward).

(3) *Medical materiel branch.* The medical materiel branch (DMOC) is informed by the DMSO of all pertinent management indicators.

(a) Number of stocked lines.

(b) Demand satisfaction/accommodation.

(c) Zero balances.

(d) Critical item shortages.

(e) Nonoperational critical equipment.

e. Records and Reports. Records and reports are maintained according to the TAMMIS users manual. (In the event of a TAMMIS failure, a backup manual system will be implemented.)

f. Division Medical Maintenance. Medical equipment repairers are assigned to the DMSO to support division units and those units attached to the division. The maintenance of medical equipment is an important responsibility of the DMSO. The DMSO medical maintenance personnel must develop a program to ensure the division's medical equipment is operational and ready to go to war. Implementation of the following programs of functions ensures the readiness of medical equipment:

(1) *Periodic services.* Services consist of preventive maintenance, safety checks, and calibration. These services must be scheduled on a

periodic basis and should be placed on unit training schedules. The frequency of each scheduled service should be in compliance with technical manuals and other publications. Considerations for these services include—

- Availability of equipment and manpower resources.
- Availability of test, measurement, and diagnostic equipment (TMDE).
- Other taskings.

(2) *Repairs.* Repair work orders must be completed in a timely manner to maintain a high readiness posture and prevent a backlog from occurring and to maintain a high readiness posture. A repairman will either repair the equipment, calibrate it, order parts required to effect repair, or evacuate the equipment for repair. Equipment is evacuated to the MEDLOG battalion (forward) when necessary repairs exceed the unit's TMDE or repair capability. The medical materiel section of the DMOC coordinates with the MEDLOG battalion (forward) for use of maintenance support (contact) teams and the evacuation of equipment.

(3) *Records.* Records for medical equipment are kept according to AR 40-61, Technical Bulletin (TB) 38-750-2, and the Supply Bulletin (SB) 8-75 Series. These should be reviewed periodically by the DMSO. Examples of required records for medical equipment (the majority of which TAMMIS-medical maintenance [MEDMNT] has automated) areas follows:

(a) DA Form 2404, Equipment Inspection and Maintenance Worksheet.

(b) DA Form 2405, Maintenance Request Register.

(c) DA Form 2407, Maintenance Request and DA Form 2407-1, Maintenance Request (Continuation).

(d) DA Form 2409, Equipment Maintenance Log (Consolidated).

(e) DA Form 3318, Records of Demands—Title Insert.

(f) DA Form 3321, Request for Acknowledgment of Loaned Durable Medical Equipment.

(g) DA Form 5621-R, General Leakage Current Requirements (LRA).

(h) DA Form 5624-R, DC Defibrillator Inspection Record (LRA).

(i) DA Label 175, Defibrillator Energy Output Certificate.

(j) DD Form 314, Preventive Maintenance Schedule and Record.

(k) DD Form 2163, Medical Equipment Verification and Certification.

(l) DD Form 2164, X-ray Verification and Certification Worksheet.

(4) *Repair parts.* Mandatory parts lists (MPLs) and prescribed load lists (PLLs) need to be monitored routinely. An MPL to support medical equipment is published annually in SB 8-75 Series. Most medical equipment repair parts can be requisitioned through the Class VIII system; however, some repair parts needed to repair medical equipment fall in the category of Class IX repair parts (that is, common fasteners, electrical components, and others). Requisitions for Class IX repair parts are sent through the organization's supporting motor pool and require stringent monitoring and follow-up efforts. Special considerations for medical repair parts are explained in AR 40-61.

g. Division Blood Management.

(1) Blood requirements for the division are determined by the division surgeon. Only packed liquid red blood cells are expected to be available to the division. Blood products are provided to Army MTFs in the division by the DMSO. The DMSO coordinates through the MSMC to identify backhaul ambulances to transport blood to the requesting unit. The DMSO obtains packed liquid red blood cells from the MEDLOG battalion (forward). Shipment of blood from the corps to the division is either coordinated by the MEDLOG battalion (forward) with the corps movement control center (MCC) or accomplished by backhaul on medical vehicles' (air and ground). Emergency resupply can be accomplished by air ambulances from the medical battalion, evacuation. Most of the demands for emergency resupply come from the FSMCs.

(2) Blood support is a combination of four systems (medical, technical, operational, and logistical). Blood support must be considered separate from laboratory support. The distribution of all resuscitative fluids (including albumin) is managed by the MEDLOG units. In the long term, theater blood management is based on resupply from the continental United States (CONUS) donor bases (Armed Services Whole Blood Processing Laboratories [ASWBPLs]). At the division level, storage and transportation refrigerators allow the DMSO to provide blood as far forward as the FSMC. The DMSO obtains liquid blood from the MEDLOG battalion (forward) . See FMs 8-10, 8-10-9, and 8-55 for definitive information on blood management.

(3) The DMSO informs the medical materiel branch (DMOC) of the current availability of blood in the division. The DMOC prioritizes the movement of blood products as required. Air assets should be considered along with ground assets for the transportation of blood.

h. Medical Logistics Battalion Support.

(1) The MEDLOG battalion (forward) is a modular organization with the primary mission of providing C2. It provides staff planning, supervision of operations, and administration of assigned or attached units (see FM 8-10-9). This unit provides Class VIII supplies, optical fabrication (single vision), medical equipment maintenance support, and blood storage, processing, and distribution. It provides unit and supply point distribution to divisional and nondivisional units. The MEDLOG battalion (forward) is a corps asset and is under the C2 of the medical brigade or medical group.

(2) All requests from the division are submitted to the MEDLOG battalion (forward) according to the TAMMIS users' manual.

2-6. Division Preventive Medicine Section

The division PVNTMED section is responsible for—

- Supervising the command PVNTMED program (see AR 40-5).
- Ensuring PVNTMED measures that protect division personnel against food-, water-, and vectorborne diseases, as well as environmental injuries (for example, heat and cold injuries), are implemented.

This section is assigned to the MSMC. Its missions in the division are monitored according to the division CHS plan and coordinated as appropriate by the DMOC. The PVNTMED section is staffed to provide advice and consultation in the areas of environmental sanitation, epidemiology, and entomology, as well as limited sanitary engineering services and pest management. Additional information pertaining to PVNTMED staff and specific functions is discussed in FM 8-10.

a. Preventive medicine activities begin prior to deployment to minimize disease and nonbattle injuries (DNBIs).

(1) Actions taken include–

- Ensuring command awareness of potential medical threats and that appropriate PVNTMED measures are implemented.
- Monitoring immunization and chemoprophylaxis status of division personnel.
- Monitoring the status of individual and small unit PVNTMED measures.
- Monitoring PVNTMED measures against heat and cold injuries and food-, water-, and vectorborne diseases.

(2) Commanders and PVNTMED planners must be proactive and initiate action on presumptive information to reduce the medical threat early. They cannot wait until the incapacitation of troops occurs before taking action; for example—

- Mosquito populations near troop assembly areas must be suppressed without waiting for confirmation that they do indeed carry malaria or other disease-causing organisms.
- Sand flies in towns along routes of march must be suppressed without waiting for the incubation period of sandfly fever to lapse.
- Inadequate sanitation practices must be brought to the attention of responsible commanders before the first case of dysentery appears.

Lack of, or delay in, implementing preemptive actions can significantly impact on the deployment force's ability to accomplish its assigned mission.

b. Supported units can request PVNTMED support through the division medical channel. The DMOC is notified when a request for PVNTMED support is submitted through the medical companies. The DMOC or MSB coordinates PVNTMED missions for either requested or preemptive actions.

c. Preventive medicine operations are characterized by preemptive action, increased soldier and commander involvement, and priority to combat units. To accomplish this, the PVNTMED section may be deployed as a team to support specific units or operations (for example, deployed in DS of a brigade- or battalion-sized task force) as required. Such teams are task-organized by the division PVNTMED officer based on the particular medical threat. Preventive medicine section operations and activities may include—

- Assisting the surgeon in staff estimate preparation by identifying the medical threat.
- Assisting the division surgeon in determining disease prevalence in the AO.
- Conducting surveillance of divisional units to ensure implementation of PVNTMED measures at all levels and to identify actual or potential health threats and recommending corrective action as required.

- Assisting divisional units in the training of PVNTMED measures against heat and cold injury, as well as food-, water-, and vectorborne diseases.
- Monitoring the immunization and chemoprophylaxis program.
- Monitoring the health-related aspects of water production, distribution, and consumption.
- Monitoring DNBI incidence to optimize early recognition of disease trends and recommending initiation of preemptive disease suppression measures.
- Conducting epidemiological investigations of disease outbreaks and recommending PVNTMED measures to minimize effect.
- Monitoring division-level resupply of disease prevention-related supplies and equipment, including water disinfectants, insect repellents, and pesticides.
- Conducting limited entomological investigations and control measures.
- Monitoring environmental and meteorological conditions, assessing their health-related impact on division operations, and recommending PVNTMED measures to minimize heat and cold injuries, as well as selected arthropodborne diseases.
- Assessing the effectiveness of field sanitation teams.
- Deploying PVNTMED teams in support of specific units or operations as required.
- Training unit field sanitation teams (see FM 21-10-1).

2-7. Division Mental Health Section

The DMHS is the medical element in the division with primary responsibility for assisting the command in controlling combat stress. Combat stress is controlled through sound leadership, assisted by CSC training, consultation, and restoration programs conducted by this section. The DMHS enhances unit effectiveness and minimizes losses due to battle fatigue (BF), misconduct stress behaviors, and neuropsychiatric (NP) disorders. Under the direction of the division psychiatrist, the DMHS provides mental health/CSC services throughout the division. This section, acting for the division surgeon, has staff responsibility for establishing policy and guidance for the prevention, diagnosis, treatment, and management of NP, BF, and misconduct stress behavior cases within the division AO. It has technical responsibility for the psychological aspect of surety programs. The staff of this section provides training to unit leaders and their staffs, chaplains, medical personnel, and troops. They monitor morale, cohesion, and mental fitness of supported units. Other responsibilities for the DMHS staff include—

- Monitoring indicators of dysfunctional stress in units.
- Evaluating NP, BF, and misconduct stress behavior cases.
- Providing consultation and triage as requested for medical/surgical patients exhibiting signs of combat stress or NP disorders.

- Supervising selective short-term restoration for Hold category BF casualties (1 to 3 days).
- Coordinating support activities of attached corps-level CSC elements.

The DMHS normally collocates with the MSMC clearing station (treatment platoon). The staffing of the DMHS allows for this section to split into teams which deploy forward to provide CSC support to the brigades in the division. One DMHS NCO and one mental health officer (social worker or psychologist) will routinely support each maneuver brigade as its CSC team. For definitive information pertaining to the DMHS, see FMs 8-10-1 and 8-51.

2-8. Division Optometry Section

The optometry section provides—

- Optometry services, including routine vision evaluation and refractions.
- Evaluation and management of ocular injuries and diseases.
- Eyewear frame assembly using finished single-vision lenses.
- Eyewear repair services within the division AO.

a. The optometry section is assigned to the MSMC and is staffed to provide optometry support in remote locations and forward areas as required.

NOTE

Optometrists manage ocular diseases and injuries according to medical protocols (established by the division surgeon or higher medical authority) and refer patients to other health care providers as appropriate.

b. All division optometry sections are staffed with two optometry officers, an eye sergeant, two eye specialists and an optical laboratory specialist. Figure 2-5 depicts the eyewear repair or fabrication flow. See FMs 8-10-1 and 8-10-24/Change 1 for additional information on the optometry section.

2-9. Division Dental Services

The primary mission of division dental elements is prevention and treatment of dental disease. A dental officer and a dental specialist are assigned to the MSB and each FSB.

a. The senior dental officer assigned to the MSB serves as the division dental surgeon. He exerts technical control over all division dental elements. He advises both the division and DISCOM surgeons on dental activities within the division. His responsibilities include—

- Advising the division and DISCOM surgeons on the dental health of the command.
- Coordinating through the DMOC for corps dental support, as required.
- Planning and supervising the preventive dentistry program for the division according to AR 40-35.

b. Division dental personnel are responsible for—

- Monitoring the dental health of the command.

- Providing emergency and sustaining dental care.
- Conducting the division preventive dentistry program.
- Assisting the medical treatment elements in mass casualty situations.
- Assisting mortuary affairs personnel in the identification of remains.

NOTE

Identification of casualty remains is a part of the overall mortuary affairs operation undertaken by Quartermaster Corps units. Mortuary affairs operations are not a doctrinal AMEDD function; however, dental personnel and units are uniquely qualified to support such operations when needed in the identification process.

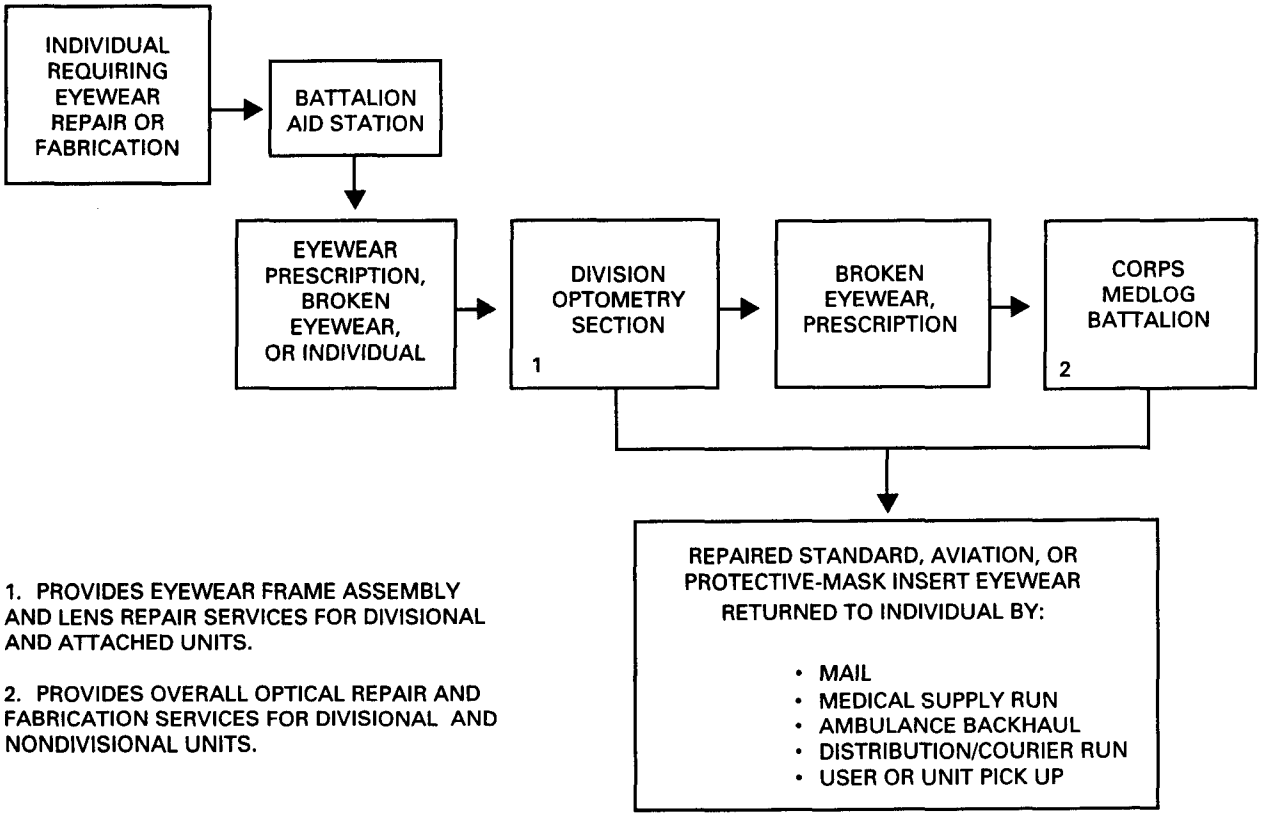


Figure 2-5. Eyewear repair or fabrication flow.

CHAPTER 3

DIVISION COMBAT HEALTH SUPPORT OPERATIONS

Section I. PLANNING COMBAT HEALTH SUPPORT FOR DIVISION OPERATIONS

3-1. Division Combat Health Support Planning

a. Division CHS operations involve all of the factors which must be considered in the initial developmental stages of the division CHS plan. For information on conducting health service support in joint operations, see Joint Publication 4-02. The CHS plan is updated to meet tactical or CHS operations requirements. The following factors should be considered:

- Mission.
- Commanders's intent.
- Planning guidance.
- Tactical plan.
- Enemy.
- Terrain.
- Troops.
- Weather.
- Threat (including medical threat).
- Operational conditions.
- Operational constraints.
- Military population supported.
- Civilian populace in the AO.
- Medical personnel status.
- Equipment status.
- Supply status including Class VIII.
- Wartime host-nation support.
- Indigenous medical services.
- Communications capability.
- Nuclear, biological, and chemical defense.
- Nuclear, biological, and chemical casualty considerations.
- Training status.
- Casualty estimates.
- Medical evacuation requirements.
- Medical evacuation capabilities.
- Corps CHS.
- Nonmedical support requirements from division (engineers, transportation).
- Division support requirements.
- Special operations requirements.
- Army airspace command and control.
- Records and reports requirements.
- Phases of operations.

- Courses of actions.
- Information requirements (maps, essential elements of friendly information, updates).
- Policy and procedure updates.

b. The division CHS plan is developed by the DMOC staff according to guidance found in FMs 8-10,8-10-6,8-10-8,8-10-9, 8-42,8-55, 100-5, 101-5, and in consultation with the division surgeon. After the CHS plan has been approved by the division commander, it is incorporated into the division CSS plan. For information on conducting health service support in joint operations, see Joint Publication 4-02.

3-2. Division Support Command Operation Plan and Operation Order

The DISCOM OPLAN and OPORD, when published, are developed by the DISCOM S2/S3 section using input from each of the staff elements of the DISCOM headquarters.

a. The chief of the DMOC is responsible for supervision and development of CHS input for the DISCOM OPORD and OPLAN. The division CHS plan serves as the base document for this input. The division CHS plan is revised or updated based on mission analysis or changes in CHS requirements. The DMOC chief is tasked by the DISCOM S2/S3 for CHS input to the DISCOM OPORD and OPLAN for support of division operations. The S2/S3 indicates time-line requirements. The DMOC chief is involved in the initial stages of the CSS planning process. In this role, he should be aware of any CHS planning requirements.

b. The chief of the DMOC tasks the medical operations branch to collect, receive, analyze, and update all information which could affect CHS operations. Information used to develop the CHS input is derived from—

- Mission analysis.
- Medical and general military intelligence and threat summaries from corps intelligence producers, corps medical brigade, and theater battlefield technical assets (see FM 8-10-8 and FM 34-54).
- Personnel estimates.
- Combat health support estimates.
- Casualty estimates (developed or obtained from S 1).
- Main support battalion and FSB status updates.
- All planning considerations that were identified in paragraph 3-1.

c. The medical operations branch develops a CHS plan based on guidance received from the DISCOM commander and DMOC chief. The DMOC provides CHS operational planning updates to the division surgeon. The CHS plan is briefed to the DISCOM commander for approval, as required. The CHS plan is provided in written format or presented orally to the DISCOM S2/S3 in a six-paragraph format of the OPLAN (FM 8-55) within the prescribed time lines identified in the oral or written tasking.

d. The DMOC has a primary responsibility for the coordination of division and corps medical assets in support of the division. Supporting medical elements should be pre-positioned according to the CHS plan and anticipated requirements. Division and corps evacuation assets should be task-organized to support the area of greatest casualty density. All supporting medical elements should be

issued the maximum allowable levels of Class VIII and other required supplies. The DMOC must establish and maintain continuous communications with division medical companies located in forward areas. The medical operations branch maintains a situation map and should use charts to monitor functional areas which may include—

- Corps ground and air ambulance assets.
- Army airspace command and control overlays.
- Status of evacuation platforms.
- Division to corps evacuation schedule.
- Division to corps evacuation delays.
- Supply status including critical Class VIII shortages.
- Critical medical personnel shortages.
- Pending resupply missions from corps.
- Critical medical equipment shortages.
- Medical maintenance backlog.
- Patient status board (for example, awaiting evacuation).
- Hospitals supporting the division.
- Blood status.

Section II. CONDUCTING COMBAT HEALTH SUPPORT FOR COMBAT AND MILITARY OPERATIONS OTHER THAN WAR

3-3. Combat Health Support for Division Offensive Operations

a. The objective of an offensive operation is to destroy or bring under control the forces of areas critical to the enemy's overall defensive organization. This is accomplished before the enemy can react. The four general forms of offensive operations are—

- Movement to contact.
- Attack.
- Pursuit.
- Exploitation.

Offensive operations are characterized by aggressive initiative on the part of the commander. The commander initiates rapid shifts in the main effort to take advantage of opportunities. He maintains the momentum and launches the deepest and most rapid destruction of enemy defenses possible. Although these operations are roughly sequential, any offensive operation can change. It has the potential to develop into either a more rapidly progressing operation or a defense. The entire series can proceed by step from movement to contact to an eventual pursuit; however, an attack can quickly shift forward or backward as enemy resistance varies.

b. Basic considerations which influence the use of medical units in supporting combat operations are—

- The commander's plan (his concept of the overall operations).
- The anticipated patient load.
- The expected area of casualty density.
- The expected combat environment (conventional, NBC, smoke and obscurants).
- Mission, enemy, terrain, troops, and time available (METT-T).
- All CHS planning factors identified earlier in this chapter.

c. The following are essential characteristics of CHS in offensive operations:

(1) As areas of casualty density move forward, the routes of evacuation lengthen, requiring forward displacement of MTFs and evacuation assets, thereby extending evacuation lines to supporting facilities.

(2) Heaviest patient loads occur during disruption of the enemy's main defensive position, at terrain or tactical barriers, and during assaults on final objectives.

(3) Unit-level medical elements may be required to furnish temporary emergency medical support to indigenous or displaced persons. They perform this humanitarian act if time and resources permit. The extent of this support is decided by the tactical commander; however, assistance is normally confined to emergency medical treatment and advance trauma management.

(4) The major casualty area of the division will be the zone of the main attack. As the attack accomplishes the primary division task, it receives the first priority in the allocation of combat power and related combat support and CSS. The division commander's allocation of forces indicates roughly the areas which are likely to have the greatest division CHS requirements.

(5) The greatest medical challenge for the tactical commander is the movement of casualties from point of injury to casualty collecting points to facilitate evacuation to MTFs. This process will become increasingly more difficult as the battle area extends.

d. Coordination is the key to successful implementation of division CHS. Coordination must continue as various forms of the offensive operation are initiated. When the tactical situation or unexpected events force changes to the CHS plan, the DMOC staff aggressively coordinates those changes as expeditiously as possible. The DMOC staff monitors the effects of division CHS to identify flexible responses which will enhance CHS operations. Coordination with all medical elements in the division area, as required (FSB, MSB, supporting corps medical elements, and supported units), must be continuous. The DMOC staff is involved in coordinating the following CHS requirements in support of offensive operations:

(1) *Treatment elements.*

- Augmentation or reconstitution.
- Personnel and equipment replacement.
- Emergency resupply of Class VIII.
- Relocating medical elements.
- Preventive medicine measures.
- Combat stress control.

- Coordinating corps CHS augmentation in support of the division.
- Combat health support augmentation using division medical assets.
- Enemy prisoners of war casualty management.

(2) *Evacuation elements.*

- Locating patient collecting points and AXPs.
- Establishing ambulance shuttle systems.
- Updating the medical evacuation plan, as required, with the corps MRO.
- Monitoring road clearances for corps evacuation vehicles.
- Using nonmedical evacuation platforms.
- Monitoring mass casualty management procedures.
- Refueling and resupplying corps evacuation assets.
- Replacing personnel, equipment, and vehicles.
- Coordinating A2C2 plans.
- Monitoring large area obscurant use for air ambulance A2C2 planning.
- Monitoring NBC casualties.

3-4. Combat Health Support for Division Defensive Operations

a. Division CHS is influenced by the same basic considerations discussed previously in connection with offensive operations. Patient load reflects lower casualty rates, but forward area acquisition of patients is complicated by enemy actions and initial direction of maneuver to the rear during a mobile defense. Combat health support personnel are permitted much less time to reach patients, complete necessary emergency treatment, and remove them from the battle site. Increased casualties among medical personnel further reduces the medical treatment and evacuation capabilities in forward areas.

b. The heaviest patient work load, including those produced by enemy artillery and NBC weapons, may be expected during initial enemy attacks and in counterattacks. The enemy attack may disrupt communications and delay both air and ground evacuation of patients.

c. Because reserve combat forces play a decisive role in defense, location of MTFs must not complicate or interfere with their choice of maneuver. A CHS plan for maneuver reserve forces must be prepared for implementation on short notice. Medical elements identified to support this plan should be used to assist other medical units while awaiting deployment with the reserve force.

d. The depth and dispersion of the mobile defense creates significant time and distance problems inpatient evacuation support to security forces. Security forces may be forced to withdraw while simultaneously carrying their patients to the rear. The use of air ambulances expedites the evacuation of these patients, but requires detailed A2C2 coordination and is dependent on the tactical situation.

e. The probability of initial enemy penetration and the need to reduce support area clutter requires locating medical treatment elements farther to the rear than in the offense.

f. The nature of the defending force's missions and employment requires modification of normal division-level CHS methods. Medical companies are located to the rear of brigade and division AO. During static situations, initial commitment of division ambulances in support of aid stations is minimal. Lengthy, unsecured ground routes may permit patient evacuation only at periodic intervals. In many cases, the MSRs are all but shut down in the brigade area to prevent the enemy maneuver force from exploiting them as high speed avenues of approach into the division rear. This is done to channel the enemy force into engagement areas but it has the negative affect of limiting the ground ambulances' ability to evacuate casualties from the forward areas. The MSMC may need to maintain a high degree of mobility to support areas of high casualty density as the battle develops. The DMOC must maintain a current status of the FSMCs and of the tactical situation. Threat information pertaining to evacuation routes, both air and ground, must be disseminated to all medical evacuation assets.

g. Medical units must be repositioned prior to the defense. This is done to ensure that they can continue to treat and evacuate without having to move. This should be planned to ensure a continuum of care even if the defense becomes a retrograde.

3-5. Retrograde Operations

a. A retrograde operation is a maneuver to the rear or away from the enemy. It is part of a larger form of maneuver to regain the initiative. Its purpose is to improve the current situation or prevent a worse situation from occurring. The objectives of a retrograde operation are to—

- Gain time.
- Preserve forces.
- Avoid combat under undesirable conditions.
- Maneuver the enemy into an unfavorable position.

Retrograde operations may facilitate repositioning forces, shortening lines of communications (LOCs), or permitting unit withdrawal for employment elsewhere. Commanders can use retrograde operations to harass, exhaust, resist, delay, or damage an enemy. Success in retrograde operations requires strong leadership, exemplary organization, and disciplined execution. Because of their effects on other units, retrograde operations require the prior approval of the next higher command. As do other operations, retrograde operations rely on logistics support. Logistics planners advise commanders and operational planners on the status, capabilities, and limitations of the logistics support for retrograde operations. Logistics and CHS planners assist in formulating courses of action, adjusting support operations to conform to the commander's decisions. Logistics unit commanders and staff officers play a key role in assisting and preparing the force for retrograde operations.

b. The three forms of retrograde operations are delays, withdrawals, and retirements. In delays, units yield ground to gain time while retaining flexibility and freedom of action to inflict maximum damage on the enemy. Withdrawing units, whether all or part of a committed force, voluntarily disengage from the enemy to preserve the force or release it for a new mission. In each type of a retrograde, a force not in contact with the enemy moves to the rear—normally by a tactical road march. Commanders direct the retrograde OPLAN and coordinate complementary operations to enhance the probability of success.

c. Combat health support in retrograde movements may vary widely depending upon the operation, the enemy reaction, and the situation. Firm rules that apply equally to all types of retrograde operations are difficult to establish, but certain factors must be considered in CHS planning for retrograde operations.

(1) The effects of time on evacuation and treatment and the number of patients cleared from any battlefield are dependent upon the time and means available. In stable situations and in the advance, time is important only as it affects the physical well-being of the injured. In retrograde operations, time is more important. As available time decreases, the DMOC, the brigade surgeon, and the division surgeon must evaluate the capability to collect, treat, and evacuate all patients.

(2) Evacuation routes are required for the movement of troops and materiel, causing patient evacuation in retrograde movements to be more difficult than in any other type of operations. Command, control, and communications may be disrupted by the enemy. The measures taken to counteract factors impeding evacuation during retrograde movements are beyond the scope of medical authority. For successful evacuation, planning for such events, in conjunction with the appropriate medical authority, should be included in tactical standing operating procedures (TSOPs). Mobility of division medical companies is enhanced by evacuating patients directly from the battalion aid station (BAS) to corps hospitals. However, this technique should only be used when the tactical situation requires rapid relocation of Echelon II MTFs.

(3) Special emphasis must be placed on the sorting (triage) of patients, and consideration must be given to the type of transportation available for evacuation. Seriously wounded patients should be evacuated by the fastest means available. Proper sorting and rapid evacuation of patients lessen the work load on MTFs. This should be a coordinated effort between air and ground modes of patient evacuation.

(4) During a retrograde operations, CHS elements usually displace by echelon and hold patients for the shortest possible time. Locations for successive positions from forward to rear areas must be planned in advance. Since the general direction of movement is toward the location of existing medical elements, initial locations may be placed farther to the rear than in other types of operations. For continuity of support, the next rearward location is occupied by an MTF prepared to function before the forward facility is closed or displaced.

(5) Frequency of displacement is determined by the rate of movement, the distance involved, and the tactical situation. Medical units must be displaced before there is danger of involvement in the action of forces conducting the retrograde operations. Displacement can be made by echeloning within units or by moving complete units.

(6) Future operations to be undertaken at the conclusion of the retrograde operations must be considered when planning CHS. This consideration is most important in maintaining a continuum of care.

(7) When the retrograde operation involves a rearward passage of lines, detailed advance planning between surgeons of the units concerned is required. Prior planning for casualty collecting points, AXPs established with corps evacuation assets and treatment elements, and Class VIII resupply must be accomplished. In retrograde operations, mobility of all CHS elements must be maintained. This permits their rapid movement without the need to abandon patients. The CHS planner can assist in maintaining this mobility by keeping the aid station free of patient accumulation, keeping the clearing station patient load low by coordinating evacuation with supporting medical elements, and by recognizing increases in patient loads early. These principles hold true to units

conducting a passage of lines internally in a division. The CHS plan for support of both divisions during the passage of lines stipulates that the passing division transports its own patients to the rear. Critically sick or injured patients may be transferred to the division in place to expedite their treatment. This technique is employed to preserve the mobility of CHS in the division which is to assume the covering force or defensive role. For definitive information on retrograde operations, see FM 100-5.

3-6. Military Operations Other Than War

a. In addition to war, there are many other Army missions which are prolonged. Military operations other than war (MOOTW) occur during peacetime and conflict. Conflict is characterized by hostilities short of war to secure strategic objectives. The National Command Authorities may commit US Army units to the full range MOOTW including—

- Nation assistance.
- Security assistance.
- Humanitarian assistance and disaster relief.
- Support to counter drug operations.
- Peace enforcement operations.
- Peacekeeping operations.
- Arms control.
- Combatting terrorism.
- Show of force.
- Attacks and raids.
- Noncombatant evacuation operations.
- Support for insurgences and counterinsurgencies.
- Domestic support operations.

b. In MOOTW, the provisions of CHS and health education play a more direct role in countering both the medical and general threat. Combat health support in the full range of MOOTW can be defined as those actions encompassing all military health-related activities taken or programs established to further US national goals, objectives, and missions. For definitive information of CHS in the operations identified above, see FM 8-42.

3-7. Mass Casualty Operations

Procedures for mass casualty operations should be contained in the TSOP of each unit. Tactical standing operating procedures for mass casualty operations are coordinated through the principal staff, approved by the command, and coordinated with subordinate and higher commands. If mass casualty operations are viewed as part of area damage control (ADC) missions, then the medical requirements will be integrated into the overall plan.

3-8. Integrated Battlefield

a. Health planning factors on the integrated battlefield include—

- Increased casualties.
- Supply and resupply disruption.
- Contamination of unit equipment, supplies, and personnel.

- Compromised medical evacuation.
- Mission performance degradation due to individual protective postures.
- Prolonged treatment procedures due to decontamination.
- Disruption of LOCs.
- Equipment damage (high altitude electromagnetic pulse).
- Targeting of specific areas.
- The need to adjust CHS to meet the complexities generated.

b. The integrated battlefield will present mass casualty situations which will develop quickly and have long-lasting residual effects. The range of weapons, NBC weapons/agents, directed-energy weapons, and weapon delivery systems will cause high casualty rates, especially in poorly trained and improperly equipped troops and units. Echelon III and Echelon IV MTFs may well be target areas; this will compromise hospital services.

c. The flexibility of the proposed hospitals and their component construction allows reconstitution of other hospital units or the ability to task-organize to meet the medical needs of the combat zone.

d. The requirement for patient selection/sorting (return to duty [RTD] and nonreturn to duty [NRTD]) is of extreme importance. Many of the patients, particularly those with mild symptoms or combat stress, have excellent RTD potential. These individuals, if promptly and properly treated, may RTD in hours to days and significantly influence the outcome of the battle. It is important not to over evacuate soldiers with minimal or no exposure to NBC hazards to hospitals. Putting these soldiers in hospitals could verify for them that there is really something wrong other than simple fatigue and stress. It could influence their thinking and cause them to exaggerate the severity of their conditions. Putting these soldiers in hospitals could slow their recovery and possibly result in their developing a chronic disability.

e. Those potential RTD patients with chemical effects or radiation exposure requiring hospitalization will be evacuated to CSHs. Combat stress casualties will be evacuated to the appropriate combat stress unit.

APPENDIX A

GUIDE FOR GENEVA CONVENTIONS COMPLIANCE

A-1. General

a. The conduct of armed hostilities on land is regulated by both written and unwritten law. This law of land warfare is derived from two principal sources—

- Practiced and accepted customs.
- Lawmaking treaties, such as the Hague and Geneva Conventions.

b. The rights and duties set forth in these sources are part of the supreme law of the land; a violation of any one of them is a serious offense.

c. An in-depth discussion of the provisions applicable to medical units and personnel is provided in FM 8-10 and FM 27-10.

A-2. Distinctive Markings and Camouflage of Medical Facilities and Evacuation Platforms

This paragraph implements STANAG 2027 and QSTAG 512.

a. All US medical facilities and units, except veterinary, display the distinctive flag of the Geneva Conventions. This flag consists of a red cross on a white background. It is displayed over the unit or facility and in other places as necessary to adequately identify the unit or facility as medical.

This paragraph implements STANAG 2931.

b. Camouflage of medical facilities (medical units, medical vehicles, and medical aircraft on the ground) is authorized when the lack of camouflage might compromise the tactical operation. If the failure to camouflage endangers or compromises 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. It is not envisioned that large, fixed medical facilities will be camouflaged.

NOTE

As used in this context, camouflage means to cover up or remove the emblem. The black cross on an olive background is not a recognized emblem of the Geneva Conventions and is not authorized for use.

A-3. Self-Defense and Defense of Patients

a. When engaging in CHS operations, medical personnel are entitled to defend themselves and their patients. They are only permitted to use individual small arms.

b. Medical personnel are only permitted to fire when they or their patients are threatened with attack by the enemy. Self-defense by medical personnel or the defense of their patients is always permitted.

A-4. Enemy Prisoners of War

a. Sick, injured, or wounded EPW are treated and evacuated through medical channels, but are physically segregated from US or allied patients. The EPW patient is evacuated from the combat zone as soon as his medical condition permits.

b. Personnel resources to guard EPW patients are provided by the echelon commander. Medical personnel DO NOT guard EPW patients.

A-5. 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 or prosecution. Medical personnel should inform the tactical commander of the consequences of violating the provisions of these Conventions.

b. The following acts are inconsistent with an individual or facility claiming protected status under the Geneva Conventions:

- 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.
- Combat health support capabilities decremented.
- Prosecution for violations of the law of war.

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 not recommended.
- Allowing anyone to kill, torture, mistreat, or in any way 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 the distinctive Geneva Conventions emblem for transporting nonmedical troops, equipment, and supplies.
- Using a medical vehicle as a tactical operations center.

e. Possible consequences of violations described in *d* above are—

Criminal prosecution for war crimes.

- Medical personnel being considered prisoners of war rather than retained persons when captured.

NOTE

The use of smoke and obscurants by medical personnel is not a violation of the Geneva Conventions (see FMs 8-10-6 and 3-50 for information on the use of smoke).

APPENDIX B

TACTICAL STANDING OPERATING PROCEDURE

B-1. General

All DMOCs must establish TSOPs. These TSOPs should be detailed and cover all aspects of division CHS operations.

B-2. Sample Tactical Standing Operating Procedure

This appendix provides a sample TSOP for the DMOC. The sample shown is an annex from the division and DISCOM Service Support Standing Operating Procedure (Wartime and Military Operations Other Than War). There is not a standard format for all TSOPs; however, it is recommended that the annex follow the format used by its higher headquarters.

Volume II of DISCOM Service Support Standing Operating Procedure
(WAR AND MILITARY OPERATIONS OTHER THAN WAR)

ANNEX T (MEDICAL), ____ INFANTRY DIVISION SUPPORT COMMAND

TACTICAL STANDING OPERATING PROCEDURES

I. PURPOSE

This annex has been prepared to standardize operations and CHS procedures for the DMOC in time of war and military operations other than war.

II. GENERAL

A. The division surgeon is normally located at division rear CP.

B. The DMOC will be located with the DISCOM at the division rear CP.

III. ORGANIZATION AND MISSION

A. Medical Operations Branch.

1. Responsible for developing the CHS plan/annexes to DISCOM operations.

2. Responsible for reallocating corps-level medical units/elements to the division.

3. Responsible for developing and maintaining CHS troop levels in coordination with the division surgeon.

4. Responsible for (in conjunction with the DISCOM surgeon) planning, monitoring, and allocating PVNTMED and division mental health/CSC resources and programs.

5. Responsible for reviewing and forwarding all medical information of potential intelligence value to the DISCOM S2/S3.

6. Responsible for coordinating and managing the disposition of captured medical materiel.

7. Responsible for coordinating the timely submission of all required reports.

8. Responsible for planning and coordinating patient evacuation to corps MTFs.

9. Responsible for developing and coordinating the division mass casualty plan for treatment and evacuation.

10. Responsible for coordinating with the medical evacuation battalion for medical evacuation support and for the forward siting of corps ambulances within the division.

B. Medical Materiel Management Branch. Responsible for coordinating and managing the CHL, blood, and medical equipment maintenance program for the division. As a general rule, the Class VIII resupply will be coordinated and monitored by the DMSO that is located with the MSMC.

C. Patient Disposition and Reports Branch. Responsible for coordinating patient dispositions, preparing statistical reports, and submitting reports to higher headquarters. They will also track the evacuation of patients in and from the division.

D. Medical Communications Branch. Responsible for operating and maintaining the medical operations communications net with all DISCOM and corps medical units.

IV. ECHELON II COMBAT HEALTH SUPPORT

A. The DISCOM provides Echelon II medical treatment, evacuation, and Class VIII resupply on an area basis through the deployment of FSMCs and the MSMC. One FSMC operates in DS of each maneuver brigade and locates an MTF in the BSA of the supported brigade. The MSMC locates and establishes an MTF in the DSA.

B. Combat health support is provided on an area support basis to nondivisional units operating within the division AO.

v. MEDICAL EVACUATION

A. General.

1. Evacuation is based on the principle that rear higher echelon medical units are responsible for evacuating patients from supported units. Lower echelon supported and supporting units must ensure evacuation support plans are complete and current by close, direct coordination. See FM 8-10-6 for an in-depth discussion of medical evacuation; for additional information, refer to FMs 8-10, 8-10-1, 8-10-4, 8-10-24, 8-42, 8-55, 63-20, and 63-21.

2. Patients are evacuated no further to the rear than necessary to obtain that medical care which will return them to duty. Patients are evacuated by the means of transportation which most clearly meets the treatment demands of their wounds, injury, or illness.

3. Allied military personnel, treated or held in a division MTF within reasonable proximity of their own national facility, are classified and processed as follows:

a. Allied military personnel requiring further treatment, but in stable condition for immediate transfer, are returned to their own national medical facility, as coordinated through liaison with the corps or division surgeon.

b. Allied military personnel requiring further stabilization are retained in US medical channels until they can be safely transferred to their own national MTFs. Complete arrangements for reception of the patient by the gaining MTF are completed prior to the evacuation.

c. The preferred method for evacuation of NP and BF casualties who can be managed without medications or physical restraints is nonambulance ground vehicle. If physical restraints and/or medications are required during transportation, ground ambulance is preferred. An air ambulance should only be used if no other means of evacuation is available. Physical restraints are used only during transport and medications are given only if needed for reasons of safety. Those NP/BF patients with life- or limb-threatening conditions are evacuated by the most expedient means available. If evacuation is by air ambulance, physical restraints will be used. See FMs 8-10-6 and 8-51.

d. Patients are not held longer than 72 hours in the division holding elements of the MTFs. If patients cannot be treated and returned to duty within 72 hours, they are evacuated as soon as possible.

B. Control of Property and Equipment.

1. Soldiers evacuated from the BAS (Echelon I) will be transported to the next higher (Echelon II) MTF with their protective mask and clothing only.

2. Any property and equipment arriving with casualties other than the protective mask and clothing at the FSMC will be collected and turned in to the parent unit for final disposition. The FSB S4 coordinates the return of property and equipment to the casualty's unit.

3. Under combat conditions, protective masks are kept in the immediate proximity of each patient throughout their period of evacuation and stay at MTFs. In MOOTW, the protective mask policy for patients will be based on the NBC threat and the policy established by higher headquarters.

C. Ground Evacuation.

1. Ground evacuation is considered the primary means of evacuation in the combat zone. Ground evacuation will be accomplished by organic ambulances; however, in emergencies any military

vehicle may be used. Aeromedical evacuation forward of the DSA cannot be expected unless allied forces have air parity or superiority.

2. When dedicated medical evacuation means are not available, ground/air assets will be used to backhaul casualties to MTFs.

3. Maneuver battalion medical platoons will provide ground evacuation from the maneuver elements back to the BAS. Company aid posts and patient collecting points will be established as a part of the battalion medical support plan.

4. The ambulance platoon of the FSMC will provide ground evacuation from the BAS. The medical platoon of separate battalions attached to the brigade will receive ambulance support on an area basis. The ambulance platoon also provides area support ambulance coverage for the BSA.

5. The ambulance platoon of the MSMC provides area support ambulance coverage for the DSA and supporting corps units attached or OPCON to the division.

D. Rules for Ambulance Use and Ambulance Personnel.

1. The use of medical evacuation vehicles will be restricted to—

a. Transportation of sick or injured personnel.

b. Transportation of medical personnel.

c. Transportation of Class VIII supplies/equipment and blood.

2. Medical personnel assigned to the ambulances will—

a. Adhere to the tactical commanders's standards for uniform and camouflage and other requirements identified in the supported unit's TSOP.

b. Participate in the medical training being conducted at the supported medical element.

c. Assist with patient treatment as required.

NOTE

Caution should be exercised by the BAS or treatment team officer in charge/noncommissioned officer in charge so as to allow the ambulance crew adequate rest in order that they may safely perform their evacuation duties.

d. Perform preventive maintenance checks and services (PMCS) on their vehicles.

e. Ensure their vehicle is restocked with required Class VIII, full of fuel, and ready for the next evacuation mission.

3. Medical personnel assigned to the ambulances which are positioned with the supported medical element will not be required to—

a. Perform duties as kitchen police (KPs), EPW or perimeter guards, or drivers of other than their assigned vehicle.

b. Violate the provisions of the Geneva Conventions.

E. Air Evacuation.

1. Aeromedical evacuation is the preferred method of evacuation and will routinely be used when—

a. Life, limb, or eyesight is in jeopardy.

b. Speed, distance, and time are factors in assuring prompt and adequate treatment.

c. There is a critical need for resupply of Class VIII or whole blood/blood products.

d. There is a critical need for movement of medical personnel and equipment.

2. Aeromedical evacuation support to the division will be provided by air ambulances from the supporting corps medical evacuation battalion. Where tactical situations permit, a helicopter landing site should be marked with a letter "H" or a letter "Y," using identification panels or other appropriate marking material. See FMs 8-10-6 and 57-38 for a complete description and guidelines for establishing a helicopter landing zone.

3. Precedence for air ambulance evacuation is provided in FM 8-10-6.

VI. DECEASED PERSONNEL

A. Principles Governing Medical Disposition of Deceased Personnel.

1. The deceased, as determined by the senior medical authority, are not evacuated with other casualties nor are they evacuated on medical vehicles. A US Field Medical Card (FMC), DD Form 1380, should be initiated, signed by a physician, and attached to the remains, if possible.

2. Deceased personnel are segregated from other casualties.

3. Prior to their transport from a graves registration collecting point operating in forward areas, all deceased personnel must have an FMC which is signed by a medical officer.

B. Use/Nonuse of Principles Governing Medical Disposition of Deceased Personnel.

1. These principles are not an absolute.

2. Field commanders should have an understanding of the rationale behind the above principles when making command decisions pertaining to deceased personnel.

VII. ENEMY PRISONERS OF WAR

A. All EPWs will be provided medical care according to the articles of Geneva Convention for the Amelioration of the Conditions of the Sick and Wounded in Armed Forces in the Field, dated 12 August 1949.

B. Enemy prisoner of war patients will be segregated from US and allied personnel.

C. Enemy prisoner of war patients will be reported through normal medical reporting procedures.

D. Enemy medical personnel are considered retained personnel and shall receive the benefits provided by the Geneva Conventions. Retained enemy medical personnel will be used to the maximum extent possible to care and treat EPW patients.

E. Enemy prisoner of war patients will be evacuated through medical channels.

F. Enemy prisoner of war patients will be under armed guard at all times. Guards are the responsibility of the echelon commander.

G. Enemy prisoner of war patients will be searched prior to every step while in the medical treatment and evacuation system.

H. Information on EPW patients will be coordinated with the prisoner of war information center to maintain accountability of captives in medical channels. See FM 19-4 for additional information on EPWs.

VIII. CLASS VIII SUPPLY

A. Battalion aid stations will request Class VIII resupply from their supporting FSMC.

B. Forward support medical companies will request Class VIII resupply from the DMSO located in the MSMC. The DMSO is responsible for maintaining the division basic load of medical supplies.

C. Property exchange will be accomplished for all medical materiel (litters, evacuation bags, wool blankets, IV stands, and splints) accompanying patients during evacuation.

D. Air and ground ambulances moving forward should be used to the maximum to carry Class VIII resupply and replacement medical personnel.

E. Medical maintenance will consist of–

1. Operator/user-level maintenance which requires that medical personnel exercise their responsibilities by performing operator PMCS, to include—

a. Maintaining equipment by performing routine services like cleaning, dusting, washing, and checking for frayed cables and loose hardware.

b. Performing equipment operational testing

c. Replacing operator-level spares and repair parts that will not require extensive disassembly of the end item, critical adjustment after the replacement, nor extensive use of tools.

d. Annotating appropriate documentation.

2. Division medical equipment repairers will exercise their responsibilities by—

a. Scheduling and performing their PMCS functions, electrical safety inspections and test, and calibration, verification, and certification services.

b. Performing unscheduled maintenance functions with emphasis upon the component-level repairs and replacement of assemblies, modules, and printed circuit boards.

c. Operating a medical equipment repair parts program.

d. Maintaining a technical library of operator and maintenance technical manuals (TMs) and/or associated manufacturers' manuals.

e. Conducting inspections for new or transferred equipment.

f. Maintaining documentation of maintenance functions in accordance with the provisions of TB 38-750-2 or the DA standard automated system.

g. Collecting and reporting data for readiness reportable medical equipment according to AR 700-138.

h. Notifying the supporting MEDLOG battalion (forward) of requirements for maintaining support services, repairable exchange, or replacement from the Medical Standby Equipment Program (MEDSTEP) (see AR 40-61).

IX. BLOOD MANAGEMENT POLICIES AND PROCEDURES

A. Responsibilities.

1. The division surgeon is ultimately responsible for the division's blood program.

2. The DMOC, in coordination with the division surgeon, is responsible for the overall planning and execution of the division's blood program according to TM 8-227-11.

3. The HSMO of the MMMB monitors and coordinates the division blood program. The DMSO, in coordination with the DMOC, is responsible for managing blood inventory levels and ordering blood for the division.

4. Medical company commanders, through their treatment platoon leaders, monitor blood usage and inventory levels.

5. The medical laboratory specialists of each area support treatment squad are the technical advisors to the medical company commanders and treatment platoon leaders on all matters pertaining to the blood program.

6. Each medical company will maintain an inventory of between 30 to 50 units of Group O packed red blood cells for wartime operations. In MOOTW, the division surgeon will establish inventory levels. The DMSO will maintain 30 to 50 units of Group O packed red cells for each medical company supported. Blood stockage levels will be adjusted as necessary to meet division blood requirements.

B. Delivery of Blood.

1. Blood will be shipped by air when circumstances permit. Unless otherwise requested, 15 percent of the blood requested should be Rh Negative. During shipment, blood will be continuously maintained at a temperature within the range 1 degree to 10 degrees Centigrade.

2. Blood still on hand 5 days before expiration date will be kept properly refrigerated and returned to the DMSO.

C. Blood Management Report.

1. Depending on the tactical situation and the command policy, the blood report (BLDREP) may be transmitted by voice or written means (transmitted electronic message, telephonically, or by courier).

2. Medical companies will submit their requirements for the following day and the status of blood on hand to the DMSO with information copies to the DMOC and division surgeon. Medical companies will consolidate and submit requirements as of ____ Z daily to arrive not later than (NLT) _____ Z on the reporting date.

X. MANAGEMENT OF MASS CASUALTIES

A. Mass casualty situations occur when the number of casualties exceed the available medical capability to rapidly treat and evacuate them.

B. All DISCOM medical companies must have procedures in place to respond effectively to mass casualty situations. The potential of disasters in war and MOOTW require that DISCOM medical companies

be prepared to support mass casualty situations. They must be able to receive, triage, treat, and evacuate large numbers of casualties within a short period of time. Contingency plans for mass casualty support must be developed by all DISCOM medical companies in coordination with their battalion S3. Unit mass casualty plans as a minimum will address the following subject areas:

1. Planning and training requirements.

2. Medical duty positions.

3. Nonmedical personnel positions and duties, including litter teams, perimeter guards, crowd control, and information personnel.

4. Location of treatment areas, to include triage, delayed care, immediate care, minimal care, and expectant care areas.

5. Support requirements beyond the unit's capability.

6. Medical evacuation.

7. Use of nonmedical transportation assets.

8. Nuclear, biological, and chemical casualties.

9. Return to duty procedures.

10. Medical records and reports.

C. The DMOC should be informed of any mass casualty situation by the most expedient means available. The information should include as a minimum: location, anticipated number of casualties, and additional support required.

D. The DMOC directs and coordinates CHS requirements for the requesting unit. Supporting corps and DISCOM medical units in the chain of evacuation are alerted of the situation.

XI. PREVENTIVE MEDICINE

A. The division PVNTMED section is located in the MSMC in the DSA.

B. The PVNTMED section is responsible for supervising the division's PVNTMED program as described in AR 40-5. This section ensures PVNTMED measures are implemented to protect division personnel against food-, water-, and arthropodborne diseases, as well as environmental injuries (for example, heat and cold injuries). This section provides advice and consultation in the areas of environmental sanitation, epidemiology, sanitary engineering, and pest management.

C. Preventive medicine personnel will conduct evaluations to identify actual and potential health hazards, recommend corrective measures, and assist in training personnel in disease prevention programs.

D. Preventive medicine support is requested through the DMOC and formal tasking is accomplished through the DISCOM support operations section, through the MSB support operations section to the MSMC.

E. All unit-sized elements in the division will establish unit field sanitation teams. Preventive medicine personnel will assist in the training of field sanitation teams in the aspects of environmental sanitation and the limited control of animal reservoirs and disease vectors.

F. Company/battery/troop commanders will–

1. Use trained field sanitation team members on all field exercises to assist in preserving the health of the unit and reducing the incidence of DNBI which will hinder mission accomplishment (FM 21-10).

2. Ensure the field sanitation team members take to the field all required field sanitation equipment and supplies to perform their duty (AR 40-5).

3. Enforce food and water safety standards. Unless otherwise stated, water will be treated to at least 5 parts per million chloride residual and will be obtained from approved sources only. Safe handling, storage, and preparation of food will be according to AR 30-21, AR 40-5, and FM 21-10.

4. Plan for the construction of hygienic devices, such as handwashing devices in the unit area. They will also enforce personal hygiene measures to reduce the threat of disease.

5. Motivate subordinates to execute individual preventive measures (such as using insect repellents; carrying an extra pair of dry socks; and/or eating or drinking from approved sources only).

6. Develop and enforce the unit sleep plan which provides soldiers with a minimum of 4 hours of uninterrupted sleep in a 24-hour period. If sleep is interrupted, then 5 hours should be given. During continuous operations when uninterrupted sleep is not possible, blocks of sleep which add up to 6 hours in a 24-hour period are adequate for most people. Remember, 4 hours each 24-hour period is far from ideal. Do not go with only 4 hours sleep each 24 hours for more than 2 weeks before paying back sleep debt. If at all possible, give 6 hours of sleep a day to individuals (such as ambulance drivers) whose key duties are vulnerable to sleep loss.

7. Plan for measures to prevent environmental injuries (such as heat or cold) (see FM 21-10).

8. Obtain and disseminate information on the medical threat so soldiers can reduce their risk of DNBIs.

9. Request PVNTMED consultation/assistance through the DMOC and/or the MSB support operations section.

XII. DIVISION DENTAL SERVICES

A. Dental treatment facilities are located in each FSMC and in the MSMC. Dental sick call hours are established by each medical company and distributed to supported units.

B. The division dental surgeon establishes policies and procedures for dental services in the division. He plans and supervises the preventive dentistry program for the division according to AR 40-35.

C. In wartime operations, division dental services are limited to emergency, preventive, and general dental care (see FM 8-10-19).

D. In MOOTW, dental services are METT-T driven but, as a minimum, include emergency, preventive, and general dental care. In some operational scenarios, specialty dental care will also be provided in the division.

E. Dental personnel will assist medical treatment personnel in mass casualty situations.

XIII. DIVISION MENTAL HEALTH/COMBAT STRESS CONTROL

A. The DMHS is located in the MSMC. One DMHS NCO and one mental health officer (social worker or psychologist) will routinely support each maneuver brigade as its CSC team. The division psychiatrist, assisted by the mental health staff, is responsible for supervising, coordinating, and providing mental health/CSC support for the division.

B. The division psychiatrist, assisted by the mental health staff, prepares mental health/CSC estimates as directed or required to support CHS operations. These mental health/CSC estimates may pertain to the following subject areas:

1. Mental health status of the division.

2. Current status of morale and unit cohesion in division units.

3. Battle fatigue casualty estimates.

4. Effect of fatigue and sleep loss.

5. Percent of casualties; intensity of combat.

6. Home-front stressors (natural disaster, unpopular support of the conflict, terrorist attack in or around home base).

7. Restoration requirements.

8. Corps CSC support requirements.

9. Coordination of consultations (critical events debriefings) following critical events such as a fatal accident, rear battle incident, or other catastrophic event.

C. The division psychiatric or mental health staff should be consulted prior to the evacuation of NP patients from the division.

XIV. OPTOMETRY SERVICE

A. The optometry section is organic to the MSMC,

B. Optometry services in the division include–

1. Routine vision evaluation and refractions.

2. Evaluation and management of ocular injuries and disease,

3. Spectacle frame assembly using presurfaced single-vision lenses.

4. Spectacle repair services for units within the division AO.

C. The optometry officer is responsible for advising commanders on all matters relating to vision, to include protective eyewear (ballistic and laser protection).

D. This section ensures that division procedures are established for personnel who require optometry services. These procedures may include the following:

1. Each soldier requiring prescription eyewear deploying with two pair plus inserts for protective mask.

2. Personnel authorized to wear contact lenses deploying with two pairs of standard eyewear.

3. Optometry section maintaining a copy of the most recent prescription for each soldier assigned to the division.

4. Soldiers requiring optometry services being referred from their supporting MTF.

5. Eyewear that is broken or in need of repair being sent to the optometry section for repair or replacement.

6. Request for replacement of lost eyewear being forwarded to the optometry section.

XV. GENEVA CONVENTIONS COMPLIANCE

A. Medical Facilities.

1. All US medical facilities and units, except veterinary, will display the distinctive flag of the Geneva Conventions. This flag consists of a red cross on a white background. It is displayed over the unit or facility and in other places as necessary to adequately identify the unit or facility.

2. Camouflage of the medical facility (medical units, medical vehicle, and medical aircraft on the ground) is authorized when a lack of camouflage might compromise the tactical operation.

3. The order to camouflage may be given by a brigade-level or higher commander.

NOTE

As used in this context, camouflage means to cover up or remove the emblem. The black cross on an olive background is not a recognized emblem of the Geneva Conventions.

B. Defense of Medical Units.

1. The medical unit's defense plans must be coordinated with the defense plans of adjacent units in the same area. A medical unit will not be employed as part of the combat reserve of a tactical unit.

2. The medical unit commander is responsible for the local security of his unit (to include perimeter defense).

3. Personnel of medical units are entitled to defend themselves and their patients.

4. Personnel of medical units are only permitted to fire when they or their patients are threatened with attack by the enemy. Self-defense by medical personnel or the defense of their patients is always permitted.

XVI. MEDICAL REPORTING

A. Field Medical Card. The FMC will be initiated for each new patient and for cases required to be carded for record only. This will be accomplished according to AR 40-66 and FMs 8-10-6 and 8-230. Field Medical Cards will be conspicuously attached to the patient's clothing.

B. Daily Disposition Log. The DDL is maintained by all Echelon I and Echelon II MTFs assigned or attached to the division. Information from this log is extracted, when required, and provided to the S 1 or the supported unit requesting the information. The DDL is also the primary source document for information needed in the preparation of the PSR and the PE&MR. See Appendix 1, page B-16, for a sample format.

C. Medical Reports Format. Formats for medical reports are required to maintain consistency and continuity in reporting procedure for information submitted to the DMOC and to the division headquarters. Data contained in these reports are required to support the division surgeon's capability projections and to assist the DMOC in coordinating and planning CHS operations. Data is also extracted for consolidated reporting to higher headquarters. The guidelines presented below should be followed exactly.

1. Each line of information is divided into a number of fields. Each field has a minimum number of alphanumeric characters as indicated in the sample format provided (see Appendix 2, page B-17).

2. Each field is separated by a single slash (/).

3. The end of each set of fields is indicated by a double slash (//).

4. If information from a prior report has not changed, "NC" will be entered in that field (/NC/).

5. Reports are formatted according to special instructions and reports format. A sample message is provided with each appendix.

D. Medical Situation Report, Battalion Aid Station. The Medical Situation Report, BAS, is a daily patient summary report. This report is used to inform the commander of the battalion's patient, Class VIII, and medical equipment status. This report is submitted daily, covering the events in a 24-hour time period beginning and ending at _____ Z. The report is also forwarded NLT _____ Z to the supporting medical company. The battalion surgeon (platoon leader) or platoon sergeant is responsible for this report. This report may be dispatched via courier, FAX, and/or teletype. See Appendix 2 for a sample format.

E. Medical Situation Report, Medical Companies. The Medical Situation Report, Medical Companies, is a daily patient summary report. This report is submitted daily as of _____ to arrive NLT _____ Z to the DMOC. The following information will be included in line six of this report:

1. Status of all assigned and attached ambulances, to include—

   a. Total number of ambulances.

   b. Number of ambulances that are operational.

   c. Number of ambulances that are nonoperational.

2. Status of personnel, identify shortages by area of concentration (AOC) or MOS.

3. Treatment of any EPW will be entered in this section.

4. Identify all patients seen during the reporting period with a number and provide the following information in the order provided below:

   a. Nationality.

   b. Name.

   c. Rank.

   d. Service number.

   e. Unit.

f. Date of birth.

g. Diagnosis.

h. Disposition.

i. Date of disposition.

j. Gaining unit.

5. A hard copy of each BAS's Medical Situation Report must accompany the submitting medical company's report. See Appendix 3, page B-18, for a sample format.

F. Medical Situation Report, Medical Operations. The Medical Situation Report, Medical Operations, is a consolidated patient summary report. This report is consolidated by the DMOC and pertains to the previous 24 hours. It is submitted daily to the division surgeon usually NLT____Z from the DMOC. See Appendix 4, page B-19, for a sample format.

G. Patient Evacuation and Mortality Report. The PE&MR is prepared by all Echelons I and II MTFs assigned or attached to the division. The purpose of this report is to provide a status of patients seen by division MTFs. This is a weekly report compiled as of 2400 each Sunday and distributed each Monday to supported units. See Appendix 5, page B-20, for a sample format.

H. Patient Summary Report. The PSR provides a status of patients seen by the DISCOM'S subordinate medical companies and includes their subordinate elements (dental, optometry, mental health, or attached units). The PSR is a weekly report compiled as of 2400 each Sunday. It is prepared by all Echelons I and II MTFs operating in the division AO. It is submitted each Monday to the DMOC. See Appendix 6, page B-21, for a sample format.

I. Blood Report. The Blood Report is a required report for requesting blood support. Echelon II MTFs may request only Group O Positive and O Negative liquid red blood cells. See Appendix 7 for sample formats (Sample Format A, page B-22, for written blood report and Sample Format B, page B-23, for voice message format). Master menu codes for the blood reports are shown in Table B-1, page B-24.

J. Logistical Status Report. The Logistical Status Report provides updates to the DMOC on the logistical status to include Class VIII of DISCOM medical units. The chief, DMOC, will determine the frequency and times for submission of this report based on the mission and CHS planning requirements. See Appendix 8, pages B-25 and B-26, for a sample format.

K. Team Movement Report. The Team Movement Report is used to track the status and location of teams (PVNTMED, combat stress, veterinary, ambulance, and treatment teams). See Appendix 9, page B-27, for a sample format.

L. Report Codes. Codes for use in compiling reports are shown in Appendix 10, page B-27 (Tabs A through D, pages B-28 through B-33).

APPENDIX 1

SAMPLE FORMAT (DAILY DISPOSITION LOG) TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

DAILY DISPOSITION LOG

DTG:

NAME	GRADE	SSN	UNIT/NATION	INJURY/ILLNESS STATUS	DISPOSITION TIME
SHAW, L.	03	000000000	A TRP RECON	GSW, L-LEG/WIA	CLR-0900Z
BAKER, C.	E4	000000000	C3, 6 INF/US	SICK/MIGRAINE/ DIS	RTD-1400Z
DEVLIN, J.	E6	000000000	A1, 6 INF/US	LACERATION-L HAND/NBI	CLR-1200Z
EPW (UNKNOWN)			EPW	FRAG WOUND OF HEAD/DOA/KIA	MA-1220Z
IVANOVICH, N.	04	000000000	EPW	SW R-ARM/WIA	MP/BDE SCTY ELEM-1400Z
WORTHINGTON, P.	E8	000000000	B TRP RECON SQDN/US	BF/DNBI	CLR-1640Z
JENSEN, S.	E5	000000000	6 PANZER/GE	BURN, 3D DEGREE CHEST/ABDOMEN/WIA	CLR-1400Z
EDWARDS, F.D.	02	000000000	C BTRY, 3 FA/US	PUNCTURE WOUND R-ANKLE/WIA	CLR-1400Z
PRUITT, M.	E1	000000000	B TRP RECON SQDN/US	CHEMICAL INJ SYSTEMIC/WIA	15TH CSH-1705Z
MARLOW, E.	E3	000000000	B TRP RECON SQDN/US	DE INJ BOTH EYES	15TH CSH-1815Z
TREVINO, A.	E7	000000000	A TRP RECON SQDN/US	UNCONTROLLED VOMITING-BW/WIA	CLR-1900Z

NOTE: THIS LOG, IN THE ABOVE FORMAT, IS MAINTAINED BY ALL DIVISIONAL TREATMENT FACILITIES. IT DOES NOT LEND ITSELF FOR TRANSMISSION. HOWEVER, THE INFORMATION MAY BE EXTRACTED AND PROVIDED TO AGENCIES RESPONSIBLE FOR PREPARING THE CONSOLIDATED FEEDER REPORT.

LEGEND:

BDE	BRIGADE	DTG	DATE-TIME GROUP	L	LEFT
BF	BATTLE FATIGUE	ELEM	ELEMENT	MA	MORTUARY AFFAIRS
BW	BIOLOGICAL WARFARE	FA	FIELD ARTILLERY	MP	MILITARY POLICE
CLR	CLEARING (STATION)	FRAG	FRAGMENTATION (WOUND)	NBI	NONBATTLE INJURY
DE	DIRECTED ENERGY	GE	GERMAN	R	RIGHT
DIS	DISEASE	GSW	GUN SHOT WOUND	RECON	RECONNAISSANCE
DNBI	DISEASE AND NONBATTLE INJURY (PURPLE HEART NOT AUTHORIZED)	INF	INFANTRY	SCTY	SECURITY
		INJ	INJURY	SQDN	SQUADRON
		KIA	KILLED IN ACTION (PURPLE HEART AUTHORIZED)	TRP	TROOP
DOA	DEAD ON ARRIVAL			US	UNITED STATES
				WIA	WOUNDED IN ACTION (PURPLE HEART AUTHORIZED)

APPENDIX 2

SAMPLE FORMAT (MEDICAL SITUATION REPORT, BAS)

TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

FM: BN AID STATION

TO: CDR, FSMC //

INFO: BDE SURG // DMOC (AS APPROPRIATE) //

CLASSIFICATION: (AS APPROPRIATE)

SUBJECT: MEDICAL SITUATION REPORT (BAS)

LINE ONE: AS OF: DTG IN ZULU TIME

LINE TWO: LOCATION (SIX DIGIT GRID COORDINATES)

LINE THREE: NUMBER OF PATIENTS SEEN (INCLUDING TYPE OF PATIENTS [W=WIA, D=DNBI])

LINE FOUR: NUMBER OF PATIENTS RETURNED TO DUTY

LINE FIVE: NUMBER OF PATIENTS EVACUATED FROM BATTLE AREA

LINE SIX: NUMBER OF PATIENTS AWAITING EVACUATION

LINE SEVEN: NUMBER OF OPERATIONAL AMBULANCES BY TYPE OF VEHICLE (M996, M113)

LINE EIGHT: LOGISTIC STATUS (GREEN, AMBER, OR RED/USE REPORT CODES IN APPENDIX 11)

APPENDIX 3

SAMPLE FORMAT (MEDICAL SITUATION REPORT, MEDICAL COMPANY)

TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

FM: MEDICAL COMPANY COMMANDER

TO: DIVISION MEDICAL OPERATIONS CENTER

INFO: NONE

CLASSIFICATION: (AS APPROPRIATE)

SUBJECT: MEDICAL SITUATION REPORT

LINE ONE: AS OF: DTG IN ZULU TIME

LINE TWO: PATIENT STATUS (WIA, DNBI)//UNIT DESIGNATION//** TOTAL NEW PATIENTS SEEN/ CONSOLIDATED BY EACH FSMC (BAS TOTAL [W=,D=])/FSB (W=,D=)/PNT RTD (BAS TOTAL=+FSB=#)//TOTAL # PATIENTS EVACUATED TO BDE REAR(DSA=#, TO CORPS)//# OF NEW PATIENT HOLDING//END OF DAY HOLDING CENSUS

LINE THREE: UNIT STATUS

**6 DIGIT COORDINATES//# OF COTS AVAILABLE FOR HOLDING//# OF COTS OCCUPIED//# OF COTS UPLOADED ON VEHICLE, TIME NEEDED TO GET HOLDING AREA OPERATIONAL.

**INDICATES THAT OPERATIONAL COTS ARE ASSEMBLED AND READY FOR PATIENTS

LINE FOUR: ANTICIPATED UNIT MOVE IN NEXT 24 HOURS/*#; IF NONE, REPORT "O" UNIT//ANTICIPATED NEW LOCATION//ANTICIPATED TIME BECOMING OPERATIONAL (DTG)//

*PROJECTED NUMBER OF PATIENTS REQUIRING EVACUATION TO REAR

LINE FIVE: COMBAT HEALTH LOGISTICS

**GREEN, AMBER, OR RED

**DENOTES MEDICAL PERSONNEL MAKING DETERMINATION OF COLOR STATUS BY UNIT STOCKAGE LEVEL AND PROJECTED OPERATIONS. CLARIFY ALL AMBER AND RED STATUS IN REMARKS. GREEN=80-100%; AMBER=65-80%; RED=LESS THAN 65% OF INITIAL STOCKAGE LEVEL

LINE SIX: EVACUATION ASSETS

NUMBER OF AMBULANCES OPERATIONAL IN BSA/DSA

LINE SEVEN: INCLUDE # OF NBC PATIENTS//# OF EPW PATIENTS// PERSONNEL SHORTAGES//MAJOR END ITEM SHORTAGES (BASIS FOR LINE FIVE STATUS) USE REPORT CODES IN APPENDIX 11

APPENDIX 4

SAMPLE FORMAT (MEDICAL SITUATION REPORT, MEDICAL OPERATIONS)

TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

FM: DIVISION MEDICAL OPERATIONS CENTER

TO: DIVISION SURGEON

INFORMATION: NONE

CLASSIFICATION: AS APPROPRIATE

SUBJECT: MEDICAL SITUATION REPORT

LINE ONE: AS OF: DTG IN ZULU TIME

LINE TWO: PATIENT STATUS

TOTAL NEW PATIENTS W=#, D=#//NUMBER OF RTD//# OF PATIENTS EVACUATED TO CORPS/ /# OF NEW PATIENTS IN HOLDING STATUS//END OF DAY HOLDING STATUS CENSUS

LINE THREE: UNIT STATUS

*UNIT DESIGNATION//6 DIGIT GRID COORDINATES//# OF OPERATIONAL COTS//# OF UNOCCUPIED COTS//# OF COTS UPLOADED ON VEHICLES, TIME NEEDED TO BE OPERATIONAL.

*ONE PARAGRAPH FOR EACH FSMC ASSIGNED OR ATTACHED TO THE DIVISION AND ONE FOR THE MSMC COMPANY. TO BE REPORTED AS ALPHA, BRAVO, CHARLIE, ETC.

LINE FOUR: ANTICIPATED OPERATIONS IN NEXT 24 HOURS; IF ONE, STATE UNIT DESIGNATION// ANTICIPATED DTG CLOSING TIME (NONOPERATIONAL)//ANTICIPATED NEW LOCATION// ANTICIPATED OPERATIONAL TIME//

LINE FIVE: COMBAT HEALTH LOGISTICS

DMSO IDENTIFICATION, GREEN, AMBER, OR RED//UNIT ID WITH AMBER OR RED//UNIT ID WITH AMBER OR RED, STATUS LEVEL (AMBER OR RED)

APPENDIX 5

SAMPLE FORMAT (PATIENT EVACUATION AND MORTALITY REPORT)

TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

PATIENT EVACUATION AND MORTALITY REPORT

DATE TIME GROUP (DTG): _____

(FROM) / (TO)

ALPHA (EVACUATED)

NAME	GRADE	SSN	*UNIT/NATION	TENTATIVE DIAGNOSIS	DESTINATION DTG
WILSON, C.	03	000000000	A TRP RECON SQDN/US	MULTIPLE GSWs ABDOMEN AND L-THIGH	15TH CSH/ 251015Z MAR 86
O'BRIEN, S.	05	000000000	HHC, CAB 7ID/US	FUO	15TH CSH/ 251215Z MAR 86
HULLEY, A.	05	000000000	HHC, 3D BN 6 INF/US	ACUTE MYOCARDIAL INFARCTION	15TH CSH/ 251535Z MAR 86

BRAVO (EXPIRED)

NAME	GRADE	SSN	UNIT/NATION	CAUSE OF DEATH	DTG
BOUNDER, R.	E3	000000000	B TRP RECON SQDN/US	BURN, THERMO, 3D DEGREE 26 PERCENT	251415Z MAR 86
STUART, M.			EPW	FRAGMENTATION WOUND OF HEAD	251600Z MAR 86
FAULKNER, W.F.	E5	000000000	6 PANZER/GE	RADIATION BURN/MULTIPLE GSWs-SEVERE TRAUMA	251805Z MAR 86

NOTES:

1. THIS IS A BY-NAME REPORT WHICH INCLUDES TWO CATEGORIES OF INFORMATION: THE NAME, GRADE, SSN, UNIT, DIAGNOSIS, AND DESTINATION AND DATE-TIME- GROUP OF PATIENTS EVACUATED (ALPHA); AND THE NAME, GRADE, SSN, UNIT AND CAUSE OF DEATH OF PATIENTS WHO EITHER DIED EN ROUTE, OR WHILE AT A REPORTING MTF (BRAVO).

2. THIS REPORT, WHEN COMPLETED, WILL BE CLASSIFIED IN ACCORDANCE WITH LOCAL COMMAND POLICY—ENCODE/ENCRYPT FOR TRANSMISSION.

*UNIT/NATION FOR ENEMY PRISONER OF WAR WILL BE LISTED AS "EPW."

APPENDIX 6

SAMPLE FORMAT (PATIENT SUMMARY REPORT) TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

PATIENT SUMMARY REPORT

DTG: _____

(FROM) / (TO)

		WIA	NBI	DISEASE	*NP	TOTAL
	PATIENTS					
ALPHA	US	_____	_____	_____	_____	_____
BRAVO	ALLIED	_____	_____	_____	_____	_____
CHARLIE	EPW	_____	_____	_____	_____	_____
	DISPOSITION TOTALS					
DELTA	RETURNED TO DUTY			_____		
ECHO	EVACUATED BY AIR			_____		
FOXTROT	EVACUATED BY GROUND			_____		
GOLF	EXPIRED EN ROUTE			_____		
HOTEL	EXPIRED IN MTF			_____		

NOTE: THIS REPORT, WHEN COMPLETED, WILL BE CLASSIFIED IN ACCORDANCE WITH LOCAL COMMAND POLICY–ENCODE/ENCRYPT FOR TRANSMISSION.

* NEUROPSYCHIATRIC STRESS-RELATED PATIENTS SHOULD BE RECORDED HERE.

APPENDIX 7

SAMPLE FORMAT (BLOOD REPORT) TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

SAMPLE FORMAT A

MESSAGE BLOOD REPORT

FM: CDR CHARLIE MED 34FSB

TO: DIVISION MEDICAL SUPPLY OFFICE

INFO: DIVISION SURGEON

CLAS UNCLAS

OPER/VALIANT EAGLE

MSGID/BLDREP/CMED34FSB/1012221//

REF/A/CDRUSACOM/O90300ZJAN92/-/NOTAL//

ASOFDTG/100001ZJAN92// (LINE 1)

REPUNIT/CMED34FSB/G/BZ44327432// (LINE 2)

BLDINVT-/-/20JS// (LINE 3)

BLDREQ/30JSW// (LINE 4)

BLDEXP/2JS// (LINE 5)

BLDEST/30JS// (LINE 6)

RMKS/RECEIVED 30JS/TRANSFUSED 30JS/SHIPPED O/ (LINE 7)

REFRIGERATOR NEEDS REPAIR//

DECLAS (LINE 8)

*REPORT EXPLANATION:

(1) LINE 1, ASOFDTG: DAY-TIME ZONE OF THE BLDREP.

(2) LINE 2, REPUNIT: NAME, DESIGNATOR CODE, AND ACTIVITY BREVITY CODE OF REPORTING UNIT.

(3) LINE 3, BLDINVT: USED TO REPORT THE TOTAL NUMBER OF EACH BLOOD PRODUCT ON HAND AT THE END OF THE REPORTING PERIOD. TOTAL THE BLOOD PRODUCTS AT THE END OF THE REPORTING PERIOD.

(4) LINE 4, BLDREQ: USED TO REPORT THE TOTAL NUMBER OF EACH BLOOD PRODUCT REQUESTED AND TIME FRAME NEEDED.

(5) LINE 5, BLDEXP: USED TO REPORT THE ESTIMATE OF THE NUMBER OF EACH BLOOD PRODUCT WHICH WILL EXPIRE WITHIN THE NEXT SEVEN DAYS.

(6) LINE 6, BLDEST: USED TO REPORT THE ESTIMATE OF THE TOTAL NUMBER OF EACH BLOOD PRODUCT REQUIRED FOR RESUPPLY WITHIN THE NEXT 7 DAYS.

(7) LINE 7, CLOSTEXT OR RMKS: USED TO PROVIDE ADDITIONAL AMPLIFYING INFORMATION IF REQUIRED.

(8) LINE 8, DECL: MANDATORY IF THE MESSAGE IS CLASSIFIED.

APPENDIX 7

SAMPLE FORMAT (BLOOD REPORT) TO ANNEX T, MEDICAL REPORTS (CONTINUED)

_____ INF DIV TSOP

SAMPLE FORMAT B

VOICE TRANSMITTED BLOOD REPORT

LINE 1	151215Z
LINE 2	CHARLIE MIKE 34 HOTEL
LINE 3	20 JS
LINE 4	29 JSW POSITIVE 3 JSW NEGATIVE
LINE 5	2 JS POSITIVE
LINE 6	119 JS POSITIVE/21 JS NEGATIVE/TOTAL 140
LINE 7	RECEIVED 27JS POSITIVE AND 3 JS NEGATIVE, TRANSFUSED 17 JS POSITIVE AND 3 JS NEGATIVE, NO UNITS SHIPPED, REFRIGERATOR NEEDS REPAIR
LINE 8	(AUTHENTICATION IN ACCORDANCE WITH SOI)

*REPORT EXPLANATION

(1) LINE 1, ASOFDTG: DAY-TIME ZONE OF THE BLDREP.

(2) LINE 2, REPUNIT: NAME, DESIGNATOR CODE, AND ACTIVITY BREVITY CODE OF REPORTING UNIT.

(3) LINE 3, BLDINVT: USED TO REPORT THE TOTAL NUMBER OF EACH BLOOD PRODUCT ON HAND AT THE END OF THE REPORTING PERIOD. TOTAL THE BLOOD PRODUCTS AT THE END OF THE REPORTING PERIOD.

(4) LINE 4, BLDREQ: USED TO REPORT THE TOTAL NUMBER OF EACH BLOOD PRODUCT REQUESTED AND TIME FRAME NEEDED.

(5) LINE 5, BLDEXP: USED TO REPORT THE ESTIMATE OF THE NUMBER OF EACH BLOOD PRODUCT WHICH WILL EXPIRE WITHIN THE NEXT SEVEN DAYS.

(6) LINE 6, BLDEST: USED TO REPORT THE ESTIMATE OF THE TOTAL NUMBER OF EACH BLOOD PRODUCT REQUIRED FOR RESUPPLY WITHIN THE NEXT 7 DAYS.

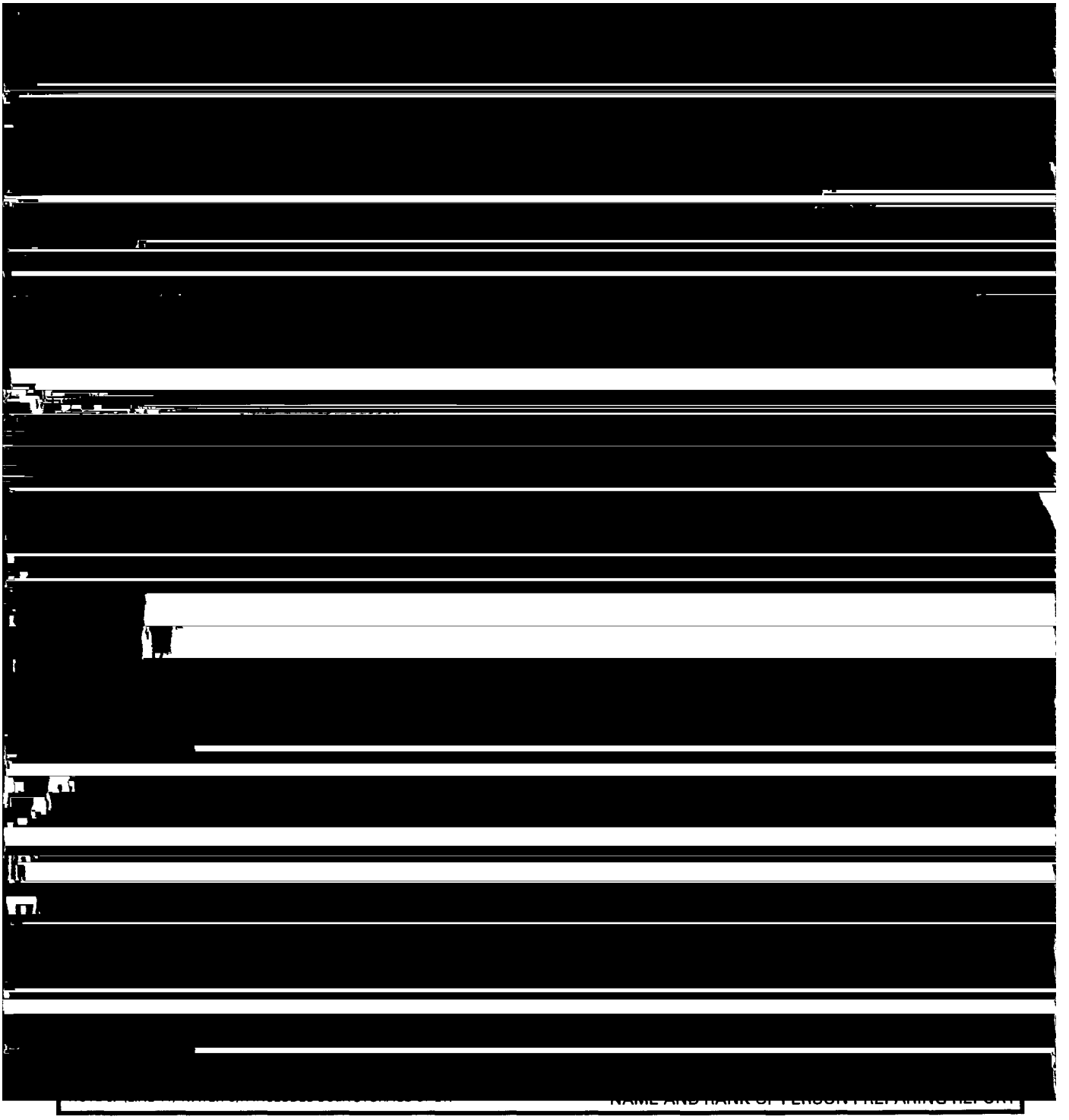
(7) LINE 7, CLOSTEXT OR RMKS: USED TO PROVIDE ADDITIONAL AMPLIFYING INFORMATION IF REQUIRED.

(8) LINE 8, AUTHENTICATE: AUTHENTICATION, IF REQUIRED.

Table B-1. Master Menu Codes

CATEGORY	CODE	DEFINITION
MANAGEMENT	A	JOINT BLOOD PROGRAM OFFICE (JBPO)
	B	AREA JOINT BLOOD PROGRAM OFFICE (AJBPO)
	C	ARMED SERVICES WHOLE BLOOD PROCESSING LABORATORY (ASWBPL)
	D	BLOOD DONOR CENTER (BDC)
	E	BLOOD PRODUCTS DEPOT (BPD)
	F	BLOOD TRANSSHIPMENT CENTER (BTC)
	G	BLOOD SUPPLY UNIT (BSU)
	H	MEDICAL TREATMENT FACILITY (MTF)
	I	NAVAL VESSEL (NV)
BLOOD PRODUCTS	J	RED BLOOD CELLS
	K	WHOLE BLOOD
	L	FROZEN RED BLOOD CELLS
	M	FRESH FROZEN PLASMA
	N	FROZEN PLATELETS *
	O	CRYOPRECIPITATE
	P	TO BE DETERMINED
BLOOD GROUPS	Q	RANDOM GROUP AND TYPE O, A, B
	R	RANDOM GROUP AND TYPE O, A
	S	RANDOM TYPE O
	T	RANDOM TYPE A
	U	RANDOM TYPE B
	V	RANDOM TYPE AB
TIME FRAME	W	REQUIRED WITHIN 12 HOURS
	X	REQUIRED WITHIN 24 HOURS
	Y	REQUIRED WITHIN 48 HOURS
MISCELLANEOUS	Z	NOT APPLICABLE OR SEE REMARKS

* THERE CURRENTLY ARE NO FROZEN PLATELETS. HOWEVER, THIS CODE IS USED WHEN DEALING WITH PLATELET CONCENTRATES WHEN THEY ARE POOLED RANDOM DONOR PLATELETS OR PLATELET PHERESIS CONCENTRATES.



APPENDIX 8

SAMPLE FORMAT (LOGISTICAL STATUS REPORT) TO ANNEX T,

MEDICAL REPORTS (CONTINUED)

LOGISTICAL STATUS REPORT (CONTINUED)

LINE 9: CL IX, REPAIR PARTS	O/H	REQUIRED
A.		
B.		
C.		
D.		
E.		
F.		
G.		
H.		
I.		
J.		
K.		
L.		
M.		
N.		
O.		
P.		
Q.		
R.		
S.		
T.		
U.		
V.		
W.		
X.		
Y.		
Z.		

LINE 10: VEH AND EQUIP	O/H	REQUIRED
A.		
B.		
C.		
D.		
E.		
F.		
G.		
H.		
I.		
J.		
K.		
LINE 11. WATER	**O/H**	**REQUIRED**
A. GALLONS		
LINE 12: OTHERS OR CONT. OF LINE	**O/H**	**REQUIRED**
A.		
B.		
C.		
D.		
E.		
F.		
G.		
H.		
I.		
J.		
K.		

LINE 12: OTHERS (CONT)	O/H	REQUIRED
L.		
M.		
N.		
O.		
P.		
Q.		
R.		
S.		
T.		

APPENDIX 9

SAMPLE FORMAT (TEAM MOVEMENT REPORT) TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

FM: MEDICAL COMPANY

TO: SUPPORT OPERATIONS FSB//SUPPORT OPERATIONS MSB//DIVISION MEDICAL OPERATIONS CENTER

INFORMATION: NONE

CLASSIFICATION: AS APPROPRIATE

SUBJECT: TEAM MOVEMENT REPORT

LINE ONE: UNIT WILL BE REPORTED AS ALPHA, BRAVO, CHARLIE, ETC.

LINE TWO: CURRENT LOCATION, SIX DIGIT GRID COORDINATES

LINE THREE: DEPARTURE AS OF: (DTG IN ZULU TIME)

LINE FOUR: DESTINATION AND ROUTE

LINE FIVE: ARRIVAL AS OF: (DTG IN ZULU TIME)

LINES TWO THROUGH FOUR ARE REPORTED PRIOR TO DEPARTURE FROM ANY SITE; LINE FIVE IS REPORTED UPC ARRIVAL.

APPENDIX 10

SAMPLE FORMAT (REPORT CODES) TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

1. PURPOSE: TO LIST MEDICAL CODES USED TO ASSIST MEDICAL UNITS IN FILLING OUT MEDICAL REPORTS AND CLASS VIII RESUPPLY REQUESTS.

2. FREQUENCY: N/A.

3. RESPONSIBILITY: DIVISION SURGEON.

4. ADDRESSEES: ALL MEDICAL UNITS.

5. TRANSMISSION: N/A.

6. REPORTS FORMAT: N/A.

7. REMARKS:

A. EACH MAJOR COMMAND (MACOM) ESTABLISHES REPORTING CODES WHICH MEET OPERATIONAL REQUIREMENTS FOR THEIR UNITS.

B. THE FOLLOWING TABLES (TABS) WILL ASSIST IN COMPILING THE REPORT AS REQUIRED.

APPENDIX 10

SAMPLE FORMAT (REPORT CODES) TO ANNEX T, MEDICAL REPORTS (CONTINUED)

_____ INF DIV TSOP

(1) TAB A: TABLE OF MINIMUM ESSENTIAL SUPPLY ITEMS

(2) TAB B: DISEASE CODES

(3) TAB C: AUTHORIZED ABBREVIATIONS

(4) TAB D: CAUSE OF CASUALTY

TAB A (TABLE OF MINIMUM ESSENTIAL SUPPLY ITEMS) TO APPENDIX 10 (REPORT CODES) TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

SURGICAL DRESSING MATERIEL

090	BANDAGE, GAUZE ROLLER
091	FIRST AID DRESSING
092	BURN DRESSING
093	GAUZE, ABSORBENT
094	BANDAGE, COTTON PLASTER OF PARIS, IMPREGNATED
095	COTTON WOOL, ABSORBENT

GASTROINTESTINAL

100	ANTIHELMINTIC
101	ANTIDIARRHEAL
102	ANTIDYSENTERIC
103	ANTACIDS

TAB A (TABLE OF MINIMUM ESSENTIAL SUPPLY ITEMS) TO

APPENDIX 10 (REPORT CODES) TO ANNEX T, MEDICAL REPORTS (CONTINUED)

_____ INF DIV TSOP

MISCELLANEOUS

110	DISINFECTANTS
111	ANTISEPTICS
112	DETERGENTS, SURGICAL
113	HYPODERMIC SYRINGES AND NEEDLES
114	SURGICAL SUTURE/LIGATURE MATERIEL
115	SPLINTING MATERIEL

TAB B (DISEASE CODES) TO APPENDIX 10 (REPORT CODES)

TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

DISEASE CODES

DISEASE	CODE
CHOLERA	000
TYPHOID FEVER	001
PARATYPHOID FEVER	002
OTHER SALMONELLA INFECTIONS	003
BACILLARY DYSENTERY	004
AMEBIASIS	006
OTHER ENTERIC INFECTION	008
PULMONARY TUBERCULOSIS	010
PLAGUE	020

TAB B (DISEASE CODES) TO APPENDIX 10 (REPORT CODES)

TO ANNEX T, MEDICAL REPORTS (CONTINUED)

_____ INF DIV TSOP

DISEASE CODES

DISEASE	CODE
TULAREMIA	021
ANTHRAX	022
BRUCELLOSIS	023
DIPHTHERIA	032
SCARLET FEVER	034
ERYSIPELAS	035
MENINGOCOCCAL INFECTION	036
TETANUS	037
ACUTE POLIOMYELITIS	043
SMALLPOX	050
CHICKEN POX	052
MEASLES	055
RUBEOLA	056
YELLOW FEVER	060
VIRAL ENCEPHALITIS (UNSPECIFIED)	065
INFECTIOUS HEPATITIS	070
EPIDEMIC PAROTITIS	072
MONONUCLEOSIS	075
EPIDEMIC LOUSE-BORNE TYPHUS	080
Q-FEVER	083

TAB B (DISEASE CODES) TO APPENDIX 10 (REPORT CODES)

TO ANNEX T, MEDICAL REPORTS (CONTINUED)

_____ INF DIV TSOP

DISEASE CODES

DISEASE	CODE
MALARIA	084
RELAPSING FEVER	088
SYPHILIS	090
BLENNORRHEA	098
VENEREAL ULCERS	099
LEPTOSPIROSIS	100
INFLUENZA	470
OTHER (IF THIS CODE IS USED, PROVIDE DETAILS.)	989

TAB C (AUTHORIZED ABBREVIATIONS) TO APPENDIX 10 (REPORT CODES)

TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

AUTHORIZED ABBREVIATIONS

ARMS AND SERVICES:

AVN	AVIATION
ABN	AIRBORNE
AD	AIR DEFENSE
AMINF	ARMED INFANTRY

TAB C (AUTHORIZED ABBREVIATIONS) TO APPENDIX 10 (REPORT CODES)

TO ANNEX T, MEDICAL REPORTS (CONTINUED)

_____ INF DIV TSOP

AUTHORIZED ABBREVIATIONS

ARMS AND SERVICES:

AMPB	AMPHIBIOUS
ARMD	ARMORED
ARTY	ARTILLERY
AT	ANTITANK
ATGM	ANTITANK GUIDED MISSILE

COMMAND LEVEL:

AG	ADJUTANT GENERAL
BDE	BRIGADE
BN	BATTALION
CO	COMPANY
DIV	DIVISION
GP	GROUP
HQ	HEADQUARTERS
PLT	PLATOON
RGT	REGIMENT

NATIONALITY:

BE	BELGIAN
CA	CANADIAN
GE	GERMAN
NL	NETHERLANDS/HOLLAND

TAB C (AUTHORIZED ABBREVIATIONS) TO APPENDIX 10 (REPORT CODES) TO ANNEX T, MEDICAL REPORTS (CONTINUED)

_____ INF DIV TSOP

AUTHORIZED ABBREVIATIONS

NATIONALITY:	
UK	BRITISH
US	AMERICAN

TAB D (CAUSE OF CASUALTY) TO APPENDIX 10 (REPORT CODES) TO ANNEX T, MEDICAL REPORTS

_____ INF DIV TSOP

CAUSE OF CASUALTY TO BE USED FOR MASS CASUALTY REPORTING.

ACCIDENT:	AIRCRASH
ACCIDENT:	MARITIME
ACCIDENT:	MOTOR VEHICLE
ACCIDENT:	RAILWAY
ACCIDENT:	FIRE
ACCIDENT:	INDUSTRIAL
ACCIDENT:	POISON
ACCIDENT:	NATURAL DISASTERS
ACCIDENT:	OTHER CAUSES
BATTLE:	CONVENTIONAL
BATTLE:	NUCLEAR
BATTLE:	BIOLOGICAL
BATTLE:	CHEMICAL

GLOSSARY

ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

A2C2 Army airspace command and control

AAD admission and disposition

ABCA American, British, Canadian, and Australian

ACO airspace control order

ACP airspace control plan

ACM airspace control measures

ACUS area common-user system

ADC area damage control

admin administration

ADP automatic data processing

ADSO assistant division signal officer

AG Adjutant General

AM amplitude modulated

AMEDD Army Medical Department

AMEDDC&S Army Medical Department Center and School

AM-IHFR amplitude modulated—improved high-frequency radio

AMRT amplitude modulated receiver transmitter

AO area of operations

AOC area of concentration

AR Army regulation

Armed Services Whole Blood Processing Laboratories Tri-Service operated facilities located at USAF airheads in CONUS that receive blood from CONUS-based blood donor centers. Its functions include replacing blood from the blood donor centers, storing blood, and distributing blood to Blood Transshipment Centers located in the communications zone.

assign To place units or personnel in an organization where such placement is relatively permanent and/or where such organization controls, administers, and provides logistical support to units or personnel for the primary function, or greater portion of the functions, of the unit or personnel.

asst assist/assistant

ASWBPL See Armed Services Whole Blood Processing Laboratories.

ATACS Army Tactical Communication System

ATCCS Army Tactical Command and Control System

ATCCS-CHS Army Tactical Command and Control System—Common Hardware/Software

ATF aviation task force

atch See attach.

attach(ed) The temporary placement of units or personnel in an organization. Subject to limitations imposed by the attachment order, the commander of the formation, unit, or organization receiving the attachment will exercise the same degree of command and control

thereover as he does over units and persons organic to his command. However, the responsibility for transfer and promotion of personnel will normally be retained by the parent formation, unit, or organization.

augmentation The addition of specialized personnel and/or equipment to a unit.

authorized stockage list A list of items from *all* classes of supply authorized to be stocked at a specific echelon of supply.

AVIM aviation intermediate maintenance

avn aviation

AXP ambulance exchange point

BAS battalion aid station

basic load For other than ammunition, basic loads are supplies kept by using units in combat. The quantity of each item of supply in a basic load is related to the number of days in combat the unit may be sustained without resupply.

bde brigade

BF battle fatigue

biological agent A microorganism that causes diseases in man, plants, and animals, or causes the deterioration of materiel.

BLDREP blood report

Blood Transshipment Center A United States Air Force operated facility located in the communications zone that receives blood from CONUS-based Armed Services Whole Blood Processing Laboratories. Its functions include inspecting, re-icing, storing, and issuing blood to blood supply units, medical treatment facilities, and medical treatment elements.

bn battalion

boundary A control measure normally drawn along identifiable terrain features and used to delineate areas of tactical responsibility for subordinate units. Within their boundaries, units may maneuver within the overall plan without close coordination with neighboring units unless otherwise restricted. Direct fire may be placed across boundaries on clearly identified enemy targets without prior coordination, provided friendly forces are not endangered. Indirect fire also may be used after prior coordination.

- *Lateral boundaries* are used to control combat operations of adjacent units.
- *Rear boundaries* are established to facilitate command and control.

br branch

brigade support area A designated area in which combat service support elements from the division support command and the corps support command provide logistic support to a brigade. The brigade support area normally is located 20 to 25 kilometers behind the forward edge of the battle area.

BSA *See* brigade support area.

BTC *See* Blood Transshipment Center.

built-up area A concentration of structures, facilities, and population.

C/ch chief

C2 *See* command and control.

camouflage The use of concealment and disguise to minimize detection or identification of troops, weapons, equipment, and installations.

It includes taking advantage of the immediate environment as well as using natural and artificial materials.

casualty Any person who is lost to his organization by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing in action, beleaguered, besieged, or detained.

cbt combat

CDR commander

CH chaplain

chain of command The succession of commanding officers from a superior to a subordinate through which command is exercised.

chemical agent A chemical substance intended for use in military operations to kill, seriously injure, or incapacitate man through its physiological effects. Excluded are riot control agents, herbicides, smoke, and flame.

CHL combat health logistics

CHS *See* combat health support.

cl class

cmd command

co/CO company/commanding officer

collecting point (health services) A specific location where casualties are assembled to be transported and/or medically evacuated to a medical treatment facility; for example, a company aid post.

combat health support All support services performed, provided, or arranged by the Army Medical Department to promote, improve, conserve, or restore the mental and/or physical well-being of personnel in the Army and, as directed, in other services, agencies, and organizations. These services include, but are not limited to, the management of health service resources such as manpower, monies, and facilities; preventive and curative health measures; the health service doctrine; evacuation of the sick (physically and mentally), injured, and wounded; selection of the medically fit and disposition of the medically unfit; medical supply, equipment, and maintenance thereof; and medical, dental, veterinary, laboratory, optometric, and medical food services.

combat intelligence That knowledge of the enemy, weather, and geographical features required by a commander in planning and conducting combat operations. It is derived from the analysis of information on the enemy's capabilities, intentions, and vulnerabilities and the environment.

combat maneuver forces Those forces which use fire and movement to engage the enemy with direct fire weapon systems, as distinguished from those forces which engage the enemy with indirect fires or otherwise provide combat support. These elements are primarily infantry, armor, cavalry (air and armored), and aviation.

combat medic A medical specialist trained in emergency medical treatment procedures and assigned or attached in support of a combat or combat support unit.

combat service support The essential capabilities, functions, activities, and tasks necessary to sustain all elements of operating forces in theaters at all levels of war. Within the national and theater logistic systems, it includes but is not limited to that support rendered by service forces in ensuring the aspects of supply, maintenance, transportation, health

services, and other services required by aviation and ground combat troops to permit those units to accomplish their mission in combat. Combat service support encompasses those activities at all levels of war that produce sustainment of all operating forces on the battlefield. It includes the functional areas of supply, transportation, maintenance, combat health support, personnel support, and field services. Also, besides supporting an "operating force" that may be joint, multinational, and/or interagency in nature, Army CSS may involve providing support to civilians, such as refugees, disaster victims, or members of other agencies.

combat support Fire support and operational assistance provided to combat elements. May include artillery, air defense, aviation (less air cavalry and attack helicopter), engineer, military police, signal, and electronic warfare.

combat trains The portion of unit trains that provides the combat service support required for immediate response to the needs of forward tactical elements. At company level, medical, recovery, and maintenance elements normally constitute the combat trains. At battalion, the combat trains normally consist of ammunition and petroleum, oils and lubricants vehicles, maintenance/recovery vehicles and crews, and the battalion aid station.

comm communication

command and control The exercise of command that is the process through which the activities of military forces are directed, coordinated, and controlled to accomplish the mission. This process encompasses the personnel, equipment, communications, facilities, and procedures necessary to gather and analyze information, to plan for what is to be done, and to supervise the execution of operations.

command group A small party that accompanies the commander when he departs the command post to be present at a critical action. The party is organized and equipped to suit the commander and normally provides local security and other personal assistance for the commander as he requires.

command post The principal facility employed by the commander to command and control combat operations. A command post consists of those coordinating and special staff activities and representatives from supporting Army elements and other services that may be necessary to carry out operations. Corps and division headquarters are particularly adaptable to organization by echelon into a tactical command post, a main command post, and a rear command post.

commander's estimate The procedure whereby a commander decides how best to accomplish the assigned mission. It is a thorough consideration of the mission, enemy, terrain, troops, and time available, and other relevant factors. The commander's estimate is based on personal knowledge of the situation and on staff estimates.

commander's intent Commander's vision of the battle—how he expects to fight and what he expects to accomplish.

communications security The protection resulting from all measures designed to deny unauthorized persons information of value that might be derived from the possession and study of telecommunications, or to mislead unauthorized persons in their interpretation of the results of such possession and study. Includes cryptosecurity, transmission security, emission security, and physical security of communications security materials and information.

communications zone That rear area of the theater of operations, behind but contiguous to the combat zone, that contains the lines of communication, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces.

concealment The protection from observation.

concept of operations A graphic, verbal, or written statement in broad outline that gives an overall picture of a commander's assumptions or intent in regard to an operation or series of operations; includes at a minimum the scheme of maneuver and the fire support plan. The concept of operations is embodied in campaign plans and operation plans particularly when the plans cover a series of connected operations to be carried out simultaneously or in succession. It is described in sufficient detail for the staff and subordinate commanders to understand what they are to do and how to fight the battle without further instructions.

CONUS continental United States

CP *See* command post.

CSC combat stress control

CSH combat support hospital

CSM Command Sergeant Major

CSS *See* combat service support.

DA Department of the Army

DD Department of Defense

DDL Daily Disposition Log

direct support (1) A mission requiring a force to support another specific force and authorizing it to answer directly the supported force's request for assistance. (2) In the North Atlantic Treaty Organization, the support provided by a unit or formation not attached to, nor under command of, the supported unit or formation, but required to give priority to the support required by that unit or formation.

DISCOM division support command

disp disposition

displace To leave one position and take another. Forces may be displaced laterally to concentrate combat power in threatened areas.

div division

division support area An area normally located in the division rear positioned near air landing facilities and along the main supply route.

DMHS division mental health section

DMMC division materiel management center

DMMO division materiel management office(r)

DMOC division medical operations center

DMSO division medical supply office

DNBI disease and nonbattle injury

DOD Department of Defense

DS *See* direct support.

DSA *See* division support area.

DTG date-time group

DTO division transportation officer

Echelon I (Level I) Unit level—The first medical care a soldier receives is provided at this level. This care includes immediate lifesaving measures, advanced trauma management, disease prevention, combat stress control prevention, casualty collection, and evacuation from supported unit to supporting medical treatment. Echelon I elements are located throughout the combat and communications zones. These elements include the combat lifesaver, combat medic, and battalion aid station. Some or all of these elements are found in maneuver, combat support, and combat service support units. When Echelon I is not present in a unit, this support is provided to that unit by Echelon II medical units.

Echelon II (Level II) Duplicates Echelon I and expands services available by adding dental, laboratory, x-ray, and patient holding capabilities. Emergency care, advanced trauma management, including beginning resuscitation procedures, is continued. (No general anesthesia is available.) If necessary, additional emergency measures are instituted; however, they do not go beyond the measures dictated by the immediate needs. Echelon II units are located in the combat zone-brigade support area, corps support area, and communications zone. Echelon II medical support may be provided by a clearing station, forward support medical company, main support medical company, forward support battalion medical company, main support battalion medical company, corps area medical companies, area support medical company (Medical Force 2000), and communications zone medical companies.

Echelon III (Level III) This echelon of support expands the support provided at Echelon II (division level). Casualties who are unable to tolerate and survive movement over long distances will receive surgical care in hospitals as close to the division rear boundary as the tactical situation will allow. This may be provided within the division area under certain operational conditions. Echelon III characterizes the care that is provided by units such as the mobile army surgical hospital, the combat support hospital, and the evacuation hospital. Operational conditions may require Echelon III units to locate in offshore support facilities, third country support bases, or in the communications zone.

Echelon IV (Level IV) This echelon of care is provided in a general hospital and in other communications zone-level facilities which are staffed and equipped for general and specialized medical and surgical treatment. This echelon of care provides further treatment to stabilize those patients requiring evacuation to the CONUS. This echelon also provides area combat health support to soldiers within the communications zone.

echelon of care A North Atlantic Treaty Organization term which can be used interchangeably with the term *level of care.*

echeloned displacement Movement of a unit from one position to another without discontinuing performance of its primary function. Normally, the unit divides into two functional elements (base and advance); and, while the base continues to operate, the advance element displaces a new site where, after it becomes operational, it is joined by the base element.

echelonment Arrangement of personnel and equipment into assault, combat follow-up, and rear components or groups.

emergency medical treatment The immediate application of medical procedures to the wounded, injured, or sick by specially trained medical personnel.

EPW enemy prisoner of war

essential elements of friendly information The critical aspects of a friendly operation that, if known by the enemy, would subsequently compromise, lead to failure, or limit success of the operation and, therefore, must be protected from enemy detection.

evac *See* evacuation.

evacuation (1) A combat service support function which involves the movement of recovered materiel from a main supply route, maintenance collecting point, and maintenance activity to higher levels of maintenance. (2) The process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities.

evacuation policy A command decision indicating the length in days of the maximum period of noneffectiveness that patients may be held within the command for treatment. Patients who, in the opinion of an officiating medical officer, cannot be returned to duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities.

FARPs forward area rearm/refueling points

FAX facsimile

FM field manual/frequency modulated

FMC US Field Medical Card

FM-VHF frequency modulated–very high frequency

forward edge of the battle area The forward limit of the main battle area.

forward line of own troops A line that indicates the most forward positions of friendly forces in any kind of military operation at a specific time. The forward line of own troops may be at, beyond, and short of the forward edge of the battle area, depicting the nonlinear battlefield.

fragmentary order An abbreviated form of an operation order used to make changes in mission to units and to inform them of changes in the tactical situation.

FSB forward support battalion

FSMC forward support medical company

G1 Assistant Chief of Staff (Personnel)

G2 Assistant Chief of Staff (Intelligence)

G3 Assistant Chief of Staff (Operations and Plans)

G4 Assistant Chief of Staff (Logistics)

G5 Assistant Chief of Staff (Civil Affairs)

general support Support that is given to the supported force as a whole and not to any particular subdivision thereof.

genr generator

GRC ground radio communication

GS *See* general support.

GSE ground support equipment

HF high frequency

HHC headquarters and headquarters company

hlth health

HQ headquarters

HSMO health service materiel officer

HSSO health service support officer

IHFR improved high-frequency radio

information requirements Those items of information regarding the enemy and his environment which need to be collected and processed in order to meet the intelligence requirements of a commander.

intel *See* intelligence.

intelligence The product resulting from the collection, evaluation, analysis, integration, and interpretation of all available information concerning an enemy force, foreign nations, or areas of operations, and which is immediately or potentially significant to military planning and operations.

intelligence preparation of the battlefield A systematic approach to analyzing the enemy, weather, and terrain in a specific geographic area. It integrates enemy doctrine with the weather and terrain as they relate to the mission and the specific battlefield environment. This is done to determine and evaluate enemy capabilities, vulnerabilities, and probable courses of action.

IV intravenous

kHz kilohertz

KP kitchen police

kw kilowatt

LAN local area network

lines of communication All the routes (land, water, and air) that connect an operating military force with one or more bases of operations and along which supplies and military forces move.

LOC *See* lines of communication.

local security Those security elements established in the proximity of a unit to prevent surprise by the enemy.

log *See* logistics.

logistics The planning and carrying out of the movement and the maintenance of forces. In its most comprehensive sense, those aspects of military operations which deal with—(1) design and development, acquisition, storage, movement, maintenance, and distribution of material; (2) movement, evacuation, and hospitalization of personnel; (3) acquisition or construction, maintenance, operation, and disposition of facilities; and (4) acquisition or furnishing of services.

LTOE living table(s) of organization and equipment

MACOM major Army command

main battle area That portion of the battlefield extending rearward from the forward edge of the battle area and in which the decisive battle is fought to defeat the enemy attack. Designation of the main battle area includes the use of lateral and rear boundaries. For any particular command, this area extends from the forward edge of the battle area to the rear boundaries of those units comprising its main defensive forces.

maint maintainer/maintenance

MASH mobile army surgical hospital

mat materiel

MCC movement control center

MCO movement control office(r)

med medical

medical equipment set A chest containing medical instruments and supplies designed for specific table of organization and equipment units or missions.

medical intelligence A functional area of technical intelligence resulting from the collection, evaluation, analysis, and interpretation of foreign medical, biotechnological, and environmental information.

medical treatment facility Any facility established for the purpose of providing medical treatment. This includes aid stations, clearing stations, dispensaries, clinics, and hospitals.

MEDLOG medical logistics

MEDMNT medical maintenance

MEDSTEP Medical Standby Equipment Program

MEDSUP medical supply

MES *See* medical equipment set.

METT-T mission, enemy, terrain, troops, and time available

mgt management

MMMB medical materiel management branch

MOOTW military operations other than war

MOS military occupational specialty

MPL mandatory parts lists

MRO medical regulating office(r)

MSB main support battalion

MSE mobile subscriber equipment

MSMC main support medical company

MSR main supply route

MSRT mobile subscriber radiotelephone terminal

MTF *See* medical treatment facility.

MTOE modified table(s) of organization and equipment

NATO North Atlantic Treaty Organization

NBC nuclear, biological, and chemical

NC node center/no change

NCO noncommissioned officer

NLT not later than

NP neuropsychiatric

NRTD nonreturn to duty

ofc office

off officer

OP operator

OPCOM *See* operational command

OPCON *See* operational control.

operational command The authority granted to a commander to assign missions or tasks to subordinate commanders, to deploy units, to reassign forces, and to retain or delegate operational and/or tactical control as may be deemed necessary. It does not of itself include responsibility for administration or logistics. May also be used to denote the forces assigned

to a commander. DOD: The term is synonymous with operational control and is uniquely applied to the operational control exercised by the commanders of unified and specified commands over assigned forces in accordance with the National Security Act of 1947, as amended and revised (Title 10, United States Code 124).

operational control The authority delegated to a commander to direct forces assigned so that the commander may accomplish specific missions or tasks that are usually limited by function, time, or location; to deploy units concerned; and to retain or assign tactical control of those units. It does not of itself include administrative or logistic control. In the North Atlantic Treaty Organization, it does not include authority to assign separate employment of components of the units concerned.

operation annexes Those amplifying instructions which are too voluminous or technical to be included in the body of the plan or order.

operation map A map showing the location and strength of friendly forces involved in an operation. It may indicate predicted movement and location of enemy forces.

operation order A directive issued by a commander to subordinate commanders for effecting the coordinated execution of an operation; includes tactical movement orders.

operation overlay Overlay showing the location, size, and scheme of maneuver/fires of friendly forces involved in an operation. As an exception, it may indicate predicted movements and locations of enemy forces.

operation plan A plan for a military operation. It covers a single operation or series of connected operations to be carried out simultaneously or in succession. It implements operations derived from the campaign plan. When the time and/or conditions under which the plan is to be placed in effect occur, the plan becomes an operation order.

OPLAN *See* operation plan.

OPORD *See* operation order.

ops operations

PAD patient administration and disposition

PSD personnel service detachment

PE&MR Patient Evacuation and Mortality Report

PLL prescribed load list

plt platoon

PMCS preventive maintenance checks and services

pnt patient

POL petroleum, oils and lubricants

PSR Patient Summary Report

PVNTMED preventive medicine

QSTAG Quadripartite Standardization Agreement

reconstitution The total process of keeping the force supplied with various supply classes, services, and replacement personnel and equipment required to maintain the desired level of combat effectiveness and of restoring units that are not combat effective to the desired level of combat effectiveness through the replacement of critical equipment and personnel. Reconstitution encompasses unit regeneration and sustaining support.

rept report

ROZ restricted operations zones

rpts reports

RTD return to duty

S1 Adjutant (US Army)

S2 Intelligence Officer (US Army)

S3 Operations and Training Officer (US Army)

S4 Supply Officer (US Army)

SAAFRs standard Army aircraft flight routes

SB supply bulletin

sec section

SGT sergeant

SICP standard integrated command post

SINCGARS single-channel ground and airborne radio system

SOI signal operation instructions

SOP standing operating procedures

SPC/spec specialist

Spt support

Sr senior

STANAG See Standardization Agreement.

Standardization Agreement The record of an agreement among several nations to adopt like or similar military equipment; ammunition; supplies and stores; and operation, administrative, and logistics procedures.

sup supply

supv supervisor

surg surgeon/surgical

svc service

TACCS Tactical Army Combat Service Support (CSS) Computer System

TAMMIS Theater Army Medical Management Information System

TB techrical bulletin

tech technician

technical control The specialized professional guidance and direction exercised by an authority in technical matters.

theater of operations That portion of an area of conflict necessary for the conduct of military operations, either offensive or defensive, to include administration and logistical support.

TM technical manual/team

TMDE test, measurement, and diagnostic equipment

TOC tactical operations center

TOE table(s) of organization and equipment

TSOP tactical standing operating procedure

ULC unit-level computer

US United States

USAF United States Air Force

veh vehicle

VHF very high frequency

warning order A preliminary notice of an action or order that is to follow. Usually issued as a brief oral or written message, it is designed to give subordinates time to make necessary plans and preparations.

WX weather

XO executive officer

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